

# Physician Update



A MERCY MEDICAL CENTER PUBLICATION

LATE SUMMER 2008

## Staff Announcements

Mercy Medical Center would like to "welcome" the following health practitioners who were appointed to the Medical Staff April, May and June 2008:

Physicians

**Mona Arabi, MD**

*Department of Anesthesia*

**Isac Bloch, MD**

*Department of Surgery*

**Helen Chisholm, MD**

*Department of Radiology*

**Spencer Haller, MD**

*Department of Medicine & Pediatrics*

**John Murphy, DO**

*Department of Medicine*

**Nam Hoon Park, MD**

*Department of Anesthesia*

**Mohammad Rahman, MD**

*Department of Medicine*

**Abhishake Raina, MD**

*Department of Medicine*

**Howard Raymond, MD**

*Department of Radiology*

**Elizabeth Rose, MD**

*Department of Pediatrics*

**Mark Skalski, MD**

*Department of Medicine*

**Jonathan Sudol, DMD**

*Department of Surgery/Dental*

Allied Health Staff:

**Lindsey Casey, NP**

*Clinical: Nurse Practitioner*

**Stacey Panasci, PA**

*Clinical: Physician Assistant*

**Susan Plante, NP**

*Clinical: Nurse Practitioner*

**Heather Wightman, PA**

*Clinical: Physician Assistant*

## New Chief Operating Officer Joins Mercy Medical Center

### Senior Vice President/Chief Medical Officer Appointment



*William G. Bithoney, MD*

We are very pleased to announce the appointment of William G. Bithoney, MD as Chief Operating Officer of Mercy Medical Center and Senior Vice President/Chief Medical Officer of the Sisters of Providence Health System, effective September 2, 2008.

As Chief Operating Officer of Mercy Medical Center, Dr. Bithoney will be a member of the Sisters of Providence Health System (SPHS) Senior Leadership Team and serve as champion of strategies to assure active physician

leadership in Mercy Medical Center programs, processes and decision-making. He will direct the overall medical affairs related to health care delivery, health care quality as well as the medical management of patient care for Mercy Medical Center, Providence Behavioral Health Hospital, and Weldon Rehabilitation Hospital. Dr. Bithoney will be responsible for all medical services involved in the provision of care in accordance with the Mercy Medical Center Medical Staff by-laws, the Mission and goals of the hospitals and its affiliates. Dr. Bithoney will also be responsible for oversight and coordination of the Mercy Internal Medicine Services.

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## Mercy Medical Center Adds New da Vinci® Surgical System

### Robotic Technique Enhances Surgery Capabilities

Mercy Medical Center has added the da Vinci® Surgical System, a minimally invasive device that utilizes a state-of-the-art robotic platform to enhance surgical capabilities and serve as an alternative to many traditional, open surgeries and conventional laparoscopic procedures. With the da Vinci® System, surgeons are able to perform even the most complex and delicate procedures through very small incisions with remarkable precision.

"Mercy Medical Center continues to introduce the most advanced surgical tools and techniques, so that patients



*Dr. Raphael deLima (right) and Joe Provoda of South Hadley, the first patient to undergo surgery with Mercy's new da Vinci system, performed by Dr. deLima.*

in Western Massachusetts can have access to leading-edge medical technologies,"

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# The Message You Hope Never to Have to Send



Winthrop F. Whitcomb, MD, Director, Clinical Performance Improvement, Mercy Medical Center

**Paul Levy,**

CEO, BI-Deaconess Medical Center

*“This week at BIDMC, a patient was harmed when something happened that never should happen: A procedure was performed on the wrong body part.”*

Mr. Levy wrote this in an open letter to the community and put it on his blog on July 5. He goes on to point out that prior to incision, the surgical team neglected to perform a “time out,” or a last-minute check when the surgical team confirms “right patient, right procedure,

right side.” It goes without saying that the “time out” is a crucial step, whether performed prior to surgical incision or done prior to clearing a jet for take-off. Thank you for devoting your attention to this process.

**Surgical Quality—Process of Care Measures**

I would also like to thank the surgeons who take my calls when I point out that we have missed an opportunity to use prophylactic antibiotics appropriately or prescribe prophylaxis for venous thromboembolism (VTE) after surgery. It is clear that our surgeons wish to “do the right thing” related to quality of care, and have been very cooperative despite the growing burden of regulatory oversight. We now have one of the most robust surgical quality programs in the state. For example, in 2007 Mercy Medical Center achieved the following results:

- 92% of patients received a prophylactic antibiotic within 1 hour prior to incision (MA average –91%, US average –84%)
- 97% of patients had appropriate prophylactic antibiotic selection (MA average – 93%, US average – 91%)
- 90% of patients received appropriate venous thromboembolism prophylaxis within 24 hours prior surgery to 24 hours after surgery (MA average – 88%, US average – 77%)

What follows are a few reminders. In the course of writing orders, please remember to:

- Prescribe prophylaxis for VTE so the patient receives it within 24 hours after incision, at the latest. If you feel chemical prophylaxis is contraindicated, please indicate this and the reason why in the medical record.

