DR. TED ROBERTO, 32, POMPTON PLAINS

Paperless records bring new hurdles

Job: Podiatric surgeon, New Jersey Foot and Ankle Specialists

Location: Chilton Medical Center, Pompton Plains

"I spend a lot of time seeing patients in the hospital, so I can tell you firsthand that transitioning to electronic health records has been a constant struggle and a huge stress, especially for doctors who have been keeping paper records for 20 or 30 years. The hospital has a set of staff just to train these doctors and still maintains a support staff. It's very common, too, for private practices to hire consultants to help with the training of their office staff, medical assistants, receptionists and doctors.

"Built into each electronic medical record is a set of protocols that we doctors must follow. Each year we don't follow them, we get cut by another percentage point as far as our reimbursements from any government-sponsored plan. Documentation is huge, especially now because you know the government is watching like hawks."

Back story:

Before starting New Jersey Foot and Ankle Specialists two years ago, Ted Roberto worked with a medical practice still keeping paper records. Since he has a computer science background, he led the charge there to transition to electronic health records (EHR), a mammoth effort. Conversion to EHRs has rolled out under several laws, including the Affordable Care Act, which requires doctors to use the Physician Quality Reporting System and, starting in 2015, reduces Medicare payments for doctors who do not comply.

Current scenario:

» A few hours every night, Roberto works on his electronic health records at home so he can maximize time with patients in his office during the day.

» To alleviate this situation, he is experimenting with using a medical scribe in his office. A scribe transcribes on a tablet what a doctor says as he interviews and examines a patient. To employ one is an added cost, Roberto said, but it allows a doctor to be a doctor. The only other option is to type on the computer while he is talking to a patient, which he doesn't want to do.

» Everyone in the medical world is walking on eggshells, including patients nervous about seeking medical care because they're leery of their new high deductibles and unsure what their new health care plans cover.

» Roberto has chosen to be an out-of-network doctor for many insurance companies because the reimbursement rate is higher. That means he can spend a lot more time with patients, which makes him and them happy. If he accepted only in-network patients, he said, he'd have to see two-and-a-half times as many people in a day — 50 or 60 — to make the same money.

Dr. Ted Roberto of NJ Foot and Ankle Specialists talks about the federal mandate regarding electronic medical records. TANYA BREEN/STAFF PHOTO

A look ahead:

As the reality of the Affordable Care Act settles in the years ahead, Roberto fears government plans will cut their reimbursements rates even more and health care providers will have no voice in negotiating. Consequently, he predicts, the volume of patients doctors will have to see, just to run their businesses, will have to rise. "Obviously, that means less patient contact time because you can only see so many people in a day," he said. "Then you've got to go do your notes. It's intimidating."

JAN AUGUSTYN, 48, SUCCASUNNA

Diabetes patient can get his medication now

Before Affordable Care Act: Charity care

Since Affordable Care Act: Medicaid

Job: Gas station manager temporarily out of work due to an injury

"I'm glad the Medicaid did come through. When I didn't have the money, I'd wait till the following week to buy my medications. You can't do that with diabetes. You've got to get your medications right away, and now I can."

"To tell you the truth, I really don't know anything about the Affordable Care Act. It's all new to me. I learned that everything was changing in January. They hit me right there in the doctor's office and told me I had to go to charity care and get my coverage upgraded. Charity care told me to fill out papers for Medicaid."

Back story:

Two years ago, Jan Augustyn discovered he had Type 2 diabetes when he thought he was having heart attack pain and was brought to a hospital. Instead, it was discovered his blood sugar level was more than 500, well over the typically normal level of 70 and 120 milligrams per deciliter. He kept up with those medications he could afford, paying cash through Wal-Mart's $4 Prescription Program, which charged him $4 per drug for a 30-day supply.

In January, a piece of metal went through Augustyn's left foot, which was numb because of his diabetes. Unbeknownst to him, two of his toes became infected, requiring treatment and necessitating the insertion of stents in his leg to get blood circulating to his toes.

