

Hospitals' Collaboration Benefits Patients' Health

When Michigan Health Connect (MHC) was established, its founding members shared a common vision for the handling of patient healthcare information. They agreed to collaborate and not compete when it came to clinical data.

“The CIOs in this region said, ‘let’s agree that we are not going to make healthcare information one of the things we compete on,’” says Bill Lewkowski, CIO for the Wyoming, MI-based Metro Health. “That was one of our ground rules when we started working together.”

The leaders recognized that collaboration in this area would ultimately improve patient health. “The three founding health systems said, ‘why can’t we collaborate and do the right thing on behalf of patients and the physicians trying to serve them?’” says Douglas Dietzman, executive director for MHC, headquartered in Grand Rapids, MI.

Patrick O’Hare, CIO for the Grand Rapids, MI-based Spectrum Health explains further. “If you look in terms of our health systems’ organizational missions, they are to improve the health of the communities we serve. How can we have that as a mission without recognizing we need to collaborate in this space?”

Lewkowski explains how MHC was formed. “There were some early attempts to organize a RHIO or health information exchange in the region. With all good intentions they were trying to move forward, but they got bogged down and there was no momentum. So the CIOs in this region got together and agreed that it was extremely important. We began to strategize on how we could make it happen.”

(See **MHC** p. 2)

Hospital Leverages Personal Relationships to Build Critical Mass for Technology Use

Timothy Bullard, MD, Orlando Regional Medical Center’s (ORMC) chief medical officer, and Carlos Carrasco, the hospital’s vice president of business development, say that their biggest challenge in creating a way to share images between facilities was not the technology itself. Rather, it was gaining acceptance from users, both inside and outside their hospital system.

(See **Orlando Health** p.3)

INSIDE:

Page 5 Interest in mPHRs Growing Among Consumers

Page 8 Our Take: Now That We Have Electronic Health Information, the Issue Becomes Control

Page 7 A Reminder about our Copyright Policy

MHC from page 1

The CIOs looked for common ground, beyond their shared philosophy on patient healthcare information. “Independently and in parallel, we had arrived at the decision to use the same vendor for clinical messaging,” says O’Hare. “So it made sense to directly collaborate and advance this strategy without a lot of fanfare and getting caught up with who is funding what.”

MHC was established in 2009 as a non-profit corporation to facilitate and manage health information exchange in the state of Michigan. Spectrum, Metro Health, and Novi, MI-based Trinity Health, were the original members providing initial funding and governance.

With a formal structure in place, the CIOs began addressing technology requirements, beginning with their shared health information exchange vendor, Medicity, based in Salt Lake City, UT.

“We found we could leverage our Medicity technology to build an HIE platform based on a federated model,” says Lewkowski. “Before long, participating physicians were able to access a single point of entry to view clinical data, regardless of where a patient received services.”

“If you look at it from a provider perspective, in metropolitan Grand Rapids we have a lot of physicians using services from two or three of our health systems,” says Lewkowski.

“Instead of having each health systems provide specific and unique technology for their doctors, we have a single point of entry for the physician practice, regardless of where services are performed,” he adds. “It all goes to the same place for the physician at their office.”

Currently the HIE is pushing data from hospitals to providers, though MHC has plans to incrementally deploy more functionality. “We are in the process with a couple of health systems to put in infrastructure for capabilities like query and pull-down of demographics to get information on a patient that may not have been seen in an office before,” says Dietzman.

Unlike many HIEs, MHC is 100 percent funded and governed by its member health systems. “We have taken no federal or public funds to this point,” says

Don't miss your next issue!

If it's been more than six months since you purchased or renewed your subscription to *Inside Healthcare IT*, be sure to watch the mail for your renewal notice or call customer service at 443-206-4584. Renew your subscription early to save on the list price!

Inside Healthcare IT Subscriber Services

Start/Renew my subscription to **Inside Healthcare IT**.

