10 Years
eHEALTH INITIATIVE
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Utilizing Existing Data Exchanges to Create ACOs

Dial-in information:
1.800.747.0367

September 14, 2011

About eHealth Initiative (eHI)

- Since 2001, only national, non-partisan group that represents all the stakeholders in health care.
- Mission to promote use of information and technology in healthcare to improve quality, safety and efficiency.
- Focused on education and advocacy.
- Coalition of over 200 organizations is one of most influential groups in data issues, HIT and HIE.
- eHI is the only group tracking the progress of over 260 regional, state and local initiatives working on health information exchange for 8 years.

What Does eHI Do?

- Work with our members to influence policy
- Convene multi-stakeholders to build consensus
- Members contribute through virtual forums:
  - Meaningful Use and Health Reform Policy
  - Connecting Communities through Health Information Exchange
  - HIT Infrastructure for Accountable Care
  - Using Health IT to Coordinate Care
  - Data Analytics and Research
- Inform and mobilize reports, weekly newsletters, educational events and policy alerts.

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
- The webinar is being recorded.
  - Members can access slides and replays of any webinar for free from eHI's store
  - Non-members can purchase access to any webinar replay for $25.00
  - eHI Store
    - http://www.ehealthinitiative.org/store.html

Thank You to Our Sponsor

Overview of Our Agenda

- **Introduction and Welcome (3:00 – 3:10 PM)**
  - Jennifer Covich Bordenick, CEO, eHealth Initiative
- **Beacon Community Program Update (3:10 – 3:25 PM)**
  - Craig Brammer, Deputy Director, Beacon Community Program at the Office of the National Coordinator for Health IT (ONC)
- **Brookings – Dartmouth ACO Pilot & Data Strategy (3:25 – 3:40 PM)**
  - Kenneth C. Wilson, MD, MS, CPE, System Vice President, Clinical Effectiveness & Quality, Norton Healthcare
- **Dual Benefits of Community and Safety-Net Participation in ACOs (3:40 – 3:55 PM)**
  - Katherine Taylor, Solution Architect, Covisint
- **Panel Discussion (3:55 – 4:25 PM)**
- **Closing (4:25 – 4:30 PM)**
  - Jennifer Covich Bordenick, CEO, eHealth Initiative

Craig Brammer,

Deputy Director,

Beacon Community Program at the Office of the National Coordinator for Health IT (ONC)

Connecting America for Better Health

Beacon Community Program Update

September 14, 2011

Program Aims

1. Build and strengthen
2. Improve
3. Innovate

What Are They Doing?

Transitions of Care

- Information flow; hospital discharge process improvement and standardization; transitions coordinators (work with patients on medication reconciliation and self-care plans through transitions); includes PCPs, hospitals, specialty practices, and long-term care settings

Care Management

- Trained individuals using standardized protocols for identifying and managing high risk patients and others needing follow-up and services, and working with patients and PCPs in creating self-care plans, including medication management.

Computerized Clinical Decision Support

- Embedded within EHR and/or HIE systems and Utilized by multiple members of the care team (e.g. physicians, care managers, etc.)

Physician Data Reporting & Performance Feedback

- QI reports informing providers of actionable items to maintain the highest standard of care in their patient population (e.g., guidelines and/or specific cost, quality, population health measure outcomes and/or analytics)

Public Health Registry-Based Management

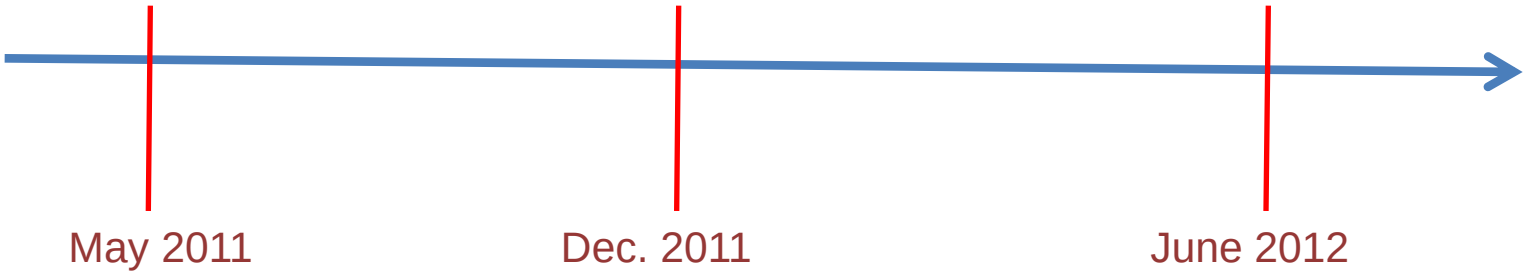
- Registries could target preventative services and could be disease-based; often in partnership with public health departments

Others (e.g., PHRs, telemedicine, telehealth)

Summary of "Core" Interventions in 2011

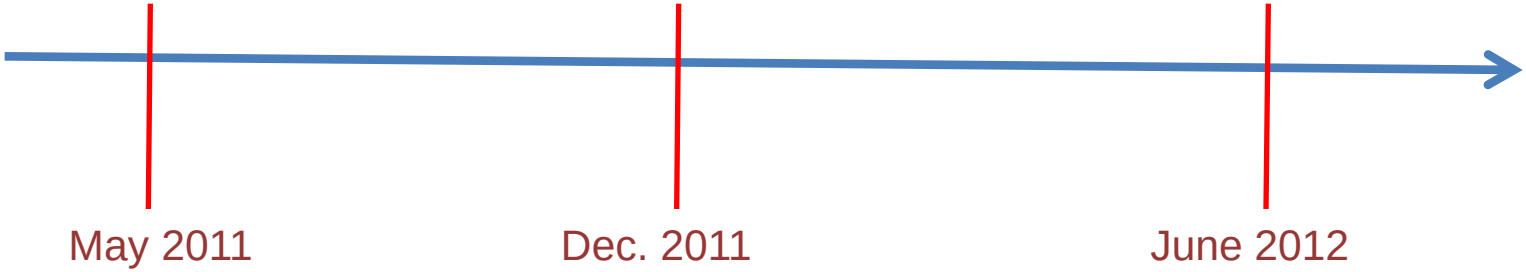
Intervention	# of BCs	~# of patients "touched" in 2011	~# of providers "touched" in 2011
Transitions of Care	12	250,000	~50 settings (including hospitals, SNFs, etc.)*
Care Management/PCMH	13	300,000	2,500
Computerized Clinical Decision Support	13	350,000	1,800
Physician Data Reporting and Performance Feedback	12	550,000	1,900*
Public Health Registry-Based Management	11	200,000	700*

"Show Us The Path"



"Show Us The Path"

"So far, our Beacon care managers have 'touched' 1,800 chronic disease patients deemed to be 'high risk.' We identified 500 care gaps, including 30 serious medication errors. We will continue to track this and by the winter will be able to say with more confidence how many readmissions we think we have avoided in the first cohort." (Keystone Beacon)



Results

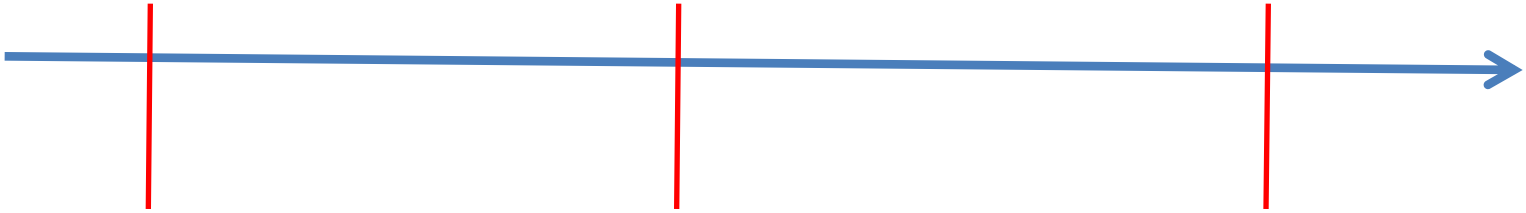
Some communities with small-N results with right "sign", mostly anecdotal.

