James L. Holly, M.D.

Managed Care and Electronic Patient Records
By James L. Holly, MD
Managing Partner, Southeast Texas Medical Associates, LLP
www.jameslhollymd.com
Thursday, May 11, 2000
TEPR, San Francisco, California

As Managing Partner of Southeast Texas Medical Associates, LLP and as President and Medical Director of the Golden Triangle Physicians Alliance (a 400 doctor-owned IPA), I have responsibility for all medical decision-making and utilization management for the IPA. Two and a half years ago, my partners and I determined to transition our practice from a paper/document medical record to an electronic/data medical record. We chose the NextGen EMR, which was developed and is marketed by Clinitec. While I am not here today to sell you NextGen, our practice is enthusiastic about our relationship with Clinitec and with the NextGen product.

In the past five years, Southeast Texas Medical Associates has committed its future to two beliefs:

1. Managed Care strategies can provided excellent care to my patients while helping control the cost of that care.
2. Electronic Medical Records is the only methodology and/or technology, which can make this happen at the provider level.

Once you get by the methods of managed care: precertifications, limited provider panels, formularies, authorizations, referrals, etc, you are left with the dynamics of Managed Care. Those dynamics are:

1. A continuum of Care model of delivery, which addresses the quality component of the value equation, and which is a data issue.
2. An integrated delivery network organization of that delivery, which addresses the cost component of the value equation, and which is also a data issue.

In the history of medicine, the following has been the nature of medical records:

1. In the 18th Century, for practical purposes, medical records -- as a documentation of individual patient treatment -- did not exist.
2. In the 19th Century, medical records were not much better, but those that existed were based on pencil and paper.
3. In the 20th Century, the standard of excellence for medical records was transcription. This was a vast improvement, but fundamentally employed the same methodology as the 19th Century -- paper. Fundamentally, 18th, 19th and 20th Century medical records were documents.
4. In the 21st Century, medical records will be based on some form of electronic medical records.

19th and 20th Century medical records, except for research programs, were essentially transactionally driven. That means that when a patient “showed up” a record of the transaction between the provider and the patient was made. This is going to change in the 21st Century:

1. Providers are going to have to think about his/her patients when they don't show up.
2. Providers are going to interact with their patients in a real-time continuum of care model of healthcare delivery. Which is responsible for both quality and cost.
3. Providers of healthcare services are not only going to have to think about their patients when they are not "there," they are going to have to think about them as:

    a. A person
    b. A population
    c. A problem (disease state)
    d. A preventive healthcare opportunity

This kind of strategic thinking about our patients when they are not in our office or on our phone will require:

1. **Systems** which provide
2. **Data** over time and which is
3. **Accessible**, both as to:

    a. Connectivity and as
    b. To relationship with other information, i.e., a relational database,
    c. Through which, every provider can have access to that data base at every point of care the patient accesses and
    d. From which database, information can be drawn and care strategies can be developed whether

        1) Interventional or
        2) Preventive.

These systems, this data and this accessibility will guarantee that we will function with both a continuum of care and in an integrated delivery network.

The limitations of the old document-based system and/or of any new system which principally depends upon a document, even if that document is electronically generated, are illustrated by:

1. If a drug were recalled, there was no effective way of determining which patients were on the drug therefore being able to notify each one to stop it, and to call the office for a substitute.[1]
2. There was no systematic way of seeing how many patients with diabetes and hypertension were on an ace inhibitor, which is protective of renal disease.[2] The same applied to many other disease states.
3. There was no effective way of continually bringing the family, social and past medical history forward in the chart to make it an interactive part of every patient encounter.[3]
4. There was no way of determining how many patients had not had a pap smear, mammogram or occult blood screen, short of asking those questions when the patient came for a different illness.[4] Therefore, preventive healthcare was driven by acute healthcare, which essentially didn't work. And, even when the provider kept excellent records, there was no way to access that information short of picking up and examining each patient record.
5. If the healthcare provider were at a different location than where his/her charts were stored, the paper chart, no matter how extensive and well organized, was little improvement over the 3x5 card. The patient and provider were dependent upon the memory of the provider for continuity of care.[5]
6. Patient allergies, drug interactions and the use of drugs in certain disease states were dependent upon the physician's knowledge and/or memory, not on the interactivity of various capacities of the medical record.[6]
7. Everyone wanted quality in healthcare, but it was difficult to define and almost impossible to prove.[7]

