



What is The RAC?

It is not the RACK, the medieval torture machine, but it comes close.

The RAC is the Recovery Audit Contracting program which is “mandated by Congress and has a primary goal of identifying Medicare improper payments. Improper payments include overpayments and underpayments.” They go on to say that improper payments may occur “because of incorrect coding, lack of sufficient documentation, no documentation, use of an outdated fee schedule or billing for services that do not meet Medicare’s coverage and/or medical necessity criteria, etc.” Notice the emphasis is on meeting Medicare’s requirements and behavior that usually result in overpayments.

The practical consequence of a RAC decision usually results in a determination that Medicare has overpaid the hospital. They can then require that the hospital

reimburse Medicare for the overpayment(s).

Kuakini has recently received denials based on RAC determination that the services were either “not reasonable or necessary” or “did not meet the Medicare coverage requirements”.

Examples of surgical denials include admissions to the acute facility for surgical procedures such as laparoscopic cholecystectomy, rotator cuff repair, pacemaker placement including defibrillators, kyphoplasty and vertebroplasty. The rationale is generally that there were no “extenuating circumstances or past history” that required an acute hospital admission.

Medical denials include syncope, transient ischemic attacks with a negative workup (e.g., negative scans), back pain and chest pain with a negative workup for a cardiac source.

In most medical cases, admission to Observation Status initially would have been the prudent course of action. In surgical cases, Observation Status would probably not be allowed should the patient be sent home the same day. Direct discharge from ACS is a good course in uncomplicated cases. If the patient is deemed Observation Status, there should be acceptable documentation as to why the patient had to remain beyond the usual ACS stay post op.

Changing a patient from Inpatient to Observation may trigger a medical record review. This may result in no payment to the hospital if it is determined that the patient should have been in Observation Status from the beginning.

Full accreditation
survey expected
before
August 2011

Joint Commission PPR Findings

The Joint Commission surveyor completed Kuakini Medical Center's annual Periodic Performance Review (PPR) on December 15 and 16, 2010. The PPR is an annual evaluation of the hospital's compliance with all of Joint Commission's standards.

Kuakini anticipates the full three-year accreditation survey anytime before **August 2011**. The full survey will be unannounced until 7:30 a.m. on the day of the survey and involves up to three surveyors over a course of three to four days.

Reminders for the upcoming accreditation survey:

- **Active Time Out process.** Every team member, including physicians, should participate in Time Out.
- **Do Not Use Abbreviation (DNUA).** The surveyor found "u" in the patient's computerized

record. "u" is on the Do Not Use Abbreviation list and should never be used. (Last year's PPR found "QD" in patient records, which is also a Do Not Use Abbreviation.)

- **Illegible handwriting.** The surveyor was unable to read progress notes written by staff and physicians. If your handwriting is illegible, please print carefully. (This finding was also noted in last year's PPR.)
- **All entries in the medical record should be dated and timed.** Most physicians date entries, but frequently miss indicating the time.
- All telephone and verbal orders should be signed within 48 hours.
- Avoid verbal orders unless it is an emergency.

- **Surgeons need to mark the surgical site.** As part of the Universal Protocol to prevent the wrong site during surgery, the surgeon must mark the surgical area.
- **Policies that require review and/or updating.** Departments should review their policies/procedures and update staff regarding any changes.

Administrative Staff Gary K. Kajiwaru, *President and Chief Executive Officer* • Gregg Oishi, *Senior Vice President and Chief Operating Officer*
• Quin Ogawa, *Vice President, Fiscal Services and Chief Financial Officer* • June Drumeller, *Vice President, Clinical Services* • Dr. Nobuyuki Miki, *Vice President, Medical Affairs*

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Editor/Photographer: Michelle Orian, *Public Relations Specialist* **Contributing Writers/Photographers:** Donda D. Spiker, *APR, Manager of Marketing and Public Relations* • Mel Martinez, *Media Production Specialist* • Ken Yatomi, *Marketing Specialist*

Layout and Design: Anne Shimabukuro, *Graphics and Design Specialist*

Article contributions and ideas should be sent to: Kuakini Health System, Marketing and Public Relations, 347 N. Kuakini Street, Honolulu, Hawaii 96817; Phone: 547-9168; or m.orian@kuakini.org. Visit the Kuakini Health System website at www.kuakini.org.

