MEDICAL STAFF

Huntington Hospital NEWSLETTER

VOLUME 49, NUMBER 06 June, 2011

From *The President*

Originality is the fine art of remembering what you hear but forgetting where you heard it.
- Laurence J. Peter

The doctor x-rayed my head and found nothing
- Dizzy Dean

The Huntington Hospital Honor Wall lies along a pathway, running east-west from the Valentine Building to the La Vina Building, and north of the Della Martin Center. At each end of the wall is a concrete slab, some four by five feet, with raised double scrolls and "1908" across the center. These are remnants of the Fowler Memorial Building. Adjacent to the Honor Wall is a rectangular slab with a flower box on top; an inscription on its face states, "Fowler Memorial Hospital." Seems someone attempted to rename Pasadena Hospital before the Henry E. Huntington Trustees in the 1930s. The central portion of the wall contains several plaques. Prominent are the O. S. A. Sprague Memorial Building plaque honoring his wife and the E. M. Fowler Building plaque honoring her husband. A small brass plaque honors six early medical staff members who lobbied the Pasadena Hospital Association to construct a community hospital: Fitch C. E. Mattison, Charles Lockwood, Arthur T. Newcomb, Henry Sherk, Henry Sherry, and Henry B. Stehman.

Fitch Mattison was an influential member of the community, and would become an early president of the medical staff. Dr. Lockwood, a surgeon, would become the first "chief of staff" in 1912. Arthur T. Newcomb, a surgeon, was instrumental in hospital and community affairs. Henry H. Sherk, a surgeon, was one

Continued on page 3

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 of May 2, 2011 and by the Governing Board on May 26, 2011.

PRESIDENT'S REPORT

The April event report was presented. There were a total of seven event reports during the month with no specific trend.

ADMINISTRATIVE REPORT

Report from President/Chief Executive Officer:

Mr. Steve Ralph reported on the following items:

- The board membership consists of twenty-one members, five of the twenty-one members are lifetime members. With the passing of Mr. Len Marangi, the board has appointed Ms. Jaynie Studenmund to replace Mr. Marangi as a lifetime board member.
- Phase 2 of the construction of the emergency department (ED) building will be completed by this fall. The transition to the new building is anticipated to occur in late 2011.

Continued on page 2

Inside:

Summary of the ***Minutes***

Executive Committee Meeting

continued from page 1

Approximately an additional thirteen months will be needed to retrofit the old ED before the additional beds will be available.

Report from Vice-President of Quality and Performance Improvement/CMO:

Dr. Paula Verrette reported on the following items:

- Institutional Review Board Audit
  The Food and Drug Administration conducted an audit of the Institutional Review Board and research program. The hospital passed the audit without receiving any recommendations. She noted that Ms. Gomez should be congratulated for her efforts to ensure the successful audit results.

- Health Navigators
  The hospital is establishing a program of health navigators. The health navigators are social workers who will assist selected patients with chronic congestive heart failure disease to transition from the inpatient setting to the necessary outpatient setting. The navigators will help the patients understand their medication needs and follow-up care. The program is aimed at preventing these patients from requiring readmission.

Report from the Chief Nursing Executive (CNE):

Ms. Bonnie Kass, RN, BSN, vice president/CNE, reported on the requirements for ordering MRSA screening. She noted that since Title 22 prohibits the use of standing orders, the MRSA screening order is being placed on all the pre-printed order sheets. She reported that the implementation of CPOE house-wide will help resolve this issue.

BOARD CERTIFICATION REQUIREMENTS

The EC is considering proposals to make board certification a requirement for active staff privileges with exemptions yet to be determined based perhaps on duration of active staff membership, duration of board certification or similar criteria; after review the issue will be routed to Bylaws Committee for further discussion. Any Bylaws change is subject to vote of the medical staff as a whole.

