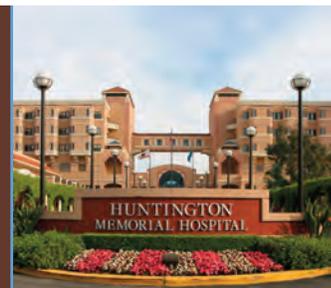


medical staff NEWSLETTER

May 2014

volume 52, issue 5



From the **President**

"Government's first duty is to protect the people, not run their lives."

"It isn't so much that liberals are ignorant. It's just that they know so many things that aren't so."

- Ronald Reagan



Universal Health Coverage in Various Countries

Part Two

Portugal

Portugal's health care system is a classic, universal, single-payer system run by the National Health System (NHS) and funded by tax revenues. About 25% of the population, mostly government workers, military, telecommunication workers, and their families are under industry or occupation-based insurance systems known as "subsystems". Only 10 percent of the population has private insurance through their employers. Primary care physicians and hospital based physicians are public employees whose salaries are paid directly by the NHS. Since it is permitted, NHS doctors are allowed to have their own private practice; however, the service rendered by a NHS doctor in his/her private office is not reimbursable by NHS. Patients in that situation have to pay out-of-pocket.

Although the benefits under the NHS are extensive and cover all necessary inpatient and outpatient services, there are co-payments required for diagnostic tests, hospital admissions, consultations with specialists, and prescription drugs. The co-payments can reach up to 40% of the total medical cost to patients. In addition, access to care

remains a serious problem. The average general practitioner, who serves as the gate keeper for the NHS, has to take care of more than 1,500 patients leading to long waits and difficulties for patients in getting appointments. Except for emergencies, a referral is required for all patients to obtain specialist or hospital care. Even though permission is granted for a surgery to be performed, more than 150,000 Portuguese out of 10.6 million of the population in Portugal have to be placed on waiting lists for surgery. Also, due to its limited funding, modern medical technology is not commonly available in Portugal. Often, many patients pay out of pocket to see private physicians; and in some cases, many cross the border to seek medical services from Spain.

Greece

The Greek health care system is highly centralized and is a single-payer system funded through payroll taxes and in part through general tax revenues. It is controlled by the Ministry of Social Health and Cohesion which sets up "social insurance funds" for employers to contribute for their employees. These social insurance funds are specific to

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**Don't forget to get
your TB test!**

 **Huntington Hospital**

Board 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 April 7, 2014 and by the Governing Board Subcommittee on April 11, 2014.

Medical Staff Appointments



Doan, Steve, MD
Geriatrics
625 S. Fair Oaks Avenue
Suite 245
Pasadena, CA 91105
626-229-9865 (office)
626-229-9867 (fax)



Schneider, Nicole, MD
Internal Medicine
100 W. California Blvd.
Academic Hospitalist
Medical Group
Pasadena, CA 91105
626-352-1444 (office)



Tsai, Annie, MD
Anesthesiology
100 W. California Blvd.
Anesthesiology Department
Pasadena, CA 91109

Allied Health Professional Appointments

- Dryer, Isaiah, CCP – Perfusionist
- Melander, Sheila, NP – Nurse Practitioner
- Paniouchkine, Ivan – Perfusion Assistant
- Pensinger, Carlos, CCP – Perfusionist
- Villalobos, Jose – Perfusion Assistant
- Wheelock, Leshia – Perfusion Assistant

Medical Staff Resignations

- Ali, Mir, MD, Cardiovascular Disease – effective 4/30/14
- Burrell, Whitney, MD, Plastic Surgery – effective 5/31/14
- Carey, Joseph, MD – Plastic Surgery – effective 5/31/14
- Denham, Jeffrey, MD – Internal Medicine – effective 5/31/14
- Eshom, James, MD – Internal Medicine – effective 5/31/14
- Harty, Niall, MD – Urology – effective 6/30/14
- Huang, Thomas, MD – Internal Medicine – effective 5/31/14
- O'Brien, Kevin, MD – Pediatrics – effective 5/31/14
- Schumacher, Mariah, MD – Ophthalmology – effective 4/30/14
- Shavelle, David, MD – Cardiovascular Disease – effective 5/31/14
- Tobis, Scott, MD – Urology – effective 6/30/14

Allied Health Resignations

- Haines, Marianne, NP – Nurse Practitioner
- Parker, Walter, CCP – Perfusionist
- Soltes, Serena, RN – 5150 Status
- Stanford, Riviera, CCP – Perfusionist

From the **President** *continued from page 1*

different industry sectors. Therefore, each fund has its own benefits package, contribution rates, and types of providers. Not surprisingly, powerful worker unions will protect or lobby the Ministry of Social Health and Cohesion for more benefits for their members. All hospitals are operated by the National Health Service (NHS), and all physicians are reimbursed by the (NHS) through salary or contract for fee-for-service. The reimbursement rates for both hospitals and physicians are extremely low. Balance-billing to patients is prohibited. In order to contain costs, not only is modern health care technology availability is very limited in Greece, but also hospital staffing is in extreme shortage.