Implementation

"Here is what we are trying to accomplish and how we're trying to accomplish it."

"Show Us The Path"

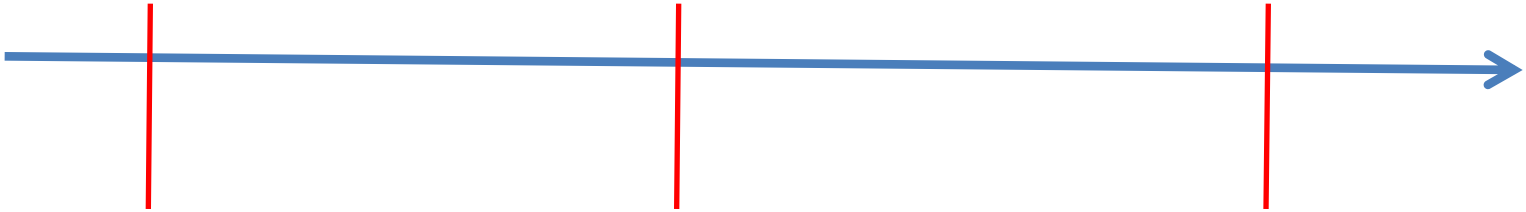
"By December 2011, we will have 15% (202) of our target (new) docs (1440) using our Doc-2-Doc specialty referral system. We will be able to report counts of communications between referrals and report outcome measures for these interactions. This will get local stakeholders' attention because it will suggest important cost impacts." (Tulsa)



	May 2011	Dec. 2011	June 2012
Results	Some communities with small-N results with right "sign", mostly anecdotal/stories.	All communities with very early, tentative results from first 2 cohorts. Weak statistical power and small N.	
Implementation	"Here is what we are trying to accomplish and how we're trying to accomplish it."	"We are still new at this but here are some concrete learnings so far."	

"Show Us The Path"

"By April 2012, 7,000 asthmatic children will have received documented asthma action plans from providers, obtained consent and registered across all 47 school districts in our community; achieving 25% population target. This number will grow to 18,000 by April 2013." (Southeast Minnesota)



	May 2011	Dec. 2011	June 2012
Results	Some communities with small-N results with right "sign", mostly anecdotal/stories.	All communities with very early, tentative results from first 2 cohorts. Weak statistical power and small N.	All communities with early, tentative results from waves 1-3 with growing statistical confidence, larger N's, and deeper impacts.
Implementation	"Here is what we are trying to accomplish and how we're trying to accomplish it."	"We are still new at this but here are some concrete learnings so far."	"Here is how we are refining our work to reflect our early learning."

Examples: Consumer eHealth in the Beacons

Remote Patient Monitoring	• Indianapolis has set up a RN call center and is aiming to reduce readmissions for 1,500 – 3,000 high-risk CHF & COPD patients through the use of Intel's Health Guide • Buffalo is wiring the home of 100 multi-CC patients with a number of remote monitoring devices (CardioCom, Bluetooth Scale, Health Buddy) and aiming to reduce readmissions
PHRs/ Patient Portals	• 5+ Beacons will have patient portals and PHR functionality operational by the end of the year; will have more than 10,000 patients signed up • For instance, Keystone is implementing PHR that uses aggregate HIE data from all providers, allows patients to input notes that become part of their clinical record, and includes 2-way messaging services with care managers.
mHealth	• NOLA, Detroit, Cincinnati, and NC are considering mHealth as a public engagement "campaign" (see below) • San Diego is using a mHealth application to improve accuracy/use of an immunization registry (N=2000) • North Carolina is piloting Asthmapolis with five providers, and harnessing its population level data for use by their care managers
Patient engagement (and mHealth)	• We are interacting with ADA and CDC to launch an mHealth-enabled patient activation campaign targeted to at-risk diabetic individuals, which will cut across multiple Beacons and connect with local resources (includes Voxiva, Secretary's Text4Health Taskforce, and 2-4 Beacons)
Patient-reported outcomes	• Several Beacons (e.g., Mayo, Geisinger, perhaps CO) are testing the uses of PRO measures embedded in EHRs to inform MU2/3

Technical Assistance – Priorities by Domain

	In 2011 the primary objective of the domain will be to:	*Affinity Group/Meeting Topics include:*
Clinical Transformation	•Support successful implementation of clinical interventions •Enhance QI skills	• Care Transitions and Practice Transformation • Skills training for managers/staff • Improvement coaching for leaders
HIT/MU	• Identify and resolve technology obstacles in achieving clinical transformation and meaningful use	• Cross ONC collaboration to support adoption and sustainability of technology • HIT/Clinical transformation alignment • Interoperability with S&I Framework
Measurement	• Build and strengthen performance measurement infrastructure	• Strategic and implementation planning • Utilization measurement development • Data to drive performance feedback/QI
Leadership and Stewardship	• Ensure strategic alignment with local and national stakeholders and priorities • Support common operational issues (e.g., governance and communication)	• State/national delivery system reform efforts • Regional governance • Local and national communication • Project Managers/Beacon "advisors"
Sustainability	• Better understand "business models" for services that can enable QI and help communities coalesce around paying for these services	• Sustainable business planning: modeling ROI, pricing, achieving scale • Planning for health reform and the new accountable environment

What are we learning?

