The Bulletin

HUMBOLDT-DEL NORTE COUNTY MEDICAL SOCIETY

JULY 2011

IN THIS ISSUE:

CMA Advocacy:
State Budget Summary

HAPPY
INDEPENDENCE DAY

No Pressure, Just Savings!

Spending more than you have to for workers' compensation insurance doesn't make sense. Workers' Compensation premiums are on the rise again, right at a time when reducing practice expenses is a priority for every physician.

The Humboldt-Del Norte County Medical Society-endorsed Workers' Compensation program, with its 5% member discount (15% depending upon where you place your group health insurance), will be even more important to members this year.

When you place your coverage with Employers Compensation Insurance Company, the endorsed program insurer, chances are your savings will exceed the 5% program discount.

Rather than guess what your savings can be, take a moment to contact Marsh and let us show you how your membership in the Humboldt-Del Norte County Medical Society can deliver a quality insurance program and exceptional savings to you.

Please call a Client Service Representative at 800-842-3761 today. The process is simple and fast.

Let us show you...
how your membership in the Humboldt-Del Norte County Medical Society can **save you money**.

Endorsed by:

HUMBOLDT — DEL NORTE COUNTY MEDICAL SOCIETY

CMA California Medical Association and 30 County Medical Associations and Societies

Underwritten by:

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America's small business insurance specialist.®
Employers Compensation Insurance Company

Administered by:

MARSH

THE BULLETIN

CMA

In This Issue:

Original tree art by
Samuel P. Burre, M.D. (1957) and adorned by
George Ingraham, M.D. (2002)

The Bulletin 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/Crescent City (707) 465-0980; FAX: (707) 442-8134; E-Mail: hdncms@sbcglobal.net Web page: *www.hdncms.org*

HAL GROTKE, M.D.

The Democrats in the State House passed a budget of questionable legality. It was appropriately vetoed. The legislators won't get paid until there is a budget adopted. At the time of this writing they have 4 days to get it done. It seems slightly less unlikely that there will be a budget for the new fiscal year than it was a year ago. Those of us who depend on getting paid for care provided to patients on Medi-Cal may not get paid for that part of our work for a while. I have mixed feelings about the legislators experiencing working without getting paid. I think people should get paid for the work that they do. I don't pirate music or books or software. I don't accept "professional courtesy" for the medical care I receive. We don't have any recourse against the private insurance companies that continuously fail to pay us fairly. We will see if the recent passage of voter initiative to withhold pay will have any effect.

This weekend was the CMA District X (ten) caucus meeting in Santa Rosa. The local news out of the caucus is adoption of a resolution proposed and written by Dr. Mastroni. After traveling to the Midwest to renew board certification he had the idea that the computer portions of certifications should be administered and proctored locally throughout the state, specifically at state universities. The caucus accepted the resolution that CMA take a position of encouraging specialty societies to allow such testing. The resolution will be considered at the CMA House of Delegates.

There have been a couple of exciting public health cases locally in recent weeks. There was a patient with measles. Laboratory confirmation of the diagnosis was complicated by the fact that the patient had been immunized. She was infected with wild-type virus while traveling in China. When she completed her travel she briefly returned to work at a busy restaurant before seeking care. We are now out of the incubation period, and it appears that there have not been any secondary cases, locally. I don't know whether there were any other infected travelers on the flight across the Pacific. There was ample opportunity for sharing the virus in that setting.

The other, more interesting, public health case locally was a child who survived rabies infection. She was just the third American and eighth person ever to survive after becoming ill with rabies. In recent years, we have heard much about heavy burden of rabies infection among local fox populations. This person apparently was infected by a feral cat. I know in my neighborhood all the foxes have died, most shot to death by sheriff's deputies after exhibiting unusual behavior. There remain many stray cats. For years I have discouraged neighbors from feeding stray cats, and I've encouraged them to get the cats immunized and sterilized. Many of the cats are semi-adopted by neighbors. I need to approach those neighbors again. I suppose I should offer to capture those cats and take them for appropriate preventive services myself. Doing so would require that I find time actually to do it. Do I have any volunteers to help get this done? §

SAVE THE DATES:

MEDICAL SOCIETY TALENT SHOW

RESCHEDULING FOR EARLY 2012

******** ***MORE INFORMATION TO FOLLOW***

"LESSONS LEARNED IN LITIGATION E.H.R. BEST PRACTICES"

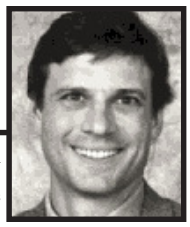
SEPTEMBER 7, 2011 (1-3 P.M. AND 7-9 P.M.)

