

#FOCUS

Physician

News for the EAMC Medical Staff & Affiliates



Happy Birthday!

October 1Brandon Johnson
 October 2Rekha Lall
 October 6Eric Senn
 October 8Amanda Austin
 October 10Scott Greer
 October 10Alan Moore
 October 12Donthamsetty Rao*
 October 14Bill Blythe
 October 14Gary Leung
 October 15James Harris*
 October 17Lee Johnson
 October 22Kevin Jackson

*EAMC- Lanier Physicians

Meetings and Conferences

- **Cancer Conference:** Tuesday, October 6 and Tuesday, October 20; Noon; Classroom C. Lunch will be served.
- **Pediatric Advanced Life Support Renewal:** Tuesday, October 6, 8 a.m.- 4:30 p.m. Health Resource Center. Call 334-528-1260 to register.
- **Advanced Cardiac Life Support Renewal:** Thursday, October 15, 8 a.m.-5 p.m. Health Resource Center. Call 334-528-1260 to register.
- **Pediatric Advanced Life Support for Inexperienced Providers:** Wednesday, October 21 - Thursday, October 22; 8 a.m. – 3:30 p.m. Health Resource Center. Call 334-528-1260 to register.
- **VCOM Clinical Case Presentations:** Thursday, October 22, 7:30 – 8:30 a.m. Classroom B.
- **Advanced Cardiac Life Support for Inexperienced Providers:** Wednesday, October 28 – Thursday, October 29; 8 a.m. – 3 p.m.; Health Resource Center. Call 334-528-1260 to register.

Patient and Family Advisory Council Coming Soon to EAMC

(Editor's note: this is part two of a two-part series)

Patient and Family Advisory Councils (PFAC) are well-recognized best practices for patient and family engagement and a transformational indicator of excellence for hospitals across the country. Throughout the past decade, EAMC has been incorporating components of patient-family centered care and patient engagement into our health care delivery model.

Earlier this year, we began assessing our organization's readiness for a PFAC. By assessing, researching and networking with hospitals that have already established PFAC, EAMC has developed our operating infrastructure and we are now ready to move to implementation.

How can you help us?

We have a formal application, short interview, immunization, and background check process that potential council members will go through, similar to that of other volunteers who serve EAMC. We need your help to refer potential members.

Do you know of a patient or patient family member that would be a good fit?

- An example would be someone who has been a patient/family member for EAMC (inpatient, outpatient, ED, residential facility, etc.) in the last two-three years.

We are looking for patients and/or family members who:

- Are coping well with their health condition
- Are able to speak about their experience of care constructively
- Are able to listen and hear differing opinions
- Are comfortable speaking with candor in a group setting
- Are passionate about improving health care for others
- Are willing to participate in a monthly, two-hour meeting
- Are willing to sign and commit to our confidentiality and privacy requirements and want to work in partnership with EAMC/EAMC-Lanier

We are also looking for physician champions for patient-family engagement and patient-family centered care.

If you would be willing to refer a potential member, or would like additional information, please contact **Pat Grace** (Patient Experience) in the coming weeks. Patients and families typically feel very honored that their physician(s) would recommend them for this partnership!

For more information about PFAC, please contact Pat Grace, patient experience, at patricia.grace@eamc.org or 334-528-1262.

Do we have your current email address? If you would like to receive the *Physician Focus* via email, please drop us a line at medstaffsvccomm@eamc.org and give us your email address.



Surviving Sepsis Bundle: Treat Sepsis in a FLASH (Fluids, Labs, Antibiotics, Shock, Hour)

Beginning October 1, EAMC will be measured on how well we treat patients who present with or develop severe sepsis or septic shock while in our facility.

SEPSIS STEPS

<u>SIRS</u>	<u>SEPSIS</u>	<u>SEVERE SEPSIS</u>	<u>SEPTIC SHOCK</u>
T: >100.9 F < 96.8 F RR: >20 WBC: >12,000 <4,000 or <10% bands	2 SIRS + Confirmed Or suspected infection	Sepsis + Organ dysfunction	Severe sepsis With <u>persistent</u> Hypotension Signs of Organ Dysfunction

Organ Dysfunction is evidenced by any one of the following:

- SBP<90 or map <65, or a SBP decrease of more than 40 points
- Creatinine >2.0, or urine output <0.5 ml/kg/hr for 2 hours in a patient without renal dysfunction
- Bilirubin >2mg/dl
- Platelet count <100,000
- INR>1.5 or aPTT >60 sec
- Lactate >2mmol/L

Severe Sepsis 3 hour Resuscitation Bundle

to be completed within 3 hours of the time of presentation with severe sepsis

F - Fluids	Administer 30 mL/kg Crystalloid for Hypotension or Lactate ≥ 4 mmol/L
L- Labs	Measure Lactate Level AND Obtain Blood Cultures Prior to Administration of Antibiotics. Re-measure Lactate If Initial Lactate Was ≥ 2 mmol/L
A- Abx	Administer Broad Spectrum Antibiotics
S- Shock	Monitor for Signs and Symptoms of Septic Shock
H- Hour	Be mindful of the Time

