North Coast Physician

In This Issue:

Cover Photo
"Humpback Whale"
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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Random Observations

Lee Leer, M.D.

This article is not about electronic medical records. Yet, I must complement the developers of St. Joseph's EMR for managing to remove all aspects of intelligibility and usefulness from its printed emergency department reports. ED reports used to be clear, concise, and useful. Now, frankly, I just throw the 10 pages of gibberish into the trash and ask my patients what they recall from their visit and go from there. Congratulations to whomever wrote the program that generates the data that someone somewhere thinks suffices for an acceptable clinical note. I offer my sympathies to our emergency physician colleagues who have to live with this system, and to all of my outpatient colleagues who have lost the ability to gain useful information from a medical record. At least we're all trudging into the dark together.

Ah heck, let's go ahead and make the whole editorial about EMR's since there's nothing else important in healthcare to talk about these days, given that Candidate Romney has now re-defined himself as a staunch supporter of Medicare (though he personally doesn't want it) and advocate of all the popular aspects of the ACA, even while pledging to immediately overturn the whole affair and turn healthcare over to the states as his first act as President. Interesting how he's all for states' rights except in cases of gun control and reproductive freedom. Oh, and taxes and labor law. And other things that he thinks might pander to the idiot wing of his party.

But I digress. EMR's. My practice's EMR has a wonderful Health Maintenance component that pops up as soon as we open any patient's chart – either for scheduling, billing, or to start an office note, review labs… whatever. The first thing we see is the health maintenance template, showing us only the services that are due for said patient. This allows us to empower our schedulers, billers, MA's, office manager – anyone who enters a patient chart - to order an overdue hemoglobin A1c, or mammogram, or office visit. So, imagine my surprise today when I got a pop up reminder that my 65 year old patient was due for: Hep B Surface Antigen testing, HIV test, Chlamydia test, blood type, and a few other things that I can't recall. None of this made any sense, until I realized that this is probably what obstetricians are expected to screen for in pregnant women. I checked her chart to make sure we hadn't inadvertently made the poor woman appear pregnant with errant record keeping. Nope. So my office manager called tech support. Two aspects of this call surprised me. First: tech support actually responded the same day we contacted them. Second: they told us that this just wasn't such a big deal and was causing no harm. Oh, and they had no idea why it was happening and they could not fix it. Have a nice day, they said, and: "is there anything more we can do to help you today?" So surprise number two pretty much cancelled out the good will generated by surprise number one.

Recently, we got our "report card" from the HDNIPA, which scores us on aspects of diabetic care. As always, and as is true of the entire county, we scored horribly in documenting diabetic eye exams (one needs to be recorded annually for each patient). For years, I've assumed our low score was because we simply had failed to (1) take the time to do the ophthalmology referrals during the 15 minutes in which we're supposed to check feet, document the clinically worthless urine microalbumin, discuss diet, exercise, medication, and the 5 active problems that the patient actually cares about and (2) document the eye visits that had indeed happened but hadn't been entered into the record. I would have been wrong. Or at least, I would have left out the third part of the problem: which is that the IPA has not been extracting our data regarding eye exams… instead apparently relying upon outside sources (insurance data?, reports from eye care specialists?) to determine our patient's care. I know this because finally our EMR has evolved to the point that one doesn't need a PhD in computer science to run a report that extracts such data as "how many diabetics are due for eye exams?" It turns out that our in house data shows significantly better results than does the IPA's evaluation. On checking with the IPA we learned that this aspect of the data we were "dumping" to them was not being used. There is a similar problem with patient satisfaction reports. Each month, we mail satisfaction surveys – using the same questions as are used by the Blues – to a spectrum of our patients with all insurances, and we always get a more positive response than what the Blues report to the IPA. To be clear: the response we get from a wider swath of our patients is consistently more positive than is the response a couple of insurance companies use to help the IPA determine our annual "bonus" payment. Our survey responses have never erred in the other direction.

