

MEDICAL STAFF

Huntington Hospital NEWSLETTER

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From The President



I got the bill for my surgery. Now I know what those doctors were wearing masks for.

- James H. Boren

A fashionable surgeon, like the pelican, can be recognized by the size of his bill.

- J. Chalmers Da Costa, MD

Fee-for-service, whereby the physician submits a bill to the patient, who, in turn pays the fee from his pocket, has been the archetype compensation model for numerous generations of doctors. This model has been greatly modified in recent decades.

On June 22, 1850, the San Francisco Medical Society was founded, and therein published a fee bill of some interest. A copy of this schedule was given to Henry Huntington in 1924, and, in part, included the following:

For a single visit	\$32
For a written opinion	\$50-100
For an autopsy	\$200
For ordinary labor	\$150
To reduce a fracture	\$50-100
To remove Gallbladder stones	\$500-1000
Tracheotomy	\$500
Arm or leg amputation	\$300
Extirpation of tumors	\$100-1000
Trephining	\$1000
Operation for cataract	\$1000
For operation of aneurism of subclavian, carotid or femoral.....	\$500-1000

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Summary of the Minutes for MEC

Executive Committee Meeting

As provided by the Bylaws of the Governing Body and as the designated sub-committee of the Governing Board the following items were presented and approved by the Medical Executive Committee on July 11, 2011 and by the Governing Board on July 28, 2011.

PRESIDENT'S REPORT

- The June event report was presented. There were a total of five event reports during the month. No specific trends were identified.

ADMINISTRATIVE REPORT

Report from Chief Nursing Executive:

Ms. Bonnie Kass, RN, Vice President/CNE presented the list of contracts due for renewal. There are four transfer contracts due for renewal, as follows:

- California Acute Dialysis
- Pasadena Dialysis
- Hemacare
- Haemostat

Report from the Director of Healthcare Services:

Ms. Gloria Gomez, CPMSM, reported on the following items:

- Medical Staff Department Changes
Mary Weiler has resigned her position at the hospital.

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Summary of the Minutes

Executive Committee Meeting

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The existing coordinators will staff her meetings until the position is filled.

- Display Case

Ms. Gomez reported that pictures of the individual MEC members will be utilized in the display case in the hallway outside of the Medical Staff Office. She reported that one physician per month will be highlighted in the display case, beginning with the medical staff leaders.

- Medical Staff Orientation Program

Ms. Andrea Stradling will be working with Ms. Gomez to revamp the physician orientation in order to include the medical staff leadership in the orientation process.

- Pictorial Roster

The Department is working on a pictorial roster to send out to the physicians and board members. The roster will include an alphabetical version as well as a specialty roster.

IRB STUDIES

New Study Approvals:

1. HMH 2011-008: Postoperative bleeding with administration of Ketorolac in the perioperative period (PI: Nicholas Sagan)
2. HMH 2011-013: Revisiting the usefulness of D-dimer in the workup of pulmonary embolism (PI: Jonathan Hechanova)
3. HMH 2011-014: Hypertension and microalbuminuria (PI: Tevan Ovsepyan)

MEDICAL STAFF APPOINTMENTS

- John Colias, MD – Orthopedic Surgery
- Fernando Fleischman, MD – Thoracic Surgery
- Amy Hakim, MD – Gynecologic Oncology
- Jesse Hill, MD – Anesthesiology
- Padma Kasula, MD – Hospice & Palliative Care
- Evangelia Kirimis, MD – Hematology/Oncology

- Reed Levine, MD – Neurology
- Wei-Chien Lin, MD – Obstetrics & Gynecology
- Nu Lu, MD – Hematology/Oncology
- Ellen McDonald, MD – Internal Medicine
- Heather Moreno, MD – Diagnostic Radiology
- Reema Munir, MD – Diagnostic Radiology
- Shylaja Nandi, MD – Family Medicine (Joining Huntington Medical Foundation)
- Gia Novell, MD – Endocrinology
- Christian Ochoa, MD – Vascular Surgery
- Cynthia Parenti, MD – Anesthesiology
- John Quigley, MD – Orthopedic Surgery
- Sonal Ram, MD – Pediatric Critical Care
- Christopher Tirce, MD – Anesthesiology
- Shai-Yung Tsai, MD – Family Medicine
- Jeffrey Wade, MD – Emergency Medicine
- Bertram Yuh, MD – Urology