IRB STUDIES

The following new studies have been recommended for approval:

- HMH 2011-004: MISO-OBS-205: A Multi-Center, Open-Label, Phase II Study of the 200 mcg Misoprostol Vaginal Insert (MVI 200) to Obtain Pharmacokinetics in Women at Term Gestation (THE MVI-PK Study) (PI: Neil Singla, MD)
- HMH 2010-048: Intra-operative Imaging to Predict Sentinel Lymph-node (SLN) Status in Breast Cancer and Melanoma (PI: Rahim Aimaq)
- HMH 2011-002: Lymph Node Dissection in Emergent versus Elective Colectomies in Colon Cancer (PI: Aaron Lewis)
- HMH 2011-005: Immediate Breast Reconstruction Outcomes Following Radiation Therapy (PI: Jeannie Shen, MD)
- HMH 2011-006: Practices to Avoid IV/Feeding Tube Misconnections in the NICU (PI: Sandy Beauman, RN)

MEDICAL STAFF APPOINTMENTS

- Abajian, Michelle D., MD – Pediatrics – joining Descanso Pediatrics
- Doyle, Kate T., MD – Diagnostic Radiology – joining Virtual Radiology
- Farnad, Fariborz A., DMD – Oral/Maxillofacial Surgery – solo
- Gerberich, Bradley K., MD – Emergency Medicine – joining Huntington Emergency Group
- Jarrahnejad, Payam, MD – Plastic Surgery – solo
- Kirk, John H., MD – Obstetrics & Gynecology – solo
- Seyedin, Majid, DPM – Podiatry – solo

MEDICAL STAFF RESIGNATIONS

- Boutros, Jason, MD – Internal Medicine – effective June 30, 2011
- Castner, Edward, MD – Psychiatry – effective April 26, 2011
- Clavijo, Leonardo, MD – Interventional Cardiology – effective May 31, 2011
- Horns, Richard, MD – Hematology/Oncology – effective June 30, 2011

Continued on page 3

From *The President*

continued from page 1

of ten members of the Pasadena Medical Society who met to support the first city charter in 1900; this included a provision for the prohibition of saloons in the city. Dr. Sherk was chief of staff in 1913 and President in 1922. Henry Sherry was the father of Leroy Sherry, who was the senior general surgeon in Pasadena and a dominant force at Huntington Hospital, until his retirement after WW II. Henry Stehman came to Pasadena because of his tuberculosis. He was the first physician to be asked to serve on the Pasadena Hospital Association board of directors in 1911.

Circa 1907-08, the Pasadena Hospital Association had a president, a vice president, a secretary and a treasurer. There were seven directors; none were physicians, though the Association did have a physician advisory board. The 1907-08 annual report is interesting:

1) Annual staff membership dues: $5
2) Lifetime staff membership dues: $100
3) There were three departments: medicine, surgery, and obstetrical
4) The Sprague Memorial building was the medical wing, with 36 beds and "the latest and best appliances."
5) The original hospital building was the surgical wing, with 22 beds, "with complete and convenient operating rooms, and appliances necessary for the best surgical work."
6) The Clara Baker Burdette maternity building, was erected 1904-5, with 12 beds and "with a complete delivery room and convenient nursery."
7) $600 maintained a bed in a private room for one year
8) $300 maintained a bed in a ward for one year
9) $5,000 would endow a bed in a ward for perpetual free use by patients
10) $10,000 would endow a room and bed in perpetuity

Of note, Mrs. Henry E. (Clarabella) Huntington, who had endowed a bed, objected strenuously, according to early board minutes, when a physician charged her maid for his services while she occupied this free bed.

Continued on page 4

Summary of the ***Minutes***

Executive Committee Meeting

continued from page 2

- Jandial, Rahul, MD – Neurosurgery – effective May 31, 2011
- Keens, Thomas, MD – Pediatric Pulmonary – effective May 31, 2011
- LaGuardia, Elizabeth, MD – Pediatric Pulmonary – effective May 31, 2011
- Martin, Anthony, DPM – Podiatry – effective May 31, 2011
- Matthews, Ray, MD – Interventional Cardiology – effective May 31, 2011
- Ward, Sally, MD – Pediatric Pulmonary – effective May 31, 2011
- Wong, Wilson, MD – Diagnostic Radiology – effective May 31, 2011

PRIVILEDGE CARD REVISION

- Revised Family Medicine Privilege Sheet:

  Revisions include the addition of criteria and privileging for Addiction Medicine.

