Ever since the enactment of Medicare in 1965, government and politics have become major forces in reshaping American medicine. Only a handful of physicians have been able to avoid the rules, regulations, blandishments and threats of the Medicare program. These are now administered by CMS, the Center for Medicare and Medicaid Services.

Some 25 years after the debut of Medicare, physicians discovered that while Hilary Clinton's health initiative went down to defeat, its section on physician fraud and abuse lived on. It was adopted in its entirety by Medicare as administrative law, which is just as binding as legislative law. Many of the provisions are so Draconian that they appear not to have been enforced. Which is, more or less, how the interaction of law and politics works as usual... If this leaves physicians unsure where they stand, everyone seems to have learned to live with it.

Next we come to President Obama's 2010 Patient Protection and Affordable Health Care Act. Like Hilary Clinton's bill, it contains some measures that physicians generally support, but the overall structure is similarly legalistic, complicated and unwieldy. (It is 1,000 pages longer than Hilary's bill.) The new law offers many job opportunities in the more than 120 health care agencies that it creates. It also invites the Internal Revenue Service to participate. One would have to ignore all past experience to believe that such an expanded corps of regulators will have a benign impact on physicians.

Because of the hassle-factor, some physicians currently do not bill Medi-Cal for services they provide. The same is true for the intensive phone management of home care for patients who are discharged from the hospital while still suffering from serious ancillary complaints. Time logs must be kept and they have to add up to at least an hour per month to claim reimbursement. Even then, claims have been routinely disputed. I myself simply gave up on the process.

Clearly, the new law attempts to be supportive of primary care. The devil, however, remains in the details. For example, a bonus of 10% is awarded to primary physicians. But it only applies if 60% of services to Medicare patients are "primary care services." How will these ultimately be defined? Who can predict or depend upon a bonus that is statistical and opaque in the course of practice? Will this and similar measures entice young physicians into careers in primary care? My guess is that the horse-trading and outright bribery that were so prominent in Congress during the creation of the legislation will not work in enhancing primary care.

Nor are new primary physicians likely to be very popular with their specialist colleagues who will be squeezed by the promise of $500 billion dollars in savings from the Medicare program and who will then see primary physicians as not sharing their pain. Whatever shred of collegiality that is left after nearly three decades of managed care will further unravel.
The San Mateo County Medical Association sponsored 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 sponsored program insurer, chances are your savings will exceed the 5% program discount.

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In the current economic climate, spending more than you have to for workers’ compensation insurance doesn’t make sense. Workers’ Compensation premiums are on the rise again, right a time when reducing practice expenses must be a priority for every physician.
Have You Kept Your Eye on State Activity?

By John Hoff, MD
SMCMA President

Most of our attention recently has been focused on Federal healthcare reform, but there has been ongoing legislative and regulatory activity at the state level as well that warrants your attention.

In the current state legislative session, three bills have been introduced that call for eliminating the ban on the corporate practice of medicine. These proposals would allow hospitals to control the delivery of medical care by hiring and charging patients for physician services. All three proposals are currently being held in legislative committees Inactive Files or Postponed, but at any time an author can ask for a bill to be moved back on the active agenda file.

We physicians strive to provide the very best medical care as efficiently and as cost effectively as possible. The trend has been to provide more treatment on an outpatient basis and to keep patients out of the hospital. This is clearly not in the best financial interests of most hospitals.

If hospitals are allowed to hire and charge for physician services, a division of the physicians' loyalty to the patient can be created, commercial exploitation of medical care can occur, and lay control over physicians' professional medical judgment can be exerted. Placing doctors under the oversight of hospital administrator and CEOs who are under enormous pressures to cut costs or increase revenue will threaten the independent medical judgment necessary to ensure patients are protection. In the end not only will higher health care costs result, but also will diminished quality of care provided to patients in California.

This is not to say that the hospitals don’t have legitimate concerns. It can be difficult to recruit physicians into the area, but hospital districts have failed to show why allowing corporate entities to directly hire physicians would work where other incentives have failed. These incentives include the right to guarantee to a physician a minimum income for a period of no more than three years from the opening of the physician’s practice; a guarantee to purchase necessary equipment by the physician; the provision of reduced rental rates of office space in any building owned by the district or any of its affiliated entities, and the provision of other incentives to a physician in exchange for consideration and upon terms and conditions the hospital district’s board deems reasonable and appropriate.

