

SEPTEMBER/OCTOBER 2008

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Health First medical quality initiatives

For Medical Staff members
at CCH, HRMC, and PBH

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Quality Leads: Pressure ulcer rule change impacts physicians *By Jim Palermo, MD, HF Chief Quality Officer*

Starting this October, Medicare will no longer routinely pay to treat hospital-acquired pressure ulcers, stating in its new guidelines that pressure ulcers can “reasonably be prevented through the application of evidence-based guidelines.”

[Read complete article](#)



e-Physician: Electronic prescribing (e-prescribing) *By David P. Hurwitz, MD, HF Medical Director of Clinical Informatics*

The prescription pad has long been a mainstay of medical practice. Prescribing medication often punctuates the end of a clinical encounter, occurring for example at hospital discharge or at the conclusion of an outpatient office visit. As of March 2008, only about seven percent of the 560,400 office-based physicians in the United States were actively writing electronic prescriptions (e-prescriptions).

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Physician e-Xcellence is published by Health First for physicians on the Medical Staffs at Cape Canaveral Hospital (CCH), Holmes Regional Medical Center (HRMC), and Palm Bay Hospital (PBH).

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Quality Leads:

Pressure ulcer rule change impacts physicians



By Jim Palermo, MD, HF Chief Quality Officer

Starting this October, Medicare will no longer routinely pay to treat hospital-acquired pressure ulcers, stating in its new guidelines that pressure ulcers can “reasonably be prevented through the application of evidence-based guidelines.” The new guideline also carries significant responsibility for physicians regarding pressure ulcer documentation.

Patients with a secondary diagnosis of a pressure ulcer at discharge will not be assigned to a higher-paying MS-DRG unless the ulcer was “present-on-admission” (POA) and documented as such by the physician in the patient’s history and physical (H&P) in the patient’s medical record—with treatment and prevention recommendations also documented in the medical record progress notes. Treatment documentation is crucial to show that caregivers did everything possible to prevent a POA pressure ulcer from worsening. Physicians must also fully document any extenuating circumstances that might place a patient at risk for developing a pressure ulcer, such as a head injury that requires immobilization.

In addition to documenting the pressure ulcer as POA, its location and stage must be clearly documented in the patient’s H&P, so it’s important to become familiar with recent changes to the National Pressure Ulcer Advisory Panel’s staging guidelines. In February 2007 the panel added two new pressure ulcer categories and definitions for “deep-tissue injury” and “unstageable.” These changes have been incorporated into HF policies and our Certified Wound Ostomy Continence Nurses (CWO CN) are providing pocket-sized “staging cards” for all physicians on staff at HF hospitals. The cards contain photos plus descriptions of the six categories considered to be official pressure ulcer stages.

“We also want physicians to know that we’re available at each facility as a resource,” says **Donna Crossland, RN, BSN, CWO CN**, the Wound/Ostomy/Continence nurse at CCH. “The physician who’s responsible for this new documentation requirement is the doctor who’s admitting the patient. We’re asking Emergency Department [ED] personnel to pass along any information to the admitting physician if a suspected pressure ulcer is noticed in the ED.”

Crossland and her HRMC counterparts—Shawna Philbin, RN, BSN, CWO CN, and Lynne Lake RN, BSN, CWO CN—are part of an HF team looking at the impact of the new Medicare rule. A systemwide education effort is underway to heighten nurse and physician awareness of POA pressure ulcers and emphasize pressure ulcer prevention.

“We need to document that patients and family members are being educated on risk factors related to pressure ulcers and stress the importance of early mobilization, off-loading, and nutrition,” says Philbin.

Based on a pressure ulcer risk assessment using the Braden Scale Assessment tool, a nurse may begin implementation of HF’s Pressure Ulcer Prevention Protocol (PUPP), and will then seek a physician’s order to implement other treatments in the PUPP. Standard order sets for treatment and prevention when a physician documents a POA pressure ulcer are currently being developed and were expected to be approved and in place starting this September.

I appreciate your efforts to help prevent pressure ulcers in our patient population and your attention to this important new documentation requirement. Hospital-acquired pressure ulcer rates will eventually be listed on publicly-reported quality-of-care reports, both for hospitals and physicians. This new rule is also yet another sign of the growing Medicare emphasis on pay-for-performance based on measurable, pre-established best practice and outcome expectations.