- Revised Ophthalmology Privilege Sheet:

  Addition of orbital decompression under the category I Orbit surgery privileges.

DEPARTMENTAL POLICIES AND PROCEDURES AND ORDER SETS

For specifics go to Medical Staff Services on Shared Point (intranet)

DEPARTMENT OF MEDICINE: 1 item

DEPARTMENT OF PEDIATRICS:
Neonatal (NICU): 6 items

DEPARTMENT OF SURGERY: 4 items

MEDICAL STAFF CREDENTIALING POLICY:

- Criteria for Reappointment Terms - revised

ORGANIZATION WIDE POLICIES AND PROCEDURES: 11 items

ORDER SETS: 3 items

OTHER Protocols and Guidelines: 3 items

James Shankwiler, MD
Secretary / Treasurer Medical Staff

From *The President* *continued from page 3*

In 1920, the first x-ray unit was installed, and a laundry and power plant were constructed. With $500,000 from a 1921 fundraiser, construction started on the South Wing, a "modern" four story, fireproof building. In 1922, the Pasadena Dispensary opened where the east parking lot now resides. A physical therapy building opened in 1928. This decade of progress and growth came to a halt with the market crash of 1929. Pasadena Hospital teetered on the edge of bankruptcy and closure.

Henry E. Huntington died in 1927, during surgery in Philadelphia (probably a good thing it did not occur at Pasadena Hospital). His estate left two million dollars for a hospital with emphasis on "service to the needy." Appeals to the trustees of his estate came from Good Samaritan Hospital, but, in the end, the trustees decided to focus locally at the near-bankrupt Pasadena Hospital. The deal was struck in1936, and none-too-soon. The Huntington Trust stipulated a name change for the hospital, to memorialize Henry's uncle-mentor, Collis P., and his son, Howard E., who died in 1922. Thus, the official name of Pasadena Hospital became The Collis P. and Howard E. Huntington Memorial Hospital.

This bequest allowed the pay down of hospital debt, the establishment of a hospital trust, and the construction of the 1940 Building, a four story extension to the north of the West Wing along Congress Street. Three of the original buildings were demolished during its construction. The building contained six operating rooms on the second floor; the hospital entrance was moved from Fairmount Avenue to Congress Street; new gates, bought by Mrs. Huntington from the estate of Sir Nicholas Carew, Surrey, England, and crafted in 1714, were donated to grace the new entrance.

The 1938 Building housed pediatrics and radiation therapy, and was located "west of the so-called West Wing." This would later be remodeled for a new Pediatric Pavilion, which opened in 1966. In 1995, the area was converted to a critical care area for pediatric patients.

The Jenks Convalescent Unit (now rehab) opened in 1951. Herbert and Martha Jenks had been residents of Pasadena for over forty years. In Rhode Island, he had been president of Pawtucket Manufacturing Co. before moving west. Martha died at her cottage at the Huntington Hotel and left $190,000 to the hospital. The next year the Institute for Medical Research opened on the east side of Fairmont Avenue. The Maternity Wing (now the Della Martin Center) opened in 1957, funded by Edward R. Valentine, the grandson of the founder of J. W. Robinson Department Stores. Mr. Valentine would later donate for the construction of a new building for radiology, which has his name to this day.

The Wingate Building opened in 1964. Mr. William H. Wingate, at age 95, changed his will and left his entire estate to Huntington Hospital. The estate was thought to be worth $500,000, but was revealed to contain early IBM stock, worth some five million dollars at the time of his passing.

A five-year building program was planned in 1968:

1) Phase One: the update and expansion of essential facilities, such as house staff quarters, office space, kitchen and cafeteria, laundry, and maintenance shops.
2) Phase Two: Valentine Radiology Wing completed
3) Phase Three: Herbert L. Hahn Building construction, beginning in 1971. This extended the Wingate Building south along Fairmount Avenue, and contained the Health Science Library on the first floor, and an outpatient dispensary and pharmacy on the ground floor.

The La Vina Building was completed in 1984, and included the Braun Auditorium, a lobby, administrative offices, patient rooms and critical care areas on the upper floors, including cardiology services.

