CIO Forum
January 19, 2011
Draft Meeting Summary

Participants

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Michele Alexanian, MA Health Data Consortium
Meg Aranow, Boston Medical Center
Leon Barzin, Massachusetts Medical Society
Mark Belanger, Massachusetts eHealth Collaborative
Karen Bell, MD., CCHIT (via phone)
Ken Bernard, Health New England
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Michael Brown, MD., Harvard University Health Services
Ray Campbell, Mass. Health Data Consortium
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Renee Fosberg, Emerson Hospital
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Nael Hafez, Pediatric Physicians' Organization at Children's Hospital
John Halamka, MD., CareGroup Healthcare System
Arthur Harvey, Boston Medical Center
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Steve Hulverson, CSC Consulting
Joseph Imbimbo, Tufts Health Plan
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David Kates, NaviNet
Judith Klickstein, Cambridge Health Alliance
Arvind Kumar, CRICO/RMF
Michael Lee, MD, Atrius Health
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Marie Maloney, Senior Whole Health (via phone)
Keith Maxwell, Mass. League of Community Health Centers
Christina Moran, MA eHealth Collaborative
Matthew Moss, South Shore Hospital
Thomas Murphy, South Shore Hospital
Dan Nigrin, MD, Children's Hospital

Ike Nnah, Radius Hospital
James Noga, Partners HealthCare
Dennis Puls, Winchester Highland Management
David Querusio, Harvard Pilgrim Health care
Pat Rubalcaba, Partners HealthCare
Paul Sawyer, MACIPA
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Bill Shickolovich, Tufts Medical Center
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Micky Tripathi, Massachusetts eHealth Collaborative
Gordon Vineyard, MD, MA Health Data Consortium
David Wessman, Division of Healthcare Finance and Policy
David Whitman, Dimock Community Health Center

Summary

Announcements

The Consortium's next major event was the annual Health Information Technology Conference, HIT'12: The Future is Now, on February 3rd at the Burlington Marriott. There was a keynote presentation from Ashish K. Jha, MD., Associate Professor at Harvard School of Public Health.

The CIO Dinner was held on Tuesday, February 7 from 6-9pm at the Beacon Grille, 400 Trade Centre 128, Woburn. Our guest speaker was Dr. Ronald Dunlap, VP of Mass Medical Society.

Federal HIT and HIE Update

John Halamka, MD, CIO Caregoup

The HIT Standards Committee meeting focused on the first quarter goals, quality measure standards, NwHIN Exchange Refinement, and value sets/vocabulary mapping. Updates for the next three quarters include building provider directories, improving the Digital Imaging and Communication in Medicine standard, coordinating governance, building a one stop shop for downloadable resources, and implementing a Green CDA. Stage three of Meaningful Use will include a lot more health information exchange, data and analytics and patient engagement.

The state submitted the Implementation Advance Planning Document (IAPD) to CMS and received encouraging signs of approval. They ran a vendor forum and asked for written comments describing HIE capabilities. There were various responses, but no vendor has actually built what they have described. MeHI is finishing up the HIE operating plan, but the last mile is tricky because they must ensure that EHRs connect seamlessly to the provider directory. It is difficult to provide all the resources to connect

providers to the standards backbone. Progress on 5010 is a little behind, and has been harder than anyone assumed.

(please see handout)

Roundtable Discussion: The Role of Healthcare IT in Accountable Care

Paul Sawyer, CIO, MACIPA
John Halamka, MD, CIO, BIDMC
Jim Noga, CIO, Partners Health Care
Michael Lee, MD, Director of Clinical Informatics, Atrius Health

John Halamka: ACOs have changed the business model to one where hospitals succeed when their waiting rooms are empty, rather than full. The Pioneer ACOs are going to be the ones to figure out how this new model will make money.

Paul Sawyer:

MACIPA is the smallest organization of the five Pioneer ACOs, with 11,000 attributed patients. Various IT technical drivers for the Pioneer ACO include quality measures, EHR setup (in-house and out), EHR vendor engagement, secure data exchange between MACIPA and CMS, common methodology of identifying ACO patients across all systems, and practice engagement. The concerns of this pilot include not having enough resources to expand the IT department and not altering the quality of service currently provided. The biggest concern is that this project is like "building a plane while in flight". Everybody is nervous and trying to understand the best way to accomplish this, even after they're already in take-off.