Diminishing the quality of care is not the appropriate way to increase access to physician services where there is none today. There are ways to address that shortage without allowing hospitals to control physician employment. Increasing slots to allow residents to train in California, developing the medical schools at UC Merced, UC Riverside, and expanding access to California’s loan repayment program will truly ensure physicians go to and stay in rural and underserved areas.

Finally, the POLST form that became law in California on January 1, 2009 is finally here; it is meant to complement the Advance Health Care Directive and is not intended to replace that document. POLST (Physician Orders for Life-Sustaining Treatment) is a mechanism to allow physician orders for seriously ill patients and those who are in very poor health to be recognized throughout the health care system, from the Emergency Department to hospitals throughout the entire state of California, regardless of where the physician has privileges. The document, clearly recognizable in its bright “pulsar pink” form is meant to remain with the patient. The original form is to accompany the patient when being transferred from one level of care to the next.

Physician training sessions are being held at the various hospitals throughout the county. In addition the San Mateo County POLST Coalition, along with the San Mateo County Medical Association and the Hospital Consortium of San Mateo County will conduct a two-hour CME program, including dinner, on Tuesday, May 25, 2010 at 6:00 P.M. at SMCMA Headquarters to discuss the use of the POLST form and how to introduce it to your patients. We are fortunate to have Gary Lee, MD, a Santa Clara palliative care physician, and Doris Hawks, JD, an attorney specializing in elder care. This would be a good time to figure out how this all works before your patients and their families come to talk to you about this.

For more information on POLST, please visit www.capolst.org
The new law also promotes large group practice with cash incentives that small group or individual physicians cannot hope to obtain because of their limited ability to comply with the complex regulations governing statistical assessments of their practice activities. Furthermore, only a minority of practicing physicians are in large group practices and since government seems to favor this mode, the majority of physicians may be disadvantaged in future payment schemes.

All physicians will be affected in one way or another and it is impossible to predict all the ramifications of the Obama health bill. Nevertheless, the thrust remains an increase in documentation and greater standardization of care in the service of “best practices.” Apart from the meaningfulness of compliance, this will be a particular problem for primary care because of the time and cost of compliance across a broad range of illnesses and other health problems. This alone will be a strong incentive to an increase in specialty care, which is widely considered to be less cost-effective. Again, this is an example of government “solutions” that tend to work at cross-purposes to one another. That is the inevitable result of politicizing medicine.

Left out from any consideration at all, are the attributes that have made medicine a unique profession over the millennia. These are professional freedom, autonomy, and personal stature in the community — all of which are tied to greater continuity of care for patients and greater job satisfaction for physicians. It was just these traits that that have traditionally induced young physicians to enter the field of primary care despite the long hours and low pay that have always been there. As for professional freedom, it promotes an ethos of service in all physicians.

The new health legislation reinforces the trend against all these hard-to-measure strengths of traditional medicine. They are anathema to the unholy triad of economists: lawyers and politicians who have decided to create a New Medicine in their own image. Ω
As mentioned recently in our NEWSletter, a study by the Center for Studying Health System Change reports how hospitals and physicians in California have gained market power to negotiate high payment rates with private insurers.

The report discussed various strategies implemented by hospitals and physicians that have strengthened their leverage in negotiating prices with private health plans. The report suggests that California’s experience is a cautionary tale for national health reform. Proposals to promote integrated care through models such as accountable care organizations (ACOs), groupings of providers given financial incentives to deliver efficient, high-quality care could lead to higher rates for private payers across the United States.

Six geographic areas in California (San Francisco/Oakland, Sacramento, Los Angeles, San Diego, Riverside/San Bernardino and Fresno) were examined to explain the growing market power for providers who now have a stronger bargaining position over health plans. The report also explored why some of the proposed payment reforms and organizational delivery models at the national level may also exacerbate the trend toward greater provider market share. The concern is that such provider dominance could offset some or all of the potential of reforms to lower premiums through increased efficiency in delivery, and that policy makers need to address the issue of provider market strength.