Options	No. of Issues	Cost
Electronic	25 issues	\$399
Print & Electronic	25 issues	\$429

For discount group pricing, call 443.206.4584

Name _____
 Title _____
 Organization _____
 Address _____
 City,St/ZIP: _____
 Country: _____ Email: _____
 Phone: (____) _____-_____
 Check enclosed (make payable to Algonquin Professional Publishing, LLC/Federal ID No: 20-0784208)
 Charge my credit card: MC VISA AMEX
 Acct. No. _____
 Exp. Date _____ 3-4 digit CV# _____
 Signature _____

Mail to: Algonquin Professional Publishing, LLC, PO Box 818, North East, MD 21911 Tel: 443-206-4584 Fax: 410-658-7358
 E-mail: custservice@insidehealth.com Web: <http://insidehealth.com>

Dietzman. “I don’t want to be in that situation that a lot of HIEs are going to be down the road, where state and federal funding is pulled and they don’t have anything else to fall back on.”

Member health systems contribute to MHC based on a formula that considers the size of each organization. Physicians are able to participate in the HIE at no charge.

“Our goal is not to charge physicians or other providers using services of the HIE because we want to promote sharing of information,” says Lewkowski. “That is a differentiator from other HIEs. We don’t charge transaction fees or implementation fees; we don’t charge physicians anything.”

Dietzman points out that the MHC model would not necessarily work in every geographic region. “There are environments where health systems compete hard on interfaces and clinical data exchange,” says Dietzman. “That creates a whole different dynamic.”

MHC’s approach appears successful, and the organization now boasts 470 connected physician offices, 1,700 providers, and nine participating hospitals. “I think we have a very sustainable model at this point and one I think will continue on,” says Lewkowski.

“We have created an HIE that embraces the involvement of the health systems and not one that creates a third party HIE that is trying to make its own case for its own funding mechanism,” he says.

O’Hare again points to clinical data collaboration as a key factor contributing to MHC’s success. “We are doing this to serve the patient, to drive costs down, and add value to the collective delivery of healthcare in our area,” says O’Hare. “We’re not competing around patient information. We will continue to compete in other ways, but in this space we will, in fact, collaborate.” ■

—Correspondent Michelle R. Noteboom

Orlando Health *from page 1*

Part of Orlando Health, ORMC and its pediatric counterpart, Arnold Palmer Hospital, are central Florida’s only Level I trauma centers. Orlando Health comprises six additional facilities that share images through a common PACS environment.

Additionally, the facility serves as a hub for trauma transfers from about 10 hospitals outside the Orlando Health network. As a busy referral center, ORMC needed to find a solution that would enable the hospital to better manage and care for its trauma transfer patients.

“High quality medical care depends on matching the right patient with the right resources at the right time,” Carrasco says. “The difference that having timely access to medical images makes in accomplishing this goal is enormous.”

The hospital eventually selected SeeMyRadiology.com, a cloud computing solution from Accelarad.

While Carrasco and Bullard say the technology itself has been relatively easy for users to master, they anticipated a much greater challenge in building a critical mass of referring hospitals to use the system.

“Everyone’s got so many IT things on their plates right now, it’s difficult to get their attention,” says Bullard.

Personal relationships were key to getting the right people to the table for initial discussions, they found. And when Bullard and Carrasco didn’t have a contact at a particular hospital, they didn’t hesitate to bring

Follow us on Twitter for previews of upcoming stories, breaking news, and opinion.

<http://twitter.com/InsideHealthIT>

Orlando Health *from page 3*

in reinforcements. “As an ER physician I know a number of my colleagues at other hospitals, but I don’t know everyone,” says Bullard. “We learned quickly that sometimes the only way to get in the door initially was to have our CEO or CIO make a connection with their counterpart at the other hospitals.”

Bullard credits his hospital’s leadership with much of the success when it came to building a collaborative environment among the participating hospitals. “Our entire C-suite really bought into the project and helped make it happen, both internally and externally,” he explains.

Carrasco and Bullard say that through trial and error, they found the right formula, and now work with six system-based facilities as well as eight additional health systems, four of which are going live soon.

