

Special points of interest:

- Hey Doc, You Rock!

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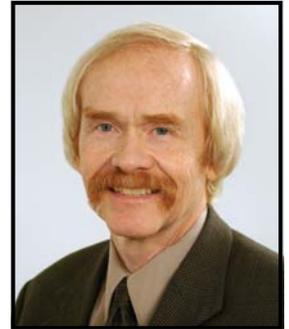
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Medical Staff Update February 2015

“Hey Doc, You Rock!” Recipient Chosen for January & February



Rockin Doc: **John Mathis MD, Gastroenterology**
Nominating Staff: **GI Lab-Outpatient Surgery**
Medical Education: **Indiana University School of Medicine**
Date on Staff: **07/01/1981**

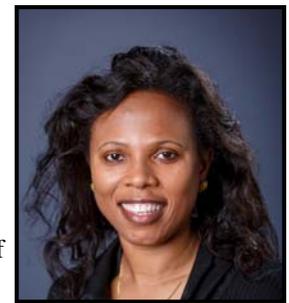
According to the 25 associates who nominated him, John Mathis, M.D., possesses “the heart of what every physician wants to be.” Providing care to each and every patient like they were family, “He is literally up all night seeing patients before going home ... he takes all the time a patient needs, maintaining eye contact and truly listening ... no face in a chart or eyes focused on a laptop screen for him. He works all hours if that is what the patient needs, and he never rushes the patient—or the nurse!”

He has and always will be considered a true team player by his associates: “He doesn’t hesitate to assist staff with moving patients or walking them to their rooms until he is sure they are comfortable.” He won’t leave until the patient is cared for and staff members have received the support they need. “With Dr. Mathis, the patient comes first. I’ve seen this as his coworker and as his patient!”

Dr. Mathis is a superb example of a doc that rocks! The descriptive adjective that comes up most often in his nominations is “compassionate.” Besides possessing a great sense of humor and making coworkers smile, associates say he is “very kind, compassionate, tranquil and calming.” “You will never hear him yell or throw a fit!” And to boot, “He is extremely competent ... and an excellent educator.”

In fact, the staff thinks so highly of him that they choose him for their own “GI GUY!”

Rockin Doc: **Marjorie Daoud MD, Infectious Disease**
Nominating Staff: **11South Staff**
Medical Education: **Pennsylvania State Univ. College of Medicine**
Date on Staff: **07/25/2013**



The nurses who work closely with Dr. Daoud, an infectious disease specialist, have nothing but good things to say about her. “I have never met a doctor who is so polite and knowledgeable.”

Dr. Daoud is patient and kind to each and every patient as well as to every staff member. She is mindful of staff time restraints and also is willing to work with the patients on their terms: “If the patient has just fallen asleep and has not been getting rest, rather than waking them, she will come back later. She always puts the needs of those she encounters first.”

Her patient-care skills are remarkable. “Dr. Daoud spends quality as well as quantity of time with her patients. She explains things in simple, easy-to-understand language, allows time for the patient to ask questions and answers them honestly ... I like her honesty with patients. She cares about them and it shows.”

She communicates well with physicians, nurses and staff, and knows how to deal with challenging situations. “I remember one patient who would see Dr. Daoud and say, ‘Go away—I don’t like you!’ and would pull the blanket over her head to show her dislike and refuse to let the doctor examine her. But Dr. Daoud was persistent. The patient finally realized that Dr. Daoud truly cared about her and wanted to stop the infection to save her foot. After that the patient agreed to see Dr. Daoud every day, and was seen smiling after each visit.”

Another nurse summed it up this way: “Dr. Daoud is so down to earth, personable and compassionate. She has a wonderful sense of humor and yet still exudes professionalism ... she can always be seen with a smile on her face!”

A Byte of IT ... From Your CMIO, Dr. Ken Elek

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CPOE Safety

We recently completed an evaluation put forth by the Leapfrog Group, a consortium of corporations committed to helping improve the safety of electronic health records. In preparing for and completing this evaluation several issues have come forth.