What do we make of all of this? Basically that the ability to ask the computer the right questions and the ability to get the correct answers are works in progress. Sadly,

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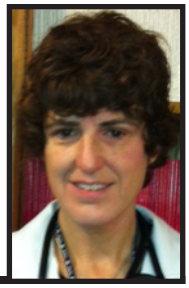
SJE Hospitalist Update: Looking Back, Looking Forward

JENNIFER HEIDMANN, M.D.
Facility Medical Director, TeamHealth West, St. Joseph Hospital



It is hard to believe we are nearing the end of 2012. Time flies when you are having fun. Or something like that. Before the year ends, I wanted to reflect on what the St Joseph Hospital hospitalist group has been up to, and to mention some exciting projects and news as we head into a new year.

We have seen big changes this year in how we do our day to day work. Mainly this involves less use of pens, and more use of typing fingers. The hospitalists went live with computerized order entry in February. We built many order sets and continue to try to improve the system. Discharges are time intensive, but I do think it's better for patients and, hopefully, for the primary care providers, as there is a legible list of diagnoses, follow up and medications. One of the projects moving forward is medication reconciliation. I am advocating strongly with administration to make this a priority. It deserves our full attention, and likely we need dedicated people to do the detective work necessary to find out what people are actually taking at home. Another thing we are doing now is our SOAP notes on the EMR. This is new, within the last month, and we are just getting our feet wet, but if you want to check it out on your hospitalized patients, you can go to Other Reports in Meditech and see the progress note for that day, which appears instantly when we write it.

Computers have certainly been a focus this year. But staffing has been another issue we have faced. We lost some great full time docs, but the good news is two of the three that left us have returned! Dr Wahidullah and Dr Yasmin Siddiqi are back with our team. We have just hired a new ACNP to be Karen Ayers' partner. Danita Packard, ACNP is a very experienced hospital medicine NP. She starts late November/early December. We have some regular "envoys" and locums who come up monthly for a year or more, and so they feel part of the team. Dr Lidia Everett is our newest member. Also, Dr Borna Solomon, Dr Tony Tran and Dr Nantida Hong have been our newer "regulars". And we have a full time nocturnist who lives here in town, Dr Gerald Buntin. He works about 21 night shifts per month, and is very strong in critical care. If you get a chance to welcome him to our community and thank him for watching over your patients at night, please do! I have recently interviewed some other strong candidates interested in full time work here, and will keep everyone posted on how that proceeds.

Looking ahead, the most visible change coming is the new tower. It opens November 11. If you haven't yet toured the place, do! It is lovely. It will take some getting used to in terms of navigation, but the space is one that will promote healing. Other projects that we hope to do in coming months include a closer relationship with our Care Transitions team (led by Sharon Hunter) and brainstorming on how we can better "flow" our patients in and out of the hospital. With Sharon's leadership, we are partnering with Open Door Clinic as a pilot to be in close contact with the PCP throughout the admission, to get patient's records from clinic in the charts ASAP (without necessitating access to the EMR by us) and working toward a smooth discharge back to the PCP. We are also targeting patients with certain dx, such as COPD and CHF, who tend to have higher admission rates. Yesterday, I met with a team of people from the community, Care Transitions, and Open Door Clinic, led by Dr Hunter, to discuss better care in the hospital of patients on suboxone, and better transitions for those addicted to opioids who might be good candidates for suboxone. Other things being discussed include an observation unit for diagnoses such as rule outs and TIAs, perhaps staffed by our NPs in conjunction with the other hospitalists, and the possibility of a follow up clinic staffed by hospitalists as a stepping stone back to PCPs that focuses on the acute issues in patients at high risk (eg on coumadin or antibiotics, marginally housed, mentally ill, or not yet established with a PCP). Finally, Open Door and Care Transitions has a grant from Robert Wood Johnson to focus on superutilizers, and the hospitalists are working along with them and the ED to identify these patients with the ultimate goal of starting to develop systems to better serve them in the community and decrease ER and hospital visits.

I still hope to get together the hospitalists and PCPs for a meal and discussion. When we send out an invitation for this, please consider joining us. §

Contact information: (707) 445-8121 x7119 / Jennifer.Heidmann@stjoe.org

Did You Know.....

Members can request to have Physician Recruitment notices posted to the Medical Society's Website at no charge.