While on average nationally, commercial insurers’ hospital payment rates are nearly 30 percent higher than Medicare rates in California. After a downward trend in hospital prices for private-pay patients in the 1990s, a rapid upward trend began around 1999 that produced average annual increases of 10.6 percent over the period 1999-2005, a nearly doubling of California hospital prices.

If ACOs lead to more integrated provider groups that are able to exert market power in negotiations, the report suggests that the lessons learned from California show the opposite: a definite shift in negotiating strength toward providers, resulting in higher payment rates and premiums. The report notes that there are some strategic differences in the six Californian markets it researched, noting that Riverside/San Bernardino and Fresno hospitals and physicians remain relatively dispersed geographically with many physicians remaining in small practices represented by IPAs instead of forming multispecialty groups. The majority of large, horizontally integrated hospitals have been formed in northern California. While the structures vary, they have become increasingly sophisticated in developing organizational forms, primarily to increase their negotiating clout with health plans.

While California retains a “corporate practice of medicine” bar, there are ways to facilitate hospital-physician alliances through the formation of medical foundations that employ physicians. While the rationale for ACOs is to work together as an integrated delivery system to improve quality and efficiency, one clear goal of the alliance between hospitals and physicians is to improve negotiating clout for both. And while the large clinically integrated groups have great leverage, the exception is the truly independent doctors who are vulnerable to having no choice but to take what a health plan offers as reimbursement.

The report claims that the only factor moderating providers’ market share in California is the presence of Kaiser Permanente; providers are somewhat constrained from pushing for higher payment rates which could lead to higher non-Kaiser insurance premiums and a loss of market share to Kaiser.

The shift is in who holds the upper hand in negotiating payments; once held by the insurers, the power now rests with health care providers. The report concludes that the push in Congress to restructure health care delivery with ACOs should pay attention to the California-style integrated care systems because they currently produce higher prices that undermine cost containment. Market mechanisms must be found to discipline providers’ use of its growing market power, the report recommends.
Insurance Preauthorizations: How to Make the Process Less Painful

by Victoria Stagg Elliott

The frustrating process of preauthorizing medical care with third-party payers does not have to take as much time as it does, practice management experts say. The process can be automated. Or, practices can note what issues trigger a denial, and adjust their processes to quicken and gain approval. And while insurers normally view precertification as a nonbillable service because it’s considered part of a medical visit, evidence of how much time it takes can be used as a negotiating chip with insurers.

“It’s supposed to be built into the revenue for the services that doctors are providing, but it can be an administrative nightmare for practices. Every insurance company requires something just a little bit different,” said Rhonda Buckholtz, vice president of business and member development at the American Academy of Professional Coders. “But we can simplify the process as best we can.”

The first step is to analyze how the office handles the process. Is it possible to get some preauthorizations completed before the patient comes in? Are there insurer-provided online tools that the practice is not taking full advantage of? For example, Elizabeth Woodcock, principal of Woodcock & Associates in Atlanta, said she worked with an endocrinology practice that entered precertification information into an insurer’s online system. But, rather than submitting it electronically, staff printed it out and faxed it, which took additional time. “Make sure you are using all the automation that the payer allows,” Woodcock said.

Experts also suggest creating some kind of tool that staff can refer to with all the policies and procedures of various insurers. This does not have to be particularly high-tech. For instance, Buckholtz has set up three-ring binders at several medical practices she has worked with. The binders can be particularly handy if the person who usually handles preauthorizations is out of the office.

Dealing with denials of the initial request for precertification also can be time consuming, but experts say the situation is another opportunity to look for time savings. Are there consistent issues that trigger a denial? Are certain codes always left off? Are necessary lab tests not being noted? “Go back through the process and ask: ‘Am I doing everything right?’” said Marilyn Happold-Latham, an independent practice consultant in Portland, OR.

Experts also advocate starting the preauthorization process before the patient leaves the office. At the end of a visit when it appears preauthorization will be needed, a staff member who handles the process can be called in to get it started while the file is still open and information is still fresh in everyone’s mind. “You want to capture all of the information before the patient ever leaves the room or the practice,” Buckholtz said.

