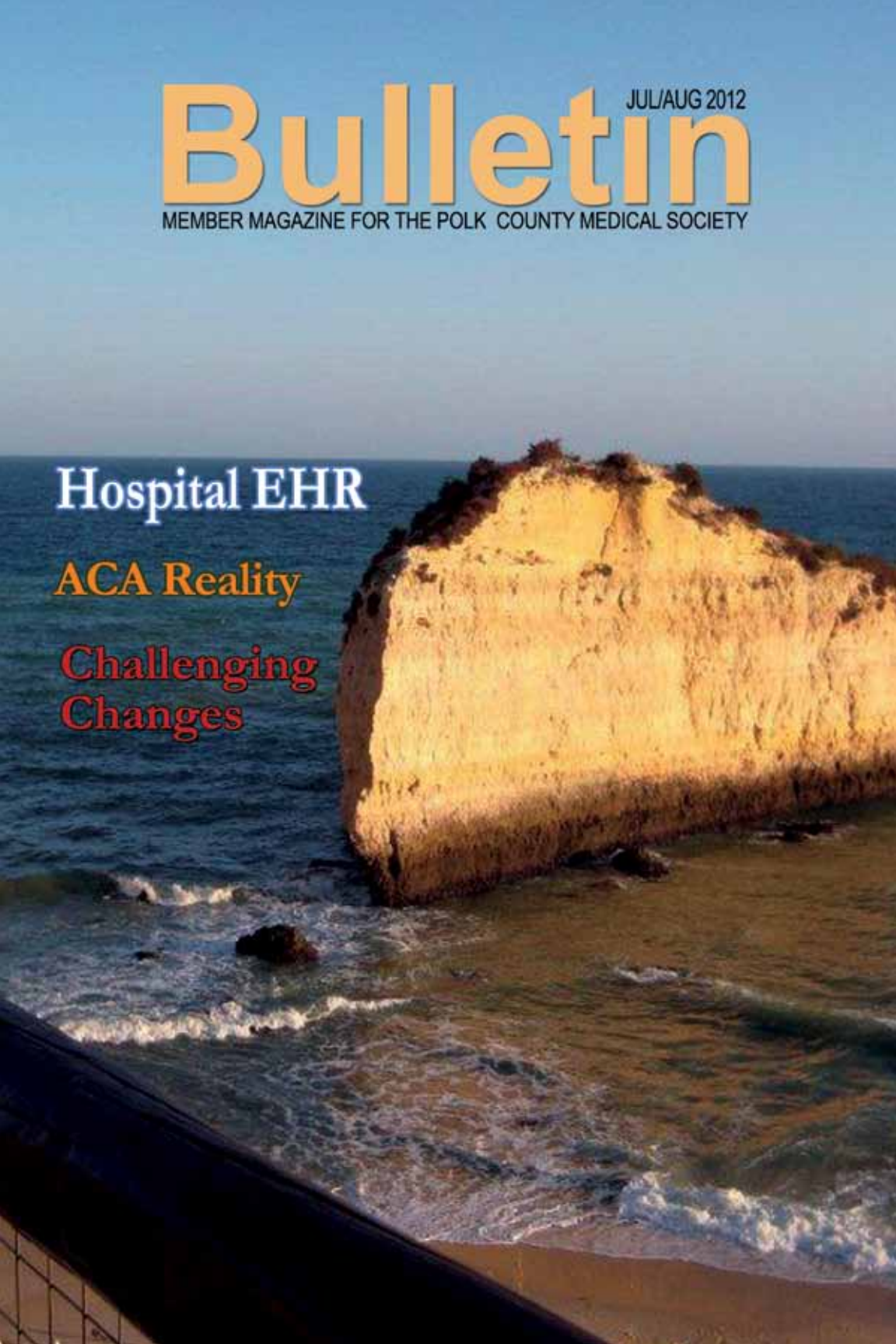
Bulletin

JUL/AUG 2012

MEMBER MAGAZINE FOR THE POLK COUNTY MEDICAL SOCIETY



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Bulletin

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MEMBER MAGAZINE FOR THE POLK COUNTY MEDICAL SOCIETY

Inside This Issue

Feature Articles

Monthly Articles

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Articles and editorial inquiries should be directed to:

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NOW THAT
THAT'S SETTLED - ??