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e-Physician

What IT can do for YOU, and what YOU can do with IT

Electronic prescribing (e-prescribing)

By David P. Hurwitz, MD,
HF Medical Director of
Clinical Informatics



The prescription pad has long been a mainstay of medical practice. Prescribing medication often punctuates the end of a clinical encounter, occurring for example at hospital discharge or at the conclusion of an outpatient office visit. As of March 2008, only about seven percent of the 560,400 office-based physicians in the United States were actively writing electronic prescriptions (e-prescriptions). Since the majority of medication prescriptions remain handwritten, the possibility of legibility error remains pervasive. Incorrect interpretation of illegible handwritten prescriptions by pharmacists can lead to drug-dispensing errors, increasing the risk for significant harm to patients, which can be severe or fatal. According to the Institute of Medicine, 1.5 million Americans are injured every year by drug errors.

The screenshot below is an actual prescription written by a cardiologist from a highly publicized case of prescription legibility error.

MEDICAL CENTER HOSPITAL
500 - 600 W 4TH STREET ODESSA, TEXAS Ph 333 7111

FOR [Illegible] AGE _____
ADDRESS [Illegible] DATE 6/23/05

Plendil 20mg # 120 -
20mg P.O. Q6hr

NO REFILLS REFILLS _____
FERRUS SULFATE 300mg # 100
300mg P.O. TID E meals

LABEL Humulin N
30 units SQ Q6hr
[Signature]

PRODUCT SELECTION PERMITTED DISPENSE AS WRITTEN

D.E.A. # _____

730 637 7100 1H 88-270

Three medications were prescribed for this patient. The bottom two—Ferrous Sulfate and Humulin N—are legible, but the name of the first medication prescribed is far less clear. The prescribing cardiologist intended to prescribe Isordil, 20 mg four times per day for angina. The pharmacist interpreted the prescription to be Plendil (a calcium channel blocker), 20 mg four times per day. Although the maximum dose of Plendil is 10 mg per day, the patient was dispensed this medication at a dose of 20 mg four times per day. The following day, the patient began experiencing palpitations and sought treatment at a local emergency room where he was diagnosed with myocardial infarction and died several days later. Although pharmacist error (not recognizing the inappropriate dose of Plendil) clearly contributed to this patient’s death, the illegible prescription was the initiating factor.

Additionally, illegible prescriptions often result in pharmacy call-backs to physicians. The Centers for Medicare & Medicaid Services (CMS) estimates there are approximately 150 million phone calls annually from pharmacists to physicians to decipher their prescriptions. This adds substantial work burden on pharmacists, physicians, and their staffs.

Illegibility errors have led CMS and many organizations to call for physicians to move to e-prescribing, which is analogous to sending a prescription to a pharmacy via a secure email. E-prescribing technology is currently available and can be used in a standalone manner or integrated into an electronic health record.

Some benefits of e-prescribing include:

- Legible prescriptions
- Rapid, secure transmission to a pharmacy
- Decision support capability, e.g., drug-drug interaction checking, drug-allergy checking, patient health plan formulary, and drug-cost availability
- Bi-directional communication between the pharmacy and physician—the pharmacy electronically notifies the physician when prescriptions are due, when the patient has filled a prescription, and can inform the e-prescribing physician of all medications filled by the patient, including ones prescribed by other physicians

(continued on page 4)

- Patient satisfaction— because of reducing or eliminating patient or caregiver wait times for picking up the prescription at the pharmacy
- Interim step for physicians who have not yet adopted electronic health records to incorporate one component of healthcare IT into their practice

Some of the disadvantages include:

- Cost—estimates from CMS for e-prescribing are approximately \$3,000 per physician to purchase and install the system, with monthly maintenance costs ranging from \$80 to \$400.
- No current controlled-substance e-prescribing capability (Note: the US Drug Enforcement Agency has proposed new regulations allowing e-prescribing Schedule II and higher controlled substances)
- Incomplete pharmacy participation (approximately 73 percent of 57,000 retail pharmacies had received e-prescriptions as of March 2008)
- Standalone e-prescribing that is not integrated into an electronic health record is less efficient due to:
 1. Redundant data entry, including patient demographics, medication list, and allergy history
 2. Less efficient access to clinical information needed for making more fully informed prescribing decisions—e.g., availability of lab data that might be notable for a recent elevated serum potassium level, which is relevant when prescribing ACEI or ARB drugs

