Overcoming Technology Adoption Barriers for Practicing Physicians – If Technology is the Answer, what are the Questions?: Dr. James Morrow

Stephanie Hill: Welcome back everyone. It is with great pleasure that I introduce to you Dr. Jim Morrow, Vice President and Chief Information Officer of North Fulton Family Medicine in Cumming, Georgia.

Dr. Fulton will share with us the challenging realities that a family medicine practice comes up against when trying to incorporate technology into daily workflow…no small feat for physicians who are already struggling to find enough time for their patients.

Please welcome Dr. Morrow.

Dr. James Morrow: Thank you very much Stephanie. I really appreciate being asked to come and
speak to such an important group today. It's not every day that I get asked to do that. And I am very excited about that. I'm planning to leave time at the end for questions; that's how I know if you liked it and were paying attention so please ask questions when we get through.

I am in fact a family doctor, that's 90 percent of what I do. I'm in a group in Metro Atlanta; just north of Atlanta. We have right now three; in a month it will be four locations, right now with 10 doctors but will soon be 12. We started doing electronic medical records, in 1998; we installed December 18, 1998 we went live. It's one of those days that you remember. At that time we did not realize that we were doing anything that anybody else wouldn't be doing. I have since come to realize that not many people were not doing it in 1998 and I think that's really unfortunate that so few people are doing it even today. There are a lot of things we've learned, some the easy way and some the hard way that I would like to share with you.

According to Robert Metcalfe, who actually invented the Ethernet, he is one of the reasons that we are here today. The value of the network increases as the square of the number of users on it. We've found this to be true already in our small practice because the server that we put in originally served the four doctors we had when we started or the five doctors we had when we started and also our employees and as we started to add people we didn't have to do anything except plug in another keyboard and another computer and we could work right along and everything was great. We saw a great economy scale and because of that, we have been able to expand to the size and the number of providers that we have today. Speaking of our providers this is me - Cartoon… doctor with back to patient, paper on the floor, hunting for password. This is what a lot of doctors think life will be like when they put in a computer (referring to slide cartoon) and it just doesn't have to be that way. When I joined the group in April of 98 we had one office. I opened

the second office in April of that year. In 1998 we had five doctors early in the process when we installed the medical record, about a month into it, the youngest guy in the group came to us and said you know I didn't go to medial school to write a keyboard and I didn't plan to use the keyboard; I'm going to go back to dictating. Well we had been spending an arm and a leg on transcription. And we went from an arm and a leg to zero overnight and we told him we'll you can do that because there's a module for transcription -- but you're going to pay for the transcription because that's how we're financing this entire thing, by not paying for transcription. He said well I am not going to pay it and we went back and forth and eventually he left on good terms and went down the street and joined another group. And six months later they put in EMR and he is still there having been able to actually read the writing on the wall. So we went from 4 doctors in 1998 to 10 and no PA's to 10 We went from 100 patients a day to over 400 patients a day. And we certainly added servers because we needed one for this and one for that. But the entire thing about the network still comes to pass because we have not increased by the multiple of four the number of servers and the amount of network enterprise that we have. We did go from 4.7 FTE's to provider in 98 to 2.8 in 2004. And we're up a little bit now I think it's about 3.1 or 3.0 something now, but that's a pretty good decrease. No one got fired, no one was asked to leave. We turned filing clerks into scanning clerks, if someone left, we replaced them right away. We thought we were in an area that could support it. We were in an area in Atlanta where we thought we could grow successfully and we thought we needed too and we wanted too. So the FTE's were just kind of spread out over a larger number of providers in a fairly short course. People ask why we succeeded and others did not. When I was first asked that I had absolutely no idea. The biggest reason I can tell you because anything else was never an option. We did this because we were about to go under financially, decreased reimbursements and increased costs. We were having trouble with that particular model and we needed to do differently and we just set out to do this and not succeeding just never occurred to us. We did not have the benefits of attending TEPR where I went last year and spoke and the people all over the meeting were talking about how difficult this is and how hard this is and how expensive this is and what a nightmare this is. I said but first let me tell you, please don't leave here more concerned and more decided not to do EMR than when you got here, because of all the sorrow stories and the bad stories people are telling you. Because they will tell you that. And of course people who don't succeed are more vocal than those that do I suppose. They have strong positions of how to initiate change. So that was one of the first things. We had a real champion; my senior partner now, and at the time the sole owner of the group saw that we needed to bring these costs under control. We had a good implementation team which in part also was dumb luck. But we had him, and myself and our head nurse and my office manager and then people also from the vendor, making up the implementation team. We had our own little jobs that we had to take care of and we did and that worked out very well. And we had a company that put service above everything else, and that has continued to this day and I will tell you to this day they are not the company that we started with, but it's all the same medical record, but nonetheless it's all the same medical record. We originally bought from Glaxo Pharmaceuticals. You don't think about them a lot of times as being an EMR business, but they were, they owned this particular product. And about 6 weeks