“When you’re discussing a project of this magnitude, you need to have the CEO or the COO at the table, and sometimes both,” Carrasco explains. “You also need the CNO, the nursing and physician director of the emergency department. And, sometimes, but not always, you need IT.”

Whether or not IT is involved in the initial meetings has a lot to do with how the department is viewed within a particular hospital. “The decision has to be made by the top executives that the project is of value before it filters down to IT. The key is whether another hospital wants to engage at an executive level with your hospital to share images,” Carrasco adds.

It’s not always initially clear who the leaders are, Bullard adds. “It’s not always the person with the most important title who is the real opinion leader. Sometimes it may be the IT person, sometimes it’s the ED director, sometimes it’s the CEO. Once you sit down at the table, you get a sense of who those folks are.”

Bullard says that once the commitment is made to use the technology, the implementation process is fairly

simple. SeeMyRadiology.com allows any user with appropriate permissions to log on to the Web-based application and upload DICOM images in full diagnostic resolution.

Subscribing sites can view the images from anywhere around the world using a web portal. The portal is also available on smart phones or other mobile devices.

The technology is also cost-effective, enabling participating systems to eliminate costs associated with duplicate image storing. “We pay one monthly fee for an agreed-upon feature set. As we grow, we have the flexibility to increase this as needed,” says Carrasco.

Additionally there was no cost to the outside sites to participate.

“As the hub site, Orlando Health is assuming the costs for the service. All the outside sites had to do was give up a little server space and a little time to learn the system. If we were going out and asking them to finance this though, I’m betting it would be a little more difficult to get outside organizations to participate,” Bullard says.

Bullard and Carrasco say the process of building buy-in was also helped by the nature of the system’s platform, which created what Carrasco describes as a “demilitarized zone for sharing.”

“Everyone’s got issues about privacy. Because we’re not getting into their system and they’re not getting into ours, it makes it much easier to have a conversation about how we can use the system to benefit all of us,” Bullard adds.

In implementing the system in-house, Bullard and Carrasco conducted most of the in-house training themselves. “Ninety percent of the functionality was being used by 20 percent of the physicians. We knew the ones we had to target and it took five to ten minutes to

train each user. We used the existing physician portal so all they had to do was click on an icon,” Bullard explains.

Since implementing the system earlier this year, ORMC receives about 90 percent of acute care transfers’ images through SeeMyRadiology.com and expects to achieve 98 percent by the end of the year and Bullard believes the hospital’s investment is a win-win for doctors, patients and the health system.

“Imaging is a critical component to make determinations about whether or not the best patient care means a transfer from one facility to another, and describing an image over the phone is difficult,” he says. “Early research studies show that 30 to 50 percent of the decisions to transfer a patient from a facility or not would be altered if imaging was available.” ■

Interest in mPHRs Growing Among Consumers

Mobile is where it’s headed when it comes to Personal Health Records (PHR), according to John Moore of Chilmark Research.

Moore and other researchers, legal scholars, and representatives of consumer, patient, and industry organizations shared their takes on the growingly complex arena of PHRs at “Personal Health Records – Understanding the Evolving Landscape,” a day-long Roundtable hosted by the ONC to collect information for a Congressional report mandated the HITECH Act to make recommendations related to the application of privacy and security requirements to non-HIPAA Covered Entities.

“Health happens wherever you are,” said Moore during one of the four panel discussions held during the Roundtable, citing an example where patients used their cell phones to enter their blood glucose levels into their PHR and receive reminders and alerts.

A study released earlier this year from Deloitte found interest rising among consumers in using a mobile device to access and maintain their health records. Additionally, the study found that fifty percent of consumers want a personal monitoring device to alert and guide them to make improvements in their health or treat a condition.