The main problem with the Greek system is its corruption. Since there are long waiting lists for medical services, system's rationing, bureaucracy, and inefficiencies, many bribe the system and/or use their political influence to get ahead of the waiting lists and receive special treatments. Furthermore, there are many abuses in the system, and there are many people gain the system through holes in the system or even through illegal practice. Clearly, the Greek system is in desperate need for reform.

Netherlands

The Netherlands has quite a market-oriented national health care system in Europe even before 2006, when reforms were introduced. The old system requires workers with income of below €32,600 to enroll in government-controlled "sick fund" financed through a payroll tax and a flat-rate per-capita premium. Those with higher incomes may enroll too in the funds or opt to purchase private insurance. The funds offer a uniform benefits including physician and hospital care, specialist care, diagnostic tests, prescription drugs and dental care for children. The new system replaced the old health care options requiring all Dutch citizens to purchase a basic health insurance

from one of the private insurance companies. The companies can offer varying deductibles with a small level of price competition. Policies also offer rebates to policy holders who uses no health care services in a given year. Price competition under the new system increased the purchasing power of its citizens.

Price control is through negotiation with providers on quality, quantity, and price of services. Also, primary care providers work as a gate keeper. Pharmaceutical prices are capped nationwide. Individuals may choose more expensive drugs by paying out of pocket.

Although the Dutch system falls short of a true free market model, the results are encouraging. The waiting lists from the old system have shortened in the new system. The annual growth rate in health care costs has leveled off from 4.5% to 3%. By allowing competition among insurance plans, hospitals, and physicians, and by allowing consumers to make decisions on choosing insurance based on price and quality, the Dutch system appears to be in the right track for health care delivery.

Great Britain

The British National Health Services (NHS) is a highly centralized single-payer system wherein the government pays for health care through general tax revenues. Most physicians and nurses are government employees. Only about 10% of Britons have private health insurance. For years, the central system relied heavily on controlling spending; however, the government now is facing a financial shortage in providing health care services. NHS spending will have to nearly triple by 2025 just to maintain the current level of services.

There are problems with the current level of services. Long waiting lists are a critical level of concern. Cancer patients could wait as long as eight months

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From the **President** continued from page 3

for treatment; roughly 40% of cancer patients never got to see an oncologist. Nearly 20% of colon cancer patients who were considered to be treatable at the time of diagnosis were deemed to be incurable by the time treatment is finally offered due to the long waiting lists of receiving care. Including other services, more than half of British patients wait more than 18 weeks for care. Not only does the British system contain long wait lists, but also it contains rationalization of care. Many patients were denied services, such as kidney dialysis, open heart surgery, and other expensive treatments based on their profiles that were judged to be too ill or aged for the procedures to be cost effective. In addition, David Cameron, the Prime Minister of Great Britain, has proposed the NHS to refuse treatment to individuals who don't practice healthy lifestyles.

Although the government is considering making steps toward market-based reforms, majority of the British citizens believe the need for health care reform is urgent. They like the idea of making it easier for patients to spend their own money on health care to enhance the quality.

Switzerland

Switzerland has the most market-oriented health care system among countries with universal health coverage. The Swiss system is based on managed competition. It leaves the provision of health care and insurance to private companies but provides a highly regulated market place as a framework which these health care companies should operate within. Swiss law requires all citizens to purchase a basic yet extensive health insurance. These insurance policies are purchased based on an individual basis wherein insurers cannot reject an applicant based on one's health status. Premiums from healthier people subsidize the premiums for the less healthy. Due to basic

requirement on offering the basic health coverage and the inability to choose their clients based on their health status, insurers compete primarily on price. They generally manage prices by varying the level of deductibles and copayments. Swiss insurers operate as cartels to negotiate provider reimbursements on a cantonal basis. Since there is no employer mandate to contribute to health insurance for workers, the Swiss are exposed to the full cost of their insurance purchases. Many Swiss are very price conscious on deciding the level of deductibles and copayments based on their financial abilities and their willingness to accept certain risks. The Swiss government offers subsidies to low income citizens making these individuals to pay no more than 10% of their income on health care insurances.