after we went live we got a certified letter –which is just never good, anybody here ever get a good certified letter?--saying after 12 months Glaxo Pharmaceuticals would no longer support this electronic medical record. We spend a better part of the year, I had been involved for about eight months before we implemented and spent a lot of time looking and deciding over this whole thing and then we get this letter. We liked the product and we just decided we would hold on and not jump ship. Although they said we could get our money back, we couldn't get our efforts, time and sweat back. So fortunately for us a good company came along and bought them. And this has been a company that continues to put service in front of everything else. So the reason you really succeed with kind of thing is return on investment.

Now I've got, as you will learn, a lot of opinions and I have a couple of opinions about return on investment (ROI). ROI is a wonderful thing and it goes without saying. My problem with ROI is the doctors who have not yet implemented electronic records tend to believe that without a ROI, they're not going to do it. And if they continue to have that same attitude they are not going to do it. Because there is no guarantee that you are going to get a return on your investment, although we have been very fortunate in that regard. But I'm a big believer that implementing electronic records is the cost of doing business. Practice management systems came along and we kind of got away from the peg board not long after I went into practice in 85 and I don't know a single physician whoever looked at a real good billing system and thought, now how am I going to make money, extra money, more money because I am using this system. What they did was, the health plan said you have got to bill electronically and they said ok we need a computer that's the way it went and sure they spent a lot of money but they didn't bellyache. I've never heard people bellyache about practice management systems as I've heard about electronic medical records. It's a wonderful thing and the truth is, this is what it is going to cost to do business. Everyone that's heard me talk has heard may say that I firmly believe that with in 5-8 years it's going to be mandatory that you use electronic records. President Bush did not make the comment he did, in two state of the union addresses in a row about people in America and electronic records and not mean it. And I firmly believe that it will come to pass that you will not have a choice.

In real dollars, actual numbers are based on time studies and function studies that I administered at the time we were seeing based on 100 patients a day. 100 patients a day were spending $29,000/year, creating new charts we were spending $9,000 a year, looking for charts was $16,000. Transcription was $110,000/year. That's a lot of money. And I have done this every way you can do it. There's no better note short of an electronic there's no better note than a transcribed note and they are expensive. A lot of doctors and I can tell you right now if you are talking to people in your plan, they will tell you, well I don't dictate and transcribe so I can't save $110,000 a year. There is a lot of truth in that. Over the whole first year, we saved a total of $200,000+. My numbing task of taking lab results from the printer, punching holes in the paper, finding that chart and putting it in that chart, putting it on the doctors desk and waiting for a response that was $16,000 a month. The whole process, we were spending $16,000/month on that, $32,000 for letters and

$25,000 just to buy the paper and the products to make the charts. 44 hours a day we were spending, now saving. That was $239,000 for the year at 100 people a day. That is real money to me. At 400+ people a day is tremendous. The fact that we've been able to save this money continually is very impressive to me and it is something that I am very proud of.