It's early but…

Clearly defined populations

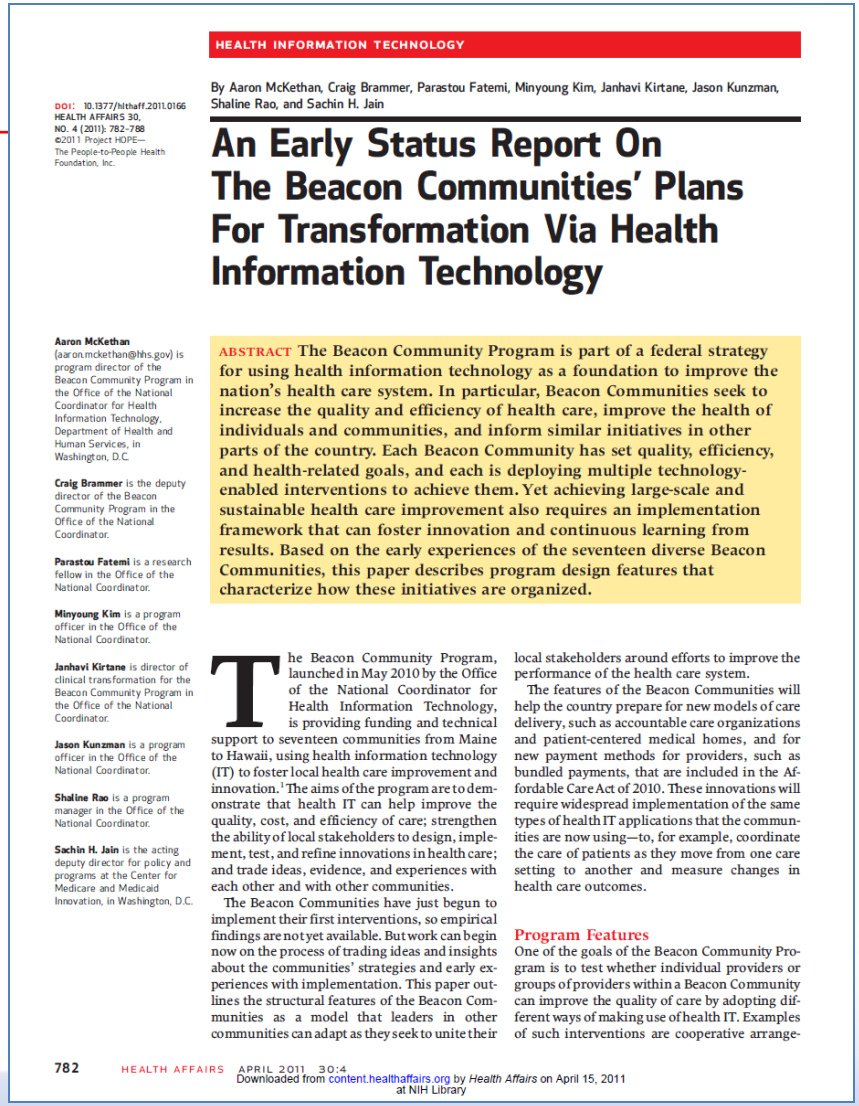
Strong leadership & governance

Specific health care objectives

Performance measures and feedback systems

Evidence-based interventions

Strategies to learn from interventions



HEALTH INFORMATION TECHNOLOGY

DOI: 10.1377/hlthaff.2011.0166
HEALTH AFFAIRS 30,
NO. 4 (2011): 782–788

By Aaron McKethan, Craig Brammer, Parastou Fatemi, Minyoung Kim, Janhavi Kirtane, Jason Kunzman, Shaline Rao, and Sachin H. Jain

An Early Status Report On The Beacon Communities' Plans For Transformation Via Health Information Technology

Aaron McKethan (aaron.mckethan@hhs.gov) is program director of the Beacon Community Program in the Office of the National Coordinator for Health Information Technology, Department of Health and Human Services, in Washington, D.C.

Craig Brammer is the deputy director of the Beacon Community Program in the Office of the National Coordinator.

Parastou Fatemi is a research fellow in the Office of the National Coordinator.

Minyoung Kim is a program officer in the Office of the National Coordinator.

Janhavi Kirtane is director of clinical transformation for the Beacon Community Program in the Office of the National Coordinator.

Jason Kunzman is a program officer in the Office of the National Coordinator.

Shaline Rao is a program manager in the Office of the National Coordinator.

Sachin H. Jain is the acting deputy director for policy and programs at the Center for Medicare and Medicaid Innovation, in Washington, D.C.

ABSTRACT The Beacon Community Program is part of a federal strategy for using health information technology as a foundation to improve the nation's health care system. In particular, Beacon Communities seek to increase the quality and efficiency of health care, improve the health of individuals and communities, and inform similar initiatives in other parts of the country. Each Beacon Community has set quality, efficiency, and health-related goals, and each is deploying multiple technology-enabled interventions to achieve them. Yet achieving large-scale and sustainable health care improvement also requires an implementation framework that can foster innovation and continuous learning from results. Based on the early experiences of the seventeen diverse Beacon Communities, this paper describes program design features that characterize how these initiatives are organized.

The Beacon Community Program, launched in May 2010 by the Office of the National Coordinator for Health Information Technology, is providing funding and technical support to seventeen communities from Maine to Hawaii, using health information technology (IT) to foster local health care improvement and innovation.[1] The aims of the program are to demonstrate that health IT can help improve the quality, cost, and efficiency of care; strengthen the ability of local stakeholders to design, implement, test, and refine innovations in health care; and trade ideas, evidence, and experiences with each other and with other communities.

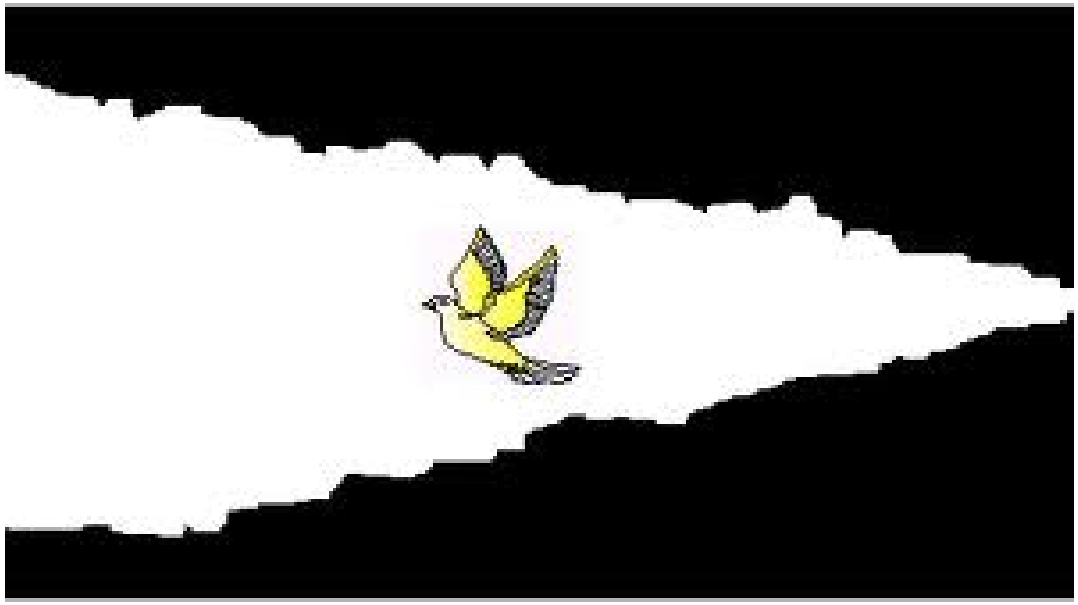
The Beacon Communities have just begun to implement their first interventions, so empirical findings are not yet available. But work can begin now on the process of trading ideas and insights about the communities' strategies and early experiences with implementation. This paper outlines the structural features of the Beacon Communities as a model that leaders in other communities can adapt as they seek to unite their local stakeholders around efforts to improve the performance of the health care system.