An integrated healthcare delivery system (IDS) produces collaboration between every person participating in the care of a patient and the sharing of information on that patient

---

[1]Recently, both Rezulin and Propulsid have provided our practice the opportunity to search our records and to notify each patient on these drugs as to how they should proceed. Several weeks, before this conference, our local newspaper had an article about a danger of Plavix. That same day, we mailed a letter to all of our patients on Plavix explaining to them what they should do and whether they should continue the medicine or not.

[2]SETMA is now able to do this and has begun disease-state management strategies to improve the compliance and health of our patients.

[3]SETMA now requires that every provider review these at every visit and we audit charts to make sure that this is being done.

[4]SETMA has designed Access reports to examine each one of these issues and others, based on HEDIS and NCQA standards.

[5]All of SETMA's providers now have high-speed Internet access from their homes in order to respond to patient inquiries after hours and on the weekend. Also, SETMA is capturing in the CPR all patient telephone calls and the responses to those calls (over 190,000 incoming calls per year).

[6]With CPR, these functions are now automatic and do nor depend upon the memory of the provider. This gives the patient confidence that their medications are safe when they take them and when they are taken together.

[7]The ability to examine the preventive health initiatives of a practice and the ability to examine compliance with national standards of care, along with NCQA and HEDIS standards moves SETMA toward the day when it will be possible to "prove" that we are providing superior care. Additionally, the auditing and "grading" of each providers performance on the CPR is another quality measure, which insures that our patients are receiving quality healthcare.

at every point of the patient's entry into the healthcare system. It means that the primary care physician and the specialist have common goals and incentives, and that they share the same information about the patient. It means that the home health agency, hospice, DME, physical therapy, reference laboratory and long-term care facility have a common vision and a seamless interface when dealing with the patient.

The IDS model is realized when each member of the healthcare delivery team has access to the patient's record and when the patient's record is updated and available to other members of the team at and from every encounter with another IDS team member. Without this sharing of information, at best the patient's care will be segmented and inconsistent.

Continuum of Care Model

What truly differentiates a continuum of care is that care management drives patient care. And, care management is a database function. If the patient's record is available at every point of contact with the healthcare system, there will not be:

- Redundancy – repeating the same test or procedure simply because one healthcare provider does not know that another provider has the information.
- Inefficiency – collecting the same information about the patient — past medical history, family history, etc. — multiple times simply because there is no effective means for sharing that information from provider to provider.
- Excessive cost – A plan of care has always been a part of healthcare. Sometimes that plan of care will be treatment and instruction to return if the patient doesn't improve; sometimes it will be referral to a specialist, and sometimes it will be observation and testing if the patient doesn't recover. Whatever the plan of care, it should be:

    - Documented – CPR allows this to be done every time.
    - Discussed with the patient – CPR allows for this to be documented every time.
    - Followed – CPR allows the provider to follow-up the patient, even if the patient doesn't keep his/her follow-up visit.

- Defensiveness – the best defense against an accusation of inadequate or substandard care is a complete history and physical and an agreement between the provider and the patient as to a plan of care. CPR allows the provider to document a plan of care with which the patient agrees. When that plan is based on sound medical judgment and an excellent record, the need for excessive and often expensive tests to prevent lawsuits will be eliminated.
- Lack of follow through – Patients often discontinue treatment and/or fail to seek follow-up when they begin to feel better. CPR allows the provider to track patient follow-up and to make certain the patient's treatment or evaluation is completed. With CPR, SETMA has designed an electronic tickler system, which allows consistent follow-up on patients who require further, essential testing or repeat testing. For instance, if a person needs a follow-up chest x-ray in six months, SETMA has an

electronic solution for reminding the patient and the provider to make sure the test is done.