- When writing preoperative orders, especially antibiotics, please refer to the new (as of August 2008) preoperative order sheet for both inpatient and outpatient surgery. Prophylactic antibiotic regimens are determined by the Centers for Disease Control, therefore please follow the guidelines on our order sheet.

**What About Surgical Outcomes?**

I am delighted to announce that as of this autumn, Mercy Medical Center will be participating in the National Surgical Quality Improvement Project (NSQIP) sponsored by the American College of Surgeons. NSQIP is a “prospective, peer controlled, validated database to quantify 30-day risk-adjusted surgical outcomes, which allows valid comparison of outcomes among all hospitals in the program.” In other words, it allows us to examine postoperative complications, such as infection or respiratory problems, and compare our complication rate as an institution (or broken down by a given subspecialty) with an expected complication rate based on patient severity of illness and comorbid factors. NSQIP is not intended to profile individual practitioners. NSQIP will allow us to base improvement strategies on patient outcomes derived from clinically validated information.

**Hospital Acquired Infections**

Hospital Acquired Infections (HAIs) have emerged as the dominant patient safety issue this year. Of the nine Centers

for Medicare and Medicaid Services’ proposed 2009 ‘no-pay’ conditions for hospitals, five are HAIs. The single best approach to HAI prevention is hand-washing. Please remember to wash your hands between every patient, even if you have donned gloves.

**Results of Joint Commission Mock Survey – Physician Issues**

Recently, an independent consultant identified three major physician issues that may affect Mercy Hospital’s accreditation when the Joint Commission performs its next survey, anticipated for 2009:

1. Illegible handwriting. If two individuals cannot decipher handwriting, it is determined to be illegible.
2. Entries into the medical record – orders or progress notes – that are not timed and dated. Please put the time and date next to all entries into the medical record.
3. “Pre-populated” documents. This means that operative notes, discharge medication reconciliation forms, and any other form of documentation may not be performed before the actual event. That is, operative notes may only be written after surgery, and discharge medication reconciliation may only be performed on the day of discharge (for inpatients) or at the actual time of discharge (for patient receiving an outpatient procedure).

Thanks for your attention and your commitment to the highest quality of care!

## Did You Know?

Code Care...because we do care.  
To ensure "Great Care all the Time"



The following article recently appeared in Mercy Medical Center's Nursing and Education Newsletter

### Live May 1, 2008...

Code Care will provide our patients and families an avenue to summon immediate help when they feel they are not receiving adequate medical attention in an emergent situation.

### How does it work?

- Patient or family can call the Code Care line;
- Call 4911 from patient's phone;
- Notify operator that this is a "Code Care;"
- Operator will announce overhead and also page the Code Care Team;
- Responders: Patient's RN, other Unit Staff, Unit Based Supervisor or Manager, Administrative Supervisor and Spiritual Care.

### When should patients/family members call a Code Care?

- Noticeable medical change in the patient that needs immediate attention and a member of the health care team is not available.
- Breakdown in how care is being given and/or confusion over what needs to be done for the patient in an emergent situation.
- Code Care is NOT a replacement for a RRT (Rapid Response Team) or ERT (Emergency Response Team).

### How will patients/families know about Code Care?

- Information in the patient guidebooks that they receive on admission.

# Documentation Strategies

Lisa McCusker, Compliance Officer, Director HIM/MSO

Medical Record documentation requirements are determined by various regulatory agencies as well as the Joint Commission. The medical staff rules and regulations also regulate documentation in the record. This article will serve as a quick reference guide to assist you in record documentation improvement.

## Documentation Time Frames

- **H&P** – Must be completed within 30 days and 24 hours of admission.
- **Progress Notes** – Must include patient's condition, and the physician's assessment plan. The rule of thumb is to complete progress notes the same time/day you see the patient.
- **Orders** – Must be dated, timed and authenticated. This ensures if you are audited that they were carried out in a timely manner consistent with patient care and condition.
- **Informed Consent** – Must be documented prior to the initiation of any procedure or the start of anesthesia.
- **Operative Reports** – Must be on the record immediately after surgery.
- **Anesthesia Record** – Must be documented immediately prior to and after surgery.
- **Discharge Summary** – Rule of thumb is within 30 days after discharge, but for continuing patient care immediately or within 7 days.
- **Completed Medical Records** – Must be completed by physicians within 30 days after discharge of the patient.
- **Joint Commission** measures medical record delinquency rates based on quarters.

Legibility of the record is a patient care issue as well as a liability issue for the physician and the organization. Many physicians are now being sued due to poor legibility of their records that have resulted in an adverse event to a patient. Following is an explanation of what liability a record poses when not accurately documented:

## Legal Side of the Medical Record

1. Rule Number One in any venue, "Not documented, not done."
2. The Medical Record is a legal document that can be used in a law suit.
3. Entries made after established timeframes can be challenged in court.
4. Informed consent is a conversation between a patient and a physician, document in the record that you had a conversation with the patient and write a brief note about the conversation. Having a staff person obtain a patient's signature on the form provides you with the least protection in any proceeding.