And some offices have had luck on increasing pay rates by approaching insurers with information about how much time preauthorizations take. “Most physicians avoid going to the table or picking up the phone, but it can be a huge step forward,” Woodcock said. “But don’t just say, ‘I want more money.’ Have quantitative data on how much it costs to be a participant in their program. Does it always work? Of course not, but you have a much better shot than if you never picked up the phone.”

Some practices also have tried to have patients handle preauthorizations, although with little success. For example, the staff at Black Hills Orthopedic & Spine Center in Rapid City, S.D., tried having patients handle preauthorizations, but found that it actually took up more practice time, not less. The staff spends nearly 20 hours a week on preauthorizations despite doing everything else it can to streamline the process. “The complexities are far too challenging,” said Jennifer May, MD, one of the practice’s rheumatologists. “We have considered this, but it just leads to too many phone calls and questions from patients. We end up doing it anyway.” Having the patient handle preauthorizations also may contravene insurer contracts.

Several medical societies, including the American Medical Association, have policies advocating that utilization review efforts focus on outliers rather than all physicians. The AMA also strongly supports fair compensation for administrative costs when providing services to managed care patients. Ω

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Doctors to Begin Filing Claims in $350M UnitedHealth Settlement

Physicians eligible for reimbursement resulting from the history-making $350 million settlement with UnitedHealth Group are getting help from the American Medical Association in filing claims.

AMA has created a web page for doctors, medical groups and IPAs to determine if they qualify for compensation, to download claims documents and to submit them correctly. Visit http://www.ama-assn.org/ama/pub/advocacy/current-topics-advocacy/private-sector-advocacy/health-insurer-settlements/unitedhealth-ucr-settlement.shtml.

AMA spokesman Robert Mills said there’s likely a concentration of eligible doctors in San Jose, Santa Clara and Sunnyvale where 18 percent of the PPO market is controlled by UnitedHealth.

On Jan. 15, 2009 Minneapolis-based UnitedHealth Group, one of the nation’s largest health insurers, reached a settlement in a lawsuit filed against it by AMA, the Medical Society of the State of New York and the Missouri State Medical Association. UnitedHealth and other health plans had used database products owned by UnitedHealth subsidiary Ingenix Inc. For 15 years these flawed databases caused doctors and their patients to be underpaid for out-of-network services.

In addition to the guidelines for filing claims that AMA is providing to all doctors, whether or not they are AMA members, the association’s Practice Management Center is offering AMA members personalized help and AMA’s Managed Care Advisory Group will handle claims submission at a discount for members. All claims must be filed by Oct. 5, 2010 and the final settlement hearing is scheduled for Sept. 13, 2010.

Lawsuits similar to the one filed against UnitedHealth have been filed against Aetna, Cigna and WellPoint Inc. They are all currently in discovery and the WellPoint suit has a hearing date on May 24, Mills said.

Chronic Conditions on Rise in California: Long-term Solutions Sought

A study published in March by the California HealthCare Foundation and prepared by the UCLA Center for Health Policy Research found that chronic conditions are increasing. A chronic health condition might be active asthma, CHF, diabetes, hypertension, or psychological duress.

In the same report, about one in every six California children reported some form of chronic health condition, which is more than double the last national report of 7% (source: Chronic Diseases: The Power to Prevent, The Call to Control: At A Glance 2009, available at http://www.cdc.gov/chronicdisease/resources/publications/AAG/chronic.htm).

According to a study from the Centers for Disease Control and Prevention, chronic health conditions make up more than 70% of health care costs in the United States (The Burden of Chronic Diseases and Their Risk Factors http://www.cdc.gov/nccdphp/burdenbook2004/).

33 counties in California have chronic condition rates that are above average. In San Mateo County, 37.8 percent of adults and 17.2 percent of children have chronic conditions. Half of residents in the Tehama-Glenn-Colusa county area have a chronic disease. And while the overall incidence is lowest in Marin County, income and economics are only some of the barriers to care.

All the information in the world, though, does not affect change. Addressing chronic conditions requires a second type of reform: create policies and programs that reduce the conditions from starting in the first place.

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Get Privacy Right, So We Can Move On Already

By Lygeia Ricciardi

A national survey released this month by the California HealthCare Foundation shows that 66% of Americans believe we should address privacy worries, but not let them stop us from learning how technology can improve our health care. Amen.

