

CSA District Director Reports

The reports of district directors that appear below contain personal views expressed individually by each director rather than statements made by or on behalf of CSA.

CSA Board of Directors Meeting, April 21, 2007

Gregory Gullahorn, M.D.—District 1 (Imperial & San Diego Counties): San Diego has seen dramatic evidence of effects of collapsing health care funding in the face of increasing demands for resources. I believe we would all agree that we should be efficient and effective in our use of resources; however in times of ever-increasing mandates, restrictions, and regulations, it behooves us to periodically restate and reassess our primary objective. I believe that to be first and foremost the health and safety of our patients. Following directly from that is the right and the need for physicians to be able to exercise their clinical judgment and autonomy on the basis of medical need, rather than reimbursement or payer mix.

Establishing limits on medical care is a legitimate topic for political debate amongst our society and government as a whole, and a debate in which physicians must take a leadership role. As a society, we have not yet chosen to make such decisions—everyone acknowledging the difficulty of these choices and reaching consensus. By default, however, we have deferred to a belief that “market forces” can shape the most efficient use of our health care expenditures and somehow “cure” our system. This is the nucleus of the managed-care approach, for both government and private “third-party payers.” As a physician, and as an individual citizen, I question the merits of this basic assumption. Health care economists, sociologists, and even medical anthropologists have long held that medicine operates differently from other market economies. Health, as a “product,” is difficult if not impossible to measure, but its intrinsic value is extremely high. I freely admit that I do not have the answers, but I cannot ignore the problems.

I would like to mention stories evolving around three San Diego hospitals that have in different ways been pressured by the gap between resources and demands.

I have previously discussed the saga of Alvarado Medical Center, its administrator, and Tenet Health Care. After two trials alleging illegal payments by Alvarado for physician relocation ended in mistrials, Tenet reached an agreement with the Office of the Inspector General to sell Alvarado by February of this year or face exclusion from all federally funded reimbursement programs. The three major healthcare networks in San Diego had concerns about the purchase price, combined with the projected \$70 million needed for seismic retrofitting and other improvements, and there was significant concern in the

District Director Reports (cont'd)

community about losing the acute care facility and its emergency care. Plymouth Healthcare, a group formed by two Los Angeles area brothers, both pediatricians, reached an agreement with Tenet. Although the medical center continues to face the challenges of negotiating adequate reimbursement from private insurers to make up for losses with indigent, Medi-Cal, and Medicare patients, Alvarado has managed to remain open and fully functional.

I have also previously reported long-term plans by UCSD to consolidate their inpatient facilities to their La Jolla campus, turning the Hillcrest Medical Center into an ambulatory and emergency care center. This had precipitated concerns about leaving gaps in the availability of trauma, emergency, and indigent care in South San Diego. The sale of Paradise Valley Hospital to for-profit Prime Healthcare has further heightened concerns about availability of care for the underinsured and uninsured in South San Diego.

Releasing the first phase of its study, the San Diego County Safety Net Study identified multiple challenges to the area.

Challenges

The San Diego safety net is vulnerable. The system faces significant challenges, including:

- Shrinking reimbursement from commercial and public payers
- Growing numbers of under- and uninsured patients
- Drug and technology costs
- Potential closure of South Bay hospitals, which would impact all providers

Steps Toward A Solution

- Improved funding for hospitals and providers
- Better use of existing resources
- Improved collaboration among providers, using technologies such as telemedicine to improve care

Earlier this month (MARCH 2007), the San Diego County Board of Supervisors voted unanimously to oppose the proposed transfer of 385 inpatient beds by UCSD from Hillcrest to its Thornton Medical Center in La Jolla. Speaking before the Board, UCSD Medical Center CEO Richard Liekweg stated that UCSD is committed to maintaining state-of-the-art facilities in both Hillcrest and La Jolla. A planned presentation before the U.C. Board of Regents regarding the transfer of inpatient beds has been postponed, pending further

District Director Reports (cont'd)

public discussion. Liekweg did state that UCSD has proposed a 125 to 150 bed expansion of its Thornton Medical Center by 2014, and that these beds would be subtracted from the Hillcrest total. UCSD plans over \$80 million in improvements to its Hillcrest medical center, however, to meet seismic standards, expand emergency services, and for general improvements. Liekweg noted that UCSD pledges to maintain a full-service hospital with level-one trauma center and burn unit in Hillcrest for at least the next 20 years.

