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CHICAGO MEDICAL SOCIETY
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OF COOK COUNTY

Newsletter, 2011, Vol. 114, No. 6

Is an EMR in your future?
(See page 13)

PRESIDENT'S MESSAGE

What you need to know about EMR/EHR

October has brought unseasonably warm and dry weather. The Internet "cloud" and more traditional media are increasingly jammed with political static about improving a weak economy and selecting a Republican candidate for the presidential election is still more than one year away.

Physicians in Illinois press on, caring for patients while wondering what to expect from the legislature in Springfield on renewal of the Medical Practice Act or from the Congress in Washington, DC, on Medicare SGR (sustainable growth rate) funding reform.

An increasingly pressing issue for Chicago-area physicians is the adoption of electronic medical/health records (EMR/EHR). As noted in an article by journalist Howard Wolinsky elsewhere in this issue (page 13), the use of electronic technology in medical practices in Illinois lags somewhat behind the current national average.

Our physician colleagues just north of us in Wisconsin claim a substantial lead in the use of EMR/EHR, perhaps because a larger

percentage of them are employed. Large hospital and multispecialty groups tend to be early adopters of electronically facilitated practice activities.

Your Chicago Medical Society, by popular request, has scheduled a quarterly Midwest Clinical Conference on Nov. 5, that will be devoted to "EHRs," achieving "Meaningful Use," and qualifying for stimulus funds. (For information, go to cmsdocs.org or call (312) 670-2550, ext. 338.)

Please consider attending this event yourself, sending your office manager, or, best of all, attending along with your office manager. No medical practice is too small to be planning how EMR/EHR will fit into their future. You will feel empowered rather than challenged. Your patients and practice will benefit too.

Your Chicago Medical Society will help you get there!

Thomas M. Anderson, MD
President,
Chicago Medical Society



Flanked by family members, Bob Malizzo tells how hospital mistakes that took his daughter's life spurred him to join UIC's Patient Safety Panel, rather than sue. *Page 4.*

Patient safety summit moves ball forward



Welcoming health care professionals to the Chicagoland Patient Safety Summit at UIC were, from left: Dr. Thomas M. Anderson, CMS president; Helen Liebelt, president, Chicago Health Executives Forum, and Dr. Donald W. Aaronson, medical director of patient safety, Advocate Lutheran General Hospital.

In the years since the landmark 1999 IOM, "To Err is Human," the health care community has struggled to find a solution to the complex problem of medical error. And despite the attention the report generated, the number of hospital patients harmed each year remained stagnant between 2002-2007, according to the New England Journal of Medicine. Fortunately, the tide is shifting.

THE RECENT CHICAGOLAND PATIENT SAFETY Summit is evidence the patient safety movement is gaining momentum in the U.S., according to summit organizer and moderator Martin Hatlie, JD.



Summit organizer, attorney Martin Hatlie. Addressing a crowd at the UIC Forum building, Mr. Hatlie was one of many distinguished experts leading the Sept. 15-16 summit, which the Chicago Medical Society co-hosted along with the Chicago Health Executives Forum, University of Illinois at Chicago Institute for Patient Safety Excellence, Partnership for Patient Safety, and Project Patient Care.

Mr. Hatlie is widely credited with putting the issue of patient safety on the map. A former civil rights attorney and lobbyist for the AMA, Mr. Hatlie founded the national Patient Safety Foundation in 1997 and was its first executive director. He currently heads Project Patient Care, a group working to mobilize health care organizations in metropolitan Chicago. He also oversees the Illinois-based Partnership for Patient Safety, which seeks to improve the reliability of health systems worldwide.

Mr. Hatlie had a simple message for conference goers: by collaborating we can improve quality and eliminate disparities in the health care setting.

Bridging the patient safety-medical liability chasm

A revolution in care at UIC



Dr. Timothy McDonald, a pioneer in the patient safety movement.

when a hospital discovers an error, the response should be comprehensive, compassionate, multi-disciplinary, and sustained.

"Sorry alone is not enough and it doesn't work," Dr. McDonald said. "You need full trans-

FOLLOWING THE release of the IOM report in 1999, it became clear to Dr. Timothy McDonald, anesthesiologist at UIC Medical Center, that harm to patients is never a simple incident, but a process that involves a number of disciplines and departments. He also felt that

parency, you need to pay for your mistakes and give patients what they need, and you need to learn from those errors internally."

Today Dr. McDonald is a widely hailed pioneer in the patient safety movement. He holds multiple titles: chief safety and risk officer for health affairs at the UIC Medical Center, co-executive director of the university's Patient Safety Institute for Excellence, and author of "The Seven Pillars Approach to Patient Safety."

His team is credited with persuading all sectors of the UIC health system to replace the costly policy of "deny and defend" in clear cases of error with a fully integrated patient safety and transparency program in 2005. In addition to the high-risk specialties and administrators, Dr. McDonald's team convinced insurance companies, such as ISMIE, to come on board with his federal grant extending the process beyond UIC.

Dr. McDonald knows that when the whole team

(continues on page 4)

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works together and physicians maintain an ongoing dialogue with patients, everyone benefits. Patients are far less likely to sue and the integrity of the profession is upheld. The policy further upholds transparency as the best teacher. "Physicians don't learn through lawsuits," Dr. McDonald said emphatically.

