midland memorial hospital

Medical Staff Newsletter

Medical Staff Services are the foundation of a solid, well governed medical staff that prides themselves in providing Midland Memorial Hospital and its customers with the highest quality of patient care possible.

Culture of Ownership: Core Action Values 7-12

Core Action Values 7 through 12 give you a roadmap for getting things done in the world. High achievers are always driven by a sense of Purpose that is greater than simply trying to make a living, and they have a Vision for the future; they Focus their time, money, and energy on what it takes to bring about that ideal future, and they do it with Enthusiasm, and a commitment to Service; and in doing all these things they become the sort of person that other people want to follow—they become Leaders.

Core Action Value #8-Vision

Humans are the only creature that can see something in the mind's eye that is invisible to the outside world. Cherish this God-given gift—cultivate it, use it to create your ideal future.

www.joetye.com

Volume 3, Number 10

October 2015

Introducing Our New Practitioners

October 2015

Clyde N. Ellis, MD—Colon and Rectal Surgery, Texas Tech
Archana Gutta, DDS—Hospital Dentistry
Robert K. McCarver, DDS—Hospital Dentistry
Ali N.Chhotani, MD—Pediatrics, Pediatric Hospitalist
Katherine E. McGraw, MD—Pediatrics, Pediatric Hospitalist

Continuing Medical Education—See Page 6

Midland Memorial Hospital is accredited by the Texas Medical Association to provide Continuing Medical Education for physicians. Midland Memorial Hospital designates this live educational activity for a maximum of 1.0 *AMA PRA Category 1 Credit(s)*™ for each teaching program throughout 2015. Physicians should only claim credit commensurate with the extent of their participation in the activity.

Physician Education for Improving Documentation

Physician Education Modules are available through 3M and are available by specialty. Notify Rebecca Pontaski, Medical Staff Manager if you would like a login.

Medical Staff Services Reminders

- Physician referrals should all be emailed to the mmhcredentialing@midland-memorial.com inbox. In addition this inbox is also used for appointment and reappointment applications.
- Texas Electronic Registrar (TER) Death Registration System—Since 2007, state law requires that all cause-of-death information and medical certifications to the DSHS be submitted electronically. Physicians who do not sign death certificates in a timely fashion face a $500 fine per violation from the TMB.
- It is peak season for students and others who want to come in and observe practitioner work. Anyone who will be observing a practitioner needs to complete and provide some information before they are able to do so. Please contact the medical staff office at 432-221-4629 for this information and process.
- Contact Rebecca Pontaski or Alma Martinez for additions to future newsletters.

Medical Staff Leadership

Chief of Staff
Sari Nabulsi, MD

Chief of Staff Elect
Michael Dragun, MD

Past Chief of Staff
John Dorman, MD

Department Chairs
Hospital-Based Services
Larry Edwards, MD

Medical Services
Larry Oliver, MD

Surgical Services
T.M. Hughes, MD

Rebecca Pontaski, MHA, CPMSM, CPCS, RHIT
Medical Staff Manager
432-221-1625

Alma K. Martinez, RHIT
Medical Staff Coordinator
432-221-1510

L. Michael Pallan
Credentialing Specialist
432-221-2165

Amber Machado
Credentialing Specialist
432-221-2261

Medical Staff Office Fax 432-221-4253 CME Hotline 432-221-1635

New Information

Forward Thinking will return next month.
Lawrence Wilson, MD, MBA, FACEP
Vice President, Medical Affairs/CMO