One further note regarding UCSD was the announcement that they are closing their Heart Transplant program, largely due to low volume. Talks are underway with Sharp Healthcare in San Diego, which currently operates its own separate heart transplant program, to explore combining services. Current guidelines suggest a minimum of 12 transplants a year. Based on population averages, San Diego would project a need for 21 to 22 adult heart transplants per year, suggesting that duplicate programs do not make sense.

Alluded to in discussing UCSD is the sale of Paradise Valley Hospital in National City. The more-than-100-year-old institution has traditionally provided a significant portion of care for Medi-Cal, Medicare, and uninsured patients in San Diego's South Bay. Previously owned by nonprofit Adventist Health, the hospital board had announced last fall that in the face of losses of over \$2 million per month, they must either sell or close the facility. For-profit Prime Healthcare emerged as the sole viable buyer, in a deal conditionally approved by the California Attorney General in February. Under the arrangement, Prime Healthcare has agreed to operate the hospital as an acute general care facility until at least 2012, and to maintain all of Paradise Valley's services (including indigent/charity care) at current levels for five years.

Prime Healthcare has developed a reputation of acquiring institutions in financial trouble and "turning them around" through tough financial choices. Whether those choices can be reconciled with the realities of the population in the area while maintaining services as outlined in the agreement with the Attorney General remains to be seen. The *San Diego Union Tribune* reported concern by physicians on the Paradise Valley Medical Staff that policy decisions were being made without their approval. Included in the changes is the new requirement for physicians to get approval of the hospital medical director before admitting patients to the ICU, and a stipulation that telemetry would be discontinued after 48 hours unless approved by a review committee.

District Director Reports (cont'd)

Stanley D. Brauer, M.D.—District 2 (Mono, Inyo, Riverside and San Bernardino Counties): Greetings from District 2!

At Loma Linda, as with all teaching hospitals in California, United Healthcare is adversely impacting reimbursement. United is currently negotiating new contracts for all the PacifiCare patients they acquired last year. Despite assurances to the contrary, it is clear that they (United) will impose the 50 percent reduction in payment with any concurrency while teaching residents. Since concurrency occurs in most of our cases, this is a huge cut in payments. They have forced this methodology in other parts of the country and it has eroded the income of anesthesiology teaching programs.

United Healthcare continues to expand aggressively in the Western United States. Their contract disputes with hospitals and physicians in Denver last fall made national news. On the March 12, 2007 report, United announced a buyout of Sierra Health Services, which is Nevada's largest HMO.

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On a more positive note, the job market continues strong for residents completing their training. Our senior residents are finding excellent offers in and out of California. Kaiser Fontana is considering a pilot for the use of propofol by anesthesia providers in the GI lab for colonoscopies after successful pilots at two other Kaiser Permanente sites in Southern California.

Plans have been approved at the Kaiser Permanente Ontario Vineyard campus for an additional medical office building and a hospital, which should be completed around 2012. Construction has already begun on a new large parking structure. Building will begin soon on a Kaiser Permanente MOB in Redlands located near Pharaoh's Kingdom.

There are the usual crises about billing and collections in the desert, and shortages of anesthesiologists for every venue (although not consistently at any particular site). Some CRNAs are moving into certain situations (outpatient ophthalmology being one). There is a need for better understanding in the community hospitals and outpatient facilities of how to implement supervision of CRNAs (either by anesthesiologists or surgeons) and how to know the bylaws and policies/procedures are properly constructed to assure physician supervision.

The Coachella and Temecula Valleys continue to see growth with expansion of hospital and outpatient facilities.

District Director Reports (cont'd)

Wayne Kaufman, M.D.—District 3 (Northeast Los Angeles County): Growth seems to be the key word for District 3 this year.

Work is being completed on the new Los Angeles County–University of Southern California Medical Center, the largest building project ever undertaken by the County of Los Angeles. It is scheduled to open on November 1, 2007, though this is probably optimistic. It will have 24 operating rooms on a single floor with an elevator that has direct access to the emergency/trauma room. While there is a great deal of excitement about the move between the old county hospital and the new one, already several problems have cropped up. Questions about whether there are adequate numbers of beds, medical record storage, and call room facilities for residents and faculty have made everyone anxious. The County has already contracted out other hospital beds in private institutions to help with any shortage created when moving from the larger facility to the small, more up-to-date hospital.

