Questions, Comments, Story Ideas? Send them to thescope@mmc.org

The Scope

A Newsletter for Medical Professionals

January 26, 2017

"The difference between genius and stupidity is that genius has its limits." - Einstein

The Scope *appreciates the enthusiastic response of readers contributing quotes. This quote was submitted by Michael Roy, M.D., Chief of Medicine. Please submit a favorite you'd like to share with others by emailing The Scope.*

A Compact Between Maine Medical Center and Its Medical Staff

Peer Support

for the MMC Medical Staff
PeertoPeer@mmc.org
Physician leader: Christine Irish, MD
Confidential * One-on-One * Peer Support

Dear Members of the Maine Medical Center Medical Staff,

Greeting Colleagues,

This January brings us unpredictable winter weather and an unpredictable healthcare environment with the potential repeal of the Affordable Care Act. We appreciate that many of you are advocating for your patients through professional societies. All politics aside, we encourage everyone - exercise your citizenship. As healthcare providers, we are potent advocates on policy. Advocate for access to affordable health insurance for our patients and communities.

In this issue, please read about MaineHealth's discussion regarding potential governance reunification. Medical Staff across the system are key to this discussion. We encourage all of you to understand the background and process for these discussions. Please speak up with questions and comments. We will provide a steady source of updates and materials on this subject in the coming months.

This issue includes many important items on logistics of practice: how to prepare for e-prescribing controlled substances and, how to use the new HELP button in Epic EHR. There is also information pertinent to the inpatient setting: attention and documentation on the patient status (observation versus inpatient) and documentation for Respiratory Failure.

Please read news about the Chief of Family Medicine and Interim Chief of Critical Care Medicine.

We want to congratulate Dr. Bob Trowbridge on receiving a renowned national teaching award, and this week we celebrate Certified Registered Nurse Anesthetists (CRNAs). CRNAs are unique professionals. Read below to see how they are supporting the community this week.

Sincerely,

Joel Botler MD

Joel Botler, M.D.
Chief Medical Officer

Lisa Almeder, M.D.
Medical Staff President

In This Issue

Electronic Prescribing of Controlled Substance (EPCS) for MaineHealth – Action Required

In response to the Opioid Crisis, Maine State Law requires all prescriptions for controlled substances to be transmitted electronically after July 1, 2017. Using a combination of Imprivata, Epic and SureScripts, MaineHealth will give prescribers the tools to successfully prescribe medications meeting patient needs while complying with the new state law. After July 1, 2017, there is a fine of $250 to the individual prescriber for each Controlled Substance prescription written on paper. See below for how to prepare.

Federal DEA Rules govern how we implement EPCS and conduct Supervised Enrollment for this program. **MaineHealth will begin Supervised Enrollment for EPCS in February 2017.** MaineHealth will enroll 2,600 prescribers prior to May 1 to meet the State deadline of July 1, 2017.

Federal EPCS Rules require:

- Access Approval for each individual prescriber

- EPCS Enrollment with an Enrollment Supervisor (face-to-face meeting with identification)
- Dual Authentication of every prescription for Controlled substance

MaineHealth will use a password, RSA token and fingerprint readers to authenticate prescriptions. Two of these three options must be used to authenticate the Controlled Substance prescriptions. Security compliant fingerprint readers will be installed on PCs in high-volume areas and may be used by prescribers where they are available.

Who needs to Enroll?
All prescribers who use Epic to prescribe Controlled Substances for patients upon discharge home must enroll.
Discharges include ED, Urgent Care, Inpatient, Outpatient, and Same Day Surgery encounters for patients who are going home.

When and Where?
Your Practice Manager, CMO or Service Chief will provide details as to when and where Supervised Enrollment will be available. Please enroll promptly when requested.