“The personal health record embedded in mobile communication devices – mPHR – is the ‘killer app’ that may change the game for providers, consumers and payers,” said Paul Keckley, Ph.D., executive director, Deloitte Center for Health Solutions and the study’s lead author. “Considering that treating chronic disease accounts for more than 70 percent (\$1.7 trillion) of the total \$2.4 trillion in health care spending in the United States, the business case for mPHRs is solid for helping to reduce costs for managing chronic conditions, such as diabetes and obesity.”

(See PHRs p. 6)

People on the Move

Joseph E. Heins, PharmD, formerly with DocuSys, has joined First DataBank as vice president, global product management and marketing.

Eurica Sadler-Lane has been promoted to chief financial officer of Molina Healthcare of Florida’s health plan, a subsidiary of Molina Healthcare, Inc.

Dan Schwartz, formerly with WoltersKluwer, has joined Advanstar as Editorial Director, Healthcare.

Jean-Paul Creusat, M.D., formerly with ROI Healthcare Solutions, has been named chief medical informatics officer for Ardent Health Services.

PHRs *from page 5*

While interest in using mPHRs is on the rise, particularly among GenXers, concerns about privacy and security abound.

In a recent survey, Patient Privacy Rights, the nation's health privacy watchdog, and Zogby International found that in an online survey of over 2,000 adults, nearly 97 percent believed that doctors, hospitals, labs, and health technology systems should not be allowed to share or sell their sensitive health information without consent.

Additionally, 98 percent of those surveyed opposed insurance companies sharing or selling health information without consent.

Despite those concerns, however, other surveys have found that Americans pay more attention and become more engaged in their health and medical care when they have easy access to their health information online.

For example, "Consumers and Health Information Technology: A National Results from a National Consumer Survey on Health IT," a study released by the California Health Care Foundation in April, found that:

- two-thirds of the public remain concerned about the privacy and security of their health information, but the majority of those who are using a PHR are not very worried about the privacy of the information contained in their PHR;
- most PHR users and non-users say we should not let privacy concerns stop us from learning how health IT can improve health care;
- more than half of adults are interested in using online applications to track health-related factors, and almost half are interested in medical devices that can be connected to the Internet;

- of those who do not have a PHR, 40 percent express interest in using one.

The survey also found that while privacy was a concern, a more significant barrier to PHR use and adoption was consumers' perception that a PHR wasn't a necessary health management tool. ■

Factors that Would Encourage Individuals to Sign up for a PHR

- Trust in the organization: 57%
- Strong laws or fines for organizations who shared information with others: 54%
- An individual was told by his/her doctor that the information was safe: 52%
- The website had a detailed privacy policy: 51%
- An individual's friends or family used the PHR and said their information was safe: 50%
- An individual would be informed if anyone looked at the information who shouldn't have: 50%
- The website contained a seal of approval, similar to those on banking sites: 48%
- An individual knew about the government's privacy rules: 46%

Source: Lake Research Partners, national health IT consumer survey, 2009- 2010

A Reminder About Our Copyright Policy

Thank you for subscribing to *Inside Healthcare IT*.

Many free sources of information allow you to freely forward, copy, and share. Because our information is advertiser-free, unbiased, and labor-intensive to collect and report, our subscriber agreement has specific terms under which we license the copyrighted newsletter to you personally. Here are some quick reminders of what you can and can't do with your subscribers-only information.

- If you receive a paper subscription, you may route your original copy to anyone in your office.
- If you receive our electronic format, it works very much like a software license. Only the number of copies for which you subscribe may exist at any time, i.e. you cannot forward the electronic file by e-mail or place it on a network or shared drive. Unless you have a multi-copy subscription, that means the original copy may not be duplicated or made publicly available in any way.
- It is a copyright violation to photocopy, forward, or post the newsletter in any way that allows non-subscribers to read it.
- You may, on an occasional basis, copy a single story and send it to a colleague.
- If you find our newsletter of general interest in your organization (and we hope you do!) we offer multi-copy subscriptions at significant discounts. Please contact us for more details.
- We offer a newsletter site license for subscribers who wish to regularly distribute paper or electronic copies of *Inside Healthcare IT*.
- We allow you to reprint a single article with advance permission. The request process is easy, fast, and free

for subscribers. Requesting permission ensures that you are not violating copyright law.