"You can't fix something if you don't understand how it happened and can't openly discuss it."

Dr. McDonald cautioned that communication following patient harm must occur on a timely

basis because "every hour that goes by without communication causes more harm to both the patient and the medical provider.

Highly trained, socially intelligent people are selected for the task of communicating with patients. And not only do the doctor and hospital express empathy for the adverse outcome but they also apologize for mistakes if they resulted in harm. They also offer the injured family emotional support and facilitate resolution, sometimes financially.

Effective communication was crucial following case of unexpected harm at UIC



Bob Malizzo, with daughter Kristina Chavez, and wife, Barb, discuss the death of their daughter Michelle Ballog due to hospital mistakes, and how they now work with UIC on hospital safety.

The following case of patient harm caused by hospital medical mistakes demonstrates how an effective communication and resolution process can ease a family's sense of loss, grief, and anger. This approach is associated with a reduced number of claims and lawsuits at UIC.

FOR CONFERENCE GOERS, THE MOST POWERFUL moments were undoubtedly those spent listening to the Malizzo family of Hobart, Indiana, as they recounted the tragic death of daughter, Michelle Ballog, at UIC Medical Center, following a routine procedure to replace a temporary stent in her liver in 2008.

The family's ordeal began when they were told "things had gone terribly wrong," and that Michelle, a 39-year-old mother of two, had gone into respiratory failure and cardiac arrest. She died days later.

Michelle's death seemed impossible because she had no history of heart problems, according to parents Bob and Barbara, and surviving daughter Kristina Chavez. Adding to their disbelief was a feeling of betrayal after they had carefully chosen UIC Medical Center for Michelle's ongoing treatment.

And when Dr. Timothy McDonald and colleagues first approached them in their grief,

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NEWS FOR CHICAGO PHYSICIANS



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promising a full investigation and prompt report back, they were doubtful, even though Dr. McDonald suggested that the hospital probably made several mistakes.

In fact, Bob said he fully expected UIC to cover up the events leading to his daughter's death. When they learned from Dr. McDonald that a series of mistakes had in fact occurred, Bob could barely contain his anger.

But to their surprise and unexpected relief, the doctors fully explained the tragic chain of events. The investigation, they stated, found that Michelle's respirations had not been adequately monitored, thus making it difficult to notice when she stopped breathing and needed immediate CPR.

Bob, Barbara, and Kristina recalled how the physicians apologized profusely and even wept along with them. They were also assured that UIC would compensate their son-in-law and two children who kept asking if their mother would be going to heaven.

Remorse, compassion, and transparency from

both the hospital and doctors helped the family to accept their loss and heal more easily than if they had pursued litigation, they told the audience.

"When doctors apologize, you feel vindicated," Bob said, adding that, "Litigation creates anger, and hatred towards the hospital and doctor."

Information from the tragedy helped spur national guidelines requiring the use of a capnograph to monitor carbon dioxide concentrations in the blood of all patients who receive sedation for procedures regardless of whether an anesthesiologist is present.

In addition, UIC now requires an anesthesiologist to be present during this type of procedure. Nurses have been retrained to respond appropriately when patients go into cardiac arrest. Members of the Malizzo family serve on the hospital's patient safety committee, helping hold the facility accountable for improving care. Patient advocates hope that more hospitals will follow UIC's example, noting the case highlights the important role that patients and families can play in reducing errors.

"Make this meeting powerful"



Dr. James Galloway, U.S. Assistant Surgeon General.

PATIENT SAFETY IS a concern at even the best hospitals, according to co-moderator U.S. Assistant Surgeon General James M. Galloway, MD.

Citing statistics from *Health Affairs* and the CDC, he stated that adverse events occur in nearly one out of every three

hospital admissions, and health care-associated infections lead to 99,000 deaths every year.

"Let's make the summit as powerful as possible to move the ball forward," Dr. Galloway exclaimed.

To encourage health care stakeholders to work together rather than through separate strategies, the U.S. Department of Health and Human Services launched a public-private collaboration,

known as the Partnership for Patients (P4P), to unify hospitals, employers and government into a single initiative, Dr. Galloway reported.

Under this collaborative model, the Henry Ford Health System was able to coalesce various safety interventions into one effort, thus reducing harm to patients by 25% from 2008-2010. Henry Ford has now set a goal of 50% by 2012, Dr. Galloway said.

As a starting point, P4P identified nine areas for improvement and goals for hospitals to meet within three years. Those areas are adverse drug events, catheter-associated urinary tract infections; central line associated blood stream infections; injuries from falls and immobility, obstetrical adverse events, pressure ulcers, surgical site infections, venous thromboembolism, and ventilator-associated pneumonia.

Dr. Galloway wears a number of hats: he is rear admiral in the U.S. Public Health Service, U.S. Department of Health and Human Services, acting regional director and regional health administrator for Region V. A CMS member, he invited the Society to participate in the citywide Building a Healthier Chicago initiative in 2008.