With completion of the La Vina Building, the total number of licensed beds came to 573. This made Huntington Memorial Hospital the second largest private hospital, on one campus, in California. Then there were earthquakes.

James Buese, MD
President Medical Staff

EMR Adoption is NOT a Spectator Sport

Rebecca Armato, Executive Director, Physician and Interoperability Service

Focusing Beyond Meaningful Use to Deliver Meaningful 'Value'

Just as the right medical treatment is critical to a patient's survival, the right approach to EHR selection and adoption is critical to the health/survival of a physician's practice. It is not just about the technology. Making the wrong decision for the wrong reasons and expecting their EHR vendor to successfully implement an EHR in a way that supports their practice without the physicians' engagement or involvement will cost much more than the $timulus funds being offered to physicians. EHR selection and adoption is not a spectator sport – physicians have to be actively engaged and remain focused on evaluating features that support not only patient quality, safety, outcomes, privacy and security, but also support the efficiencies and viability of their practice.

In order to be successful, physicians have to consider the following:

1) Deployment is NOT the same as utilization. Technology makes it possible – the art is making it personal to physicians and their staff. One size doesn't fit all and it's important to find one that works the way they think.
2) Functionality isn't the same as usability. It isn't about the number of bells and whistles the application has, or just about the number of 'mouse clicks' required to qualify for "meaningful use" incentives. The focus should be on how can you use this technical tool to redesign workflows and improve operational efficiencies that deliver meaningful "value" and are supportive, not disruptive during clinical decision making, care and treatment of their patients.
3) Data isn't the same as information – collaboration/connecting will be key. Evaluate how the EHR not only captures information on care provided inside the walls of the practice and how "seamless" the information is available and actionable during future visits. What happens within the walls of your practice equates to 40 percent of your staff's efforts – but there is 30 percent effort before and 30 percent effort after the visit to manage your patients' care (referrals, orders, tests, phone calls, etc.) – so you have to evaluate how securely and effortlessly can it receive and exchange information, in your community, region, state and nationally – that supports care collaboration with physicians and care givers in other settings, as well as meeting evolving requirements for ACOs, medical homes, and developing Federal programs. This is one of the core drivers behind Huntington Health eConnects initiative to support your practice and care in our community. Sophisticated clinical decision support built into an EHR is useless if information you receive can't be "translated" or consumed by your EHR.

FOCUS: Practices that have experienced satisfaction and success from EHR adoption are those that focused on the basic core functionality first:

1) **Patient Registration:** Staff entry and patient entry through patient portals and kiosks
2) **Scheduling:** Not just for patients, but for physicians, equipment and resources
3) **Clinical Documentation:**
    a. Physician, MA, and nursing documentation
    b. Testing and treatment order templates
    c. Decision support alerts for key conditions and treatment
    d. Quality and outcome reporting
4) **Accounts Receivable:**
    a. Charge capture, claim submission and insurance payment posting
    b. Patient statement and payment posting
    c. Management reporting
5) **Communication and Care Collaboration:**
    a. Consult, referral, care transition between caregivers

Continued on page 6

EMR Adoption is NOT a Spectator Sport *continued from page 5*

b. Patient communication (secure email, telephone calls, remote monitoring devices)
c. Capturing/tracking/handling mail/paper/faxes
d. Medication history, formulary, eligibility, electronic prescribing
e. Electronic exchange of reports and results
f. Secure access to EHR from handheld devices (iPhone, iPad, Droid, Blackberry, etc)

With all the press about implementation failures, I've witnessed real and recent success stories of EHR adoption and know you can too:

# and Type of Physicians	Monthly Cost Savings	Staff Hours Saved per Month	Staff Hours Saved per Day
1 Primary Care, 1 NP, 12 Staff	$1,710 6 Months Post Go Live	197	10.9
1 Specialist, 2 Staff	$365 8 Months Post Go Live	105	5.25
3.5 Specialists, 7 Staff	$3,314 6 Months Post Go Live	227	11.4
3 Primary Care, 11 Staff	$252 6 Months Post Go Live	207	9.9

* *FTE: Full Time Equivalent*

At Huntington Hospital we are conducting seminars, providing educational resources, EHR selection toolkits and an e-prescribing application that encourages physicians to "baby step" into technology adoption, while providing them breathing room to evaluate and implement the right EHR. We are also building an infrastructure that supports care collaboration across multiple applications so that care collaboration and handoffs between the inpatient, outpatient and private practice setting can occur to support instantaneous intelligent decision making at the point of care that will improve the quality and lower the cost of care.

