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.

Have You Taken The Pickle Pledge?

"I will turn every complaint into either a blessing or a constructive suggestion."

By taking the pickle pledge, I am promising myself that I will no longer waste my time and energy on blaming, complaining, and gossiping, nor will I commiserate with those who steal my energy with their blaming, complaining, and gossiping.

www.joetye.com

Volume 2, Number 12

December 2014

Introducing Our New Practitioners

November 2014

Floyd Barry, MD—Medicine, Pediatric Hospitalist
Robert Chisholm, MD—Hospital-Based Services, Emergency Medicine
Holly Neal, PA-C—Physician Assistant, Surgery for Dr. Deme
Da'Nay Roy, RDA—Registered Dental Assistant for Drs. Youngblood and W. Jones

Continuing Medical Education

December 18, 2014
Annual Medical Staff Meeting and Holiday Party
6:00pm to 9:00pm, Midland Memorial Hospital, Conference Center
Cocktails and hors d'oeuvres, Medical Staff Meeting, and Speaker Joe Tye

Culture Change and Values
1.0 AMA PRA Category 1 Credit with Ethics

Preparing for ICD-10—Physician Education Opportunity

Please go to the MMH website—www.midland-memorial.com, under 'For Physicians', Preparing for ICD-10, for information on ICD-10 training through 3M. Notify Rebecca Pontaski, Medical Staff Manager if you would like a login.

Medical Staff Services Reminders

- On the new Midland Memorial Hospital webpage, under 'Find a Physician' is a listing of all physicians on staff. Please review your information for accuracy and notify the medical staff office of any changes.
- 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.

In Addition

If you would like to submit information for future newsletters, please email the information to Rebecca Pontaski at rebecca.pontaski@midland-memorial.com.

Medical Staff Leadership

Chief of Staff
John Dorman, MD

Chief of Staff Elect
Sari Nabulsi, MD

Past Chief of Staff
Larry Wilson, MD

Department Chairs
Hospital-Based Services
Steven Rea, MD

Medical Services
Larry Oliver, MD

Surgical Services
Jeffrey Durgin, MD

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

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

Betzy Martinez
Credentialing Specialist
432-221-2165

Esther Griego
Medical Staff Assistant
432-221-4629

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

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New Information

Forward Thinking: Physicians, Nurses and Staff at Midland Memorial Hospital Making a Difference

In the Wednesday, December 3rd Wall Street Journal (WSJ) buried on page A6, was a report that Hospital acquired injury/illnesses have decreased by 17% between 2010 and 2013. Problems such as falls, infections and adverse drug administration have been reduced to the tune of saving about 50,000 lives over the three year period. The Department of Health and Human Services estimates that reflects 1.3 Million fewer harmful incidents and a savings of over $12 Billion (with a B) over the three year period.

That is an unprecedented improvement over the three years of safer, higher quality and cost effective health care. So despite the bite of increased oversight, increased requirements for documenting why a Foley is placed, increased work for a nursing team members, alerts about fall risks, etc., it is paying off with saved lives and decreased cost. Just ask Dr. Shelton Viney if he thinks the NSQIP process has been good for patient care. Or ask Dr. Gerardo Catalasan about his protocols to decrease ventilator associated pneumonias. At the end of the day the guidelines and regulatory oversight improved patient safety and the quality of the care delivered.

Something that has become clear to me is that setting up systems to provide clarity in order sets and documentation and to follow best practice guidelines will further improve safety and value in our health care system. However, that won't matter if it makes the practice of medicine and providing care for patients more difficult for doctors and nurses. We, the providers of health care and the end users of order sets and documentation templates, have to be the authors and architects of the developed products. We are the ones that know what makes sense and is functionally reasonable.

This week at Surgical Control Committee and OB Section there were conversations about how to document so that we are in compliance with oversight requirements **AND** make the documentation reasonable for the surgeons involved. Dr. T.M. Hughes, chairing Surgical Control, recognized that if the operative report were built around a template that included required information and the required information was communicated to all physicians it should resolve a current ongoing compliance problem. In OB section Drs. McBrayer, Venegas and Welsh came up with a relatively simple means to help capture information needed to assure early deliveries are properly documented when necessary and are reviewed if no clear indication for early delivery is apparent. With further effort this process may be transformed into a user friendly EMR based process.

