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 Value #6—Faith

Cornerstone #1: Gratitude

Complaining is the anti-prayer-whining about blessings that have not (yet) showed up rather than being thankful for those that have.

Cornerstone #2: Forgiveness

The real beneficiary of forgiveness is not the one who is being forgiven, it's the one who is doing the forgiving.

Cornerstone #3: Love

The Beatles were right: there's nothing you can do that can't be done and there's no one you can save that can't be saved—all you need is love.

Cornerstone #4: Spirituality

People who really do believe that whoever dies with the most toys wins end up being the biggest losers in life.

www.joetye.com

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August 2016

Introducing Our New Practitioners

August 2016

Parker Bassett, DO—General Surgery
Srinivasa Reddy Donthi Reddy, MD (Dr. Donthi Reddy) — Psychiatry
Phillip Guillen, MD— Orthopedic and Hand Surgery
Viktor Miro, MD— Internal Medicine/Hospitalist

Continuing Medical Education—See Page 5

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 2016. Physicians should only claim credit commensurate with the extent of their participation in the activity.

Reminder

Cologne/Perfume/Scented Lotions is prohibited in patient care areas. Please remember to comply with the dress code policy.

Clinical—Personal hygiene products such as perfume, cologne, aftershave and heavy lotions or deodorant are prohibited in the direct patient care areas.

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, BAT-OM, RHIT
Medical Staff Coordinator
432-221-1510

L. Michael Pallan
Credentialing Specialist
432-221-2165

Jennifer Bryant
Credentialing Specialist
432-221-2262

Missy Taylor
Executive Assistant
Medical Affairs/Medical Staff Services
432-221-4629

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Medical Staff Newsletter

New Information

Forward Thinking

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

Moving to Value

This year 85% of Medicare Fee for Service (FFS) payments will have a quality link. 30% will be paid through some type of Alternative Payment Model (APM) such as an ACO, Bundle payment, etc. In 2018 90% of FFS payments will be tied to quality measures and 50% of those will be paid through an APM.

Also coming is an expansion of the bundle payment model. Starting in July of 2017 ninety eight regions (Midland is not in one of them, yet) will be paid a single bundle through their hospital for the care of Acute Myocardial Infarctions and for Cardiac Bypass surgery. The bundle will cover the acute episode of care and for the subsequent ninety days. To learn more please take a look at the following link: http://healthjournalism.org/blog/2016/08/watch-for-potential-pitfalls-as-cms-tests-a-new-bundled-payment-program-for-cardiac-care/

To be successful within in the model of care we must fulfill the triple aim: High quality, safe care, efficient care (no unnecessary testing or procedures) and improve the patient experience. In my view to meet those three goals in a sustainable fashion, we need one more target for a quadruple aim: We have to develop a healthcare delivery model that fulfills the triple aim and is not more burdensome to those delivering healthcare.

The Institute of Medicine *"Better Care at a Lower Cost: the Path to Continuously Learning Health care in America"* published the six areas of wasted expense in health care, and who is best situated to fix each area. Not surprisingly, we, the clinicians, own three of the six. The six are: Unnecessary Services ($210 B per year nationally), Inefficiently Delivered Services ($130 B), Excess Administrative Costs ($190 B), Prices that are too high ($105 B), Missed Prevention opportunities ($55 B), Fraud ($75 B). The three we as clinician have the responsibility for are: Unnecessary Services, Inefficiently Delivered Services, and Missed Prevention Opportunities. That's $340 B of the total $765 B!

In the arena of unnecessary testing, at MMH, we can look at the use of vascular ultrasound. We are on track to order over $500k in echocardiograms on inpatients this quarter. In conversation with our cardiologist many of these could be done as an outpatient or not at all. At least two this past weekend, when 24 echo's were ordered on admitted patients, were ordered on patients that had another echo within the past two months. You might think the condition had changed, but the case was that the admitting provider did not know of the recent study, so was ordering what was thought to be a new study. Importantly, the outpatient testing is reimbursed the inpatient testing is not. The message—thoughtful treatment, considering the best interest of the patient, but also the most efficient pathway of care can help the patient and our healthcare delivery system remain healthy.

Similar efficiency problems are seen with MRI's and other advanced diagnostic testing. In the emergency room I recently overheard a provider ordering a venous dopplar to rule out a DVT. Almost proudly stating, "I am ordering that based on the chief complaint (No history or examine had been performed). The chief complaint was "non-traumatic leg pain". The patient was obese and fluid overloaded with symmetrically swollen and painful legs. DVT in the differential, yes, but likely and needing an acute study?

Being the leader:
So let's be thoughtful about ordering studies and if we do, make sure we are ordering the correct study at the right time and place. We can solve these and other problems with the team of providers and support staff we have working with us. We can follow best practices and accepted standards. We will whittle away at the $340 Billion lost on unnecessary and inefficiently delivered services.

