



Dimensions Healthcare Committed to Improving Customer Service and Patient Satisfaction

Patient Experience and Customer Service are hot topics among hospitals these days. One of the reasons is the Government's focus on the patients' perception of how well they were treated by the healthcare workers that serve them during their hospital stay. Medicare requires that every hospital be measured through HCAHPS, a standardized random survey of recently discharged patients. Results of these surveys can now be viewed on-line by the public and the press. Bottom line is, everyone gets to see who's doing well and who's doing "not so well." As of now, both of our hospitals have room for improvement. From these surveys we have found the quality and satisfaction issues that impact patient perceptions of our organizations. The questions asked in the HCAHPS survey seem to focus and measure mostly nursing and physician behaviors. Some examples include:

- Nurses listening carefully
- Doctor Communication
- Courtesy/respect of doctors
- Doctors listening carefully to patients
- Pain Management

DHS is committed to increasing Patient Satisfaction scores. We will do this by consistent attention to the following behaviors:

- ▶ Improving Communication
 - ✓ Telephone answering (Medelearn)
 - ✓ Hallway Greetings
 - ✓ ID Badges
 - ✓ Communication Boards
 - ✓ Thank You Notes
 - ✓ White Boards
 - ✓

Clinical areas will also focus on responsiveness to pain management and other immediate patient needs such as toileting. All departments are now implementing performance improvement plans for satisfaction issues specific to that area. Is HCAHPS alone enough to measure all of the different ways that hospitals can impact the patient experience? The answer is unclear at this time, but what is clear is that we need our physicians to help us improve our patient experience. Survey or not, The World is watching. Stay tuned for more on Customer Service and Patient Satisfaction

LOOK OUT FOR A FAX ON A COMMUNITY PRESENTATION SERIES FOR YOUR PATIENTS WITH TYPE II DIABETES "JOURNEY FOR CONTROL" COMING TO LRH SOON!

***LRH HAS PARTNERED WITH THE AMERICAN CANCER SOCIETY TO PROVIDE OUR COMMUNITY MEMBERS WHO ARE UNDERGOING CHEMO OR RADIATION FOR BREAST CANCER WITH THE "LOOK GOOD...FEEL BETTER" PROGRAM. REFERRALS FROM OUR PHYSICIAN OFFICES.
For more information call 301-497-7914****

WOUND CARE CENTER

New Director, Caryn Vollmer, is happy to announce that Dr. David Baek will be joining the physician panel beginning July 7th. He will be here doing his weekly clinic on Tuesday afternoons. Dr. Baek is very involved with the podiatric dept at LRH, and his expertise will be an added benefit to the Laurel Wound Care Center and our physician team of Drs. Gelber and Orellano. To make a referral to the Wound Care Center, call us at 301.725.7255.

“THE OXFORD KNEE” comes to Laurel Regional Hospital

Laurel Regional Hospital is the only hospital in the area performing a minimally invasive partial knee replacement. Smaller incision and quicker healing time is not only its claim to fame, but when used in conjunction with the nerve block procedure by anesthesia, patients are looking at faster recovery and a return to normal function with less pain. Dr. James Kunec, our orthopedic surgeon who trained in Oxford, England to perform this replacement, held a community presentation on Wednesday, June 24, where 60 people attended!

PHYSICIAN TOWN HALL MEETINGS ◀

Two physician town hall meetings were held in May to share with the department chairs the draft strategic plan of the hospital and to hear ideas and issues concerning the physicians and departments. Mr. Moore was grateful for the feedback and the decision was made to have a town hall meeting for physicians with the executive staff on a bi-monthly basis, gathering insight from all of our medical staff on ways that we can work together to make positive changes within the hospital and the community to help and support our medical staff.

The next Physician Town Hall will be held on Monday, August 3rd @ 5:30 PM in the board room with the executive team. We value your thoughts and opinions. Please mark your calendars and make an effort to attend. A reminder will be faxed to your offices on Friday, July 31.

LRH has Electro Physiologists Available 24 / 7

Dr Adam Strickberger and Dr Ganesh Venkataraman have joined our staff and are available to implant cardiac devices here in the cardiac cath/ vascular lab.

They have been around the hospital meeting physicians and staff and bring their expertise from Washington Hospital Center.

© 202-213-6109 pager 866-474-0357

.....LOOKING GOOD.....

HOPE YOU HAD AN OPPORTUNITY TO VIEW AND USE THE
RENOVATED 2ND AND 3RD FLOOR PHYSICIAN'S LOUNGE !

