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Healthcare Accountability

Health Information Technology (HIT) and Electronic Accountability Records Can Make It Happen

This book answers the questions that you have been asking to which there had been no answers!

BRIAN W. KELLY

LETS GO United States of America!

Healthcare Accountability

Health Information Technology (HIT) and Electronic Accountability Records (EAR) Can Make It Happen!

President Bush and President Obama both agree that a database of health records needs to be stored. 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. 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" that is going on in Congress today.   Congress is getting ready to spend a trillion dollars on a government take-over of healthcare that improves the lives of 17% of the people and disrupts the lives of the other 83% with less healthcare and more taxes. You cannot take $500 billion from Medicare to make it better. Will senior citizens will have to find employment again to buy back what they will have given up? The big winners are the trial lawyers and the big insurance companies. The people are left holding the bag. In this book, we describe in reasonable detail in words that any American can understand, how to make the healthcare system -- both ER and Medicaid more accountable so that Medicare does not have to pay the price for all. There is no free lunch and this book shows the technology solutions that can help you avoid having to pick up the tab.

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

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Editor, Melissa L. Sabol
<u>Healthcare Accountability</u>
Author Brian W. Kelly
Health Information Technology and Electronic Accountability Records Can Make It Happen

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 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 would first like to thank my immediate family, starting with my lovely and dear wife, Patricia. Pat is as lovely as a bright and sunny day. She is still a kid and she makes me feel younger just watching her in action. My Pat is number one. Just today she painted the kitchen and did not complain that I was writing this book. She is my hero. It does seem like yesterday that we met and, I am tickled that life happens for real and not just in fairy tales as my lady has added a magical sense to my life and our family's lives.

What a life! Thank you. Thank you Pat for being there in the morning, during the day, and the evening. Thank you for quietly taking care of everybody else's problems and making them your own. Thank you for the care you extend to all our children, including our dog Bennie and our cat, the huge tabby tomcat, Buddy. Nobody can get by a day without you.

You are my beauty and my lady. I love when you announce yourself after coming in from school or from shopping, "Hello You Lucky People!" I can't wait to see you. I hear you buzzing around the house as I write and it always puts a smile on my face.

Your daddy, Smokey, became a best friend to me and I loved how he always called you his little girl "Packy." The "Smoke" and the "Skip" are now with the Angels but the memories are forever. I do smile thinking of you and I love you dearly and I love how you make our family a family. Thank you Packy for all you do to keep me and our whole family well and mostly, thank you for being so nice and for just being you.

I would also like to thank my twenty-five year-old daughter, Katie, who has been Daddy's little girl now for all of her 25 years. You are one of the brightest people in the whole world but more than that, you are among the kindest and the sweetest. You are my Irish Rose. You have been able to put life's struggles in perspective and you face things and work them out positively like no one else ever could. I am very proud of you and even more proud as I see you work with the clients in your profession. They are not as fortunate in life as most and I revel that I would never know that from speaking with you. How wonderful it is watching you offer pure kindness and caring for the people who really need you. You are just wonderful and that is that. People that Mom and I meet for the first time can't wait to tell us what a sweetheart you are. I do already know. Though you are grown up and quite capable, thank you for always being Daddy's Little Girl. I love you very much.

Thanks also go out to my twenty-eight-year-old son, Michael, who graduated from Law School and who passed the BAR exam first time. Congratulations Attorney Michael. You know I know how hard it has been with the tragedies you experienced to pick yourself up and move forward to your achieved success. I was first proud of you that you came back and that you faced life head-on, but now I am proud because you did not compromise. You succeeded in spite of what many would have seen as insurmountable difficulty. I am continually proud of the person that you are and the person that you continue to become. You are on your way to being a fine lawyer. You have learned that nothing in life worth having is easy and you have knocked down barrier after barrier to be the person that you have become. Congratulations Son! You are a good man. You are also a good son. I'm proud of that big heart and my wonderful good son.

Thanks to my tall and handsome twenty-nine year-old son, Brian, who knocked 'em dead in Law School and graduated Magna Cum Laude and then killed the BAR exam. You were an essential ingredient in helping me pull many of my books together, especially this one. In my books and in my other writings, when I have been flat on

knowing how to say something, you always have the right way to say exactly what I would have said if I were blessed with your wonderful talents. I know that your first love is music and that Law is on the side unless the family needs you. Thanks for that too! You have my blessing in all your endeavors.

Your music projects have all been met with great acclaim and your several hundred music videos are a phenomenon. You are a master musician with the organ and the piano. Your snappy arrangements of music that others have written and your creativity in your own pieces is beyond belief. You have many an option in life and being a living Mozart can certainly be one of them.

Your Internet music work has been successful and the reviews you get are always excellent and outstanding. Congratulations on this lifetime feat. You have no idea how hard it is for regular people like your Mom and I to be able to come close to creating the beautiful music you make with seemingly effortless motion. I suspect that it is not effortless, but you are about the best I have ever seen. I am very proud of you, son. You are a wonderful son and I love you deeply. Again, thank you as you help me like nobody else can.

Mom and I are very proud of all of our children and we thank each of you for your work in academia, in life, for the family, and your efforts on our behalf.

A special thank you also goes to Dr. Patrick Kerrigan, whose job never ends. He is right here at the beginning of my acknowledgments list because without him, my list would be shorter for I benefit greatly from the wonderful medicine of Doctor Patrick Kerrigan. Dr. Pat recently dug out a bad cyst on the back of my neck that was infected by a spider bite. He took personal time late Friday to help me as I could not breathe. All of my neighbors offered words of encouragement as I hobbled into the car. Dr. Pat checked it out, and after more than an hour of direct service, he sent me on my way, breathing.

Everybody loves Dr. Patrick Kerrigan. Recently he was the "Man of the Year" for the Friendly Sons of St. Patrick. Even others than I know he is worthy of honor and recognition. Yet, he is a humble man who loves his God and Country. For our family he is the man of the decade and many more to come. Dr. Pat, thank you for keeping us all well. Thank you for curing the spider bites and all the other maladies that befall my children and all of us. Thank you for being the kind of doctor that will do his best even if punished by Obamacare. Thank you for making your patients your priority.

Thanks also to the Kelly extended family who are always there to lend a helping hand. Barb, Kim & Dave, Dawn, Cindy & Dave Boyle, Megan and Sean are some of the most wonderful family in my life. We don't see them enough but we love them to pieces. And, of course my friend, dad Joe, with the angels, always gets his plugs in to keep things OK. Don't worry Joe, we'll get it right!

Thanks also to Melissa and Paul Sabol, Paul IV and their beautiful baby girl, Amy. Melissa, you are the newest member of the editorial team and your work is excellent and your sense of humor permeates this work. I thank you also for appreciating my sense of humor or my flattest lines would be even flatter, and the areas in which I peaked would not be so lofty. As the Editor of Wilkes-BarreRecord.com, you are a master. Thank you so much for your work in this book and all books. It would not have been at this quality level if it were not for your hard work. And, don't forget the white liquid in the garage.

I am not ashamed to talk about my best friend in all of life, Dennis Grimes, who is always there to help. Dennis is the consummate CIO and he is my consigliore. Is that an Irish word? Whether as a CIO or as an expert tradesman, Dennis does everything right. From Java programming to replacing a vanity to putting in some tile and dressing it up to look new, Dennis is the best. Professor Grimes is on the faculty with

me at Marywood University where he teaches Java and all the heavy lifting topics. He is very talented and very helpful and very nice. Earlier this year, when Pat and I were in the car and in the process of leaving for the Cayman Islands to deposit some cash --- believe me I am kidding about that part, Dennis got the frantic cell call from Pat about the white sanitary item upstairs flowing over and not stopping. Yes, he is also a plumber and everything else that needs to be done. He is the best.

Dennis reviews most of my work and he really gives a darn. Thanks Bucko for all your help. There are other Grimes' involved. Barbara Grimes, Patricia Grimes Yencha, Elizabeth (Wizzler), Mary the PhD & Scott, Denyse back from the U.K., Grandma Viola, and Angel Grandpa Dennis, Angel Grandma Gert and Angel Aloysius Ankenbrand, also pitch in whenever the opportunity arises. Mary Gert Ankenbrand, Barbara's wonderful sister is also a prime contributor and I am thankful for all the fillings she has provided for this work.

