Welcome To Mississippi Baptist Health Systems

Physician Leadership Program
If your actions inspire others to dream more, learn more, do more and become more, you are a leader.

– John Quincy Adams
Objectives for Mississippi Baptist Medical Center
Physician Leadership Program

Upon completion of this program, the physician will be able to:
1. Employ self-awareness to enhance their effectiveness as a leader.
2. Understand their roles as a leader according to the MBHS bylaws.
3. Understand the importance of professionalism as a physician leader.
4. Understand the importance of verbal, non-verbal and written communication among their peers, the leadership of the hospital, and with the employees to help influence change as needed.
5. Facilitate an effective meeting.
6. Skillfully manage and resolve conflicts.
7. Understand and demonstrate the importance of confidentiality.
8. Understand the significance of proper credentialing and thorough reviewing of privileging and reappointing of physicians.
10. Understand and demonstrate how to review and approve FPPE and OPPE among the medical staff.
Objectives for Mississippi Baptist Medical Center
Physician Leadership Program

12. Understand the importance of accreditations, regulatory compliance, quality and clinical improvement processes of the MBHS.
13. Understand and demonstrate the ability to make sound financial decisions that balance quality patient care while promoting the success of the physicians and the MBHS.
15. Understand their legal protection as a physician leader.
16. Understand the importance of physician leadership in Clinical Integration and MAN.
17. Understand the MBHS organizational chart, the roles of MBHS Board of Trustees and the MBHS Board of Directors, and the locations of the primary care clinics.
Our Mission Statement
Our Mission is to pursue the highest quality healthcare, guided by our Christian Faith.

Our Vision Statement
Our Vision is to be the best healthcare system, recognized nationally for quality and trusted by our community.
<table>
<thead>
<tr>
<th>Board Member</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arthur Skip Jernigan, Chair</td>
</tr>
<tr>
<td>Jernigan, Copeland &amp; Anderson</td>
</tr>
<tr>
<td>Douglas M. (Matt) Buckles, Sr., D.Min</td>
</tr>
<tr>
<td>First Baptist Church, Vicksburg, MS</td>
</tr>
<tr>
<td>Paul Calhoun</td>
</tr>
<tr>
<td>Haddox Reid Eubanks Betts, PLLC</td>
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<tr>
<td>Alveno Castilla</td>
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<tr>
<td>Butler</td>
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<tr>
<td>J. Kane Ditto</td>
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<tr>
<td>StateStreet Group, LLC</td>
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<tr>
<td>James Robert Futral.,Jr., M.Div.,Ph.D.</td>
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<tr>
<td>Broadmoor Baptist Church</td>
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<tr>
<td>Robert M. Gathings, Jr.</td>
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<tr>
<td>Forman, Watkins, &amp; Krutz, LLP</td>
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<tr>
<td>David Landrum</td>
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<td>Primerica Financial Services</td>
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<td>Lee Miller</td>
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<td>Miller Transporters</td>
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<td>Dorian E. Turner</td>
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<tr>
<td>Dorian E. Turner, PLLC</td>
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<tr>
<td>Paul D. VanLandingham, M.D.</td>
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<tr>
<td>Jackson Medical Clinic</td>
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<tr>
<td>Harry M. Walker</td>
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<tr>
<td>Trustmark Bank</td>
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<tr>
<td>Tammy Young, M.D.</td>
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<tr>
<td>Jackson Oncology Associates</td>
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Mississippi Baptist Health Systems, Inc.
2016-Board of Trustees

• Ultimate responsibility for the management of the hospital.
• Meet every month except July and November
• Voted in for 3 year term and can serve up to 6 years
• If Chairman, can rest for 1 year after the 6 years, and serve another 3 year term for a total of 9 years of service.
## Mississippi Baptist Medical Center, Inc. 2016 Board of Directors

**January 1, 2016**

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
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</thead>
<tbody>
<tr>
<td>Karlen Turbeville</td>
<td>Chair</td>
</tr>
<tr>
<td>Samuel T. (Todd) Lawson, MD</td>
<td>Baptist Heart</td>
</tr>
<tr>
<td>James Robert Futral, Jr., M.Div., Ph.D.</td>
<td>Broadmoor Baptist Church</td>
</tr>
<tr>
<td>Alex Haick, M.D.</td>
<td>The Surgical Clinic Associates</td>
</tr>
<tr>
<td>H. Douglas Hederman</td>
<td>Hederman Bros. Printing</td>
</tr>
<tr>
<td>David Landrum</td>
<td>Primerica Financial Services</td>
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<tr>
<td>Lee Miller</td>
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2016 Board of Directors

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2015 BOARD OF REGENTS
Standing L-R: Chris Coleman, Chris Anderson, Chris Waterer, Alon Bee, Joe McCaskill, Andy Wimberly,
Whit Hughes (Foundation President), Dolph Baker, Bill Ashford, Kane Ditto, Bill Lampton, Jason Greener
Seated L-R: Dudley Wooley, Margaret McLarty, Rick Calhoun (Chairman), Mary Shapley, Kurt Metzner, Tommy Thames (Vice Chairman)

BAPTIST HEALTH FOUNDATION | MISSION STATEMENT
Our Mission is to support Mississippi Baptist Health Systems in providing the highest quality healthcare,
guided by its Christian faith, through financial support and stewardship.

BAPTIST HEALTH FOUNDATION | VISION STATEMENT
Our Vision is to be our community’s preferred healthcare charitable organization, recognized for
extraordinary stewardship, involving all those wishing to share gifts of time, talent, and resources.
Pastoral Care Services & Faith Relations

- Special Services / Blessing Of The Hands
- Trained 8 Clinical Pastoral Education students
- Over 14,000 patients per year / Over 600 employees per year
- Over 200 services and devotions
- 13 active Faith Groups / Connect Events / Pastor Roundtables
- Initiated volunteer pastoral care programs at BMC-A, BMC-L, BMC-Y
Relational skills are the most important abilities in leadership.