How can I prepare for Supervised Enrollment?
- Please double check your identification expiration dates and confirm that you have an RSA token.
- Make certain that the ID names match your legal name and that the IDs are not expired.
    - *Acceptable: Robert Smith MD, Dr. Robert Smith*
    - *Not Acceptable: Dr. Bob, Dr. Smith, B. Smith MD*

What do I need to present for Supervised Enrollment?
1) Two pieces of identification:
    a. One must be government issued with a photo (Driver's License or Passport) to verify your identity with the Enrollment Supervisor.
    b. Second ID may be your hospital ID as long as it has your full name.
2) RSA token: Hard token or soft (phone) token.
3) Network password (to log in).
4) Your fingers. *Fingerprint images are not retained in Confirm ID. The image is converted to a 16-digit number which is used to match your fingerprint going forward.*

What happens at Supervised Enrollment?
1. Provide two pieces of ID, one must be government issued with a photo (Driver's License or Passport) to verify your identity with the Enrollment Supervisor. IDs must show your full name and cannot be expired. The Enrollment Supervisor will record the type of ID and expiration dates.
2. Present your RSA token. The Enrollment Supervisor will record the serial number and expiration date.
3. You will log in to Confirm ID with your network password.
4. You will record fingerprints of your two index fingers.
5) The entire process takes about ten minutes and must be conducted in person.

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Quality Improvement Audit Offers Opportunity for Enhanced Patient Upgrade and Discharge Documentation 1

By Christopher Wellins, M.D., Medical Director of Care Management

MMC was recently audited by Livanta which is the Quality Improvement Organization (QIO) with oversight for MMC regarding Medicare/Mainecare short-stay inpatients. There have been previous audits which I have reported in this venue. We performed very well on the audit; however, there were a few take-home messages from the reviewers as follows:

- ***Document justification when and why a patient is upgraded from Observation to Inpatient***
  When upgrading a patient from observation to inpatient (which you may be asked to do by a Utilization Review Nurse) it is very important for them to see documentation about why this change in patient class has been made. If you have already written your progress note for the day it is sufficient to add a brief addendum to that note. If you have not written your progress note for the day yet, you should include in that note the reason that the patient is being upgraded to inpatient. Again, brief statements are fine such as, "given positive blood cultures in this patient who presented with fever she/he will require inpatient level of care for further evaluation and treatment . . ." We have asked the Utilization Review Nurses to remind you about the importance of this documentation.

- ***Document the unanticipated rapidity of improvement when an Observation patient is discharged in less than two midnights***
  If an inpatient is discharged in less than two midnights, it is **very important** that there be a statement in the progress note or discharge summary that the patient improved more rapidly than anticipated and therefore is able to be discharged in less than two midnights. When you are discharging an inpatient who has been in house for less than two midnights, a Best Practice Advisory fires regarding need for this documentation. Many providers are putting a brief statement in the BPA itself, but that will likely not be viewed as sufficient by Livanta. The language needs to be included in the progress note or discharge summary. For example, "This patient's COPD exacerbation responded to treatment more quickly than anticipated at the time of admission and therefore he/she is felt safe to be discharged…" **If you do not include this language, the case is essentially not appealable and MMC will not be paid.**

- ***Avoid changes in patient status just prior to discharge and/or speak directly and review with Care Manager***

In general, changing patient class from observation to inpatient or vice versa very close to the time of discharge generally raises auditing suspicion. If you think that it is appropriate to do so, please contact the case manager in your clinical area to discuss the situation.

Questions? Contact Chris Wellins

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Acute Respiratory Failure Documentation Improvement

The Clinical Documentation Improvement (CDI) team has identified considerable opportunities for improvement around the diagnosis of Acute Respiratory Failure. In the coding world, terms like, dyspnea, respiratory distress and respiratory insufficiency point primarily to symptoms and do little to represent the severity of illness and resource consumption in this population. There is a clear disconnect between the coding and clinical worlds on the use of these terms.

In the coding, public reporting and reimbursement worlds, the term "Acute Respiratory Failure" is thought to be a better representation of the underlying condition and garners a higher level of illness severity (SOI) and risk of mortality (ROM).