There are no waiting lists in the Swiss system as there is no global budget for the Swiss government on health care. Not surprisingly, the Swiss spend a high GDP, up to 11.5%, on health care, second only to the U.S. In addition, Swiss citizens enjoy a high degree of access to modern medical technology.

The Swiss system is not without problems. Since it is the requirement for everyone to purchase basic health insurance which must include inpatient and outpatient care, care for the elderly and the physically and mentally handicapped, long-term nursing home care, diagnostic tests, prescription drugs, and even complementary and alternative therapies, some consumers are forced to purchase insurance even if they believe the cost outweighs their needs. Secondly, there is a push to expand the basic coverage from different special interest groups making the cost for the basic coverage higher. Furthermore, the cartel structure for

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From the **President** continued from page 4

negotiating reimbursement schedules can create distortions in physician practice, creating wasteful incentives, and inhibiting innovative approaches for price restructuring.

Germany

Germany has become a model for national health care with their national health insurance through so-called statutory sickness funds. The sickness funds not only cover extensive medical services, ranging from physician costs, hospital and chronic care, diagnostic tests, preventive care, prescription drugs, and dental care, but also cover 70-90% of gross salary for up to 78 weeks to individuals who are ill. Low income people are required to be enrolled into these funds; whereas, higher income people can choose to enroll into these funds or purchase private insurance. This sickness funds provided through a payroll tax split between the employer and the employee on an equal basis. The tax, which varies depending on the fund chosen by the worker, usually averages around 15% of wages.

The problems in the German system are the following. First of all, the system is running a profound deficit leading to a strong push for the government to raise payroll tax. Secondly, although there is no official government publication on waiting lists and rationing of care, there are studies showing these issues exist and are concerning. Third, Germans have less access to modern medical technology than Americans. Finally, there is increasing bureaucratic interference in how physicians practice medicine by restricting price and reimbursement rates. Although up to 76% Germans believe in the necessities of health care reform, Germans are reluctant to fully embrace the market reform. This can be due to German belief in equal access to the same quality of care for everyone is more important than their own access to the best possible care.

Canada

Canada's system on health insurance is decentralized and is financed by the provinces and the government. The system is similar to that of the US Medicaid program. To qualify for federal funding which comes from general tax revenue, the program on a province should meet the five criteria, namely; universality, comprehensiveness, portability, accessibility and public administration. Canada's health care system uses between one-third to one-half of all its social welfare spending. Each province provides its own primary care doctors, specialists, hospitals, and dental care. However, routine dental care, physiotherapy, and prescription drugs are optional. These services are given by providers on a fee-for-service basis reimbursed to them by the Canadian government.

There is an on-going debate whether to allow private insurance to service those health care needs that are not covered by the national health care system in Canada. At one time, all provinces prohibited private insurance. In 2005, Quebec struck down this prohibition on private insurance contracting. There is now pending litigation on this controversy in several other provinces. Because of this wrangling, many private clinics now offer specialized services that are not covered by the national health care system. Since these services are barred by the Canada Health Act, many offer such services in the black market which considerably reduces the patients' waiting time as compared to those done by the state.

The waiting period has been a major complaint by the Canadian citizens according to the survey conducted on Canadian physicians by the Fraser Institute which reported that as many as 800,000 are waiting for treatment at any given time. There have been 50 deaths alone in Ontario while waiting for cardiac catheterization as per

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From the **President** continued from page 5

a study conducted by the Canadian Medical Association Journal. In addition, another problem in the Canadian system is a shortage of physicians. Due to this shortage, preventive medicine is not effectively delivered. 59% of Canadians believe that their system requires fundamental changes; however, Canadians would not like to have the system similar to the U.S.

Conclusion

It is very difficult to compare health care systems in various countries because each country is unique unto itself and has its own political and national character. However, these countries do have similarities with regards to the issues they face with regards to health care. Some of the problems that exist are:

1. Universal health insurance does not mean universal access to health care.
2. Rising health care spending is common making more pressure on raising tax revenue, fee schedule fixing, imbursement restriction, higher copayments and out of pocket charges, and less modern technology availability.

3. Those countries that have single-payer systems or systems heavily weighted toward government control are the most likely to face waiting lists, rationing, and restriction on the choice of physicians and hospitals.
4. Excessive politics can affect a system tremendously. Political leaders would pass legislation just so they could win the votes even if it would be detrimental to the beneficiaries. In order to sustain the system longer, borrowing more money and adding more to its national debt becomes a common theme.
5. Dissatisfaction and discontent with a nation's health care system seems to be universal.
6. There is a tendency to move away from centralized government control system to more market-oriented reform.

Since Obama Care is driving toward a centralization of care, problems similar to those listed above will be seen in American health care in the future.

