EHR Forum
October 27, 2011
Meeting Summary

Participants

David Bachand, New England Quality Care Alliance
Ray Campbell, Mass. Health Data Consortium
Jeremy Davis, Mt. Auburn Cambridge IPA
Michelle Fine, New England Quality Care Alliance
Tim Griesmer, Emerson Hospital
Joanne Jackson, Clinical & Support Options
Myrna Jean-Charles, Tufts Medical Center
Patrick Littlefield, JPL Ventures
Barbara Lund, Mass. eHealth Collaborative
Ginger Lyons de Neufville, Mt. Auburn Cambridge IPA
Allison Perkins, Beth Israel Deaconess Medical Center
Dennis Puls, Beacon Partners/Winchester Highland Management
Craig Schneider, Mass. Health Data Consortium
Micky Tripathi, Mass. eHealth Collaborative

Summary

Announcements

The start time of the next and future EHR Forum meetings will be 9:00 instead of 8:30.

MHDC's next conference is Payment Reform: Innovation for the Nation on Wednesday, December 14th at Babson College. The morning session will have keynote presentations by Meredith Rosenthal of Harvard, Dr. Gene Lindsey of Atrius, Dr. Bruce Hamory of Geisinger, and Sarah Iselin of the Blue Cross Foundation. The afternoon session will be interactive workshops, including one facilitated by Dr. Barbara Spivak of MACIPA. Registration is open at www.mahealthdata.org.

Please save the date for MHDC's yearly health IT conference on February 3rd at the Burlington Marriott. Registration will open in early December.

There [was] an event on payment reform on November 2nd sponsored by the Executive Office of Health and Human Services and the Massachusetts e-Health Institute. On a related note, the Governor has

increased pressure on the Legislature to act on his payment reform/cost control bill by the end of the calendar year.

Discussion: HIE Initiatives

Jeremy Davis:
About a year and a half ago MACIPA launched an HIE effort using the eClinicalWorks eHX platform. Their network has about 19 different databases across 43 practices. MACIPA expects 80-90 percent of practices to have the system deployed by the end of the year. One effective strategy was to identify power users/champions, and to start with them as pilots.

A lot of effort was put into addressing privacy and security, and to developing consent forms and processes. We used consultants and external legal expertise. The patient opt-in rate is 96 percent. While this was successful, it requires significant effort by the front desk and patient education.

“Health information exchange” may be thought of as two different parts of speech: either a noun or a verb, as a repository or active clinician to clinician communication.

Q: Do you need opt-in consent for any/every flavor of HIE?
A: No, not for doctor-doctor exchange. To date, all of our exchanges have been within the MACIPA system, and we might have to re-visit the policy once we begin exchanging with clinicians outside of our system.

Q: Do you have a data warehouse?
A: Yes. We are starting to aggregate the continuity of care document information, but we haven’t begun to analyze free text information.

Micky Tripathi and Ray Campbell reported that the Massachusetts eHealth Collaborative is about to get meaningful use certification, and that 1 million records are being transmitted via NEHEN. The new state HIE strategy is to create a “pipe” to transmit clinical information, but there will not be a statewide repository.

It was asked – now that we have all of this data – what do we do with the data. Some organizations are looking for outliers, others are using the data for benchmarking, and for inspiring friendly competition among physicians.

Q: What is the impact of risk contracting, payment reform, and ACOs on your HIE efforts?
A: (Ginger) All of our contracts are full risk, so this has a huge impact on why we need to exchange clinical information. Also, the increasing role of hospitalists id driving the need for HIE. Allison Perkins added that in a relatively short period of time the physician perspective has moved from “wouldn’t it be nice” to have HIE to “why don’t we have it?”.

Allison Perkins:
Our goal is coordination of care and quality of care. We have eClinicalWorks in most of 75 practices with a total of 200 doctors (some have athenaHealth and a few other systems), and we are using the eHX platform. We are working on integration with labs and radiology.

The WebOMR tool can be seen with a "magic button". We are currently working on a reverse magic button, which would be a viewer of the EMR from ambulatory settings to the hospital.

BIDMC is using the Mass. eHealth Collaborative's Quality Data Warehouse. Physicians are not yet receiving reports, and once the system goes live the BIDPO management will receive the reports. It is really too much data for individual doctors to manage or act upon.

Our efforts to create provider-to-provider functionality have had about a 15 percent success rate. We are promoting it as "social networking for providers"; it is a channel, not a repository. The ultimate goal is to exchange data across healthcare systems.

Q: Are you using your system for immunization records?
A: Not yet, but it is a new capability that we have.

Q: Do the 4 percent who did not opt in get notified when data is transmitted?
A: They do not need to be notified, because clinician-to-clinician transmittal is part of treatment/payment/operations.

Q: Has anyone studied who these 4 or so percent of people who opted out are?
A: It does not seem that any organization has collected data on this, but anecdotally it is either people who know practice employees or privacy zealots. Opt-in has been successful – even a behavioral health practice had an opt-in rate exceeding 90 percent.

Comment: One reason opt-in is so high is that patients can see the benefits of better labs and referrals. MHDC's Elliot Stone intern, Dr. Nakhle Tarazi of Steward, did a project on the patient experience of care with EHRs, and the most dramatically positive results were easier access to labs, specialists, and prescriptions.

Dennis Puls:

Winchester Highland Management is a joint venture between the hospital and the IPA. Winchester has been described as the "wild west," because the hospital subsidized EMRs for practices but did not specify which product to buy. At one time there were more than 17 different EMR products across 100 practices; today we have 8 plus the Partners system, with eClinicalWorks and athenaHealth the most prevalent. The interfaces between these systems are complex, and although the eHX platform would

work, those without eCW would have a lesser functionality. Instead, we are evaluating Medicity as the primary vendor for our HIE solution; interfaces are challenging with so many EMRs in place.

Q: What is the status of your meaningful use adoption?
A: Winchester has a handful who are in the process of attesting, and should do so by the end of the year.
For BIPHO, about 80 percent of the PCPs should be able to by the end of the year, and most specialists by the end of the first quarter next year.
MACIPA expects about 50-60 percent of the PCPs to attest by the end of the year.

Next Steps

The next meeting will be held on Thursday, December 15th from 9:00 – 11:00.

Future meeting topics:

- Massachusetts eHealth Collaborative Quality Data Warehouse
- IMPACT project
- State's legislative agenda for HIT and HIE
- Other topics to be addressed in 2012

In addition, members of the EHR Forum are welcome to attend the ICD-10 Forum. The next meeting of the ICD-10 Forum will be Friday, December 2 at 9:00 in the MHDC office.