North Coast Physician

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

Cover Photo

"RED SAIL"

Stephen Kamelgarn, M.D.

North Coast Physician is published monthly by the **Humboldt-Del Norte County Medical Society**, 3100 Edgewood Road, P.O. Box 6457, Eureka, CA 95502. Telephone: (707) 442-2367; FAX: (707) 442-8134; E-Mail: hdncms@sbcglobal.net
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The Procrustean Bed

Luther F. Cobb, M.D., FACS

There is a chapter in Greek mythology regarding the challenges Theseus (he of the Cretan Minotaur legend) faced on his journey to becoming a hero. The story goes that there was an innkeeper who kept a house by the side of the road, where he offered free lodgings and hospitality to any passing stranger. They were invited in (one at a time, of course) for a pleasant meal and a night's rest in his special bed, with the unique property that its length exactly matched whoever lay upon it. What he didn't mention until too late was that the method of this miraculous fitting was that, if the wayfarer was shorter than the bed, he would stretch the poor fellow with the rack, and if he was taller, his legs would be "adjusted" (with sharp implements) until he fit. A primary example of "bait and switch" tactics. Theseus managed to get out of the trap and put Procrustes in his own bed, with fatal outcome for the innkeeper. And Theseus went on to other challenges.

Okay, you might say, where is this going? I think it is analogous to our current situation with that bane of current medical practice, Electronic Medical Records.

It is not all that widely known that EMR's are not a new idea. The first one I ever heard of (and used) was designed by an MD turned computer scientist in Silicon Valley named Bradner Hisey. (I got to know him when he was a patient of mine at Stanford, but that's a different story). He observed, as did many of us who trained around the era of the 60's and 70's, that there was a lot of "scut" work assigned to the lesser minions in the medical and surgical training hierarchy, the clinical clerks and interns. A lot of this involved literally fetching paper reports from the clinical or pathology labs, radiology reports and (gasp) actual film x-rays (developed in that primitive enclave known as a darkroom), written reports such as H&P and operative reports, etc etc. It was the responsibility of the lowest person (at that point usually the lowest man, but that was starting to change) on the totem pole to have all these data for review by those gods, the Chief Resident and Attendings, and woe betide those who didn't have the goods on rounds. (And yes, we did rounds at least twice a day, even on weekends, and spent countless hours hanging around waiting for the upper echelons to arrive, and of course we trudged through the snow, uphill both ways, 12 months a year, etc; (not really, but we LOVED it, at least in retrospect).

But I digress. It was Dr Hisey's revolutionary idea that all these bits of information could be collated and presented in electronic form, and be readily available to electronic data stations (primitive for the time, but serviceable) at all nursing stations and other loci where information was useful. This was implemented at El Camino Hospital in Mountain View, which was loosely associated with the Stanford program, although not a formal part of the teaching program.

So.... Silicon Valley, that hotbed of entrepreneurial spirit and innovation, leapt immediately to implement this advance, right??

Of course not. No other hospital in the area took it up, it remained proprietary, and everywhere else, we slogged on with paper records late into the 1990's and beyond.

So, how did we get to where we are today, wherein we all spend at least as much, if not more, time with the EMR's than face to face with patients (not counting the recent non F2F encounters forced upon us with the Covid-19 interregnum). It is pretty much universally acknowledged that neither we physicians nor our patients prefer to talk to one another with our backs turned, while we tap on keyboards (for those of us not fortunate enough to have scribes, but that's another story). Well of course, it has, like most changes, to do only with money. Lots of money.

Bob Dylan has been quoted as saying that "Money doesn't talk, it swears". I believe this is pertinent. By the time of the first Obama Administration term, the nation was involved in a deep recession brought on by the sub-prime mortgage meltdown, and the Federal Government was looking for ways to inject money into circulation to keep the economy from melting down into a slag heap. Then, as now, we had divided government, so there was incentive politically to do something but not so much as to make "the other side" look good, or "our side" look bad. Many folks not involved in medical care had long observed that medical records had not been updated to the standards of most other industries, in that they were still mostly on paper, and imaging was still on film. In the Stimulus Bill that finally emerged from Congress, there was provision for what in prospect looked like a handsome sum for purchase and implementation of EMR's (which in retrospect was not anywhere near enough, of course), with only the proviso that the records show that they were being wisely put into effect according to "Meaningful Use" criteria. (Now widely referred to as Meaningless Abuse").