Edmund Tse, MD

President of the Medical Staff

Celebrating Milestones

The following physicians hit a service milestone in the month of May. The Medical Staff would like to recognize the following physicians for their service and dedication to Huntington Hospital.

20 Years (on staff 05/1994)

Eshom, James L., MD – Internal Medicine
Sinay, Moises, MD – Neonatology
Tse, K. Edmund, MD – Nephrology

15 Years (on staff 05/1999)

Chang, Luke H., MD – Anesthesiology

10 Years (on staff 05/2004)

Julian-Wang, Beth E., MD –
Obstetrics & Gynecology
Turner, Todd R., MD – Internal Medicine

Doctor's Day 2014

Doctor's Day was celebrated on March 26 & 27, 2014, to honor the medical staff for all of their hard work and dedication throughout the year. Events were held over the course of two days to allow the physicians an opportunity to attend at least one event. Overall the events were well attended.

On Wednesday, the North Patio was transformed into old Hollywood for a lunch celebration. The physician's were able to walk the red carpet and get their photo taken by the paparazzi. Lunch consisted of prime rib, fresh seafood, sushi, potatoes, lobster bisque, salad, and vegetables. For dessert the physician's were able to indulge in a variety of mini pastries and coffee. To help jump start their Thursday morning, physicians were treated to breakfast in the Doctor's Lounge. The menu included eggs, omelets, chef's potatoes, assorted pastries, and fruit.



A special congratulations goes to the winners of the Doctor's Day raffles:

| Name | Prize |
|------------------|--------------------------------|
| Meriel Wu, MD | Parkway Grill Gift Certificate |
| Eric Bourne, MD | Macy's Gift Certificate |
| Alison Yim, MD | Parkway Grill Gift Certificate |
| Julie Yang, MD | Macy's Gift Certificate |
| Bryan Jick, MD | Parkway Grill Gift Certificate |
| Paul Lin, MD | Macy's Gift Certificate |
| Amal Obaid, MD | Parkway Grill Gift Certificate |
| Irma Gonzalez | Macy's Gift Certificate |
| Paul Lin, MD | Parkway Grill Gift Certificate |
| Robert Posen, DO | Macy's Gift Certificate |
| Laura Sirott, MD | Parkway Grill Gift Certificate |
| Nirmal Kumar, MD | Macy's Gift Certificate |

more photos on page 8

ICD-10

Hello, my name is Pamela Eustace, and I am the ICD-10 Program Manager at Huntington Hospital, working under the leadership of our ICD-10 executive sponsors and champions: Dr. Paula Verrette, Jim Noble, Debbie Tafoya, and Kim Markey. You'll be hearing more in the coming months about ICD-10 activities at Huntington. We are exploring opportunities to partner with our Huntington Medical Staff to make this transition go smoothly. At the recent Medical Staff meeting, I had the opportunity to meet some of you and I wanted to thank you for sharing your ideas and insights.

With the recently passed SGR legislation, which included a delay for the ICD-10 compliance date by at least a year, there is a lot of uncertainty in the healthcare industry in what this will mean. CMS is currently reviewing the rule language and determining if it can be amended or if changes are necessary. Until CMS comes out with a statement, our ICD-10 team is proceeding based on new target compliance date of 10/1/2015.

A physician impact team is in development, working closely with our physician champion,

Dr. Gabriella Pearlman. Gabriella completed her internal medicine training at Huntington Hospital and is very excited to be a part of the ICD-10 team. She is currently serving as the Chief Medical Resident and will be staying at Huntington to join the internal medicine faculty. Gabriella is currently pursuing her MBA at the Wharton School of Business. She has an interest in quality improvement, and is working hard to ensure a smooth transition to ICD-10 for the entire medical staff. On a personal note, Gabriella is married to Dr. Boris Pearlman, who is also on the medical staff at Huntington. They have two children who were both born at Huntington Hospital. We'll have more to share on the physician impact team's activities later this year.

Watch for a link to a survey we'll be getting out to you and your office staff in June as an opportunity to give feedback on where you are with ICD-10 and what will provide value for you in your ICD-10 preparation. In the meantime, if you would like to contact me, my email is Pamela.Eustace@huntingtonhospital.com.

Doctor's Day 2014 Photos



Clinical Alarm Safety

The Joint Commission added a new goal to the 2014 National Patient Safety Goal (NPSG) intended to address issues related to clinical alarm safety. The new goal is housed under NPSG.06.01.01- Improve the Safety of Clinical Alarm Systems. As healthcare professionals, we are familiar with the ever present sound of these clinical alarms in our patient care areas. Their fundamental purpose is to promote patient safety by warning caregivers of potentially dangerous conditions.