Over the past months I have written several times about the importance of us physicians working closely with the hospital administration. We are two essential elements to the successful delivery of health care in our community. We, the care providers, are an essential element to navigate the complex road ahead. We must figure out how to continue to deliver care while accounting for improved communication from primary care, acute care and post-acute care. The goal must be, within the triple aim, to reduce the cost of delivering high quality care while helping improve our patient's experience. Much can be said about this formidable task. If the ambition of accomplishing this does not whip you into a frenzy of excitement, perhaps the attached article, "**The Three-Year Plan**"(page 3), will inspire a level of interest. Essentially, the SGR fix brings with it, by 2019, an expectation that we will be working within a program that can demonstrate high quality health care at an improved cost. Whether we choose to stay with the Merit-based Incentive Payment System (MIPS) or choose an Alternative Payment Model (APM). In either case we will need to collaborate and partner with our hospital to be successful.
The other half of the team, our Hospital, is in this with us to assure we are successful. The Hospital administration is committed to the same goals of improved cost, high quality care while improving the patient experience. We need physician leaders working with the Hospital to accomplish our lofty goals. Many of you have received invitations to the Physician Leaders in Medicine program that will kick off on the 15th of October. This is sponsored by our Hospital and the Medical Staff Office for our benefit. Please attend if you can. I have seen a preview of the content and it will be provocative.

Of Importance:

- The new CRUSH protocol (Our Sepsis Bundle) has been implemented. It is essential that the parameters for managing SIRS patients be followed. It is **the latest CMS Core Measure.** It began 1 October. Our Sepsis Committee has worked overtime assuring we got this out on time and kudos to them for the hard work. **There are specific time and volume parameters. Please familiarize yourselves with it.**
- ICD-10 is here! Please note that problem lists that were established prior to 1 October 2015 will need be updated. **ITEMS IN PROBLEM LIST THAT WERE PLACED PRIOR TO 1 OCTOBER 2015 ARE GOING TO BE 1CD-9 AND WILL NEED BE UPDATED. THIS CAN BE DONE BY EDITING AND REPLACING THE PROBLEM LIST ITEMS**. Also, the codes you see assigned to the problem list items that you add **ARE NOT ICD-10 CODES. Please do not use the codes in the problems list as your billing codes - they are not accurate.**

From the Desk of your Chief of Staff will return next month.
Sari Nabulsi, MD, MBA, FAAP

The Three-Year Plan

July 29, 2015 • Winthrop Whitcomb, MD, MHM

Although 2019 may seem like a long way away, it isn't too soon to start thinking about and preparing for the Merit-based Incentive Payment System (MIPS) or its (seemingly preferable) alternative, participation in an alternative payment model (APM) such as an ACO, a medical home, or a bundled payment program.

In April, Congress permanently repealed Medicare's sustainable growth rate (SGR) formula for controlling physician payment. In yet another sign that we are in the midst of the biggest healthcare transformation in a generation, the 18-year-old SGR formula will be replaced by a far-reaching package of payment reforms. Here we will focus on the MIPS and its alternative, an APM, which involves assuming risk for financial loss or gain and measuring and reporting on quality.

The MIPS replaces three existing quality measurement programs that, to greater and lesser degrees, physicians have struggled with:

- Physician Quality Reporting System (PQRS);
- Value-based payment modifier; and
- Meaningful use of electronic health records.

MIPS will not totally eliminate these programs but will instead incorporate yet-to-be-defined elements of them and, presumably, though it is yet unclear, add new elements. For 2015-2018, the current payment system will remain intact. For 2019, physicians will have a choice. Either they must participate in MIPS, which will likely be complex and involve some administrative burden, or derive at least 25% of their practice revenue from an APM.

For 2015-2018, the current payment system will remain intact. For 2019, physicians will have a choice. Either they must participate in MIPS, which will likely be complex and involve some administrative burden, or derive at least 25% of their practice revenue from an APM.

For those participating in MIPS, physician payment rates will be subject to an up or down adjustment based on performance in four categories: quality, meaningful use of EHRs, resource use, and clinical practice improvement.