Current scenario:

» Starting in April, Augustyn still goes to Wal-Mart for his eight medications but, with his Medicaid card, pays $4 for five medications. He is hoping three other medications that were previously too expensive for him to buy, such as one for nerve damage and another for serious heartburn, will be covered now.

Jan Augustyn KATHY JOHNSON/STAFF PHOTO

» Now he doesn't have any excuses to avoid treatment because he's not covered. He goes to doctor offices without the stress of worrying about what he has to pay for.

» Augustyn continues to go to a diabetes, heart and foot doctor as he continues to be affected by issues of nerve damage and blood circulation. Soon he will have the blood flow in his neck checked.

» He is upset that his podiatrist does not accept Medicaid. "I was shocked," he said. "They'll get me another podiatrist, but I'm comfortable with the one I had."

A look ahead:

Augustyn has signed up for a diabetes support group at Morristown Medical Center to get guidance on how to better live with the disease. He also hopes the state government will provide more in-person education about Medicaid in hospitals and clinics for people like him who aren't adept at using computers. "I think they need to explain what's available to people like me," he said, "people who don't really understand."

EDYTHE TOUSSANT, 66, FLANDERS

E dythe Toussant participates in a Zumba Toning class at North Jersey Health and Fitness on Friday in Ledgewood. KAREN FUCITO/CORRESPONDENT

From 'dream come true' to 'doable'

Before Affordable Care Act: $0 premium Medicare Advantage HMO policy

Since Affordable Care Act: $70 premium Medicare Advantage PPO policy

Job: Music therapist, guitarist, and vocalist

"For me, being eligible for Medicare was a godsend. The original $0 premium Medicare Advantage policy I had was a dream come true, though the new $70 premium Medicare Advantage policy is wonderful. You can call a nurse practitioner at any time to ask their advice about different things. You get extra help."

Back story:

For 17 years, Edythe Toussant worked as an independent music therapist without health insurance. To pay all her medical expenses, including screening tests, she saved money and paid cash out of pocket. When she became eligible for Medicare at 65, she could hardly believe that her $0 Medicare Advantage plan completely covered her screening tests, including mammographies. Even so, she paid $295 a month, out of pocket, for two medications—for osteoporosis and ocular hypertension —and sometimes skipped taking them.

But last year, Toussant, like 80,000 other New Jerseyans on $0 premium Medicare Advantage plans, received a cancellation notice. She worked with the State Health Insurance Assistance Program (SHIP) at NORWESCAP and learned $0 premium plans were no longer available in Morris County. With SHIP's help, she chose a $70 premium Aetna Medicare Advantage plan and now pays $45 per prescription, one of which must be renewed monthly.

Current scenario:

» Toussant calls the current cost of her Medicare Advantage plan and prescriptions "doable" as long as she doesn't cut back on her work schedule.

» Through SHIP, Toussant applied for the state Pharmaceutical Assistance to the Aged and Disabled (PAAD) program, which helps pay the premiums and drug costs of eligible New Jerseyans. If she is approved, her monthly premium will be cut to $35 and her prescription costs drastically reduced to as low as $5 or $7 per medication.

» Both Toussant's old and new Medicare Advantage plans include a Silver and Fit provision, meaning the insurance companies pay gym memberships. Toussant enjoys Zumba Toning classes at North Jersey Health and Fitness in Ledgewood.

A look ahead:

Toussant encourages senior citizens to take advantage of Silver and Fit memberships. "These memberships are the way seniors can prolong their ability to be healthy," she said. "You've got to eat right, of course, but you've also got to exercise. I imagine that if not enough seniors use Silver and Fit, it'll go away."

CARE

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ated in) the 1960s. People associate anything difficult going on in health care with this law, but the truth is the system had all kinds of problems before.

"The law can certainly be blamed for not fixing all those problems," he added, "but it's getting a lot more blame than it deserves for making things worse."

A case in point are cancellation notices received by 80,000 New Jersey senior citizens — 4,500 of them in Morris County — who were enrolled in $0 premium Medicare Advantage plans. Since the notices came when enrollment in the Affordable Care Act was being heavily advertised, people tended to attribute the cancellations to the Act.

