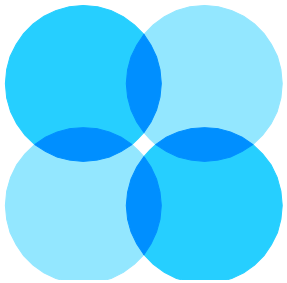
What Does eHI Do?

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

Thank You to Our Sponsor



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Overview of Our Agenda

- **Introduction and Welcome (2:00 – 2:05 PM)**
  - Jason Goldwater, Vice President, Research and Programs, eHealth Initiative
- **Healthcare Trends, Impact of Trends and New Capabilities and Information Needed (2:05 – 2:20 PM)**
  - Laura Kolkman, RN, MS, FHIMSS
    President, Mosaica Partners
- **Health Information Exchange & the Health System Enterprise (2:20 – 2:35 PM)**
  - Anita Samarth, President & Co-founder, Clinovations
- **Reports, Data issues & Lessons Learned: Care Does Improve (2:35 – 2:50 PM)**
  - John Haughton, Chief Medical Officer (CMI), Covisint
  - Nancy Wise, BSN, RN, Team Lead for Practice Engagement VT BluePrint for Health project, Covisint
- **Questions and Answers (2:50 – 3:25 PM)**
- **Closing (3:25 – 3:30 PM)**
  - Jason Goldwater, Vice President, Research and Programs, eHealth Initiative

Laura Kolkman, RN, MS, FHIMSS

President, Mosaica Partners

eHEALTH INITIATIVE
Real Solutions. Better Health.

A New Era of Healthcare:
Using Connected Health Information for Healthcare Delivery

eHealth Initiative Webinar

June 12, 2012

Laura Kolkman, RN, MS, FHIMSS

President, Mosaica Partners

Mosaica Partners – Who We Are

About Mosaica Partners

- Mosaica Partners is a nationally recognized Health Information and HIE consulting firm
- Our clients include: the federal government, states, regions, communities, ACOs, IDNs, Payers,HIE/HIT vendors, and organizations that manage and share health information electronically
- Our employees and network of associates include clinicians, consultants and researchers

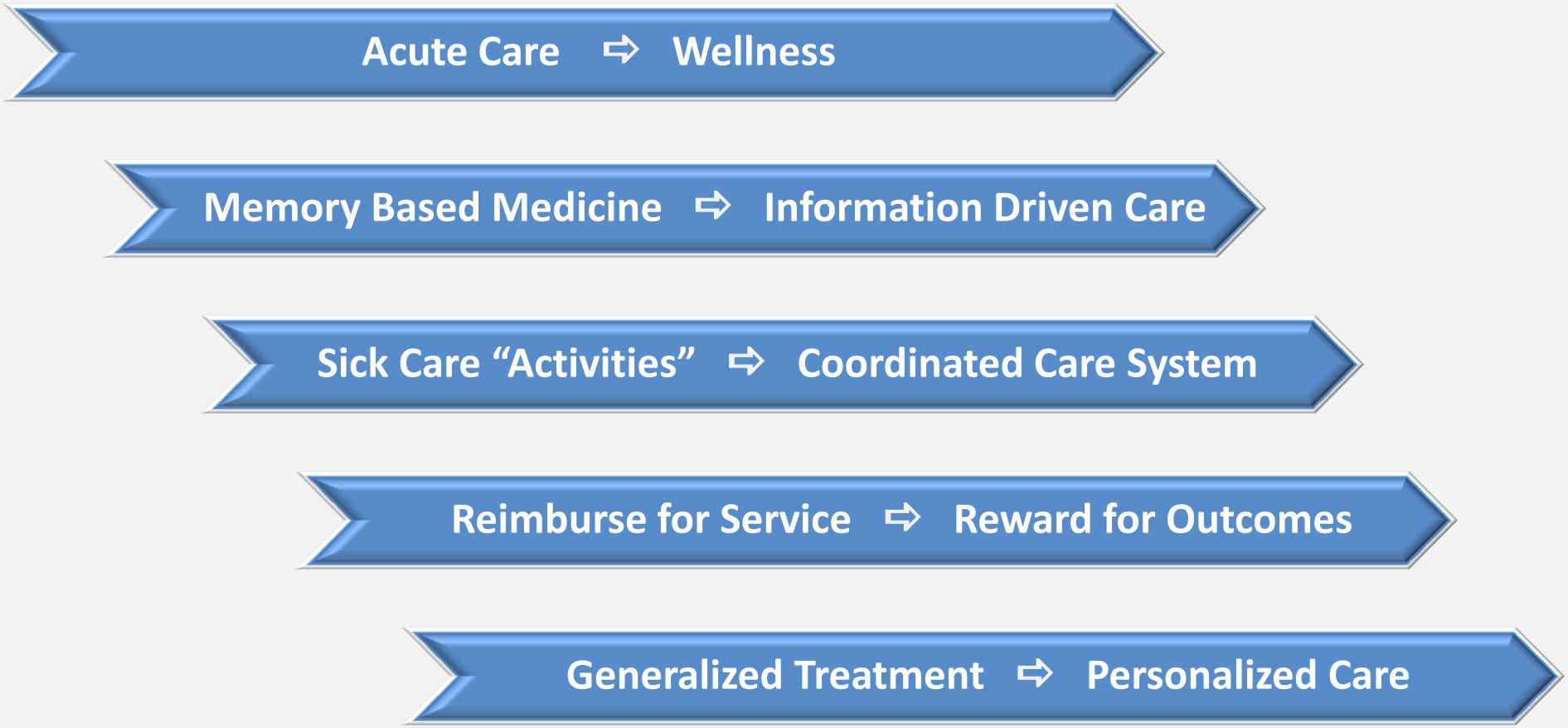
Mission

Our mission is to improve the quality of health care by enabling, improving and advancing health information exchange.

Agenda

- **Healthcare Trends**
- **Impact of the Trends**
- **New Capabilities Needed**
- **Information Needed**

Healthcare Trends



Impact of the Trends

Emerging Models of Care

PCMH, emphasis on wellness

New Payment Models

ACO, bundled payments, capitation

- Greater need for payer/provider collaboration
- Greater need for mixing of payer/provider data
- Greater involvement of the consumers/patients
- Enormous increase in need for and use of information

Attributes of a Patient-Centered Medical Home

Care Coordination

Monitoring, Feedback & Support

Provider Teams

Life-Long Continuity of Care

Patient Involvement

Quality Incentives

Easy Access to Care

Electronic Records

PCMH Care Coordination Capabilities

- Individual care management
- Patient tracking and alerting
- Referral management
- Results management and alerting
- Evidence based decision support
- Analysis and feedback

Care Coordination requires near-real-time sharing of health information

Attributes of an Accountable Care Organization

ACO Care Coordination Capabilities

- Individual care management
- Patient tracking and alerting
- Referral management
- Results management and alerting
- Evidence based decision support
- Analysis and feedback
- Population management
- Predictive modeling to identify high risk patients
- Individual, shared care plans
- Manage transitions of care
- Coordination with non-clinical resources

Care Coordination requires near-real-time sharing of health information

The Need for Information

- Determine baseline levels of service utilization
- Understand on-going patient utilization of services
- Identify key populations for proactive care coordination
- Coordinate and target care strategies
- Identify when patient intervention is needed
- Track progress against performance measures

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Real Solutions, Better Health

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Challenges and Opportunities

ACOs have major challenges ahead

- Access to large amounts of data
- New analytics requirements
- Increased need for data exchange
- Optimum care coordination

HIEs have a huge opportunity

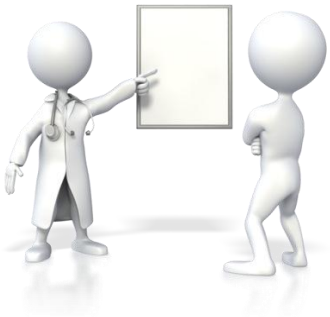
- Have the trust relationships in place
- Already exchange health information
- Understand the privacy and security requirements for exchanging PHI

The New Era of Healthcare

Gather Data

Analyze

Coordinate



Better Outcomes

Focused on Better Patient Outcomes

Thank You

Laura Kolkman, RN, MS, FHIMSS
President, Mosaica Partners

LKolkman@MosaicaPartners.com
www.MosaicaPartners.com
727 570 8100

Anita Samarth

President and Co-founder, Clinovations

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Health Information Exchange & the Health System Enterprise

eHealth Initiative Webinar

Anita Samarth,
Clinovations President, Co-founder

June 12, 2012

Background

Anita Samarth, Clinovations President & Co-founder

- Technical Assistance Director, eHealthDC - Regional Extension Center for DC
- Supporting ONC Programs for: State HIE Technical Assistance, Certification Testing
- Co-author of eHI HIE Toolkit Module – *Connecting Technically*
- Co-author of *EHRs for Dummies* (Wiley Publishing)
- Prior employment: eHealth Initiative, GE, First Consulting Group, Accenture

Clinovations Overview

- Washington, DC based healthcare management consulting firm
- Over 50 full-time staff
  - 60% clinical staff, 25% physicians
  - Clinical strategy, implementation guidance, technology optimization, health IT policy expertise
  - Partner with clients and technology providers (e.g., CTG, analytics vendors) for analytics infrastructure
- Commercial sector client examples
  - MedStar Health, Catholic Health East, Inova Health System, Adventist Health Care, Presence Health
- Public/non-profit sector client examples
  - DC Regional Extension Center (eHealthDC), Office of the National Coordinator (ONC), Substance Abuse and Mental Health Services Administration (SAMHSA)

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Goals for the Next 15 Minutes

- ✓ How do hospitals and health systems look at population health?
- ✓ How do independent providers and solo practitioners look at accountable care?
- ✓ Why is this so hard?
  - ✓ What can an EHR do? What can't it do?
  - ✓ A look at primary care in the District of Columbia.
- ✓ What is needed for coordinated care?

