

Observing Healthcare

Improving Care in Independent Practice

By Richard L. Reece, M.D., for HealthLeaders News, Aug. 25, 2003

Independent physicians own most clinical offices. Indeed, independent physicians in small groups are the lifeblood and the heart of our health system. The reasons are simple.

1. Thirty percent of doctors are solo or in groups of three or less. Sixty percent are in groups of six or less. They are often the only physicians in middle-sized cities, small towns, and rural areas. Physicians prefer self-employment and clinical independence of small groups.
2. Clinical offices of independent physicians are where most decisions affecting quality care are made. But despite any assertions that the clinical office may be the heart of healthcare, recent articles and books paint a picture of gloom on the quality of care provided in independent practices. To improve overall quality in our health system, we must improve care in independent practice, for that is where most care is delivered.

But how do we improve care in independent practice? The answer may not be in something clinical, but in how physicians manage their information and technology needs.

Recent Articles Document Lack of Quality in Private Sector

A May 29 2003 New England Journal of Medicine article found the VA health system's quality of care substantially improved after system wide engineering began in 1994. A central feature of this reengineering was an electronic medical record (EMR) instituted in all VA centers.

As compared with the Medicare fee-for-service program, the VA performed significantly better in all 11 similar quality indicators involving preventive, outpatient, and inpatient care. The authors attributed the superior VA performance to a "systematic approach to measurement, management, and accountability for quality," made possible in large part by the system wide EMR.

Such a systematic approach is not possible in the fee-for-service Medicare program, where most care is provided by independent physicians and where less than 5 percent of clinical offices and 10 to 20 percent of hospitals have EMRs.

A subsequent NEJM article "The Quality of Health Care Delivered to Adults in the United States," based on telephone interviews of 13, 000 patients and reviews of 6, 712 medical records, found patients received proper diagnosis and treatment only 55 percent of the time. The telephone study was based on a random sample of adults living in 12 cities. A RAND research team, which wrote the article, received written consent to examine the patients' medical records for the most recent two year period. The team evaluated 439 quality indicators for 30 acute and chronic conditions. It found little difference between physician recommendations of preventive care (54.9 percent), acute care (53.9 percent), and chronic care (56.1 percent). The authors say improving care will require a major information system overhaul, with automating of clinical decision making, measuring, and reporting of quality indicator performance.

On July 1, Laura Landro, an assistant managed editor of the Wall Street Journal, wrote an op-ed piece saying every patient record ought to be wired into the health system. She laments: "For a country that leads the world in medical science and new drug discovery, we are woefully backward when it comes to using technology to help better manage health information. In an era when it is possible to sequence the medical genome on a computer, our doctors still scribble their orders in often-illegible handwriting and record our medical histories on paper. Despite mounting evidence that electronic medical records,

treatment guidelines and computerized order entry systems can help reduce medical errors, fewer than 5 percent of American primary care providers and only 10 to 20 percent of hospitals use such systems."

On July 15, two practicing physicians responded to Ms. Landro's comments. The first said, "In addition to the lack of a standard, there is the problem of undercapitalization of most independent medical practices." The second noted, "Laura Landro's suggestions are wonderful, nebulous, and in a perfect world may actually improve health care." He complained that that EMRs were too expensive for physicians in private practice and opened the floodgates to lawyers and others who had no business reading the charts.

Books Presenting the Kaiser Point of View

In "From Chaos to Care: The Promise of Team-Based Medicine" (Perseus Publishing), David Lawrence, M.D., chairman emeritus of Kaiser Permanente, describes the "mission impossible" of physicians in solo practice or small groups through the eyes of Dr. Landers, a fictional solo physician. "In spite of his motivation to be a high-quality physician, Dr. Landers can't deliver on the promise of modern medical care. He lacks the time, the money, and the organization to do so. And he will fall further and further behind if he continues to practice as he does today. The forces are too strong and the changes too profound. Physicians like Dr. Landers and his colleagues - independent, autonomous professionals who practice as craftsman, alone or in small, single-specialty groups - are already being overwhelmed by those forces; as a consequence, the dangerous and expensive gulf between what patients need and expect and what they get grows wider each day."