Hospitals have a license to house patients, physicians have a license to treat them, and only by working together, adopting the right tools and processes can we meet the healthcare needs of our community. If our support, encouragement and assistance persuades community physicians to stay in practice just ONE more day – in that ONE day they would have saved, healed, touched more than 11,000 people in our community. And perhaps, among those 11,000 might be the one person that cures an incurable disease, "fixes" healthcare, becomes the next Gandhi, Mother Teresa, Desmond Tutu, De Vinci, Einstein, president of the United States, **or** grows up to become a physician who goes on to treat, heal, save 11,000 more lives. Physicians are an endangered species - somewhere between a national treasure and a natural resource – and we need to do *everything* we can to ensure you not just survive – but thrive.

Huntington Hospital will continue to provide educational seminars and services, including conducting a free readiness assessment to help you navigate all the requirements and incentive programs to help you to achieve meaningful use – to recognize "meaningful value" of adopting and optimizing technology for your practice and patient care. 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

From the Health Sciences Library…

Continuing series on electronic books:
Books in Hematology, Oncology & Palliative Medicine

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).*

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- *Abeloff's Clinical Oncology* [MDC]
- *Devita's Cancer* [O]
- *Hoffman's Hematology* [MDC]
- *Walsh's Palliative Medicine* [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.

California's Name Comes From?...

A 16th Century Spanish author named Garci Rodriguez de Montalvo, who wrote the four-volume Amadís de Gaula, published in 1508, a "modern" rewrite of chivalrous tales from several centuries before. The books feature prominently in Miguel Cervantes' Don Quixote and, given the title character's fixation with Amadis' exploits, is likely what drove Mr. Quixote stone cold bonkers. Montalvo also wrote the bestseller Sergas de Esplandián – Exploits of Esplandián – published in 1510, which recounts the deeds of Amadis' son. It includes an episode involving female warriors from an island named "California." Stranger things have happened but that's where the state name comes from – a 500-year-old Spanish potboiler. The author says the Amazons who lived here had "beautiful and robust bodies." In addition:

"On this island, California, there were many griffins, who lived in the arid lands in huge flocks, the like of which could not be found anywhere else on Earth. When the griffins gave birth, the women came, wearing thick leather to protect them, and took the young. They brought them to their caves and raised them.

"When the young griffins were ready, they fed them the men they had captured and the boys they had borne, with such frequency and skill that the griffins would not harm the women. Any man who entered the island was immediately killed and eaten by the beasts, which, if they were not hungry, would still grab them and fly through the air, and when they were tired of carrying them, would let them fall, so that they were killed…."

CMA Capital Insight, blog on California politics published by Greg Lucas

ED2 Electronic Documentation

Starting in May, the ED2 documentation is now available in the EMR under "Other Reports" as "Emergency Room Visit Note."

Physician Informatics

2011 ePrescribing protects against 2012 and 2013 CMS Penalties

Beginning January 1, 2011, CMS offers ePrescribers an opportunity to earn an incentive payment of 1 percent (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 percent 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 percent 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 Huntington Rx? 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: 626-397-2500 or email:

Becky Pangburn: becky.pangburn@huntingtonhospital.com;
Vera Ma: vera.ma@huntingtonhospital.com;
Joe Limmer: joe.limmer@huntingtonhospital.com

ISTAT Go-Live May 31st 12:30 p.m.

In our ongoing effort to address patients' timely access to care, the emergency department will begin using a point of care testing (POCT) instrument known as an ISTAT to run Chem 8 (including H&H), initially on select patient populations. The goal of this implementation is to run key labs with a anticipated turnaround time (TAT) of 15 minutes from time of order, carving off an anticipated Lab TAT of 45-90 minutes. The ISTAT machines have been correlated with the current chemical analyzers used in the laboratory to give comparable results.