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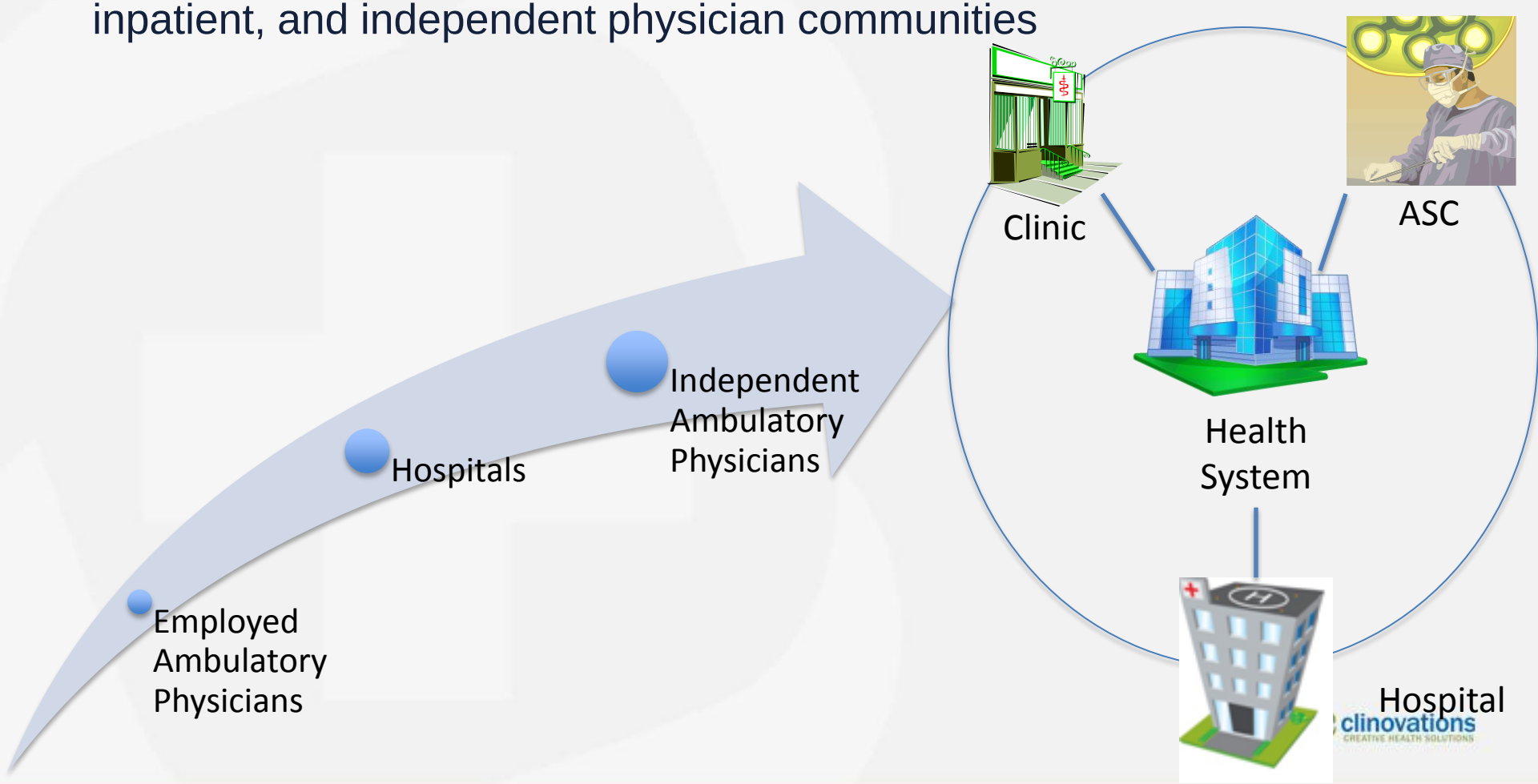
External and Internal Drivers

Health System Integration Strategy

Health systems are embarking on a comprehensive strategy to enhance the delivery of patient care across their employed ambulatory, inpatient, and independent physician communities



Sample Systems in a Single Hospital

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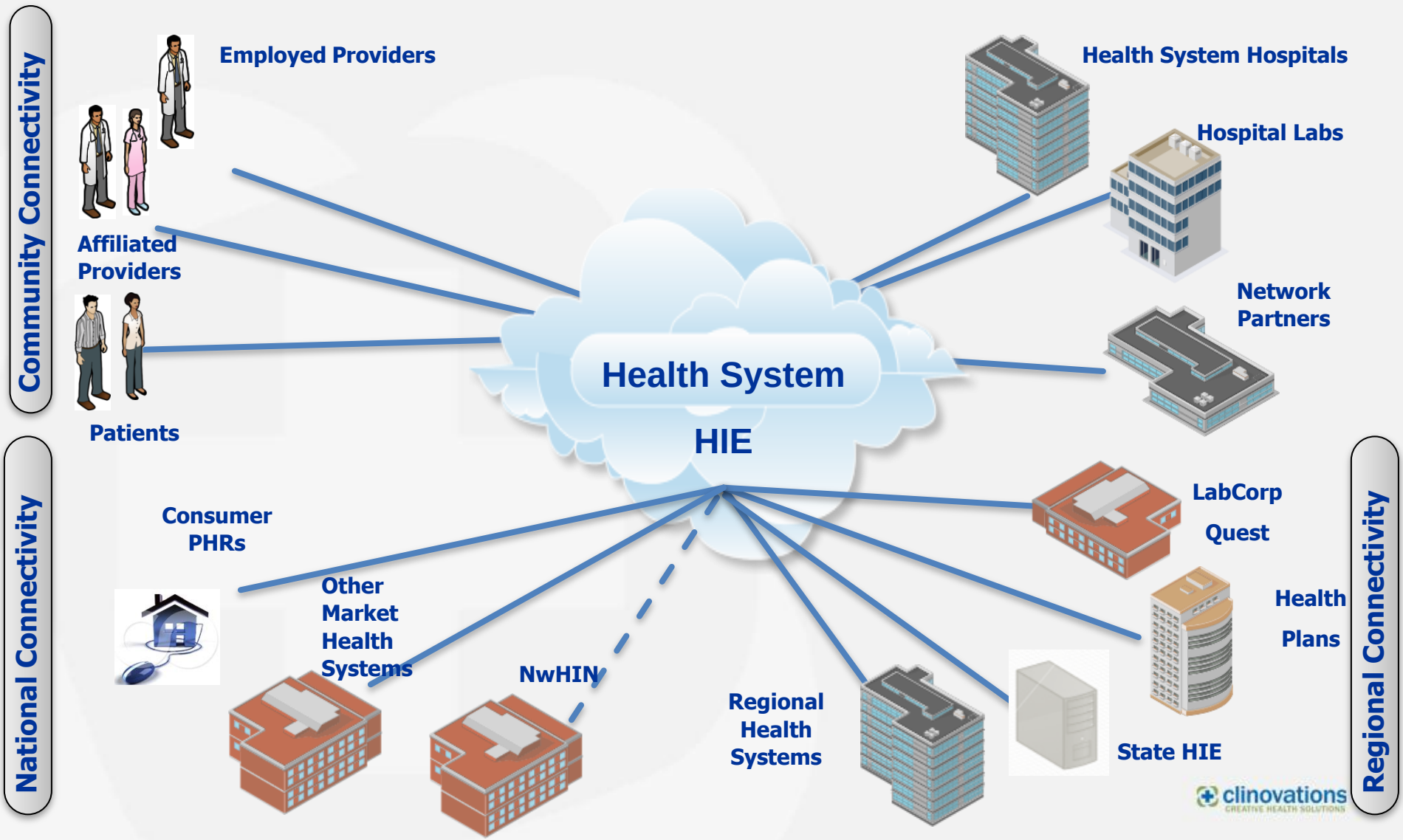
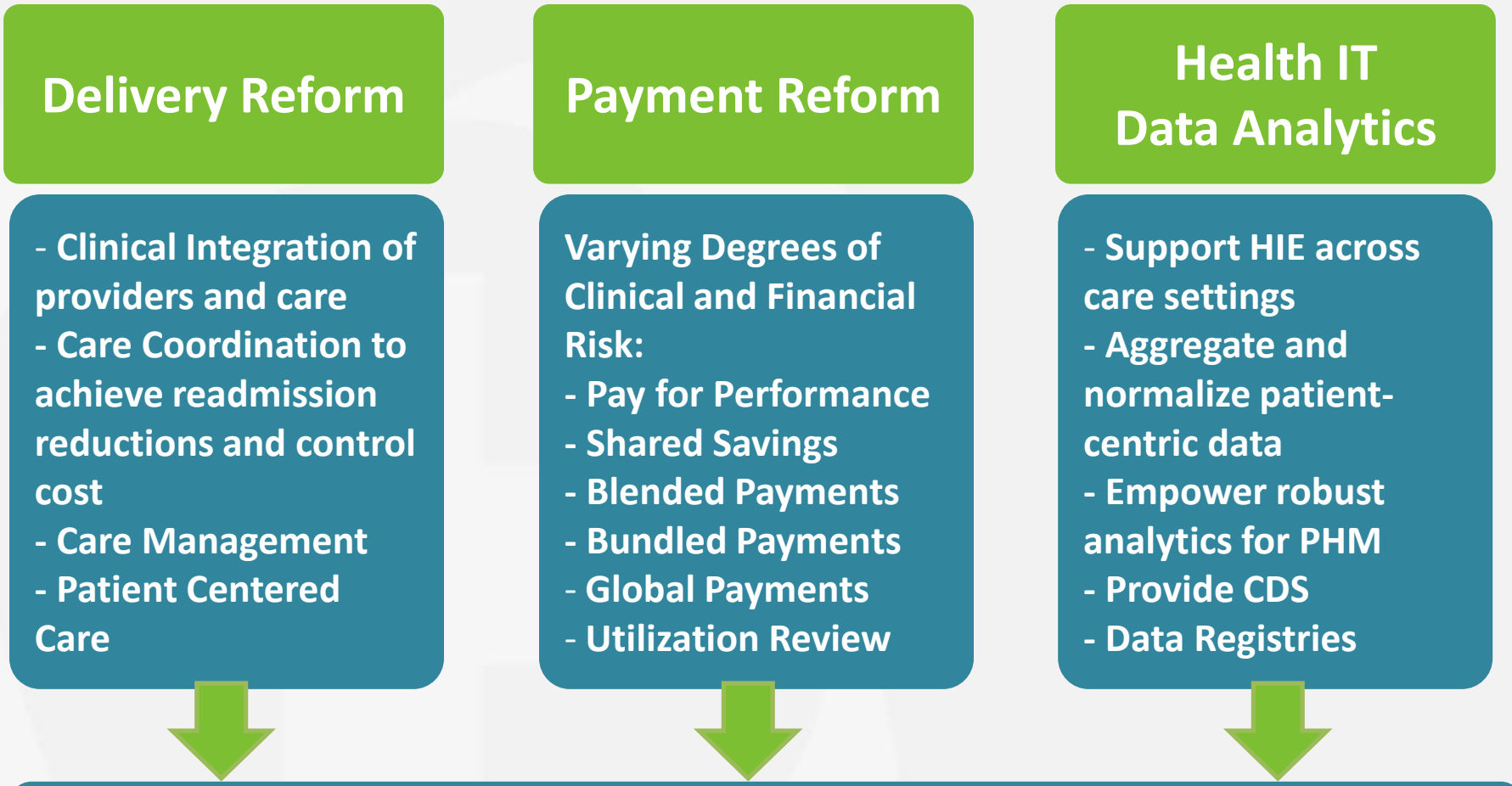
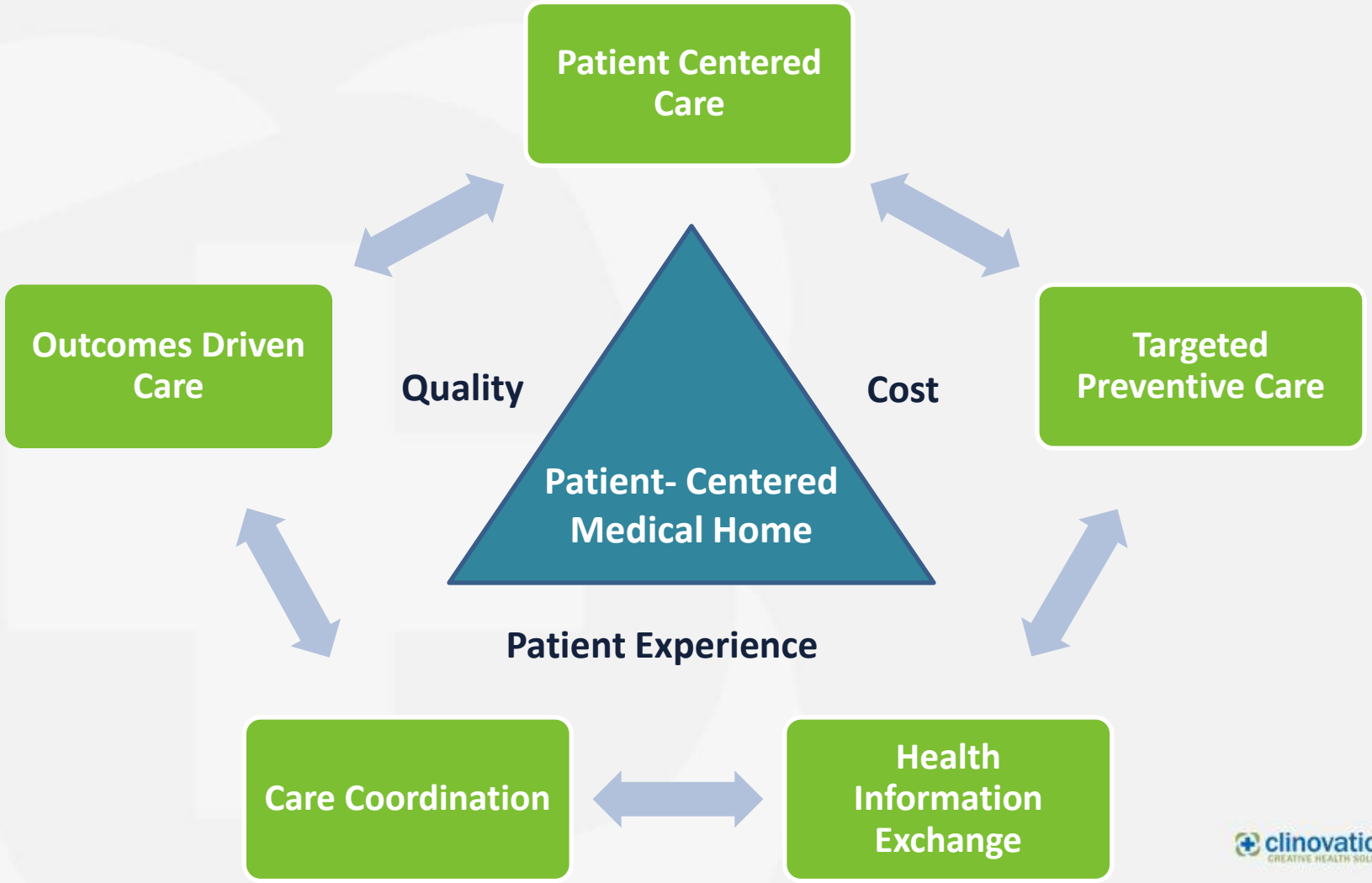
Goal: Fully Integrated Care Continuum