******** ***MORE INFORMATION TO FOLLOW***

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

"DERBY"

LEE LEER, M.D.



This will be my first editorial composed on an iPAD. Please let me know if you can tell the difference. Perhaps the iPAD will make it a little more edgy, but in an easily consumed, non-threatening sort of way. Perhaps you'll read this and realize it wasn't really something you needed, but you very much enjoyed it nonetheless, for reasons you can't explain. Should you go out and buy an iPAD after reading this, please don't forget to mention my name to your sales person.

Months ago, when I scheduled last week off from work, our plans had been to enjoy a family backpacking trip. A celebration of Jane's graduation. A chance to get her - and yes us - away from smart phones and other electronic devices. As luck would have it, everything changed... except my week of vacation. Jane left for Nicaragua three weeks before we thought she'd need to, Nancy needed to spend the entire week learning how to save HSU money by teaching via the Internet, winter decided to last a few extra months… and we acquired a puppy.

This is how it came to pass that my big backpacking vacation week was instead spent at home with a 10 week old dog. Mind you, the dog was greatly anticipated by all. He's a beautiful little (well, he *was* little) boxer/cattle dog mix. Spotted black and white. Quite the charmer. But, it so happens, he's a puppy. Our last dog came to us as a 6 month old, and before that when I was a child our family kept dogs outside, so raising puppies is not something I have significant experience with.

I've raised a human baby, and spent days being her primary caregiver when she was an infant, toddler, etc. So I sort of expected something similar. Turns out that humans babies and toddlers bite a lot less. Plus, the whole diaper thing really changes the dynamic. I mean: there was no taking my eyes off of Derby. And I still had to explain a few wet spots on the carpet to Nancy when she returned home from work and made her inspection rounds. All my grand plans to charge through my Rosetta Stone Spanish, write this essay, go on daily bike rides, read ALL of our accumulated *New Yorkers*... all more or less abandoned or at best significantly truncated.

Instead, I at first found myself feeling as if I had wasted this time from work. Rather, I reasoned, to have stayed at work and hired someone to babysit the dog during the day than to squander my valuable and rare free time just to stay home. And, to be honest, part of me still feels that way. But there was a different appreciation that emerged. Yes, I learned to slow down and appreciate that these hours with my puppy would never be repeated. There was more, though. Dogs essentially live in the moment. No lamenting the past, no contemplating the future. To survive, I needed to do the same. Derby became my spiritual guide on a quest I didn't realize I was on. Our time together helped me better appreciate living in the now. Helped me look at the one I was with right now and to be there for him.

Which finally, dear reader, brings us to the medical tie in. Thank you for your patience. We all struggle with making our encounters with patients "real." Or at least I hope the rest of you do a bit of struggling too. We lament the distractions of charting, coding, authorizations, in- or out-of-plan referrals. Some of us blame Electronic Medical Records for our distractions. Admittedly, I have often thought that if it were just possible to really practice medicine - mano a mano with the patient, as it were - then all joy would return and the world would be in balance. What Derby has helped me to realize, though, is that the lack of one distraction begets another, and it really doesn't matter what the distraction is. For me last week the challenge was in letting go of my pre-conceptions about how the week should have been. When I sat around wishing I was in the Sierras, and missing my absent wife and daughter, I was ignoring the wonderful little fellow whimpering right in front of me. I was missing the beauty of the moment in which I happened to be living. In order to be useful in any interaction with another being, we need to first recognize our distractions, and second we need to learn to ignore them. Yes, the world of medicine is complicated. Complicated in very different ways than it was just 5, or 10, or 20 years ago. But not necessarily more complicated. At least now when I'm seeing my 5 PM patient, I'm not distracted by the hospital admissions awaiting me. Or, if we go back 50 years, by the home visits and deliveries awaiting me.

As a geriatrician, I see an inordinate number of patients who (1) have a large number of problems, and (2) are slower than the average 30 year old at expressing their concerns during an office visit. I can choose to see their crumpled list of questions, their clippings from Dr. Gott, and their inability to deliver a linear narrative as so much annoyance, and lament abandoning basic research at such an early age. Or, I can enjoy the challenge, and the gift, of being in a position to help this person in front of me sort the wheat from the chaff.