The IDS will have elements of the insurance, care-delivery and continuum-of-care models, but preventive care, health promotion and community health will drive the care delivered by an IDS.

SETMA Moves Toward an IDS

With Clinitec's NextGen EMR, Southeast Texas Medical Associates' (SETMA) has integrated its healthcare delivery system with templates designed for:

- Primary Care
- Home Health
- Nursing Home
- Physical Therapy
- Specialty Consultation
- Emergency Care

The ability of each for these entities and healthcare partners to share a common database and to make updates of that database instantly available to every other member of the healthcare team is the backbone of SETMA's IDS. The reality is that whether a family physician, a cardiologist or an endocrinologist, the initial information needed on a patient is the same: chief complaint, history of present illness, review of systems, allergies, past medical history, family history, social history, and habits. If this information can be shared, it will make the IDS more efficient and more effective, and that will increase the excellence of the care.

Information systems also enable the healthcare provider to drive the delivery process because of the data, which is available. Traditionally, healthcare providers only responded to the care request of their patients. Now, providers can structure and deliver preventive care and routine care, which is more cost sensitive and higher quality. Healthcare driven by the provider is: higher quality, more cost-effective, preventive and more effective. The only way the healthcare provider can drive health care is with records, which give him/her the capacity:

- To measure outcomes,
- To monitor preventive care and
- To make patients' healthcare database available at every point of the patient's access to healthcare.

Healthcare driven by the patient is: typically more expensive, poorly managed and thereby less effective. Also, healthcare driven by the patient is typically based on static medical records, which are driven by acute medicine, rather than health maintenance and preventive care issues.

Constable or Counselor?

Healthcare providers must never lose sight of the fact that they are providing care for people, who are unique individuals. These individuals deserve our respect and our best. **Healthcare providers must also know that the model of healthcare delivery, where the provider was the *constable* attempting to impose health upon an unwilling subject, has changed. Healthcare providers progressively are becoming *counselors* to their patients, empowering the patient to achieve the health the patient has determined to have.** This is the healthcare model for the 21st Century and the computerized patient record is the tool, which makes that model possible.

Providers and patients being collaborative in the patient's health initiatives is a data driven dynamic and it requires the sharing of that data between patient and provider.

Managed Care and the Computerized Patient Record: Realities, Rights & Responsibilities

Managed Care is the free-market's response to the realities of the healthcare industry. The first reality is that there is no possibility of healthcare financing and management ever returning to the *laizze faire* style practiced up until twenty years ago. *Someone is going to control and manage healthcare. The only real question is, "Who?"* The financing of healthcare will never return to a system where the medical decision making process takes place in isolation and independent from the question of "Who is going to pay for the services?"

Second, because of the expense of technology and of increasing access to healthcare by a larger population, it is possible for healthcare alone to bankrupt the United States government. Unchecked, the cost of healthcare delivery can prevent the balancing of the Federal budget. The financing of healthcare will never return to a system where the medical decision making process takes place in isolation and independent from the questions of, "How much is a service worth and how much is society willing to pay for it?"

Third, this means there are limited resources to continue to provide the excellent healthcare, which the citizens of this country presently receive. Someone has to allocate those resources. Who? The financing of healthcare will never return to a system where the medical decision making process takes place in isolation and independent from the question of, "What is society's responsibility to its most vulnerable citizens as far as access to affordable healthcare is concerned?"

Fourth, the government has assumed, by law, the responsibility of providing healthcare to a certain segment of our population, and the government is not going to surrender that responsibility. The facts of this reality are explained by the AAPCC – the Actual Average Per Capita Cost. This is a calculated figure based on HCFA (Health Care Finance Administration) payments for healthcare in the United States. It is calculated on a county-by-county basis for every county in America.

