

# EHRs Selection

An Optometrist's Guide



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## Introduction

Electronic Health Records (EHRs) are a hot topic in optometry circles today. While interest in EHRs is being driven by programs such as PQRI, considerable attention is given to the end-user experience without sufficient emphasis on the technology platform required to drive the EHRs through to their final requirements. Those requirements do not begin and end in eye care, rather in the big picture of health care. By examining what's happening in hospitals across the country, we are able to see where eye care must go as an integral part of the medical community.

Through this guide, look to be informed about health care reform and new healthcare technology standards but also expect to see a vision of what's possible for the clinical practice of optometry as the most modern health care technology is brought to bear upon the problems and challenges facing our industry.

## EHRs – passive versus active

### not all EHRs are created equal

Traditional or “passive” software systems do one thing very well: move paper to computers. A transition to electronic data can create some new efficiency for your office, but effectively replaces *paper* work with *computer* work. Efficiency gains may yield marginal clinical improvements yet can be negative for the business since traditional systems take more time to make the same money. All things being equal, paper is an easier, faster and cheaper method of data capture.

Think about electronic health records you’ve already seen, the exam forms in particular. Lots of fields to fill in? Drop down menus? Some free-text capabilities perhaps, maybe even voice recognition. You get the *impression* of moving to the next level but truth be told someone chose it because it most closely resembled their paper exam form. In reality, it takes longer to find all the fields and the eyes tire of looking through busy screens to find the fields requiring completion.

**Active systems on the other hand go beyond a simple paper-to-computer information transfer. Like all paradigm shifts, things are seen and done in a fundamentally different way.**

So the first step in your EHRs selection process is to recognize that all EHRs are not created equal. Some programs feature misleading bells and whistles on the surface but simply give you an electronic way of doing the same old same old. Be ready to look deeper.

#### Note the “intelligent” capabilities and benefits of active EHRs:

- Decision trees that assist the provider in consistently using best practices
- Formatting that allows *only* what has been selected to be viewed, in order to make analyzing pertinent data more efficient
- Data-selection monitoring within and between the decision trees to give warnings :
  - required information not completed
  - required procedure not completed or documented
  - conflict between two findings
  - data indicates potential for a more complicated diagnosis
  - recommended tests not completed
- Ability to offer a possible diagnosis and document it using a variety of clinical approaches depending on the condition
- Ability to build in specific procedures for both providers and staff to ensure consistency of delivery
- Ability to recognize that findings require additional testing or workup then automatic checking to make sure requirements are completed
- Ability to require that all reports, orders, etc. for any specialized testing are completed in a best-practice fashion before the case may be closed

- Ability to respond to changing situations and rapidly add new content *without programmer input*:
  - new regulations or industry requirements (external best practices)
  - change in office procedures (internal best practices)
  - change in evidence-based medicine or recognized best practices
- Ability to integrate ActiveCE™ (see section to follow)
- Ability to track PQRI outcomes or any outcome of interest to the provider or practice
- Ability to compare outcomes against those of other practices

# Monitoring & Responding to the Industry: RAC Audits, Malpractice

## your EHRs can help or hinder

Currently, two important issues deserve the attention of every optometrist: RAC audits and patient instruction re. the risks of dilation. OD Professional's ActiveEHRs™ are helping clients incorporate required changes in both areas into everyday practice.

### RAC Audits

Recovery Audit Contractors are hired by Medicare to review (audit) past records and claims, and assess fines or penalties where an existing health record does not substantiate the claim. The RAC 2007 pilot program yielded a return of \$308M into the Medicare coffers – no surprise that the program has been vigorously expanded for 2008! In fact, RAC has recently been made a permanent part of the Medicare program. Therefore, it is a new reality for every optometrist, one deserving of careful attention and preparation.