Across the street, the new Norris Inpatient Tower is anticipated to open this June. This will increase the number of operating rooms to 24 at the University of Southern California University Hospital. Plans are currently being made to staff these rooms. Most of the inpatient services currently being provided at Norris Cancer Center will be transferred to the Tower when it becomes fully functional.

City of Hope has also experienced increased growth and is currently expanding its anesthesiologists to nine (up from four only nine years ago).

On March 14, 2007, the District had a meeting attended by 30 members at the Arroyo Chop House (hosted by BioPharma). We discussed the current issues affecting anesthesiologists including challenges to the right-to-balance bill, the chiropractic board fiasco, and Governor Schwarzenegger's health care plan. Afterwards, Dr. Jerrod Levy, Director of Cardiothoracic Anesthesiology from Emory Healthcare, gave a lecture on "The Management of Hypertensive Emergencies in the Acute Care Setting."

Christine A. Doyle, M.D.—District 4 (Southern San Mateo, Santa Clara, Santa Cruz, San Benito and Monterey Counties): Not much is going on in District 4 lately (for which most of us are quite happy!)

The following is a list of the continuing and newly-elected delegates with their affiliated groups and hospitals and miscellaneous other interesting items about them. The number in parentheses is when their term expires. This list includes the current delegates and newly elected delegates (who take office at the Annual Meeting).

District Director Reports (cont'd)

The Delegates

Bryan Bohman (09) is a member of Associated Anesthesiologists in Palo Alto. He has just begun his term as Chief of Staff at Stanford University Medical Center.

Chung-Ih John Chou (10) is a member of the Palo Alto Medical Foundation. The foundation provides services at Stanford, LPCH, Palo Alto Surgicenter, Menlo Park Surgical Hospital and Fremont Surgery Center.

John Cellar (08) is a member of Group Anesthesia Services (GAS), practicing at Good Samaritan (San Jose) and Los Gatos Community hospitals. He is a partner of CSA President Mark Singleton.

Rich Novak (08) is also a member of Associated Anesthesiologists in Palo Alto. He serves as the Assistant Chief in the Department of Anesthesiology at Stanford, representing the members of AA and PAME. He also authors a regular column in "The Gas Pipeline"—the monthly newsletter from the department.

William Feaster (10) is a pediatric anesthesiologist associated with Lucile Packard Children's Hospital at Stanford. He also has his MBA and is a Certified Physician Executive.

Mark Rigler (10) is a member of Anesthesia Medical Group of Santa Cruz, and a staff anesthesiologist at Dominican Hospital in Santa Cruz. He also sits on the board of Anesthesiologists Associated Inc., an anesthesia-only billing group with clients throughout California, Oregon, Washington and Idaho.

Carla Shnier (10) is a staff anesthesiologist at Santa Clara Valley Medical Center. She trained at UCSF.

Frank Takacs (10) is a member of Monterey Peninsula Anesthesia Medical Group and a staff anesthesiologist at Community Hospital of Monterey Peninsula.

Sydney Thomson (10) is a member of Coast Anesthesia, which practices predominantly at O'Connor Hospital in San Jose. She is a skilled renaissance fencer, and will shortly be beginning the Masters at Arms program at San Jose State. She is also an alternate delegate to the ASA.

District Director Reports (cont'd)

The Alternate Delegates

Thomas Shaughnessy (08) is a member of Sutter Health, primarily on the Peninsula. Prior to joining Sutter, he was a faculty member at UCSF, and served as Delegate and Director for District 6. He is also a Critical Care specialist.

Vanila Singh (08) is a Clinical Assistant Professor at Stanford, and completed her Pain Management fellowship at Cornell.

Paul B. Coleman, D.O.—District 5 (Kern, Tulare, Kings, Fresno, Madera, Merced, Mariposa, Stanislaus & Tuolumne Counties): The Central Valley's new University of California Merced is in the early stages of creating a health science program that will include undergraduate medical education and hopefully lead to a UC Merced School of Medicine. This program is focused on developing initiatives that will address health problems specific to the Central Valley. The Valley currently lags significantly in both primary care and specialist physicians. With these shortfalls expected to increase with time, a plan to develop a UC Merced School of Medicine is seen as critical to addressing the health care needs of this rapidly growing area. Medical education for the proposed medical school will be based on a regionally distributed model. This will permit leveraging existing health care resources in the Valley, thereby bypassing the high cost of constructing a new and university-owned teaching hospital, and will provide training of students at clinical sites throughout the region. The proposed model for education is based on academic partnerships and utilizes existing resources in the Valley such as UCSF Fresno and sister UC campuses at Davis and San Francisco. A primary goal will be to increase the number of health care professionals practicing in the Valley, particularly those committed to serving the needs of the area.

