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The ABCs of health literacy

Nearly 90% of US adults are less than proficient in reading, understanding and acting on medical information, according to One in three patients has “basic” or “below basic” health literacy, meaning they struggle with tasks such as completing a health insurance application or understanding a short set of instructions about what liquids to avoid drinking before a medical test.

This literacy gap has medical consequences. Patients with poor literacy skills have much worse health outcomes than patients who can read well. They make more medication or treatment errors, are less compliant and are 50% likelier to be hospitalized, says the National Patient Safety Foundation.

There is often a chasm between the physician’s understanding of treatment and what the patient believes. More than 200 patients at one clinic were asked to tell researchers about their weekly regimen of warfarin, and they got it right only 50% of the time, says an October-November 2006 study in the *Journal of Health Communication*.

The literacy problem can seem too big for any single doctor, but some interventions have been shown to be effective. For example, a primary care practice using simplified explanations, picture-based materials and the “teach-back” method of ensuring understanding achieved superior outcomes for low-literacy diabetics.

Separate toolkits published by the AMA and the Agency for Healthcare Research and Quality advise that physician practices take these steps to help low-literacy patients:

- Have people, not machines, schedule appointments. Help patients prepare for visits by having them bring in medications and a list of questions.
- In the office, use clear and easy-to-follow signage, and encourage patients

to ask questions of physicians, nurses and office staff. Help patients complete forms, and use forms that are easy to read, in the patient’s language and only ask for essential information.

- Use patient-education materials that are written at a sixth-grade level or below, with large type. Also communicate important information orally, with video or pictures.
- Help patients referred for tests, procedures and consultations by reviewing instructions and providing transportation directions. Give them information about literacy and other nonmedical support programs.

Though it can be hard for physicians already in practice to change how they communicate, the literacy gap between doctors and patients starts as early as medical school.

Physicians should explain concepts to patients the way they would to an elderly relative, many experts say. Leave out esoteric biomedical details. Instead of telling a patient to see her cardiologist, refer her to the heart doctor.

These are the definitions of the four health literacy levels based on what task the patient can perform.

- 14% Below basic level: Can circle date of upcoming medical appointment
- 22% Basic level: Can read clearly written pamphlet and explain value of screening test
- 53% Intermediate level: Can read over-the-counter medication label, identify drug interactions
- 12% Proficient level: Can define medical term after reading complex document

Source: “The Health Literacy of America’s Adults: Results From the 2003 National Assessment of Adult Literacy,” US Dept. of Education, National Center for Education Statistics, September 2006 (nces.ed.gov/pubs2006/2006483_1.pdf)

PCMS NEWS

SAVE THE DATE!

Saturday, June 9, 2012

PCMS President’s Installation and Awards Night

Celebrating the Inauguration of

Harvey B. Lefton, MD

151st President

The Philadelphia County Medical Society

To be held at The Rittenhouse Hotel

210 West Rittenhouse Square

Philadelphia, PA

PCMS seeks physician volunteers

President Elect Harvey B. Lefton, MD, is seeking member volunteers with interest in possible appointments to PCMS Committees and Sections during her term of office through June, 2013. PCMS would like to develop a diverse list of interested talented expertise to help formulate Society focus and activities.

The list of Committees and Sections appears below. If you are interested in serving on PCMS Committees or Sections, please call Mr. Mark C. Austerberry, Executive Director, at 215-563-5343, Ext. 101.

- Editorial Review Board – Oversees content of PCMS monthly newsletter, *Philadelphia Medicine*
- Delegate Caucus to PAMED Annual Meeting – Develop and review resolutions pertaining to the practice of medicine and governance of The Pennsylvania Medical Society. Delegates attend PAMED House of Delegates in October held in Hershey, PA
- Public Health – works with the Philadelphia Department of Health in advocating for healthcare for the citizens of Philadelphia. Promotes good health practices through its block captains programs.
- Membership – Oversees member benefits programs and outreach to physicians.
- Young Physicians Section – For physicians 40 years and younger
- International Medical Graduates Section – forum for IMGs to discuss common concerns
- Residents/Fellows Section – forum for discussion of common concerns.

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Editorial

A reason to unite: educating patients about using healthcare effectively

By Lynn M. Lucas-Fehm, MD, JD



As the much debated Patient Protection and Affordable Care Act (aka ObamaCare) awaits its Constitutional reckoning, a potential opportunity has emerged. The void that might be left by repeal of the mandate (or possibly the entire law) could produce a “carpe diem” moment where physicians can become active participants in healthcare reform.

A conceptual analysis makes a good starting point.

The economist Milton Friedman summarized his theory on why the healthcare crisis occurred in his 2001 article “How to Cure Health Care.” He stated:

“Two simple observations explain both the high level of spending on medical care and the dissatisfaction with that spending. The first is that most payments to physicians or hospitals or other caregivers for medical care are made not by the patient but by a third party—an insurance company or employer or governmental body. The second is that nobody spends somebody else’s money as wisely or as frugally as he spends his own.

“No third party is involved when we shop at a supermarket. We pay the supermarket clerk directly; the same for gasoline for our car, clothes for our back, and so on down the line. Why, by contrast, are most medical payments made by third parties? The answer for the United States begins with the fact that medical care expenditures are exempt from the income tax if, and only if, medical care is provided by the employer. If an employee pays directly for medical care, the expenditure comes out of the employee’s after-tax income. If the employer pays for the employee’s medical care, the expenditure is treated as a tax-deductible expense for the employer and is not included as part of the employee’s income subject to income tax. That strong incentive explains why most consumers get their medical care through their employers or their spouses’ or their parents’ employer.”