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Seven Pillars of Patient Safety

Honest communication following medical mistakes remains the exception today despite widespread acknowledgment that disclosure is the appropriate, ethical response to patient harm. UIC is the only hospital system in the state that has published information and data about its comprehensive process and was recently awarded an AHRQ grant to support a three-year effort to replicate features of the program in ten other Chicago-area hospitals to increase transparency and accountability of medical errors.

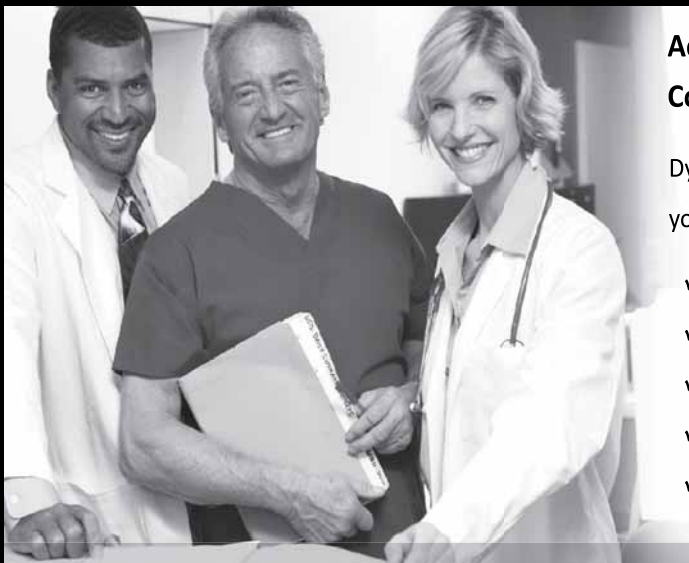
UIC's patient safety program is founded on Dr. McDonald's seven guidelines or pillars:

Incident reporting, investigation within 72 hours, disclosure and communication, apology and remediation, system improvements, data tracking and analysis, education and training.

The most recent data shows that the "seven pillars" process has led to an increase in valuable incident reports from 1,500 to at least 7,000 incident reports annually, prompted more than 100 investigations with root cause analysis, translated into hundreds of system improvements and served as the foundation for almost 106 disclosure conversations and 20 full disclosures of inappropriate or unreasonable care causing harm to patients. This entire process is associated with a reduction in claims and lawsuits and a reduction in medical malpractice premiums at UIC. Further research is ongoing to quantify the magnitude of these improvements.

CMS Workshop: "How to Make the Transition to EHR's, Achieve Meaningful Use, and Qualify for Stimulus Funds," Saturday, Nov. 5 from 7:30 a.m. to 2 p.m. at University Club of Chicago. For information, go to www.cmsdocs.org, or call 312-670-2550, ext. 338.

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REP. DAVIS "MAKES ROUNDS"

Mini-internship looks at future of oncology

THE STATE OF ONCOLOGY CARE DURING an era of dwindling reimbursement was the topic of a CMS Mini-internship at Ingalls Memorial Hospital on Sept 1.

Pairing Mark Kozloff, MD, an oncologist-hematologist, and medical director of Ingalls' cancer care program, with Rep. William Q. Davis (30th Dist.), the internship included a tour of the oncology unit and roundtable discussions with physicians and administrative staff.

Dr. Kozloff relayed to Rep. Davis the challenges of caring for cancer patients while struggling to keep the lights on. His Ingalls colleague, Cheryl Woodson, MD, said she shares the same worries in her primary care practice. Joined by Ingalls CEO Kurt E. Johnson, participants gave Rep. Davis their views on Illinois' new Medicaid managed care program, Medicare-imposed red-tape, and insurance companies that play doctor.

Rep. Davis met several oncology unit patients, and expressed his admiration for Dr. Kozloff's bedside manner as the doctor made his rounds. Rep. Davis also learned about clinical drug trials at Ingalls that contributed to new cancer medications, such as Avastin and Rituxan. According to clinical trials nurse Lynn Muir, RN, Ingalls was involved in the STAR trial to evaluate tamoxifen and raloxifene and the TAILORx study.

Dr. Kozloff told the group that his private practice had shifted over to an EMR system in late August, requiring the staff and doctors to work extra long hours inputting patient data. Dr. Kozloff said he has a hard time giving patients a diagnosis while simultaneously trying to type into the computer. He would much rather attend to the patient first and then input the information.

For his part, Rep. Davis stated that "real world observations of policy decisions are always time well spent." He was most impressed by the high number of minorities who are participating in the clinical trials. He relayed his hopes that physicians will continue to reach out to their legislators.



From left: Lynn Muir, RN, OCN, clinical trials research nurse, Ingalls Memorial Hospital Cancer Research Center; Mark Kozloff, MD, oncologist/hematologist, medical director of Ingalls Cancer Care, and Monroe Medical Associates; Rep. William Q. Davis (30th Dist.).

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Is an EMR in your future? Maybe the time finally has come

By Howard Wolinsky

You've heard it before: There's an Electronic Medical Records (EMR) software system in your future.

Sure, the federal government has been saying it for years. President Bush aimed, with bipartisan support, to get everyone onto EMR/Electronic Health Records (EHR) by 2014.