Providing a clear clinical picture in the EHR is a top priority for all clinicians. As we strive to adequately represent the severity of illness and resource consumption of our patient populations, CDI will at times highlight clinical scenarios noted to impact our query rate:

- *Is your patient hypoxic (requiring supplemental O2 to maintain an SaO2 >88%), are they requiring BIPAP, intubation or back to back nebs to maintain an SaO2 >88%?*
- *Is your patient with Acute Systolic Heart Failure or Suspected GNR Pneumonia requiring supplemental O2 and aggressive pulmonary toilet?*

The differences in the clinical interpretations of "Dyspnea," "Respiratory Insufficiency" and "Respiratory Distress" are vague at best. However, using the term "Acute Respiratory Failure" for this patient population will improve our quality scores and expected outcomes.

Capturing this diagnosis in the ED, inpatient units and/or ICU and then harnessing the functionality of problem oriented charting is essential. Noting the diagnosis is only half the battle, providing the clinical documentation to support the care provided is the final piece.

Attached to this short segment is a "90 second Update," created by CDI for educational purposes. The hope is that you will take the 90 seconds it takes to review and keep it in the back of your mind.

Questions? CDI Physician Advisors Team, Samir Haydar haydas@mmc.org and Ian Neilson Neilsi@mmc.org

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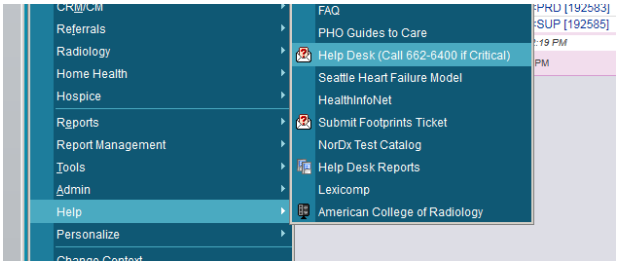
Use the Epic Help Desk Button to Report Epic Issues

The Epic “Help Desk button" is now activated. The Help Desk button gives users a way to report detailed information about an issue directly from Hyperspace, without making a phone call to the traditional Help Desk. For non-critical issues, users can report issues immediately after they occur. Help Desk may also enhance point-of-care capture of difficult workflows and general questions.

Help Desk is meant to supplement, but not replace, the existing processes for reporting issues to the support team. Messages sent from Help Desk provide contextual information, including the user's ID, profile and a screen shot at the time that the user reports the issue.



See more information and instructions.

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New Chief of Family Medicine Welcomed

Elisabeth Wilson, M.D., M.P.H.**,** will be joining MMC as our new Chief of Family Medicine, beginning in July.

Dr. Wilson's roots are in New England, and she graduated from Tufts Medical School. She then completed her Family Medicine residency at the University of California at San Francisco, where she has remained in a variety of roles. Currently, Dr. Wilson is a Professor of Family and Community Medicine, as well as her department's Vice Chair of Education.

In her 10+ years at UCSF, Dr. Wilson has excelled in both clinical and academic spheres. Some of her primary areas of focus include: improving medical education, reducing health care disparities, increasing workforce diversity and promoting primary care. She is also interested in mentorship and research.

Dr. Wilson will bring great energy and passion to this position, and she is committed to

helping primary care move forward. She will be a valuable addition to MMC's Chiefs' group.

Dr. Wilson will be replacing Ann Skelton, M.D., who has had a remarkable career at Maine Medical Center. After completing her residency here in 1990, Dr. Skelton became the Family Medicine Program Director in 1995. She assumed the position of Chief of Family Medicine in 2001, where she has provided outstanding leadership for the past 16 years. Under Dr. Skelton's guidance, the Family Medicine Department has grown significantly.

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Welcome New Interim Chief of Critical Care

Please welcome David Seder, M.D., to the role of Interim Chief of Critical Care Medicine, beginning February 1, replacing Tom Van der Kloot, M.D., who is stepping down from the position. The interim role will continue as MMC embarks on a national search for a permanent chief of the department.

Dr. Seder completed both his internal medicine residency and his fellowship in pulmonary disease and critical care medicine at MMC. He then completed another year of training in neurocritical care at Columbia Presbyterian Medical Center, before returning to Maine in 2009. As Director of Neurocritical Care at MMC, Dr. Seder has overseen its evolution into a nationally recognized program.