With this technology we are hoping to have time to diagnosis and definitive treatment decreased and ED door-to-admission time shortened as well. Inpatient units should be able to see the Chem 8 (including H &H) results in the EMR under the respective laboratory tabs.

The emergency department currently has an average of 300 patients leaving without being seen per month who leave secondary to capacity issues within the ED. Your assistance in support of this initiative will increase capacity and access for waiting patients, and improve throughput for patients waiting for this diagnostic testing.

Please feel free to contact Karen Knudsen or myself with your questions.

Jeanette Abundis, RN, MN
Executive Director Emergency and Trauma Services

Payback for Doctors at Energy and Commerce

By Jack Lewin, May 13, 2011 (Dr Lewin is CEO of the American College of Cardiology, past exec of the CMA)

Last week the House Energy and Commerce Committee had a landmark hearing to ostensibly evaluate alternatives to the Medicare SGR physician payment formula (or the SGRrrr expressed as a growl) in a hearing titled: "The Need to Move Beyond the SGR." The idea is to eradicate the SGRrrr. Hello. It's getting to be about time, now that the formula has accumulated over $300 billion in national debt, due to its flawed design by Congress and their inability to face the bad advice they got to stop the nonsense and dump it. This hearing is a follow up to the Committee's March 28 letter to 51 medical organizations requesting feedback on long-term physician payment solutions. The half-dozen panelists' suggestions for an SGR replacement varied slightly; however, all agreed that a full repeal and replacement with a new payment model is necessary for sustainability within health delivery.

Despite some differences around the edges, the proposals from the AMA, the American Academy of Family Physicians (AAFP), the American College of Surgeons (ACS), the American College of Physicians (ACP), and the American Osteopathic Association (AOA) lay out remarkably similar paths toward eliminating fee-for-service (FFS) reimbursement or drastically reducing its role. Don't you think this is remarkable?

The AMA and other **physician reps advocated for a 5-year period of stable payments while new payment models focusing on quality and efficiency are tested and evaluated**. This makes sense. AAFP suggested an increased focus on patient-centered homes, as well as an increase in the primary care incentive payment included in the Affordable Care Act (ACA) to 20 percent. The AMA is getting aggressive about payment reform, in part as a means to once again push Congress to fix the SGRrrr mess. Costs are going through the roof for insurance and Medicaid and everything else. Except – believe it or not – for Medicare – which for the first time in many years is projected to inflate at ONLY 3-4 percent over the coming decade. But, of course, by 2020, with the Boomers in full force in consuming Medicare costs, the Medicare costs are going to explode.

The SGRrrr will cut payments to doctors in 2012 by 30 percent, effectively killing Medicare access for many patients. Of course, if the SGRrrr were to be eliminated at full cost, that would add $300 billion in Medicare costs to the debt dilemma. I don't think they have the guts to do it, but we should work at making it happen.

Congress can and will hold payments to doctors flat in fee-for-service Medicare until some kind of payment reform is implemented that changes the cost curve, which is one reason that Medicare costs are lower than previously. But none of this is sustainable. Most doctors will just throw in the towel. Even AMA, despite pressure to protect the status quo, is realizing that new payment models are needed, and fortunately they are working with us and others to figure out how to get out of the mess we're in.

Clinical Laboratory ENA Testing Change

As part of the Clinical Laboratory's on-going quality assessment and improvement activities, we will be changing to a different manufacturer for our Extractable Nuclear Antibody (ENA) testing, effective April 25, 2011.

Because of this change, anti-centromere antibodies will no longer be reported as part of the ENA profile. However, these antibodies are detectable and will continue to be reported, if present, by ANA-IFA. ANA-IFA is included in the Autoimmune Panel and the SLE Reflexive Panel. Centromere antibodies may also be ordered as a single test which will be sent to a referral laboratory.

Karen Watkins
Lab Manager

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MEDICAL STAFF
NEWSLETTER

June, 2011