Now I'm not an accountant; I would never pretend to be an accountant and I would never be an accountant—I'd go nuts.. But these numbers are calculated by taking the total amount of money we spent, from salaries to medical supplies to Braves tickets and dividing by the total number of patients we saw in that year. To me that is a real number. It is $112 per patient. With electronic medical record, and got pretty good with this maybe 6-9 months later, it lowered to $79. $33 per visit, that's not bad, at the time we were seeing 130. This next one's my favorite one. $2.5 million a year we were able to save at 130/day. And if you're thinking, there's no way in the world--fine, cut by half I don't care. We're seeing over 400/day now. I should be lathered in gold; but I am not because I am very lucky. I practice in the nicest office I have ever seen. We pay our people well. We've been able to do things and put it back into the system. We have been able to do some of the things that I will show you here in a minute that we could not have done if we hadn't been saving money. We've been able to hire better physicians and more people and provide them with all manner of benefits all the way down to the check-in person, from the check in person to my senior partner with all the benefits we can imagine. I think frankly, that our patients benefit from this. The attitude in our office is not one of drudgery and despair and slave work, it is one of gee I am happy to be here and working and lets take care of you. Which I think it is the way it should be.

One of the things that is very important is online access. And more importantly family medicine. We have for three years; I think it is now been, allowing patients to access a good part of their information online. Now this is one of those things that really is not new to me, it's old hat. I guess. At the time it was revolutionary that a patient could go onto a secure site and they continue to want to use Outlook, and I love Outlook but it's not secure on the patient's end of it, that's for sure. They will send me an email about Lord knows what I will say, why don't you go to the other site and lets talk about that. So we are able to get messages from patients in a secure fashion, and quickly. If I am working in an exam room and we have a desktop PC in every exam room with a thin screen monitor. In 1998 that was not cheap we paid we paid $1210 each for 15-inch thin screen monitors and in 1998 that wasn't cheap. I have got 25 exam rooms in my office today, and I would not want to pay that amount today and now you know they are free with an HP. If I am in an exam room sitting there talking to Stacy who is there about who knows what, and I am sitting there pretty much like this and we are talking and I have got the computer here and I am making some notes and all of a sudden it will pop up where I have a message. Stacey is of course talking about the same things that I have heard the last five times she has been there and of course it is all in the chart already, so I don't need to keep typing that in every single day, so she's talking and I am nodding and talking and I am looking at this next note that somebody sent me about their Lipitor causing some muscle aches and I am just typing away and Stacey of course thinks man he is putting in every word I say into that computer,

when in fact what, I am responding to Joe who needs information on his body aches. I hesitate to tell this story because you all are saying; you need to pay attention to Stacy. I will do that if Stacy is telling me something that's new and different that I haven't heard. Everyone that has ever been in an exam room knows that a lot of what people tell you is repeat information and they go on and on. I can do two things at once. I'm paying attention. That kind of workflow and efficiency is—is tremendous.

I think it's a win:win situation. I hate a phone system with a passion. We determined a long time ago that the most expensive piece of equipment is the telephone. I absolutely despise it. Patients don't get calls back and they have answering machines and ever since "HIPPER" you can't even leave a message on their answering machine. The fact that we can go in here with a system where we can them send notes, tell them your cholesterol is high, you can see it here, you can go here, you can do these things. Just revolutionized practice for us--even if I do answer someone else when they are in the room. So those are some of the things we can do. It gets the patient so much more involved. It works beautifully and it involves the patient so much more in their own care. I think that is very important because as we've heard earlier today if you get patients to own some of this and take responsibility then you have a much better chance of getting the diabetic to take eat right lose weight and take their medicine then if you don't do that.