The steadily increasing use of alarm-equipped medical devices has presented caregivers with an array of alarms to manage, and when not managed effectively, patient safety may be compromised. Alarms that are poorly understood or improperly used may not provide adequate warning of changes in the patient's condition. The proliferation of alarm signals has contributed to the phenomenon known as "alarm fatigue", where caregivers that are subjected to the constant sound of alarms become desensitized to their meaning and fail to recognize truly urgent conditions when they arise.

Over the coming months, we will work toward complying with this National Patient Safety Goal. As a first step, we have formed a Clinical Alarm Management Committee under the leadership of Izabella Gieras, with representatives from Nursing, Respiratory Care, Clinical Technology, Risk Management, and Accreditation. There is also ad hoc representation from Medicine, Surgery, Cardiology, Radiology and Information Technology. This multidisciplinary team is responsible for assessing the current management of alarm systems, identifying areas for improvement, and implementing any changes in technology, policies or procedures necessary to ensure clinical alarm safety.

As we move toward compliance, team members may visit your care areas to observe, interview, and possibly ask you to assist them by sharing your experience and expertise. Also, a patient safety survey will be sent to pertinent clinical end users asking them to provide input on clinical alarms.

I appreciate your assistance and contribution during this process. If you have any questions, please contact Izabella Gieras at 626-397-5248 or myself at 626-397-5058.

Thank you,

Gloria Sanchez-Rico, RN, BSN, MBA, NEA-BC
VP, Chief Nurse Executive

Getting to Know Your Medical Staff Leaders

Joseph K. Davidson, MD, joined the Medical Staff in March 2004. He is currently the Chair of the Ophthalmology Section. He is board certified by the American Board of Ophthalmology.



Dr. Davidson grew up in the Pasadena area. During several of his summers home from college, he worked at Huntington Hospital as a transcriptionist in the Emergency Department, and also as a secretary in the Neonatology office. Several of the doctors with whom he worked with during those summers are still on staff at Huntington Hospital today.

Dr. Davidson attended Harvard University where he obtained his B.A. degree, cum laude. He obtained his medical degree at Georgetown University in 1992, and completed his ophthalmology residency at McGill University, which included a year as chief resident. He has completed three fellowships; one studying ophthalmic pathology at the Armed Forces Institute of Pathology and two fellowships in ophthalmic plastic and reconstructive surgery.

Dr. Davidson currently has offices in Glendale and Pasadena. As an oculoplastic surgeon, he specializes in cosmetic and non-cosmetic surgery for the eyelids and eyebrows, including aging changes, malpositions, and skin cancers; for the orbit, including Graves disease, trauma, and tumors; and for the tear drains, including watery and/or dry eyes.

In his spare time, Dr. Davidson enjoys reading, computer programming, and travel. Recently he and his wife, Laura, have visited the various countries in Central America. Most recently, Dr. Davidson returned from his first trip doing volunteer surgery in the African country of Cabo Verde. Dr. Davidson is fluent in English and French.

FROM PHYSICIAN INFORMATICS – H@NK

Provider Videos on Key Workflows Now Available

H@NK webinar videos are available now from the hospital website in the Physician Only page. These videos are 2-6 minutes in length and review key components of important workflows. You can watch these videos from your PC, tablet, or smart phone.



huntington - access - network - knowledge

- Message Center Overview
 - ◆ High level overview of folders used in the Message Center
- Patient List
 - ◆ Proxy – How to proxy a patient list
 - ◆ Relationship – How to create a relationship list
 - ◆ Provider Group – How to create a provider group list
- Orders
 - ◆ PowerPlan Favorites – How to create and save PowerPlan favorites
 - ◆ Single Order Favorites – How to create and save order favorites
- PowerNote
 - ◆ Attestation – How to create a pre-op note with informed consent, blood consent, and any changes to existing H&P.
 - ◆ Immediate post-op Note – How to create an immediate post-op note using PowerNote
- Discharge
 - ◆ How to perform a patient discharge



CME Corner

Medical Grand Rounds

Topic: Expansion of Insurance Coverage in LA: How Successful was the ACA

Speaker: Dylan Habeeb Roby, Ph.D. Assistant Professor, Department of Health Policy and Management, UCLA Fielding School of Public Health

Date: May 9, 2014

Time: Noon – 1 p.m.

Place: Research Conference Hall

Objectives:

1. Apply knowledge of the Medi-Cal expansion, Low Income Health Program Transition, and access to insurance coverage through tax credits to understand the impact of access barriers and potential help available for their patients.
2. Understand how payment and delivery incentives change under the Affordable Care Act through new insurance coverage programs and through demonstrations and pilots being implemented due to the law.
3. Analyze individual patient situations related to insurance coverage and suggest options for coverage to facilitate access to appropriate health care services.
4. Understand the diverse communities who are likely to be explicitly left out of the ACA coverage expansions, as well as the populations less likely to sign-up for coverage due to language barriers and the cost of insurance coverage.