In the private sector, the principle is the same. While there is no Trust Fund, private companies have budgets and must meet them. Managed care allows industry to budget its healthcare costs by transferring the "risk" to another company. In order to remain competitive, private industry must control healthcare "risk."

The second relevant issue is "responsibility."

Each "player" in healthcare delivery today is in an unspoken partnership, which has actual and implied responsibilities.

- Payers (managed-care companies),
- Providers (physicians and other deliverers of health services) and the
- Patients (insured).

Each "player" has its peculiar responsibilities. The payers, of course, have responsibility for operating within the "realities" of the AAPCC and/or contract, and for making sure that access to healthcare is maintained. Balancing these responsibilities is a function of the core values and integrity of the managed-care company and of HCFA regulations. Providers are responsible for providing outstanding care. In managed care, healthcare is more directed toward preventative healthcare than to treating a problem, which has already developed. Physician must be aware of the differences in cost for care. The reality is that care obtained at one place, which is equal to the quality of care obtained at another, can be three times as expensive. To conserve the healthcare resources for the benefit of everyone, the physician's responsibility is now, not only to assure quality, but cost-effectiveness as well.

The patient has responsibilities in the managed-care system as well. In order to get the expanded benefits and cost decrease of managed-care, the patient is responsible for utilizing physicians who have contracted with the managed-care company and who are committed to complying with utilization management guidelines, pre-certification of procedures and review of care. The patient also has a responsibility to avoid habits, which cause increased health problems when and where possible, and to cooperate in obtaining preventive care, which can decrease the cost of maintaining health before serious and costly problems develop.

The Third Relevant Issue is Rights:

Within these "realities" and "responsibilities," what are the patients' and providers' rights? The patient has the "right" to excellent healthcare and to access to needed care. However, the rights of the patient must be balanced with the rights of the managed-care company and with the rights of the healthcare providers who provide care. Likewise, the rights of these latter two groups must be balanced against and with the rights of the patient. The patient has the "right" to choose any PCP (Primary Care Provider) who is in the contracted network of the managed-care company and/or for the IPA (Independent

Physician Association). And, the patient has the right to go to any specialist who has agreed to cooperate with the managed-care company.

But, the patient's right to choose his physician cannot interfere with the right of the managed-care company to manage the "risk," which it has assumed. The patient has the right to request that their favorite physician contract with the managed-care company. But, the physician has the right to refuse. And, the managed-care company has the right to expect the patients and providers to comply with the utilization management guidelines and standards required to manage effectively the "risk" the company has assumed.

Providers have rights also. Most physicians have resorted to demanding their right to lead health care management. The new realities result in that demand being rejected. If providers wish to exert influence over the delivery of healthcare, they will have to accept their responsibilities and collaborate with payers and patients.

Managed Care and the Computerized Patient Record

In the context of these realities, rights and responsibilities – and in the context of physicians and other healthcare providers have a "change of mind," how can CPR help us? The standards to which healthcare providers are going to be held in the future are much higher, more rigorous and more enforceable than ever before. For the previous generation of physicians, the question of a Medicare audit was "If"; for the next generation, the question is "When?"

New standards of care are being enunciated by:

1. HEDIS, The Health Plan Employer Data and Information Set, which is the National Committee on Quality Assurance's standardized set of about sixty performance measures for managed care plans. It has become the industry standard and is at the core of most health plan report cards being developed all across the United States. It is the standard against which all healthcare providers are going to be judged.
2. The National Committee for Quality Assurance (NCQA) is an independent, not-for-profit organization dedicated to assessing and reporting on the quality of managed care plans, including health maintenance organizations (HMOs). It is governed by a Board of Directors that includes employers, consumer and labor representatives, health plans, quality experts, regulators, and representatives from organized medicine. The NCQA indicates that within two years, they are going to be offering NCQA certification to individual medical groups as well as to health plans. The time will come when NCQA certification will be a critical component for success in the emerging medical marketplace.
3. National Standards of Care are going to apply – not only in lawsuits, as they are now – but in provider evaluation and contracting decisions. More and more, in addition to board certification, clinic performance as measured by these standards is going to be the entrée to participating in heath plans, as well as board certification.

