Wisconsin Ob.Gyns. Help Each Other Manage Call

'There is a real brotherhood and sisterhood of obstetricians who will cover for one another.'

BY JANE SALODOF MACNEIL
Southwest Bureau

SCOTTSDALE, ARIZ. — A telephone survey of 66 physicians, each representing an obstetric group in Wisconsin, found that most groups did not have formal rules regarding call responsibilities or provisions for physicians to recover after being on call.

Yet 16 groups delivered babies at more than one hospital, leaving open the possibility that there would be simultaneous call at different locations, according to a poster presentation at the annual meeting of the Central Association of Obstetricians and Gynecologists.

"Most of [the respondents] said, 'We just call one of our colleagues if we need extra help, and they will come on in. We help each other,' " one of the investigators, Dr. Charles W. Schauberger, said in an interview. "There is a real brotherhood and sisterhood of obstetricians who will cover for one another."

Avoiding call at multiple locations was the first of three "call best practices" recommended by Dr. Schauberger, medical director for quality and performance improvement at Gundersen Lutheran Medical Center in La Crosse, Wisc., and his coauthors.

The second and third best practices were, respectively, having a formal backup system and restricting work after being on call "to avoid difficult or complicated surgery or medical care," he said.

The survey found a wide variety of ways of handling call, but no perfect call system. Dr. Schauberger and coauthor Dr. Robert K. Gribble, of Marshfield Clinic in Marshfield, Wisc., conducted the physician-to-physician survey by telephone. Working with third coauthor Brenda Rooney, Ph.D., of Gundersen Lutheran, they identified 70 "call pools" and obstetric groups in the state. After accounting for two physicians who declined to participate and those who did not return calls, there was a total of 66 participants.

The size of call pools ranged from 1 to 11 physicians, with 5 physicians being the median staffing, according to the investigators. Physicians were usually on call for 24 hours, but many groups had longer call duties on weekends.

Everyone provided obstetric care and emergency department consults on call. A large majority also did regular office work (82%) and provided backup for family physicians (68%). Others (24%) provided backup for midwives, but none performed home deliveries. Separately, more than 30% taught residents and about 25% taught students while on call.

Only 23% of the groups had formal rules governing call responsibilities. Just 26% had provisions for recovery after call, and 21% had decreased call with age. Some physicians said they did not do surgery on the day after being on call.

Asked how often they questioned their ability to provide safe care due to too many call responsibilities, 8% of respondents said occasionally. When asked the same question due to sleep deprivation, 1% said frequently and 11% said occasionally.

Although most physicians delivered at only one hospital, the survey found 10 physicians delivering at two hospitals, 4 physicians at three hospitals, and 2 physicians at four hospitals. Initially, Dr. Schauberger was surprised to find physicians providing multiple coverage.

"After I got to talking to the doctors, the rationale for it became apparent," he said. "When you have patients that have insurance and can deliver in any hospital they want, they may choose to deliver in [a particular] hospital because they had a friend who had a good experience there. And if you want to keep that patient, you will have privileges in that hospital also."

Nonetheless, Dr. Schauberger expressed concern about the risk that a physician might not be available in an emergency. "The problem is if you are trying to deliver a baby in one hospital and have a patient in another hospital, you can't provide emergency care for that patient," he said. "If you are in the same physical proximity, you can manage more than one patient at a time."

Another concern related to the contrast between call as experienced by residents and the real-world experience of obstetric groups. The investigators described resident call as being more intense and highly focused, occurring in-house, and carrying a higher likelihood of no sleep. They said private practitioners spend longer hours on call (sometimes over 2 or 3 days), have multiple responsibilities, and may cover in multiple hospitals.

"I'm not sure residents who are being trained these days have a very good understanding … that what their call is in residency will be significantly different from what it will be in private practice," Dr. Schauberger said. ■

Physicians Face a Costly Challenge With Medicare's New 'E-Prescribing' Rule

BY JENNIFER LUBELL
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Without the proper technology, physician practices may find it difficult to participate in Medicare's new "e-prescribing" standards under the Part D drug benefit, physician groups claim.