Getting Wiser

MARY MEENGS, M.D.
Utilization Management Director, HDN IPA

When I was in my residency, 23 years ago, I was admitted to Northwestern Hospital in Chicago for a lumpectomy and axillary node dissection. Everything went smoothly, but I was kept for 3 days. A few years later, the mother of a friend of mine, age 69, had the same surgery as an out-patient. I thought about that a lot as I moonlighted to pay off that bill (I went out of network because lumpectomies were somewhat new then). I was very healthy (well, except for the cancer!), no meds, and my pre-op tests were perfect (CBC, UA, chem panel, CXR, and EKG---for a 33 year old). Early in the morning of post-op day 2, a med student came into my room to draw labs. I tried to negotiate with him (because I was going to be paying the full, inflated price)---no fever, no meds, no IV, fluids going in and out just like they're supposed to, ambulatory, etc---but he finally begged me, saying "I'll get in trouble with my attending if I don't get these". So I relented and eventually paid $120 for a CBC and lytes, normal of course.

Nothing special about that story, quite ordinary for 1989, but it serves as yet one more illustration of how the medical standard of care changes over time. Now we have Evidence Based Medicine and patients who look things up on the internet and something officially called Shared Decision Making. How can we be sure we stay in step?

In his article for the September issue, Dr. Michaels talked about the Choosing Wisely campaign and the recommendations from the American College of Cardiology. The National Physicians Alliance conceived and piloted the project, subsequently developed by the American Board of Internal Medicine Foundation. Choosing Wisely challenges different medical specialty societies to identify 5 common tests or procedures whose necessity should be questioned and discussed by the patient and physician. The goals were "to help physicians be better stewards of finite health care resources" and to improve the quality and safety of health care. Nine medical specialty groups were the first to publish their list of "Five Things Physicians and Patients Should Question", and the Choosing Wisely initiative was announced to the public in April of this year. Consumer Reports joined the ABIM Foundation in the development and publicity of the campaign, along with 14 other consumer-oriented organizations. Twenty-one other specialty societies have signed on, and will publicize their recommendations in 2013.

The Quality Management Committee (QMAC) of the IPA has begun featuring one set of recommendations at each of its monthly meetings. As an example of what these lists look like, here are the two we've already covered:

American College of Radiology

1. Don't do imaging for uncomplicated headache.
2. Don't image for suspected pulmonary embolism without moderate or high pre-test probability.
3. Avoid admission or preoperative chest x-rays for ambulatory patients with unremarkable history and physical exam.
4. Don't do CT for the evaluation of suspected appendicitis in children until after ultrasound has been considered as an option.
5. Don't recommend follow-up imaging for clinically inconsequential adnexal cysts.

American Academy of Family Physicians

1. Don't do imaging for low back pain within the first six weeks, unless red flags are present.
2. Don't routinely prescribe antibiotics for acute mild-to-moderate sinusitis unless symptoms last for seven or more days, or symptoms worsen after initial clinical improvement.
3. Don't use dual-energy x-ray absorptiometry (DEXA) screening for osteoporosis in women younger than 65 or men younger than 70 with no risk factors.
4. Don't order annual EKGs or any other cardiac screening for low-risk patients without symptoms.
5. Don't perform Pap smears on women younger than 21 or who have had a hysterectomy for non-cancer disease.

Each of these items is annotated with descriptive reasoning and justification, and each page has a "How this List was Created" section and details of source references. All of this information, and the other specialty lists, can be found at www.ChoosingWisely.org . Some of these items will likely sound simple and obvious, especially if they come from your specialty, but I think it's quite a challenge for primary care providers to keep up with all the current recommendations from different fields. I can tell you that some of the requests for authorization which get denied in our IPA because they don't meet the guidelines for medical necessity (furnished by health plans, Milliman, and imaging societies) are items found on these lists. And, I think it's helpful to know what your patients are likely to be reading in their AARP magazine.

