The Green Mountain Physician

A Publication of the Vermont Medical Society

"Not for ourselves do we labor"

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In This Issue:

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Experienced Health Care Industry Veteran Named VITL President and CEO

Talking EHRs with David Cochran, M.D.

In Vermont Information Technology Leaders' (VITL) search for a new president and CEO, the non-profit public/private partnership was looking for someone with the experience, expertise and vision required to lead the organization's efforts to encourage physician practices to adopt and implement electronic health records systems. All it takes is a one look at the background of David Cochran, M.D., to see that VITL got the person they were looking for.

Dr. Cochran comes to Vermont from Harvard Pilgrim Health Care, where he served as senior vice president for strategic development. Prior to that position, he was Harvard Pilgrim's associate medical director for clinical practice systems. Among his many qualifications for the top job at VITL where his roles in implementing new clinical information systems and electronic medical records, automating one of the first health screening guidelines in a health plan, serving as the director of several health centers in the Boston area and caring for patients as an internist at Harvard Community Health Plan.

The *Green Mountain Physician* recently sat down with Dr. Cochran to discuss his new position and his vision for EHR in Vermont.

Green Mountain Physician: What excited you about the VITL CEO job?
Dr. Cochran: When I was approached about coming to Vermont I learned that there was an appreciation in the state about how the delivery of health care could be changed by electronic health records. There was also a commitment to make electronic health records an important part of the Blueprint's promises and a commitment to technology over a period of years, which is what it will take.

GMP: What do you hope to accomplish at VITL?
Dr. Cochran: I would hope that over a two to three year period we very successfully are able to bring the vast majority of physicians, hospitals and other providers onto the health information exchange, enabling them to use electronic health records and to demonstrate in conjunction with others in the state the value of doing that in the context of transforming how we deliver care. I expect us to be a model for others around the country

GMP: What do the HIT components of the American Recovery and Reinvestment Act of 2009 mean for Vermont physicians?
Dr. Cochran: Both challenges and opportunities. The challenge is that the major sources of funding both nationally and in Vermont are going to be paying close attention to the meaningful use of technology starting in 2011. And that's going to have a significant impact on physician reimbursement – it will be positive in the early years, negative in subsequent years – at a time in which physicians are already challenged in their practices. The challenge of adopting information technology on their own is huge. The opportunity is to work with organizations like VITL and others to adopt technology and achieve meaningful use in the timeframe allowed.

GMP: Will the financial incentives provided by ARRA be enough to convince physicians to make the switch?

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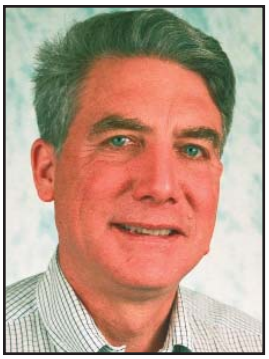
Letter From the Executive Vice President



While the debate over health care reform has consumed cable news networks and mobilized interest groups on both sides, one major piece of legislation with far-ranging impacts on the delivery of health care was passed earlier this year with much less rancor and attention.

As part of the "American Recovery and Reinvestment Act of 2009" passed by congress and signed into law by President Barack Obama last February, the federal government has made a major investment in the adoption of electronic health records (EHRs).

For physicians worried about the cost of implementing EHRs, the most important part of the legislation is most likely the $19 billion in Medicare and Medicaid Health Information Technology (HIT) incentives. Early adopters could receive as much as $44,000 in incentives over a five-year period, while non users will begin facing penalties of minus-one percent of Medicare fees in 2015, minus-two percent in 2016 and minus-three percent in 2017 and thereafter. Rural physicians, of which there are many in Vermont, could see even higher incentives as there will be a 10-percent bonus for health professionals in shortage areas.

