

MEDICAL STAFF

Huntington Hospital NEWSLETTER

VOLUME 49, NUMBER 03 March, 2011

From The President



“You want a friend in Washington? Get a dog.”

Harry S. Truman

“Ditto in Sacramento.”

James Buese

MICRA (Medical Injury Compensation Reform Act), which the California Legislature enacted in 1975, has been around longer than the majority

of physicians presently on the Huntington Hospital’s medical staff. Most of us, therefore, take for granted the legal atmosphere of medical malpractice in California, and the insurance premiums we pay for malpractice insurance.

In January of this year, the Consumer Attorneys of California (CAOC) announced their intention to introduce a bill in the upcoming legislative cycle to alter MICRA. Specifically, they want a major increase in the \$250,000 cap on non-economic damages. With a Democratic governor and legislature, the CAOC must feel emboldened to press their agenda. They very well may attempt to completely negate the provisions of MICRA.

A bit of history: In the early 1970s a medical malpractice insurance crisis gripped California. Premiums soared some 300 percent due to the increase in frequency and severity of claims, and large jury awards. Some specialists, such as OB and neurosurgery, stopped practicing due to rising costs, or unavailability of coverage. A few brave souls, including several at Huntington Hospital, practiced without insurance. On January 31, 1975, the San Francisco Chronicle reported, “A major healthcare crisis loomed yesterday with the cancelation of malpractice insurance, effective

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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 of February 7, 2011 and by the Governing Board on February 24, 2011.

PRESIDENT’S REPORT

- The January event report was deferred until the next meeting.
- A general medical staff meeting is being planned for mid April. Notices will be sent out once the date has been confirmed.

ADMINISTRATIVE REPORT

- Steve Ralph reported that the Magnet survey was held January 17-19. The feedback received from the surveyors was very positive. Obtaining Magnet designation will assist in retaining quality nursing staff. Only a small number of hospital in Southern California have received the Magnet designation.

MEDICAL STAFF APPOINTMENTS

- Samuel Chung, MD – Hematology/Oncology – joining Wilshire Oncology Medical Group

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From The President

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May 1, for most physicians in eight northern California counties.” On February 22, 1975, the L.A. Times reported, “Eight thousand physicians in Southern California face loss of medical malpractice insurance. This represents the bulk of physicians in eight counties.” Things went so far as to precipitate a strike by physicians in Northern California, which brought most hospitals to a standstill; physicians at sixty hospitals in Southern California joined the work stoppage.

In response, then governor Jerry Brown (how do you spell irony?) called a special session of the California Legislature to solve the “malpractice crisis.” During the special session, by a bi-partisan vote, legislators enacted MICRA, which provided the following:

- 1) Limits attorney contingency fees on a sliding scale
- 2) \$250,000 limit on non-economic damages only
- 3) Ensures compensation for economic damages, such as present and future medical costs, lost wages, future earning, custodial care and rehabilitation
- 4) Provides a statute of limitations
- 5) Requires advance notice of a claim
- 6) Allows for binding arbitration
- 7) Provides for periodic payments for future damages
- 8) Reform collateral source rules: prohibits claiming multiple payments for the same injury. For example, if a plaintiff has health insurance coverage, those benefits would reduce the award amount.

In the early years after MICRA was enacted, most trial courts refused to enforce many of its provisions, especially the non-economic damages cap, as they believed the California Supreme Court would eventually invalidate the law as unconstitutional. It took ten years, until 1985, for all provisions of MICRA to be uniformly applied.

The impact of MICRA has been manifold:

- 1) Increase patient access to healthcare by keeping physicians, hospitals and clinics open
- 2) MICRA has prevented the wholesale loss of OB and Neurosurgery specialists
- 3) Injured patients receive awards 26 percent sooner than patients in other states

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Summary of the Minutes

Executive Committee Meeting

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MEDICAL STAFF APPOINTMENTS *continued*

- Andres Falabella, MD – Anesthesiology
– joining City of Hope Medical Group
- Earl Moore-Jeffries, MD – Anesthesiology – solo
- Anthony Senagor, MD – Colorectal Surgery
– joining USC Department of Colorectal Surgery

MEDICAL STAFF RESIGNATIONS

- Surjit Kahlon, MD – Pediatrics
– effective 4/30/2011
- William Luxford, MD – Otolaryngology
– effective 1/31/2011
- Benjamin Santos, MD – Emergency Medicine
– effective 2/24/2011
- Martin Weiss, MD – Neurosurgery
– effective 2/28/2011

TREASURER’S REPORT

- Dr. Shankwiler presented the financial report for the fourth quarter of 2010.