Critical performance indicators, such as HEDIS, national standards of care and NCQA certification are going to be increasingly used as measures of clinical performance.[8]

Computerized Patient Records can be utilized not only to meet these standards of care, but also to prove that they are being met. In the thirteen months that SETMA has been using EMR, we have had five HEDIS audits, all of which have resulted in a superior rating. We are gradually building national standards of care guidelines into the database of our EMR, NextGen. In all of these areas:

- NCQA Certification
- HEDIS audits and/or compliance
- Medicare audits and/or compliance
- National Standards of Care

CPR is the only record keeping and patient management tool, which can solve the complex problems facing healthcare providers in the 21st Century.

Review of Southeast Texas Medical Associates' Use of CPR

SETMA's implementation strategy was based on a resolute determination to make the system work and to get all of the benefit from the system, which is available. Currently, SETMA's CPR implementation provides the documentation of:

1. Over 50,000 patient encounters per year.
2. Over 190,000 incoming telephone calls per year
3. The responses to those telephone calls.
4. All x-rays and EKGs – over 5,000 of each per year.
5. All Nursing Home patient visits including hydration assessments, fall assessments, skin assessment, etc.
6. All laboratory ordering and reporting for in-house reference laboratory. We continue to work on interfacing with reference laboratories outside of SETMA.
7. All home health visits in SETMA's home health agency.
8. All physical therapy visits in SETMA's physical therapy clinic.
9. All hospital admissions and discharges with diagnoses and medications, which represents over 22,000 daily hospital visits per year.
10. All medications used to treat a patient, including checking for drug/drug interactions and patient/drug allergies.
11. Return to work authorizations.

[8]The following is one of the standards, which NCQA has established in regard to the signing of medical records. It demonstrates how specific the standard is and how electronic medical records meet those standards. HEDIS states: "For medical record entries dated after July 1, 1999, NCQA will not accept stamped signatures as appropriate author identification. However, NCQA will continue to accept handwritten signatures, unique electronic identifiers, and initials." For more information on both HEDIS and NCQA see www.ncqa.org.

12. Waivers of payment for Medicare and Medicaid charges.
13. All referrals to specialists
14. Follow-up instructions for additional or future testing. SETMA has designed a unique electronic tickler file, which enables us to make sure patients who require follow-up testing get it.

SETMA's implementation also has resulted in SETMA's ability to:

1. FAX all prescriptions to pharmacy.
2. E-mail laboratory results to our patients.
3. Communicate with our patients via e-mail.
4. Receive request for appointments, referrals, billing information or laboratory data via SETMA's web site on the Internet.
5. Utilize an electronic super bill for association of ICD-9 codes and CPT codes.
6. Create a billing event automatically from the patient's examination room.
7. Providing patients with educational information automatically at the point of encounter, which is personalized, for each patient and for the practice.
8. Develop extensive Microsoft Access reports on:

    a. Immunizations
    b. Disease state management
    c. Preventive health issues, male and female
    d. Practice patterns
    e. Provider patterns
    f. Payer patterns

9. Compare provider performance as to quality of records and appropriateness of assessment.
10. Incorporate multiple health assessment/prevention questionnaires into the routine office visit.
11. Allow the provider to look at "information over time," following trends for vital signs, laboratory work and procedures.
12. TeleHealth, which allows SETMA to place an automated call to our patients with chronic disease to get interim follow-up from them and/or to make sure they are following our instructions for care.

