

# MEDICAL STAFF

Huntington Hospital NEWSLETTER

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## From The President



*The art of being wise is the art of knowing what to overlook.*

– William James

*Don't find fault, find a remedy.*

– Henry Ford

*Baseball is the only field of endeavor where a man can succeed three times out of ten and be considered a good performer.*

– Ted Williams

The Joint Commission (TJC), formerly the Joint Commission on Accreditation of Healthcare Organizations, is an American based not-for-profit organization, which deems healthcare organizations (HCO's) for state and federal entities. TJC accredits over 19,000 HCO's in the United States, representing 91% of all hospitals. The federal government and the majority of state governments have come to recognize TJC accreditation as a condition of licensure, and Medicare/Medicaid participation and reimbursement. In addition, many insurers look to TJC approval in contracting with hospitals. Inspections, known as surveys, are typically on a triennial cycle, with findings available to the public in an accreditation report on the Quality Check web site. TJC's declared mission is "To continuously improve health care for the public, in collaboration with other stake holders, by evaluating health care organizations and inspiring them to excel in providing safe and effective care of the highest quality and value."

Ernest Codman, MD (1869-1940) was born in Boston, attended Harvard undergrad and medical

*continued on page 2*

## 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 August 11, 2011 and by the Governing Board on August 11, 2011.

#### MEDICAL STAFF APPOINTMENTS

- Andre Atoian, MD – Anesthesiology
- Sheila Bonilla, MD – Allergy and Immunology
- Steven Chen, MD – Anesthesiology
- Jonathan Hechanova, MD – Internal Medicine
- Timothy Jackson, MD – Orthopedic Sports Medicine
- David Samimi, MD – Ophthalmology
- Robert Schuster, MD – Anesthesiology
- Maria Torrone, MD – Diagnostic Radiology
- Amy Wang, MD – Hematology/Oncology

#### MEDICAL STAFF RESIGNATIONS

- Sandy Lee, M.D. – Ophthalmology
- Kevin Lemley, MD – Pediatrics
- Michael Neely, MD – Pediatric Infectious Disease
- Barney Rosen, PhD – Psychology
- Joana Tamayo, MD – Obstetrics & Gynecology
- William Tap, MD – Hematology/Oncology

*continued on page 2*

### Inside:

From the President	~ ~ ~ ~ ~ 1-3
Summary of the Minutes	~ ~ ~ ~ ~ 1-2
From the Health Sciences Library	~ ~ ~ ~ ~ 4
Physician Informatics	~ ~ ~ ~ ~ 5-6
Accreditation Council for Graduate	
Medical Education Site Visit	~ ~ ~ ~ ~ 7
CME Corner	~ ~ ~ ~ ~ 7

# Summary of the Minutes

## Executive Committee Meeting

*continued from page 1*

- Richard Tsai, MD – Orthopedic Surgery
- Amber Tyson, MD – Physical Medicine & Rehab
- Jeffrey Wertheimer, PhD – Psychology

### **POLICY AND PROCEDURE REVIEW**

*Expedited Credentialing and Privileging Process – New*

**James Shankwiler, MD**

*Secretary/Treasurer, Medical Staff*



## From The President *continued from page 1*

school, trained in surgery at Massachusetts General Hospital, and contributed to anesthesiology, radiology, orthopedics, and the study of medical outcomes. Dr. Codman was an early advocate of hospital reform and acknowledged founder of what today is known as outcome management in patient care. He was the first American physician to systematically follow patient's progress through recovery. With the use of "End Result Cards," Codman tracked his outcomes by following his patients for at least a year post surgery. He led a life-long pursuit to establish an "End Results System" to track outcomes as an opportunity to identify clinical misadventures that would serve as a foundation for improving the care of future patients. He further believed all information should be made public so as to guide patients in their choice of physician and hospital. While attending at MGH, he established the first M & M conference; by 1914 the hospital refused his plan for evaluating surgeon competence, and he lost his staff privileges. Dr. Codman subsequently opened his own hospital to pursue his performance measurement and improvement objectives. He was instrumental in founding the American College of Surgeons and its Hospital Standardization Program.

