North Coast Physician

In This Issue:

Cover Photo
"Autumn Sunlight on the Waves #3, 2011"
Stephen Kamelgarn, 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.

North Coast Physician is published monthly by the **Humboldt-Del Norte County Medical Society**, 3100 Edgewood Road, P.O. Box 6457, Eureka, CA 95502. Telephone: (707) 442-2367; FAX: (707) 442-8134;
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EMR: Pet Peeves #1

Stephen Kamelgarn, MD

The world is weird enough that I think it's about time I go into Andy Rooney mode. You know the drill; get all worked up and crazed over some piece of cultural trivia that is actually meaningless, but somehow, maddening, nonetheless.

What dust-mote is it this time that has me all hot and bothered? Well, it has to do with our Electronic Medical Records systems, and the hard copy output we all seem to be getting from these "brand-spanking new expensive Electronic Medical Records Systems." Forget, for the moment, that our means of record keeping is transitional, at best: we (or me, at least) don't wish to go back to the old-fashioned paper chart days with their loose, scattered, misfiled and illegible notes and reports; but EMR software isn't quite ready for prime time yet. But that's grist for another diatribe.

However, there's one small facet of EMR, and I don't care which EMR system you use, that drives me nuts. And, that is reading the hard copy of the medical record that comes in from the outside. When electronic records are printed the hard copy has all kinds of gobbledy-gook on the page: insurance information, pages of med reconciliation, health maintenance check boxes, ICD-9 codes in 45 different places and somewhere, buried deep in all this verbiage, is the note that you're looking for. It makes trying to read those records quite trying.

Our own EMR system is one of the worst offenders. I have no problem reading our records on the monitor, but when we print some out to accompany a patient to the ER or a consult, it's almost impossible to find the note that's describing why you're sending the patient in the first place, thereby obviating the ER doc's need to re-invent the wheel. And now, beginning yesterday, the output on our printed prescriptions has changed to conform to this insanity. Our EMR doesn't allow for us to transmit controlled substances prescriptions electronically, so we must print a hard copy. Now the new hard copy not only has the drug you're prescribing, but it also has the patient's insurance information, ability to speak English, marital status, allergies and long meandering sigs injected by the program. In order to get all this stuff into the appropriate area on the prescription pad the print is shrunk down to about 3 point type making it almost impossible to read by anyone other than a bald eagle.

This seems to be a uniform problem across the board. I can't think of any outside records that I've gone through lately that have been printed from an EMR that doesn't suffer from minutia logorrhea. St Jo's has recently gone to an EMR system, and reading the new notes is "joy unbounded." Now when I read my patients' ER notes I learn everything except why the patient came, and what the clinician found. That information is buried deep on page 4 after you've gone through three pages of medicine reconciliation data (usually wrong) and insurance nonsense.

I'm not saying that all this information is unimportant, it's just that it's unimportant to me. All of this information has meaning to someone, but it's generally of import to people other than the clinician. This is output that is a biller's delight. This is output that warms the cockles of a cost cutting insurance company's heart. Auditors just love the way it prints out. Market researchers start palpitating when they read the print.

I know this is a minute, meaningless diatribe, getting all worked up about something as trivial as the printed format of medical records. I mean, isn't the important part just having the information available? So who cares if you have to spend a couple of extra minutes looking for what you want? It's all there, isn't it? But I'm just paranoid enough to believe that there are darker forces at work, and the relegation of clinical data to relative unimportance is emblematic of the changes in healthcare that are occurring at light speed.

As physicians become more connected, they become more assembly line industrialized. No longer is our clinical judgement paramount, but we are merely a cog in a "healthcare team." I know that this sounds incredibly retro-paternalistic to the way medicine was. But I'm not longing for the "good old days," when nurses stood in the presence of doctors. I like the idea of the physician being one member of an integrated team. It's just who are my fellow teammates? If the team I'm on is a panoply of nurses, health educators, clinical specialists and other para-medical personnel there would be no problems.

However, as the format of our hard copy output indicates, our true "health care team" teammates are auditors, insurance 'droids, billers, lawyers and an army of nameless, faceless bureaucrats hell-bent on minimizing risk and maximizing profits. The clinician is seemingly demoted to bat boy, water carrier and halftime entertainment. I know that this truly reflects the medical practice climate in 21st Century America, but do I have to have it shoved in my face? Would it be too outrageous to

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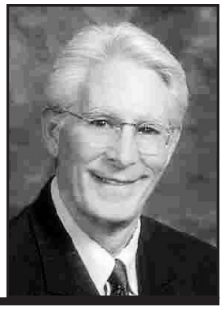
Del Norte Update



MARK H. DAVIS, MD

Del Norte District Chair

I am updating you as to the problems we are having with Sutter Health. First, we have had an overwhelming response from our local citizens. We have now had two Town Hall meetings where we have had over totals of over 400 attendees. We have had over 1200 people sign our petition to stop the regionalization of our hospital. We had a meeting with the regional President of the Sutter West Bay region, Mike Cohill come and talk to us on 8/2/12. The highlights of that meeting were:

Critical Access

Mr. Cohill said that in Lakeport, CA, Critical Access was the only option other than going broke and closing the hospital. He also said those may be the only options for Sutter Coast Hospital. We also learned, for the first time, that Sutter has hired an outside consultant to study the feasibility of Critical Access at Sutter Coast Hospital.