One of the most interesting results of our implementation is the reviewing of telephone calls with a patient during their follow-up appointment. Patients are fascinated with the fact that we know when they called, why they called and what we told them to do. It gives them confidence that their access to care extends beyond the office visit and it gives them confidence that they have a relationship with a provider who cares. **It is a perfect illustration of how "high tech" can extend and expand the meaning of "high touch."**

Implementation Strategy

When SETMA implemented the CPR, we determined to do it a little differently than others. We knew that it was not possible to "be a little pregnant," so we abandoned the idea that we would start using the CPR with the last few patient of the day. We began with the first patient of the day on January 26, 1999 and, as a result, in four days, we were seeing all of our patients on the CPR. For the past fifteen months, every patient at SETMA has been seen on the CPR.

SETMA drove the process of implementation with the guiding principle that we refused to accept anything but complete and total implementation. We published a booklet entitled, *More Than A Transcription Service: Revolutionizing the Practice of Medicine with Computerized Patient Records*. We gave copies to our providers, our patients, and our payers, to anyone who would listen. We talked implementation; we dreamed implementation, and, we implemented. It was with "sheer dogged endurance" that we accomplished the task. It was hard and it cost a great deal of energy, money and effort, but now that it is done, we couldn't be more pleased. And, now, all of the things, which were so difficult, are easy; all of the things, which took a great deal of time, now almost seem to happen by themselves.

Pitfalls to avoid

If a practice is to be successful in implementing CPR, they will, for a brief time, give more attention to CPR than perhaps it seems they are giving to their patients. But, ultimately, the provider must not give more attention to the record than to the patient. We must never be in the position of saying, "We're sorry, madam, that your husband died, but here's a copy of his outstanding computerized patient record." "High tech" does not require the sacrifice of personal, human contact. In fact, after the implementation process, "high tech" will promote "high touch." But, in the short run, the commitment to CPR must be at the top of everyone's list.

On the other hand, the provider cannot give more attention to the patient than to the record. Healthcare providers never want to find themselves in the position of saying, "I know we did that examination, but I don't have any record of it." The balance between "high touch" and "high tech" is important, but in the long run the two are complementary not conflicting.

Another pitfall to avoid is failing to utilize the strengths and capacities of the CPR. If the CPR is only a gloried transcription machine, it isn't worth it. In *The Fifth Discipline*, Peter Senge also declares, "The more complex a problem, the more system the solution must be." The practice of medicine and healthcare delivery are so complicated today they require systems solutions.

- Without the ability to track HEDIS data, it will be impossible to "prove" that you are doing quality work.
- Without the ability to examine patterns of behavior among the providers in your group, it will be impossible to improve the quality of care.

- Without being able to monitor the behavior of your patients, it will be impossible to affect the health of a population of people.

Without systems, none of these things can be done effectively. In the future, primary care doctors are going to be a cross between clinician, counselor, epidemiologist, and business man/woman. To integrate each of these functions, without neglecting the attention, which the individual patient deserves, systems are going to have to care the burden of the capturing, documenting and the analyzing of the data necessary to accomplish each of these functions.

Selling the CPR

Once a healthcare provider has been "sold" a CPR system, the sells task has only begun. Any successful implementation of a CPR requires the "selling" of the idea to several different groups. SETMA has never stopped this selling process to

- Our providers,
- Our patients
- Our payers
- Our community.

SETMA's patients now expect to have a record, which is complete, accurate and accessible. Their expectations are such that quality care for them begins with the capturing of precise and accurate data about their healthcare events whether in the clinic, on the telephone or in the hospital. SETMA's healthcare providers now expect to challenge every patient with preventive healthcare issues many of which are irrelevant to the event which precipitated the current encounter, but each of which addresses long-term health needs of every patient. SETMA's customers, the payers, who pay our charges, are coming to expect the kind of documentation which gives them the ability to properly access the quality of care and appropriateness of care which their membership is receiving from SETMA providers.