Fresno's University Medical Center, the only level one trauma and burn center in the Valley, is relocating to Fresno's Community Regional Medical Center campus this April. As part of this move, the two facilities are currently in the process of merging their anesthesia services. Community Anesthesia Providers has also brought on board two new physicians to help keep pace with the increasing surgical volume at Community Medical Center Clovis.

Modesto's Memorial Medical Center's new seven-story tower, expected to open this spring, will create an increase from 300 to 400 beds and 11 to 18 operating rooms that will include unique features such as a fresh-air waiting space.

Kaiser's new hospital in Modesto has run into delays. Construction should be completed this summer, but the facility will not open until October 2008, a year after the originally announced date. According to media reports, more

District Director Reports (cont'd)

than six Kaiser Hospitals are scheduled to open in California in the next few years, and the nonprofit firm does not want to open all of them at once. In addition, the Oakland-based health care provider is focusing on deployment of its online medical records system at its clinics and hospitals in Northern California.

Helen T. O’Keeffe, M.D.—District 7 (Alameda and Contra Costa Counties): This is my last report as District 7 Director. I would like to use this forum to encourage all Alameda-Contra Costa anesthesiologists, especially ones new to the area, to be involved with the CSA. It is good to be exposed to a wider view on how our profession interacts with the larger world, and inspiring to work with the quality of people in the CSA. I really mean this!

When I started out in this great profession back in the 1970s, there was a poor relationship between the Permanente Medical Group (Kaiser) physicians and both the CMA and CSA. It is gratifying to have seen closer relationships and trust develop between various modes of practice. It is also essential: We are all affected by the same problems, and we should all support the CSA. Who else is motivated to be in our corner? There are analogies to the current relationship between M.D. anesthesiologists and CRNAs. At this point in District 7, only the Kaiser Foundation Hospitals are using significant numbers of CRNAs in their ORs.

The only major practice change in our area is that a new Kaiser hospital is opening this fall in Antioch, actually slightly ahead of schedule. It will have a full OB service and, at the start, four to six ORs. Antioch, in the east part of the Bay Area, used to be a small town, but now it is seeing a build-up of more affordable housing and a rapid population increase.

Peter E. Sybert, M.D.—District 9 (Del Norte, Humboldt, Lake, Marin, Mendocino, Napa, Siskiyou, West Solano, Sonoma, Trinity, Colusa, Glenn, Butte, Plumas, Tehema, Shasta, Lassen, and Modoc Counties): It seems like the old phrase about living in interesting times is applicable in parts of the District.

In Chico there has been substantial conflict. Since there are many sides to this story, I have chosen to follow it primarily through what has been published in the local newspaper. Briefly, in 2006, a hospital CEO, new to that title in August 2005 after having served as COO since 1997, elected *not* to renew the contract with the anesthesia group that had provided services there for years. After what appears to have been a very difficult time, the CEO received a “no confidence” vote from the medical staff and departed. Two members of the Board of Directors resigned. The contract for anesthesia services was given to

District Director Reports (cont'd)

a new entity, some of whose members were already in practice at the hospital, but apparently most of the anesthesiologists have elected not to join the new group and have moved on either to other local practice opportunities or elsewhere in the state and even out of state.

Since then, and I know nothing about the clinical details, the newspapers have reported three perioperative deaths at the facility that have fueled controversy in the newspaper as to what role, if any, anesthetic care played in these tragedies. The facility is going through its investigation and the local coroner has apparently started his own investigation. The local newspaper claims that a new anesthesia group is being formed to provide services, and members of the original group allegedly are being approached as to whether they would be interested in returning. I recognize that a tragic outcome can occur at any facility at any time for a host of individual and combinations of reasons.

There is much excitement in Sonoma County. Sutter Medical Center of Santa Rosa has decided to stop providing inpatient services by the end of 2007 because of persistent financial losses. That move would take 238 of 963 licensed hospital beds out of service (2005 OSHPD). Sutter has operated the facility under contract to the Board of Supervisors, which apparently may have some say in determining the circumstances under which Sutter can transfer its obligations.

