eHEALTH INITIATIVE

Real Solutions. Better Health.

Bridging the Gap Between Providers and Payors

Dial-in Information:

800-954-0603

August 29, 2011

About eHealth Initiative

- Mission is to drive improvements in the quality, safety, and efficiency of healthcare through information and information technology.
- Over 200 members of eHI
- In addition, EHI serves as a resource and tracks the progress of Regional Extension Centers, and 260 regional, state, and local initiatives working on health information exchange (HIE)

eHI Membership

- eHealth Initiative members are some of the most informed and influential executives in the health care industry
- Membership is open to all interested organizations
- Join online at our website www.ehealthinitiative.org or contact Amy Eckenroth, 202-624-3265, Amy.eckenroth@ehealthinitiative.org

Housekeeping Issues

- **ALL LINES ARE MUTED**
  - **To ask a question or make a comment, please submit via the chat feature and we will address them in the order received at the appropriate time**

Overview of Our Agenda

- **Introduction and Welcome (3:00 – 3:05 PM)**
  - Diane Jones, Vice President of Policy and Government Affairs, eHealth Initiative
- **Care, Collaboration and Community - Real World Improvement Projects (3:05– 3:20 PM)**
  - John Haughton, MD, Chief Medical Information Officer, Covisint
- **Linking Payors and Providers with Health Information Exchange (3:20 – 3:35 PM)**
  - Jamie Ferguson, Vice President of Health Information Technology Strategy and Policy, Kaiser Permanente
- **Questions for Mr. Ferguson (3:35 – 3:40 PM)**
- **Bridging the Gap Between Providers and Payers (3:40 – 3:55 PM)**
  - Sam Ho, MD, Executive Vice President and Chief Medical Officer, UnitedHealthcare
- **Panel Discussion (3:55 – 4:28 PM)**
- **Closing (4:28 – 4:30 PM)**
  - Diane Jones, Vice President of Policy and Government Affairs, eHealth Initiative

Housekeeping Issues

- **Slides and Recording of Webinar**
  - Members can access slides and replays of any webinar for free on eHI's members-only site
    - Non-members can purchase access to any webinar replay for $25

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http://www.ehealthinitiative.org/store.html

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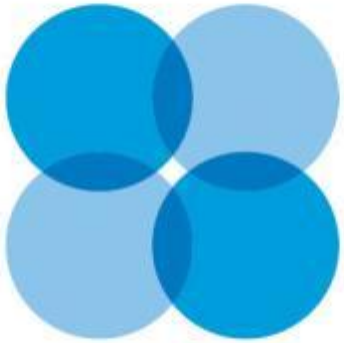
John Haughton, MD

Chief Medical Information Officer,

Covisint

Care, Collaboration & Community



Real-World Improvement Projects

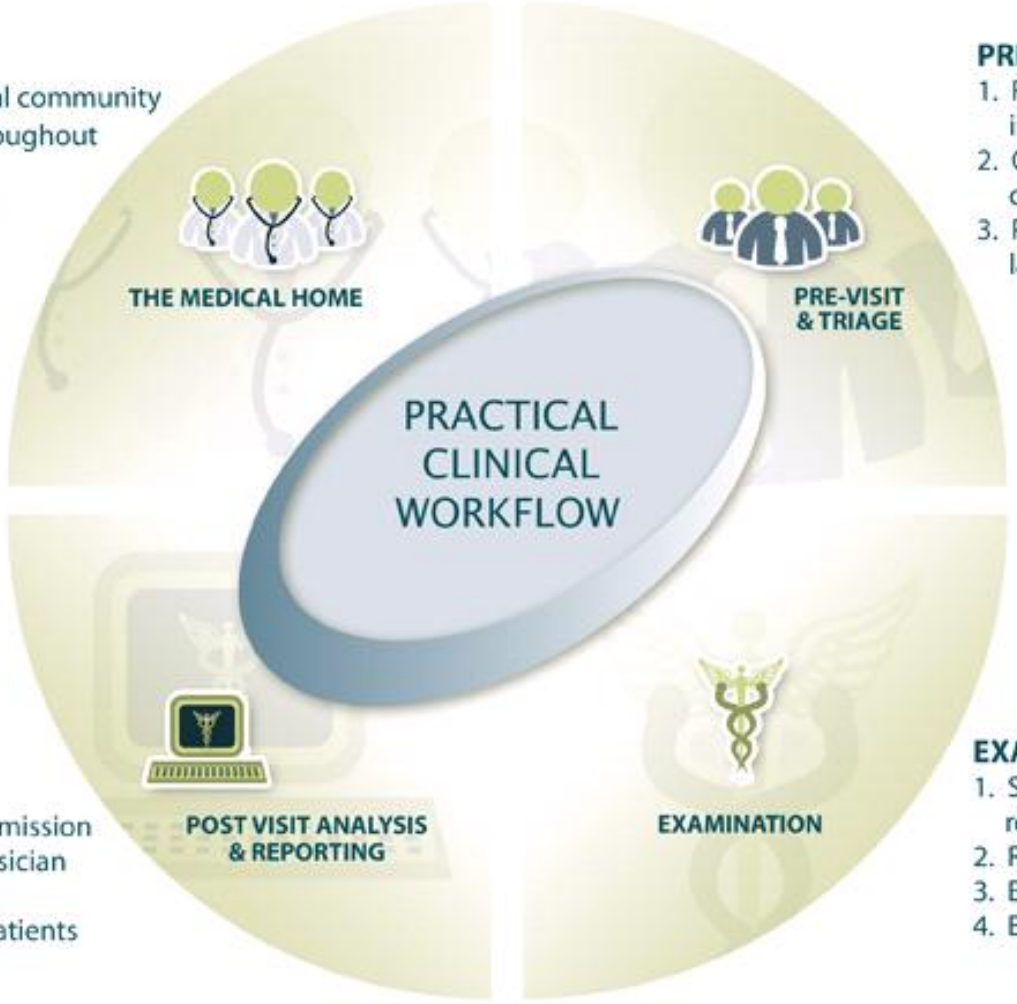
John Haughton, MD MS
www.covisint.com
Cell 443 694-3991
Email: Jhaughton@covisint.com