Over the past two years, as our critical care volume and severity of illness continued to rise, Dr. Van der Kloot has done an excellent job of improving our quality and outcomes. We are fortunate that he will continue to serve MMC as a clinician, as the Director of Rural Education, and as Physician Leader, Clinical Learning Environment Review.

Join us in thanking Dr. Van der Kloot and in supporting Dr. Seder and the Critical Care team throughout this transition.

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Robert L. Trowbridge Jr., M.D., FACP, to receive national award from the American College of Physicians

Maine Medical Center’s Robert L. Trowbridge Jr., M.D., FACP, has been awarded the Herbert S. Waxman Award for Outstanding Medical Student Educator from the American College of Physicians

(ACP), a national organization of internists.

Dr. Trowbridge, of Cape Elizabeth, is the director of Medical Student Education and Faculty Development in the Department of Medicine and director of the Division of General Internal Medicine at MMC.

He is an Associate Professor of Medicine at the Tufts University School of Medicine. Dr. Trowbridge also serves as Director of the Tufts University – Maine Medical Center Longitudinal Integrated Clerkship, which places "Maine Track" students at urban and rural hospital sites within the state.

Dr. Trowbridge is author of 20 peer reviewed papers and 17 book chapters and has edited seven books, including *Teaching Clinical Reasoning*, published by the American College of Physicians. In addition, Dr. Trowbridge has won more than 15 teaching awards at MMC, Tufts University School of Medicine and the University of Vermont College of Medicine.

The award will be presented at ACP's Convocation Ceremony on Thursday, March 30, 2017, at the San Diego Convention Center, where ACP is hosting its annual scientific conference, Internal Medicine Meeting 2017.

The Herbert S. Waxman Award for Outstanding Medical Student Educator was established by ACP's Board of Regents in 2003, in honor of the late Dr. Herbert S. Waxman, former ACP Senior Vice President for Medical Knowledge and Education. The award recognizes an outstanding internal medicine educator who spends a significant amount of time teaching medical students.

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Celebrating Our CRNAs

MMC employs more than 75 CRNAs who work in the operating rooms, labor and delivery, endoscopy, cardiac catheterization lab, radiology and at Scarborough Surgery Center. We use the anesthesia care-team model in which CRNAs work in collaboration with anesthesiologists to provide high-quality, patient-centered care.

Our CRNAs are recognizing CRNA Week (January 22 – 28) by raising funds for a good cause. This year they are donating to A House for ME, which proposes a new way to provide housing and support services to people with Intellectual Disabilities and Autism Spectrum Disorders.

Thank a CRNA this week for providing important and dedicated patient care!

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MaineHealth System Unification

Industry trends have accelerated a dialogue on fiscal and governance unity across the MaineHealth system.

The consensus has been growing for more than a decade. A seamless, comprehensive continuum of care leads to better health for our patients and our communities. Yet MaineHealth's current governance and operating models do not allow us to fully develop and leverage such a care continuum.

For providers across our system, the growing misalignment between our governing and operating models and the forces of change within the industry will be felt most directly when it comes to patient care. So far, we have found ways to minimize the impact on our patients. But the resource and structural challenges presented by our current system will grow. Already, issues such as recruitment (nearly 28 percent of our physicians system-wide are over the age of 60), access to primary and specialty care and the need to continue to build a seamless continuum of care have risen as chief concerns when it comes to better serving our patients. Unification can help with all these challenges.

There is much stress at our community hospitals because they remain dependent on relatively complex procedures and specialty care to pay the bills, even as the tidal forces of health care reform and technological innovation drive these patients to larger medical centers. The impact of this at a time of lagging public reimbursements and new calls to invest in primary care and population health is plain. Within MaineHealth, our PPS hospitals struggle, and even our Critical Access members find themselves stretched. Maine Medical Center, meanwhile, continues to grow while trying to keep up with increasing acuity and volume.

Unifying our members fiscally will help us manage through these trends.