There are three qualities a leader must exemplify to build trust: **competence, connection, and character.**

You build trust with others each time you choose integrity over image, truth over convenience, or honor over personal gain.
Click here to review the services at Baptist
Hospital Support Services

- Clinical Pharmacists
  - Anticoagulation Service
  - Diabetes Management Team
  - Nutrition Support Service
  - Pharmacokinetic Service (24 hr antibiotic line)
- Discharge Planning/Case Management/Social Workers
- Nutrition & Bariatric Center (*also includes outpatient diabetic education and medical weight management*)
- Clinical Dieticians
- Stroke Coordinator
- Rapid Response Team
- PICC Team
- Wound Care (Inpatient & Outpatient)
Support Services continued

- Risk Management
- Compliance & Safety Officer
- Data Management
- Medical Staff Services
- Rehab & Sportscare, OT and Speech (SLP)
- Lymphedema specialists (and certified Lymphedema Clinic)
- Infection Prevention Coordinators
- Clinical Psychologist & Psychiatrist
- Health Information Management (601-968-1717)
- IT Support (MD help line)
- Corporate Communications
- Education Resource Center
- A qualified nurse can pronounce a patient who has expired if **NOT** on life support (MS BON rule)
### Important Phone Numbers

<table>
<thead>
<tr>
<th>Service</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administration</td>
<td>601-968-5130</td>
</tr>
<tr>
<td>Medical Staff Services</td>
<td>601-968-5003</td>
</tr>
<tr>
<td>IT support</td>
<td>601-968-1050 or 8888</td>
</tr>
<tr>
<td>Central Intake</td>
<td>601-968-1228</td>
</tr>
<tr>
<td>Health Information Management</td>
<td>601-968-1717</td>
</tr>
<tr>
<td>Quality Data Management</td>
<td>601-968-1333</td>
</tr>
<tr>
<td>Dictation</td>
<td>601-974-2700</td>
</tr>
<tr>
<td>Emergency Department</td>
<td>601-968-1700</td>
</tr>
<tr>
<td>Hospitalist Phone</td>
<td>601-988-5281</td>
</tr>
<tr>
<td>Hospital Information Desk</td>
<td>601-968-1776</td>
</tr>
<tr>
<td>Security</td>
<td>601-968-1010</td>
</tr>
<tr>
<td>Education Services</td>
<td>601-968-1712</td>
</tr>
<tr>
<td>Chaplain</td>
<td>Call Operator</td>
</tr>
<tr>
<td><a href="http://carenet.mbmc.org/Phone.aspx">http://carenet.mbmc.org/Phone.aspx</a></td>
<td>For other numbers</td>
</tr>
<tr>
<td>Paragon Training</td>
<td>601-973-1682</td>
</tr>
</tbody>
</table>
Baptist Critical Access Hospitals

Baptist Medical Center Leake click here for details and click here for the open house.

Baptist Medical Center Attala click here for details and click here for the open house.

Baptist Medical Center Yazoo click here for details and click here for the open house.
Baptist Medical Clinic
Primary Care Network
MADISON CAMPUS
MAIN STREET
NORTHTOWN
SPILLWAY
WALMART
CLINTON HEALTHPLEX
DOGWOOD
BYRAM
Occ Health
RANKIN
BRANDON
RANKIN
Network of clinics conveniently located to serve a variety of healthcare needs. All have access to the resources of Baptist Health Systems. Clinic services include board-certified staff, state-of-the-art facilities and cutting-edge technology.

**Baptist Family Medicine**

1490 W Government Street, Suite 10
Brandon, MS 30142
601-826-1936

Carrie Nash, DO
Kim Loo, FNP-C

7275 Siwall Road
Byram, MS 39272
601-373-7722

Scott A. Davis, MD
William K. Harris, MD
Douglas L. Younger, MD
Pam Bingham, MSN, PA-C
Joanna Mason, PA-C

106 Clinton Parkway
Clanton, MS 39056
601-824-9605

Joseph B. Montgomery, MD
Christy Nkhoma, MD
Scott French, FNP-BC
R. Jackson Williams, FNP-BC

151 East Metro Parkway, Suite 103
Flowood, MS 32322
601-692-3288

Rance O. Dyess, MD
Scott M. Kelly, MD
Margaret Prohanna, FNP-BC

461 Baptist Drive, Suite 104
Madison, MS 30110
601-605-2383

Timothy C. Chen, MD
Lindsey Baas, FNP-C

6250 Old Canton Road
Jackson, MS 30211
601-857-1015

Brad Castle, MD
Larry L. Collins, MD
Cindy Garrett, MD
Lauren B. Treadwell, MD

2173 Main Street
Madison, MS 30110
601-605-3858

Bruce Black, MD
Bard Johnston, MD
Ashley B. Pullen, MD
Baptist Internal Medicine
3011 Greenfield Road
Pearl MS 39208
601-825-9000
David Flemming, MD
Lucius E. Sams, III, MD

Baptist Cardiovascular Surgery
501 Marshall Street, Suite 302
Jackson, MS 39202
601-969-7047
William J. Harris, III, MD
W. Stewart Horsley, MD
Daniel Ramirez, MD
Lynne Currie, FNP-BC
Mary Gordy, FNP-BC

Baptist Thoracic Surgery
501 Marshall Street, Suite 302
Jackson, MS 39202
601-466-4767
A. Michael Koury, MD, FACS

Baptist Neurological Associates
1200 North State Street, Suite 420
Jackson, MS 39202
601-355-3353
Nader Atalla, MD
Angela Chandler, MD
Gerald P. Randle, MD
Richard E. Weddle, MD
Gina Burke, MSN, RN, NP-BC
Leigh Langford, MS, FNP-C

Baptist Gynecologic Oncology
501 Marshall Street, Suite 307
Jackson, MS 39202
601-968-3330
James L. Moore, Jr., MD
Throughout Baptist Health Systems we always provide the highest quality healthcare within a Christian Healing environment. The Baptist Standards of Performance are expected behaviors that all staff agree to model and champion in our organization to create this environment.
**Positive Attitude**

“Now who will harm you if you are eager to do what is good? But even if you do suffer for doing what is right, you are blessed. Do not fear what they fear, and do not be intimidated, but in your hearts sanctify Christ as Lord. Always be ready to make your defense to anyone who demands from you an accounting for the hope that is in you.” 1 Peter 3:13-15

- I always exhibit empathy and a positive attitude towards patients, visitors, and fellow caregivers.
- I always strive to take care of myself (physically, mentally, and spiritually).
- I always strive for a heart of peace, not of war.
- I always acknowledge patients, visitors, and fellow caregivers with a smile within ten feet and a greeting at five feet.
- I always practice phone etiquette, elevator etiquette, and giving directions with a positive attitude.

**Acts and Communicates Respectfully**

“But speaking the truth in love, we must grow up in every way into him who is the head, into Christ.” Ephesians 4:15

- I always introduce myself and my role whether it be in person, on the phone, or answering a call light.
- I always listen carefully and communicate to patients, visitors, and fellow caregivers in a courteous and respectful manner.
- I always explain in a way patients, visitors, and my fellow caregivers can understand.
- I always respond to a service opportunity by hearing the story, empathizing, apologizing, responding to, and thanking the patient, visitor, or fellow caregivers that brought it to my attention.
- I always thank our patients for choosing Baptist because I know they have a choice.

**Timely Response**

“Put these things into practice, devote yourself to them, so that all may see your progress. Pay close attention to yourself and to your teaching, continue in these things, for in doing this you will save both yourself and your hearers.” 1 Timothy 4:15-16

- I always respond in a prompt and productive manner to the needs of patients, visitors, and fellow caregivers.
- I always provide duration information to patients, visitors, and fellow caregivers, explaining how long procedures, wait times, call backs, and other activities will take.
- I always anticipate patient, visitor, and fellow caregiver needs and take ownership in addressing them to their satisfaction.

