“You eat what you kill.” This is policy and philosophy that most Providence’s ministries (hospitals) live by. For every dollar we at Tarzana Hospital make, we get to keep 65 cents – half of which (37.5 cents per dollar) is spent by the Medical Staff. A few months ago the Medical Staff formed the Physician Capital Committee, a fifteen member physician committee representing most departments and divisions within the hospital. It is up to this committee to determine which new medical equipment and technologies to purchase for the hospital.

Now, allow me to put on an administrative hat (which I don’t like to do) for a few minutes to state my point. It is imperative that we the Medical Staff make every effort to ensure the hospital remains profitable. We all agree that the government is broke and is trying to find ways to deny payments to doctors and hospitals. This brings me to readmissions, length of stay, and utilization – three key issues which can greatly reduce a hospital’s profits.

1. Hospital Readmissions are in the news. The New York Times wrote “It is one of the biggest avoidable costs on the nation’s medical bill…One in five Medicare patients returns to the hospital within 30 days. Readmissions cost the federal government an estimated $17 billion a year”.

As a result Obama Care contains provisions to reduce Medicare payments to hospitals with high readmission rates.

2. Length of Stay is another troubling factor contributing to economic waste. Each diagnosis or DRG has a specific number of allowable hospital days, beyond which Medicare will deny payments for the extra days. It is estimated that it costs the hospital an additional $200,000 for each 0.1 day increase (beyond allowable) per year.

3. And last but not least, overutilization also leads to significant financial loss. The era of admitting a patient to the hospital and ordering a one million dollar workup is long gone. Repetitive tests (doppler studies, echoes, blood tests, etc.) and extended ICU stays are not reimbursed unless indicated and such indication is clearly documented in the patient’s record. The hospital will ultimately have to eat up the costs.

In summary, despite the government’s actions to reduce payments to hospitals and doctors, together we can ensure the success and prosperity of our hospital with just a few simple modifications. We should be mindful about reducing hospital readmissions, length of stay, and overutilization. These simple measures, if applied without compromising patients’ safety and quality of care, can make us a profitable hospital. In turn, this will allow us, the Medical Staff, to purchase the latest technology in the medical field (PET Scan, new angiogram suite and cath lab, OR lights and anesthesia machines, newborn incubators, colonoscopes, broncoscopes, etc.) to not only remain competitive among LA hospitals, but also better serve our patients and our community.
Quality care, excellent outcomes and patient satisfaction have always been a priority at our hospital, measured and discussed routinely. Now they take on a new level of importance because they are under scrutiny from the government (Centers for Medicare and Medicaid Services), Providence and, in turn, our community.

Our quality, outcomes and patient satisfaction are good in most areas. But now good isn’t good enough. We need to rise to the level of care that meets the standards set by our government (CMS) and the expectations our patients have always had. We need to go from good to great.

This issue of MD Connect gives you some education about Value Based Purchasing and the impact it will have on our organization. In a nutshell, how our patients rate us will determine how we get paid. Today, many of our patients give us 8 out of 10. That seems pretty good, but in the eyes of CMS that score could cost us millions of dollars in revenue. From this point forward we need to achieve 9’s and 10’s.

This is an outstanding organization, and we have been able to have great organizational pride in the work we do. This new system is going to be a challenge for us, requiring a culture change among senior leadership, management, physicians and employees. But I am confident we can do this because I’ve seen us pull together many times to achieve difficult goals, and I know we can work together to make this happen.

To help us get there, we have engaged the Studer Group, a company with a proven track record in this kind of change in hospitals. Some of your co-workers were sent to a conference and returned excited and willing to make the changes. In the coming weeks you will learn more about this program from your manager, and our cover story provides more detail as to why our sustained improvement is so important. Recently we met with the medical staff and they agreed to collaborate with us on this important and needed culture change in our organization. I am very excited about the work we will do together and the increased satisfaction it will bring to not just our patients, but employees and physicians as well.
Value Based Purchasing: Why it is Important

Many of our physicians have been in practice long enough to know that changes in healthcare are happening at a rapid pace. In fact, every aspect of healthcare is evolving and changing so fast that we have to be flexible and willing to adapt quickly, or face consequences that could seriously affect us operationally and financially.