CARDIO CATH / VASCULAR PROCEDURES IN HOUSE

For information or to schedule a procedure call (301) 497-7997

Services:

Diagnostic left and right heart catheterizations
Insertion of temporary and permanent pacemakers, including Biventricular Defibrillators
Transesophageal echocardiograms
Cardioversions
Swan ganz catheter insertions
Intra Aortic Balloon Pump insertion
Implantable cardiac monitors
Diagnostic and Interventional Peripheral vascular studies: Including but not limited to
angioplasty and stent placement, CV line insertion, etc...

Reminder.....Informed Consent Update

- **New consent** form is 2-sided
- Reverse of form is Anesthesia Consent
- **Both sides must be completed**; if Anesthesia Department is not involved, procedurist must complete both sides, i.e. local anesthesia and procedural sedation
- MD must complete the name of the procedure to be performed on the consent; **abbreviations are not allowed**.
- **MD must sign the Physician Declaration** regarding obtaining informed consent and validating procedure, side, and site. [This is now located at the bottom of the form. Sign both sides if you are doing the anesthetic.]
- If laterality is involved, **sign the site** with your initials; **don't use an X**.
- **Physician Certificates of Patient Incapacity** [DHS 2-574] are required when patient lacks decision making capacity. **2 certificates are required**; the exception is when a patient is unable to communicate by any means only 1 certificate is required. **We recommend you complete one certificate upon admission when admitting a patient who lacks decision making capacity**. The second one must be done within 2 hours of the procedure and can be done by the procedurist.
- A new category of surrogate decision maker has been recognized by the State of MD; this is a domestic partnership.
- **Domestic partner is a new recognized status equal to spouse**.
 - **Domestic Partnership**: is defined as a relationship between two individuals who:
 - 1. Are at least 18 years old;
 - 2. Are not related to each other by blood or marriage;
 - 3. Are not married or in a civil union or domestic partnership with another individual; and
 - 4. Agree to be in a relationship of mutual interdependence.

OUR QUALITY LEADER IS QUALITY.....

Welcome to Brigid Krizek, our new guru of quality, who's tasked with keeping us on task in delivering quality care to all of our patients.

If you haven't met her, don't worry.....you will..... 😊!

PHYSICIAN REHAB CENTER REFERRALS

The Physical Rehab Center (PRC) at LRH offers comprehensive acute physical rehabilitation to patients who have a range of diagnosis that impact their ability to function. The PRC is designed to help patients who require intensive multidisciplinary therapy and 24 hours of nursing care in order to meet their rehabilitation goal of returning to community living.

The referral and acceptance procedure for the PRC involves communication between our admission coordinator(s) and the health care team. We recommend that **physician's order physical and occupational therapy services prior to, or at the time of, a PRC consultation.** Once the PRC consultation is ordered, our admission team is dedicated to responding to referrals within four hours, Monday through Friday.

The PRC consultation will trigger a full workup by an admission coordinator. The admission coordinator will complete a case review which includes documentation of the patient's medical and clinical profile, insurance verification, and discharge plan for the patient. **Based on the data gathered, the admission coordinator will make a determination as to whether the referred patient is accepted to the program and notify the referral source. Admission to the PRC should occur prior to 7pm.** Delays in admissions beyond 24 hours will require a new workup from the PRC admission team.

Please note that a **dictated physician discharge summary is required upon admission to the program.** This requirement will help ensure that the medical and therapy services provided to patients are timely and appropriate. Thus, LRH nursing units should not send or receive a patient to the PRC unless this requirement is met.

If you have questions about the referral procedures for the PRC, feel free to contact Laurie O'Connell at 301-362-2003.

ON OUR MEDICAL STAFF: DR. REZA GHORBANI, BOARD CERTIFIED IN PAIN MANAGEMENT IS AVAILABLE FOR PATIENT REFERRALS @ 301-220-1333

Dimensions 23rd Annual Golf Tournament – July 27, 2009

Information and entry forms can be obtained at www.dimensionshealth.org or contact Vaughn Barkdoll, Tournament Director, at (301) 583-4034.

LRH Medical Staff Dues

Medical Staff dues notices for fiscal year 2009-2010 will be mailed in early July. In keeping with the Bylaws/Procedures of the Medical staff, failure to pay dues by December 31, 2009 will be considered a voluntary resignation of membership and privileges. If you have any questions, please contact the Medical Affairs Department at (301) 497-7976.

CME LECTURES END FOR THE SUMMER

Please be reminded that the Thursday Lecture Series break for the summer and will resume in September. See you in the Fall.