To help overcome the cost barrier for physicians, CMS will begin paying bonuses next year to physicians who e-prescribe, though over time, the bonuses will be phased out and replaced with penalties for those who do not e-prescribe (see chart below):¹

<u>Year</u>	<u>Incentive</u>	<u>Penalty</u>
2009	2%	None
2010	2%	None
2011	1%	None
2012	1%	1%
2013	0.5%	1.5%
2014 & beyond	None	2%

*Source: The Medicare Improvements for Patients and Providers Act of 2008

Whether or not these financial incentives and penalties will be enough to encourage the vast majority of physicians to adopt e-prescribing is unclear. For e-prescribing to be successful, it must be easy to set up and use, reliable, secure, efficient, and reasonable in cost. Additionally, all

pharmacies need to be ready to accept e-prescriptions, and laws need to be updated to permit electronic controlled substance prescribing.

While the above discussion is focused primarily on physician office-based e-prescribing, there is also a substantial opportunity to incorporate e-prescribing within Sunrise Clinical Manager (SCM) to help make discharge prescribing more efficient, seamless, and safer within the electronic health record environment. The “Prescription Writer” module of SCM, while not commonly used, can be configured to incorporate e-prescribing functionality. I’m currently exploring how to make this happen, which most likely will occur after SCM is upgraded to its newest version (5.0) next year. Eventually, I expect e-prescribing at discharge to become the norm across all Health First hospitals and a key component of efforts to provide safe, high-quality, and efficient care for our patients.

Reference:

1. From: Glendinning, David. “E-prescribers see Medicare bonus, but late adopters will face pay cut” *AMNews*. Online at [amednews.com](http://www.ama-assn.org/amednews/2008/08/04/gvl10804.htm) (Aug. 4, 2008): <http://www.ama-assn.org/amednews/2008/08/04/gvl10804.htm>

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Patient Safety:



Hand hygiene: Physicians as role models

By Jim Palermo, MD, HF Chief Quality Officer

One of the first things we learn in medical school is that proper hand hygiene is an important way we can protect our patients. Chances are that message of “wash your hands” even began in childhood, with lots of reminders from our parents. So why do so many doctors fail to follow this proven standard of safe, preventive care?

“Why do so many doctors fail to follow this proven standard of preventive care?”

What’s the reality?

Our observational data suggests that physicians are the least likely members of the healthcare team to adhere to our hand-hygiene policy, which requires hand washing or use of the alcohol rub before and after patient contact both in and out of patient rooms.

Getting into the habit

Instilling hand hygiene as a “habit” or second-nature action into a physician culture requires a belief that the value of hand hygiene to both patients and physicians outweighs the “hassle factor” and time commitment of methodical hand washing or use of alcohol rub. Our professional literature and the lay media is rife with data, as well as compelling outcomes and stories that clearly and unquestionably identify hand hygiene as the most important deterrent to hospital-acquired infections.

“So, as data-driven disciples of evidence-based-medicine, why have we physicians not universally incorporated hand hygiene into our workflow?”

I’m asking you to make it a personal matter and ask yourself that question. There may be some elements of evidence-based medicine that you don’t particularly subscribe to, but the fundamental premise of the value of hand hygiene is not only evidence-based but also intuitive.

“Be a role model for other members of the healthcare team and your patients.”

You’re the role model

You are held in very high regard and respected by all of the other members of the healthcare team as a role model for them and your patients. Health First has put alcohol-based hand-rub solutions within easy reach of all patient care settings. Use them and tell your patients that you’re sanitizing your hands to protect them. They’ll appreciate your efforts to fight the spread of healthcare-related infections. That’s the standard of care we expect for our families and ourselves. We owe our patients nothing less.

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2008 Hurricane Season: An update

The already busy 2008 Atlantic Hurricane Season reminds us of the critical need to prepare *before* a storm threatens. In addition to reviewing this year's one-page "2008 Hurricane Season: A Physician's Guide" *Physician e-Xcellence* Supplement, which you can find on the HF intranet, *Inside Health First*, by clicking on "Physician Toolbox" > "Physician e-Xcellence" > 2008: "June/July Supplement", here are some more recent updates and reminders:



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hospitals. These suggestions would guide immediate, intermediate, and long-term physician response to emergency events—with areas of focus to include influx of patients and hurricane-related responses. The Committee welcomes physician input to this planning process. Contact **Safety & Security VP Jim Kendig** at 434-5224 to get involved.