The features of the Beacon Communities will help the country prepare for new models of care delivery, such as accountable care organizations and patient-centered medical homes, and for new payment methods for providers, such as bundled payments, that are included in the Affordable Care Act of 2010. These innovations will require widespread implementation of the same types of health IT applications that the communities are now using—to, for example, coordinate the care of patients as they move from one care setting to another and measure changes in health care outcomes.

Program Features

One of the goals of the Beacon Community Program is to test whether individual providers or groups of providers within a Beacon Community can improve the quality of care by adopting different ways of making use of health IT. Examples of such interventions are cooperative arrange-

Beacon as Canaries



- Performance measurement
- Vendors/interfaces
- Role of community (CMS visit)

"Task 13" Medicare measures
Providing insight into progress

- Data Analysis Task was added/executed March, 2011
- Subcontractors include Buccaneer and Brandeis University
- Task Goals
  - Test the degree to which community-derived approaches contribute to improvements in quality and efficiency – impacts
  - Implement a framework that will permit time-sensitive (quarterly) and reliable inferences regarding performance; inform mid-course adjustments to the respective program activities – formative feedback
  - Used in concert with other Community activities to drive improvement and monitoring

"Task 13" Medicare measures

DIABETES	RESPIRATORY
Hemoglobin A1c (HbA1c) Testing	COPD Admission Rate *(AHRQ – PQI)*
LDL-Cholesterol Screening	UTILIZATION
Dilated Eye Exam in Diabetic Patients	Cost of Care (Descriptive Measures)
Short-term Complications Admission Rate *(AHRQ – PQI)*	Plan All-Cause Readmissions (HEDIS 2011)
Long-term Complications Admission Rate *(AHRQ – PQI)*	30-Day Post-Hospital HF Discharge Care Transition Composite Measure
Uncontrolled Diabetes Admission Rate *(AHRQ – PQI)*	30-Day Post-Hospital AMI Discharge Care Transition Composite Measure
Rate of Lower-Extremity Amputation *(AHRQ – PQI)*	Prevention Quality Indictors (AHRQ)
PREVENTIVE CARE	Ambulatory Care: Summary of Utilization of Ambulatory Care in Outpatient Visits and ED Visits (HEDIS 2011)
Breast Cancer Screening	
Colorectal Cancer Screening	Cost of care for chronic disease episodes
HEART HEALTH	
CHF Admission Rate *(AHRQ – PQI)*	Notes: 1) First "community-level" reports issued in July; first provider-level reports issued in Sept/Oct 2) No Pt D data (which therefore excludes good measures: filled Rx for lipid-lowering drugs, beta blocker post MI, aspirin use)
Hospital 30-Day Heart Failure Readmission	
CAD: Angina Without Procedure Hospital Admission Rate *(AHRQ – PQI)*	
Hospital 30-Day AMI Readmission	
Lipid Profile	

Kenneth C. Wilson, MD, MS, CPE,

System Vice President, Clinical Effectiveness & Quality,

Norton Healthcare

Brookings – Dartmouth ACO Pilot & Data Strategy

Kenneth C. Wilson MD, MS System Vice President for Clinical Effectiveness and Quality

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15 Out-patient Centers

1.5 Million yearly patient encounters
$1.5 Billion yearly revenue
11,000 Employees
500 Employed Providers
2,000 Physician Medical Staff
1,857 Licensed Beds
60,000 Admissions/year

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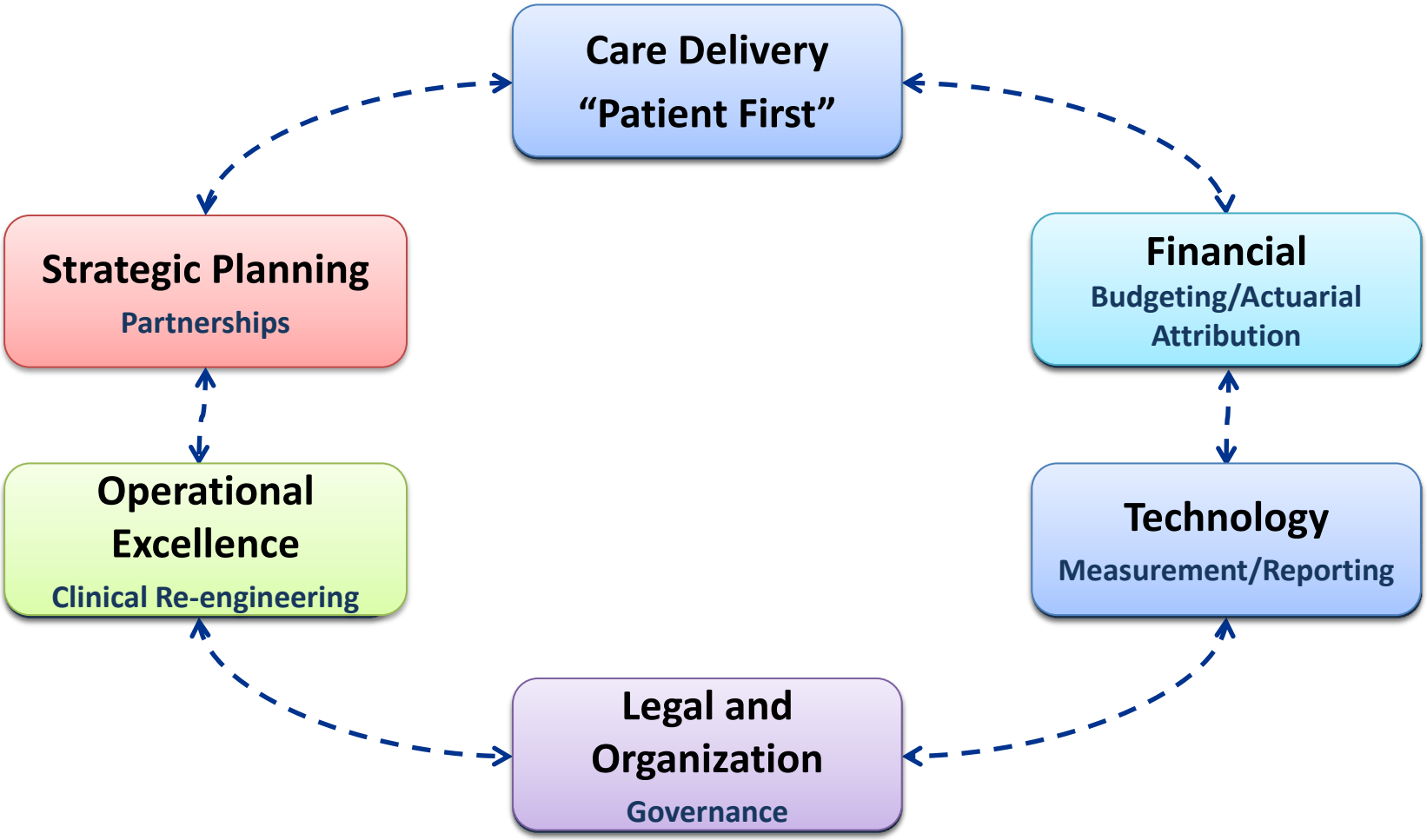
Journey for Accountable Care

