

## UPDATE ON MEDICAL STAFF PERFORMANCE WITH HOSPITAL QUALITY INDICATORS

By Mark A. Greenberg, MD

Medical Staff compliance on the key quality indicators for AMI, CHF, CAP, AF and CVA was overall excellent in the final quarter of FMQAI's (Florida PRO) "6<sup>th</sup> Scope of Work." Compliance with the indicators was generally at or above the compliance goal of 90% with the exception of ACE inhibitor use and early administration of antibiotics for CAP. Members of the Medical Staff are to be applauded for their performance in carefully documenting the high quality of care they delivered.

As noted in a prior article, effective July 1, 2002, JCAHO is measuring quality indicators for AMI, CHF, and CAP. As a result, LMHS's performance on these indicators is now a part of the System's credentialing process.

Also, effective July 1, 2002, JCAHO and FMQAI are now using the administration of antibiotics **within four hours** of the diagnosis of CAP as the new standard of care. LMHS has taken several steps to facilitate rapid administration of antibiotics to patients with CAP:

1. Supplies of commonly used antibiotics for CAP have been increased in the ED.
2. Physicians and staff in the ED have been educated to address antibiotic use for pneumonia as a "**stat order**."
3. Nursing staff on the units have been educated regarding the necessity for rapid administration of antibiotics for CAP. However, physicians admitting patients with CAP also have to do their part and clearly order that the first dose be given "**now**" or "**stat**." (The pneumonia order set clearly stipulates that the first dose of antibiotics be given within four hours). Given the attention being provided by regulatory agencies to the rapid administration of antibiotics in the setting of CAP, failure to specify a timeframe for the first dose will place the ordering physician at a significant liability risk in the event of an adverse outcome.

Documentation of ACE inhibitor use in the setting of CHF and AMI continues to be a problem. In general, this is primarily a failure to clearly document in the chart prior intolerances to ACE inhibitors such as cough or angioedema that have necessitated the use of ARB's.

I am confident that a collaborative approach by physicians and LMHS staff will ensure continued performance improvement on these very important quality indicators. Finally, please feel free to contact me at 334-5969 or 939-7555 if there are process issues or barriers that discourage successful compliance.

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### I N • T H I S • I S S U E

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  - Have You Heard about Net Access?
  - Anesthesia Manpower Shortages
- HIPAA • Continuing Medical Education

## COGENT HOSPITALIST PROGRAM: STATUS REPORT

*Chuck Krivenko MD*

Consistent with the commitment that I made to the Medical Staff leadership, the following is a status report for the first two months of the Cogent Inpatient Management Service.

Presently 58 primary care physicians have enrolled in the program. The average daily census for the program in August and September was 15.8.

Patient satisfaction rates for August and September were 100% and 98%, respectively, compared to the Cogent National figure of 99.2% (n=80).

Consults per discharge were 0.7 for August and 1.1 for September. These mirror the Cogent National figure of 1.14 for consults per case.

Length of stay for the program is 1/2 day less than the overall inpatient LOS.

Mortality rate for all Cogent patients was 3.26% compared to an overall LMH mortality rate of 3.94%.

Re-hospitalization rate for the two months for seniors was 3.3%, below the Cogent National figure of 9.2%.

Presently, the service is available at LMH and HP with hopes of establishing the program at CCH by December. If you have any questions regarding this information or the hospitalist program, please contact Marcia Stein or me at 335-7813.

## DIRECT ADMIT REVIEW FOR LEVEL OF CARE

*By Mark A. Greenberg, MD*

Medicaid and Medicare have set in place regulatory programs to assess whether or not acute care admits actually meet "criteria" (as defined by the InterQual ISD Manual).

Medicaid has implemented a prior authorization program (see May 2002 edition) while Medicare requires random retrospective chart audits. In general, those admits that do not meet acute care admit criteria are appropriate for observation status (see June 2002 edition for a detailed discussion on "**observation**").

As a result of the aggressive State and Federal scrutiny of admits, the Emergency Department (ED) Case Managers have been reviewing ED admits and targeted direct admits for the appropriate level of care. In the ED setting, case managers and social workers are available to aid in arranging for home health and other support services as well as providing criteria to

clarify whether or not a patient should be an acute admit or placed in observation. The targeted diagnoses for direct admit review are as follows:

- Altered Mental Status
- Bowel Obstruction/  
Fecal Impaction
- Chemotherapy
- Chest Pain
- CHF
- Diarrhea
- Dehydration
- Esophagitis
- Fever
- Gastritis
- Gastroenteritis
- Nausea and Vomiting
- COPD
- Pain
- Pneumonia
- Syncope/Dizziness
- UTI

For direct admits, the case manager's role is not to challenge the need for admission but to clarify, when necessary, the level of care needed: Acute Admit Status or Placement in Observation.