Angel Gert found her way to heaven recently and all of us had time to reflect on how wonderful she was in life, and how she always put others first. Thank you Grandma Gert and enjoy the sunshine above the clouds. Your daughters and all of us think you are wonderful and we know that you are close to God. By the way, Dennis the real Grimes in the Ankenbrand family is an author himself and a little while ago, he picked up the "pen" again threatening to create some nice management articles. I think he lost the pen again. Dennis helps me in whatever way I ask, especially when I am stuck. I really appreciate all you do for me, "D." Barb and Dennis' daughters Wizzler and Partricia, (yes I said Partricia and not Patricia cause that's what I call the lady.) mentioned earlier, may one day surprise Dad and Mom by becoming officers in the Northeast Pennsylvania Computer Users Group, the AS/400 group that dad started. Partricia's husband Jason is the best accountant, CFO-type in Northeastern PA. Thanks also to Mary Jo "Frederick," and her two brothers Norman and Joey for their contributions.

And never last on any list is my out of town friend, Joezer Mickey, a long time friend. I promised Joezer my next book would be non-technical as I planned to move the publishing business to children's books, human interest books, and third party authors. Joezer, sorry, I got caught up in the moment. Don't show this to any of your small children. It will scare them. My thanks to Pegzie Mickey for making sure that Joezer is always the great man that he is..

Big thank you's go to Gerry Rodski and Joyce Heck, and Dr. Amanda Rodski, Angel Frank Rodski from "Who Cares," etc. and all the Rodskis including the two Rodski trunks that were once in the garage. They always enjoyed Brian's music and they encouraged me to visit them as the cache of the red vintage was always kept close by. God bless the Tobes.

Still having their shelled peanuts and raw eggs in golden beverage every Saturday morning in God's land are the Kelly parents -- Edward J. & Irene McKeown Kelly. What a team! The silk stockings are in the humor position all the time and the TV shows are the best of the best. They continue their guidance from the great upstairs and they provide direct intervention as needed. My brothers and sisters and their families are also always there to help.

Edward (Eudart) Kelly Jr., now living among his friends at B'nai and his boys, Eddie Jr., John, and Robert Kelly, are all thanked for their fine contributions from the muse.

Nancy (Nancara Boom) and Angel Jim Flannery (Leland K. Zard), Renee (Bean), Billy Kimble (a.k.a. Billiard Peph) Jimmy (Jim Bob), Bridget (Bridge), Bailee Roo (one of the finest Roos in all of the USA), Mary (MaaWee) & Danny Delucia (DanMan -- highly skilled member of the fam), Michael (McPike) , Ken (La Rue) & Jen (LaRue) & Genevieve (Viva La Vieve). Angel David (Davidow a.k.a. Brunoch Zard) is always ready for action. Can't forget the Q's for all their fine assistance --

Stephen (P.Q. Whoozer), Matthew (M.Q. Peph),), and of course not to be left out are Anna Mae, Joe and Rosalie Ferro , Anna (Grandma), Raymond (the faux Sparkey), and the real Sparkey of recent email fame. BTW, the real Sparky is Anthony Faltyn, father to Norie, Paula, Toni, Artie, Joey, Mary Frances and Pattie. His wonderful wife is now an angel, Anna Mae and his current best friend is the lovely Rita, who has never been a meter maid. Jim Flannery Sr. will celebrate his sixth year with the Lord this next St. Patrick's Day Weekend, and my wonderful nephew David has been up there with his Dad most of the time. I love them both and I still do. Eternal truths live on--- there is still turkey in the Fridge. Thanks for the continual inspiration

I am so tickled to have the finest pack of brothers and sisters that any person could ever dream of having. Every one of the Ed and Irene siblings for example, have a twin that loves them. Some even have two twins that love them. Mary and Joe are twins and we know they love the heaven out of us and we love them back. Thanks also to Carol Goode and Randy for their great work with Eudart in the wonderful Elizabeth St. years. .

Still counting Kelly brothers and sisters, the first typist in the publishing company long ago was sister Mary (Maracus), now bringing in the bucks with her homemade quilt venture known as www.mimisquilts.com, the finest quilts in the Northeast. I always get help from husband Bill Daniels, a computer miffintiff at a Catholic College down the road. Bill enjoys life and all his fine grandchildren. There are more: But wait. Mrs. Sarah Daniels is one of the finest ladies that have ever helped make the negative, positive. The most hidden person on the positive trail since Zorro or the Count of Monte Christo is my good friend Gary Daniels who is so much of a Patriot, he will not even mention his own name if it might take something from somebody else.

How about two summers ago and the newlyweds Megan (Meggledeebaigledee) & Jason Kauwell. We heard the little bones while they were growing and now there is a little Nathan wearing those bones. The airwaves have been full of munchkinetti pictures ever since. Yes, there is also Bill Jr. (Billdog) & Vicky, the most patient lady since young folks learned to be patient.   Liz (Weezler) & Brian Ginochetti (Gino of Vino fame), Sophia (Chubby Cheeks DeNardo,) Elise (Fleure D'Leese), & King Luke Daniel Ginochetti (LukeyD, a.k.a. Luke-a-Duke), a semi new force with which to be reckoned. He was the only new force until the Megler (above) got in the act. The munchkinettis are about to take over and so they shall.

The count continues with Diane (the marvelous and beautiful Diser) and brother Joe (Smith, Seethourow, Cement) Kelly, Tara (Tara Lara) and Colleen (Collowishes), There are a few angels requiring mention, Puffy and Fluffy, fine residents of Kingston for years and now there is the ever alive Foxey Girl. Our angel Harry Ashford is now with his angel Josephine and all of their children know that God is taking care of everything. Unless, of course God needs some plastering up there, and then the master Harry Ashford will surely show his work.   Joanne, Ricky, Briana and Eric Bayer always provide needed assistance. Cheryl Danowski, Sheila & Joe Bunk, Diane Danowski and Derek are ready for the call. Mike Danowski and Billy Suchadelski from Billy's make sure the Beverage Aire is working daily.

Keith (Keith E Rue, the Diamondman) and Dorie (Thea) Zinn, Keith, Matt, and the newlyweds, Jennifer & Daniel Richard Evans, plus Uncle Harold Zinn, The proud parents Bill and Cathie Fetterman help as often as possible with the help of Ken and Karen Evans (Kennethra and Knaren Knevans) -- always on the help lines. Thank you all. And, how about those Back Mountain stalwarts and their contributions,-- Kevin and Mary Kay Covert, and of course the Bob and Nancy Edgertons.

Don't let me forget Patricia's parents, Arline (Skippo) and Stanley (Smokey) Piotroski, the finest angels who continue to guide us in our lives. Cathy (the Postmaster General) and Martin (Marty) Piotroski, the family chef, Marty Jr., back in WB, Still kind of newlyweds Erin & Mike Olshefski, Lynny (Lynnstermacher) , and Scott Piotroski

(Scott Trosk), MacKenzie (Maccadackadoo), Merek (Amerreeek), Myranda (Myranda Roo,) and MacKiley (Smiley MacKiley), plus the fabulous and exciting Barbara Jewel, Teddy and Maureen O'Door, the Red Hat Ladies, and Angel Fran Bartlomovitz. And of course, there are the Frostbutters -- Brian (Big Brian F-- lotsa Brians), the two Mrs. Frostbutters, Brian (Little Brian F), Hanna, Beth and Dante (the Inferno Guy!).

From Boston there's help from Dr. Susan (Suetrinka) Piotroski and Dr. Mitch (Shuffleboard / Scooter) Bornstein, Johann Anstett has challenged Mitch to a duel on the S-board but no response yet! Matt and Allie, the Bornstein children, who call yours truly uncabunk, are always pitching in. Plus, their extended family in which one special person stands above the crowd, and in Boston it is the great and grand Nick (Nicky Nickopoulis). Thank you all for your miraculous contributions.

From Washington, there is help from the Pentagon but the best help comes from the State Department's own Dr. Stan Piotroski, the miffintiff for global assurances among minds. No, that is not AIG. Stan is so creative that his paintings cost more than some of my cars have over the years. Thanks Stan. Back on the local trail there's the lovely Carol Piotroski, as wonderful a lady as ladies can be with a spirit to match. You are the best Carol and I know that for sure. I am tickled to know you. Thank you for all the inspiration Carol and of course, Merry Christmas Carol. The best also to Justin Piotroski (Dr. J.), Denise, Sister Marlene Weitzel, and Angels Ferd & Carrie Weitzel,

More help always with Bill Rolland- Notre Dame's # 1 fan and one time master of accommodations, Bill Kustas, Steve and Shelly Bartolomei, and of course the great musical cutter Harrison Arthur and his friend Harry Heck Jr., wife Nancy and newborn, Connor. More thanks to two individuals, Judy Jones and Jerry Reisch and never last and never least, Judy Judy Judy Seroska, Amy and Emily & the mythical bon vivant and computer wizard, Pierre Le Kep, sister Patti and Karl, and Mr. & Mrs. Kepics (Steve and Jennie).