There is an opportunity to avoid MIPS altogether, however. One of the most notable elements of the SGR fix is its push for physicians to participate in APMs such as ACOs, medical homes, bundled payment arrangements, and other payment models now being evaluated by the CMS Innovation Center. Physicians who gain a substantial portion—this means 25% in 2019 and 2020, and likely more thereafter—of their revenue through APMs like these will have the dual benefit of being exempt from MIPS participation and receiving a 5% annual bonus through 2024. After that, physicians in APMs will receive annual fee increases of 0.75%, while all other physicians will receive only a 0.25% increase.[1]

Strategic Thinking for Hospitalists: Enter an APM

If you're asking yourself where you want your hospitalist practice to be in three years, I would suggest the answer is "in an alternative payment model of one kind or another."

If you are an employed practice, strategic planning will involve assessing the APMs your hospital or health system is participating in and planning how your hospitalist practice can become a formal member of the arrangement.

If you are a freestanding practice, you should become a student of the APM policy coming from the CMS Innovation Center, and determine the best "insertion point" for your practice, such that you gain at least a quarter of your revenue through an APM within three years.

Dr. Whitcomb is Chief Medical Officer of Remedy Partners. He is co-founder and past president of SHM.
Email him at wfwhit@comcast.net.

Reference

1. Steinbrook R. The repeal of Medicare's sustainable growth rate for physician payment. JAMA. 2015;313(20):2025-2026.

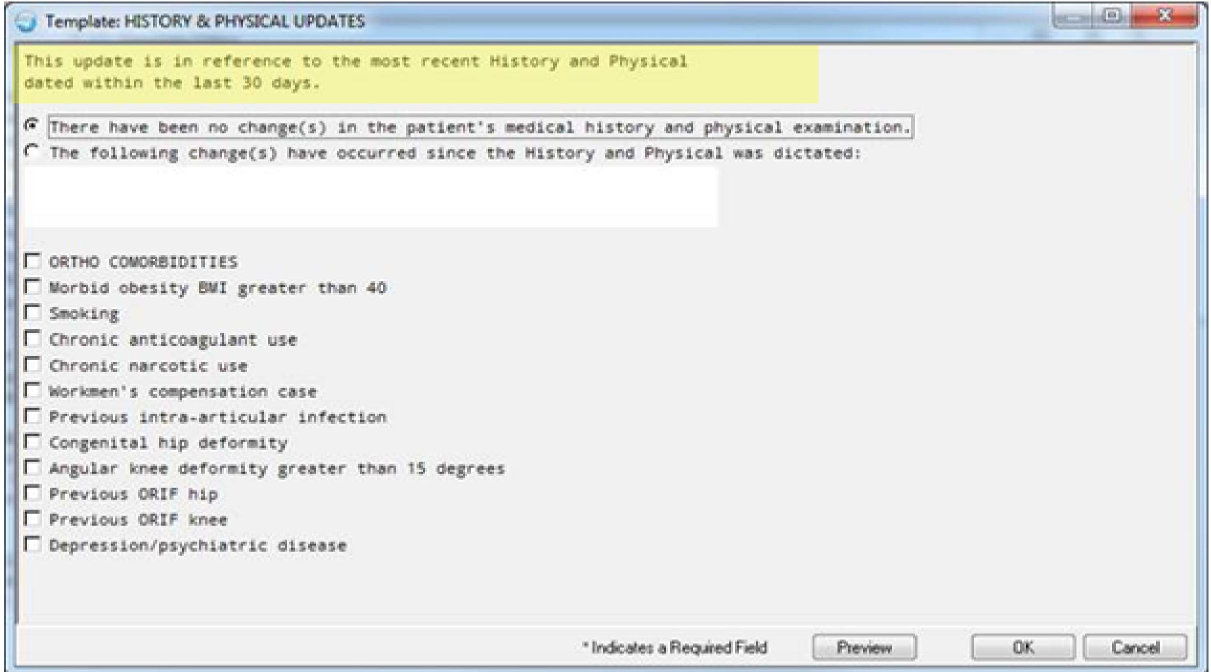
DNV 2015 Survey
History and Physical Non-Conformity

Midland Memorial received a non-conformity finding for History and Physical documentation in the September 2015 survey. The Surveyors cited H&Ps not documented within 24 hours of patient admissions and H&Ps greater than 30 days prior admission. The requirements for appropriate H&P documentation is clearly outlined in the Medical Staff Bylaws and is a requirement of CMS.