**Highest Professional Standards**

“Let the favor of the Lord our God be upon us, and prosper for us the work of our hands—O prosper the work of our hands!” Psalm 90:17

- I always make sure that the patients and their families remain the focus of why I come to work each day.
- I always model proper personal hygiene and maintain a well groomed, professional appearance.
- I always take ownership of my role and profession by consistently seeking professional growth opportunities, new knowledge, and competency within my profession.
- I always practice “Commitment to my Coworkers” and contribute to the team in a professional manner.
- I always practice and promote a safe and clean environment.
- I always practice and promote a quiet, healing environment in patient care areas.
Commitment to My Co-Workers

I will accept responsibility for establishing and maintaining healthy interpersonal relationships with you and every other member of this team.

I will talk to you promptly if I am having a problem with you. The only time I will discuss it with another person is when I need advice or help in deciding how to communicate with you appropriately.

I will establish and maintain a relationship of functional trust with you and every member of this team. My relationships with each of you will be equally respectful, regardless of job title, level of educational preparation, or any other differences that may exist.

I will not engage in the "3Bs" (Bickering, Back-biting, and Blaming).

I will practice the "3Cs" (Caring, Commitment and Collaboration) in my relationship with you and ask you to do the same with me.

I will not complain about another team member and ask you not to as well. If I hear you doing so, I will ask you to talk to that person.

I will accept you as you are today, forgiving past problems, and ask you to do the same with me.

I will be committed to finding solutions to problems, rather than complaining about them or blaming someone for them, and ask you to do the same.

I will affirm your contribution to the quality of our work.

I will remember that neither of us is perfect, and that human errors are opportunities, not for shame or guilt, but for forgiveness and growth.
The best executive is the one who has sense enough to pick good men to do what he wants done, and self-restraint to keep from meddling with them while they do it.

– Theodore Roosevelt

Most of the important things in the world have been accomplished by people who have kept on trying when there seemed to be no hope at all.”

- Dale Carnegie
The Medical Staff Office is responsible for coordinating all most all of medical staff functions; all credentialing and privileging of new members as well as reappointment and emergency/temporary appointments; policy formulation and revision for the medical staff; and, review and revision of medical staff bylaws, rules and regulations.

Right Click, Open Hyperlink, & Visit Public Site

MBHS Bylaws and Regulations
MBHS Code of Ethics
Credentialing – Why does it matter?
1. Mr. Tanner had an ulcer on his large toe. He went to wound care and then to surgery to remove his toe, but ended up having an amputated foot. He sued the surgeon for malpractice and the hospital for negligent credentialing. This had occurred on several occurrences at other hospitals prior to him being on staff here.

2. Jane had a robotic cholecystomy with complications by the newest surgeon on staff. The hospital later found that the surgeon had never been credentialed in robotic surgery. The surgeon and the hospital were sued.

3. Suzie came in for a vaginal delivery but the ob-gyn on call who was new to the hospital was quick to do a C Section. The patient sued him and the hospital. This Ob’s C Section was doubled others and had been in disciplinary action at the last hospital but no one had verified with them.

**Credentialing ...... It Matters!**

Patients trust you as a hospital.
Composition of the Credentials Committee:

(1) The Credentials Committee shall consist of 7 members of the Active Staff selected for their interest or experience in credentialing matters and who meet the eligibility criteria set forth in Article III, Section 2 of these Bylaws.

(2) The President of the Medical Staff will appoint a committee chairperson, subject to approval by the Executive Committee. The chairperson of the Credentials Committee will be appointed for a term of two years and may be reappointed for additional terms.

(3) Members of the Credentials Committee will be appointed by the President of the Medical Staff, subject to approval by the Executive Committee. Members of the Credentials Committee will serve an initial term of two years and may be reappointed for additional terms.

(4) To the extent possible, Credentials Committee members will serve staggered terms, so that the Committee includes experienced members.

(5) Service on the Credentials Committee will be considered the primary Medical Staff obligation of each member, and other Medical Staff duties, of an administrative nature, will not interfere.

(6) New members of the Credentials Committee are expected to obtain specific education and training regarding the credentialing process.
Purpose of the Committee:

Service on this committee shall be considered as the primary medical staff obligation of each member of the committee and other medical staff duties shall not interfere.

The Credentials Committee is intended to be a medical and dental peer review committee as defined by Mississippi Code Section 41-63-1, as amended. All proceedings and records of the Credentials Committee are intended to be confidential pursuant to Mississippi Code Sections 41-63-9 and 41-63-23, as amended. The Credentials Committee is formed and created for the sole purpose of quality improvement and assurance through effective peer review.
The duties of the Credentials Committee shall be:

(1) to review the credentials of all applicants, to make such investigations of and interview applicants as may be necessary, and to make recommendations for appointment, reappointment and delineation of clinical privileges to the MEC in compliance with these bylaws:

(2) to review, as questions arise, all information available regarding the professional and clinical competence of persons currently appointed to the medical staff, their care and treatment of patients and case management, and, as a result of such review, to make recommendations to the MEC for the granting, reduction or withdrawal of promotions, privileges, reappointments, and changes in the assignment of appointees to the various sections;

(3) to review any medical staff member who has been identified as a "chronic offender" of medical record completion requirements contained in the Medical Staff Policy and Procedure Manual;

(4) to review reports concerning the clinical privileges of medical staff appointees referred by any other medical staff committee, the President of the Medical Staff, the Administrator or the Chairperson of the Board and to make such recommendations as provided by these Bylaws;

(5) to develop, implement, and oversee policies concerning physician health issues and to act as the Physician Help Committee pursuant to the Medical Staff Impaired Physician Policy and Referral Procedure.

(6) Through the chairperson of the Credentials Committee, the chairperson's representative or such members of the committee as are deemed necessary, be available to meet with the Board or its applicable committee upon the Board's request on all recommendations that the Credentials Committee may make to MEC.
CREDENTIALING TIPS

1. No shortcuts. Don’t Rush it. Give Medical Staff the time needed.
2. Don’t let anything slip through the cracks.
3. Don’t accept incomplete applications.
4. Verify each line on the application.
5. Use the telephone for additional verification.
6. Keep digging to make sure everything is lining up.
7. If Red Flags....Don’t over look them
8. Peer Evals: Check each one and try to get them all back if you sent a request
9. If information doesn’t look favorable – get applicant to sign a release to obtain all information from past locations

Patient Safety Starts Here!
The Application **Red Flags Questions**

1. Current licensure or registration
2. Voluntary or involuntary relinquishment of licensure or registration
3. Voluntary or involuntary termination of staff membership
4. Voluntary or involuntary reduction or loss of clinical privileges
5. Evidence of unusual pattern of behavior
6. Evidence of unusual pattern of excessive number of professional liability actions resulting in a final judgment
7. Documentation of applicants health status
8. Numerous professional moves
9. A lapse in dates of work
10. Relevant practitioner specific data compared to aggregate data
11. Morbidity and mortality data if available

Looking for any discrepancies on application and on written/oral responses. Look for **RED FLAGS**!
CREDENTIALING AGING PHYSICIANS: CONSENSUS OR CONTROVERSY?

https://www.hortyspringer.com/ac/2015/CAPCC08-15/CAPCC08-15.htm

August 13, 2015

A. What is the nature and extent of the issue?

B. Laws and accreditation standards require hospitals to ensure the competence of practitioners who are granted privileges.
   1. Corporate negligence and negligent credentialing doctrines.
   2. Hospital licensing regulations.
   3. Medicare Conditions of Participation.