Reimbursement is always dependent on proper and thorough documentation:

## How Documentation Affects Reimbursement

1. Payers look for the physician documentation first.
2. "Medically necessary" services are determined by physician documentation that is thorough, timely and validates the medical necessity of admissions, transfers and any care provided to a patient.
3. Coders can only code by what was documented, "not documented not done."
4. Delaying critical pieces of documentation, such as an Operative Report or Discharge Summary will delay claims and reimbursement for the organization.
5. Severity of Illness is critical to reimbursement and accurate documentation is a must to properly code and bill.

In summary we all need to be aware of the rules and regulations of the organization for timely record completion as well as our responsibility to safeguard the records. The goal is to accurately reflect the patient's stay in our organization and appropriately seek reimbursement for the services that we are all providing; the record is the document that does this.

Next Issue – Present on Admission

## Mercy Adds New da Vinci® Surgical System

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said Vincent McCorkle, President and Chief Executive Officer, Sisters of Providence Health System. "Addition of the da Vinci® Surgical System is another example of Mercy's commitment to clinical excellence. Mercy surgeons already provide outstanding outcomes; with robotic technology, they are redefining standards of clinical care."

Using the da Vinci Surgical System, the surgeon performs the operation from a console, while viewing a 3D image of the surgical field. The surgeon's fingers grasp the master controls below the display, with hands and wrists naturally positioned relative to their own eyes. The system seamlessly translates the surgeon's hand, wrist and finger movements into precise real-time movements of surgical instruments inside the patient.



"The da Vinci® Surgical System enhances surgical capabilities by providing better visualization, precision, dexterity and control," said Robert Kasper, MD. "Specific benefits for surgical patients may include reduced blood loss and trauma to the body, less postoperative pain and risk of infection, a shorter hospital stay, faster recovery and less scarring, depending on the type of surgery they have."

Currently, the da Vinci® Surgical System is utilized for prostate surgery at Mercy Medical Center, although plans call for expanding its use to gynecologic and other surgeries.

## Mercy Hires New COO

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Most recently, Dr. Bithoney has functioned as an independent consultant for Price Waterhouse Coopers in the role of Acting Senior Vice President for Administration at Grady Memorial Health System in Atlanta, GA.

Additionally, Dr. Bithoney served as Physician in Chief at Saint Vincent Catholic Medical Centers in New York City where he participated as a senior member of the management team.

Dr. Bithoney also served as Chief Medical Officer at Mercy Health System in Philadelphia, a member of Catholic Health East.

Dr. Bithoney is a graduate of Yale University School of Medicine, New Haven, CT and also served a Residency in Pediatrics at Yale University School of Medicine. He is Board-Certified in Pediatrics and is a Fellow of the American Academy of Pediatrics.

## Robert J. Kasper, MD Retires From Administration

Dr. Robert Kasper recently retired from his position as Vice President of Physician Services for Mercy Medical Center. Dr. Kasper has been an integral part of Mercy Medical Center for the past 34 years. He began his career as a general surgeon in 1974.

During his tenure as a surgeon, Dr. Kasper devoted much of his personal time to helping the people of Jamaica. On these annual trips he and his contingent of medical support, often Mercy employee volunteers, would care for needy patients and perform surgery.

Dr. Kasper then began the administrative phase of his career in 2002 as an Assistant



*Robert Kasper, MD, (seated), his wife Jeanne Marie Kasper (left) and her mother, Elizabeth B. Sullivan. Dr. Kasper is seated in the chair he was presented in appreciation of his years of service to Mercy Medical center and SPHS.*

to the Vice President of Medical Affairs and was later promoted to Vice President of Physician Services.

Thankfully, we have not seen the last of Dr. Kasper as he will continue his affiliation with Mercy as a surgical assistant to our surgeons, including his son, John Kasper, MD.

"Dr. Kasper served as the quiet strength of the SPHS Leadership Team," said Vincent McCorkle, President and Chief Executive Officer, Sisters of Providence Health System. "He is a phenomenal person as well as a superb and beloved surgeon. We all wish him the best on this next phase of his journey."

Dr. Kasper then began the administrative phase of his career in 2002 as an Assistant

## Mercy Physician Liaison

Carol Gaines, MT, (ASCP), has taken on additional responsibilities as a Physician Liaison for Mercy Medical Center. In this position, she is responsible for



*Carol Gaines*

developing and maintaining strong relationships between Mercy Medical Center and the local physician community. She also works to enhance physician and office staff understanding of the services offered at Mercy Medical Center, streamline the referral process and improve overall satisfaction.

Gaines also serves as Account Manager, Physician Practices, for Life Laboratories.



A member of the Sisters of Providence Health System and Catholic Health East, sponsored by the Sisters of Providence.

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