covisint
Enabling information ecosystems

PRACTICAL CLINICAL WORKFLOW
For Electronic or Paper-based Offices

THE MEDICAL HOME
1. Create your online medical community
2. Guideline-driven care throughout patient's life
3. Condition-based patient outreach & follow-up

PRE-VISIT & TRIAGE
1. Review demographic information
2. Guideline-driven alerts focus care team
3. Prepare patient for known labs/exams



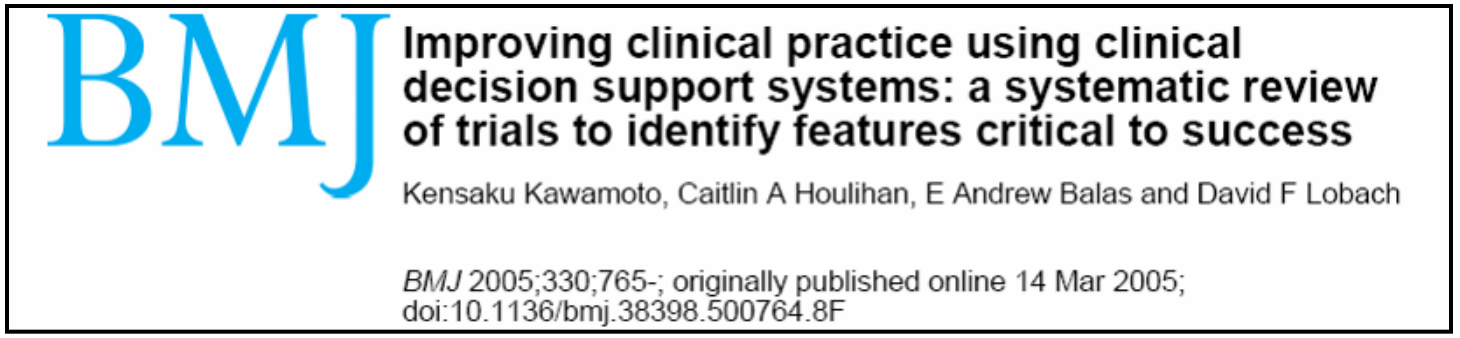
POST VISIT ANALYSIS & REPORTING
1. PQRI/P4P reporting & submission
2. Reporting by patient, physician and clinic
3. ID & communicate with patients needing care

EXAMINATION
1. Single view of patient's relevant clinical data with alerts
2. Review latest lab & Rx data
3. Electronic Prescribing
4. Efficient progress note

Real-World Improvement Projects

- **Provider and Community Initiatives** working together, with / without the payer…
- **Payers cooperate** – Offer access to clean data. Shared profiles / exchange.
- **Payers compete** – partnership with providers ($/contracting/shared savings). Coordination in disease / care management.

First, What Makes Healthcare Safer, Better, Faster?



- Automatic **Decision Support** as part of **Clinical Workflow**
- Provision of Recommendations rather than just assessments
- Decision support available at the time and location clinical encounter
- Computer-based decision support

Review of >10,000 articles to find 80 relevant comparative studies of what works to improve care

Effective Implementation, Deliver Value at each stop…

Patient AND Population
Clinical AND Administrative uses

Pages in Existing Portal / EMR
Extended Web Application

State / Plans

Patient / Clinic
Information
Collection
And
Decision Support

Cross-
Organization

Simple Exchange

Population
Performance
Reporting Registry
and
Clinical Workflow
(outreach & recall)

Hospitals

Vermont Blueprint - Innovation in Healthcare

15-30% improvement in care / cost: Decreased Rate of ER & Admissions after first year

KEY INNOVATION

Having community health teams work with primary care providers to assess patients' *needs, coordinate community-based support* services, and provide multidisciplinary care for a general population.

A web-based central health registry will capture all patient data.