- **Quest Elementary School** is the site of this year's special needs shelter that will be staffed by Health First associates when and if activated. Physicians on HF hospitals' Medical Staffs may volunteer to assist at this facility, and those assisting may also evacuate their families to this location if needed. Contact **Jim Kendig** at the above number for more information on this or any emergency response-related question.

Physician 2008 Hurricane Season updates

- Call the Medical Staff Office at CCH, HRMC, or PBH when a storm warning is issued to ensure they have your contact information. Communication interruptions are one of the most common problems in a storm's aftermath, so provide multiple means of contact.
- Before an impending storm, the **Health First Information Hotline** at 321-434-8989 will be activated. Select **Option #4** for Medical Staff-specific updates for Medical Staff members at each HF hospital.
- The new Pro-Health & Fitness Center in Viera is now available for respite shelter for Medical Staff members and associates who will need to report to a hospital or HF facility after the storm as well as for their family members if needed; however no pets are allowed. The new Center was activated during Tropical Storm Fay. To access this shelter in a future storm, contact your Medical Staff Office so they can include you and as many of your immediate family members as requested.
- The evacuation system, which tracks CCH patients evacuated in the event of a storm, is being moved to a Web-based system, instead of an internal intranet system later this fall. Once activated, the Web-based system will allow real-time access to following a patient's transition from CCH to HRMC.
- The HF Emergency Management Committee is creating Storm Response Action Lists for the physicians who chair individual medical specialty committees at HF

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Do a checkup on your Fall calendar!

September 2008

- 12** CME —VTE/PE Prophylaxis and Treatment: **An Urgent Call to Action for a Common but Preventable Disease**, Joseph Caprini, MD, Northwestern University Feinberg School of Medicine, Evanston, Illinois (11:30 am to 1:30 pm, HRMC Auditorium)*
- 16** CCH Annual General Medical Staff Meeting (6:30 pm, CCH Medical Plaza Conference Room)
- 19** CME —**Latest Advances in Fertility Preservation**, Sejal D. Patel, MD, University of Central Florida College of Medicine (11:30 am to 1:30 pm, HRMC Auditorium)*

24 PHYSICIAN-ONLY BLS/CPR AND ACLS RENEWAL COURSE*

Registration and refreshments: 4 to 5 pm
Course time: 5 to 9 pm
Cost: \$175

* This physician-only course will be conducted at the **Training Center of Health First in the Rivercrest Professional Center at 3470 North US 1 in Melbourne**. For more information or a faxable course registration form, please call **321-434-1972** or fax to **321-254-0795**.

* *Course only for physicians or physician-extendors*

- 24** HRMC Medical Staff Department Meetings (6 to 7 pm, Melbourne Hilton Rialto); immediately followed by **HRMC General Medical Staff Meeting** (7 pm, Melbourne Hilton Rialto)
- 26** CME —**Therapeutic Hypothermia**, James Shaffer, MD, HRMC (11:30 am to 1:30 pm, HRMC Auditorium)*

October 2008

- 10** CME —**Treatment of Hip Fractures: Review and Update**, Jeffrey O'Brien, MD, HRMC (11:30 am to 1:30 pm, HRMC Auditorium)*
- 24** CME —**Hyponatremia in Heart Failure: Current Concepts and Future Directions**, Kamalendu Chatterjee, MD, FRCP, FACC, University of California, San Francisco (11:30 am to 1:30 pm, HRMC Auditorium)*
- 28** HRMC General Medical Staff & Department Meetings (5:30 pm, Melbourne Hilton Rialto)
- 31** CME —**Tobacco-Free Campuses: November 20, 2008**, Michael Ott, MD, HRMC (11:30 am to 1:30 pm, HRMC Auditorium)*

November 2008

- 7** CME —**2008 Virology Grand Rounds: Issues and Strategies in Managing HIV in Diverse and Underserved US Populations**, William O'Brien, MD, University of Texas, Medical Branch of Galveston (11:30 am to 1:30 pm, HRMC Auditorium)*
- 14** CME —**Surgical Treatment of Obesity**, Patrick Domkowski, MD, PBH (11:30 am to 1:30 pm, HRMC Auditorium)*

*For all continuing medical education (CME) sessions, lunch is from 11:30 am to 12:30 pm, and the presentation is from 12:30 to 1:30 pm. For information and CME records, call **Dee Rogers** at **434-1966**.

Please note: CMEs at the new HRMC Auditorium are video-conferenced into the PBH Community Room.

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