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Healthcare & Welfare Accountability

The Trump Way

Brian W. Kelly

LETS GO United States of America!

President Donald J Trump, Master Builder: Healthcare & Welfare Accountability

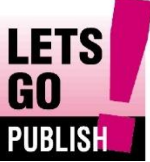
Electronic Accountability Records (EAR) Can Make It Happen!

President Bush and President Obama both agreed that a database of health records needs to be established on behalf of the people. It is a good idea. There needs to be a record of each citizen in the United States so that it will be much easier to get a full picture of a patient in any medical provider setting from doctor's offices, laboratories, imaging, and other specialties. This book defines the terms for these online records and discusses the entities that would like to own your health data. It also offers suggestions as to which entity would be the proper custodian of such vital data.

Most Americans are aware of the major battle on health insurance and healthcare "reform" as in Obamacare, which continues in the Halls of Congress even today. A Democratic Congress and the former POTUS decided by themselves to spend a trillion dollars on a government take-over of healthcare. They knew it would possibly improves the lives of just 17% of the people and they also knew that it would disrupt the lives of the other 83% by providing them with less healthcare, less medical provider choices, and more taxes. You cannot take $500 billion from Medicare for Obamacare and make Medicare better. It is insane. Will senior citizens have to find employment again to buy back what has been stolen by government without their permission?

The big winners of course are trial lawyers and the big insurance companies. The people have been left holding the bag. In this book, we describe in reasonable detail in words that Americans can understand, how to make the healthcare system -- both ER and Medicaid more accountable so that government does not have to pay the price for all – including illegal interlopers. There is no free lunch and this book shows the technology solutions that can help you avoid having to pick up the tab

Because government healthcare solutions are a form of welfare, this book also describes how to account for any freeloader who takes from the system. What happens today if somebody on welfare for 50 years wins a couple hundred million on the PowerBall?



B R I A N   W .   K E L L Y

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Original Editor, Melissa L. Sabol
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President Donald J. Trump, Master Builder: Healthcare & Welfare Accountability
Electronic Accountability Records Can Make It Happen

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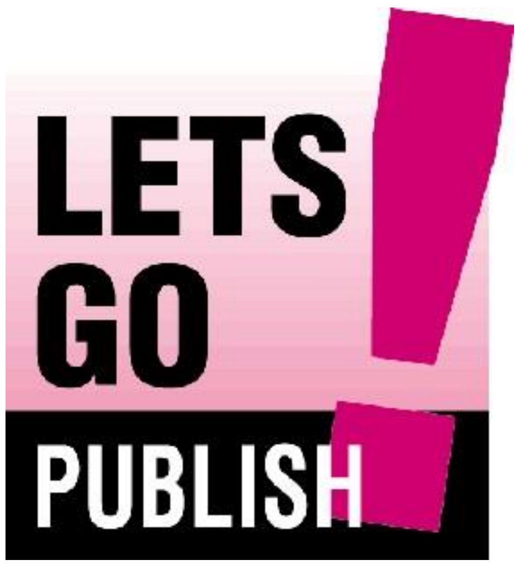
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Dedication

I dedicate this book
To the magnificent McKeown Girls
Who, while beautiful among all beauties in their outward appearances possess an inward beauty that separates these ladies from the rest.

They are the daughters of Nick and Emma McKeown. Along with their very remarkable husbands, I list them in order of birth: Kathleen and Angel Dave Conklin, Rita and Frank DeRiancho, Joan and Tommie Nelson. You can't even imagine how high on the kindness scale these people operate. They are also wonderful first cousins and avid supporters of all of my writing efforts.

My wife, my whole family, my brothers and sisters, and all of our other wonderful cousins and all the friends you have touched are tickled to know and be known by the inimitable McKeown Ladies.

Thank You and the Best!

Acknowledgments

I would like to thank many, many people for helping me in this effort.

I appreciate all the help that I have received in putting this book together as well as all of my other 78 published books.

My printed acknowledgments had become so large that book readers "complained" about going through too many pages to get to page one of the text.

And, so to permit me more flexibility, I put my acknowledgment list online, and it continues to grow. Believe it or not, it once cost about a dollar more to print each book.

Thank you and God bless you all for your help.

Please check out www.letsgopublish.com to read the latest version of my heartfelt acknowledgments updated for this book. Click the bottom of the Main menu!

To sum up my acknowledgments, as I do in every book that I have written, I am compelled to offer that I am truly convinced that "the only thing you can do alone in life is fail." Thanks to my family, good friends, and a wonderful helping team, I was not and continue to be --- not alone.

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Preface:

How about a free lunch? The US government gives millions of lunches away every day in one way or another. Did you get one today?

When I updated this original 2008 book about then current, domestic, political and constitutional issues intertwining with public consciousness, I became immersed, once again, in that vortex of all-too-familiar concerns about our government. I was compelled to add a few paragraphs about the Obama presidency considering the transparent failures of the coronated administration.

As I undertook the task of updating, I became so smothered in the existential issues that had since developed that I was pushed to delve further into the examination of the underlying issues. Thus, the project moved beyond what one may consider to be a standard update/ revision to the point that, when I received the book back from the editor, I noticed that she had split the original book not once but twice and had created two additional, entirely distinct books.

An update to the first book, *Obama's Seven Deadly Sins*, was released concurrently with this book in the summer 2016. It advises that the deadliest sin of all is indeed Obama's approach to healthcare, or what many now call Obamacare. *Healthcare and Welfare Accountability: The Trump Way*, was within Obama's Seven Deadly Sins as a chapter and when split, it was first released as *Healthcare Accountability*.

In summer 2016, in the middle of the Trump presidential campaign, I modified it to reflect how a future Trump presidency might view such accountability. Here I am again with President Trump at the helm of the Big Ship US. Now we examine what President Trump is likely to do in the area of accountability. I make some very strong recommendations.

The editor had originally separated what had grown to be a huge book because its message was off the mark for that book. However, she noted that it offered a coherent, common sense solution to the biggest problem with US healthcare for all -- its huge cost. It happens that the much of the same overall solution can be applied to the current high-cost US welfare system.

She suggested that it be released as its own separate offering and that's what I did. The original book, *Healthcare Accountability* offers a unique and compelling solution to the problem of healthcare cost. It is still available on Amazon & Kindle.

The book is based on a notion that other writers have chosen never to explore -- individual accountability. It is inherently against the socialist model of the Democrats. The additional chapter on welfare accountability blends well into the overall theme.

Most Americans are aware of the major battle regarding health insurance and healthcare "reform" that was at its peak in the fall of 2009. Both houses were ready for conference amidst a torrent of claims of sleazy deals for Senate votes. Though the people were dead against it, the Congress, ruled by Democrats, was more than ready to spend a trillion dollars or more on a government take-over of healthcare, which ultimately passed in March 2010 as Obamacare.

The purpose of the take-over was, purportedly, to improve the lives of 17% of the people -- those that the government determined to have no access to healthcare, a determination with which many constituents tend to disagree. After all, what is Medicaid and EMTALA?

Unfortunately, the plan was designed to disrupt the lives of the other 83%, by reducing their healthcare access and adding more taxes to their burden. Senior citizens would eventually pay the most to support this block of 17%, which despite Congress and the president's promise does include illegal aliens.

Logic dictates that you cannot take $500+ billion from Medicare to make it better. Will Senior Citizens have to find employment again to buy back what they will gave up to Obamacare?

The big winners, in this scenario, were the trial lawyers and the big insurance companies. The people (as in We the People) were left holding the bag. In this accountability book, we describe, in reasonable detail and in words that any American can understand how to make the healthcare system -- both ER and Medicaid, and the remnants of Obamacare more accountable to the people.

It is a simple idea so that people on Medicare do not have to bear such a high price for all. There is no free lunch and this book shows the technology solutions that can help all Americans avoid having to pick up somebody else's health tab.

In order to attain accountability, we must begin to keep track of things. President Bush and President Obama both agreed that a database of citizen health records needed to be compiled and it is, indeed, a very good idea. When President Trump slogs through all of his early to-dos, we can bet that he too will agree that a database of electronic health records for citizens is a great idea and we need to make it work.

In such a system, there would be health records for each citizen in the United States. In this way, it would be much easier to get a full picture of a patient in any medical provider’s setting. You go in, give your cards, and poof, the provider you have never met has your permanent medical record known as an Electronic Health Record.

This book provides a logical and clear blueprint that defines the terms for organization of online database records and discusses the entities that are positioned to "own" your health data. It also offers suggestions specifying which entity would be the proper custodian of such vital data.

This book on accountability) identifies the best means of managing the collection of health records in a "system in the sky." Additionally, the book helps Americans understand the issue and gives a solution that assures privacy and locks out the bad guys who want your health data so bad they can taste it. As a bonus, it offers a cogent solution for welfare accountability.

Why did Brian W. Kelly write this book?

Brian W. Kelly wrote this book because he cares and I am publishing this book because I care. This book points out many of the issues and makes a case for patient accountability and then shows how it can be achieved. It identifies the best means of managing the collection of health records in a "system in the sky."

Additionally, it will help you understand the issue and give you a solution that assures your privacy and locks out the bad guys who want your health data so bad they can taste it. As a bonus, it offers a cogent solution for welfare accountability. President Trump would do well to have his team evaluate this book for adoption into the overall Master Builder's Plan.

I hope you enjoy this book and I hope that it inspires you to take action to help the government of the United States to stand firm against any attacks on democracy from without or from within. Stopping politicians from giving away the resources of the country to buy votes is a good way to start. When President Trump drains the swamp, we intrinsically know things will be better. A little accountability can go a long way.

I wish you all the best

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About the Author

Brian W. Kelly is a retired Assistant Professor in the Business Information Technology (BIT) program at Marywood University, where he also served as the IBM i and midrange systems technical advisor to the IT faculty. Kelly developed and taught many college and professional courses in the IT and business areas. He is also a contributing technical editor to IT Jungle's "The Four Hundred" and "Four Hundred Guru" Newsletters.

A former IBM Senior Systems Engineer, he has an active consultancy in the information technology field, (www.kellyconsulting.com). He is the author of dozens of books and numerous articles about current IT topics. Kelly is a frequent speaker at COMMON, IBM conferences, and other technical conferences and user group meetings across the United States.

In 2006, Brian began to write patriotic / political books. When this book was first introduced, it was his seventh patriotic book and it joined his other great informers: Taxation without Representation, Obama's Seven Deadly Sins, Healthcare Accountability, Jobs! Jobs! Jobs!; Americans Need Not Apply!; and Kill the EPA!

This is Brian's 101st book.

Chapter 1 Does Government Want You To Be Incapable of Action - Any Action?

Get your permission slip quickly

Does it seem that more and more of the people you know are looking to become more dependent on the government? Do they want the government to seize most of what they were once able to do without a permission slip when they were free of encumbrances? Sorry about that! It is now 2017 and the second term is over. I almost forgot. We are still mostly free, but many of our freedoms have been under attack for eight years. We are free still and unaccountable for much, which means freedom will pass us by if it is not first stolen.

Do you want any jurisdiction over your own life? Are you willing to give up control simply because somebody promises a nice dinner and a few drinks? Is your healthcare a right that the government is obliged to provide? Or is it something that you have earned by working for it?

Do you really care about pleasing the statists by granting them permission to redistribute your heard earned healthcare to a more deserving fellow? Would it matter if it was all promised as not being a risk to your own healthcare? Would you give up your policies for redistribution so that government could offer you an alternative that may be substantially less caring? I did not think so!

Of course, if you have nothing at all and do not want the chance to make it in the world as an individual; if you have no money, and your parents don't want you stealing their best frozen

dinners and their best booze, then I can understand why you may like government but you will never have much of a life.

I know that most readers of this book are not looking for a lecture. That is not my purpose. Few of my readers are dependent on government but we are among many who are. President Obama made the situation lots worse. Today there does not seem to be any shame to be on the take. Nobody seems to care that their neighbor is paying the bill for them.

Being dependent on government is a big disease today as Uncle Sam and Uncle Barack over the last eight years teamed up to offer an opium for the masses. It once was Religion, but since many have shut God out of their lives, it now is material goods. Has government become your boss? Is government responsible for you living or dying. If so, plan on having a short-life.

Who has the best offer? In the 2008 election for example, the one with the most to give-away seemed to be Barack Hussein Obama. But after eight years, the problem is that the country is going to hell and nobody got anything anyway. The big Obama stash never helped the people.

For years, there were those members of the very low information crowd who believed sincerely that the President was going to give them a pile of cash out of his huge "stash:" Maybe he would even give them a nice new home. It seems like Obama is all-powerful he just does not part easily with his cash. He is so powerful that he was single-handedly able to destroy the best healthcare system in the world. His message was that he would accommodate a mythical few who are, as he said, not covered?

When he did this and now that it is beginning to really happen, are you concerned that you will be labeled a "racist," or a "nasty dude," if you don't go along with the President on all he suggested? After all, he knows what he is doing, right! Whether you know it or not, you have already given him control of your

health. Hopefully before you realize you need healthcare to have health, the next President, Donald J. Trump, will repeal and replace the nasty Obamacare legislation destined to make us a weaker nation.

How would you handle somebody temporarily down on their luck? If they needed a house, would you give them yours? The statists will tell you that we had to nationalize healthcare and create Obamacare to solve the mythical problem of the mythical man who has no healthcare.

Wouldn't you rather shell out a few bucks and pay for the guy's care if you could? Nationalizing healthcare means that you no longer have yours and I no longer have mine. Everybody has the same. And when socialism takes a country, it means nobody has anything, including healthcare. Eventually the ants stop working and the grasshoppers have nobody to sponge from.

It is true that there was not much in place for those who need temporary health insurance coverage. But, a government takeover was not what was needed. Their circumstances don't matter. It could be due to loss of their own policy coverage when hard times hit, when they are between jobs or when they no longer qualify as a dependent under a spouse's or parent's plan. Then, of course, there are those with no insurance—the uninsureds.

Were Obama and Pelosi right? Was the only solution for you to give up your own healthcare to help somebody else get some? Donald Trump thinks you should be able to keep your own healthcare.

If Obama is not right, the moment you agreed through your weak Democrat Congress to give up your own healthcare, he would have owned you. If Obamacare was not such a pig, they might have had it running before President Trump took office but they were incompetent and could not make it work.

Hopefully we will have this solved shortly. Never forget that Obama was happy to own you and he would have been pleased to pass title to Hillary. Please remember that It would have been you, and not the mythical man, who had no healthcare worth a grain of salt. We just avoided this.

Just so we all know, President Trump believes in the safety net for those who need it, not for those who do not need help but want freebies. He also believes in accountability. He is a good man. He believes that we should help helpless people but he also believes that government programs should not make people helpless. Who would that help?

Unlike many in the prior administration such as VP Biden, Donald Trump believes that he and other wealthy Americans should relinquish their Social Security benefits. I do not recall hearing about proposals such as that from his opponent. Mr. Trump knows that widespread fraud exists in the Medicare, disability insurance, and food stamp programs. He plans to fix it without destroying the safety net. Mr. Trump supported the 1996 Welfare Reform Act's work requirement as did Bill Clinton.

Can Medicaid be improved to cover everybody?

Life will change now that Donald Trump is President and it will be for the better. We should be able to look at the federal government as a partner and friend instead of an adversary. Much of this book about the federal government under President Obama, operating as an adversary. Kelly and Trump right now feel that if we can keep the feds out of the deal, under a Medicaid type enhancement, which I would suggest, I think we can handle it. The Feds under Obama would have poisoned all reform if they got involved. Thankfully we now have President Trump's and a superior Cabinet team.

All people facing hardship, who hit bottom, not just women with children or those with disabilities but everybody who is down on their luck, should be eligible for a temporary Medicaid immediately after the lapse in their current insurance policies. By having a strong economy as we will have soon, less and less people will need the government because they will have their own healthcare. In the meantime, we need to help all in dire circumstances, but we also need a way to get back the dollars we spend on such charitable works.

Obamacare should not be replaced. It should be repealed and the marketplace should decide the rest. Those who are hurt by this should get a temporary Medicaid pass. The last thing we need is another government takeover.

My Democrat tendencies do come out every now and then, but this temporary measure would have no hard-left stuff and would not mean that the pre-2010 residue ever gets fully dismantled. But, it does mean that when times are better for the patient, they need to pay back the "loan." The terms should be very, very relaxed and should never be more than 5 to 10% of income.

There needs to be a way for any patient to be able to pay back the people's treasury for the helping hand. There is no free lunch! There may be a postponement of the lunch tab but free is not in the cards anymore with Donald Trump as president. After all, somebody always pays and it is not necessarily rich people like the Clintons.

We all want accountability

Let me say that again. Without government, without any insurance in the world, life will be as accountable as in olden times. When I went to the doctor as a kid, I had to have the doctor’s fee in my pocket when I was seen. My dad had very little but getting well was priority over everything else.

If somebody needed help before all of the helping hands of government were dispatched, the neighbors, church groups, and relatives would chip in and help—not a government that then all of a sudden believed that it owned you.

When you recovered from illness or major financial setback, your pride would make sure that you would work off anything the neighbors loaned you and you would pay it all back. You might even throw in a little extra if your full bounty were intact.

The reason so many people are taking from their neighbors through the government today is that nobody asks for a dime back and you never see your neighbors' faces. Yet, it was your neighbors not the government who helped you—even today.

The Trump accountability plan would change it so that nothing from neighbors or neighbors through government would be given forever. Everything over time must be paid back. The exception of course is charity with no payback necessary. But, success brings a certain amount of charitable duty.

The ideal would be that any citizen, in any kind of financial difficulty, who needs healthcare, would immediately be covered by an enhanced Medicaid, at the outset of the problem and would require the cooperation of three separate entities: the state government, which would sign off on the enhancement of state-administered Medicaid, the federal government, which would underwrite the augmentation and a third entity, which will be addressed later in this book.

Ironically, the feds have been put in such poor shape that in Obamatimes the solution would probably require borrowing from the Chinese, who would be tapped to fund it. I assure you, I have a much better idea coming up.

The good news is, that there is no Obamacare necessary, meaning that as much of pre-2010 system as exists today can

stay in place. That would mean that whatever is left of the 83% of Americans who got stiffed by the government would not ever have to move to Obamacare or Obamacare II as the II version would never hit the streets.

After the repeal, those who had moved, would be able to resume life as normal with adjustments for the time spent off track. Even though Obamacare has been "alive" for over six years, most of the objectives of the universal healthcare notion are not accomplished even if government has declared them accomplished. Things are worse; not better. The right idea is Americans helping Americans. Isn't that a neat idea? Does anyone remember, “United We Stand”?

What is Medicaid?

According to the National Conference of State Legislatures, Medicaid can be defined as follows:

Authorized by Title XIX of the Social Security Act, Medicaid is a means-tested entitlement program [this mean that if you are rich, you get none and if you are half-poor, you get a proportional allotment of help] All help right now is funded by state and federal dollars, that pays for health and long-term care services on behalf of eligible individuals (Poor and half-poor).

The program even pays Medicare premiums and, in some cases, other cost-sharing requirements for low-income Medicare beneficiaries, who are known as dual eligible. Medicaid is a good program for sure but it must be kept solvent by people paying their share of the load—even if it means paying it back later.

Statistics are hard to come by using typical government sources. Total spending on Medicaid in FY 2005 was $316.5 billion. In 2013, the tab was $433.2 billion. This accounts for about 18 percent of total national spending on personal health

care. Medicaid pays for a substantial share of the cost of many categories of services. The program, a major source of payment for providers that serve the "uninsured," is the largest source of public funding for mental health and substance abuse services.

Medicaid is also the largest source of health insurance for children in the United States. In 2005, the program covered one in every four in 2005 (28 million). In 2013, along with CHIP, this went up to one out of every three children. Medicaid funds more than one in three births and is the also the largest source of public funding for family planning.

In 2005, the program covered more than 7 million of Medicare's almost 44 million enrollees (about one of every six). In 2014, there are 53.8 million Medicare enrollees, and about 10 million are funded by Medicaid. It provides long-term care coverage for 60 percent of nursing home residents, 44 percent of people living with HIV/AIDS, and 15 percent of all Medicare beneficiaries. Clearly, Medicaid really lends a big helping hand.

Is everybody covered?

The answer to the title question is, "no." Medicaid does not provide assistance to all low-income people. Instead, Medicaid eligibility is based both on financial criteria and on being a member of a certain covered category, including children, pregnant women, the elderly, people with disabilities and certain parents.

Medicaid is a partnership between the states and the federal government and can be characterized as a federally authorized program (in many ways mandated) that is administered by states. States must operate their Medicaid programs in accordance with an approved state plan.

In my research into how the eligibility requirements plays out in practice, from speaking with several doctors, including those

working in the General Practice, Pediatric, and ER/ Trauma areas, in different states, this is not the spirit of the law. It does not stand alone either as the EMTALA Law comes into play in emergency rooms to assure all are treated. In the interest of providing a better understanding of my idea of enhanced Medicaid, let's now explore the glory that is EMTALA.

Let me express my confusion on Obamacare being so needed. If the states and the federal government actually believed that there was a need for full insurance stipends for a percentage of the population who could not afford health insurance, then (please think about this), why were these poor people not always on Medicaid.

But, if the supposed 17 million who enjoy the Obamacare subsidies today would not have qualified for Medicaid by the income rules set up by the states and the Feds, then how is it that they qualify for Obamacare? Help me with that. Poor people should be helped by a charitable notion like Medicaid, not a healthcare redistribution scheme such as Obamacare. Right? Was this just another Democrat scheme to pass out government money to the people to get votes?

What about the increased demands of emergency rooms?

Even if you are unaware, you will find many illegal aliens in Emergency Rooms. Instead of getting into an emergency as an emergency, sometimes patients, such as some of my own family members have had to wait as much as 16 hours for service. I suspect if I experience this myself in the small berg in which I live, the wait is more than likely longer in many other places. I am not talking average of 16 hours. For me, it was my max time ever but it is substantially longer in and out like the "olden days." Many of those waiting cannot speak English. Under what healthcare plan are these folks entitled?

There is a great program that causes the lines but adds to the ability to get care in the United States. It is poorly run but every hospital seems to make do even if lines are extended. The program is called EMTALA.

EMTALA stands for the Federal Emergency Medical Treatment and Active Labor Act. It is also known colloquially as the Patient Anti-Dumping Law. This 1986 act was written initially to prevent patient dumping and as such it requires strict adherence to rules designed to prevent patients in ERs or hospitals from being discharged or "dumped" in other locations such as nursing homes or even other hospitals, purely so that the dumping hospital would avoid the expense of treatment.

Since then it has become the safety net for many, especially the illegal population and those who have no social worker, who often use the program's benefits as their only means of health care.

EMTALA requires most hospitals (those that accept Medicare patients/ payments) to provide an examination and needed stabilizing treatment, without consideration of insurance coverage or ability to pay. This means that when a patient arrives at an emergency room and asks for attention regarding an emergency medical condition, the hospital is legally obligated to treat the patient. There are consequences most hospitals do not wish to endure if they do not adhere to EMTALA guidelines. As such the program is very good.

Since EMTALA has been the guiding principal since 1986, ER managers, doctors, and other care providers know that EMTALA requires the hospital to provide a medical screening examination along with any necessary stabilizing treatment to every patient who requests it. Until those obligations are fully met, the patient must remain in the care of the hospital. Under

the law, until stabilized, the hospital may not introduce the notion of reimbursement… but many do for survival purposes.

Hospitals naturally find the bill onerous, but if you read about the patients that hospitals were dumping prior to this bill, your pity for hospitals would quickly wane. You see in EMTALA, the screening examination and stabilizing treatment must be performed without delay. During this period, the hospital may not inquire about a prospective patient's method of payment or their insurance status. Care is the first thing provided. Having been in ER's more than I wish. I like you know that there is no immediacy unless there is near death. The ER's are that busy.

Hospitals have a lot at stake and so they have built their ERs and they have trained their care providers with reasonably elaborate measures/ techniques so as to not violate the prohibitions of EMTALA. On the one hand, hospitals must collect information or they never will be paid. Despite this financial need, the priority must be on making the patient stable. That sounds about right.

Yet, somebody must pay the bill and most of these bills are not paid by the federal government. How can that be? EMTALA created a new class of patients called the *Unfunded Mandate* long before the Obamacare mandate. These patients receive whatever care they need and it is often very expensive care for which neither hospital nor providers will be paid. Of course, the institution and physicians -- must still pay their own expenses, from nurses' salaries to electric bills. The feds insist they provide service but provide no funds.

Because healthcare is not cheap, very, very large sums of money are involved. For example, at my own medical center, I learned that the cost of uncompensated care for the "unfunded" was $233,000,000, which represented one quarter of the Hospital's entire annual operating budget. There is not an industry in the land where federal law requires them to give away 25% of their

goods and services, and stay in business while being prohibited from raising prices?!