TOWARD THE TRIPLE AIM

By Christina Bielaszka-DuVernay

DOI: 10.1377/hlthaff.2011.0169
HEALTH AFFAIRS 30,
NO. 3 (2011): 383–386

INNOVATION PROFILE

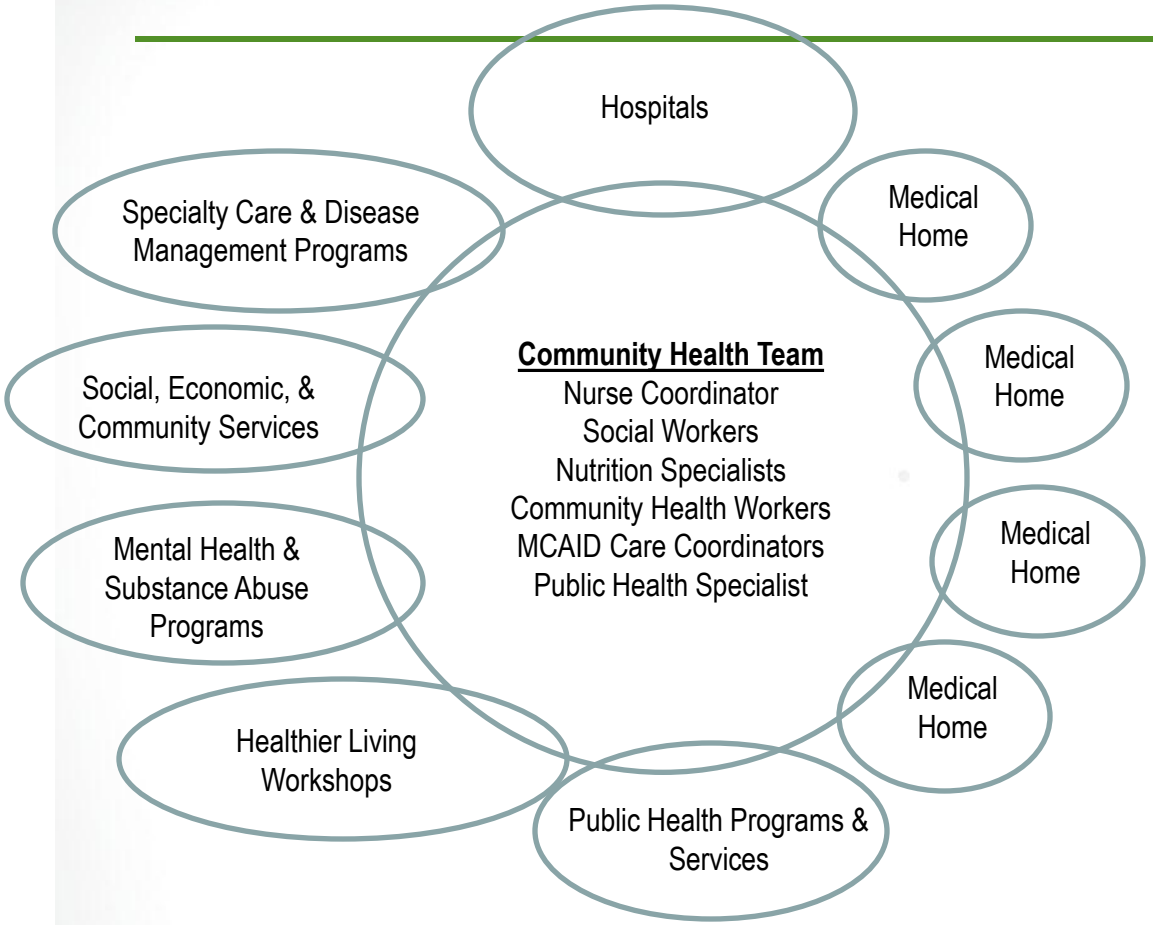
Vermont's Blueprint For Medical Homes, Community Health Teams, And Better Health At Lower Cost

Christina Bielaszka-DuVernay (cmd6@columbia.edu) is a freelance editor and writer based in Baltimore, Maryland, and is the former editor of *Harvard Management Update*.

SYSTEM The Vermont Blueprint for Health is a statewide public-private initiative to transform care delivery, improve health outcomes, and enable everyone in the state to receive seamless, well-coordinated care.
KEY INNOVATION Having community health teams work with primary care providers to assess patients' needs, coordinate community-based support services, and provide multidisciplinary care for a general population. A web-based central health registry will capture all patient data.
COST SAVINGS A recent analysis of the first pilot program found significant year-over-year decreases in hospital admissions and emergency department visits, and their related per person per month costs. Further savings are forecast once comprehensive financial reform is in place. When rolled out statewide, the initiative is projected to save 28.7 percent in incremental health spending in the state by its fifth year.
QUALITY IMPROVEMENT RESULTS A qualitative assessment of pilot sites suggests that providers and patients value the role of community health teams in connecting patients with behavioral health, chronic care management, and social services support. Objective assessments suggest early improvements in clinical quality and use, such as better control of hypertension.
CHALLENGES For the initiative to be financially successful, there must be a measurable reduction in avoidable emergency department visits and hospitalizations. Insurers must shift spending away from remote call centers, disease management, and mailings, and into support for community health teams.

VERMONT Blueprint for Health

Smart choices. Powerful tools.