First is the issue of dose range checking. We have this tool available to us but currently only have it turned on for the Emergency Care Center, Surgery and Pharmacy. The principle is to select the medications for which an inappropriate dose would cause an issue and have an alert come up on the screen when the inappropriate dose is selected. The current tool is set up using age criteria but can be more elaborate if desired. The elaborations would include things like renal function and other lab checking. We plan to turn this tool on in the first couple weeks of 2015. I'm not anticipating that there will be many alerts come up since we already use a tool called Knowledge Driven Medication Ordering or KDMO for short. The KDMO tool presents the ordering provider with the most common doses and frequencies for a particular medication. Therefore, it's a lot less likely that an inappropriate dose will be typed in. We also have order sentences built for many of the medications; this is the box with doses and frequencies you see when you order a medication; which should also limit the number of dose range alerts that come up. My request of you is to report inappropriate alerts so we can investigate and correct where necessary. All you need to do is leave me a voicemail when it happens and I would appreciate the following details; patient FIN number, medication, dose selected and why the alert was inappropriate. Let me know if you have questions about this.

The next issue is therapeutic duplication. Currently we do not have duplicate checking turned on since our Cerner physician resource recommended we let pharmacy manage this function and not the physicians. At times I hear concerns from nursing that physicians are not paying attention to what the physician seeing the patient just before them ordered or even paying attention to previous orders at all. I plan to meet with the P&T committee to help evaluate the potential scope of this problem.

I also plan to look at drug-diagnosis alerts but this is a much more complicated subject for which there are no "pre-built" resources and would need to be done from scratch.

On another subject, the topic of placing orders on patients who are going to be admitted from the ECC but are still physically there has come up again. Please remember the following outlined workflow: All orders to be completed on the floor are put in a PowerPlan which is placed in the planned state. The nursing staff activates the PowerPlan when the patient gets to the floor. Activation may not be done immediately upon arrival to the floor but neither were paper orders "activated" immediately upon arrival to the floor; you just didn't know about it since there was no mechanism for you to know. This workflow is to be followed whether you are a primary care physician or a specialist. The main thing to remember is that any medication order placed in the emergency department is not verified by pharmacy and nonmedication orders go to the ECC nurse's task list. The only medication orders that should be placed outside the planned state while the patient is still in the ECC are medications intended to be given initially in the ECC and should be for one dose. Subsequent doses should come from the PowerPlan.

One of the enemies of safety when it comes to ordering is varying from the accepted workflow. This workflow has been communicated to and approved by the nursing staff from the leadership down. Please do not risk patient safety by adopting a nonstandard workflow. There are safety measures in place that are nullified for an inpatient order when an attempt is made to treat it like an ECC order. Let me know if there are issues with the workflow so either tweaking or education can occur to improve the workflow or the understanding of how it works. Just like in the paper world, no system is perfect nor does it work perfectly every time but attempting to go outside the accepted system is the most dangerous way to approach it.

Please also remember that I can't help with any issue unless it is reported to me. My request is that I have at least a patient FIN to investigate, the nature of the issue, approximate date and time, and the PC number where the issue occurred.

Please watch for an email each week announcing changes to the Cerner system and Know As You Go's (KAYG's) to help explain them.

Let me know what I can do to help make your experience with our electronic record better. My office number is 647-3070, my pager is 472-4639 and my email address is kelek@beaconhealthsystem.org.

Documentation Improvement Tidbits

The Copy and paste feature is certainly a useful tool but please make sure to review and update your notes on a daily basis.

Please avoid describing acutely ill patients as having “no acute distress” (“NAD”).

Doing so can create an appearance of being out of touch with the patient’s condition and serve as grounds for auditors to dispute the diagnosis.

Respiratory Failure

Respiratory failure continues to be a challenging condition for physician documentation.

Respiratory failure is commonly defined as respiratory dysfunction resulting in abnormalities of oxygenation and/or carbon dioxide (CO₂) elimination and is classified as either hypoxemic (type I) or hypercapnic (type II), or a combination of both.

These distinctions are clinically important and have diagnostic and therapeutic implications, but current coding rules consider them “non-essential” terms that do not affect the code assigned.

Physicians won’t be required to use them with ICD-10, either, though the coding system will allow for these distinctions.

The correct diagnosis is essential to accurately portray a patient’s severity of illness and influences quality scores, performance indicators, clinical outcome measures and hospital revenue.

Even chronic respiratory failure contributes to severity classification.

