Community-Based Health IT Initiatives: How Do You Make Them Work?

Nov 08, 2005, 03:00 PM-04:30 PM

Scott Young

This is Scott Young. Thank you all for attending today's teleconference community-based health IT initiatives, how do you make them work. I direct the health information technology portfolio at the Agency for Health, Research, and Quality. It's my pleasure to moderate this session today. We're going to have some introductions of our panelists today, go through some questions and answer. I'm going to pose the questions at our panelists and have them respond. And then we're going to open the floor up to you to really hear your comments, concerns, and questions. You know, really, external collaborations around health IT are not simple enterprises. Organizations, needs, and interest differ from those in the community and region. I mean, it's a group of stakeholders in many communities, the types of payers, types of providers, types of entities that participate in any kind of change in a health care environment or system are varied in many. And their interests are varied in many as well. We're going to talk about community based health IT initiatives. Regional health information. How do you find the right people to bring to the table and achieve the common objectives? How can you accomplish in the standards of certificates the types of changes we'd like to see in quality, safety, efficiency, and effectiveness? And what are the crucial questions, such as the ones we've assembled today to gain their firsthand knowledge and experience to make these health IT collaborations work? Let me

introduce our, our panelists today. Dr. David Bates is from Brigham and Women's hospital where he is the Chief of the Division of General Medicine and Primary Care and Medical Director of Clinical and Quality Analysis for Partners Health Care Systems, Professor of Medicine at Harvard Medical School, and is a practicing general internist. Dr. Bates is widely published in quality, safety, health information technology, and the intersections of all three of those enterprises. He is a leader, not only in Boston and Massachusetts, but nationally and internationally as well. With such varied topics as regional health information organizations, clinical decision support, and patient safety. Dr. Mark Frisse serves at the Vanderbilt Center for Better. At the Vanderbilt Center for Better Health, he's responsible for coordinating regional, state, and national projects into the application of information technology to advance care, statewide health information infrastructure to support patients. Prior to assuming this position, the doctor was vice president at First Consulting Group's clinical transformation team working to advance quality and safety through the advance of technology. I want to say a personal thank you, and welcome to both of our panelists. So -- thank you for joining us. I'm going to ask a series of questions, I'm going to direct them to one of our panelists, and at the conclusion, I would like the other one to react and provide additional incite. Local state and regional stake holders, how do you characterize what RHIO?

Mark

Scott wants to know what a RHIO is and what's in for individual providers in the kind of communities each of you live. I describe it as a place holder to a wonderful idea. I believe attributed primarily to David as really a reflection of everything our health care system isn't and what needs to be addressed. Many people use RHIO in a very generic kind of sense. To me, again, it's almost any effort that involves data exchange beyond the current fragmentation of our current health care system. And if you look at what they are, they're trying to address what we believe is a fairly unsafe and broken health care system. The problems in our communities, about 25% of our children in our communities can move from year to year according U.S. census. People get care from multiple physicians, even if we stay in the same house, with the same employer, and do everything right all of our lives, we still get different cards, plans, different PBM cards along the way. Added to that is the problem that we seek care from multiple different hospitals and the handoffs are very, very weak in many cases. So, even if our medical practitioners and pharmacies invest more into information technology and try to address the issue on their own, they find that there's no standard approach to getting the history. I find it interesting if I have a 401K plan, I can plot my investments over time, but can't keep track of my cholesterol. We all use as an exercise to address fundamental issues, like the policy, required to bring information to the point of care.

Scott Thank you. David, Your thoughts, any reaction?

David I would agree with what has just been said.

Scott Very good. In your state of Massachusetts, David, what do you see as the competing demands of RHIOs, what are the kinds of decisions that, that stake holders, leaders are making. RHIO or invest in X what is going on there?

David Let me start by giving a short thumbnail about Massachusetts. Not everybody may know about what's been going on there. And I think that'll be helpful as we go on. This is a little bit of my frame of reference. I'm working with a group called the Massachusetts Health Collaborative, which is a collaborative that's gotten together to try to increase the use of electronic health records. And the collaborative was formed when the Massachusetts American College of Physicians convened a multi- stake holder meeting in which we brought together the key provider groups, purchaser groups, the state government, basically all of the key stake holders, and got them in a room and made the pitch that, you know, wouldn't we all be better off if we moved forward with health care IT. At the same time it had been having a lot of internal conversations about what they could do to increase the health information technology. And along with the collaborative came together to form this group that's called the

Mass eCollaborative started in September 2004, a nonprofit. We $50 million from Blue Cross. There are about 35 different groups on the board. It's a very broad and multidisciplinary group, basically representing all of the key stakeholders. We made the decision early on that we couldn't move to basically sharing data right away. What we decided to do was to get several communities to begin adopting electronic health records to implement data exchange in those communities and then look and see from there how that went. A lot of the work so far has been to select the three communities. We had a state-wide selection process, 35 applicants that were all terrific, and picked three of those. And we also went through a vendor process, issued a request for vendors and asked them to respond. They have to agree to represent data in standard formats and to allow extraction of data so that we can measure quality. And my group's role has been to lead the evaluation component of that. So, you know, we're at the point where we're about to answer some of the questions that Scott asked. But key issues that have arisen as we've done this, is privacy and security. They come up with scenarios they hadn't thought of before. The docs in particular are quite nervous about this, perhaps the smaller practitioner doesn't have a lot of interaction with outside businesses. There's no cookie cutter formula -- the information exchange models are, are not entirely worked out either, and they are different approaches one could use, different arguments in various directions, and it's not clear on which the best one will be. And the final

thing, the legal costs, when you do something like this tend to be high because you're trying to work out a lot of agreements that most organizations have not previously had.