Working through all the Piotroski helpers we find a host of help from Cousin Joey from West Virginia, Angels Johnnie and Georgie, to Louise, with our own Mary (Dale) & Jude Goya, Richard & Sharon Dale, Mike, John & Laura, Artie & Tammy, and Joanne & Dave, Theresa, Georgie, & Roseanne (Honey), Eddie and the newest Angel, Barbara Hahn, Nancy, Suzanne & Frank; Danny and MaryAnn Oleniak, Raymond, Mary, and Jennifer; Angel Russ (the Ghost of Offset Past) and Bernadette Banta, Russ & Lisa, Mike & Holly, Scott & Wendy, Sherrie & Dave.

Of course, the long list of helping hands continues with lots of wonderful people with regular names like Jeanne and farmer Joe Elinsky, two of the nicest people in the world, plus the farm is pretty nice also. Then, there are the "kids," Angel Jeannie Elinsky, Scott and Lorie, (Heaven's own doggies -- Beckett, Winston and Chance), and the new wonderful lampshade wearing, chubbing-up every day-boy Logan, Marie Mericle, Kim & Rob (Santa) Mericle, the Mericle Munchkins, Kelly, Katie, Christin, & Robby -- Penny & Larry Stirewalt, Sunny and Spencer, and also the cast and crew from the Brace Place.

Thanks also to Eddie and Rose Hourigan & the Juniors, young Eddie Jr. and Joseph. Now that I am thinking about Joey Hourigan, he looks just like Father Gavitt, (who just celebrated his 25th in the Priesthood) though neither know why -- and neither are complaining. It helps to have good people on your side in all you do. Father Gavitt is as good as it gets. Joe H. is almost as good. The fact that they are such wonderful people to me, is a gift. Thank you. BTW Father Terry's father's son Father John hit a home run at Father Gavitt's 25th.

Always willing to proof a paragraph and maybe two is John (Johann Johann) and Carol (Caaaal) Anstett, Grandma Leona . While I was editing this book, Leona had her 98th birthday. She is still beautiful and has so many stories that I can't capture them all. She looked at me in , as my wife pat would say, that big and burly black coat. She

took another hard look and then she said it. Leona said "you lost weight didn't you." After I said something inane, she said, you don't look as ah, ah, ah (we could all hear the wheels rolling). Then she said it, "ROUND." Hah! we all got a laugh.

Always an inspiration is the wonderfully "Heights-Oriented" angel, Grandma Annie (from Mayflower). The fruitcake has never been quite so good. When Mrs. Demmeck (Annie) was thinking she was not doing good, I came to visit here and she looked at me and said, "Kelly, what are you doing here, I am half-dead." My friends and her daughter remember me saying to her, "well then let me talk to the other half." What a lady!! So lucky am I.

Monsignor Joseph Rauscher is clearly an honorary Anstett and I thank him for his help as well of the help of his new buddy, the Cardinal, who was able to get Johann Johann Sr. to church on Saturday instead of Sunday -- even though Penn State football was on. Of course, there is Johnny (the NBC Director aka Johann Johann Jr.) Anstett, Erica Anstett and Ed Stehle. Johann Johann Sr. has a number of important roles. Besides a church lector, he is the large vessel tester at St. Conrad's, and he is the neighborhood taster back in the 'hood. Also, helping along the Gulf coast are other "Anstetts" -- Joe and Betta Demmick, Christopher & Emily Demmick.

The list goes on with Carolyn and Joe Langan, Keith and Kevin Langan, Bob & Cathy Wood, and Cousin Eddie, Aldo & Joan Casseri, and the rest of their broods.

From Wilkes-Barre we have Karen and another angel, Al Komorek, my great friend for many years. Also, there is my Godson, Michael, who is newly engaged, and Al Komorek Jr., Bob and Nettie Lussi cannot escape the magical web due to their own contributions and then, of course, there is Joell and Jamie Lussi.

Bernie (Bernardo), Cathy, Brian, and Alison Healey have made their mark in every work I have produced. Joe & Julie Mantione, great people, Bill and Laura Brace, by the raging Susquehanna, Georgio and Shirley Morio Vitanovec, the best Slovak Red, ninety-five years in a row, John and Suzanne Vitanovec, when your having more than one.

Bill and Debbie Milz, Mike and Patti Milz and all the Milzes, Dr. Haragopal Penugonda and Dr. Dwaraki Penugonda, wonderful friends and protectors of our family. Attorneys Kim and Ruth Borland have always been very helpful. Frank and Donna Pasquini and all the Pasquini kids know how to leave their muse tidbits. Paul & Sue Shovlin do their best to make all the books successful. Bernie and Susan Mengeringhausen, Rich and Marian Chukonis, Mayor Tom and Patti Leighton, Mercedes Leighton, Angels Maxine and Simon Coblenz, Larry Coblenz, Rhea & Dave Brown, Phyllis, Barry & Abby, Ben & Alexis Pezner. And, of course Joseph and Mary O'Brien, and Tom Madigan are always there to help. Dr. Haragopal Penugonda keeps me healthy and makes sure I am ready for the holidays each year. Dr. Dwaraki Penugonda keeps Dr. Harry well enough to do the job. Thank you all.

Bonnie and George Mohanco, Becker and Robin Mohanco, Lilya, Josh, and Alaina Like Mohanco -- BTW, Josh is a real Patriot serving the US in a war zone right now with the State Dept. Thank you. Hey who said something about Dirty Big Louie? Thank you to all my fellow members of St. Conrad's Society, including Thurwald 'Buddie" Holmgren, Bernie Hummer, and all those who are there when needed. Special thanks also to Bob Yanelavage for the number of years he takes off my appearance with each hair cut. He's a pro. If only he could finish the gallon faster, my confidence would grow. And, of course there is Bob Amory, my first barber whose "cuts" got me to where I am today. Congratulations on your retirement Bob! And thank you to Daniel J. Flood, the inimitable, legacy NEPA Congressman who continues to help me with my voice lessons.

Let's not forget the GAR gang of Paul (Chef better than Boy R Dee) & Cathy Radzavicz. This fine couple can even sing German songs. Shhhh!!! plus Rachel and Mike Sulkowski, and the full Naples GAR gang. Thanks for the memories and inspiration from Roy and Rosemary Bartlett, the hosts of the party from the Gulf, Ross and Ann Marie ("50" Stoney) Livingstone, Coach Madelyn (Madeline) and George (Gino- Geo & George the Dragon Slayer geotheds) Elias, Claire and Chip Godfrey, Yogi and Marie Michaels, Eddie Baker, the Captain and First Mate on the gulf..... the Manischewicz Brothers (Manno and his other brother Manno) as well and their major competition - the Christian Brothers. and of course, Dennis, "Bucko" Grimes.

Other helping hands include Dr. Lou and Marie Guarnieri as well as Mary and Cindy Guarnieri, and the new Dr. John, the newest Chiropractor. all of whose hands have been indispensable. I can't forget Mike and Cathy Kurilla, their daughters, Kristi, (the oldest) Susan & Jessica (Senior year at Temple) And, of course my long time friend Frannie & Angel Joann Kurilla, his sons Anthony and Frank & his wife Tanya and the two little ones, Ashley (now 5) & Kristi. I sure miss those trips to Canada with 5000 Dice champion Joanne, the Windsor, and all the nice tries at getting the language right. We did get the beverages right! Watch out for flying chocolate bunnies!

I love all my friends including Jerry and Hedy Cybulski and the Elmer L. Meyers crew, Linda DeBoo Buynak, and Bob Buynak, Paul and Diane Grimes, Pat the Peach Fahey Lawson, Mary Claire and Barry Payne. Ellen Simms McGlinchey, Joe Rasimas, Bill and Karen Amesbury, Jack Keller, My good friend Nathan (Nate) Fink, John and Cathy Martinson Marty and Cathy Kane, Stanley and Rita Pohutsky, Marty and Mrs. Devaney, John and Jim Maloney, Carl Steinbrenner, Earl Bisbing, Jimmy Askew, Jack Bond, "Bondie," Steve Wasserstrom, Donnie "Red Sox" Berman, Clem Norman, Angel Dick Conrad, Mimi Harrison, Romaine and Angel Charlie Bosak, Mary Ann (Toney) Stillarty and Bob Stillarty, Joe the Chief el Heffe LaSarge, Sherry Jones Hornberger, Alan and Joan Cole Melberger, John and Susan Rose, Bobby Broody, Bob and Karen Fountain, Jerry Pesnowski, and Dave and Nancy Books. Thanks also to Dr. Rex Dumdum from Marywood-- my Academic mentor, Dr. Sam Dagher, Dept.Chair, Art Comstock, Marie Griffin & Roxanne Hoover, Captain Mark George, Atty Jim Zaydon, Dr. Gale Jaeger, Dr. Charles Lipinsky, George Marcinek, Atty Brian Petula, Dr. Chris Speicher. Special thanks also to the E. L. Meyers Class of 1965 for some early training in the art of writing.