However, non-specific terms (such as hypoxia, severe dyspnea, respiratory insufficiency or distress) result in the assignment of codes that do not reflect any significant respiratory problem even when, as an extreme example, endotracheal intubation is necessary.

Chronic Respiratory failure

Chronic respiratory failure is characterized as a combination of hypoxemia, hypercapnia and hypercarbia (renal compensation for hypercapnia by retention of bicarbonate). In the absence of an acute exacerbation, the pH level will be normal (7.35-7.45).

Any degree of respiratory acidosis (hypercapnia with pH <7.35) indicates an acute decompensation in these patients— so-called acute-on-chronic respiratory failure. The latter term is preferred for severity classification, because “respiratory acidosis” results in an incorrect code that will not reflect the presence of respiratory failure.

The treatment of chronic respiratory failure includes chronic supplemental oxygen therapy (“home O₂”), so the diagnosis should apply to all patients who receive this.

It’s important to document chronic respiratory failure for coding purposes because it is always considered a significant comorbidity contributing to a patient’s severity of illness, even if it seems clinically intrinsic to another condition like severe COPD and treatment is unaffected.

Acute respiratory failure

Acute respiratory failure is defined as one of the following:

pO₂ <60 mm Hg or SpO₂ (pulse oximetry) <91% breathing room air

pCO₂ >50 and pH <7.35

P/F ratio (pO₂ / FIO₂) <300

pO₂ decrease or pCO₂ increase by 10 mm Hg from baseline (if known)

A pO₂ less than 60 mm Hg measured by arterial blood gas (ABG) on room air is the “gold standard” for the diagnosis of acute hypoxemic respiratory failure (excluding patients with chronic respiratory failure whose baseline pO₂ is often less than 60 mm Hg).

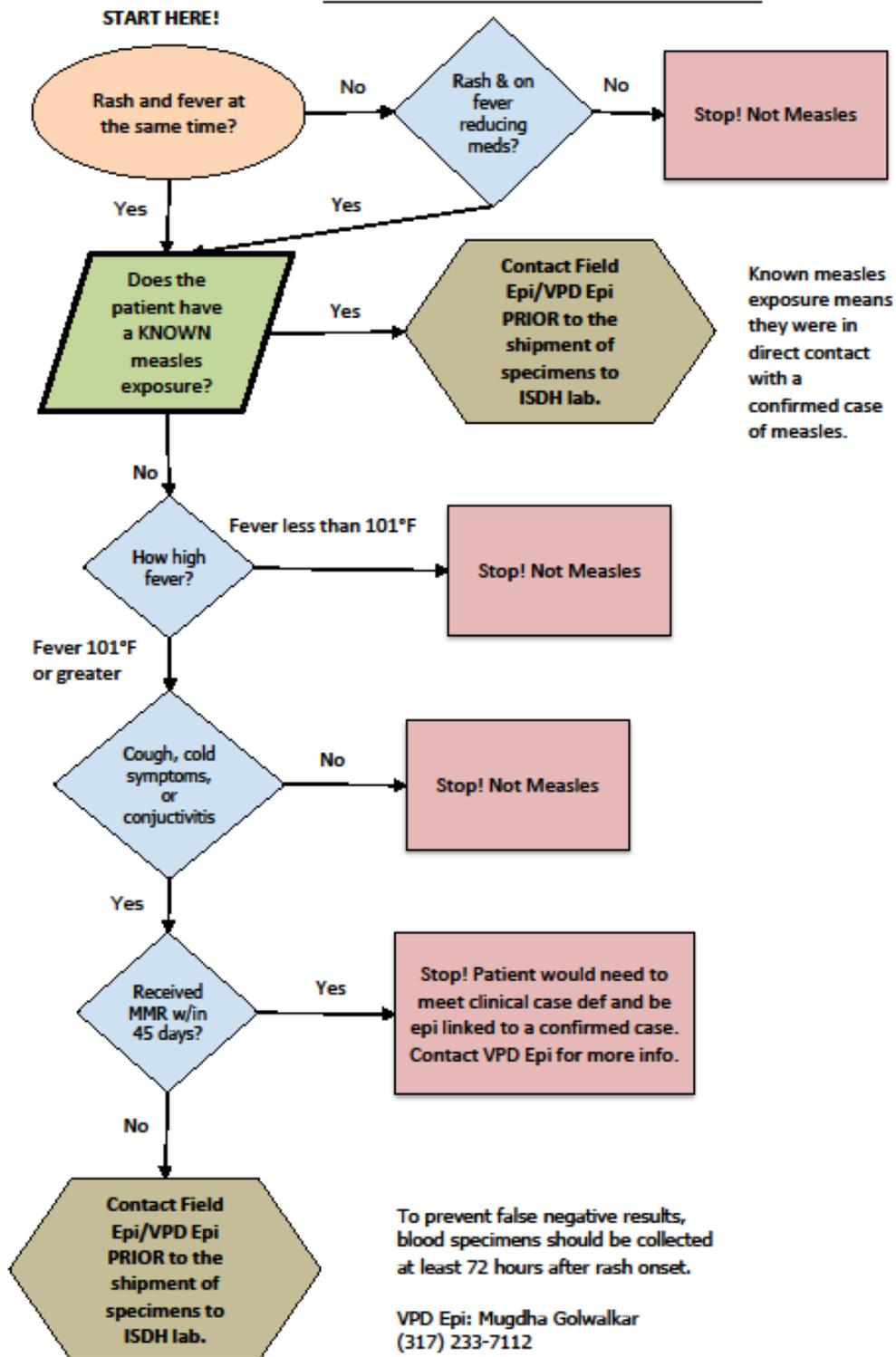
Management requiring endotracheal intubation and mechanical ventilation or initiation of bi-level positive airway pressure nearly always means the patient has acute respiratory failure, but this is obviously not required for the diagnosis.