Lynn M. Nelson, M.D.

The background for this article relies heavily upon a recent (specifically 2/25/12) Wall Street Journal article by retired family practice physician Dr. Ken Murray. "Charlie", a respected orthopaedic surgeon whom Dr. Murray also describes as a mentor of his, was diagnosed with pancreatic cancer and offered intervention including a surgical procedure which could triple (from 5% to 15%) his five year survival odds – albeit with a poor quality of life. "Charlie" made an informed and obviously very personal decision to focus on quality, rather than quantity, of his recent days and thus declined surgery, chemotherapy, and radiation therapy. He immediately closed his practice and focused upon spending time with his family.

In a survey of 765 physicians, approximately ten years ago, Joseph Gallo and co-authors evaluated the end of life decision making process of physicians. While only 20% of the general public had created an advanced directive, 64% of physicians had. CPR certainly can be lifesaving as is commonly portrayed in TV and movies; however, physicians with a terminal condition may decline CPR by an advanced directive as they recognize that only 8% of patients undergoing CPR survive greater than one month (per a 2010 study of 95,000 cases of CPR by Susan Diem).

Dr. Murray notes that in previous eras doctors recommended and did what they believed was best. Our medical system today, however, is based upon what patients choose (which certainly is best in the vast majority of clinical situations). Physicians generally strive to honor their patients' wishes, but may recommend more treatment than they themselves would choose to avoid imposing their values on the vulnerable. Physicians are in a unique position to understand and to have discussed with their families the limits of even modern medicine in treating terminal conditions.

This article is certainly not intended to remind physicians of their mortality. Nor is the purpose to naively suggest that physicians with a difficult task of treating terminally ill patients alter their recommendations. Rather, the goal is to remind physicians of the awesome opportunity and responsibility each of us carries in influencing our patients' most important life decisions.

The VA Central Iowa Health Care System (VACIHCS) is currently searching for qualified and dedicated health care workers to support our Medical Center in keeping with our commitment to caring for our nation's Veteran Heroes. Physicians must be board certified or board eligible.

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—Thomasine Durham

Challenging Changes
PCMS Actively Engaged In Process

Kathie J. Lyman

Dr. Nelson, Polk County Medical Society President, has written this month about the historic June 28, 2012, United States Supreme Court rule of a 5-4 decision that the **Affordable Care Act** is in fact constitutional. In the prevailing opinion, Chief Justice John Roberts wrote that the penalty imposed for failing to comply with the requirements that all Americans purchase health insurance – better known as the individual mandate – is a tax rather than a penalty, a power expressly given to Congress authorized by the Constitution. ***A plain English analysis of the ruling can be found on the web at:*** http://www.scotusblog.com/2012/06/todays-health-care-decision-in-plain-english/. However, the one thing that this new ACA law does not change is the Polk County Medical Society physicians' continued deep commitment to care for their patients. Trying to sort out how to do this with so many changes is however a little more challenging.

The Polk County Medical Society knows all too well about the uninsured in Iowa who need specialty care and don't have coverage either because they are working poor, or uninsured. The PCMS and hospital partners have contributed well over $7 million of specialty care to Iowans in need over the past several years. They are part of the 32 million uninsured Americans who will now gain affordable and comprehensive health insurance coverage because of the law. This law will protect against denial for pre-existing conditions which has been a major problem for people securing insurance previously. But, we all know that not all Iowans or Americans will chose to purchase some type of insurance coverage. There will continue to be a need for the VPN program and for PCMS specialty volunteers.