PRIVILEGE CARD REVISION

- Neurology Privilege Sheet (Revisions include the addition of criteria and privileging for Teleneurology, Telestroke, Teleepilepsy, Deep Brain Stimulation and Vagus Nerve Stimulation).

DEPARTMENTAL POLICIES AND PROCEDURES AND ORDER SETS APPROVED

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

MEDICINE: Three items

OBSTETRICS AND GYNECOLOGY: Two items

DEPARTMENT OF SURGERY: Trauma Services: 27 items

ORGANIZATION WIDE POLICIES AND PROCEDURES: 1 item

James Shankwiler, MD
Secretary / Treasurer Medical Staff



From *The President* continued from page 2

- 4) Patients receive larger share of their awards.
From 1999-2009, more than \$245 million was redirected from attorney fees to patients
- 5) Stabilization of medical malpractice insurance rates
- 6) While MICRA has reduced the incentive to litigate the weakest claims, it has not affected access to courts for individuals with justifiable claims. Medical malpractice lawsuit filings, per capita, are 22 percent higher today than before MICRA (what has the litigator per capita number done between 1975 and 2011?)
- 7) A cap on non-economic damages has controlled run-away jury awards. Other states have fared poorly, with multiple awards in the \$13-\$30 million range, including millions for pain and suffering.

A 2008 study by California's former non-partisan state legislative analyst found that merely doubling the non-economic damages to \$500,000 would increase health-care costs in California by \$9.5 billion annually. The impact would not only raise insurance rates, but also pressure physicians and facilities, especially those that treat the under/uninsured, to curtail services or close. The California Large Loss Trend Study, conducted by Medical Underwriters of California in 2008, showed thirty cases with:

- 1) Five jury verdicts, one settled by arbitration, and twenty-four settlements, which included three structured settlements, based on the purchase of an annuity
- 2) Southern California represented 73 percent of the cases and 70 percent of the awards
- 3) Hospital related cases were 77 percent, down from 90 percent the year before.
- 4) Birth injuries, failure-to-treat, and delay/failure to diagnose accounted for 87 percent of the cases and money awarded.
- 5) The long term trend of \$1+million awards was not negatively affected by MICRA:
1973-84: Eleven awards/year
1985-96: twenty-three awards/year
1997-2008: thirty-four awards/year

A Yale Journal of Health Policy, Law and Ethics study in 2004, titled "Effective Legal Reform and Malpractice Insurance Crisis" stated: "It is reliably estimated, by entities as diverse as the U. S. Congressional Budget Office, the U.S. Department of Health and Human Services...and, the American Academy of Actuaries, that passage of reform similar to MICRA in states currently lacking statutes would result in premium savings of 25 percent to 30 percent annually."

A Harvard publication, "The Harvard Medical Practice Study," states, "that there is no relationship between the presence or absence of medical negligence and the outcome of malpractice litigation. The only variable that predicts the outcome of claims is the degree of injury. A severely injured plaintiff is likely to be compensated in court whether or not the physician was at fault."

It is apparent that physicians and attorneys have antithetical approaches to medical malpractice. The legal system's approach to patient injury is accusation and punishment. Attorneys claim that large punitive awards will teach physicians and hospitals not to repeat the errors. In reality, they are attempting to punish bad outcomes, so that the result is either to limit the service or procedure, or to waste money on defensive medicine in response to the perceived lawsuit risk. In contrast, physicians and hospitals have embraced non-punitive quality management systems, so as to discover the causes of complications and improve outcomes.

In closing, please be mindful of what MICRA provides for both you as a practitioner, and for its contribution to the financial stability of healthcare access in California. MICRA needs your support at this time to defend it against the legislative onslaught of the CAOC. The California Medical Association is at the forefront of lobbying on behalf of MICRA. By joining this organization, and, in particular, contributing to CALPAC (California Medical Association Political Action Committee), you can directly support MICRA and the practice of medicine in California.