C. Laws also protect practitioners from discrimination based on age or impairment.

D. Is there a trend toward consensus in adopting credentialing criteria related to age, or is there continued controversy?
Credentialing

Credentialing - Initial appointment
Credentialing - Verification Process
Credentialing - Approval and orientation
Credentialing - Reappointment
Credentialing - Telemedicine

( page 45 of bylaws will work on link)

to review right click on each one and click on Visit our Public Site at bottom of login box
Appointment and Reappointments

http://ppm.mbmc.org/dotNet/documents/?docid=11510&mode=view

(page 39-66)
Medical Staff Services and Quality Data Management Services provides information and support regarding FPPE and OPPE to all section chiefs for credentialing, reappointments, and for Professional Practice Evaluation Process.
ACCREDITATION
Baptist Medical Center & Restorative Care Hospital
The Joint Commission (TJC) accredits health care organizations and programs nationally & internationally.

Why accreditation?

• Public expectation
• Demonstrates commitment to standards of performance
• Required for many accreditations, certifications and distinctions
• Required for reimbursement for services
• Facilitates risk assessment and reduction
• Provides CMS “deemed status” (required for payment for services)

Source: http://www.jointcommission.org

Baptist HEALTH SYSTEMS
Disease Specific Certifications:

<table>
<thead>
<tr>
<th>Heart Attack (ACS)</th>
<th>Inpatient Diabetes (Advanced)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart Failure</td>
<td>Prematurity</td>
</tr>
<tr>
<td>CABG</td>
<td>Breast Cancer</td>
</tr>
<tr>
<td>Primary Stroke (Advanced)</td>
<td></td>
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</tbody>
</table>

- Baptist Medical Center – more certifications than any other hospital in the state
- Additional standards are required for these certifications
- **Key:** Team approach to provide best care for specific patient groups. Each team has physician champions.
- **Focus:** Evidence-based practice, patient self-management and team approach to care
Recognitions

• NAPBC Accredited - Center for Breast Health
• Blue Distinction + for cardiac care, hips, knees & spines
• Cancer Center – Commission on Cancer Accreditation
• Accredited Outpatient Cardiac Rehab program
• Multiple Healthgrades quality recognitions (Top 2% in nation for safety and patient experience + many others)
• Numerous other departments are accredited and/or have certifications – for all see http://www.mbhs.org/healthcare-quality-and-accreditations/
MBMC is a Primary Stroke Center

The state of Mississippi has an state-wide Stroke Network.

awarded

2015 Get With the Guidelines Stroke Awards Gold Plus
Leadership is a potent combination of strategy and character. But if you must be without one, be without the strategy.

– Norman Schwarzkopf
QUALITY
Baptist Medical Center reports the following Quality Measures to the public (Joint Commission) with an example of data for each:

Other measures are also reported publically – such as infections

- **Immunizations**
  - Example - making sure patients receive both influenza and pneumonia vaccines before discharge when appropriate. Influenza must be addressed September – March; pneumonia all year long.

- **Perinatal Care**
  - Example – not delivering babies too early unless the doctor feels it is medically necessary (not for patience or physician’s convenience)!

- **HCAHPS (Patient Experience)**
  - Example - did the patient feel they got help as soon as they wanted?

- **VTE (Venous Thromboembolism)**
  - Example – did patients taking Coumadin receive discharge instructions? Must be documented

- **HBIPS (Hospital Based Inpatient Psychiatric Services) – Senior Behavioral Health**
  - Example – was the patient’s discharge continuing care plan documented?

- **ED (Emergency Department)**
  - Example – What was the median time from arrival in ED to discharge from ED for patients admitted to the hospital?

- **Sepsis bundle** will also be required starting in 2015

Reimbursement for hospital services by CMS is based on quality measures, care coordination & patient experience.
Organ & Eye Donation

• Federal and state law requires hospital to notify MORA of all potential organ donors and patient deaths

• MORA/MLEB Referral Line Triggers – unit staff must call within 1 hour
  – Vented with neuro injury & GCS 5 or less
  – Before brain death testing
  – Decision to withdraw care or vent support
  – Cardiac Death

1-800-362-6169

MORA Staff will approach the family as appropriate

For more info:  http://www.msora.org/
## Performance Improvement Projects

| Blue Distinction – Hip & Knee, Spine & Cardiac | Continuous Improvement- quality & infection control for this pt population. An additional focus has been on a significant decrease in blood utilization. |
| Joint Commission Disease Specific Certifications | Continuous improvement in the management of a specific disease and/or patient population. |
| Target Zero (Infections) | Hand Hygiene compliance and on-going education. |
| CLABSI & CAUTI | Goal reduce hospital acquired infections |
| Medication Safety Team | Focused group that meets bi-weekly to review medication events related to the overall medication process. |
| Patient Safe Handling | To reduce employee and patient injuries |
| MBSAQPI | Metabolic and Bariatric Surgery accreditation requires data used for improvement purposes |
## Performance Improvement Continued

<table>
<thead>
<tr>
<th>Utilization Review Team – Readmissions &amp; Length of Stay</th>
<th>Focus: HF, Pneumonia, and Stroke; overall length of stay variances over “expected”</th>
</tr>
</thead>
<tbody>
<tr>
<td>HCAHPS: Overall Experience and Physician specific questions. Publically reported.</td>
<td>Organization-wide for all areas with focus for nursing questions in areas with nurses</td>
</tr>
<tr>
<td>Reduction of falls with injury</td>
<td>To reduce overall number of falls with injuries</td>
</tr>
<tr>
<td>Physician Task Force</td>
<td>Focused initiative for physician feedback and participation related to CPOE and EHR</td>
</tr>
<tr>
<td>VTE5 and Warfarin education</td>
<td>Pharmacy leaders provide focused staff and patient education, action plans to improve this core measure.</td>
</tr>
<tr>
<td>Length of Stay Project</td>
<td>Communicate anticipated day of discharge and work with discharge planning/case management to facilitate discharge</td>
</tr>
<tr>
<td>Joint Commission Core Measures</td>
<td>Reported to the public on the JC web site – the information must be documented for compliance. 2016 Measures include Emergency Department, VTE, HBIPS (Inpatient Psych – SBH), Perinatal Care and Immunizations (Influenza &amp; Pneumonia) measures</td>
</tr>
</tbody>
</table>
Internet Sites: Compare Quality Data Available to Public & Employees

- **Hospital Compare**: can compare three hospitals [http://www.hospitalcompare.hhs.gov/](http://www.hospitalcompare.hhs.gov/)
- **Joint Commission**: can compare six hospitals for quality measures [http://www.qualitycheck.org/consumer/searchQCR.aspx](http://www.qualitycheck.org/consumer/searchQCR.aspx)
- Centers for Disease Control – mandatory infection control data is reported to the public
- Employees – data is available forums, units, departments
Get on board! Core Measures

Nothing But 100% Core Measure Performance

Don’t be left behind, now is your chance to shine!