Our senior leadership has been hosting forums and visiting units to educate our employees about a new change in health care that will affect how hospitals get paid based on safety, quality and patient satisfaction scores. This program is called Value-Based Purchasing (VBP).

We have always focused on safety, quality and customer service because it simply is the right thing to do. But now these areas take on a new level of attention because the Centers for Medicare and Medicaid Services (CMS) finds them important as well, and as part of VBP will pay us based on our compliance with measured goals.

As you know, our economy is struggling and the government is looking for ways to save money. Focusing on quality process measures and patient satisfaction in hospitals is a way to do this, because our scores, which now must always be excellent, will determine how we get paid. If we don’t meet the goals set by CMS, we could lose a portion of Medicare reimbursements that can grow to nearly $5 million per year.

This financial loss would have serious consequences to us because it affects our ability to reinvest in our human and capital resources. Therefore, we need to put our attention on improving areas where we can go from being good to great, and that means holding each other accountable to always do the right thing.

Because how our patients rate us will determine how we get paid, one area of focus is customer service, which is measured through both Press Ganey patient surveys and Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS). However, HCAHPS will be the tool of choice the Centers for Medicare and Medicaid Services (CMS) will use to set target goals that we must meet in order to be reimbursed for our services.

We have tried different approaches to improve our service scores, and have seen positive results, but none that have been sustainable. We must see improvement and it needs be everlasting. To help us get there, we are partnering with the Studer Group, a company with a proven track record on organizational change.

Together we will focus on the following goals:
• Alignment of action and accountability in all that we do
• Focus on outcomes and execution
• Providing “evidence-based” tactics to drive results
• Training and development to help us achieve our full potential
• Improve customer service

To achieve these goals, our employees will spend more time with their managers, who will focus in on key areas of improvement. Our leaders themselves will be taking development courses so they have the appropriate tools to ensure successful outcomes. Leadership will increase their regular rounds to ensure the needs of our employees and the expectations of our patients are being met.

(Continued on back cover)
Colorectal Cancer Care at Providence Tarzana

A seamless patient experience is the goal of the colorectal cancer care team at Providence Tarzana Medical Center. Our highly-trained multidisciplinary team has many years of experience in the prevention, screening, diagnosis and treatment of colon and rectal cancer. All aspects of care are provided to your patients with the highest levels of both expertise and compassion.

One of our program highlights includes newly added ultrasound technology, allowing our board-certified colorectal surgeons to stage rectal cancer, adding a level of diagnostic accuracy previously unavailable. We are the only hospital in the Valley with this technology.

Additionally, our dedicated nurse navigator will be there for your patients to coordinate, explain and ease their way through the entire continuum of care.

SERVICES

Prevention/Screening
- Colonoscopy
- Sigmoidoscopy

Education
- Individualized education from RN Navigator
- Community lectures
- CME’s
- Dedicated Tumor Board
- Cancer and ostomy support groups

Staging
- Ultrasound staging of rectal cancer prior to treatment
- Pathologic staging of colon and rectal cancers
- Pre-operative biopsy evaluation
- Post-operative staging

Treatment
- Neo-adjuvant therapy
- Radiation and chemotherapy for rectal cancer prior to surgery

- Laparoscopic and traditional colon and rectal surgery
- Adjuvant therapy
- Chemotherapy for colon and rectal cancers following surgery

Complete Ostomy Care
- Pre-operative stoma site marking and education by board-certified ostomy nurses
- Inpatient ostomy education & support
- Home health ostomy services (in partnership with Providence Home Care)
- Follow-up appointments at PTMC Wound & Ostomy Clinic

Research
- Participation in national clinical trials

For more information, or to contact our Nurse Navigator, Desirée DiMichele, RN, CWOCN, please call (818) 757-8826.
Far more than simply an information technology or medical records initiative, the federally mandated conversion of all HIPAA-covered entities to ICD-10 in two short years (October 1, 2013) will be complex and costly for all concerned. Consider the following challenges for providers:

- An eight-fold increase in the number of diagnostic (inpatient and outpatient conditions) and in-patient procedures, going from a combined total now of 18,000 - 144,000. For example, in the new ICD-10 diagnosis codes (ICD-10-CM) alone:
  - 50% are related to musculoskeletal system specificity
  - 36% are used to distinguish laterality

- With the granularity and specificity required for ICD-10, a complex one-to-many, many-to-many, or even many-to-none mapping will result for diagnoses and in-patient procedure selections used today. A one page ‘super-bill’ used by a physician’s office currently could easily translate to ten or more pages (depending upon specialty).
  - Paper-based billing practices could therefore become very unwieldy and necessitate the purchase and installation of automated solutions if an EMR has not been installed.