Drivers of Accountable Care



Population Health, Accountable Care, and PCMH



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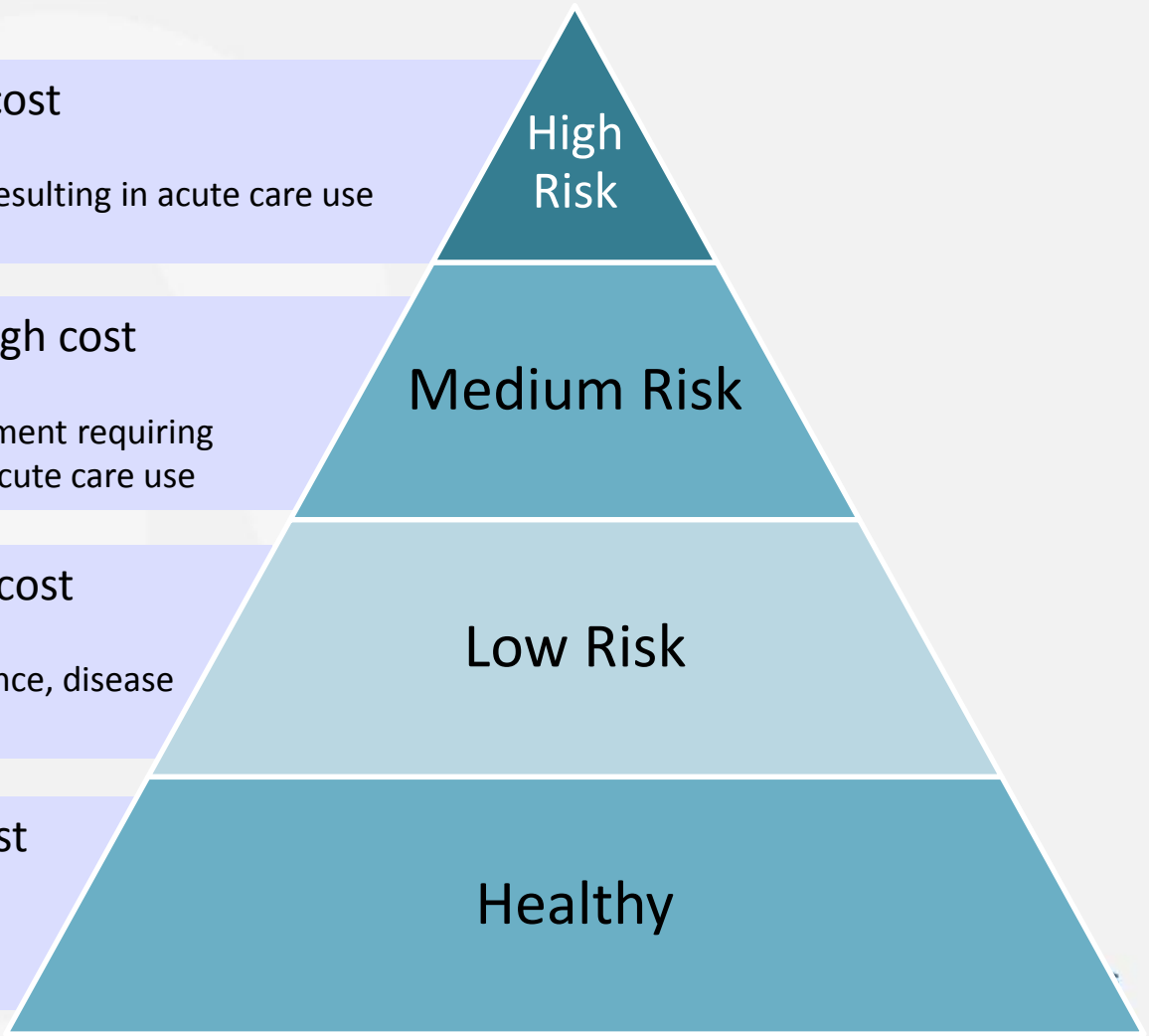
Accountable Care:
Define, Segment, and Analyze the Population

Level 4: high risk/high cost
- Multiple chronic conditions
- Poor disease management resulting in acute care use
- Polypharmacy

Level 3: medium risk/high cost
- Multiple chronic conditions
- Fluctuating disease management requiring limited hospitalization and acute care use

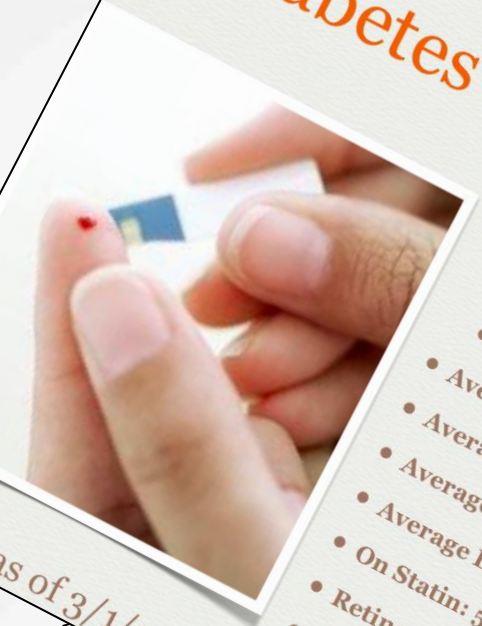
Level 2: low risk/lower cost
- Single chronic conditions
- Patients typically in compliance, disease controlled

Level 1: healthy/low cost
- No chronic conditions
- Focus on prevention/ health promotion



Population Management

Diabetes Patients: 24944



- Average Age: 62
- Sex
  - Female: 55%
  - Male: 45%
- Average A1C: 7.3
- Average BMI: 34.08
- Average BP: 133/65
- Average LDL: 92.3
- On Statin: 57.8%
- Retinopathy: 0.5%
- On MyChart: 8.0% (10% Code Given)

as of 3/1/11

Total CHF Patients: 3053

- Average Age: 73
- Sex
  - Female: 57%
  - Male: 44%
- Average BMI: 30.43
- Average BP: 129/71
- Average LDL: 84.0
- Average K: 4.2
- Average Cr: 1.64
- On ASA: 55.5%
- On ACE/ARB: 63.0%
- On MyChart: 2.9%

- Data as of 3/1/11

Independent Practice Challenges

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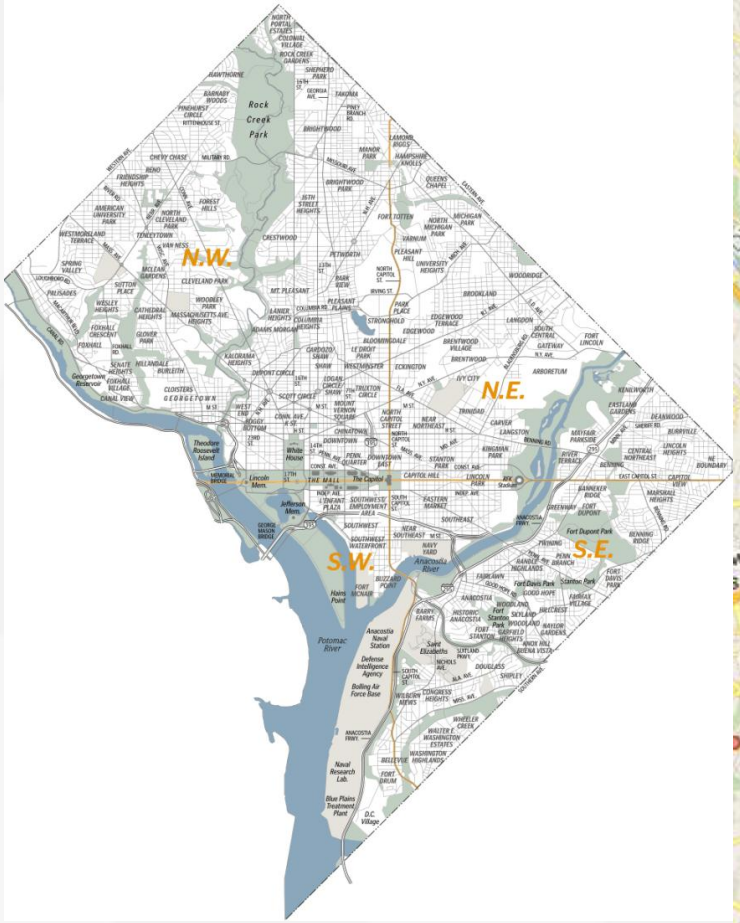
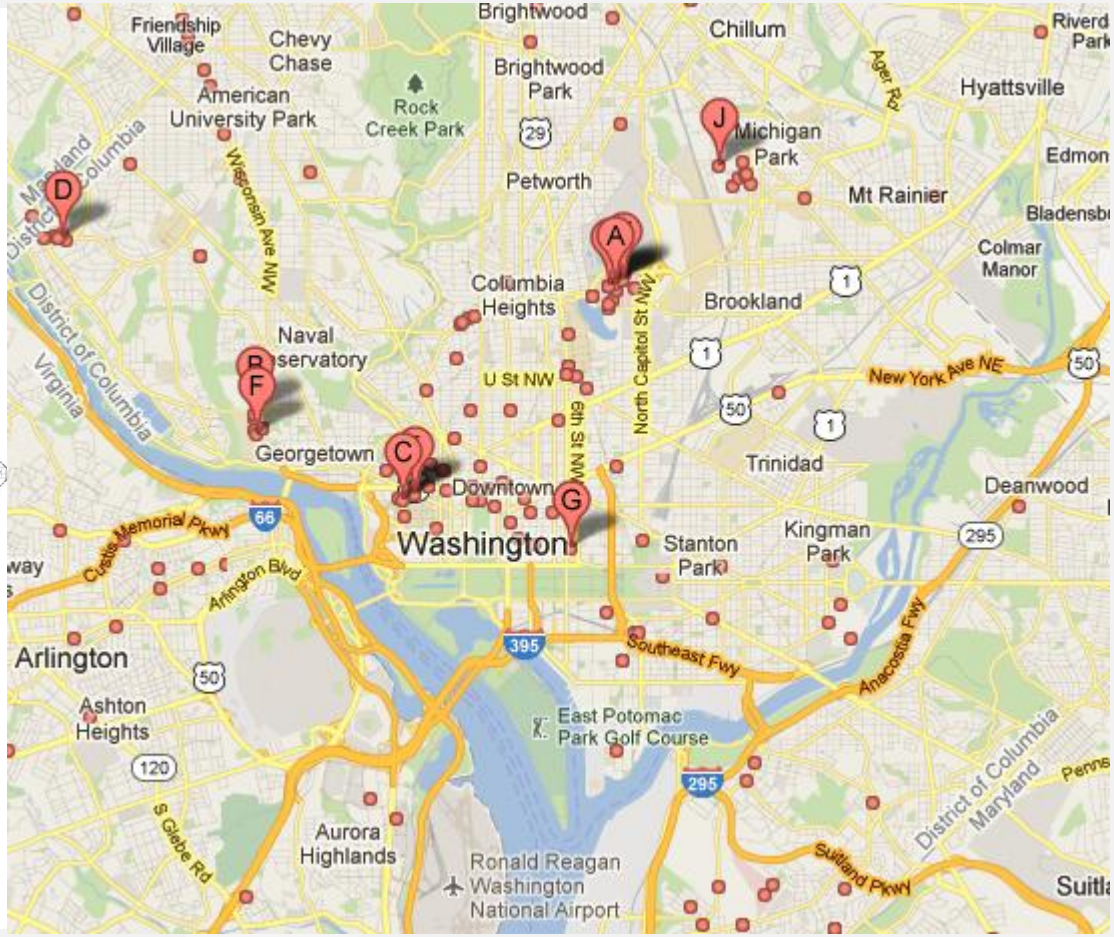
District of Columbia Example