Starting in the fall of 2008, the number of Medicare audits to be completed nationwide will increase substantially through Recovery Audit Contractors. Hospitals have already been advised to expect between 3 – 5 audits per week for the coming year. No announcement has yet been made with regard to individual provider audits, but the information emerging through the program indicates they have identified imaging throughout medicine as a primary audit target. Since eye care is an obvious area where imaging is heavily utilized, it is prudent to prepare for audits in this area.

Offices audited for imaging will require:

- An order for the test in the exam record
- A clear statement of medical necessity for the additional testing
- An Interpretation & Report of the images or test, one that is separate from the main exam form

OD Professional is preparing users in two ways for RAC audits:

- i. For new exams, the ActiveEHRs require completion of the above components before the provider may sign off on the exam.
- ii. For imaging and specialized testing completed within the past two years, the ActiveEHRs allow the components listed above to be completed on previous tests.

It is important to be aware that medical practice management groups are suggesting hospitals self-audit their records in preparation for RAC. The audit should include all elements necessary

to pass the audit as well as identifying tests and images ordered where a clear medical necessity is not apparent. In these cases, self-reporting a return does not result in any penalty.

## **Malpractice: the Need for Patient Instruction on the Risks of Dilation**

In the past few months, several law suits against ECPs have been won by patients who were dilated, sustained injury then successfully brought legal action against their eye care provider. The patients claimed they were not adequately informed of the risks of being dilated. As a result, the largest carrier of malpractice insurance for Ophthalmology is strongly suggesting that each time a patient is dilated, detailed instructions be given to the patient then documented. Further, it must be documented that the patient understands the risks.

ODPro's ActiveEHRs incorporate the requirement to give these instructions, allow easy documentation, and ensure consistency by providing a warning to the provider if this was not documented at signout. The ActiveEHRs let the ECP choose the exact instructions to be given, and provide the ability to document that each portion of those instructions was actually communicated to the patient.

## Raising the bar on Continuing Education

### active EHRs lead to Next-Generation Optometric CE

As health care reimbursement moves from fee-for-service to pay-for-performance, there will be increasing pressure for optometric continuing education that results directly in improved and measurable clinical performance. This shift will create demand for optometric education that immediately augments the provider's ability to improve patient outcomes.

Numerous studies indicate that one common need in the move toward evidence-based medicine is an increase in continuing education. The most significant change is the demand for CE programs not simply of interest or to fulfill a CE requirement but specific teaching aimed at improving clinical performance. The same tools that are able to track clinical performance can also serve to track changes in clinical performance following a CE event. Just as reporting clinical outcomes becomes possible, reporting clinical change resulting from CE will be just as possible. The tools to do this are already incorporated into active EHRs.

#### Implementation a barrier to traditional CE

A significant barrier to incorporating the knowledge gained through traditional CE is how to implement the knowledge clinically. Traditional paper records and passive EHRs cannot be easily or quickly modified to incorporate new concepts and practices. Often the provider is left having to keep the knowledge within his or her own knowledge base with no effective tool to share the knowledge with colleagues or to implement the knowledge efficiently into clinical practice. Providers have attempted every method under the sun to bridge the gap between the educational and clinical settings, including file folders with procedures and guidelines, additional paper records when appropriate, or "cheat sheets" used in certain clinical situations. None of these methods lends well to efficiency or consistency of delivering best practices.

#### Active EHRs reduce barriers to implementing knowledge

Active EHRs provide a whole new dimension for incorporating new knowledge into the clinical setting. By definition, they can be modified easily by non-programmers making them the perfect platform in which to incorporate new knowledge. Some active EHR providers work with CE providers to incorporate clinically relevant issues into the EHR even before the CE is presented. Users of these EHRs can leave the presentation, workshop or seminar with new processes or procedures already incorporated into their EHRs, ready for immediate use the first day back in the clinical environment.

### **Tracking new outcomes**

Providers interested in outcomes and who utilize active EHRs have the ability to measure the change in clinical performance that resulted from the CE experience. Active EHRs incorporate powerful tracking systems that make it possible to immediately detect and track changes in clinical performance. Thus, the actual effect on clinical practice of CE can be readily evaluated. Providers can, therefore, assess quickly whether the new clinical information gained in the CE process improved clinical outcomes. If the CE included recommendations for gathering additional information, or to do additional tests or record different information from existing tests, datamining capabilities integral to the active EHRs can immediately assess whether, or to what extent or level of consistency, those things are being accomplished.