Thus it came to pass that medical records, including most office charts and hospital records, became clogged with tons of stuff that satisfied the people who paid the bills, because of regulations regarding Evaluation and Management (E&M) codes with respect to things that had to be included into the record to reach a higher level of

"Procrustean", Continued On Pg. 21

"Procrustean", Continued From Pg. 5

billing.

Because it's all about the billing, right?

So we now are inundated with notes that incorporate enormous amounts of fluff, especially stuff that is obviously cut and pasted verbatim from prior notes, just so those who determine whether payment is properly remitted, whoever they may be, at long term retrospect, can find deficiencies in record-keeping and "claw back" incorrectly billed encounters. For those of us who try to use these documents for actual care, it has become a real hassle to try to sift through these notes to find the few nuggets of novel input from a physician's actual cognitive input from the encounter in question.

(A short digression)

I once inquired of an official from the Centers for Medicare and Medicaid, at an AMA committee meeting, if we could implement the "red letter Bible" system. As a child growing up in the Southern Baptist Church in Tennessee, the most common Bible in circulation was the "red letter Bible", which had all the words attributed to Jesus printed in red, so they could easily be identified. I suggested that perhaps a system in medical records could be implemented wherein all old material cut and pasted or imported from lab reports, etc, be printed in black, and information dictated or typed by the physician at the encounter in question be printed in red, so those of us who had to sift through all that could at least figure out what was new, and what the current thinking was from the treating physician. The official said that was a cool idea. End of story, at least so far as I am aware. (But I'm still on the AMA Delegation, I have not given up quite yet.)

But I ramble on. What we really need here is another tale from the ancient Near East, that of the Gordian Knot. The legend goes that Gordius, the king of Phrygia (in west central Anatolia, current Turkey), had tied a knot of surpassing complexity, and declared that only the future ruler of all Asia could untie this knot. Alexander the Great of Macedonia passed by, was presented with the challenge, and solved it by cutting the knot in two with his sword. And then went on to rule all Asia up to the Central Asian areas, Persia, India, etc before dying at the age of 32, after reportedly weeping "for there were no more worlds to conquer".

Folks lived fast in those days, I guess.

My point being, at this time, so much energy and effort is fruitlessly being expended in assembling electronic medical records that are not doing what they were designed to do, which is improve medical care. Studies have been done recently that showed that even the touted "killer app" (pardon the expression) of EMR's, decreasing medical errors, turns out to be untrue, and that in fact errors are induced in these systems at a greater rate than when we used the old system. And of course, they are not fulfilling one great mandate of the original legislation, interoperability, wherein one record cannot talk to another. If banks were to operate this way it would never be tolerated.

I don't think I have the answer, but I do think we need to take a hard look at why things are not better than they are, and why what ought to have been a good, useful idea, is really otherwise.

We can do better. Call Alexander.

(By landline....) *§*

Open Forum

COVID19 has really changed things. However, while many activities are suspended, others are on the rise

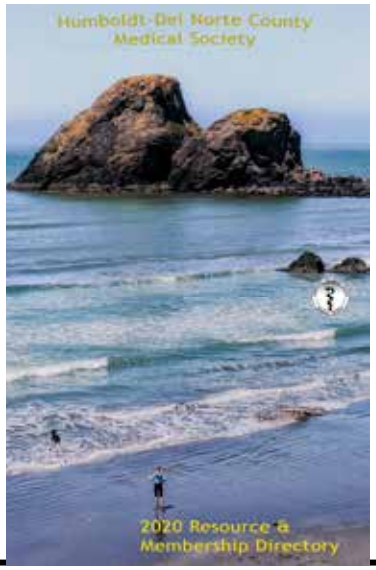
Emily Dalton, M.D.

Diner parties are out; masks are in.
Dining in is out; carry out is in
Travel is out. Gardening is in.
Vacations are out, hot tubs are in.
Get togethers are out; Zoom meetings are in.
Swimming is out; cycling is in.
Shopping is out; online ordering is in
Choir is out; online musical performances are in
Hand sanitizer and plexiglass are in.
Port-a-potties are now not only disgusting, they are dangerous.