Health IT Framework

Evaluation Framework

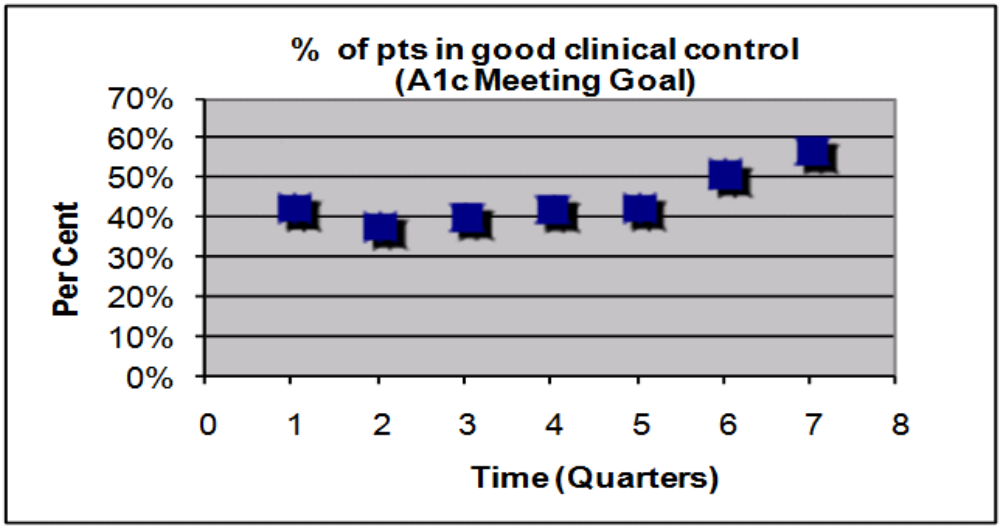
- A foundation of medical homes and community health teams that can support coordinated care and linkages with a broad range of services
- Multi Insurer Payment Reform that supports a foundation of medical homes and community health teams
- A health information infrastructure that includes EMRs, hospital data sources, a health information exchange network, and a centralized registry
- An evaluation infrastructure that uses routinely collected data to support services, guide quality improvement, and determine program impact

Results from the Field … Care Improves 25% to 50%

VERMONT Blueprint for Health
Smart choices. Powerful tools.

"We have a website called DocSite that we have been working with to facilitate [care improvement and cost containment] and we are going to make sure that the entire state has this capacity soon."

The Honorable Jim Douglas –
Governor of Vermont
Chair National Governors' Association
2009-2010



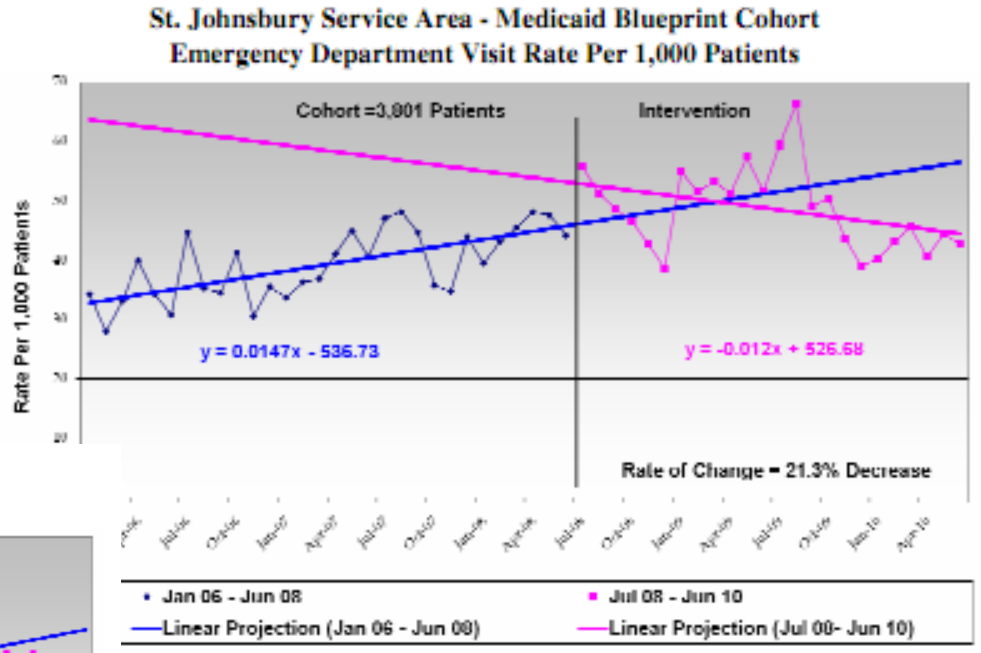
Results for 12 month diabetes improvement collaborative in Primary Care Practices* :

- Average A1c down 7.42 to 7.17
- 42% improvement in A1c's meeting goal (<7) (57% vs 40%)