### **Comparing outcomes of CE**

Active EHRs include datamining capabilities. This means that the effect on clinical performance across a broad range of providers participating in CE can be measured. This will, at some point, lead to the ability to compare the effectiveness of one CE presenter against other presenters of similar information. Ultimately, attendees will be able to utilize such data for CE program selection.

One area that will help providers make better decisions is patient compliance. In outcome-based medicine, patient compliance is a major factor in provider quality assessment and quality scoring. Therefore, healthcare is seeing a significant increase in ways to assess and improve patient compliance. Datamining capabilities will assess the effect of the variously proposed methods for improving patient compliance, making possible scientific evaluation rather than mere assumptions or impressions about the results.

## OD Professional ActiveEHRs™ with ActiveCE™

### what the others aren't giving you

EMRlogic is dedicated to keeping its clients ahead of the change curve within health care. It may go without saying that OD Professional's next-generation **ActiveEHRs™** with **ActiveCE™** are capable of everything we've discussed above ... and below. ActiveEHRs make clinical tools immediately available to you in order for your practice to maximize its position and adapt quickly to eye care reform. However, even the ActiveEHRs™ are just one component of the complete business and clinical solution, the Enterprise solution, available from EMRlogic Systems.

At EMRlogic, we are often asked what the complete OD Professional™ package includes. Aside from "everything!" there are several hidden jewels whose added value is not immediately apparent but which also contribute significantly to staying ahead of the health care change curve.

#### **ImageManager**

OD Professional's complete image-capture and telemedicine solution, integrated with ActiveEHRs. The most comparable product to ImageManager on the market today may be Topcon's CSG system (previously ANKA).

#### **PatientManager**

This online patient communications and education portal is available as a standalone product from 3conX Corporation, and is called EyeconX. The standalone version does not have the ActiveEHRs integration benefits of PatientManager.

#### **ActionTracker**

OD Professional's embedded ActionTracker is an eyecare version of Speedminer, also built on the CACHÉ database by InterSystems. Speedminer is a powerful embedded business intelligence application with dynamic dashboard capabilities used in hospitals around the world but not available in any other eyecare application.

### What else is "everything"?

1. **CACHÉ.** OD Professional is the only eye care software solution that runs on health care's gold standard database, CACHÉ. Johns Hopkins, Mayo Clinic, Keiser Permanente, Epic, the Veteran's Administration, Partners Health are just a few of the top health care organizations that count on the speed and stability of CACHÉ. Needless to say (perhaps?), CACHÉ is no ordinary database and cannot be compared to the databases used by any of our competitors. In some cases, competitors may require that you purchase user licenses for your database as "an integral part of the operating environment". With OD Professional, you will not require SQL Server licenses, for example. CACHÉ is a superior database, all included in your ODPro package.

2. **PROACTION Client Services.** What exactly is included in the services from that other company? On-site or online training? And how much? What about flights, accommodations and per diems? And what happens when you need *additional* help?

Did we say “everything”? At OD Professional, our goal is a smooth transition and your complete satisfaction. We don’t watch the clock or count the hours. We do what it takes to get you up and running smoothly and if a site visit is necessitated, we do it ... because there’s no greater investment in our success than *your* success.

3. **Ongoing Support & Updates.** Many companies make software updates available for purchase at an additional fee. Others set a limit on the hours of assistance available then charge per hour once the limit has been exceeded. At OD Professional, we want to hear from you when the need arises. We also want your business running on the latest and best we have to offer. That’s why our Support & Updates package price includes unlimited toll-free assistance and all future updates for the software functionality you’ve purchased. (We distinguish between an “update” and an “upgrade”. An update is a new release for functionality you already use. An upgrade means that you’re moving up to new functionality. Additional charges apply when purchasing an upgrade.)