Recently I was given the opportunity to get tested for COVID19. My esteemed colleagues and I sat spaced apart at a large table and shoved cotton swabs up our own noses while being timed with a stopwatch. This mutual nose picking session was a most singular experience, but it's still better than having someone else shove a cotton swab up your nose.

Throughout the COVID crisis my adult son has been in Japan. He got a job teaching English there several years ago, and loved it there so much he stayed on. Japan has taken a very different approach to handling the COVID 19 crisis. My son says the most aggressive restrictions the government took was to "suggest" an optional curfew after 8 pm. However, he says, the Japanese usually comply with such requests. All the shops, salons and restaurants stayed open, and schools were closed only briefly. How can two countries handle the same infectious disease so differently and get such contrasting results? It's mystifying. People think the Japanese may be padding their numbers, but my son swears there are no corpses piling up on the street corners in Tokyo.

I suspect part of the reason lies in the fact that Japanese culture already provides for a significant degree of social distancing. Masks are generally worn in public, greetings are accomplished with a bow, and people speak softly and never eject spittle in the course of a normal conversation. My son reports that Japan recently announced they have defeated the virus, and life is back to normal with no restrictions. One can't help but be jealous as we eat our cold carry out meal, staring into the same sheltered faces we have been looking at for three months; our hair growing ever longer. §



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Editorial and Publications Committee would like to encourage you to join the committee. Meetings are held quarterly 12:15 - 1:30 pm at the Medical Society office. Come help coordinate our member publications.

A House of Cards

Corinne Frugoni, M.D.

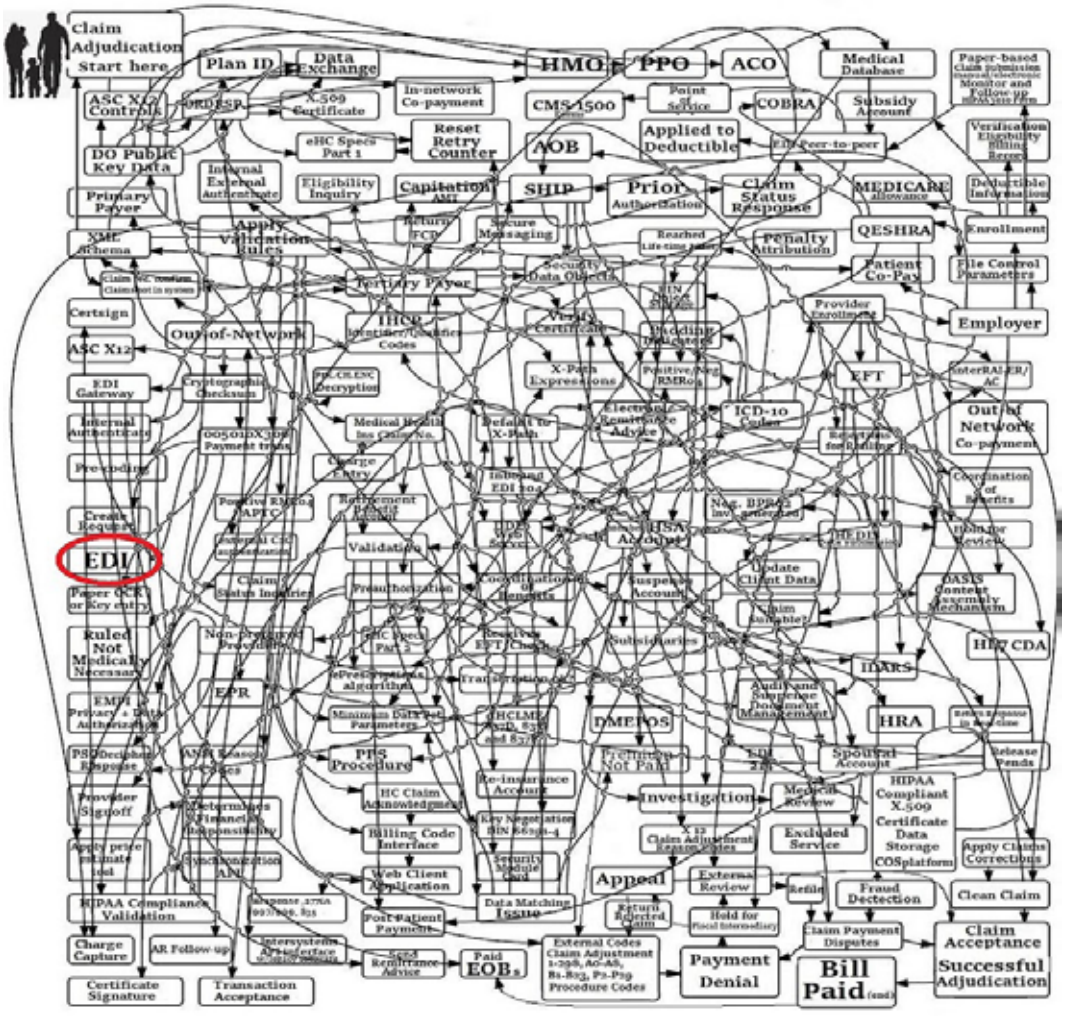
What are the hot topics in the United States these days? COVID, Racism, Health Insurance; three good reasons to promote Improved Medicare for All, also known as Single Payer.

