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: First 6 Core Action Values

The first six Core Action Values will help you lay a solid foundation of character strength. Character is substantially defined by Authenticity and Integrity; it is refined through Awareness, Courage , and Perseverance; and it is reflected in Faith. Character is destiny, and the work that you put into laying this solid foundation will help to assure that your path in life leads to a bright destiny.

Core Action Value #4—Courage

We often think of courage in terms of prowess on the battlefield or the playing field. Fortunately, in the world of today most of us are not called upon to perform such acts of physical courage. Rather, what we most need is moral courage. The fears that we need to surmount are not of physical violence, but rather have to do with our relationships and our careers, running out of time and money, and with ultimate spiritual questions such as the meaning of life and the reasons for death. Standing up to those doubts and fears requires a different sort of courage, but summoning that courage is essential if you are to achieve your most authentic goals and dreams, and become the person you are meant to be.

www.joetye.com

Volume 3, Number 6

June 2015

Introducing Our New Practitioners

June 2015

Adenike Esho, MD—Internal Medicine
Eric Crandall, MD—Emergency Medicine
Hayan Orfaly, MD—Internal Medicine/Hospitalist
Hezekiah Sobamowo, MD—Internal Medicine/Hospitalist

Continuing Medical Education

- June 10th — 'Update on Dense Breast Imaging' by Jess Dalehite, MD

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

- 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.

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

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.

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

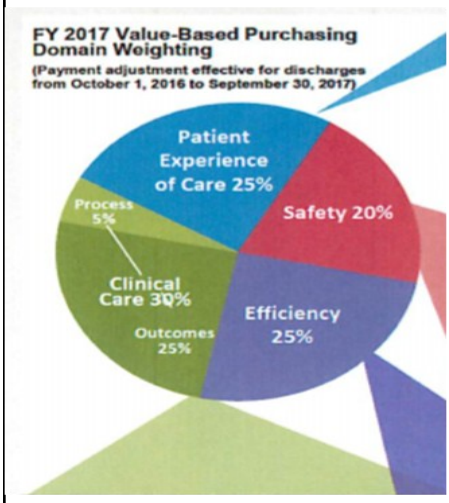
Forward Thinking

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

At Medical Executive Committee (MEC) on the 2nd of June we had a spirited conversation about convenience. Whether awakening patients at 3 AM for blood draws for the convenience of physicians or if allowing patients a less interrupted night and inconveniencing doctors was the right thing to do. The conversation was broader than that as you might expect. We are not a destination hotel and our patient's health and safety sometimes does require they be inconvenienced. On the other hand it was pointed out some labs are inadvertently left ordered, patients drawn, with little to no useful information being obtained?

Dr. Oliver pointed out he has started explaining to many of his patients the reason the "vampires" would visit at 3 AM, and the importance to him of the timing. His experience has been that when he takes the time to explain, and his patients and their families understand, they are fine with the inconveniencing. Taking time to explain what we are doing…, Huh…there's an idea. In the end, the question of physician convenience or patient convenience? The answer was a resounding "yes".

Sometimes there is no "yes" vs. "no" Not one or the other, but really, both are right. It depends on the circumstances. MEC ultimately agreed to change the default draws to more convenient times for our patients. That being 10 PM or 6 AM. Draws at 3 AM will remain an option when needed. The point is to be thoughtful of the patient. What you need to help them, and how you would like to be treated if you were the patient. My guess is many times the more convenient hours will work just fine. The implementation of the change will begin 22 June.



Another conversation at MEC was about the expectations set by Centers for Medicare and Medicaid Services (CMS) through the Value Based Purchasing (VBP) program. In 2015 CMS is withholding 1.5% of our Hospital payments to be used in the VBP program. We can either lose the revenue, get some of it back, or even earn a surplus depending upon how we are graded. If you take a look at the included pie chart, 25% of our grade is based upon the patient experience. Included in the patient experience is Communication: with nurses, with physicians and the responsiveness of the hospital staff. We can all do a better job communicating.

Dr. Oliver's example above is an excellent one. He has recognized that his patients are more accepting of his care when he takes the time to explain what he is doing and why. We have a tendency to use jargon and "medical speak" that is largely lost on our patients. They may continue to politely nod while we speak, but they are not hearing what we think they are. Try this, ask your patient what they are in the hospital for (their diagnosis) and what the treatment is. If you do that a few times I think you may be surprised. What can we do? Slow down, use non-medical terms, ask if the patient or family understands. Give them time. Let them know that others (nurses, respiratory and physical therapists, pharmacist, etc.) will be by to reinforce topics. If you don't have the time to repetitively go over topics, at least let them know you care and that others of your team will be by to reinforce topics.

I am going to work with Marcy Madrid, VP, Planning and Marketing, and see if we can develop some information about how our patient's perceive our communication with them. Perhaps some reminders of what we might do to improve the perception. Getting this our in front of us may help.