That is the plight of hospitals and they have been forced to make do. And, most have developed clever ways to survive that save an awful lot of money while at the same time, doctors, nurses, and hospital administrators are donating huge sums and their time to the effort. This program needs plaudits as well as fine tuning.

Hospitals are forced to do whatever they must in order to keep their doors open. For example, they differentiate insured patients from uninsured. They use egregious methods such as charging $5 per aspirin, double billing, creative accounting, up-coding, cherry picking patients, etc. Many methods are in fact illegal and yet are done every day. Further, hospitals aggressively go after insured patients who have unpaid bills. These are now known as the underinsured.

Be careful asking questions!

Even though it may seem quite natural to begin to collect the demographic information for a medical record, and in that process delve into financial or insurance questions, it is strictly verboten. EMTALA prohibits any such inquiries if they delay examination or treatment. Because the hospitals are burdened with the necessity to prove that they are compliant and not delaying treatment with financial/ insurance inquiries, the questions are often deferred and sometimes no information is gathered at all before or after treatment.

Quite frequently, very often patients, especially illegal aliens, simply get their belongings and leave rather than stop to say thank you and provide the necessary billing information.

Sometimes, when the hospital personnel go ahead and attempt to gather the needed information prior to treatment, the patient

will get up and leave the ER and they will never return other than for another "emergency." Too often, when a prospective patient is questioned about their insurance/ financial status, they will run the other way. Ironically, that does not prevent these "poacher-type" patients from calling and complaining because they did not receive proper treatment.

If they issue a complaint, it is a serious matter for hospitals. Thus, the hospital logs the arrival of every patient and logs all of what has occurred to the "prospective patient." Sometimes, it is only the careful logging of all actions taken prior to a patient leaving that saves the hospital from a bad EMTALA audit or a bad investigation result.

EMTALA compliance is regulated by the CMS (The Center for Medicare and Medicaid Services), a division of the Department of Health and Human Services (HHS). There are significant financial consequences for violating EMTALA rules.

Before we continue with EMTALA, let me show you the blustery opinion of those who think that EMTALA is poppycock, and does not serve as an adequate safety net for uninsured because it does not provide dental coverage and preventive care. Then I will show you another opinion, a bit more subdued but just as emphatic arguing that EMTALA is a vital piece of the safety net because it is always available.

Blustery Opinion vs. EMTALA as a Means of a Health Safety Net

> "Are you kidding?? I work in healthcare and the Emergency Rooms are already terribly over crowded, is this idiot suggesting that when you have a cold to run to an ER and plug it up using it as a Doctor visit??

What a typical out of touch response to a HUGE problem from some wealthy politician who has never had to go without. You and the bleating sheep that cluelessly follow you and allow you to spoon feed them what you want them to hear make me sick!!! I pray, every day that the Bloated, Corrupt current administration is soon gone…"

More Subdued but Forceful Opinion - EMTALA is the Safety Net

There is no healthcare "crisis," any more than there is an auto-insurance crisis.

You, the individual, purchase auto insurance for the "catastrophic" events (i.e. accidents). What's not included in that insurance is maintenance… things like oil changes, tire rotations, tune ups, car washing, etc. Why should health insurance be any different?

In fact, if Americans only had insurance for "catastrophic" health problems and paid out-of-pocket for their own routine doctor visits, the cost would drop significantly. This is a simple rule, not only of economics, but of human nature… when there is a third-party "other" (Medicaid, Medicare, health insurance, your trust fund or your parents because you're still living in their basement) picking up the tab for something, the individual consumer doesn't actually SEE the cost, the expense, and doesn't actually have the opportunity to compare costs.

That said, the costs become astronomical because the individual is missing from this equation, replaced by a bureaucracy making that purchasing decision. No responsibility equals higher costs.

By the way, I bet you see this coming already. Healthcare Accountability means that there is no free lunch from your neighbor. Eventually, when healthcare accountability comes on line, every dime of care will be paid back. Then, there will be some concern for the costs.

Value of EMTALA as a safety net

It is not my intention to pull anybody into a philosophical argument on the merits of universal healthcare. I know that I cannot afford the best health insurance for my own family. So, I get what I can and if my net worth is not enough to sustain us in a crisis, then it's time to look for Medicaid. The fact that the EMTALA exists helps us all.

Even though it may not cover colonoscopies and dental care, it is a big comfort to me and many other Americans. I applaud the doctors and hospitals who provide this care to legal Americans and even illegal aliens. Can it be better? Yes, it can, and that's what we should be working on rather than permitting Obamacare to dismantle the entire health insurance industry and hope that President Obama and now President Donald J. Trump, can put it back together again.

Considering the government's fine work with figuring out the H1N1 Swine Flu rationing six years ago, when they gave Wall Street the available doses, I would hate to be one of the poor souls on the federal government healthcare plan that needed care. Who wants a government bureaucrat deciding what procedures they need?

EMTALA can certainly be enhanced, as can Medicaid, so that there is less pain associated with it. Unfortunately, just like Medicare got stiffed, Obama has also stuffed the EMTALA program by reducing funding to pay for Obamacare.

No matter what anybody says, the fact is that only people who are denied care are truly uninsured. Everyone who gets care is effectively insured by some mechanism. To make it better, the US could use “free" clinics without overnight beds and we could also use a lot of overnight beds for the homeless and hard-liner druggies who actually do use the beds in ERs to get out of the cold. ER expense should not be needed for all the EMTALA patients who today fall under its huge helpful wing.

Because Medicaid is state run (run by individual states), it would not provide the federal government and it's progressive/ socialist wing another edge in eliminating capitalism and the American Dream. EMTALA is run by hospitals and physicians who do an awful lot of pro bono real charity work for Americans. Thank you.

Two of the biggest objections of Obamacare, from the American people, were government control and costs. By simply tweaking the current Medicaid/ EMTALA system, either the hospital or the states would retain administrative control and President did not have to become the US Chief Medical Officer. Most of the costs involved were already currently built into the system.

The EMTALA scenario for a patient

Many people benefit from EMTALA. When a patient arrives, they are either screened or triaged. Hospitals that have adapted to EMTALA know who to move to the "Real ER," and who to move to the ER serving as a clinic. So, successful ERs have adapted to reality to help with overcrowding and ambulance diversions.

In NY ER's for example, very early in the patient process, the patient is given a drink and a sandwich. In some cases, this is all they want, as there is an awful lot of abuse in the system, which hospitals have learned to address. Depending on the condition,

patients are either admitted or they receive a battery of tests and are deemed okay and they are discharged.

There are also plenty of cases in which people enter the ER simply looking for a couple days' worth of lodging and hot meals. Since the hospitals are used to dealing with these typically "repeat offenders," they have developed a protocol that allows for these "patients" to be easily recognized and discharged, which often results in the "patient" walking to the nearest pay phone, calling 911 emergency and trying again. This is reality and successful hospitals have learned how to adapt and they continue to survive. Yes, it can be better. But it was not bad enough to warrant the destruction of your health care system.

Enter Medicaid into the process

Most ERs have social workers available. These social workers know the Medicaid law and one of their objectives is to save the hospital from having to eat any charges. They can, and in fact do, register patients for Medicaid on the spot. Is it possible that the aggressive sign-ups in ERs results in a rounding up factor for the patient? In other words, in states where the patient would have to be disabled, though not necessarily legally disabled, as in SSI, would a case worker not plug in a disability code on the Medicaid application to help the patient?

A doctor I spoke with from a very large city hospital noted that just about everybody who comes to their ER is on Medicaid, and very few are just EMTALA. It helps the hospital get some compensation for treating the EMTALA patients. Though nobody knows for sure, this doctor's perspective is that many illegal aliens are also on Medicaid.

The Medicaid Law is different state by state, but apparently, there are very few people who visit the ER with just EMTALA assistance. Medicaid in Pennsylvania and the CHIP program are examples where the poor (children at least) do get preventive

care, tests, and even dental. It is not really a bad deal. Instead of a family doctor, the patient goes to a special clinic in which they receive excellent care, both as a preventive measure and when they are not well.

Again, with enhancements to Medicaid and to EMTALA, there would be no need for Obamacare and the bankrupting of the treasury and the elimination of real individual controlled health insurance. Add to that unlimited coverage, unstoppable coverage, no preexisting conditions, shopping across state lines, tort reform (malpractice) and a few other tweaks, and everybody wins. For those of us that trust the government less than insurance companies and who trust all doctors intrinsically more than all bureaucrats, adding on to what we have is the best option, without destroying anything in the process.

Does anybody have insurance?

What kind of insurance do Americans have? Here are some categories:

- ✓ **EMTALA et al** - First on the List
- ✓ **SCHIP** -- Not Bad for Kids
- ✓ **Potential Medicaid**
- ✓ **Self-Insured + Potential Private Coverage**
- ✓ **Potential Employer Coverage**

Now, let's take a look at each of these "types of insurance" in some degree of detail.

EMTALA et al - first on the list

We might also call this self-insured or free care depending on your perspective. It is not the best, but it is completely free to the patient (if they choose not to pay.) At a minimum, everyone in

this category is self-insured. We all have enough money to buy insurance, until all our worth is exhausted.

We know that the EMTALA requires hospital emergency rooms to provide emergency care without any regard to the ability to pay. In addition to our net worth, this can be counted as additional insurance. On top of all this, in many cities, there is the availability of additional free care. Estimates of the value of free care are from $1,000 to $1,500 per uninsured person per year.

These clinics include Shepherd's Hope, Lazarus Free Medical Clinic, and St. Thomas Aquinas Medical Clinic in Florida. In California, of course, they are bankrupt and counties were ordered by the Supreme Court to provide essential medical care to residents who cannot afford to pay for it themselves. One might consider that free and also free of Obamacare.

SCHIP -- not bad for kids

The State Children's Health Insurance Program SCHIP is another tool specifically designed for children, though in some states is used to augment Medicaid funding. It was authorized by the Federal Balanced Budget Act of 1997. Its purpose was to extended health insurance coverage to children in families with incomes slightly higher than the Medicaid income eligibility cutoff. The Children's Health Insurance Program Reauthorization Act was signed into law by President Obama on 2/4/09 and it expanded these benefits even further and increased eligibility. Strangely, not all children have been reached by the bill. Those who are very young (less than one year old) and children nearing the age of 18 are the least likely to be covered.

Potential Medicaid

As noted above, the "theoretical statistics" indicate that just about one of every four "uninsured" persons who is eligible for

Medicaid or SCHIP (for children) for some reason has chosen not to enroll. The unpublished statistics appear to be substantially higher -- perhaps 3 of 4 or better. CHIPS percentages would be even higher because it supports children whose parents earn from 1.5 to as much as three times the federal poverty level in some states.

Medicaid enrollment is a mere formality and in fact can often be done, as noted previously, right in the ER. In many states, it can also be done several months after the care has been delivered. I am not suggesting that there is any chicanery going on here, but the doctors I spoke with said that they were fairly sure that most of their walk-ins were Medicaid.

Self-Insured + potential private coverage

Many people with higher incomes simply choose not to buy insurance for themselves or their children. At their income levels, they are effectively self-insured. Rush Limbaugh for example noted on his program that he carries no insurance.

When an illness shows up at the doorstep, through hook or crook, there is also the possibility of buying private insurance. Some of the real numbers show that about one-third of the uninsured are in households earning $50,000 or more, and more than half of those earn $75,000 and up. These people can clearly afford to buy their own medical care directly and they can certainly afford insurance. They don't need Obamacare but Obama has them in the justification as if they have no insurance because they are too poor. That is chicanery for sure. But, when your objective is to take over healthcare and not to make it better, such chicanery is a necessary part of the package.

Six states have guaranteed issue and community rating in the individual market. In other states, many are protected by the Health Insurance Portability and Accountability Act (HIPAA) and many have access to state subsidized risk pools allowing

access to private insurance after illness has occurred. Sorting out how many people potentially have access to different types of private coverage would be another useful Census function.

Potential employer coverage

If Al Gore were writing this, he would suggest that the 800 pound gorilla in the room, which he would call the inconvenient truth, is that about 80% of the uninsured are living in a household with someone in the labor market. At least one fifth and perhaps as much as 25% have been offered coverage at work, but turned it down. They chose no insurance to avoid the cost of their contribution in order to have more disposable income. Quite frankly, so would I. Yet, Obama included these refusers in his healthcare justification.

If the need arises, they can always enroll. Also, since it is easier to get a job when you have one, many who already have a job can probably land one with employer-provided coverage (if needed). Some might even be able to renegotiate with a pay cut to have their employer provide insurance. It helps to know that the HIPAA law prohibits employers from denying employees (actually anybody) coverage because of their (or a family member's) health status.

Despite how dire the need for Obamacare would appear to be in the low-ratings media, the fact is that in general, in America, it is surprisingly easy to get someone else to pay your medical bills - even if you don't have a Blue Cross card or Obamacare.

http://www.ncsl.org/default.aspx?tabid=14052#who

What is my point in all of these statistics? The fact is that Obamacare was justified to the masses as if nobody had health insurance when in fact, based on the discussion above those who do not have health insurance other than the terribly poor have simply refused coverage for one reason or another. They want

either you or I or both you and I to pay for their healthcare insurance, and of course Obama wants that also.

Who pays for EMTALA?

Now that we know what EMTALA is and we know that the patient is supposed to pay for EMTALA care, we are staged for the next part of our discussion. Before we go there, let us again acknowledge that the EMTALA patient often gives a bogus address and is not required to show identification. Therefore, much of the time, the bill for EMTALA winds up being on the back of the ER or the ER doctor. Some ER doctors donate as much as $100,000 per year in unreimbursed ER care. Anybody getting care for free in our system should be required to provide valid identification to help assure that there will be an ER there when they choose to benefit from EMTALA the next time.

A story from 9/4/2016. Just today I went into a grocery store nearby and I bought a few items. The total was less than $25.00. I paid by credit card. I had a thing called a gold card which I used to get a discount on certain items. Almost everybody at this store has one. I thin gave my credit card which has a chip in it for better authorization. I then signed the signature pad. So there were three proofs of who I was. The store clerk then asked me for ID. People all around me at various checkouts, who were on welfare, had a thing in their possession called an Access card. It did not have their picture. They did not have to show ID.

They did not need additional ID. I rummaged through my wallet holding up the line looking for my driver's license. I could not take my merchandise home without having that card. So, I needed four forms of ID. Yet, EMTALA patients and voters somehow would be disenfranchised if they were required to have ID? What about not being able to eat. I say everybody has an ID especially the poor because that gets them their food. So, who are we kidding America?

Who pays for Medicaid and SCHIP/CHIP?

States and the federal government share in the cost of Medicaid and CHIP. The federal share of a state's Medicaid expenditures is determined by a formula. The formula itself has a name-- the Federal Medical Assistance Percentages (FMAP). CHIP is different, but includes the notion of sharing. The law recognizes that some states are poorer than others. States with per capita incomes below the national average receive larger federal matching percentages, and those with per capita incomes above the national average receive smaller matching percentages. Every state receives at least a 50 percent match.

States are not required to participate in Medicaid, although a large financial incentive exists to do so. Currently, all states have a Medicaid program except Arizona, which has what is called a "special demonstration project." In essence all states have Medicaid. If a state chooses to participate, Medicaid is an entitlement to the state as well as to individuals, as long as covered services are provided to eligible people in accordance with federal statute and an approved state plan or waiver. In other words, the federal government will pay its share of the Medicaid costs as long as individuals covered, services provided, providers reimbursed, and rates paid are consistent with the state's Medicaid state plan or specific waivers approved by the federal government.

The federal government should give us all a tax break and let the states collect from their own residents to fund Medicaid. It would actually not cost as much when we took out the big bloat from the federal government employees.

The big three do not pay for Medicaid/ EMTALA?

In very few of the magnificent programs designed to help the poor and even those above the poverty level to afford healthcare, are the big three sources of bill paying that I learned growing up. Everybody is very familiar with these three. They are "Me, “Myself," and "I." They do not pay for Medicaid or EMTALA. They do pay for Medicare.

Isn't that hard to believe? If you delve into some of these programs more deeply you would find some requirement for co-pays and small payments, but as a rule, there is no requirement to pay at all. It is a free lunch on the taxpayers for good Americans who are poor, cheating Americans and illegal aliens. Even when there is an expected payment, as in EMTALA, as my father would say, "Try and get it!"

The fact is that you cannot get blood from a stone. Nobody is suggesting that. But, wouldn't it be nice if the person receiving the service helped in some small way, before, during, or after receiving the care or the insurance/ coverage? (Let us be reminded here that Medicaid and CHIP serve much the same function as insurance.) If the patient actually was expected to participate in the payment of the life-saving services rendered, or the fee for having an insurance safety net, the patient would then be called accountable.

Accountability

Right now, the patient is basically not accountable and the “Kentucky Windage” from the programs quietly implies that the patient need not be concerned about the mundane notion of paying somebody else back for their labor, which in turn permitted the patient to survive.

This is called accountability. The purpose of this book is to discuss healthcare accountability as it pertains to the patient and as it pertains to John Q. Public's ability to keep track of what is owed. Without a tally, clearly there can be no accountability.

We will also discuss welfare accountability which is a great piggyback notion once the databases and systems are set for healthcare accountability. Welfare accountability will be a mere add-on. It will pay off big in making all citizens accountable. There is no free lunch!

Chapter 2 Raw Ideas for Accountability -- A Starter Set

It all starts with a few good thoughts

What's coming next is a set of initial ideas and not some major formulation ready to be signed into law. But, it makes sense. The primary concern of any effective healthcare system is that people get quality care when they need it. The debate today in this book is who pays the bill and how do they pay it. There is nothing in Obamacare for example that makes the *care* in health*care* any better.

As noted in Chapter 1, in many cases, and, of course, the whole essence of Obamacare, is that often, the patient is left out of the financial and the "care" equation. The supposition in this book is that a public willing to help an individual with health concerns should expect to be repaid sometime after the patient gets well.

The patient should be accountable to pay the public back for any share of EMTALA or Medicaid or any non-charity welfare that was expended on his or her behalf. The debt to the public should be removed only when the patient passes on.

Accountability for payment should ultimately be with the patient, while accounting for what is owed is with the public, and IMHO, not through the government. The system should work even better than the current system does now.

Nobody would necessarily be denied any help that they need. Again, regarding Medicaid and CHIP type programs, the states would make the determinations, as they do now, based on eligibility, which admittedly, is already liberal. Over time, by

accounting for Medicaid expenses back to the individual's identity, eventually something could and in most cases, would be paid back. The people's treasury would gain from the one-time recipient of Medicaid insurance. The amounts may be meager but no government service that is not paid by taxpayers for taxpayer or public benefit should be free.

The same accounting can be used for EMTALA charges paid by the public as well as co-pays and other charges that are deemed the patient's responsibility, but for circumstances cannot be paid at the time of service. As noted often at discharge, patients refuse to sign anything and skip the process. Capturing their retinas via a scan or their fingerprints would be all that would be needed if they skipped their discharge interview.

Please put that on the tab

Here is one more thing that all should be able to appreciate. The records that would catalog the "insurance” tab and all the "owed to the public" tabs should not be government controlled nor should they be insurance company controlled. The best approach would be a consortium of doctors -- not hospitals and no corporations, running a big time "in the sky database" and accounting system. I trust Doctors. After all, they took the Hippocratic Oath.

This system would be authorized to pay the national treasury for funds that it collects from Medicaid and / or EMTALA patients or any others as noted in its charter. The IRS would not have access to the records and the consortium systems would have no access to government records. Perfect!

Care would have to be built into such an enhanced Medicaid system so this notion would not become the feared "public option." There can never be a government takeover of any facet of healthcare, such as that proposed in 2009 and passed in 2010 as Obamacare. Under an accountability system, everything (the

US health insurance and healthcare system) starts out the same as it was and it gets enhanced to the extent that it can be afforded.

The existing law gets refinements for exclusions, revocations, dropped policies, selling across state lines, tort (malpractice) reform and all the logical corrections needed for the current system to be fair. But, the government gets 100% out of the healthcare system.

As Medicaid and/ or CHIP gets enhanced, it would still be administered by the states, which is a scenario infinitely better than a scenario in which the Obama Administration or a post Trump Administration is in control of the entire health industry. President Trump, please keep healthcare out of the purview of the US government forever. Please get the Congress to pass laws assuring that.

There are a lot of other solutions that are non-disruptive to the health insurance and healthcare needs of most Americans. EMTALA should not go away, as it would be needed for foreign visitors and for illegal aliens, who under the Annual Guest Plan would have their own EAR Records. They too would have their biometrics taken and they would get a bill for service.

Collection systems that are reasonably non-aggressive would also have to be built to augment the information in the accountability database. As a computer systems designer by trade for years, I could design the gross requirements myself. It would not be rocket science.

Uninsurables don't like the underside of busses

The notion of an uninsurable is a very nasty idea that has entered our language recently as more and more citizens find out that they cannot get insurance. This notion has been brought upon us by greedy corporations and their insurance holdings.

The fact is that if one insurance company decided to take all the uninsurables, they would go out of business. Consequently, reform is needed to create a risk pool for the shared risk of all companies to handle the once uninsured and perhaps even the never insured with pre-existing conditions. The auto companies use a term called "assigned risk," which might also work fine in this regard. Don’t you think?

Besides eliminating the notion of uninsurable, any reform worth its salt would have to eliminate lifetime maximums, and as noted above, denial for pre-existing conditions would also be gone. There would be no reason why children could not get their parents insurance until they were 30 years old or perhaps even older. Make the numbers right!

Many states have enacted such laws already. The states are obviously more capable of dealing with people in need than is the federal government. After eight Trump years, my far s that we get another tyrant in chief and if we have not passed the baton to the states by then, the feds could make another grab for healthcare when nobody expects it.

In other words, children should always be able to get their parent's insurance for all ages, and of course, they would have to pay the premiums. All these ideas can be legislated, without busting up a system that once worked well, simply so that the federal government can have control.

And when the public treasury pays for anybody down on their luck, the amounts of insurance or treatment that are not paid should be added to the patient accountability record. They become due to be collected at some point in the future. If one out of 2 are never collected, the system is still more self-sustaining than today.

Some might joke that forty is the new thirty, but this could go a long way to making the idea of uninsurable a thing of the past. As noted, such previous uninsurable's could be placed in an assigned risk pool and gain their insurance from one of the many participating companies. They would not be part of Medicaid until their needs are within their own payment criterion.

US Citizen taxpayers should not care. The recipients would pay or their parents would pay the fare. Insurance companies would be obligated to give them a fair rate, and if they do chose not to pay as they should, they could be dropped just like anybody else. In that case, we will have created a different kind of uninsured -- one who chooses not to pay. In this case, their insurance by choice would be their net worth as it always has been since the 1800s.

If there are no extenuating circumstances that would make them eligible for any help, then their not being in the insurance pool ought to be OK. To make Medicaid an effective way of dealing with people who would opt in and opt out only when they become ill, a method needs to be developed to discourage such flip-flopping.

Either the actual charge for care would become the accountability bill or perhaps as much as a six month or one year Medicaid premium amount would be added to the accountability record for each "new" illness when coverage has lapsed.

Yes, in this system, the value of the Medicaid "policy" would be calculated and it would be added to the patient's accountability record as long as they are eligible for Medicaid. Afterwards, it would become due and collectible with reasonable limitations.

Insurance companies -- risk pool

Insurance companies do need to be watched closely with checks and balances on their operations. Placing the federal government in charge of such a task is not the answer. It would be like going from the frying pan directly into the fire.

Instead, the solution is to establish necessary fair-play government regulations to be enacted to assure that anybody who otherwise would have been rejected, but can pay, is given the opportunity for health insurance. In this case, a concerned Congress needs to be accountable for passing the proper legislation.

By enabling the notion of a risk pool, no single insurance company would be affected more than any other. An efficient, public-based, state v. federal based non-governmental insurance oversight committee also needs to be formed in each state. It should be funded by mandatory contributions by insurance companies in proportion to their gross revenues.

The commission would be a bully pulpit and a "Consumer Reports" agency, so that insurance companies would conduct business in an ethical manner and thus avoid any midnight deals, or windfall profit deals permitted against the public. Watchdogs are necessary for corporations to have the right to exist. With nobody watching, profit is the only motivation.

Chapter 3 Temporary Insurance Safety Net

There when you need it?

If there are temporary issues in insurance coverage, no matter what the cause, for these short durations, a desirable solution is just around the corner. For example, for those Obamacare people who right now are collecting stipends and paying little to nothing for health care, Medicaid can be the temporary buffer between these folks and no coverage.

Of course, our lawmakers would need to quickly come up with a recommended solution which IMHO would not be government getting more involved. I am sure President Trump would be on this hot potato before the press even knew it could be an issue.