The backpacking trip would have been great, and I look forward to the next one. But it was Derby who re-energized me and helped me actually look forward to going to work tomorrow. Who got me excited about focusing exclusively on the "now" in 20 or 25 different brief encounters during the course of 8 hours. Hopefully - thanks to Derby - I'm now enlightened enough to not spend all day lamenting his absence. §

Where Would We Be Without MICRA? After 35 years, It's Still Good Public Policy

The "Consumer Attorneys" (better known as personal injury lawyers) are threatening to renew their attack on the *Medical Injury Compensation Reform Act* of 1975 (MICRA), California's nationally-acclaimed tort reform law. Yet, despite all of their well-worn and specious arguments calling for higher limits on malpractice awards, MICRA's attributes as well-reasoned public policy remain as compelling today as they were when it was enacted in 1975.

During the early and mid-1970's, the number of extremely large medical malpractice awards prompted nearly all commercial malpractice insurance companies to leave California. The two remaining companies had increased the cost of malpractice coverage so significantly that few doctors could afford it. In a period of just a few months, 60% of all doctors in California were operating without malpractice coverage. After temporary closure of many physician offices and clinics, and a physician 'sit-in' in the Governor's office, the Legislature called a special session to address the malpractice insurance crisis. As a result, the Medical Injury Compensation Reform Act (MICRA) was born.

The above excerpts illustrate the period of uncertainty and anguish in 1975, leading up to MICRA's enactment. The ACCMA and several other component medical societies issued numerous communications that year to inform the membership of the demise of the commercially underwritten professional liability group coverages, provide legislative updates, and report on the creation of NORCAL Mutual Insurance Company, one of the first doctor-owned professional liability insurers in California. The CMA House of Delegates levied an assessment of $300 per member on the CMA membership to fund their efforts to solve the crisis.

MICRA is the centerpiece of affordable and accessible, high quality medical care in California and is an enduring public policy success. It ensures that patients suffering malpractice shall receive full and unlimited compensation for actual damages and, at maximum, an additional quarter-million dollars for non-economic damages and "pain and suffering." It contains meaningful and reasonable tort reform to reduce litigation and moderate its costs, including: 1) placing reasonable limitations on personal injury lawyers' contingency fees to reduce the tremendous financial incentive personal injury lawyers had (up to 50% of awards) to pursue frivolous cases; 2) allowing periodic payment of awards in excess of $50,000, giving insurers a more affordable means to pay large awards and ensuring that money will be available to the injured patient over time; 3) allowing disclosure of collateral sources of recovery received by the injured patient from Workers' Compensation, disability or health insurance or other sources, to prevent double recovery of those losses; 4) establishing a statute of limitations, and; 5) what is considered by experts to be the most effective provision of MICRA, a $250,000 cap on subjective, non-quantifiable, damages for mental anguish, or what is termed "pain and suffering." It also increased the state licensing agency's ability to monitor the competence of physicians and established arbitration as an alternative dispute resolution process.

The personal injury lawyers' main strategy against MICRA is to argue that its quarter-million dollar cap on pain and suffering has, over time, kept awards low and thus, restricted access to the courts for aggrieved patients. Consequently, they call for a significant increase in the cap and establishment of an annual cost of living adjustment. But factual analysis shows that awards have grown in size at a much faster rate than the cost of living, despite having a cap on "pain and suffering" damages in place. This is because nothing in MICRA limits an injured patient's ability to recover all objective, quantifiable present and future losses, a fact that personal injury lawyers often obscure. The law also allows for assessment of "punitive damages" when a physician's conduct is deemed egregious or intentionally harmful. The California Legislature purposely established this cap to address an overriding societal concern: preservation of accessible and affordable health care. In 1975, then Assemblyman Barry Keene aptly described the legislature's thinking when it capped pain and suffering damages at $250,000 and chose not to include a cost of living index:

Patients' rights to recover for non-economic losses, chiefly 'pain and suffering,' were severely limited in the belief that there are limits to what society can afford in an area of great subjectivity in which it is not always possible to compensate with dollars."

