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.

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February 2015

Introducing Our New Practitioners

February 2015

R. Scott Akins, MD—Radiation Oncology
Rajesh Gutta, DDS—Oral and Maxillofacial Surgery
Natalie Yaklin, PA-C—Physician Assistant, Dr. Gurru

Continuing Medical Education—2015 Global Series

Medicine Approach and Practice: Enhancing Provider Performance through Outcome Based Principles
Presented by Ronald Tanner, DO, PhD
February 2015 Series -

- Acute Kidney Failure—February 12th—Conference Room C
- Dizziness—February 19th—Conference Room C
- Acute Diarrhea—February 24th and 26th—Conference Room C

All programs start at 12:15p—Bring your lunch, refreshments will be provided. For more information, a flyer has been emailed to everyone.

February 18, 2015

Best practices in the Management of Heart Failure—ACC/AHA Heart Failure Guidelines—Leela Lella, MD
12:15 p.m.—Conference Center: Rooms C&D—Lunch will be provided.

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

- 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
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

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

New Information

Forward Thinking: Try the Kool-Aid—Manage Up
Lawrence Wilson, MD, MBA, FACEP
Vice President, Medical Affairs/CMO

A common comment from medical staff at MMH is that it is frustrating that our staff is not performing up to expectations. A commonly repeated frustration is that I&O's and drain outputs are not recorded properly. Others complain that no matter how much they ask, "fill in the blank" is never done when they come to round. Occasionally some of us reach the point of frustration for our patient safety and yell at a staff member or otherwise lose our composure in front of staff or worse in front of patients.

The initiative to bring about a culture of ownership amongst the hospital staff has the potential to move the needle towards improving the quality of care delivered at MMH. For success, it takes all of us to participate. It is no panacea. Spending time reviewing authenticity, integrity, awareness, courage, perseverance, faith, purpose, vision, focus, enthusiasm, service and leadership will not in itself translate into improved documentation of fluid outputs.

But read those core action values again. Do you think a nurse that is embracing a culture that values his integrity and her awareness might be more helpful? A nurse with vision, faith and purpose may be more likely to fulfill our healthcare mission? Might they be more tuned into the importance of knowing how much drainage a wound is putting out or the net fluid gain or lost for a CHF patient? How about a case manager or social worker that embraces purpose, vision and focus? May she better recognize she is part of a complex team trying to safely maneuver a patient through our hospital to get them efficiently discharged and informed about future care needs, avoiding complications or readmission?

How does this impact us as physicians? Let me provide two scenarios. First, when you arrive at the bedside, and review the EMR, there is no place you can find the I&O's on a patient you are aggressively diuresing. Exacerbated, you let the nurse know he is incompetent. That the sole reason the patient is here is to improve fluid overload and decompensated heart failure; doesn't he read the chart? Doesn't she know the importance? Never mind, it will never change, forget the concern. You leave, demoralized, and receive a reminder a week later, by way of an incident report, suggesting your concern for quality of care was perceived as unprofessional behavior.

Now, let's say the same patient is admitted and you go to the bedside with the nurse and mention to the patient that her nurse is exceptional and will be helping you record all her fluid in and out. That as an excellent member of the MMH team he always assist in this critical part of the hospital stay. You let the nurse know to be sure and convey the same information to the night nurse and to let the night nurse know the importance of having a tally at 07:00 when you plan on returning.

Let's say in the morning, the I&O's are not readily available. You call the nurse and ask for the I&O record. The conversation is about the excellent care you know the nurse provides and that those recordings are a critical part of the care. The nurse, due to your calm and non-judgmental delivery, expresses that staying up with recording in the EMR- Carevue- is a challenge. It leads to a meaningful conversation about how we need a simpler, user friendly, means of documenting the I&O's. That leads to a process review, and ultimately to improved quality of care.

The latter case is taking the culture of ownership seriously and "managing up" with staff that wants to deliver the quality of care you want to deliver. Which of those two scenarios exemplifies the better leader? Which scenario leads to improved quality care to our patients? In which do you see yourself?

Those that read this and conclude I am drinking tainted kool-aid, it hasn't changed and it never will, etc. etc. I understand the skepticism. However, we are investing time and money to introduce change among our staff. I believe it can work. It won't happen in one interaction or as easily as I can write about it. Nothing worth having ever does. But what is the alternative?

One of our colleagues observed that, "he has beat his head against this for years and nothing has changed. We need more than talk." I agree. Let's stop beating our heads against the wall. Let's try respecting the effort to change the culture. Let's try managing up, educating, and providing leadership toward process change.

