



To: Paul Tang, MD, Chair, and David Bates, MD
HIT Policy Committee, Office of the National Coordinator
From: Jeanie Gentry, Vice President Allied Health Services
Date: August 1, 2010
Re: Statement for Committee Hearing, August 5, 2010

Presenter Biography

Jeanie Gentry is the Vice President of Allied Health Services at St. John's Lutheran Hospital (SJLH), a Critical Access Hospital in Libby, Montana. In addition, she is also a Founding Board Member of the Health Information Exchange of Montana (HIEM), a network spanning over 17,000 square miles in one of the most rural areas of the country. Jeanie holds a Business/Human Resource Development BS degree, and a Master of Health Administration degree from Montana State University. She has worked in Executive positions for 25 years, and has been at St. John's for 12 years where she leads Lab, Imaging, Rehab, Respiratory Therapy, Sleep Lab, HR, and Computer Information Systems. She has a passion for electronic health information projects, and is always looking for new ways to use technology to improve care for patients and efficiencies for providers. Libby is known as a Superfund site and designation as a Public Health Emergency location due to the high percentage of residents suffering asbestos related diseases (ARD). Jeanie has served an integral role over the last ten years in responding to the many healthcare needs of the community's ARD patients and using HIT to meet those needs. In her personal life, Jeanie is the married mom of nine-year-old triplets, and she loves to fly-fish.

Dr. Tang and Dr. Bates,

Thank you so much for inviting me to participate in this hearing. I am honored to learn from all of you, and to represent the very rural healthcare providers in my remote corner of Montana.

Over the past ten years, HIT has become my new passion. I have spent countless hours planning and implementing HIT in my little 25-bed hospital, in clinics in my town, and in the HIEM—one of the smallest but most successful HIE's in the country (in my opinion). St. John's Lutheran Hospital has had much of its clinical records in electronic format

since 2001, and we are completely digital in our Imaging department. All of our primary care clinics are either live or in the process of implementing EHR systems by the end of this year, and all of these systems will be integrated with our hospital Meditech system by year-end. Through the HIEM, all of our practitioners have access to real-time data from throughout our region in a fully integrated, single-patient view electronic health record (EHR). This information is consolidated from the all the CAHs, the one tertiary care hospital and many of the clinics and specialists in our primary referral area. The HIEM is also in the middle of building hundreds of miles of our own fiber network to transport all this data. We are one of the few FCC Rural Health Pilot Projects who have had checks cut and glass lit. Many of our members feel we are in excellent shape to meet the final criteria for meaningful use in 2011. As you can imagine, we are excited about this progress that has taken many years of planning, cooperation and hard work to accomplish!

As one of the most rural networks, one of the smallest networks, but one of the most successful networks to accomplish the dream of a fully integrated EHR, I tell you this background not just to brag (although that is fun) but to explain the original purpose and ongoing vision that fills us with the passion to keep working even when tempers flair (since none of us have common ownership) and money is tight. *We stay focused on our patients and what is right and best for them.* And that is exactly what you've asked me to tell you about today—the impact of all this fancy EHR stuff on our patients and their healthcare.

The HIEM Vision, and the Vision of each of our members regarding HIT Strategy, is to have “the five rights of healthcare” relate to HIT. We want our practitioners to have the *right* information about the *right* patient at the *right* time in the *right* place so they can make the *right* decision quickly every time. We believe it is impossible to provide good healthcare without good HIT. In answering your three questions, hopefully my experience can provide some concrete examples about how this is true, and how our HIT efforts have impacted the lives of patients.

1. What issues and deficiencies in care transitions can be effectively addressed by HIT?

I believe the easiest way to illustrate this is with two personal examples. First, imagine traveling for business around the country or even the world...but with a banking system modeled after our healthcare information technology. Your bankcard would only work at your local bank. You could use it to make purchases at a store, but only if the store had their own account at your same bank. Your card would be useless in other stores, or other towns or other countries. Sound horrible? It is! But thankfully, your financial information has been deemed much more important than your life-and-death healthcare information. Banks have invested heavily to make sure that you can withdraw money and make purchases anywhere you go because they know you will be traveling.