****NEW MEDICAL STAFF MEMBERS****

Please join us in welcoming the following new members to the Medical Staff of Laurel Regional Hospital:

Richard L. Holmes, PA-C	Emergency Department		
Deron O. Page, PA-C	Emergency Department		
Olabisi Emenanjo, PA-C	Emergency Medicine	Ronnie Jacobs, MD	Medicine/Hospitalist
		Izuchukwu Obi, MD	Medicine /Hospitalist
		Lynn Bergren, MD	Medical Imaging
		John Mattingly, MD	Medical Imaging
Newton Andrews, MD	Medicine / Cardiology		
Raymon Nelson, MD	Medicine / Cardiology		
Mark W. Miller, MD	Medicine / Pulmonary (Sleep)		

❖ **Maryland Medical License Expirations: Last names M to Z**

Reminder: If your last name begins with the letters M-Z don't forget to renew your Maryland Medical License by **September 30, 2009.**

Please note: The MBP will NOT send you a renewal application by mail. Please go to the MBP website at <http://www.mbp.state.md.us> for further information, or contact the MBP at **410-764-4705**. Renewal forms are available online in mid-July.

Medical Staff Officers for 2009-2010

Syed Sadiq, MD	President
Tristan Orellano, MD	Vice President
Isabella Martire, MD	Secretary/Treasurer
Michael Carlos, MD	Member-at-Large
Darryl Hill, MD	Member-at-Large
Rene Gelber, MD	Member-at-Large
Gita Shah, MD	Interim VPMA

KUDOS: Special thanks to **Frank McCormack, MD** for all of his hard work and efforts with the LRH Medical Staff Bylaws.

Thank you to Syed Asad, MD, Anu Kurichh, MD, Rene Gelber, MD and Drs. Gita Shah and Syed Sadiq for serving the past two years on the MEC.

DID YOU KNOW.....?????

Hospital Acquired Conditions (HACs) and Potentially Preventable Conditions (PPCs) (synonymous) Determines What Reimbursement a Hospital Will Receive.....

The New System – 52 of the 64 PPCs will now be used to identify problem cases but not be subject to reduced reimbursement individually. How it works:

The Underlying Groundwork:

- 1) 3M has determined for each of its PPCs the average additional reimbursement a Maryland hospital would get for treating the PPC.
- 2) There are 314 DRGs in the APR system each with 4 levels of severity for 1,256 unique patient cells. 3M has calculated for each one the average number of each

PPC found in the data from FY 08. **Thus each DRG/SOI cell now has an expected or average number of each of the 64 PPCs. This equals 80,384 possibilities (1256 * 64).**

The Methodology:

- 1) The 3M model reviews each set of procedures, diagnoses and diagnoses present on admission for each case. Using its set of definitions of what constitutes each of its PPCs, cases are identified as having HACs or not.
- 2) Numbers of the various HACs/PPCs are accumulated by DRG/SOI and compared with the expected values for each. A positive difference will result if the hospital has more than an expected PPC with a negative difference occurring if there are less than expected.
- 3) Each DRG/SOI now has 64 sets of expected and actual occurrences of PPCs. Each PPC's expected and actual numbers are now summed regardless of the DRG/SOI from which they came.
- 4) The net positive or negative difference between expected and actual for each PPC is multiplied by the previously calculated value of excess resource usage per PPC. A positive result means excessive resource usage. A negative means averted resource usage.
- 5) The results which are now in dollars of all PPCs are summed to get a net excessive/averted resource usage for the hospital. This net result is divided by the amount of inpatient revenue so as to translate the net result into a percentage that can be used to compare hospitals with each other.
- 6) The %s will be used to develop a ranking from the best hospitals (those with negative values denoting averted resource usage) to the worst (those with high positive values denoting excessive resource usage).

Using the Rankings:

- 1) **Each year, the HSCRC will reduce the amount of inflation hospitals receive across the board. That will create a pool to facilitate rewarding the best performing hospitals with amounts greater than the inflation reduction. The worst performing hospitals will get little or nothing back and incur a net loss. This is called scaling.**
- 2) Scaling already exists for the Core Measures program and for the Reasonableness of Charges program. It is not clear yet how all three of these scaling methodologies will be combined.

NEWS FROM EMR AND HIPAA UPDATES:

This was a real good find from an article written back in 2002. 7 years ago and this information still rings true. The article is for the AAFP and is called "Why I Love My EMR" by William D. Soper, MD, MBA. He gives these common excuses for not implementing an EMR:

- a.. An EMR is too expensive
- b.. I don't need an EMR to be a good doctor
- c.. Is it safe to keep my records on a computer?
- d.. What if the electricity goes off?
- e.. What about patient confidentiality?
- f.. What about HIPAA?
- g.. Where do I find time to learn a new system?

- h.. How can I convince doctors who are dragging their feet?
- i.. How do I find time to see patients and enter my own data?
- j.. What do I do with my old records?
- k.. How do I decide which system to buy?
- l.. Won't technology improve and prices go down?

Then, he ends with his bottom line:

“ What's the bottom line?