### **The bottom line**

To get the same functionality with any other EHRs that you get with OD Professional’s Enterprise solution, you would need to spend additional money, as outlined above. These items will all eventually be required to meet new regulations, or to remain competitive as outcome-based medicine becomes more ingrained into everyday optometric practice. It’s a question of buying the package up front and being early to take advantage of the new opportunities these technologies bring, or waiting until later to pay more and lose the new opportunities. At ODPro, we want our clients to have every technology advantage, to be leaders in their communities and the field at large, and to build the best practices in the eye care industry. Better business. Better care.

## New capabilities required under health care reform beyond passive EHRs

While EHRs are creating much of the buzz in optometry today, less popular is health care reform, (e.g. PQRI and value-driven health care). Yet this movement forms an essential-to-understand foundation for the must-haves in any EHRs solution. What will health care reform require of *your* EHRs? Providing an electronic form of patient data is only the beginning. Many drivers are in place to require the use of EHRs in all health care practices. The effort involved at the national level to develop standards and mandate EHRs is not simply so each of us can have electronic data in our office. The question is what can be done with the data once it is electronic, portable and interoperable? What must our EHRs do, not simply for *us* but for national health care cost reduction? Many EHR systems exist but few vendors are familiar enough with the technical and functional requirements being driven by health care reform. Of greater concern, some systems are technically incapable of meeting the new standards.

1. **CCHIT readiness.** Although CCHIT certification criteria for most specialty EHRs (eye care included) have not yet been developed, the requirements to utilize certified EHRs are already in place for Medicare reimbursement. Specialty EHRs can be “CCHIT ready” even if the certification process is not yet available. Does the vendor have a plan for meeting the certification requirements? The importance of this step must not be underestimated as certification is a major commitment on the part of an EHR vendor.
2. **Mandatory portability.** Not only must patient health information be electronic, HIPAA-compliant electronic communications with other health care facilities will be mandated. Some EHRs can already meet the required standards. Considering EHRs without this capability means purchasing additional software at some point. EHRs will also need to meet national portability standards.
3. **Patient compliance.** Value-driven health care centers on *outcomes*, possibly the biggest change health care providers must grasp. Patient compliance now has a direct impact on the provider’s outcomes or “value score”. In order to drive the best outcomes, providers must ensure patients are engaged in co-developing their Plan of Care, and that they follow the agreed treatment plan. Both steps require a way of maintaining contact with the patient to drive compliance when the patient is not in the office. Some EHRs have already teamed with software solutions that provide this capability. Again, EHRs without this capability will mean either purchasing or contracting for this type service in the future, at additional cost.
4. **Measurable outcomes.** Value-driven health care will progressively require the

reporting of more complex clinical outcomes. Outcomes will need to be tracked and reported by the EHRs. Only in the early years of PQRI will reporting be accomplished through the billing component. True outcomes will be measured and reported through EHRs. Such tracking will involve multiple information components capable of drawing conclusions about the plan and resulting outcome. One of the proposed outcome measures for 2008 was to report on what percentage of glaucoma patients achieved a 15% reduction in IOP from pre-treatment levels. (This measure was withdrawn for 2008 but is now back in PQRI 2009.) We can do the calculations manually for this type of outcome, but as we are required to track more and more outcomes, we will want EHRs that allow us to designate what we want tracked. Using tracked outcomes, comprehensive active EHRs will be able to extract the necessary data, complete the required calculations, and provide a HIPAA-compliant report that can be included in any reporting requirement.