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A few of the significant challenges to implement the law are:

Medicare Payment Reform – Our Medicare program's financial health edges closer to a cliff each day Congress fails to enact reform. Currently, physicians face an across-the-board reimbursement cut of about 30% on January 1, 2013. Without Medicare payment reform, our Medicare patients' access to care is in peril.

Medicaid Reform –The ACA builds coverage through significant Medicaid expansion. Patient's already receiving care through Medicaid face hurdles that those with other forms of insurance do not. The ACA provides for a temporary and limited Medicaid reimbursement increase, but more must be done to fix this program.

Medical Liability Reform – Despite a dire need for liability reform, Iowa has never passed any medical liability reform. Federal reform is needed to help physicians with liability reform to be able to recruit the medical workforce Iowa needs. We currently have an inadequate number of doctors to meet the needs of Iowa patients and medical liability reform is a component of a comprehensive policy to address our medical workforce needs.

Physicians know that we absolutely must reduce the law's red tape and bureaucracy that interfere with patient care. Today's health care system is riddled with hundreds of regulations imposed by federal health law that do little to improve patient care but instead divert our time and energy away from our patients. Until we address these issues, our journey toward a sensible and cost-effective health care system that works for patients and doctors is far from over.

The Polk County Medical Society ADVOCATES on behalf of physicians. PCMS board members will meet in Washington in September with our Iowa Congressional Delegation as we work towards positive solutions in implementing the new ACA laws. Some of the first issues we will address are:

Encourage Congress to immediately fix and repeal the flawed Medicare Sustainable Growth Rate (SGR) physician payment formula

Enact liability reform laws

Oppose an Independent Payment Advisory Board which will mandate arbitrary spending cuts, force more physicians out of the program, and limit seniors' treatment options

Help fund the huge need for more

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DOCTORS IN THE NEWS

Congratulations to Roger Ceilley, M.D., who was named an Honorary Lifetime Member of the American Academy of Dermatology.

Congratulations to Magdi Ghali, M.D., who was featured in the **Des Moines Register Health Section**, July 4, 2012 as the primary investigator, and the only one in Iowa, for new blood pressure treatment evaluation, as part of the Medtronic SYMPLCITY HTN-3 pivotal research trial.

Congratulations to Edward Hertko, M.D., who accepted the Iowa Medical Society's Washington Freeman Peck Award on behalf of medical volunteers at Camp Hertko Hollow. The volunteers have devoted their time and hearts to helping diabetic children manage their disease for over 45 years.

Congratulations to Robert Zeff, M.D., who was featured in Q Magazine's health & Wellness section July 2012 on vein issues and treatment options.

NEW MEMBERS

Cloos, Carla R., M.D.
Education: University of Iowa Carver College of Medicine, Iowa City, IA
Residency: University of Nebraska – Anesthesia, Omaha, NE
Specialty: Family Medicine

Dr.Cloos currently practices at West Grand Medical Associates, 119 19th Street, Suite 106, West Des Moines, IA.

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United Way thanks these medical professionals for their Leadership Circle contributions of $1,000 or more during the 2011 United Way campaign. Together, we improve lives and promote a healthier central Iowa, through Education, Income and Health.

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In Memory of

Carolyn Jeanne Dorner, M.D.

Carolyn Dorner died in Des Moines on June 13, 2012. She was born in Iowa City where her father was on the faculty of the University of Iowa College of Medicine. She grew up in Des Moines and graduated from Theodore Roosevelt High School. Carolyn attended Carleton College and earned a B.A. from the University of Iowa and subsequently master's degrees in English and Public Health from Harvard University. She taught English early in her career before realizing her dream of becoming a physician. She earned her medical degree from the University of Iowa and interned at Santa Clara Valley Medical Center in California. Carolyn completed her residency in anesthesiology at the University of Iowa and practiced in Des Moines, Chattanooga, and later in her career at multiple locum tenens sites throughout the country. In her retirement, she volunteered and traveled extensively, participating recently in a palliative care teaching initiative in Tanzania.

