



Got Quality?

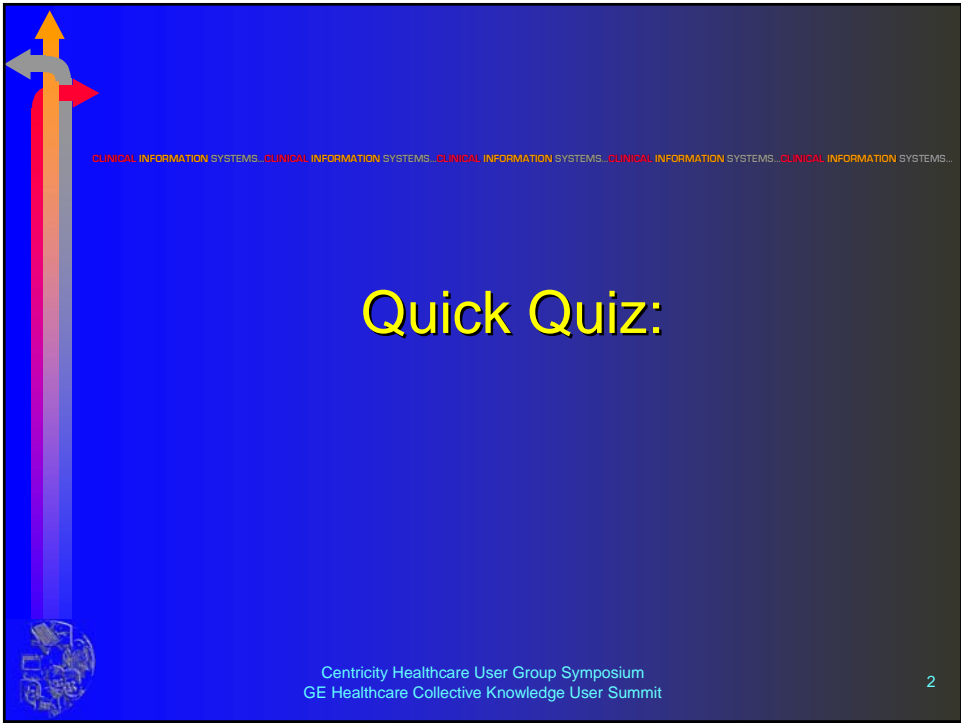
CLINICAL INFORMATION SYSTEMS...CLINICAL INFORMATION SYSTEMS...CLINICAL INFORMATION SYSTEMS...CLINICAL INFORMATION SYSTEMS...CLINICAL INFOR...

A (Relative) Success Story: Evans Medical Group

Robert J. Lamberts, MD

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Quick Quiz:

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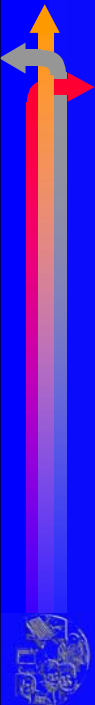


1. What is an “EMR”?

- A. Electronic Medical Record
- B. An insult from a computer (“Eat My RAM”)
- C. A computerized version of “PMS”
- D. Nothing; we call it “EHR”, “CPR”, “EPR” or “CHR”
- E. A totally awesome thing that will save the world from imminent peril

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2. What is “CPO”?

- A. Centricity Physician Office (*formerly Logician*)
- B. Computerized Political Organization
- C. A computerized version of “PMS”
- D. CPOE before it is entered
- E. A totally awesome thing that will save the world from imminent peril

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3. What is “CHUG”?

- A. Centricity Healthcare User Group
- B. A computerized frat party
- C. What computers do before (or after) they crash
- D. Coat Hanger User Group
- E. A meeting of incredibly intelligent people who are charming, delightful, and who together will save the world from imminent peril

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4. What will this talk cover?

- A. Our practice – where we are today and where we are going
- B. What this little piece has to do with the big picture – why this matters
- C. Lessons learned on the road
- D. Other stuff (to possibly include ways to save the world from imminent peril)

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Evans Medical Group: Who we are

- Private practice
- Primary Care
- Suburban
- 4 Physicians
- Mix fee-for-service, PPO, HMO, Medicare, Medicaid



Other Characteristics

- Overhead runs approx 60%
- Highly value quality
 - Try to talk with our patients
 - Try to apply evidence-based standards
 - Try to offer the best service possible
- Do our own billing – avg. 80-90%
- We have struggled to meet overhead.



In short...

We are typical.

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Typical?

Not quite!

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Logician (CPO-EMR)

- Purchased *Logician* in 1996 (4.0)
 - Same year practice became independent
- Only 1 present employee and 1 physician were around when EHR was started
- “Paperless” in 1998
- Workflow and EHR usage have been co-developed to maximize efficiency
- One of the earliest offices to extensively create and use our own forms



Our office

- Terminals in each exam room
 - Physician entry via forms and some typing
 - Vitals, EKG, Spirometry now imported directly through hardwire link
- Image scanning of all paper documents
- Direct interface with lab and PM software (newly installed CPO-PM)
- LabCorp Interface

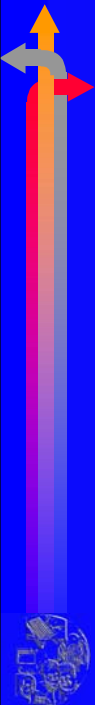


Our Office (continued)

- Use mostly custom forms, but are ever increasing use of CCC content
- New office in January 2004 – designed around EHR. No space for charts.
- Run searches to bring in Patients:
 - Immunizations
 - Hemocult / Cholesterol
 - DM, HTN, Asthma

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Quality

- 90% Pneumovax at one point.
- 50+% of A1c under 7
- Average LDL in Diabetics <100
- Average A1c for Diabetics of 7.1
- Report Card for Immunizations of 95%

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“Backwards ROI”

- Chart Pulls – estimated at \$3 per pull
 - In 2003, we had 53,222 patient documents generated
 - This equates to \$159,666
- Dictation – we do none at this time
 - Estimate dictation of ¼ of our encounters
 - Estimate \$0.10 per line, 50 lines per note
 - Gives \$23,315 saved
- Grand total of \$183,000 (12% of collections)

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Where we stack up:

- An amazingly advanced and forward-thinking practice deserving of national recognition
- On the “cutting edge”
- “Leading the revolution”

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Among this Audience?