Here's a screen shot of our site. And again it is a secure site; it is hosted by our vendor. I put a link on the website and it takes them directly to the site they use a user name and a password that we provide them when they are in the office. It's kind of interesting when we first started doing this I put a link on the website and said send me an email and I'll give you the user name and password. I realized we are not using email because that wasn't secure in the first place, how much sense does that make, so they receive the user name and 8 digit alpha numeric password that they can fortunately change very easily. The site looks like Yahoo email or anything else; Hotmail might not be a bad example. Most everyone can maneuver around this site it's really not difficult. If I sent them a message, it would say message from Dr. Morrow and here's the subject and they would open that up and it reads just like any other email. For example for the lab result page they can go to the lab page and see any one of their labs. They can sort them by how far back they want to go basically. One month to I think six years is the farthest it goes currently. I often have patients in the office that will say, I need you to send a copy of this lab to doctor so and so, my cardiologist. I have a thousand electronic ways to remind me to do that but the truth is I like my patients to do that. So I will tell them will you get your lab results on line. And they will say yeah. I have about 80 percent of our patients are doing this. I'll ask the patients to give the lab results to their cardiologists and I lay it on them because I like them spending their time and energy doing that more then my staff. So this is where they can see their lab results. They can also see medication lists, send me a message. A lot of people, when I mention this say you'll get messages about every hangnail every sunburn and every single thing. That's true to a certain degree. But when they first put phones in the office, it was probably the same thing. I am sure they had people

calling up saying, I have this and I have this. And I am sure the doctor said, come on over, come on over, come on over. They probably called in saying I'm having chest pain and shortness of breath and a dull aching sensation in my arm and what do I do? I have not gotten that email. I hope not to get that email. But if I do get that email, I'll simply call the patient and say 911 is on the way. They have really not abused this; it has been a very, very helpful site for us. The fact that we have engaged the patients in doing this has been a tremendous thing for us and I think it's tremendous for them.

The slide Bruce showed talking about the elderly being less likely. That's true to a degree, not quite with us to what he had. I find my 80 year old farmer from the northern part of the county is as eager to get online and send me a message with 55 blood sugars, all separated by comas as much as anyone. It works great. It's sometimes not the person you think who is going to be hesitant. It's been very revolutionary for us. Because you can see medication lists, it's pretty handy – it's not a true PHR, but I had one family who goes skiing to Utah with 18-20 members. He obviously is not a family doctor. I suggested that he take the family doctor with him there would be a lot less bad things that would happen. Every year, someone ends up in the hospital. Either in the ER or someone is admitted to the hospital with pneumonia or altitude sickness or something. So sure enough the patriarch of the family ended up in the emergency room this year. I had just changed one of his medications about four or five days earlier. So he goes to the ER his medicine is in the hotel, the ER asked what medicine he was taking and he said, well I take this and this and this and my doctor just put me on this new one, it's that little blue pill. He couldn't remember the name. The ER doctor asked if someone could drive the 30 miles to the hotel and the patient said if you can get on the Internet, you can go here and do this and you can I'm taking. So that's what they did.

I have one diabetic who lives and works in Dubai. He comes twice a year to the office and he mails me HB1ACs and he's doing beautifully. He rarely has to see a doctor over there. To him, I'm his doctor. And that is pretty cool to have a patient in Dubai. I don't even know where Dubai is..

People are very concerned, as they should be, about security with electronic records. They are very aware of security there was a company right down the street who managed to release millions of peoples' information to who knows who. So they get concerned about that. It's important to address these with patients when they bring it up. Also in everyday work, make sure you do have secured networked. I just had a new patient who said I'm not 100 percent sure I want to be a patient here, as I understand you use a computer for your records. I told her I could understand that, and told her we do everything to make her records secure. I told if she was concerned about that, there was a practice across the parking lot uses paper records and the janitor can read the records at night. She did not think about that, and neither did I back then. When I was doing paper records they were right there. So she is still our patient and we get along great.