This is particularly heartening news given that the same survey also documents for the first time real consumer benefits from the use of personal health records (PHRs). Seven percent of American now use PHRs, more than double the number in 2008. According to the survey, significant proportions of PHR users feel they know more about their health and health care, ask their doctors questions, feel connected to their doctor, and even take action to improve their health as a result of using a PHR.

It gets better. Though current PHR users fit the profile of early adopters of technology in general (wealthy, highly educated, tech-savvy men), it’s the less privileged that report the greatest benefits. People with multiple chronic conditions, low incomes, and less education are among those most likely to take steps to improve their health as a result of using a PHR. Given that chronic disease accounts for about 75% of the $2.3 billion our nation spends on health every year, that’s a big deal. As economist Jane Sarasohn-Kahn remarked on the findings, PHRs may be able to “bend the cost curve”—if enough people with chronic conditions improve behaviors just a little, they could save enough to repay all $46 billion that the Stimulus Package is putting toward health IT through HITECH.

Consumers Are Headed in the Right Direction

A 2005 California HealthCare Foundation survey found that 67% of Americans were concerned about the privacy of their personal medical records—about the same as today. But the new survey also compares people who are using PHRs to those who aren’t. PHR users are a little less concerned than non-users about the privacy of their health information overall. And only 40% are worried about the information that is actually in their PHRs. Why? There are several possibilities, but it could be in part because familiarity with the tool brings comfort. Before ATMs were commonplace, lots of people were unsure about getting cash through a hole in the wall.

While it’s true that people who don’t use PHRs cite privacy as a top potential barrier (followed by no perceived need), 40% of non-users say they want to use a PHR anyway, and more than half are interested in remote monitoring devices and other health applications. That’s pretty significant when you figure that a large proportion of people consider themselves healthy (and are thus not interested in tracking their health).

The survey also points the way toward greater adoption by asking non-users what factors would contribute to their use of one. Reports include knowing that it comes from a trusted source, strong laws and fines for misuse of information, and encouragement from their doctor. It’s also notable that those whose doctors use an electronic medical record have a higher level of interest in using PHRs—so perhaps the HITECH support for EHR adoption will help tip the balance for PHR adoption, too.

Where Policymakers Need to Go

Privacy is sometimes cited as a—or even the—primary barrier to health IT adoption, and people are concerned about it for good reason. Discrimination, embarrassment, physical harm, and avoidance of needed health care services are among the risks associated with getting it wrong.

But there are some good ways to mitigate privacy risks, including both technical and policy approaches. Among recommendations the California HealthCare Foundation has articulated:

- Congress should develop consistent PHR privacy safeguards (which would include PHRs not covered by HIPAA)
- The Administration should ensure that there is rigorous enforcement of current health privacy rules (HIPAA is notoriously under-enforced)
- The Department of Health and Human Services should raise public awareness of PHR benefits and risks

This last point is essential because consumers need to consider privacy risks in the greater context of health IT benefits, yet most know very little about either. Again, it’s not that privacy is not important—rather, it’s imperative that we get it right so we don’t forfeit the many benefits of health IT. The new survey helps to document some, but I suspect we’ll see more evidence that health IT can improve the quality, efficiency, and convenience of care, even saving lives. Qs

Lygeia Ricciardi, founder of Clear Voice Consulting and part of the leadership team of Clinovations, worked closely with the California HealthCare Foundation on shaping and interpreting the survey described above.
My ‘AHA’ Moment
Learning to Treat the Patient, Not the Illness

by Jordan Shlain, MD

My “aha” moment came while working like a slave at my resident’s outpatient clinic. The hospital was rife with acute drama [trauma?] and complicated cases, compared to the mundane requests of managing high blood pressure in moderately compliant patients. Colds, sprained wrists, asthma, and a myriad of primary care conditions didn’t get me excited. I was destined for a specialty or a subspecialty or even a sub-subspecialty.

Our clinic director approached the residents on that fateful Friday afternoon and described a seventy-eight-year-old lady who was blind, hypertensive, and in atrial fibrillation, with recent bilateral mastectomy and hip replacements. She had a fever and was too weak to come to clinic. She lived on 43rd and Balboa near the beach. I thought, “Anything to get out of here, and near the beach. I’m in.”