The 6-Hour Septic Shock Bundle

to be completed within 6 hours of the time of presentation with severe sepsis

- Apply Vasopressors (for Hypotension That Does Not Respond to Initial Fluid Resuscitation to Maintain a Mean Arterial Pressure (MAP) ≥ 65 mm Hg
- In the Event of Persistent Arterial Hypotension Despite Volume Resuscitation (Septic Shock) or Initial Lactate ≥ 4 mmol/L (36 mg/dL):
 - Measure Central Venous Pressure (CVP)
 - Measure Central Venous Oxygen Saturation (ScvO2)
- Re-measure Lactate If Initial Lactate Was ≥ 2 mmol/L

Blythe's Thank You to Nurses Reaches Thousands

On September 13, one of the co-hosts of the popular daytime talk show, *The View*, asked why a nurse competing in the recent Miss America pageant, was wearing a doctor's stethoscope during a monologue about her duties as a nurse. The comments resulted in backlash online from nurses across the U.S. Within hours, a Facebook group, "Show Me Your Stethoscope," was created. Dr. Bill Blythe was one of the many physicians who used this incident in the media as an opportunity to show his appreciation for nurses. His post on the Facebook group page was shared thousands of times and had more than 400,000 likes. Below is Blythe's post:

THE TRUTH ABOUT NURSES, FROM AN UNGRATEFUL, SELFISH, ARROGANT SURGEON

Yesterday I posted a silly photo in support of this movement, but tonight I want to say something serious while there is ample attention. When a patient comes to our hospital for surgery, these are the people who take care of them:

The Pre-Op Nurses meet the patient, make sure they are ready for surgery, complete mountains of paperwork, reconcile their medications, sign permits, check labs, answer questions, allay fears, and make certain the patient is properly prepared for surgery. And they put up with me.

The Circulator Nurse is in charge of the OR. She makes certain the room, equipment, personnel, implants, disposables, medications and every other detail are ready. She oversees that everything is checked twice, that everything is documented properly and that the proper surgery is performed on the right part and the right patient every time. Her job is to ensure that we do everything right, every time, with no exceptions. She makes certain that every sponge, needle, gauze, blade and specimen are properly accounted for. And she puts up with me.

My CRNA puts the patient to sleep and attends to them through every moment. She listens to their every breath and heartbeat. She makes sure they are asleep, safe and comfortable. She holds children her lap and talks to them like a mother while they go to sleep. She makes certain every patient goes to sleep and wakes back up as safely as possible every time, no exception. And she puts up with me.

The people who operate directly with me are Nurses or Techs, not doctors. They make sure we have the proper instruments and equipment. My Scrub hands me what I need before I ask for it. She can anticipate what I am going to need next better than I can many times. She makes my job easy and she makes me look like I know what I am doing when sometimes I am less certain. The person across the table from me is often an RNFA or SFA. They operate directly with me - tie the knots, cut the suture, retract, hold, pull, control the bleeders, close the wounds and a million other things. I simply could not do what I do without them. And they put up with me.

The PACU Nurses take the patients from the CRNA and recover them from anesthesia and surgery. They assess and dress wounds. They treat pain and anxiety and fear. They hold screaming babies in their arms until they are awake. They hold hands of grown men who are disoriented and fearful. They reassure and calm the parents, children and spouses of the patients. They give wound, medication and discharge instructions, and they transfer patients to their



"I simply could not do what I do without them."

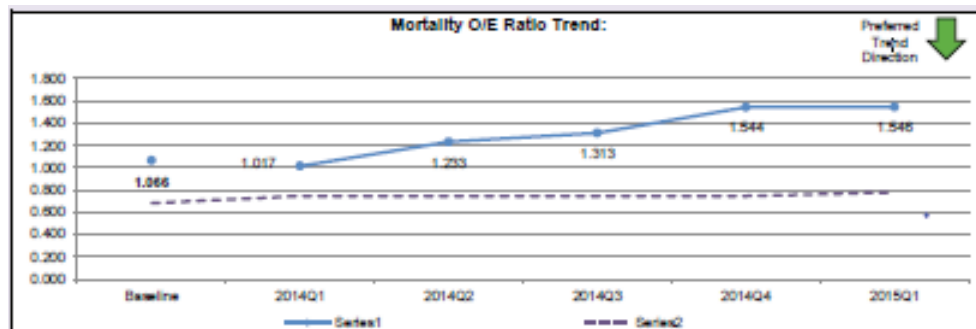
room. They land the plane, and it's as important a job as any in the world. And they put up with me.