Santa Rosa Memorial Hospital, with 365 licensed hospital beds (2005 OSHPD), and Sutter have announced an arrangement whereby SRMH will accept most of the Sutter clinical load. SRMH is moving aggressively to create new beds from office areas, move administrative staff to new locations, has announced a commitment to spend several hundred million dollars in facility expansion. The project is massive for the county with the transfer of OB services, neonatal ICU, OR, open heart, ICU, med/surg wards, radiological services, and emergency room visits.

There are lots of meetings, discussions, and reports about what Sutter can and cannot do, what SRMH can and cannot do, and what the Board of Supervisors will and will not allow. The medical/surgical community is rethinking its practice options as one of the three major facilities is closing its doors. The county safety net system needs to be reworked.

The various district hospital CEOs are engaged in discussions of what new service lines their facilities can provide OR areas into which they can expand. eICUs for several facilities are being discussed for some smaller hospitals that currently do not operate ICUs. How this all settles out is an open question; however, the possibility for community good is, I believe, very good. There are

District Director Reports (cont'd)

advantages to consolidating two open-heart programs, neonatal units, pediatric service lines, etc., in one city where higher facility volumes have the potential to improve patient outcomes and use limited resources more efficiently.

Owen Shea, M.D.—District 10 (San Luis Obispo, Santa Barbara and Ventura Counties): Hospital administrators in District 10 have acknowledged that adequate anesthesia coverage comes at a cost. Most anesthesiologists and groups now receive support for their services to ensure adequate coverage. Various support models exist in this district, and many groups are negotiating with administrators for additional coverage in a climate where hospital case loads continue to decrease. There seems to be no end in sight to the proliferation of free-standing surgery centers in this district, which creates staffing issues for both the anesthesiologists and hospital administrators. Despite the pressure to hire additional anesthesiologists for this increase in operating rooms, most groups have resisted. The financial implications of this in a district with a high cost of living will challenge our district members in perpetuity.

There has been significant local, state and national coverage of the recent organ harvest attempt that occurred in San Luis Obispo at Sierra Vista Hospital owned by Tenet. This case involved an attempt to harvest organs from a patient who only met the criteria for “cardiac death.” This patient was brought to the operating room, extubated and then approximately 80 mg of ativan and 200 mg of morphine were ordered by the transplant surgeon and administered by a hospital ICU nurse. This patient did not subsequently expire until hours later in the ICU. There was **not** an anesthesiologist involved in the care of this patient perioperatively. The details of this case are complicated and information can be found using any search engine with the words Sierra Vista Hospital, organ harvest and San Luis Obispo. There are current investigations through the California Medical Board, Department of Health Services and local law enforcement regarding this event. I urge all anesthesiologists practicing in California to review any policies regarding organ harvesting at their hospital, particularly those that pertain to the “cardiac dead” patient. This episode is a nightmare for the physicians and nurses involved and a public relations disaster for the hospital. Mostly though, it is a tragedy for the family and patient who experienced the event

Twin Cities Hospital (Tenet) serving Paso Robles, Atascadero and Templeton has nearly completed a \$30 million remodel which adds 30 beds to a community that has experienced rapid population growth in the last 10 years.

District Director Reports (cont'd)

After thorough review of pediatric case numbers, anesthesiologists in Santa Maria determined that they could not achieve adequate case numbers required for credentialing. All children younger than six months are transferred to other facilities unless the medical status prohibits safe transfer.

Kaiser Permanente in the Ventura area has contracted with anesthesiologists at Community Memorial Hospital for patients who previously had been with the Buenaventura Medical Clinic. Additionally, successful negotiations between Blue Cross/Shield and the anesthesiologists have been finalized, benefiting both the patients and the contracting physicians.

The most visible news in Santa Barbara County is the Cottage Health System's \$750 million renovation and construction project for three hospitals in Santa Barbara. Santa Ynez and Goleta Valley Cottage hospitals will have nearly \$100 million invested toward renovation and meeting the state's new seismic standards. Santa Barbara Cottage Hospital is building an entirely new hospital at a cost of \$500 million, with occupancy expected as early as 2009. The anesthesiologists have been involved actively in the design of this program which will include additional neurosurgical, neurovascular and interventional stroke programs.

Lastly, we want to thank all of our colleagues in District 10 who donate yearly to both the ASAPAC and GASPAC. We urge every member to support our PACs through regular donations. Without your donations, we have absolutely no voice! It is that simple.