Q: What does your time table look like? What do you hope to accomplish?
A: The schedule is still being developed; we have created an internal task force. We are still taking the measures and understanding the data for phase 1, but there is no real deadline.

Q: Was it difficult to explain the project to your patients?
A: CMS demanded specific controls around the letter that went out and there wasn't much description. We have set up a help line where patients can call us at MACIPA, and have assigned a project leader who responds directly. We have also done some work on our website and re-worded the information.

Michael Lee, MD:

Atrius serves over 1 million patients. The Medicare ACO pool is the most complex, self-directed group of patients. This project demands a cultural switch, but is difficult because we can't advertise to patients that we want them to do this; we are only allowed to say what CMS permits.

The IT role is figuring out how to identify data, and then manage different types of reporting throughout the entire practice. The hardest part of the IT role is to make actionable data and engage patients. 90% of this change is operational and outside of the role of the IT department.

Jim Noga:

All of us are being asked to bend the cost curve, so the biggest question for this Pioneer project is how do we minimize cost? Another question we have encountered is how to properly ID patients in the EMR? Our Claims Data Warehouse is being used to minimize loss by understanding costs. The rural wage index adjustment benefits us because we have some rural hospitals in our network. We have developed a loyalty cohort registration system to identify the day-to-day care team that needs to be engaged in a patients care, because their listed PCP is not always, in fact, the primary caregiver.

We have identified a need for an interoperable EHR Record, health maintenance and alerts, population management, and registries. The three key interventions that need to be developed are: (1) Identify patients on a consistent basis (2) Build a case management system that tracks linkage to other systems (3) Develop more active and useful alerts. Connective health is also important; we must be able to manage chronic conditions outside clinical settings.

Q: How many patients are involved?
A: 48,000

Q: Beyond claims data, do you get any other additional data outside the ACO?
A: Not really, the advantage of the Pioneer ACO program is that you know your enrollees beforehand, as opposed to the shared savings program where patients are determined retrospectively.

Michael Lee- The Pioneer program has a lot of advantages. We won't necessarily lose money and we get data at the beginning (just got 1st data upload from CMS after 2 weeks).

John Halamka, MD.: We must exchange data to common registries and with other Pioneer ACOs.

Q: Eastern MA had a cluster of awardees, do you get any sense that CMS is looking at MA as a cluster or individually?
A: I just think we were all daring enough to apply- Only 100 hospitals in the whole country applied. We have an opportunity to work together ("managed procurement").

ML: There is this notion of hospitals having such large fixed costs, that reducing medical expenses doesn't impact much; however Partners is trying to cut $300m in costs by closing beds and reducing visits.

JH: BI needs to become smaller; community hospitals need to start seeing more people for lower cost care. We need to reduce the fixed costs.

JN: We haven't hit the tipping point for managed care yet, but we will

JH: The next informatics project is an alert system- commercial EHRs haven't built the alerts that we need.

JN: We need case managers who will follow up/track patient progress
ML: Many patients don't even have the internet (1/4) making care in the home difficult. We need a better system for communicating.

Q: What is the Personal Health Record (PHR) Strategy?

A: ML: We have a tethered EHR: the issue of integration should be a core strategy. Twenty-five percent of the population is not sufficiently enabled to operate a PHR system. It is not part of the core strategy now, but likely will be in the future.

PS: We're coming up with ideas and trying them out- that's the nature of a pilot

JN: We need to become more active in Palliative Care.

ML: I agree, we need to make sure advanced directives and Health Care Proxy documents are filled out, even before the last 2 months of life.

Q: What is the biggest challenge to implementation?
A: JH: Once you have the information, how do you make it actionable by issuing alerts, reminders, events?
PS: This isn't an IT problem, IT is part of the solution, but accountable care is mostly an operational challenge
JN: What are the right actionable interventions? How do we avoid alert fatigue?
ML: 1. Getting the sufficient resources to act on 2. Communication of all internal systems
JH: IT is not the biggest hurdle, but we will be held responsible.

Future Meeting Dates:

March 29, 2012 (Please note new date)
May 17, 2012- CIO Retreat, MIT Endicott House, 80 Haven St. Dedham, MA
July 26, 2012
September 20, 2012
November 8, 2012