Core Measure Resources:
www.QualityNet.org
www.Hospitalcompare.hhs.gov
www.jointcommision.org
www.medqic.org

“QUALITY IS EVERYBODY’S BUSINESS”

The goal of core measures is to have evidence-based care for our patients because it’s the right thing to do!

Baptist Medical Center

Resource Management

If you have questions regarding Core Measures, contact:
- Karlene Cooper Stroyer, RN ex: 1333
- Vickie Gerrard, RN ex: 1259

➤ What are Core Measures?
They are the use of standardized – or “core” – performance measures in treating an identified illness or core measure set also known as “Hospital Quality Measures” or “Core Measures”.

➤ How many core measure sets are being participated in by Baptist and most accredited hospitals?
Currently there are five identified core measure sets being participated in by MBMC which are measured by TJC and CMS accredited hospitals all over the country – Acute Myocardial Infarction (AMI), Heart Failure (HF), Pneumonia (PN), Surgical Care Improvement Project (SCIP), and Stroke. A hospital’s performance will be measured by its adherence to the core measure guidelines. This means that for each diagnosis, there are sets of evidence-based treatments, diagnostic tests and standards to follow. The facility’s practitioners and nursing staff are expected to comply with these guidelines.

➤ What are the MDs and nursing staff’s role in core measures?
Use of order sets by MDs guarantees that all diagnostic and treatment components of each measure set are completed and documented at a precise time. Nursing staff must also ensure that these orders are carried out and documented at the right time on the right document (e.g. Nurse notes, Care Manager, OR records, etc.). Remember, no documentation means no intervention was done and negative scores are given to set measures.

➤ What does it mean to receive high scores on core measures?
The goal is 100% in our core measure compliance. This means that patients with core measure diagnoses were given timely and appropriate care. Our scores are publicly reported as well as for all hospitals in the surrounding area. The goal of core measures is to have evidence-based care for our patients because it’s the right thing to do! Getting the recommended care means patients are more likely to have better outcomes.
Core Measures

Below are five core measures that MBMC is participating in and submitting to both CMS and TJC for public reporting. Listed below are the things one must always remember to do when a patient falls under a core measure set such as AMI, HF, PN, SCIP, and Stroke. Getting the recommended care means patients are more likely to have better outcomes.

1. Acute Myocardial Infarction (AMI)
   1. Aspirin on arrival
      (Unless contraindicated, documented)
   2. Aspirin/Beta blocker at discharge
      (Unless contraindicated, documented)
   3. ACEI or ARB for LVSD
      (Ejection fraction <40%)
   4. Smoking Cessation Counseling
      (Smoker within prior 12 months - Cigarettes only)
   5. Fibrinolysis within 30 minutes
      OR
   6. PCI within 90 minutes

2. Heart Failure (HF)
   1. Discharge instructions on:
      - Medications (reconciliations must match)
      - Activity
      - Diet
      - Symptoms Worsening
      - Weight
      - Follow-Up
   2. LV function evaluation
   3. ACEI or ARB for LVSD
      (Ejection fraction <40%)
   4. Smoking Cessation Counseling
      (Smoker within prior 12 months - Cigarettes only)

3. Pneumonia (PN)
   1. 1st Dose of Antibiotic within 6 Hours
   2. Pneumococcal and/or Influenza Vaccine
   3. Blood Cultures Prior to Antibiotics
   4. Smoking Cessation Counseling
      (Smoker with prior 12 months - Cigarettes only)
   5. Appropriate Antibiotic selection
      a. Non-ICU admission
      b. ICU admission
      c. Pseudomonal Risk
         (Pseudomonal risk, Bronchiectasis, Structural Long bone with chronic cartilaginous or repeated antibiotic use documented by MD)

4. Surgical Care Improvement Project (SCIP)
   1. Appropriate Antibiotic Selection
   2. Antibiotic within 1 hr before incision time
   3. Prophylactic Antibiotic discontinued within 24 Hours After Surgery (CABIG within 48 hours unless infection is documented)
   4. Beta blocker taken prior to admission
      (documented estimated time of last dose taken)
   5. Beta blocker preoperative tx
      (24 hrs before surgery)
   6. Appropriate preoperative Hair Removal
   7. VTE prophylaxis order
   8. VTE Therapy Implemented 24 hrs before to 24 hrs after surgery
   9. DC intraoperatively placed Foley cath by POD1 or POD2
   10. Documented postop temp >36/96, BF 30 mins
      prior anesthesia to 15 mins post anesthesia
   11. Postoperative 6 am glucose - cardiac surgery patients (>200; Postop Day 1 & 2)

5. Stroke
   1. IV rt-PA Arrive by 2 Hour, Treat by 3 Hour
   2. Early Antithrombotics
   3. DVT Prophylaxis
   4. Antithrombotics
   5. Anticoag for AFib/AFlutter
   6. Smoking Cessation
   7. LDL 100 or ND - Statin
   8. Dysphagia Screen
   9. Stroke Education
   10. Rehabilitation Considered
Ethical Issues

- Ethical issues may arise in the care of patients.
- Each involves a unique set of circumstances.
- Ethical issues/conflicts of care, include but are not limited to:
  - Withholding, foregoing, or withdrawing of life-sustaining equipment
  - Refusal of treatment
  - Over/under treatment, under-informing by practitioner
  - Conflicts regarding patient autonomy/doctor’s orders/family wishes
  - Omission of treatment
  - “Ordinary” vs “extraordinary” care
  - Abuse or suspected abuse (see Abuse Policy)
  - Advance Directives questions (see Advance Directives Policy)
  - Termination of Pregnancy (See Medical Staff policy)
The hospital has a process to follow when ethical concerns arise:

1. Staff notify the area supervisor or House Supervisor.
2. Supervisor notifies the Nurse Manager, Clinical and/or Department Director.
3. As indicated, the Director notifies the Vice President or Administrator on call for the hospital.
4. Risk Management or a VP should notify the following as appropriate:
   a) Medical Director of Service/Chief of Section, Risk Manager, Pastoral Care, Case Manager, Social Worker, Legal Counsel, & patient’s physician.
   b) Medical Director
   c) Board of Trustees