Firewall, antivirus and backup. These make a nice bullet on the slide but they are absolutely critical. When we started we didn't have the world's greatest IT

company backing us up and doing the server matanence and being sure that firewall and anti virus was updated. I was in the office and our server was about 12 miles away. One day our speed was ridiculously slow -- I told them I could have walked the data to Alpharetta faster to them. So I called the company and asked why it was so slow. They called me back about five minutes later and said some guy in Germany is saving DVD files to your server you're your open port. He told me he could block him. Well that gives me a warm fuzzy feeling. I don't even want to know what kind of files he was saving, I didn't ask and he didn't know. And then antivirus is so incredibly important, we ended up with the KLAS virus in about 2001 and we were down for about two and a half days in 2001 working on paper and then after that we had to put everything back in and it ended up costing us thousands of dollars. The IT company, yet a different one, a second one, had assured us they were doing everything necessary in the way for AV. I'm sure that's the way I worded it in my deposition --and they really weren't. Backup became incredibly important because we had a tape backup but we had never tried restoring data for that tape. We got lucky. We did not loose a lot of financial on that tape. Today, every hour on the hour, all data is backed up to a bank of servers in Austin Texas. If we do have a disaster, as soon as I get an Internet connection I can get access to that. When Hurricane Rita came through, right after Katrina, I read about this doctor who religiously backed up his files, checked the backup and took them home; he lived about a block from the office. Both of them were destroyed. Here he thought he was doing all the right things and yet he was still wiped out anyway.

I have been fortunate enough this year to be doing some work with him, on a project called Katrina Phoenix, which is a project where we are trying to take some of the packages on the Gulf coast that were destroyed by Katrina where they watched their records float down the river and bring them back up electronically. We have numerous vendors that are giving donations of software and hardware and we already got one back up which has seemed like forever which is just a year, but I am sure it seems like forever to these people, but we have one back up and many more in que now to go ahead and get going again electronically. The difference for them is going to be astronomical needless to say.

What does all this do for our patients and us? The major reward is the better outcome. We can really show that we are doing better. We can monitor these things. We can search for people that are over 50 and have not had a colonoscopy or a PSA in the last year. Or diabetics that have not had an A1C being able to do that is wonderful. When Vioxx was pulled off the market, we did a simple search and started making phone calls; we had 300 people to call. There were more of them taking Vioxx but at different doses. You can't do that on paper. There's no way in the world to do that on paper. Drug recalls are a very regular thing anymore. Sitting in the exam room, I can bring up a patient's cholesterol. This is a real patient, you can see the doses of Lipitor goes up and stays and the cholesterol comes down. You can show patients and the visual sticks with them. The results are not always great but the point is the patients appreciate this and can get a lot from that. This is taken right from the data inside the EMR.

We can now receive reports from the hospital near us securely, legibly and electronically --much faster than we ever could be before. Whether it is a CAT scan of the chest, whereas before you might get a faxed copy the next day as soon as it's transcribed at the local hospital, we get this in the EMR. This was written by a couple guys who got fed up with a big company and decided to do it on their own and now they are doing it all across the country now. They can tie hospitals and doctors offices, even doctors who don't have EMR. You don't have to have an EMR, just computer access. They will feed you these reports as soon as they're finished. The idea of the amount of money you could save if we didn't have recheck CBCs and X-rays on patients in the hospital over the weekend. My nurse will take two hours to get the information from the hospital; that's terrible. And the patient is having to repeat the same X-Rays on Monday morning. . I'm thinking you could take care of a lot of people from the money saved not having to do blood counts and x-ray repeats on Monday morning on those who were seen in the ER over the weekend. Before I went on the computer, I didn't know if I didn't received a lab I ordered. At the time I was seeing 60 people a day. How I am going to know that and be able to manually track that. The ability for us to know we're ordering test, getting results and getting the results to the patient is fantastic. The first thing that I think of when I hear that sentence come out of my mouth is, why would you not be doing that all along? The answer is it's difficult and expensive. That's the honest truth.