MEDICAL STAFF RESIGNATIONS

- France Adamson, MD – Pediatrics
- Andy Chen, MD – Internal Medicine
- Laura Evans, MD – Family Medicine
- Loren Geller, MD – Orthopedic Surgery
- John Gruen, MD – Neurosurgery
- Richard Menendez, MD – Pediatrics
- Jimmy Yue, DO – Internal Medicine

PRIVILEGE CARD REVISION

Revised Privilege Sheets:

The following revised privilege sheets were recommended for approval:

- Nephrology

Proposed revisions to the Nephrology privilege sheet were presented. Revisions include the deletion of procedures currently on the internal medicine privilege sheet, relocating the ventilator management privileges from the Core privilege section to the Supplemental privilege section, and modification to the competency requirements for the supplemental privileges.

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Summary of the Minutes

Executive Committee Meeting

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DEPARTMENTAL POLICIES AND PROCEDURES AND ORDER SETS

For specifics go to Medical Staff Services on Sharepoint (intranet)

DEPARTMENT OF PEDIATRICS:

- Maternity/Neonatal/L&D Policies and Procedures: 1 item
- Neonatal: 72 items
- Maternity/Neonatal: 1 item

- Neonatal and Newborn: 2 items
- Infant Crash Cart Inventory List

ORGANIZATION WIDE POLICIES AND PROCEDURES: 13 items

James Shankwiler, MD

Secretary / Treasurer, Medical Staff



From The President *continued from page 1*

Despite the above fees being high for their time, society members could not agree to the fee schedule. Subsequently, the society folded in less than two months.

Though the average fee paid by a patient was quite low in the 1800's, physicians varied their fees depending on the wealth of those they cared for. Some of the fees charged the well-to-do before and after the turn of the 20th century sound like bank robbery today. These fees were asked of and freely paid by wealthy people who would consult "only the best." The fee was often based on Dunn and Bradstreet's financial rating of the patient. A top surgeon in Baltimore in the late 1800's could command \$10,000 and up. A west coast urologist billed an estate, as was often the case, \$50,000 for a nephrectomy. One astronomical fee of \$50,000 led to an Act of Congress: when Roswell Park (1852-1914) billed this amount for the care of President McKinley, congress decreed that, thereafter, a physician could only bill for his travel expenses for treating the President of the United States (would \$100/mile be acceptable?).

Prior to the 1920's, there was relatively little that hospitals and physicians could do for patients. Care was simple, of low technology, and cheap. Much physician care, including surgery, was done at home. The bigger cost to the patient was loss of income while sick and

not working (remember, patients were put to bed for weeks and months for many illnesses), as opposed to the physician fee. If there was insurance, it was for "sickness," similar to disability insurance, to replace lost income, rather than health insurance.

The first health insurance plans began during the Civil War. They only covered accidents related to travel by rail or steamboat. These early insurers paved the way for more comprehensive plans covering all illnesses and injuries. In 1847, the first group policy with comprehensive benefits was offered by Massachusetts Health Insurance of Boston. Insurance companies issued the first individual disability and illness policies in 1890. Nevertheless, the vast majority of patients, physicians, and hospitals dealt with bills in a fee-for-service arrangement. Individuals did not see value in the insurance, which was far from readily available.