* *Pre-Blueprint results using DocSite. Paper Practices. Limited Connectivity*

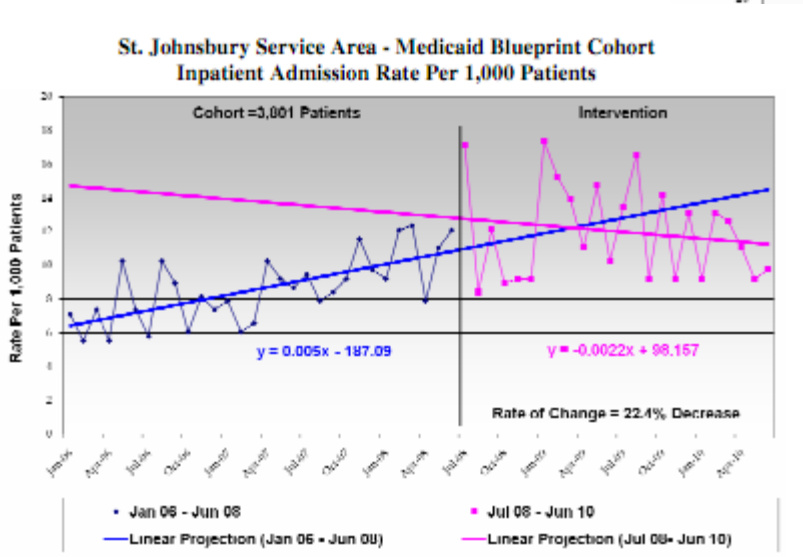
Utilization Results – after 1 year, 20% rate decrease in trend for ER and Admissions

ER Use Trend Down



Department of Vermont Health Access

Data Provided by Department of Vermont Health Access
Analysis Prepared by Jeffords Institute Fletcher Allen Health Care



Admit Rate Trend Down

VERMONT Department of Vermont Health Access

Data Provided by Department of Vermont Health Access
Analysis Prepared by Jeffords Institute Fletcher Allen Health Care

AHIP
Center for Policy and Research

Trends and Innovations in Chronic Disease Prevention & Treatment

An Update on Medicare Advantage Plans

Presbyterian Healthcare Services
New Mexico

PRESBYTERIAN

Reinventing Diabetes Care

Upon finding that no single approach was effective in addressing gaps in care for members with diabetes, Presbyterian Healthcare Services (PHS) revamped its diabetes disease management program in 2004 to create a new, multidimensional program. The new approach includes: online tracking; care coordination; case management; diabetes education; a pay-for-performance initiative; and a team-based system to improve hospital care for individuals with diabetes. Approximately 14,000 members participate in the program, 23 percent of whom are Medicare beneficiaries.

Giving Doctors Tools to Promote Recommended Services

All of PHS's Medicare Advantage members are patients of Presbyterian's physician group affiliate, Presbyterian Medical Group (PMG). PMG tracks information on members' use of diabetes-related health services in an online registry called DocSite. Prior to office visits for individuals with diabetes, physician office staff download reports from DocSite that identify gaps in members' use of recommended care, such as HbA1c blood level testing, eye and foot exams, cholesterol testing, and kidney disease screening. These reports are placed in members' charts so that physicians can review them and discuss next steps during office visits.

Using a Team of Experts

Medicare Advantage members' primary care physicians coordinate care with multidisciplinary teams that work onsite at Presbyterian Medical Group. These teams include certified diabetes educators, pharmacy clinicians, nurse care managers, behavioral health counselors, and a lay community health worker called a *promotora*.

patients' care teams for prompt follow-up.

Nurse care managers coordinate with the *promotora*, track members' use of recommended diabetes-related services, and likewise refer beneficiaries to other team members as needed. For example, nurses may refer members to behavioral health counselors for treatment of depression or to pharmacists for more information about medications.