*continued from page 2*

We want to make the direct admit process as unobtrusive for physicians as possible. To prevent a phone call from the case manager, provide a brief summary of the reasons for admission. The summary could simply be in the form of a copy of the office progress note that deals with the admission. When additional information is needed, the case manager can review the admit with a nurse so as to minimize any disruption to the admitting

physician's schedule. Again, the goal is simply to clarify the level of care needed and thereby comply with regulatory statutes, while minimizing the impact of the process on the admitting physician.

Please feel free to direct comments or suggestions to Dr. Greenberg at 939-7555 or 334-5969.

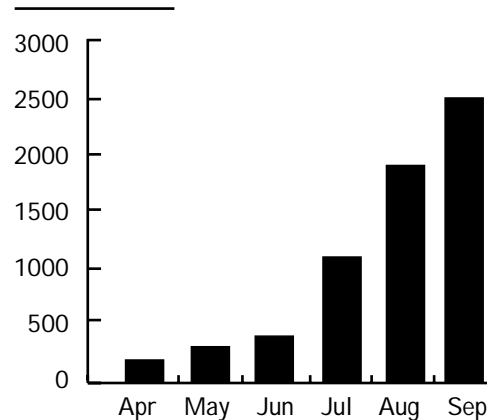
## HAVE YOU HEARD ABOUT NET ACCESS?

Net Access is the web-based computer system that provides physicians easy, real time access to patient clinical information across our LMHS facilities. It is accessible from all of the clinical computers in the patient care areas as well as from home or office over the Internet. The program has received an overwhelming positive response from a great number of physicians. Over 300 physicians have signed up to take advantage of this great new tool, and the list is growing every day. If you haven't heard about Net Access, ***ask these physicians what they like about the new tool.*** These physicians are the top, most frequent users of the Net Access system:

M. Haupt, M.D., Emergency Medicine  
G. Fortier, M.D., Emergency Medicine  
R. Kupsaw, M.D., Emergency Medicine  
C. Schultz, D.O., Emergency Medicine  
D. Goldberg, D.O., Trauma Surgery  
L. Lynch, M.D., Internal Medicine  
N. Schodolski, M.D., Internal Medicine  
A. Wappi, M.D., Internal Medicine  
D. Traiger, M.D., Family Medicine  
M. Garcia, M.D., Family Medicine  
A. Hameed, M.D., Gastroenterology  
S. Harris, M.D., Gastroenterology

W. Keith, M.D., Gastroenterology  
A. Mathew, M.D., Pulmonary Medicine  
H. Sachs, M.D., Pulmonary Medicine  
A. Siegel, M.D., Pulmonary Medicine  
I. Vyas, M.D., Pediatric General Surgery  
N. Witham, M.D., Pediatrics  
N. Celebrado, M.D., Pediatrics  
T. Schiller, M.D., Pediatrics

Total Logons



To learn more about this great new tool, please contact Karen Mueller at 335-7753 or [karen.mueller@leememorial.org](mailto:karen.mueller@leememorial.org)

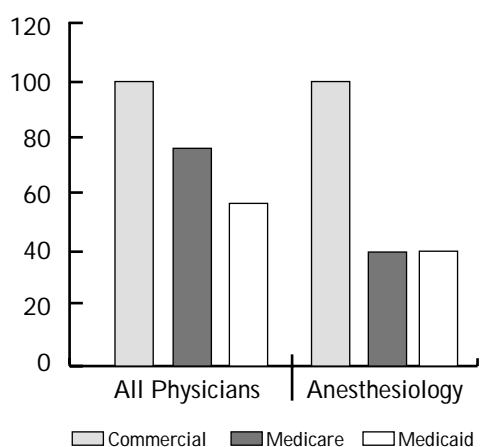
## ANESTHESIA MANPOWER SHORTAGES

*By Jim Poucher, Manager MAPMC*

“Never have so few come to serve so many.” This may very well be the medical mantra in the retirement State of Florida a year or so from now as Medicare continues to reduce reimbursement to physicians. Current projections include a fourteen-percent (-14%) average decrease to all physicians over the next three years following an average cut of 5.8% in 2002.

The cause and effect phenomenon produced by Medicare payment reductions is unfortunately being played out by the current national shortage of anesthesiologists and certified registered nurse anesthetists. Decreased enrollments in both anesthesiologist and nurse anesthetist training programs occurred during the mid-1990's concomitant to a significant rollback in Medicare reimbursement for anesthesia services beginning in 1994 that has yet to be corrected. This disparity is depicted in the following graph based on national data. (Source: ASA Newsletter).