In the most recent legislative attack on MICRA (1999), when the personal injury lawyers made the same pitch to the Legislature, professional liability insurance experts and actuaries predicted that insurance premiums would more than double for all physicians and triple for high-risk specialties (i.e. OB/GYNs and surgeons) if the cap on "pain and suffering" damages were to be increased. That's because an increase in the cap would not only raise the award, it would also stimulate more frivolous litigation and all the attendant costs that come with it. Studies also indicate that the annual cost of health care could increase by nearly $10 billion in California if the cap were doubled to $500,000. For "safety net" hospitals (U.C. teaching hospitals, public hos-

"MICRA", Continued Next Page

"MICRA, continued

pitals, children's hospitals), which are mostly self-insured, this would take scarce funding away from direct patient care to cover these added litigation and health care costs. And if the MICRA cap is raised the bulk of the cost would be born by high risk physician specialties (OB/GYN, surgery) and these safety-net institutions, reducing both access and services for California's uninsured and most vulnerable patients. The argument that the "cap" should be adjusted after all these years pales when considering the higher social goal of delivering medical care to those who need it.

MICRA Has Moderated Malpractice Insurance Costs and Preserved Access to Care

Prior to the MICRA reforms the cost of malpractice insurance in California was exceeded only by the cost for physicians practicing in New York City. Since MICRA's passage the average national cost of malpractice coverage has increased by 854%, while California's costs have risen only 287%. Current California malpractice insurance costs are in the lower half of rates among all states, and rates in Northern California are in the lower third among all states. In comparison to the states with the highest malpractice insurance premiums, none of which have MICRA reforms, rates in Southern California are about 40% of those rates, and rates for Northern California are almost half again lower than rates in Southern California. This has resulted in substantial savings in malpractice insurance costs for physicians.

As noted previously, this moderation in the cost of malpractice coverage has significantly benefitted self-insured institutions that play a huge role in the safety-net for low-income and uninsured patients.

The Political Battle To Preserve MICRA

Personal injury lawyers intend to once again obfuscate the issues and minimize the detrimental impact that weakening MICRA would have on patients and our health care system. They will trot out the well-worn argument that it is reasonable to increase the cap on "pain and suffering" because it hasn't changed in 35 years, and failure to do so is robbing patients' of their right to justice. They will also prey on public animosity toward the insurance industry by claiming that preserving MICRA simply allows greedy insurance companies to rack up more profits, ignoring the fact that roughly 50% of malpractice coverage in California is self-insured and only 10% of coverage is provided by traditional commercial insurance carriers. The remainder is underwritten by organizations that have no commercial profit motive, including doctor-owned malpractice insurers sponsored by medical societies and other "co-op" type coverage of various types. The personal injury lawyers are also reviving scurrilous attacks on the medical profession, claiming physicians either over treat or withhold treatment from patients for profit.

Thank you to the Alameda-Contra Costa County Medical Society for permission to reprint this article from their Jan-Feb 2011 ACCMA Bulletin.

JUNE 15, 2011

e meeting was called to order by President, Hal Grotke, M.D. at 5 p.m.

S/C to approve the minutes of the May 18, 2011 Executive Board eting, as presented.

REED to send out copy of one of the presentations given at recent CMA Leadership Academy: "What Will Change in althcare And How To Make Sure It Changes The Right Way" was presented by Harold Miller from the Center for Healthcare ality and Payment Reform and Network for Regional Healthcare provement.

PORTED that we are now able to upload the DocBooksMD on iPhone, iPad and other apple based smart phones. (The id app should be available soon). Members will need their MA ID number to access this member benefit. Suggested inding non-member contact information for our members use.

PORTED that our nomination for the "Spare Change" program the NORCAL Community Involvement Fund Grant was not of the selected recipients for 2011.

ENTIONED that Ron Jones, M.D. is our representative to the RCAP Counsel, which is the sponsoring counties advisory dy to NORCAL. Reported that Dr. Jones was appointed to ve on their governing board and was selected to serve on the ms review board, which unfortunately, causes a conflict with ving on the local Medical Quality Review Committee. A new air will be selected at the next meeting.

ALTH DEPARTMENT Update was presented as follows:

-Last month a Humboldt County child was diagnosed with ies, and miraculously survived. She was cared for by UC Davis ng a Milwaukie protocol, whereby she was given ketamine and on life support until the neurotoxin wore off. CDC and CDPH ne to town to help with the investigation. We did not identify a rce, but it was presumed to be feral cats. An extensive commu- campaign was conducted to identify potentially exposed ple. Ten health workers received prophylaxis.

is week we received confirmation of a measles case in a young man who

received two MMR vaccines. She was exposed to measles in na . CDPH is handling the issue of exposed airline passengers. Her case was attenuated by prior vaccination, making the clinical and laboratory diagnosis challenging. Kudos to the astute clinician. CDPH laboratory has PCR testing, which is more sensitive than the testing done by commercial labs. We have done press outreach about potential exposure at China Buffet and Hometown Buffet. We have also contacted employees and patients at the medical office, restaurant employees and family members. So far there have been no secondary cases reported. The incubation period is up on 6/14. Information for medical providers was posted on the Humboldt Health Alert website and distributed by broadcast fax and e-mail. Thanks go to the Medical Society for sharing its up-to-date contact information.