- Typical
- Do some things well, other things not so well
- Early adopters who are being passed by many newer users

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Compared to where we should be?

- Not even close

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Why do we have such a low opinion of ourselves?

- We see ourselves as “tall midgets”
- Being the best among those offering bad medicine – is that something to be proud of?
- Some of you are taller midgets than we are
- But you still are midgets

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Conflicting Messages

- In one arena we are recognized national leaders in the “cutting edge” of medicine
- Here, and among avid EMR users, we are in the upper 25%, but certainly not in the lead
- In the general medical community, we are fanatics, and EMR is still mostly a curiosity.

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The reason people don't clamor for EMR:

- People don't know what "good medicine" really is
- People don't realize how much "bad medicine" is being done
- They don't realize how bad it is because they don't know how good it could be
- There are few (if any) example of "good medicine"

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Good Medicine: what is it?

- Up to current standards - completely
- Proactive – does not wait for an episode of care, but finds those who are in need of care and offers it to them
- Available – patients have easy access to the healthcare they need
- Efficient – no duplication of work, no unnecessary tests or medications
- Consumer focused, but driven by providers
- Open – consumers should know the quality (or lack of it) that they get.

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What it would look like?

- Population-based – all people would get care based on demographic or disease
 - All children properly immunized
 - All disease management standards followed
- Consumer-focused – let people know the state of their healthcare (i.e. send “report cards”)
- Obsessed with quality – constantly looking at the quality rendered and working to fix any problems

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Is anyone here close to accomplishing this?

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What we *really* want:

Value

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What is value?

- $(\text{Quality} * \text{Quantity}) / \text{Cost}$
- At the present time, only cost is known in healthcare
- If Quality and Quantity are defined, then the *proper* cost can be assigned
- There is *no relationship* at the present time of cost to Quality or Quantity

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The disconnect:

- Caused by encounter-based medicine: the more you do, the more you get paid
- The problem here is that this is reimbursed regardless of quality
- The quantity of healthcare given to a single patient is determined by documentation, not care
- The goal: minimize both quality and quantity = minimize value

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What this means to my practice:

- We are in a moral struggle to balance our desire for quality but need to make money
- The goal of EMR in this setting is to allow us to get the best quality in the least time (there will always be a disincentive to spend time with patients until healthcare is quantified differently)
- We have yet to see a dime for doing a good job

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How this can change?

- Define quality
- Measure quality
- Redefine quantity
 - Disease-based
 - Population based
- Open up things: let consumers know what the value they are getting

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The first step: Computerization

- Record care
- Measure quality
- Report quality
- Adhere to quality standards

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Is there hope?

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“By computerizing health records, we can avoid dangerous medical mistakes, reduce costs, and improve care”

George W. Bush
State of the Union Address, January 20, 2004

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“In order to realize a new vision for health care made possible through the use of information technology, strategic actions embraced by the public and private health sectors need to be taken over many years.”

-David Brailer: “Framework for Strategic Action” – July 21, 2004

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“And while there is no consensus yet on all the changes needed, we both agree that in a new system, innovations stimulated by information technology will improve care, lower costs, improve quality and empower consumers.”

- Sen. Bill Frist and Sen. Hillary Clinton – *Washington Post* 8/25/04

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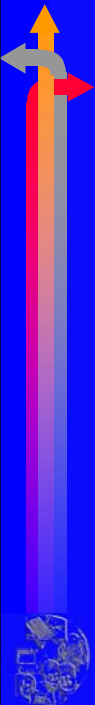


Keep your fingers crossed...

But don't hold your breath.

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In the meantime....

Some advice from a war-weary veteran

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Believe in what you are doing

- The passion comes from caring about patients
- The belief that we are able to use EMR for better care
- The vision to see the potential benefits

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Physician Buy-In

- Leadership – have someone that sees it with passion
- Teamwork – other physicians need to understand the benefit enough to be willing to change the way they practice
- Standardization – physicians must be willing to do things in a standard way. Don't try and customize for every provider

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Staff Buy-In

- Leadership – office administrator needs to share the vision
- Staff – need to understand why
- Include people in the process – even if it is just “running things by” your staff before implementation



Set reasonable goals

- A little success is better than a lot of failure
- Yes, you can do a lot, but too much vision can lead to a lot of nothing
- A good idea at the wrong time is a bad idea – wait for the time to be right



Count the cost before changing *anything*

- Every change creates “ripples”
- There will always be unforeseen consequences
- Try changes in small settings before generalizing them

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Why are you here?

- Computers?
- Healthcare?
- Reform?
- Free tickets for the open bar?

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What we can accomplish: A transformation of Medicine

- Improved quality through use of standards
- Improved care through efficiency
- Less mistakes
- Less money spent on bad medicine
- Accountable care – good healthcare can actually out-earn bad medicine!
- Can we even solve the crisis within the healthcare system??

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My final sage advice:

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Be Excellent To each other...



...and party on, dudes
- Bill and Ted

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