President Obama picked up on the theme and, in the face of a national economic crisis, put some big bucks behind it. In 2009, the president made EMR part of the American Recovery and Reinvestment Act. "Our recovery plan will invest in electronic health records and new technology that will reduce errors, bring down costs, ensure privacy and save lives," he told a Joint Session of Congress in February 2009. Nineteen billion dollars were committed to the effort.

Also, the Health Information Technology for Economic and Clinical Health Act (HITECH) made federal incentive payments available to doctors and hospitals when they adopt EHRs and demonstrate use in ways that can improve quality, safety and effectiveness of care.

Researchers from the National Center for Health Statistics reported this year that its surveys show that use of EMR/EHR has increased among office-based physicians from 2001 through 2010.

The center reported:

- Preliminary 2010 estimates showed that 50.7 percent of physicians reported using all or partial EMR/EHR systems. In comparison, 41.6 percent of Illinois physicians used an EMR/EHR system while 75.4 percent of Wisconsin physicians used an EMR/EHR system.
- The percentage of physicians using "basic" health records systems nationally has increased to an estimated 24.9 percent nationally in 2010 from 10.5 percent in 2006. The percentage using fully functional system was an estimated 10.1 percent in 2010 up from 3.1 percent in 2006.

Daniel Marino, president of Health Directions, an Oakbrook Terrace consultancy specializing in implementing EMR systems, said, "We're starting

The number of doctors using EMR is expected to grow in future years as physicians began qualifying this year for bonuses through Medicare and Medicaid EHR Incentive Programs.

to see a big increase in the Chicago area. The hospital-owned groups like Advocate Medical Group are on an EMR. It's the independent groups which the adoption is still fairly slow." His firm worked on the Advocate implementation.

The number of doctors using EMR is expected to grow in future years as physicians began qualifying this year for bonuses through Medicare and Medicaid EHR Incentive Programs.

As a result of the incentives, the Congressional Budget Office estimates that 90 percent of doctors will be using comprehensive EHR by 2020. Lee Shapiro, president of Allscripts, the Chicago-based Electronic Health Records company, said, "Historically, adoption has been low. It was typically only the larger, more sophisticated groups that were taking advantage of Electronic Health Records."

He said penetration of electronic systems is less than 10 percent in small practices.

As part of the American Recovery and Reinvestment Act, two organizations have been established to help Chicago area physicians reach the goal of improving the quality and value of care they provide by attaining or exceeding meaningful use of electronic health records. (See accompanying story on Meaningful Use.)

One organization is aimed at physicians practicing in the 606 Zip Code. This is the Chicago Health Information Technology Regional Extension Center (CHITREC), a partnership of Northwestern University, the Alliance of Chicago Com-

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munity Health Services and more than 40 local and national collaborators. For more information, go to <http://www.chitrec.org/>.

The other center covers most of the Chicago suburbs. The Illinois Health Information Technology Regional Extension Center (IL-HITREC) is a partnership of the Metropolitan Chicago Healthcare Council and Northern Illinois University. For more information, go to <http://www.ilhitrec.org/ilhitrec/>.

Daniel Marino, president of Health Directions LLC, said smaller practices especially need support in implementing EMR.

"Because they don't have a lot of money, the smaller practices really rely on the vendor. And oftentimes they're not pushing the vendors to really customize the solution to their clinical workflow or vice versa," Mr. Marino said.

"The vendor isn't necessarily telling the practice how to change their clinical workflow. Physicians who have been on paper for 20 and 30 years don't know what they don't know. So they're listening to the vendors give them direction and a lot of times what the vendors have begun implementing is these out-of-the box approaches to EMR implementation. The No. 1 reason why EMR implementations fail is because the system doesn't complement the physician's clinical workflow and vice versa."

Health Directions is one of IL-HITREC's preferred, vetted consultants to work with primary physicians in small practices to implement EMR. The program will work with 500 primary care physicians from suburban Cook, DuPage, Lake, Will, and Kankakee counties.

The project aims to:

- Assist in the selection of an electronic health record system, including hardware and network infrastructure and IT services.
- Provide onsite project management for implementation of an EHR in physician's office including individualized and on-site coaching, vendor coordination, consultation, troubleshooting and other activities required to assure that the physician is able to use the EHR system in a manner that meets meaningful use standards.
- Provide support for practice and workflow redesign necessary to achieve meaningful use of EHRs in an efficient manner.

"Realize that we are talking more than just taking the same practice and digitizing it. We're talking about a real transformation in the way we deliver care."

--Fred Rachman, MD

What you need to know about electronic medical records

Fred Rachman, MD, said moving to an Electronic Medical Records (EMR) or Electronic Health Records (EHR) system means more than being able to bill and schedule appointments electronically. He said an EHR can enhance patient care—ensuring patients receive appropriate care based on the latest practice guidelines and so that elements such as immunizations and cholesterol hemoglobin A1c or other tests are up-to-date.

"Realize that we are talking more than just taking the same practice and digitizing it. We're talking about a real transformation in the way we deliver care," said Dr. Rachman, chief executive officer of the Alliance of Chicago Community Health Services, a network supporting advanced health information technology use by healthcare organizations providing care to patients who are uninsured or underinsured.

The Alliance network shares an EMR system covering 400,000 patients seen by 350 physicians and other providers affiliated with 30 safety-net health-care organizations in 10 states.