Not true, according to Meredith Persson, project specialist for NORWESCAP, a nonprofit serving low-income populations in Northwest New Jersey. Persson supervises Senior Health Insurance Program (SHIP) counselors, a group of trained volunteers who helped many Morris senior citizens find new Medicare plans.

The situation, she said, was about the bottom line of the insurance companies.

"If you talked directly to most companies about the cancellations, their answer was, 'It's because of the Affordable Care Act,' " Persson explained. "The Centers for Medicare and Medicaid Services told us directly that was not the case. Overall, Medicare was not affected by the act. Every Medicare Advantage plan was compliant, and most also covered above and beyond."

Those seniors who were cut loose in Morris County did not have the option of choosing any other $0 premium Medicare Advantage plan, according to Persson, who explained insurance companies decide what areas they will service. The nine counties in which such plans are still offered are more socioeconomically disadvantaged than Morris. (See accompanying profile of Edythe Toussant of Flanders.)

But there's no doubt some disruption in health care is attributable to the act, according to Cantor.

"If we wanted it to be simple, we would need something like Medicare for everybody, like the Canadian system," he said, "but there's no political appetite for a change like that, so we're left with a complex patch to a complex system."

Overwhelmed doctors

In recent years, doctors have been besieged by a flurry of trends and governmental mandates affecting their practices.

For starters, there just aren't enough primary care, or family, doctors. Discouraged by high medical school tuition costs and increasingly lower reimbursement rates, especially for Medicaid, medical students are favoring more highly paid specialty fields.

Most likely, the country will require almost 52,000 additional primary care doctors by 2025 to meet the health care demands of an aging and growing population, according to the American Academy of Family Physicians. A total of 8,000 of those are needed solely to keep pace with treating previously uninsured Americans.

At the same time, doctors are buying software and training staff to comply with Electronic Health Records requirements rolled out under numerous programs and laws in the past five years. Also in play is a new ICD (International Statistical Classification of Diseases) code system that will increase the number of diagnostic codes from 13,000 to 68,000 — a change the American Medical Association projects will cost small practices between $57,000 and $226,000 to implement.

Throughout Morris, some patients are finding their doctors are retiring early or joining hospital staffs.

"The Affordable Care Act is not the problem here," said Michael Murphy, an emergency department doctor and CEO and co-founder of ScribeAmerica. "But it's driving the volume of patients, which exponentially compounds all the other problems that were there. If you have all these problems with 30 patients, it's not that bad. If you have all these problems with 300 patients, then it's really, really bad."

These days, he added, doctors have to see all 300 patients just to stay in business.

In response, a new profession has been born — medical scribes for private practices, which is what ScribeAmerica provides.

A scribe, Murphy explained, is in an exam room with a doctor and patient, writing, in real time, a so-called narrative medical exam that includes the patient's complaints, the doctor's observations, diagnostic coding, prescriptions, and more, all in compliance with the latest laws and regulations.

"Scribes allow physicians to see 35 or 40 patients a day, leave at 5:30, and go home to their families," he said. "Scribes allow doctors to stop being data entry specialists and focus on what we all went to medical school for."

At $20 to $25 an hour, a scribe can make a big difference in a doctor's well-being, according to Murphy. Scribe America was founded in 2004. But since 2009, when the first law mandating electronic health records was passed, the company has grown 90 to 100 percent, year after year. It now has 3,700 employees in 41 states. (See accompanying profile of Ted Roberto, podiatric surgeon, of Pompton Plains.)

Confused patients

Access to private health insurance plans on the Health Insurance Marketplace has been a godsend to some people, particularly those previously uninsured with preexisting conditions. (See accompanying profile of Jimmy Stoney of Morristown.)

But many who purchased a private plan on the marketplace aren't quite sure what their policies cover. They're also leery of the overall high-deductible trend, which has nothing to do with the Affordable Care Act and is even impacting employees covered by corporate policies.

"With high deductibles, people are looking for the most cost-effective way to get their health care," Murphy said. "Urgent cares are exploding. You see a new urgent care on every corner. Instead of paying the emergency department deductible of $150 to $250, people can go to an urgent care and spend $15 to $30.

"They may not receive the same level of care, though," he added. "You're definitely not go-

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