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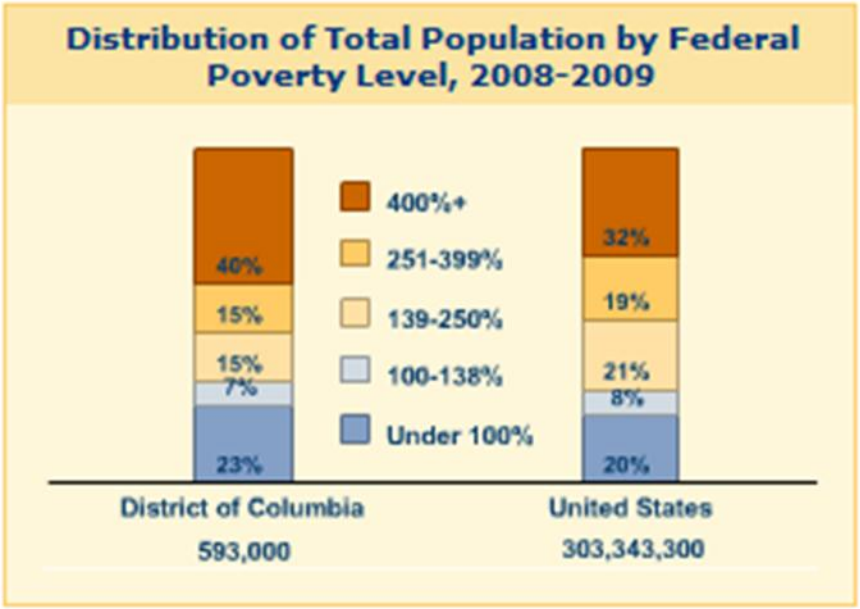
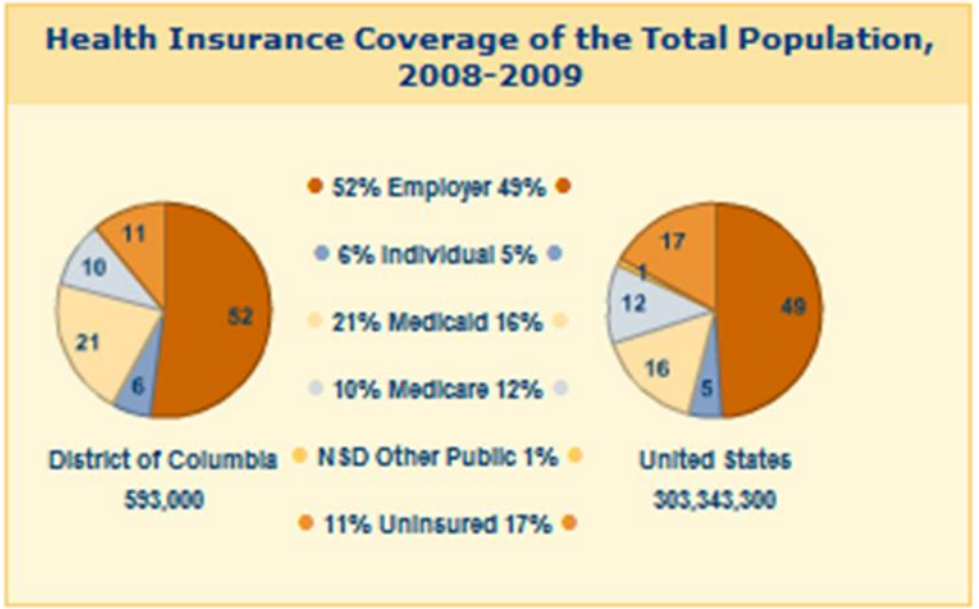
The Hard Part: Making it Work



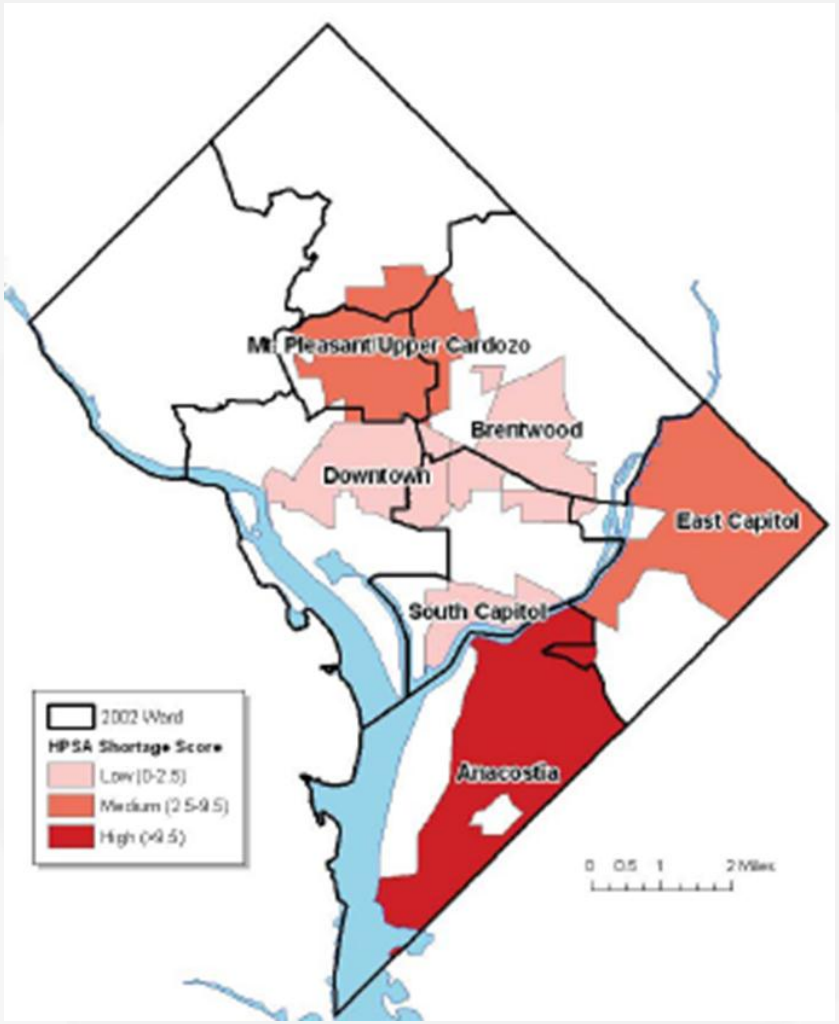


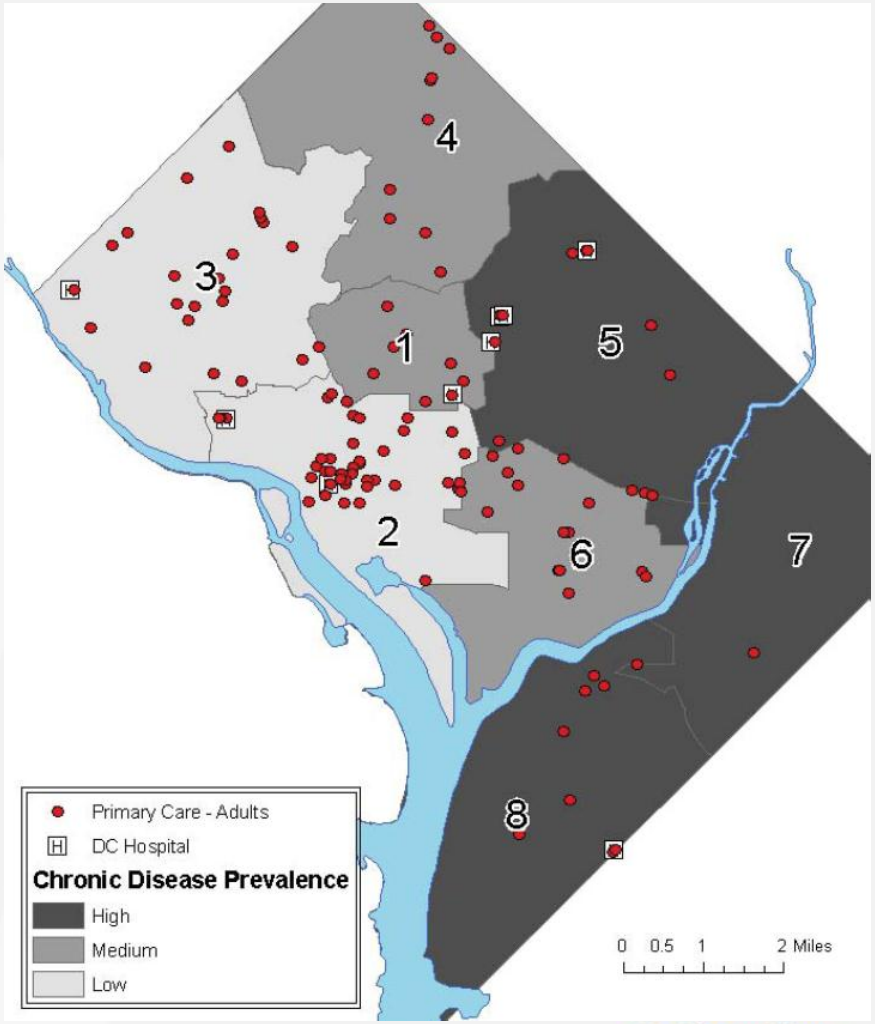
Source: Kaiser Family Foundation State Health Facts