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"DO NOT USE" ABBREVIATIONS OR DOSE DESIGNATIONS¹

ABBREV./ DOSE EXPRESSION	INTENDED MEANING	MISINTERPRETATION	CORRECTION
Zero after decimal* (1.0 mg)	1 mg	Mistaken as 10 mg if the decimal point is not seen.	Do not use trailing zeros for doses expressed in whole numbers
No zero before decimal dose (.5 mg)	0.5 mg	Mistaken as 5 mg	Always use leading zero before a decimal when the dose is less than a whole unit
MS, MSO ₄	morphine sulfate	magnesium sulfate	Write "morphine sulfate"
MgSO ₄	Magnesium sulfate	Morphine sulfate	Write "magnesium sulfate"
Q.D., QD, q.d., qd	daily	The period after the "q" mistaken as an "l" causing drugs to be administered four times daily instead of daily.	Write "daily."
Q.O.D., QOD, q.o.d., qod	every other day	Mistaken as "q.d."(daily) or "q.i.d. (four times daily) if the "o" is poorly written.	Write "every other day."
U or u	Unit	Mistaken as a zero (0) or a four (4), causing a 10-fold overdose or greater (4U seen as "40" or 4u seen as 44.); mistaken as cc	"Unit" has no acceptable abbreviation. Write "unit."
I.U. or IU	international unit	Mistaken as IV (intravenous)	Write "international unit"

¹ Applies to all orders and all medication-related documentation that is handwritten (including free-text computer entry) or on pre-printed forms.

* **Exception:** A "trailing zero" may be used only where required to demonstrate the level of precision of the value being reported, such as for laboratory results, imaging studies that report size of lesions, or catheter/tube sizes. It may not be used in medication orders or other medication-related documentation.

Approved by the Medical Care Evaluation Committee on February 8, 2011.
Approved by the Executive Committee of the Medical Staff on February 15, 2011.

Surgery Power Plans Revised

In an effort to standardize and to increase compliance with the Centers for Medicare and Medicaid Services' (CMS) and Joint Commission's required quality measures, the following revisions were made to the postop surgical power plans where appropriate:

Tubes/Lines/Drains:

- Added "Remove after 48 hours" to the *IO Indwelling Urinary Catheter* item.
- Physician documentation of a reason to keep the urinary catheter/foley is required on the first or second postop day, if the catheter remains in place.

Antibiotic Prophylaxis: Beta Lactam Allergy

- Added to power plans where this section was missing.
- Reminder – If Vancomycin is ordered for surgical prophylaxis, a documentation regarding why it is being used is required by the physician.

Thromboprophylaxis:

- Revised/added this section in the appropriate power plans.
- This section now includes a checkbox to indicate the reasons why medication is not being ordered (i.e., "immediate postop bleeding risk"). This box should be checked if the medication will not be given within the first 24 hours after surgery.

Should you have any questions, contact Lynette Nakama, Quality Management Coordinator, at 547-9234 or ext. 8234.

Pharmacy Renal-Dosed Lovenox® (enoxaparin)

Pursuant to the Joint Commission National Patient Safety Goal to improve the safety of anticoagulation medications and in an effort to improve the ongoing pharmacy monitoring of anticoagulation medications, the following changes to enoxaparin Computerized Physician Order Entry (CPOE) ordering options were implemented in February 2011:

- KMC inpatient pharmacists began automatically "renal dosing" enoxaparin for those patients who had an estimated creatinine clearance [CrCl] of <30ml/min

(as calculated by the Cockcroft-Gault equation).

This was facilitated by the creation of pre-built instructions in all enoxaparin orders, for pharmacy to renal dose if CrCl <30ml/min. The option to remove this instruction was made available to those physicians who prefer to monitor their patient's CrCl independently.

- New enoxaparin PowerPlans and "ad-hoc" orders were created in order to help direct prescribers to the appropriate ordering option and to help pharmacy determine the indication for the

enoxaparin. The new ordering options include:

- Enoxaparin TREATMENT for NEW STARTS PowerPlan, which is intended to be used for patients being started in-house on "treatment doses" (or "weight based doses") of enoxaparin.
- Enoxaparin TREATMENT continuation ad-hoc orderable, which is for those patients who have already been receiving enoxaparin in-house and the order needs to be continued upon transfer to a new nursing unit. (This

order may be "added to phase" within a transfer PowerPlan.)