Health Coaching to Overcome Barriers to Care

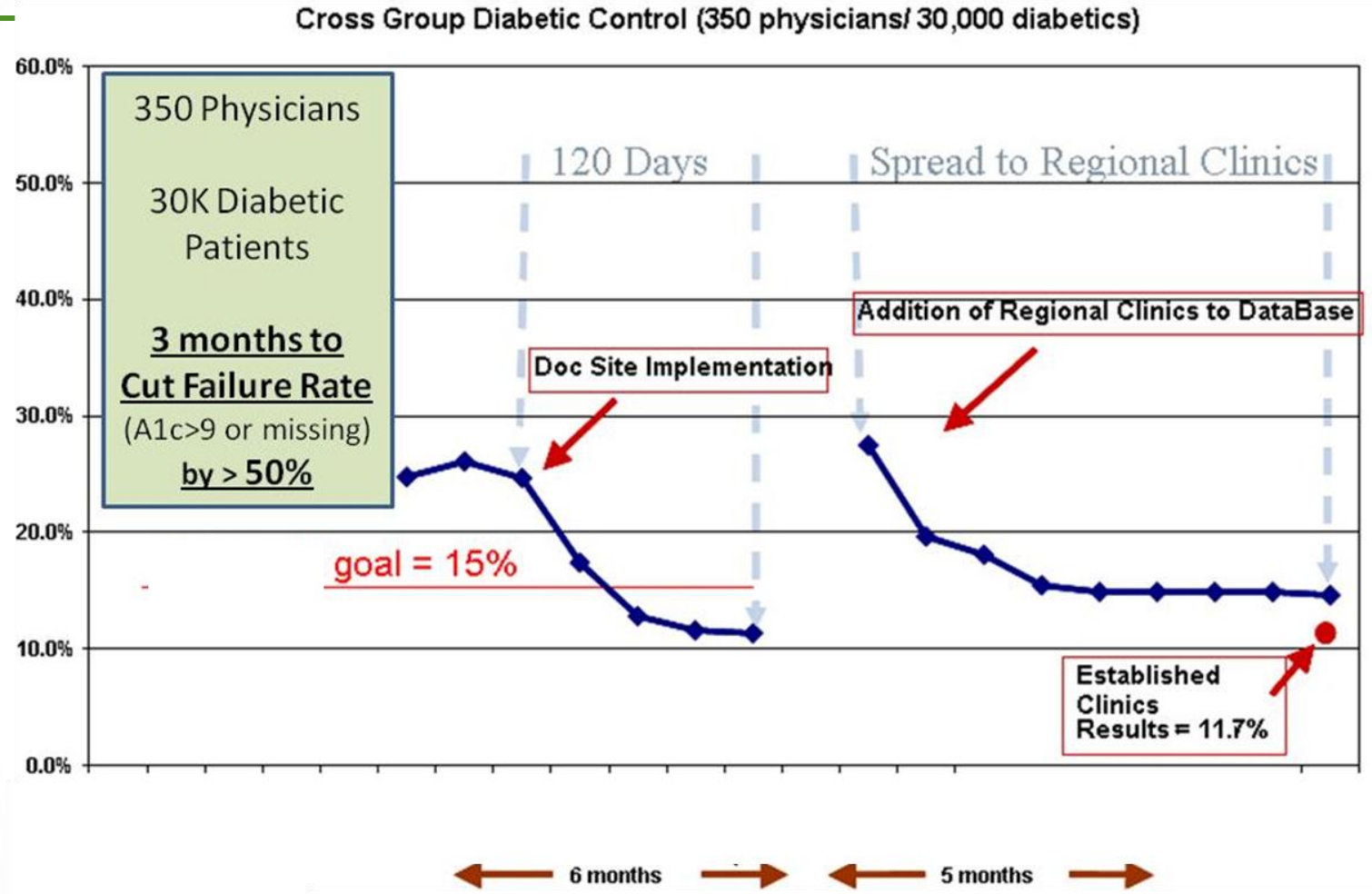
Based on information from DocSite and from PHS's ongoing analysis of claims data, nurse care coordinators make phone calls to members who have not had tests and procedures recommended for diabetes care. During these calls, nurses identify members' needs, help them overcome barriers to following physicians' treatment plans (e.g., lack of transportation, inability to afford medications), and provide coaching to help them live healthy lifestyles.

Providing Extensive Help to Meet Multiple Needs

Individuals with multiple chronic conditions and/or those facing major barriers to effective care (e.g., members with no

The Goal is Quality Improvement: Improve Care in 3-6 months

Admission rates 26% less for Medicare diabetic patients with team-based care



Thank You

Jamie Ferguson,

Vice President of Health Information Technology Strategy and Policy, Kaiser Permanente

Bridging The Gap

Linking Payors And Providers With Health Information Exchange

Jamie Ferguson
Fellow, Institute For Health Policy
VP HIT Strategy & Policy, Kaiser Permanente

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Bridging The Gap: Discussion Agenda

- Choices and Issues In Health Information Exchange
- Kaiser Permanente HIE Experience And Lessons Learned
- The Next Steps

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Where Is Health Information Exchange Going?

"If you don't know where you are going, any road will take you there."

— Lewis Carroll

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Key HIE Mechanisms Used For Treatment Today

It is not the technology, it is integration of computable data that matters

PHR, Web, & Blue Button

- Variety of standards and mechanisms employed
- Unstructured free text
- Limited content/vocab standards

Direct Project eMail

- MIME, s/MIME, SMTP
- Unstructured or structured free text; IHE XDM optional
- Limited or no content/vocab standards

Vendor Proprietary

- Variety of models
- Vendor-specific content specs tied to vendor EHR data model
- No vocab standards

NwHIN Exchange

- IHE XCA, SOAP
- HL7 CDAr2 data content specifications
- SNOMED and LOINC vocab same as MU reporting

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Considerations For Alternative HIE Choices

HIE methods useful for treatment, and payment, and other purposes

Simple Point to Point Push, e.g. Direct	Centralized Data Repositories	Inter-Enterprise Exchange, e.g. NwHIN
▪ Low cost and easy to get started	▪ Massive security breach target	▪ Addresses the widest variety of use cases
▪ Potentially less secure	▪ Data normalization becomes financially unsustainable	▪ National content standards for computable data
▪ Unable to automate fully	▪ Data aggregation may be exploited for commercial gain	▪ Local autonomy
▪ Hard to integrate the whole care team	▪ Conflicts of interest are unavoidable	▪ High security with provenance and non-repudiation of origin
▪ Impossible to query for relevant data		

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Additional Considerations For Future HIE