Going back to the top of the list of helpers is my wonderful and huge pack of McKeown cousins. My brothers and sisters and I brought our children to our family home as long as our Mom and Dad were on this earth. We loved to see them mingle and enjoy the company of all their first and second cousins. Now, because they know them so well, it is beautiful that our kids love their cousins. Well, our Mom and Dad did the same thing with us. And, we love our adult cousins too. OK since Mom was the baby of her family, some of our first cousins actually were friends with our Mom and Dad even before we met them but hey, the point here is, we love each other.

The list of these fine people begins with our Uncles and Aunts on Mom's side, since we lived by the McKeowns and with Grandma and Grandpa McKeown. Many of these are now Angels, but all have been major contributors to all writing I have ever done.

Uncle Nick and Aunt Emma McKeown, Dave and Kathleen Conklin, David & Debbie, John & Audrey, Kathy & Butch Parker, Jimmy, Johnny, Paul & Donna, Joseph & Laurie, Nicky & Margie, Mary & Kevin O'Brien, Jeanne & Brian Norris; George Kasiski, John and Debbie Kasiski, Linda Kasiski, and Dawn Seely; Cousins Cathy and Dave have such a large and wonderful clan, they can't fit their own children and their children and their children in for dinner at the one table. Did I say table? I meant house. But, they do. What a superb crew. How amazing to be in their midst.

Rita and Frank DeRiancho, Frank & Janet, Steven & Kitty, Donna, Danny, Brian, and Susan; Each year, cousin Rita sponsors a cousin party that is for only those who are of the Grandma / Grandpa McKeown lineage. In-laws are not only invited; they are expected. From my own experience, if only one of us could come, my wife would be hoping I got the short straw and she was in. Then, she'd be trying to figure out how I could get in also post facto. Cousin Frank DeRiancho, a fine fellow in his own right, is often at the party. Hey, it's at his house. He has white hair like the Irish guys so he fits in. He actually likes us. But, if the truth be known, it's only because we liked him first. Now, at Rita's ahem, 20th birthday party in the late fall 2008, Frank was so occupied he looked like a detective on an important murder case, like one of those fancy TV mystery novels. He was clearly the detective. So, now, what to call him? Hah! Columbo! It fits like a glove and I actually think he likes the moniker.

Joan and Tom Nelson, Tommy & MaryJayne, Michael & Joanne, Tammy & Kenny Reynolds, Timmy & Christine, Kevin & Brooke, Andrew & Jolene Dickson. Cousin Joanie had a case of TB when she was young and as the head majorette in Bloomfield High, she had many suitors and was going steady with a young man. When she got TB, he no longer came to see her. But Tommy Nelson did. Eventually Joan fell in love with Tommy and unlike any couple I have ever seen, at all times, they adore each other. Erich Segal, author of the weeper "Love Story," could have had another best seller on this story. Now that Tommy is retired from being a steamfitter, the huge Harley with the trailer for luggage can be seen carrying this handsome and pretty couple all over the country and into Canada several times a year. BTW, Tommy a very masculine and very strong steamfitter fell into the Hudson one day on the job before he retired. Joan always had another set of dry clothes ready just in case. Tommy came out of the water, stopped in the rest room (job johann) and came out fresh and dry. Then, he worked the rest of the day.

Now, after all these years, I wish I wasn't 7,321 years old so that I could have even more time with my cousins. Maybe there are nicer people on earth. Maybe there are . Maybe, just maybe... but, then again, this crew of cousins are the real thing and I love them all above as well as the other cousins on the list below. They're all amazing. And there are more of them...

Local from 66 Horton St. for a million years are angels Aunt Ruth and Uncle Joe McKeown. Uncle Joe told the Twins and I that we could not tell any stories out of school. But, he was a great man who we all loved dearly. And how about the Al Jolson tunes coming from the record player hooked up to the table radio. That was great technology. I for one thought Al Jolson had a lot of potential as a singer but then I learned that he had died even before I was born. "Mammmy." Wow, what great days.

Then we've got other great cousins Joe McKeown Jr. (Pookey) and his lovely wife Kathy McKeown, their kids and spouses, Patti & Joe, Mike & Lisa, Kevin & Megan, and then there are those Kellys on Kathleen McKeown's side, Angels Cornelius and Kathleen Kelly, Helen and Angel Joe Drexinger, Alice and angels Bonnie and Joseph Jr. Joe Jr. has a cohort Melvin Manhart, and another named Red Jones. He and Red are two of the best Square Dance callers in the nation. Well, I think so. I heard them in action. Kathleen tried to teach us how to Square Dance but I think we need a lot more lessons.

A new Angel Aunt Louise joined with Uncle Jimmy McKeown and their son Jerry McKeown in heaven just about a year ago. Their kids, my cousins, include angel Jerry, Patsy McKeown Toole and Angel Jim Toole, as well as Danny and Tisch McKeown, who now claims to be a German deprived of the Octoberfest for a fate of the clouds (snow). These are their helping children: Pat and David McKeown / Hidalgo, Caitlin and Conner; Maureen and Dominic McKeown / Bucci, Gabrielle, Olivia and Dominic (twins), and Michael; Dan & Tracey McKeown, (Jr.) Dan Jr. is known to those who grew up with him by his confirmation name of Brian; Karen and Steve McKeown / Ortman, Zach, Amelia, and Will.

Tina McKeown & Jimmy Slabinski, friend of Tina and a friend of Dogs everywhere, except one are all ready to help. Cousin Patsy married Angel Jim Toole, the brother of a judge who the president of a college. I knew him from my days at IBM but did not know he was a cuz til awhile after those days. Cousin Patsy is a great lady and her husband was a fine man. Cousin Dan is a Judge someplace but Trish is the real judge in the family. They travel hither and yon to be with their cousins for many events from the Cousin-fest in the summer, to the Square dances with cousin Joe, to the great German Night celebration at St. Nicks. As Lawrence Welk would say, a wunnerful, a wunnerful...

Uncle Gene & Aunt Helen McKeown, Help comes from first cousin Angel Jean and Hank Fibick, and second cousin Richard Knaus and his wonderful family. Richard and I were best friends for many years while he was living in the area. Thanks for all your help on the books, Rich. Lois and Gertrude are two other first cousins who are special ladies themselves. Thanks for all the help.

Angels Aunt Nina and Jim Brady, and cousin Jimmy Brady Jr. - another recent angel - - what a guy! Cousins Tommy and Mary Rowan, Arlene from WB, Tommy's Mom, who ran the corner establishment bearing her name for so many years, Arlene and Richard May -- another young angel, Tommy Rowan Jr. & Madeline, and all the other McKeown cousins, uncles & aunts who can't make it to the special muse event every summer in Montrose. If you can get a ticket to this, you are a lucky person indeed. Thank you, indeed.

More McKeowns include Angels John and Mary (Grandma & Grandpa), Uncle Henry, Aunt Francie, Alice & Lolo, Elizabeth, and Alice who we never got to meet but we know pray for all of us with the rest of the McKeown brothers and sisters because they know we all need it. Who knows when one of these fine angels will become members of the muse?

Of course, there's the Kellys, many of whom are also Angels, and their great help in the muse category starting with Angels Grandma and Grandpa Kelly, Angel Uncle Martin Kelly, the first born who died when he was just 53. Then there is our wonderful Angel Aunt Marie & Angel Bud Hopko, Angel Aunt Helen and Clarence Berger, Bonnie & Bergie and their families, Aunt Catherine and Leonard Lamascola, and all the half Italian, half Irish cousins - still FBIs. Angel Uncle Pat & Aunt Mary Kelly, Pat and Kim, Tommy, Sharon & Bob Yale, Maureen & Bill Roussedge, Jerry (Jud) Kelly. Angel Uncle Mike & Aunt Fran, Mary Lou and Ellen, Angel Uncle Joe Kelly & Angel Aunt Marguerite Kelly and Angel Aunt Helen Kelly. Aunt Kit and Angel Uncle Phil Kelly (Red Cloud Kelly is also on the list for his past due diligence in writing postcards and other memorabilia under an American Indian fictitious name act) Uncle Johnnie Kelly is still the youngest of the "Fighting Kellys." Thank you also to all the unmentioned Kelly cousins, uncles & aunts who once shared the Christmas tree lights at 913 Scott St.

Another set of acknowledgments to this special category, Holly Goncheroski, Patricia Singer, Marla Hunter, Malinda Hunter, Sam Ashby, Conrad Miller, Hector De Los Santos, Brad DeFraim, Angel Kelly Gorham, Dave Thompson, Scotty Huber & Julie Casey (never let 'er go you cur!), Kevin the Walloper Doyle & Attorney Pat Doyle.