In 1951, The Joint Commission of Accreditation of Hospitals (JCAH) was created by merging the Hospital Standardization Program with similar programs run by The American College of Physicians, The American Hospital Association, The AMA, The Canadian Medical Association, and The American Osteopathic Association.

It was renamed JCAHO in 1987, and TJC in 2007. TJC advocates the use of patient safety measures, the spread of information, the measurement of performance, and the introduction of public policy recommendations.

The Joint Commission International was established in 1997 as a division of Joint Commission Resources, Inc (JCR), a private, not-for-profit affiliate of TJC. It extends TJC's mission worldwide by improving quality of patient care in more than sixty countries. So-called international hospitals seek accreditation to demonstrate quality and JCI accreditation is considered a seal of approval by medical travelers from the US.

Of note, section 125 of the Medicare Improvement for Patients and Providers Act (MIPPA) of 2008 removed TJC's statutorily guaranteed accreditation authority for hospitals, effective July 15, 2010. Now, TJC's hospital accreditation program is subject to the Centers for Medicare and Medicaid (CMS) requirements for accrediting organizations seeking deeming authority. To avoid lapses, TJC must submit an application for hospital deeming authority consistent with these requirements and within a time frame that will enable CMS to review and evaluate their submission (the irony and creeping government intrusion noted). CMS will make the decision to grant deeming authority.

All HCO's, except laboratories, are subject to a three year accreditation cycle. With regards to hospital surveys, the

*continued on page 3*

## From *The President* continued from page 2

TJC does not make its findings public. However, it does provide the organization's accreditation decision and date awarded, and any standards that were cited for improvement. Entities deemed to be in compliance with most or all of the standards are awarded accreditation. Unannounced surveys began January 1, 2006, and occur in 18 to 39 months cycles. In contrast, JCI gives advanced notice of inspection to international hospitals, allowing considerable preparation time.

Preparation for a Joint Commission survey is a challenging process. At a minimum, a hospital must be completely familiar with current standards, and be able to examine current processes, policies, and procedures relative to these standards, and be able to improve any areas that are not currently in compliance. The hospital must be in compliance with standards for at least four months prior to an initial survey. The hospital should also be in compliance with applicable standards during the entire period of accreditation, which means surveyors look for a three-year period of implementation of standards.

Surveyors generally work, or have worked, in the health care industry, but devote half, or less, of their time for TJC duties. They travel to HCO's to compare the operational practices and facilities against established Joint Commission standards and elements of performance.

Substantial time and resources are devoted by hospitals to prepare for and undergo TJC surveys. The average fee charged the TJC in 2008 was \$46,000, and varies with the size and complexity of the institution. In addition, the hospital pays for the surveyors' travel, living expenses and accommodations. Certainly, a number of hospital employees and outside consultants are devoted to Joint Commission preparation and ongoing maintenance. Additionally, there has been voiced concern over a lack of verifiable progress towards meeting TJC's stated goals. Although TJC increasingly cites and demands "evidence-based medicine" in its regulatory requirements, there is concern in regards to a perceived paucity of evidence demonstrating significant quality improvements, despite increasingly stringent and expensive requirements. Further, TJC

has been criticized for its relationship with its consulting subsidiary, Joint Commission Resources.

TJC does not have a monopoly; not all states use its services. Some states have set up their own alternate assessment procedures. TJC is not recognized for state licensure in Oklahoma, Pennsylvania, and Wisconsin, while in California, TJC is part of a joint survey process with state authorities, such as DHS. There are several alternative accreditation organizations, including Healthcare Facilities Accreditation Program (HFAP), The Accreditation Commission for Health Care (ACHC), and Healthcare Quality Association Accreditation (HQAA). HFAP is older than TJC, having been in operation since 1945. On September 26, 2008, CMS granted deeming authority for hospitals to DNV Healthcare, Inc (DNVHC). DNVHC is an operating company of Det Norske Verites (DNV), based in Oslo, Norway. DNV has been in operation since the mid 1800's.