Often, normal temporary insurance issues occur when people are between jobs and we all know COBRA is too expensive. That's when a short-term Medicaid arrangement, very much in the spirit of unemployment compensation, would do the trick nicely.

Unlike unemployment compensation, the insurance plan would not be free, unless employers or former might volunteer to pay the Medicaid for a period of time. And, yes, we should ask them for help.

An overarching accountability system is a prerequisite to making all this work. In this instance, if the person's net worth were not enough to pay for the insurance, then the person would get a form of Medicaid insurance aligned with unemployment compensation for the duration of their term of unemployment.

Since there is no “free lunch,” a database “in the sky” run by doctors or those non-governmental entities that have universal trust, would record the Medicaid expense in the individual's accountability ledger.

If the person instead opted for a derivative of the EMTALA via a clinic-like system, then the healthcare costs (rather than the "Medicaid Insurance Costs") would be applied to the ledger. In either case, the amount due, again, would be like a loan and tracked for life. When the individual is back on his or her feet, they can pay back the loan for the insurance/ healthcare services.

I would suggest that for those who never become well off, we collect 1% to 10% of their income from any source. The percentage will depend on what they can afford but would never be less than 1%.

Though the cost for this would be accounted in the individual's ledger, and it would be expected to be paid when the individual is less needy, there would be no nasty collection agencies involved to intimidate. There would be accountability and yet, nobody would harass anybody in this program in the fashion of today's debt collectors—such as the despicable student debt collectors.

In several other of my books as well as this one, I suggest that there really is no free lunch. So, anybody who may have read one of my books in the past might want to scream at me to remind me that I believe there is no free lunch. I am not getting soft. There is still no free lunch. It is a puzzle to me that, at least theoretically, EMTALA users are expected to pay for their services eventually, but Medicaid users get a freebie on us for which nobody ever asks to be paid.

My perspective is that nothing from government should be free, since it is from the people's treasury. It is not from the sky or a

benevolent plant someplace, and it is not produced from the waste of the engines of the Starship Enterprise. There is no poof magic. This book, however, is about healthcare accountability only.

Pay the rent!

In the current scenario, hospitals are permitted to hound their insurance patients ad infinitum for EMTALA amounts due, but Medicaid patients, solely because they were able to achieve the grand prize, the "health access card," do not have to pay into the current system -- ever. No government agency is commissioned to track the amount or to try to collect the Medicaid insurance cost for what the Medicaid recipients cost the system? Why is that?

One of the excuses you might hear is that Medicaid benefits vary by state and have complicated rules, so a lot depends on many facts that are difficult to discern. Like Donald Trump, I believe that if there is a will; there is a way. States should get together with representatives from all fifty states and grind out the rudiments of a national plan, still implemented by the states that eliminates all the complicated rules. The federal government can sweeten the pie for states that are cooperative in solving the problem.

It is the way it is because people have needed help and there are so many crooked lawmakers, who have had no problem buying their votes by giving eternal care from your pocket book or wallet or both. There is no free lunch in any of the suggestions made in this book. Of course, bona fide charitable organizations should continue to be able to offer free assistance to anybody. The US government is not a charity. Now, do you feel better? So, how do we do this?

Enhanced Medicaid -- a real help

An enhanced Medicaid could relax the income guidelines a bit, and would not insist that people exhaust all their assets to participate. There might be instances in which Medicaid could put a claim on assets to prevent them from being sold without the amount owed being repaid.

But, nobody should have to liquidate their homes or family heirlooms in order to be eligible. Additionally, they should not have to liquidate their lives to pay the bill, given reasonable time periods and at minimum, achievable repayment amounts. Nothing new is every perfect. That is fair. If you want fair, that is fair. Fair is not getting a free lunch forever.

Unmarried adults would automatically qualify if they met the income criteria. The current system encourages unwed mothers. This would plug a big hole in the current Medicaid law. Because Medicaid would be somewhat easier to get, many American EMTALA users would want to begin to be serviced by Medicaid (as noted previously medical providers believe that this number is already large). But Medicaid, just as EMTALA, would not be free. There would be no free lunch. A record would be kept and compared every year automatically to income.

Electronic Account/ Accountability Record

For this all to work, we would need to implement something that I have labeled the National Electronic Account/ Accountability Record (EAR) that would be very similar in concept to an Electronic Health Record. Another effective name could be Personal Accountability Record. For this book, we will refer to the idea as the EAR system and the individual account record as the EAR.

The purpose of the EAR would be to capture the bills and the payments and hold the net balance of anybody who has not paid a qualified health bill, such as EMTALA, a Medicaid or CHIP co pay, or a Medicaid "premium," or any cost that has been picked up by taxpayers, typically through government. Healthcare is not free. Insurance is not free. It costs the provider to be able to provide the service and it costs the public to pay for those who do not pay.

Just like today's EMTALA, an enhanced version of EMTALA as well as an enhanced Medicaid would not be free. It might seem free when you get the service just like a new TV seems free until the Credit Card bill comes in. If you are a sharpie like I think you are, since you are reading this book, you noticed that the term, Electronic Account/ Accountability Record was shortened to EAR so that it could piggy back on some of the efforts already going on for Electronic Health Records (EHR). http://en.wikipedia.org/wiki/Electronic_health_record.

For now, let's say that an Electronic Health Record (EHR) is an electronic version of a patients full medical history, that is a cumulative database from the data maintained by all medical services providers for a given patient over time. It may include all the key administrative clinical data relevant to that persons care under all providers.

It would also include demographics, progress notes, problems, medications, etc. It is something that would be stored in a huge database in the sky accessible to all medical providers—hospitals, image labs, doctors' offices, etc. Medical providers would have the ability to update a patient database with new visit, new prescription, and other vital information.

An Electronic Medical Record, or EMR is a derivative of the term medical record. It is an electronic health record for sure but it is germane only to one provider practice. This record is different for each doctor or hospital or lab that you have ever

visited. They keep their own records. When you visited your family doctor for example, back in the days when they were not automated, they had a thin folder of papers which was your records for their practice. It was called the Medical Record. Over time, the paper in the folder grew.

Over time, more papers were added and eventually the folder was one inch and then two inches and sometimes three inches thick. Since you can always visit a doctor without your family doctor's permission or knowledge, this record would not have all provers' information in it.

When your doctor automated his or her practice, they scanned the more current papers into what is now called an Electronic Medical Record. They then implemented what is called a practice management system which provided the software to update their new electronic records.

Over time, these records are uploaded to the big database in the sky with a record for each person whoever was a patient anyplace in the US. This central repository would maintain the Electronic Health Record of every citizen in the US, and perhaps ultimately the world.

Enhanced Medicaid safety net

Today, everybody is entitled to EMTALA, but theoretically at least only select individuals meet the criteria for Medicaid—based on rules of individual states. Again, the supposition regarding Medicaid is that there are more on the program than the actual rules permit. I learned this by speaking with ER doctors and other medical personnel.

This Enhanced Medicaid safety net for Medicaid then would be very much like a loan. Actually, it would be more like a student loan without the grabby collectors involved. There would be no more outright grants for healthcare and perhaps other notions

such as corporate welfare, or individual welfare from the federal government.

I have not evaluated it as a solution for college subsidies, regular welfare, SSI, or other programs, in which no individual currently pays. However, it ought to work fine. Though I am not for income redistribution for the sake of equality, a certain social safety net level would help our society in a myriad of different ways. The idea always should be that the beneficiary pays the amount “loaned” back some day. Thus, it is tracked.

The health insurance "loan" would be just like a grant, however, until you were ready to pay it back. It would reflect the value of the implied Medicaid "Premium." It would not be onerous like credit card debt, and it actually would not be as bad as a Sallie Mae education loan in which they call and call and call until you have to change your phone number.

It would be a loan though, perhaps never to be paid back in practice but with the expectation that it would be paid. There would always be a record of the loan forever, but there would be no bill collector per se. I suspect there could be ways to develop incentives for people to pay their bills when they are able, but I will leave that to the sociologists. From my perspective, the important thing right now is that we account for it, and we enable input in the form of charges, payments, and outputs such as bills and inquiry results.

So, instead of a grant or a Medicaid payment to a hospital that you never have to pay back, you would get automatic catastrophic insurance for no apparent charge and during the periods in which Medicaid supplies your insurance, a predetermined Medicaid Insurance fee (basically a premium) would be added to your account, in something called an Electronic Account / Accountability Record (EAR).

The EAR is explained in detail in later chapters. You can choose to pay it back immediately when you are back on your feet, or you can make payments. But if you are incapable of paying normal payments, perhaps when you become a millionaire, you will choose to pay that "loan" back all at once. Why would you not?

I presume that nobody in the transition phase would be on Medicaid for any great length of time. That would be the intention. It would be only until you got back on your feet. Would you ever have to pay back the loan? Yes, you would. I have not done the math because it is complicated and I do not have access to complete information, but I figure that everybody will pay back something to whichever pot from which they got the money. I would expect that a normal payout range would be from 1% to 10% of the balance per year with a very low interest rate. Lower percentages could be negotiated based on solid criteria. Nobody should pay less than a certain amount per years such as $100.00. But, we'll let the experts figure that out.

Everybody pays

Everybody would pay. Though it may sound silly, I would suggest that even those on welfare would and should pay, perhaps as little as $10.00 or 1 % to as much as 3% or some other token amount per month, so that everybody knows in their own heart that there is no free healthcare or health insurance lunch. Getting those who are helped by the program to be accustomed to paying back is part of the psychology of ever getting paid.

Surely, while somebody is collecting unemployment benefits, the expanded Medicaid would cover them so there is no trauma. However, even with an individual collecting unemployment, there is still room for a very small token automatic payment that can be made by the individual from his or her unemployment proceeds. Nothing should appear to be free. In this way, for

everybody with a balance, who has any income whatsoever, at least token amounts are paid, so the fact that this is a debt is not lost on the individual.

What we all must remember here is that any money that is not paid back to the treasury eventually necessitates additional taxes to recover the funding. If we don't take some measures to attempt to collect the debts of those receiving free healthcare services, surely we will find ourselves in the proverbial bread lines as well.

In case you aren't aware, COBRA, or Consolidated Omnibus Budget Reconciliation Act, allows for former employees to continue to participate in their former employer's group health insurance, if the former employee pays the monthly premium, which, of course, is typically rather expensive, especially for someone who is a former employee with no new job.

The idea of simply repaying a debt incurred from health services is nothing like COBRA. Instead, it is something that everybody—even those in hard times—knows that while nothing is free. Nobody should be forced to make large payments on anything while they are down on their luck. The point, here, is that there is no free lunch and everybody must know that they must contribute and nobody is denied help or coverage, ever...and there is no rationing. Period. Since eventually more money would be available to pay providers, I can see this expanding and improving medical care in the US rather than weakening care or rationing care as in the Obama system.

Chapter 4 The Electronic Account/ Accountability Record - First Look!

Your personal accountability ledger in the sky

I had originally thought of suggesting the term, Electronic Billing Record as the name for the database in the sky. However, it had already been taken for another purpose. Physician Practice Management Systems (software) have their own subsystems called Electronic Billing and thus, they have Electronic Billing Records. So, now that you know what I am talking about, here is what I propose we call, it, "Electronic Account/ Accountability Records." or EAR. EAR then will mean:

- ✓ **Electronic** -- Stored in an Internet Accessible Database
- ✓ **Account** -- An account of what you owe
- ✓ **Accountability** -- All patients are accountable for their unpaid medical charges
- ✓ **Record** -- A group of facts about an individual

These records can be used to hold all the amounts owed for an individual "patient" from all health sources covered-- such as EMTALA and Medicaid, Assigned Risk, or whatever is deemed appropriate. A good systems engineer and more than likely a good team of such engineers would be required to design the overall system to be implemented incrementally.

The notion is very feasible and with today's technology it does not have to cost a zillion dollars. It should pay a large part of its cost itself, and eventually, as people get back on their feet and

begin to make payments, it can become a revenue generator for the people as a payback. As you may know, this money remains unaccounted today, and thus, all of it is uncollectible, even if one were inclined to pay it back.

Do you know of anybody who may have won the lottery, who then immediately writes a check to the government? If the government is not counting, asking, or demanding, logic suggests that the government is not going to get a dime.

The Electronic Account/ Accountability Record for an individual would live as long as the individual lives and at least the unpaid medical bills for the individual would live just as long. Any collection revenue provided from the EAR system would help provide funding for healthcare. All people would be expected to pay for their own healthcare -- legal and illegal, poor and rich, eventually. Of course, many would not be able to do so.

Of course, the record may live longer as there may be living relatives who just might be inclined to pay off the debt of a deceased former patient so that their lifetime EAR is clean.

The simplicity of the idea is as simple as "Field of Dreams," the movie. You may recall the ball park notion in the movie, and the catch line that has been used in many ways ever since, "If you build it, they will come." To match the catch line in that popular movie, the American health system can adopt a few catch lines such as the following:

- ✓ "If you keep track of it you will know what they owe."
- ✓ "If you know what they owe, you can bill them."
- ✓ "If you bill them, they will pay."

Pre-Billing

In the early days of computers, there were a lot of schemes that involved unscrupulous experts trying to increase their clandestine revenue. One such scheme, I called pre-billing. When I would instruct new data processing students, I used pre-billing as a ruse topic. I initially defined it as companies billing random customers before they ever received an order. Students were astonished as it was a prevarication. I did get their attention.

There actually was a real notion of pre-billing which meant that a copy of the order pick-list in a warehouse operation would also be used as the bill to the customer. This was called pre-billing because the bill was ready before the goods were even picked. Yes, I joked with my students that pre-billing meant that charlatans and rogues would send out bills randomly to companies. In other words, they billed before they provided a good or service.

Because the Accounts Payable (A/P) systems in the 1980's often were not fine-tuned, quite often the rogues and the charlatans would get a check from a reasonably high percentage of the companies that that they had illegally billed. Most companies did not check bills thoroughly like they do today. If they received a bill, they simply paid it. Many American households work the same way.

The point is that the A/P departments in companies had to receive a bill to pay it. Some did not have purchasing systems, which would have helped them know what they had ordered. Even if a company receives an illegitimate bill today, there is still some level of propensity for the company to pay it, though this does not happen often-- as much as it once did.

The same propensity exists in US households. When an official bill from the government—especially the government, shows up in the mail box, there is some chance that it would be paid regardless of what it is about.

Now think of all the folks who one day needed EMTALA or Medicaid, who went on to get a college degree and then became a millionaire or at least got comfortable in their lives. They would have full capabilities to pay even an old medical bill or the value of their Medicaid support, if there was a record of it. Today, nobody, even millionaires, pay because nobody keeps track of the bill. I was very surprised that we do not even track those whose bills we pay, whether or not we choose to bill them.

No poll tax

Today in America, everybody over 18 who is a citizen has a right to vote. Let's say we have the EAR system in place and we have an EAR record on file including every individual's EMTALA bills or unpaid Medicaid premiums. Without trying to create an elitist voting class, theoretically, we could explore permitting only those over 18 who are paying their minimum EAR balance regularly to vote.

I am not sure that it is a good idea as stated, but it would be good to have an incentive for all to pay back Medicaid or EMTALA when they can at least at a minimal level. The fact is there is a risk in a dependent society with fewer and fewer contributing and more and more taking from the system that conceivably at some point it would be the takers, and not the givers, who would be determining how much they get by voting. Just as a poll tax is not fair, citizens not pulling their fair share should not demand payments through the electoral process from anybody for any reason.

Please note that this is not a well-formed thought and it may have more trouble spots than positives in implementation. So I put it out, just as a thought, not as something that I would necessarily recommend. I'd love to have input on this. What do you think? Should people who only take from the system be able to vote for their favorite "give me more" politician?

Back to Enhanced Medicaid, EMTALA and the EAR

EMTALA payment losses to hospitals are not supposed to be reimbursable through the people's treasury. As all other forms of reimbursement have tightened their stipulations in recent times, it is virtually impossible for hospitals to bury the cost of unreimbursed EMTALA services. Admittedly, this has created a problem for a number of hospitals. Perhaps that is why a social worker is so ready to sign an EMTALA patient into the Medicaid system. They are incented to do what they can to “make” the patient eligible so the hospital ER can get paid easily from Medicaid. Otherwise hospitals go out of business—and many have.

EMTALA is an unfunded federal mandate. However, it cannot be ignored. It must be adhered to for a hospital to receive Medicare funding. When enacted, the provisions governing EMTALA-related care had been predicated on the ability of providers to cross-subsidize care for the uninsured through revenues from other payers and revenue sources.

Unfortunately, in practice as everybody is getting better at finding loopholes and closing them down, that source of funding EMTALA, through internal cost shifting, is an increasingly lacking financing strategy. Consequently, hospitals face growing economic pressure to pay the costs associated with managing their ER's.

With the EAR in an expanded EMTALA role, hospitals would have another opportunity for reimbursement after their own attempts to collect amounts due have failed. If Medicaid had expanded eligibility, coupled with EAR on the accountability side, patients would get both preventive and catastrophic care.

Providers, other than ERs in hospitals, just as today, would still have the ability to opt in or opt out of expanded Medicaid. The difference is that the bill (the amount you owe from your healthcare experience) would stay a permanent part of your record until it is paid.

As noted above, when a person dies, the EAR would have a claim on the estate, just as would a nursing home. There would be no federal government control of healthcare as none would be needed. There would be no "public" option as Medicaid is a state program and would remain so. Under no circumstances would the federal government control health care and that is one of the major advantages of the enhanced EMTALA, enhanced Medicaid, and the EAR database system *in the sky*.

Neither the government nor the insurance companies would get to hold the records or bank the payments from the EAR. Besides those who are in Medicaid and those who are covered by EMTALA, as noted above, with expanded Medicaid, those who lose their healthcare insurance temporarily, could automatically be eligible for this state run insurance for the same length of time as the maximum period of unemployment benefits. Just like everything else in life, there is no free lunch. When people get back on their feet again, they owe the EAR system.

The generous, beneficent, and magnanimous Are Welcome!

Those who are much better off than most of us will be encouraged by the system managers to contribute to the EAR fund as a charitable donation. This is a far more worthwhile idea than the government's latest call for donations to pay off the National Debt. I'll bet somebody gets their checkbook out and sends in a few bucks. Bill Gates and Warren Buffet combined could not make a dent in the National Debt.

The so-called "rich," with the adoption of the enhanced Medicaid and the EAR, at least theoretically, would not be taxed through the nose by Obamacare. Perhaps even Democrats, such as Joe Biden and Al Gore, could be treated for "Cheap VEEP" disease, and they too, along with a lot of other cheap Democrats, could be encouraged to donate to an EAR Trust Fund.

What a nice gesture for those who wanted to jack up everybody's taxes to pay for healthcare—to instead help pay off the EARs of some who have extreme health debt captured in their EAR accounts.

The original targets of all of the Obamacare tax hikes would find some humor in that instead of Extreme Makeover Home Edition, we could have Extreme Makeover EAR Edition. We could even have contests to see which politicians are the most and the least giving. And, of course, there is probably room for a "Grinch of the Year" award.

Any donor to EAR could pick specific people randomly or they could pick people they know, or they could apply their donations on account. At the end of each year, the "on account" donations would be applied to all EAR accounts in the same proportion, or the same amounts, and the EAR system would

pay those who had provided the service if they had not otherwise been reimbursed.

Enhanced Medicaid/ assigned risk summary

You can see that even without other improvements, by enabling assigned risk provisions for insurance carriers, strengthening Medicaid and initiating EARs and continuing the EMTALA efforts, we've got the 47 million or 30 million or 17 million or whatever the number, of uninsureds covered. More importantly, it avoids the threat that the federal government, arguably the least capable entity in the US to run any business, would take over a business enterprise totaling more than one sixth of our economy.

Even more importantly than that, the government would have no control of the health or health choices of all other Americans. Thanks, but no thanks. Additionally, those on Medicaid would be encouraged to get their own insurance through a private carrier as soon as their financial situation improved. Enhanced Medicaid is only temporary just like unemployment benefits. The debt would remain, but the collection of the debt would not be via the IRS or today's nasty bill collectors. It would be expected that those who had received public help would pay back the debt in time. There is no free lunch.

Medicaid today helps those Americans with children or those disabled who cannot pay. Individuals may be denied Medicaid for a number of reasons though in practice more get on Medicare than probably should by law. Today the entrance to Medicaid in many states requires the liquidation of assets. The EAR method is far more humane as patients are in essence being loaned the necessary funds for care and to an extent, they would be taking the equivalent of a "student loan," and a reverse mortgage against their assets.

I have already shown how EMTALA covers everybody and Medicaid covers more types of care as an insurance mechanism just for Americans. Many Americans under age 65 who, by the rules of their own states, cannot pay for healthcare, are sometimes entitled (under current law) to receive Medicaid for free. It really is up to the state.

So, if we are already paying the price for all people legal and illegal to be covered, one way or another, I keep coming back to the question, "Why is it that the lawmakers wanted to offer extra to the 30 million or 47 million (includes illegals) currently "uninsured?" Why is this such a big deal? Clearly the EAR notion and an enhanced Medicaid, in which personal responsibility for medical debt is written into the plan, is a better idea than crashing today's system. Donald Trump will repeal and replace Obamacare. Using EAR's and the information in this book will go a long way to making the new system great. The replacement of course should not add to the federal bureaucracy.

Chapter 5 Attributes of a Good Health Care Plan?

Danger: government can own the world

You may or may not know that the Obama government had already decided to keep your health records in a big "database in the sky" called electronic health records (EHR). Without consultation with the medical community, Obama decided to keep your records himself. Hopefully President Trump will change this. Obama actually did this in the stimulus bill He did not wait until Obamacare passed in 2010.

The danger of course is that the US Government has no HIPAA Law for itself. They started to steal your health records even before Obamacare passed. Nonetheless the EHR is a very good idea, with the single exception that none of us should want either the federal government or the insurance companies to hold any information about our health.

We need to fight to change this as the Stimulus Bill of February 2009 has already funded the government as the caretaker of our records. That's like inviting the fox and the weasel in as permanent guests of the hen house.

Both the EAR and the EHR need to be secure from government observation and intrusion. Government management is out of the question. So, the system itself needs to be under the control of people we trust. I would suggest that it be under the control of a consortium of doctors who practice health care today in the US. I do not trust AARP or the AMA. I would suggest that it be operated by a company that we can trust, such as IBM, which

has demonstrated business savvy and ingenuity. This company would, then, in turn report to the consortium. I would like to see a consortium of AMA and non-AMA doctors with no AMA leaders in charge of the Electronic Health / Accountability systems.

EAR: attribute for a good health plan?

Few Americans are for disrupting the status quo and creating garbage out of everybody's health plan. Yet, the Fall 2009 proposal that passed the House and the Senate bill that got its first test on November 21, 2009, and was signed into law in March 2010, all but promised to do exactly that. One could conclude that there were so many bad things in the original five bills that started the mess that the people would be more than willing to accept any plan that showed even slightly more progress. Just because it's not the worst plan ever, doesn't mean it's the best either!

By simply employing an enhanced EAR system to catalog healthcare debits, credits, and balances, and listening to the needs of the people, we could easily manage to tweak our current healthcare/ health insurance system so that it would be mostly self-sustaining and all inclusive. This could have been managed without completely destroying a system, only to spend years and trillions of dollars arguing over every minute detail of building a brand-new system.

A good national health initiative including EHR and EAR, run by doctors, would provide access to healthcare at a price that most could afford, and those who could not afford the health care would have an eternal bill in their EAR that they can pay when they are able. Either way, our national treasury still comes out ahead, maybe even it will be black ink someday!

Does common sense have a role?

Though the purpose of this book is accountability, the road to better accountability can be paved with some other good ideas. Like all spiritual individuals who believe in God, I would advocate promoting common sense reforms to healthcare, which would help make it of higher quality and more affordable for all while reducing substantially the number of uninsured Americans. Nothing good happens overnight, so I would not suggest that anything be done in a hurry, but rather after lots of discussion, lots of town meetings, and lots of prayer.

More importantly, I repeat that it should be done slowly and incrementally, one step at a time. The first legislation I would want passed regarding record keeping would be a change to HIPAA that eliminated health record access by insurance companies and that it would be illegal for insurance or financial companies to keep medical records. This would be followed quickly by the EAR system and the EHR system with emphasis on paperwork and error reduction and accountability, and minimal government intervention.

All the while we are making it better, we must first remember, at all times, that despite the rhetoric on the hard left, nobody in the US is without access to healthcare. So, we should try to improve EMTALA and enhance Medicaid, while adding the obligation to pay for both of these systems (via the EAR).