Characteristic	Ward 1	Ward 2	Ward 3	Ward 4	Ward 5	Ward 6	Ward 7	Ward 8
Population (in thousands)	80.0	82.8	79.6	71.4	66.5	65.5	64.7	61.5
Age 0 to 17 years (%)	17.0	10.6	12.9	20.6	21.8	19.1	27.9	36.7
Age 65 years and older (%)	7.7	9.1	13.8	17.1	17.8	11.4	14.0	6.4
African American (%)	43.2	30.4	6.3	77.9	88.2	68.7	96.9	91.8
Caucasian (%)	35.2	56.2	83.6	10.3	7.9	27.2	1.4	5.8
Hispanic (%)	23.4	8.6	6.5	12.8	2.5	2.4	0.9	1.5
Family income <FPL (%)	20.0	10.9	2.7	7.9	14.3	19.2	21.6	33.2
Family income< 1.85xFPL (%)	37.8	21.5	5.5	18.0	28.1	31.8	36.5	51.7
Median family income (in $1000s)	58	132	191	81	55	68	45	35

Source: 2000 Census Data, 2008 RAND Health *Assessing Healthcare in the District of Columbia*

The Opportunity: Improving Patient Care
District of Columbia





Source: 2008 RAND Health
Assessing Healthcare in the District of Columbia

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EHRs, HIE, & Chronic Conditions

Chronic Disease Management: Diabetes

- Creation of a diabetes flowsheet or equivalent template that supports collection and display of:
  - HbA1c
  - LDL
  - Creatinine
  - Microalbumin
  - Blood pressure
  - Tobacco use
  - BMI
  - Influenza vaccination
  - Retinal exam date
  - Foot exam date
- Report and/or alerting for patients with overdue HbA1c test
- Follow-up report or reminders for patients with HbA1c > 7.0%
- Documentation of patient self-management goals in After Visit Summary related to:
  - Diet and exercise
  - Glucose monitoring
  - Self-administered foot exam
  - Medication adherence
- Other Data:
  - Discharge Summaries
  - Labs ordered by other providers

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Accountable Care
Health System Leadership Roles & Drivers

CMO/CMIO
Population health management (PHM)

CIO/CTO
Business Intelligence (BI)

CFO
Value-based reimbursement (VBR)

IT Catalyst — **Adoption of EHR and HIE to enhance shared decision making**

- Managing new types of electronic information
- Sharing data with patients and providers electronically
- Improving data flow and analytics for better patient outcomes

Reimbursement — **New models and incentives to ensure value and patient-centered care**

- Meaningful Use
- PCMH
- PQRS and HVBP
- Bundled Payments
- Accountable care/Shared savings

Transparency — **Leveraging data analytics to support evidence based care**

- Care Coordination
- Physician Engagement
- Consumer Engagement
- Public Reporting
- Predictive Analytics

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Supporting Execution and Delivery of Results: PHM/Accountable Care Strategic Roadmap

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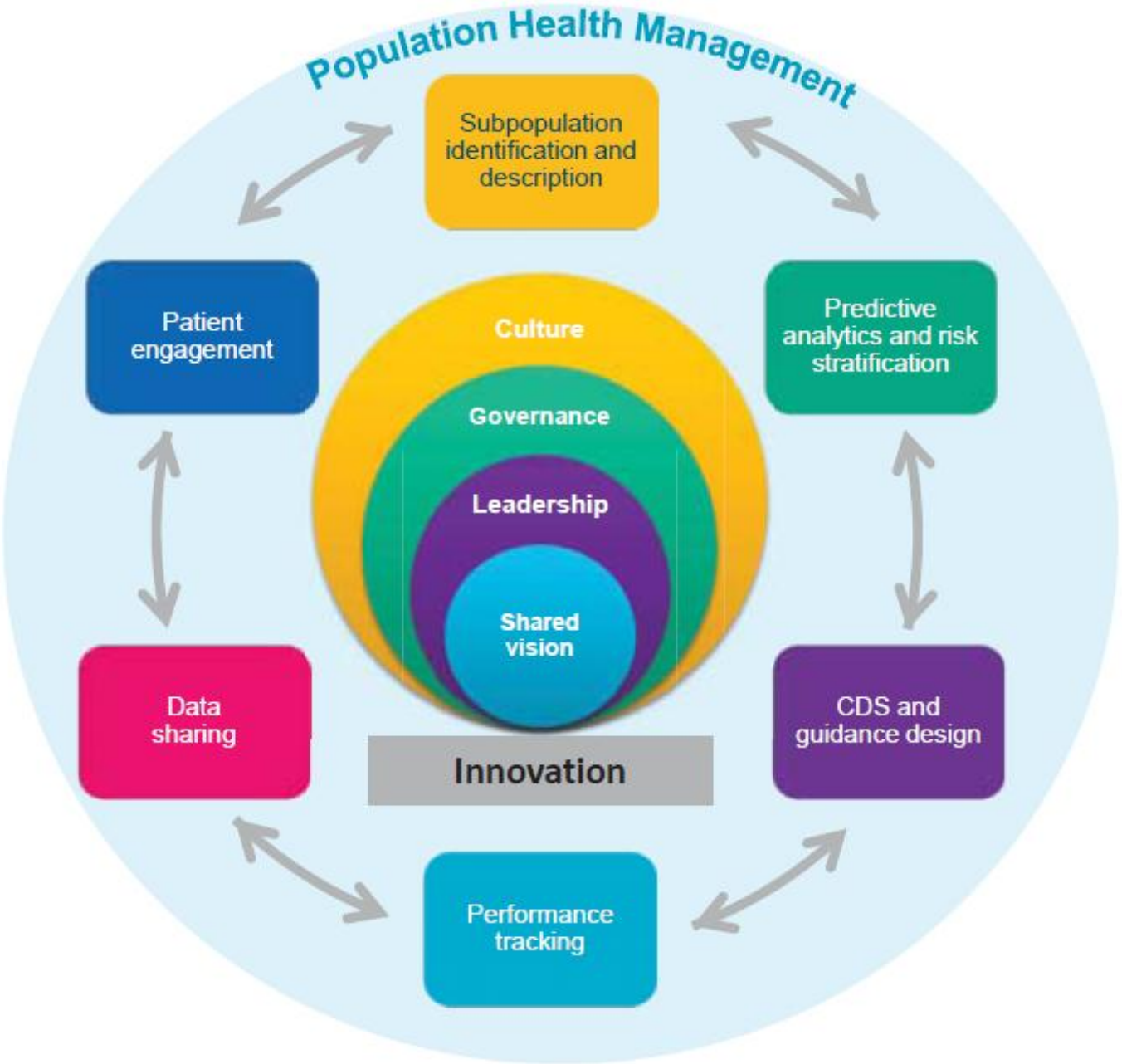

Capabilities Required to Support Population Health Management

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©CTG and Clinovations 2012 – White Paper - Population Health: Leveraging Data and Analytics to Achieve Value

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Thank You

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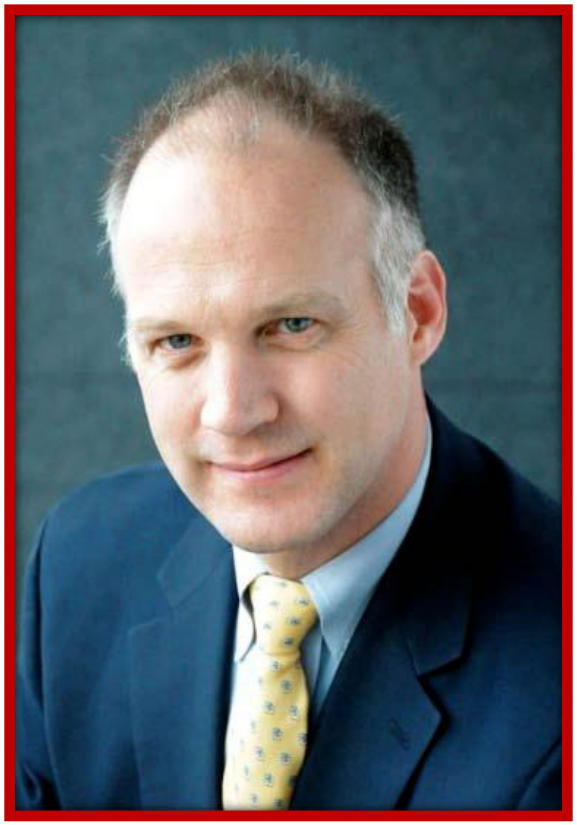
John Haughton

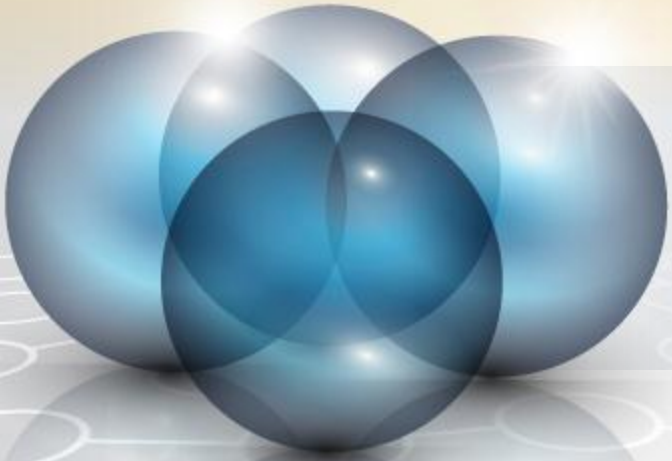
Chief Medical Officer, Covisint



Nancy Wise, BSN, RN

Team Lead for Practice Engagement
VT BluePrint for Health Project, Covisint

covisint | a Compuware Company



Reports, Data issues & Lessons Learned: Care Does Improve

And Yes, *Sometimes it's hard to do*

Nancy Wise – Practice Improvement Lead

John Haughton – Medical Information Officer

Providers improve care, decrease admissions with point-of-care alerts – Payers publish & say it works

AHIP Center for Policy and Research

Trends and Innovations in Chronic Disease Prevention & Treatment

An Update on Medicare Advantage Plans

America's Health Insurance Plans

April 2008

Presbyterian Healthcare Services
New Mexico

Reinventing Diabetes Care

Upon finding that no single approach was effective in a
diabetes, Presbyterian Healthcare Services (PHS) revan
in 2004 to create a new, multidimensional program. The
coordination; case management; diabetes education; a
based system to improve hospital care for individuals v
participate in the program, 23 percent of whom are Me