Hospital Ownership

Despite prior claims by Sutter Regional VP Dr. Toni Brayer and Sutter Coast CEO Eugene Suksi that Sutter Coast Hospital is owned by Sutter Health, Mike Cohill said the opposite. "Sutter Coast Hospital is a separate hospital. Sutter Coast Hospital owns it." (Mike Cohill, 8/2/12).

Regional Representation

When asked about a guarantee of local representation on the Regional Board, Mike made it clear that was not an option, but did say our county would probably get a seat on the 32 member Regional board, filled by a Sutter appointee.

Cash Transfers from Sutter Coast to Sutter Health

I asked Mr. Cohill if Sutter Coast Hospital participated in their excess cash transfer policy. He said very emphatically yes they did. I asked him if our local board approved this transfer and he said no. I then pressed him as to how this was transacted. He stated it was a centralized movement of funds that was generated in Sutter Health. I suggested that it would be beneficial if we were able to use these excess funds to fund needed equipment for use in for instance our OR for upgraded equipment need to take care of patients. It sounds like these funds once transferred are the property of Sutter Health.

Hospital Bylaws Changes

A recently discovered issue is the sweeping hospital bylaws changes which the Board quietly approved in Feb. 2011. Two deletions--language requiring the local Board to have a majority of Del Norte County residents, and the community mission statement--had been in place since signature of the 1986 Healthcare District Lease Agreement with Sutter. Our hospital mission statement, which states we are to "care for the sick, injured, and disabled…" is now gone. Instead, the new bylaws direct the local Board to be loyal to the Corporation and Sutter Health, "always furthering the interests of the Corporation…" I personally believe this change of mission of Sutter health brings into question their not for profit status. A 501(c)(3) not for profit public benefit corporation is supposed to have a public benefit. Given the change in their mission to furthering the interests of the corporation I don't see where the public benefit is. It's been removed. Maybe their not for profit status should go the same way as the care of the sick injured and disabled went, removed. None of these bylaws changes were ever announced to the Medical Staff, and I suspect were never divulged to the Healthcare District either. Mr. Cohill told us he knew the medical staff was unaware of these bylaws changes when they were enacted.

Other bylaws changes infringe on the Medical Staff's independent self-governance, and state that in the event of a dispute, Sutter Health bylaws prevail over our hospital bylaws, which also prevail over medical staff bylaws. I did point out to him then that the law trumped even Sutter Health's bylaws. I brought up Business and Professions code 2282 and SB 1325 were pertinent here that guaranteed the medical staff duties and responsibility of doing peer review and credentialing each of which according to the Sutter West Bay region bylaws would be usurped by the subcommittee of the Quality committee of Sutter Health.

Where to go from here

Andy Ringgold, the chair of the local hospital board made the following verbal commitment to the Medical Staff: because our concerns were not resolved at the 8/2 meeting, the Board of Directors would take no further action on Critical Access or Regionalization, even if the TRO, the temporary restraining order, is not extended, until at least one additional meeting between the Medical Staff and the Board of Directors takes place.

Medical Staff News

The Sutter Coast Hospital Board of Directors were informed at this meeting that the Medical Staff has formed a committee to

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Do You Practice AIDET?

HARPREET DUGGAL, M.D., FAPA
Medical Director, Humboldt County Mental Health

Reading the title, I bet your first thought was, "What, another acronym?"

Your professional role as a service provider to clients in the healthcare domain impels you to take a closer look at AIDET, which is now the standard of service delivery in leading hospitals across the nation. So what does AIDET stand for? In Quint Studer's book, Hardwiring Excellence: Purpose, Worthwhile Work, Making a Difference, he explains what this is. Studer is the former president of Baptist Hospital in Pensacola, Fla., and is a health care consultant and founder of the Studer Group.

A: Acknowledge the client. Whenever possible, address the client by his or her last name. Be aware of any existing information about the client, smile and shake the client's hands. Have the client comfortably seated, make good eye contact and pay attention to your non-verbal communication. A favorable first impression goes a long way in having a satisfied client.