Physicians are not economists and the intricacies of tax law are not part of our training. However, understand-

ing Milton Friedman’s article does not require an MBA. The insurmountable healthcare spending that consumes so much of the GDP is at least in part secondary to the design of the system where third parties not patients are responsible for providing healthcare coverage.

Given Mr. Friedman’s analysis it is ironic that the major issue being considered by the Supreme Court is the mandate that requires individual acquisition of health insurance if a person does not have third party provided coverage.

Regardless of the Supreme Court’s decision, a huge challenge for physicians will be in educating our patients about how to effectively and responsibly utilize the healthcare system. A lot of work has gone into legislation mandating electronic health records to achieve efficient communication of medical information. Perhaps similar energy should be applied to developing a system to educate patients about utilization of the healthcare system, preventive medicine, nutrition and lifestyle choices so we shift from treating disease to preventing it.

The need for improved communication also includes effective interaction with our legislators. Physicians need to work together no matter what their specialty. Although the healthcare reform legislation under review by the Supreme Court was written to remedy a system destined for financial disaster, the endless legal, bureaucratic, and tax requirements attached to the ACA make its implementation onerous. Any meaningful healthcare reform cannot be a bureaucratic quagmire that requires a tax attorney and MBA to negotiate.

So as the Supreme Court weighs its decision, we should not sit back and wait. Now is the time for us to work with each other to develop an alternative plan and send a united message to our legislators.

Over the past year I have listened to my fellow physicians’ concerns, complaints and ideas. It has been my pleasure to hear from you. As my tenure ends I want to thank all of you for reading my monthly comments and appreciate your feedback.

Dr. Lucas-Fehm is President of PCMS.

How to reduce legal risks with EMR

As the number of electronic medical records increases, so do certain legal risks, medical liability experts say. Common mistakes doctors make with EMRs and how attorneys recommend that physicians reduce their liability risks:

Mistake: EMRs allow users to move quickly through patient records, but cutting and pasting information makes it easy to paste incorrect information.

Recommendation: Refrain from copying and pasting EMR data, and be cautious when moving from one patient's record to the next.

Mistake: Computer programs can help doctors make a differential diagnosis, but the templates don't often include every possible symptom and corresponding medical condition.

Recommendation: Doctors should not become overly dependent on electronic diagnosis aids. Electronic systems are no substitute for hands-on diagnosis.

Mistake: Because EMRs allow physicians to move through patient charts much more quickly than paper charts, attorneys are noticing that some doctors are not being thorough when writing notes electronically.

Recommendation: Physicians should keep meticulous electronic notes on each patient and take time to document each chart.

Mistake: Some practices can fail to safeguard electronic patient data.

Recommendation: Practices should encrypt all information on computer devices and have policy that discourages employees from taking portable devices out of the office.

Mistake: A system may not clearly indicate changes to records.

Recommendation: Physicians should install systems that show transparency when modifications are made and/or have a program lockout period where no more modifications can be made to a record.

Mistake: Doctors may fail to follow notification requirements in the event of a data breach.

Recommendation: Be clear on what your state law requires when a data breach occurs, and make sure employees follow the rules immediately.

Mistake: Doctors may destroy or delete electronic records when a lawsuit is possible.

Recommendation: If doctors suspect they are being sued, they must preserve all electronic data related to the patient in question, including emails, phone messages and computer records.

Pertussis immunization urged for seniors

The American Geriatrics Society endorses the new recommendation because there are probably many unreported cases among older adults.

To help bolster waning pertussis immunity among Americans, a federal vaccine advisory committee expanded recommendations for the Tdap immunization to include all adults 65 and older. Vaccinating this age group is expected to reduce incidence of the disease in the US and prevent pertussis-related complications among the elderly, who have an increased risk of developing pneumonia and being hospitalized than other age groups, according to the Advisory Committee on Immunization Practices.

The committee recommends that physicians routinely administer GlaxoSmithKline's Tdap vaccine Boostrix to all adults who have not previously received the immunization or who are unsure whether they received it.

Doctors who only have Sanofi Pasteur's Tdap vaccine Adacel can use it to immunize adults, although it has not been approved by the Food and Drug Administration for the 65-and-older group, ACIP said at a Feb. 22 meeting in Atlanta.

The 15-member committee advises the Centers for Disease Control and Prevention on vaccine issues. Adacel is FDA-approved to prevent tetanus, diphtheria and pertussis in people 11 to 64 years old. Data show, however, that it is safe for use among older adults as well, said Jennifer Liang, DVM, a CDC epidemiologist.

Within five years of childhood pertussis shots, immunity declines to about 70%.

The new guidance updates ACIP's June 2010 recommendation that Tdap be administered to adults 65 and older who anticipate having close contact with a child less than a year old.

Preventing future e-prescribing penalties

Penalties for failing to meet the requirements of Medicare's electronic prescribing program will increase during the next two years. The 2013 penalty will be 1.5%, and the 2014 penalty will be 2%.

Doctors can prevent penalties in several ways:

2013 penalty

- Report at least 25 unique e-prescribing events in 2011
- Report at least 10 e-prescribing events on claims between Jan. 1 and June 30, 2012.
- File a hardship exemption by June 30, 2012.

2014 penalty

- Report at least 25 unique e-prescribing events in 2012.
- Report at least 10 e-prescribing events on claims between Jan. 1 and June 30, 2013.

Source: 2012 Electronic Prescribing Incentive Program: Future Payment Adjustments, MLN Matters (www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1206-.pdf)

Change of address?

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pcms people



Timothy R. Dillingham, MD, MS, has been named chair of Physical Medicine and Rehabilitation (PM&R) at Penn Medicine. He was formerly chair of PM&R at the Medical College of Wisconsin. His research interests include the rehabilitation and long-term outcomes for amputees. He is also widely recognized as an expert in the electrodiagnosis of patients with limb symptoms and musculoskeletal disorders.

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