A ton of thank-you's go off to the almost in-laws. Angels Mr. & Mrs. Morrissey and Angels Mr. & Mrs George B. Lewis. Their spiritual help is always assuring. Mrs. Lyla Lewis, a.k.a. Sal took her trip as an angel just a few summers ago. Thank you to Angel Bobby Morrissey and his living angel Mary. And, wow, Angel Tommy Morrissey is now with his bro. Thanks also to Chuck and Marilyn Gallagher, Tom and Lucille Buck for their continual guidance and inspiration. And that Janie Livingston and Margo and Jack keep helping whenever possible.

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Preface:

Why did Brian W. Kelly write this book?

When your author, Brian W. Kelly, decided to update his 2008 book about then current, domestic, political and constitutional issues intertwining with public consciousness, <u>Taxation Without Representation</u>, he became immersed, once again, in that vortex of all-too-familiar concerns about our government. He felt compelled to add a few paragraphs about the Obama Presidency in light of the transparent failures of the newly-coronated Administration.

As he undertook the task of updating the original 2008 text, he became so smothered in the extensive issues that had since developed that he was compelled to delve further into the examination of the underlying issues. As a result, the project moved beyond what one may consider to be a standard update/ revision to the point that, when he received the book back from the editor, Melissa L. Sabol, he noticed that she had split the original twice and had created two additional, entirely distinct books.

The first book, <u>Obama's Seven Deadly Sins</u>, is being released concurrently with this book. It advises that the deadliest sin of all is indeed Obama's approach to healthcare, or what many now call Obamacare. This book, <u>Healthcare Accountability,</u> began as the last chapter in <u>Obama's Seven Deadly Sins.</u> The Editor separated it because its message was off the mark for that book. However, she noted that it offers a coherent, common sense solution to the biggest problem with US healthcare for all -- its cost.

She suggested that it be released as its own separate offering and that's what Brian W. Kelly has done. This book, <u>Healthcare Accountability</u> offers a unique and compelling solution to the

problem of healthcare cost. It is based on a notion that others have chosen not to explore -- individual accountability.

Most Americans are aware of the major battle regarding health insurance and healthcare "reform" that 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 was more than ready to spend a trillion dollars or more on a government take-over of healthcare. 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).

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 will pay the most to support this block of 17%, which may very well include illegal aliens. 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 have given up?

The big winners, in this scenario, are the trial lawyers and the big insurance companies. The people (as in We the People) are left holding the bag. In this book, we describe, in reasonable detail and in words that any American can understand (substantially less words than the bill in which Obamacare is proposed), how to make the healthcare system -- both ER and Medicaid, more accountable. 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 keep track of things. President Bush and President Obama both agree that a database of citizen health records needs to be compiled and it is, indeed, a very

good idea. In such as system, there would be 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.

This book provides a logical and clear blueprint that defines the terms for organization of online 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.

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.

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.

For now, I wish you the best

                                                  Brian P. Kelly, Publisher
                                                  Scranton, Pennsylvania

Chapter 1

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

Get Your Permission Slip Quickly

Is everybody you know looking for the ability to be 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? Sorry about that! It is not yet 2013 and the second term has not yet begun. I almost forgot. We are still free, but many of our freedoms are now under attack. We are free still and also unaccountable for much, which means freedom will either pass us by, that is, if it is not first stolen.

Do you want any jurisdiction over your own life? Are you willing to give control up because somebody is going to take you to dinner and/ or buy you a few drinks? Is healthcare a right that the government is obliged to provide? Do you really want to please the statists, possibly at the risk of having no healthcare for yourself? If you have no money, and your parents don't want you stealing their best frozen dinners and their best booze, then you are more than likely a candidate for the physical equivalent of the opium for the masses. It once was Religion, but since many have shut God out of their lives, it now is material goods.

Who has the best offer? In this past 2008 election, clearly the one with the most to offer was Barack Hussein Obama. Some think he is going to give them cash out of his "stash:" maybe even a nice new home. Can this powerful President destroy the national healthcare system to accommodate a mythical few who are, so he

says, not covered? Are you concerned about being labeled a "nasty dude," if you don't go along with the Prez on all he suggests? After all, he knows what he is doing, right!

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 you must 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?

It is true that there is not much in place for those who need temporary health insurance coverage. 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. Is the President right? Is the only solution for you to give up your own healthcare to help somebody else? If Obama is not right, the moment you agree to give up your own healthcare, he will own you. Make sure you know that. It will be you, and not the mythical man, who has no healthcare worth even a grain of salt.

Can Medicaid Be Improved to Cover Everybody?

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. All people facing hardship would be eligible for Medicaid immediately after the lapse in their current insurance policies. 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 current system gets dismantled, but, it does mean that when times are better for the patient, there needs to be a way for this patient to pay back the people's treasury for the helping hand. There is no free lunch!

The ideal would be that any citizen, in any kind of financial difficulty, 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 are in such poor shape that this solution would probably require borrowing from the Chinese, who would be tapped to fund it, or perhaps it could be the unindicted coconspirator (a new idea) who might over time be able to fund it (discussed later in the book as a substantial funding alternative). The good news is, there would be no Obamacare necessary, meaning the current system can stay in place (83% of Americans do not have to move to Obamacare) while many of the objectives of the universal healthcare notion are either accomplished or are declared accomplished. It would be 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, funded by state and federal dollars, that pays for health and long-term care services on behalf of eligible individuals. The program pays Medicare premiums and, in some cases, other cost-sharing requirements for low-income Medicare beneficiaries, who are known as dual eligible's.

Total spending on Medicaid in FY 2005 was $316.5 billion, accounting for 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). Medicaid funds more than one in three births and is the also the largest source of public funding for family planning. The program covers more than 7 million of Medicare's almost 44 million enrollees (about one of every six), and 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 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 that is administered by states. States must operate their Medicaid programs in accordance with an approved state plan.

I do not suggest that the information above is wrong in anyway, for as of 2005, it was completely accurate. Even Federal Government Cabinet Members such as HHS Kathleen Sebelius has a tough time getting statistics from their databases that are less than three years old. It's no way to run a country but when government is involved, expectations should rightfully drop.

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.

What about that Emergency Room Thingy?

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 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 can avoid the expense of treatment. 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.

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.

Hospitals find the bill onerous, but if you read about the patients that hospitals were dumping prior to this bill, your pity will 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. 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 prohibition of EMTALA. On the one hand, hospitals must collect information or they never will be paid. On the other hand, the priority is on making the patient stable. That sounds about right.

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.

Sometimes, when the hospital personnel go ahead and attempt to gather the needed information prior to treatment, the patient will simply leave the ER and they won't return. Too often, when a prospective patient is questioned about their insurance/ financial status, they will run the other way. Then, they will call and complain because they did not receive proper treatment.

Whether they issue a complaint 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, 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 crap 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 a emphatic

arguing that EMTALA is a vital piece of the safety net yet as 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, everyday that the Bloated, Corrupt current administration is soon gone and we get Obama/Biden in to try and fix the mess you made of our country."

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.

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 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, even though it may not cover colonoscopies and dental care, is a big comfort to me. 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 dismantling the whole health insurance industry and hoping that President Obama can put it back together again. Considering the government's fine work with the H1N1 Swine Flu rationing to Wall Street first, I would hate to be one of the poor souls on the federal government healthcare takeover plan.

I think that EMTALA can be enhanced, as can Medicaid, so that there is less pain associated with it. 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 who want to 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 its 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 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 the President would not have to be the Chief Medical Officer, and much of the costs involved are 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.

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.

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. Though nobody knows for sure, his 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 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:

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- **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 of 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. 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.

"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."
http://www.acuf.org/issues/issue116/080922gov.asp

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% were 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.

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

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.

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 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." Isn't that hard to believe? If you delve into some of these programs more deeply you may find some requirement for co-pays and small payments, but as a rule, there is no requirement to pay. 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.

Chapter 2

Raw Ideas for Accountability -- A Starter Set

It All Starts with a Good Thought

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 is who pays the bill. As noted in Chapter 1, in many cases, and, of course, the whole essence of Obamacare, is that more often than not, the patient is left out of the equation. The supposition in this book is that a public willing to help an individual with their health concerns should expect to be repaid some time after the patient gets well. The patient should be accountable to pay the public back for any share of EMTALA or Medicaid that was expended on his or her behalf. The debt to the public should die 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 not through the government. The system should work even better than the current system does now as 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 pretty liberal. Over time, by accounting for Medicaid expenses back to the individual, eventually something could be paid back to the people's treasury from the recipient of Medicaid insurance. 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 they cannot be paid at the time of service.

Please Put that on a 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 would not be government controlled nor would 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. 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.

Care would have to be built into the 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 as Obamacare. Under the proposed 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 system 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. 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 after 2012, any subsequent administration is in control of the entire health industry.

