North Coast Physician

In This Issue:

Cover Photo
"Another Cloudy Day"
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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Dedicated to serving you

JAMES T. HAY, M.D.
President

CMA is about you, me and the patients we serve. Those of us serving in leadership roles have taken new approaches this year to change CMA from an organization whose membership currently represents a minority of California physicians to one that will eventually include nearly all of us who practice here. We can only do that by listening to you better, by telling our stories better and by recognizing our human needs as well as our economic ones. Both our new website and our new approach to broader communication and a routine survey process constitute a first step. We are listening, and we will address your needs.

We have already returned over $2.7 million this year to members who sought help with insurance billing disputes. We provided members with free access to legal advice on every conceivable subject related to the practice of medicine through our medical-legal library documents. And, of course, as documented elsewhere in this report, we have continued the legislative and legal advocacy you expect. We have won many more battles than we lost, protecting MICRA, vaccine availability, Healthy Families, Every Woman Counts and, more broadly, the profession and the public health. Joining with other organizations, we also created California Public Protection and Physician Health, Inc., to reestablish a physician health program in our state and preserve patient safety by helping the doctors who need it.

No other organization can find common ground for all of us when we view issues differently because of our specialties, modes of practice, location and patient demographics. CMA created the kind of compromise that is only possible from a statewide organization when we developed a proposal to fix the geographic disparities in Medicare. We are continuing to lobby for its adoption.

Additionally, we have so far successfully blocked reductions in access to care for Medi-Cal patients with legal action at both state and federal levels. And, we came to the courageous conclusion that a prohibition-style approach to marijuana was not working. We adopted policy to legalize, regulate and control its production and distribution so we can know what our patients are using and where they are getting it. We also believe this policy will enable better research to define its benefits and harms, as we would for any other potential medicinal agent.

From CEO to receptionist, the CMA staff is amazingly dedicated to you, me and our profession. The working relationship among them, the Board of Trustees and Executive Committee has never been better. And it is all for and about you, members of the most dedicated of all professions. §

KEEP US UP-TO-DATE

Have you changed your E-Mail Address? ....or posted a web page for your practice? Please let the Medical Society know so that we can update our records and link to your page from the Medical Society's Web Page.

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

The Need for Peer Review hasn't Changed

Emily Dalton, M.D.

In recent years major changes have occurred in the way health care is structured and delivered. Since I started working in Eureka in 1995, solo and small practices have morphed into into larger groups, doctors have have gravitated from general "jack-of-all-trades" medicine toward specialization, and control has shifted from physicians to 3rd party administrators. Whether in the office or the hospital, we have all felt squeezed to do more with less--to see more patients, work more rapidly, practice more cost effectively, and to prescribe more efficiently.

How does one maintain a reasonable work pace, avoid burn-out, and take the time that patients deserve under these pressures? How do hospitals do more with less, pass inane inspections that have more to do with counting measurable details than medical improvements, and still deliver quality medical care? How much fat can be cut from health care before things get dangerous? A few years ago, images of a woman dying on the floor of an LA ER shocked the nation, but no improvement in financial support for emergency rooms ensued. As a society, it is in our best interest to fund our emergency rooms to the hilt. Any one of us could need a good emergency room any time. Why is it that things have to get really bad before a response is generated?

We are all faced with the dilemma of how to maintain quality while having less time and fewer resources. Despite cut backs, quality review by our peers is important and can help us maintain good medical practices in the modern medical environment. No one can practice in a vacuum, and we all need checks, balances and encouragement to practice at our best. Better that we police ourselves than leave it to some one else.

A year and a half ago, St. Joseph Hospital changed its peer review from specialty-based to a multi-disciplinary format. The "Clinical Peer Review Committee" includes physicians from surgery, orthopedics, radiology, anesthesia, internal medicine, OB and pediatrics who identify and address ways to improve medical care by examining cases and determining what could be done better. The committee addresses a range of issues from individual skill building, to systems issues like updating protocols or improving inter-service co-ordination. After cases are reviewed, recommendations are made as to what action, if any, is appropriate. The committee has deliberated through numerous difficult and complicated cases, and in the 18 months I have participated, I have been impressed by the thoughtfulness, sensitivity and professionalism displayed by those involved. I would encourage anyone interested to consider joining this committee--it is an important one.

For those physicians not involved in hospital care, there is less peer review available. Specialty-specific case review conferences are held regularly, though usually through one of the hospitals. For example, OB and pediatrics have have quarterly case reviews of antenatal, postpartum and infant care, and St. Joseph also holds a bi-annual pediatric case review conference. Continuing medical education conferences offers some opportunity for peer review, although most of the time is structured in lecture format. Grand Rounds provides opportunity to ask case-specific questions about medical management, but only if the topic is pertinent to your problem case.