This low demand for health insurance was matched by the unwillingness of commercial insurance companies to offer private insurance policies. They felt health was not an insurable commodity because of the high potential for adverse selection and moral hazard. That is, people in poor health may claim good health and people may engage in risky behavior after purchasing health insurance. "The

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opportunities for fraud [in health insurance] upset all statistical calculations. . . health and sickness are vague terms open to endless construction. Death is clearly defined, but what shall constitute such loss of health as will justify compensation is no easy task (Insurance Monitor, July 1919, Vol. 67, p38).” Attempts at national health insurance were defeated due to lack of public support, physician opposition and insurance company non-participation. In addition, a large portion of commercial insurances’ business was for a burial benefit, and health insurance legislation forbid them from offering this product; they also felt this opened the door for more government regulation of the insurance industry.

In 1904, the American Medical Association formed the Council of Medical Education (CME) to standardize requirements for medical licensure. The CME contracted Abraham Flexner of the Carnegie Foundation for Advancement of Teaching to evaluate medical education. Flexner’s highly critical report, published in 1910, stated the current medical education system “resulted in enormous over-production at a low level, and that whatever justification in the past, the present situation. . . can be more effectively met by a reduced output of well trained men than by further inflation with an inferior product.” Flexner argued for stricter entrance requirements, better facilities, higher fees and tougher standards. Subsequently, the 131 medical schools existing in 1910 fell to 81 schools in 1922. A consequence of the increase cost of educating physicians was an increase in professional fees. After Flexner’s report, further movements for standardization and accreditation began, which included specialists, such as the American College of Surgeons, and hospitals, which sought accreditation. Of the 692 large hospitals examined in 1918, only 13% were approved; by 1932, 93% of the 1600 hospitals examined met the American college of Surgeons criteria. All these improvements increased the cost of health care.

By the 1920-30’s, the price of medical care rose due to improved science, technology and advanced medical procedures. Demographic changes included the urbanization of America and growing affluence. As a

consequence, the public’s perception of medical care shifted from that of low efficacy to that of higher scientific reliability and technology. A paradigm shift from home care to hospital care was underway.

In 1929, the first modern group health insurance plan was formed. Teachers in Dallas, Texas contracted with Baylor Hospital for room, board and services for a monthly fee. The non-profits Blue Cross and Blue Shield first offered group plans in 1932; they were successful because of negotiated discount contracts with physicians and hospitals, in return for increase patient volume and prompt payment.

Employee benefit plans proliferated in the 1940-50’s. Strong unions bargained for better benefit packages, including tax-free employer-sponsored health insurance. The wartime Wage Freeze (1939-1945) actually accelerated the spread of group health insurance. Unable to attract workers by paying more, employers expanded benefit packages.

Grant programs began to expand in the 1950-60’s. Disability benefits were included in Social Security coverage for the first time in 1954. Medicare and Medicaid were created in 1965; at that time, private sources paid 75% of all health care costs. By 1995, Medicare covered 50% of total costs. Today’s total is presumed higher.

Generations ago, fee-for-service prevailed. Though the aforementioned anecdotes show some phenomenal payments, overall, fees were quite modest. In particular, many patients could afford little for a physician’s care. Most physicians had a modest income, and the occasional large fee paid by the wealthy offset the average meager compensation. As the cost of medical care escalated along with the quality of physicians and hospitals, the original system of fee-for-service was rapidly replaced with third party fee schedules. Time will tell how much Accountable Care Organizations, and the like, bend the physician and hospital payment arrangement.

Jim Buese, MD
President Medical Staff

Physician Informatics

Critical Care Unit (CCU) Automating Paper Flowsheet:

The CCU will be moving from a paper flowsheet to an electronic format. The July implementation date was postponed due to technical issues. The new implementation date will be communicated when it is set.