James M. Moore, M.D.—District 11 (West Los Angeles County [western portion]): Many practitioners in our district see their overall caseload declining to some extent, although there are practices where the opposite is true. As the belt continues to tighten around the waistline of hospital finances, administrators turn to anesthesiologists as gatekeepers of operating room efficiency. Many district members feel that case delays by anesthesiologists are minor, but we are nevertheless pressed to redouble efforts to shave off a minute here and there from operating room turnovers. Meanwhile factors beyond our control, such as nursing and surgeon efficiency, contribute to delayed start times and lengthen not only turnover times but operating room times as well. A comprehensive approach to efficient operating room management must consider all the structures and processes of care involved, of which anesthesia care is but one.

Currently one of the greatest challenges to efficient practice management is the expansion of off-site anesthesia care. As the demand for off-site anesthesia services continues to increase, so do the accompanying obstacles of inherent

District Director Reports (cont'd)

scheduling inefficiency, difficulty in staffing distant locations, and billing problems such as currently exist with gastrointestinal endoscopic procedures. Off-site anesthesia takes us away from the controlled familiarity of the operating room environment, and often in these alternate locations, we are not accorded the same equipment, patient access, and assistance to which we are accustomed. One member expresses frustration at the process for cardiac defibrillator insertion procedures at his institution. Typically, after the patient has sedation for the device placement, only then is the anesthesiologist contacted to provide anesthesia for cardioversion with no prior knowledge of the case. Unfortunately this scenario is familiar to many of us, and the difficulties of off-site anesthesia care will continue to be one of the principle challenges facing our specialty for the foreseeable future.

At the Centinela Freeman Regional Medical Center, the clinical work appears to be shifting among the three campuses. At the Memorial campus, formerly Daniel Freeman Memorial Hospital, the emergency and operating room services closed recently. At the same time, caseloads are increasing at the Centinela and Marina campus locations, resulting in a net increase in the caseload and the number of new positions for anesthesiologists.

On the educational front, Cedars-Sinai Medical Center now has a fully accredited residency program in anesthesiology. Cedars-Sinai has assumed responsibility for training residents formerly at King/Drew Medical Center, whose school of medicine recently withdrew from residency accreditation. At Children's Hospital, the number of fellows in pediatric anesthesia will increase from six to seven for the coming academic year, and in an extremely competitive match this year, UCLA once again filled all its residency positions.

Finally, congratulations should be extended to District 11 member Dr. Noel Chun, who was recently elected to the Board of Directors of the Beach Cities Health District, a public health agency serving a large southern California community. Dr. Chun's dedication, culminating in a successful campaign, and his commitment to serve his community reflect well on our district, and he is to be commended.

John A. Lundberg, M.D.—District 12 (Southeast Los Angeles County): JCAHO continues its unannounced surprise inspections. They now may target specific departments (ER, pulmonary lab, OR, Radiology, etc.), and follow the paperwork of specific patients. When they visit and inspect, there is a ripple effect throughout the hospital of awareness that the surveyors are present. Overall though, the new inspections create less fanfare than in days past when they announced their inspections far in advance. A welcome change.

District Director Reports (cont'd)

Surgicenters continue their dominance in the outpatient surgery business and capture most of the outpatient procedures, while the hospitals perform the bigger complex procedures and operations. Quality control at surgicenters is mostly self-governed within the surgicenter, with the emphasis on medico-legal malpractice avoidance and patient satisfaction. Accreditation does not appear to be as complex as with hospitals. Patient satisfaction is very important to surgicenters because they rely on repeat visits by patients. All surgicenters give the patient a questionnaire to complete at home, and they are analyzed and used for patient satisfaction improvement guidelines. It's a very effective motivating tool for the nursing staff because they personally see the patient's written comments.

Charles R. Drew University of Medicine and Science has given notice to the County of Los Angeles that it will file against the County a \$125 million lawsuit citing deliberate breach of contract in its decision to close the 537-bed facility. Pierce O'Donnell, legal counsel for the University, stated "Los Angeles County's flagrant breach of its clear contractual obligations has not only severely crippled the University, but the County's chronic gross mismanagement of the hospital and the loss of accreditation and federal Medicare funds has left 1.7 million victims in its wake." After loss of JCAHO, the hospital lost approximately \$200 million in annual federal funds with a budget of \$380 million annually. The King/Drew Anesthesiology Program is now integrated with Cedars/Sinai. Their graduates have had excellent pass rates on the written and oral boards.

Spine surgery and endovascular surgery have made huge technologic advances in the past decade. Hospitals have invested heavily in equipment (tables, instruments, fluoroscopy, OR rooms, etc.), and patient volume has increased and probably will continue to do so. Open heart surgeries have continued their decline in the community hospitals. Without adequate volume it has been more difficult to maintain competency of nursing staff, anesthesiologists, and surgeons.