What does unification mean? It means a single budget and balance sheet across the system. It means a single employer for all who work within the system. It means establishing a unified Board of Trustees that will govern across the system in way that is more nimble than our current structure. What doesn't it mean? It does not mean the loss of all local identity and local medical staff structure. All our member hospitals are required to maintain their local medical staffs under the terms of their licenses. It does not mean backing away from giving our patients excellent primary and appropriate secondary care in their communities. It does not mean ceasing to do locally those things that make sense locally. Perhaps most important for providers across the system is the fact that system governance and fiscal unity is a matter apart from organizing under a single, unified

medical group. Governance unity will make it easier for providers to work more closely, but whether and how such working relationships are formed is a matter that must be taken up among our providers and their leadership.

A decades-long dialogue

Since its founding nearly 20 years ago, MaineHealth has been discussing and moving toward greater unification. That trend continued with the approval by our member boards of the recommendations of the Governance & Structure Ad Hoc Committee two years ago.

Indeed, there has been much good work done toward the goal of greater unity. We continue our plans to move our clinical and administrative operations to a single IT platform on SeHR. We have established service lines in cardiovascular, oncology, behavioral health care and pediatrics. We have unified specific operational functions including human resources and information technology, while creating system-level support in areas such as audit and compliance, legal and marketing and communications. More recently, we've adopted a new MaineHealth Strategic Plan, have created a set of system-wide values and have nearly completed the creation of new member strategic plans that align with that of MaineHealth.

It is becoming apparent, however, that all this may not be enough to be successful in the future health care environment.

Our community hospitals are coming under enormous pressure. Across the country, more than 70 rural hospitals have closed since 2010. Within our system, our PPS hospitals – often called "tweeners" – have struggled to stay in the black. This has led to layoffs, wage freezes and benefit cuts in some locations. Even those hospitals designated as "Critical Access" have been challenged, despite the fact they are allowed to bill CMS at more favorable rates.

How unification helps

As this conversation moves forward, the goal of leaders across the system is to keep patient care at its center. Unification should allow us to use our collective resources to deliver a care model across the entire system that is rational and equitable and meets the tenets of the Triple Aim of better care, better health in our communities and lower cost. It will provide a mechanism to serve all our communities, rather than depending on each community to stand on its own. It will leverage the strength that we have together to meet external challenges and help with the conversion from volume to value-based reimbursement rather than individual members each struggling to meet those same challenges alone.

By unifying our governance and fiscal structures, we can harness the industry forces now impacting our health system. Resources can more easily flow to where they are needed. Care for our patients can be delivered in its most appropriate setting, whether that's at a high-volume center of excellence or at the local level where a clinical need has been identified and system resources are brought to meet it.

Our community hospitals won't be freed of responsibility to the bottom line, but nor will they have to stand entirely on their own.

This will create more stability that should be beneficial to our patients and the communities we serve. Notably, it will help us to continue to invest in our employees – an imperative we often refer to as the fourth leg of a "Quadruple Aim" across our system

What are the challenges with unification?

A good deal of civic pride and identity is tied to our local health systems. Fiscal unity necessitates a governance model that spans the MaineHealth system. The model that emerges from it must be inclusive to succeed.

There also remains, significant legal and structural issues that must be addressed before we could combine separate entities into a single, $2 billion organization with 18,000 employees. As daunting as these are, however, they are no more challenging than managing the inconsistent financial results of MaineHealth's member hospitals.

Also, our employees and physician colleagues will have to adapt to changes large and small. This is change that could be unsettling.

And for providers, there is more work to do and more to consider. Providers are very interested in opportunities to collaborate across the system. These might include making it easier for providers to practice in multiple locations - filling the gaps that can occur in rural settings – creating opportunities to build careers across the system and extending education and research activities now concentrated at Maine Medical Center across the system. But all these opportunities depend on how we structure ourselves as a provider group or groups, which is an important and parallel conversation that must take place among our providers and their leadership.

Some may also worry that their voices may get lost in a larger system. A single governing body is likely to be far more transparent than multiple boards whose roles and responsibilities are not always clear to everyone across our system. And should providers be organized in a way that allows them to speak with a unified, system-wide voice, it is likely that such a voice would hold substantial sway within the organization.