Three new components will be added to support this change to an electronic flowsheet, all information viewable in the EMR: 1) an interface from the patient monitors into Meditech 2) IV intake and titration information and 3) Visual Flowsheet. The new monitor interface will pull the patient monitor data directly into Meditech. The IV intake and titration information will be entered into Meditech by the nursing staff. The Visual Flowsheet (VFS) will be an additional view-only tool accessed through the Meditech EMR which pulls together pertinent patient information in an easy spreadsheet format. For more information and available training options, please contact **Vera Ma 626-397-3908** or vera.ma@huntingtonhospital.com

2011 ePrescribing protects 2012 and 2013 CMS Penalties

Beginning January 1, 2011, CMS offers ePrescribers an opportunity to earn an incentive payment of 1% (based on claims submitted no later than February 28, 2012) for all covered professional services furnished from January 1, 2011 – December 31, 2011. Currently, CMS' proposal is to levy 1% of Medicare revenue penalty in 2012 against physicians who fail to report the ePrescribing measure on 10 unique Medicare patient visits between January and June 2011. To avoid penalties in 2013 (1.5% of Medicare revenue in 2013), physicians must report at least 25 unique Medicare encounters between January – December 2011. *Due to the volume of public comments from AMA, medical societies and other organizations – CMS may change these penalty requirements – but they currently stand as listed.* Interested in HuntingtonRx? Please contact **Joe Limmer at 626-397-3348** or email Joe.Limmer@huntingtonhospital.com

Huntington Rx and Huntington Health eConnect initiatives are designed to assist you in meeting incentive requirements as well as improve patient safety and practice efficiencies around care collaboration. If you are interested in these programs, future seminars, or have questions, please contact **Rebecca Armato at 626-397-5090** or email Rebecca.armato@huntingtonhospital.com. Other resources that provide information on the federal incentive programs and certified electronic health records are listed below:

Complete list of ONC-ATCB Certified Electronic Health Records

- <http://onc-chpl.force.com/ehrcert>

Complete list of ONC-Authorized Testing and Certification Bodies ATCB)

- <http://healthit.hhs.gov/portal/server.pt?open=512&mode=2&objID=3120>

Follow the latest information about the EHR Incentive Programs on Twitter

- <http://www.Twitter.com/CMSGov>

Official web Site to register for Medicare/Medicaid EHR Incentive Programs (Registration opened January 3, 2011)

- <https://www.cms.gov/EHRIncentivePrograms/>

Call, email or stop by the Physician Informatics office

Physician Informatics Office:
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From the Health Sciences Library...

Continuing series on electronic books:

Books on Surgery, including Plastic Surgery and Orthopedics

Electronic books are accessible from anywhere on-site and also available off-site for those with Citrix or Connect login access or by using password access (contact library to set up). The best way to find what ebooks the library subscribes to is to search for them on the library's Online Catalog (upper left of Health Sciences Library Sharepoint page) or browse them by title and by subject using the links under the Electronic Books section (also on Library's SP page).



Below ^{MDC} denotes books on MD Consult, ^O from Ovid, ^{AM} from Access Medicine, ^G from Gale. The library online catalog also includes other titles of interest that are freely available on the web (^{WWW} after a title denotes free web access). Mobile access to MDConsult ebooks is available by navigating your mobile browser to <http://mobile.mdconsult.com> and logging in with your MDConsult offsite login. Mobile access to AccessMedicine book chapters is available by navigating to the chapter of interest and clicking on "Download for Handheld" link on the upper right.

- The 5-Minute Orthopaedic Consult, 2nd ed., 2007 ^O
- Campbell's Operative Orthopaedics, 11th ed, c2007 ^{MDC}
- DeLee & Drez's Orthopaedic Sports Medicine, 3rd ed., 2009 ^{MDC}
- Essentials of Physical Medicine and Rehabilitation, 2nd ed., 2008 ^{MDC}
- The Gale Encyclopedia of Surgery, 2004: A Guide for Patients and Caregivers^G
- Genetics for Surgeons. c2005 ^{WWW}
- Grabb and Smith's Plastic Surgery, 6th ed., 2007 ^O
- Guide to Peripheral and Cerebrovascular Intervention. c2004 ^{WWW}
- Operative Surgery Manual, 2003 ^{MDC}
- Rutherford's Vascular Surgery, 7th ed., 2010 ^{MDC}
- Sabiston Textbook of Surgery, 18th ed., 2008 ^{MDC}
- Schwartz's Principles of Surgery, 9th ed., 2010 ^{AM}
- Skeletal Trauma: Basic Science, Management, and Reconstruction, 4th ed., c2008 ^{MDC}
- Skeletal Trauma in Children, 4th ed., c2008 ^{MDC}
- Surgical Treatment: Evidence-Based and Problem-Oriented. c2001 ^{WWW}

Books on Critical Care & Emergency Medicine

The library has 11 electronic books in Critical Care & Emergency Medicine.