The History and Physical (H&P) examination (if needed) must be completed within 24 hours after admission or before a planned surgical or other procedure, whichever happens first. The H&P may be recorded up to 30 days before the hospital encounter, but must be updated as to the patient's current medical condition. The update, which must be recorded in the Electronic Medical Record (EMR), must occur after admission and within 24 hours of admission or immediately prior to a surgical procedure, whichever happens first.

The Surveyors also noted the date of the original H&P was not documented in the H&P update. Due to the onset of ICD10, a new version of History & Physical UPDATES template in CareVue was scheduled for release on October 1. The new template has been amended in an effort to address the issue identified during the survey.

A statement (highlighted in yellow) has been added to the template.



Physician Orders for Lab, Radiology Services, and Other Services after ICD-10 Implementation

CMS is not requiring the ordering provider to rewrite the original order with the appropriate ICD-10 code for lab, radiology services, or any other services after ICD-10 implementation on October 1, 2015, including Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS).

Products and services that require a diagnosis code on the order will use ICD-9-CM codes if written prior to October 1, 2015. If the order is for a repetitive service that will continue to be delivered and billed after October 1, 2015, providers have the option to use the General Equivalence Mappings (GEMs) posted on the 2016 ICD-10-CM and GEMs web page (https://www.cms.gov/Medicare/Coding/ICD10/2016-ICD-10-CM-and-GEMs.html) to translate the ICD-9-CM codes on the original order into ICD-10-CM diagnosis codes.

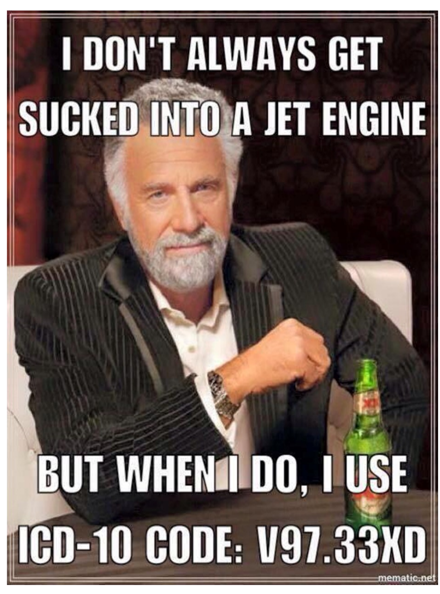
CareVue Problem List and ICD-10 Conversion

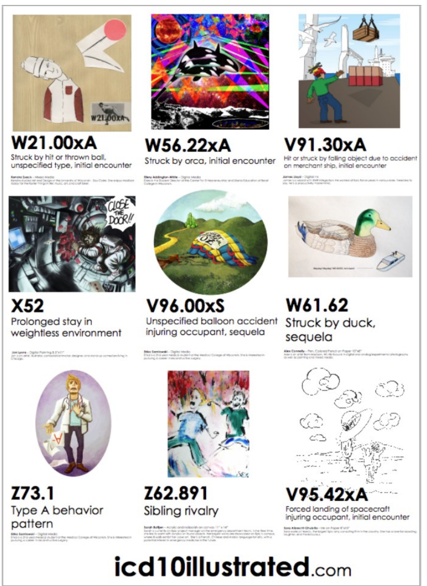
All problems added to a patient's chart prior to 10/1/15 will have an ICD-9 code associated with them when displayed in a note template

You must individually update each problem for them to be associated to an ICD-10 code when a note is created

THESE ICD-10 CODES SHOULD NOT BE USED FOR BILLING. There shouldn't be an expectation of 100 % correct conversion between SNOMED and ICD-10.