For those of us who maintain board certification, some sort of test or educational activity comes up every seven to ten years, and while this differs from direct case review, these activities can help improve our education and skills.

If you do something obnoxious, illegal or offensive, the medical board may get involved and review a case you handled or examine your medical practice. The medical board responds to complaints, and focuses on behaviors more than medical care. Most of us would not feel that this is a good avenue for quality review.

Malpractice suits are a terrible way to get feedback on medical management, but those of us who have been sued know that accusations make one very sensitive to the the particular issue at hand, and do affect subsequent medical decision making.

In summary, as we practice medicine during this time of change, we need to consciously seek out evaluations, second opinions and assessments of our decision making. It is not enough to rely on the training we had at the beginning of our careers, especially for those of us who have been in practice for a long time. The kind of peer review available will be different for each type of physician. Those physicians who have part or all of their practice in the hospital will automatically be included in some peer review process. Docs who practice on a outpatient basis may need to seek out creative ways to get peer review. Whether we join the CPRC committee, discuss cases at conferences, do case review in our practices, or run issues by a respected colleague, we all benefit from the process whereby we have another set of experienced eyes review and evaluate our work. §

EMR—Another View

JAY DAVIS, M.D.

I still remember the first time I used a word processor. It was like magic. Whole paragraphs could be easily moved around the page. Clumsy constructions could be deleted in a keystroke, and before you ever set ink to paper, you knew that what you had written was what you wanted. What great advance over the typewriter! For the small effort required to learn the program, the reward was huge.

Consider now the EMR. Eight months ago, we began using an electronic medical record at HSU, and I find precisely the opposite situation: for a very small benefit, there is a steep price in frustration and inefficiency, and potentially patient care.

Admittedly, the EMR provides distinct advantages. The digital format offers unprecedented opportunity for clinical researchers. I know that in the future I will bask in the reflected glory of the data-miners who—poring over the gigabits of digital information we produce—will discover that women on oral contraceptives who drink 3 cups of coffee in the morning, and only urinate twice before noon have fewer attacks of dysmenorrhea than those who use IUDs, drink herbal tea, and refrain from ice skating.

If the word processor made us the master of the written page, the EMR has made us the slave. In bygone days, I could make a referral on a paper form that was both obvious and easy. Nobody had to explain what was meant by "Specialist Name, Patient Name, and Reason for Consultation." By contrast, making a referral on our EMR is a five-screen counter-intuitive process that can bring grown clinicians to tears. I have watched fill-in providers struggle to do the simplest thing in our EMR. They may be superb diagnosticians, but even they cannot penetrate the mysteries of our unyielding, clueless, computer program. Let me rephrase that. Obviously, they can learn the program. But at what cost? And for what benefit?

Our EMR has enslaved us in other ways as well. No longer can an MA order labs. The physician is now the Clerk-in-Chief. Want your assistant to call in a prescription to the pharmacy? No can do. Want your MA to order a lab test for you? Forget it. Oh, and remember diagnostic coding—that odious task once the province of a clerically trained person? That's your job too. Are doctors too important to do clerical work? Maybe not. But is that the best use of their time?

And consider this: in the bad old paper days, I could quickly peruse a chart, running my eyes over entry-after-entry, getting a sense of the patient's history. No longer. Each visit is now a separate encounter that must be clicked opened, then clicked shut. By the time I have clicked my way into the fifth visit, how likely am I to remember the first?

I don't think the problem is mine alone. Psychologists have found that we remember things in "situational packets"—and changing "packets" leads to lost information. Thus when we walk from one room to the next in search of something, we may forget what we were looking for when we arrive in the new room, because the cues were all left behind.

Shortly after we adopted our EMR, I asked colleagues in the community about experience with theirs. All of them reassured me that in anywhere from 6 to 12 months, our efficiency levels would return to the pre-EMR levels. We wouldn't be any more efficient, mind you, we'd just return to our pre-electronic level. Did they realize what they were saying?

If these programs are difficult to use, at least they're not cheap. Ours cost tens of thousands of dollars to purchase, and we pay an annual fee of several thousands more. But wait, it gets better.

I learned today that the maker of our EMR is offering—for a mere $2,000—a way to make the program accept readings from a Welch-Allen BP-measuring device. Think about that. How would you respond if Dell Computer offered a way to attach your iPod, but only if you paid 200 bucks for the privilege?

Please do not think me a Luddite. I love good technology, with the emphasis on "good." There can be no argument that digital information, instantly readable and accessible, is a great boon. Without question, it's wonderful to have access to X-rays from across town, and ER reports from around the country. But if the programs can't talk to one another, and if each one requires six month to learn, how good are they really?