Carolyn was the proud mother of four children: Scott, Erika, Matt, and Adam, and enjoyed four delightful grandchildren. She balanced her professional life and her role as a mother at a time when flexible work schedules were far less commonplace than today. There were only nine women in her graduating class from medical school and they faced substantial challenges in their lives as residents and practicing physicians. Carolyn followed with interest the changes in medicine over her lifetime that resulted in greater numbers of women physicians and was pleased that both her daughter and niece pursued medical careers.

My sister, Carolyn was a caring physician and a remarkable mother. She is missed by patients, colleagues, friends and family.

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physicians in rural states to care for America's growing, elderly population

Rebuild the Medicaid physician network by enacting competitive Medicaid payments to physicians

The ACA law does not change the PCMS mission to collaborate with our partners in healthcare to advocate for what our patients need most. We will continue to work towards improving our health care system by making it more affordable and accessible for all Americans without sacrificing choice and quality of care. As we move forward, the PCMS is actively engaged in the process. With input and participation from our members together we can offer solutions that protect our ongoing efforts to improve access, quality, and value of our physician's in this changed healthcare environment.

Early Adopter EMR

Larry Severidt, M.D.

Broadlawns Medical Center began their transition to an electronic medical record in 2006. As an early adopter of electronic medical record, Broadlawns Medical Center is starting to see the benefits of their decision.

"The electronic medical record has enhanced patient care, providing access to legible documents across the full spectrum of care within our Medical Center. With the addition of real-time access to radiology and lab results our physicians are able to offer efficient and effective treatment for all patients," said Dr. Vincent Mandracchia, Chief Medical Officer and Senior Vice President of Broadlawns.

In 2010 Broadlawns was the first organization in the state to be recognized as a high level adopter of electronic medical records. Only 1% of hospitals nationally were able to achieve this "Most Wired" distinction. Broadlawns Medical Center was once again recognized as one of the nation's most wired hospitals according to the latest "Most Wired Survey" published in the July, 2012 issue of Hospitals & Health Networks magazine. Broadlawns was also certified this year by the National Council for Quality Assurance as a patient centered medical home.

"We are at the point now where providers and staff continue to identify ways to enhance processes and utilize the information being gathered," said Kyle Hansen, Director of Information Technology at Broadlawns.

The Broadlawns Family Medicine and Transitional Year Residency programs have also benefitted from the early adoption of the electronic medical record. With all of our departments fully integrated into the electronic medical record, it allows ready access to all needed information to provide comprehensive patient care. The resident physicians have been an integral part of the implementation process and have added much to the value of a continuously evolving system.

Broadlawns Family Medicine Residency currently has alumni practicing in 56 of the 99 counties in Iowa. Over the past several years over 60% of our graduates have gone into rural practice within the state of Iowa. By incorporating the development of the electronic medical record into the residency program, graduates are better prepared to assume leadership roles in assisting their community hospitals with implementing effective electronic medical record systems.

Castles, bridges and food, oh my…

Louis E. Schneider, D.O.

L-R: Pedro, "the bus-driver," Mike Hubbell, Bill Caldbeck, Pat Schneider, Dr. Lou Schneider, Diane Caldbeck, Peggy Fisher, and Larry Stelter

When Pat and I took a cruise a couple of years ago, one of our stops happened to be in Lisbon Portugal. Being there for only two days was not enough, so for one of Pat's significant birthdays we decided to go back and spend some time. (I know, I know, they are all significant)

So, this year with 3 other couples we headed to Portugal for 10 days. Since there were so many of us, we opted out of driving 2 or 3 cars and decided instead to have a driver and large van. "The largest they had," I told the travel agent since Pat always takes one suitcase just for shoes and we had three other women who did the same.