Developing clinical decision support (CDS) is becoming more and more important in the ever changing world of health care delivery with oversight of safety, quality and cost. The benefits of CDS will only be realized if the CDS provides the right information to the right people through the right channels (e.g., EMR, mobile device, patient portal), in the right intervention formats (e.g., order sets, flow-sheets, dashboards, patient lists), at the right time in the patient care process to make a difference.

If done correctly CDS will help integration & care coordination by communicating best practice through multiple disciplines, reduce variation and unintentional oversight, enhance workflow with pertinent instructions, reduce the potential for medication errors through alerts and reminders, and reduce unnecessary calls to physicians for clarifications & questions about orders To make CDS work for us, the physicians and end users must drive the development of the CDS systems and provide governance of the process. Clearly we are the main stakeholders. Currently our ITPAC is working on developing a governance process to help operationalize the development of CDS in our current EMR system (CareVue) while looking forward to the probability we will have a new EMR platform in the future.

I hope you are all proud of the work that you have already done to make our hospitals safer and less costly. At the same time, think about developing clinical decision support systems with your colleagues in your area of practice. Discuss it within your section and committee meetings; join the ITPAC if interested. Recognizing that 50,000 saved lives in three years is something to be proud of, improving upon that in the next few years is one of the reasons we went to medical school. CDS will help us accomplish that if we help build it to meet our needs.

Referring Practitioner Process

Every registration department will need to follow guidelines when requesting a new Referring Practitioner to be entered into the Admissions/Discharge/Transfer (ADT), Electronic Health Record (EHR), and Radiology Information (RIS) systems. Refer to Policy Tech Reference # 6889 for more information.

Reminder the registration department should not register the patient or perform the test/procedure until all the information has been completed.

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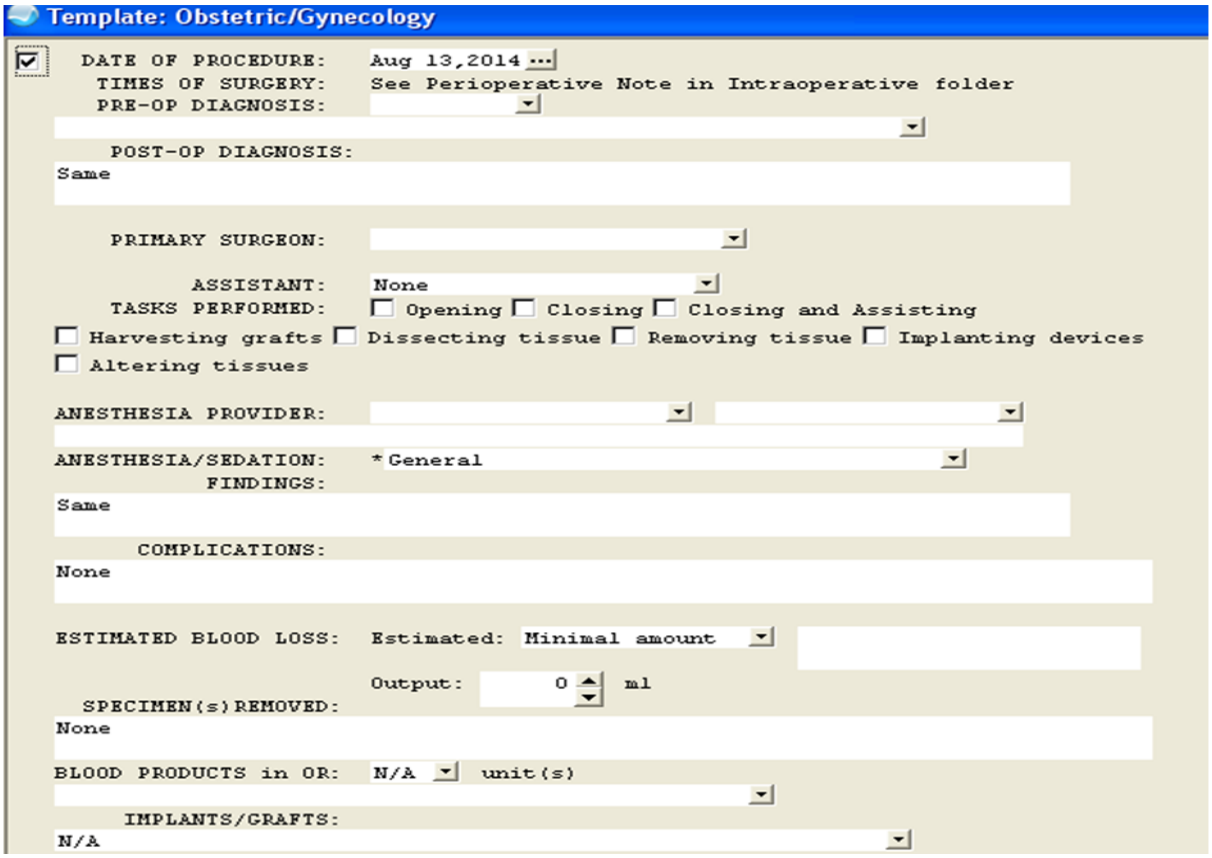
Operative Report Requirements