There are few, in America, who do not think the Republicans mucked up their opportunity to drive the US further up the path of prosperity over the first six of the Bush years. Their record was less than adequate. Democrats had been in full control during the last two years of the Bush Administration and Barack Hussein Obama became the people's choice in 2008, as he offered his promise of "change." Eight years later in 2017, health care is on the verge of collapse. Thankfully, President Trump is

addressing this and hopefully, the notion of an EAR is in the works.

The change that people were looking for, and the intrusive change that Obama and Congress brought upon us, was not the change for which America was indeed searching. As a Democrat, I saw the former President much too willing to enter my life, and tell me I can begin to leave my brain at home. Mr. O was ready to take care of everything. I wanted Mr. O stay in Washington or go to Cambridge every now and then for a beer...and up to the Vineyard. Just stay out of here.

My Democrat friends and I do not all see eye to eye on many things, but there are a few conservative Democrats out there who are as, in a word, *disgusted,* as the Republicans with what is happening to the country. If you have learned the art of critical thinking, you know that these Obama happenings were not occurring for the good of the country. They did, however, help Obama and his powerful intimidating administration. IMHO, it would have not been much longer that that the change would have been irreversible. I believe Donald J. Trump, our new president has the will and the smarts to make it all right.

This magic moment

Unfortunately, the bulk of the Democrats, are still caught up in "this magic moment," and these Democrats have not made it from the campaign floor back to the living room, or maybe more accurately, the kitchen table covered in bills. They are still enamored with the former POTUS and if the "man" or Hillary were for it, they are too. It's that simple. Going on three months after the election, they still praise Dem leaders and they have not stopped their whining.

My favorite quote to describe this phenomenon is from General George S. Patton: "When everybody is thinking the same thing, somebody is not thinking." A number of my Democrat friends

got so entrenched into Obama thought, that it was like a Vulcan mind meld, and they still have not let go. It does not serve our country well.

For years, the corrupt media and the Democrats were still fighting George Bush's memory., They got Obamacare passed anyway. That is a story for another day. With President Trump, at the helm the nightmare is slowly ending.

The cries of socialism from power-seekers are a ruse --

With the notions of the EHR/ EAR system briefly discussed above, EMTALA and Medicaid with a few bumps in improvement and a few requests for payment have the potential to stop the cries of the federal government/ socialists to take over healthcare. My own speculation is that even if it was a Cadillac plan, and cost absolutely nothing, the socialist power grabbers, when Barack Obama was in charge, would have been happy to take it all over and drive the whole thing into the sea. Then, of course, a real communist state could be formed and perhaps for a small minority, life would not be that bad.

So, is it possible that, without the disruptive Obamacare, we can improve these two vital programs (EMTALA and Medicaid) just a bit as noted in prior discussions, along with the assigned risk notion to handle the insurance company issues? It would do us well to cover the 30/47 million uninsured today (if they really exist) and also take care of those who temporarily lose insurance. All of the insurance company gripes would also disappear. That is an awful lot of good for such modest changes, without bringing in the former Commander in Chief to become Chief Medical Officer.

Some thoughts on COBRA

Unless the business itself is in a hardship/ bankruptcy situation, the employer could pay for one month COBRA for each year a dismissed employee was with the company up to perhaps one full year. An extra tax credit may help make this notion more palatable for employers. Overall, it is fair and just like unemployment compensation, companies with volatile employment records can begin to set up funds to cover those contingencies.

In situations in which COBRA cannot work for one reason or another, the Enhanced Medicaid described earlier (with EAR) should be an option. Of course, I am not advocating a "free lunch." The bill is due and payable, but the patient always lives.

Nobody should be denied health coverage. But the costs must be paid back. Perhaps the employers can contribute to the EAR fund once it is established. And EMTALA is the finest safety net from a patient perspective that has ever been devised. It should be made more palatable for the care providers.

We are certainly smart enough, in this country, to figure out a way to handle this the best way, undoing the crashed system known today as Obamacare. A sidebar to the unemployment fund itself is probably the best idea for transitioning workers. Just like the unemployment compensation fund, there needs to be a similar fund for unemployment health insurance. Since all people are covered to an extent in today's healthcare safety net, making the net stronger and better is a far more worthwhile goal than getting out the steel ball, the wrecking crane, and the bulldozer, before we find out whether the new building is even designed to work.

Chapter 6 States Are Better Problem Solvers than the Feds

Idaho and other states make good examples

You may have first heard of the notion of the EHR/ EAR system in this book, but states are on to solving problems typically long before the federal government even knows there is a problem. More than seven years ago, Idaho built something they call the Idaho Health Data Exchange and they saw it as a way of bringing down care costs in Idaho. It is an electronic network connecting over 1,000 Idaho physicians, with 30 hospitals and 10 data centers.

Can you imagine how upset the feds are that a state with a potato as its state flower is upstaging the Administration in giving people the best that they can get at the least cost? If only that were the feds' objective with Obamacare in 2010, the debate would be over. Instead of being too busy with a scheme for full control, the federal government should have been moving forward incrementally. Idaho this time, not Iowa, would have won the debate.

In Idaho, Idaho businesses are not too happy about the state of healthcare costs, and businesses have been the scapegoat, according to some who are not happy with all that goes well in Idaho. They cite 120% bumps in insurance premiums over the last ten years. Welcome to my world. Nothing is cheap today. Isn't that life? But, yes, we can make it better.

Idaho businesses see a big part of the problem being caused by poor communication between providers, patients and insurers.

Think again about the EHR/ EAR system that I propose, as well as any others that do not permit the federal government to own and run it all. The EHR/ EAR system is the essence of information sharing and knowing all costs and where the costs come from. Knowing the facts enables you to deal with the facts and this can help all people take more of a personal responsibility for their health.

Do you recall how much everybody in the old E.F. Hutton ads paid attention when they knew the conversation included the "best broker" at the time according to the advertisement? "When E.F. Hutton Speaks, everybody listens."

Idaho ranked best on health care costs

In a February 2009 report from the Small Business and Entrepreneurship Council, the SBE ranked Idaho as the top state in regards to providing health care for small businesses. This is an important list for a number of reasons. The first reason is that the SBE's mission is to educate elected officials, policy makers, business leaders and the public to advance initiatives that enhance the environment for entrepreneurship, business start-up and growth.

Don't you find it interesting that Idaho is number 1? Illinois is ranked # 20 and Massachusetts is wiping up the rear at # 51. The only chance for Massachusetts to move up is if Washington DC chooses not to be ranked as a "state."

Illinois, as you know, is the former home of President Barack Obama. It is ranked in the middle at # 20. Then, of course, there is good ole Massachusetts, which has a statewide healthcare plan. They are ranked at 51. If you are like me, you must wonder why nobody ever checked out Idaho as a national model.

The SBE ranks the best and worst states when it comes to policies affecting healthcare costs for small businesses. Since small businesses provide the jobs for the economy as large corporations choose India or China to find their "American Workers," this group, which represents 70,000 businesses in the US, is as good as it gets to find a national barometer for potential success.

Not to rub it in but, topping the SBE list for providing the most business friendly policies when it comes to health care is Idaho; followed by Utah; Iowa; and Michigan tied for fourth with Ohio; and Alaska, rounding out the top five. South Carolina, South Dakota, Pennsylvania, Nebraska and Wyoming complete the top 10. We'll recheck Michigan in a few years as it is in the list because of strong unions. Besides dead last Massachusetts, the least friendly states for small business and healthcare are California and Vermont, Connecticut, Maine, and Washington. The District of Columbia as noted was included and it did fine at # 12.

No Virginia, there are not 51 states but stats for Washington DC are kept separately.

Obamacare gag order

As noted several times, this is not a book-form attack ad against Obamacare, which is already on its way to the repeal barn. On January 4, even before the inauguration of President Trump, The Senate passed a procedural motion 51-48 to begin debate on a budget resolution that will result in overhauling Obamacare. To me, that means repeal.

This book is about individual accountability in healthcare, and I have not lost the theme. The fact is that the bulk of the American people do not want the government in control of any of their lives.

So, on the way to more specificity on the EAR/ EHR database in the sky, let's talk a bit about the conditions under which it would be approved and built. They were not favorable as the Obama administration had preferred to create dependency. There was little regard for helping the less fortunate and the poor participate in something that would give them self-respect and healthcare, instead of just healthcare for free on someone else's (our) dime.

You may recall, way back in October 2009, that the White House (WH) got really upset that insurance companies across the nation felt they had a right to tell their clients what to expect and not to expect from the Obama Medicare cuts. A number of conservative media outlets, including Lou Dobbs Tonight (hopefully, also tomorrow – but Lou was kicked off MSNBC) offered that the Obama administration had attempted to use its regulatory power to suppress criticism of its Obamacare plan. Outrageous, but true.

Health insurers, such as Stellman from Idaho, have a reason to be angry because the big government Medicaid office, which handles Medicaid and Medicare, instructed all insurance companies in late 2009, to shut the "h... up" about the truths in Obamacare. The agency is the now infamous "CMS," which conjures up the same negatives as the IRS if you are a doctor, who wishes to help patients, and your overarching ambition is not to "suck up" to the government just so your reimbursement rate can be higher than the doctor down the street.

I mean the US government's ministers of propaganda said to cease sending what it called “misleading” information about the healthcare bill to clients.

Insurers were burning about what clearly was a White House attempt to control information about possible Medicare cuts. The White House simply did not want seniors to know the truth as Congress and the WH had a few little plans about healthcare

that would be uncomfortable to discuss openly. For all the years since Obamacare passed, it has been one lie after another.

Though EARs and EHRs and accountability may, by some accounts, have nothing to do with Senior Citizen politics, the reason the care for seniors (Medicare) is predicted to go down the tubes is so the government can rob Peter (Seniors) to pay Paul (17% or whatever the percentage really is who have no health insurance). The real irony is that these representatives actually think we are not watching. They actually think thought they would get reelected again. Finding a Democrat in Congress or in state governments today requires a lot of effort and it is getting worse.

Let me give you just one example of how Democrats are paying the price for Obamacare etc. Just a little over two years after they used their control of the state House, state Senate, and governor's mansion to pass a bevy of progressive policies—one of the nation's highest minimum wages, tighter gun laws, and huge spending on rural broadband internet, to name a few—Democrats will be the minority party in both chambers of the Minnesota legislature next year. The people are beginning to realize the power of their vote.

To add a little muscle to what had just been a "gentle suggestion, from the friendly White House, regarding the "don't tell seniors what we are really up to" initiative, the WH used its power of intimidation. The culprit this time was Humana, a well-respected insurance company that does a lot of Medicare Advantage business. Obama expressed his disdain for Medicare Advantage even though 33% or more of seniors subscribe to its "advantages." So, since Obama was doing away with a prime business product of Humana, the company felt obliged to tell its clients, (seniors) that Medicare Advantage was going away. Something immediately hit the fan.

Follow the money

There was a lot of speculation that the Medicare Advantage Program would also cut into AARP profits from its own insurance activities and AARP was a big backer of Obama and Obamacare. Because AARP was positioned to benefit substantially from a financial perspective if there was no Medicare Advantage, there were suggestions on the floor that said AARP sold out to the Obamacare notions because the AARP guys all had the chance to be millionaires.

It has nothing to do with what is good for seniors. Looks like AARP was playing the role of Judas in the great healthcare debate. With friends like AARP, seniors need no enemies.

You may know that the American Medical Association represents only about 17% of doctors today, as doctors have been getting sick of the AMA's money grubbing practices. They see a big windfall for AMA administrators and so the AMA endorsement of Obamacare has nothing to do with the 80% of the doctors who are not members of the AMA. Follow the money and there is a lot involved. Yes, I think we have found a second Judas for seniors and the rest of us.

Humana is an AARP competitor

Poor Humana (OK they are doing quite well for now) violated the secrecy pact demanded by the White House by giving a 100% accurate account to its clients of what was happening to its Medicare clients overall, and Medicare Advantage, in particular. Humana met Rahm Emanuel and David Axelrod face on. Neither was pleased and that is why unconfirmed reports indicate that Humana is now facing a full-scale government audit. The moral of the story is that it is not nice to fool Big Brother (aka the Government).

The White House vigorously warned insurers and healthcare companies they could face legal action if they spread what the White House called "misinformation about the healthcare bill." That sure sounded like a gag order. No, it could not be, this is not Russia! At least yet!

Would it not be nice to find an independent agency, such as the consortium of doctors and other health providers that I would like to see involved in the EHR/ EAR system, to advise the American people on healthcare options rather than have government gag orders? I bet this group could give us all about ten different generic insurance plans and approximate costs so that we have a barometer with which to gauge the quality of our insurance.

That would go a long way in helping us know how good our plans can be and how much they should cost.

Chapter 7 Are There Simple Steps that Can Be Taken?

Deport Pelosi --- to where?

Some of my friends suggested that nothing can be done that would help the country unless Nancy Pelosi was no longer in the game as the Speaker of the House. Well, this is our seventh year without Pelosi and Obamacare is still the law of the land—though barely. If she were gone, they said as far back as in 2009, America might have a fighting chance.

Knowing that people in my own extended family use EMTALA as their only form of healthcare insurance is not necessarily the best feeling. But, guess what? It does not mean that it is not worth the funds that prevent a potential health catastrophe. More and more young people use EMTALA because it is that good of a deal, compared with any other alternatives open to them.

So, as a first step, how about accepting that EMTALA is a great safety net and Medicaid offers the certified poor an opportunity to have the healthcare they need. EMTALA and Medicaid are used today by those legal and illegal. Yes, illegal aliens get Medicaid. No, it is not permitted by law.

Those not willing to lie get EMTALA. It is that simple, but this 800-pound gorilla in the room is something nobody wants to discuss. I bring this up because there is nobody who would be denied care. No, they do not have the $15,000.00 policy that I had to pay out of pocket on top of what IBM pays. Nor do they have to pay the $15,000.00. Yes, that is more than half of my

IBM pension, if that matters to anyone wanting to give my policy to somebody who never earned it. If healthcare were an unlimited commodity, the answers would be different. The fact is if there are scarce resources, those who have accumulated the wax for the candles, through hard work, get the light.

My beef is that so many want to denigrate the services of EMTALA and Medicaid and I want to laud them. Everybody gets taken care of and there is a major incentive for those in the 17% to get a job and get their own health insurance rather than taking from those who have worked so hard.

Options

There are a lot of options perhaps with more dignity than EMTALA, but I am not sure exactly how much dignity I want to deliver to those who choose not to participate in the job market. Once we know what we have, such as the EMTALA and Medicaid offerings, which are phenomenally substantial and unlike the Pelosi version of Medicare, there is no gatekeeper for them, we can make other things work.

How about starting more and more clinics, such as the alternate ERs or like those run by Medicaid in some states? For Americans, the EMTALA and Medicaid systems do need to be strengthened. A reasonable objective would be to build an adjunct system to EMTALA so that those who otherwise would go to an expensive ER for normal healthcare or preventive treatment could instead go to an ER-like-clinic or a Medicaid clinic or a charitable pro-bono clinic, after making an appointment. And, yes, why should they not get preventative care?

I would like to see wireless systems built for the poor so that they could get free access to the Internet and have a real doctor assigned for health concerns, and as an initial screener for preventive care. Each patient or registrant should get a

refurbished, software ready PC from a university or from a high school or other government institution. They should be able to participate in forums, and be able to send/ receive emails to screeners who can direct their inquiries to someone whose mission is to give the best answer. Think of all the trees that would be saved!

Here's an example. Somebody says something like this in an email:

> I am having trouble breathing. I have a lump on the back of my neck that was not there two weeks ago, and every day it becomes more difficult to breathe. What would you suggest Doctor?

Quite frankly for that, if I had no other means of healthcare, I would show up at the ER. That is an emergency. My wife in my case (yep, I was the patient) tracked down our Doctor Patrick Kerrigan, who met me in his office on a day off because he is a great doctor. He spent about an hour and a half treating me. Finally, I can write again, though some might argue that point.

For lots of other notions, however, email and direct submission techniques from a PC for symptoms, to someone affiliated with the primary care giver, would be effective. It would not cost a ton either. Telemedicine needs to be exploited to the extent that it can be effective.

Preventive care/ cost of technology

If the government thinks that everybody should be getting pap tests or colonoscopies or mammograms or whatever test you think is appropriate to count as preventive care, then those would be done by techies with their results read by physicians with computer guidance systems. Build tons of these things. Put self-service models in amusement parks, theatres, grocery stores, banks, hospitals, etc. If I can use K-mart's instant checkout, I can give myself an MRI in a souped-up no risk self-serve

environment. Technology can bring that forth and it would cost lots less as the units could be deployed everywhere.

Ironically after I wrote the above paragraph in the first look at this issue in late November 2009, the government began coming out with strange guidelines for women's health which seemed willing to place a societal cost on saving women from cancer. Again, these bureaucrats, hired since the February 2009 Stimulus Bill, must do something. I would suggest give them a few years off. They are dangerous.

If the cost of MRIs and Digital X-rays are too much for the system to handle, then the government, on all of our behalf, should buy 500% more of those units and pay for improvements so that fewer technicians are required to get results. Perhaps a universal health card, or a state driver's license could be a trigger for a self-service MRI, along with a bar-coded, or an RFID, doctor's order. Maybe the doctor's order should not be a requirement if we can get the self-service units to be inexpensive like the blood-pressure units we find just about everywhere. Tell me why not?

Perhaps nobody wants to check out at K-mart or Wal-Mart in the non-monitored lane, but if you can pick up a free MRI from the state by placing your ID and the doctor's orders into the device, that sounds pretty good to me.

How about adding more processors and more independent digital scanners in these huge behemoth units that cost so much and are such a cost burden on the healthcare system? They are miserably slow. I do not know what the problem is, but I have tuned large computers for years. There are too few scanners and too few processors that can independently collect the data. If I am wrong on the real problem and the processors are tuned up and more scanners are added, I can tell you one thing for sure. The MRI will take a lot less time.

Why not add processors and scanners to the individual units and make it worthwhile for the companies to design and develop such technology. For years, I wondered why we would not take a few of the best of the best people and invite them to one of the on-time daily Obama Press Conferences? Why not have these wonderful scientists, who let's say, develop a 30 second MRI or perhaps a crystal-clear ultrasound immediate image, gain prestige and notoriety for their efforts? Why should we the people not honor those who make our lives better? Right now, we do not even know who they are.

Unrewarded competency

In everything I see today, the government wants to punish the best and the brightest and tell them to be mediocre and equal to everybody else. Why not herald their specialness? They can achieve results that no one else achieves. Eventually, with no help from Uncle Sam, or the American people per se, these bests of the best learn that they can avoid government imposed starvation wages after medical school by being excellent in everything they do. Why not tell them right from the start they are important and permit them to become rich while leveraging their skills for the good of the people?

As the saying goes, my family never had a pot to tinkle in. That about does it. We were not Rockefellers or Carnegies or Kennedys. We loved being regular people. We did not expect anything from government. Several us got to take advantage of federal school loans and university scholarships and grants and plain old loans to move our lives forward. The Rockefellers and Carnegies and Kennedys had some family finances to help them through. Indirectly any aid that my family got came from families like the Rockefellers or Carnegies or Kennedys. We are now considered middle class. We are not against the poor in any way, as that was who we were, though we may never have known it.

The middle class pays a lot of taxes, but nowhere close to the Rockefellers or Carnegies or Kennedys. This generation and several before in the middle class understand what it is like to be "poor." If instead of being offered scholarships for achievement, we were offered subsistence compensation and free healthcare, and we had not yet achieved enough to realize we were poor, how many of us would take the booty rather than bet on the come (come bet in craps)?

Nobody knows what they know until they know it! The societal happenings in the 1960s 'til now helped poor people achieve rather than take from the system. This was a good investment of all the people, whether they be Kelly's or Rockefellers or Carnegies or Kennedys.

So, the point is there is no free lunch. After being demonized for decades, the rich in America (and yes, they are still rich), at times called the Robber Barons, decided that it would be good to tap into the natural talent of the American citizen and help them get through college and become a more productive member of society. Small investments in education created a phenomenon of talent that corporations and government and unions and private enterprises gobbled up and could not get enough of. This was good for all.

Today, there appears to be little emphasis on excellence and a lot on what excellent items will be given to "me" by the government. My father and I would both say, "expect nothing and you will not be disappointed!"

EMTALA assures, in my opinion that nobody who needs care will die. Why is that not enough? What turn of the century immigrant had such an assurance? Which seventy-year-old out there ever heard his parents talk about what the government had given them, other than perhaps one of those five-pound yellow-orange surplus cheese boxes? Yes, though it was somewhat like

Kraft Velveeta, but more firm, just like Velveeta, it was darn good.

Thank the entrepreneurs who built America and accept, if you have chosen not to work, that you have a good deal in EMTALA. If you've never experienced Velveeta or "Relief Cheese," you have probably missed something. And, if you are lucky to have a clever social worker, you may even have Medicaid, and I know that if you have an even better social worker, you are on SSI.

I ask the same society that knows what I know, "Where are the breakaway incentives for all the good people trapped in these marginalizing funks?" Why can excellence no longer trump all? Why can the best of the best no longer be heralded as such? We can't blame it on the Bossa Nova, but we can blame it on a system that rewards lack of effort over lots of effort.

A better system

Unlike the current procedure, which demands just about nothing from the receivers of care, it would also help to have the EAR (Electronic Account/ Accountability Record) system in place. In this system, nobody gets an intentional free ride. It would also help to have an EMR (Electronic Medical Record)/ EHR (Electronic Health Record) system in place for efficiency and cost control.

That's not the end of the story. It would also help that individuals were trained to be self-sufficient—enough that they worked as hard looking for a job as they did once they got a job.

There is no free lunch. Even in EMTALA, lunch might be served. Even so, there is always a "days late" cashier. EMTALA expects that you will pay, but over time those expectations have dimmed a bit. Many escape the payment net and feel they have bilked the system, and think that it is okay. It is not okay.

When the bills come in from EMTALA, if the patient has even given their correct identification, today the bills become used for campfire fodder. If the patient is illegal, the bills are sent to somebody else's address. Even though hospitals are burdened by EMTALA and many have gone out of business because of it, the American part of this is that nothing gets in the way of the patient getting care. Yes, the EMTALA system needs to be paid back at some time in the future, but the patient lives. Eventually, that which is written off in the short-term should be uploaded to the EAR system and never forgotten.

American EMTALA and/ or Medicaid patients would have real records kept in the most efficient IT setting that HIT (Health Information Technology) software can provide. All of this would provide better care and because of the added efficiency, quality care could be delivered at the least possible cost. And because of the EAR system, introduced in this book, (you heard it here first folks), those grateful to have received lifesaving care, as soon as they can, will have the opportunity to thank their neighbors by paying them back.

No Garbage

Without disrupting the status quo and creating garbage out of everybody's health insurance as the current Obamacare legislation did, a little tweak and a few surgically accurate small snips would have worked a lot better than the Affordable Health Care Act! But, of course there is no better news than President Trump's plans to repeal it ASAP!

Did the Obamacare agenda really include healthcare?

Looking logically, as I have been trained in my computer years with IBM, it seems to me that a real health plan would have

looked lots different. It would have provided access to multiple healthcare insurance options at various prices that most could afford. Everybody would agree that nobody should make a buck off the backs of the poor. However, the only real big change, in Obamacare, is that control of an individual's health changed from the person to Obama. I am so glad he is gone.

The former President of the US wanted so much to control all of his subjects (in my humble opinion) that he was prepared to run yet another show. If there is some other value in the Pelosi November 7, 2009 legislation other than Obama controlling the whole shebang, it sure was never obvious.

To force everybody in America to change their health insurance to satisfy one huge ego was shameful. Too bad that the "blue dog" Democrats in the House did not have enough guts to fight for their constituents. They chose to follow Pelosi rather than their own constituents on her anti-American, anti-capitalist, socialist, redistribution agenda. Blue as they might have been at one time, my vote helped assure that they were gone in 2010. Yet their Republican Replacements chose to be wimps and not take on the master planner.

Without Obamacare, a.k.a. the great health destroyer of 2010, those who could not afford any healthcare policy would still get care via an enhanced EMTALA or an enhanced Medicaid plan, as we have been outlining in detail so far in this book. Anybody who would intentionally parch the breadbasket of the US (California Farmland) to save a minnow, surely will not listen to a word I write. I do not run the risk of ever meeting Ms. Pelosi, and I am quite fine with that.

The real conundrum, can politicians get credit?

As discussed, the invoice for all "free" healthcare, provided by enhanced EMTALA or enhanced Medicaid, would come due immediately upon the individual recovering and being

financially capable. Payments would be reasonably small based on income but there would be small payments even for those on welfare. Eventually a good many invoices from such individuals would be paid using the EAR system, run by a consortium of doctors and patients.