In a similar vein, "Epidemic of Care: A Call for Safer, Better, and More Accountable Health Care" (Jossey-Bass) George C. Halvorson, Lawrence's successor at Kaiser, and George Isham, M.D., medical and chief health officer for HealthPartners in Minneapolis, argue that independent physicians are heterogeneous, of varying ages, educational exposures, and influences of drug sales representatives. "So," say the authors, "inconsistency happens. That's understandable, particularly when so many American doctors are trying to run a business, see a full load of patients, hire and fire staff, comply with all the employment laws, and then do all necessary medical reading and learning, in addition to all the other professional, political, and personal time pressures that make life today so challenging. It isn't easy. Those doctors need help to stay current - help that needs to be extended to the physician right at the point when patients are receiving care."

Physician Fears

Why do less than 5 percent of primary care physicians and 10 to 20 percent of hospitals use EMRs? It's good question. In my experience, it's a fairly easy question to answer.

1. The fear of lack of functional utility of most current EMR systems.

Most systems concentrate on "back-office" business functions. These are important. But most physicians seek EMRs that facilitate and speed clinical practice. They want systems that enhance patient satisfaction, that give immediate access to the patient record, that painlessly yield useful clinical information at the point of care, that document the patient encounter and ease coding, and that captures the complete picture of the patient-physician exchange in a way that justifies proper payment.

2. The fear that they will be enslaved by computers that tether them to a keyboard or march them through endless computer menus.

These tasks consume time disrupt patient flow. Brent James, M.D, of Intermountain Health Systems, captured the essence of this disruption problem in 2001 NEJM editorial, "To be widely accepted by practicing clinicians, computerized support systems for decision making must be integrated into the clinical work flow. They must present the right information, in the right format, at the right time, without requiring special effort. In other words they cannot reduce clinical productivity."

3. The fear that the quality data they supply to Emirs will be used against them by government bureaucrats in faraway Washington or distant suburban HMO suites or by practice lawyers right in their home town.

They are skeptical because they have yet to see physicians rewarded for quality performance and because some of them have been excluded for HMO networks for obscure reasons.

4. The fear they will never get their money back after investing in a state of the art EMR.

These fears may be justified. Kaiser says it plans to invest \$2 billion in a comprehensive point of care EMR and another \$1 billion for maintenance. And this comes after the first Kaiser EMR investment failed. If you do the math, that amounts to \$182,000 each for Kaiser's 11,000 physicians and a \$91,000 year maintenance fee for each physician to support the system.

Less Than Optimal

Independent physicians in the United States deliver a less than optimal quality of care, as measured by adherence to quality indicator standards. A RAND telephone survey of 13,000 adults indicates physicians made the proper quality recommendations only 55 percent of the time, and a VA analysis found the VA outperformed physicians serving Medicare patients in the private sector on 11 of 11 quality indicators.

The main reason for this quality deficiency in private practice appears to be lack of electronic medical records (EMRs), which are used by only 5 percent of primary care physicians and 10 to 20 percent of hospitals. Obstacles to independent physician use include upfront expense, discomfort with computers in practice settings, fears that EMR data will be used against them, and doubts about return on investment on expensive systems.

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Quality Improvement in Independent Practice Part 2: Solutions

By Richard L. Reece, M.D., for HealthLeaders News, Sept. 5, 2003

Independent physicians' failure to deliver consistent measurable higher quality healthcare may be due to the lack of widely available, affordable, usable, and practice-efficient electronic medical records (EMRs) at the point of care. This is a serious problem. Private physicians in outpatient practices deliver almost 90 percent of primary care in the United States, yet only 5 percent have EMRs.