So how do practices do this and do it well? Where do people fail? About half of EHR implementations are likely to fail. A lot times the reason is because they bought a particular product but mostly they didn't train and implement, they didn't do what we talked about here. I believe that a successful implementation is done as a group. If you have a group of doctors that are 6 or 8 in one or two offices, I recommend that you talk to these providers and implement all at once, not piecemeal. If you have multi-specialty groups, do a department at a time. Don't do one doc here and one doc there. If you have umpteen providers and you are at umpteen locations, then do them two at a time. It has to be mandatory. Just like when we told Paul who said he didn't' want to do the keyboard thing. We said well this is the way we do it now, so take off, if you don't do take that hard line you will never be successful.

You have to create templates. I was talking to a guy who wants 15 or 20 templates before he goes live. I've been live since 1998 and I don't have but three templates to date. I've got some, but you don't need a template for everybody that's got tennis elbow or everybody whose got swelling of the feet. It is just not necessary. . A template is the pre-completed physical exam for a normal male under 40 in this case. This is the same thing that everyone that dictates and you can dictate while carrying on another conversation with someone. The template is no different from that. The pertinent findings that you find to be different from what you anticipated are all right there and easy to complete. For review of systems, you might have a few without any pertinent info. Another important thing is to create like an Excel spreadsheet of lab orders. Creating templates and a superbill before your live date is very important, another important thing is to create like an Excel spreadsheet of

lab orders. If you do these two things before you go live, your implementation will go so much more smoothly, it's unbelievable.

Now I usually have three slides that I use for training because I tend to really beat this up and I started doing that a year and a half ago when we began doing beta testing for a particular vendor for a few years now. Last year in the spring we were putting in a new version I didn't really realize how different some of the stuff was. We had won the Davies award so we thought we could do it easily. I was in Arizona giving a talk and my phone started ringing and people were panicking because there were a lot of changes that we had done with zero training and we failed miserably with that beta, so they pulled it out. I got back and we did some training. It just really really enforced that we need training, I tend to beat training up but it is important. A lot of times people might buy an EMR, they might spend a $1,000 and somebody will send them a CD in the mail and it might or might not have a manual with it and they call that an EMR and they think they are electronic but they are not practicing good medicine at least. So without training it's easy to fail. You also need a champion. It's usually a doctor, but doesn't have to be one. Someone who is vocal and knows a little bit about computers is a plus but not a requirement. I thought this was going to be easy, and then I said and a network is what exactly? Because I didn't know anything.   And I still don't in large part. Knowing a little bit about computers is a plus but it is not a requirement.

Why should doctors participate in this? 84 percent of doctors agree that computers make for a better quality and 78 percent think it has a beneficial effect on interactions within the health care itself. 85 percent think you should use a computer to write a prescription but have of them don't intend too. 89 percent think you should computerized the patients summaries but have of them don't intend too. 83 percent think you should computerize treatment records, which of course is all of what the EMR does. One problem is initial cost. It's not cheap. Doctors are, as you know, working with thin margins. Working with increased costs, decreased reimbursements. It takes a lot time there. You really have to want to do this. They have concerns about security and maintenance costs. Even the people on the Gulf coast who we're giving EMR to for a year for free are asking about what it is going to cost to maintain this in future years. . A lot of times it is hard to do that. Sometimes the numbers are not as bad as sometimes the customer thinks it might be.

What can you all do as a health plan to help? And why should you help? There is a group up in the Boston area, a technology group.   You can see if you save $100, provider saves $11 and $89 is other. Other is a nice word for the health plan. Eleven percent to provider; but 100 percent of cost goes to the providers right now. If you take this alone, why would you as a doctor even want to do this? It goes back to some of the things I mentioned earlier, about better quality and practicing better medicine, being a better physician. No question in my mind that I'm a much better physician with EMR than I ever was without it.   So this is one the things I hope will