There are a lot of other solutions that are non-disruptive to the health insurance and healthcare needs of most Americans. EMTALA would not go away, as that would be needed for foreign

visitors and for illegal aliens. They too would get a bill for service.
Collection systems that are reasonably non-aggressive would
have to be built to augment the information in the accountability
database.

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.

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 or 40 years old. Many states have
enacted such laws already. These states are obviously more
capable of dealing with people in need than the federal
government.

Perhaps 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 works, simply so that 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, and are thus
due to be collected at some point. .

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 uninsurables could be placed in an assigned risk pool and gain their insurance from one of the participating companies. They would not be part of Medicaid unless it became a needs-based situation. They would pay or their parents would pay the fare. Insurance companies would be obligated to give them a fair rate, and if they do not pay as they should, they can be dropped just like anybody else and 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.

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 on Medicaid. Afterwards, it would become due and collectible with reasonable limitations.

Insurance Companies -- Risk Pool

Insurance companies do need to be checked and balanced. 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 is affected more than any other. An efficient, public-based, state vs. federal based non-governmental insurance oversight committee also needs to be formed in each state, 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. Often, these temporary insurance issues occur when people are between jobs and 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 might volunteer to pay the Medicaid for a period of time.

An overarching accountability system is a prerequisite to making all this work. In this instance, if the 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. A database "in the sky" 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 then 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. 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.

In several other books, 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 actually get a freebie on us. My perspective is that nothing from government should be free, since it is from the people's treasury. This book, however, is about healthcare accountability only.

Pay the Rent!

In the current scenario, hospitals are permitted to hound their 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?

It is like that because people have needed help and the lawmakers 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 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 in order 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 would have to liquidate in order to be eligible, nor would they have to liquidate in order to pay the bill, given reasonable time periods. Unmarried adults would automatically qualify if they met the income criteria. This would plug a big hole in the current Medicaid law. Because Medicaid would be so much 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.

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 is very similar in concept to an Electronic Health Record. Another effective name could be the Personal Accountability Record. For this book, we will refer to the idea as the EAR system and the account as the EAR.

The purpose of the EAR would be to capture the bills and the payments and 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." Healthcare 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 or EMTALA as well as an enhanced Medicaid would not be free. 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.
http://en.wikipedia.org/wiki/Electronic_health_record

Enhanced Medicaid Safety Net

Today, everybody is entitled to EMTALA, but theoretically at least only select individuals meet the criteria for Medicaid. Again, the supposition regarding Medicaid is that there are more on the program than the rules allow. This Enhanced Medicaid safety net for Medicaid then would be very much like a loan. Actually, it would be more like a student loan. There would be no more outright grants for healthcare and perhaps other notions such as corporate 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. 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 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 Fannie 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 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.

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 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 payout range would be from .5% to 10% of the balance per year with a modest interest rate. 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 $5.00 or .5 % to as much as 3% or some other token amount, 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 getting paid ever.

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 proceeds. 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 have to 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 their former employer's group health insurance, provided that the former employee pays the monthly premium, which, of course, is typically still 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, but instead, something, so 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 knows they must contribute and nobody is denied help or coverage, ever...and there is no rationing. Period.

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. 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.

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.

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, pre-billing was a ruse topic. However, there was a real notion of pre-billing which meant that a copy of the pick-list in a warehouse operation would also be the invoice. They called this pre-billing because the bill was ready before the goods were picked. I would joke 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 billed. Most companies did not check bills 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, there is some chance that it would be paid regardless of what it is about. 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 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 premium. 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. 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. 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.

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 ERs.

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 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 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. Yet, 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 last 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 "account" donations would be applied to all EAR accounts in the same proportion, 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 (President's new number) uninsured 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 want 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.

Chapter 5

Attributes of a Good Health Care Plan?

Danger: Government Can Own the World

You may or may not know that the government has decided to keep your health records in a big "database in the sky" called electronic health records (EHR). This is a partly a 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 your 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. 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 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.

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 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 self-sustaining and all inclusive. This can be managed without completely destroying a system, only to spend years and trillions of dollars arguing over every minute detail of a 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 in the black 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 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."

The change that people were looking for, and the intrusive change that Obama and Congress are bringing upon us, just may not be the change for which America was indeed searching. As a Democrat, I see the President much too willing to enter my life, and tell me I can begin to leave my brain at home. Mr. O will take care of everything. I'd rather Mr. O stay in Washington or go to Cambridge every now and then for a beer... 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 Obamahappenings are not occurring for the good of the country. They do, however, help Obama and his powerful administration.

This Magic Moment

Unfortunately, the bulk of the Democrats, is 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 Commander in Chief and if the "man" is for it, they are too. It's that simple. 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 are so entrenched into Obamathought, that it is like a Vulcan mind meld, and they are not letting go.

Unfortunately, I cannot find any sense in alternative Democratic proposals to the big ones that are already out there, having passed various levels including the full House on Nov. 7, 2009. I am not suggesting that the Republicans have a market on ideas. It would be nice if another Democrat began to talk the same sense that Pat Caddell speaks. Most Democrats do not know how far from mainstream President Obama and Ms. Pelosi and Mr. Reid really are. They are all still fighting George Bush, and if they can convince us that is a worthy mission, that gives them all a free pass to do whatever they want, and that is not good. Yet, they are doing it anyway. That is a story for another day so I will give it only a few more paragraphs.

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, Barack Obama at the helm, would be 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 of us, 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 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 Commander in Chief to be the 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. 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, without crashing the whole system for 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 works.

Chapter 6

States Are Better Problem Solvers than the Fed

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. Idaho has built something they call the Idaho Health Data Exchange and they see 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, the debate would be over. Instead of being too busy with a scheme for full control, the federal government should be 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 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, ya gotta wonder why nobody is checking 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. My respect for the American people goes far beyond pulling a stunt like that. 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 are not favorable as the current administration would prefer to create dependency rather than have the less fortunate and the poor participate in something that gives them self respect and healthcare, instead of just healthcare for free on someone else's (our) dime.

You may recall, 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) offered that the Obama administration's attempt to use regulatory power to suppress criticism of its Obamacare plan is simply outrageous.

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 said to cease sending what it called "misleading" information about the healthcare bill to clients.

Insurers are burning about what clearly is a White House attempt to control information about possible Medicare cuts. If it were over, I would have used the verb, "was" in the last sentence. 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. 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 about 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 irony is that these representatives actually think we are not watching. They actually think they are going to get reelected again.

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 hates Medicare Advantage even though 33% or more of seniors subscribe to its "advantages." So, since Obama is

doing away with a prime business product of Humana, the company felt obliged to tell its clients, (seniors) that Medicare Advantage was going away.

As an aside, the November 7 house bill and the November 21 Senate bill takes off the shroud and gets rid of it completely. Yet, Obama's goons are not trying to strangle any of the House members who voted on the bill (only because he could not get away with it -- yet.)

Follow the Money

There is a lot of speculation that the Medicare Advantage Program cuts into AARP profits from its own insurance. Because AARP would benefit substantially from a financial perspective if there was no Medicare Advantage, there are suggestions on the floor that say AARP sold out to the Obamacare notions because the administrators all have the chance to be millionaires. It has nothing to do with what is good for seniors. Looks like AARP is 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. (the Government)

The White House vigorously warned insurers and healthcare companies they could face legal action if they spread what the White House calls "misinformation about the healthcare bill." That sure sounds like a gag order. No, it can't 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 suggest that nothing can be done that would help the country unless Nancy Pelosi is no longer in the game as the Speaker of the House. If she were gone, they say that America might have a chance. Knowing that people in my own extended family using EMTALA as their only form of healthcare insurance is not necessarily the best feeling. But, guess what? It does not mean that it is net worth that funds the 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 legal or 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 pay out of pocket on top of what IBM pays. Nor do they 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 new Pelosi 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.

Ironically after I wrote the above paragraph 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 Xrays 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. Why not take a few of the best of the best people and invite them to one of the daily Obama Press Conferences? Why not have these wonderful scientists, who, lets 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 are able to achieve results that no one else achieves. Eventually, with no help from Uncle Sam, or the American people per se, these best 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?

My family never had a pot to urinate 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. A number of 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 Kellys 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 sixty 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 pretty darn good.

Thank the entrepreneurs who built America and accept, if you have chosen not to work, that you have a pretty 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 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 that it is okay. It is not okay.

When the bills come in from EMTALA, if the patient has even given their correct identification, the bills become used for campfire fodder. If patient is illegal, the bills are sent to somebody else's address. Despite the fact that 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 life saving 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 all the current Obamacare legislation does, a little tweak and a few surgically accurate small snips can work a lot better. By now, of course, we all know that the 2000+ page Reid bill was the Senate's offering and the monstrous 1990 page Pelosi bill was the House's offering while this book was being written. Eventually, the Pelosi bill passed at 220 to 215 much to the chagrin of most of the nation. Reid's bill got its first test November 21, 2009 in a rare Saturday Senate session.

