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OnCall

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A Newsletter for the Physicians and Office Managers of the Lourdes Health System

www.lourdesnet.org

Keys to Improving Doctor-Patient Communication



What do patients want from their physician? Sure, they want someone who is clinically competent, but more likely a doctor who will listen to them. Numerous studies have revealed that patients want more and better information about their condition and outcome, side effects of treatment, relief of pain and advice on self-care.^{1,2}

But are physicians listening? With an increasing practice volume—and a corresponding decrease in time spent per patient—the dialogue patients crave often does not occur. Indeed, according to Jerome Groopman, MD, author of “How Doctors Think” and a professor of medicine at Harvard Medical School, doctors interrupt their patients within 18 seconds of the start of their conversation.

Communication affects everything a physician does, including patient history, diagnosis and treatment, said Gaurav Mathur, MD, who practices palliative medicine with VITAS Innovative Hospice in Mount Laurel. “While we have tools such as CT scans and blood tests, how do we know the right tests to order unless we listen to the patient and hear what they’re saying?” asked Dr. Mathur, who spoke to medical staff at Our Lady of Lourdes Medical Center recently.

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Proper doctor-patient communication also can lead to better patient outcomes. A meta-analysis of four decades of studies found that clear communication makes a difference not only in patient satisfaction, but resolution of chronic headaches, lower blood sugar values in diabetics, improved blood pressure readings in hypertensives and other health indicators.³

Dr. Mathur offers the following tips for improved doctor-patient communication:

- **Respect your patient.** Patients today are savvy healthcare consumers who want to be active participants in medical decision making. Patients are keen to switch physicians if you don’t meet their expectations.⁴ Know your patient will come armed with Internet-researched questions and try to answer the most relevant.
- **Balance your need to talk while listening to the patient.**
- **Know who you are treating.** Often, a spouse, child, sibling or friend can be present during care. While these individuals are important, don’t let the patient get sidelined in his or her own care. In addition, in a hospital situation where many family members may be present, be sure to get the patient’s permission before discussing healthcare information.
- **Avoid jargon.** Saying “allergen” rather than “this is the thing that caused your rash” seems natural and saves time. However, most patients did not go to medical school and probably won’t understand. Some will nod their head, pretending to understand, while others will stare blankly. The result: miscommunication and poor adherence to treatment plans.
- **Give information in small doses.** Yes, you’re in a hurry, but don’t overwhelm the patient with test results, your diagnosis and treatment plans in three minutes. Slow down. Wait for a reaction if one is

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Medical Mythology: Separating Fact from Fiction in the Age of Evidence-Based Medicine

By Stephen Kabel, DO

Evidence-based medicine continues to garner controversy among medical professionals. Below we have excerpted an article that appeared in the winter 2010 issue of The Journal of the New Jersey Association of Osteopathic Physicians and Surgeons. The article by Dr. Kabel challenges some common assumptions that are still being practiced. Because diabetes is so prevalent, we focused on two myths related to this condition.

Medical myths are things we have been taught or told that are just plain wrong. Like the proverbial apple that keeps the doctor away, they are bits of information that are passed down from generation to generation and become entrenched over time.

As we have entered an age of evidence-based medicine ... we are expected to use the most current and best evidence

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Lourdes Corporate Compliance: Integrity in Action

When it comes to the violation of corporate compliance policies, intention does not matter. An unintentional violation is just as relevant as one that is deliberate. You may be aware that new laws concerning HIPPA bring increased scrutiny (and enforcement) of patient privacy and confidentiality, but in addition, corporate compliance is concerned with issues such as:

- Dishonest communication
- Conflicts of interest
- Stealing/misuse of assets
- Environmental/safety issues
- Proprietary information – misuse
- Discrimination and harassment
- Inappropriate gifts
- Fraud, abuse or false claims
- Improper lobbying/politics

Active corporate compliance programs help organizations to maintain the highest ethical standards.

“At Lourdes Health System, we are dedicated to maintaining an atmosphere of transparency to ensure all patients, physicians and associates feel confident in reporting areas of concern and questionable behaviors,” said **Barbara Holfelner, RN, MSN**, vice president for risk management, patient safety and compliance. “Corporate compliance is truly integrity in action, and is an expression of our Core Values and Mission.”

Remember, it is everyone’s responsibility to report, in good faith, concerns about actual or potential wrongdoing related to governmental rules, laws and regulations, organizational policies/procedures and the Lourdes Health System Code of Conduct.

If you have questions or concerns about a specific behavior or situation related to compliance, please contact the Lourdes Compliance Hotline number at **1-877-215-5697**. This service is available 24 hours a day, 7 days a week. It is confidential, anonymous and promises to provide complete follow through of your concerns.

“We appreciate your service to the medical staff of Lourdes Health System hospitals and our patients,” Holfelner said. “Do not hesitate to call me directly if you require any clarification or guidance of any corporate compliance issues.”

To contact Barbara Holfelner, call 856-757-3642.