In Vermont, the state legislature and Governor Douglas took significant strides toward positioning the state for EHR implementation and taking advantage of federal initiatives by enacting H. 444, a bill that includes several health information technology provisions. Key features of the bill include:

- Giving the secretary of administration or a designee responsibility for overall coordination of the state's health information technology plan and authorizing him or her to apply for U.S. Health and Human Services implementation grants;
- Designating Vermont Information Technology Leaders (VITL) as the exclusive operator of the state's health information exchange network;
- Mandating the creation of a certified EHR technology loan fund within the state IT fund, of which physicians will be able to use to facilitate the purchase of EHR systems, enhance utilization of the systems, train personnel or improve system security;
- Requiring health insurers to pay a fee into the state's health IT fund; and,
- Allowing the secretary or designee to apply for federal funds in order to facilitate EHR adoption in the state.

In This Issue of the Green Mountain Physician
We at the Vermont Medical Society felt that the issue of EHR's was important enough to warrant an edition of the *Green Mountain Physician* devoted to it. Accordingly, in this issue you'll find a discussion with VITL's new president and CEO, David Cochran, MD, an article detailing Fletcher Allen Health Care's recent experience in implementing a comprehensive EHR system, and advice on preparing your practice for EHRs from SymQuest Group's Bill Burbank.

We hope you find the information in this issue informative and helpful, but please note that this will not be the last time you hear from us about EHRs. VMS is actively following, and providing input into, the rulemaking and implementation stages of this complex health care delivery issue. As new information and resources become available, we will pass that information onto you, our members.

As always, please feel free to contact VMS staff with any questions or comments that you might have.

Sincerely,

Paul Harrington
Executive Vice President

Preparing for EMR

By Bill Burbank, Healthcare Specialist, SymQuest® Group

Many practices today are beginning to evaluate electronic medical record (EMR) systems as the first step in adopting this technology within their offices. The process of researching software, speaking with vendors and implementing technological change within a practice can be very intimidating. Using the expertise of a technology partner to guide you through the process is an excellent way to reduce anxiety and accelerate successful implementation of your practice's new EMR system.

Each EMR vendor publishes a list of requirements for their software (often referred to as the System Environment Specifications). However, beyond the basic vendor server and workstation requirements there are many other options requiring thought and consideration. Practices will need to evaluate and define various other hardware components within the scope of their particular needs and practice. Some of the most common include:

- Will the EMR be server-based or web-based?
- Laptop, tablet or slate PC?
- How will providers access patient records from outside the practice?
- What does the EMR require for an integrated fax system?
- What printers and scanners will be needed?
- How much downtime can be tolerated, and what is the plan for disaster recovery?

There are four key phases to building the computer network foundation necessary to support an EMR system. They are: 1) Assessment of the practice's current computer assets to determine what can (and cannot) be re-used; 2) Understanding the software vendor's configuration requirements as well as the needs/wants of the providers; 3) Developing a budget for implementation of the new network, network management and support post-implementation; and 4) Coordination of the network installation to meet the software vendor's implementation timeline as well as the practice's operational needs.

Network assessment is the most critical step, as your network serves as the backbone for all other components and drives many other decisions. It is also the simplest phase to accomplish and can be completed well before vendor selection. Often a network that appears to be running well is unable to accommodate the needs of your new EMR software. For example, workstations with insufficient memory or low disk space are often not noticed until new software arrives. Wireless security, Internet firewall, anti-virus software, printers, scanners, and the current state of network health should all be inventoried. (During our assessments we sometimes find networks with little or no security, failing workstations and spyware or malware no one knew was there).

Once the assessment is completed, it is a straightforward process to use the information and work with the software vendor to develop a budget for upgrading and/or adding components to meet requirements. This is also the time to define a network support plan to keep the network healthy and stable as the practice increase utilization.

The process of selecting an EMR system is not easy. Office managers and providers often feel overwhelmed with the choices and decisions that must be made – not to mention the process of adopting a new way to interact with patients and deliver care. The most successful implementations happen when the practice focuses on the EMR software selection as well as operational changes the practice must embrace. A technology partner experienced with EMR implementations can take on the responsibility of the computer network implementation details. This will allow the practice's focus to remain on the EMR software and its impact on workflows, minimizing surprises along the way that can add cost and delay success.

