



*Sutter Medical Center,
Sacramento*

A Sutter Health Affiliate

SMCS Physician

Message from Tom Gagen, CEO

June 2008

During our Hospital Week barbecues for staff and physicians last month, we created a passport event titled "SMCS: Building Toward the Future" that was toured by hundreds of our employees. I was very happy to see a number of physicians who also enthusiastically explored the virtual site and were excited to see what is planned and how the Master Site is taking shape.

The virtual tour included six two-sided, 7-foot-tall boards detailing the plan and décor for each floor of the three clinical buildings: the Sutter Medical Foundation Building currently under construction; the remodeled Sutter General Hospital, to be renamed the Ose Adams Medical Pavilion; and the Anderson Lucchetti Women's and Children's Center, which will break ground Oct. 13.

I hope you are as excited as I am about the upcoming campus. Our Master Site team worked with physicians, nurses and other clinicians and did their research on future technologies to ensure that, when the new campus opens in 2011, it was built for the future and not just the present.

Every month inside our employee newsletter, Insights, we have a page titled "Construction Zone" that highlights aspects of the Master Site and gives construction updates. Physicians who have access to the SMCS Intranet site can view the issues at <http://smcs.sutterlink.net/news/insights/>. Hard copies are also available at locations throughout our campuses, including the physician lounges. I encourage physicians to check out this page monthly and feel the excitement experienced daily by those who work at Sutter General Hospital and the Buhler Building.

Also, on the Internet and available to the public, you can view a time-lapsed camera of the SMF Building being constructed. You can see what the building looks like today, or any day in the past year. Or, click on "time lapse" and view the shots in fast motion to see the progression of the building from when it was just a gigantic dirt hole. You can connect to the Web page by going to www.suttermedicalcenter.org/expansion/ and click on the link at the right that says, "Check out our medical campus construction project web camera."

Sutter Health has made a \$665 million commitment to the grandfather of the system, Sutter Medical Center, Sacramento. I want to assure our physicians that the project is being constructed with a focus on you and our other clinicians, our patients and the even the entire community. It will be a medical community of which you will be proud.

If you have any questions or concerns about the project, please don't hesitate to call me at 733-8999; Larry Maas, the assistant administrator over the Master Site, at 454-6865; or Director of Patient Care Planning Cindy Banta, R.N., at 454-6820. We appreciated your comments over the years as we planned this project and we look forward to working together to make "the medical center of the future" a reality.

SMCS Welcomes New Medical Staff Members

Cesar K. Ang, M.D.

Midtown Internal Medicine Group
5025 J St., Suite 201
Sacramento, CA 95819
(916) 452-7256
Specialty: Internal Medicine

Deborah A. Chong, M.D.

Healthcare for Women
7601 Hospital Drive, Suite 220
Sacramento, CA 95823
(916) 689-3433
Specialty: Obstetrics and Gynecology

Vicki P. Duong, M.D.

Tri-River Pediatrics
7240 E. Southgate Drive, Suite D
Sacramento, CA 95823
(916) 428-8134
Specialty: Pediatrics

Michael J. Murray, M.D.

1130 Conroy Lane, Suite 100
Roseville, CA 95661
(916) 773-2229
Specialty: Reproductive
Endocrinology

Shayesteh Pashaei, M.D.

3301 C St., Suite 200-E
Sacramento, CA 95816
(916) 446-0424
Specialty: Pathology,
Dermatopathology

Scott C. Yu, M.D.

Sutter Emergency Medical
Association
2100 Powell St., Suite 940
Emeryville, CA 94608-1803
(888) 883-7362
Specialty: Emergency Medicine

Michael S. O'Mara, M.D.

5901 River Oak Way
Carmichael, CA 95608
(916) 423-3255
Specialty: Surgery, General (Surgical
Hospitalist)

Medical Executive Committee Report

On behalf of the medical staff, the Medical Executive Committee approved a donation of \$2,500 to the Nursing Scholarship Program at Sutter Medical Center. For many years, the medical staff has been supporting this program, which has helped numerous nurses obtain their nursing education. The nurses are very appreciative of the support by the medical staff.

Emergency Preparedness Events and the Effect on Physicians

Physicians at SMCS play a very important role during a period of officially declared emergency in which the emergency management plan has been activated. In the coming months, This monthly newsletter will include a review of the physician's role during a disaster and also review the emergency management code system used at SMCS. Let's start with the physician's role during a disaster such as an earthquake, plane crash, terrorism event, etc.

Physicians would report to the hospital where you are on call or to the closest facility where you have privileges. If you are unable to reach a facility where you have privileges, go to the closest hospital, but make sure you bring proof of licensure so emergency credentialing can be conducted.

- **Emergency room physicians**, or those with **military triage experience**, would most likely be assigned to the Triage Area and Immediate Treatment Area.
- **Surgeons** would be assigned to the OR to treat patients who need emergency surgery. Remember, trauma patients will also be arriving at non-trauma facilities.
- **All other specialties** will most likely be utilized to evaluate current patients for potential discharge or transfers to a lower level of care. You could also be assigned to treat patients with minor to moderate injuries.

Here are some important acronyms to know about the emergency management system.

HEICS: Hospital Emergency Incident Command System
SPI: (Your personal roles in disaster)
Safety First – Yours, Then Others
Plans – Follow the Plan
Instructions – Follow Instructions

If you have any questions about SMCS' response to a disaster or terrorism event, feel free to contact the Emergency Preparedness Coordinator Loni Howard, R.N., MSN, at 916-733-8579 or by e-mail at HowardL@sutterhealth.org.