I volunteered to make the house call. I grabbed my stethoscope, a dipstick, and a handful of antibiotic samples, and jumped in my 1983 Alfa Romeo Spider Veloce convertible and drove the home of Ms. Jose. She was from Australia and had married a U.S. GI in World War II. They’d lived in this flat for forty years until he had died four years ago.

She could navigate that flat—blind, mind you—perfectly. She was delicate with a happy and large smile. I noticed long tangles of telephone cord snaking across the floor, clearly a hazard for a blind person. She made chamomile tea, we sat on her couch overlooking the Pacific Ocean, and she told me her life story. It was the most fantastic history of present illness I had ever heard: A love story, a war, dogs, far-away lands, kids, and the flat on Ocean Beach. She eventually got to the part about the fevers. As the medical saw goes, 90 percent of a diagnosis can be found in the history. After a brief exam, I dipped her urine, which was positive for nitrites, blood, and white cells.

I had fortunately brought some ciprofloxacin samples and gave her a complete treatment course and asked for her phone number. I called her daily until her fever had subsided. The next week I informed my resident clinic director that I needed to visit Ms. Jose for follow-up . . . and this time I brought my dog, Java. My visit lasted another hour, and I followed up with a run on the beach with Java. Our visits were timeless, and over the years she became one of my favorite patients. There was no shortage of chronic medical problems to manage.

Ms. Jose transformed my understanding of taking care of a medical problem (or set of problems) into taking care of a patient. I felt like I was transported back fifty years, to when house calls were the norm and Marcus Welby was the model. The relationship that developed reframed my understanding of doctoring — making the “office visit” experience seem sterile, rushed, and problem-focused rather than patient-focused.

Her furniture, the smell of her flat, the food in the fridge, the photos around the house gave new meaning to “present history in context”— which is not part of our current clinical experience.

I have since made thousands of house calls and much prefer illness visits at home and wellness visits at the office. Context is everything! Ω

Jordan Shlain, MD, is a practicing internist in San Francisco. He started the first affordable concierge medical practice in the city.
Will Electronic Medical Record Systems Meet Expectations?

SMCMA Staff

Policymakers and health administrators have high hopes that electronic medical records will improve the quality and reduce the cost of health care. As a result of the American Recovery and Reinvestment Act (ARRA) of 2009, the US government is expected to provide billions of dollars in order to help physicians and hospitals implement electronic records systems. However, there have been reports about the challenges of using the technology in traditional medical practices.

For example, Neill Patel, Associate Medical Director of the AtlantiCare Special Care Center and Rushika Fernandopulle of Renaissance Health, published an in-depth analysis of their electronic medical records system which provides insights beneficial to physicians and groups that are considering going paperless.

Special Care Center was designed from the ground up to care for the sickest, costliest patients. Typical diagnosis included diabetes, hypertension, asthma, chronic obstructive pulmonary disease, coronary artery disease and congestive heart failure. Based on the ambulatory intensive care unit model, the Center’s combined features of the chronic care model and the patient-centered medical home in order to deliver more intensive outpatient primary care to their patients. The center was designed from the start to be a paperless practice complete with computers in all exam rooms and work areas and securely networked personal wireless tablets.

Their paperless system proved to have many benefits right from the start. Charts were always readily available both in the office and on call via a secure web interface, which also eliminated the need to hunt down documents that were scattered throughout the office because records are kept in one place. And since records are typewritten, the tedious and frustrating process of deciphering illegible handwriting was eliminated as well, which also eliminated misinterpretation.

Medication lists were stored electronically as well, which reduced the amount of time it took to prescribe refills for patients who took an average of eight medications each to a mere fraction of the time it took to hand write. Changing patients’ medications was just as easy by using e-prescriptions – an outbound prescription module with a direct connection with their pharmacy.

Communication with team members, outside consultants and patients was easy. Since all records were electronic, it took just a few keystrokes to share information. A patient portal was built into the system so that patients could log on and view their own records, and clinical notes could easily be sent from one team member to another.