- Initiated as part of Brookings – Dartmouth Commercial Pilot
- Initial managed care partner Humana
- Future plans for other manage care providers as model develops.
- Patient population – 1.24 million in community
- Current included groups: NHC employees/Humana employees – 10,000
  - Other groups in process
- Approximately 300 physicians included
  - Primary Care and Specialists
- Consideration to expand into other reimbursement partnerships

Operational and Strategic Disciplines of Accountable Care



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Attribution Considerations

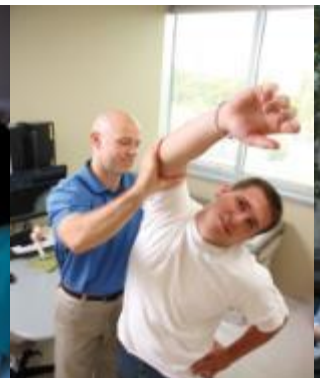
- Attribution
  - Use of Dartmouth-Brookings model
  - Prospective attribution
  - Priorities: PCP E/M visit, Specialist E/M

- Questions remaining
  - How to deal with patients moving in or out of area
  - How to account for mortality
  - Dealing with individuals that do not receive care in index time period

Clinical Re-Engineering

- Improved care coordination and communication
- Improved access – physician extenders – email – phone call etc.
- Prevention and early diagnosis
- ED and Immediate Care Center visits
- Increase generic medication utilization
- Hospital re-admissions and multiple ED visits
- Improved management of complex patients
  - Care Coordination
  - High Resource Utilizers




Performance Measurement

- Quality “Reassurance” – Financial savings not at expense of patient care
- Provides Standardized and actionable information on quality to inform improvement activities by providers
- Nationally replicable and available for use by private payers, Medicare, etc
- Establishes a foundation for public reporting

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Quality, Cost and Performance Strategies

Change the Paradigm from “Quality” to “Value”

- Data is Key to Success
- Significant Infrastructure Needed for Improvement
- Transparency with Public and Physicians
- Integrate Care Management and Quality to Gain Value
- Focus for Success

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Data Population Management

Health Plans and Health Systems bring different strengths

Health Plans

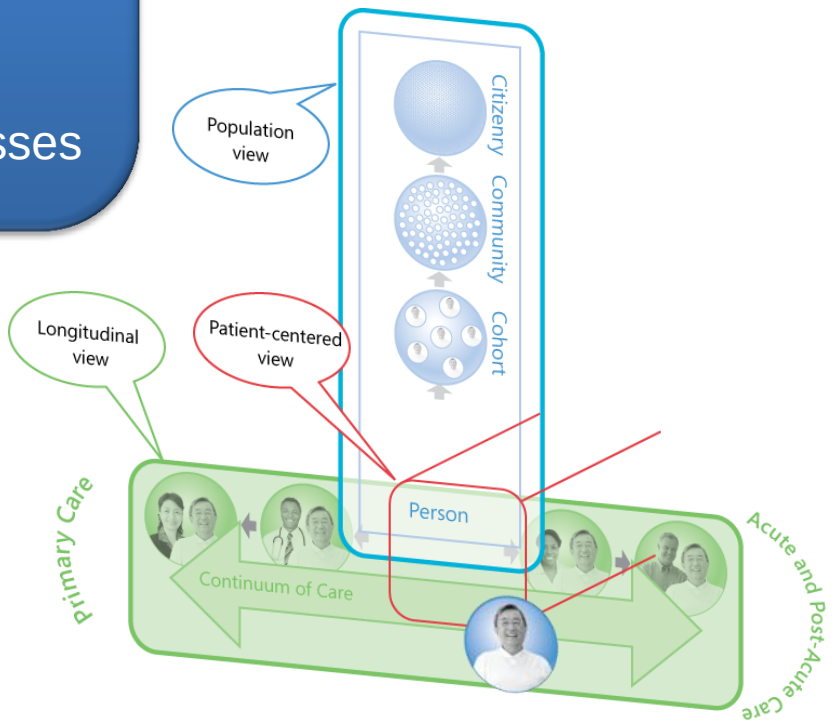
- Longitudinal data
- Specific population
- Access to actuarial analysis for trending forward
- Information on non-ACO expenses
- Claims-based utilization and quality metrics
- Capturing data not seen by ACO

Health Systems

- Clinical data, especially EHR data
- Individual patient data across health plans
- Closer to real-time
- Data from billing systems
- Clinician analysis for re-engineering processes
- Depth of understanding trends within the ACO

Patient Centered Health Outcomes
Data Drives Results

- Timeliness of Data is Key
- Registry Population Management
- Actuarial Analysis
- Claims Based Data
- Patient Health Data Across Health Plans
- Clinical Analysis for Re-Engineering Processes



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Connecting Care Across the Continuum

"Enterprise Data Asset"

- Enterprise Data Aggregation
- Process & Performance Improvement /real-time Quality Management
- Research Platform
- A Platform for Disease and Population Management
- HealthVault integration

"Connecting the Continuum"

www.qualityoflife.org

Health Vault Community Connect

"Consumer Health Platform"

- Employee and Patient Empowerment
- HealthVault Web / Applications
- HealthVault Solutions Ecosystem
- Healthcare Communities

