Reforming America’s health care system remains one of the top issues for voters in this election cycle. The presidential candidates have listened, and each has proposed their own plans to tackle this monumental task. At this juncture the plans put forth by the candidates tend to be rather broad “shells” that lack the specific details needed to truly analyze and accurately determine their costs and the impact they would likely have. As would be expected, the devil is in the details.

In my last article, I laid out the basic arguments for and against universal health care. This issue will attempt to compare the health care reform proposals put forth by the three remaining presidential contenders so that the plans can be compared side-by-side and hopefully provide some much-needed clarity for this amazingly complex issue.

The information below is gleaned from the candidates’ websites and supplemented by speeches they have delivered on the topic, campaign debates and news reports. This is an overview of their plans - the 30,000 foot view. I will summarize the salient points as best as I can but encourage the reader to research further on their own.

From a physician’s perspective, I feel that this single issue has the greatest impact on our (and our patients’) futures - more than the war on terror, the economy, taxes, or immigration reform. So, with that introduction, the following are the top 10 health care reform topics you’ve been dying to ask the candidates about.

1) Overall goal for health care reform:
   - **Hillary Clinton**: Provide affordable universal coverage through a mix of public and private insurance, expand public insurance.
   - **Barack Obama**: Same as above.
   - **John McCain**: Allow access to affordable health care by paying only for quality care, having diverse insurance choices that are determined by individual needs, encourage personal responsibility. Leverage competition among private sector to effect reforms.

2) Approach to expanding access to coverage:
   - **Hillary Clinton**: Provide affordable universal coverage through a mix of public and private insurance, expand public insurance.
   - **Barack Obama**: Same as above.
   - **John McCain**: Allow access to affordable health care by paying only for quality care, having diverse insurance choices that are determined by individual needs, encourage personal responsibility. Leverage competition among private sector to effect reforms.

3) Requirement to obtain coverage:
   - **Hillary Clinton**: Individuals must have health insurance, large employers must provide coverage or contribute to the cost of coverage, small employers not required to provide coverage but are given incentives to do so.
   - **Barack Obama**: Require all children to have health insurance, require employers to provide “meaningful” coverage or contribute a percentage of payroll towards the public plan.
   - **John McCain**: No provision, opposes mandates for coverage.

4) Premium subsidies to individuals:
   - **Hillary Clinton**: Refundable tax credit for families set to ensure that premiums could not exceed a fixed percentage of family income.
   - **Barack Obama**: Federal subsidies (income-based) to help individuals purchase the new public plan or another qualified insurance.
   - **John McCain**: Provide a tax credit of $2,500 for individuals or $5,000 for families to purchase insurance. Require states to develop a financial “risk adjustment” bonus to supplement tax credits for high-cost and low-income families.

5) Premium subsidies to employers:
   - **Hillary Clinton**: Federal subsidies would partially reimburse employers for health care costs if employers guaranteed savings would be used to reduce employee premiums.
   - **Barack Obama**: Refundable tax credit for small businesses as incentive to offer coverage (except high-income small business). A “retiree health legacy initiative” would provide a tax credit to employers who provide retiree health benefits.
   - **John McCain**: No provision.
6) Changes to private insurance:

**Hillary Clinton**: Prohibit denial for pre-existing conditions, prevent “unjustified” premium increases, require insurers to disclose the percentage of premiums going to patient care and administrative costs, allow children to be on parents’ plans up to age 25, require insurers to pay out a “reasonable share” of premiums on benefits in low competition areas.

**Barack Obama**: Require insurers to guarantee issue and renewal, mandate preventative services and chronic disease management and meet a minimum loss ratio to ensure high value. Prohibit insurers from stratifying premium cost based on age, gender, occupation or risk of developing disease.

**John McCain**: Promote competition by allowing insurance to be sold across state lines, allow small business and self-employed ability to purchase insurance from any organization or association that would be portable and bridge the time between retirement and Medicare eligibility.

7) Proposed tax changes related to health insurance:

**Hillary Clinton**: Employer-provided health premiums would remain exempt from income tax except for those earning over $250,000/year.

**Barack Obama**: No provision.

**John McCain**: Tax code reform that eliminates the bias toward employer-based insurance. Expand health care saving accounts (HSA), allow cheaper multi-year policies.

8) Cost containment:

**Hillary Clinton**: The 7-Step Strategy to Reduce Health Costs
- A national prevention initiative
- “Paperless” information technology system
- Elimination of insurance discrimination to reduce administrative cost
- Chronic disease management coordination
- Develop an independent “Best Practices Institute” to help w/ consumer choices
- “Smart Purchasing” initiatives to allow negotiated prices for prescription drugs, limit direct-to-consumer advertising, change patent laws to increase availability of generic drugs
- link medical error disclosure w/ physician liability protection

**Barack Obama**: Invest $50 billion in IT, promote prevention and chronic disease management, pay Medicare Advantage plans the same as traditional Medicare, require hospitals to report cost and quality data, promote generic drug production, allow drug re-importation, repeal the ban on direct drug price negotiation between Medicare and the drug companies, promote insurer competition through the national “Health Insurance Exchange” and by regulating the percentage of the premium that must be paid out in benefits.

