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Accountable Care Workgroup, Meaningful Use Workgroup, Quality Measures Workgroup, Information Exchange Workgroup

Oral Remarks

I have been a physician in private practice for the last 25 years. Having worn many hats as quality improvement chair and physician hospital organization medical director, I have rolled out IT solutions in my own practice, coordinated the production of hundreds of order sets with our Kettering Network EMR, and directed network wide process improvement projects. These experiences have shown me the hurdles and difficulties in meeting budget and providing care.

Let me walk through a typical day in my life. My first patient is at 7 AM. His primary care doctor has referred him to me. He has no idea why he was sent to me and I do not have access to any information. His only complaint is problems with his hands and he has been told it is gout. Unfortunately the lab and family doctor's office is not yet open for us to get his most recent information. I nevertheless come up with a plan of care. And the patient is on his way.

I'm off to the hospital, since I am on the ICU service. Overnight a gentleman was admitted for pneumonia. He does not normally come to our hospital system so I do not have easy access to his records. He informs me that he cannot be in the hospital long since he has an appointment with a thoracic surgeon for his esophageal cancer. I start searching on line for his records from other institutions, having to go through screen after screen of data that have no clinical importance. I find no documented diagnosis of cancer. Eventually I get to the path report and it turned out not to be cancer at all. The referral is cancelled.

I go on to my next patient. She is on a ventilator with no family. The medication reconciliation shows she is on a multitude of medications, all with possible drug-drug interactions, including two blood thinners. She is anemic and her abdomen is firm. Could she be bleeding internally? A CAT scan of her abdomen was ordered and comes back fine. We finally get a hold of the family and they said that she was on those medications last year for a knee replacement and has not been on them recently. We call her family doctor who tells me an entirely different list of medications! The family brings in all her medications from home, which does not at all coincide with her current medication reconciliation.

Now my office calls me and informs me that the very first patient of the day with hand pain was not referred over to me for gout but rather for a colonoscopy due to his occult positive stool!

The next day I have to supervise our internal medicine residents at their clinic. We have a facility set up, where one half of the building is a Federally Qualified Health Clinic (FQHC) with a nationally top rated EMR. Unfortunately it does not interface with a single practice or hospital network. My residents are across the hallway at the specialist clinic where we this last week installed another nationally top rated EMR and of course this does not interface with the FQHC EMR! We literally are leaning across the divider and asking the primary care physician, why are we seeing your patient and can you tell me their labs? Even if two different practices have the same EMR vendor they do not communicate in anything even close to seamless. To do any disease management is fraught with problems. Yes they are certified EMRs and yes they can send CCD documents. But to do this in any scale is impossible.

Each EMR/HIE provides a different snap shot of the patients care. For each physician a patient meets they have a different portal for them to get information about themselves. They have the PCP portal, their urologist portal, orthopedic portal, etc. Each has a different user name and password. All with a different story to tell with all the silos of misinformation. What is needed for a successful ACO model is a single understanding of the patient not multiple understandings.

As circumstances are now, the meaningful use criteria drive things to a document-based model. Connecting the data silos together does not drive quality but raises costs, hampers data mining and efficiency. In striving to improve care, communities have developed and launched

health information exchanges utilizing the existing criteria and uniformly they have failed to live up to the promise. They do not have all the data about patient care and if they did they do not provide actionable data to drive quality for the individual let alone the community. Existing vendors do meet the meaningful use criteria as written but they are not motivated in working to improve things. They are ignoring the issues. They are very slow to respond and their architectural requirements hamper and constrain their product. In my heart I think they all realize they have a Potemkin village. The answer is a patient centric model.

Notes to follow