DNVHC is the first new CMS-accredited program in over forty years. It uses a significantly different approach to surveying, analysis and patient outcomes. DNVHC historically has been involved in manufacturing industries. It utilizes the ISO 9001 program (International Organization of Standardization); a quality system standard widely used in the manufacturing world to create a framework that provides a set of management principles to dictate how to perform quality control. Used in the auto industry, the ISO process is a quality management system with heavy emphasis on leadership and accountability, which is shown to reduce costs, better manage workflow, and improve health outcomes. DNVHC has acted as a consulting company to HCO's, but agreed to end that business once it became an accrediting authority, per CMS decree. The survey style has been characterized as "holistic," collaborative, with a noticeable difference in the attitude of surveyors whereby discussion of problems is promoted. DNVHC Surveys of hospitals is annual.

As an aside, Norway has been ranked #1 in the world for quality of life, despite recent events. What part has Det Norske Verites played in establishing this high quality in its home country?

**Jim Buese, MD**  
*President Medical Staff*

# From the Health Sciences Library...

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## HOW MEDLINEPLUS CAN HELP YOU MEET MU

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**L**ooking for a resource that can address a Meaningful Use need for your office EHR system?

The National Library of Medicine (NLM) has developed a resource for you. It's called **MedlinePlus Connect** and it is **FREE**. Since **MedlinePlus Connect** helps EHRs identify patient-specific education resources, it can assist health care providers in meeting one of the 10 criteria for **meaningful use** of certified EHR technology.

**MedlinePlus Connect** allows you to link patient portals and electronic health record (EHR) systems to MedlinePlus.gov, an authoritative, up-to-date resource for health information for patients, families and health care providers. MedlinePlus brings together information from NIH, other federal agencies, and reputable health information providers. It covers a wide range of health conditions and wellness issues.

Patients using portals or EHRs that have implemented **MedlinePlus Connect** can access easy-to-understand health information on MedlinePlus that is directly related to their diagnoses, medications, and lab tests. **MedlinePlus Connect** does not have to be used exclusively to link to patient education information. Many EHR systems can be configured to link to more than one source of consumer health information.

**MedlinePlus Connect** automatically maps the information using the codes mentioned below, once they have been input into the EHR. Full details, including an online demonstration, are available at <http://medlineplus.gov/connect>. **MedlinePlus Connect** accepts the coding standards already in the organization's system, such as ICD-9-CM, SNOMED CT CORE Problem List Subset, RxNorm, NDC, and LOINC. It will support ICD-10-CM when it becomes the U.S. standard. **MedlinePlus Connect** only needs to be set up once and NLM will regularly maintain the vocabulary mappings and topic links for you.

To use **MedlinePlus Connect**, contact your EHR vendor or work with their in-house technical staff to follow the instructions in the technical documentation at <http://www.nlm.nih.gov/medlineplus/connect/technical.html>.

**MedlinePlus Connect** can now serve any health IT system that uses the HL7 Infobutton Standard.

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



# Physician Informatics

## Below are FAQs about HuntingtonRx and other Certified ePrescribing...

### How will Medicare know I am ePrescribing?

For 2011, providers need a single billing G-code (G8553) for prescriptions transmitted electronically for Medicare patients. A G-code can be reported for a Medicare patient office visit where electronic prescribing occurred. Additionally, CMS introduced new changes to the coding of orders for the ePrescribe incentive program.

G8553 – At least one prescription created during the patient encounter was generated and transmitted electronically using a qualified ePrescribe system.

NOTE: Eligible providers who do not adequately report under the ePrescribe program will be subject to a 1% penalty beginning 2012. The penalty will increase to 1.5% in 2013 and 2% in 2014. There is a ruling offering hardship codes under consideration – as soon as they are finalized, HMH will provide those codes and exemptions in the next newsletter.

For more information, please visit:

<http://www.ama-assn.org/resources/doc/hit/faq-cms-incentive-program.pdf>

### How can I ensure my G-codes are reaching Medicare successfully?

If you are submitting zero \$ G-codes on your Medicare claims and not receiving the N365 Denial Remark Codes on your EOMBs then your codes are not reaching Medicare and you should take immediate action.