The Federal Government is offering bribes and threats to get clinicians to use EMRs. Because of this coercion, doctors are settling for the "least bad" programs. Several of the part-time docs at our clinic assure me that, wretched as our program may be, they've seen worse. That's small consolation.

I keep thinking back to my experience with the word processor. Nobody forced me to give up my old typewriter. I did it eagerly because the new technology was vastly superior to the old.

When the EMR makes doctors' lives easier and more efficient, there will be a voluntary migration from paper charts. The fact that we are being coerced to use them is consistent with my experience that these contraptions are nowhere near ready for prime time. §

Multidisciplinary Cancer Care

M. ELLEN MAHONEY, M.D.

Program Director

In 1922 the Commission on Cancer was established. This program, administered and led by the American College of Surgeons, is a consortium of all of the major cancer organizations dedicated to improving survival and quality of life for cancer patients through standard-setting, prevention, research, education and monitoring of comprehensive cancer care. The monitoring function is performed by the National Cancer Data Base, an invaluable source of information on cancer care and ideas for improvement.

Since 1990, St. Joseph Hospital has been one of only 1500 organizations accredited by the Commission on Cancer. Unless you have been on the Cancer Committee you are probably not aware of the benefits of this accreditation because until now it was focused primarily on structural aspects of cancer care, i.e. services available, data submission, reports to the community. As of January 1, 2012, the Commission has drastically increased upped the ante to become much more involved in patient-centered care, especially prospective care. In the coming months I will be reporting to you on our progress in several of these areas, from survivorship care plans to enhancements in nutrition, prevention, psychosocial distress care, patient navigation, outpatient palliative care, and clinical trials. We will continue to partner with community organizations and physicians already involved in cancer care improvement, but we also be increasing our commitment at the hospital level to meet the new standards and to enhance the services provided to our patients with known or suspected cancer.

The reasons behind this enhancement are not hard to discern when one looks at the advances in cancer diagnosis and treatment, along with the increase in complexity. Although there are national guidelines for best practices in the diagnosis and treatment of each type of cancer, the art of medicine is applying those standards to individual patients who bring with them pre-existing comorbidities and preferences. Cancer medicine is increasingly a team effort, and the best care is achieved with an approach that brings the patient and their primary care provider together with all of the cancer specialties to design a prospective care plan from the options available before any definitive care is delivered. The desire of patients for this type of prospective review is evidenced by the number of patients who travel to one of the universities to have their case reviewed by a tumor board there. I spent part of my career receiving those referrals at a major university, and two of the lessons I learned were that a university tumor board is only as good as its weakest member, and that we could not really individualize treatment recommendations as far as the patient may want because we were not going to have an ongoing relationship with the patient that would allow us to adjust care if needed. The best tumor boards are composed of experienced clinicians dedicated full-time to the care of patients that they are committed to. The best tumor boards for patients in our region are the ones that are staffed by our own excellent medical and radiation oncologists, pathologists and radiologists, surgeons, and other specialties that support optimal cancer care. To enhance this expertise further, we will soon be announcing an affiliation with a major cancer center to provide direct support in difficult cases, streamlined referrals, and telemedicine services.

Primary care providers are often faced with cases that need multiple specialties, or times when they do not know where to send the patient first for best care. You can refer to medical oncology, radiation oncology and surgery all at once by referring to the newly-enhanced Multidisciplinary Cancer Care Team. We will give you advice on the most effective workup if you want to direct the patient's care until the diagnosis and treatment plan are made, or, if you prefer, we will order the tests and arrange for the patient to be presented to the multidisciplinary team. Some of the cases will be appropriate for the Wednesday noon Tumor Board, and if so, we will be sure you are invited to add to the discussion. If you have preferences for which clinicians you want to see take care of the patient, we will honor those requests, even if the clinicians work exclusively at another hospital. The goal of the Cancer Care Program is an optimal outcome for your patient, not a financial gain for St. Joseph. To refer a patient for review, please call 445-8121 ext 4400 to request the fax-back form, or fax a note to 269-3863. You can also email ellen.mahoney@stjoe.org for referrals and information. And if you use the IRIS system for referrals, our access will be established through that program very soon. Prospective treatment planning using multiple specialties and best practices is what you would want for yourself, and we owe our patients no less. In the upcoming months, I will report further on the program and the services available to you and to your patients.