If you can and to the extent that you can, put financial incentives in place. You can, provide a financial incentive to practices to put in EMR. I don't pretend to know

what all the ways that you could legally or ethically or financially or possibly do that. I do know that if you will consider what you can do for the practice financially to help with this it will be a giant help. If you have pay for performance incentives, let physicians know about that. I think most physicians are completely ignorant about that; they do not understand what it means or what it would take for them to participate in that and how they might actually benefit from that. They have to be educated about that. Reduce the roadblocks to providing care. Having the collaborative and cooperative interaction with practices that I see so much more today than I even four years ago is a huge way to go about doing that. Assist practices on all the things that need to be studied before you put in electronic records. Help the practices understand there is an ROI. Help them understand that; because to be honest with you, doctors are not businessman. There are two things we don't get in medical school; business and nutrition. We don't get anything about nutrition and we get nothing about business. . In 1982, I got zero on business and zero on nutrition all through so if you can help them understand that it would be huge. It will not cost them $100,000 of they are a one-man group, because their neighbors have said that and it will not. So you can help them understand that.

You can provide them electronic registries, PHRs, med lists and databases that all people on the plan can have access to. That's a real good start. It's not an electronic record but it's a real good start. WellPoint gave everyone a PDA or desktop PC to encourage electronic prescriptions. That was three years ago; ahead of the times. There has been a complete shift with electronic prescription; it's now possible to know that not only did you gave the patient the prescription but that they picked it up from the pharmacy. I don't know how many patients I've got because they won't tell me but their blood pressure is still high and say, yeah I am still taking the medicine doc, and they have never been to the drug store. They come because their wife makes them come, in case you are wondering why would they even come; their wife makes the appointment for them. Being able to know they picked it up there's a lot better chance they'll take it.

Success depends on you and I use "you" as the complete collective term to describe everyone involved. Health plans are so acutely involved in everything that doctors do in every day life. I run into doctors occasionally that have completely disavowed themselves with health plans. "What are you smoking? I don't know how you do that; I can't imagine having more than one patient if I did that. The evolution of healthcare and health that I see is here; it is part of our everyday life. It is something that is incredibly exiting to me. It has so drastically changed the quality of the care that I am able to render You do se a real return investment in dollars but the real return is being a better doctor and having better outcomes, documenting better and taking care of patients in the way they need to be.

I have a few minutes I believe and I would love to take questions.

Susan Miller, Humana: Do you charge for secure messaging?

Dr. James Morrow: No, we do not.

Susan Miller, Humana: Do you take online visits?

Dr. James Morrow: I do what you would call an online visit, but I don't bill for it. It doesn't feel right—I know this is old fashioned. I don't charge people for no shows either.

Mary Anne Stump: Could you give me a little bit of a sense of the metrics you're using on consumer satisfaction involved with electronic records?

Dr. James Morrow: I'm a family doctor and country one at that. Are you asking, "Do the patients like this and how do I know?" I don't have metrics or anything concrete. We do have a survey and I like the idea of making those public and publishing them. I'm going to do that when I get back. We are repeatedly being told by patients that they like it.

Brigid Bonner, United Healthcare Group: With the advent of health plan risk assessments and other inbound information like pharmacy data that health plans have, what are you doing to create linkages between those big databases in the sky and what the consumer can do in their computer ...

Dr. James Morrow: Right now, nothing. The online portal was created by our vendor. My goal is to have links for a variety of disease processes, links to NCQA, links to the cholesterol registry so we can see exactly what your cholesterol should be and anything and everything like that. If you Google that kind of thing you end up with so much info you can't do anything with it. So my goal is to send patients specific links that they can go to. We do have boilerplate messages we send out and I'd like to include links to websites. That's the next step; adding to the education experience for the patient. That's the next thing we're planning.

Hector Rodriguez, Microsoft: You started to talk about plan provider collaboration. How are you maintaining the relationship with the plan? Has feedback started?

