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From the Editor

MQIC: MedicaLogic Quality Improvement Consortium

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Like many clinicians, especially those in primary care fields, I often wonder about many of the tightly held shibboleths of outpatient practice. For example, do we really know which particular statin helps lower cholesterol most effectively in real world practice? How often should a stable hypertensive patient be seen? And, how can we help to improve compliance rates with complex pharmaceutical regimens? In a word, I often wonder if what we are doing is efficient and beneficial for many of our patients. I know that there must be a better way.

In this space previously ("The Vision for a National Quality Report," September 2001), I have discussed the recent Institute of Medicine (IOM) landmark trilogy of reports calling on all healthcare entities to take decisive action to create the 21st century health care system – a system based on improved safety, effectiveness, patient centeredness, and one characterized by the timely and efficient delivery of services. These reports specifically recommend the rapid adoption of information technology in support of national goals for health care.

While technology alone is surely not the answer, the development of new information tools linked to the Internet may go a long way toward achieving those aforementioned IOM goals. I would like to report now on the efforts of one firm and a team of physicians and information scientists devoted to improving ambulatory care practice in the country. I will first describe the development and launch of the MedicaLogic Quality Improvement Consortium (MQIC) and discuss the evidence to support its design and long-range goals. I will report on my interviews with some early participants in this unique national program. MedicaLogic, a wholly-owned subsidiary of GE Medical Systems (Milwaukee, WI), operates three principal electronic medical record products including Logician, Chart Note, and Practice Profile. We will focus our attention on Logician. Logician currently boasts approximately 12,000 physician users at more than 500 sites across the country with literally millions of digital patient records. Astute readers of the newsletter will recall an article featuring the 10th Annual Raymond C. Grandon Lecture delivered by the senior physician leader of Medscape (at one time a component of MedicaLogic) on "E-commerce: What's Ahead for Healthcare" (September 2001). Dr. Abbie Leibowitz described Medscape's "Digital Health Solution" and its vision of a digital health record linking Logician to hand-held prescribing devices and consumer education web portals.

Today, according to Dr. Kevin Tabb, Director of Disease Management and Clinical Data Services for MedicaLogic, the company seeks to join with key Logician users to create the MQIC. Through this consortium, individual members will contribute aggregated de-identified patient data to a MedicaLogic HIPAA-compliant database. The goals of the parties involved in aggregating such information are to improve patient care, strengthen clinical reporting among consortium members, and enhance the use of clinical data for research with appropriate partners. Specifically, the MQIC will 1) provide access to anonymous patient de-identified pooled data for research and quality improvement purposes; 2) provide summary reports and information

about patterns of care for clinics, providers, and patients; and 3) participate in revenue sharing with outside medical partners in a strictly privacy compliant manner. In short, the MQIC will offer participants an expansive portrait of quality and care among members, while allowing more specific and detailed performance improvements to occur at the local level. Through the diffusion of health information among members, as well as support for research to improve quality of care and patient safety, the MQIC hopes to provide opportunities to harness the power of information systems technology to improve healthcare delivery and outcomes. How exactly might this work?

Through the creation of normative reports on the care of patients with a limited number of diseases, practitioners will have an opportunity to benchmark their performance against national standards. After reviewing these individualized benchmarking reports, users will reassemble periodically to meet and discuss specific opportunities for improvement in practice. For example, practitioners who are at variance with the National Diabetes Quality Improvement Project (DQIP) indicators might convene a working group to review possible process improvements in one another's practice. Clinicians who are having difficulty complying with the National Cholesterol Education Program guidelines¹ or related national programs² would benefit from an opportunity to discuss these improvements together in a non-punitive, non-regulatory environment focused on improvement. Among the key chronic conditions targeted by the MQIC are diabetes, asthma, heart failure, and acute myocardial infarction. Readers will recognize that these clinical conditions are specifically referred to in the IOM reports, and several are so-called "core measures" targeted for improvement by major national organizations such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the National Committee on Quality Assurance (NCQA), and the American Medical Association (AMA).

The MQIC will utilize quality indicators from some of these organizations with regard to the care of patients with diabetes mellitus, for example. Among the key quality indicators will be hemoglobin A1C tests done in the reporting year in question, eye exams, lipid profiles, and specific indices with regard to the control of blood pressure and LDL cholesterol. Individual practices or groups participating in the MQIC will reap several key benefits, among them the opportunity to benchmark their individual performance against both a group norm as well as nationally accepted standards of practice. Participation in the consortium will give clinicians an opportunity to test their adherence to these guidelines and together collectively search for improved processes of care without undue scrutiny from any regulatory body.

Current MQIC participants are very enthusiastic about this path-breaking activity. Mr. Deane Morrison, Chief Information Officer of Capitol Region Healthcare in Concord, New Hampshire, reports that "to reap the full potential from our investment means we have to become more efficient and learn how to practice better." The nearly 120 employed physicians have been using Logician for more than 175,000 patient charts. Capitol Region Healthcare, according to Mr. Morrison, believes that "quality will improve and utilization of resources will be more appropriate."

Dr. Scott Yates, Medical Director of the North Texas Medical Group outside of Dallas, Texas, believes that his five partners will have "really for the first time an opportunity to reflect on how they are already practicing." Dr. Yates calls Logician "very robust" and hopes that the MQIC will give his partners insights into patient

compliance and group adherence to national practice norms such as aspirin for myocardial protection.

Some caveats are in order here. MedicaLogic hopes to create various types of reports based on the aggregated de-identified data and develop partnership arrangements with other parties interested in such information for long-term promotion, disease management, and prevention programs. MedicaLogic will sell reports to private sector firms such as pharmaceutical companies, disease management companies, and the like. The proceeds from transactions will be directly shared with the MQIC partners. Consortium members will have the right to opt out as a data contributor to the described reports. In addition, a national external advisory board, of which I am a part, will make recommendations to MedicaLogic and to the consortium regarding the advisability of their participation in individual products. Both Morrison and Yates report that all funds gleaned from the MQIC activity will be re-invested in continuing medical education activities for the participating physicians. Surely, there are some risks involved – patient confidentiality, pressures to focus on drug utilization, and the daunting technical task of aggregating disparate information from across the country.³

While I am not naive enough to believe that any single electronic record offers a one-source solution to the IOM challenges, I do believe that the MQIC is a laudable step in the right direction. Through the national advisory board of the MQIC, I hope to focus these path-breaking physicians to become more self-reflective and self-evaluative. My hat is off to them for their willingness to participate in a largely untested and unique program. I challenge other firms and naysayers to create comparable systems (and safeguards). As usual I am very interested in your views. You can reach me at my email address: david.nash@mail.tju.edu.

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