midland memorial hospital

Newsletter

Medical Staff

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 #12—Leadership

To understand the distinction between management and leadership, and to appreciate that at one time or another, we all have the opportunity, and the obligation, to serve in a leadership role.

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Introducing Our New Practitioners

February 2016

Jim K. Maruthoor, MD—Internal Medicine/Hospitalist
Marc E. Whitaker, MD—Emergency Medicine
Joel S. Wolinsky, MD—Neurology/Neuromonitoring
Adebayo S. Adewale, MD—Internal Medicine/Hospitalist
Paul D. Lifland, MD—Orthopedic Surgery
Isaac JT Osborne, MD—Internal Medicine/Hospitalist
April McCain, DA—Dental Assistant, Dr. Archana Gutta
Joe R. McFarland, CRNA—Nurse Anesthetist, AMGPB Group
Lacey Rodriguez, RN—Surgical Assistant, Dr. Eric Venegas

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Continuing Medical Education—See Page 4

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.

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
Gerardo Catalasan, 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 Campos
Credentialing Specialist
432-221-2261

Jennifer Bryant
Credentialing Specialist
432-221-2262

Missy Taylor
Medical Staff Office Assistant
432-221-4629

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

midland memorial hospital
Medical Staff Newsletter

New Information

Forward Thinking
Lawrence Wilson, MD, MBA, FACEP
Vice President, Medical Affairs/CMO

Length of Stay

Midland Memorial continues to fight through difficult financial times. Overall volumes are down, that activity we do have is not being managed very efficiently and we struggle with reimbursements. The issues are multifactorial but it seems clear business as usual will not help us survive the storm.

One area we on the medical staff can help improve the bottom line is to work on improving the use of our hospital beds. Our Length of Stay (LOS) is at least a day longer than would be expected based upon the diagnoses and the case mix index of our patients. There are few steps we can help improve the LOS and efficiency of our care delivery.

Documentation: Document all problems and complicating medical conditions. The CDIS will provide queries and it is helpful to work with them. It impacts your Health Grades if you manage a complex patient, do not document the level of complexity, and the patient is in the hospital longer or had a complication. It appears your care is inefficient or you have too many complication with "simple cases" when the real issue is documentation.

Communication: Be intentional about your care plan. Work with the Case Managers (CM) to make sure there is a known expectation about LOS by day one or two of the hospitalization. Make sure the floor nursing staff, pharmacy staff, PT, RT etc. are all aware of your care plan. It may add a few minutes to rounding, but it can shave days of the LOS.

Practice Variation: Services such as the hospitalist service or any specialty with several practitioners should in general manage similar conditions the same way. It helps those carrying out the orders to be able to generally predict the plan of care. It also seems reasonable that with many conditions the care plans have recognized best practices. Still it is notable that depending upon the provider decision vary quite a bit. Different providers have longer or shorter LOS for the same conditions. Some level of standardization of care and more robust clinical pathways can decrease variation in care, improve quality of care and reduce the LOS.

Right patient, right bed: We continue to have practitioners that are reluctant to transfer patients out of the critical care unit despite the recommendation of our intensivists. The decision, at least some of the time is concern of the quality of care support outside the unit. Should we not actively help improve that quality of care support rather than overuse and misuse our limited and expensive resources? Similarly there is a reluctance on some practitioner's parts to transfer to the LTACH or other post-acute care environments. Again this needlessly drives up the cost of care and increases our LOS. Once again the argument is frequently, "my patient isn't ready". By the time the practitioner feels the patient is ready, they are often no longer eligible for the facility. I ask that those of you that have these conversations with CM please develop specific triggers that you agree are best practice. Then we can remove biases and subjectivity from the decision process. Our goal assuring patients get the right level of care and the right cost point.

None of the ideas above are revolutionary. They are discussed in most all hospitals and healthcare systems across the country. We have a real need to improve our LOS and cost of care delivery. The medical staff has an opportunity to impact these metrics by virtue of us being the decision makers and documenters of the medical conditions. Start with taking the time to document well, participate in and lead the care team on the floors for your patients, and develop best practice pathways of care while assuring the use of objective criteria about bed assignments. Our communities health care delivery systems success depends on us improving these measures.

New Information

Forward Thinking Continued
Lawrence Wilson, MD, MBA, FACEP
Vice President, Medical Affairs/CMO

Free Standing Emergency Departments

We now have four Free Standing Emergency Departments (FSED) in Midland. Two are run by ExcelER, one by Neighbors, and the final one is FastER run by a local group and located on the West campus.

The model of care is to provide un-appointed care for "any condition" and either releasing to follow up as needed or sending to a hospital if the condition requires more care. You have no doubt seen their ads and their marketing as patient-centric, near zero wait with full service. Limitations include not having physician's on-call for them so when specialty care is needed they have some delays. Also they have no defined pathway to admit their patients efficiently.

Last week I visited with ExcelER and Neighbors. Some of our Midland patients have been transported to Odessa for admission and some of our medical staff have been bothered by calls as though they were on call for these facilities and they do not wish to be burdened in that fashion. What I see is they have low volumes and treat mainly minor conditions. We do want to keep our Midland citizens in Midland and therefore we do want to keep communication open with them. We will continue to try to make the transfer process work for them so that we can take the best care possible of our patients.

In the meantime if you have had issues with calls from these facilities it may be helpful to advise your patients that you do not wish to be on-call for several new ERs. Further if they feel they may need hospitalization, that there will be added steps when coming from those facilities.