The selling of the CPR not only encouraged each participant in the healthcare process to "buy in" to the concept, but it also put SETMA in the position of "having to" succeed. Once we announced that we were going to do CPR, and once we "bragged" on what it would accomplish for our practice and our patients, we had no choice but to succeed. Selling the CPR is not unlike the Spanish Explorer, Hernan Cortez who arrived on the Yucatan peninsula in the year 1519. One historical account relates the events:

> "The Spanish soldiers were divided between their desire for fame and wealth and their fear of defeat and death. 'We're only 500,' they told Cortez, and he answered, 'Then our hearts must be doubly courageous.' 'We are dying of fevers and Indian attacks,' others complained. 'Then let us bury our dead at night so that our enemies will think that we are immortal.'
>
> 'Let us go back to Cuba, let us sail back,' others said in frank mutiny. 'But there are no ships,' Cortez answered, 'I have sunk the ships, right here. There is no

way but up, there is no retreat. We must go forward to Mexico and see if this great Montezuma is as great as he proclaims himself to be.' So, the soldiers cheered and acclaimed Cortez as their leader, and all cried 'Forward, to Mexico, to Mexico!'"

Cortez insured the success of his mission by making it impossible for his troops to retreat. He burned the ships. In many ways, the "selling of the CPR" is like that. It makes going back impossible and makes going forward to success the only alternative.

The Information Systems Department

Whether the IS Department is one person who "knows more about computers than others," or is a fully equipped department with network and systems engineers, the issues are the same. The IS Department exists for the support of healthcare delivery. The goals and objectives of each IS Department must be spelled out, but some are generic:

1. To facilitate the effective and excellent treatment of all patients.
2. To securely store all patient records.
3. To make the patient records available at ALL times, with minimal, if any, interruptions because of system complications.
4. To make all changes and/or upgrades to the system at times when there is minimal need for the records, i.e., after-hours and/or weekends.
5. To have a "can do" mentality about solving new problems and/or providing new functionalities for the system.

The IS Department exists for the care of patients, not the care of patients to support an IS Department. While this distinction may seem trivial, it has tremendous practical implications.

Interim judgment of value of CPR and particularly Clinitec's NextGen

It is the future and the future is now. There is no way to do managed care effectively without CPR and there is no way to meet the documentation and preventive care demands of all health plans in the future without CPR. If healthcare is going to be driven by the provider, it is going to be so because of excellent records and particularly excellent Histories and Physicals. The only way both to integrate healthcare databases and to utilize that database at every patient encounter is with CPR.

Now that SETMA is virtually paperless, we find ourselves to be more efficient and more excellent in all areas of our practice. Without CPR, we could not be consistently performing at the level, which has become the acceptable standard in our practice.

CPR is not easy to implement, and it is not easy to modify an existing practice to comply with Managed Care principles, but the two compliment each other and make it possible to be successful in the new healthcare environment.

In closing, let me share with you a quote from a young attorney with whom I shared the idea of "sinking your own ships," as a metaphor for implementing CPR at SETMA. Speaking of the Cortez story, he said:

> "I have always loved that analogy. I was wondering if other doctors realize the implications of what SETMA has done. By showing that it is technologically attainable to have a paperless office, with electronic safeguards against giving contraindicated medicines and losing or misplacing files, you have in essence raised the standard. Doctors with paper files can no longer claim to be acting prudently, when information is missed due to legibility or misplacement of paperwork, since there is an available cost-effective alternative.
>
> "As an example, plaintiff lawyers typically compare a company with an unsafe working condition to DuPont, which has some outstanding safety procedures and a good record, to the chagrin of other industry. SETMA may find itself being the 'DuPont' of med/mal cases in the future.
>
> "You have burned your ship, but I wonder if your colleagues realize that their sails are on fire as well?"

This summarizes the subject as well as it can be from one standpoint. At least one standard of excellence for healthcare delivery in the 21st Century is going to be the quality of records, which a healthcare provider maintains. And, no other system of record keeping can compete with electronic medical records.

James L. Holly, MD
Managing Partner
Southeast Texas Medical Associates, LLP
www.jameslhollymd.com