Audience: Primary Care Physicians, Internal Medicine, Specialties

Method: Lecture

Credit: 1.0 AMA PRA Category 1 Credits™

Second Monday

Topic: Alcoholism

Speakers: Barry I. Blum, MD and David D. Pinsky, MD

Date: May 12, 2014

Time: Noon – 1 p.m.

Place: Research Conference Hall

Audience: Primary Care Physicians, Internal Medicine

Method: Lecture

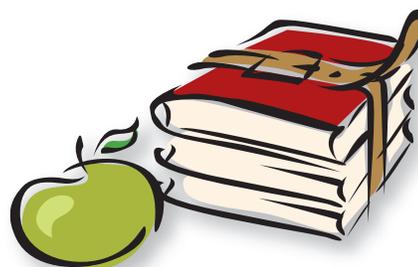
Credit: 1.0 AMA PRA Category 1 Credits™

Reminders

Online Evaluations

This year the Huntington Hospital’s CME program will undergo reaccreditation through the IMQ. Evaluations are critical for the hospital to retain accreditation and to improve our future programs. **The evaluations are also required to receive your CME credit.**

To complete the survey, after you attend each CME approved activity a link should be sent to your email account. If you do not receive this email please contact Maricela Alvarez, the CME Coordinator at (626) 397-3770 or via email at Maricela.Alvarez@huntingtonhospital.com.



Physician's...You are the Patients Experience!

A monthly communication to assist physicians in patient engagement and the patient experience.

Reviewed by: Shant Kazazian, MD

What to explain to your patient and family

- Special therapeutic interventions
- Treatment options
- What to expect in their recovery
- Medication changes

A good first impression and effective communication by a physician reduces patient anxiety and sets the stage for the entire patient experience.

Patient centered communication-“responsive to a patient’s needs, values, and preferences”

- Knock on the door
- Introduce yourself
- Sit down-research shows that even 30 seconds makes a difference
- Smile
- Show empathy and respect
- Shake hands
- Make eye contact
- Speak slowly
- Active listening behaviors- let the patient speak without interrupting them
 - ◆ Listen attentively
 - ◆ Elicit concerns
 - ◆ Answer questions honestly
- Demonstrate sensitivity to a patients cultural and ethnic diversity
- Don't use medical terminology – the patient will NOT understand

* These cards are available in the Medical Staff Office

Positive

- [Our physician] is EXCELLENT in every way.
- Especially pleased with [our physician]. He made us feels extra comfortable and took great care of our son.
- [Our physician] should be used as a model as to how a patient should be treated.

- All the DRS. ESPECIALLY _____ were so compassionate with us & our situation. They were reassuring & quelled our worries!!

Negative

- Never came into my room, peeked in, mumbled
- Dr. never discussed w/me results of my surgery. I saw him for moments when my vision split & blurred but he never told me procedure wasn't as successful as I would have liked.

For additional information you may contact: Stacy Miller, Director, Volunteer/ Customer Services, ext. 5212; Alison Birnie, Clinical Director, ext 3686; or Bobbie De La Rosa, Director, Medical Staff Services, ext. 3778

* 

What to explain to your patient and family

| | |
|----------------------------------|------------------------------------|
| What to expect in their recovery | Specific therapeutic interventions |
| Medication changes | Treatment options |

Hospital HCAHPS Survey Items for Physicians
Physician reimbursement will be affected in the future

"During this hospital stay, how often did doctors treat you with courtesy and respect?"

"During this hospital stay, how often did doctors listen carefully to you?"

"During this hospital stay, how often did doctors explain things in a way you could understand?"

Reference: "Effective communication, or the lack of it, is probably one of the most important factors for patient satisfaction." (Mayo Clinic Proceedings, 2010).
 "Twenty percent of all Medicare patients discharged from hospitals were readmitted within 30 days and 24 percent within 90 days. The Joint Commission rightly believes that improving communication between physicians, as well as between physicians and patients, is a major contributing factor to readmissions." (The England Journal of Medicine, 2008).