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

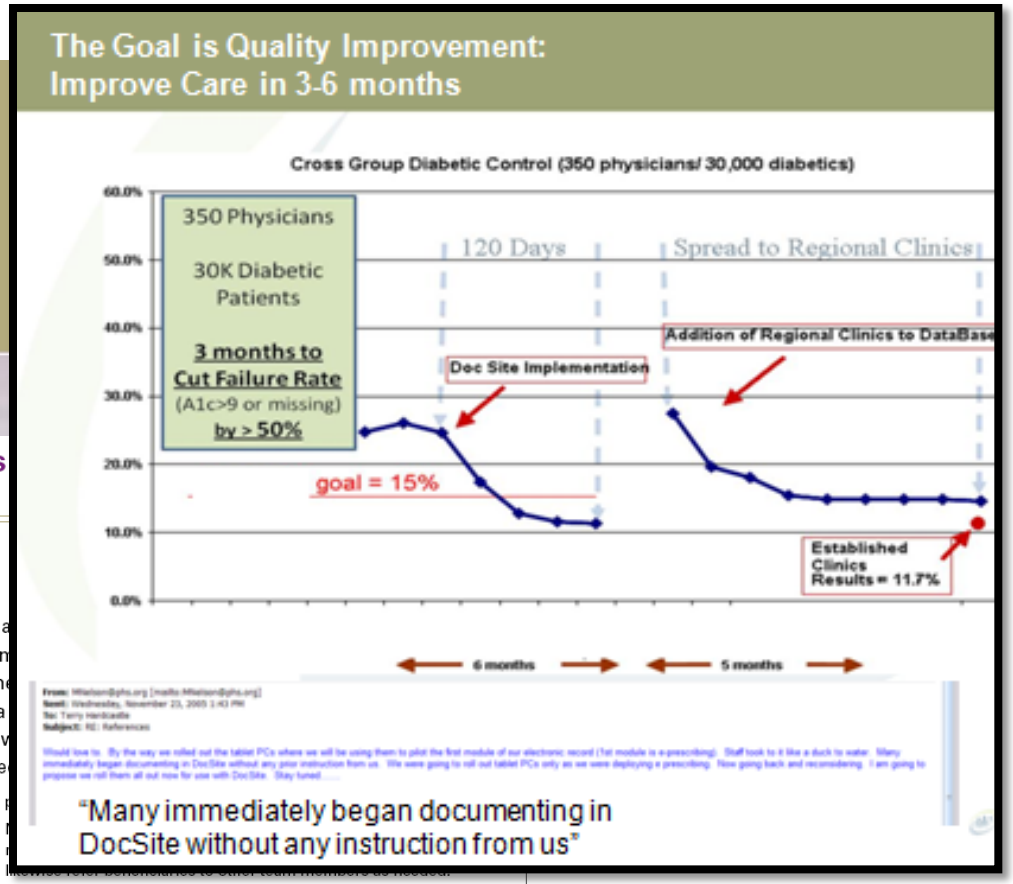
Medicare Advantage members' primary care physicians coordinate care with multidisciplinary teams that work onsite at Presbyterian Medical Group. These teams include certified diabetes educators, pharmacy clinicians, nurse care managers,

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



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

Improvement in care / cost: Decreased trend rates for ER & Admissions

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

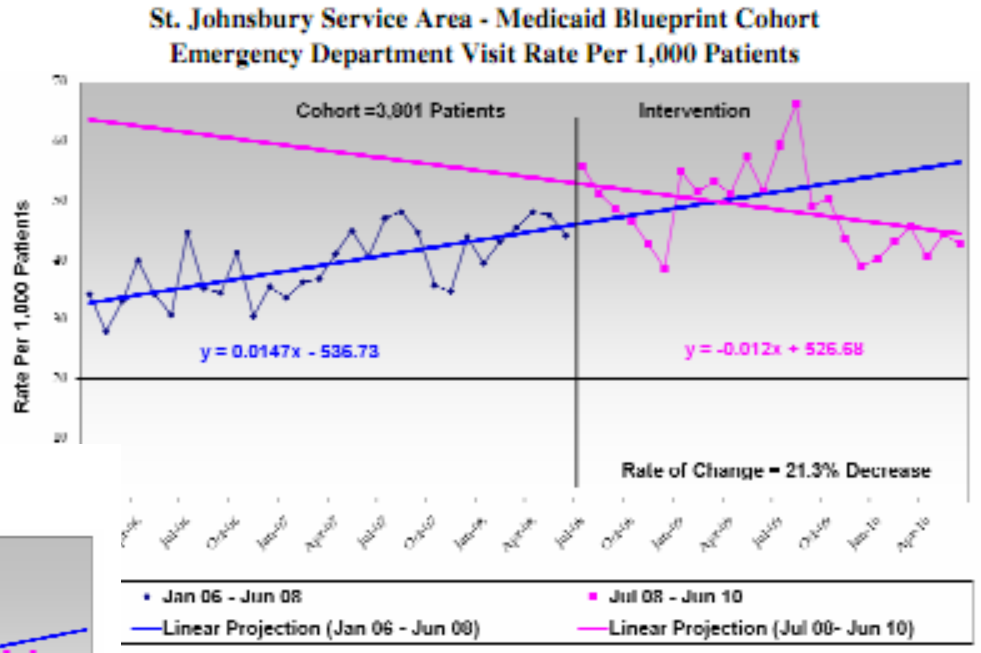
Vermont's Blueprint For Medical Homes, Community Health Teams, And Better Health At Lower Cost

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.

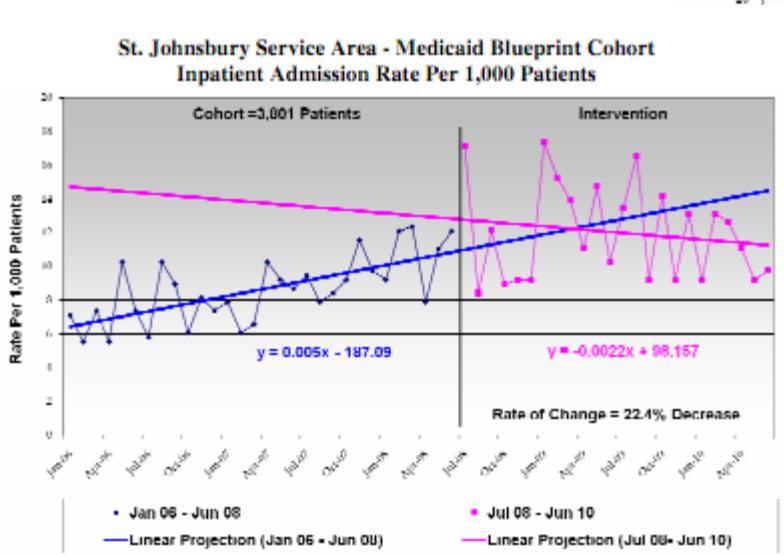
Utilization Results – after 1 year, 20% rate decrease in trend for ER and Admissions

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

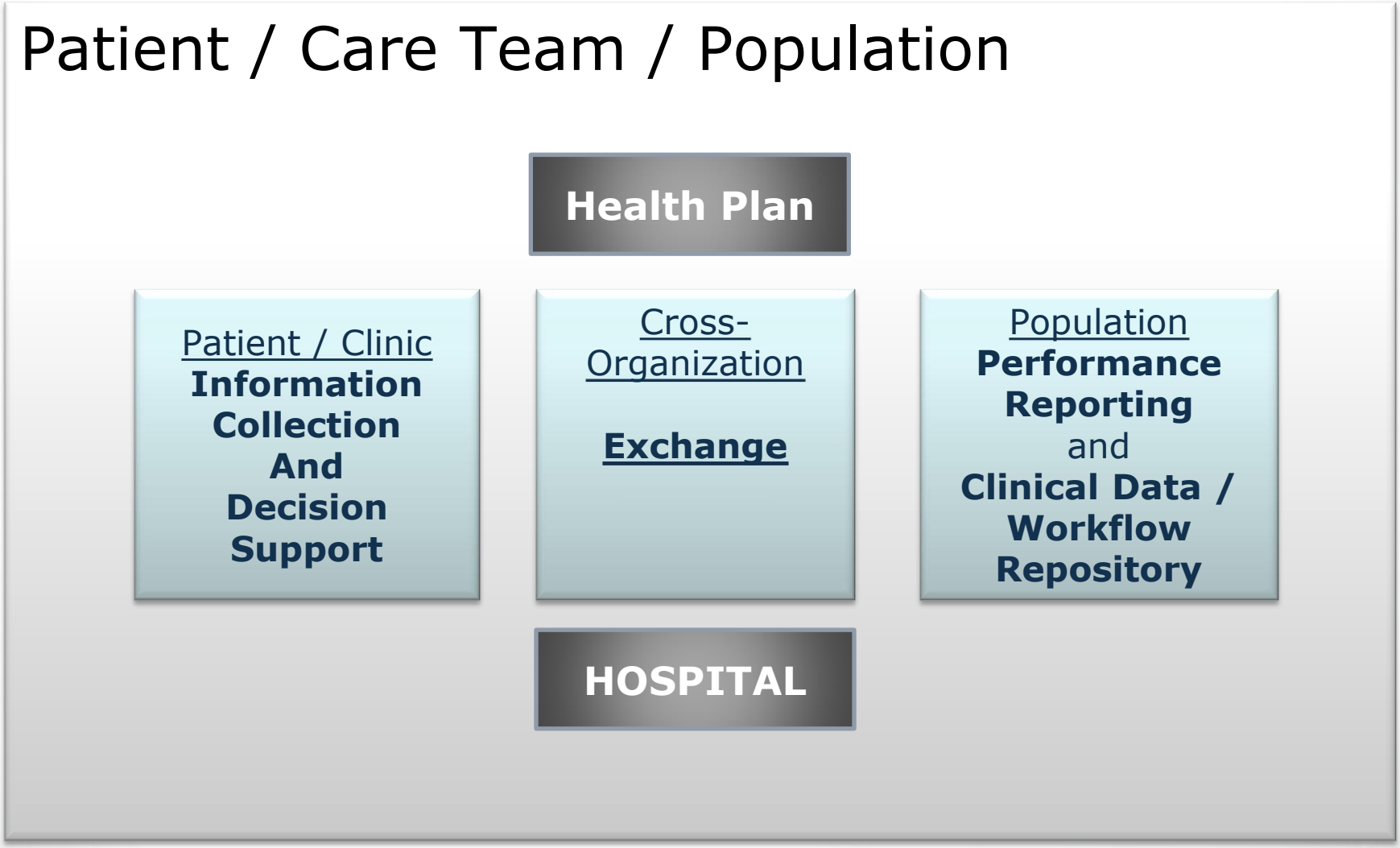


Admit Rate Trend Down

VERMONT Department of Vermont Health Access

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

A Full Care Community



Example – Comparative Analytics

Performance Report By Condition and Measure

Condition: HTN

Site: Independent Practice 1

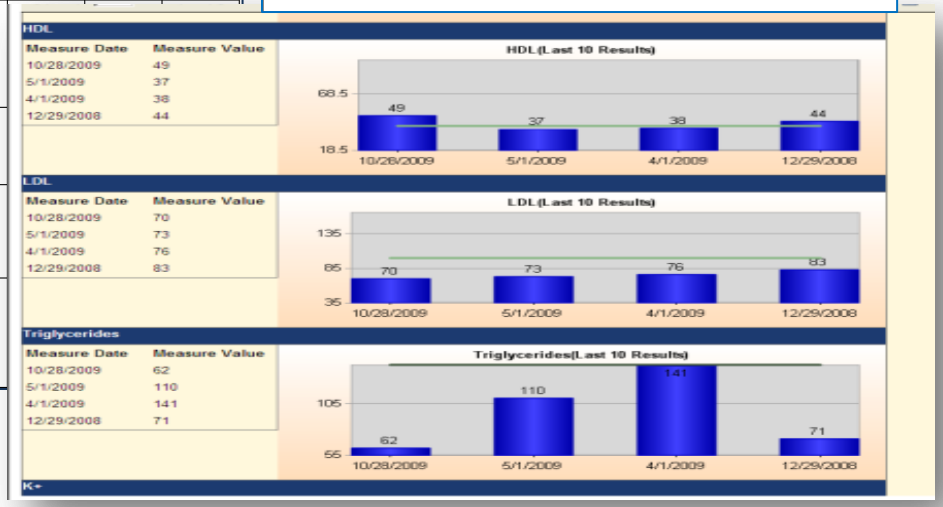
Instructions:
- **Measures are listed in Visit Planner order**
- **Click on Organization Name for a list of all patients with the condition**
- **Click on Measure Name in blue for a display of results for each group in the organization and comparative benchmarks**
- **Click on Measure Denominator for a bar graph of the percent of patients with a measure test/assessment by month and in last 12 months**
- **Display of measure data is based on last measure result during the time interval. For measures without a specified time interval, averages are based on the last measure result at any point in time.**