-Medical practices may not be aware that they are required by OSHA to document IgG

positive status or two MMR after 1968, or get a signed declination from employees. Employees without documentation could be required to stay home for two weeks if exposed. Varicella immunity and receipt of TdaP must also be documented.

DISCUSSION was held regarding rescheduling of the Medical Society Talent Show and whether the meeting should be combined with the annual meeting in December. **M/S/C** to schedule separate meetings - the annual meeting in December at Baywood Golf and Country Club with the CMA President or President-Elect and reschedule the Talent Show to January or February 2012, which will also give the committee additional time to work on the program.

DISCUSSION followed regarding the upcoming District X Caucus meeting in Santa Rosa on June 25th. Mentioned that Elizabeth McNeil, CMA VP Federal Relations will be attending to give an Federal Update. Business in preparation for the 2011 CMA House of Delegates meeting will be done at this meeting. **M/S/C** to endorse the resolution authored by Dr. Mastroni "Professional Board Certification Exams" directing CMA to work with the Specialty Societies to assess the flexibility of the locations for recertification exams, expanding local testing whenever possible. Mentioned that there was also another local resolution being crafted regarding developing a checklist and tools for patients to use to ensure that appropriate protections are used in releasing their patient information.

REPORT from the CMA Leadership Academy was presented.

"BRIEFS", Continued Next Page

"BRIEFS, continued

Mentioned that there were several good handouts at the meeting that we're waiting for copies.

REPORTED CMA requesting input from local physicians regarding the impact of the proposed changes to the Healthy Families program in rural areas. Agreed that the impact will differ depending on primary care versus specialists and whether the primary care are a Rural Health Clinic or a Federally Qualified Health Center.

REPORTED that Redwood Anesthesia Group is negotiating to join the St. Joseph Heritage Foundation as of September 1st. Dr. Grotke reported on the two new physicians joining Redwood Family Practice this summer.

STRESSED peer-to-peer recruitment (and retention) efforts on an on-going basis.

There being no further business, the meeting was adjourned at 8:10 P.M. §

☎

ECONOMIC ADVOCACY CMA REIMBURSEMENT

HOTLINE: (888) 401-5911

"NORCAL, continued

Sample forms that utilize SBAR, I Pass the Baton and SHARED can be accessed on the Association of periOperative Registered Nurses (AORN) Web site in its Perioperative Patient Hand-off Toolkit at: www.aorn.org/docs_assets/55B250E0-9779-5C0D-1DDC8177C9B4C8EB/44F6B4B2-17A4-49A8-86F218EDBF23516A/HandOff_SampleTools.pdf (accessed 8/3/2010). These forms can also be found in *Improving Hand-Off Communications*, Ed. Meghan Pillow, 2007, available for a fee from the Joint Commission on its Web site at: http://www.jcrinc.com/Books-and-E-books/IMPROVING-HAND-OFF-COMMUNICATION/1225/ (accessed 8/3/2010).

NEED HELP WITH NEGOTIATING CONTRACTS?
CMA's contracting toolkit, Taking Charge, which can be downloaded at no charge from the CMA website *(in the Members Only section)*. www.cmanet.org/ces.

CLASSIFIED ADVERTISEMENTS

JOB OPPORTUNITIES

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

PART TIME (TEMPORARY) URGENT CARE PHYSICIAN OPPORTUNITY – seeking a Board Certified Family Practice or Emergency Medicine Physician to work at St. Joseph Urgent Care Center on a part time basis for approximately 6 months. **If interested, please contact Eric Gerdes, D.O. at** ericgerdes@cep.com

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)*

BUSY PSYCHIATRIC PRACTICE with Psychiatrist and P.A.-C looking for mid-level practitioner to join practice (part time at first) Pleasant office environment and staff. Practice focuses heavily on psychopharmacology and brief supportive counseling. Psychiatric experience a big plus but will train and supervise the right person. Please Fax Resume to 707-826-2481

TRANSCRIPTONIST AVAIL 4+ yrs exp. in GP, OB-GYN ultsnds, IM, ortho, cardiac, ltrs & C notes. Local/Reliable. (707) 725-6517 or (707) 845-6181.