Summary

The rapidly changing industry landscape is forcing the conversation about fiscal and governance unification across MaineHealth sooner than many of us had anticipated. These trends are proving highly disruptive for our members and threaten to undermine our efforts to provide excellent, patient-centered care. This instability is making it harder for them to focus on our vision and deliver against that vision and the Triple Aim. Unification will allow us to harness these disruptive forces. The result will be a premier health care system where patients get the best possible care as close to home as possible; where communities experience greater health and wellbeing as well as mitigated costs for care; and where our employees gain greater stability and opportunity across a large dynamic health care system that provides the most innovative and highest quality health care

possible.

Click here to read more about MaineHealth Unification, and see minutes from MaineHealth member meetings.

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Publications

Parry TJ, Ganguly A, Troy EL, Luis Guerrero J, Iaci JF, Srinivas M, Vecchione AM, Button DC, Hackett CS, Zolty R, **Sawyer DB**, Caggiano AO. Effects of neuregulin GGF2 (cimaglermin alfa) dose and treatment frequency on left ventricular function in rats following myocardial infarction. Eur J Pharmacol. 2016 Dec 16.

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Carpenter JP, Cuff R, Buckley C, **Healey C**, Hussain S, Reijnen MM, Trani J, Böckler D; Nellix Investigators. One-year pivotal trial outcomes of the Nellix system for endovascular aneurysm sealing. J Vasc Surg. 2016 Dec 13.

Manson JE, Brannon PM, **Rosen CJ**, Taylor CL. Vitamin D Deficiency - Is There Really a Pandemic? N Engl J Med. 2016 Nov 10;375(19):1817-1820

Binks AP, **Desjardin S, Riker R.** ICU Clinicians Underestimate Breathing Discomfort in Ventilated Subjects. Respir Care. 2016 Dec 13.

Liu JM, **Rosen CJ**, Ducy P, Kousteni S, Karsenty G. Regulation of Glucose Handling by the Skeleton: Insights From Mouse and Human Studies. Diabetes. 2016 Nov;65(11):3225-3232.

Manson JE, Brannon PM, **Rosen CJ**, Taylor CL. Vitamin D Deficiency - Is There Really a Pandemic? N Engl J Med. 2016 Nov 10;375(19):1817-1820.

Hoffman M, **Gerding JP**, **Zuckerman JB**. Stroke and myocardial infarction following bronchial artery embolization in a cystic fibrosis patient. J Cyst Fibros. 2016 Dec 6.

Gridley T. Twenty Years in Maine: Integrating Insights from Developmental Biology into Translational Medicine in a Small State. Curr Top Dev Biol. 2016;116:435-43.

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Calendar

2017 Med Staff Dinners – Save the Date

- April 5, Dana Center Lobby
- September 20, East Tower Patio

Dinners begin at 5:30 and run until about 7 p.m.

Maine Medical Center Medical Executive Committee Meeting Schedule 2017

- January 20
- February 17
- March 17
- April 21
- May 19
- June 16
- July 21
- August 18
- September 15
- October 20
- November 17
- December 15

All meetings are held from Noon - 2 p.m. in the Dana Center Boardroom. Lunch is served.

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Story Ideas?

Your participation is essential to making The Scope a dynamic and sustainable publication. Please submit articles of 250-300 words to thescope@mmc.org. Include practitioner's byline with title and appropriate contact for further information. We publish two times each month.

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Medical Staff Value, Mission, and Vision Statements

Value Statement
The Medical Staff of Maine Medical Center values both individuality and collaboration. We will continually pursue higher value health care. We embrace a culture of curiosity and life-long learning. We are partners with Maine Medical Center, and we mirror its values of compassion, service, integrity, respect, and stewardship.

Mission Statement
The Mission of the Medical Staff of Maine Medical Center is to provide affordable, high-quality health care to our community. We teach future health care providers and develop innovative ways to improve the health of our community. In partnership with the Medical Center, we proudly accept our responsibility as one of Maine's leaders in patient care, education, and research.

Vision Statement
The Medical Staff of Maine Medical Center will be the driving force within Maine Medical Center leading the way to making Maine the healthiest state in the nation.

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Maine Medical Center
MaineHealth

centered around you

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