Similarly, providing 40% or more supplemental oxygen implies that the physician is treating acute respiratory failure since only a patient with that disorder would need that much oxygen.

There ought to be some indication in the record that a patient with acute respiratory failure has, for example, respiratory distress (even if mild), tachypnea (normal respiratory rate is generally 8-16), dyspnea, shortness of breath, wheezing, etc.

Maliha Iqbal, MD, Medical Director, CDI Program, miqbal@beaconhealthsystem.org

Measles Flowchart



Last updated: 2/6/2015

Lung Cancer Screening

As you may know, lung cancer kills more people annually than breast, colon and prostate cancer combined. At Memorial Hospital of South Bend, we are taking steps toward identifying patients sooner who are at risk for lung cancer through screening and investing in technology to aid in the diagnosis of lung cancer.

Patients meeting the criteria below are candidates for screening*:

- Ages 55-74
- 30 pack year history of smoking and current smoker
- 30 pack year history and have quit within the past 15 years

To refer a patient for lung cancer screening, please call: Pulmonary and Critical Care Associates at 574-246-9350.

Patients with lung nodules now have access to minimally invasive techniques for acquisition of tissue to test for lung cancer or other diseases. Memorial Hospital has invested in both Electromagnetic Navigation Bronchoscopy (ENB) as well as Endobronchial Ultrasound (E-BUS). *"ENB allows us to acquire tissue from peripheral lesions in the lung that otherwise would require a more invasive approach,"* states Dr. Al-Ani, Pulmonary & Critical Care Physician, trained in both technologies.

If you are currently managing a patient with a lung nodule and would like further evaluation by a Pulmonary Specialist, please call 574-246-9350 .

BrainWorks asks that you participate in a brief survey about your specialty and brain health. As terms like "cognitive health" and "brain health" become more mainstream, this information allows BrainWorks to gather an organizational picture of the types of brain based inquiries being received along with the response patterns and creates an opportunity to explore if and how BrainWorks programs and services may better support your department needs.

For those of you who may not be familiar with BrainWorks, we are a department within Community Health Enhancement at Memorial Hospital. Across the community, and within Beacon Health System, BrainWorks translates insights from neuroscience into easy to implement actionable strategies for healthy brain development, performance and resilience across the lifespan. We do this through the developing and delivering educational programs, training sessions, and curriculum in story telling formats which focus both on how we perform day to day, and the long term benefits to learning about and living a brain healthy lifestyle. BrainWorks additionally provides local and national professional development programs and webinars enabling neuroscience to be used as part of leadership style and day to day operations.