**John McCain**: Adopt medical malpractice reforms that limit frivolous lawsuits and excessive awards and provide safe harbors for practice within clinical guidelines, promote competition among providers by paying only for “quality” and encouraging use of alternative providers and treatment centers (e.g. NP’s, retail outlet clinics), require drug companies to reveal drug prices, allow re-importation and faster introduction of generics, permit nationwide sale of health insurance, invest in prevention and chronic disease management, increase consumer information regarding treatment options through greater “transparency” regarding medical outcomes.

9) Improving Quality and Efficiency:

**Hillary Clinton**: Invest in “Best Practices Institute” and increase federal payments for excellence in care, prohibit payments for treatment of avoidable medical errors, provide federal recognition to physician-driven maintenance of certification (MOC) programs to keep providers up-to-date, fund web-based tools to provide consumers with information on provider performance.

**Barack Obama**: Develop an independent institute to monitor provider effectiveness and require reporting of preventable medical errors, reward provider performance through the National Health Insurance Exchange, promote preventative care and chronic disease management, require health plans to collect, analyze and report quality data and price transparency and “hold the plans accountable”.

**John McCain**: Change provider payments to encourage coordinated care (e.g., single bill for high quality in a given DRG rather than individual services), deployment of a health IT system, require transparency from providers regarding outcomes, quality and cost, bar Medicare payments for preventable errors or mismanagement, establish national standards for measuring and recording treatment and outcome data, deploy “telemedicine” where cost-effective in rural and underserved areas.

10) Financing:

**Hillary Clinton**: Estimated cost is $110 billion/year. $54 billion will come from limiting the tax exclusion for employer-paid health insurance and elimination of the Bush tax cuts, $35 billion will come from savings due to the modernization and quality initiatives, $21 billion will come from Medicare private plans, recapturing Medicare/Medicaid payments to hospitals for the uninsured, and constraining prescription drug costs.

**Barack Obama**: Estimated cost $50-65 billion/year. Expects much of the financing will come from savings within the system and additional revenue through the elimination of the Bush tax cuts.

**John McCain**: Not yet specified but suggests that cost containment measures would make insurance more affordable.

This is what we have to work with so far. As you can see there is a lot of “blue sky” in these proposals and not a lot of detail - where the devil usually hides. I encourage you all to stay abreast of this issue because of the obvious profound effect these reforms may have. I want physicians to be informed, out-front, vocal and taking the lead on this issue so that politicians and bureaucrats won’t be the ones to define our profession. The next few months should be interesting. Get in the game!
Through months of work, analysis and input, St. Joseph’s is developing a strategic plan that will be used to guide our decisions through the year 2011. Because of your importance as a member of our team, I want to invite your input into the discussion.

*St. Joseph’s Hospital and Medical Center is a Catholic teaching hospital driven to deliver an exceptional patient experience. With an academic emphasis, we relentlessly strive to maintain excellence and uniquely integrate the best practices from clinical medicine, education and research.*

St Joseph's will remain committed to its mission and plans to fulfill this commitment by:

- Delivering medical services
- Strengthening our leadership position in the community and nation
- Engaging all of our physicians
- Diversifying ambulatory services

All of these goals will be extremely important in the future for the patients we serve. Particularly important to you is our goal of physician engagement. You are crucial to delivering medical care to our patients. We are committed to strengthening our working relationship with you.

To that end, members of our leadership team want to involve you in our discussion about how we can better serve your needs. If you would like to meet with someone from St. Joseph’s Administration, please call Charles Alfano, M.D., Vice President of Medical Affairs, at 602-406-4095 and a meeting time will be scheduled with the appropriate leaders.

We look forward to meeting with you and working together to make St. Joseph’s a hospital that continues to offer outstanding care and services.

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**Doctors’ Day – 2008**

We’re celebrating you twice! Please join the festivities!