Improving Communication

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appropriate, saying, “Does this make sense to you?” Summarize and ask the patient to explain/repeat back to you. Remember, not every patient learns everything the first time.

- **Don’t get caught up in the details.** A patient may get hung up on a particular test result and tune out the rest of what you are saying.

- **Offer options for treatment.** Telling the patient the different modalities available for treatment, including the one you recommend, makes the patient feel involved in the process.

- **Talk about the patient and the illness as a whole and how it is affecting him or her.** Give a realistic picture of the illness, the po-

tential side effects of medications and therapies and what may lie ahead, such as rehab. Provide timetables in ranges, so as to better manage expectations.

To contact Dr. Mathur, call 856-778-0222 or e-mail him at Gaurav.mathur@vitas.com.

¹ Richards T. Chasms in communication. *British Medical Journal*. 1990;301:1407-8.

² Meryn S. Improving doctor-patient communication. *British Medical Journal*. 1998;316:1922.

³ Rao JK, Anderson LA, Inui TS, Frankel RM. Communication interventions make a difference in conversations between physicians and patients: a systematic review of the evidence. *Medical Care*. April 2007;45:340-349.

⁴ Kaplan SH, Greenfield S, Gandek B, Rogers WH, Ware JE. Characteristics of physicians with participatory decision-making styles. *Ann Intern Med*. 1996;124:497-504.

Joint Commission 2010: Universal Protocol Time Out

The Joint Commission has released the 2010 Universal Protocol Time Out Goal to clarify processes for safe surgery. The revised goal includes new modifications of performance and changes to the goal language. The Universal Protocol includes the correct patient, correct procedural site and correct procedure. The goal improvements emanated from previous standards and have an optimal design for the reduction in wrong-site surgeries. The goal promotes significant procedural teamwork.

The pre-procedure verification process includes relevant documents such as the patient’s history and physical. A checklist is used for safety. The procedure site is marked when the patient is awake and involved in the process, which usually occurs in a location prior to the procedure room. At Lourdes Health System, the accepted site marking is the word “Yes,” and the marking can only be performed by the proceduralist. A time out is immediately performed prior to starting the procedure. In the event that two or more procedures are being performed, a time out is carried out prior to each separate procedure.

Lourdes Health System’s Universal Protocol – Time Out Policy is detailed in policy AS0070ADM. Information for patients is available through the Joint Commission’s Speak Up™ initiative website at http://www.jointcommission.org/GeneralPublic/Speak+Up/about_speakup.htm.

For more information, contact the patient safety office at 856-365-4095.



Think In Ink: Clinical Documentation Improvement at Lourdes

Guidelines for the Discharge Summary

CLINICAL DOCUMENTATION

The clinical documentation improvement (CDI) specialists review daily documentation by the physicians on all Medicare charts. CDI specialists seek to improve documentation so as to capture appropriate coding. This proper coding with the highest level of specificity directly affects reimbursement to the hospital.

When the patient is discharged, the gold standard for coding is the discharge summary. This summary should state the final diagnosis, which is the condition that is the chief reason for admission. All other diagnoses that are treated, evaluated, monitored and coexist should be documented for completeness of the discharge summary.

A good practice is to review the chart thoroughly prior to dictating the discharge summary to make sure that the patient's care and treatment are completely reflected. A good tool is the CDI worksheet (located on the chart in back of the progress notes) that lists the working primary diagnosis and all secondary diagnoses. If there are developments that required a further evaluation and caused a delay in discharge, this should be explained in the discharge summary. This is a desirable practice to develop with the impact of recovery audit contractors (RAC) or other outside auditors.

Diagnoses that have been "suspected," "probable" or "ruled out" during the course of the patient's hospitalization also should be clarified in the discharge summary. These conditions may not be coded unless they are referenced in the summary as still being evaluated and requiring further follow-up after discharge.

Precise and timely dictation of the discharge summary for the coders not only will present a concise clinical picture, it will avoid any future questions regarding compliance. And remember, if a diagnosis or treatment is not documented, it cannot be coded and reimbursement will not occur.

For more information, contact Judith Bates, RN, BSN, CDS at 856-757-3161.

Up-Front Collections Program Underway

Effective May 12, Lourdes Health System has initiated a new policy concerning the collection of co-payments and other out-of-pocket expenses from patients who present for services at Our Lady of Lourdes Medical Center, Lourdes Medical Center of Burlington County, as well as our outpatient offices.

This new policy is an effort to align Lourdes with a standard practice that is in place at many regional and national centers. This change comes after careful consideration at a time when healthcare facilities are struggling in this difficult financial environment. Since many private offices and other hospitals have a similar policy in place, we

believe that this change will go unnoticed by a majority of patients. Nonetheless, we wanted you to be aware in case there were any comments or concerns expressed by your patients.

Thank you for your understanding in this matter. We believe this will be a positive step in strengthening the financial position of Lourdes Health System as we move toward the future.