In addition to mandatory reporting, it is likely that many optometrists, as they become aware of the value of tracking outcomes, will want to do so voluntarily for virtually any condition. **The ability of active EHRs to efficiently and effectively track whatever is of interest to the provider will be one of the biggest benefits of going to EHRs in the first place.**

5. **Electronically-auditable reports.** To meet interoperability requirements EHRs will need not only to include diagnostic tests and reports, but also reports containing extracted data to be incorporated into the EHRs at the receiving office. Simply creating and sending, or faxing, a Word document will not meet these requirements. Already-established standards dictate that reports will be HL7-XML reports. Although an on-screen report may *appear* to be a Word document, individual elements of an XML report can be identified and extracted automatically and used wherever required by the receiving office. For example, the receiving office may be tracking the outcomes of a diabetic patient, their software creating a timeline graph of VA and IOP for every time the patient is seen in any office. The report format sent by the eye care provider will need to be such that the system can extract the reported VA's and IOP's and place those values in the graph generated by their EHRs. Likewise, eye care EHRs will need to be capable of utilizing data supplied by their reports for tracking and documentation purposes. All EHRs, therefore, must meet HL7-XML standards.

6. **Data mining and business intelligence.** Once data is electronic, the ability to analyze both clinical and business data becomes limitless. Some EHRs have data analysis and data mining capabilities built in. Providers should seek real data mining tools and not be fooled by canned reports with the appearance of a dashboard. No list of reports pre-defined by the software company can equate a true and embedded Business Intelligence solution. This means the ability to create any type of analysis and display the results in the most meaningful format,

be that a table, graph or chart.

7. **Audit capability.** Once electronic data meets portability requirements, it is likely we will see payers adopt automatic audits as a pre-requisite for reimbursement. This gives the payer a means of ensuring best practices are incorporated into the workflow and treatment plan, and also provides a way of making sure everything billed was also completed. For example, most dental payers currently require every x-ray to be submitted along with the claim for reimbursement. Optometry EHRs will need the ability to generate an HL7 compliant XML report plus the ability to include diagnostic test results in required audits.

8. **Best practices.** The means to obtain best outcomes is to utilize best practices. EHRs must assist the provider in the consistent use and documentation of best practices. If EHRs use a traditional format with lots of fields and drop-down menus, or data-entry by various menus into fixed fields, providers will have to rely on more extensive training of both assistants and professional staff to ensure that best practices are consistently employed in all patient care. The alternative is EHRs that accomplish the task and automatically document the best practices employed. EHRs should clearly incorporate best practices and document that they were used in the care of every patient.

## New opportunities in health care

### more than just electronic data

New opportunities abound in times of change. The Bridges to Excellence program is a good example of a missed opportunity, a train that has already left the station for the majority eye care providers. Essentially, Bridges to Excellence involves private funding for physicians who are prepared to see fewer patients and do a better job of reporting outcomes. The potential sum is approximately \$100,000 per year per physician. Significantly for eye care, one of the reporting requirements is a documented annual diabetic eye exam. Due to low levels of responsiveness and participation by eye care providers, many physicians are resorting to national reading centers. ECPs are missing a fine opportunity to develop strong referral relationships. With substitute resources in place, the opportunity is all but gone in some regions. So, the question is, “How many more opportunities will we pass up before we get proactive as a profession about health care reform?” Trains leave the station full or empty; it doesn’t matter.

Let’s consider a different kind of opportunity, one we can still get in on: the impact of EHRs not only on patient care but also on continuing education, as described above, what we will call, next-generation continuing education, or active CE. While most continuing education lectures and presentations include latest information or the use of new technologies, the primary teaching method remains the use of traditional lectures and electronic media.

By contrast, an active CE program incorporates the latest EHRs and communications technologies to improve the speed and efficiency with which information can be presented and incorporated into clinical practice. Active CE also includes technologies that track outcomes, and which ensure beneficial patient outcomes.

Three hallmark capabilities of active CE:

- 1) Rapidly add information, fields or processes to clinical workflow within the EHR
- 2) Track and analyze outcomes of the newly taught processes
- 3) Communicate information and results with any other health care facility

**Adaptive Clinical Workflow.** Early EMRs required that *programmers* add new fields or other data. This meant a complicated change control process: change request, approval, prioritization and scheduling, programming, testing, release to alpha and beta test sites, and ultimately release to the end user. Such a process often took months or more for the requested change to become available clinically.