Staff have the right to address ethical concerns/conflicts while caring for patients.
## VALUE BASED PURCHASING FY 2016

Below are the final Value-Based Purchasing domains, measures and weights for Fiscal Year 2016 as shared by Centers for Medicare & Medicaid Services (CMS). (Payment adjustment effective for discharges from Oct. 1, 2015 to Sept. 30, 2016)

<table>
<thead>
<tr>
<th>Measure ID</th>
<th>Measure</th>
<th>2016 Threshold (percent)</th>
<th>2016 Benchmark (percent)</th>
</tr>
</thead>
<tbody>
<tr>
<td>MORT-30-AMI</td>
<td>Acute Myocardial Infarction (AMI) 30-Day Mortality Rate (shown as survival rate)</td>
<td>84.75</td>
<td>86.24</td>
</tr>
<tr>
<td>MORT-30-HF</td>
<td>Heart Failure (HF) 30-Day Mortality Rate (shown as survival rate)</td>
<td>88.15</td>
<td>90.03</td>
</tr>
<tr>
<td>MORT-30-PN</td>
<td>Pneumonia (PN) 30-Day Mortality Rate (shown as survival rate)</td>
<td>88.27</td>
<td>90.42</td>
</tr>
</tbody>
</table>

### Patient Safety Indicators

<table>
<thead>
<tr>
<th>Measure ID</th>
<th>Measure</th>
<th>2016 Threshold (percent)</th>
<th>2016 Benchmark (percent)</th>
</tr>
</thead>
<tbody>
<tr>
<td>AHRQ PSI-90</td>
<td>Patient Safety Indicator composite</td>
<td>6.23</td>
<td>4.52</td>
</tr>
<tr>
<td>CLABSI</td>
<td>Central Line-Associated Bloodstream Infections</td>
<td>0.465</td>
<td>0.000</td>
</tr>
<tr>
<td>CAUTI</td>
<td>Catheter-Associated Urinary Tract Infection (CAUTI)</td>
<td>0.10</td>
<td>0.000</td>
</tr>
<tr>
<td>SSI - Colon*</td>
<td>Surgical Site Infection (SSI - Colon)</td>
<td>6.80</td>
<td>0.000</td>
</tr>
<tr>
<td>SSI - Abdominal Hysterectomy*</td>
<td>Surgical Site Infection (SSI - Abdominal Hysterectomy)</td>
<td>7.50</td>
<td>0.000</td>
</tr>
</tbody>
</table>

### HCAHPS Survey Dimensions

<table>
<thead>
<tr>
<th>Measure ID</th>
<th>Measure</th>
<th>2016 Threshold (percent)</th>
<th>2016 Benchmark (percent)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication with Nurses</td>
<td>53.99</td>
<td>77.67</td>
<td>86.07</td>
</tr>
<tr>
<td>Communication with Doctors</td>
<td>57.01</td>
<td>80.40</td>
<td>88.56</td>
</tr>
<tr>
<td>Responsiveness of Hospital Staff</td>
<td>38.21</td>
<td>64.71</td>
<td>79.76</td>
</tr>
<tr>
<td>Pain Management</td>
<td>48.96</td>
<td>70.18</td>
<td>78.16</td>
</tr>
<tr>
<td>Communication about Medicines</td>
<td>34.61</td>
<td>62.33</td>
<td>72.77</td>
</tr>
<tr>
<td>Hospital Cleanliness &amp; Quietness</td>
<td>43.08</td>
<td>64.95</td>
<td>79.10</td>
</tr>
<tr>
<td>Discharge Information</td>
<td>61.36</td>
<td>84.70</td>
<td>90.36</td>
</tr>
<tr>
<td>Overall Rating of Hospital</td>
<td>34.95</td>
<td>69.32</td>
<td>83.97</td>
</tr>
</tbody>
</table>

For tools and resources that move these metrics and enhance patient experiences, visit www.studergroup.com.
NATIONAL PATIENT SAFETY GOALS
National Patient Safety Goals:

**Identify patients correctly for meds & treatments**
- Use at least two identifiers (Name & Date of Birth);
  Can other identifiers be used? **YES, in addition to** Name & DOB if ANY concerns
- Make sure patients get the correct blood.

**Improve staff communications**
- Quickly get important test results to the right person (including MD)

**Improve safety of using medications**
- Label all medications (in basins, syringes, etc.) that are not already labeled. **Only exception:** IMMEDIATE administration – applies to procedural areas, surgeries, and all patient care areas..
- Take extra care with patients who take medications to thin blood thinners. **Example:** use standard orders, get baseline lab work, teach about food/drug interactions, educate patient & family

**Why?**
Most frequent cause of harm to patients in hospitals.
National Patient Safety Goals:

Check patient medicines (inpatients, ED, outpatients, clinics)
- Find out what medicines each patient is taking and compare to new medicines being ordered in the hospital.
- Give a list of the patient’s medicines to their next caregiver or to their regular doctor before the patient goes home.
- Give a written list of the patient’s medicines to the patient and their family before they go home. Explain the list and importance of carrying a list at all times.
- Tell patients to always take a current list of medicines to every doctor visit.
- Reason: Avoid duplications, omissions, interactions, and not abruptly stop important medications – to be sure it is OK for patients to take their home medicines with their hospital medicines.

Prevent infections
- Wash hands – use guidelines from Centers for Disease Control
- Use proven guidelines to prevent infections
  - that are difficult to treat
  - of the blood from central lines
  - from urinary catheters
  - after surgery
- Educate patients and families on prevention of infections
Medication Reconciliation:

Record and pass along information about a patient’s medications. Applies to inpatients and outpatients.

Medication reconciliation is intended to identify and resolve discrepancies—it is a process of comparing the medications a patient is taking (and should be taking) with newly ordered medications.

The comparison should address duplications, omissions, and interactions, and the need to continue current medications. The types of information that clinicians use to reconcile medications include (among others) medication name, dose, frequency, route, and purpose.

**Note:** Some patients may get medicines in small amounts or for a short time. Make sure it is OK for those patients to take those medicines with their current medicines.

*In outpatient departments, this may be limited to pain medicines, antibiotics, new medicines added, etc.*
Medication Reconciliation continued

- Required on admission, transfer, and discharge for all patients.
- Should be completed using the electronic medical record.
- In many settings, the nursing staff will obtain the list of medications being taken by the patient and enter the information electronically for reconciliation by the physician.
- On discharge medication reconciliation should address all medications prior to admission, discontinued medications, and added/changes to medications.

Nationally, the most frequent cause of readmission involves medications and is often a patient safety issue.
Clinical Alarm Safety

Make improvements to ensure that alarms on medical equipment are heard and responded to on time.