Jim Buese, MD
President Medical Staff

From the Health Sciences Library...

Continuing series on electronic books: Books in Reference & Study Guides

Electronic books are accessible from anywhere on-site and also available off-site for those with Citrix or Connect login access or by using passworded 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. The library online catalog also includes other titles of interest that are freely available on the web (^{www} after 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.

There is one Study Guide title, *Sesap 14: Surgical Education and Self-Assessment Program* (passworded access, contact library for more information).

There are 32 Reference titles, including:

- *The 5-minute orthopaedic consult* ^o
- *The 5-minute toxicology consult* ^o

- *Citing Medicine: the NLM Style Guide for authors, editors and publishers* ^{www}
- *Clinical dermatology: a color guide to diagnosis and therapy* ^o
- *Current Clinical medicine* ^{MDC}
- *Emergency response guidebook* ^{www}
- *Ferri's clinical advisor* ^{MDC}
- *The Harriet Lane handbook: a manual for pediatric house officers* ^{MDC}
- *Healthy people 2020* ^{www}
- *ICD-9-CM: international classification of diseases* ^{www}
- *International travel and health* ^{www}
- *The Merck manual of diagnosis and therapy* ^{www}
- *Merriam-Webster's medical dictionary* ^{www}
- *MGMA physician compensation and production survey*
- *Operative Surgery manual* ^{MDC}
- *The Osler medical handbook* ^{MDC}
- *Patient Safety and quality: an evidence-based handbook for nurses* ^{www}
- *Practical guide to the care of the medical patient* ^{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. If you are unable to access any of our resources from onsite, e.g., get an access denied message, please contact the library with the computer # and location.

Seeking Medical Director, Robotic Surgery

Huntington Hospital seeks a medical director: robotic surgery. Interested candidates must meet the following criteria to qualify for consideration:

- *Board certified in his/her surgical specialty;*
- *Proficient in conducting robotic surgical procedures;*
- *Active member of the Huntington hospital Medical Staff.*

Interested candidates should forward their curriculum vitae to:
Ms.Lila Cheney, RN: Executive Director: Obstetrical and Surgical Services at: lila.cheney@huntingtonhospital.com

Maury Kulwin
Executive Director: Ambulatory and Cancer Services

Save the Date

Doctor's Day

Thursday, March 31, 2011
Breakfast – Doctors' Lounge,
Wingate Building
Lunch – West Tower North
patio (by fountain)

Save the Date

Physician General Staff Meeting

Tuesday, March 22, 2011



An Atypical Disease Presentation

On December 16, 2010, I slept late. At 9:00 a.m. I got up and went to the bathroom. I didn't feel dizzy nor did I have shortness of breath or chest pain. The only unusual thing was that I felt sweaty. I didn't feel faint but suddenly found myself on the tile floor. I got up and sat on a stool wondering what I might have missed before. Once again I went down and when I tried to get up I noticed fresh red blood on the tiles.

I sat up and called my friend Alice, the first "favorite" in my cell phone. Good thing I was in the habit of carrying a portable phone in my robe routinely. I realized something bad was happening and just wanted someone to know. My son lives in Redlands and this was too far.

"Alice, I don't feel well..." She knew me well enough to understand that an unusual event was happening. I was always there for everyone in need; I had not been in need myself before now.

"Do you want to call the paramedics?"

"I can't," I said. "I am upstairs." Never mind that I had the phone in my grasp.

Our bedrooms were on the second floor and I had to figure out how to get down. I soon realized there was no way help could reach me unless I could unlock the door.

"We are on our way."

It seemed logical to go wash up before leaving. "How could I go to the hospital just out of bed?" After two more falls I was ready to start the descent. I looked in the mirror and saw that I was white as 92 brightness paper. I talked to my ghostly image.

"That's it? That's how it ends?" *No answer.* I put on my robe but lacked the strength to tie it.

When my husband started having gait difficulties due to Parkinson's disease, I had suggested that we move to a

one story house. He was unconvinced, so I had adapted the house to his needs with banisters at the entry's short stair case, bathroom grab-bars and two chair-lifts, one on each side of the stairwells separated by a small landing.