The Nurses in the ICU and Floor take care of the patients, not me. The ICU nurses are infinitely more capable of monitoring and assessing sick patients than am I. I try to stay out of their way and let them do their job, and they let me know when they need me. The Floor Nurses take care of every detail of every patient: what and when they eat; medications; wound care; ambulation; checking vitals, labs, weights, sugars, pulse oximetry, I's & O's; draw and check labs; start and re-start IV's; and countless other things that only nurses understand. They spend time with the patient and family all day. They educate and answer questions. They pray with the patient and family. They cry when their patients die. And they put up with me.

The truth is that if a patient is in the hospital for 48 hours, they may see me for the smallest fraction of that time. I say a brief hello before surgery, I operate, I speak to the family, and I make rounds each morning. I may spend 15 minutes each day at any one patient's bedside. The rest of it — every second, every bit, every detail, everything — is performed by the Nurses. Honestly, the one who probably needs the stethoscope least is me.

And in the end, through it all, they put up with me!

Clinical Documentation News



What's wrong with this picture? It's going in the wrong direction.

Does it accurately reflect the care we provide? Absolutely not.

What is the O/E Ratio and why do we use it? O/E ratios are risk-adjusted datasets. Codes are assigned a SOI (severity of illness) and ROM (risk of mortality), and both are on a 4-point scale. When SOI/ROM is adequately captured, O/E declines as the expected pool rises. When clinical acuity is not captured in the documentation, the O/E ratio reflects a higher than expected ratio, giving the appearance that a sick patient is healthy. While mortality rates have remained constant through the years, our O/E ratio has risen, indicating that our documentation needs improvement to reflect the SOI/ROM accurately.

How do we improve our Observed-to-Expected (O/E) ratios? By improving the quality and accuracy of our documentation we not only improve the coded data sets, but more importantly, provide the truest clinical picture of our patients. For example, comorbid conditions greatly impact the O/E ratios, in addition to knowing the right words to use. EAMC has expanded the Clinical Documentation Improvement Program (CDIP) to provide specialty-based guidance to physicians on these topics.

More about CDIP: The goal of the CDIP program is to ensure medical records claims match the clinical acuity of the patient, in order to promote the following: a complete and accurate medical record, clean risk-adjusted data sets (publicly reported data sets), and a smooth transition into the ICD-10 world. The CDIP staff are all RNs and are currently being assigned to physician specialty groups.

How do the CDIP nurses communicate with physicians? Through queries. These can be verbal, written, or electronic. Verbal and/or face-to-face queries tend to result in the highest compliance rate and satisfaction among physicians, so, this is strongly encouraged. However, what we really hope for is that you share your communication style preference with your nurse so that he/she can tailor a plan that best suits your schedule. With our increased staff, our goal is to place and resolve queries concurrently; thus, reducing the amount of queries you receive after discharge. We

are also consolidating the process—only CDI nurses will apply queries, not coders. In the event a coder finds opportunity, he/she will refer to the CDI nurse to communicate with you. We are working hard to revitalize the “new” CDI program and look forward to partnering with you.

How long do I have to answer a query? MEC passed an escalation policy that goes into effect October 1, 2015 that outlines the expectation of physicians to answer queries. Essentially, the physician will be contacted via multiple escalating channels for approximately five business days if queries remain unresolved or partially resolved. If all steps are exhausted, the physician will be referred for suspension. We do not anticipate this occurring; instead, we expect that you and your CDI will find the best way to communicate and resolve queries with minimal interruption to your day.

What if I disagree with the query or don't understand why it's being asked? Contact your CDI nurse!

Why should I care? Consumers are shopping for the best health care using publicly reported data sets on the web — that means your patients may choose Birmingham if you are depicted as having poor quality scores from claims based on data that is, like it or not typically not inclusive to you. Check out some of the websites. Like it or not, your performance is judged based on coded data, which is a reflection of your documentation. Quality, payment, and health care value as portrayed to the consumer and by payers is all assessed and evaluated based on your documentation.

The pharmacy formulary update:

Nivolumab (Opdivo®) has been added to the formulary for the treatment of metastatic squamous cell NSCLC for patients with disease progression following treatment with platinum based chemotherapy in addition to the indication for metastatic or unresectable melanoma.

Certolizumab Lyophilized (Cimzia Lyo®) has been added to the formulary for the treatment of rheumatoid arthritis, ankylosing spondylitis, Crohn's disease and Psoriatic Arthritis in the outpatient infusion center.

Ivabradine (Corlanor®) has not been added to the formulary at this time as it is contraindicated in acutely decompensated heart failure. The pharmacy will provide the medication through the process of a non-formulary request for inpatients who do not have their own supply available during hospitalization according to hospital policy.

Congratulations to Lee OB/GYN, Winners of the Cornerstone Golf Tournament



The winners of the 22nd Annual George Brooks, Jr. Memorial Golf Tournament that benefits Cornerstone of EAMC finished 18 under par. From left to right are **Dr. Joel Pittard, Greg Smith, James Salter and Dr. Kenny Harris.**