Dr. James Morrow: It has started. They are aware we're using electronic records. We've contacted the larger plans about this and we want them to help us in any way to let patients know we're doing this. We've met with larger plans to get that point across. At the same time saying we're doing a better job, can we have more money? It's been a process of us keeping the plans informed on what we're doing. Because if they don't know what we're doing they can't make any decisions about that. We've been trying to let them know.

Hector Rodriguez, Microsoft: What do you do next?

Dr. James Morrow: Next is increasing the online portal and decreasing the paper in the office. We're interested in capturing signatures electronically. We're trying to get the patient more involved in the healthcare process; because more informed

ones are smarter and healthier. Getting the patients to have more ownership of the entire process.

Participant: How do you feel about the payers getting in the space of coaching patients what they should be asking their doctor?

Dr. James Morrow: I love it. Because I don't think patients can have too much of that kind of information. And patietns tdon't have any idea what to ask and where to start – so If insurance companies can drive them to the website and show them what to ask, print them off and bring them with you. Then you will use your time so much more effectively; they'll get better care. I think that's huge. If it takes insurance companies to drive the patients to the sites that will educate them about that, then I'm all for it.

Alan Smit: Where do you see the benefits about accruing and percentage. Looks like the benefits accrued to you.

Dr. James Morrow: Those were 2004 numbers. I'm not real sure. A lot of research on that. I think they're generally on the right track. I've always heard we get 13-15 percent of the benefit, so 11 might be low.

Russell Bennett, UnitedHealthcare Latino Health Solutions: I love the fact you're the physician and CTO. That's cool. Do you find you have to train the patients and how do they fall into the protocol of using email appropriately?

Dr. James Morrow: They will not sense it. You do absolutely have to train the patient. Do you get on the internet? Of course. Then I'd like to be able to send them online. I'd love that. You have to use IE because others won't work. That's fine. I'm going to set you up for user name and password. First thing you do is change the password and make it something you can remember. Don't mail me about life threatening things or skinning your knee, but if you need me and you have a question that you feel is appropriate, don't hesitate to mail me.

Russell Bennett, UnitedHealthcare Latino Health Solutions: Also the response time. I think of things in the evening I want to ask my doctor, then forget to call in the morning. The asynchronous timing is wonderful.

Dr. James Morrow: I tell them that if you send it to me during the day quickly, then I'm not here so call or send mail to my nurse. We don't have an auto reply and we need to do that.

Russell Bennett, UnitedHealthcare Latino Health Solutions: One thing you should have in the health plan list of physicians, it should say if you're a member of certain practices you can interact with them by email. That would differentiate you**.**

Dr. James Morrow: That's very true. I hope the Wellpoints, CIGNAs, and Aetnas are listening.

Participant: Do you have some patients that have come to you specifically because you're online?

Dr. James Morrow: We have. Marketing is a tough thing for family doctors. We don't have a big budget for marketing. It's basically word of mouth and our patients that have a good experience will go out and tell others.

Brigid Bonner, United Healthcare/Specialized Care Services: Does this system help you with referrals? Do you see wanting to close the loop so you can control and know what's going on with your patients?

Dr. James Morrow: When I do a referral, while I'm in the room, I'll generate a referral letter and send that to a patient care coordinator so she can check with the insurance company and make sure they're in the plan. So when the patient walks up to the window, it's done. The people who wrote the interface between the hospital and EMR, has a product that allows them to see the referral. It's a software agent; we're in the process of developing. The malpractice insurer has told us that if I refer you to a cardiologist and you don't go and then you have a heart attack, it's my bad. The insurer says it's on me. Then we can talk to people about why.

Michael Tarino, Definity Health: On your slide of things plans can do is reduce roadblocks to quality care. What were you thinking of?

Dr. James Morrow: I was thinking when I have a patient in the office with the worst headache of their life; let me send them for a CAT scan or MRI. Don't tell me they need to see a neurologist first. If you're on a certain plan I have to say, "I need to first refer you to the guy upstairs."

Thank you very much.