The FSED phenomena has developed traction in Texas. Un-appointed health, albeit more expensive, seems to have a market especially when primary care is difficult to access. We are forced to adapt to the changing market forces, but improving our access to care and educating our patients about the pros and cons of this new service line can also mitigate the growing pains.

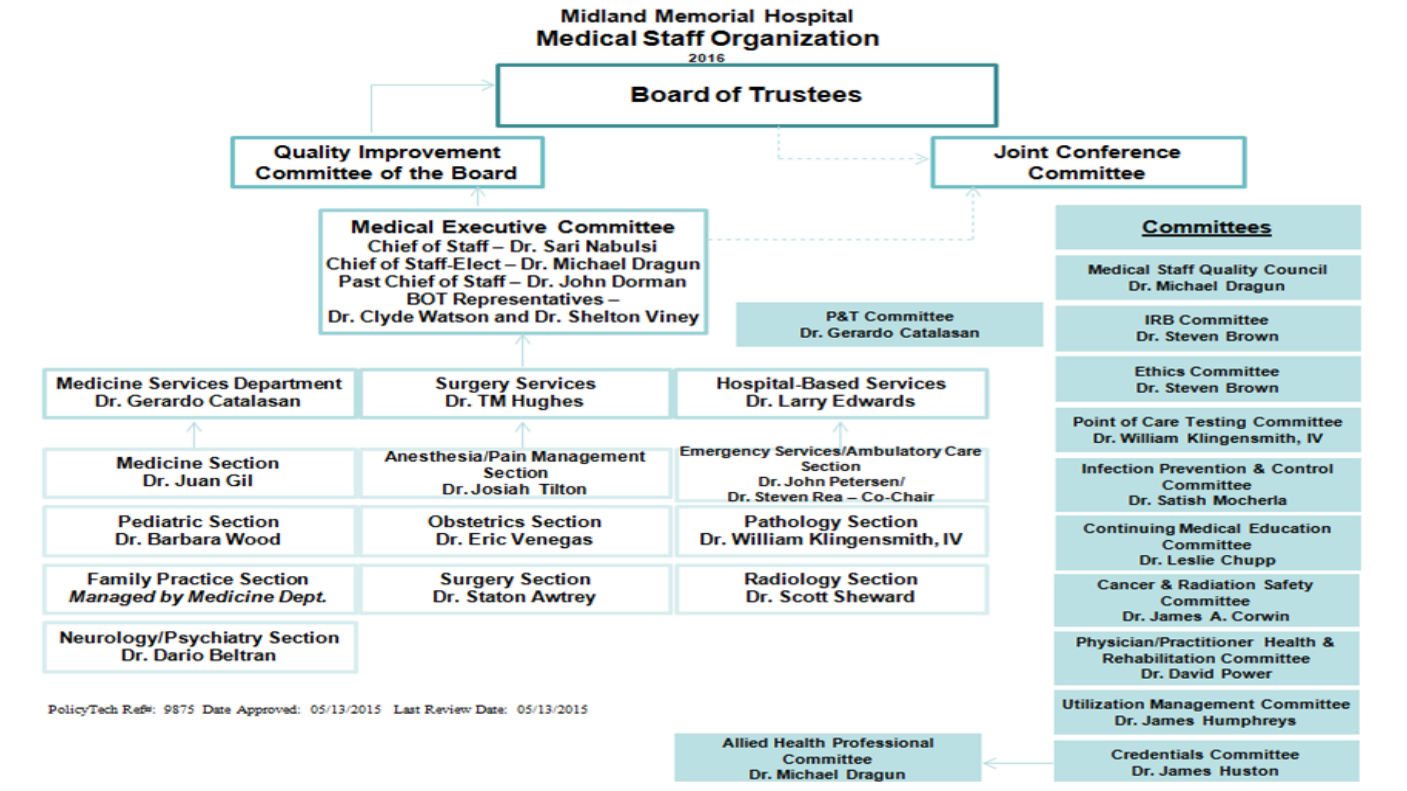
Continuing Medical Education
February 2016

"Capacity Evaluation and Understanding Rules and Regulations of Therapeutic Restrain of Patients"

Speaker: Shailesh Jain, MD
Date: February 23, 2016
Dinner Time: 12:00 p.m.
Presentation Time: 12:15 p.m.
Location: Conference Center—Room D
*Ethics Credit

"Capacity Evaluation and Understanding Rules and Regulations of Therapeutic Restrain of Patients"

Speaker: Shailesh Jain, MD
Date: February 29, 2016
Dinner Time: 5:30 p.m.
Presentation Time: 6:00 p.m.
Location: Conference Center—Rooms C&D
*Ethics Credit



CONGRATULATIONS!

You made a difference and it shows

Shane Huffman, MD

Date 12/9/15 Dept. Endo

I applaud Dr. Shane (First Name) Huffman (Last Name)

Went Above & Beyond Because: Dr. Huffman listened to our concerns regarding a critical pt. He stepped in to assist the nurses by explaining to the Dr. the possible complications of procedure. He took time to speak with the pts family. He took time to help nurses transport pt because of the critical state of pt. As nurses we greatly appreciate the support!!!

(Patient name)

Chelsea Perri RN Suzanna Hewitt RN

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

Rhonda L. Hagey-Levert, MD

Patient Comment:

Mr. & Mrs. Wells, were very happy with Dr. Levert-Hagey, they enjoyed their conversation with doctor and understood the plan, patient was excited that she was also being discharged today and thanked us.