– There are MANY alarms heard during the day – bed alarms, IV pumps beeping, monitors alarming – to name a few. One issue to address is who can change parameters for certain alarms.

– Others may hear alarms going off on patient equipment, when passing by a patient room – respond and alert the patient care staff when needed so they can respond!

– The Clinical Alarm Task Force is meeting to make improvements to ensure that alarms on medical equipment are heard and responded to appropriately. One activity is to determine which alarms could be an irritant versus those that could be a safety issue if not responded to immediately.

In 2015, the hospital was required to develop a policy & procedure for clinical alarm management. This is being done by the Clinical Alarm Task Force headed by the director of Biomedical Engineering.

2016 – Hospitals are required to monitor to see if alarms are heard and responded to on time.

– For more information: http://www.jointcommission.org/sea_issue_50/
GENERAL PATIENT SAFETY
EMERGENCY CODES/ALERTS

- Code 55 – Bomb Threat
- Code 99 – Cardiac/Respiratory Arrest
- Cardiac Alert – Urgent Heart Attack to Cath Lab
- Code Blue – Infant Cardiac/Respiratory Arrest
- Stroke Alert – Urgent possible Stroke in ED or hospital
- Dr. Red – Fire
- Code Adam – Infant Abduction
- Code Orange – Imminent Danger – active shooter or weapon seen
- Tornado Warning – Tornado watch
- Tornado Emergency – Tornado on ground within 10 miles
- Rapid Response – Change in patient observed – can be called by anyone.
- Code Yellow – Un-witnessed fall with possible injury (NEW)
Fire Safety: Fire Plan Steps

**Investigate:** Find source of smoke/fire

1. **Rescue:** Remove people from danger

2. **Alarm:**
   - If inside hospital call 1710
   - or pull alarm; departments & clinics off campus: call 911.

3. **Contain:** Close room door

4. **Extinguish:** Use extinguisher as needed

**RACE to fire safety** = **R**escue. **A**larm. **C**ontain. **E**xtinguish

Physicians – call out for staff to help
EMERGENCY PREPAREDNESS & DISASTER PLAN

• Yearly drills
• External disasters (outside hospital)  
  Example: bioterrorism, plane crash, tornado

• Internal disasters (inside hospital)  
  Example: Power outage, fire
• Emergency Plan located on CareNet  
• All employees considered essential  
• Physicians volunteering during a disaster must  
  have 2 forms of federal identification and care  
  will be evaluated
To report Quality or Safety Concerns:

Discuss with

- Your immediate supervisor, or
- House Supervisor (x1258)
- Risk Manager (x1103), or
- Enter concerns into RiskMan., or
- Report **ANONYMOUSLY** by calling the hotline at **973-1500**.
- After reporting concerns, if you feel problems have not been addressed, voice your concerns to Department Director, President of the Medical Staff, Vice President/CMO, or Chris Anderson, CEO (ext 5130).
- If after speaking to hospital leaders, you still feel the safety/quality issues have continued, you may contact the Office of Quality Monitoring at The Joint Commission (TJC) at 1-800-994-6610.

*Note: You will not be disciplined or action taken for reporting.*

Restorative Care: Procedure varies slightly – see posted
Health Information Management
2 MIDNIGHT RULE

Surgical procedures, diagnostic tests, and other treatments are generally **appropriate** for inpatient hospital payment under Medicare Part A when:

The physician expects the patient to require a stay that crosses **at least 2 midnights**, and

Admits the patient as an **inpatient** to the hospital based on that expectation

Conversely, surgical procedures, diagnostic tests, and other treatments are generally **inappropriate** for inpatient hospital payment under Medicare Part A when:

The physician expects to keep the patient in the hospital for only a limited period of time that **does not cross 2 midnights**

CMS anticipates such services should be submitted for Part B payment (outpatient)
2 MIDNIGHT RULE: Unforeseen Circumstances

- Unforeseen circumstances may result in a shorter stay than the physician’s expectation (that the beneficiary would require a stay 2 midnights or greater)
  - Death
  - Transfer
  - Departure against medical advice (AMA)
  - Unforeseen recovery
  - Election of hospice care
- Such claims may be considered appropriate for hospital inpatient payment
- The physician’s expectation and any unforeseen circumstances in care MUST be documented in the medical record
EXCEPTIONS TO THE 2 MIDNIGHT RULE

• In certain cases, the physician may have an expectation of a hospital stay lasting less than 2 midnights, yet inpatient admission may be appropriate.

• **Includes:**
  - Medically Necessary Procedures on the Inpatient-Only List
  - Other Circumstances
    • Approved by CMS and outlined in subregulatory guidance
    • New Onset Mechanical Ventilation*
    • Additional suggestions are being accepted at IPPSAdmissions@cms.hhs.gov (subject line “Suggested Exception”)

* NOTE: This exception does not apply to anticipated intubations related to minor surgical procedures or other treatment.
2 MIDNIGHT RULE: START CLOCK

• 2-Midnight benchmark “clock” starts:
  - When hospital care begins
    - Observation care
    - Emergency department, operating room, other treatment area services
    - The start of care after registration and initial triaging activities (such as vital signs)
    - Exclude excessive wait times

★ The decision to admit as inpatient needs to take place prior to the patient’s second midnight in the hospital. (2-Midnight benchmark)

★ Order inpatient as soon as you know the patient will need to receive inpatient care that will span 2 Midnights or greater.
2 MIDNIGHT RULE: Questions?

HEALTH INFORMATION MANAGEMENT DEPARTMENT

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  Compliance Coordinator
  Office: (601) 960-3386

• Whitney S. Raju, MD
  Physician Advisor, Clinical Documentation Improvement Program
  Office: 601-968-4673

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  Director Health Information Management
  RAC Coordinator
  phone: 601.973.1681
  fax: 601-968-1319

Baptist Medical Center
Medical Staff
Officers/Committees
January 2016

(Click Here)

Coming together is a beginning, and staying together is progress, but only when teams sweat together do they find success.” - John Maxwell
Believing in people before they have proved themselves is the key to motivating people to reach their potential.”

“The greatest mistake we make is living in constant fear that we will make one.”

“Leadership is developed daily, not in a day.”

“Talk to people, not above them.”