The Centers for Medicare & Medicaid Services (CMS) requires 10 elements to be documented in an Operative Report.

- Name and hospital identification number of patient
- Date and times of the surgery
- Name of surgeon(s) and assistants or other practitioners who perform surgical tasks (even when performing those tasks under supervision)
- Pre-operative and post-operative diagnosis
- Name of the specific surgical procedure(s) performed
- Type of anesthesia administered
- Complications
- A description of techniques, findings, and tissues removed or altered
- Surgeons or practitioners name(s) and a description of the specific significant surgical tasks that were conducted by practitioners other than the primary surgeon/practitioner (significant surgical procedures include: opening and closing, harvesting grafts, dissecting tissue, removing tissue, implanting devices, altering tissues)
- Prosthetic devices, grafts, tissues, transplants or devices implanted.

Midland Memorial was found to be non-compliant with this requirement in July 2014. The Standardized Operative Report Templates were altered in August 2014 to ensure the required elements were present in the Operative Report. Each element line must be present and have appropriate documentation attached. This is true even if the documentation provided is "None" or "N/A." No line should ever be removed from the template of left blank. Please review the provided examples of templates and errors noted in chart audits.



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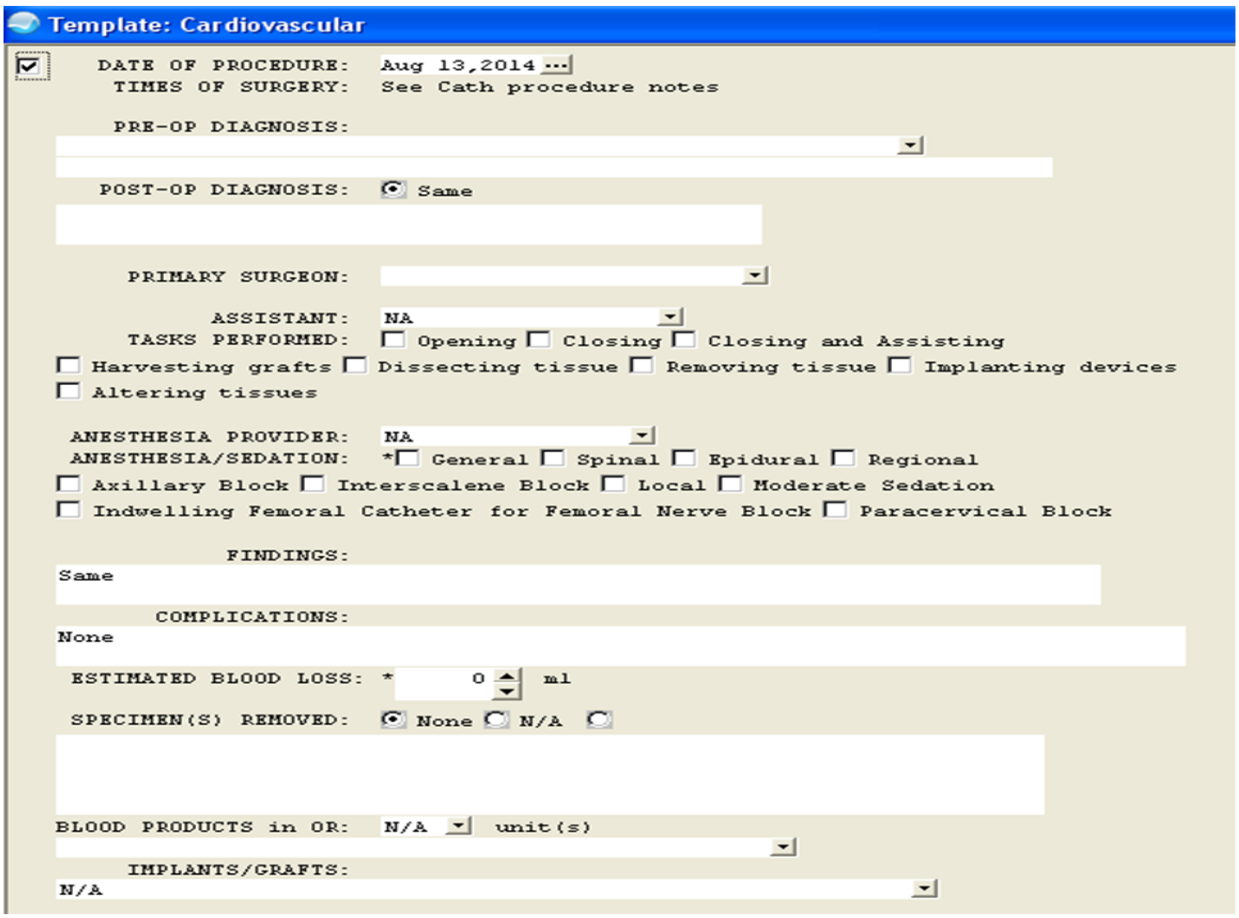
Template: Cardiovascular