Beautiful Lisbon, Portugal

We arrived in Lisbon and were whisked away to our first hotel, the Pestana Palace. An absolutely beautiful, fully restored 12th century Palace converted to a hotel. It was complete with gold gilded ceilings and breakfasts that made us wonder if our van would be large enough. Portuguese breakfasts were huge, filling and delicious! Lots of meat, cheese, eggs and pastry and that was just the start. Once our stomachs were full we headed off to explore Lisbon. The palace was not in the heart of the city so we took cabs to the main square on the Tega River where we began our walking tour. Lisbon was by Portuguese standards, unseasonably warm. Temps in the 90's but somehow being from Iowa it was ok. Lisbon has a smaller version of the Golden Gate Bridge, designed by the same architect, so we had to get a closer

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inspection. We hiked to the top of the hills so we could get a better perspective of the fortifications of Castillo de Sao Jorge, a beautiful fort with spectacular views of all of Lisbon. Since it was so hot we felt the need to quench our thirst so we stopped at a quaint little restaurant on the way down the hill. Boy were we lucky. The restaurant owner Alex was very entertaining and we felt like we were in our own little restaurant. Fresh fish, local wines and wonderful bread. By the time we left, Alex had given us all mementoes of the restaurant and we also bought a piece of art right off the wall that was done by a local artist that we fell in love with. Sorry it was the only one they had.

The next morning we were to leave for one of Pat's favorite shopping spots in Cascais. But after breakfast, it appeared we had been ditched by our driver or so we thought. As we waited in the Palace for our driver, finally the concierge decided to take things into her own hands. Pretty soon she motioned us to follow her down the drive and low and behold we saw our driver and vehicle. A very large, blue 50 passenger bus for the 8 of us. We couldn't stop laughing but I guess it's my fault since I did say Pat traveled with a lot of luggage. On we went with Pedro, our chain smoking bus driver. Cascais is a quaint little village with outdoor restaurants and wonderful shopping. Pat can attest to the shopping, I can attest to the food. After a brief stop we were on to Sintra which happened to be the summer palace of the King. The Portuguese loved their palaces and built them well. Sitting outside, you felt like you were dropped off in a Disney postcard. Everywhere you; looked there were castles, fortresses and green pastures with cows and horses. Breathtaking!

Porto was next and it is an interesting city with lots of different styles and looks in architecture. Many, many ornate churches and even boasts a bridge designed by Gustav Eiffel. We watched a young couple getting married on the river walk and of course by then we were hungry again. Pedro picked us up and it was off to Amaranthe. One of the most beautiful settings of any city I have ever seen. Here we stayed at the Casa de Calcada, a 16th century rebuilt palace that had every comfort known to man. Not to mention a five star restaurant that was one of the best we have ever had anywhere. Amaranthe is dominated by a striking church and monastery built in the 1500's and directly outside our hotel room view. On Saturday, as we had drinks in the courtyard we watched yet another large wedding party and all that went with that.

Our room would have housed all 8 of us but Pat refused to share. After all it was her birthday.

From Amaranthe, we were off to Coimbra and a little wine tasting. The winery was actually built recently and was in a round shape. Inside the building was built just like a corkscrew, no stairs just round and round you walked. It had the feel of something you would see in a James Bond movie, all stainless steel and spotless. But you could just imagine the villain doing a shootout in the middle. Good wine also. Then we had the opportunity to visit a brand new resort called L'and Vineyards which had just opened. This was truly an architect's dream. Everything was modern and state of the art. I pad's in all the rooms and special features in the bathrooms. They had buttons to wet, dry and wipe yourself all at once. Pat could hardly keep me out of there.

The next day we headed to Evora which a beautifully preserved medieval town, completely walled and wonderfully preserved. We felt like we must be in a Harry Potter movie at one point. There were hundreds of young people on the streets chanting and singing in costume. But another group of them were dressed in long, black wool capes and black suits, all in 90 degree temps. Found out the cape people were actually upperclassmen who got to force the younger kids into doing whatever they wanted. This included skits, song and dance. It was very entertaining and we applauded a lot. From there we landed in the Algarve, which is where the Portuguese go on vacation. And it was easy to see why, huge cliffs dipping into the ocean overlooking sandy beaches and unbelievable gardens. We did not do much here but enjoy our surroundings since we had to head back to Lisbon in 2 days.