Today's choices must look to the future of integrated, personalized care

- Genomics
  - Sequencing technology and genomic data are advancing rapidly
  - Each genomic signature is the most unique identifier for each individual
  - Over 500 actionable genetic SNPs influence treatment in oncology therapy (1)
  - Over 70,000 SNPs known to affect disease development, course, response to therapy (1)

- Trust
  - HIE depends on sustained public trust
  - Security and confidentiality can be best addressed by those who have a direct care relationship with the patient

(1) Where's the Signal Amidst the Noise?, John E. Mattison, *The Future of Healthcare (Conference Papers),* Corporate Research Group, August 2011

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Kaiser Permanente Experience In HIE

Kaiser Permanente Operational HIE Experience

Extending data integration across organizations and jurisdictions

- Nationwide Health Information Network (NwHIN):
  Virtual Lifetime Electronic Record (VLER) with KP, VA and DoD
  - Sharing HL7 Continuity of Care Documents in real time during patient care visits
- Microsoft Health Vault Pilot Project with KP's My Health Manager
  - PHR transfer of longitudinal summary records at member's request
- Colorado Health Information Exchanges (CORHIO and Epic Network)
  - Transferring medical records among providers for clinical care coordination
- NwHIN Expansion Is In The Process Of Operational Implementation
  - Social Security Administration: medical records sharing for disability claims
  - State level HIE organizations: multiple state level integration implementations
  - Special focus on safety net providers, disadvantaged communities/populations

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NwHIN Exchange Lessons Learned

Results in patient care operations since September 2009

- HHS data specifications (HL7 CDA and CCD C32) were much easier to implement than expected
- Standard clinical information specifications and data integrity are critical to patient safety
- Unique patient identification is the biggest unsolved issue today
- Operational processes and requirements for patient authorization and consent vary by jurisdiction and applicable law; these processes need to be streamlined and automated

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Next Steps

The Next Step In HIE: The Care Connectivity Consortium

- Announced April 6, 2011: Mayo Clinic, Geisinger Health System, Intermountain Healthcare, Kaiser Permanente, and Group Health Cooperative Plan to Securely Share Patient-Specific Data Through Care Connectivity Consortium
  - The goal of the consortium is to demonstrate better and safer care with better data availability
  - Committed to sharing complete medical record data for treatment purposes, starting with critical continuity of care data elements and expanding the data set over time
  - Using national standards, the same as NwHIN Exchange
- Status: On-track, working towards operational implementation
  - Future: expansion to additional participants for data exchange
  - Future: consideration of additional use cases

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The Path Ahead: Discussion Points

- Provider HIE using computable clinical data; SSA is using these for disability claims
- Payors with an interest in automation can embrace the same methods
- Safety, quality and efficiency are reasons to exchange computable data; the genomic data explosion makes computability and data quality just as important as security and trust for future data sharing

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Sam Ho, MD

Executive Vice President and Chief Medical Officer, UnitedHealthcare

Bridging the Gap Between Providers and Payers

August 29, 2011

Sam Ho, M.D.
EVP, Chief Medical Officer

UnitedHealth Group Business Model

UnitedHealthcare

Health Benefits

- UnitedHealthcare EMPLOYER & INDIVIDUAL
- UnitedHealthcare MEDICARE & RETIREMENT
- UnitedHealthcare COMMUNITY & STATE
- UnitedHealthcare MILITARY & VETERANS

Data
Services
Analytics

Health Services

- OPTUMInsight™
- OPTUMHealth™
- OPTUMRx™

Foundational Competencies

Expertise in clinical care management and access

Advanced, enabling technology

Health data — actionable health intelligence

Bridging the Gap: Immediate Goals

UnitedHealthcare

HIE sustainability and mutual value:

- Administrative Simplification and Lower Operating Costs
  - Eligibility status
  - Claims submission and adjudication
  - Remittance advice (RA)
- Clinical Information → Improved Quality and Cost Outcomes
  - Enabling appropriate utilization—e.g., labs, x-rays, Rx
  - Care coordination—e.g., transitional care, admission/readmission mgmt
  - Medical management to assess cost-effective services
  - Managing HEDIS gaps in care and chart reviews
- Virtual integration of delivery system—improved patient care
- Delivery system Quality Improvement for performance assessments, value-based payment, narrow/tiered networks, PCMH or ACOs

Early Stage Examples

- Sharing ED utilization w/ PCP by mining plan data, not HIE.
  - Enhance physician-facility relations
  - Create opportunities for patient coaching and engagement
  - Improve care coordination
  - Reduction in ED over-use and mis-use and inpatient admissions
- HEDIS gap closure and improvement
  - UHC's physician portal, which displays physician-specific gaps in care, by patient, by condition, by clinical service
  - On-line, secure environment, near real-time, illustrates the promise of HIE