- Enoxaparin for Thromboprophylaxis ad-hoc orderable is for those patients who are started or continued on enoxaparin for VTE prophylaxis only (non-weight-based doses).

For questions or suggestions, please contact the Kuakini inpatient pharmacy at 547-9131 or ext. 8131.

**Amendments to the
Kuakini Medical Center Medical Staff Bylaws and Rules and Regulations
Approved by the Active Medical Staff on November 9, 2010
Approved by the Board of Directors on December 29, 2010**

The following is a summary of amendments to the Kuakini Medical Center (KMC) Medical Staff Bylaws and Rules and Regulations which were approved by the Active Medical Staff on November 9, 2010, and subsequently approved by the KMC Board of Directors on December 29, 2010.

1. Article X, Clinical Departments, was amended to delete the Department of Family Medicine and place the specialties of Family Medicine and Pediatrics under the Department of Medicine. Article X was also amended to delete “House physician” from the list of Medical Services under the Department of Medicine.
2. Rules and Regulations, Section 8, Credentialing, was amended to delete Sections 8.3.2 through 8.3.2.2. pertaining to credentialing for the Department of Family Medicine. Specialties previously credentialed under the Department of Family Medicine (Family Medicine and Pediatrics) will now come under the rules for the Department of Medicine.
3. References to “full privileges” were removed from the following sections of the Medical Staff Bylaws and Rules and Regulations:
 - 1) Article VI, Clinical Privileges, Sections 3a and 3b.
 - 2) Rules and Regulations, Section 3.1.6.1.
 - 3) Rules and Regulations, Section 9.1.2.1.6.
 - 4) Rules and Regulations, Section 10.1.5.

For other details regarding the approved amendments or for an updated copy of the Medical Staff Bylaws and Rules and Regulations, please contact Medical Staff Services at 547-9274 or ext. 8274.

ARISE at Kuakini

The ARISE (Alert and Rested Individuals Share Experiences) Group, a Kuakini Medical Center sleep disorders support group for patients and their families, held its first gathering on February 11. About 20 people attended the bi-annual meeting, which featured a special lecture, *How Often Should I Have a Sleep Study*, by Dr. Marc Kruger, Medical Director, Kuakini Pulmonary Sleep Disorders Center. The meeting also included continuous positive airway pressure (CPAP) and BiLevel machine pressure checks by home care companies.

For more information about the ARISE Group and the Kuakini Pulmonary Sleep Disorders Center, call 547-9119 or ext. 8119.

Kuakini Health Care Team Cookbooks \$15 each



A collection of over 250 recipes from Health Care Team members, physicians, volunteers and friends.

Pick up your copies from: Kuakini Foundation, 547-9296 or Marketing and Public Relations, 547-9168.

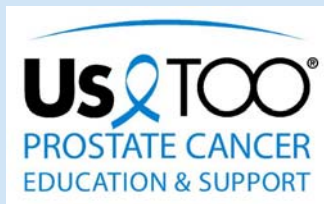
Kuakini Health System Support Groups

Cancer Support Groups



Breast Cancer Education and Support Group

- **Who:** Breast Cancer Survivors
- **When:** Every last Thursday of the month, 10:30 a.m. - 12:00 p.m.
- **Where:** Kuakini Health System HPM-1 Classroom
- **Contact:** Kuakini Education Services, (808) 547-9594 or (808) 547-9788



Us Too Prostate Cancer Support Group

- **Who:** For those diagnosed with prostate cancer, their families and friends
- **When:** Every second Wednesday of the month, 7:00 p.m. - 9:00 p.m.
- **Where:** Kuakini Health System PB-5 Classroom
- **Contact:** Jeanne Foster, Patient Care Coordinator / Support Group Facilitator, (808) 547-9749

Sleep Disorders Support Group

ARISE — Alert (and) Rested Individuals Share Experiences

- **Who:** Patients diagnosed with sleep disorders, their families and friends
- **When:** Bi-annually, dates TBA
- **Where:** Kuakini Medical Center, meeting room TBA
- **Contact:** Kuakini Pulmonary Sleep Disorders Center, (808) 547-9119



Oncology Committee Studies for 2010

Major Study for 2010

“Minimally Invasive Surgery Update – Colorectal Cancer”
Racquel Bueno, M.D.