"Guiding People to Good Decisions"
Friday, May 11, 2012 See Pg. 16

CMA ANNOUNCES SPONSORED BILL PACKAGE

February 24, 2012, was the last day to introduce legislation for this year's session. While the California Medical Association (CMA) will take a position on hundreds of bills in the coming weeks and months, we there are also nine new sponsored bills that were subject to the February deadline, a few of which are listed below. A full summary of CMA-sponsored bills, including legislation on a physician health program in California, will be forthcoming.

SB 1318 (Wolk) Health facilities: influenza vaccinations – This bill would require all health care workers in health care facilities, including physicians, to either receive the influenza vaccination or wear a mask to help prevent the spread of influenza.

AB 1742 (Pan) Health care coverage: payment for benefits – Requires Knox-Keene regulated PPO products to authorize and permit assignment of an enrollee's or subscriber's right to reimbursement for covered services to the provider furnishing those services. The bill provides for the direct payment of individual insurance medical benefits by a health insurer to the person who provided the hospitalization or medical or surgical aid, and limits the amount of the reimbursement to the amount of the benefit covered by the policy.
AB 1746 (Williams) Schools: nutrition: beverages – This bill would ban the sale of sugary sports drinks during school hours at middle and high school campuses throughout California.

AB 2109 (Pan) Communicable disease: immunization exemption – This bill would require a parent or guardian seeking a personal belief exemption for their child to obtain a document signed by themselves and a licensed health care practitioner saying they have been informed of the risks and benefits of the immunizations, as well as the public health risks of the specified communicable diseases. This bill preserves a parent's option to exempt their child from immunizations, but also ensures that such a decision is an informed one.

AB 2063 (V. Manuel Perez) Immunizations for children: reimbursement of physicians – Requires a health care service plan or health insurer that provides coverage for childhood and adolescent immunization to reimburse a physician or physician group in an amount not less than the actual cost of acquiring the vaccine plus the cost of administration of the vaccine. The bill would prohibit the imposition of deductibles, coinsurance or other cost-sharing mechanism for the administration of childhood or adolescent immunizations or for related procedures. The bill also prohibits the plan from requiring a physician or physician group to assume financial risk for immunizations, whether or not those immunizations are part of the current contract.

.....keep us on the "map"... plan to attend

MEDICARE / PALMETTO GBA WORKSHOP

DATE: **APRIL 26, 2012**
TIME: **7:30 A.M. - 4:30 P.M.**
LOCATION: **RED LION INN, EUREKA**

How To Register:

1. Create a profile at the new Palmetto GBA Event Registration Portal.
   To access the portal, click on the Spring Tour icon from the Palmetto GBA J1 Part B home page or from the Learning & Education section of the J1 Part B Web site.
2. Log into your Event Registration Portal profile and you will be able to register yourself or other people for any workshops including the Spring Tour Workshops in the portal before registration closes.
3. Choose "Print" or "Digital" (online PDF) version of your Spring Tour Workbook when registering for individual workshops. You will not be able to change your selection after the registration is closed.

CLASSIFIED ADVERTISEMENTS

JOB OPPORTUNITIES

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

WANTED ADVANCED PRACTICE CLINICIAN for multi-clinician Family Practice office with >20 years of experience, 2 locations; Fortuna and Ferndale, on the beautiful Northern Coast of California. Competitive salary and benefits package, Rural Health Clinic with federal loan payback options, equal opportunity employer. Minimum of 2 years experience required. For more information please call, 530-941-7612, or fax CV to 707-725-2978. *(db911)*

FNP/NP or PA-C NEEDED. Pt time with option of full-time. Inpatient experience preferred, but not required. Contact Nina, 725-4477. *(rg1011)*

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)*

PROPERTY FOR SALE/ RENT/ LEASE

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.

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MISCELLANEOUS

FIREWOOD FOR SALE. Call (707) 499-2805

INTERESTED IN WEB DESIGN?

Do you feel artistic? Have you always thought about designing your own Web site, but couldn't find the time or energy? The Editorial and Publications Committee is looking for a group of interested physicians to work with our webmaster in the design and update of the Medical Society's website. If you're interested, please contact Penny at the Medical Society, 442-2367 (or hdncms@sbcglobal.net)

ARE YOU A CONSORTIUM MEMBER?

Our Consortium for Continuing Medical Education is accredited by the CMA Institute for Medical Quality to plan and accredit local programs to meet the needs of our physicians. Credit is provided for Grand Rounds, Tumor Board, Cardiac Cath Lab, UCSF Case Conference, Neo-Natal Resuscitation, etc. In addition to coordinating programs based on the feedback we get from the membership, we also work with the HDN Foundation/IPA, Hospice, Public Health and other local agencies in coordinating CME credit for physicians.

HELP SUPPORT LOCAL EDUCATION - BE A CONSORTIUM MEMBER