Source Systems

Microsoft Amalga Unified Intelligence System

Amalga Web

Microsoft HealthVault

Health Manager

Powered by Microsoft HealthVault

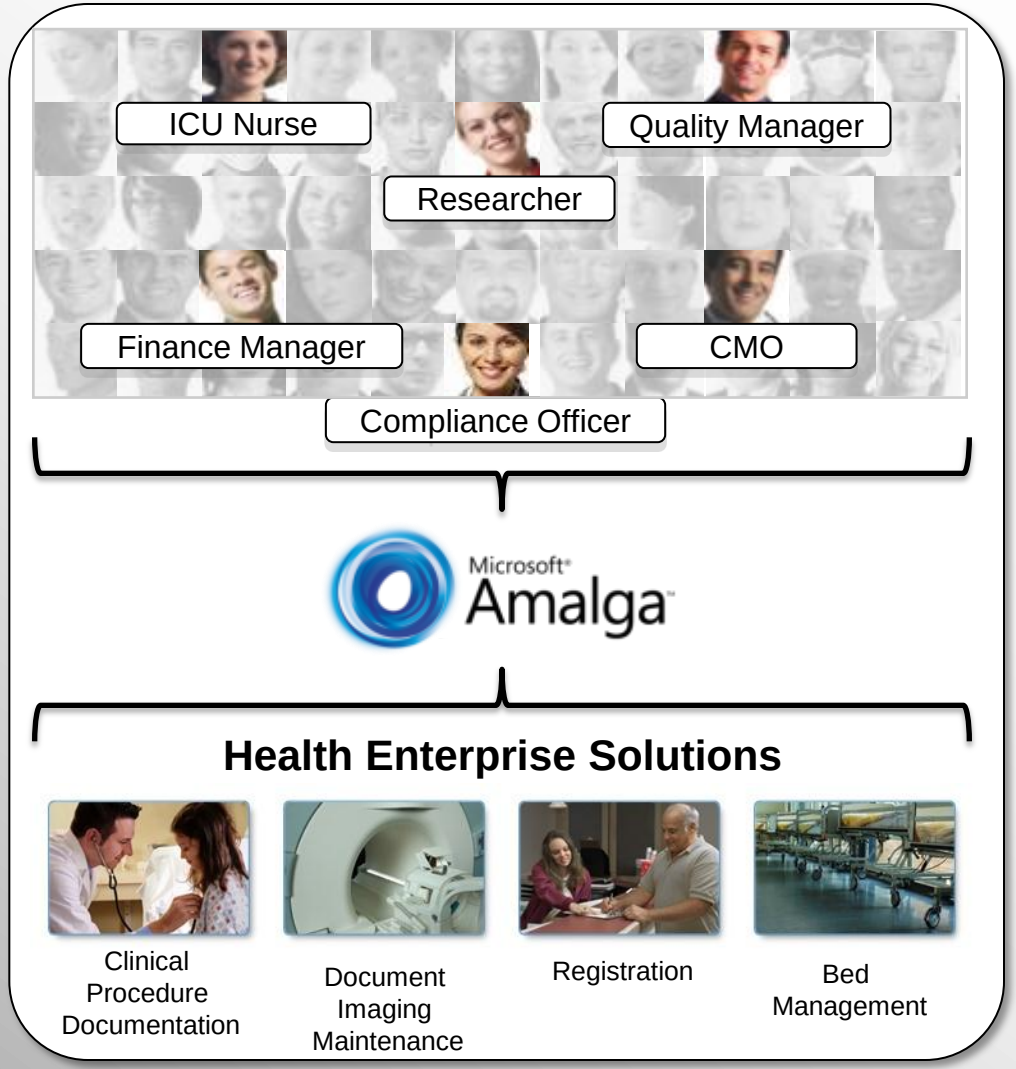
Rich Ecosystem of HealthVault Partners

StayWell Health Management

American Cancer Society

Amalga Unified Intelligence

Your health enterprise data strategy



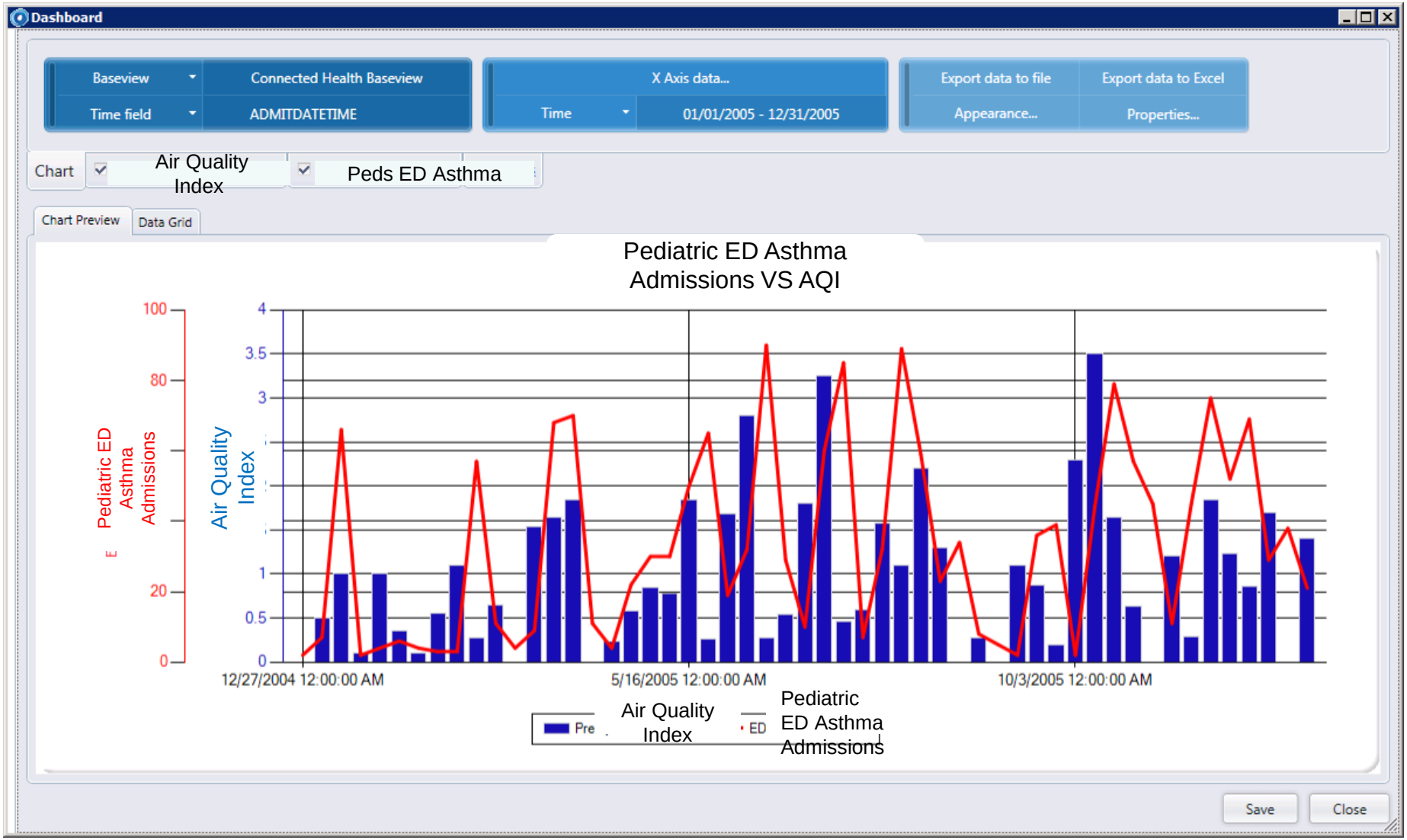
ACO Pilot Partner with Microsoft

Data Input from Outside Sources

Humana
Press - Ganey
Medicare/ Medicaid
Sure Scripts/ Pharmacies

Develop Registries

Norton Neuroscience Institute
Norton Cancer Institute
Orthopedics
Vascular Surgery
Cardiology
Endocrinology
Infectious Disease



Questions?

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Katherine Taylor,

Solution Architect,

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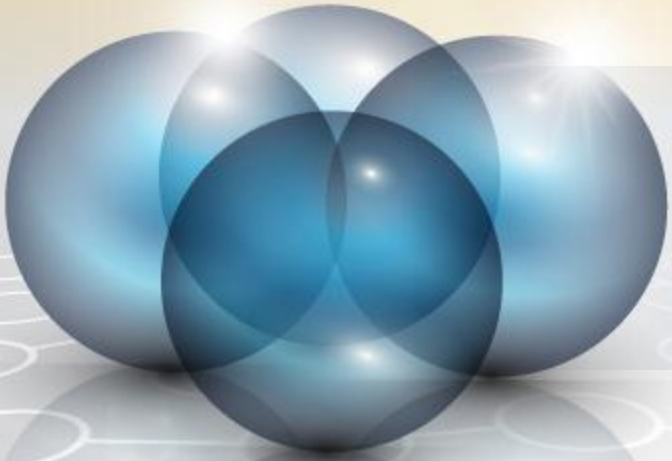


Dual Benefits of Community and Safety-Net Participation in ACOs: Providing Quality and Financial Incentives for the Community At-Large

Covisint for Communities

Objective

This presentation provides the audience alternatives to achieve continuity of care for the entire community while simultaneously reducing costs and adding quality and financial incentives by utilizing legacy HIEs as the foundation for ACO models.