The Covid-19 virus has exposed the longstanding complex web of our health care system that has unmasked the disparities caused by racism and health insurance accessibility. Our health care financing is so fragmented and dysfunctional that it compromises access and quality of care for many Americans. Our health indices fall far short of all other industrialized countries. The nation continues to operate in a reactive mode. Structural racism maintains this unjust and at times deadly system. The virus shows the need to reform how health care is provided for all Americans with a simplified universal publicly funded payer system.

Our health indices fall far short of all other industrialized countries. What does life expectancy have to do with payment processing in the U.S.? It guarantees unequal access to health care leading to poorer outcomes. It is what we can expect when we cede responsibility to corporate insurance companies to fix our health care system. These companies treat health care as a commodity and their ultimate responsibility is to produce maximal profits for their shareholders. All countries ration care but the U.S. rations care by race and income which increases disparities in health outcomes among various populations not found in other countries with universal health coverage.

Let's talk about our health claims processing system. The topic may sound very dry but the outcomes are fascinating. The multiple stake holders and multiple conditions makes the U.S. claims payment infrastructure the most complex claims process system in the world. Below is a flow chart of a typical insurance claim documented by Henry Broeska, Ph.D health economist at UC Irvine that roughly represents the health claims processing system in the U.S.

"Cards", Continued on Pg 9

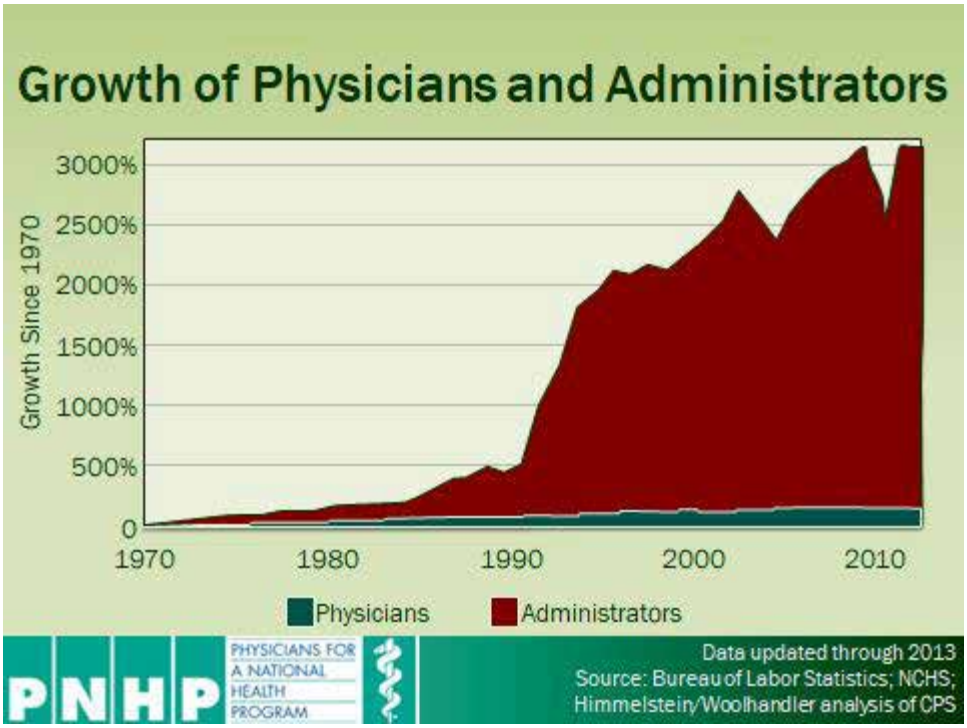


U.S. Claims Adjudication System (presented by Henry Broeska, Ph.D)

"Cards", Continued From Pg 8

There are over 100,000 rules that may apply to any single claim. Looking at the chart, it becomes obvious why there is an average of 7 administrators to handle the work load of 10 physicians. Terms of contracts change so rapidly that 42% claims are rejected on first submission. That increases the revenue cycle time to over 60 days. This complex payment system has evolved as a result of giving the responsibility to the market to try to fix the system along with the digitalization of data beginning in the 1990s. The rules and regulations to prevent fraud and maintain the secure transfer of health data between multiple organizations require that every box in the chart is connected to the other boxes for the processing of an individual