North Coast Physician

In This Issue:

Cover Photo
"da Pelican"
Robert Soper, M.D.

The Editorial and Publications Committee encourages our member's comments for publication. Please submit electronically prior to the 15th of the month preceding publication.

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CMA President Message

Judge Issues Final Ruling - Blocks State's Attempt to Slash Medi-Cal Reimbursement Rates

James Hay, M.D.

President, California Medical Association

Dear Colleagues –

Early February, because of the efforts of a coalition led by the California Medical Association, a final ruling was issued by Judge Christina Snyder of the California Central Federal District Court, which blocks a 10 percent Medi-Cal reimbursement rate reduction. Her decision is a huge win for physicians in California and for the patients they treat.

California faces a budget deficit every year, and to close that widening gap, programs are cut and services are slashed. Medi-Cal is a program that is constantly targeted, and proposals always seem to include reducing reimbursement rates for physicians as a short-term solution. CMA has repeatedly informed the state, the federal government and the courts about the unacceptable impact of those cuts.

Year after year, we're obliged to tell the same story: if Medi-Cal rates are cut, physicians will be forced to stop accepting the patients that need care the most. Thanks to the hard work of CMA's legal and legislative staff, our voices have been heard, yet again. As we argued, Judge Snyder's ruling stated that "fiscal crisis does not outweigh the serious irreparable injury plaintiffs would suffer absent the issuance of an injunction."

It is more important than ever that we fight these fights and that we set a precedent for other states to follow. As the nation faces a changing health care landscape over the coming years, it is also critical that we physicians stand together. We thank our members for helping us accomplish this important outcome, preventing deterioration of access to care. My hope is that this achievement will serve as a reminder to those who are not yet members, and encourage them to join CMA today. To have continued success winning these battles for all California physicians and patients, it is crucial that we gain the support of those that benefit most.

To read the full statement issued by the coalition of plaintiffs in CMA et al. v. Douglas, please visit CMA's website www.cmanet.org.

James T. Hay, M.D.

California Medical Association President

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EMR 8 Years On

Lee Leer, M.D.

We at Eureka Family Practice have been using our current Electronic Medical Record (EMR) since 2006. Prior to that, we had a different EMR for 2+ years. So, we've been electronic for more than 8 years. As such, it would be reasonable to assume that by now we'd all be proficient electronic providers and would be well on our way towards our second installment of Meaningful Use (MU) dollars from the government. Were these assumptions correct, I'd have nothing to write about this month. Sadly, we're still struggling.

In fairness, we struggled with information management back in the pre-EMR days too. But the struggles were different: finding lost charts; finding lost reports; sorting out apparently meaningless problem lists and hopelessly out of date medication lists; getting notes in charts in a timely fashion; routing and tracking messages from patients, other providers, and the like. No, the good old days weren't so good at all, at least not vis a vis information management.

Now, if we've lost one chart, we've lost them all: i.e., the system is down. Fortunately, in the 8 years we've been "paperless"(more on that term in a moment), we haven't experienced more than a day or two of unplanned down time. Reports, if scanned into the right chart, and if labeled correctly, are quite easy to find. Messages are impossible to lose - though quite possible to delete without answering, to ignore, or to route to the wrong person.

Medication lists now, one would think, ought to be close to perfect. Except they're not. Some of us enter all the patients' OTC meds as well as prescribed meds, so the list is (arguably) accurate, but could be 20 items long. Long enough to obscure a few important prescriptions that are subsequently forgotten about. Outside providers also prescribe for our patients, but we have no electronic connection with any of them, and we don't always get the message that meds have been changed. When we do get the message, we don't always act on it. I must admit, for example, that when I get a written report from a consultant, I seldom update the med list based on the consultant's report. My reasoning is partly that I'd rather wait to confirm the change with the patient, and partly laziness. In any event, the result of all this is that these beautiful looking computerized medication lists cannot be counted on. I cringe when the hospitalists log on to EFP's site and open a newly admitted patient's chart. Most of what they read is correct. Indeed, most of the time it's entirely correct, but it's embarrassing how inaccurate we can sometimes be.

Problem lists? I don't know where to start. Our system allows us to differentiate between major ongoing problems (e.g., hypertension) and acute problems (e.g., ankle sprain). Unfortunately, if we don't push the correct button, everything can become a major problem. Furthermore, some of us like to use problem lists to remind ourselves of significant events (e.g. "had chest CT 6 months ago - normal"). So, like med lists, some problem lists become so long that important items can be easily missed, especially if the patient is seeing someone other than his/her primary provider.