Objective cont'd

- *How do FQHCs and other safety net providers fit into the Accountable Care Organization (ACO)?*
- *What role would a Community Health Center effectively play in such a collaborative?*
- *What benefits does the stereotypical ACO participant receive when engaging with FQHCs in their local area?*
- *How does the existing Health Information Exchange integrate with the Accountable Care Organization?*

Introduction

- According to the Affordable Care Act, CMS must have established a shared savings program to promote accountability for patient populations through high quality and efficient service delivery by January 2012.
- In an effort to create truly effective community partnerships for successful accountable care organizations, collaboration amongst ACOs and federally-qualified health centers (FQHCs) and other safety net providers must occur.
- Even the smallest community health centers possess powerful leverage in negotiations with even the largest inpatient provider organizations to develop accountable, shared-savings collaboratives.
- This presentation provides the audience examples and means to provide continuity of care for the entire community while reducing costs and adding quality and financial incentives for all ACO participants.

http://www.healthcare.gov/news/factsheets/accountablecare03312011a.html

HIE/ ACO Patient/ Provider Service Integration Goals

- Assist other entities in viewing FQHCs and safety net providers as community assets and business partners
- Engage ACO partners with existing systems to create mutually beneficial collaborations that increase access and address shared objectives
- Apply FQHC benefits as a ‘utility’ - allowing virtually all health care players in an existing Health Information Exchange (HIE) to realize positive patient outcomes and financial incentives
- Engage in a true Patient-Centered Medical Home initiatives via existing Health Information Exchanges

Safety Net ACOs Provide the Following Benefits:

- ***Private Providers:***
  - Emergency Room Re-Direction (no longer the PCP of choice)
  - Expansion of providers without increasing competition (FQHCs do not compete for Medicare patients)*
  - Increased quality ratings from federal agencies and other organizations
  - Strong foundation for Patient-Centered Medical Home (PCMH)
  - Saves time and money by supporting automated processes via EHR integration
  - Reduction of preventable admissions by coordinating care with disparate provider types in community-based care team coordination

- ***FQHC/ Safety Net Providers***
  - Increased visits via ED Re-Direct and/or uninsured and underinsured populations
  - 2012 Medicare funding subsequently increases center's Medicare population as well capability to add and expand new services
  - Non-Exclusivity to a single ACO
  - Expand or enhance access, capacity, the continuum of care or the quality of care
  - Better integrate health services (dental, behavioral/ mental health, vision, etc.)
  - Increase facility resources (i.e. by adding additional patients, increases in Section 330 grant funding)
  - Better position safety net providers for new or additional funding including Medicaid ACOs, state Medicaid waivers

Scenario: Emergency Room Redirection

- Emergency Rooms are providing care for minor injuries and common ailments like strep throat, the flu and allergies and chronic care management for the Medicaid/ Medicare/ uninsured patient population
- By integrating safety net providers into existing HIEs/ ACO emergency room redirection can be accomplished via the Covisint Performance-Based Care Solution

Scenario: Emergency Room Redirection

- As part of discharge services for Medicaid/uninsured patients, patients who presented to a participating hospital emergency room with a non-emergency primary care needs, will have an appointment set with a safety-net provider in their respective community via the HIE/ACO

- Additionally, the HIE/ ACO also provides such group services as:

  - 1) public education campaigns
  - 2) financial disincentives
  - 3) redirection to primary health care centers and
  - 4) use of alternative clinics.

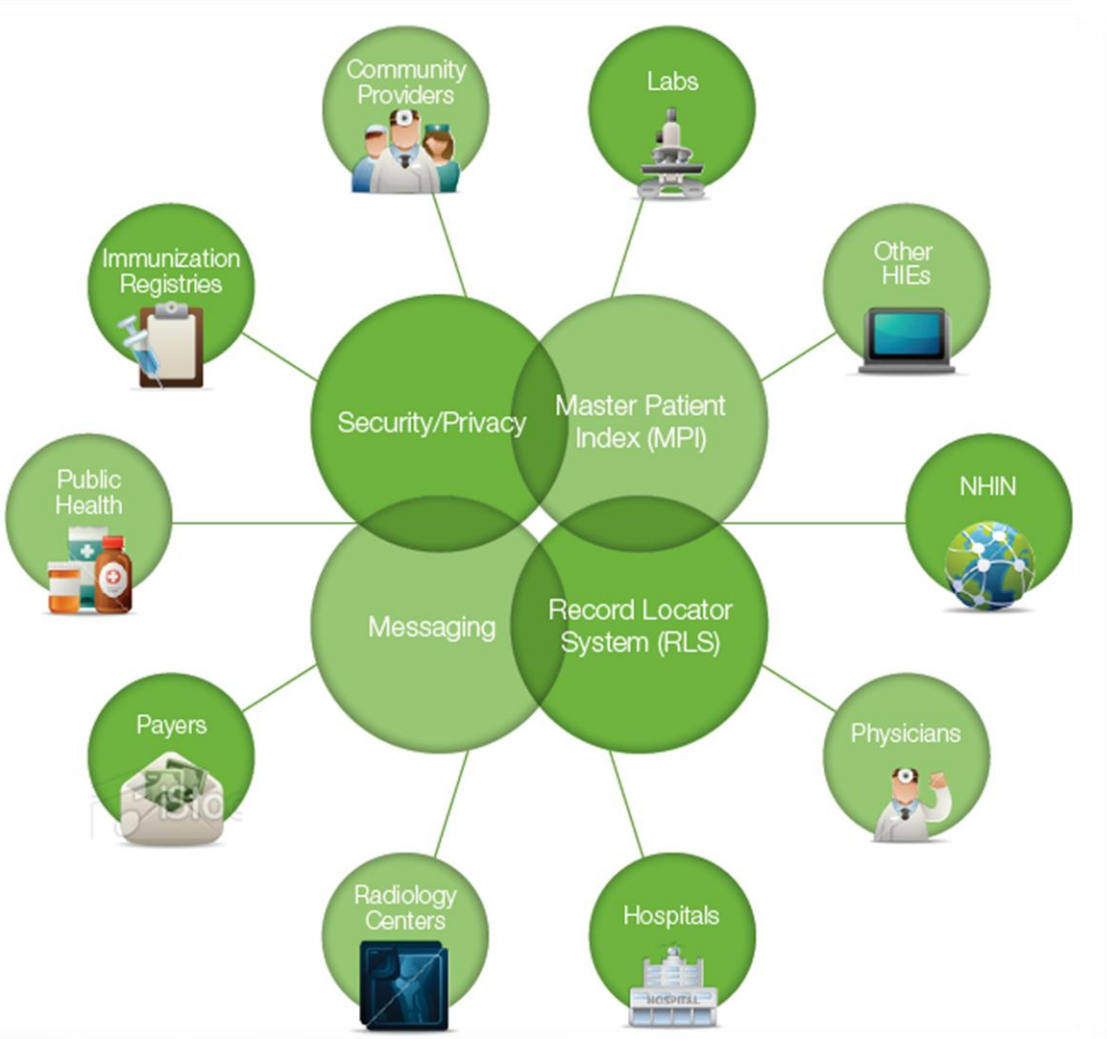
Scenario:
Patient-Centered Medical Home (PCMH) Safety Net Model