New programming technologies, however, make it possible now to add information to an

active EHR *without programmers*. This results in a streamlined process whereby new information, protocols or workflow items can be incorporated rapidly into the EHR, in many cases on a same-day basis.

Presenters of active CE may now prepare in advance clinical EHRs that incorporate new information, protocols and processes. Attendees of a lecture, or individuals who read an article, may then gain immediate access to the updated EHR. Since active EHRs allow users to synchronize immediately to an automatic update containing the new information, the problem of how to incorporate the new information clinically is eliminated. The tools to begin utilizing the new information may be provided automatically as a result of participating in the CE program.

**Tracking Outcomes.** The second hallmark of active CE is the ability to track the effects of the new information on patient and clinical outcomes. As health care moves toward reimbursement based on measuring and reporting outcomes (pay-for-performance), it becomes critical to track and analyze every change in clinical practice and ensure *improved patient outcomes* are the result. Further, just as clinical care moves toward measurable outcomes, CE will follow suit and become subject to the same scrutiny. CE that results in improved clinical outcomes will be the CE providers increasingly select.

**Portability of Health Information.** The third hallmark of active CE is the ability to share clinical results, to combine the outcomes from one office with outcomes in other offices. Outcomes need not only be tracked but mined and analyzed. Effective data-mining starts with data-sharing, and that requires portability. Portability, together with the right data-mining tools, makes it possible for providers to assess the effectiveness of the care they provide against care delivered by other similar providers. Portability also makes it possible for eye care providers to participate more effectively in the overall medical community, by sharing electronic data with every other type of health care facility. In effect, this makes the user of an active EHR part of a large user group in which the experiences of every office can quickly be shared with all other users of the active EHR. **This is precisely the technology leap that can fill the current void of evidence-based medicine for eye care.** The result can be a stronger profession and the opportunity for all involved to deliver the best patient care possible.

# On being an eye care leader

## connecting to the rest of health care and the eye care marketplace

Value-driven health care has implications at all levels for both providers and patients. Eye care leaders, be they leaders of group practices or professional associations at the state or national levels have a special responsibility to help our profession prepare now.

### **1. Leaders must understand the basic principles of value-driven health care in order to:**

#### **a. Develop the best long term plan for the organization**

Without knowledge of the basic principles of health care reform, organization leaders will find it difficult to develop effective new strategies and procedures and adapt their organization to the changes involved in the reform process. We readily understand that our organizations are evolving; as leaders, we have some degree of control over these changes. However, the move toward value-driven health care is a type of ‘climate change’ over which we have relatively little control. If we cannot control the changes in our environment, we must at least understand them.

#### **b. Deliver a consistent message to members at all levels of the organization**

The principles of value-driven health care are fairly straight forward but the implications vary tremendously depending on the practice setting, the type of provider and the current status of health care reform. Members will increasingly read and hear about reform in a variety of contexts. The information may be confusing or contradictory. Much of it will necessitate a different way of thinking about almost every aspect of providing patient care, so members will increasingly rely on the organization to provide guidance through the process. They will expect their leaders to articulate how reform relates to their particular circumstances.

All sizable organizations have multiple levels of administrative staff that interact with members. It is important that staff at all levels understand the basic principles of health care reform, know the formal position of the organization regarding these changes, and have a consistent message to deliver to members.

#### **c. Design a simple position statement regarding health care reform**

Most of us are by now familiar with organizational mission and vision statements. A concise statement that can be shared with all members can bring clarity and consistency of purpose for the entire organization.

## **2. Leaders must drive the message that “time counts!”**

### **a. Opportunities in early phase of reform**

Health care reform is not a government led program waiting for regulations or a bill to be passed. It is a payer-led movement well underway. Eye care, and especially optometry, is far behind in understanding and taking part in the process. As with all system changes, there are both new opportunities and the loss of existing ones. Income streams change over time. Value-driven health care offers many new opportunities but some are already disappearing. As new referral relationships are established to meet the new demands of value-driven health care, it will become increasingly difficult for providers to take advantage of the new opportunities.