The most important thing you can do to be sure that Medicare is receiving and recognizing your G-codes is to regularly review your Remittance Advice Notices. Currently G-codes are returned on a Remittance Advice with a Denial Code of N365 which indicates

“This procedure code is not payable. It is for reporting/information purposes only.” This is a denial you want to see because it means that Medicare has processed your G-codes – not seeing this N365 Denial means that Medicare is not receiving your G-codes.

If you are not seeing the N365 Denial, please first check that your data entry representative(s) are not manually suppressing the \$0.00 (zero dollar) line items. You will want to make sure the \$0.00 (zero dollars) line items are present on your Medicare claims.

If you are unsure about your Practice Management G-code setup and are not receiving the N365 Remark Codes on your Explanation of Medicare Benefits (EOMB) contact Client Support for your Practice Management system immediately for assistance with your G-code setup

### 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**. If you didn’t ePrescribe for 10 unique patients before June 30, as soon as CMS rules are final on additional hardship codes they are considering – we will publish how physicians can claim exemptions or hardships to avoid the 2011 penalties. As we currently understand, you have until October 1 to claim the exemption and/or hardship, but CMS may extend that date since the additional exemptions are not yet finalized.

*continued on page 6*

DON'T STOP ePRESCRIBING this YEAR – 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](mailto: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](mailto: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/>

#### **Critical Care Unit (CCU) Automating Paper Flowsheet:**

The CCU will be moving from a paper flow sheet 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 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](mailto:vera.ma@huntingtonhospital.com)

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

#### **Physician Informatics Office:**

**626-397-2500** or email:

#### **Becky Pangburn:**

[becky.pangburn@huntingtonhospital.com](mailto:becky.pangburn@huntingtonhospital.com);

#### **Vera Ma:**

[vera.ma@huntingtonhospital.com](mailto:vera.ma@huntingtonhospital.com);

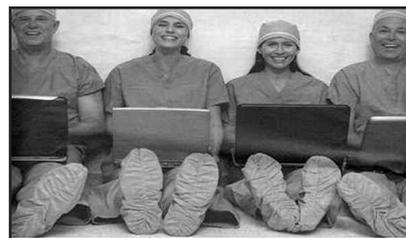
#### **Joe Limmer:**

[joe.limmer@huntingtonhospital.com](mailto:joe.limmer@huntingtonhospital.com)

## Accreditation Council for Graduate Medical Education Site Visit

**H**untington Hospital Graduate Medical Education will undergo an institutional site visit by the Accreditation Council for GME on Tuesday, September 13, 2011. If any staff physician wishes to review our GME report which was submitted to the Governing Board and the MEC please email [arvid.underman@huntingtonhospital.com](mailto:arvid.underman@huntingtonhospital.com) and a copy will be transmitted electronically.

## Save the Date



**EHRapalooza -  
HMH Braun Auditorium**

**October 18<sup>th</sup> Lunch or  
October 25<sup>th</sup> Dinner**

## CME Corner



### UPCOMING FIRST THURSDAY:

**Topic:** What's New in Anticoagulation Therapy

**Date:** September 8, 2011

**Time:** 8:00 am

**Place:** Research Conference Hall

**Gap Analysis:** Provide an update to physicians regarding the new anticoagulation therapies and their uses.

**Objectives:**

1. Have physicians feel comfortable in using the new agents.
2. Understand the use of anticoagulants in orthopedic patients.
3. Explain the newer therapies in patients with atrial fibrillation.
4. Outline the various components of cultural/linguistic diversities that relate to patient demographics, diagnosis, and treatment.

**Speaker(s):** Dr. Gary Conrad, Dr. Todd Dietrick, and Dr. Casey O'Connell

**Credit:** 1 *AMA PRA Category 1 Credit*<sup>TM</sup>

### UPCOMING MEDICAL GRAND ROUNDS:

There will be no Medical Grand Rounds for September due to the Labor Day holiday.



## Huntington Hospital

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# MEDICAL STAFF

N E W S L E T T E R

September, 2011