

Is technology the Rx for health care?

Central Texas clinic sees encouraging results in test program

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When Steve Conti makes house calls, he travels into some of the deepest cracks of the health care system, treating asthma patients in Central Texas who often don't have insurance or family doctors.

But he arrives with at least as much detailed information about patients as his counterparts in private practice because of a unique technology project launched three years ago.



Medical workers at the Rosewood Zaragosa Community Health Center in Austin, including, from left, Dr. Kumar Pandian, Jesus Rosas-Moreno and Dr. Pratina Kumar, are able to get information about patients who often don't have insurance or family doctors from a database with the Indigent Care Collaboration.

Chris Carson

FOR AMERICAN-STATESMAN



Dr. Steve Conti has used a database of medical records called I-Care to help treat about 500 patients in Central Texas. The system allows him to track treatments and manage patient health.

Mark Matson

FOR AMERICAN-STATESMAN

About 500,000 patients in Central Texas have opted into the Indigent Care Collaboration's I-Care database of medical records, which is one of only a handful of such systems nationwide. Of those given a chance to opt in, coordinators said, few have declined. They add about 125,000 patients to the database each year.

"It helps the providers stay on top of the disease, and it makes the patient more confident in the support from the system," said Conti, who runs the asthma management program at the Seton Healthcare Network. "Hopefully, as this is spread out across the system, we'll see health care costs come down."

In the past three years, he has treated about 500 patients outside a hospital or clinic, using the system to track treatments and help manage their health so they can avoid expensive trips to the emergency room or extended stays in the hospital. And it has the potential to save a lot of money on care for uninsured patients, a part of the health care system whose resources are stretched thinner by the day.

The system cost the Indigent Care Collaboration several million dollars, interim Executive Director Ann Kitchen said. To date, it has saved more than \$4 million by getting patients on prescription drug coverage alone, Kitchen said. And as the program continues, the group expects to save millions more by reducing redundant care, medical errors and expensive emergency room visits.

"You're gaining on it, particularly over time," she said. "It's definitely you're saving more than you're spending, and more and more every time."

But the collaboration's I-Care program is one of surprisingly few stories of information technology filtering into the U.S. health care system. Virtually all health care and technology experts agree that similar programs could bring the same productivity gains to physicians that they did to business.

That is one of three main topics of discussion for more than 2,100 delegates coming to Austin this week for the World Congress on Information Technology.

The U.S. is far behind many other developed countries in the integration of technology into health care.

"What it means is we'll continue to have all the inefficiencies, the lack of safety," said Don Detmer, a physician and CEO of the American Medical Informatics Association. "Until we decide to do this, we'll continue to underperform."

Broader use of electronic health records, for example, could save billions, according to David Brailer, who recently stepped down as national coordinator for health information technology at the U.S. Department of Health and Human Services.

Studies say the \$2 trillion U.S. health care industry could eliminate more than \$300 billion in costs each year by integrating technology networks. In 2004, President Bush set a goal for most Americans to have electronic medical records by 2014, and the administration doubled federal funding for health care technology programs to \$100 million.

Technology companies such as Intel Corp., Dell Inc. and IBM Corp. see potential for huge savings on employee health care costs and for sales of computer hardware, software and services.

Seeking better system

The debate comes at a crucial time. The number of working-age Americans without insurance increased to 41 percent last year from 28 percent in 2001, according to a report released last week by the Commonwealth Fund, a private health care policy foundation in New York. And the mass of baby boomers is approaching the age when expensive chronic diseases typically strike.

The Indigent Care Collaboration in Central Texas coordinates the "safety net" programs at most hospitals and clinics in Travis, Hays and Williamson counties, making it a watchdog for people who have little or no insurance.

Such patients often see multiple doctors, who rarely have a medical history from which to work, Kitchen said. The group's I-Care database provides at least a list of previous diagnoses and medications, so physicians can avoid redundant or harmful care.

"It's really a twofer," she said. "If we can improve the system, it both helps the individual get better care . . . and it cuts costs."

There are other benefits, too. In addition to collecting individuals' health records, the I-Care database allows researchers to make the information anonymous and pool it. That could allow them to identify trends — for example, to research why a particular ZIP code has a high rate of diabetes among its residents. Then they can look to adjust their education programs or clinics or even identify the source of the trouble.

"Why is that so (prevalent) there? Is it because there's an environmental concern there we've overlooked? Those are exactly the types of questions we want to ask," said Adolfo Valadez, medical director of the Austin/Travis County Health and Human Services Department. "I think with a little refinement, we are very close to being able to ask those questions."

A similar network on a global scale could identify symptoms of a potential pandemic in time to contain it. On a national level, Homeland Security officials might be able to use such a database to predict the spread of a bioterrorism attack.

But consumers get jittery about the privacy of sensitive medical records, especially when it involves mental illness and depression, said Stephen Shortell, dean of the School of Public Health at the University of California, Berkeley. Most of the technical problems for securing such databases have been solved, Shortell said.

"Privacy is a matter of convincing the American public that their data is secure and they can have confidence in it," he said.

No consensus – yet

But there is little agreement in medical circles about how best to bring computer technology to the business of health care. Today, there are more than 160 electronic medical-record companies or systems, said Louis Burns, general manager of Intel's digital health group and a keynote speaker at the World Congress.

And those systems often don't work well together, stifling the broader use of the technologies, Lawrence Casalino, an assistant professor at the University of Chicago, where he has researched electronic medical records, said in an e-mail.

"Choosing and implementing a system takes a lot of leaders' time," Casalino said. "And it almost guarantees them a lot of criticism from within the organization."

That's just one reason only 20 percent of physicians have integrated technology networks, according to the Technology CEO Council.

"Ultimately, it's a huge money saver," said Detmer, head of the informatics group, the members of which are doctors with strong technology backgrounds.

"There's no question it's going to happen because, frankly, you can't practice medicine without it, given the growth of the knowledge base."