Does 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 health changes to Obama.

The President of the US wants so much to control all of his subjects (in my humble opinion) that he is prepared to run yet another show. If there is some other value in the Pelosi November 7, 2009 legislation other than Obamacontrol, it sure is not obvious. To say that everybody in America must change their health insurance to satisfy one huge ego is shameful. Too bad that the "blue dog" Democrats in the House did not have enough guts to fight for their constituents. They have chosen to follow Pelosi rather than their own constituents on her anti-American, anti-capitalist, socialist, redistribution agenda. Blue as they may be, my vote says they are gone in 2010.

Without Obamacare, a.k.a. the great health destroyer of 2009, 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. 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 that 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 Obamanites, this would not be tolerable as there could 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?

I am conservative, but not 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 one day, just like everybody else. 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.

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."

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 Barack Obama, Nancy Pelosi, Harry Reid, and a lot more Democrats than you would ever imagine would say "no." 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 we, the American Public, helped anybody. 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.

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 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?

Too Many Interested Third Parties

In a simple plan to keep track of what those who are 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 patients' 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, which have a lot of political capital invested in Obamacare. 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, November 7, in the House. In the future: Whatever Madame Pelosi calls it right now, the objective, admitted by Michael Moore, 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."

It may be called a public option, a consumer option, a Pelosi 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 on 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 them back? That's why the "loan idea" will not fly in the Congress of the United States.

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? Because no accountability records have 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 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. But, we do not know who they are.

Commonsense Reforms, Not a Takeover

Like all spiritual individuals who believe in God, I would advocate promoting commonsense 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 fairer, with no gatekeepers. Keep that in mind when you go to the polls, the very next time, that this whole pretend crisis is simply an Obama power grab.

Chapter 8

Manual Records in Healthcare

Electronic Medical Records Start With Paper Folders

You've been there. You put your one hour of waiting time in the crowded 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 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 and 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 any other metric that is new. 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 theirs your medical record. Most of them are not inclined to share their records with the others unless requested.

Folder Automation = EMR

In each setting, the data is unique to that provider, though your family doctor may have summaries of most of the other providers' materials in your "folder." Your family doctor, in most scenarios, is the quarterback for you in the health game. If your doctor is fully automated, then your record may be called an *Electronic Medical Record* (EMR) and 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. You filled them out and they filed them. That is your provider 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 data from the big manila folder. Even so, that folder, representing all of 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 awhile. It does take a long time to migrate. You may see the folder 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 EMR.

What may be happening is that your doctor's staff is scanning information into your electronic medical record (EMR). The formal definition of an Electronic Medical Record (EMR) 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 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 others kept for specific purposes.

HIT and Medical Informatics, In Most Cases, Are Good

EMRs are part of a growing discipline of 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 the pleasure of teaching Health Information Technology (HIT) at King's College in Wilkes-Barre, PA. HIT is the application of computers and technology in healthcare settings and is thus, a superset of Medical Informatics. I also serve as Assistant Professor in Business and Information Technology at Marywood University, as I have shared with you previously. By reason of my twenty-three years experience with IBM, my years as a computer consultant, and the thirty plus books and numerous technical articles 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." 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

> "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 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. 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. 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.

President Bush had the right idea that his initiative would move the country forward towards EMR/ EHRs. His government IT professionals apparently let him down. They'll do the same for Obama also, as nobody seems capable of getting the notion implemented or caring whether it is done right. 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 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 targets the year 2014, just as the Bush mandate. Obama seemingly has put real teeth into his plan. The teeth he put in 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 helps the President, should we really care?

Yes, of course we should really care. That was merely a hilarious comment on my part, don't you think?

Chapter 10

Stimulus Bill Created 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. The House passed its bill on November 7 and the Senate vote was November 21. The bill was to be ready either by Christmas or in early 2010. This section of the Stimulus Bill already passed in February 2009 sets the stage for the grand takeover of the whole system that the hard left fully expected to have been completed by the end of 2009.

Though most Americans thought that we were still debating the issue in late 2009, the bureaucracy for Obamacare passed along with the Stimulus Bill. 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 is not the end but the beginning.

Some very controversial sections of the overall plan, that our slippery Congress and 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 bill that nobody read? Oh, sorry, they did not read it! That does explain a lot.

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 "sneakinski" 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. The irony of the "porkulus" bill is that few people in America and the world, for that matter, even knew it 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 Databases Are an 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 Pa 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. Wait til they hit knee and hip replacements, tonsils, and dialysis! 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 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 "stimulatus" bill, they already have enough control of our health records that all Americans need to be concerned.

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. And you thought this was a battle that was yet to come. The Army of Barack Obama is in many ways deceitful and it never intends to lose, no matter how many Americans choose to stand to face the charade.

There is nothing wrong intrinsically with EHRs and EMRs. What is wrong is that Nancy Pelosi, Harry Reid, and Barack Hussein Obama plan to be the database administrators. Having government run the databases is an opportunity for the worst kind of corruption this country has ever seen. They know that. So, they already funded it in the "porkulus bill."

Bush's Plan Was Intended to Be Innocuous

When President Bush put together his mandate six or more years ago, it was far more harmless than the Obama plan. Bush created a new bureaucracy at the time called the Office of the National Coordinator for Health Information Technology. Obama's law piggybacks on this bureaucracy to actually do the work. This group, already in place, is to put together a plan for building this system so that it achieves President Bush's objective of the "utilization of an electronic health record for each person in the United States by 2014." This is mostly good, but the federal government should not be in control of the data.

Doctors should be in control. People trust practicing doctors. Government has proven it cannot be trusted by the mere enactment of this bill. By 2014, Americans will have a chance to place a President in office that is not solely for the collection of personal power and these databases can be freed from government control.

President Bush did not spell out who would control the data. Insurance companies have been preparing to control the data and this would be almost as bad as the government owning the data. 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 intend to create a federally run electronic database exchange that includes every American's "medical history and problems lists." Like the Gecco 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.

Without extreme protection, everybody's medical records will 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 Obamaczars will be culling the records to find who is loyal and not loyal to the President and perhaps they will leak your records to unfriendly sources. This system has the potential to take all of the good parts of the HIPAA bill and nullify them de facto. But it will be good for the Obama regime as they will have the health records of all their enemies.

Don't worry; there is nothing in the law to make you give the government your information. Perhaps that is moot as you probably have little of your own information anyway. Doctors and other providers will get a higher reimbursement rate if they provide your records. Nice idea, right!

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. 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 make more money if they go along to get along. The Obama system plays on providers optimizing their reimbursement schedule from the "state." Can you really believe that this has been the law for about a year already? Obama may already own your personal information. This sure is a "change," most Americans did not expect.

So, let's say you send up your information in EHR format to the Obamabases. Those providers who choose to adopt the Obamaway of making meaningful use of the EHR notion, are justly rewarded by government carrots, such as higher reimbursement rates (bonuses) paid by the government for procedures.

If you choose to represent patients instead of the government and you decide to take Obama down for being too intrusive or because the collection of such private data on citizens is unconstitutional-- long before you as a Doctor can prevail, you will be punished in one way or another. You know that. If you are a doctor or another medical provider, if you go against the grain, you will not make as much money, and if your rate gets so low, you may have to end your practice. As in most Obamaschemes, independent thought is not welcome on this subject.

Those doctors who choose not to cooperate may get a personal visit by Barack Obama and an invitation to have a beer in the Rose Garden. Of course, to attend, you will have to wear a white coat or agree to put one on for the photo-op. I shouldn't joke, but in this administration what is unusual is becoming more usual.

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?

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

2010 when we replace every breathing member of Congress, it needs to be undone.

Yes, I am hoping that either Americans go after their Congressmen now for a repeal of at least this part of the Stimulus Bill or they replace the current set of Congressmen with a new set of lawmakers who come from the people and who will choose to do the people's work, not that of an eccentric President.

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, Nancy Pelosi or Barack Hussein Obama could be made to not be in charge of your health records, the notion of EMR and EHR can be very effective and can help you 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

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. 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.".

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. And, 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 EMR. Emphasis was always on billing and accounts receivable.

For each software package that existed or each analyst that designed a new 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 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 getting out the patient's bill and collecting it than they were about keeping any relevant medical history on the patient. Any medical history, such as diagnosis, was kept merely to support the financial reimbursement requirement. So, instead of automating medical records, most providers kept huge clinical archives in big paper folders. The paperwork (information) from each new admission or service was 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 pendaflex folders and added the new data.