There has been a relatively low turnover rate in anesthesia staffs here. Housing prices have peaked and leveled off. Starter homes are about \$1 million which discourages many newcomers. Overall the quality of recent graduates of anesthesiology training programs has continued to improve.

Paul B. Yost, M.D.—District 13 (Orange County): District 13 had a successful dinner meeting on October 4, 2006, at Antonello's that was sponsored by Abbott. Dr. Roy Soto from SUNY Stonybrook gave an excellent talk on "Volatile Anesthetics." Following the talk, there was a great discussion on several topics

District Director Reports (cont'd)

including the following: payment for noncontracted services, Blue Cross denials for MAC cases, and Medicare issues. Another dinner meeting is scheduled for March 22 at Roy's in Newport Beach featuring Dr. Roy Greengrass, who will be talking about continuous peripheral nerve blocks. The talk is being sponsored by I-Flow. An additional dinner meeting is in the works for early June, sponsored by Abbott.

Some CSA members, including the LPAD chair, Dr. Pauker, have been lobbying local politicians on behalf of the physician community in general and anesthesiologists in particular.

General issues from around the County:

Orange County has been relatively quiet over the last quarter. Volumes at most hospitals seem fairly stable with the exception of three smaller hospitals, all of which were bought by the same entity. Surgical volumes at those facilities have dropped precipitously. Several hospitals have gone live with computerized physician order entry (CPOE), with its expected headaches and issues: one hospital requires a minimum of two hours of education to learn the software. There is still an ongoing trend toward efforts to open specialty surgery centers, which would divert higher paying lower risk cases to freestanding facilities (without call requirements). So far, it has been challenging for anesthesiologists to achieve a full partnership role in many of these efforts. There is a continuing trend toward "lateral expansion" at many—if not most—facilities with many groups being forced to hire more people, but without a clear vision of an actual increase in work. Many groups are negotiating stipends with their hospitals, using data on lateral expansion of anesthetizing locations without an increase in work load. An interesting and potentially disturbing trend is the emergence of performance standards for payment of some hospital stipends.

Hoag Hospital: Volumes have been good. The hospital did go live with CPOE. There has been some lateral expansion with the opening of five new GI suites and six new operating rooms. The Hoag group has a multimodal pain therapy program.

Saddleback Hospital: A JCAHO review with all of the requisite nail-biting has taken place. They also have recently rolled out a CPOE program with the usual glitches and issues and, it is hoped, some improvement in patient care. Saddleback is in the process of opening three new outpatient ORs in a joint program between physicians and the hospital. Volumes have been stable, but the acuity of patients seems higher.

UCI: Volumes at UCI have been stable. The university is in the process of building a new hospital, and they have expanded some services, especially

District Director Reports (cont'd)

neurosurgical. UCI is in the process of interviews for a new chairman, and the search has drawn some nationally recognized anesthesiologists from around the country.

CHOC/St.Joseph's: AAMG continues to try and work with Blue Cross regarding appropriate payment for GI cases. They also are anticipating opening of the new patient care center this summer, and they are modestly expanding their group accordingly. CHOC has also recently initiated a CPOE program, and the CHOC/St.Joseph's third annual anesthesiology symposium took place on March 17, with excellent speakers, headlined by Dr. Samuel Wald from UCLA, and record attendance.

Kaiser: They are anticipating the opening of their new hospital in Irvine, which is scheduled for early 2008 with eight ORs and two procedure rooms. Kaiser is continuing work on the concept of "highly reliable surgical teams" that use evidence-based medicine to provide the highest quality anesthesia and medical care.

Fountain Valley Hospital: Fairly quiet, with some decrease in adult cardiovascular volume (national trend).

Western Medical Center: Fairly quiet, with stable surgical volumes

Jeffrey B. Glaser, M.D.—District 14 (Los Angeles County [northwestern portion]): Certainly all physicians, and especially anesthesiologists, are facing difficult times ahead. Looming on the horizon are further Medicare cuts, decreasing private payer reimbursement, denial of more types of services for lack of medical necessity, P4P, and even a threat by the Governor to tax physicians 2 percent of our gross receipts. The momentum for a universal health plan at both the state and federal levels seem to be gaining ground.

