Five HIEs to Watch

Written by: Jeff Byers
Wednesday, February 02 2011

What can Inland Northwest Health Services, Norman Regional Health System, MedVirginia, HEALTHeLINK and Quality Health Network teach other health information exchanges—and possibly your organization—about sustainability, integration, practice management and EMR adoption? Read on to discover what makes these five regional HIEs worth watching.

1: Inland Northwest Health Services (INHS) | Spokane, Wash.

Data sharing across competing facilities sparks better care
INHS provides EMR services to 750 physicians and hosted practice management services in eastern Washington and northern Idaho.

Currently there’s a backlog of 100 physicians waiting to be added into the system for data-sharing benefits, says Mike Smyly, chief business development officer for the Information Resources Management (IRM) division of INHS. “Data sharing has changed the culture of our community from ‘How do I protect the data from my competition’ to ‘how do I share the data with my competitors for better patient care?’ ”

Thirty-eight hospitals are currently linked to INHS’ master patient index (MPI)—via a GE Centricity EMR for physician services and Meditech’s Enterprise Medical Record for hospitals; another six hospitals have recently signed on to participate in the exchange. Meditech’s electronic MPI has been leveraged to integrate patient data among inpatient and ambulatory clinical data, Smyly says.

In addition, INHS provides analysis services for EMR implementation and customization for physicians and hospitals. INHS also has implemented a “community image store” in collaboration with its radiology partner, Inland Imaging, where referring hospitals send images via Inland Imaging’s integrated PACS.

INHS’ hosted EMR services cost a 650-bed hospital 25 percent to 30 percent less than what the hospital would have paid to deploy an EMR itself, Smyly says.

“If you can establish trust in a community ... you take away data as a competitive advantage and focus on results,” he says.

2: Norman Regional Health System (NRHS) | Norman, Okla.

An infrastructure for pushing ambulatory data
Getting facilities and federal agencies to exchange ambulatory data is no simple task, but that doesn’t mean it can’t happen. NRHS has 75 physicians connected in the Norman, Okla., region and is looking to expand to federally qualified health centers (FQHCs) in the state, says Brian A. Yeaman, MD, CMIO at NRHS. The exchange is being used to help reconcile medications and problem lists, among other daily operations, he says.

In January 2010, NRHS, comprised of three hospitals, went live with Oklahoma Physician Health Exchange (OPHX), built on eClinicalWorks HIE software, to integrate ambulatory data. To broaden its reach, NRHS, as a part of Greater Oklahoma City Hospital Council, also has joined SMRTNET, a regional health information organization (RHIO) based in Norman. The SMRTNET RHIO currently includes 3 million discrete patient encounters in the network and includes data from more than a dozen Oklahoma hospitals.
Currently, OPHX—which facilitates electronic referrals and reconciliations—is sustained by monthly subscription fees of $25 per provider.

The SMRTNET/OPHX integration is driven by not duplicating a large number of interfaces: “We have a hub for ambulatory data now, with a lot of bidirectional interfaces,” says Yeaman. “Without strong HIE, we are going to continue to live in silos and we have to move away from that and construct an information network to allow greater communication.”


First HIE to connect with NHIN, VLER
MedVirginia, formed in 2000 by a coalition of Virginia not-for-profit hospitals and physicians, boasts a couple of firsts. In 2009, MedVirginia was the first community-based HIE service provider to harness the Nationwide Health Information Network (NHIN) framework, to streamline disability determination for veterans. And in December 2010, it became the first community-based HIE to connect to the Virtual Lifetime Electronic Record (VLER), a collaboration between Veterans Affairs (VA), the Department of Defense (DoD) and civilian health systems that connects the health records of the active-duty military personnel and veterans, says Michael Matthews, CEO of MedVirginia, based in Richmond.

Data are stored on a central database and comprise radiology reports, diagnoses, procedures performed, OR notes and discharge summaries. Currently, 14 hospitals are providing data to the exchange, as are two reference labs with about 115 physician practices and 1,100 physicians accessing data through a secure provider portal, he says.

Since harnessing the NHIN framework, MedVirginia has reduced the disability determination period from 84 days to 46 days and processed more than 5,000 disability determination requests. In some cases, the turn-around time has been shortened to one to two business days, Matthews adds.

“When you talk in terms of [saving money on items like] paperclips, it’s hard to monetize” the benefits of information exchange, he says. However, faster collection of medical evidence does translate into cost savings by reducing the amount of time it takes to receive a payment following service, according to a case study by MedVirginia. The study showed that, as a result of the MedVirginia-NHIN-SSA data exchange, Richmond-based health system Bon Secours realized $2.1 million in payments on uncompensated care cases that the facility might not have collected otherwise, Matthews says.

4: HEALTHeLINK | Buffalo, N.Y.

'The value is the data'
As a Beacon Community and a RHIO, Western New York Clinical Information Exchange (a.k.a. HEALTHeLINK) has built a repository of 40 million results, with 1.7 million results added to the exchange on a monthly basis.

HEALTHeLINK currently has more than 90 percent of the lab reports and nearly 75 percent of the radiology reports available for the eight counties in its service territory. HEALTHeLINK uses Axolotl Elysium tools to provide clinical messaging and clinical data delivery functions to physicians, says Daniel E.Porreca, executive director. “You’ve got to be careful not to focus solely on the technology,” he says. “It’s for better care. The value is the data.”

Major projects under way at HEALTHeLINK include an initiative to set up an EMR-to-EMR exchange that will package relevant clinical information from primary care providers into a CCD and send it via HEALTHeLINK between disparate EMRs, says Porreca.

HEALTHeLINK went live with the first such exchange between primary care and specialists four months ago and is looking to upload the second EMR from a second vendor for the exchange during the current fiscal quarter, he says.

As a Beacon Community, HEALTHeLINK is putting into place technology such as telemonitoring to create a wider, deeper information base about the diabetic population and to facilitate better communication between patients and providers.
“While we’ve done a lot, we realize we have a long way to go,” says Porreca.


‘We created a medical neighborhood’
QHN was created as a RHIO by a collaboration of Mesa County Independent Physicians Association (IPA), Rocky Mountain Health Plans (RMHP), St. Mary’s Hospital and Community Hospital. The goal was to provide quality care to the 150,000 patients in Mesa County.

QHN went live in 2005; currently about 85 percent of physicians in Mesa County are connected to the system, says Dick Thompson, executive director of QHN. “We created a medical neighborhood so not only are the hospitals and labs connected, but also … surgical centers and home health hospices and pharmacies.”

Services range from results delivery to e-prescribing, electronic referrals, CPOE and web-based population management tools. QHN also offers an “EMR lite” that includes clinical decision support, but does not provide scheduling and billing, says Thompson.

QHN delivers 125,000 lab and radiology results per month to providers as well as tens of thousands of progress notes, e-prescriptions, referrals and other clinical messages. That breadth of data helps to populate a longitudinal patient record, providing aggregate data across QHN’s community. One provider was able to decrease medical record staff by 25 percent to 30 percent because of the connectivity; another eliminated a referral coordinator and replaced that position with a clinician because care coordination is handled electronically, says Thompson.

Sustainability will continue to be a major hurdle that HIEs must clear, but as these five efforts show, funding isn’t the only metric to watch. When it comes to building an HIE that works, one formula for success definitely does not fit all.

Copyright © 2011 TriMed Media Group, Inc.