We would like to have some lively and enlightening discussions at future QMAC

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many people – at all levels of care – are unable to discern useful data from garbage. Well-intended clinicians delude themselves into thinking that they can understand and make use of untamed and unlimited amounts of data. With this delusion firmly in hand, they become administrators, entrepreneurs, or consultants, and they foist their delusions on the rest of us. On the other end of things, good computer scientists delude themselves into believing that they can figure out what clinical medicine needs, without ever having been clinicians themselves. Oh yes, and this also teaches us that private health insurance companies lie when it benefits them financially.

In the meantime, good clinicians continue to be clinicians, and excellent and astute computer scientists stick to what they know. And these two groups, that should be working together to design ideal systems, continue to exist in independent silos.

Thank goodness for the fact that I can still sit down in my exam room, put my computer on the counter, look my patient in the eye, and have a meaningful encounter, from which both my patient and I emerge richer for the experience. When I can get a computer to accurately record that reality, and transmit it accurately to all the involved parties: payers, colleagues, and administrators, then I'll believe that the age of the EMR has really arrived. §

"HDN IPA" from pg 6

meetings. There may be illustrative cases presented from our authorization archives. The meetings are held at 12:15 pm on the 2nd Friday of each month, at the IPA/Foundation office. Scheduled topics are:

Nov 9, 2012: American College of Physicians

Dec 14, 2012: American Gastroenterological Association

Jan 11, 2013: American Society of Clinical Oncology

Feb 8, 2013: American Society of Nephrology

If you are able to join in for any of these meetings, please contact Erica Dickinson at edickinson@hdnfmc.com, or 443-4563, ext. 14 so she can take your lunch order. If you can't make the meetings, I encourage you to look over the guidelines on the website. In the press release for the campaign kick-off, Dr. Christine K. Cassel, president and CEO of the ABIM Foundation said "These societies have shown tremendous leadership in starting a long overdue and important conversation between physicians and patients about what care is really needed. Physicians, working together with patients, can help ensure the right care is delivered at the right time for the right patient. We hope the lists released today kick off important conversations between patients and their physicians to help them choose wisely about their health care." §

Anatomy of a Rebate

RONALD JONES, M.D.
NORCAP Representative

In today's' legal climate it's difficult to believe that there was a time when medical malpractice suits were so infrequent and the cost of liability insurance was so low that the California Medical Association included professional liability insurance as a no cost benefit of membership.

Although this idyllic situation came to an end after World War II, reasonably priced malpractice coverage remained available in California until the 1960s, when a new class of aggressive and creative personal injury attorneys identified physicians as ideal targets for contingency fee litigation. By the late 60s, million dollar policy limit demands became common, and medical malpractice insurers began to raise premiums and withdraw from big metropolitan markets. In May of 1973 the major Northern California malpractice insurer no longer had the necessary reserves to continue writing malpractice insurance and withdrew from the state after non-renewing all of its policyholders. Many of our physicians recall the ensuing malpractice crisis of 1975: many physicians left or threatened to leave California, many refused to treat any but emergency cases, many went "bare", and many refused to practice at all until the situation was satisfactorily resolved.

Jerry Brown, then serving his first term as governor, called the legislature into emergency session to deal with the situation, and in an uncharacteristically short amount of time, MICRA (the Medical Insurance Claims Reform Act) was passed.

The same year, Northern California physicians banded together at the county medical society level to form NORCAP – the Northern California Physicians Council – which in turn formed NORCAL Mutual—a new kind of policyholder-owned medical liability insurance company. Founded by and for physicians, the company's vision was and continues to be to insure and defend policyholders against non-meritorious claims while disseminating information on best practices to avoid liability pitfalls.

From its inception, NORCAL has maintained close ties to its sponsoring medical societies through NORCAP. The Humboldt-Del Norte County Medical Society Medical Quality Review Committee (MQRC) and Medical Liability Seminars are two examples of this involvement. As the Humboldt-Del Norte County Medical Society's NORCAP representative I am your local liaison with the NORCAP Council. In the unlikely event disputes between NORCAL and local policyholders arise, I am available to answer questions and even take inquiries and concerns to the Council, which in turn can act as an advocate for you with NORCAL.