Chart notes are hardly better. Some of us use highly modified templates and hand type most details of the note; others use templates and rely much more on the menu-driven aspects of templates, such that a note for a URI can morph into a 3 page dissertation on all that is not wrong with a patient. Others dictate - some using a traditional transcriptionist, others using an internet based transcribing service, and one using Dragon voice recognition software. When we installed our current system, this flexibility seemed quite nice. Now, I personally wish it would go away. None of our notes look alike, the transcribed notes often don't properly link important items to other parts of the chart, because they're missing the command lines that are in templates, and the Dragon notes are, shall we say, amusing. Yet we all struggle on with whichever method we thought was easiest in the beginning and now steadfastly refuse to abandon. I can't tell you how many times I thanked my mother for making me take typing classes during that summer back in the '60's!

Paperless. What a clean, proficient, tree-saving sound that has to it. Except, it's not clear to me that we actually use less paper now than before. Some of us are uncomfortable using the computer in the exam room, and instead bring in printed face sheets for each patient: including problem lists, med lists, and copies of all recent labs, imaging studies, etc. When we used paper charts, none of us seemed to need to have the problem list from the chart REPRINTED so we could not carry the chart into the exam room. Yet, some of us won't get comfortable with using the computer like a chart. On the other end of the spectrum, some of us are quite comfortable searching through Google and UpToDate with our patients during visits.

And these are just some of our foibles and idiosyncrasies.

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They all pale in comparison to the problems that have come from the software vendor. While I would be happy to vent to anyone who wants specifics, I won't bore you here with details. Suffice to say that we've had problems with software "glitches" that were only made worse by the patches that were supposed to fix them; with tech support being either unavailable or downright wrong (I can't tell you how many times Tech A has contradicted Tech B, only to find, after we talk with Lead Tech C, that they're both wrong). Upgrades and patches are supposed to be easy to install. Usually, however, the instructions that come with them (when we get any instructions at all) are wrong. Usually, a call to tech support is necessary. I can only say that I'm glad we pay our office manager a salary rather than an hourly wage. Too many weekends, nights, or early mornings, she's had to go to the office to work with tech support and or local IT to fix some software problem or another.

And this is, I still believe, one of the better EMR's out there. It is used by university faculty practices as well as small and large single and multi-specialty practices across the country. It has been affiliated with a research network that has been tracking and reporting on meaningful use targets for more than 10 years - long before meaningful use became MU. It has a vibrant users group that is composed of some of the most interested and dedicated physicians I've encountered.

For the foreseeable future, of course, almost all of us not only have to learn to navigate one EMR, but several: one for each site we work. In my case, there's the office EMR, the hospital EMR, and that horrid EMR at Planned Parenthood (at least, I know that things can always get worse!). In 8 to 10 years, many of the current products will have died, and those that survive will probably all look quite a lot alike, will function remarkably well, and will be able to easily communicate with one another.

But until then, wow! It amazes me that so many people can come at EMR's from so many different angles: some undervaluing them or even discounting them entirely; others ascribing EMR's with the ability to save American healthcare. The reality, of course, is somewhere in the middle, and is a moving target. To deny that EMR's have helped improve the care of our patients - with their ability to track health maintenance needs, monitor for drug interactions, allow for shared data across wide geographic stretches (to give just a few examples) - is tantamount to denying the reality of human-caused global warming. By which I mean, some of us still deny it. Like global warming deniers, EMR deniers are pig-headed and insulate themselves from the world in a fact-free cocoon of their own creation. Yet, on the other extreme, the government policy gurus who currently drive EMR development have done both us and our patients a disservice. In their efforts to "do it all" and in their belief that EMR's are the answer to all our problems, policy makers have needlessly complicated requirements for MU certification. They have forced us clinicians to focus so much energy on trivia (e.g., "did I generate a computerized order entry for that INR my medical assistant just did on my patient?") that we can easily lose focus on our patients.

Some day, when medical historians look back, the story of the EMR, the story of how medicine learned to collect, store, and usefully process information, will be the primary medical event of the early 21st century. It will encompass and eclipse every breakthrough, every drug, device, and stem cell. For now, however, we are living the Chinese curse. We are living in interesting times. §

Did You Know....

The Medical Society offers NOTARY PUBLIC services for our members at no charge.

ISHMAEL

GEORGE INGRAHAM, M.D.