After MEC, Dr. Oliver approached me and mentioned he is continuing to read a book I had talked with him about, Atul Gawande's, *Being Mortal*. We both have found it a really good read. It discusses many topics around the end of life decisions our patients sometimes face. One of the take home concepts for me was that when faced with acute health care problems, that we should include what the patient is looking for when coming to us for care. What does she or he value? We may be surprised and it may lead to alternative therapies than we may have suggested without asking the question(s). We sometimes have the tendency to think our patient's come looking for our advice about what they should do, when they may also be searching for how they can meet their own goals and values. There is much more to the book. Well worth the time to read.

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

Five Facts about ICD-10

To help dispel some of the myths surrounding ICD-10, the Centers for Medicare & Medicaid Services (CMS) recently talked with providers to identify common misperceptions about the transition to ICD-10. These five facts address some of the common questions and concerns CMS has heard about ICD-10:

1. **The ICD-10 transition date is October 1, 2015.** The government, payers, and large providers alike have made a substantial investment in ICD-10. This cost will rise if the transition is delayed, and further ICD-10 delays will lead to an unnecessary rise in health care costs. Get ready now for ICD-10.

2. **You don't have to use 68,000 codes.** Your practice does not use all 13,000 diagnosis codes available in ICD-9. Nor will it be required to use the 68,000 codes that ICD-10 offers. As you do now, your practice will use a very small subset of the codes.

3. **You will use a similar process to look up ICD-10 codes that you use with ICD-9.** Increasing the number of diagnosis codes does not necessarily make ICD-10 harder to use. As with ICD-9, an alphabetic index and electronic tools are available to help you with code selection.

4. **Outpatient and office procedure codes aren't changing.** The transition to ICD-10 for diagnosis coding and inpatient procedure coding does not affect the use of CPT for outpatient and office coding. Your practice will continue to use CPT.

All Medicare fee-for-service providers have the opportunity to conduct testing with CMS before the ICD-10 transition. Your practice or clearinghouse can conduct acknowledgement testing at any time with your Medicare Administrative Contractor (MAC). Testing will ensure you can submit claims with ICD-10 codes. During a special "acknowledgement testing" week to be held in June 2015, you will have access to real-time help desk support. Contact your MAC for details about testing plans and opportunities.

Keep Up to Date on ICD-10
Visit the CMS ICD-10 website for the latest news and resources to help you prepare. Sign up for CMS ICD-10 Industry Email Updates and follow us on Twitter.

cms.gov

The following message was originally shared by Mr. Russell Meyers, President/CEO on Tuesday, May 26, 2015 to all employees of Midland Memorial Hospital. A ceremonial event to mark the beginning of the new invisible construction project was held that Tuesday morning in the Abell-Hanger Courtyard.

Tuesday Message
Ground Breaking: Invisible Architecture

Those of you who have been around for a few years may remember the detailed process that went into the design and construction of what is now the Dorothy and Clarence Scharbauer Jr. Tower. For over a year, we worked on creating the blueprint to ensure we built a structure that would meet the short and long term needs of our community and our workforce. We spent time refining the plans to ensure it would be functional, yet beautiful, and could withstand the West Texas weather. When we broke ground in 2010, there was no question what the final product would look like because we all had a vision of what we were planning to build...The same holds true today as we begin construction on our new invisible architecture. We have been working for over a year to layout the blueprints of what kind of culture and atmosphere we want to build, to make this not only a high-quality hospital, but a great place to work. As we developed our Mission, Vision, and Core Values statements, we began creating our construction documents. The design process was refined through several planning sessions to ensure we incorporated all the necessary steps and milestones to get to a final product that matched all we had envisioned. Over the past few months, we've taken our design plans and held dozens of training sessions (Culture of Ownership classes) to be sure our construction crews had all the necessary tools and skills to complete this great task ahead...This morning we officially broke ground, figuratively putting our shovels in the dirt to continue building what we have designed. A lot of clearing of debris and leveling of the ground has already taken place over the past year, but today we recognize that the work has only just begun. Just like it took time to build our beautiful new tower, so it will take time and diligence to build our invisible infrastructure: the expectations, attitudes and standards we have developed together. Our staff and our community will benefit immensely—so let's get to work!

RECEIVED APR 09 2015

Date 4/14/2015 Dept. Emergency Dept.

I applaud Dr. Jon Rosenthal & Staff
First Name Last Name

Went Above & Beyond Because:

Dr. Rosenthal went above & beyond my expectations and treated me with superior care, and the rest of the staff was very professional.

(Patient name) Jimmy T. Cole

Written by Bev. Pt. request.

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

Dr. Jon Rosenthal
CONGRATULATIONS!
You made a difference and it shows.

Dr. Robert Chisholm
CONGRATULATIONS!
You made a difference and it shows

Date 20 May 2015 Dept. Emergency Dept.

I applaud ER Staff, Gabe & Dr. Robert Chisholm
First Name Last Name

Went Above & Beyond Because: this has been a painless, easy visit to the ER. Everyone was very nice & professional Thank you for taking care of our daughter.

(Abigail Ornelas.)
(Patient name)

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