

Testimony for the Quality Measures and Clinical Quality Workgroups
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Care Provider Panel

Douglas A Spotts, MD
Physician/Owner of Douglas A Spotts, MD Family Medical Care, PC, Lewisburg, PA

Thank you for the opportunity to speak to you about the implications of health IT enabled clinical quality measures. My name is Douglas Spotts; I am a family physician and owner of a 5,000 patient private practice in central Pennsylvania. We are dedicated to providing personal, high-quality primary care to our patients. I and the majority of the staff are lifelong residents of the communities from which our patients come, and those relationships contribute to the personalized care we are able to provide.

We have been using an electronic health records system since February of 2010. The entire staff at my practice is convinced that the EHR is a great tool for enhancing the quality care we provide our patients. We believe the clinical quality measures data it can generate will contribute to the personalization we already have. We are excited about the potential to identify population groups by problem, monitor status, and provide additional education and support, all with the goal of improved health care from the provider and improved quality of life for the patient. The ability to accomplish this is at the heart of what it is to practice *primary* care and to be a patient centered medical home. As excited as we are with the potential of the EHR to enhance the personalized care we provide, at present it is more cumbersome in some key situations .

At present, the practice has three full-time practitioners—myself and two physician assistants—and one part time physician, one day per week. Our clinical coordinator is an LPN who also covers tasks in the nursing station; our business coordinator is also our primary billing specialist. Half of the nursing and office staff are part time employees, in part to provide depth of coverage when someone is sick or on vacation. I tell you this to highlight the core challenge of implementing Meaningful Use criteria in a small, independent primary care office, namely dedicating staff to the tasks of running reports, mapping data, and implementing measures. Reimbursement rates for primary care do not provide enough income to support additional staff time for this purpose. Incentives for showing Meaningful Use can offset some additional staffing, but we need to provide the upfront investment of staff time to get to the point where we can apply for the MU incentives.

A similar challenge to an independent primary care office is funding initiatives to address the clinical quality measures with patient population groups. The reports have little use if they do not result in engaging patients in additional education or support around their clinical issues. There needs to be reimbursement for such measures, to cover staff time and materials.

Another challenge to full meaningful use of IT enabled clinical quality measures is the ongoing training necessary to understand this new paradigm of practice. We have excellent clinical and office staff, but implementing EHR is much like learning a new language and being immersed in a different culture. In this case, the culture itself is not fully developed; we use one of the major EHR systems, but it is not yet fully certified for MU1. So, even as we learn and become more proficient, the system constantly evolves. The timeline of the system's certification and that of the incentive for implementing MU are not necessarily in sync. The constant state of learning an updated system and new reporting can serve more as a distraction to staff than an encouragement for engagement in new initiatives. And, the quality clinical information we know intuitively or experientially is not always readily accessible from the EHR.

All this being said, we proceed with working toward MU implementation. What remains to be seen is if it financially feasible for an independent primary care site with no income from ancillary services to fulfill MU in its required format. Will small, independent primary care practices be able to survive in this new culture?