Summer, 1967. They brought twelve year old Ishmael to the ER shaking with fright and pain. He had been squeezing through a hole in a damaged fence (East Oakland had a lot of those) and had somehow gotten a perforation of his right eye from a splintered picket. The Chief Resident took him to surgery, where the protruding iris and choroidal tissue was excised, the vitreous was snipped off, and the sclera was sutured with 8-0 silk (which we thought was a really tiny suture). The lens was missing and there was blood in the back of the eye: the state of the retina was unknown. Over the next forty-eight hours there seemed to be no infection, which meant that we might not be compelled to remove the damaged eye right away; but brought up another possibility: Sympathetic Ophthalmia; an auto-immune reaction to the injury which, once the initial signs appeared, would inevitably destroy not the injured eye, but the remaining healthy eye. It was known, however, that if the injured eye was removed within a week of the injury sympathetic ophthalmia would not occur. The injured eye still had bare light perception, but it was very unlikely that it would ever have useful vision. With the potential for sympathetic ophthalmia, there was good reason, if not a clear indication, to advise removing the injured eye, even though the incidence was less than one percent. On the other hand, if the eye was removed that would mean another operation, a glass eye, and the permanent loss of a "spare" eye which might be of some use in the future. Although the possibility of sympathetic ophthalmia was very small, it wasn't zero; and the probability of an injury to the other eye was even less. What to do? Call in staff consultants, of course.

One consultant was upset that we had waited as long as we had: "you guys should have had that eye out two days ago!" (he had seen a case) another felt that sympathetic ophthalmia was "a chimera, a coincidence: there is no such disease"(he had not). Ishmael's parents wanted to keep the injured eye. So did Ishmael. To say that we residents were divided is understatement squared. I was happy not to be the chief, who decided to leave the eye in. Ishmael went home, returning to clinic every day until the peaceful good eye suggested that the bullet had been successfully dodged. "Late onset" sympathetic had been described, but was virtually unknown.

Winter 1967: Ishmael's good eye remained quiet. The blood in the injured eye cleared slowly, showing that the retina, or maybe part of it, was still there. He could see whether a hand in front of the eye was moving or still.

Spring 1968: The good eye was fine, the probability of even late onset sympathetic essentially zero. With a strong lens in front of the injured eye, Ishmael could read medium size print with the material held very close. Not that he would ever want to, since the good eye was seeing 20/20; but the eye did not look badly and he didn't need to be troubled with a glass eye.

Winter 1969: I was chief resident now. Ishmael continued his occasional clinic visits. He enjoyed good vision in the good eye. The injured eye, although unused, (there was too much difference between the eyes for them to be used together) looked presentable and was comfortable. And then one afternoon Ishmael was in the ER again with a terrible blunt injury to the good eye. This time, there was no decision to make. What had been a normal eye that morning was now shreds of retina protruding through a large rip in the sclera: the eye had ruptured. We told Ishmael's parents. We told Ishmael. We questioned our belief in a beneficent cosmos. And then we took Ishmael to surgery and removed what remained of his eye.

Spring 1970: Ishmael, with the use of a very strong pair of glasses, was able to read typewriter print successfully if slowly. He was "doing OK" in school. He could take care of himself without assistance for almost everything. He was looking forward to finishing school. He was doing OK.

I have lost touch with Ishmael and the other patients I knew in residency. I had a follow-up from the program a year later, but as new docs moved up, the link went still. Ishmael would be in his late fifties now. If we had removed the first injured eye in 1967 he would have spent almost all of those fifty years in complete darkness. If we had guessed wrong, and he had contracted sympathetic ophthalmia, he might have had the same result, or close to it.

You would think that a case like this, with decisions being made under pressure and the outcome uncertain, would at least result in teaching a lesson, a set of absolute principals for future cases, a guide star for use with the next Ishmael; but there seems to be no guidestar. Perhaps that is the lesson. §

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"Dynamics"

JENNIFER HEIDMANN, M.D.

The piano has a confusing name. Piano means soft in Italian. But we don't always play softly. Turns out this is just a lazy version of the original name: pianoforte, or maybe fortepiano. Forte means loud, and what was amazing in the old days about this instrument is that you could produce variations in volume of sound. Now we take that for granted, but at the time it pretty much blew people's minds. Our ability to change moods and sounds during the course of a piece of music allows us to pull people in emotionally. Dynamics speak to our human need for change, and for dissonance with resolution.