About the author: *Bill Burbank is a Healthcare Specialist for SymQuest's Network Services group. Bill acts as a technology advocate for practices and works with EMR software vendors to ensure network readiness for the new EMR software. Bill, who has over 25 years of experience implementing software applications and technology solutions, can be reached at wburbank@symquest.com.*

Vermont Medical Society

Our Story: Fletcher Allen's PRISM Electronic Health Record System Goes Live

By Chuck Podesta, Chief Information Officer and Jim Michelson, MD, PRISM Medical Informaticist

Fletcher Allen is very pleased to announce the successful implementation of the first phase of our electronic health record, PRISM (Patient Record and Information Systems Management). This leading-edge technology, supplied by a nationally renowned software vendor, is now being made available to Vermont and Northern New York's community hospitals and physician practices at a competitive cost through our PRISM Regional initiative, described below.

Background

In April 2008, Fletcher Allen received state approval through the Certificate of Need (CON) process to begin the $57 million, three-year phased implementation of our electronic health record system. PRISM will serve all of Fletcher Allen's more than 30 facilities in Vermont, including the approximately 750 physicians who are credentialed at Fletcher Allen – nearly one-half of the physicians practicing in Vermont. PRISM will be compatible with other health records systems in the state, making it a critical element in the statewide, integrated, electronic health infrastructure being coordinated through Vermont Information Technology Leaders (VITL).

Our software vendor for the project is Epic Systems Corporation. Epic is a Wisconsin-based health care software firm with a wide range of experience in implementing electronic health record projects at hospitals, integrated health care organizations, and physician practices nationwide, and is ranked one of the top electronic health record vendors in the country.

PRISM Timeline

Due to the significant scope of the project, PRISM is being implemented in stages. Since early June 2009, we have been live with Phase One of the project, which includes our pharmacy, emergency department, Walk-In Care Center, and inpatient areas. Phases Two and Three are in development, and include all our ambulatory clinics, our oncology department, our data warehouse, an organization-wide scheduling system, and MyChart, a feature that allows patients to securely access portions of their electronic record via the web. We anticipate that PRISM will be live across all areas by the end of December 2010.

PRISM Phase One Preparation

Gearing up for Phase One was an intense, sometimes challenging, but ultimately rewarding process. Employee engagement and communication at all levels of the organization was the key to success. Work on the project began in February 2007 with the inclusive selection process of our software vendor, Epic Systems Corporation. Upon receiving CON approval in April 2008, the project got fully underway.

During this time the PRISM team – representing several clinical areas as well as information services – was recruited to develop the clinical design and perform the technical build of the system, and project governance committees were created to oversee the direction of the project. A communications taskforce was also created to coordinate the frequent communications associated with the project to our employees, community partners, patients and the public.

Shepardson 4 Unit Secretary Mary Carpenter (left) consults with PRISM/Epic team member Eric Fouts and Lenore Shaw, R.N.

Phase One Go-Live

The Go-Live process itself was staggered – the inpatient pharmacy went live in early May, followed by the Emergency Department, inpatient Rehabilitation, and Walk-In Care Center on June 3 and the remainder of the inpatient areas on June 6. Because medication administration impacts all other areas going live and is critical to patient safety, we felt it made sense to bring PRISM live in the pharmacy first to ensure it was functioning optimally.