Those who cannot pay their "insurance bill" would be given the insurance as a loan automatically on their EAR. Again, it would eventually be paid back by the individual. Remember, there is no free lunch. In the "loan" scenario, there is no politician who gets credit for giving anybody anything other than a loan.

If you examine the EAR system on its merits, it is not at all bad. Its only drawback seems to be that there would be no Federal Government CEO required. For the Obama team, before time ran out on them, this was not tolerable as there would be no Obamacare trophy available, if EAR approaches were permitted to supplant Obamacare. Worse yet, can you imagine how uncomfortable it would be if somebody actually discovered that Obamacare itself is unnecessary? With an EAR, EMTALA and an enhanced Medicaid, who needs it.

Donald Trump as President is lifting all those unnecessary constraints.

I am conservative, but not exactly like Barry Goldwater, and I am not a Republican, nor am I aspiring to become one. Mr. Goldwater ran against Lyndon Johnson in the 1960's. I am not going to run for President, but I may run for Congress again.

Though I heard it often, Goldwater's message did not reach me and impact me as a teenager who loved JFK and wanted to believe that LBJ would provide more of the same JFK-ness if needed. I remember hearing and seeing that catch phrase in the Goldwater campaign: "In your heart, you know he's right." I knew then that I wanted nothing to do with Goldwater because in my heart, back then, I thought he was full of crap. I do feel

differently at this time about Goldwater. In my heart, I am positive Trump is right.

In your heart, you know this is right

I am more knowing now than then, and much more conservative. JFK was the best, as many people today see Obama. Regarding the EAR proposition, I keep thinking that if I say something profound like, "In your heart, you know the EAR, the *no-free-lunch-system* is right," there's going to be a young whip like my former self calling me on it. I would have called out any of JFK's detractors when I was a teen. But, the fact is, "in your heart, you know I am right." Obamacare must go!

Does this hurt the opportunity of an American individual to receive healthcare? Picture a doctor's office shutting out any patient. I can't. Everybody's life should be saved post haste. There should be no hesitation or delay in health service. Likewise, nobody else should have to pay for that person's trip to the dispensary. Hopefully their life is saved even if they can never afford to pay it back.

Once an individual's life is saved, society's obligation is satisfied. Society has done its duty. Now, what of the duty of the individual who is now alive and not dead? Does it not make a lot of sense that accounting for what is owed is a huge prerequisite to ever having the possibility of receiving payment? Is it not that simple? As a computer expert for so long, it hurts and I have a hard time believing that as a country, we have no idea who we help today and how much we help them. One might be able to forgive not keeping track of this in days gone by.

Suppose the enhanced Medicaid system was able to bill those it helps tomorrow. Suppose that in a certain percentage of cases, the patient would be pleased to pay the insurance bill. Of course, we are talking about after getting well and being financially back

on their feet. My fear, even in this positive scenario, is that guys like Barack Obama, Nancy Pelosi, Harry Reid, and a lot more Democrats than you would ever imagine would say "no, it's free... it was never meant to be paid back."

I think their posture would be that we should not ever be permitted to collect and that it is insulting to keep a record of how much any taker for any reason owes the American Public. I hope I am wrong. Their fear, of course is that this notion might work and perhaps more people would choose to be self-reliant rather than government-dependent.

What do you think? Should there be a totally free and even secret lunch? Suppose that every other day, you buy the same stranger's lunch, and suppose that on the even days, you buy your lunch and he buys his own lunch. He never buys nor offers to buy your lunch but instead, on those even days, he hides and eats his lunch in private.

Is something wrong with that scenario? Suppose at the end of one particular day and every day thereafter, you see this stranger being picked up in a huge limo with a driver dressed to the nines. The driver serves him a nice glass of champagne as he enters the limo and then the driver closes his door and drives away with the poor person comfortable in the back. Would that be ok? What would not be ok?

At what point, does that make something wrong with the original scenario? Should people be given the opportunity to be able to be nice back to those who have been nice to them? Should they pay their own way at a time when they can?

Should we expect that they will? Should they pay back the community when they can for the non-charitable assistance they receive from the community? Of course, I am talking about the dollars the government confiscates from citizens to run its programs and then gives freely to strangers. Should there be an

implied obligation to pay back when your time has come, and you are no longer needy? Or is it proper for those who are helped to think it is an entitlement and thus it never needs to be paid back? Who would that have been that gave these particular "poor people" such an entitlement?

Who pays for the free lunch?

In the real world, that which is called a free lunch means that somebody else has given up a lunch or its equivalent. When government coercion is involved, through the innocuous term, "taxation," this is simply not fair. In Robinson Crusoe's world, fiscal goodness meant, "he didn't borrow or lend." The Platters would say, "To each, his own." Why not keep track of what everybody takes from the system? It does not mean that we will ever collect, but why not try to collect some day? What is right is right!

Too many interested third parties

In a simple plan to keep track of what those who at one time were needy take from society, what is the downside? Those who benefit can pay back the amount taken when they are no longer needy. The problem or downside is that there are many interested third parties involved. I would bet there would be no problem on the patient’s' side. Patients just want to get well and stay well.

So, what is the downside? Just one really big thing! It does not serve the purposes of the special interests with huge agendas. They have a lot of political capital invested in Obama-style health insurance. People helping themselves might mean big government is not needed, and then, what would become of our fine politicians?

Moreover, keeping track of what the once needy owe the public does not push forward the need for a single payer health

insurance system (government controlled) as passed, in March 2010. In the future: Whatever the agenda-driven Democrats call it right now, the objective, according to Michael Moore, liberal protagonist, is a single payer system. Next time you hear the term, "single payer system," if you love the Democrat party more than your family's health then say "aye." But, if you love your family and your life, say "no" as quickly as you can.

It may be called a public option, a consumer option, a Pelosi option, a Hillary option, or whatever, and it leads to a single payer system. Based on your own knowledge of government and the needs of the power brokers, do you think that those who want power, not healthcare, want any distractions to their takeover plan? Now, we have come full circle and we are back to our discussion of the EAR system.

Do you think they would really go for keeping track of the cost of enhanced Medicaid or enhanced EMTALA or any of their "gifts" of your money to other citizens or non-citizens? Do you think when politicians give the gift of your money to someone other than you that they want you to get the credit? Where would the politicians who promised their voters something for nothing go if all of a sudden, the recipients of the politician's gifts had to pay the gifts back when they were able? That's why the "loan idea" will not fly in the Congress of the United States. For the people's sake, however, it should.

Those who benefit would love to help

Despite the politicians, the reality is that there are few millionaires among us today who were once on EMTALA or Medicaid. But there are some. The sin is that we do not even know who they are. Should we not know this at some level? They took from the public treasury to make themselves well and now they are in the position to help twenty or fifty others. Should they help?

Because no accountability records have ever been kept, we cannot even ask them for a little help, even if they were inclined to give it. More than likely, they do not even know the dollar value of what they received, and I bet as good Americans, they would be tickled to help if asked.

We can send a man to the moon and did so first--way back in 1969 and still we do not know who we have helped with medical services. I think they would pay their bill if we were to bill them. I would also bet that there are a number of hundred-thousandaires and multiple ten-thousandaires who may now feel just fine, who we the people helped at one time, who otherwise may have died. I think they would have no problem paying their health bill from even ten or twenty years ago if we knew the amount and would permit small payments at a time. But, we do not know even know who they are.

Commonsense reforms, not a takeover

Like all spiritual individuals who believe in God, I would advocate promoting common sense reforms that help make health care more affordable for all, to reduce the number of uninsured Americans, and to increase the quality of all health care. Nothing good happens overnight so I would not suggest that anything be done in a hurry, but rather after lots of discussion, lots more town meetings, and lots of prayer.

As I have said more than a small number of times so far in this book, we must first remember that despite the rhetoric on the hard left, nobody in the US is without health care. With just a few tweaks rather than a full dismantling, the care could be even better than the care that Obamacare might yield and fit would be fairer, with no gatekeepers. This whole pretend crisis was simply an Obama power grab. Trump will be deep-sixing it soon and I can't wait.

Chapter 8 Manual Records in Healthcare

Electronic medical records start with paper folders

You've been there. It may have changed very recently but you remember how it was if it has changed. You put your one hour of waiting time in the crowded Doctor's Office waiting room. Then, you get your chance. You are invited into one of many examining rooms. The nurse comes by and she takes your vitals.

She isn't crying so you figure you are OK. She has this huge folder in front of her inches thick and she asks if you are still taking vitamin C, Echinacea, blood pressure meds, and so on and you give her the information as requested. She takes this huge folder with her, adds or corrects some information, and then sticks it on the front part of the door in a slip holder for the doctor.

You hear the doctor grab it and a few minutes later he's in the room with that big folder. He tells you your blood pressure is OK and he tells you about any other metric that is new—especially those not within the limits. He goes over your blood work, and hopefully he is smiling at the end of the soliloquy. All the while he is writing in this record. It is very convenient for him and the staff has done most of the setup "prep" work. Then, you have your conversation about the current visit.

What he has in that big folder is his private medical record of you. Your doctor is a medical provider. In the healthcare system of today with rigid definitions, with no adjectives, your

doctor is a "provider." A medical record is something that is held by a particular medical provider on your behalf. If you go to a chiropractor or you get X-rays or you have a separate Urologist, or Gynecologist, or you have been to a hospital, it may be helpful to know that they too have a record for you. They all call their record about you—"your medical record." Most of them are not inclined to share their physical records with the others unless requested, and then they send copies.

Folder automation = EMR

In each setting, the data is unique to that medical services "provider," though your family doctor may have summaries of most of the other providers' materials in your medical record "folder." Your family doctor, in many scenarios, is the quarterback for you in the health game. He or she knows all about your health.

If your doctor has recently automated his or her practice, then your paper records may have been scanned and this new electronic record is technically called an *Electronic Medical Record* (EMR). In today's modern offices, the doctor updates it via a station in the exam room, a laptop or perhaps a little tablet unit or a handheld unit with a pen-like stylus or some other means.

So, there are MRs, which are medical records in each provider's office, which document everything about you, at least pertaining to that specific doctor. You remember the heavy clipboards, and punishing details required before the first step beyond the waiting room/ treatment boundary in your first visit and sometimes when you change insurance companies. You filled them out and they filed them. That is your provider's manual medical record.

Manual to electronic -- not easy

When doctors' offices, or other offices that hold a medical record about you, are in transition from the manual "big folder" method

to the EMR, they are migrating all of the paper data from the big manila folder (s). Even so, that folder, representing all your encounters with that provider, plus those that perhaps your former provider (doctor) passed on to the new doctor (provider), may still be there for quite a while. They would not delete them but would typically archive them in case they need them in the future.

It does take a tremendously long time to migrate (years). You may see the folder for a while as an adjunct to the EMR, if the provider chooses to migrate piecemeal, and thus the physical folder may keep getting smaller depending on how much progress is made in the migration to the EMR.

What may be happening is that your doctor's staff is scanning information into your electronic medical record (EMR) as part of the practice management system application software package used by your doctor. The formal definition of an Electronic Medical Record (EMR) therefore is a medical record in digital format that typically works with special software that your healthcare provider has purchased. Transitions are painful for everybody, and efficiencies are often compromised during the transition and during the first months and sometimes the first few years of live operation.

Just as the company for which you work may have a computer based system to handle material requirements planning in the manufacturing shop, or to create journals and general ledgers in a CPA shop, or to register students in an Academic Environment, or provide a Web based order entry system in a sales shop, computers can also be quite effective in a doctor’s office, clinic, hospital, or other health provider. There are also other records available in medical software, such as billing records, appointment records, and other records kept for specific purposes.

More than likely at the end of the migration process, your doctor's staff will not have scanned everything into your EMR. They will make global decisions for example to take just the last several years and leave the rest of the paper in an archive rarely retrieved. They may also make value decisions such as scanning your last MRI no matter how old it is if you are being treated for that particular malady at the time.

HIT and Medical Informatics, in most vases, sre good

EMRs are part of a growing discipline called Health Information Technology (HIT), which some also call Medical Informatics. A simple definition of medical informatics is "Computer applications in medical care." An academic definition of Medical Informatics takes a little more time to read and makes quite a few more points:

> "Medical Informatics is an emerging discipline that has been defined as the study, invention, and implementation of structures and algorithms to improve communication, understanding and management of medical information. The end objective of biomedical informatics is the coalescing of data, knowledge, and the tools necessary to apply that data and knowledge in the decision-making process, at the time and place that a decision needs to be made. The focus on the structures and algorithms necessary to manipulate the information separates Biomedical Informatics from other medical disciplines where information content is the focus."
> http://computerscience.lakeheadu.ca/wp/?pg=38

An even better definition of Medical Informatics comes from William Hersh, Department of Medical Informatics & Clinical Epidemiology, Oregon Health & Science University, Portland,

OR, USA. Hersh defines biomedical and health informatics (BMHI) or health and biomedical informatics as:

> "The optimal use of information, often aided by the use of technology, to improve individual health, health care, public health, and biomedical research."

Health Information Technology

I have had the pleasure of teaching Health Information Technology (HIT) at King's College in Wilkes-Barre, PA as part of their Master's Degree Program. King's offers a Master of Science in Health Care Administration, which is designed to provide students with the professional knowledge and the management skills necessary to be effective and socially responsible leaders in regional, national, and global health services systems. HIT is a sub discipline in such a program.

HIT thus is the application of computers and technology in healthcare settings and is thus, a subset of Healthcare Administration and a superset of Medical Informatics. At the time that I wrote the first version of this book which was apolitical, I also served as Assistant Professor in Business and Information Technology at Marywood University.

By reason of my twenty-three years' experience with IBM;, my years as a computer consultant; and the 101 books and numerous technical articles that I have written, I am considered by many as an expert in the computer industry.

As advanced as the many pieces of Health Information Technology used in the healthcare field may be, the field itself, in terms of provider automation (doctors, small clinics, etc.,) is far behind the times when compared to other "industries." However, it is catching up as witnessed by the number of small practices with some form of automation. Consider the banking

industry for a second. No matter how small a branch office may be or how small an individual bank or credit union may be, they have a major investment in technology that can be seen at the teller window and in the back-office as well as those consumer phenomena, the automated teller machines (ATM).

Additionally, there is a major worldwide network connecting all banks and thus all ATM's and the system in place for processing checks is both exhaustive and extremely efficient. A few Presidents and I agree on this one:

> "We have the most inefficient healthcare system imaginable. We're still using paper. Nurses can't read the prescriptions that doctors have written out. Why wouldn't we want to put that on an electronic medical record that will reduce error rates, reduce our long-term costs of healthcare, and create jobs right now?"
>
> - US President Barack Obama, February 9, 2009
> [It has gotten better but it is still behind the times. BK]
>
> "We will make wider use of electronic records and other health information technology to help control costs and reduce dangerous medical errors. President George W. Bush, 2006 State of the Union Address Jan 31, 2006.

Chapter 9 Bush Mandate: EMR/ EHR in Ten Years

Preparing for the big database *in the sky*

In 2004, President Bush announced the goal of ubiquitous Electronic Medical Records (EMR) and Electronic Health Records (EHR) in 10 years. That means it should have been fully functional by 2014. It is not functional at all. So far, like the computer systems behind Obamacare, it has been a bust.

EHR and EMR are often thought of as the same, though they are different in scope. For now, you may think of them as being quite similar in structure. The fact that they would be similar in structure means than an IT Designer would have lots of reusable material if they solved one or the other database design.

Bush's idea was right on the mark years ago, but it is unlikely that we will achieve that goal of 2014 for a lot of reasons that are too big to get into in this book. Former President Obama also is for EMRs and EHRs. Let me say that I think the idea is very attainable, but not without grassroots level work and a commitment to make it happen.

Government implementers are surely a way to slow it down. Having government procuring departments working over their friends in software companies is also an impediment to getting work done with unnecessary expense.

EHR systems are designed to store data accurately and to capture the state of a patient across time. It eliminates the need to track down a patient's previous paper medical records and assists in ensuring data is accurate and legible. It can reduce risk

of data replication as there is only one modifiable file, which means the file is more likely up to date, and decreases risk of lost paperwork. Like most things in life, it is easier said than done.

President Bush had the right idea that his initiative would move the country forward towards EMR/ EHRs. An EHR in the big database in the sky is impossible to achieve without ordinary physicians' offices having practice management computer systems that automate EMR's and provide facilities to upload data to EHRs.

Bush's government IT professionals apparently let him down. They did the same for Obama also. Over Obama's eight years nobody was capable of getting the Bush notion implemented but Obama was a proponent. I think he lost interest.

They IT folks did not even seem to care whether it was done right or done at all. President Bush always offered some pick-a-part commentary when he spoke on important matters. Here is a little part of a Bush speech about his big health initiative, which was to be the movement to take EMR/EHRs off the wish list and into the doctor's offices by 2014.

> "On the research side, we're the best -- we're coming up with more innovative ways to saves lives and to treat patients, but when you think about the providers' side, we're kind of still in the buggy era."

I cannot know whether Bush knew he was right on the "bugs" or not. The fact is that most small doctor's offices do not have practice management computer systems or have partial implementations, and thus they have nothing to link into a big health “database in the sky.”

When I teach my MBA Class on Health Information Technology, my students immediately pick up on the value of an

EMR and even more so, an EHR and a new notion called a Personal Health Record (PHR). We will look at these, in reasonable detail, shortly. To bring this home to all of the readers, I found a nice little quote, in a blog on the Internet, shortly after the George Bush announcement.

Value of EHR

I separated this quote from its author as its author more than likely does not want to be in this book. This quote is not from George Bush. It is from a blogging American Citizen, who will remain nameless. Somebody on the Internet knows intrinsically from experience that an EMR/ EHR would be beneficial to patients, though it is uncomfortable to doctors to use in its present anemic implementation state.

> "I am all for standardizing medical records. When I go to a hospital ER, I shouldn't have to repeat my medical history 5 times or more. Just give them my number and they can pull my medical records from the Internet from a secure server.
>
> If I am in the pain of 10 on a 1 to 10 scale, chances are I may not be able to give them the level of detail on my past medical history needed to treat me. What if I pass out from the pain or am unable to tell them my medical history?
>
> Mistakes got made, prescription medicine that I needed was denied because a hospital doctor did not ok it or verify that I needed it. My wife bringing a prescription bottle with my name on it was not enough. An electronic medical record could show that my primary care doctor prescribed me the medicine so it is ok for the hospital to give it to me. I happen to have high blood pressure, GERD, and colitis, without my medicine for them, they can get out of control and in the case of high blood pressure, even kill me. I see this as a major problem that can be solved with electronic records"

The blogger got it right. He lists many of the reasons why an EHR would be very helpful to the American public when they become patients in any health provider setting.

How does President Obama feel about President Bush's 2014 plan?

Without giving President Bush any credit, President Obama fully endorses the ideas of President Bush and the 2014 deadline. In fact, the language of the 2009 Stimulus Bill specifically targeted the year 2014, just as the Bush mandate. Obama seemingly has put real teeth into his plan. The target was not met and is still a way's away. The teeth Obama put into the program however, are designed to bite every American, unfortunately as his bill, like everything else that he does, goes too far and impacts the freedom of Americans, as well as our privacy. But if it helped President Obama, would that not be enough? Hmmmm!

Yes, of course we should really care.

Chapter 10 Stimulus Bill Created a Health Bureaucracy

Surprise -- The takeover bureaucracy is funded

Under the secrecy of the Stimulus Bill, that marvelous 1071 page piece of legislation rammed through in February 2009 without anybody taking time to read it, Congress and the President took a big swipe at nationalizing health insurance at the database records level. This is not good and though many are unaware, it has been the law since early 2009, when the bill that the Republicans called the "Porkulus Bill" was overwhelmingly passed, with mostly Democrat participation.

Most Americans thought that the healthcare debate was continuing into Winter 2009, at least and of course the bill was passed in March 2010 and it has been stumbling to get to full implementation ever since.

The germane section of the Stimulus Bill for EHRs had already passed in February 2009. It set the stage financially for the grand takeover of the whole system that the hard left fully expected to have been completed by the end of 2009. Of course, the Bill, which passed in 2010, known as Obamacare has had problems being implemented and is still in terrible shape. President Trump has vowed to get rid of it because it hurts America and Americans.

Though most Americans thought that we were still debating the issue of a big database in the sky and many had tied it in with Obamacare. The bureaucracy for Obamacare passed it along with the Stimulus Bill while Obamacare still being debated.

That's how important it was for Obama to take over our health records. He wanted ultimate control of our health. Ordering that government would control our medical records was his first step in taking over full control of our health. Did you want to give your health up to the government?

It seems that some of the rationing bureaucrats got sick and tired of doing nothing productive and they decided to test their mettle against the American public in late November 2009 by publishing new guidelines for Mammograms and then for Pap tests. American Women rose up as expected and the White House blamed its bureaucracy when the heat was too hot to handle.

Yet, the bureaucracy had already shown its cards. This was not the end but the beginning. Healthcare even Medicare has been getting worse since that day. Colonoscopies, for example, which were once available every 5 years for example, are now ten years apart. There is a lot of time to get sick and die in between.

Some very controversial sections of the overall plan, that our slippery Congress and former President passed with the Stimulus Bill, includes a full administrative force to assure that federal government is in control with or without Obamacare. How is it possible that nobody noticed all that in the 1071 page stimulus (porkulus) bill that nobody read?

It looks like a little over 200 pages of the stimulus law's 1,071 pages deal with President Bush's EMR/ EHR project intended to provide full Electronic Health Records (EHR) by 2014. Obama has about 216 pages of "sneaky" stuff that actually provides the legal framework, and perhaps even a mandate, to collect your personal medical records, as well as those of every other American's, into a federally coordinated electronic database. Big brother!

The irony of the "porkulus" bill is that few people in America and the world, for that matter, even knew this aspect of EHRs had been funded. To show how real this is, some of the language of the new law is given in the paragraphs after the brief Q & A.

A Brief Q & A

Let's first ask a few simple questions, the answers to which are in the law:

Question 1: The law uses terms such as "qualified electronic health record." What does this term mean to the government?

Answer 1: The law says that a "qualified electronic health record means an electronic record of health-related information on an individual that -- (A) includes patient demographic and clinical health information, such as medical history and problems lists; and (B) has the capacity -- (i.) to provide clinical decision support; (ii.) to support physician order entry; (iii.) to capture and query information relevant to health care quality; and (iv) to exchange electronic health information with, and integrate such information from other sources."

Question 2: The law uses terms such as "enterprise integration." What does this term mean to the government?

Answer 2: The law says there is a mandate that your “electronic health record" (EHR) must be able to communicate with "other sources". It is this communication that helps us form the definition of "enterprise integration."

This term, the law says, "means the electronic linkage of health care providers, health plans, the government and other interested parties to enable electronic exchange and use of health information among all the components in the health care infrastructure in accordance with applicable law."

The law builds upon the existing bureaucracy that was created by President Bush. This is known as the "Office of the National Coordinator for Health Information Technology." The law is written so that this office is to put together a plan for building this system so that it achieves the "utilization of an electronic health record for each person in the United States by 2014."

Government controlled databases are a definite assault on our privacy

Though EHRs are an undeniably good thing, having the federal government in any way in charge of personal records is not a good thing. In a February 9, 2009, Bloomberg.com piece by former New York Lt. Gov. Betsy McCaughey, she chose to tell us more about this "Obama happening," which can best be described as a nasty assault on our privacy. It is much more than just EHRs.

> Obama and company have placed themselves in charge of "federally controlled health databases about citizens." These will contain the records of all Americans (no information on illegals is to be kept).

The stimulus incentives added a sinister provision that created this thing called the "Federal Coordinating Council for Comparative Effectiveness Research." Did you know about this? I did not know either until I did a lot of digging. The Mammogram and Pap test notions are their first works of "merit."

In other words, real dollars are already being spent on the Obama style of Obamacare because Obama and Pelosi and Reid agreed on facets of healthcare in the Stimulus Bill that neither

the people nor the Congress read before it was enacted. Yes, it is hard to believe but; believe it!

Government should not control private records

This new council is not innocuous and it can be far reaching in terms of who lives and who dies in the future. Mammograms and Pap tests are their first foray. Can it become a death panel? Absolutely!

Wait 'til they hit knee and hip replacements, tonsils, and dialysis! Already I see 80-year olds who are otherwise healthy whose kidneys begin to fail. Somehow, they are not getting dialysis—even a few times to help see if things can be cleared up. When did that happen? I got the feeling that we had a new our new Obamacare motto: "Get sick and die and save the country a buck!" I pray that Donald Trump assures this is ripped out of whatever is left from Obamacare after the repeal.

If you trust the government, this should be no problem for you. But, on the other hand, if you do not trust the government, then this is the type of takeover move that helps set the stage for the rationing panels and the death panels that healthcare hyperbole has brought us in 2009. But, is it hyperbole? McCaughey notes that this council

> "Sets the stage for the creation of a nationalized health-care system that engages in British-style rationing."