"Most primary care physicians will be unable to afford to implement this technology on their own, particularly with the projected cuts in Medicare physician payments of 4.4% in 2006 and a cumulative 26% reduction from 2006 to 2011," Neil Kirschner, Ph.D., senior associate for regulatory and insurer affairs with the American College of Physicians, said in an interview.

The Centers for Medicare and Medicaid Services in a final rule established the standards for electronic prescribing, or e-prescribing, of drugs covered by Medicare's prescription drug benefit that started Jan. 1, 2006, according to the Federal Register. CMS also plans to pilot test initial e-prescribing standards, which may be included in a final rule to be issued by April 2008.

"These standards will allow Medicare, physicians, hospitals, group practices, other health providers, and prescription drug plan sponsors and Medicare Advantage organizations to take advantage of e-prescribing technology to improve medication prescribing for Medicare beneficiaries that participate in the new prescription drug program," said Mike Leavitt secretary of the Department of Health and Human Services.

For the most part, medical organizations expressed support for the agency's e-prescribing initiative.

But few practices are currently employing this technology, Dr. Kirshner said. "Surveys vary, but the percentage of practices using it ranges somewhere from 5% to 18%." The number is even lower for the typical small practice, he added.

Dr. Kirschner said the recent release of safe harbor antikickback and Stark exception rules allowing hospitals, group practices, and Medicare Part D drug plan sponsors to provide necessary e-prescribing technology to physicians may help facilitate its use.

As of Jan. 1, Medicare required drug plans participating in the new prescription benefit to support electronic prescribing.

E-prescribing is optional for physicians and pharmacies under the new standards, but as of Jan. 1, 2006, Medicare required drug plans participating in the new prescription benefit to support electronic prescribing.

Jeff Trewhitt, a spokesperson for the Pharmaceutical Research and Manufacturers of America, said PhRMA supported the development of a standardized e-prescribing system. In addition to reducing errors and the administrative costs associated with health care, the system would also promote more effective care of drug therapies for chronic conditions. He agreed, however, that such a system must be designed and implemented correctly. "Keep in mind that the systems needed to convert to an e-Rx system don't even exist yet."

CMS's new standards for e-prescribing include the following technology:

- NCPDP SCRIPT, Version 5.0, for transactions between prescribers and dispensers for new prescriptions, refill requests and responses, prescription change requests and responses, prescription cancellation requests and responses, and related messaging and administrative transactions.
- ASC X12N 270/271, Version 4010 and addenda, for eligibility and benefits queries and responses between prescribers and Part D sponsors.
- NCPDP Telecommunication Standard, Version 5.1, and supporting NCPDP Batch Standard, Version 1.1, for eligibility queries between dispensers and Part D sponsors. ■

Physicians Can Ease Switch to EHR With a Step-by-Step Approach

WASHINGTON — Physicians are often reluctant to leap into an electronic health record system because of its complexity and the expense involved, Dr. Daniel Sands said at a health care congress sponsored by the Wall Street Journal and CNBC.

"If you're a doctor, what do you do? How do you get that [EHR] if you can't take the one big leap?" he said.

One way to start is by using electronic communications with patients and with office staff, he said. "Why don't you get rid of those stupid yellow Post-It notes you use for phone messages? A simple step like that is a good way to get people engaged with technology," said Dr. Sands of Harvard University, Boston.

Electronic prescribing is another way to bridge the gap, said Dr. Sands, who is also chief medical officer of ZixCorp, a Newton, Mass., company that sells electronic prescribing software. Medications can be prescribed using various electronic devices, including desktop and laptop computers, handhelds, and even mobile phones. Studies have shown that electronic prescribing can reduce medication errors substantially, therefore "this should be the standard of care," he said.

Another step is to use online clinical reference materials, Dr. Sands continued. "We have lots of data showing that physicians are often faced with questions when taking care of patients, and they can't find the answers because they don't have time, so they just move on. And that's really scary."

Rather than looking for answers "in a book that's out of date as soon as it's printed, maybe looking online would be a great place to start," Dr. Sands said.

—Joyce Frieden