You may review the policy electronically at <http://www.lourdesmed.org/physicians/documents/95261flyer.pdf>. To request a hard copy or for questions, contact Maria Wence, corporate director of patient access, at 856-757-3676.

Medical Mythology *Continued from page 1*

in making decisions about the daily care of our patients. Not only do our patients expect it, but insurers and health policymakers expect it as well. If we do not learn from the research and insist on keeping faith in the myths, we end up sacrificing quality care because even the most experienced clinician is nothing without evidence, just like the best evidence is worthless without clinical experience.

Diabetes

Should tight control be the goal in type II diabetics, and should we aim for near normal hemoglobin A1c (HbA1c) levels? The 2004 National Committee for Quality Assurance (NCQA) in its Bridges to Excellence Program established a goal of HbA1c < 7.0 percent in 50 percent or more of a physician's patients. The 2006 NCQA raised the standard to HbA1c < 7.0 percent in all diabetics. This became the new criteria for the Healthcare Effectiveness Data and Information Set, the tool used by health plans to measure performance on important dimensions of care and service. Prior to 2006, it was 9 percent.

What's the evidence? The 1998 UK Prospective Diabetes Study compared metformin with conventional treatment or intensive treatment with a sulfonylurea agent or insulin. No benefit was found for any single macrovascular endpoint for any treatment arm. Only metformin lowered microvascular disease and reduced the aggregated macrovascular endpoints. Intensive treatment actually showed a higher morbidity and mortality. A 20-year follow-up study showed that the results were diminished but still positive for metformin only.

In addition, the ACCORD trial published in 2008 was stopped early because of a 22 percent excess all-cause mortality in the intensive treatment arm. The intensive treatment arm also saw a higher rate of significant hypoglycemia and weight gain.

So what can we say? Currently, there is no well-conducted RCT that shows a major benefit in lowering HbA1c < 8.0-9.0 percent in regard to macrovascular disease in type II diabetes mellitus. Intensive treatment is probably detrimental and metformin is the only glucose-lowering agent consistently shown to help with microvascular disease.

Sliding Scale Insulin (SSI)

SSI was first described in 1934 and based on urine glucose monitoring. There is no standardization in schedules, with most physicians learning it in residency as taught by senior residents. It has traditionally been scheduled every four-to-six hours without regard to meals. Why is it still in use? Tradition, it's easy to use, straightforward and it makes you feel like you are doing something. What's the evidence? An RCT evaluating basal/bolus (mealtime) insulin regimen showed superior glycemic control compared with SSI. SSI has no literature to support its use. Fifty-two trials from 1966 to 2003 in a Medline search failed to find even one positive study. In fact, SSI was described as nonsensical 45 years ago.

Dr. Kabel, a general internist, is vice president of the medical staff at Lourdes Medical Center of Burlington County. He is president of the Burlington County Society of Osteopathic Physicians and Surgeons. To contact him, call 856-461-6200. To obtain the entire article, visit www.njosteo.com.



AROUND THE HOUSE

- Lourdes Medical Center of Burlington County has been certified a Primary Stroke Center by the New Jersey Department of Health and Senior Services. The program meets Primary Stroke Center criteria by having a specially trained, multi-disciplinary team available around the clock, board-certified neurologists on call, neuro-imaging capabilities and acute rehabilitation services. **Scott Sharetts, MD**, is medical director.

- Lourdes Health System consolidated obstetrical services at Our Lady of Lourdes Medical Center, effective May 21. The emergency department at Lourdes Medical Center of Burlington County will continue to provide emergent delivery services to any woman who presents and is imminently about to give birth. Following delivery, arrangements will be made to transport the mother and baby to the mother's hospital of choice in coordination with her physician.

- Lourdes Emergency Department at Deborah Heart and Lung Center in Browns Mills opened in March, serving residents in Burlington, Mercer and Ocean counties. Patients requiring admission with cardiovascular issues are transported to adjacent Deborah; most others go to Lourdes Medical Center of Burlington County.

- Cardiologist **Reginald Blaber, MD**, recently was appointed chairman of the department of medicine at Our Lady of Lourdes Medical Center. Dr. Blaber, president of Lourdes Medical Associates, replaces **Alan Pope, MD**, who was named chief medical officer.

- **Matthew Finnegan, MD**, was appointed chief of the division of general surgery at Our Lady of Lourdes Medical Center. He replaces **Kenneth Leese, MD**.

- Congratulations to oncologist **Stephen Vasso, MD**, who retired after 40 years of service to Our Lady of Lourdes Medical Center.

On Call
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On Call is intended to provide physicians and their office staffs with news and information that will assist them in their daily practice.

Please direct any comments or suggestions to our Writer/Editor at bernsteinj@lourdesnet.org. Membership on the medical staff of Lourdes Health System hospitals does not suggest an employment or agency relationship. A ministry of the Franciscan Sisters of Allegany, New York and a member of Catholic Health East.