

C O M M E N T A R Y

Look to states for HIE funding

BY JOAN R. DUKE AND JAMES OAKES, HIMMS Fellows

SINCE 2004 WHEN President Bush set the goal of every American having an electronic health record by 2014, there have been many federal and state initiatives to promote healthcare information technology. At the state level, the recognition of the importance of healthcare IT has brought together diverse stakeholders to address challenges of healthcare information and supporting technology. Drivers for these efforts include:

- Ensuring healthcare information is secure and private;
- Making healthcare information available where it is needed;
- Providing value to patients, providers and payers to improve healthcare;
- Ensuring equal access to healthcare;
- Defining best practices and standards.

Since early 2007, 208 bills have been introduced across all 50 states to encourage adoption of health-
Nineteen of these bills signed into law in 16
Some legislation has

funding of state initiatives, or established exploratory task forces to facilitate progress. In addition, governors in 15 states have signed 20 executive orders, which are designed to drive improvements in healthcare through the use of IT.

VERMONT, MINNESOTA VISION

We focus on two states, Vermont and Minnesota.

In July of 2005 Vermont Information Technology Leaders, Inc. (VITL) began envisioning that their network would share real-time clinical information among state healthcare providers to improve patient outcomes while reducing service duplication and reducing cost. VITL completed a plan in July 2007, producing a roadmap to encourage the use of healthcare information technology and calling for a statewide network to exchange data among healthcare organizations. Grants were awarded to five Vermont primary care practices; a chronic care information system; and a project to share medication history information among hospitals for patients visiting emergency departments.



Joan R. Duke



James Oakes

care IT. have been s t a t e s . authorized



NO-INTEREST LOANS

Minnesota recently approved a new \$6.3 million electronic health record revolving account and loan program. The program provides no-interest loans of up to \$1.5 million to help Minnesota's rural hospitals and small town physician, clinics, and other community healthcare providers replace paper records with EHRs as part of the state's e-health initiative.

The packages also include a \$7 million interconnected electronic health records grants program. Minnesota law requires all state healthcare providers to use electronic patient health records by Jan. 1, 2015, so they can exchange patient health information and deliver optimal care at all points of the healthcare system.

BIG STEP FORWARD

The Vermont and Minnesota programs to award grants and loans to physicians and hospitals to implement EMRs represent a huge step forward. These programs will encourage adoption, but do not address the key reason why EMRs should be used. (The EMR is typically referred to as the record within a care setting whereas the EHR spans several care settings). To gain widespread adoption, there must be a value proposition understood by practitioners who are being encouraged to use electronic medical records. Early adopters have shown savings in storage

DUKE see page 10

Newsmaker interview

INTERVIEWED BY RICHARD PIZZI, Associate Editor

How did you get interested in healthcare IT?

I was a fellow in pulmonary medicine from 1980-1982. There was a lot of interest in the very earliest computers, and we had an opportunity to build the programming for a pulmonary function lab. That peaked my interest. My first job was at Bay State Medical Center (Springfield, Mass.) in 1982. It was there that I met Richard Rydell, the new CIO at the hospital. I got involved with the IT staff, telling them that their current product didn't do much for us physicians. I thought there should be more physician involvement in the purchase of the next system. Rich Rydell asked me if I was serious about getting involved in IT. I said yes, and then approached the hospital's chief of medicine, who allowed me to spend 20 percent of my time working on IT issues. In two years, I was up to 50 percent. Currently at Shriners, I spend 90 percent of my time on IT.



What does a chief medical information officer do, and how is a CMIO different than a CIO?

The CMIO handles all of the content in a healthcare IT system, whereas the CIO understands the instrument itself. The real value of healthcare IT systems is how we affect the process of patient care. We've confused the value of IT systems in healthcare by focusing on the technology itself, rather than emphasizing content that improves the quality and safety of care. If done poorly, automation can slow down care. The value

of the CMIO is as a "translator." He or she is someone who can navigate between the worlds of medicine and technology. In some cases, the CMIO can be the only guard against implementing a wonderful piece of software in a horribly wrong way.

BRIA see page 10

WILLIAM BRIA, MD

- CMIO Shriners Hospitals for Children
- Pulmonary critical care physician
- Adjunct clinical associate professor, University of Michigan
- AMDIS board president

LETTERS

Continued from page 8

a bit like judging the quality of a restaurant by the size of the grocery bill.

On the pricing side, the plethora of contracts negotiated with doctors and hospitals by private sector plans means there is no information that is especially useful to consumers on this front either. Even when information is presented to consumers, there is no evidence that any significant number of them use it to change decision-making. This has been documented in survey after survey - most recently by the California Health Care Foundation just last week.

HIT will play a prominent role in the transformation of healthcare, but it will be driven by payers and providers, not patients.

HIT will be adopted when CMS, employers, and large health plans insist upon it as a condition of participation and not before. We will probably also need a full remodeling of provider payments to give the sorts of incentives needed to encourage physicians and hospitals to install the required technology. Health information exchanges will be built when the federal government realizes they are public utilities and pays to have them constructed.

Kim D. Slocum

President

KDS Consulting, LLC

IT essential in Medicare billing review

BY RICHARD PIZZI, Associate Editor

IN THE FACE OF AN upcoming federal crackdown on Medicare billing, a significant majority of *Healthcare IT News* readers say their organizations will use information technology to comply with auditors' requests for documentation.

Seventy-one percent of readers who responded to the most recent News Monitor poll said that IT would serve a critical function in ensuring they emerge unscathed from Medicare audits.

Twenty-nine percent of poll respondents said healthcare IT would not play a major role in the upcoming Medicare billing audits.

One hundred and fifteen people responded to the question.