Dr. Rachman said an EMR is good for care: "At the patient level, an EMR that's been well implemented can search the patient criteria that have been recorded and compare them to practice guidelines and provide to the clinician at the point of patient care a recommendation that this patient meets these criteria, should have this laboratory test, or should be on this medication, etc., and prompt the

A key factor is what the government refers to as Meaningful Use criteria, which must be met for a physician to qualify for bonus payments from Medicare and Medicaid.

clinician right then and there when face-to-face with the patient to make a right decision.”

The Alliance received funding from a variety of sources, including local and national foundations, the Health Resources and Services Administration, and Agency for Healthcare Research and Quality, as a demonstration project five years ago to customize General Electric’s Centricity EMR system. The American Medical Association was a partner, layering in quality performance standards to support clinical decision-making, said Dr. Rachman, a pediatrician who still sees patients at Erie Family Health Center. In its EMR-based quality program, the Alliance focuses on preventive care, diabetes, cardiovascular disease, HIV, and asthma.

“Through reporting on aggregate populations, one can look and see how a particular clinician or a practice location is doing with respect to these measures. You can look at different patient populations to see if there are patient factors that are influencing it. By analyzing the quality data, you can identify factors that might lead to improving performance,” he said.

Dr. Rachman said an EMR also could help in research by finding patients meeting study parameters in the database.

“Without the EMR, it would have been very laborious and expensive to do this research with manual chart audits. Now it’s all tremendously streamlined. It’s a huge benefit,” he said.

The EMR doesn’t only help large practices. Wendell Wheeler, MD, runs a solo pediatric practice caring for 3,000 patients with a nurse practitioner in South Holland and Roseland. Medicaid covers about 60% of his patients. He has used the Amazing Charts EMR system for about 10 years.

He likes Amazing Charts because the system “flows” the same way he was accustomed to taking his notes. “Using Amazing Charts was a no-brainer for me,” said Dr. Wheeler, who is computer savvy and runs the system on his own server. “It’s a fairly complete electronic medical record with the exception of the practice management section, which hopefully will be available in the near future. It does electronic chart, electronic prescriptions. It can track immunizations and disease management.”

Mark Dente, MD, chief medical informatics officer with Barrington-based GE Healthcare, said the biggest issue for small- and medium-sized practices is whether they are set up to handle EMR technology. “Probably they are not. So, they need to be thinking, ‘Gee, I can get into and meet Meaningful Use and become part of the future of healthcare, but how am I going to manage that when I don’t have an IT staff. So there’s the whole issue of technology itself.’”

A key factor is what the government refers to as Meaningful Use criteria, which must be met for a physician to qualify for bonus payments from Medicare and Medicaid. The first incentive payments were made in May.

Physicians considering electronic record systems “should be looking at the aims of Meaningful Use and the long-range goals for transformation of the health-care system,” Dr. Rachman said.

Meaningful Use criteria start by requiring functional systems and advancing to requiring systems with some clinical support. They ultimately will require demonstrating that patients’ health outcomes are improving because of the EMR. (See accompanying chart.)

Dr. Rachman urged physicians thinking about EMR systems to ask their colleagues in similar practices what their experiences have been. He suggested sticking with the most commonly used systems in the Chicago area. He said popular systems in the Chicago area include Clinical Works, NextGen, Allscripts, EpicCare, and GE Centricity.

“In a dense market like Chicago, it is helpful to look at other products in widespread use in the area because we think that will create the ability for practices to work with each other and to problem solve. It will also be likely that there will be support services available within the area around those products,” said Dr. Rachman, who also serves as co-director of the Chicago Health Infor-

(continues on page 16)

mation Technology Regional Extension Center, which helps smaller physician primary care and safety net practices (fewer than 10 physicians) find and implement the EHR system best for their practices.

Along these lines, Daniel Marino, president of Health Directions LLC, an Oakbrook Terrace consultancy that sets up EMR systems, said: "You don't want to just select an EMR to solve the problems of the day. You want to select an EMR that's going to strategically help your practice and support the business side of your practice and position you well for the future."

He added that physicians should consider an EMR system an investment in their future. They shouldn't look for the cheapest software to save money, but rather look at the entire cost of ownership. "Make certain to purchase a good quality system because it's going to be the core and underpinnings of a transformation of practice over years to come," he said.

Mr. Marino said physicians should ask vendors if their systems support their specialty and their clinical workflow. "One of the primary reasons why system implementations fail or why physicians don't use an EMR is the system doesn't necessarily complement their workflow. How are the templates set up? What are the electronic functional components that are going to support their practice style or their way of seeing patients?"

Lee Shapiro, president of Allscripts, the Chicago-based EHR company, says doctors should check on the financial stability of the software company and make sure it is focused on the future with a research and development budget aimed at enhancing the product.

He said that doctors should ask questions:

- Is the product robust enough to keep pace with the changes in healthcare delivery and financing?
- Does the product connect with other healthcare providers and stakeholders, no matter which vendor?
- Does the company have a spectrum of products to address the upcoming changes in the health-care industry?

He said useful features include electronic appointments/scheduling, email, remote access, filing insurance, referrals, and e-prescribing.