New Information

Forward Thinking Continued

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

Cybersecurity Enhancement

Working with our Cybersecurity personnel, compliance and legal services, we have recognized a potential for significant breaches in our control of Personal Health Information (PHI). Such a breach can happen unintentionally and each of us individually can be held responsible. Next week in Medical Executive Committee we will discuss this topic, followed by notification for all medical staff; there will be instructions about the new process of accountability.

First every Medical Staff with remote access to our EMR will be required to sign a form acknowledging personal access and responsibility for keeping the access secure. An application for remote access will need be completed. Then everyone in her or his office that will be granted access will be required to provide their identification and agree that the medical staff member is responsible for notifying IT if anyone leaves the office or a new person is granted access. Finally any third party vendors (coding and billing services) will be required to complete an application and agreement as well. Four separate letters of agreement and applications will be sent to each medical staff member requesting remote access. Once sent, there will be a sixty day window to complete the process. Please be prompt in completed this. External (HIPPA) auditors take this seriously and we will be obligated to remove remote access from those unable to comply.

Best Practice in Perioperative Care Resource Stewardship

Patients undergoing surgery are managed with parenteral medications during the immediate peri-surgical time. When they begin to eat and drink again we do not always remember to immediately introduce PO medications. It turns out there are is about a $500k savings if with can make that transition sooner in a little over 50% of the cases. Recognizing the special cases where PO may not be appropriate, our P&T committee worked with Surgical Control to develop a safe policy that has been approved by MEC. Going forward a switch will be made to oral medications automatically by pharmacy when specific parameters are met (safety guidelines) and the attending surgeon may always revoke the order. Please contact Medical Staff Office if you would like to see the specifics of the policy.

Midland Health Teams up with the AMGA in Developing Clinically Integrated Network

We have ambitious plans for Midland Health. They are necessitated by the changes in healthcare delivery and the reimbursement for the same. To remain financially healthy and to keep our patients healthy we must learn to work differently. Bundle Payments and other alternative payment models are being utilized by the payors. Cory Edmondson and I are participating in a fellowship through the American Medical Group Association (AMGA) to learn how other systems have developed collaborative networks, or Clinically Integrated Network's (CIN), and have done so with success. We will be inviting some of you to participate in Webinars about e process and to get involved.

Operating Room Efficiency

Operating Room morning start times and room turnovers have both been long recognized sources of wasted time. It directly impacts the quality of care delivered when needed cases are delayed or bumped to accommodate limitations on room availability. A multidisciplinary team led by MSA surgeons Drs. Shelton Viney and Dan Copeland, along with Jessica Hawkins, MSN, RN, Director of Perioperative Services, are working a process improvement solution to these long standing problems. We look forward to an improved efficiency model for all stakeholders to review in the near future.

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Forward Thinking Continued

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CMS Proposes Bundled Payment Models for Cardiac and Hip Fracture Care

The Centers for Medicare & Medicaid Services has proposed a new payment model that would bundle payment to acute care hospitals for heart attack and cardiac bypass surgery services. In addition, the proposed rule would expand the existing Comprehensive Care for Joint Replacement (CJR) model to include other surgical treatments for hip and femur fractures beyond hip replacement. Under both the new cardiac bundled payment model and the expanded CJR model, the hospital in which the initial services are provided would be held accountable for the quality and costs of care for the entire episode of care from the time of the hospital stay through 90 days after discharge. The hospital would either earn a financial reward or be required to repay Medicare for a portion of the costs based on its performance on cost and quality for the episode. The cardiac model would be mandatory for hospitals in 98 geographic areas across the country. The models would begin in July 2017. For more, see the CMS factsheet. "Hospitals are under a tremendous burden to help ensure these complex models work for patients," said American Hospital Association Executive Vice President Tom Nickels, noting that this is the third mandatory demonstration project from the agency in a little over a year. "America's hospitals are committed to improving care coordination thoughtfully and systematically in order to create better value for our patients and communities...We will fully analyze the proposals and we look forward to improving them so they are reasonable and workable for patients."

The article comes from **The American Hospital Association's Physician Leadership Forum, August 4, 2016.**
www.ahaphysicianforum.org/news/current.html

New PCR Panel for Meningitis—August 1, 2016

Beginning **Monday, August 1st**, the Midland Memorial Hospital Laboratory has began offering the **Meningitis/Encephalitis Panel by PCR**. The simultaneously detects the following bacteria, viruses and yeast:

1. *Escherichia coli* K1
2. *Haemophilus influenza*
3. *Listeria monocytogenes*
4. *Neisseria meningitides*
5. *Streptococcus agalactiae* (Group B *Streptococcus*)
6. *Streptococcus pneumonia*
7. Cytomegalovirus (CMV)
8. Enterovirus
9. Herpes simplex virus 1 (HSV-1)
10. Herpes simplex virus 2 (HSV-2)
11. Human herpesvirus 6 (HHV-6)
12. Human parechovirus
13. Varicella zoster virus (VZV)
14. *Cryptococcus neoformans/gattii*

Limitations include:

1. CMV and HHV-6 can exist in latent form and can reactivate during infection caused by other pathogens.
2. Viral shedding of VZV may occur in the CNS and may not be indicative of CNS infection.