Patients travel, too. We don't want them to, and perhaps our reluctance to share information electronically has something to do with the fact that it is one way to keep

patients tied to us as practitioners and hospitals. If they go to a new doctor, obviously that doctor won't have all the history and information the current doctor has, so it is a type of barrier to making transitions between care providers and situations.

The second example is my son, Daniel. He is one of my nine-year-old triplets, and was born with a number of weird little anomalies like some fused vertebrae and only one kidney and such. Lest you worry, he is fine and happy. But he has required a lot of pediatric specialists to poke and prod and provide care for him over the years. We have Dr. Cuskelly, our family practice doc in Libby, Dr. O, the Ortho doc at Shriners in Spokane, Dr. Starr, the pediatric urologist in Spokane, Dr. Miller, the allergist in Missoula, Dr. Pete, his dentist in Kalispell, and many others. On top of these are the ER docs wherever we may be when Daniel has a problem.

I found out early on with Daniel that none of these docs were really "in charge" of coordinating all his care. As a first time Mom, I had imagined that all Daniels records from everywhere would go to Dr. Cuskelly. He would keep Daniel's master record and help me decide what to do next with Daniel and coordinate all these people. As you can guess, that wasn't how it worked. On some occasions Dr. Cuskelly would get a very nice note, or a copy of a note, from a specialist. But it was days or weeks or even months after Daniel saw that specialist, and not timely enough to help me decide what to do next. Besides, Dr. Cuskelly was swamped and didn't have time to sort through all of that information.

Then I discovered that the specialists didn't talk to each other, either. Dr. Miller (Missoula) had no idea what lab tests Dr. Starr (Spokane) had just done, so he would just run them again. Dr. O (Spokane) didn't have the x-ray from last week from Libby, so he would just take another one. I began to see a lot of duplication of services and a lot of time wasted trying to reconstruct information that should have been accessible.

Now, I'm not just any old Mom. I'm in charge of HIT at a hospital! And, with my HR hat on, I know I'm going to have to face renewal negotiations with BCBS at the end of the year, and all this waste is going to cost me one way or the other. So...I started "Daniel's Complete Health Record." It was an old 3-ring binder. Every time he had an appointment, I made sure I got a copy of all the notes, lab results, rad reports, etc. I got copies of all of his x-rays and kept them. Pretty soon, when Daniel and I went to a doctor appointment, I came in with a large attaché case full of information. Then, when Dr. Miller ordered a lab we had just had run last week, I pulled out the results and told him to use these instead.

Unfortunately, not every Mom is going to keep a 3-ring binder with every single note, result and report in it. Silly Moms...they probably expect those of us in the healthcare "system" to share and coordinate information sort of like their banks do with their checking account.

I have shared this perspective with hundreds of others through the past several years as I try to evangelize the world for HIT. And I'm surprised how many others have similar stories and frustrations. Patients don't always stay in one place, and when they move from the big hospital with the surgical specialist to their hometown with the ER docs down the street, it is poor healthcare not to have their information available to help them when they have complications in the middle of the night! It can be every bit as serious as giving the patient a wrong medication!

HIT can effectively address deficiencies in these many transition situations. If access to information about Daniel was easy to obtain and was consolidated from all the disparate systems into one single-patient view of all of his information, I believe each of Daniel's physicians could have been more productive, saved costs, and ultimately made better decisions about his care.

I'm proud to say that today, if Daniel saw a specialist in Kalispell, his information would be electronically available immediately to all the physicians in Libby that might care for him. If he saw a doc in Libby, and ended up in the ER in Kalispell, they would be able to see all of the Libby information, including his current meds, allergies and problem lists. It's like a 3-ring binder...only better!

2. How is HIT being used (or will be) within care to expedite...

a. Referrals with a team?

In Libby, our ER docs work 24-hour shifts. They do this because they like a lot of time off for other pursuits. When Dr. Maloney works a shift, it will be a number of days before he even comes in to the building again. Without a good HIT system, critical lab results or radiology reports will sit in his box far too long.

Fortunately, our system has given us the capability to set up teams of providers and push critical information to all those in a call-rotation group, or in the ER case, all the ER docs. This allows whoever is on shift next to handle the critical information because it's in their "work basket." Understanding the flow of the providers within a team has led our HIT solutions to improve that flow, not make it worse.