Classes, training programs, curriculum, and education workshops in a story telling style focusing both on big picture goals, and day to day strategies that translate insights from neuroscience into stories, goals, and easy to incorporate action steps such that incorporate insights from neuroscience into daily life for expanded health and wellbeing for your brain, and your life, at every age.

In advance, thank you for your time to complete this brief survey. Your responses are anonymous. Take survey here https://www.surveymonkey.com/r/BrainWorks_PKPX37M

Medical Staff Officers

President
John Mathis, M.D.
 Vice President
Philip Kavanagh, D.O.
 Secretary-Treasurer
John Jacobs, M.D.

Medical Staff Office

Vice President Medical Affairs
Cheryl A. Wibbens, M.D.
 Medical Staff Coordinator
Pamela Hall, CPMSM, CPCS
 Physician Relations-Administration
Tawnn Hoover
 Executive Assistant
Mariellan Weaver
 Phone: 574-647-7920
 Fax: 574-647-6691
 E-mail:
 mweaver@beaconhealthsystem.org

Please send any information you would like to see included in future newsletters to

Mariellan Weaver,
 mweaver@beaconhealthsystem.org
 or contact her at 574-647-7920

You may view current and previous Medical Staff Updates at
www.qualityoflife.org/docs/hospital/newsletter

CME Opportunities

2015 Fall CME Schedule Held 12:10–1:15pm in the Auditorium at MHSB

“Update Organ Donation”

March 25, 2015

Presented by: Tim Taber, MD, FACP, Indiana Organ Procurement Organization

Please call Linda Magnuson at 574-647-7381 or email lmagnuson@beaconhealthsystem.org for more information and CME opportunities

Happy Doctor's Day!

Thursday, March 26th 11:00-2:00 p.m. Gourmet lunch served in physician's surgeon lounge

Monday, March 30th : DOCS Day Gourmet Breakfast & Lunch

6:30-9:00 a.m. Breakfast with a chef in the Epworth Conference Room

6:30-9:00 a.m. Breakfast casserole/fruit, etc.. For CBU Physician Lounge

11:00-2:00 p.m. Lunch with a chef in the Epworth Conference Room

Welcome New Medical Staff Member(s):

Nicholas Abel, MD
Diagnostic Radiology
 Radiology Inc.
 620 W. Edison Rd., Suite 110
 Mishawaka, IN 46545

Harun Fakioglu, MD
Pediatric Critical Care
 BMG-Memorial's Children Hospital-Critical Kids
 615 N. Michigan Street
 South Bend, IN 46601

Michael Johansen, DO
Pediatric Cardiology (telemedicine)
 Pediatric Cardiology Indianapolis
 705 Riley Hospital Drive
 Indianapolis, IN 46202

Kuumba Long, MD
Ophthalmology
 Cataract & Laser Institute
 611 E. Douglas Road, Suite 102
 Mishawaka, IN 46545

Jason Ransom, MD
Family Medicine-Refer & Follow
 BMG-MedPoint 24 Main Street
 6913 N. Main St., Suite 300
 Granger, IN 46530

Aisha Shareef, MD
Neurology
 Specialists on Call
 1768 Business Center Drive, Suite 100
 Reston, VA 20190

Szabolcs Szabo, MD
Interventional Cardiology
 BMG-Advanced Cardiovascular Specialists
 610 N. Michigan, Suite 400
 South Bend, IN 46601

Jennifer Brake, MD
Sports Medicine
 BMG-Sports Medicine South Bend
 111 W. Jefferson Blvd., Suite 100
 South Bend, IN 46601

Kathryn Hanlon, MD
Neurology
 BMG-Ireland Road
 1815 E. Ireland Road
 South Bend, IN 46614

Richard Lango, MD
Neurology
 Specialists on Call
 1768 Business Center Drive, Ste. 100
 Reston, VA 20190

Pravin Pratap, MD
Cardiology
 Midwest Cardiology
 611 E. Douglas Road, Suite 208
 Mishawaka, IN 46545

Fabio Savorgnan, MD
Pediatric Critical Care
 MHSB Children Hospital-Critical Kids
 615 N. Michigan Street
 South Bend, IN 46601

Gregory Sutton, MD
Gynecologic Oncology
 Michiana Hematology-Oncology
 5340 Holy Cross Parkway
 Mishawaka, IN 46545

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REGISTRATION BEGINS JULY 8, 2014.

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