- Between staff training, revision of forms, process changes, IT costs, and the disruption to cash flow, an AMA-commissioned study estimated the following costs related to ICD-10:
  - Small practice (3 docs/2 office staff) = $83,290
  - Medium practice (10 docs/1 coder/6 office staff) = $285,195
  - Large practice (100 docs plus coding staff plus 50+ office staff) = $2.7M
  - No reimbursement of these expenses is available from the ARRA funds that promote the installation of electronic medical record systems.

- Readiness requirements earlier than Oct. 1, 2013 are starting to surface as other entities prepare for the cutover. The National Council for Prescription Drug Programs (NCPDP), for example, has recommended that physicians start using ICD-10 codes on prescriptions beginning March 1, 2013 (to avoid disruption with medication refills).

- Although CMS has emphatically stated that the October 1, 2013 launch date requiring ICD-10 codes for claims submission will not be rolled back because it is tied to CMS payment reforms, other payers may choose to change from ICD-9 to ICD-10 codes until a later date. Thus, a significant burden will placed on a practice to bill each payer with the appropriate codes (either ICD-9 or ICD-10) and then be able to switch to ICD-10 when each payer requires that methodology.

- There is much to do, and time is ticking
The following revisions and/or additions have been made to the Medical Staff Bylaws:

Recommendation was made to add to the Delineation of Privileges for OB/GYN – Ferning Credentialing Criteria: Physicians wishing to perform Ferning in Labor & Delivery need to demonstrate competency prior to the granting of the privilege and annually thereafter. Competency is demonstrated by satisfactorily completing the written examination given by the Medical Staff Services Department. Evaluation of the examination will be performed by the Physician Director of Pathology. Documentation of such is maintained in the physician's credential file for evaluation at the time of reappointment in order to determine competency.

ESSURE Competency: ESSURE Hysteroscopic Tubal Sterilization criteria: (1) Completion of a didactic training and laboratory course and submission of proof of completion (certificate) to the Medical Staff Services Department, and (2) Successful completion of observation of a minimum of three (3) cases either by a physician currently utilizing the equipment or a certified manufacturer’s representative. (Documentation of observation will be maintained in the physician’s credential file). The wet lab must be done on the date of the procedure as part of the observation by the physician or certified manufacturer’s representative.

UROGYNECOLOGIC PROCEDURES (VAGINAL/APICAL SUSPENSION AND USE OF GRAFTS AND MESH)

Physicians requesting Urogynecologic procedures must satisfy the following criteria: Certificate of completion of preceptorship training in vaginal support systems with use of specific grafts or mesh for pelvic prolapsed and subsequently satisfactorily complete six proctored cases.

OTHER IMPORTANT MEDICAL STAFF INFORMATION:

1. Length of Stay information is being reviewed as part of OPPE and reappointment. This is now possible given new systems that are in place.
2. Reminder: All orders must be signed, dated and timed within 48 hours
3. Reminder: In order for a DNR/DNI to become effective, there must be documentation in the medical record that a discussion has occurred.

We recently added more content to the physician portal of Providence Tarzana Medical Center’s website. When you visit the site, you will now be able to access the following information:

- Medical Staff Services Contacts
- Medical Staff Bylaws
- Medical Staff Rules/Regulations
- Roster
- MD Connect Newsletter
- Medical Staff Calendar
- CME Calendar
- Pharmacy News

It is easy to access. Simply log onto your computer and type www.providence.org/tarzana into your web browser and you will arrive at our home page (see image). Then click on the physician tab in the top right corner and it will you take you right to the tabs for the content listed above.
### Real Estate for Rent or Lease

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<td>Call Sandra at (818) 342-1515</td>
<td>free patient parking</td>
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### Appointments

The following physicians were appointed to the Medical Staff:

- **Janet Horenstein, M.D.**  
  Maternal Fetal Medicine
- **David Bliss, M.D.**  
  Pediatric Surgery
- **Amer Vokshoor, M.D.**  
  Neurosurgery/Spine Surgery
- **Linda Barkodar, M.D.**  
  Internal Medicine
- **Shaftq Cheema, M.D.**  
  Pediatric Intensive Care
- **Peter Chung, M.D.**  
  Pediatric Surgery
- **Jeffrey London, M.D.**  
  Internal Medicine
- **Ragu Nathan, M.D.**  
  Teleradiology
- **Luis Ochoa, M.D.**  
  Neonatology
- **Dan Streja, M.D.**  
  IM/Endocrinology
- **Stephen White, M.D.**  
  IM/Rheumatology
- **Benjamin Yashare, M.D.**  
  Internal Medicine
- **Thomas Graham, M.D.**  
  Emergency Medicine
- **Jeanette Mastrullo, M.D.**  
  Plastic Surgery
- **Francoise Menteer, M.D.**  
  Internal Medicine
- **Mark Sobers, M.D.**  
  Internal Medicine
- **Robert Yaman, M.D.**  
  Internal Medicine
- **Raluca Arimie, M.D.**  
  Cardiology
- **Reza Orakzai, M.D.**  
  Cardiology
- **Deana Attai, M.D.**  
  Breast Surgery
- **Mohammed Iqbal, M.D.**  
  IM/Non-Admitting
- **Nader Javadi, M.D.**  
  Hematology/Oncology
- **Adam Richards, M.D.**  
  Medicine
- **Munaf Kadri, M.D.**  
  Neonatology
- **Roy Ayalon, M.D.**  
  OB/GYN
- **Dean Allgeyer, M.D.**  
  Anesthesiology

### Resignations

- **Esfandiar Esfandiard, M.D.**  
  Internal Medicine
- **Michelle Oliver,**  
  Nurse Practitioner
- **Janet Salomonson, M.D.**  
  Plastic Surgery
- **Tracy Gijsbeke, M.D.**  
  Pediatric Surgery
- **Marta Bill, PA.**  
  Physician Assistant
- **Paul Milberg, M.D.**  
  Plastic Surgery
- **Marcie Kamman-Varec, MSN, NNP**  
  Neonatal Nurse Practitioner
- **Alex Gitelman, M.D.**  
  Orthopedic Surgery
- **Larry Rosen, PA.**  
  Physician Assistant
- **Mi Chang, M.D.**  
  Nephrology
- **Mona Sanghani, M.D.**  
  Radiation Oncology
- **Jeffrey Meier, D.O.**  
  Orthopedic Surgery
- **Bruce Ascough, M.D.**  
  Plastic Surgery
- **James Stein, M.D.**  
  Pediatric Surgery
- **Moshe Wilker, M.D.**  
  Orthopedic Surgery

### Deceased

- Alex Michaelson, M.D.
The ever-changing healthcare environment is requiring all hospitals to be accountable, forcing many to change a culture that has existed for many decades. “Because we have always done it that way” is something we hear often, but will no longer apply. Change requires us to be nimble and accept new ways of doing things. Change encourages open minds and attitudes, because unwillingness to learn new approaches is certain to result in failure.

We all know the benefits of working together, and will continue to do so to ensure high quality, safety and customer service at all times. This guarantees we will be paid appropriately for services we provide to our patients, but most importantly providing this level of service has always been, and will always be the right thing to do. We look forward to achieving great results with all of you!

**Value Based Pricing**
(Continued from page 3)

**MEC Votes on 2012 Capital Expense Allocation**

The Medical Executive Committee reviewed the 2012 capital requests and voted on the following items, totaling $1.3 million:

- OR Tables
- C-Arm Surgical
- Motorized Cart for Bedside Procedures
- Fluid Containment System
- Laryngoscope
- Bronch Scopes
- Horseshoe Headrest
- Vascular Access Monitor
- ACT Machine
- Spyglass
- Flexible Scope
- GI Scope
- Anesthesia Machines
- Glidescope
- Fluoro Table
- Heartlab PACS System
- Portable XRay Unit
- Incubator Transport
- Tonopen (ED)
- AV Equipment
- Autodialer
- Wand (RFID)
- Auditorium Dimmer System
- Pediatric 3D Echo
- Bladder Scanner
- Medical Air Compressor Replacement
- Emergency Power Generator
- Boiler Tank Replacement
- Central Station Upgrade