This same basket problem and solution has been replicated in many other settings for nurses, primary care physicians, therapists, etc. Quickly accessible information about patients who are shared between co-workers is a key benefit of HIT.

b. Referrals outside a team?

The examples mentioned about Daniel above mainly relate to referrals from one team to another. Our HIT systems have also been able to help in some of the following settings.

- We have implemented a system to "email" patient information and Images to physicians outside our PACs system network so they can quickly

receive those images and pull them into their own PACs system for viewing/analysis. This system is fully compliant with HIPAA guidelines and has helped us be able to get images to any trauma facility far in advance of a patient arriving by life flight services.

- When a provider in our network refers a patient outside his team now, a link to the patient's EHR can be sent via the HIEM's secure provider messaging. This saves time and reams of paper. Our goal is to eliminate faxing someday.
- A special focus for the HIEM has been availability of information for our ER physicians AND information from the ER visit back to the primary care physician for follow-up. The new integrated EHR has made it possible for a patient's family physician to immediately have access to all data from the ER visit as soon as it is in the hospital EMR. This helps facilitate care between these providers and improve compliance with follow-up instructions.

c. Transitions between settings?

Most of the examples listed above also relate to a patient presenting in varied healthcare settings. Some additional examples of how I have seen our HIT applications help include the following.

- Home Health nurses now have full access to the records generated at the hospital during their patient's stays, including all labs and medications.
- Information from our Home Health visits will soon be available electronically in the same record so that physicians, therapists and nurses can follow up based on complete information.
- A telestroke project has made it possible for neurologists in Kalispell to consult real-time with ER docs and stroke patients in our remote ER's. The patient's consolidated EHR is available to both docs to make the best decision possible for the patient when every minute counts.

3. How can HIT assist with care coordination in chronic disease management?

Within our HIEM network, we have two large populations of chronic disease patients. First, we encompass two Native American reservations, the Blackfeet Reservation and the Kootenai-Salish tribe. These populations particularly have a high incidence rate of diabetes. In Libby, we have a large cohort population of people with ARD.

One of the key functions of our consolidated EHR system is the ability to designate a patient as part of a chronic disease registry and assign panels of reminders or profiles for those patients. For example, diabetes patients will have a variety of exams/tests that must be checked periodically such as A1C, foot exams, eye exams, etc. These reminder panels will check for results across all providers within our network. Any and every physician accessing that patient's record will be alerted to indicators that fall outside the parameters built into the system. We believe that making more providers aware of the patient's status regarding diabetes will help reinforce compliance at every turn for our patients. This functionality was developed and tested and Vanderbilt University Medical Center, and we have transferred that technology to our network in Montana.

In conclusion, it is my firm belief that HIT solutions do lead to better care between providers and within care setting transitions. I have witnessed this in my own rural community and region.

I would like to add one comment about the meaningful use criteria as it relates to rural healthcare providers. Our experience in Montana is most likely ahead of the curve for most rural communities. We have been working on this HIEM project for well over five years now. Integration does not happen quickly when disparate systems, and more importantly, disparate organizations, must come together and work as one. None of the organizations in our HIEM network are under common ownership. In fact, many of us energetically compete with each other. Hundreds of detailed decisions must be made as part of a project like this, and sometimes the competitive natures of our business put speed bumps in our path to completion of the project. We have been fortunate that with time and continual focus on our patients' needs, we were not derailed by those speed bumps. But working out those issues is a process that cannot be forced or by-passed.

In addition, few of our rural communities have the technical personnel to implement these types of projects. Even if we have funding (or incentive funding) for HIT, it will be useless if we have no one on the ground to do the hard implementation work. Vendors are notorious for over-promising and under-delivering in HIT, and it takes people without our own organizations on a daily basis to keep the focus on completing the projects. It would greatly help us to be able to use some of the available funding for recruitment of qualified technical personnel for these projects. I urge you to continue listening closely to rural organizations when concerns about timelines are expressed.

Again, thank you for the opportunity to participate today. I look forward to discussing these items with you in person, and I welcome the chance to participate in any further discussions regarding HIT.

Thank you,

Jeanie Gentry

Jeanie Gentry, MHA

VP, Allied Health

St. John's Lutheran Hospital

Cell: 406-291-0032

Email: jeanie.gentry@sjlh.com