Bridging the Gap : Long Term Goals

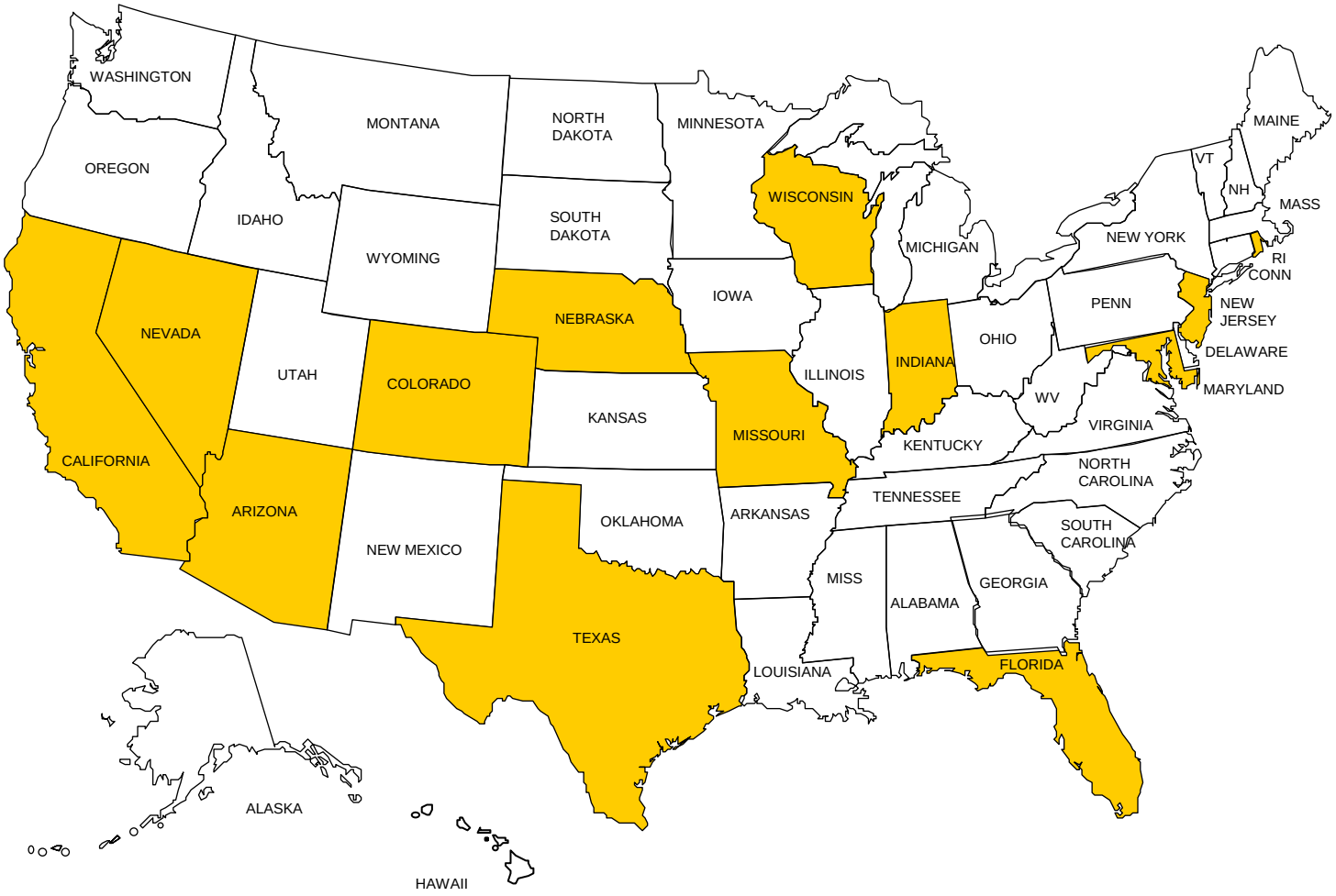
UnitedHealthcare

Long term Providers' and Plans' common ground is

- Smart HIEs that identify
  - Real time notifications to payers and PCPs of a patient's ED visit or IP admission
  - Opportunities for appropriate utilization, sites of service
  - Timely access to patient's medical, lab, xray, Rx history – improve quality, safety, and reduce cost
  - HEDIS gaps in care for timely intervention
  - Care coordination for transitional care and disease management
- Smart HIEs as the foundation
  - For transparency of quality and cost measures
  - For health care delivery system innovation – PCMHs and ACOs
  - For provider payment reform – value-based payments, bundled payment, risk-sharing, capitation

Bridging the Gap: States where UHG Market Executives are currently involved in HIE Planning

UnitedHealthcare



UnitedHealthcare®

Questions?

Panel Discussion

Thank You to Our Speakers

- John Haughton, MD, Chief Medical Information Officer, Covisint
- Jamie Ferguson, Vice President of Health Information Technology Strategy and Policy, Kaiser Permanente
- Sam Ho, MD, Executive Vice President and Chief Medical Officer, UnitedHealthcare

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Take Advantage of eHI Events and Resources

- Northwest Medical Informatics Symposium
  - September 19-20, 2011
  - Davenport Hotel in Spokane, WA
  - www.nmis.info

Contact Information

- **Contact for eHI Membership:**
  - Amy Eckenroth, 202.624.3265, amy.eckenroth@ehealthinitiative.org

- **General Feedback or Questions about eHI:**
  - Ehl.info@ehealthinitiative.org

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