Obstacles to widespread EMR use in clinical offices include lack of physician access to capital, primary care physicians' dropping incomes, EMR disruptions of practice workflow, and little or negative returns on investment in EMR systems. Furthermore, the physician culture of being committed to independence and professional autonomy may make some unwilling to bow to external scrutiny or to accept quality protocols. This set of attitudes makes it difficult for doctors to shift to a digital paradigm.

Something Must Be Done

Yet something must be done. Information barriers between physicians cause awkward and potentially dangerous situations. For example, many physicians have found the only reliable way to find out what other physicians have prescribed is to instruct patients to bring all their medications to the office in a brown paper bag.

Barriers exist between physicians and hospitals as well. Most office-based legal computer systems don't "talk to" the computer systems at the hospital to which the physician admits patients, and it may be impossible for the physician to gain access to the patient's computer records from a remote location.

EMRs a Logical Solution

Still, even in the face of these problems, EMRs and other forms of information technologies present a logical and increasingly compelling solution to current problems.

- In spite of the skepticism and expense of complying with HIPPA, a \$10,000 to \$20,000 expense for most physicians, HIPPA will teach the hard lesson that you have to use a computer to standardize your coding and to present data if you're going to be paid.
- The definition of quality is rapidly emerging as the percent of times physicians comply with quality indicators for preventive, acute, and chronic care. This "percent of compliance to quality indicators" is a hard number that computers can calculate. The number lends itself to bonuses for quality, as a goal to reach or improve upon, and as an indicator for inclusion or exclusion into managed care networks.
- Events now taking place at the federal level, such as Health and Human Services announcements that it has detailed plans to build a national electronic system to keep track of patients' medical records and to license the College of American

Pathologist medical vocabulary, SNOMED, may go a long way toward standardizing patient care.

- Private initiatives are under way and are well-advanced to develop patient-generated medical histories, a giant step toward more efficient use of patients' and physicians' time and towards structuring this vital record at the point of care. These automated histories may be the health industry's analogue to the banking industry's ATM and will produce a comprehensive, transparent, and structured patient history. Furthermore, the experience of Dr. John Bachman MD, professor of primary care at the Mayo Clinic, has shown automated histories save substantial clinician time, increase accuracy of patient histories, and boost clinical productivity (Mayo Clinic Proceedings, January, 2003). James Nuckolls, medical director of the Carillon Health System in Roanoke, Virginia, oversees the work of 280 primary care practitioners. Nuckolls says practitioners now must see 21.5 patients a day to break even. If an automated medical history generated by patients saves 5 minutes per patient encounter, it will allow primary care physicians to see five more patients per day. This represents an enormous leap in productivity.
- Medem Inc., an online computer firm endorsed by the AMA and 46 medical societies, has entered into a joint venture with Cerner Corp., in Kansas City, to build computer systems that would permit physician office computers to communicate directly with hospital computer information systems.
- The Institute of Healthcare Improvement in Boston has launched far-ranging and ambitious programs featuring "idealized design of clinical office practices." These programs, began in 1999, focus on clinical outcomes, patient satisfaction, staff satisfaction, and financial performance. Prototype sites, involving mostly large primary care or multispecialty clinics, are now operating at 32 locations. They are already showing impressive results. For example, Primary Care Partners, a 25-person group located in rural Western Colorado, through advanced access scheduling, has increased patient visits by 22 percent, gross revenue by 32 percent, and net revenue by 87 percent. Other redesigned practices have solid data showing increased patient access, greater patient satisfaction with staff and physician interactions, more reliability in meeting quality indicators for prevention and chronic disease management, better outcomes, and greater operating margins for practices.

Why are efforts to improve care in independent practice settings so important? To improve quality, of course, but to boost morale, too. Donald Berwick, CEO of the Institute of Health Care Improvement, says: "We envision a system of care in which those who give care can boast about their work, and those who receive care can feel total trust in they care they are receiving."