claim. That in turn creates dozens of companies with thousands of employees at each station competing with each other to establish dominance within that particular silo of specialized functions. The increasing complexity of the process with the multiplicity of plans and codes, networks, formularies and providers charging different rates contribute to the institutionalization (read ossification) of each separate connection. This is a major source of our exorbitant health industry cost inflations. Our struggle with electronic medical records reflects similar developments. Tinkering with the ACA will not simplify this diagram. Adding a public option under whatever guise (Medicare X, Medicare Buy-In, Medicare For All Who Want it) will only add a three dimensional vortex to this already unwieldy maze. As Dr. Broeska notes "health insurance claims are like snowflakes-no two are the same."

A system that is as congested as ours needs to hire administrators to process the claims at the bottlenecks. Below is a graph from 2013 and the trend continues to this day with the numbers of administrators increasing by 3000% and the number of physicians increasing by 15%. "There is more value placed on a good revenue cycle strategy than on the delivery of health care itself."



The complexity of our health insurance adjudication system makes efficient claims processing and payment impossible. A friend once asked "will you please explain how corporate insurance gives value to the delivery of health care." No matter how many small Band-Aids are applied to this gaping wound, it will keep bleeding and contribute toward the rising inflation of health costs. The onus of financial responsibility then falls on the physician under various guises such as P4P, volume production and other metrics. Physicians give away $125 billion annually in free services for rejected claims. The patient is held accountable by limiting insurance policies available either due to income or geography, limiting networks and demanding that the patient figure out what the best bargain is when choosing an insurance policy or when they have an actual medical condition such as chest pain.

Physicians are losing their autonomy with their ability to choose type of practice and specialty. More and more are employed by large health provider institutions that mandate working conditions in exchange for easing business burdens and regulations. Other doctors who want to continue practicing independently are coping with disproportionate administrative burdens to keep small practices alive. Some are choosing to work outside the insurance system altogether. Why not create a health care