Medicare Disparity Produces Anesthesiology Shortages



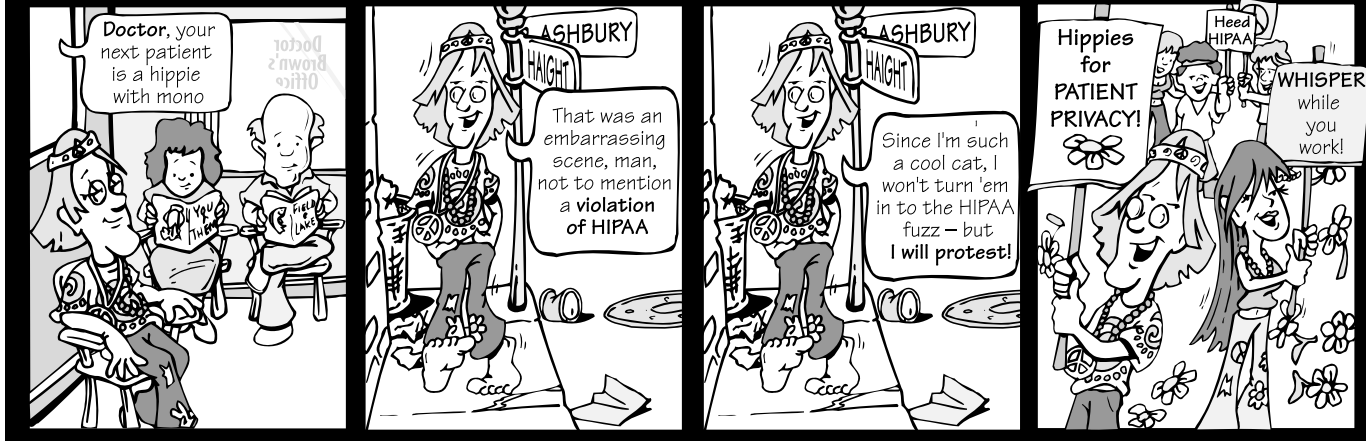
Increased surgical utilization combined with increased alternative surgical sites such as ambulatory surgery centers and surgeon's

offices have served to amplify the anesthesia manpower shortage problem. Anesthesia practices such as Medical Anesthesia and Pain Management Consultants, P.A. (MAPMC) must compete with other practices located in states and regions with better payer mixes that can afford to pay higher wages. In addition, MAPMC must compete with ambulatory surgical settings that offer work hours far more attractive than the 24/7 commitment to the community provided within the LMHS. So, in the coming weeks, there will be continuing conversations in the hallways and doctor lounges about the need to enforce the LMHS O.R. Hours of Operation Policy. Consider the anesthesia phenomenon part of a broader issue, a precursor to or predictor of future problems, particularly in Florida.

At first glance, the projected 14% Medicare payment reduction when applied to all physicians nationwide appears fair. However, there is a compounding effect on medical practices with higher than average Medicare case mixes, such as those found in much of Florida. It will produce disproportionate Medicare revenue shortfalls when compared to a similar sized practice having a less than average Medicare case mix. The results can be as disturbing. Practices that rely heavily on Medicare patient volume will find it difficult to remain wage competitive and simultaneously properly sized. Recruiting and retaining new professionals will be difficult.

In light of plans to cut Medicare payments to physicians, it is somewhat ironic that politicians continue to garner votes by offering prescription benefits to Medicare enrollees. It would be more ironic if few physicians are available to write Medicare prescriptions. If you see a mess, then write to CMS, Centers for Medicare and Medicaid Services and to Congress.

# HIPAA revolution: Whisper While You Work



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## CONTINUING MEDICAL EDUCATION – CME

- **“Early Diagnosis of Alzheimer’s, Lewy Body and Other Dementia’s”**

Alfonso Martinez, Ph.D.

**Thursday, November 7, 2002**

12:30 – 1:30 PM

Lee Memorial Hospital Auditorium

- **“Peripheral Endovascular Interventions – Endovascular Therapy for Abdominal Aortic Aneurysms”**

John Howard, MD

Thad Kammerlocher, MD

**Tuesday, November 12, 2002**

6:00 -7:00 PM

Lee Memorial Hospital Auditorium

**RSVP Dinner by November 8<sup>th</sup> – 574-0374**

- **“Beta Blockers: Perioperative Use & Indications”**

Andrew Auerbach, MD

University of California, San Francisco

Author of B-Blockers and Reduction of Cardiac Events in Noncardiac Surgery, JAMA March 20, 2002

**Monday, November 18, 2002**

6:30 – 7:00 PM Registration and Dinner

7:00 – 8:00 PM CME Lecture

**RSVP by November 14<sup>th</sup> – 574-0397**

- **“Influenza”**

Rudolf Kotula, MD

**Wednesday, November 20, 2002**

6:00 – 6:30 PM Registration & Dinner

6:30 – 7:30 PM CME Lecture

Cape Coral Hospital Meeting Room A

**RSVP Dinner by November 18<sup>th</sup> – 574-0374**

- **“Brain Bugs: Pediatric Encephalitis in Florida”**

Juan Dumois, MD

Chairman, Division of Infectious Diseases

All Children’s Hospital, St. Petersburg, FL

**Thursday, November 21, 2002**

Following the 6PM Department of Pediatrics Meeting

CME 7:00 – 8:00 PM

HealthPark Medical Center – HP 1B

**RSVP Dinner by November 19<sup>th</sup> – 574-0374**

If you have questions or would like to submit an article to

*Medical Staff News*, please contact

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