ICD-10 Funnies





Continuing Medical Education
October 2015

‘Ending the Cardiovascular Disease Epidemic with Whole Food Plant-Based Nutrition’

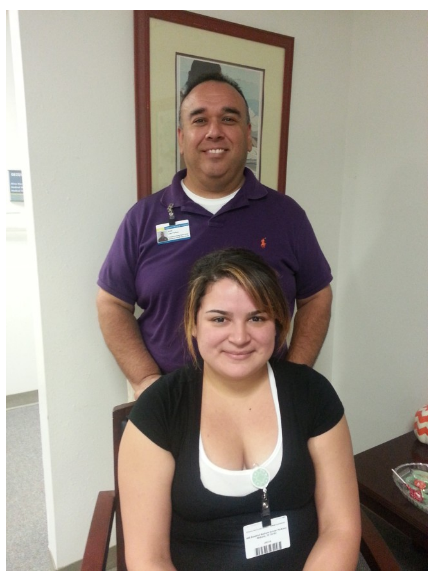
Speaker: Caldwell B. Esselstyn, Jr., M.D., F.A.C.S.
Date: October 14, 2015
Dinner Presentation Time: 5:30 p.m.
Location: Conference Rooms A, B, and C

For Physicians Only / RSVP Required

‘Health Care Reform: Strategies and Implications’

Speaker: Paul B. Convery, M.D., M.M.M., F.A.C.P.E.
Date: October 15, 2015
Dinner Presentation Time: 5:30 p.m.
Location: Conference Rooms A, B, and C

Medical Staff Office News



L. Michael Pallan and Amber Machado

The Medical Staff Office Introduces the Newest Members to the Team

Michael and Amber are new Credentialing Specialists in the Medical Staff Office and have taken over the primary role of credentialing both for initial applicants and reappointments.

Please stop by and say hi!

Edgardo Valle, MD and ER Staff
CONGRATULATIONS!
You made a difference and it shows

RECEIVED
APR 03 2014

Date 4-2-15 Dept. Emergency Dept.

I applaud Armando Rivera Beverly Lopez Bobbolo Brittany
First Name Last Name

Went Above & Beyond Because; I cannot remember everyones name, but Thank You for all the great care given here. I appreciate checking with us, giving us information as we wait for CT results, making sure we were comfortable, treating us with kindness and trying to have sense of humor even though his jokes may not be funny. Rooms very clean. Dr V very kind + compassionate

(Pat Garrett)
(Patient name)

We appreciate your feedback.
Please leave card in room when completed.

Muniru Adeniyi, MD
CONGRATULATIONS!
You made a difference and it shows

Date 6/25 Dept. Hospitalist

I applaud Dr. Muniru Adeniyi
First Name Last Name

Went Above & Beyond Because; Very above average professional Kind, Friendly and Knowledgeable. Took time to track my Labs (Na) back to 2010. Gave me a message to pass on to my specialists at UTSW in Dallas.

([illegible] 6/25)
(Patient name)

I am lucky to have him
We appreciate your feedback.
Please leave card in room when completed.
[illegible] I THANK [illegible]

Erika Stack, PA-C
CONGRATULATIONS!
You made a difference and it shows

Date 6/11/15 Dept. Emergency Dept.

I applaud P.A. in training w/ Erica Stack PA-C
First Name Last Name

Went Above & Beyond Because;
1. Erica Stack, P.A.
2. Amanda (new RN)
Treated us like family! Was wonderful, loving, to way beyond had to go!

(KARAN Lambdin)
(Patient name)
(daughter) Valerie W-Cree transporter

We appreciate your feedback.
Please leave card in room when completed.

Date 9.6.2015 Dept. Emergency Dept.

I applaud Erika B. Stack, PA
First Name Last Name

Went Above & Beyond Because; PA Erika Stack is an awesome person! She saw our daughter today after she was T-Boned in a MVAccident. My daughter was very upset & im somewhat of a panic. Stack went above & beyond assuring her she would take care of her with genuine compassion. Thank you ER

(Deyrea Lister)
(Patient name)

RECEIVED
SEP 14 2014

We appreciate your feedback.
Please leave card in room when completed.