"Cards", Continued on Pg 19

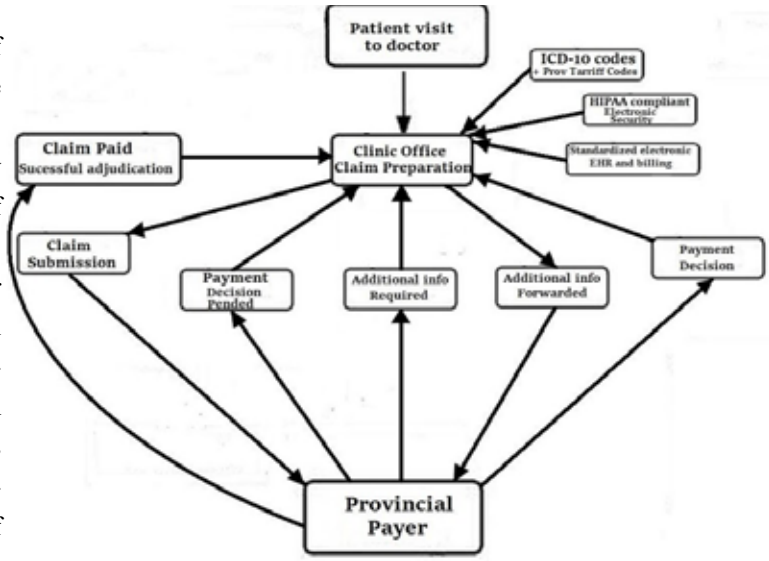
"Cards", Continued From Pg 9

system that fosters multiple avenues of care delivery and simplifies insurance to achieve work satisfaction?

Our existing health care delivery and financing structure is a house of cards wavering on collapse.

Improved Medicare for All or Single Payer is much simpler. All residents of California or the nation become members of the same plan with the same coverage. There is much less government or bureaucratic interference because patients have a choice of hospitals and physician practices and doctors do not have to negotiate multiple insurance rates and regulations. All that is required between physician and payer is a common secure electronic platform. If the CMA stopped opposing Improved Medicare For All, they could come to the table to negotiate fee schedules for physicians with regional planners as is done in other countries that have Single Payer insurance. Fraud cases become rare because the system is simple and transparent. Population health statistics become more accessible to develop state and national health policy. The system becomes invisible to the patient. There is no paperwork or choice to be made with respect to plans. A Single Payer system belongs to everyone. It creates a one tier system of the highest quality healthcare for every resident, from Congress to the person who just lost their job or was evicted from their home. Patients will not be able to choose an insurance policy but they will be able to choose their doctor. Doctors will be able to treat patients equally regardless of insurance. Formularies go out the window, networks too. A Single Payer system will not solve structural racism but it can help level the playing field.

The COVID-19 pandemic has increased the urgency for universal health care equally accessible to all residents of the nation. Millions of American residents have lost health insurance due to job losses and can ill afford medical expenses. Many will postpone care for fear of debt. There are three new pieces of legislation introduced nationally to address this crisis. The first, the Jayapal/Sanders Emergency Health Care Guarantee Act (HR 6906, S. 3790) is the most comprehensive and effective. It will bring relief to all U.S. residents for all medically necessary services with no cost-sharing. All bills not covered by private health insurance go directly to Medicare for the duration of the pandemic. It will be funded through general appropriations without impacting the Medicare Trust Fund. Drug benefits are included. Please consider contacting our representative Jared Huffman and our Senator Diane Feinstein to support the Jayapal/Sanders Emergency Health Care Guarantee Act (HR 6906, S. 3790). Senator Kamala Harris is already a co-sponsor. The Jayapal/Kennedy Medicare Crisis Program (HR 6674) is less comprehensive but provides Medicare for those uninsured from recent job loss. Enrollees pay nothing for COVID diagnosis and treatment but pay deductibles and co-pays up to 5% of income for non-COVID care. The Scott/Dingell bill (HR 6514), a form of which is currently incorporated into the Heroes Act subsidizes COBRA premiums for the newly unemployed who have had private insurance. These subsidies go to the corporate health insurers and do not cover deductibles and copays, nor does the bill cover the previously uninsured.



There are two bills in Congress that were introduced prior to the pandemic , HR 1384 and S. 1129, both called Medicare for All Act of 2019. They have multiple congressional sponsors in both houses. With minor differences, each would create a Single Payer Improved Medicare for all residents of the United States.

If you have questions concerning the topics presented in this article, please feel free to contact Corinne Frugoni at cfrugoni@reninet.com or 707 822-3141. Consider joining Physicians for a National Health Program (PNHP). PNHP has a great website https://pnhp.org that can answer many questions you may have and is accessible to all. This organization was started in 1987 to promote, educate and advocate for a Single Payer Health System for the United States. The local chapter of PNHP meets once a month in collaboration with Health Care for All (HCA). Contact healthcareforallhumboldt@gmail.com or me at the contact information above. Credit for the information and quotes in this article go to Henry Broeska, Ph.D. For more information and references from Dr. Broeska go to www.healthcare4all handbook.com/my-blog/healthcare-claims-adjudication.

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