On our last day back we all got in a little last minute shopping which is so easy to do in Lisbon. Our last dinner was recommended by our hotel and it did not disappoint. Local recipes made us all want to stay forever. Rooftop drinks and we were on our way back home. A birthday to remember for Pat and all of us as well. Next stop… Machu Picchu.

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Hospital Electronic Health Record

Mark W. Purtle, MD, FACP, VPMA
Iowa Health DM

Last month you heard about the transition of ambulatory practices to EHRs. This month the journey of Iowa Health System and specifically Iowa Health Des Moines will be described for the hospital EHR.

As part of the American Recovery and Reinvestment Act (ARRA) of 2009, the Health Information Technology for Economic and Clinical Health (HITECH) Act was created to fund and support a paperless national health information network through the adoption of electronic health records (EHR). The Medicare EHR Incentive Program was created to provide incentive payments to eligible professionals, eligible hospitals, and CAHs (Critical Access Hospitals) that demonstrate **meaningful use** of certified EHR technology. However, starting 2015, Medicare eligible professionals, eligible hospitals, and CAHs that do not successfully demonstrate meaningful use will have a payment adjustment in their Medicare reimbursement. The incentive payments are designed to help offset the significant investment hospitals and providers must make to have an EHR. The window of opportunity is 2011 to 2015 when the penalty for not having an EHR in place begins.

The meaningful use of an EHR is divided into three stages:

The Stage 1: Implementation

Focus on electronically capturing health information in a coded format, using that information to track key clinical conditions, communicating that information for care coordination purposes, and initiating the reporting of clinical quality measures and public health information.

Stage 2: Adoption

Focus on disease management, clinical decision support, medication management support for patient access to their health information, transitions in care, quality measurement and research,

and bi-directional communication with public health agencies.

Stage 3: Outcomes

Focus on achieving improvements in quality, safety and efficiency, decision support for national high priority conditions, patient access to self management tools, access to comprehensive patient data, and improving population health outcomes.

There are objectives and measures for each stage that must be met to be eligible for the incentive payments. These core objectives include many of the basic capabilities of an EHR e.g. Computerized Provider Order Entry (CPOE); drug-drug and drug-allergy interaction checks; problem lists of current and active diagnoses; active medication list and medication allergy list. A change in the EHR previously used across the Iowa Health System was necessary in order to meet these objectives. Epic was chosen and implementation affiliate by affiliate began in October 2011 at Trinity Fort Dodge. On March 3, 2012 Epic was implemented at Iowa Health Des Moines after months of build, preparation, training of staff and providers. EHR installations of this magnitude and complexity are not "out of the box" ready. For example, any order on line with CPOE must be routed electronically to the appropriate area for processing including scheduling and other tasks. Furthermore, training required significant logistics since different roles required different training. At "Go-Live" an army of 400+ were available to assist with at the elbow problem solving; training, build and IT issues and was available for the next month. A sustainability plan with in-house informaticists to drive future training, issue resolution and optimization has been developed and deployed.

Given the enormity of the task, the implementation went exceedingly well. Workflow changed significantly for all staff and for physicians/providers in a way unmatched by any recent change in the delivery of hospital care. Computerized physician order entry, online documentation by the physician/providers, problem list generation, use of standardized order sets, and med reconciliation are just of few of the workflow changes that have occurred.
Some tangible benefits have already been seen: legibility, timing and dating of notes and orders, and unapproved abbreviations are no longer an issue. Many challenges remain as optimization continues. Some institutions have opted to roll-out the EHR in stages e.g. nursing documentation then physician documentation followed by CPOE. Adoption of the EHR, under these circumstances, is delayed and may take years. Carefully orchestrated with thoughtful and comprehensive planning allows for "Big Bang" implementation and more rapid adoption. The impact to provider workflow both in the hospital and in the clinic (e.g. scheduling of tests) cannot be underestimated and requires careful analysis.