A good first impression and effective communication by a physician reduces patient anxiety and sets the stage for the entire patient experience.

| | |
|---------------------------------------|--|
| Patient Centered Communication | Active Listening Behaviors |
| Knock on the door | Listen attentively |
| Introduce yourself | Elicit concerns and calm fears |
| Wash your hands | Answer questions honestly |
| Sit down | Let the patient speak |
| Smile | Demonstrate sensitivity to a patient's cultural and ethnic diversity |
| Show empathy and respect | |
| Shake hands | |
| Make eye contact | |
| Speak slowly | |



The Navigator Program at Huntington Hospital

Background

The Centers for Medicare and Medicaid Services (CMS) Readmission Reduction Program has been established as a requirement of the Affordable Care Act. It has been effective since October 2012. It is a diagnosis-specific program that penalizes a hospital for readmissions to the same or another hospital within 30 days of discharge. The adopted readmission measures are applicable for the following diagnoses: Acute Myocardial Infarction, Congestive Heart Failure (CHF) and Pneumonia. CMS is finalizing the expansion of the applicable conditions for fiscal year 2015 to include Chronic Obstructive Pulmonary Disorder (COPD) and elective total hip and knee arthroplasty.

As a result of the CMS Readmission Reduction Program Huntington Hospital developed the Navigator Program in 2011. The program is now under the department of Care Coordination.

Who is the navigator?

The navigator is a health care professional (social worker, registered nurse or nurse practitioner) primarily involved with the coordination of care of patients both in the hospital and in the community. The navigator:

1. Acts as a liaison between medical personnel, and patients/their families
2. Assists patients with information about the patients' medical conditions and treatments
3. Explores patients' own goals for their health care, their barriers and needs in self-management, the gaps in their care transitions and the challenges healthcare providers, patients and families face in meeting patients' health goals.
4. Communicates patients' needs to the appropriate healthcare professionals.
5. Acts as a patient advocate.
6. Does not replace any existing inpatient roles and functions (care coordination, discharge planning, social work or nursing).

Overview of the navigator program

The 30-day primarily phone-based program focuses on reducing readmissions of patients who have CHF and COPD using standard evidence-based protocols. The navigation of elective total joint replacement patients is in its initial phases of development.

The navigators screen the daily hospital census, identify patients with the above conditions and automatically enroll patients in the program (certain exclusion criteria apply, such as Skilled Nursing Facility (SNF) patients, patients undergoing cancer treatment, patients on hospice). This automatic process is aimed at eliminating the need for referrals from providers and staff.

The navigators assess the patients at the bedside and collaborate with the inpatient team as needed. The navigators' primary role begins with the discharge of patients. They follow up with patients by telephone several times over the course of 30 days. The need for home visits is determined after the initial bedside assessment or first phone call.

High risk patients are assessed and navigated by the Nurse Practitioner. Patients with medical and functional challenges are navigated by the Registered Nurses and patients with primary psychosocial challenges are navigated by the Social Workers. In most cases a multidisciplinary plan of care is formulated. The navigators collaborate with each other and with outpatient care providers as needed.

Efforts are made to provide true patient-centered care. Patient challenges and concerns are communicated to the primary care practitioner (PCP), the appropriate specialists, and other involved care providers. Follow up patient calls are made to reassess and ensure that provider recommendations are being followed.

May 2014 Medical Staff Meetings

| monday | tuesday | wednesday | thursday | friday |
|--|--|--|---|--|
| | | | -1- | -2- |
| | | | - 6:30 a.m. Anesthesia Sct - CR-7 - Noon Trauma Services Committee - CR-5&6 - Noon Medicine Committee - North/South Room | - 7 a.m. Orthopedic Section - CR-5&6 |
| -5- | -6- | -7- | -8- | -9- |
| - 12:15 p.m. OB/GYN Dept - CR-5&6 - 5:30 p.m. Medical Executive - Board Room | | - Noon CME Committee - CR-8 - 12:15 p.m. OB/GYN Peer Review - CR-5&6 | - Noon QM Committee - East Room - 5:30 p.m. Neonatal/Pediatric Surgical Case Review - CR-10 | - Newsletter Submission - |
| -12- | -13- | -14- | -15- | -16- |
| | - Noon Critical Care Section - CR-5&6 | - 10 a.m. PICU/Peds QI - CR-2 - Noon OB/GYN Committee - CR-5&6 | - 6:30 a.m. Anes Peer - CR-7 - 8 a.m. Neurology - Sect CR-8 - Noon PT&D Committee - CR-5&6 - 3 p.m. Neonatal QI - CR-10 - 6 p.m. Bioethics - CR-5&6 | - 7:30 a.m. Spine Committee - CR-11 |
| -19- | -20- | -21- | -22- | -23- |
| - 8 a.m. Emergency Med Section - ED-CR - Noon GME Committee - East Room - Noon Radiology Section - CR-11 | - 7:30 a.m. Interdisciplinary Practice - CR-C - 12:15 p.m. Credentials Committee - CR C - 12:15 p.m. Infection Control Committee - CR-10 | - 7:30 a.m. Cardiology Section - Cardiology Conf. Room - 5:30 p.m. Surgery Committee - CR-5&6 | - 12:15 p.m. Pediatric Committee - East Room | |
| -26- | -27- | -28- | -29- | -30- |
| - Memorial Day - | - Noon General Surgery Section - CR-5&6 - Noon Pulmonary Section - CR 10 | - 12:15 p.m. Endovascular Committee - CR-5 | - Noon IM Peer Rev - CR-6 | |