The list of challenges was longer, some of it due to the software. That it was sluggish and unreliable was top on the list. Fernandopulle and Patel reported that about a year into the practice, the system began to slow down, often requiring a reboot and causing not only delay but necessitating a repeat of the user’s documentation process. Several times the system failed to operate for a significant amount of time, causing them to practice “blind.” E-prescribing, once up and running, proved to have a security glitch that allowed any user to send a prescription in the name of any other provider. Using flow sheets and tracking values from lab results hasn’t been evaluated because the feature that receives lab results doesn’t work.

It was also found that documentation time for physicians actually increased compared to paper charting. The system’s point-and-click templates were inadequate for the variability of patients in their practice. The system also required the clinician to structure and enter much of the data that was entered by other staff under the paper system, taking even more of the clinician’s time.

Other challenges arose because the system was designed for a single user and the Center had multiple users. The data-analysis registry could only be used by one person at a time. If one user forgot to log out, no one could use the registry until IT manually reset it. When this problem was finally fixed, others emerged. Registry query results were erroneous. On top of that, many lab values had several variants in the system; for example, hemoglobin A1c had several variants assigned to it, such as

“[these] experiences provide some important lessons for the many practices about to implement electronic health records”

CONTINUED ON PAGE 12
HGBA1c or HBA1c. Consequently, results could be stored in one of many different places in the medical record or had no place to be stored at all.

In all, the system was a poor fit for their practice. They required a medical record system that facilitated changing methods of care for patients that see several different physicians and staff members. And like paper systems, electronic systems have their own set of liabilities. Resolving issues that arise takes an IT staff or consultant and the software vendor, thereby increasing the cost of maintaining the system.

Their conclusion is that “It is perilous to draw broad conclusions from the experience of a single practice, particularly one such as the Special Care Center, which is unique in design and environment. That said, we believe that our experiences provide some important lessons for the many practices about to implement electronic health records, especially those engaged in practice redesign, as well as those that support such endeavors.” And “Even an award-winning system has on-going design issues... We believe that the complexity of software systems, coupled with the business interest to rapidly deploy these systems, leaves electronic health records susceptible to flaws and patients susceptible to medical errors.”

Physicians must be careful to choose a records system that is a good fit for their practice. Make sure to be aware of the design and functionality of the available systems and ensure that you can get quality support from the developer or vendor that you choose. Like all software, it must suit your needs.

To read Fernandopulle and Patel’s report, visit http://content.healthaffairs.org/cgi/content/full/29/4/622

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**SMCMA Nominating Committee Report**

The 2010 Nominating Committee has proposed the following candidates to officer, board, and delegation positions. Nominations may also be made by members of the Association. These nominations are to be in writing, signed by 10 active members, and delivered in person to the Association headquarters or by registered mail no later than May 28, 2010.

**Officers**

President-Elect: Gregory G. Lukaszewicz  
Secretary-Treasurer: Mary D. Giammona  
Immediate Past President: John D. Hoff

The office of the President will be filled by William J. Black, M.D., who automatically succeeds to the office after serving as President-Elect in the current fiscal year.

**Board of Directors**

Albert Bolanos, M.D.  
CJ Kunnappilly, M.D.  
Robert R. Jasmer M.D.  

Board members continuing terms: L. Albert Wetter M.D., Raymond Gaeta M.D., Thomas Hazlehurst M.D., Amita Saxena M.D.

**Delegation**

Gregory Lukaszewicz, M.D.  
James Missett, M.D.  
Robert Reisfeld, M.D.  

Delegates continuing terms: Dirk Baumann M.D., David Goldschmid M.D., Steven Kmucha M.D., Betty Lee, M.D.

**Alternate Delegates**

Albert Bolanos, M.D.  
Gordon A. Brody, M.D.  
Martin Bronk, M.D.  
Sophie Cole, M.D.  

Alternate Delegates continuing terms: Patricia Cavero, M.D., Rashmi Jain M.D., Barry Oberstein M.D.

**Nominating Committee**

Dirk Baumann, M.D.  
Raymond Gaeta, M.D.  
Mary Giammona, M.D.  

Opinions expressed by authors are their own and not necessarily those of the SMCMA. The BULLETIN reserves the right to edit all contributions for clarity and length, as well as to reject any material submitted.
Membership Update

NEW MEMBERS

JULIETTE LEE
*D
San Bruno

RETIRED

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