To be fair to legal subscribers, newsletter publishers sometimes resort to lawsuits to enforce their copyright protections. These have resulted in seven- and even eight-figure settlements from subscribers or the employer of subscribers.

We are a small business whose only revenue comes from subscriptions, not advertising. Illegally copied newsletters hurt our business as much as software piracy hurts software vendors.

Thank you for respecting our copyright policies. Please feel free to contact me at cathe@insidehealth.com if you have any questions. And, thank you once again for subscribing to *Inside Healthcare IT*.

We wish you the best for a healthy, happy, and prosperous 2011.

Catherine Schwartz, Publisher

Inside Healthcare IT

(formerly **Inside Healthcare Computing**)

**Executive Editor: Tim Dotson, RPh,
MBA, MEd, FHIMSS
(tim@insidehealth.com)**

**Publisher: Catherine Schwartz
(cathe@insidehealth.com)**

The purpose of Inside Healthcare IT, ISSN 1087-5425, is to provide an independent and unbiased source of news, trends, user reviews, and strategic insights into hospital and health care information systems technology. The newsletter is published biweekly in paper and electronic formats except for the first two weeks of August. Copyright © 2010, Algonquin Professional Publishing, LLC, P.O. Box 818, North East, MD 21901. Telephone (443) 206-4584. Reproduction without permission is prohibited by law. Subscriptions are \$467 per year, deep discounts are available for multiple subscriptions and site licenses. Web site: <http://www.insidehealth.com>

Our Take: Now That We Have Electronic Healthcare Information, the Issue Becomes Control

In the early days of the Internet, governments started putting their records online. People could check out legal actions, driver's license information, and real estate transfers from their living room instead of trudging down to the 9-to-5 courthouse basement and flipping through dusty folders.

Some citizens were upset at the perceived invasion of their privacy. They were okay with having the public information available in an inconvenient manner, but making it easily accessible worried them.

The quiet, almost unnoticed event was getting governments to move to digital information in the first place. Then came the realization of how that information could be used for purposes both noble and crassly commercial.

Healthcare is at the same crossroads. With the information track largely laid by years of software implementation projects, the debate is shifting toward the value and use of all the information those systems have made digitally available for the first time.

The signs are scattered, but clear:

- Systems vendors such as Cerner and Practice Fusion are making big money selling de-identified data of patients with whom they have no relationship other than having their private information stored on their systems.
- Health information exchange vendors Axolotl and Medicity have been acquired for eye-popping amounts by insurance companies, who surely see potential value in controlling the medical information pipelines.
- Providers are rapidly putting together accountable care organizations, with one of their main drivers being the need to collect and analyze quality information in order to get paid.
- Increasingly, the value of provider software systems isn't based on optimistically projected efficiency gains, but rather the strategic benefit of using information to manage costs and care quality.

This may be the biggest benefit of the government's HITECH "EHR in every pot" subsidy program. Providers sitting on the clinical systems fence were looking only at the most fundamental potential benefits: modest gains in efficiency and some degree of improved managerial control. It was harder for them to visualize the benefit of having a stream of real-time operational and clinical information that could support everything from improving an individual patient's care plan to making decisions about which service lines to expand or contract.

Providers will be judged on their outcome and cost data. The data-driven ones will grind out slow but steady improvement, while the seat-of-the-pants ones will find it hard to compete on intuition alone. Hospitals and doctors will be asked to make their patient data available to competitors and to patients themselves, exposing their inner medical workings in ways that were, like the government records model, always theoretically possible but comfortably impractical.

It's likely that the next phase of healthcare's IT journey will involve providers managing their data more actively: cleansing it, analyzing it to tease out trends and opportunities, and controlling it to prevent misuse. As vendors and progressive healthcare IT organizations have discovered, a rich store of electronic data may be the most valuable asset that a provider owns. ■