Going digital is costly. The conversion process isn't easy, and acquiring new skills is frustrating, hard work. However, I've found that transitioning to an EMR system has been worth every frustration and every penny. It has made me a better doctor, reduced my overhead, made my staff happy and pleased my patients. I can't convince you to let go of your paper records. That's for you to decide. But I am willing to bet that if you do, you'll get the same results I did.”

Vancomycin Dosing and Monitoring Update

The Medical Executive Committee on June 4th 2009, approved revisions to the current dosing and monitoring for Vancomycin. The maintenance dose has been increased to 15-20 mg/kg based on actual body weight. In addition, a loading dose of 25mg/kg will be considered for select obese patients with normal renal function.

Trough serum concentration must be greater than 10mcg/ml for all disease states to minimize the development of resistance. Furthermore, severe infections such as sepsis and hospital-acquired pneumonia will have a target trough range of 15-18 mcg/ml.

These revisions are consistent with the latest evidence-based practice guidelines.

Anticoagulation Protocol Reminder:

Treatment orders for warfarin and enoxaparin must be written on the **new pre-printed anticoagulation order set**. Physicians must specify the **INDICATION, INITIAL INR, and GOAL INR RANGE** for all warfarin treatment orders. For enoxaparin, **INDICATION, baseline INR** and dose based on patient's weight in kilograms must be stated. This protocol was initiated on April 15th 2009, and we count on your cooperation for its success. Thank you!



OUR NEW HOSPITALIST AND INTENSIVIST GROUPS ARE DEDICATED TO IMPROVING COMMUNICATION WITH OUR PRIMARY AND SPECIALTY PHYSICIANS. Every effort is made to get accurate names of the patient's PMD and specialists, so H&Ps and discharge summaries are cc'd and can be faxed to you by transcription before the patient has their follow up visit.

When there is a breakdown, we are trying to investigate where it occurred. We hope the communication is better than in the past and we work towards continuing improvement. We want to deliver quality care and continuity of care for our patients, good communication with our doctors and instill trust in both for our delivery of care.

Please note that the **Dimensions Healthcare Corporation's Safety and Adverse Event Hotline** can be accessed by dialing **301-618-6400**. This line is for all Dimensions's facilities and is being answered live from 9 a.m. to 5:30 p.m Monday through Friday. Weekday after hours messages are acted on the following morning while messages left after 5:30 p.m. on Friday are returned on Monday. Laurel's Risk Manager, Tresa Fitch-Childs can be reached at 77927, while the Corporate Risk Director can be reached at 82105. DHS Intranet has a full list of contact numbers, click on Risk Management.

AMA Action Alert

- Parades, picnics, barbecues and fireworks--everywhere you look during the July 4 holiday you'll see your elected officials. That is why the time to be engaged is now!
- The AMA believes that in order for health system reform to truly succeed, Medicare's sustainable growth rate (SGR) formula must be repealed once and for all--no more temporary fixes, no more of the short-term, Band-Aid approaches used in the past. We need real Medicare reform.
- If you haven't weighed in yet on the debate occurring in Congress over what to do about Medicare physician payments, you need to do so now, before the decision is made for you and legislation is drafted.
- Watch Dr. Jennifer Wiler (www.youtube.com/watch?v=aT5NqcWoNgY) talk about why it's so important for physicians to be involved in the legislative process, then use the AMA hotline at 800-833-6354 to call Sen. Barbara A. Mikulski, Sen. Benjamin L. Cardin and your elected representative in the House, or email here: capwiz.com/ama/issues/alert/?alertid=13625576&type=CO
- If you've never called a congressional office before, check out our guide to "Communicating with Congress." www.ama-assn.org/ama1/pub/upload/mm/399/comm_with_congress.pdf
- To see how the cuts will impact patients and physicians in your state, visit www.ama-assn.org/go/medicarepaymentkit and pull down Maryland.
- Please don't put this off. Your representative and senators need to hear from you now, to protect your practice in the future.

IT TAKES A TEAM.....AND WE NEED YOUR HELP.....

One of the many ways that you can support our hospital is the utilization of our **Out-Patient Services** for your patients:

BEHAVIORAL HEALTH SERVICES	301-362-2086
CARDIOPULMONARY (STRESS, ECHOs, LFTs)	301-497-7926
CARDIAC / VASCULAR LAB	301-497-7997
PULMONARY REHAB (to increase the quality of living)	240-568-2928
SLEEP DISORDER LAB (sleep studies)	301-251-5905
IMAGING SERVICES (CT, MRI, mammo, general and interventional, nuclear med, ultrasound)	301-497-7994
INFUSION CENTER (ABs, remicaide, reblast, transfusions)	240-568-3477
LABORATORY	301-497-7930
PHYSICAL THERAPY	301-497-7901
WOUND CARE CENTER	301-725-7255

THANK YOU!

TOGETHER.... WE ARE MAKING A DIFFERENCE!

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