I sat on the chairlift and pressed the button to go down. I found myself lying on the last four steps. I tried to get up on the chair again and couldn't. I was determined to reach the door, no matter how. I used my arms and scudded down on my buttocks. Muscles turned to jelly, despite my regular swimming, weights and treadmill exercises. It seemed like forward progress, though for every two to three steps I was also falling backward without being aware of it.

When I finally reached the bottom of the lower staircase, Alice was hammering at the door. With all my might, which was negligible, I yelled, "Call the paramedics!" which she had already done. The task at hand was to reach the door only four yards away. It was much harder to advance on flat surface than it was on the stairs. With my last effort I reached up to open the two locks but managed only one. I tried again, grasped the second, twisted the knob and fell backwards.

Alice had to push me away from the door to be able to enter the house. I heard Alice pleading on her cell-phone. "Where are they? This is an emergency!"

A minute later I felt a BP cuff on my arm and a needle prick where the paramedic started an IV. I was able to respond to his friendly voice but too tired to open my eyes. I remember telling him that I am a physician and as such I am aware that I have some ectopic heartbeats and to please not push Lidocaine which is often used to treat such errant heart beats but it can lower the BP. By then I was aware that my BP must be low and the cause of all the fainting. I thought that I might have had a painless heart attack that often happens in women.

They promptly loaded me in the ambulance and started down the road with alarm signal blaring. I asked them not to but they replied that they have to go fast. *I don't recall that reassuring me.*

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Emergency Department Construction Update

Anyone who has been watching the building of the ED expansion is aware that after years of planning and construction, it is starting to look like the rest of Huntington Hospital. In several months (likely this summer) the ground floor of the extension will be completed. There will be 28 emergency department beds in this phase II of construction. We plan to move into this area and close the present ED for about a year so that phase III of construction can be completed. The final phase III will combine the 28 bed ED and the renovated present ED resulting in a 54 bed emergency department: There will be 50 rooms – four of which are trauma rooms with the capacity for two beds each). ED2 will remain open during the phase III renovation/construction. When entirely finished, the result will be a state-of-the-art emergency department with a 10 room fast-tract and four zones of 10 rooms each. All rooms will be single bed except for trauma rooms. Every room will be equipped with a computer for easier ordering and access to patients' medical records.

If you have any questions or comments please speak with me or Dr. Stan Kalter.

Sincerely,
Robert T. Goldweber, MD

Top Ten Reasons Why ICD-9 Codes are Important on Out-Patient Laboratory Test Requests

10. Insurance companies will not bother you to obtain the missing codes.
9. Hospital/laboratory billers/coders will not bother you to obtain the missing codes.
8. Insurance companies will pay the claim when correct codes are provided.
7. Medicare will pay the claim when correct codes are provided.
6. When codes are missing, patients have a longer wait time while phlebotomists contact your office for the appropriate codes.
5. Your office staff will receive less phone calls.
4. Your office staff will be more efficient.
3. You will have less interruptions.
2. You will be more efficient.
1. You will have happier patients!

An Atypical Disease Presentation

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As I was wheeled into the ED at Huntington Hospital, where I had been an attending physician for almost thirty years, the critical care nursing team jumped into action. The physician on duty was Dr. Luna, a very kind and capable doctor, a respected specialist in the medical community and a colleague of many years. Because my BP was 65 he ordered intravenous fluids in large amount and oxygen. After he took my history he ordered laboratory tests, chest x-ray and EKG. I started shaking with chills as I had never before experienced. At first everybody seemed to think that I had an infection until Dr. Luna came to show me my EKG which exhibited a right bundle branch block. He asked: "Judy, you know your EKG, did you have this RBB before?"

"No" I replied. My cardiologist, Dr. Easthope was at once contacted. Dr. Geisler, his partner was there few minutes later and ordered an echocardiogram. Dr. Geisler explained that the strain of the right heart could mean only two possible events: either pulmonary emboli or right sided myocardial infarction. He favored PE, telling me that if the CT scan with contrast didn't show PE, he'd take me to the cath lab for an angiogram. He was right: the CT showed multiple emboli. From where? *I had no obvious risk factors.* The next day: a venous duplex scan of my legs revealed two clots in the left lower leg without pain or swelling. Heparin and Coumadin were started. From all the tumbling it was a wonder I broke no bones, though did have a few lacerations and some huge bruises.