Minor Study for 2010

“Perioperative Mortality of Pancreatic Cancer Patients – 2004 to 2009”
Manami Okado, M.D.

If any physician would like a copy of the study, call Medical Records at 547-9260 or ext. 8260.

New Physicians

Please welcome the following physicians to the Medical Staff of Kuakini Medical Center.



Joselito M. Amparo, M.D.
Anesthesiology
Provisional



Andrew C. Dickler, M.D.
Internal Medicine,
Cardiovascular
Disease, Critical Care
Medicine
Provisional



Gregory Y. Y. Dunn, M.D.
Radiology
Provisional



Donald J. Gaucher, Jr., M.D.
Anesthesiology
Provisional



Kory H. Kitagawa, M.D.
Dermatology
Special Consultant

Joel D. Brown, M.D.
Internal Medicine, Infectious Diseases
Teaching

Leslie Scott Miller, M.D.
Teleradiology
Telemedicine

Curtis F. Lavatai, M.D.
Anesthesiology
Provisional

James H. Turner, M.D.
Teleradiology
Telemedicine



The Kuakini Health Care Team invites you to its Annual Doctors' Day Celebration Breakfast

Mahalo for your continued partnership with Kuakini.

Doctors' Day Celebration Breakfast
Wednesday, March 30, 2011 • 7-9 a.m. • Hale Pulama Mau Auditorium

Healthful, Hearty Breakfast served by the Kuakini Health Care Team.

A token of appreciation will be presented to all attendees.

For more information, please call Kuakini's Marketing and Public Relations office at 547-9168.

Mayo

Dr. Maxwell Urata

Before a MCE meeting, we were having lunch, provided by Dietary Services. The main dish was either a plain hamburger or a veggie burger, which had a packet of mayonnaise included. There was some discussion on what we were eating. Dr. Tom Maeda, Jr. expressed appreciation for the mayo but Lori, our secretary, sniffed and made a face. She did not realize that our generation almost revered mayonnaise as the condiment that made many food items more palatable, or, for that matter, even possible.

The origin of mayonnaise, and the name, is in some dispute. In the 1961 *Larousse Gastronomique*, it is stated that the term comes from very Old French *moyeu*, egg yolk, so *moyeunaise*. Another version states it owes its name to Charles of Lorraine, Duke of Mayenne who is purported to have had cold chicken with a cold sauce, *mayennaise*, named after him, which he ate prior to the Battle of Arques in September 1589. He ate his lunch and lost the battle; so, was he rewarded for losing? Best Foods, who makes the most popular mayonnaise in Hawaii and the country, states on their

website that the name comes from the battle of Port Mahon in Minorca, which was won by Louis Francois Armand du Plessis, duc de Richelieu for the French against the English in 1756. The sauce was made by his chef who wanted to use cream and eggs, but, having no supply of cream, made do with olive oil. The resulting sauce was named *sauce mahonnaise* after the port and the victory and it is apparently still called that in Minorca. The OED states *mayonnaise* entered the English language in 1861. (By the way, this duc de Richelieu was the grand-nephew of Cardinal Richelieu, made famous as the archvillain in the Three Musketeers by Alexandre Dumas, *pere*.)

Whatever the origin, name or sauce, mayonnaise is fairly simply made with egg yolk, oil, and either lemon juice or vinegar or both and salt. Best Foods makes theirs with pasteurized egg yolks and whole eggs, oil, vinegar, lemon juice and salt with a preservative. The bottled product is not processed any further because heat could alter the product. The history of Best Foods mayonnaise and its relationship to Hellman's mayonnaise is



interesting. Hellman's began to produce its mayo in 1905 in the East and placed the famous "blue ribbon" on their label in 1912. Best Foods produced its mayo in the West. Best Foods bought out Hellman's in 1932 but retained the brand name: So, if you go east of the Rocky Mountains, it is Hellman's, and west of the Rockies, it is Best Foods. The products are essentially identical, and, in fact, are made in the same factory. They both have the blue ribbon on their labels. Have you ever noticed it?