### **b. Lost income later in reform**

The components of value-driven health care that will result in loss of current income will not come into full play until later in the reform process. Consequently, providers who delay their involvement will miss the early opportunities then be subject to the loss of traditional revenue streams without viable replacement alternatives. The key is to take advantage of the early opportunities as quickly as possible. (Part 2 of the “Getting Under the Hood” series delineates numerous early opportunities.)

## **3. Leaders must help member providers understand value-driven health care and foster good decision-making for their practices**

Value-driven health care will eventually affect every aspect of clinical practice. Until providers understand the principles at play in the reform process, they will be hard pressed to make good long or short-term decisions consistent with the way in which they will be practicing in the near future. Potentially worse is understanding the principles only in part. For example, providers who recognize the need for an EHR, but don’t understand the eventual requirements for EHRs, beyond existing capabilities, may spend their money on a product that ultimately will not or cannot meet their needs. Similarly for equipment purchases, unless instruments meet interoperability requirements for future reimbursement, the current way of thinking about equipment utilization may end up being misguided.

## **4. Leaders must use the power of their organization to help members compete better. Volume also counts!**

The manner in which individual optometrists may best compete in the value-driven health care world is yet to be determined. Organizations can actively lead their members by being a group

\that coordinates trials, shares best practices and member experiences, insights and opinions. Groups can work together with foresight and innovation to develop, try and initiate new procedures and techniques so members may thrive within the new health care structure. By developing efficient internal communications, members can collaborate and learn from each other. Sharing successful efforts, developing improved relationships with other health care providers or initiating national programs locally mean that the whole organization gains. The scale of an organization, when utilized properly, can make each member more qualified and provide the level of experience that, in the future, may be required for reimbursement. One of the fundamental tenets of value-driven health care, which is well documented by numerous evidence-based medicine studies, is that volume counts. For most medical conditions, there exists a minimum level of both patient volume and practitioner experience to attain best practices. One way to attain the minimum requirement is for providers with lower levels to associate themselves with those who have a higher level of experience in providing the specific care in question. This can be accomplished by physically relocating, but also through team management of patients or even sharing cases electronically via telemedicine . Once best practices are established and accepted as such, the organization can facilitate their adoption by individual members. Sharing the implementation steps utilized by offices that most successfully implemented the best practice amounts to more than just disseminating information.

## **5. Leaders need to contribute to optometry's professional knowledge base**

AOA's Optometric Clinical Practice Guidelines (OCPGs) represent perhaps optometry's best available starting point towards a professional knowledge base. "OCPGs are recommendations for patient care developed through a formal process ... and combine the best available current scientific evidence and research with expert clinical opinion to recommend appropriate steps in the diagnosis, management, and treatment of patients with various eye and vision conditions"<sup>1</sup>. Yet optometry, as a profession, is not well prepared for value-driven health care. Some OCPGs originate as far back as 1993 though many have been reviewed as recently as 2007. In many cases, the "best available current scientific evidence and research" was not based on measuring outcomes and best practices as defined by value-driven health care. Many of the common things we do in optometry have no formal evidence base or supporting literature. There is no comprehensive and current reference guide for selecting best practices. We have not documented the outcomes against which we want to be measured. There is no established consensus on how to measure outcomes or what to do with the results once measures are taken.

Hospitals and research institutions provide such materials for medicine but the closest equivalent in optometry is a handful of organizations with the ability to collaborate internally and develop needed knowledge bases such as those required by value-driven medicine. All optometric organizations have an obligation to consider this role for the profession and, in so doing, have an opportunity to emphasize the importance of the organization to our profession and to individual optometrists.

As optometry traverses the storm of health care reform, we will encounter a flood of decisions to be made on behalf of the profession, areas where we can offer self-directed results. Each organization can play a role in this process. The opportunity is now for members and for the profession.

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1. Ref. <http://www.aoa.org/x4813.xml>

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