How does that make you feel? Can this mean anything if the Congress and the former President lose in their attempt to steal our healthcare system and replace it with their own? In a word, yes! Even if the Pelosi and Reid Bills, when combined, do not pass and thus the threat of formal socialized medicine for the United States is gone, it is not over. You see that in the 216

pages of the "Stimulus" bill, they already have enough control of our health records that all Americans need to be concerned. President Trump needs to repeal this aspect immediately along with Obamacare.

The backroom provisions of the socialization of the US healthcare systems are already in place and the government, with stimulus, not healthcare funding, is already staffing up and moving this thing forward. So, with nothing else, this law raises significant questions about your right to privacy and the right of doctors to practice medicine according to their best judgment.

Many thought the health records storage provider issue was a battle that was yet to come. The Army of Barack Obama has always been deceitful and it never intends to lose, no matter how many Americans choose to stand up against the charade.

There is nothing wrong intrinsically with EHRs and EMRs. What is wrong is that Nancy Pelosi, Harry Reid (now Chuck Schumer), and Barack Hussein Obama planned along with Hillary and Bill Clinton and perhaps some members of the Clinton Foundation to become the health database chieftains. Having government run the databases is an opportunity for the worst kind of corruption this country has ever seen. They know that. So, in 2009, they already funded it in the "porkulus bill."

Bush's plan was intended to be innocuous

When President Bush put together his mandate thirteen years ago, it was far more harmless than what Obama changed it into. Bush created a new bureaucracy at the time called the Office of the National Coordinator for Health Information Technology. Obama's law piggybacked on this bureaucracy to actually do the work of clamping down on Americans.

This group, already in place and funded by stimulus, had the mission of putting together a plan for building a system that

would achieves President Bush's objective of the "utilization of an electronic health record for each person in the United States by 2014." Of course, the time period has been extended indefinitely and nobody in the Administration discusses where the project is right now! This is partly good, but the federal government should not be in control of the data. As far as I can tell, the system is still not built, but Obama has had control of our health records for too many years already.

Doctors should be in control of the system which should be run by IBM in my opinion. IBM has not learned how to cheat. People trust practicing doctors. Government has proven it cannot be trusted by the mere enactment of this bill and the Obamacare charade in 2010.

By 2012, Americans had a chance to place a new President in office who was not solely for the collection of personal power. If Obama were defeated, these citizen health databases could have been freed from government control. Unfortunately, hard-core leftist Americans let a lot of regular Americans down. In 2017, Donald Trump is now the man for America and Americans. Many Americans are breathing easier.

President Bush did not spell out who would control the data. Insurance companies were preparing to control the data and this would be almost as bad as the government owning the data but not quite. Right now, insurance companies and the Administration are in cahoots.

In my HIT class over the last few years, my graduate students debated the topic and none were comfortable with the government or the insurance industry in control of the records. Everybody however, understood the intrinsic value of an EMR/ EHR system and an effective database in the sky.

Why are these databases of concern?

What does this really mean? To "speak in English," it means that President Obama and his trusty team of Czars intended to create a federally run electronic database exchange that includes every American's "medical history and problems lists." They hoped to turn it over to Hillary when Obama left office. What a surprise to them.

Like the Gecko with the crumpled dollar bill, you put it in the machine, say some magic words, and the medical record and medical issues of your worst enemies come to your PC for printing. That fact had a lot of believers in HIPAA very worried

Without extreme protection, everybody's medical records can be everywhere, but where they should be. Your employer will know all about your health and can fire you if you contract a major disease or if you have a nervous breakdown. Maybe the Obama czars will be culling the records to find who is loyal and not loyal to the President and perhaps they would leak your records to unfriendly sources.

This system had the potential to take all of the good parts of the HIPAA bill and nullify them de facto. But it would have bene good for the Obama regime as they would have the health records of all their political enemies and more control than the founders ever intended. President Trump must stop this as soon as possible and help create a consortium of honest doctors—not AMA big shots.

Don't worry; there was nothing in the law to make you give the government your information. But, to get payment from government, your doctors might have been coerced. It was a sinister notion but lots of what the former POTUS did was sinister. Obama offered doctors and other providers a higher

reimbursement rate if they provide your records. For what purpose?

In my HIT classes during the last few years, we were discussing how patients might be willing to comply with the "Bush Push" for EHRs by 2014 and now indefinitely. I would like to repeat that none of the students thought that it would be a good idea for the big hand of the government to force compliance. Making government the caretaker of your health information from the big database in the sky is like giving the fox the keys to the henhouse. If I used this analogy earlier, then since it fits so well, I have used it again.

Where does the patient data come from? - Surprise!

The Obama Stimulus Bill spends 77 pages to outline how to get your data. Doctors and hospitals are given an incentive to fork over your information. They actually were to make more money if they would go along to get along. The Obama system played on providers optimizing their reimbursement schedule from the "state." Can you really believe that this has been the law since 2009 already? Obama may already have your personal information loaded on some computer someplace. This sure was a "change," most Americans did not expect.

Doctors and hospitals must play ball

The hard facts in this new bill, already passed, are that if hospitals or doctors choose not to play ball, their rates of reimbursement will definitely go down. Mr. Obama plays to win. Thus, those who choose not to cooperate with the Administration get diminishing Medicare payments. Perhaps their "paperwork" is delayed and so their payments are delayed. Does this hit you in the gut yet? It should! Your freedoms have just been eroded without your permission.

The government finally has figured out a way to get your doctor to do something that you may not want him or her to do-- to send in your records to the government. You have no say in the matter. It is now the law. Congress voted for it already. It is done, but in 2016 we replace a lot of the breathing members of Congress as well as the President.

We had the distinct pleasure of electing one of the finest business problem solvers in the world as our President. That of course is Donald J. Trump. Now, our records must be secured and made available to the medical community for EHR purposes. The EHR will form the basis of the EAR for accountability purposes.

Yes, I am hoping that either Americans go after their Congressmen now for a repeal of at least this part of the Stimulus Bill but I would be happy to see an Executive order from President Trump.

The next part of this book discusses more about what an EMR and EHR actually is, why it could be good for you and how your information can be secure without the government being able to tap into it. While we may not spend any time in the next chapters suggesting that there are big issues for citizens, those previously discussed still stand. Take nothing for granted. Stay alert!

The best laid plans of mice and men gang aft agley. If Harry Reid (now Chuck Schumer), Nancy Pelosi or Barack Hussein Obama and people like them could be forced to exit the health records business, the notion of EMR and EHR would be very effective and can all of us be more, not less, healthy. Government control is never effective. Let's go ahead and explore the notion of a clean system of EMRs and EHRs, PHRs, and even EARs, without the cloud of government control or interference.

Chapter 11 What are EMRs and EHRs?

Evolution of automated record keeping

Because the EMR and EHR are hand in glove tied in with the EAR, let us review these notions again. In health informatics, an EMR is considered by some to be one of several types of electronic health records (EHR), but in general usage the terms EMR and EHR are used interchangeably by the general public. For most purposes, this is accurate.

I am going to tell you a little story now to set the stage for a discussion on the evolution of EMRs and EHRs. In 1969, when I was a young Systems Engineer working for IBM in upstate New York, my very first account was the A. Barton Hepburn Hospital in Ogdensburg. As an IBM Systems Engineer, my job was to install and implement their Patient Billing/ Accounts Receivable/ Revenue Accounting system. It ran on a 96-column card-based IBM System/3, which at the time had no disk drives installed even though it was "leading edge" for the day.

As an aside to this aside, Medicare was in its early years and was having a tough time dealing with waste and sometimes fraud. At this hospital, I observed that they always had a big population (census) explosion around the holidays. The food was better at holiday time and Ogdensburg is a cold, cold town in the winter.

So, according to the staff, their new patients got a few nights off the street and a few fine squares, all on Medicare. The early Medicare had few controls. The hospital got paid. The moral of this story is that without rules, people do figure out how to game the system.

Billing and accounts receivable were first

For ages, hospitals such as the small to mid-sized A. Barton Hepburn Hospital in Ogdensburg, have had Information Technology (IT) systems to help them run the business part of the institution. Multi-doctor clinics were next in getting their businesses automated as they were able to afford small business computers to add efficiencies to their practices.

In the early days, in clinics, hospitals and in other provider offices, it was rare to see anybody automating the full archive of patient records known as Medical Records, the basis for the EMR. Emphasis was always on billing and accounts receivable.

For each software package that existed or each analyst that designed a new hospital application system, the patient master record always had a different shape. It is the nature of the IT application creation game. In one system, the patient name might be defined as 50 letters (characters) long whereas in another, it might be thirty or forty-five.

In some systems, there might be sixty chunks of data kept, such as date of admission, date of service, code for service, etc. whereas in other software packages, there might be just thirty.

Because these records were all designed independently by analysts to support their private software, they were incompatible with the records in any other software package. It's the nature of the beast.

The incompatibility of records and software function is one of the major obstacles today for creating an effective and homogenous EHR database in the sky.

Early packages were mostly focused on collecting billing data, and printing the patient's bill rather than keeping any relevant medical history on the patient. Any medical history, such as

diagnosis, was kept merely to support the financial reimbursement requirement. Hospitals had huge departments known as Medical Records Departments, which were separate from they IT systems departments that used computers to run the hospital itself.

So, instead of automating medical records, most providers kept huge clinical archives in big paper folders in huge rooms. The paperwork (information) from each new admission or service was physically placed in the patient's record as the service was provided or as the patient was discharged. In essence, somebody opened up the manila and penda flex folders and added the new data paperwork.

Over time, the patient's electronic record for billing and collections, in most software, was enhanced to include some health information, not just the charges. Some did a job better than others and just like the databases in the practice management systems, since these add-on databases for health information were added independently, they too were and continue to be incompatible with other software packages.

We might go so far as to say that industry standard software packages themselves that might be used by fifty or more providers are incompatible with other industry standard software that might be used by 50 or 100 or a thousand other providers. That's because the cart came before the horse. There really were no industry standards for health practice management systems though we are evolving to get to that point. that.

Overall, it has been a slow process getting health care providers, even hospitals, to be fully automated with EMRs. It still is. Most small doctor's offices still, for the most part, use the big paper folder approach. Nobody has been able to convince doctors that it is a 100% better deal for them. Maybe in some ways right now, it is not but as technology improves, it sure will be.

Choice adds complexity

One of the problems for doctors especially, in my opinion, is that there are many different software packages from which to choose, and little helpful guidance. Even if a doctor were willing to automate, there is no globally recognized must-have package that they would or could select. They have to figure out which fits them best. Doctors are doctors and not IT specialists.

They do not want that aggravation. Lots of the packages they must evaluate when making the change are poorly designed and implemented but doctors do not know that out of the chute because they are doctors, not IT guys. When you can't convince somebody that something is good for them, the bets are that it is not good for them. Don't blame the doctors.

Just being a programmer or a Windows Certified Engineer does not make one knowledgeable in medical software. Doctors have many patients who are Windows Certified Engineers and yet, they are more than likely not using a bona fide practice management system. Unfortunately, that is not where Windows Certified Engineers excel. Many providers, such as larger clinics and hospitals, who have been in IT for the long haul, have had programmers building tailored programs specifically for their institutional needs for many years.

Consequently, there is little compatibility among providers and there has been no apparent advantage for software vendors to try to be uniform. Software providers are always trying to have a must-have feature that other software packages do not have. Trying to get all packages to conform to a standard would be anathema to the notion of competition.

Additionally, there has not ever been and never will be a bake-off, to my knowledge, in which medical services providers can

witness a host of software package vendors compete for prizes such as most functional, easiest to use, etc…

Just the opposite is true in this industry. Creating the same software that everybody else has does not give a vendor a marketing advantage. Software vendors cut their eye teeth trying to add a bell or whistle to their software to make it the best in the industry. Nobody has ever convinced anybody to buy "same." Consumers, naturally, like "better" much more than they like "same."

Best cannot be the "same" as everybody else's. And that is a major source of the problem with compatibility today. Doctors are caught up in a myriad of selections, most of which would probably be OK. But, which ones?

What is compatibility

Well, it means software packages and /or databases get along well together. Let's look at the problem just a bit differently now so you can get the full perspective of the dilemma, without having to be overwhelmed with technical facts.

The reason access to the electronic medical records at medical provider A (perhaps a doctor's office) and medical provider B (perhaps a radiology office) and medical provider C (perhaps a surgeon) are not more compatible with each other is that few, if any, standards exist.

The systems being used in one location don't necessarily “talk to” systems being used in other locations. One provider's database cannot be accessed by another’s because they were not designed to be sharable across multiple systems.

An IT practitioner on the Web came up with this metaphor for this problem. It is a good metaphor and gets the point across easier than by using IT terms:

> "In many ways the incompatibilities are like the struggle between Beta and VHS in the days when standards did not exist for videotape. If your movies were on Beta, you could not play them on a VHS machine. Moving to the current day the metaphor would be the struggle between HD-DVD and Blu-Ray as the platform for high definition playback."

And so, it is the same thing recording data into patients' medical records until a standard is developed. Record 1 in package 1 is not compatible with record 1 in package 2. Doctors recognize this chaos and lack of standards.

Consequently, doctors are not interested in moving their practices to technology that may change tomorrow. They do not want to spend the time and money on one system, only to learn later that another system ultimately was the one that became the industry or government standard. Then what?

There is a big difference though between the Beta or Blu-Ray systems and the Medical practice systems. There are as many as one hundred different EMR and practice management systems that each of the respective software companies who build the packages hope will become THE standard.

Each of these companies operates independently. So, until a standards agency, such as one of the following, takes on the responsibility for making order out of the HIT chaos, it will continue to be chaos.

- International Committee for Information Technology Standards (INCITS)
- American national standards institute (ANSI)
- International Standards Organization (ISO)
- Institute of Electrical and Electronic Engineers (IEEE)

When the standards are finally developed for Practice Management Systems which update EMRs and feed EHRs, then software companies will be able to tailor their packages to meet those standards or elect to merge with another vendor or simply go out of business.

Theoretically, it does not matter which software package is used as long as they are designed to be compatible at the database and transaction level. I admit this is easier sounding than it would be in practice. I have another temporary solution that I discuss later in the book.

Once compatibility is ironed out and software can be built to provide the function and all providers are on board, there is a next bugaboo to be faced. Further concerns and issues exist regarding the privacy and security of electronic patient health and medical records. We discussed many of these issues prior to this chapter. As noted, the key to privacy and security is to keep the government and the big insurance companies out of the database business. Enough said about that.

In Chapters 12 & 13, I offer a solution to the software chaos that the software vendors may not particularly like, but doctors and patients should like.

Technology malpractice?

In 2003, Michael S. Victoroff, MD wrote the following in Managed Care Magazine. Though this was 2003, not much progress has been made, even through today:

> “I'm the world's greatest evangelist for EMRs. I am on record repeatedly (here it is again) saying, 'In most settings today, a physician's failure to use an electronic medical record constitutes malpractice.' To this I would add, 'The most important challenge for primary care today is to solve the problem of capitalizing its informatics infrastructure.'”

Victoroff goes on to say it isn't likely:

> "You see, marketing medical record software to small groups is basically a futile exercise. The vendor has to recoup the costs of development, sales, configuration, installation, training, maintenance, and support. The products are generally so bad, and the competition, so aggressive, that there is no market share for a low cost product, even if it's terrific. The technology is fragile, vendors are evanescent, and the potential liabilities are dazzling.
>
> ...Despite the growing awareness of a few developers about what a decent EMR should be, and the availability of a handful of products that actually provide useful functions, the mainstream American doctor does not see the EMR as an essential tool for practice.
>
> When doctors do take on the challenge to gain the benefits of EMR, they are sometimes challenged again by their patients as the doctor patient eye contact is reduced and some patients get a sense of dissatisfaction about the whole new experience. Some are bold enough to challenge their doctors. A doctor needs to be prepared to tell the patient what is going on to make them feel better, not neglected.
>
> For example, a doctor can tell the patient that the computer is checking for possible drug interactions and it is creating a record that could be accessed by another doctor or clinician if she ended up in the hospital. The doctor could also relate that it was helping him create an accurate record of the care she is receiving and all this takes more time to assure the data is accurate."

In most cases, such a response would satisfy a patient and permit the doctor to continue the exam. It does help that patients are assured by their doctors that they are listening to the patient very

intently while they are recording or looking something up. As we all get accustomed to EMRs, we will be more in a position to appreciate EHRs.

How are we doing on EMRs overall?

As of 2016, the adoption of EMRs and other health information technology, such as computerized physician order entry (CPOE), has been substantial in the US. More than 90% of American hospitals are fully implemented in health information technology. Over 75% of primary care physicians use EMRs. The raw facts show that the majority of healthcare transactions in the US no longer take place on paper.

Despite problems such as software incompatibility, for years healthcare practitioners (doctors, lab techs, etc.) often invested more in golf clubs than in IT. For years, they spent little more than 2% of gross revenues on HIT, and much of this was spent for a set of PCs that are used for not much more than patient scheduling.

Health IT adoption among hospitals really took off in 2012, according to a new retrospective report from HIMSS Analytics and the Dorenfest Institute for Health Information, reflected in increasing IT budgets.

At the average facility, 2.74 percent of the total operating expenses came from the IT department in 2012, up from 2.39 percent in 2011 and 2.40 percent in 2010.

The investment is meager compared to other information intensive industries such as finance, which spend upwards of 10%. You get what you pay for. High Tech service does not make a patient feel the doctor's skill is any better or worse; but, a poorly functioning teller machine or ATM directly impacts our opinion on how good a bank is.

Speaking of banks, when have you been able to take a buck from an ATM and have your bank not know it? Chances are you can take a buck from your doctor's little treasury and nobody would ever notice. Though you want doctors to be more concerned about patients than running their offices, they would be able to do the former better if they spent a little more time on the latter.

In the US, the Bush administration was studying the development of standards for EMR interoperability as a front-running item on his national healthcare agenda. President Obama also has had EMRs and EHRs at the top of his agenda, and finally IT is taking off. President Trump's mission is to make the systems functional and take out the notion of government owned health records.

There are currently multiple competing vendors of EMR/ EHR systems, each selling a software suite that in most cases is not compatible with those of their competitors. Though this is a problem, it is not today's biggest problem. Lack of adoption and also acceptance, as discussed above, is the biggest problem; but, there are a number of others.

I won't bore you with them all. Later in this book, when we talk about the EAR in just a bit more detail (not nauseating detail), there will be more of a reason for doctor and other provider participation. So, before we get back on that, let's do a better job of describing the notion of an Electronic Health Record (EHR).

Electronic Health Record (EHR)

An Electronic Health Record (EHR) may very well be shaped exactly as an EMR. In fact, in a properly designed system, it would be a superset of an EMR. The databases should be shaped exactly the same and be fully compatible. Even if it is compatible, an EHR would contain a lifetime of patient information from all provider sources, and an EMR would ethe records kept by one provider.

When I say shaped exactly, picture one of those pre-printed forms with the boxes that we often check. In an EMR and an EHR, the diagnosis code can be the same number of spaces, the provider name can be the same number of spaces, the treatment code can be the same number of spaces, but if you have two forms for two different patients, the stuff inside (the data) such as diagnosis code, provider name, and treatment code would be different.

The term EHR refers to an individual patient's full lifetime medical record, in digital format. It helps to recall that an EMR has the data just from one provider. Each provider would be the owner of its own data. The individual provider might be a hospital, a clinic, an MRI-clinic, or your primary care doctor's office. In the four cases above, there would be four EMRs just for you -- one in each of those offices.

An EHR is one record that has the information from all of the providers combined. As you would expect, keeping all this data and producing a full EHR printout would be a major, major undertaking. EMRs give single providers a big headache. An EHR, as the sum total of all the EMRs in all of the places a patient has ever been is a much larger technical task to design and implement.

Yet, it is very doable with today's technology. From a patient perspective, it is your full and complete patient record, regardless of where or when the services for you were performed.

EHR systems coordinate the storage and retrieval of individual records with the aid of computers. EHRs are usually accessed via a personal computer, such as the doctor's PC, over a network. To be complete, it consists of each and every Electronic Medical Record that any provider has ever created for you and of course, which they uploaded to the big database *in*

the sky. Thus, to repeat for effect, it contains EMRs from many locations and/or sources. A variety of types of healthcare-related information may be stored and accessed in this way.

EHRs - The System *in the Sky*

Studies have shown that EHRs are even better than EMRs in reducing medical errors. They have also been shown to increase physician efficiency and reduce costs, as well as promote standardization of care.

So, technically, though multiple terms have been used to define electronic patient care records, with overlapping definitions, the terms Electronic Health Record (EHR) and Electronic Medical Record (EMR) are not the same. EHR as noted is a global concept and EMR is a discrete localized record.

Regardless of whether the system is called an EMR system or an EHR system, or a practice management system with HER capability, it will contain the same type of information. Sometimes it helps to say the same thing a few times so that the person learning can see the subject from multiple angles. Thank you for indulging me. Once I bored my HIT Masters students, I knew they had gotten the essence of the lesson. I hope you are bored.

Think of an electronic health record as a patient's health record that has been compiled into a digital format from many provider sources and it is stored in a central repository. As such, it is accessible for inquiry and update from all participating providers, as well as the patient. The shape of the data is the summation of all the types of data stored. The types of data stored in an electronic medical record and an electronic health record would include the following:

- Patient demographics.
- Medical history, examination and progress reports of health and illnesses.
- Medicine and allergy lists, and immunization status.
- Laboratory test results.
- Radiology images (X-rays, CTs, MRIs, etc.)
- Photographs, from endoscopy or laparoscopy or clinical photographs.
- Medication information, including side-effects and interactions.
- Evidence-based recommendations for specific medical conditions
- A record of appointments and other reminders.
- Billing records.
- Advanced directives, living wills, and health powers of attorney

As you can see, there is a tremendous amount of material that can be stored in an EMR/ EHR record, thereby giving the health practitioner a full look at a patient profile before engaging in diagnostic or surgical activities.

Additionally, queries using heuristics can be made against the EHR so that the doctor is alerted to critical items in the database files rather than having to read every single line in every record every time he or she sees a patient.

Advantages of electronic medical/ health records over paper pecords

Physical records usually require significant amounts of space to store them. When electronic records are built and physical "paper" records are no longer maintained, large amounts of physical storage space are no longer required. Paper, x-ray films, and other expensive physical media usage (and therefore cost) is thereby reduced during any migration to electronic record storage. And let’s not forget the environment!

Furthermore, there are other costs associated with paper records. When paper records are stored in different locations, collecting and transporting them, securely, to a single location for review by a healthcare provider, when needed for a patient diagnosis, is very time-consuming and expensive. When paper (or other types of) records are required in multiple locations at the same time, copying, faxing, and transporting costs are very significant, as are the concerns of HIPAA compliance, as it is cumbersome to be concerned about the privacy of records when a health emergency is in process.

Reminder: keep government out of database and determinations

To wrap up this chapter, it helps to be reminded that there is nothing intrinsically wrong with Presidents Bush and Obama mandating the use of EHRs by 2014, though the target was missed. The quest is continuing despite 2014 having come and gone.

EHRs have great value in treating patients. As noted previously, the government; is not the proper owner of medical records. The founding fathers went through great pains to prevent things that had happened in the Old World that affected people negatively to be able to happen easily in the New World. Government as the safekeeping team for private records is a bad idea from all directions.

What if the government were to know that you had cancer and though it looked good for you, your treatment would cost a lot more than some reconstructive surgeries on a number of ball players' elbows?

In addition to the government being in charge of the database, the Obama stimulus bill brought in a number of new

government employees to operate the health bureaucracy and prepare for our demise, even before Obamacare might pass.

Already this group has tried to save health-care money on women's health with reductions in reimbursements for Mammograms and Pap tests. This new government has no problem striking out a few lives rather than paying a few bucks to pay for keeping those lives alive. It is a cowardly new world out there.

Thomas Jefferson on Obamacare

Their mission is to assure government's health dollars are spent "wisely." I do like the idea that clinicians and medical personnel are available, so that every patient can and ought to be saved, rather than having a bunch of bureaucratic determinators in place to make all the health determinations on a cost basis.

Giving the government, especially with Barack Hussein Obama in charge, control over the keys to life and death, regardless of whether they are inclined to turn off the ignition or not, is something that Thomas Jefferson would not have done.

“Government can do something for the people only in proportion as it can do something to the people.”

"A democracy will cease when you take away from those who are willing to work and give to those who would not"

Find the message for today in this wonderful cartoon from the American Spectator: http://spectator.org/blog/2009/08/24/a-visit-from-the-founders:

Check that out:

Figure 11-1 Cartoon From American Spectator -- Seem Familiar???