Overtime, 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 the 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 are incompatible among software packages. Overall, it has been a slow process getting 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 better deal for them. Maybe it is not.

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 could select. They have to figure out which fits them best. They do not want that aggravation. Lots of the stuff they must look at is crap, crap, and more crap. When you can't convince somebody that something is good for them, the bets would be 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 not using a bonafide 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 for their institutions 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. Additionally, there has not ever been a bake-off, to my knowledge, in which 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" than they do "same." Best cannot be the "same" as everybody else's. And that is a major source of the problem with compatibility today. Doctor's are caught up in a myriad of selections, most of which would probably be OK. But, which ones?

What Is Compatibility

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 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, they 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 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 feed EMRs and EHRs, then software companies can tailor their packages to meet those standards or elect to merge 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 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 some 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. Overall, at the patient level, a wise patient must be aware of the issues.

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 2006, the adoption of EMRs and other health information technology, such as computerized physician order entry (CPOE), has been minimal in the US. Less than 10% of American hospitals are fully implemented in health information technology. Only 16% of primary care physicians use EMRs. The raw facts

show that the majority of healthcare transactions in the US still take place on paper.

Part of the problem, besides software incompatibility, is that healthcare practitioners (doctors, lab techs, etc.) often invest more in golf clubs than in IT. They spend about 2% of gross revenues on HIT, and much of this is for a set of PCs that are used for not much more than for patient scheduling. 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 EMRs and EHRs at the top of his agenda, but there will be no need for planning as this President apparently already knows everything. I really do not mean to be making such gratuitous comments, but I do see it that way. No input required. So, there will be no studying or planning, there will be doing. You will wake up one morning and it will be done. OK, that maybe is not fair, but that's what I am seeing so far, and it is unsettling.

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 more 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 has lots more information, overall, from lots more sources than an EMR. When I say shaped exactly, picture one of those pre-printed forms with the boxes. 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 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 their 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 a 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. Thus, 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, 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. 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 Records

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. 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 is trying to save money on women's health with reductions in 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 kinda 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 determinators in place to make all the health determinations on a cost basis. Giving the government of Barack Hussein Obama 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

Figure 11-1 Cartoon From American Spectator -- Seem Familiar???
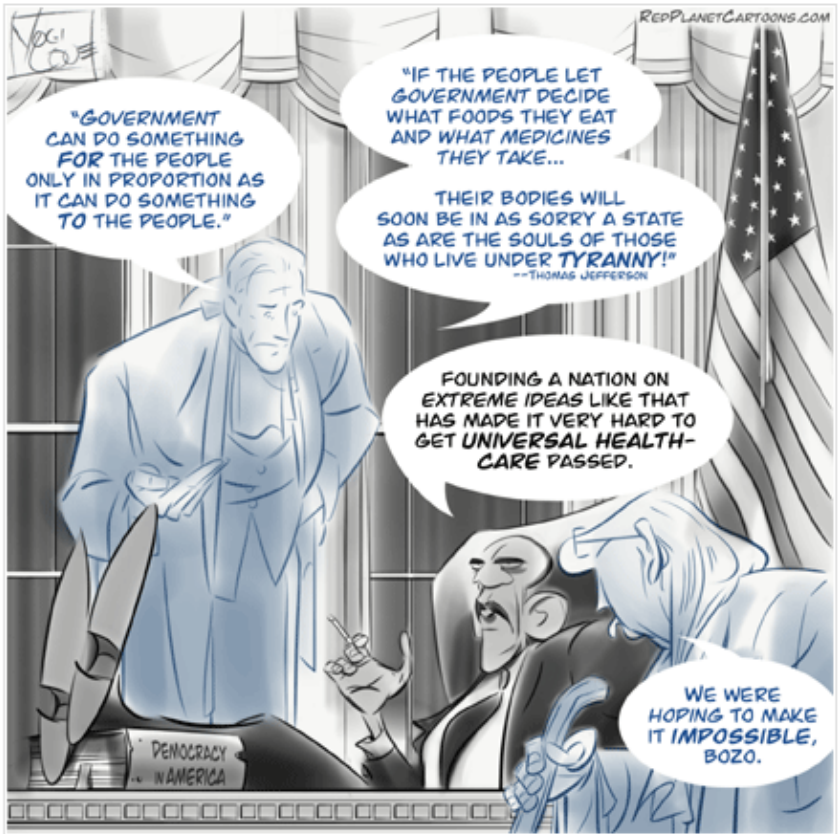
Thomas Jefferson: If people let the government decide what foods they eat and what medicines they take, their bodies will soon be in a sorry a state as the souls who live under tyranny."

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 the rest of this expose from Thomas Sowell, an American hero at:

http://www.redplanetcartoons.com/index.php/2009/08/24/jefferson-on-obamacare/

Paper Records = More Mistakes

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 to 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. Ultimately, when designed properly, such a system of health records could be accessed securely and 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 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 commercialware, 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, or 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 and if by some measurement, somebody decrees that they have gotten it accomplished, it will not be right.

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 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 can be implemented if the worker bees on the project are 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 will never work and it will always be messed up and the government is not the place you want to have in control of your 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 has that one in his hand. Because the government is also the IRS and the group that wants to absolutely own and completely control our healthcare as we look to the future from 2010, I ruled out the government as a viable caretaker of vital data, right away. Thanks, but no thanks. Again, this part of the law must be overturned.

The next group who would love to have custody and be in charge 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 they 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, they 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 Big X. I do wish my X had some power. The task, at hand, is much more difficult now as we first must remove the entire House of Representatives, and 1/3 of the Senate in 2010, get our own people in (regular people), and repeal this part of "Stimulus a la Obamacare." It would be nice if the present House and Senate would put forth, read, and sign the repeal; but, don't count on it. So, we need 2/3 on our side, in each house. That means no longer playing favorites. They all must go. Your Congressman and Senator and my Congressman and my Senator, no matter who they may be, must go. To avoid frying pan / fire syndrome, the

new candidates must pass a number of healthcare litmus tests. If you spare your Congressman from defeat, this will not work.

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, 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 are on the other team. 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.

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 purpose of 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. 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.

Look at the EMTALA law. There would be no such law if ER departments from corporate hospitals were not systematically throwing people out on the streets to increase 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.

There may be some other bad actors out there but with a good and honest, self maintaining board, 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 would 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 runs 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. The Commission 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, a substantial number of board members should be normal citizens.

The board would have no more than one official government member, one official insurance industry member, and one hospital member. None of these three would have voting privileges. The rest of the board would be 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.

The System in the Sky

If I were in control, hands down, I would use IBM computers and IBM's 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." I would outsource the running of the system to IBM Global Services for the first five years, possibly extending to ten years. 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 employed as needed.

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 dink 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 is even better than ever before. The message is that technology is affordable for many innovative uses, including EHRs and EARs, and the technology does not break down very often.

Networking has seen the same advances in reliability both in the national wiring infrastructure and in the components -- hubs, switches, routers, and firewalls. The latter 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 per month and a cheap PC, anybody can have a dial connection to the Internet today. For many, it is a better deal and far more exciting than the ubiquitous television set. For a few cents more it seems, you can have a direct connection via your phone company via DSL or the cable company. 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 in 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 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 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 let's say 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. The objective, of course, would be for all providers to be participating. Small fees for collection 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 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 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 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, my last book was The All-Everything Operating System, (type in the title and you will find sources on the Internet). 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 job transcends the capabilities of Windows, and thus it should be created with an easy to use and powerful operating system unlike Unix, Linux, or any mainframe flavored version. 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 any of the literature of the day?

More on Electronic Accounts Receivable

The same private HIPAA compliant company 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 of many doctors and such, 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.

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 system. 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) 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. All would be welcome using new standard EDI formats.

Practice Management Software for Doctor's Practices

To help 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 enterprise also build a small, Web based medical practice management system (MPMS). This would be the preferred tool to be used in all small providers' offices.

I have not evaluated whether the EHR/ EAR server complex 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 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 databases 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 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 lickety 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 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 roles 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 is not 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 $40,000 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 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 along with it.

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 and I don't like it 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

Book Summary

You Get Treatment; You Get Paid!

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 theirs.

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

cost Obama some cash, the subtle message is: why not just end it?

The bureaucrats are biting at the chomp to be freed to regulate us in ways that benefits society rather than individuals. This is the calling card of Dr. Ezekiel Emanuel who is, 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."

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 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.

For the next few years until Obamacare kicks in, if it actually passes, if I must seek medical treatment I am hoping that I am not declared a weak member of society by some automaton bureaucrat. I would surely not want to be singled out by any of those "nothing-else-to-do" Obamacrats as one who does not deserve the healthcare for which I am already paying through the nose. I suspect many of you feel the same way.

Anyway, 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!

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