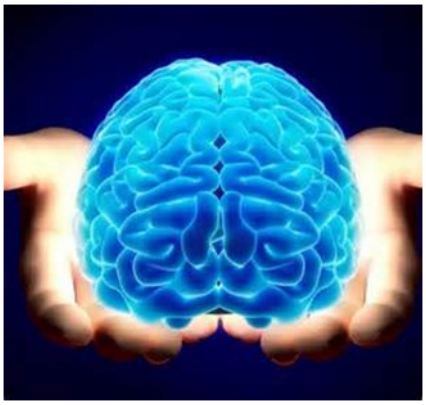
If you have any questions, please contact Taylor Johnson or Kerry Noormohamed at 221-1632.

The test is performed on Cerebrospinal Fluid from patients exhibiting symptoms of meningitis and/or encephalitis. Expected turn-around-time for results is 90 minutes from receipt of specimen in the laboratory. This test **DOES NOT** take the place of a CSF culture and results are meant to be used in conjunction with other clinical, epidemiological and laboratory data. Negative results will be cultured for organisms not included on the panel and positive results will be cultured for drug susceptibilities.

Continuing Medical Education
August 2016

GRAND ROUNDS
Delirium in the Hospitalized Patient
***CME/CNE Credit**

Date: August 30, 2016
Lunch Time: 12:00 p.m.
Presentation Time: 12:15 p.m.
Location: Conference Center—Rooms C&D



Speakers: Zeeba Mathews, MD
Lori Wingate, DNP, RN, GNP-BC
Sherron Meeks, RN, MPAL, BSN

Methodology: Didactic lecture with case presentation and self-assessment, followed by questions and answers.

Objective: At the conclusion of this course, the participant should be able to:

- Identify at risk populations for delirium.
- Implement prevention strategies for at-risk patients.
- Appropriately work up and treat patients with delirium.

Physicians
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Advance Practice Nurses and Registered Nurses
Earn 1.0 contact hour
Midland Memorial Hospital is an approved provider of continuing nursing education by the Texas Nurses Association, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation.

The CME and CNE Committee has deemed this presentation free from conflict of interest, financial relationships, or commercial support. Midland Memorial Hospital reserves the right to cancel this activity in the event of unforeseen or extenuating circumstances. Questions regarding this activity may be directed to Rebecca Pontaski at 221-1625.

Michael Dragun, MD and Brad Brock, MD

"Dr. Dragun and Dr. Brock are a great team!"

The 2016 Texas Tech University Physician Assistants attended orientation at MMH on July 29th.
Dr. Larry Wilson welcomed and addressed the group.

Thank you Dr. Wilson!

Raja Naidu, MD

Dora Nelson ▶ Midland Memorial Hospital
9 mins ·

Thank you, MMH, once again for being there for us! My husband was rushed to hospital about 1 1/2 week(s) ago while having a heart attack and the quickness of the ER staff was amazing! They diagnosed him immediately and sent him into surgery. After having stint put in and shunt taken out, he then had a 2nd heart attack while in critical care. We thank God that He put amazing people in our lives that day! Dr. Naidu was wonderful along with every single person we came into contact with. Due to the chaotic-ness of being in critical care, praying for my husband to be ok, I did not catch everyone's names'.....but to name a few: Ellen, Gosia, Holly, Sonia, Andrea are just a few I am able to remember. From ER staff to Critical Care Staff to Cardiac Nurse care to Housekeeping and everyone in between, thank you all from the bottom of our hearts for being caring and doing your jobs as if you were made for that exact position. God Bless each and everyone of you! - Dan & Dora Nelson

Like Comment Share

Midland Memorial Hospital

All Doctors

Hi Sonya!
My name is Molly Perriman & I work out here at High Sky, after a lesson with our kids on gratitude, one of our sweet girls wanted to write a Thank-You note to all the doctors! If you could please help me get it to them I would really appreciate it!
Thanks. Molly P.

Dear Doctors,
Thank you for everything you do thank you for helping to make sure were okay and doing everything you can to provide for us when we are sick I really appreciate every-thing you do for everyone you really help me to feel better when I am sick and for that I want to say thank you. God bless you.
J'Via Martinez