**On Monday, March 31**
**At the General Medical Staff Meeting**
5:30 pm - Cocktails
6:00 pm – Dinner/Business Meeting
Marley Lobby
(Just outside the Leonard Goldman Auditorium by 3rd Ave
Valet parking available at 3rd Ave, north of Thomas Road)

**On Tuesday, April 1**
6:30 – 9:30 am
Physicians’ Lounge
Made-To-Order Omelets
2008 Goals:

**Communication**
Administration is attempting to improve communication with a number of initiatives. Some of the current communications include:

- Medical Staff Newsletter (quarterly – moving to monthly)
- Physicians’ Update (monthly)
- Chief of Staff (MEC) Summary (monthly)
- Surgery & Anesthesiology Department Newsletters (monthly)
- Lunch with Linda Hunt (CEO) in the Lounge (monthly)
- VPMA/CMO meeting updates/Administrative Reports (weekly)
- Legislative Update blast faxed & emailed
- Flyers & news articles distributed in the lounge (daily)

**Engagement - Relationship Building**
- Administrative/Medical Staff Leadership meetings (weekly)
- Administrative/Medical Staff Leadership/Community Physician meetings (daily)

**Education**
- Dr. Brian Campion, St. Thomas University (leadership sessions to be announced)
- Studer Group webinars (approximately quarterly)
- Medical Executive Committee Retreat speakers (annually)
- Academic Chairs Leadership offerings

I would be happy to address any issues or concerns that you have. You may contact me at 602-406-4095.

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**Parking in the 3rd Avenue Garage**

We have received many complaints about parking in the 3rd Ave garage. Unfortunately, we are significantly underserved with regard to adequate parking for physicians. The following are measures that hopefully will help to some extent. 1) Residents who park in Medical Staff spaces are being identified by Dr. Daschbach and appropriately dealt with. 2) I periodically review the reserved spaces with Chris Bellino, our Security Manager, and eliminate or reassign those spaces that are not occupied by appropriate individuals. I would suggest for those who can't find parking, especially around mid-day, that you valet your car at the Barrow entry and the valet can validate your parking with your ID badge. I hope these options will help. When other solutions become available, I will keep the Medical Staff informed.

Charles A. Alfano, M.D.
VPMA
CLINICAL DOCUMENTATION IMPROVEMENT PROGRAM

What is it?
The Clinical Documentation Improvement Program (CDIP) is a collaborative project between the Catholic Healthcare West (CHW) Corporate Care Management Group and Corporate Coding HIM Compliance Department. This program is based on the premise that having clinical documentation that accurately reflects the severity of patient conditions and acuity of care provided, the accuracy of clinical outcomes, public reporting and hospital revenue will appropriately improve.

Background
The quality of health care today is being graded and publicly reported. These grades are most often based upon administrative and financial data from hospital claim forms. The absence of clinical documentation adversely affects the administrative data received by an ever-growing number of accreditng bodies, proprietary web-based companies and employer groups, that use the data in the development of public reports. Internal clinical audits performed by the CHW Corporate Coding HIM Compliance and Care Management teams have identified significant opportunity for improvement in administrative data, due to the lack of clinical documentation resulting in inaccurate or inadequate coding, patient severity assignment, and reimbursement opportunities.

The clinical and coding documentation specialists here at SJHMC will be including a focused documentation tip in each future newsletter to assist you in understanding and impacting areas where documentation can be improved and make a difference. Please review the tips and feel free to contact the documentation improvement specialists with any questions. You may also call if you would like for them to speak with you or group about improving documentation.

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Documentation Tip # 1

Documentation tips forms (bright pink) are being placed in front of the progress notes section of the charts to assist you in capturing many of the frequently missed diagnoses. This form is a tool for you and can be used by:

- Checking the boxes with all of the appropriate diagnoses for your patient
  - Be sure to sign and date it so that coders can code from it.
  - Physicians (including residents), Nurse Practitioners, and Physician’s Assistants can all document on and sign the form.
- Referring to the form for accurate and complete diagnosis wording in your progress notes

Using accurate and complete diagnoses will help to reduce queries left for you by the documentation specialists and case managers. If the documentation tips form is not in the chart, the Health Unit Coordinators should have copies for you.
RR6.6 Stop Orders Amend this section to note that all orders expire after 12 months.

RR 6.2 Standing Orders
The Committee discussed Standing Orders and the concern that some had about noting the standing orders in each patient’s medical record. It was determined that the existing language appropriately addresses the need to include any Standing Orders in the individual Medical Record.

RR 6 Orders
6.1 General Requirements
It was noted that there is a requirement to re-write orders when there is a change in level of care. It was recommended to amend the Medical Staff Rules and Regulations regarding Orders to reflect that requirement.

RR 7.5 Operative handwritten note and dictated report
Operative handwritten note: To communicate the patient’s status and surgical/procedural outcome to other caregivers, an initial operative or procedural note that contains, the date, surgeon, assistant surgeon, pre-operative diagnosis, post-operative diagnosis, procedure, findings, complications, specimens and estimated blood loss shall be documented (handwritten) by the surgeon/physician immediately following the surgery/procedure. The use of abbreviations is discouraged.

Operative dictated report: In addition, most operative or procedural notes require additional detail. A dictated report (for inpatients and outpatients) shall be dictated immediately following the procedure. The dictated report shall include all required elements listed above and should be authenticated promptly with date, time and signature. Failure to dictate an operative or procedure report within 7 days of the procedure may invoke the Automatic Suspension process defined in the Medical Staff Bylaws.