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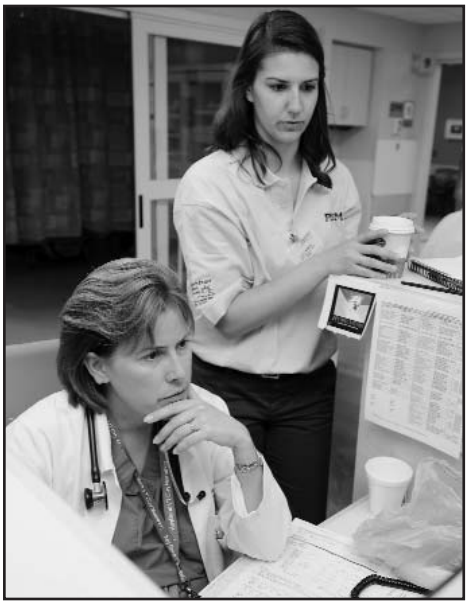
FAHC's PRISM

(Cont'd from pg. 4)

Bringing PRISM live in our ED, Inpatient Rehab and Walk-In Care Center a few days before the "house-wide" go-live allowed staff in those areas a few days to transition to the system with the benefit of intensive clinical and technical support. Employee support for the first several weeks of Go-Live included 24/7 "at the elbow" assistance from PRISM, Epic and CSC staff, as well as 24/7 phone support from our Information Services Customer Service Center.



PRISM/Epic team member Sarah Wenzel watches as Suzanne Elliott, M.D., works on the new system in the Emergency Department.

Physician Perspective on Using PRISM

Overall, the Phase One implementation has gone very well, and physicians are transitioning to PRISM well in these early weeks. Currently, 94 percent of clinical orders are entered into PRISM by providers via computerized physician order entry (CPOE). This ranks Fletcher Allen among the top 5 percent for CPOE adoption in the country. We can attribute this success to our comprehensive training program, the quality of clinical design of our order sets by the PRISM team, and the commitment of physician leadership, and most importantly the physicians themselves, to adopting the system.

Physicians are also using the clinical order sets built into PRISM to provide patient care. Our order sets were created utilizing evidence-based medicine and clinical best practice which have been shown to optimize outcomes in patient care. Physicians are finding that by placing orders using this process, they no longer have to ask themselves if they have forgotten to perform an aspect of care – making their workflows more efficient. In fact, physicians in areas where we have not yet created order sets are eager for the PRISM team to develop this functionality; evidence of their popularity and usefulness.

Further, patient safety alerts built into PRISM – including drug interactions and allergy reminders – are starting to change physician behavior. When an alert pops up in the system, we are seeing that physicians are making the decision to change their prescribing pattern based on these alerts. This is having a significant and positive impact on patient care.

This is not to say there haven't been challenges in implementation due to the fundamental changes in how we deliver care. However, from our perspective – only two months into implementation – the general feeling among providers is that implementation has been much less disruptive than anyone anticipated.

PRISM Regional

Meanwhile, development of PRISM Regional, an effort to enable Vermont and Northern New York's community hospitals and practices without electronic health records to purchase PRISM software at a competitive cost, is well underway. Physicians across the state can expect a communication with more details about PRISM Regional's ambulatory electronic health record, including a simplified pricing model, in the near future.

We remain fully committed to a statewide, integrated, electronic health infrastructure. We are signing an agreement with VITL regarding bi-directional continuity of care, stating our intent to ensure PRISM software will be compatible with electronic health records at practices in the region that are using a vendor other than Epic.

PRISM staff and Super Users gather in Austin Auditorium for a daily 6:30 p.m. debrief just before the evening shift change.

Looking Forward

The development of PRISM is a critical, clinical process, which is helping Fletcher Allen improve overall quality and patient safety while protecting the privacy of our patients' medical information. Full implementation of PRISM will strengthen our relationship with the regional provider community by promoting streamlined care delivery and offering technologic advances that will allow us to provide the best possible care experience for all our patients.

10 Questions with … Dr. Glen Neale, Immediate Past Pres.

Green Mountain Physician: Where do you practice and how long have you been practicing there?
Dr. Neale: I've been practicing in Morrisville for 18 years and part time in Newport for five years.

GMP: If you weren't a doctor, what would you be?
Dr. Neale: I would like to teach anatomy and physiology to high school students or maybe be a powder ski bum in New Zealand.