May 2014 CME Calendar

| monday | tuesday | wednesday | thursday | friday |
|---|---|---|---|---|
| | | | -1- | -2- |
| | | | - 7 - 10 a.m. Trauma M&M, Conf. Room B - Noon - 1 p.m. Thoracic Cancer Conf., Conf. Room 11 | - 7:30 - 9 a.m. Neurosurgery Grand Rounds, Conf. Room 11 - Noon - 1 p.m. Medical Grand Rounds, RSH Topic: Affordable Care Act - Noon - 1 p.m. MDisc Breast Cancer Conf., Conf. Room 11 |
| -5- | -6- | -7- | -8- | -9- |
| - 12:15 - 1:15 p.m. OB/GYN Dept. Mt, CR-5&6 Topic: Fetal Surgery | - 7:30 - 8:30 a.m. MKSAP, Conf. Room A - Noon - 1 p.m. General MDisc Cancer Conf., Conf. Room 11 | - Noon - 1 p.m. Genitourinary Cancer Conf., Conf. Room 11 - Noon - 1 p.m. Radiology Teaching Files, MRI Conf. Room | - 8 - 9 a.m. Surgery M&M, Conf. Room B | - 7:30 - 9 a.m. Neurosurgery Grand Rounds, Conf. Room 11 - Noon - 1 p.m. Medical Case Conference, RSH - Noon - 1 p.m. MDisc Breast Cancer Conf., Conf. Room 11 |
| -12- | -13- | -14- | -15- | -16- |
| - Noon - 1 p.m. Second Monday, RSH Topic: Alcoholism | - 7:30 - 8:30 a.m. MKSAP, Conf. Room A - Noon - 1 p.m. General MDisc Cancer Conf., Conf. Room 11 | - Noon - 1 p.m. Radiology Teaching Files, MRI Conf. Room | - 7 - 8 a.m. Trauma Walk Rounds, Conf. Room B - 8 - 9 a.m. Surgery M&M, Conf. Room B - Noon - 1 p.m. Thoracic Cancer Conf., Conf. Room 11 | - Noon - 1 p.m. Medical Case Conference, RSH - Noon - 1 p.m. MDisc Breast Cancer Conf., Conf. Room 11 |
| -19- | -20- | -21- | -22- | -23- |
| | - 7:30 - 8:30 a.m. MKSAP, Conf. Room A - Noon - 1 p.m. General MDisc Cancer Conf., Conf. Room 11 | - Noon - 1 p.m. Genitourinary Cancer Conf., Conf. Room 11 - Noon - 1 p.m. Radiology Teaching Files, MRI Conf. Room | - 8 - 9 a.m. Surgery M&M, Conf. Room B | - 7:30 - 9 a.m. Neurosurgery Grand Rounds, Conf. Room 11 - Noon - 1 p.m. Medical Case Conference, RSH - Noon - 1 p.m. MDisc Breast Cancer Conf., Conf. Room 11 |
| -26- | -27- | -28- | -29- | -30- |
|  | - 7:30 - 8:30 a.m. MKSAP, Conf. Room A - Noon - 1 p.m. General MDisc Cancer Conf., Conf. Room 11 | - 7:30 - 8:30 a.m. Cardiac Cath Conference, Cardiology Conf. Room - Noon - 1 p.m. Radiology Teaching Files, MRI Conf. Room | - 7 - 8 a.m. Trauma Walk Rounds, Conf. Room B - 8 - 9 a.m. Surgery M&M, Conf. Room B | - 7:30 - 9 a.m. Neurosurgery Grand Rounds, Conf. Room 11 |

Medical Staff Administration

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Medical Staff Leadership

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Newsletter Editor-in-Chief – Glenn Littenberg, MD

If you would like to submit an article to be published in the Medical Staff Newsletter please contact Bianca Irizarry at 626-397-3776. Articles must be submitted no later than the first Friday of every month.



2013 – 2014
Best Hospitals Report

- # 5 Hospital in the Los Angeles metro area
- # 10 Hospital in California
- # 33 Nationally in Orthopedics
- # 44 Nationally in Urology