It is pretty easy to make your mayo at home. Many food writers state that the home made stuff is *always* superior in taste to the store bought stuff. However, there is the Salmonella concern in using raw

eggs. The solution is to use pasteurized eggs, which can be found in local supermarkets: Foodland for one. Also, home made mayo may taste better, but it doesn't last as long as the mass produced product.

Julia Child, in *Mastering the Art of French Cooking*, says mayonnaise is comparable to Hollandaise except that the yolks need not be heated. However, she warns that it is best made with all ingredients at room temperature. One egg yolk, sized large, according to her, will absorb ¾ cup or 6 oz. of oil, but she warns that pushing the envelope increases the chance that the emulsion will “break”, that is separate or curdle. At that point, one might as well start from scratch. (There is a way of saving it by starting with a new egg yolk and oil then slowly adding the broken emulsion upon achieving a new one. But, then, you will end up with double the volume of mayonnaise than you intended.) So she says don't exceed a half cup per yolk. The egg yolk is whipped first, salt and vinegar or lemon juice (or both) is added and whipped further. The oil is then drizzled in slowly, constantly whipping, then at an

increasing rate as the emulsion forms. There, you have mayonnaise!

I have made mayonnaise using various oils. I found that using extra virgin olive oil may be overkill, unless you really love olive oil. The flavor can be too strong. Homemade mayo can be up to 85 percent oil! The commercial stuff is, by law, required to be at least 65 percent oil. The use of the acidifiers lowers the pH to 3.8-4.6, so, it is protective of spoilage, being acidic. The easy spoilage of potato salad made with mayo is an old wives' tale. Mayo protects against spoilage of potato salad, as the mayonnaise websites like to point out, and perhaps other products made with it as well.

Mayonnaise is the basis for many other sauces.

In Hawaii, we make a veggie dip of mayo and shoyu. I jazz mine up with the addition of some Coleman's mustard. I did not know that the mainlanders did not know of this combination. It made a sensation when I served *crudités* with this dip. There were even more comments because I served quartered raw button mushrooms with it.

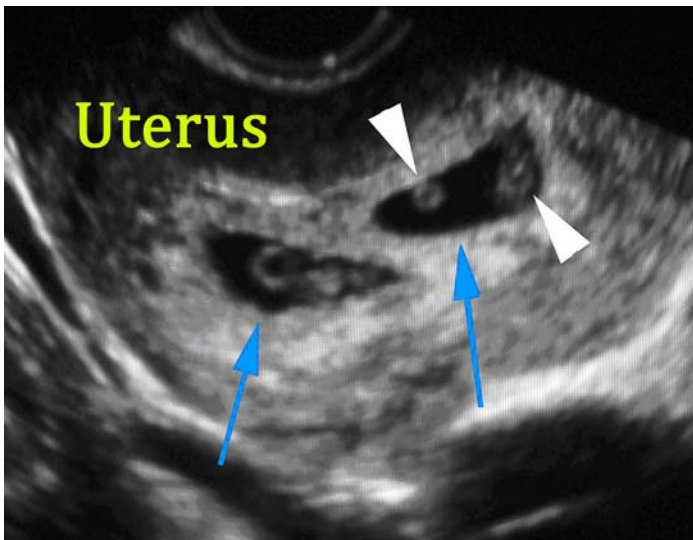
They never ate raw mushrooms before! And this was in the 1960s. (Alan Wong's famous dip/spread that is served with bread can be approximated by using mayo combined with *sriracha sauce*.)

The most famous mayonnaise based sauce is probably *sauce aioli*, from Provence, France. It is a garlicky mayonnaise used most famously with *bourride*, a fish soup, although it can be use on other things. *Aioli* is added to the poaching liquid after the fish is cooked and poured over the fish which is set in a bowl over a piece of bread or toast. The other better known sauces based on mayo are *remoulade*, *tartare* and perhaps *gribiche*, which uses whole hard cooked eggs.

Mayonnaise is an emulsion. An emulsion is a combination of substances that normally do not mix (immiscible), such as oil and water. However, if one uses an emulsifier, in this case the egg yolk and the lecithin it contains, and beats them together, the liquid in this case will suspend within the oil forming the emulsion. Technically, it is a colloidal

suspension of a liquid in a liquid.

Mayonnaise may be considered unhealthy in our current state of what constitutes healthy foods. However, for those of us who like it and were raised with it, it is indispensable. How can you make a tuna salad sandwich or egg salad without it? It just wouldn't taste the same, bad for you or not.