Investing in National Health Information Technology

Perhaps the most promising, most ambitious but longer range strategy for improving health information technology is described in a joint report by the Health Technology Center (HealthTech) a nonprofit research and education organization in San Francisco, and Manatt, Phelps and Phillips LLP, a national law and consulting firm in the healthcare field with offices in Los Angeles, New York, and Washington, D.C. Their report, "Spending Our Money Wisely: Improving America's Healthcare System by Investing in Healthcare Information Technology," recommends creating a Health Information Technology Revolving Loan Program modeled after successful federal programs established to provide states with money for local transportation and environmental initiatives (see healthtechcenter.org for copies of the report).

Congress would allocate \$4 billion over 5 years to start the program. States would match federal funds at the rate of \$1 for every \$4 of federal money. The states would form local,

non-profit Health Information Technology Corporations (HITCs) with the authority to award funds to applicants in local communities, including physicians and hospitals, for healthcare information improvements, including EMRs for clinical offices and computer systems in hospitals. HITCS would encourage physicians and hospitals to work collaboratively and across traditional barriers to invest in information infrastructure. Eighty percent of the funds would exist in the form of loans and 20 percent in the form of grants.

HITC Reminiscent of Hill-Burton Act of 1946

The proposed Health Information Technology Corporations are reminiscent of the Hill-Burton Act of 1946, which encouraged federal and local investments in hospitals. With the advent of the Internet, the massive shift to outpatient care, advances in technology, concerns about safety and quality, and rampant health inflation, the public and private sectors are looking for innovative solutions through public-private partnerships.

Most of those solutions involve information technologies. Yet, for various reasons, hospital and physician investments in IT hover around two percent of operating budgets, well behind other industries, which invest 10 percent or more of total revenues in IT. Only the federal government has the capital and incentives to catalyze IT investment. Federal and state governments pay for 45 percent of the nation's healthcare through Medicaid and Medicare. The government has invested heavily in these programs, as well as the bricks and mortar of hospitals. Why not invest in IT infrastructure at the community level?

Other Federal Revolving Loan Funds in clean water, drinking water, and state infrastructure have successfully multiplied federal investments by a factor of 1.5 to 1.8. If government initiatives helped build the nation's hospitals and research efforts at NIH and academic medical centers, government can surely invest in the health information infrastructure, which has been demonstrated to save money, increase quality, and enhance practice efficiencies.

Dr. Molly Coye, CEO of the Health Technology Center, captures the essence of the health systems problems and solutions. Speaking of the Institute of Medicine report, *To Err is Human*, she says, "The IOM report sent shockwaves through the healthcare system, but when the tremors subsided, providers were still faced with the problem without the necessary support to make it happen. Our proposal responds to the need to modernize our healthcare system through a collaborative public/private sector program; one that will act as a powerful catalyst to improve clinical outcomes, reduce errors and drastically reduce runaway health care costs." Without government support, hospitals and physicians are unlikely to embrace IT initiatives on a scale large enough to make a difference.

Solutions Summary

Quality improvements in independent practices will require private and public investments in the health information infrastructure. The infrastructure will require:

- EMRs at the point of care in most clinical practices.
- Applications that save time and increase productivity and profitability.
- Data that supports clinical decision making.
- Digital data that speeds claims processing.
- Communication of healthcare information in digital form that allows comparison of quality performance, development of quality data standards, and a common nomenclature.

Overhauling and improving the health information infrastructure will take the catalyst of federal funding because undercapitalized physicians and hospitals do not have wherewithal

or financial incentives to move decisively into the digital age. The most definitive article on the need for federal support appeared in the July/August 2003 issue of Health Affairs under the title "Federal Health Information Policy: A Cases of Arrested Development." Authors Jeff Goldsmith, David Blumenthal, and Wes Rishel conclude:

"As the postwar Hill-Burton Program recognize an unmet need for hospital capacity in the late 1940s, Congress must recognize that a modern health information architecture is an indispensable condition for safe and effective clinical practice. This cannot be achieved without federal policy interventions that create the essential preconditions for markets to function where they can and to assure that access to the benefits of healthcare IT is available for the nation's most vulnerable citizens."

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