This is our hospital. Midland Memorial exists so you may take care of your patients. So we and our loved ones may receive exceptional care if needed. If we want better care for our patients we cannot afford to stand still. We can't keep doing the same thing and expect a different result. We must be part of the solution.

Try the kool-aid and manage up!

From the Desk of your Chief of Staff
Sari Nabulsi, MD, MBA, FAAP

Dear Colleagues,

We all joined the medical profession to make a difference. Although sometimes it goes unnoticed, we work tirelessly to stay current on the latest quality care protocols and guidelines ensuring our patients receive the best care possible. We're independent thinkers by trade and care incredibly about the lives we touch, determined to do whatever it takes to save a life, improve health and eventually send each person home to their family. It is the mission of a physician to make people better, and it is for this mission that I reach out to each of you with a challenge: take a moment to really think about how effectively you are fulfilling your personal and professional mission, every day.

The quality and outcomes related to the care we provide is paramount in our professional practice but I challenge you to consider what creates a high-quality patient experience. As we've found in recent studies and white papers published, the personal touch and emotional connection with our patients is having more and more of an impact on not only their perception of the quality of care, but also their cooperation and ultimately their outcomes.

The hospital executive leadership realized this strong connection and began empathy training with their front line staff a couple years ago. After hitting a few emotional walls with staff, the focus slowly began to shift from telling people *why* they should care, to allowing employees the freedom to connect with their own personal values and thus *be organically inspired* to care for others; patients or peers.

If you haven't noticed or seen the transformation at Midland Memorial Hospital yet, I hope you will experience it first-hand soon. The hospital is actively working to create this culture of ownership and the results have been tangible. 40 employees have been trained as Master Certified Values Coaches, charged with their own mission to foster a strong foundation of values within their peers including: Authenticity, Integrity, Awareness, Courage, Perseverance, and Faith. Since this fire started spreading last year, patient satisfaction scores have begun to rise to all-time highs and the comments have been flooding in about how noticeable the change has been. Not only are our patients and visitors commenting on how friendly and positive the atmosphere is at MMH but employees are also noting how much happier their work environment has been.

I tell you all this because I want you to be aware of what an incredible movement this is flowing through the halls of Midland Memorial and I believe that your personal mission to improve the lives and health of your patients is being fulfilled more and more through these efforts.

So here's where you come in; where we as physician leaders have the opportunity to jump onboard of this amazing effort and share in the excitement of the movement. Join with me and several other physicians in Midland as we step back from the madness of our daily lives, really consider what our personal values are and how those values impact the quality of care we provide. I as well as a couple other physicians will be teaching some provider specific courses on these topics in the next few months and I encourage you to sign up and get involved. When you begin to hear for yourself about the incredible impact this movement is having on our community, you'll be glad you got on board.

MMH Chief of Staff
Sari Nabulsi, MD, MBA, FAAP

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

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.

Other Information

When Ordering Blood Products Remember—Less is Sometimes More

Since the 1999 NEJM article, "Transfusion Requirements in Critical Care", there have been over twenty clinical studies that have shown that conservative use of blood products improves outcomes. Last year, in the NEJM there was an article that showed gastrointestinal-hemorrhage patients who were treated conservatively with blood transfusions had a 45% lower mortality, fewer complications and shorter hospital stays. Our own NSQIP data at MMH similarly reflects increased complications and LOS when blood products are used.

There have been a multitude of articles in the medical and surgical literature that document blood transfusions lead to pulmonary, renal and cardiovascular complications. Whether fluid overload, degradation products or dilution influence on the immune system, there is recognized risk associated with blood product administration.

Our blood utilization committee recognizes that we at MMH are similar to the rest of the country with habits of over utilizing blood products. Whether ascribing to the practice that "if one unit is good, two is better" or choosing to transfuse solely due to a Hgb value, we can safely decrease our blood product use by at least a third.

Dr. Friez has agreed to present EBM, best practice information on blood product as a CME at MMH. Please look for the lecture and attend. The Institute of Medicine has noted a 17-year lag between new EBM information and integration into clinical practice. For the sake of our patients, let's not wait another day to improve or decision making regarding to blood product use.

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

From the Medical Staff Office...

AMCOM Intellisuite is Coming!

I'm a physician or a staff member at a physician's office. What does this mean to me?

Physician on-call information will now be centralized and available from PBX. If you need to locate the physician on-call for a given group or specialty, you need only call PBX to be connected to that individual. ***Changes to contact information or the hospital call schedule for a given physician\provider group should still be sent to Medical Staff.***