To view one level lower in the organization click here	Measure	Measure Denominator	% of Patients at Goal	Parent Org % of Patients at Goal	State % Patients at Goal	Measure Average	Parent Measure Average	State Measure Average
Independent Practice 1	Body Mass Index; patients aged 20 and older Goal: < 25 Calculated Interval: Per Visit	710	12.68%	13.73%	12.11%	29.54	30.94	33.30
	BMI for Age Percentile; patients aged 2 to 20 Goal: >= 5 Percentile & <= 84 Percentile Interval: 356 days	0	0.00%	0.00%	0.00%			
	Blood Pressure Goal: < 130/80 mmHg Interval: Per Visit	710	22.96%	27.25%	30.91%			
	Smoking Status Assessed; patients aged 11 and older Goal: = Former, Never Interval: Per Visit	710	55.35%	65.18%	29.71%			
	Smoking Cessation Activity Recommended; patients aged 11 and older Goal: = Y Interval: Per Visit	63	19.05%	24.26%	12.95%			

Last Measure Result Averages by Provider

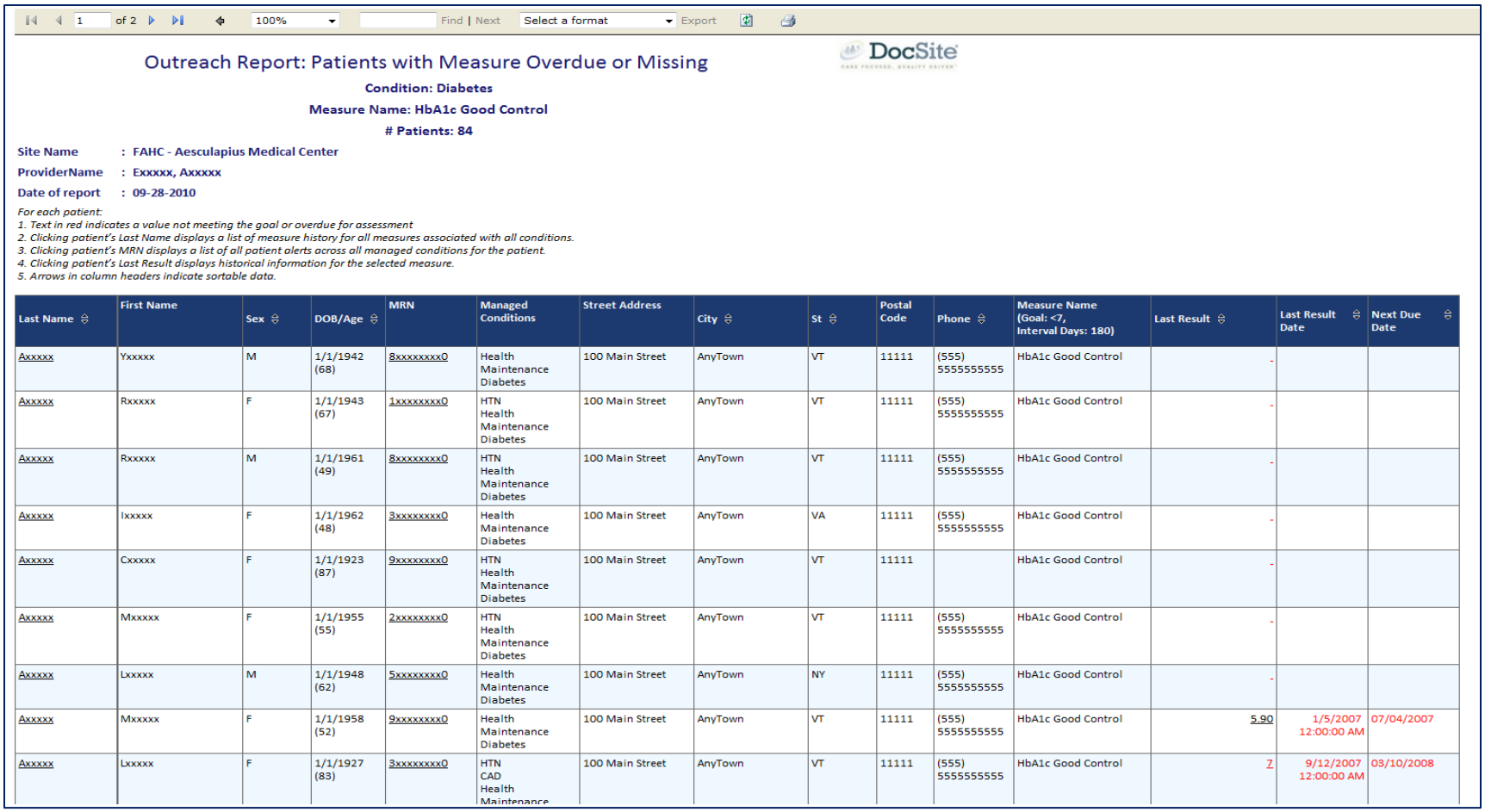
Report Run Date:9/27/2010 9:26:49 AM
Report Current As Of:9/21/2010 3:17:01 AM
Condition: HTN
Measure: Body Mass Index; patients aged 20 and older
Denominator: Patients with at least one Body Mass Index; patients aged 20 and older measure
Site: FAHC - Aesculapius Medical Center
Patient Status: Active

Provider Name	% Patients At Goal	# of Patients	Average
Axxxxx, Exxxxx	12.50%	8	21.60
Ixxxxx, Lxxxxx	23.40%	47	27.74
Ixxxxx, Dxxxxx	20.27%	528	28.81
Exxxxx, Exxxxx	15.82%	335	29.07
Axxxxx, Nxxxxx	20.91%	373	29.15
Axxxxx, Exxxxx	0.00%	7	29.50
Oxxxxx, Yxxxxx	15.66%	415	29.67
Lxxxxx, Nxxxxx	19.61%	413	29.68
Axxxxx, Exxxxx	16.64%	601	29.68
Exxxxx, Lxxxxx	17.58%	512	38.79
Axxxxx, Axxxxx	14.42%	430	45.12
Exxxxx, Axxxxx	18.12%	563	65.12
FAHC - Aesculapius Medical Center	17.72%	4232	36.57
FAHC	11.35%	10951	33.98
Vermont	12.33%	27362	33.37



Include benchmarks or organize for comparison

Example – Identify Care Opportunity



1 of 2 | 100% | Find | Next | Select a format | Export

DocSite

Outreach Report: Patients with Measure Overdue or Missing

Condition: Diabetes

Measure Name: HbA1c Good Control

 # Patients: 84

Site Name : FAHC - Aesculapius Medical Center

ProviderName : Exxxxx, Axxxxx

Date of report : 09-28-2010

For each patient:
1. Text in red indicates a value not meeting the goal or overdue for assessment
2. Clicking patient's Last Name displays a list of measure history for all measures associated with all conditions.
3. Clicking patient's MRN displays a list of all patient alerts across all managed conditions for the patient.
4. Clicking patient's Last Result displays historical information for the selected measure.
5. Arrows in column headers indicate sortable data.

Last Name	First Name	Sex	DOB/Age	MRN	Managed Conditions	Street Address	City	St	Postal Code	Phone	Measure Name (Goal: <7, Interval Days: 180)	Last Result	Last Result Date	Next Due Date
Axxxxx	Yxxxxx	M	1/1/1942 (68)	8xxxxxxxx0	Health Maintenance Diabetes	100 Main Street	AnyTown	VT	11111	(555) 5555555555	HbA1c Good Control	-		
Axxxxx	Rxxxxx	F	1/1/1943 (67)	1xxxxxxxx0	HTN Health Maintenance Diabetes	100 Main Street	AnyTown	VT	11111	(555) 5555555555	HbA1c Good Control	-		
Axxxxx	Rxxxxx	M	1/1/1961 (49)	8xxxxxxxx0	HTN Health Maintenance Diabetes	100 Main Street	AnyTown	VT	11111	(555) 5555555555	HbA1c Good Control	-		
Axxxxx	Ixxxxx	F	1/1/1962 (48)	3xxxxxxxx0	Health Maintenance Diabetes	100 Main Street	AnyTown	VA	11111	(555) 5555555555	HbA1c Good Control	-		
Axxxxx	Cxxxxx	F	1/1/1923 (87)	9xxxxxxxx0	HTN Health Maintenance Diabetes	100 Main Street	AnyTown	VT	11111		HbA1c Good Control	-		
Axxxxx	Mxxxxx	F	1/1/1955 (55)	2xxxxxxxx0	HTN Health Maintenance Diabetes	100 Main Street	AnyTown	VT	11111	(555) 5555555555	HbA1c Good Control	-		
Axxxxx	Lxxxxx	M	1/1/1948 (62)	5xxxxxxxx0	Health Maintenance Diabetes	100 Main Street	AnyTown	NY	11111	(555) 5555555555	HbA1c Good Control	-		
Axxxxx	Mxxxxx	F	1/1/1958 (52)	9xxxxxxxx0	Health Maintenance Diabetes	100 Main Street	AnyTown	VT	11111	(555) 5555555555	HbA1c Good Control	5.90	1/5/2007 12:00:00 AM	07/04/2007
Axxxxx	Lxxxxx	F	1/1/1927 (83)	3xxxxxxxx0	HTN CAD Health Maintenance	100 Main Street	AnyTown	VT	11111	(555) 5555555555	HbA1c Good Control	7	9/12/2007 12:00:00 AM	03/10/2008

Drive population management activities

Example – Identify Care Gaps

Patient Alerts

☑ **Actionable Alerts only.**

Vitals

Measure (Alert) Name	Last Value	Date Last Value	Patient Goal	Population Goal	Due Date
Height (inch)	65 in	11/29/2011			11/29/2011
Temperature	98	6/9/2011			6/9/2011

Lab

Measure (Alert) Name	Last Value	Date Last Value	Patient Goal	Population Goal	Due Date
Na+	131 meq	4/26/2010			4/26/2011
BUN	7	4/26/2010			4/26/2011
Creatinine (Plasma)	0.6	4/26/2010			4/26/2011
HbA1c	6.9 %	4/12/2011	< 7	< 7	10/9/2011
AST	11	12/22/2010			6/14/2010
HDL	50 mg/dL	2/26/2009	>= 40.0000	>= 40	2/26/2010
Total Cholesterol	232	12/22/2010			6/14/2010
Triglycerides	161 mg/dl	2/26/2009	< 150.0000	< 150	2/26/2010
LDL	126 mg/dl	2/26/2009	< 100.0000	< 100	2/26/2010
Microalbumin Cr Ratio	126.2	4/26/2010			4/26/2011

Immunization

Measure (Alert) Name	Last Value	Date Last Value	Patient Goal	Population Goal	Due Date
Tetanus					
Influenza vaccine	Done Done, Not Done, CI	9/14/2009	=	= Done	9/14/2010

Clinical

Measure (Alert) Name	Last Value	Date Last Value	Patient Goal	Population Goal	Due Date
Foot Exam Monofil / Skin / Pulse					
Peak Flow	L/min				

Apply evidenced based medicine criteria to derive patient level compliance.
Maximize point of care efficiency

VERMONT Blueprint for Health
Smart choices. Powerful tools.