A Visit from the Founders

By Yogi Love on 8.24.09 @ 6:04AM

Thomas Jefferson: "If people let the government decide what foods they eat and what medicines they take, their bodies will soon be in a sorry a state as the souls who live under tyranny."

There may be none greater than Jefferson in warning about government tyranny, but somehow many have forgotten his stark messages. It was way more than "trust, but verify!'

Reading between the lines, Jefferson admonished "do not trust government under any circumstances or when the axe falls, you will have a title you have tried to avoid all your life. That title is 'dummy,' and if it is you who gains the title, please remember, that I, your friend, told you so."

Life brings the great ones upon us, sometimes by accident. Thomas Sowell is a great one. His cautions about government out of control are as severe and stark as Jefferson's. From American Spectator, here are two paragraphs of Thomas Sowell on the eventuality of complacency:

> "Eternal vigilance is the price of freedom." We have heard that many times. What is also the price of freedom is the toleration of imperfections. If everything that is wrong with the world becomes a reason to turn more power over to some political savior, then freedom is going to erode away, while we are mindlessly repeating the catchwords of the hour, whether "change," "universal health care" or "social justice."
>
> If we can be so easily stampeded by rhetoric that neither the public nor the Congress can be bothered to read, much less analyze, bills making massive changes in medical care, then do not be surprised when life and death decisions about you or your family are taken out of your hands — and out of the hands of your doctor — and transferred to bureaucrats in Washington…"

These words could have come from Jefferson himself, but instead, they come from a man, who is a contemporary of us all, a great man who studies and analyzes and in the above two paragraphs has concluded that our democracy is very fragile and is in trouble, believe it or not. Check out some political cartoons that take a shot at explaining our situation in the US.

http://www.usnews.com/cartoons/healthcare-cartoons

Paper records = more mistakes

The good news is that paper records are going the way of the appendix. The bad news is that there are still an awful lot of paper health records.

Do you know of a doctor who has proper penmanship? Only a pharmacist apparently, can read a doctor's handwriting, and even they can't always read it. Maybe they go to a special school for that. Bits of paper and handwritten notes serving as medical records have been associated with poor legibility, a major cause of medical errors.

Pre-printed forms, standardization of abbreviations, and various standards for penmanship can encourage reliability, but again, what doctor, of which you are aware, has good penmanship? Electronic records, by definition, handle the standardization of forms, terminology and abbreviations, as well a clean method for data input and storage. Digitization standards also facilitate the collection of data for epidemiology and clinical studies, which are vital for future cures.

Many services are ordered, for patients, by their primary care physician (PCP). It helps that words like knee can be differentiated from hip and the word left can be discerned in typed words, as left is indeed much different than the word right. Cursive writing; however, begs the opposite.

Ordering x-rays and MRIs are not as much of a danger, but ordering surgical procedures in a cursive writing style may have other consequences. All cursive communication is flawed by its inherent inaccuracy. Physician's order entry is very important and the verdict is in on these disciplines. Electronic order entry and electronic records keeping have been found to reduce errors

formerly associated with handwritten documents, no matter how attractive the cursive style.

If there is a problem with entries in an EMR, there will be problems with entries in the EHR. That's why it is important for the EMR (local) and the EHR (in the sky) systems to be fully in synch and have the input well verified. Electronic systems can be designed to accept input in which mistakes are very hard to make, unintentionally.

How is the US doing?

Besides the Veterans Administration Healthcare system, and the US system in place for American Indians, the vast majority of healthcare transactions in the United States, unfortunately, still take place on paper. I have studied, primitively, the Veterans system and the American Indian system, and on the surface, they appear to do most of what I think is needed for an EHR system. There is a lot more study that needs to take place, however, before I would make any definitive conclusions.

The Veterans and the American Indian systems experience could provide valuable input to a design or redesign process of an EMR/ EHR system. With the proper attention and emphasis, I know that an even better system can be implemented – one that can withstand the rigors of national and perhaps international availability and access.

In many ways, the advantages of EHRs are intuitive and as long as the government or insurance companies are not permitted to store and coordinate the records, the system can work well.

By providing the ability to exchange records between different electronic health records systems and EMR systems, such interoperability would facilitate the coordination of healthcare delivery in non-affiliated healthcare facilities, anywhere in the country, and eventually the world. Ultimately, when designed

properly, such a system of health records could be accessed securely and readily be used anywhere in the world.

The VA system uses a package called VistA, not to be confused with Vista from Microsoft (Windows). A tremendous amount of work has been done to make this system functional. Among other things, most of the design work for a patient EMR and EHR record has been done and overall the system works. People at the VA do not necessarily rave about the system, but it may very well be a good start.

Software choices

If you are a provider, and not in the VA system, your software choices are broad and varied. Actually, they are too broad and too varied. There are well over 25 major competing vendors and many who would like to be in the top 25 ranking of EMR / EHR systems. Additionally, there are a number of roll your own in which "Eddie" or "Bob" or "Suzie" or "Marsha" has been doing the programming for years. That is the nature of the beast.

Software created and /or sold by multiple software producers is by definition, incompatible. It is incompatible with all other commercial-ware, with the VA system, and it is incompatible with the American Indian System. I don't even have to look at it to know that. And, yes, Virginia, it is incompatible with Eddieware, Bobware, Suzieware, and Marshaware. In fact, those four are definitely not compatible with each other.

There are lots of good reasons to have compatibility between and among software producers. These three top the list

- ✓ Improved billing accuracy
- ✓ Reduction in duplication of services
- ✓ Information Sharing

The fact is that it is difficult for a doctor, trained in medicine to be a business person. Most patients like it that way. We like doctors much more than we like business persons who are also doctors. Yet, doctors run businesses and they must run them successfully. Just one doctor, for example may have a support staff of five to ten people to keep the office running efficiently and keep the paperwork up to date. It is not an easy task.

When multiple doctors join together in clinics, they often find that they are now capable of sharing the expense of computer hardware and software and they can learn from each other how to use the systems effectively. A consortium similar to that which I suggest takes control of the EHR and EAR databases in the sky, could go a long way in helping small doctor's offices avoid having to do all of the hardware and software selection as well as all of the implementation tasks to cut over to an effective practice management systems supporting EMRS, EHRs and EARs.

By having the consortium determine the standards for the software, the physician's burden would be substantially lightened and the potential risk of an implementation failure is substantially minimized. Clearly this is the proper direction. We will resume this topic in later chapters.

Chapter 12 Getting the EMR/ EHR/ EAR Job Done

Standardization can help

There are so many organizations working together to make standardization happen in the health information technology industry, they must be bumping into each other. They must also be solving turf battles all the time. I would list them all, but it would bore you. The federal bureaucracy is so big that it cannot get past itself to get something done.

The federal bureaucracy's team of HIT experts will not get the job done unless President Trump puts one of his own people in charge. Another possibility is that by some measurement, somebody decrees that they have gotten it accomplished. Then, of course the Trump Team would have to check it out..

Experience counts

To get the EHR job done right, if I had the power, I would hire IBM or some other honest IT company, to sift through what is available and put together a top down system that can be used as a guide. I personally would definitely enjoy being part of this effort at the gross design level. Design is my major expertise and I know we could get it right.

The key thing is to get all the database records designed and the flows created for how the data is updated securely. Once the base records are defined and designed, the next step is to design the cooperative transactions using Electronic Data

Interchange, or EDI. Wictionary.com defines EDI as the following:

"Electronic Data Interchange: the computer-to-computer exchange of structured information, by agreed message standards, from one computer application to another by electronic means and with a minimum of human intervention."

I would take away the minimum of human intervention on this definition and say "no human intervention." EDI has been around for a long time and it is used for companies to order from each other and to send electronic acknowledgments and invoices. Even your direct deposits use a form of EDI to travel from bank to bank and to the Federal Reserve systems.

The key part of EDI is that the format of each transaction must be specifically defined so that the sending computer can package the data properly and the receiving computer can receive it in a prescribed format.

With EDI as the means to share medical records transactions, any EMR/ EHR packaged software company could make the changes necessary for their package to be compatible to the super system in the sky-- the one with the big database. The system actually could be implemented if the worker bees on the project were not saddled with considering the zillion plus government stakeholders wanting to run the show.

Ownership/ storage of electronic records

Before I had learned that the stimulus bill dictated a government solution to EHRs and there was apparently no longer room for discussion, I had already written this part of the book. We must get this law repealed so the government is not in control of our healthcare records. It cannot and will not ever work and it will

always be messed up and the government is not the place that Americans want to have control of our health records.

I saw two major groups that I knew would line up immediately to control the central repository for EHR data. One is the federal government and Obama already had that one in his hand, pre-2017.

Because the government also controls the IRS and the Obama team for years wanted to absolutely own and completely control our healthcare as we looked to the future from 2010, logic ruled out the government as a viable caretaker of vital data, right away. Thanks, but no thanks. Again, this part of the Obamacare law that must be overturned. President Trump must go back to the stimulus to get rid of all the Obamacare bad parts.

The next self-serving group that would love to have custody of all the healthcare records in the US is the Health Insurance Industry. American insurance corporations have had the opportunity (not the duty) to help Americans, rather than hurt Americans, and they have chosen not to do so.

Like all corporations, their charters include the maximization of profits but their charters say nothing about helping fellow American Citizens. Many do not know that corporations have been granted citizenship by our lawmakers from the late 19th century.

Because of their innate greed, and over-competitiveness, insurance companies are not trustworthy either. In fact, in many ways, they are a big part of the problem that we are trying to solve. Sorry, Charley.

Government would be the last choice, as they have the supposed power to control all aspects of our lives if we permit it. Insurance companies come in second to last.

So, Insurance Companies get a big X and government gets a bigger X. Like you, I do wish my X had some power. With our new President, I suspect we will all be surprised.

The task, at hand, was much more difficult before President Trump as the people were first sure that we had to remove the entire House of Representatives, and 1/3 of the Senate to get our own people in (regular people), and repeal this part of "Stimulus a la Obamacare." Of course, things seem to be going our way with President Trump but we must stay vigilant so that we can advise the president properly.

It would be nice if the present House and Senate would put forth, read, and sign the repeal for President Trump; and so, there is hope

Two down; who is in?

So, if those two are out, who is in? Who would have the size and the ethics to manage the EHR repository? The answer is that we need to create a new, not-for-profit enterprise that would be a consortium of doctors and other various healthcare professionals from the trenches along with some regular people.

I am not sure how it should be structured but it should be non-profit (I think but maybe not) and for the good of the people (that one I am sure of). Doctors are the most important part of the formula, yet the most beleaguered people in the universe.

The reason the AMA has just 17% of the doctors as members is because Doctors have ethics and the AMA does not. The AMA and the AARP have lined up on the other team to line their own pockets as my mother-in-law Skippo would say. The AARP is selling out seniors as noted previously so their leadership can have more take-home pay by being the favored stop for Obamacare. What a shame?

This new enterprise (the consortium) would be initially funded by Uncle Sam (with not much other involvement by Uncle Sam). The charter of this company, in many ways, would be both a policy maker and an IT broker for the purposes of the EHR. Eventually, practicing doctors would collectively own the company mostly exclusively, but with some regular citizens on the board.

I know I trust my Doctor. How can any of us not? I would recommend that if a Doctor is no longer practicing, then they cannot be part of this consortium. That's how I think. I don't know about other providers, but I do not trust anything run by a corporation or bureaucrats.

Look at the EMTALA law. There would be no such law if ER departments from corporate hospitals had not been systematically throwing people out on the streets to increase their profits. Hospitals need not apply.

Hospitals actually precipitated the coining of the term, "patient dumping." We need only doctors with no hospital affiliations and no AMA affiliations and no AARP affiliations. Good, honest doctors should enjoy leading such a prestigious pro-American venture.

There may be some other bad actors out there but with a good and honest, self-maintaining board of directors, who are mostly doctors, this can be lots better than Uncle Sam or Uncle Hartford/BlueCross/Humana/United/etc.

The company would be non-profit, but it would have many revenue opportunities, including securely sharing data and also by providing practice management software for small doctor's offices, clinics, and other providers. Finally, every doctor can have their own practice management system that works.

The Bureau of Labor statistics notes that there are about 500,000 physicians and surgeons in the United States, 7,600 hospitals, and 2,600 Health Clinics. I would rule out the hospitals immediately because of the "patient dumping." and corporate affiliation, and the "bigness" factor. Personally, I would rule out the small clinics, but I would defer to the single Doctor in the Single Doctor Practice to determine that.

This is the population from which this new company's stakeholders should come from. The company would manage the EHRs and the EARs, which we will be discussing shortly. Patients intrinsically trust their doctors and do not trust government, insurance companies or special interest groups such as AARP and AMA. Doctors it is!

Many doctors are sour on the AMA and thus, the AMA should not be involved. They represent only 17% of the Physicians and they did not reflect the opinions of physicians and the bulk of the general public regarding the government taking over healthcare (Obamacare). Most doctors to whom I speak say the folks who run the AMA make a lot of money on their administration of the organization and they cannot be trusted. From my eyes, the AMA cannot be trusted with the people's business. As far as regular Doctors are concerned, on the other hand, I trust my life to them on a regular basis. See how easy that was to solve?

The Patient Account and Accountability Commission (PAAC)

If I were asked for a name for the organization that would run the database *in the sky*, it would be the Patient Account and Accountability Commission. Obviously, there would be a lot of work necessary to make this system functional and efficient. Big problems need big solutions and so corporations, political hacks and financial robber barons are not welcome to be part of the formation of this new enterprise. I would certainly trust

President Donald Trump to form this organization…absolutely. He can build anything.

The Commission, when formed and functional, would be a bona fide business and ultimately would be governed by a board and a Chairman of the Board, a CEO/ CIO and the normal executives who would run the business part of this business. It would be good to have some patients (ordinary citizens) on the board. In fact, about two or three, but a minority of board members should be normal citizens.

The board would have no more than 10% official government members, one official insurance industry member, and one hospital member. None of these would have voting privileges. The rest of the board would be 51% physicians and other medical professionals and a patient or two along with a proper number of citizens. Doctors would be a super majority of the board -- at least 2/3.

Government funding would be used initially to establish the organization, with the objective that it would be self-sustaining through modest fees and other activities. There should be no government control or red tape involved in this organization's operations as it would be "people chartered." When, and if, it began to make a profit, the profits would be turned over to the people's treasury to pay off the national debt and Congress would be restricted from allocating these funds for its purposes as the Congress did with Social Security funds.

The ownership of the organization should be open to practicing physicians and surgeons only. To repeat for impact, physicians employed by hospitals or administrative agencies such as the AMA., would not be permitted to hold a stake in this new enterprise. Most Americans trust their family physicians and all physicians involved in their care. Thus, this new company would be a trustworthy venture for the good of the American people, not to make anybody rich.

Since AMA membership is $420 per year, my initial thinking is that equal shares of the new company should be offered to qualifying physicians for approximately $500.00 as a one-time registration/ investment fee and perhaps $50 per year until the organization begins to break even. When the organization turns a profit, leadership should be paid reasonable salaries but not huge. They may also maintain their medical practices.

The System *in the Sky*

We know what we know. I know that Obamacare was well over budget and the implementers were cronies of government and were in it for the bucks. If I were in control, hands down, I would use IBM computers and the *IBM i operating system* to build the "blue sky" EHR system, implement it, and bring it live. What would I call it? I would call it, "The System in the Sky." Why not?

I have written a number of technical books on IBM systems and they are available on Amazon and Kindle. The IBM i operating system is industrial strength. It is not Windows, a toy operating system. It is required to build robust applications for the system in the sky.

I would outsource the running of the system to IBM Global Services for the first five years, possibly extending to ten years and perhaps forever depending on its success. Part of the contract would be to hire and train an internal staff for the organization, so it would be self-sustaining after five or ten years of operation and no longer in need of full IBM continual care.

I would keep IBM guidance as part of the overall charter so that rogue attempts to politically influence contracts for hardware, software, and consulting expertise could be stopped at the door. Therefore, I would maintain a contractual oversight relationship

with IBM, so that the resources of Big Blue could be deployed as needed. Keep politics out of it!

EHR, EAR, Repository and Practice Management Role

Today, technology is inexpensive. Good people continue to be very expensive. Today technology is no longer "cheap." It may be inexpensive, but it is not "cheap." Even the rinky dinky PC companies from 20 years ago, that have survived, put out products today that are far more reliable than ever before. In other words, even "cheap" computers and "cheap" technology can be considered pretty darn reliable. The corollary is also true.

High level hardened technology such as IBM's Power Systems and IBM's IBM I Operating System is even better than ever before. The message is that technology is affordable for many innovative uses, including EHRs and EARs, an. Unlike PC's and PC servers, the technology seldom is down. When it is a backup immediately takes over.

Networking has seen the same advances in reliability both in the national wiring infrastructure and in the components -- hubs, switches, routers, and firewalls. These network components and others permit the high-quality wiring infrastructure to do its thing.

The Internet is a major beneficiary of this technology. For as little as $10.00 to $20.00 per month and a cheap PC, anybody can have a connection to the Internet today. For many, it is a better deal and far more exciting than the ubiquitous television set. It truly is amazing.

Businesses that are not large enough to have their own private set of leased high speed "telephone lines" connecting their various US locations together, have been able to use the Internet

to give them similar capabilities, with substantially less cost. Just about every business is connected to the Internet and every employee has a PC-type workstation on their desks. Businesses need their employees connected to conduct everyday business.

The Internet itself is amazing. It provides free access for good people and bad people alike. The level of access is unprecedented to every site in the world. Unfortunately, the bad people would be happy to steal all of your information; but, fortunately the good people have techniques available to stop them at the door.

For example, software techniques called tunneling (virtual private networking and such) permit two parties on the Internet to create a virtual pipe within which only their data can flow and into which no hacker can enter. Just like a real pipe, water can flow in both directions and just like a real pipe, unless you are in control of the spigots, intruders cannot get at the flowing water.

Substitute data / information for water and you have the capabilities of the Internet tunnels. Businesses would not be able to use the Internet to securely communicate with their other locations in the US if this secure hardware and software infrastructure were not in place. In many ways, the Internet and its well tested, almost bug-free protocols are limitless.

So, in a very feasible plan for implementation, the EHR/ EAR databases could be housed at one US location with about four to six regional centers across the US. The regional centers would have duplicate copies of the data. All of the databases would be synchronized using a private network and thus all databases would always be up to date. The secure tunneled public network (intranet) would be used by all the providers in the US and outside of the US to securely communicate with the big EHR system in the sky.

Chapter 13 Electronic Account/ Accountability System -- Phased Implementation

Start at the top and work down

The state of all healthcare software for practice management, as well as EHR processing for veterans and other government-run systems, is described well with these two words—hodge-podge. This patchwork of good intentions can continue doing its job, where applicable, while a new system built from the top down is implemented. The first phase of the implementation would be the design and construction of the EHR databases. This would use the best of breed existing systems design plus all of the non-implemented approved enhancement requests. Additionally, room would be made for future notions that would not be online in the short-term.

Design the databases

The second phase would be the design and construction of the EAR databases. This is the Electronic Account/ Accountability record, which in a normal business, might be called Accounts Receivable. The EAR database would be simpler than the EHR database to design and build.

In many ways it would take on the shape of a sophisticated open item accounts receivable system in which all unpaid medical bills from all approved sources would be posted as due. The database would also hold payment information and adjustments that have been applied to any particular medical bill. Each patient would have a total balance owed that cross-footed to the

total of all the charges, adjustments, and payments. This would assure the accuracy of the system. Each time an account is updated, the cross-foot would occur, and once a day, a cross-foot would be performed on all accounts. The big difference between this special accounts receivable system and any other is that the payee could be different for every billing entry.

Who would use the EAR system?

If, for example we have patients from assigned risk insurance companies, and the Consortium has agreed to account for these perhaps indigent medical bill payers. The scenario would include the Insurance Company having paid the hospital or the doctor for radiography service, for instance, but the patient has chosen not to make the co-payment or, for some reason, has defaulted in their payment to the insurance company.

If this were an approved scenario, the EAR database would need to be built to store the relationship between the care provider and the insurance company that has paid some or all of the bill to the care provider. For such transactions, the EAR system would need to be designed so that it could assign the bill for payment to the proper party, if it is ever collected.

I would expect that insurance companies would be happy to pay the EAR system for collecting unpaid balances and this would be a source of public treasury revenue. Quite frankly, I do not know whether I would want the EAR system to go that far, but it is conceivable and the software can be designed to be very accommodating.

Any Medicaid transaction would be posted as unpaid and the EMTALA balances, after the hospital or other provider has tried to collect them, would be posted as open and unpaid to the provider. Some methods would need to be developed to determine the split between the state and the federal government

but that would be a political thing, long after the technical pieces to accommodate the scenario were in place.

Patient payments would be able to be made via check or credit card or in person to any participating EAR provider for any EHR bill. Just like the banking system reconciles checks from banks all over the world, so also can an EAR type system be built to reconcile the from / to of payments from across the US.

The objective, of course, would be for all providers to be participating. Small fees for collection of debt that was not theirs could be given the onsite institutions (care givers typically). Initially, a servicer should be used to handle the checks and money orders that would be mailed directly to the EAR facility and to provide "customer service."

As the volumes of transactions are better understood, the EAR enterprise of the System in the sky would need to be staffed with enough clerical personnel to handle the processing of the checks and money orders. Third party customer service in America may be the preferred long term solution, and, inadvertently, provide plenty of American jobs on American soil!

Again, the intent of the EAR subsystem in the EHR system would not be to be an active collection agency for all providers. Its primary purpose would be to assure that any unpaid medical bill, regardless of its source, EMTALA, Medicaid, or anything else that is authorized, is associated with an individual and listed as due in the EAR database until the person dies.

There could be a small processing fee for Medicaid or for EMTALA or any government mandated act of charity for a patient, collectable only if the patient or holder of Medicaid insurance makes payments. Hospitals and clinics and other providers that are not part of the ownership of the organization, who wish to use the power of this system to collect co-pays, or

other fees, if such work were approved, could be assessed a small charge for such services for each item collected.

In addition to the practice management software, this would be another source of revenue for this new public consortium enterprise. Obviously, the database in the sky would need to be designed to handle all of this and more.

Using the right implementation tools

Prior to writing this book originally in 2009, my last book was The All-Everything Operating System, (type in the title and you will find sources on the Internet). Ironically, before writing The Trump Way version of this book in 2016, I also refreshed the All-Everything Operating System book for the tech advances since 2009.

As a lifetime computer systems engineer, my recommendation for computer systems would be any platform that could run the All-Everything Operating System, known in the industry as IBM i. This huge system would handle transaction processing and database processing. The requirements transcend the capabilities of Windows systems, and thus it should be created with an easy to use and powerful operating system unlike UNIX, Linux, or any mainframe flavored version. Again, I recommend IBM i.

I would recommend programming in the RPGIV language, the finest business language ever developed. To make coding even simpler, I would recommend contracting with IBM to enhance the language with a natural Web interface to the RPG language running under the All-Everything Operating System, IBM i. The job would be simpler to accomplish with these tools and much less likely to fail.

Question from anonymous reader: Can you tell me a little more about this electronic account record. I don't see that in anybody else's HIT literature of the day?

More on Electronic Accounts Receivable

The same private HIPAA compliant consortium that handles the EHRs would also support EARs. Each time a doctor updates an EMR system and provides the billing information, the software can also be set to send the billing and payment information to "the system in the sky."

The billing and payment information would update the patient's Electronic Account Record and log the amount due for any type of patient, including Medicaid patients. Emergency rooms under EMTALA would also have access to the EAR subsystem and would be able to update it with any billing data for which the patient is responsible

Once formed, the same doctors who had initially enlisted would "own" the EAR/ EHR Company. Insurance companies would be able to interact with the company under rules specified by the board, comprising, as described above.

Individuals would be able to pay any company with an EAR affiliation for any of the balances they may have accrued, regardless of the source of the service. Electronic Funds Transfer System technology (EFTS) would be used to distribute the cash to the proper end-points.

EDI would make it smooth

EDI (Electronic Data Interchange) transactions described in more detail previously, would need to be designed for providing conversational input and output to/ from the EHR/ EAR systems. Once the transaction types were designed, just as in regular business EDI systems, conversations between the EHR/ EAR system and the practice management systems used in all provider shops (Doctor's Offices, labs, etc.) could theoretically begin.

Software vendors wishing to participate would have to incorporate the new transaction types within their packages in order to participate. Therefore, the EHR/ EAR system would not force any existing software company to go out of business. Everybody would be welcome using new standard EDI formats.