Cost is a factor in choosing a system, though it's becoming easier for some physicians, especially in small, primary care practices, to leap into an EMR with government incentives.

Dr. Dente said products such as GE's Centricity are in a category known as "service as a software," which makes them easy to securely implement over the Internet. "The device is almost irrelevant, [whether] a laptop, desktop or tablet. But you have to have something that can get to the Internet. So you have to have some type of browser. What it means is I don't have to worry about backups. I don't have to worry about uploading software and updating software.

"Your contractor maintains the backend, has the infrastructure and security around the servers. These systems are all designed to work in these environments, whether they're a GE system or another."

Dr. Rachman said: "The practitioner should be very thoughtful about hosting these applications locally on a server in their own office unless they have the ability to comply with all of the needed protections and privacy, security, business continuity, etc. It's a hard road to go to host these things locally. One does need to be sure that as they're going into this with a full realization of all the complexities of hosting an application like this."

Dr. Wheeler prefers to run his EMR software on his own server, an approach that some physicians likely would not want to bother with. "Many doctors have a 'set-it and forget-it' mentality, while others want to be in control and understand the system they use," he said.

Dr. Dente said the cost of employing technologists full-time in a practice varies, but groups of 10 or more are likely to be able to afford this, especially if they already are using other computer technologies in the office, such as imaging systems.

(continues on page 18)



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The cost of training staff is another point to consider, whether it can be done online or whether it requires a more expensive trainer to come in.

Security issues appear to plague major tech companies. What can doctors do to protect their patients and themselves?

Allscript's Shapiro said: "Providers need to make sure the credentials for access to patient information are protected with vigilance. Providers should follow the guidelines established in the HIPAA (Health Insurance Portability and Accountability Act) security rules, which are actually based on best practices for information security. Since most security breaches are the result of a user revealing information that they shouldn't, user training that is frequently refreshed is a key component of a secure system."

Cost is a factor in choosing a system, though it's becoming easier for some physicians, especially in small, primary care practices, to leap into an EMR with government incentives that will be available starting this year. *(See accompanying story.)*

Eligible professionals can receive as much as \$44,000 over a five-year period through Medicare. For Medicaid, eligible professionals can receive as much as \$63,750 over six years. Medicaid providers can receive their first year's incentive payment for adopting, implementing and upgrading certified EHR technology but must demonstrate meaningful use in subsequent years in order to qualify for additional payments.

These incentives go a long way toward paying for an EMR.

What does an EMR cost? On the lower end, for example, the initial license cost for Amazing Charts used by Dr. Wheeler is \$2,000, including the first year of maintenance, and additional years are \$995 for maintenance, in-

cluding updates for e-prescribing.

But Dr. Rachman said physicians likely will have to invest far more in computers and security measures in the years ahead to meet meaningful use requirements.

Marino also said larger groups would expect to pay more. He said that depending on the system the cost per physician to set up an EMR could be \$18,000 to \$25,000. "It can go as high as \$30,000 to \$40,000 if you want lots of bells and whistles."

Bells and whistles can include patient portals through which patients can read their test results and records and make appointments, he said.

"A patient portal is really important, but it's something you don't have to have live within the first year that you implement an EMR. You could easily incorporate that the second year," he said.

He said in a subscription model the typical physician might pay \$5,000 per year after the implementation.

Dr. Wheeler said that government incentives help with the purchase of an EMR, but physicians may face additional expenses for computer dictation software, new computers, maintenance agreements and information technology.

Dr. Dente said physicians ought to factor in how well the EMR connects with other systems. "You want to make sure that you don't go through all this and end up with a siloed practice," he said.

The cost of training staff is another point to consider, whether it can be done online or whether it requires a more expensive trainer to come in, Dr. Dente said.

How long does it take to implement an EMR system?

Marino said implementation of EMR could take from 12 to 16 weeks. "It's not necessarily the physician who is involved in all components. You want to have your staff involved. Physician involvement initially is only about 10-20%. It increases as the goal nears. It comes down to the physician. We recommend that the physician puts in 12 to 16 hours of training on the EMR before going live. If physicians do that, we've found their chances for success in using the EMR go up dramatically as opposed to if they were only to put in six to eight hours of training."

As with any new technology, EMR adopters face a learning curve. Dr. Dente suggested curtailing the number of patient visits by 15 to 20% for

(continues on page 20)

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EMR IN YOUR FUTURE? *(continued)*

the first week or so as doctors and staffers become accustomed to the new EMR system.

He said it could take several weeks to several months for physicians and staff to tweak the EMR to how they want the system to work.

Dr. Wheeler said an EMR changes the way a physician practices. "You have to be prepared to change the practice workflow. You've got to be prepared for the expenses that are outside of your basic purchase of the program, including beefed up Internet, replacing hardware and associated software," he said.

And don't be surprised if you encounter some glitches. Even though various EMR systems used by physicians, hospitals, labs, pharmacies, and insurance companies are more likely to interoperate these days than in the past, Dr. Wheeler said there still could be problems. He said, for example, a lab he works with faxes him test results, though he really wants the data to be transmitted directly to patient charts electronically. Instead, he has to put a PDF file of the test results into the patient file. "The problem

is that the lab doesn't have the EMR system turned on," he said.