As a Mutual Insurance Company, NORCAL's policyholders are its stockholders. Profits realized by the company in excess of operating costs and necessary reserves are returned to its policy owner-stockholders in the form of a premium credit. This year, for the 33rd time in the past 35 years, NORCAL has declared a $12 million dividend in California and Alaska, which is about 10% of 2012 premium. Eligible insureds will see the dividend applied as a credit on their second quarter 2013 renewal invoice.

Its commitment to aggressive defense of policyholders, its grassroots origin and corporate philosophy, and its continued extensive local involvement with sponsoring medical societies are a few of the reasons why the Humboldt-Del Norte County Medical Society endorses NORCAL as its preferred provider of medical professional liability insurance. §

CMA Center for Economic Services

2012 Webinars At-A-Glance

November 7: Understanding ARC and CARC Revenue Codes
12:15 - 1:15 p.m.

November 8: Updates to Meaningful Use
12:15 - 1:15 p.m.

November 14: State Disability Ins Online for Your Patients & You
12:15 - 1:15 p.m.

November 15: Successful Medi-Cal Provider Enrollment
12:15 - 1:45 p.m.

November 28: Understanding CBAS Transition for Dual Eligibles
12:15 - 1:15 p.m.

November 29: California: A Physician Melting Pot
12:15 - 1:15 p.m.

All CMA hosted webinars are free for CMA Members. You may also visit www.cmanet.org/events to view all education events and to register. Webinars are also archived for later viewing. Questions? CMA Member Help Center: 800-786-4262

CLASSIFIED ADVERTISEMENTS

JOB OPPORTUNITIES

Also refer to Practice Opportunities on our website www.hdncms.org

FAMILY MEDICINE:

Fortuna Family Medical Group

Contact: George Jutila, M.D., (707) 725-3334

Redwood Family Practice

Contact: Debbie, (707) 443-4593

WANTED - FAMILY PRACTICE PHYSICIAN Full or part time. Aviation Medical Examiner preferred. Contact George Jutila, M.D., 725-3334 or home.md@suddenlink.net *(GJ)*

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SMITH RIVER (Del Norte) is looking for a Chief Medical Officer, Family Medicine Physician & Physician Assistant and/or a Family Nurse Practitioner.

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UIHS is an electronic health record site and offers competitive wages & benefits. In accordance with P.L. 93-638 American Indian Preference will be given. To apply or to get more information please visit our website at www.uihs.org or call Trudy Adams at (707) 825-4036.

*****SAVE THE DATE*****

"DIABETES CONFERENCE"

March 2, 2013
Red Lion Hotel, Eureka
8:00 a.m. - 12:00 p.m.

PROPERTY FOR SALE/ RENT/ LEASE

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2504 Harrison Avenue, Eureka. Call: (916) 261-8088.

FOR LEASE: Join our new professional medical facilities near Mad River Hospital. Build to suit in new Planned Unit Development. 1200 - 4000 sq. ft. spaces. Contact Mark , 707-616-4416 or e-mail: Jones202@suddenlink.net.

LODGING FOR YOUR LOCUM TENENS' AND TRAVELING NURSES' NEEDS: Third Street Suites at 1228 3rd Street offers fully furnished luxury one-bedroom apartments in Old Town Eureka. The monthly rate of $1800 includes all utilities, CableTV, and Internet, a private garage, and weekly maid service. Please visit www.ThirdStreetSuites.com for additional info & pictures, or call Regina at 707-443-3001.

MISCELLANEOUS

FIREWOOD FOR SALE. Call (707) 499-2805

CLERKSHIPS: Stanford Medical School is seeking clerkship positions in family practice for 2 students from August 28 through September 7, 2012. Please contact Kathy (kathysattler@gmail.com) or Scott (scottsattler@gmail.com) or by phone: 707 443-8183

HART MEDICAL BILLING (707) 839-3013

OFFICE EQUIPMENT & SUPPLIES FOR SALE. X-ray machine (4.5 yrs old), medical supplies, office supplies, shelving, file cabinets, office equipment and medical equipment. Contact Nancy Freemantle at (707) 616-4211.

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Inside Cover/Full Page	$275.00	7.90" x 10.40"
Business Card Ad	$65.00	Copy Ready 2" x 3.5"
Classified Ads	$5.25 per line	

DEADLINE: 15th day of the preceding month to be published