Continuing Medical Education

Due to vacation schedules in the month of June, the Medical/Surgical Grand Rounds won't be held on June 20 at Sutter Memorial Hospital. The next Medical/Surgical Grand Rounds will be held on July 18 at 12:15 p.m. at the Sutter General Hospital campus.

Don't forget to go to <http://suttermedicalcenter.org/forourphysicians/> to access the entire June CME Calendar. There are several case conferences scheduled throughout the month.

A Brief History (and Future) of Medicare Reimbursement

By Rob Schott, M.D.

SMCS Director of Medical Affairs

On Oct. 1, 1983, there was a seismic shift in the way the government paid hospitals for care of the elderly. Medicare replaced a fee-for-service, cost-based hospital reimbursement scheme with the Prospective Payment System (PPS). The intent was to control publicly funded healthcare expenditures, which grew an average of 19 percent annually from 1979 to \$32.9 billion for inpatient hospital care in 1982. (The expenditures have further grown to \$432 billion in 2007, which is 3.2 percent of the GDP, and is expected to grow to 11 percent of GDP in 75 years.) In the new scheme, hospitals were paid a fixed amount per patient discharge. Reimbursements were based on Diagnosis Related Groups (DRGs), a classification of illness categories identified in the International Classification of Diseases, Ninth Revision. Each of the distinct groupings is considered to be "medically meaningful," that is, all patients in the same DRG are expected to display a set of clinical responses, which will, on average, result in equal use of hospital resources.

On Oct. 1, 2007, a significant revision of the 1983 payment system took effect, with the replacement of the "old" DRG system (with 583 diagnosis-related groupings) with the new severity-based DRG system (Medicare Severity, or MS DRG) expanding to 745 groupings. There are three sub-groupings in the new scheme, depending on Complications or Comorbidities ("CC"): Major CCs, CCs and No CCs. The DRG weights are based on hospital costs, not charges.

Why?: There are several reasons for the overhaul, but central to the change is the need to improve quality and contain cost. In the old system, complications meant more reimbursement with higher-level DRGs. In the new system, certain hospital-acquired complications will no longer lead to a higher DRG payment. Those conditions include: objects left in during surgery, air embolism, blood incompatibility, catheter-associated urinary tract infection, hospital-acquired pressure ulcers, vascular catheter-associated infection, mediastinitis after coronary artery bypass graft surgery, and hospital-acquired injury – which include fractures, dislocations, intracranial injuries, crushing injuries and burns. This completes a tack away from DRG weights based on charges toward a system based on quality and costs, as CMS struggles to slow the growth in hospital spending. CMS recognized that under the old system of reimbursement, the consequences of poor care (i.e. hospital-acquired complications) were rewarded. No more. After Oct. 1, 2008, CMS will no longer pay, at a higher DRG, for these complications that are not present on admission. And although the proposal is budget-neutral, CMS plans to cut the reimbursement to hospitals by 1.2 percent in 2008, with further cuts in 2009 and 2010.

Physician's Role: Physician documentation, always important, is essential to capturing the illness complexity for any given hospitalization. The chronicling of the patient's hospital course, and particularly the presence of comorbidities, is an essential duty of the physician. Coders code based on our diagnoses, and if there is uncertainty, they may be asking us for clarification either through sticky notes in the chart or with a call. The completeness (and correctness) of our documentation is mission critical on multiple levels: Joint Commission accreditation, mortality risk adjustment and reimbursement, but to name a few.

I have some specific documentation recommendations (based on the new MS DRG classification scheme):

- Specify the principle reason for hospitalization and fully describe comorbidities that affect the hospital course and the length of stay.
- Specify whether an illness is acute vs. chronic.
- Use accepted abbreviations (instead of a down arrow and a K+, write "hypokalemia," or inc. BS is "diabetes").
- (As always) write legibly! (Randomly sample a few charts next time you're on the floor or in medical records.)

To illustrate some of the complexity of the new system, we can look at the changes in heart failure DRGs. Under the old system, we had one diagnosis code (428.0) to describe heart failure. Under the new system, there are at least 19 new heart failure codes. To capture the complexity of this common diagnostic category obviously requires a higher level of documentation by physicians and can be problematic for the coders.

In the Long Run: To quote English economist John Maynard Keynes, "In the long run, we're all dead." And if we can't fix the Medicare financing arrangements, we won't get much care before we check out. Social Security's current annual surpluses of tax income over expenditures will begin to decline in 2011 and then turn into rapidly growing deficits as the baby boom generation retires. Medicare's financial status is even worse. This year, Medicare's Hospital Insurance (HI) Trust Fund is expected to pay out more in hospital benefits and other expenditures than it receives in taxes and other dedicated revenues. The difference will be made up from general revenues, which pay for interest credits to the Trust Fund. Growing annual deficits are projected to exhaust HI reserves in 2019 and Social Security reserves in 2041. In addition, the Medicare Supplementary Medical Insurance (SMI) Trust Fund that pays for physician services and the prescription drug benefit will continue to require general revenue financing and charges on beneficiaries that grow substantially faster than the economy and beneficiary incomes over time. Because this growth cannot be sustained, we can expect more changes in the years ahead.