Dr. Rachman said electronic records already have paid off with improved care for patients in his network, with a drop in the average hemoglobin A1c level at all sites and even more at some centers. "Even a modest drop in hemoglobin A1C parlays into a significant decrease in patient morbidity," he said.

Dr. Wheeler said he would never return to the old ways. "I would not want to go back to paper charting. I'm very, very happy with being able to use an EMR. I like technology. I like computers. But beyond that, I think my notes are so much better than they used to be. I think the ability to get information out of the system is so much better than it used to be. I would dread going back to paper charts."

Howard Wolinsky is the former medical and technology reporter for the Chicago Sun-Times. He previously worked as a staff writer for American Medical News. He teaches in the graduate program at Northwestern University's Medill School of Journalism.




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End of Life (EOL) Care: Communication Strategies—11/2/11



Talking about death can be difficult... Evidence indicates that end-of-life discussions can improve patient and family-centered end-of-life care outcomes including whether health care workers (1) provided the desired physical comfort and emotional support to the dying person, (2) supported shared decision making, (3) treated the dying person with respect, (4) attended to the emotional needs of the family, and (5) provided coordinated care.

Many people dying in institutions have unmet needs for symptom amelioration, physician communication, emotional support, and being treated with respect. Family members of decedents who received care at home with hospice services were more likely to report a favorable dying experience.

Speakers: **Theresa M. Kristopaitis, MD**, Associate Professor of Medicine Loyola University Medical Center, Maywood, IL. *Dr. Kristopaitis has no relevant financial relationships with any commercial interests.* **Nicole L. Artz, MD**, Associate Professor, Hospitalist Clinician Educator, Director, Palliative Care Program, Loyola University Health System, Maywood, IL. *Dr. Artz has no relevant financial relationships with any commercial interests.*

At the conclusion of this CME activity, participants should be able to:

- Develop effective communication strategies for initiating “end of life” (EOL) discussions with seriously ill patients.
- Describe an approach to address conflicts which arise when caring for dying patients.
- Discuss the rationale for avoiding the term “futility” in discussion with patients and families.

The Chicago Medical Society is accredited by the ACCME to provide continuing medical education for physicians.

Council to expand, diversify



Incoming officers conduct the CMS Council meeting on July 13. From left: Drs. Thomas M. Anderson, president; Robert W. Panton, chairman of the Council, and Kenneth G. Busch, secretary.

CMS hosted its quarterly policy-making Council meeting on July 13, 2011.

SINCE APRIL, APPROXIMATELY 1,500 NEW members joined CMS under a trial membership program. New members can make their voices heard by serving on the CMS Council, which approved a plan to double in size, adding greater diversity and depth to the representative body. In welcoming representatives from associated specialty medical groups in the Chicago area, CMS hopes physicians will find easier to participate in Society policy-making. No longer will a majority of members in an organization be required to join CMS for the organization to have a voice on the Council. The new changes also add hospital medical staff organizations to the list of CMS associated organizations.

Legislative victories in Illinois

ISMS/CMS supported a number of bills enacted in 2011:

- Seatbelts for all automobile passengers in 2012.
- One-year recoupment period for insurance companies.
- Protection for student athletes against concussions.

- State immunization registry.
- Mental health parity protections.
- Amendments to Good Samaritan Act protecting both certified and non-certified individuals who provide CPR.
- MDPV (the agent in “bath salts” drug) inclusion on list of Schedule I controlled substances.
- The IDPH Uniform DNR Advance Directive must comply with the national Physician Orders for Life-Sustaining Treatment (POLST), to ensure patient wishes are respected across multiple care settings.
- License revocation for health professionals who are convicted of sex crimes.
- Changes to the Controlled Substances Act allowing for e-prescribing of controlled substances.

controlled substances.

ISMS/CMS actively opposed the following scope-of-practice expansions:

- Independent practice rights for nurses.
 - Licensure for certified midwives.
 - Prescribing rights for pharmacists.
 - Licensure for naturopaths.
- A casino smoking exemption was defeated.

ISMS will remain vigilant during the fall veto session when scope-of-practice bills are likely to resurface.

State’s Medicaid woes to get even worse

The Medicaid payment cycle is expected to increase now that extra federal funds have come to an end. ISMS will be monitoring the situation closely. Moreover, Governor Quinn removed \$276 million from the Medicaid program by cutting payments to hospitals. A simple majority vote by the General Assembly could restore the cuts, and the hospital association stated it will push for restoration. Such action could occur in the fall veto session.

COUNCIL HIGHLIGHTS *(continued)*

“Secret shoppers” posing as parents of a Cook County Medicaid patient were able to schedule appointments with specialists only 11% of the time, far less easily than parents of privately insured children, at 66% of the time. These findings appeared in the *New England Journal of Medicine* in an article highlighting the state’s dysfunctional Medicaid system.

Illinois ranks behind 40 other states in late Medicaid payments, and problems are expected to worsen as 750,000 new Medicaid enrollees join under federal health reform.