Early pregnancy ultrasound at approximately four weeks of gestation. This image of the uterus shows that it contains two distinct pregnancies represented by the two gestational sacs (the black enclosures indicated by the blue arrows). The gestational sac on the right contains the two yolk sacs of the identical twins (indicated by the white arrow heads). The gestational sac on the left contains the single yolk sac of the fraternal twin.



The triplets, Lynh, Minh and Nam (left to right) when nearly three months old.

I've been leading a double life. In one life, I interpret brain scans as a Neuroradiologist. In my second life, I am a husband and father to my wife and three-year-old daughter. However, as the pre-Socratic philosopher Heraclitus of Ephesus said, "Nothing endures except change." Recently my wife gave birth to triplets. Originally expecting "just" fraternal twins, an early pregnancy ultrasound found that one of the embryos had "split". One of the fraternal twins had become two: the fuzzy fingernail-sized cluster of black and white shapes on the ultrasound image was the beginning of our genetically identical twins, later to become Minh and Lynh. Unbeknownst to us, within days after fertilization, the pre-embryonic mass of cells duplicated: it is nature's way of cloning humans. After an at-times nail-biting pregnancy and delivery, our home has three new little residents. Although what may seem a mindless chore, the hours spent bottle-feeding provides time for reflection – hours of uninterrupted introspection.

Minh and Lynh are mono-chorionic diamniotic twins: they shared the same placenta (monochorionic) but had their own amniotic fluid sacs (diamniotic), the same situation for about a two-thirds majority of identical twins. The twins have the same genetic constitution and should be physically identical because their development is determined by identical DNA. If physically identical, their brains must also be physically identical. Are their minds identical? For the first several weeks, I could not differentiate between the identical twins, while their fraternal brother, Nam, was clearly different.

According to the philosophy of mind, one would expect that identical twins have identical minds. Their mental states (thoughts, perceptions) arise from electrochemical activity of brain cells organized throughout the brain substance, and if those brains are structurally the same, then so must the minds they foster. But are their minds the same, are they identical, completely indistinguishable? Do Minh and Lynh have the same thoughts? Do they have identical mental perceptions (qualia) of the sights,

sounds and tastes they experience in their nursery? Thwarting my investigation, I very quickly found that they would not answer my inquiries. As Cool Hand Luke would have described it: “A failure to communicate.” Although after a month or so Minh and Lynh remained nearly indistinguishable in appearance, it was becoming clear that they possessed different minds: their behaviors (i.e., personalities) became unequivocally different. Minh is more restless and desirous of human contact than Lynh, who is more acquiescent and observant.

Psychology postulates behavior has genetic and environmental roots — Nature versus Nurture. If Minh and Lynh are genetically identical, then shouldn't their differing behaviors result from the environment? They live in the same room. They are fed at the same time. Although their cradle swings are a couple feet apart, there is hardly any difference between their worlds of experiences. However, if we consider the earliest period in their lives, twins may have different experiences in the uterus. In some cases, twins may receive differing amounts of nutrition from

the placenta, classically leading to one twin being smaller than the other (Selective Intrauterine Growth Restriction) which may affect organ development. However, Minh and Lynh have always been the same size. Their environments before and after birth seem too similar to account for the differences I've observed.

Having arisen from the same embryonic cell mass implies they inherited the same genes. But genes must be expressed to do their job. Are the genes in each twin expressed the same? Geneticists have puzzled over cases of identical twins who clearly differ, such as only one twin expressing a genetic disease. How can two people with the same genes have different expressions of genetic diseases? It turns out that despite having the same genes, identical twins may have different numbers of copies of certain genes, instead of the usual two (one copy from each parent). Different numbers of copies can alter a gene's effect. The burgeoning field of epigenetics claims that small chemicals, such as a methyl group, can attach to a gene and alter its expression. Thus each twin can

have identical sets of genes, but the function of certain genes may differ between them by epigenetic effects. Alternatively, imperfections in the copying of DNA may lead to variations (mutations) in the genes that could differ between otherwise identical twins. Thus there are several ways to alter gene expression, so that identical twins — and their minds — aren't necessarily identical after all.



347 N. Kuakini Street • Honolulu, Hawaii 96817
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