RR 7.7 Progress Notes
Daily ICU Visits The current ARS R9-10-220 requires that all ICU patients be seen daily by a physician. The Medicine Department Rules and Regulations have had that requirement for some time but did not address the surgical ICUs. It was recommended that the daily physician visit to all ICU patients be included in the Medical Staff Rules and Regulations.

Progress notes shall be recorded at the time of observation sufficient to permit continuity of care and transferability. They shall be dated, authenticated and clearly and legibly written. Whenever possible, each of the patient’s clinical problems should be clearly identified in the progress notes and correlated with specific orders as well as results of the tests and treatment. Progress notes must be recorded at least daily by the attending physician or his designee, which may include House Staff with appropriate supervision or review by the attending physician’s department. Progress notes by Medical Students do not suffice. Exception to requirement for daily progress note: Patient’s condition is determined to be medically stable for discharge within twenty-four hours, as documented by the attending physician.

ICU patients must be seen at least once daily by a physician, and progress notes must be written daily by a physician or his designee. AAC- R9-10-220

Intensive Care Services
“Who Ya Gonna Call?”

If you are having difficulty navigating our facility or our systems, you have a number of resources.

The Physician Liaisons, Mimi Rockel & Daisy Delaney, make daily visits to physician offices.

John Boyd, M.D., Chief Medical Officer, Charles Alfano, M.D., Vice President of Medical Administration, and various others have been assigned to address the needs of employed and private physicians respectively and are available to assist in any way they can.

If none of the above options works for your problem situation or if you would like “one-stop shopping”, you are encouraged to contact either Amy O’Donnell, (employed physicians) or Joan Robley (private physicians) to help you find resolution, or at least someone who can help you.

We can’t promise immediate gratification, but we can promise to follow through on your concerns. Feel free to contact us at the numbers listed below:

<table>
<thead>
<tr>
<th>Name</th>
<th>Phone Number</th>
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</thead>
<tbody>
<tr>
<td>Mimi Rockel</td>
<td>602-616-6643</td>
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<tr>
<td>Daisy Delaney</td>
<td>602-451-6915</td>
</tr>
<tr>
<td>John Boyd, M.D.</td>
<td>602-406-3007</td>
</tr>
<tr>
<td>Charles Alfano, M.D.</td>
<td>602-406-4095</td>
</tr>
</tbody>
</table>

Tentative General Medical Staff Meeting Schedule – 2008

5:30 pm - Cocktails
6:00 pm – Dinner/Business Meeting
Marley Lobby
(just outside the Leonard Goldman Auditorium by 3rd Ave)
March 31
June 30
Security of e-PHI

The use of websites in which physicians and staff provide patient status updates via email poses serious threats to our patients’ Protected Health Information. If a website is unsecured, whatever PHI you are transmitting runs as free text across the internet, meaning any skillful 12-year old hacker can see it and use it and steal it. If ePHI is hacked from your website, it is considered a data security breach.

Do data security breaches really happen? You bet they do and they occur nearly every day. Check out the website [http://privacyrights.org/](http://privacyrights.org/) - Over 218 million data records of U.S. Citizens have been exposed due to security breaches since January 05. For example, last week (March 12, 2008) Harvard University’s Graduate School of Arts and Sciences web server compromised 10,000 applicants’ and students’ personal information. 6,600 SSNs and 500 Harvard ID numbers were breached in this incident.

What are the consequences of data security breaches? In the incident above, Harvard University will be required to pay for credit monitoring for each person’s personal information that was breached. The average cost is $100/person per year for three years. Harvard’s IT department and other staff involved will spend countless hours investigating and remediating the breach. And Harvard’s reputation for excellence is diminished. If students paid their application fee online, that would also require investigation and fines assessed to Visa under the national credit card standards (PCI-DSS).

If you are using an unsecured website to transmit Patient Information, you are creating significant risk for yourself, your patients, and possibly SJHMC. Get your website secured. CHW Policy prohibits the emailing of patient information without adequate data security.

For about $2,500 you can secure your website and significantly lessen the risk of a data security breach. At a minimum you need Secure Socket Layering (SSL) and 128 bit encryption. Educate yourself – do a Google search on website security. It’s well worth your time and effort.

How does one know that communicating with a website is secure? This link [https://webmail.chw.edu/exchange/](https://webmail.chw.edu/exchange/) is a secured CHW website for accessing Outlook via the internet. Notice the letter “s” after the http. That indicates the site is secure and will encrypt the data transmitted.

SJHMC is educating our nursing staff regarding CHW security requirements for transmitting PHI via email. SJHMC Employees are prohibited from emailing PHI via an unsecured website.

For any questions, please contact the Compliance Department at 602-406-5149.