Medicare cuts on the horizon

Adding insult to injury, physicians face a 29.5% cut in Medicare reimbursement on Jan 1, 2012. The final rule is expected Nov. 1. If implemented, the cuts will slash \$80 billion in Medicare spending next year. ISMS joined more than 100 physician groups to ask Congress to fix the Medicare funding formula, as part of the debt ceiling debate.

Medical Practice Act

The Act forms the bedrock for medical care in Illinois and ISMS strongly supports a 10-year extension. ISMS is also working against proposals to double the licensure fee from \$300 to \$600 and reduce the licensure cycle from three years to two.

Memorial resolution honors longtime member

The Council observed a moment of silence in honor of District 2 Trustee and President, Ashwin S. Patel, MD.

Warm welcome to 2011-2012 leadership team

President-elect Howard Axe, MD
Secretary Kenneth G. Busch, MD
Chairman of the Council: Robert W. Panton, MD
Vice Chairman of the Council: Kathy Tynus, MD

Councilors-at-Large

Edgar A. Borda, MD
E. Boone Brackett, MD
Ann Marie Dunlap, MD
Brian P. Farrell, MD
Mary Jo Fidler, MD
Earl E. Fredrick, Jr., MD
Kuhn Hong, MD

Gerald E. Silverstein, MD
Michael J. Wasserman, MD

Alternate Councilors-at-Large

Ghassan Aswad, MD
Hugo A. Alvarez, MD
Neelum T. Aggarwal, MD
Rafael Z. Campanini, MD
Zahurul Huq, MD
Rajeev Kumar, MD
William G. Troyer, Jr., MD
Cheryl Wolfe, MD

Judicial Panel

M. LeRoy Sprang, MD

50-year members recognized

Nine CMS physicians were inducted into the ISMS Fifty-Year Club. The longtime members of organized medicine included Drs. Edgar M. Asebey; James D. Eggers; Raymond J. Kiley; Kenneth J. Printen; Nasim Rana; Pushpalata J. Shah; Waldemar Taraszkievicz; Robert M. Vanecko; and Robert J. Walsh.



CMS President Dr. Anderson, *right*, presents Dr. Edgar M. Asebey a certificate honoring his 50 years of membership. Dr. Asebey was one of nine CMS members inducted into the ISMS 50-Year Club.

ISMS Testifies before Health Insurance Exchange Committee

LATE THIS SUMMER, THE ILLINOIS GENERAL Assembly decided that Illinois will run its own health insurance exchange as required by the *Affordable Care Act*. Faced with a mandate to either start a health insurance exchange by October 1, 2013, or allow the federal government to do the job, the legislature also formed a study committee to determine how to proceed – and ISMS saw an opportunity.

At the committee's second meeting, ISMS' chief lobbyist presented detailed testimony laying out the principles by which an effective exchange should operate. Addressing every aspect of the formation and operation of the exchange, from its governance and financing to requirements for physician participation and transparency, these recommendations represent the collective wisdom of Illinois physicians who understand how to meet the needs of their patients. *View ISMS' testimony online at <http://bit.ly/ISMStestimony>.*

The goal of the health benefits exchange will be to provide patients with information that helps them in choosing the health coverage that is right for them. It is our hope that the legislative study committee will heed our recommendations and create an exchange that provides *meaningful* information to patients, allowing them to make *informed* choices and increasing their access to care.

Health Reform University Draws Crowds

ISMS and ISMIE Mutual recently wrapped up Health Reform University, our highly successful series of seminars designed to educate physicians and their staff about the changes coming as a result of health reform.

Nearly 400 physicians, practice managers and other staff attended one of our six seminars. The Chicago session, which was moved from ISMS headquarters to a larger venue due to its popularity, attracted over 100 participants. Those who attended were treated to insights from Joel Shalowitz, MD, an ISMS/CMS member and clinical professor and director of health industry management at Northwestern University's Kellogg School of Management, who outlined the effects health reform will have on physicians. Participants also heard from ISMS health policy and governmental affairs experts, who discussed the particulars of some of the new regulations and how the political climate in Springfield will impact the implementation of health reform in Illinois.

Building on the success of Health Reform University, ISMS is planning more statewide seminar series to educate physicians on topics of vital interest. Watch your inbox for invitations as we move forward.



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CMS presents
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Communication Strategies
3:00-4:00 p.m.
Loyola University Stritch School
of Medicine Bldg. Room 150
(See ad on page 21)

November 4

OSHA Workshop
2:00-4:00 p.m.
Advocate Lutheran General Hospital
Park Ridge, IL

November 5

Midwest Clinical Conference Series
EHR/Meaningful Use Stimulus Funds
7:30 a.m.--2:00 p.m.
University Club of Chicago
(Phone 312-670-2550, ext. 338)

November 9

Update on the Implementation of Healthcare
Legislation and How it Affects Physician
Practices, Including the Status of ACOs
6:30-7:30 p.m.
CMS Headquarters Building
(Phone 312-670-2550)

November 10-12

AMA Interim Meeting
New Orleans Hilton Hotel

November 16

CMS Executive Committee Meeting
Online

November 17

Illinois Society of Plastic Surgeons Meeting
Metropolitan Club of Chicago

November 21

CMS Council Meeting
6:00 p.m.
Maggiano's Banquets, Chicago

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