GUEST COLUMN

Obama's $2 trillion reality

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On March 12th in an OpEd piece for the *Wall Street Journal* titled “Obama's $80 Billion Exaggeration”, respected physicians and authors Jerome Groopman, MD and Pamela Hartzband, MD questioned President Obama's claim that electronic medical records would save $80 billion annually in healthcare costs while improving quality of care. They based their conclusion on the work done by the respected Rand Corporation published in 2005 showing questionable benefits from the implementation of electronic records. Well, I agree with Drs. Groopman and Hartzband questioning the assertions made by the President but not their ultimate conclusion. What my colleagues fail to take into consideration is Obama's $2 trillion reality - a failing healthcare system that delivers questionable quality of care and inconsistent access while costing our country a significantly higher percentage of GDP than any other developed country in the world.

My focus on this OpEd piece was generated by a colleague from New York, a successful dermatologist, who is using an EMR (electronic medical record) in his clinic and is trying to understand what value such systems provide. In his mind, as similarly presented in the OpEd piece, these EMRs just generate voluminous documentation geared to optimize reimbursement rather than better patient care. In addition, there is no real data supporting the notion that these systems actually improve patient care. My responses to my colleague follow:

How sad this statement is about documentation. Yes, these systems were designed to do the administrative part of medicine, billing, better, with little effort applied by vendors to understand how to obtain better clinical and financial outcomes out of these systems. I sometimes despair that we will never be able to get great benefit from these systems until we solve the reimbursement issue. If the major reason we use these systems is to document care for billing purposes, rather document for care delivery purposes, how can we expect to save money and improve quality? The processes and workflow have to be redesigned with a deep understanding of the capabilities of the systems. The systems are just tools to achieve a particular outcome. For now, it seems that outcome is better billing. We cannot expect to achieve better, less costly clinical outcomes until we set that as a goal for these systems. Right now the driving factor for purchasers is optimizing reimbursement, for without that focus, these systems may generate better outcomes for the patient while failing to deliver an accurate reimbursement to the physician. While working on an implementation of an EMR in a hospital owned clinic in upstate New York I noticed that the problems physicians had using the system were related to getting the documentation right for billing not for patient care. Documenting patient care for patient care sake is relatively easy.

My colleague went on to ask whether these systems would be effective in delivering less expensive, better quality care if the focus of the implementation of the systems was on patient care rather than reimbursement. I responded:

For EMRs to be effective in reducing costs, they need to be implemented so that the focus is on both reducing costs and improving quality, Therefore, the workflows and processes must be modified BEFORE implementation of the systems rather than afterwards. Unfortunately, most organizations try to change processes after implementation and find the task very difficult. Both

organizations and vendors have incentives to implement first and reengineer later. Organizations find the task of process and workflow redesign both politically (i.e., impact on physician relations) and organizationally (i.e., need for expertise) demanding. Vendors, particularly those driven by quarterly earnings, cannot book revenue until the install is completed. Therefore, both stakeholders see non-reengineered implementations of EMRs the most acceptable approach. And let's not forget the entire medical team including the physicians and nurses. For EMRs to be effective, clinicians must consider a role and responsibility change to impact care. Using EMRs to provide care the same way clinicians do using paper records, fails to take advantage of the capabilities of EMRs and delivers little benefit. This is what the Rand studies are measuring, digitization of an inefficient paper process. My colleague expressed both enthusiasm and concern for the clinical database these EHRs would create. The exciting research benefits allowed for the expansion of personalized medicine as analysis of the collected data could identify specialized treatments for subsets of patients. The concern about these databases reflected their use to identify effective and ineffective treatments. Such discoveries might increase the probability the government or insurers would implement restrictions on the use of these newly identified questionable treatments. Similar concerns are associated with the United Kingdom's National Institute for Health and Clinical Excellence (NICE), an organization that determines whether the National Health Service covers the costs of a particular treatment, procedure, or drug. NICE was established in 1999 to advise the government, through objective clinical analysis, what care was clinically and cost effective. Although the NICE was established to remove politics from the healthcare funding debate, this has not been totally effective as some treatments were added to the approved list after considerable public pressure on the government. My response:

Although there is concern in the medical establishment that the Obama administration will form an organization similar to NICE that removes patient and physician choice, this fear is unfounded since such organizations already exists. Payors use their own criteria to decide what care is covered and what care is denied payment. The Center for Medicare and Medicaid Services (CMS), already pays for certain care and not others. Formation of a NICE type body will just work to standardize what is covered and what is not across the government and payors. In addition, the criteria will be based on transparent medical knowledge rather than secret guidelines developed by payors. And let us not forget the strong incentives some physicians and institutions have in providing certain types of care irrespective of their value to the patient. The most egregious of these incentives come in the form of royalty payments to research institutions based upon the frequency of use of particular equipment and drugs. This is a continuing problem in healthcare research.

I concluded my comments to my colleague as follows:

My take on what Obama is doing is that he is forcing the issue politically as he knows that pushing it from a purely scientific position would take too long to achieve any change and therefore end in failed healthcare reform. The iron is hot and the time to strike for healthcare reform is now. Obama thinks if we can get EMRs in place now, we can later take the necessary step to change how the EMRs are used to truly deliver quality care and reduce costs. He, as I, expect a tipping point. To reach that tipping point is needed a complete revision of what physicians and other healthcare providers do. But that will take a long time to happen as there are powerful interests in every quarter. Those who will lose if things change will fight that change (i.e., the AMA fighting Medicare and Medicaid in the 1960s) and those who will win are not organized to fight for their share (e.g., primary care physicians, patients). But in the end, there will be change and winners and losers. It is the natural order of things. And with technology, these changes will be disruptive and happen quicker than we expect. So for these reasons and

several more, I support the deployment of EMRs.

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