The issue became urgent when the Centers for Medicare and Medicaid Services announced plans to go nationwide to find errant Medicare billing as early as this fall. CMS decided to expand the audits after the success of its pilot Recovery Audit Contractors (RAC) program, which recovered some \$304 mil-

lion in 2006.

Under the new RAC program, doctors and hospitals could be asked to provide documentation to support the bills they submitted to Medicare as far back as 2007.

"Technology will help facilitate aggregation of data, capture data at the point of care, eliminate duplicate data entry and streamline workflow," wrote Kate Crous, corporate director of clinical information systems at Universal Health Services, Inc.

Reed D. Gelzer, MD, a consultant with Revere, Mass.-based Advocates for Documentation Integrity and Compliance, told *Healthcare IT News* that technologies such as electronic medical records could reveal billing problems.

"An organization's EMR will greatly facilitate the discovery of fraud and abuse," said Gelzer. "Most physicians are not aware that the information collected in the background by the software will

show fraudulent practices such as having non-credentialed staff providing services but then changing the author to a physician."

Some readers said their organizations did not have the requisite technology to aid them in preparing for a Medicare audit, and others claimed the technology they did have was inferior.

"The IT packages we have are so vendor proprietary that it is impossible to build a cohesive and nationally uniform coding approach," wrote

one reader.

Many readers expressed dread at the possibility of a Medicare audit without adequate IT.

"We are still very much a hybrid environment where the left hand doesn't know what the right hand is doing," wrote an anonymous reader. "Heaven help us if Medicare comes in."

MORE AT HealthcareITNews.com
Connect: NEWSMONITOR 0608



DUKE

Continued from page 9

space, staff workflow efficiency, transcription, and paper handling. They have also documented benefits in improved quality and safety of care from the use and re-use of the medical data collected such as the ability to utilize preventative reminders or analyze chronic care conditions for improved outcomes.

These benefits, though persuasive, may not be enough to remove the barrier created by the cost of the

systems and the need to make the radical change in processes to take advantage of technology. Grants and loans may ease the pain of the initial cost of implementation, but unfortunately they do not pay for what EHRs do best. EHRs make it possible to collect and display information needed to assess and treat patients from all settings of care. The advantage of coordinated, accessible data is obvious to most physicians.

Unfortunately no one pays the physician to coordinate the care of patients to ensure better outcomes. As long

as our reimbursement is on an incident rather than episodic basis, the drivers to collect the necessary information from the various settings of care with data related to the patient's problems may not be there. It may even be a disincentive because payment is enhanced by documenting the delivery of more care and more complex procedures rather than providing less care for a particular visit.

The federal government and insurance companies are experimenting with payment alternatives that may address this finan-

cial disconnection, through such mechanisms as global payments to hospital/physician consortiums and other measures. Until these discrepancies are resolved at the national level, states may be expected to continue to experiment with ways to encourage adoption of IT at the practitioner level. ■

MORE AT HealthcareITNews.com
Connect: DUKE 0608

Joan R. Duke, FHIMSS, has been involved for more than 30 years in all aspects of healthcare information systems.

She founded Health Care Information Consultants (HCIC) to assist organizations in healthcare information technology planning and management.

James Oakes' career spans 30 years in healthcare information systems and management engineering, with extensive experience as an operating manager, as a vendor executive, and as a consultant. He specializes in helping healthcare providers plan and optimize their use of information resources, systems, and technology to improve clinical, operational, and financial outcomes.

BRIA

Continued from page 9

What does your standard workweek at Shriners look like?

We are heavily invested in both the tactical and strategic aspects of IT. We have one electronic health record in the Shriners system. All 22 hospitals are served from a central facility in Tampa, Fla. The issues that I address regularly are downtime, disaster recovery, reporting to and alerting physicians, the creation of structured order sets, best practices. Another major thing we're involved with is business or clinical intelligence, e.g., mining a clinical warehouse.

The Shriners system is a self-funded charity organization. They fund both the clinical care enterprise and research. We are busily working on the information infrastructure for research and incorporating that research knowledge into clinical practice.

You were a founder of AMDIS. Why the need for it?

Rich Rydell and I wrote three books on the physician-computer connection. We have maintained a very strong advocacy for clinician involvement in healthcare IT, and in trying to promote the integration of clinical workflow needs and intelligence into the operation of IT systems. This year also marks the 17th annual meeting of the Physician-Computer Connection Symposium (July 15-18, 2008 in Ojai, Calif.).

I'm currently chair of the AMDIS-HIMSS physician community. We're creating podcasts, an IT survival guide for physicians, and we organize the Sunday symposium prior to HIMSS. We're also meeting with AHRQ and the Institute of Medicine regarding the translation of care guidelines into machine-readable form. We want to go beyond physician acceptance of IT to really demonstrating the value of these systems. Healthcare IT systems should be putting the best information and guidelines in front of the physician at the point of care. We must have higher expectations for incorporating medical information into these systems. Healthcare IT systems must include clinical decision support at their core, because that's where you influence patient safety. ■

MORE AT HealthcareITNews.com
Connect: BRIA 0608

LAN of the Free.

Introducing the new Welch Allyn Spot Vital Signs® LXi with wireless technology.

Now you can have the freedom you deserve—the new wireless Spot Vital Signs LXi integrates with your existing hospital infrastructure. Using Welch Allyn Connex™ Data Management System, the Spot Vital Signs LXi will wirelessly send vitals data to a range of EMRs. You choose the technology and we'll provide the workflow that's best suited for your hospital and your nurses, letting them wirelessly capture and document patient vitals from the bedside with no extra steps. And that's liberating for everyone.



WelchAllyn®

Advancing Frontline Care™