In the list on page 7 ^{MDC} denotes books on MD Consult, ^O from Ovid, ^{AM} from Access Medicine. The library online catalog also includes other titles of interest that are freely available on the web (^{WWW} after a title denotes free web access).

Mobile access to MDConsult ebooks is available by navigating your mobile browser to <http://mobile.mdconsult.com> and logging in with your MDConsult offsite login. Mobile access to Access Medicine book chapters is available by navigating to the chapter of interest and clicking on "Download for Handheld" link on the upper right.

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Continuing series on electronic books:

Books on Critical Care & Emergency Medicine

- Clinical Management of Poisoning and Drug Overdose, 4th ed., c2007 ^{MDC}
- Clinical Procedures in Emergency Medicine, 5th ed., c2009 ^{MDC}
- Dispensing Medical Countermeasures for Public Health Emergencies: Workshop Summary ^{www}
- Emergency Response Guidebook, 2008: A Guidebook for First Responders During the Initial Phase of a Hazardous Materials/Dangerous Goods Incident ^{www}
- Irwin and Rippe's Intensive Care Medicine, 6th ed., 2008 ^O
- Principles of Critical Care, 3rd ed., 2005 ^{AM}
- Rosen's Emergency Medicine, 7th ed., 2009: Concepts and Clinical Practice ^{MDC}
- Textbook of Critical Care, 5th ed., 2005 ^{MDC}
- Textbook of Pediatric Emergency Medicine, 5th ed., 2006 ^O
- Tintinalli's Emergency Medicine, 6th ed., 2004 ^{AM}
- Wilderness Medicine. 5th ed. 2007 ^{MDC}

If you have any problem accessing these books or have any questions about them, please contact the library at x5161, library@huntingtonhospital.com or text us at 626-344-0542.

CME Corner



UPCOMING PROGRAMS FOR THE FIRST THURSDAY MEDICAL WORKSHOPS:

No First Thursday in August

Topic: Melanoma Update

Date: September 8, 2011

Time: 8:00 am

Place: Research Conference Hall

Gap Analysis: Tremendous changes in the diagnosis and therapy of malignant melanoma over the past six months have completely changed the status quo.

Objectives: 1. Understand the BRAF oncogene and how this drives therapy.

2. Understand the CTLA-4 pathway and how this drives therapy.

3. Understand the rational selection of therapy.

Audience: Physicians

Methods: Lecture

Evaluation: Post-activity evaluation form

Speaker: Michael Wong, MD, USC

Credit: 1 *AMA PRA Category 1 Credit*TM

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MEDICAL STAFF

NEWSLETTER

August, 2011

CME Corner *continued from page 7*



UPCOMING MEDICAL GRAND ROUNDS:

Topic: Cancer Caused by
Infectious Organisms
Date: August 5, 2011
Time: Noon
Place: Research Conference Hall
Audience: Physicians
Methods: Lecture
Evaluation: Post-activity evaluation form
Speaker: Michael Wong, MD, USC
Credit: 1 *AMA PRA Category 1 Credit*TM

Topic: Surgical Treatment of Early Stage
Lung Cancer
Date: September 2, 2011
Time: Noon
Place: Research Conference Hall
Audience: Physicians
Objectives:
1. Discuss results of lung cancer surgery.
2. Description of new technology for
treatment of lung cancer.
3. Understand screening for lung cancer.
Methods: Lecture
Evaluation: Post-activity evaluation form
Speaker: Robbin G. Cohen, MD
Credit: 1 *AMA PRA Category 1 Credit*TM