Practice Management Software for doctor's practices

To help the one or two-person doctor's offices and small clinics and to aid in getting the system live prior to all of the software vendors coming on board, I would recommend that this new consortium also build a small, Web based medical practice management system (MPMS). This web-based system would be the preferred tool to be used in all small providers' offices. It would provide a service to many small providers. r

I have not evaluated whether the EHR/ EAR server complex itself should run the MPMS system as a service, but perhaps it should. It could be built on a separate server complex to avoid the potential of one system (EHR v EAR) crashing another, but it would be very closely related and much of the code would be similar and usable. The first cut would not be built as a Cadillac system, but rather as a software package that could handle most of the options available for a Doctor's practice in a simple manner.

The fully standardized EMR/ Practice Management System Package that would be built could be licensed and then marketed on a commission basis by any and all of the software companies that today have their own systems and who now create incompatible databases and programming code. Their potential customers would be all providers, regardless of whether they are part of the EAR/ EHR ownership group or not.

Doctor's offices that are part of the ownership of the "System in the Sky", should be able to access the practice management

software for a smaller fee. Software companies and others could offer support services to any provider, whether they receive practice management software access as a result of their PAAC affiliation or because they license it from one of these vendors.

Like all of the software that would be built to support EHR and EAR this, would be HIPAA compliant. The same EHR/ EAR database formats built for the big EHR/ EAR system would provide the basis for the MPMS system. Therefore, like all good Practice Management Systems it would provide the following facilities:

- Electronic patient history statements
- Electronic claims processing
- Electronic submission of medical claims.
- EOB's (posting of electronic payments)
- Scheduling appointments
- Creation of super-bills customized for each patient
- Claims tracking
- Flexible reporting facilities

Additionally, the MPMS would provide the following facilities to interface with the EHR/ EAR System:

- EHR and EAR inquiry
- EHR and EAR custom/ query reporting
- EHR and EAR automatic input
- EHR and EAR automatic payment processing.

Get a New Tire

Eventually, after patching an old bicycle tire / tube so many times that there are patches on patches and the whole tube gives the appearance of being no more road worthy than a bubble gum

tire. Everybody must eventually yield to the purchase of a new tube or a new tire.

Too many little messes out there eventually create one big mess. This big mess is not going to get fixed by fixing one little mess at a time. In fact, it may get worse. So, it really is time to replace it all, but not all at once. Regardless of how good the new systems may be, the big bang theory of software implementation does not work well.

All "at once" projects are doomed to failure. The only thing that the big bang theory ever created that was usable was mother Earth. At the time of the hypothetical big bang, this earth had no people on it; so, the big bang in many ways was a reset to zero with no systems active.

The big bang theory would not work if government took over all health insurance immediately and it won't work if we pull the plug on all other software when we get the EHR/ EAR system and the MPMS systems up and running. The ticket to success is incremental implementation.

The design of the end objective databases to hold health records, as well as patient account records, accommodates the highest level of software function that could be achieved by any medical practice management system (MPMS).

The EDI transaction definitions and native support in the EHR/ EAR system would permit any and all software to be able to interface with this new high level facility. In other words, without touching the guts and basic logic of any software system out there, by adding a few EDI transaction types to the mix, the dream of EHR and the benefits of EAR can be achieved. Though none of it may be done licketty split, it would not be a forever undertaking either.

Moreover, as an added benefit, small practices that choose to use the simple MPMS system would immediately have EMRs, EHRs, and EARs at their fingertips. Additionally, the new enterprise could make a small amount of revenue by renting the MPMS software access to the small practitioners at a phenomenally low price and to others as needed at going market prices. The new enterprise supporting the EHR and the EAR can actually make the physicians and small clinics an offer their business sense can't refuse, and we, the patients, all benefit.

Additional proof that the system is workable

Cash transactions at an ATM, or checks electronically sent among banks, use a similar notion to EDI called the Automated Clearing House (ACH) and a protocol called the Electronic Funds Transfer System or EFTS. Financial institutions not only send information using EFTS, but through the central ACH, they can distribute real cash transactions among many banks or financial institutions who are members of the Automated Clearing House. In many ways, our American banking system is based on EFTS working flawlessly with EDI as the underlying transaction formatting protocol.

You benefit also when you receive a check, such as your paycheck via EFTS. Senior Citizens get their social security checks directly deposited using the ACF and EFTS. EFTS is so similar to EDI that over time the names were merged and it is now known as EFTS/ EDI.

Why is this important? The fact is that the underlying systems to support electronic messages and electronic funds transfer are in place. It may be that an existing EDI format might be able to be used to accommodate the EAR system for input and acknowledgments.

If not, the base EDI transactions can be modified to support the function and be made to take advantage of the existing

infrastructure for provider to EAR/ Clearinghouse communication. .

Hospitals and clinics probably would have no problem communicating to the EAR clearinghouse, but private doctors may very well have initial issues. That's why we recommend the building of the MPMS system by the Consortium. To handle billing transactions and payment transactions and even adjustment transactions, EDI forms can be modified, or built from scratch, permitting small doctors' offices to participate in one of the most exciting undertakings ever implemented. Let's hope Congress does something like this rather than take over the whole system. Let's make sure we undo the Stimulus language that removes the public from any rights to their own medical records.

Personal Health Records (PHR)

In addition to the “System in the Sky” approach for EHRs and EARs, PHRs are vital for this system to work even more effectively. A personal health record is medical information that is in the possession of an individual patient (or patient's non-professional caregiver). Picture a memory stick or a cell phone type device that has all the storage needed for your personal health record -- a copy of the record from the “System in the Sky”! That's as simple as that one is.

End Note

Well, ladies and gentlemen, that is about it for the healthcare accountability portion of this book. I hope you liked it. Throughout this book, we gently coasted to crescendo. The idea is that along with (1) building an EMR and EHR system, we should (2) build an EMR/ EHR/ EAR aware practice management system for doctors to assist in their acceptance of technology, and we should (3) build an electronic account/

accountability system along with the EMR/EHR system in the sky, and all packages should talk to the "sky" via EDI.

We discussed the reasons why the EHR system and the database in the sky have great value in reducing medical errors, especially those that can result in the death of the patient.

The groundbreaking material in this book has to do with accountability. In healthcare, it is called patient accountability. I have been out to a number of Web sites trying to see what the reaction might be to any system that asks a receiver of benefits to one day give back to the system if they ever come back from their financial crisis. I was not looking for ways to move people off the welfare rolls or deny anybody access to life saving treatment. What I found was there are some very kind people on liberal blogs and there are some very practical and kind people on what would appear to be conservative blogs.

The kind bloggers clearly seem to believe that the government is actually an entity that has a life of its own and has its own resources. Most do not see government, as I do, which is like a club that has membership from the full population and all the members of the club provide the funding for the club. The members are motivated to support the club because there are things that one person does not do well, such as build roads, defend all the members from harm from another club, and other acts that are done better with group power.

The charter of the club says that the purpose is to promote the common good and does not give anybody in office an ability to confiscate dollars from the club treasury to give to any particular club member, or group of club members for any purpose. If a club member is down on their luck then the goodness of the human being would motivate club members individually, not collectively, to reach down and help those in need. That's the club I see as the government. Any confiscation of the treasury for any other purpose would not be permitted by the by-laws.

The by-laws of the club also presuppose that self-determination and individualism, not community good and group-think, are how the individual members run their lives outside of the club. So, the notion of confiscation of club members' investment in the club for any purpose would not be expressly forbidden. If my investment of the club were to be squandered on things with which I did not agree, that were against the by-laws, then I would want to leave that club. Wouldn't you?

Yet, because most see government as something funded by the pot at the end of the rainbow and not by donations from club members, when asked if welfare people, when they are on their feet should give back to the people's treasury, on the liberal blog sites, most voted no.

It was over 90% who believed that the welfare recipient, regardless of whether they eventually became a millionaire or not, would never have to pay back the money they received and used to sustain themselves from the people while they were on welfare.

None of these kind people ever offered a dollar value on how much they personally were willing to contribute because, after all, it would be better for the nasty rich, whose wealth would be legally siphoned by the government, to provide this service.

Why would anybody repay the rich? Barack Obama has defined rich as $200,000 per year in salary after stumbling on a number for a long time during his campaign. Soon, there will be no rich and no middle class, but that is not the thrust of this book.

I saw no mention (no posts, anywhere) of the idea that it might be appropriate for those, including illegal aliens and foreigners who use EMTALA or Medicaid for their health lifeline, to ever have to pay it back. I suspect that is because the same kind people who believe the millionaire should keep the cash value of

his or her prior government handouts sincerely believe that people have a right to healthcare and thus its value should never be paid back to the people who pay for it.

As an American, I can see freedom as well as life, liberty and the pursuit of happiness, as benefits of the Constitution. But from my eyes, once any person's rights start costing somebody else their savings, the first person's rights end and stealing begins.

In the club analogy, you would have no rights to any of the wealth of the club and other members would ask you to turn in your membership if you became a drain on their lives.

Government has no wealth other than what it confiscates from the people and our government has already borrowed about $50,000 per person more than what the club members have paid in. Should the club go under?

I go through this so that you do not think that I am hard hearted. I think that individuals have a moral obligation to help the needy, but if they choose not to, it is over. It is their choice. There should be no enforcement to the many moral obligations we have in life. If there were, churches would be the government.

It is nobody else's mission to steal from one who chooses not to help, even if it is to make sure they pay their "fair share." What's yours is yours and God forgive me if I take any of yours. What's mine is mine and God forgive you if you take any of mine. Nobody has a real responsibility to anybody else, other than in the precepts of their religion. The state assigns no moral duty to the citizen. In the US, we have freedom of religion, but more importantly, we have freedom, period.

We would live in chaos without such simple rules of conduct. When government is in between the stealer and the loser, it sanitizes the whole process of theft of wealth and that is just as

wrong as if I steal directly from you or you steal directly from me. Our personal freedoms end at the door of the person whose freedoms we may violate.

So, being the big thinker that I am, and having the database talents to teach and to consult in the area, I know that as an adjunct to the EMR /EHR system that everybody wants, it would be a substantially smaller amount of work to piggyback on the EMR/ EHR system that is already funded to be built than if this idea were standalone.

We need an EAR database. The EHR and EAR systems databases can be related so that by accomplishing one with a bit more work, the people of the US can keep track of who owes for Medicaid services and EMTALA and a host of other services that heretofore were forever uncollectible. Why is that OK?

The purpose of this book then is not to prescribe all of the ways that the EAR system can be used to help the people of the United States, but to suggest that it can help. And, because it can help, at a time when so much funding is being dedicated to the building of the EHR system as the database in the sky, this other project should be built immediately and along with the HER system.

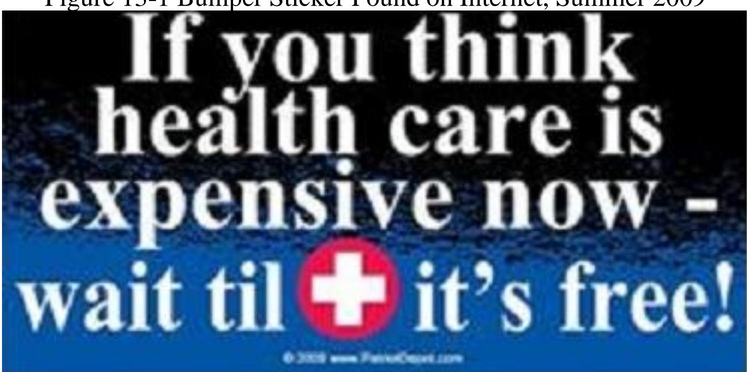
And, of course, I would not be me if I did not caution all Americans who want to retain their freedom that the building of the Barack Obama National Patient Database is underway. If the people are not smart this may soon become the Hillary Clinton National Patient Database I don't like either of those notions one bit. Neither should you.

It is a more sinister notion than the Insurance Companies of America's National Patient Database (which actually does exist) and I am not for that either. We the People must stop the nonsense of government, as in the kind of Orwellian notions we saw in the book 1984.

Government cannot be trusted with one small health fact about any of us as individuals. So, a database about the health of individuals should not exist on government soil; should not be controlled by government; and should not be regulated by government. At this point in time, there is only one generic person to trust. Anybody who has ever been healed from an aggravating illness trusts their doctor more than any other non-family member in society. Doctors should therefore run the database. And mine, Doctor Patrick Kerrigan, I must say, is the best. If I am spoiled, then spoiled we all should be!

Sometimes it is good to drive arguments home ad absurdum. In this light, I present to you the bumper sticker of the year for 2009. See Figure 13-1.

Figure 13-1 Bumper Sticker Found on Internet, Summer 2009



Chapter 14 Welfare Accountability

Free healthcare and income tax credits are welfare

In these troubling times, public welfare departments are without a doubt the fastest-growing departments in state governments. Not only is the cost of actual assistance growing exponentially, but the appropriation needed to fund the permanent welfare bureaucracy has grown substantially as well.

Despite real reductions in caseloads during the 1980s, 1990s and 2000s, many state welfare bureaus did not reduce accordingly their cases and case workers. States should certainly stop this unwarranted growth in bureaucracy but then again, states have rights over and above those of the federal government.

Welfare legislation provides real financial penalties for state and county public welfare departments, as well for cash assistance programs. If, for example, a state public welfare department fails to meet a number of federal requirements, dollars may be withheld or other penalties assessed to assure compliance. Since the federal government is like a great uncle to the states in providing money for welfare, the federal role cannot be minimized.

There are roughly 80 welfare programs overall that together comprise the single largest item in the federal budget — larger than Medicare, Social Security, or defense.

There is s ton of money being given with no chance of getting any in return. We can't even send out no-cost electronic Christmas cards as a nation to those to whom the nation's welfare programs have rendered assistance. We have no idea who they are and how much they have received. We give a lot of help but we do not keep track of to whom we give the help because there is no requirement for repayment. I think we should keep track and we should be repaid. We do however, know the totals and they are growing astronomically.

To put the numbers in perspective, and not including Social Security and Medicare, Congress the US government allocated almost $717 billion in federal funds in 2010 plus $210 billion was allocated in state funds ($927 billion total) for means tested welfare programs in the United States, of which half was for medical care and roughly 40% for cash, food and housing assistance.

In 2016, the total skyrocketed to $871 billion in federal funds $(488 Billion Medicaid; $383 Billion for other welfare). State funds in 2016 amounted to under $300 billion. Let's just say the total is $1000 Billion and that the Welfare part (State and Federal) is $500 Billion

What if over the last ten years, ½ of the welfare recipients got off welfare and became productive citizens with no dependence on the US for Medicaid or for welfare. That would be good. Suppose…just suppose that they began to pay back their welfare at 5% per year to make it simple.

That would mean that assuming a flow from prior years, there would be a $5% + 5% +5% +5% +5% +5% +5% +5% +5% +5% = a simple 50% of the funds paid back. 50% payback times 50% of the participants = 25% X 500 Billion = $125 Billion in payback. If we add Medicaid, we are at **$250 Billion**. It sure seems like this idea is at least worth a feasibility test.

Consider that healthcare accountability would involve keeping track of all kinds of small dollar amounts such as prescription drugs, lab tests, x-rays, etc. etc. etc. Together these might amount to an individual having as many as 20 charges of various kinds in one month or an average of 120 per year. Moreover, the charges would be tougher to process as they would be from multiple providers with multiple means of input into the big EAR database in the sky.

Welfare accountability would be less computer design work. The amount per transaction such as a monthly cash payment amount or access card (Food Stamp) monthly refreshes would be substantially more on the average than a doctor's visit or a prescription drug order but the number of transactions would be substantially less than the charges in the EAR backing the healthcare system.

Additionally, the entity paying is a patient or Medicare paying a specific charge as it occurs…instead it would typically a government agency like the Welfare Department or Aid to Dependent children etc. A record of their monthly payments could be electronically forwarded to the BIG EAR System in the Sky and coded as welfare—without all the work required of the healthcare charge tracking system.

Therefore, if it were deemed prudent to create a system whereby two years after a person got off welfare, they would be asked for 1%, 5%, or perhaps even 10% of their income based on a means test to repay the welfare system, it would serve all taxpayers well. Americans would actually know where and how we are spending our welfare tax dollars. Then we can get some money back into the system.

Bill Clinton is not your most conservative politician. Yet, he saw a problem in 1996 and went after a solution. Before the law was passed, with the help of Congress, more than 13 million people received cash assistance from the government in 1996. Today,

just 3 million do. Where there is a will there is a way. America is broke and we need ways to pay for things more today than ever before. The EAR system can drastically help along with a few Donald Trump jobs.

“Simply put, welfare reform worked because we all worked together,” Bill Clinton, who signed into law welfare reform, or the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, wrote in an op-ed in The New York Times in 2006. Clinton had campaigned on a pledge to “end welfare as we know it” and today it is all too apparent that he succeeded.

In 2013, a person named Tiffy, an American former college student, was concerned about welfare and whether or not people on welfare had to pay it back. Here is the question asked from a blog on the Internet:

> Ok I have never been on it and don't know anyone who has. I did take out student loans, which I guess is a type of government assistance, and I have to pay those back. So is welfare the same? Do people have to pay back what they received once they get a real job and are making enough money to cover all of their expenses? If not, why the hell not? I mean they are basically stealing money from tax payers' right? If I take out a loan from the bank and don't repay it they come either repo my car or foreclose on my home because that money belongs to the bank. So if people refuse to repay welfare aren't they stealing from the tax payers and government? I understand some people need assistance, just like when people take out student loans, but why shouldn't they have to pay it back?
>
> *"Banned"* offered a truthful guess that was right on the money:
>
> Depends on what you mean by 'welfare'. But most likely, no.

No is the right answer. No payments required. It is not like a student loan, it is more like a huge Pell Grant. It is like a gift from the government just because you are you and you need the gift. There are lots of ways those on the system can get money from multiple government sources, never required to pay any of it back even if they hit a $200 million lottery. Why is that?

Because there is no accountability for welfare. Those who give the money, the various agencies funded by taxpayers have decided it would be too much work to actually keep track of how much a given recipient has received. Trying to get something paid back is impossible unless we account for it when it is given. We do not know to whom we give the benefits.

Thus, the term—Welfare Accountability
Thus the term==Healthcare Accountability

Makes you think… doesn't it?

Chapter 15 Book Summary

You get treatment; provider gets paid!

Just so you know, Donald Trump believes in the safety net. He also believes in accountability. He is a good man. He believes that we should help helpless people but he also believes that government programs should not make people helpless.

Unlike many in the former administration such as VP Biden, Donald Trump believes that he and other wealthy Americans such as Mr. Biden and Mr. Obama and Hillary Clinton should relinquish their Social Security benefits. He knows that widespread fraud exists in the Medicare, disability insurance, and food stamp programs. Trump supported the 1996 Welfare Reform Act's work requirement.

Nobody really wants to be lectured about anything. Nobody wants to be put down when they are already down. Nobody wants the safety net that they always believed was between them and the end to be weakened or destroyed. Nobody wants what is theirs to be taken away so that somebody else can have it, no matter how deserving the other may be.

Most everybody believes that when you can provide for yourself, you should provide. Mostly everybody believes that anybody who chooses not to work for theirs should not be able to take yours.

The whole idea of Healthcare Accountability, as promulgated in this book, is so that patients are comfortable asking for treatment

for health problems. Everybody should be treated. Nobody suggests that anybody should ever ignore symptoms just because it would cost the state less to support if the symptoms went un-addressed. That may be the unwritten rule in Obamacare, but even Congress will not admit that.

My fear is that this new state, this highly society-oriented state, that does not care about individuals, would be quite happy if many of us would choose to die rather than collect our social security checks and spend our Medicare dollars. That is not the theme of this book, but it is the deal of the new bureaucracy in the Obamacare driven government.

If you have a weakness that will would have cost Obama some cash, the subtle message is: why not just end it? That is another reason why many seniors are already enjoying the Trump presidency.

The bureaucrats are chomping at the bit to be freed to regulate us in ways that benefits society rather than we as individuals. This is the calling card of Dr. Ezekiel Emanuel who was, of course, a major Obama Health Advisor and major advocate of healthcare rationing. Emanuel is well published regarding his suggested system of healthcare rationing based on what he calls the "complete lives system." President Trump must undue Emanuel's work.

The complete lives system "discriminates against older people" in that it values how much time a 60-year old theoretically has left on earth as a major determinant compared to say, a ten-year old. If there were a lot of ten-year-olds in line, sixty-year-olds would (according to Emanuel's ideas) be sent home, without the need to pack ever again.

I like the idea that healthcare, to an extent, is either unlimited or self-limiting and those who can pay get it and those that cannot pay are at the mercy of those that can. In the EAR plan, the

notion is brought forth that all patients can pay since the system automatically, in essence, writes a loan for all the patients that qualify for EMTALA care or the Medicaid insurance that a patient who cannot pay right away consumes. I worry about the subtleties and the coldness of an administration that is willing to permit women to die as individuals for the greater cost-saving of society.

Fox news Sunday addressed rationing the day after the Senate approved debate on their Obamacare bill, and after a week in which the bureaucrats let loose with their recommendations on Mammograms and perhaps also on Pap tests. The news for those listening is that the idea of women dying is now okay because it "costs too much" for society to find out which 40-year olds are going to get cancer. Hmmm!

On Fox, the Segment 2 Guest was Dr. Bernadine Healy, U.S. News & World Report's Health Editor & Former Director of the National Institutes of Health (NIH). She is an impressive person and minced no words calling this bureaucratic bumble of Obamacare rationing at its finest. She acknowledged that the bureaucrats recognize that their guidelines will mean that more women will die of breast cancer but she suggests that is okay in the minds of the bureaucrats because dollars will be saved.

On the same show, Arlen Specter talked about "outsourcing" the downgrading of Medicare by $500 billion to assure the cuts are made as the Congress can then pull a Pontius Pilate on its implementation and blame it on the guys they hire. Get out the water basin.

I believe in individualism and that every member of society should fight as hard as they can so that every other member of society should be kept well. I do not believe healthcare is an inalienable right, but I do believe it is a duty of all to assure that no one goes without proper treatment.

I do not think that the mythical collectivism of society would be enhanced while we knowingly make decisions about the type of people who are permitted to survive in the future. An initiative that would allow the bureaucrats to become grim reapers is an absolute abomination and completely avoidable.

Think of the notion of the EAR as a loan and ask yourself if this cannot expand the ability of our system to pay for healthcare. Think about the individual and the individual's three people within—me, myself, and I, as being held accountable as the number one reason why any of us get to be and to stay healthy. It is time for Healthcare Accountability.

I trust that the smart people in America will read books like this and some of my others and the others will listen to people like Michael Savage so that we do not let the Marxists doom us to an early grave simply because we have had a cold for more than two weeks or some other blather.

Don’t forget how nice it will be when everybody can contribute to their own healthcare, either while they are on their feet or off. Personal accountability should make everybody feel lots better.

One Last Anecdote

Once there was a family that had two sons. One son was very tuned in and very smart and he worked hard to make sure that the family did well. The other son was very smart but he used his smarts to be lazy and he felt like since he was born by his parents, they should make sure he was okay. The industrious son was always told that his brother needed special care, but, deep down he knew they were equal. As the sons got older, the parents, approaching the end of their lives, began to give them both part of their savings in equal proportions.

The industrious son was never heralded for his good works. Yet, much of the parent's saving had come because of the industriousness of this son who had worked hard every day. As this son observed equal shares given to his brother who chose not to work, he was confused about what to do. So, he decided that he too would take life easy and disbursements began to exceed resources and income. Eventually, the family fell out of prosperity and ... well, maybe it did not have to end this way.

When things are not fair, very often individuals change their behavior to even up the score. If work has no payoff, why work?

We are all accountable and in order to ensure continued prosperity we must all be held accountable for our actions and our debts. Our nation was built on the blood, sweat and tears of a generation that equated personal accountability with the very freedom that we have enjoyed for generations henceforth. It's not too late to unite, as individuals, to fight for our own right to have a role and our own accountability in our healthcare process.

Now, I am going to show off by signing off in a way that just came to me:

Gesundheit!

Other books by Brian Kelly: (amazon.com, and Kindle)

President Donald J. Trump, Master Builder: Healthcare & Welfare Accountability

President Donald J. Trump, Master Builder: "Make America Great Again"

President Donald J. Trump, Master Builder: The Annual Guest Plan

Great Players in Alabama Football From Quarterbacks to offensive Linemen – the Greats!

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Great Moments in Penn State Football PSU football from the start--games, coaches, players, etc.

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Wilkes-Barre, PA; Return to Glory Wilkes-Barre City's return to glory

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The Bill of Rights 4 Dummmies! This is the best book to learn about your rights.

Sol Bloom's Epoch …Story of the Constitution The best book to learn the Constitution

America 4 Dummmies! All Americans should read to learn about this great country.

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The All-Everything Machine Story about IBM's finest computer server.

Brian has written 101 books. Others can be found at amazon.com/author/brianwkelly