After 24 hours in ICU, I transferred to a monitored observation unit. The following week I was under the superb care of many of my colleagues (in alphabetical order): Drs. Easthope, Geisler, Gurevich, Hegde, Luna, Patel, Siew and Thrun.

The nurses and their helpers were kind, considerate and helpful. Some of my colleagues think that my travel to Ireland on a painting trip was the origin of the clots. Others think it was too long ago and the cause remains as bizarre as the presentation of my illness.

Meanwhile I take Coumadin and, one by one, resume my usual activities, coping with the occasional flashbacks while constantly feeling my gratitude toward my rescuers, caregivers and for surviving the experience.

Dr Judith Lowe

Physician Informatics

Problem List

Would you like to be able to easily enter a Problem List with corresponding ICD-9 codes for your patients? We can show you how!

Critical Care Unit (CCU) Automating Paper Flowsheet:

On April 18, 2011, the CCU will be moving from a paper flowsheet to an electronic format. Three new components will be added to support this change, 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 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

Computerized Physician Order Entry (CPOE) Update

Computerized Physician Order Entry (CPOE) of medication orders was successfully implemented in the emergency department in December of 2010. The emergency department physicians are now completely up with CPOE of medication and non-medication orders. Congratulations to the ED team for their hard work and successful implementation!

CPOE of medication and non-medication orders for the rest of the house will begin with the CPOE pilot in labor and delivery/maternity on April 1, 2011.

Considering Adopting Electronic Health Record for your Practice or Meeting Meaningful Use?

EHR and eRx Incentive and Penalties

On July 13, 2010, the Centers for Medicare & Medicaid Services (CMS) released the final rule defining 'meaningful use' of an electronic health record (EHR)

system, which are required in order to qualify for Stage 1 Meaningful Use incentives. Eligible professionals must demonstrate meeting certain criteria during the reporting period, which for Stage 1 is any consecutive 90 days starting after January 1, 2011. 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 achieve beyond meaningful use – to recognize 'meaningful value' of adopting and optimizing technology for your practice and patient care.

2011 ePrescribing protects 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.

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.

**Call, email or stop by the
Physician Informatics office**

Physician Informatics Office: 626-397-2500

ADDRESS SERVICE REQUESTED

MEDICAL STAFF

N E W S L E T T E R

March, 2011

CME Corner



UPCOMING PROGRAMS FOR THE FIRST THURSDAY MEDICAL WORKSHOPS:

FIRST THURSDAY:

Topic: Malpractice and How to Avoid
Date: March 3, 2011
Time: 8:00am
Place: Research Conference Hall
Gap Analysis: Knowledge Gap and Performance Gap:
Doctors do not document completely and do not communicate well with patients – frequently because they do not have time, but also because they do not understand the importance of documentation and communication.
Objectives: 1. Learn the law of medical malpractice
2. Learn how to document completely
3. Learn how to communicate effectively with patients and other providers
Audience: Primary Care Physicians and Medical Students
Methods: Lecture with a question and answer period
Evaluation: Post-activity evaluation form
Speaker: Cindy Carson, MD – Huntington Hospital
Credit: 1 *AMA PRA Category 1 Credit*TM

UPCOMING MEDICAL GRAND ROUNDS:

Topic: New Developments in Diabetes Treatment
Date: March 4, 2011
Time: Noon
Place: Research Conference Hall
Gap Analysis: Knowledge Gap and Performance Gap:
New treatments underused. Older treatments unsatisfactory with regard to risks and outcomes. Target audience is currently not able to prescribe newer treatments due to knowledge gap regarding availability, efficacy, and appropriateness.
Objectives: Gender, age and ethnicity are significant factors in treatment decisions. This is of particular importance for Hispanic populations due to the high incidence and prevalence of diabetes.
Audience: Internal Medicine, Family Practice and Endocrinologists
Methods: Lecture with a questions and answer period
Evaluation: Post-activity evaluation form
Speaker: Helen Baron, MD - USC, Endocrinologist
Credit: 1 *AMA PRA Category 1 Credit*TM