Quotes by John Maxwell on Leadership/teamwork
A leader leads by example, whether he intends to or not — John Quincy Adams
Management is doing things right; leadership is doing the right things. - Peter F. Drucker

Don’t tell people how to do things, tell them what to do and let them surprise you with their results. - George S. Patton

A leader is one who knows the way, goes the way, and shows the way. - John C Maxwell

The key to successful leadership today is influence, not authority. – Kenneth Blanchard

Our chief want is someone who will inspire us to be what we know we could be. - Ralph Waldo Emerson

A good leader inspires people to have confidence in the leader, a great leader inspires people to have confidence in themselves – Eleanor Roosevelt

Great leaders are almost always great simplifiers, who can cut through argument, debate, and doubt to offer a solution everybody can understand. – General Colin Powell

He that cannot obey, cannot command. – Benjamin Franklin
MBHS Physician Leadership Criteria

Only those members of the Medical Staff who satisfy the following criteria initially and continuously will be eligible to serve as an officer of the Medical Staff (unless an exception is recommended by the Medical Executive Committee and approved by the Board)

Members must:

(1) have served on the Active Staff for at least three years;

(2) have no pending adverse recommendations concerning appointment or clinical privileges;

(3) not presently be serving as a Medical Staff officer, board member, or department chairperson at any other hospital and will not so serve during their term of office;

(4) be willing to faithfully discharge the duties and responsibilities of the position;

(5) have experience in a leadership position or other involvement in performance improvement functions for at least two years;

(6) participate in Medical Staff leadership training as determined by the Medical Executive Committee;

(7) have demonstrated an ability to work well with others; and

(8) not have any financial relationship (i.e., an ownership or investment interest in or compensation arrangement) with an entity that competes with the Hospital or any Affiliate. This does not apply to services provided within a practitioner’s office and billed under the same provider number used by the practitioner.
Of all of our inventions for mass communication, pictures still speak the most universally understood language. Walt Disney

A man's character may be learned from the adjectives which he habitually uses in conversation. Mark Twain

Words - so innocent and powerless as they are, as standing in a dictionary, how potent for good and evil they become in the hands of one who knows –Nathaniel Hawthorne

Half the world is composed of people who have something to say and can't, and the other half who have nothing to say and keep on saying it. Robert Frost

The way to get started is to quit talking and begin doing. Walt Disney
Taking a Step Back: Why Do Physicians Lead?

Physician Leaders Take Roles to Help Steer System, Improve Care

Factors Motivating Physicians to Take Leadership Roles

2014 Physician Leadership Survey (n=108)

Respondent Ranking (1=strongest to 6=weakest)

# 1 Ability to Influence System Strategy - 33%
# 2 Ability to Improve Patient Care - 28%
# 3 Personal Growth - 26%
# 4 Career Advancement - 6%
# 5 Compensation - 5%
# 6 Prestige - 2%

Respondent Ranking (1=strongest to 6=weakest)

1 27%
2 36%
3 15%
4 13%
5 5%
6 4%

Source: Physician Executive Council Interviews and analysis.
Becoming the person others will want to follow.

A leader is one who knows the way, goes the way, and shows the way. – John C Maxwell

Click on both links

Equipping Physicians to Lead Your Medical Staff Audio
Leadership Articles
(right click and open hyperlink)

Evaluate your leadership effectiveness

7 traits of a highly effective leader

Qualities of a Superior Leader

Physician leadership articles

Engaging Physicians in the Health Care Revolution

Leadership is about emotion

Empowering your people

Become a leader people want to work for

Great Leadership
Physician Leadership Institute Articles

Physicians becoming leaders

Who needs Physician leaders and how do you get them

Leadership lessons from the 2015-womens world cup champions

8 c's of leadership in chaotic times

taking the lead: Innovation Of physician leadership

Want change? physician empowerment physician engagement

Integrated leaders: you design the culture

crisis-leadership
Communication Skills

Basic Communication Skills
Leaders: Effective communication
Workplace-communication-skills/
10-communication-secrets-of-great-leaders
4 ways to get messages to your physicians

Communication is the key
Communication-secrets
Effective ways listening can make you a better leader
Leading a Meeting

Facilitation of a meeting
Horty Springer Question of the Week

June 18, 2015

QUESTION: I was recently appointed as chair of a medical staff committee and am very happy, but I just realized that instead of merely attending meetings, I’ll have to run them, so I’m also extremely nervous. Help!!!

ANSWER: An efficient meeting is the key to making it an effective meeting, and running a meeting is hard work. Here are some tips:

Tip #1. Start on time. This is one of the most important tips. If a meeting isn’t started on time, chances are it won’t end on time, and that has consequences which we’ll discuss below. If a meeting always starts on time, the attendees will more than likely be there on time, since no one likes to walk into a meeting late, and being late disrupts the meeting.

Tip #2. Limit the conversation. What “limit the conversation” means is that if a couple of attendees in the room are making the same point, over and over again, that’s unproductive, so the chair should step in and say “Ok, any other points of view that we haven’t discussed yet?” Also, if a discussion “drifts,” the chair should step in and restate the purpose of the discussion. This can be hard to do, but it is a skill that needs to be developed. Otherwise, the participants start thinking the meeting is a waste of time, and the downward spiral begins.

Tip #3. Take an issue off-line. There are times when a meeting is getting bogged down because no one has the information needed to make a decision. For example, is the bylaws revision being discussed a Joint Commission Standard? A best practice? If no one knows for sure, further discussion will not help the committee make a decision, so that issue should be taken off the agenda until the next meeting, to research the issue.

Another reason to take an issue off the agenda is when there are so many conflicting points of view that the issue won’t be able to be resolved at the meeting. The chair knows that no matter how much more discussion there is, the issue won’t be resolved. So, the chair should stop the discussion, and maybe appoint a small group to investigate or research the issue, then bring the results back to the committee.

Tip #4. End on time. This is the most important tip. If a meeting is to end at 8:30 a.m., end the meeting. Although some attendees don’t mind going over, others will start thinking about work that needs to be done, or another meeting to go to, or an appointment to make – focus is lost. A meeting that runs on and on and on isn’t efficient and becomes much less effective as time goes on. Also, not ending on time affects meeting attendance. If an attendee knows that the meeting always goes over, he or she is less likely to attend the meeting.

Sometimes agendas are just too full, or there may have been too much discussion on one issue, etc. – that happens. But, instead of plowing on through with more and more disinterested attendees as each minute ticks by, just end the meeting, and hold those agenda items over for the next meeting. The exception is if the issue is of critical importance, but that will be few and far between.
Horty Springer: Questions of the Week

Physician Leadership Questions Of The Week
by Horty Springer
Communication: Writing

Hit Esc on keyboard to exit Slide Show. Then, double click on the graphic below to review this separate PowerPoint.

Write Better, Right Now
Webconference for Members
December 3, 2014
Michael Koppenheffer
koppenhm@advisory.com
Studer Group On Physician Leadership

Leaders : Being comfortable with uncomfortable

stopping-the-stress-cascade

10-signs-your-hospital-physician-relationship-need

Getting Physicians on Board
“Focus on Preparing Today so that you can experience Success Tomorrow” – John Maxwell

Before you are a leader, success is all about growing yourself. When you become a leader, success is all about growing others. – Jack Welch

Mark Your Calendars: Physician Leaders Lunch and Learn
4th Fridays of each month
12 noon-1:00 pm in Physician Lounge