DATE OF PROCEDURE: Aug 13,2014
TIMES OF SURGERY: See Cath procedure notes

PRE-OP DIAGNOSIS:

POST-OP DIAGNOSIS: Same

PRIMARY SURGEON:

ASSISTANT: NA
TASKS PERFORMED: Opening Closing Closing and Assisting
Harvesting grafts Dissecting tissue Removing tissue Implanting devices
Altering tissues

ANESTHESIA PROVIDER: NA
ANESTHESIA/SEDATION: *General Spinal Epidural Regional
Axillary Block Interscalene Block Local Moderate Sedation
Indwelling Femoral Catheter for Femoral Nerve Block Paracervical Block

FINDINGS:
Same

COMPLICATIONS:
None

ESTIMATED BLOOD LOSS: * 0 ml

SPECIMEN(S) REMOVED: None N/A

BLOOD PRODUCTS in OR: N/A unit(s)

IMPLANTS/GRAFTS:
N/A

In September and October, 70 patient charts were audited for the presence of the required elements. The monthly compliance ratings (13% and 14% respectively) have been reported at the monthly Surgical Control meeting. The major source of error is the removal of elements from the final report by the Surgeon. Please review the following examples:

'Assistant' line and 'Tasks Performed' box options are removed.
Name is documented in 'Assistant' box, 'Tasks Performed' box options are removed.
'Times of Surgery' line is removed.
'Complications' line and accompanying text box with the default 'None' are removed.

Rules and Regulations Information—Delinquent Medical Records

Delinquent or deficient medical records may be waived for absences from the community or sickness provided a request for waiver is made prior to or during the absence and the practitioner was not suspended for record deficiency at the time the waiver was requested. Practitioner must notify Medical Staff Services and/or Medical records of absences from deferment of records.

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Introducing

Stephen Collins, CISSP

Stephen Collins in his role as Information Security Officer at MMH supports various hospital departments and independently researches and assess, information security risk in order to assure the integrity, confidentiality and availability of healthcare information. He assists in compliance efforts working closely with the Compliance Office and informs users about security measures, explains potential threats, and implements security controls. Steve is responsible for gathering information necessary to maintain and improve security and define, create, and maintain appropriate controls in information systems in accordance with HIPAA requirements. Steve also supports the HIS staff in meeting their mission to the hospital and community as a whole.

For More Information

Stephen Collins, CISSP
Information Security Office
432-221-2135

Betzy Martinez

Medical Staff Credentialing Specialist

We are pleased to introduce the newest member to the medical staff services department. Betzy Martinez began work with us December 1st and comes to us with much medical staff office and credentialing experience. Please stop by the office and introduce yourselves to her. **Welcome Betzy!**

2014 Medical Staff Meeting and Holiday Party

Looking Back on 2014...

2014 was a busy year in the medical staff office so we would like to take the time to thank those physicians who because of their guidance and support daily and throughout the year, our jobs are made much easier—Our Chief of Staff, Dr. Dorman, Chief of Staff Elect, Dr. Nabulsi, and our Past Chief of Staff, Dr. Wilson. Also to all the Department Chairs and Section Chiefs, your support is also greatly appreciated. Thank you all again! We look forward to an even better 2015!

MMH Medical Staff Services