- The goal in establishing a patient centered medical home is to be able to provide ACO constituents with all the resources they need to manage their care.
- Through improved coordination and communication with patients we hope to involve them more in their care.
- As the existing HIE services the breadth and depth of the underserved population, the ACO community are uniquely positioned to serve the entire family unit.
- Participants can each receive services and support in a single location, and be able to receive care coordination a single team if they so choose.

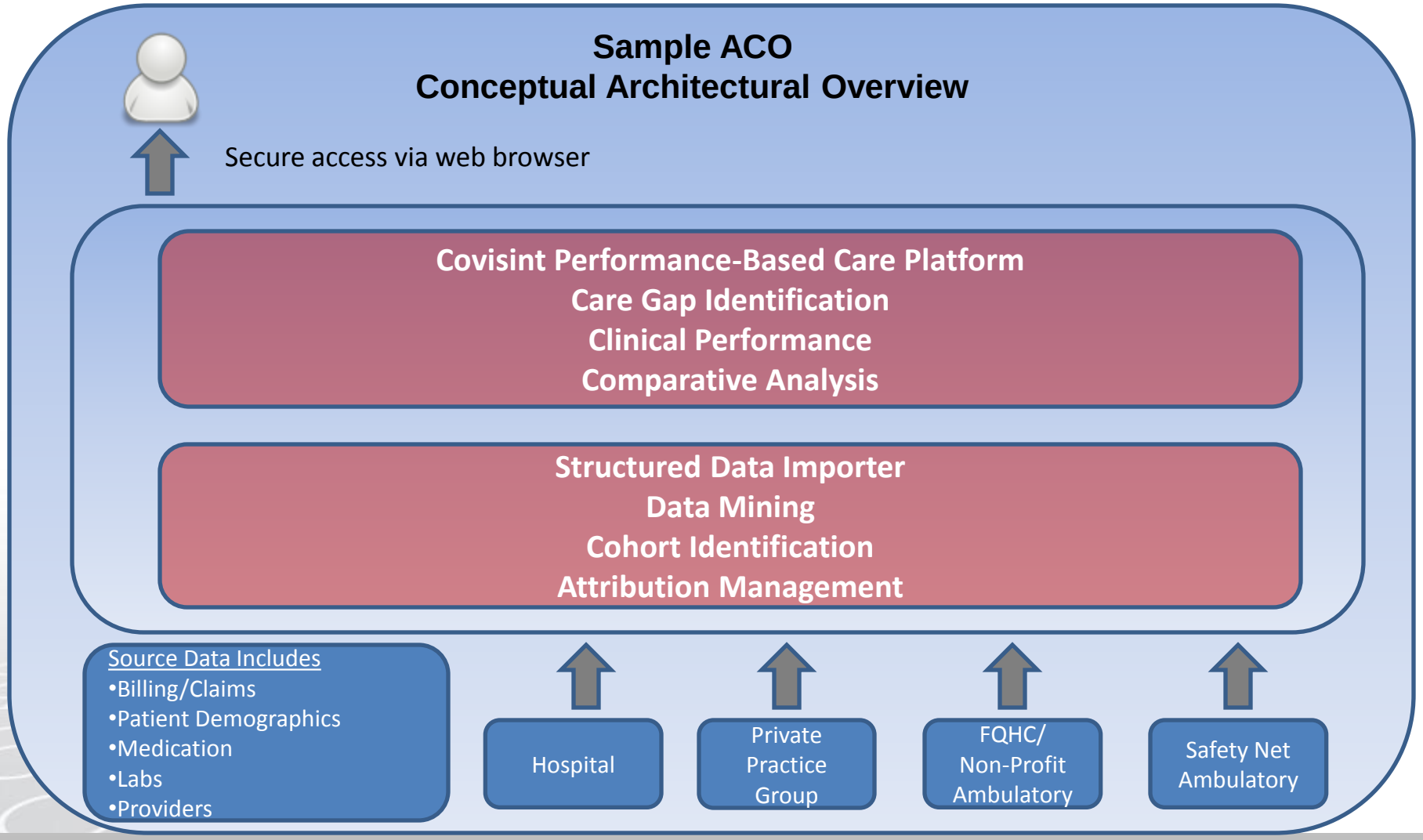
Performance-Based Care for Communities

Driving Care Coordination

Performance-Based Care - Community View



Covisint ACO Technological Architecture



Performance-Based Care – Community Benefits

- Ability to use to use an existing “umbrella exchange” – one compliant with NHIN standards – to create a series of private HIEs (communities) – where the population views and analytics are based on the community, but patients could cross communities for communication / aggregation of patient information.

- Allows a designated HIE (or a Beacon Community) to deploy an infrastructure and then offer the infrastructure to constituents in the community for them to have their own “Private HIE” or Private Health Community – using the same infrastructure.

Performance-Based Care – Community Benefits

- Powered by Covisint's tested, scalable architecture
- Used for millions of identities across government and the private sector, including the identity management used for Onstar
- Additionally, use of the DocSite Clinical Solution provides existing ACOs the standard Covisint 'Gold' Condition Measure Sets (i.e. diabetes, COPD, Heart Failure, etc.)
- Also available are the proposed Quality Performance Standards of:
  - Patient Experience of Care
  - Care Coordination
  - Patient Safety
  - Preventive Health

Thank You

Panel Discussion

Thank You to Our Speakers

- Craig Brammer, Deputy Director, Beacon Community Program at the Office of the National Coordinator for Health IT (ONC)
- Kenneth C. Wilson, MD, MS, CPE, System Vice President, Clinical Effectiveness & Quality, Norton Healthcare
- Katherine Taylor, Solution Architect, Covisint

Slides/Recording for Sale

- **Slides and recording of webinar**
  - Members can access slides and replays of any webinar for free from eHI's store
  - Non-members can purchase access to any webinar replay for $25.00
  - eHI Store
    - http://www.ehealthinitiative.org/store.html

Take Advantage of eHI Resources

- **Upcoming Conferences**
  - Northwest Medical Informatics Symposium - September 19-20, 2011 – Spokane, WA
  - 2012 Annual Conference and Member Meeting - January 11 and 12, 2012 - Washington, D.C.
- **Reports and Directories**
  - Vendor Report
  - List of HIEs and Selected Vendors
  - Sustainability Report

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- Jobs, fellowships, internships
  - jobs@ehealthinitaitive.org

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