GMP: Is there one thing from your residency that you still think of often today? If so, what is it?
Dr. Neale: If you ask the right questions and listen to your patient enough they will tell you what is wrong.

GMP: How do you relax and unwind?
Dr. Neale: I ride my bike and play golf in the summer. And I ski and snowshoe and read in the winter.

GMP: Complete this sentence. I like practicing medicine because …
Dr. Neale: … there is no job more challenging or rewarding.

GMP: What new trends have you seen recently while practicing medicine?
Dr. Neale: Increased technology and less face-to-face time with patients. It's a trend that concerns me long term from a health policy point of view.

GMP: Can you name a time in which a patient taught you something new?
Dr. Neale: I think I learn a lot from patients by trying to figure out what they want from seeing me, because it is different for many of them. Sometimes you have to drag out of them what it is they want. But they are in your office for a reason.

GMP: If you were named U.S. Secretary of Health and Human Services, what would be your first policy enactment?
Dr. Neale: I would have access to health care for all. With the need for self responsibility as a part of that as well as a system that allows for people to fairly access the system faster if they so desired. That would be not a monetary amount but perhaps a percentage of income. If a person chooses to spend ten percent of their income, they should be allowed to access care quicker than someone who says, "I don't want to spend any of my income on health care." If you want to upgrade you can, not by an absolute amount but by a percentage so it makes it fair to everybody as opposed to one that benefits only the wealthy.

GMP: What was the best vacation you've ever had?
Dr. Neale: A barge trip in Burgundy France. It was awesome. We'd go ten miles a day if that. Every afternoon we'd have a guide take us on a historic tour of wherever we were.

GMP: Why are you involved with the Vermont Medical Society?
Dr. Neale: I think it is important that physicians work to improve the system as we have the best insight into it.

News Briefs

Applications for Loan Repayment Due Sept. 18
Vermont primary care practitioners interested in receiving educational loan repayment assistance have until Sept. 18, 2009 to submit applications for the 2010 awards.

As part of the state's efforts to recruit and retain qualified professionals, repayment assistance is available for nurses, nurse faculty, dentists, and primary care practitioners (physicians, nurse practitioners, certified nurse midwives, or physician assistants). The program targets professionals committed to Vermont's most rural areas and underserved populations. Each recipient is required to sign a service commitment contract in exchange for the award; payments are made directly to the lender.

For an application and eligibility details, visit the University of Vermont AHEC web site at www.vtahec.org and click on "2010 Vermont Loan Repayment Program" in the "What's New?" box.

Farber Named OVHA Medical Director
Michael Farber, M.D., has been named Medical Director for the Office of Vermont Health Access (OVHA), the organization that administers the state's Medicaid programs. Farber, who is board certified in internal medicine, will also join the faculty of the University of Vermont College of Medicine. He will begin his new role on Oct. 1, 2009.

Farber currently serves as Medicaid Medical Director and Medical Policy Chief for California Medicaid (Medi-Cal) Managed Care Division in the California Department of Health Care Services, a position he has held since 2006.

Are you prepared for an emergeny in your office?

By Cheryl Peaslee, Medical Mutual Insurance Company of Maine

Patients and visitors commonly assume that if an unexpected medical event occurs while at a physician's office, the physician and staff members will respond with expertise and appropriate equipment to take immediate action. But in order to be prepared to manage a medical emergency in the office, physicians and their staffs need to practice EPP – evaluation, preparation and planning.

Evaluation – Adequate preparation begins with a thorough office system evaluation to determine the unique characteristics of the office setting and the patients served. Based on this evaluation, a focused plan can be developed that uses strategies designed to meet the specific needs of your patient population based on your resources.

A retrospective look at emergencies that have presented or developed will assist in formulating a profile of trends for which the office can prepare.

Office Preparation – Based on the evaluation of the office setting, patient population and available resources, determination of appropriate equipment can be made. If definitive advanced life support is readily available (such as when a practice is located in an urban area), then a minimal amount of equipment and supplies may be necessary. In more rural areas where transport times can be delayed it may be necessary to ensure the availability of adequate supplies to support the patient.