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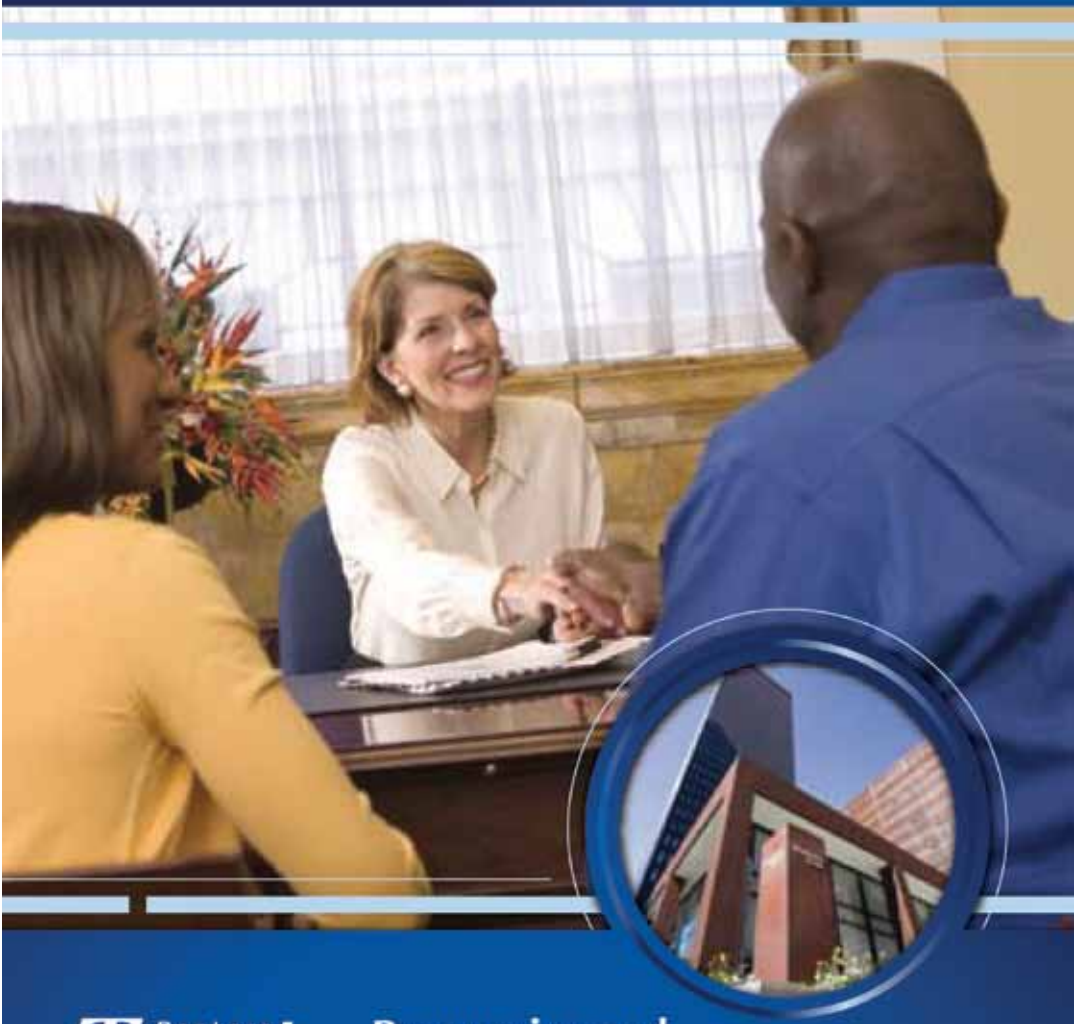

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