More than ever, it is important that physicians take an active role in ensuring that our futures are preserved on two very important fronts: (1) autonomy, and (2) financial well being. There is no doubt that the best way to accomplish these goals and preserve our professional integrity on these levels is to be involved! Being involved requires digging the proverbial head out of the sand and showing both *civic* and *professional* responsibility.

On the civic front, we anesthesiologists must do our best to educate our patients of our roles and ensure that we convey nothing less than the most professional attitudes and the most professional image with our peers, patients, community, hospital staff, and hospital administrators. Professionally, what can we do? As anesthesiologists, we often awaken early in the morning and

District Director Reports (cont'd)

frequently don't arrive home until late at night. This affords us little time to "manage the store" and defend our interests. Membership in the CSA alleviates a lot of the concerns of "managing the store." Preferably, both membership and involvement would be ideal, but it is realized that not all physicians want to take an active roll in participation. I have met with many of the anesthesiologists in my district and have encouraged membership in the CSA. Together, we have discussed the many benefits of membership. Despite these meetings, a relatively small number of anesthesiologists in my district have elected to join. For years now I have asked myself, why?

Perhaps the answer is that the "status quo" has been maintained for many years in my district. Our district enjoys a relatively well-to-do socioeconomic demographic makeup and, when things are good, it is easy to bury your head in the sand. This last year anesthesiologists have finally started to become more aware and understanding of the challenges that we face today and lie ahead in our future.

District 14 members are now realizing the importance of membership in an advocacy group such as the CSA working on our side. Recently, I held a non-CSA meeting of anesthesiologists from Burbank to Ventura to Santa Clarita. Twelve groups were represented. This forum allowed members of neighboring groups to express their concerns about the present and the future. I was able to take away a better understanding of what anesthesiologists need and are looking for in an advocacy organization. Many of these things are already being offered by the CSA, but many anesthesiologists were unaware.

With better awareness, I am hopeful, will come responsibility—the responsibility that will entice District 14 anesthesiologists not only to join the CSA, but to become involved in the only organization in our state that looks out for the specific needs of our specialty medical profession.

My goal remains education of anesthesiologists in my community and continuing to encourage membership in the CSA.

Ellen Y. Wang, M.D.—District 15 (Resident Members): At UCLA, we have been having a very good year. Improvements are always in the works. We are trying to increase our operating room efficiency by aiming to get patients in the OR at 7:15 a.m. We also have started preparing for the move to the new hospital in the fall. Our residency program had a very successful interview season, and we are very happy with the match results this year. Our CA-1s have started rotating at Olive View for a broader experience with regional techniques, and have enjoyed this experience immensely. Our CA-3s are getting ready to move on to bigger things. Five of the 21 graduating residents will be

District Director Reports (cont'd)

going on to fellowships—two in pediatrics, two in cardiac, and one in critical care. The rest will be working in great practices all over California and Arizona. The cycle starts over again with our new interns, the first class of the new four-year program that integrated the West Los Angeles VA internship with our residency.

Things are going well at Loma Linda. We were recently re-accredited for four years. We have added three more residents to the program, bringing our total to 45 residents. We are in the process of going to a four-year program with an integrated Clinical Base year. Our regional anesthesia experience is excellent, with the formulation of our specialty orthopedic hospital and a new acute pain service at the university hospital to supplement the chronic pain service and to place and follow nerve block catheters and thoracic epidurals for post-op pain control. We continue to have excellent fellows in our ACGME-approved pediatric anesthesiology fellowship and have recently received approval for our two ACGME Critical Care Fellowship positions. Our residents continue to have excellent placement out of our program. Five of our 13 graduating residents this year have matched to fellowship positions—one cardiothoracic, one transplant, and three in pain management. The other eight have found private practice positions throughout the West Coast.

This winter Stanford made the transition to a new Ambulatory Surgery Center with 12 large operating rooms designed to incorporate endoscopic procedures and modern information technology; two large treatment rooms; and an interventional radiology complex. The move to the new state-of-the-art facility will improve the efficiency and quality of patient care and was enthusiastically embraced by all. The residency program began phasing in changes to its rotations to anticipate the 2008 ACGME and RRC-mandated residency requirements. Highlights include expanded core competencies, increased teaching opportunities for residents and fellows, and expanded small-group sessions. CA-3s are looking forward to fellowships in pediatric anesthesia, cardiac anesthesia, regional anesthesia, and pain and biodesign research, as well as private practice positions throughout Northern and Southern California, Oregon, Texas and Colorado.