In our work as physicians, I think many of us have a love-hate relationship with change. The fact that we practice in a dynamic field cannot be ignored, and it can induce dizzying effects. Over the course of a century, we've developed so many options for treating people that we now have discussions about whether we create illnesses out of somewhat normal or expected human variation, just because we CAN treat them. And in our day to day lives as healthcare providers, the very way we interact with our patients is so different now that I doubt many of our predecessors would recognize us as being from the same professional species. I picture the doc of old looking at me sitting in front of my computer for the majority of my day and wondering what kind of healing could possibly result. And I picture him getting into his carriage for a 3 hour ride out to someone's home and then sitting at the bedside of their sick child all night, with no antibiotics to offer and only the practiced eye and healing touch with perhaps some extract of willow bark in hand. My own grandfather was sent home with an aspirin to treat his MI, where he died in bed, as expected. Then his son, my father, went on to receive a heart transplant for the same genetic disease. Change: good?

In the hospital, we are facing shifting ground constantly, and I am not just referring to the 5.6 quake we felt earlier this week. On February 28, the hospitalists go live with computerized physician order entry (CPOE). It will alter our work flow, and likely place us even more firmly in front of our computer screens. I think some good will come from it as well: more standardized care (with order sets that prompt us to consider evidence, and checklists so we don't miss the obvious), legible orders, and the more mercenary side effect of complying with the government's wish for "meaningful use" of the EMR. What will our Primary Care colleagues notice with this change? One thing is your patients will receive a legible print out with discharge instructions, including new prescriptions and medications to be continued, stopped or changed. We have also included in the order sets a reminder to notify the PCP of the admission. Nothing replaces direct communication, of course, but we are trying to develop systems to improve the flow of information. Please let us know if you have any feedback as we go live with CPOE. And for now, if you directly admit someone to our service from your office, you will still write your orders on paper.

Another dynamic area for us is discharge planning. Pat Waldron, RN has taken over this department, and in conjunction with Dr Jacobs, CMO and our hospitalist team, we are trying to plan for a smooth discharge from the moment the patient enters our hospital. This, like so much in our field, is a work in progress.

Most of us went into medicine to help people and to work in a field that makes you learn something new almost every day. Recently, new guidelines emerged on the treatment and prevention of venous thromboembolism. The hospital is rolling out an intensive sepsis management initiative to improve the timeliness and quality of sepsis care. The limits of our care a century ago have been replaced by sometimes overwhelming choices, but it is gratifying when our treatments can save a life, or at the very least bring comfort and healing to a patient. And though computers sometimes feel like they put up a barrier to human contact, I am quite thankful for resources like Up to Date!

Remember the date: February 28. CPOE go live for hospitalists. If you hear any loud (forte) shouting from the wards, just consider it artistic expression of dynamics. §

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Have you looked at the Medical Society Web Page lately? Comments/ Suggestions are always welcome.

Humboldt Doctors Launch New Chapter of California Physicians For A National Health Program

WENDY RING, M.D.

A group of Humboldt County physicians met on February 4th to establish a local chapter of Physicians for a National Health Plan-California. We currently have 22 physician members in the region and felt it was time to get organized. Physicians for a National Health Plan (PNHP) is a national organization devoted to achieving publicly financed health care for all. Founded in 1987, it currently has over 18,000 members and organized branches in every state. PNHP-CA is PNHP's largest state organization.

After an excellent discussion and update on the status of state and national single payer efforts, our new group decided to focus on education to "immunize" the general public from insurance company propaganda, support for state campaign finance reform, and working within our medical society to sponsor a single payer resolution for CMA's annual meeting. Several of our medical society members have introduced resolutions as individuals in previous years. CMA's position on this issue has progressed from outright rejection to recognition of single payer as a valid option with concerns about aspects of the legislation related to governance and physician input. These are issues that could be addressed if the association was motivated by its membership to move from opposition to constructive engagement.

California's state single payer bill failed last month in the State Senate by 2 votes. Single payer bills were passed twice by both houses in previous years but vetoed by then-Governor Schwarzenegger. This year, with the possibility that Governor Brown might sign a bill that would cut state health spending and stem rising expenditures, there was more insurance industry pressure on politicians. With new research showing that only half of California's uninsured will gain coverage under ACA and that chronically ill insured patients with the same high deductibles permitted under ACA often forgo needed care, its clear that "watchful waiting" to see the results of Obamacare before pressing for the elimination of for profit insurance will only result in continued unnecessary deaths. PNHP-CA is part of a coalition of statewide organizations, Campaign for a Healthy California, that will continue to work for single payer reform that would provide first dollar coverage for all Californians.

Our new Humboldt County Chapter of PNHP-CA joins chapters in LA, San Diego, Sacramento, East Bay, and Chico. Our next meeting will be on March 24 at 10am at the home of Dr. Corinne Frugoni and all are welcome to attend. Call Corinne at 822-3141 for directions and more information. You can also join online at phnpcalifornia.org §

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