State & Federal Partnerships

Example - Health information & quality infrastructure

National Guidelines & Measures
(NIH, Task Force, AHRQ)

Federal Funding & Guidance
(ONC)

State Led Health Reforms

Clinical Tracking Systems
- EMR Templates
- Registry visit planners
- Outreach reports
- Interfaces & data transfer

Guideline based Data Dictionary
(Core Data Elements)
- Clinical process data elements
- Health status data elements
- Aligned measure set
- Aligned answer options

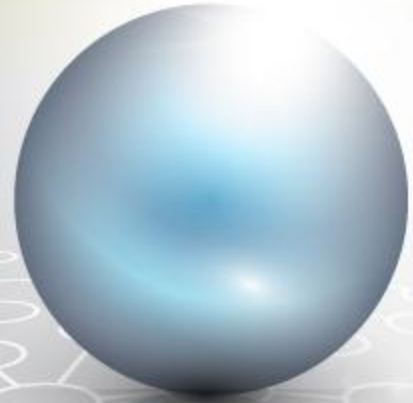
Reporting & Evaluation
- Registry reports
  - ✓ Outreach
  - ✓ Performance
- Claims database reports

Guideline Based Health Services
- Individual patient care
- Population mngt & outreach
- Coordinated health services
- Emphasis on prevention

Learning Health System

Ongoing Refinement

Guideline Based QI
- Comparative Evaluation
- Provide reports & data
- Coaching & facilitation
- Shared learning



Data Issues…

“Continuity of Care Document” or “CCD” – just exchange the message, right?

Nope! not good enough….

Numbers & Free Text = easy to map
Immunizations & Mammograms = tricky

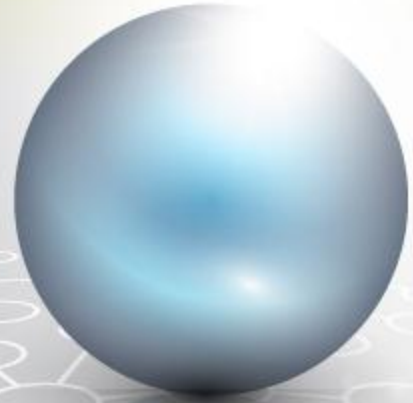
MeasureName	Count Total	Count Valid	Pct Valid	Count that need mapping	Pct Needs mapping	
BP DBP	19,221	19,221	100.00%	-	0.00%	Map Easily
Clinical Hx Comment	15,576	15,576	100.00%	-	0.00%	
Patient/Caregiver Self-Management Goals	2,614	2,614	100.00%	-	0.00%	
BP SBP	19,223	19,222	99.99%	1	0.01%	
K+	10,367	10,365	99.98%	2	0.02%	
Creatinine (Plasma or Serum)	10,732	10,726	99.94%	6	0.06%	
HDL - Male	4,640	4,637	99.94%	3	0.06%	
Body Mass Index	16,111	16,100	99.93%	11	0.07%	
Height (inch)	16,120	16,097	99.86%	23	0.14%	
HDL - Female	4,658	4,651	99.85%	7	0.15%	
Triglycerides	9,073	9,050	99.75%	23	0.25%	
Weight (lb)	19,250	19,171	99.59%	79	0.41%	
Total Cholesterol	9,753	9,704	99.50%	49	0.50%	
HbA1c	2,330	2,316	99.40%	14	0.60%	
LDL	9,347	9,222	98.66%	125	1.34%	
Microalbumin Cr Ratio	1,201	996	82.93%	205	17.07%	Tougher to Map
Smoking Status	7,884	3,820	48.45%	4,064	51.55%	
Tobacco Use/Exposure Assessment	6,701	3,225	48.13%	3,476	51.87%	
Exercise (# days/week)	9,076	3,696	40.72%	5,380	59.28%	
Tobacco Use Cessation Intervention	1,170	425	36.32%	745	63.68%	
Cervical Cancer Screening	3,771	784	20.79%	2,987	79.21%	
Breast Cancer Screening Mammogram	5,378	737	13.70%	4,641	86.30%	Tough to Map
Today's Visit Type	4,473	536	11.98%	3,937	88.02%	
Pneumovax	3,868	421	10.88%	3,447	89.12%	
Influenza vaccine	10,699	446	4.17%	10,253	95.83%	
Tetanus	9,326	68	0.73%	9,258	99.27%	
CHD or CHD Risk Equivalent (circle all that apply)	2,085	1	0.05%	2,084	99.95%	
Alcohol Use Screening	2,356	1	0.04%	2,355	99.96%	
Discussion of Prostate Cancer Screening	1,551	-	0.00%	1,551	100.00%	
Dilated Eye Exam by Ophthalmologist or Optometrist	1,441	-	0.00%	1,441	100.00%	

Mammos & Pneumovax & Visit type

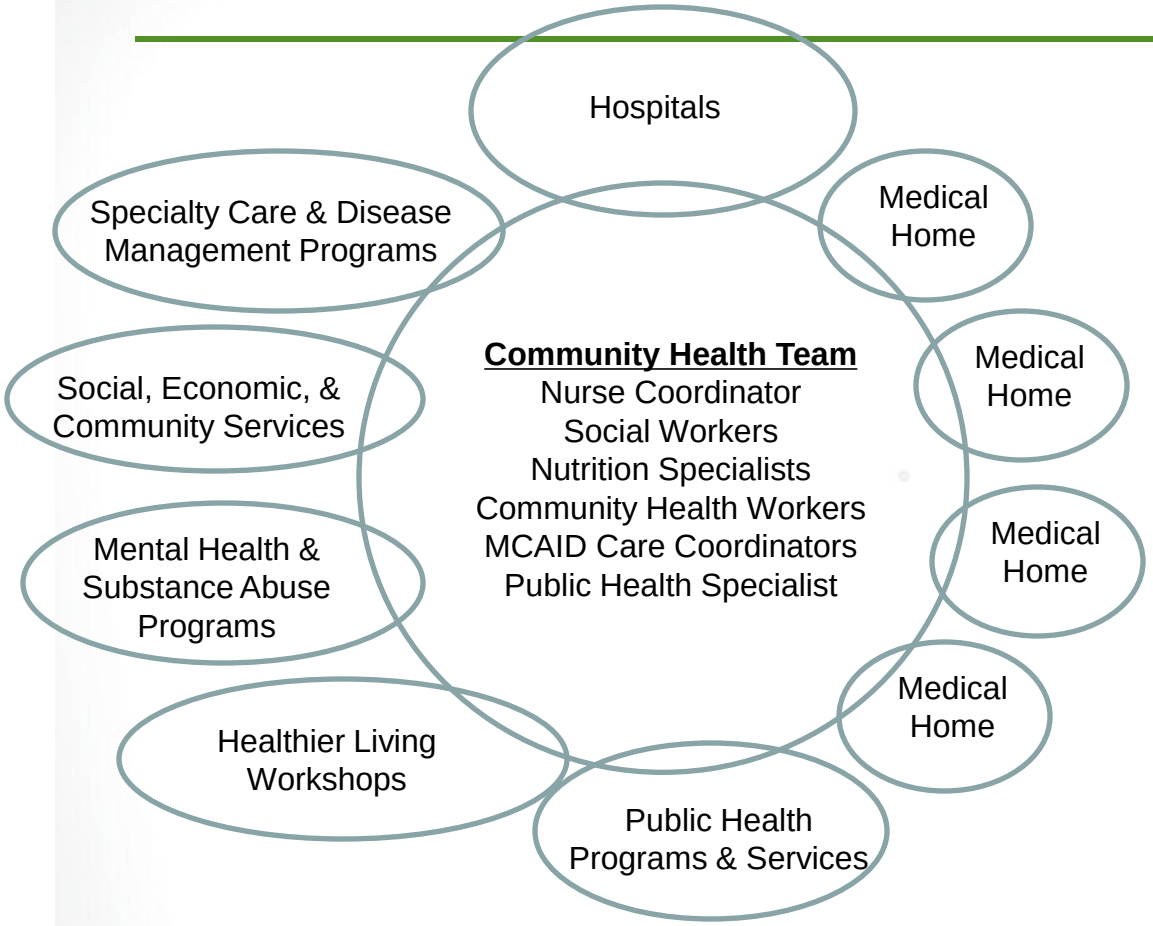
- Done-RRMC - WNL
- Done-Rye Radialogy
- Done-SVMC
- Done-Tufts Mammo Center
- dx R breast benign/ f/u 1 year
- gyn
- impression
- incomplete needs further imaging
- l
- L BREAST STABLE
- L CAT 1 NEG
- L density;fu views needed
- L dx benign CAT 2
- L normal
- L only BR3 neg
- L-Cat 1, R-Cat 0
- LEFT BREAST CYST
- LEFT BREAST CYST NEG
- left breast cysts
- Left breast mammo and US
- left breast mass

- 4/15/2010 Albany
- 5/25/1999
- 5/9/2008
- 6/27/2002
- 6/7/2004
- 6-Jul
- 5-Aug
- 8/15/2001
- 8/17/2009
- 8/17/2000
- 8/18/2009
- 8/28/1997
- 6-Sep
- after age 65 per pt in old office
- Algus
- allerg local
- allergic
- allergic reaction
- allergic, done
- AT ROWE
- at SVMC
- BFP
- Damasco
- date approximate
- declined
- Declined
- declined

- see patient cc
- sick
- sick x few weeks
- urgent
- urgent walk in
- wcc
- wcc
- Well Child Check
- Well Child Check
- Well Child Check
- Yearly H&P
- Acute
- Acute
- acute
- Consult
- Consult
- PlannedVisit



Who *Cares*?
It's the practices & patients
What matters?



- 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

Questions
Final Thoughts

Thank You to Our Speakers

- Laura Kolkman
- Anita Samarth
- John Haughton
- Nancy Wise

Slides/Recording for Sale

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

Take Advantage of eHI Resources

- **Reports and Directories**
  - Vendor Report
  - List of HIEs and Selected Vendors
  - Sustainability Report
- **Upcoming Conference**
  - National Forum on Data and Analytics in Health Care
    - August 9, 2012
    - Gaylord National Resort and Convention Center, National Harbor, MD

eHI National Forum on Data and Analytics

- Join us August 9, 2012 at the Gaylord National Resort and Conference Center
- **Todd Park**, U.S. Chief Technology Officer just Confirmed as a keynote speaker!
- Topics to Include:
  - Transforming Data into Healthcare Intelligence in Today's Market
  - Best Practices Using Data to Manage Populations with Chronic Conditions
  - Leveraging Analytics to Facilitate Accountable Care
  - Using Analytics to Enable Transparency and Quality Improvement
  - Predictive Analytics to Improve Clinical Outcomes: Four (4) Organizations Share Their Experiences

National Forum on Data and Analytics in Health Care

Thursday, August 9, 2012
Gaylord National Resort and Convention Center
Forum registration is open

http://www.ehealthinitiative.org/2012-ehi-national-forum-on-data-and-analytics-in-health-care/registration.html

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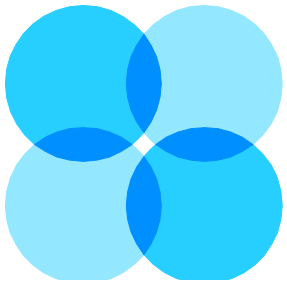

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