FOR RENT. 3 Bedroom, 2 Bathroom, Backyard with deck. Washer/dryer hookup. Walking distance to Safeway, Washington School, Sequoia Park, St. Joseph Hospital. $2500/month. Pets OK. Photos: www.3333Harrison.com; Regina 707-845-4740.

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.

MEDICAL OFFICE SPACE AVAILABLE in Fortuna. New clinic -- 2,500-5,000 sq ft. Equipt for lab; has comfortable waiting room, eight treatment rooms and 4 private offices for providers and/or office/nurse managers. Please contact Arlene Guccione for more information , (707) 725-8770 . *(JG7-10)*

FOR SALE. Local medical practice is currently offering for sale:

- -Welch wall mounted Blood Pressure Monitor
- -Metal xray storage shelves –(2) 5 tier (1) 6 tier
- -Blood draw chair
- -Ambco Audiometer model 650
- -Large Dry Erase Board
- -2 bullet proof reception desk widows with metal mounting hardware

Contact Nancy Craig at 707-442-5335 x 338

EXAM TABLE FOR SALE. LIKE NEW. $50. OBO
Contact: Elesha @ Eureka Pediatrics, 445-8416 (ME611)

ATTN. PHYSICIANS, APCs and STAFF: HOST HOUSING NEEDED for medical students rotating through Humboldt and Del Norte Counties. The medical students need a desk, bed, a quiet room and wireless access for 4 to 6 weeks at a time. The students are part of our ongoing efforts to recruit physicians to our area! Please e-mail Kate McCaffrey, D.O. kmccaffrey123@gmail.com.

CALHIPSO
California Health Information Partnership & Services Organization

Electronic Health Records: Benefits for Medical Practices

IN A NUTSHELL: Why Electronic Health Records?

EHRs and the ability to exchange health information electronically can improve the delivery of patient care. By adopting Electronic Health Records[1] and achieving Meaningful Use, clinicians can gain greater, more comprehensive access to patient information, make better decisions and save money. Other benefits include:

- Access to patient records from inpatient and remote locations for faster, more coordinated and more efficient care delivery
- Safer, more reliable prescribing
- Legible, complete documentation that facilitates accurate coding and billing
- Enhanced privacy and security of patient data
- Enhanced decision support with clinical alerts, reminders, and medical information

"Working with health IT made me a better and safer physician. Most importantly, my patients received better, safer care and improved outcomes."

– David Blumenthal, M.D., M.P.P., National Coordinator for Health IT

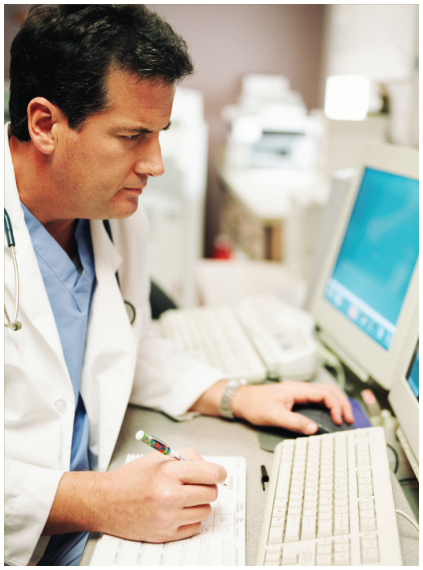
Better Informed Clinical Decisions

When all patient information is in one place, providers can make well informed treatment decisions quickly and safely:

- 97% reported that EHRs contributed to timely access to medical records and 82% reported that EHRs positively affected the quality of clinical decisions.[2]
- 80% reported that EHRs averted a known drug allergic reaction, and 71% avoided a potentially dangerous drug interaction.[2]
- By increasing access to guideline or protocol based care, delivery improvements ranged from absolute increases of 5 to 66 percent.[3]

Improved Care Coordination and Communication

One in seven hospitalizations is the result of missing clinical information.[4] Ready access to a comprehensive patient record allows the provider to effectively coordinate care and communicate with patients and other healthcare professionals. Providers using fully functional EHRs have reported the following benefits:



- Six months after EHR implementation, 72.4% reported being in agreement on treatment goals and plans with other involved clinicians, compared to 56% of clinicians without EHRs.[5]
- 72% reported that EHRs positively affected communication with patients.[2]
- Gradual EHR implementation resulted in maintaining positive patient-physician relationships and fostering the sharing of medical information.[6]

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