Providers and staff must maintain competency in the equipment that is available in the office. At a minimum, all practices should have staff trained in basic life support.

Planning – As written protocol ensures that staff members have an understanding of their respective roles during an emergency event, the key to an emergency response is a coordinated plan. Ideally, the plan should delineate specific responsibilities of each staff member. Once the plan has been developed conduct drills to practice the office's response to a medical emergency. These drills provide staff the opportunity to learn their roles, evaluate the plan, implement changes and develop confidence and skill.

Ongoing monitoring of supplies is also important to ensure that they are not outdated and are in proper working order. On a monthly basis the emergency equipment and medication should be evaluated. A log of this review should be maintained.

Lack of appropriate training and equipment may result in an adverse outcome. Do not wait for an emergency event to discover that you are ill-prepared.

Medical Mutual Insurance Company of Maine's (MMIC) "Practice Tips" are offered as reference information only and are not intended to establish practice standards or serve as legal advice. MMIC recommends you obtain a legal opinion from a qualified attorney for any specific application to your practice.

Talking EHR's

(Cont'd from pg. 1) **Dr. Cochran:** It is too early to know the answer to that question. I'm not sure yet that all physicians are fully informed about incentives or are convinced the dates will hold.

GMP: How will EHR help physicians spend more time with patients and less time pushing paperwork?
Dr. Cochran: One of the things that is a challenge for most of us who practice medicine is tracking and coordinating all of the information relevant to the patient in front of us at that time. Electronic health records allow the physician to pay more attention to the issues the patient has then and there instead of concentrating on collecting information.

GMP: Some doctors have reasonable fears about EHR. Some feel that relying on a system that could go down is too risky. Others just don't want to change how they practice medicine. When you come across these and some of the other points made by physicians, what do you say to them?
Dr. Cochran: First of all, these are all valid points. When I started working on these issues in the mid 90s many of my colleagues in the technology world would talk about physicians as being technophobes. My view was the opposite. I felt that physicians were pragmatic and wanted to have the value proven to them. Practicing with EHRs will feel different. The benefit is an opportunity to have a much safer and better care delivery system than we have today. That said, for a physician it won't necessarily feel that way. That is the purpose of the incentives, to reduce some of the barriers and encourage implementation.

GMP: If you had a crystal ball that looked into the future 10 years, what would you like to see in regard to EHRs?
Dr. Cochran: I would like to think that physicians, patients and other members of the health care community are no longer talking about EHRs, PHRs or any other HRs. I'd like us to think about our information system the same way we do about our telephone system today. Which is that we take it for granted and use it constantly to do our work more effectively.

Conferences

Primary Care Sports Medicine

Sept. 23 – Sept. 25, 2009
Sheraton Hotel
Burlington, Vt.

For more information call 802-656-2292 or go to the website at http://cme.uvm.edu

23rd Annual Imaging Seminar

Sept. 25 – Sept. 27, 2009
Stoweflake Resort, Stowe, VT

For more information call 802-656-2292 or go to the website at http://cme.uvm.edu

Advanced Dermatology for the Primary Care Provider

Oct. 1 – Oct. 4, 2009
Cliff House, Ogunquit, ME

For more information call 802-656-2292 or go to the website at http://cme.uvm.edu

VMS Council Meeting

Oct. 4, 2009
Basin Harbor Club
Vergennes, VT

For more information
Contact Stephanie Winters at swinters@vtmd.org or 802-223-7898.

2009 ACP VT and NH Scientific Meeting

Oct. 23, 2009
Trapp Family Lodge
Stowe, VT

For more information
Contact Colleen Magne at cmagne@vtmd.org or 802-223-7898.

Visit www.vtmd.org to register and for more information!

Vermont Medical Society 196th Annual Meeting
Oct. 3, 2009
Basin Harbor Club, Vergennes, Vt.

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