I: Introduce. Introduce yourself, state your professional title, what you do and your particular skill set or training if you are providing any specialized service needing a trained person. For instance, if you are a registered nurse drawing a blood sample from a client, your communication will be something like this: "Hello, Mrs. Smith. It's nice to meet you. My name is Rachel Sweet and I am the registered nurse who will be taking your blood sample today. I work with your physician, Dr. Brown, and he has requested blood work for checking your cholesterol and blood sugar levels (assuming that Dr. Brown has already informed the client why this is being done). I am very experienced and well trained at this procedure and do this routinely." This communication helps build confidence and reduces anxiety in a client and also positions the staff as a member of a team providing services to the client.

D: Duration. Every contact with a client involves a wait time for something, be it the service itself, the result for that service or the follow-up. Tell the client how long the service you are providing is going to take, how long the client is going to be there and how long he or she will have to wait to hear back for results of the service you are providing. If you anticipate delays, apologize and inform the client accordingly. Wait times have a profound influence on client satisfaction and your honest communication about duration of the service and other wait times will improve the overall perception of the service being provided.

E: Explanation. Explain the service you are providing while you are providing it. For healthcare providers, this also includes explanation of medications, treatments, therapies and follow-up. Imagine how you would feel if your loved one is admitted to a hospital and a staff person walks into his or her room, doesn't introduce him or herself or explain what he or she is doing there, inserts an intravenous line and walks away. Explaining what the service entails helps build client trust and assures a person that the services he or she is seeking are in line with what he or she is there for. After you have explained to the client what the service involves, ask: "Is there any more information you need on (name of service)?" "Are you comfortable with the recommendations I have for you?" Explain any "whys" the client has.

T: Thank you. The client chose to use your services and be sure to thank them for doing so. State, "I am glad you came in today and that we were able to help you." This will leave a lasting impression on the client and validate the client's effort in seeking your service.

Though simplistic, if this tool helps us to have more satisfied customers, then why not give it a try? §

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ask for a little flexibility from the people calling the shots? I know that nothing will be changed, but it helps me to maintain the illusion of self-importance.

Since an EMR is nothing more than a fancy-schmancy data base program, one would think that we should be able to format the output as to our needs. When Penny, for instance, prints out a report from the large data base program that the Society maintains, on all healthcare providers in Humboldt and Del Norte Counties, it is customizable in appearance, depending on the data requested. And she has a report library that contains somewhere in the neighborhood of 100 pre-made report templates. No fuss, no muss–instant report.

EMR should give me the same flexibility. I should be able to print out a record, that accompanies a patient to the ER, for instance, that omits all the insurance, health maintenance stuff (unless I deem it important enough to include) and other extraneous junk and prints only the note I want printed. Let the billers print their own damn reports.

This will, at least, provide me with the appearance of having some autonomy and control in one small area of my practice. We all must acknowledge the illusions we subscribe to, and mine is that I actually have some control in clinical situations. As long as I can maintain this illusion, that I have some control over clinical decisions, then I guess I can continue to kowtow, and put on a minstrel (sic) show for the powers that be.

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seek resolution of our grievances with the Board of Directors. In the event the dispute cannot be resolved, the Medical Staff has the right to seek relief in Superior Court guaranteed by B&P code 2282.5. At our last Medical Staff meeting, the physicians passed the following two unanimous resolutions:

First, the hospital should be seeking to expand our scope of services, such as chemotherapy and possibly renal dialysis, not reduce our scope of services offered to the community.

Second, we passed a "no confidence" vote on implementation of Critical Access designation at Sutter Coast. That is where we are at the moment. Our hearing on the extension of the TRO, the initial injunction will occur on 8/27/12 at 9 am in Del Norte Superior Court. I will supply you with an update once we know more.

I would be remiss to not inform you of the support we have received from the CMA legal department Including Long Do and Francisco Silva and the Executive Board. This has helped immeasurably. I have never been so proud to be a member of CMA and having the privilege of representing you as your trustee. §

Did You Know....

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

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

Redwood Rural Health Center
Contact: Tina Tvedt, (707) 923-2783
or ttvedt@rrhc.org

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)*

UIHS SMITH RIVER: Openings for: Chief Medical Officer; Physician; Physician Assistant and Family Nurse Practitioner;

UIHS ARCATA - PHYSICIAN NEEDED. UIHS is an electronic health record site and offers competitive wages & benefits. Must be sensitive to the needs of the American Indian Community. Computer skills & ability to work in fast paced environment required. An Application can be obtained at www.uihs.org or entire packet @ 1600

ALLIED HEALTH PRACTITIONERS NEEDED (FNP/NP/PA/CNM)

Redwood Internal Medicine - *Contact Nina, 725-4477*

CNM NEEDED. *Contact Barb 725-6108. (ja512)*

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MEDICAL OFFICE SPACE AVAILABLE - LEASE.
2504 Harrison Avenue, Eureka. Call: (916) 261-8088.

MISCELLANEOUS

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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