Scott David, I'm going to ask you to, kind of, expand on a couple of points you just made. As you've been working in your communities, you just described some of your surprises. The barriers or -- or actual efficiencies that you've noticed. What are your biggest -- in terms of effort required or benefits -- the real world bottom line net value of RHIOs?

David Sure, I don't think anybody knows what the real world benefits are. We've put together a very ambitious analysis plan to try to get it there, but you know, the truth is that we don't yet know. The biggest surprise, and barriers, really have been dealing with individual physicians who have gotten very concerned about, about what security model will you use? They run through a lot of hypothetical's. And in many ways, this shouldn't be surprising, for example, if you look at the UK and how physicians there have responded to having their data put on what's called the spine. That's caused a lot of concern there amongst providers; there's been vigorous dialogue over the net. And we're seeing many of the same things. We, in the communities, there are a number of individuals who are quite vocal and concerned about privacy and security predominantly.

Scott All right. Thank you, Mark.

Mark David, could you tell me a little bit more also, ability time line for those three communities. I mean, there's so much going on in Massachusetts, so many different initiatives. But, for example, your DED project, bringing medication information to the Boston area. Are your claims collaborative? You're looking at these three communities, when do you expect to actually have something operational in these three communities?

David The communities will all start to implement beginning in January, and the collaborative is gone through and categorized each of the physicians in the communities who are going to be participating as early adopters or middle or late. And the intent is to have all of the physicians in these communities up by the end of next year. It's been interesting, basically sorting out all of the contractual. It's not trivial to give somebody a new information system.

Scott It really almost sounds like a plan for health information technology for three towns.

David Well, it is but, you know the intent is, let me make it clear, that the intent is to basically inform the developmental plan to basically reform reimbursement, to set up ways more rational, and that provide incentives for physicians and other providers to invest in HIT and make it

economically rational to do that. Our feeling was the way things are now it didn't really make sense.

Mark I have to tell you I really admire that, because I think the major effort that many of us probably in the phone are focusing on now are making sure we're asking the right questions. I don't think any of us have any answers as you've said, David, given the background and experience your team has, the fact that you don't have answers is comforting to the rest of us who are scratching our heads. I'm comparing and contrasting to some of the initiatives in Tennessee. It's a large state with 6 million people that touches 8 other states, a lot of people live on borders, at least 3-4 very interesting and exciting initiatives in the state at the community or state level. There's the project up in Northeastern part of the state, one in Knoxville. A fairly ambitious effort of the health care plan, working to address community needs and then there's our demonstration projects. And my work focuses in Memphis Tennessee where there's a very strong health care community, very strong local efforts. St. Francis, many hospitals, we cover about a million people in three counties, and our goal with funding from the Agency for Health care Research and Quality and from the Tennessee legislature, is to take a community that has been somewhat fragmented, take these silos and very rapidly pull them together, focusing primarily on the hospital providers to see if we can demonstrate value for a patient-focused health care system. So unlike

what's going on in Massachusetts, we are working through the hospitals. We are trying and we've got live data feeds now from nine hospitals going operationally into our center and I can talk a lot more about how that's done. We've got live feeds, not in use yet not even in demonstration use because of wanting to double and triple check our issues. But we are not going to go out to what the people in Boston -- we are really counting on a robust and vendor community, including the private sector for EHR, vendors, providers of information claims transactions, clinical lab, short scripts, organizations like that. And we're just trying to create the plumbing if you will that holds it together. So in Tennessee, more than anything else, we aren't saying we have the answers, we're not even quite sure what this market is. We know that when 800 people showed up for the doctor's plan a year and a half ago, that's a sign that there's a lot of improvement needed in health care, and we're just trying to ask the right questions. David, I have to agree with you that the big surprise to us, and I think to anyone going down this road, be it community-wide or just 2-3 entities is the enormous amount of legal and administrative issues that are really uncharted territory that have to be addressed. As well as, I think fundamental issues as you've implied from this physician community and others of trust information. I think when you start talking about consumers, that's only going to get worse, and maybe we can talk about consumers later on too. So I think many of who walked into this and I hear it all over the country. Thinking this a technical problem, and the

biggest question is a centralized or decentralized architecture. In a way, that ensures confidentiality and doesn't upset anybody's apple cart.

Scott Well, Mark. Speaking of vendors, the vendor community. On your perspective, this new and changed environment is either a boom or a bust. Suppose you're the CEO of a company marketing health goods and services? How you reacting?

Mark My reaction would depend on the type of company I'm running, if it's a large, established vendor, I'm going to stick to my knitting, if I have a core base in large health care system, large practices, and I'm going to have to say that these people have an enormous burden just to get the value out of the systems they've already bought from me. So I'm going to spend a lot of my time working on work flow, making my emergency departments measure efficient, making my scheduling systems work, getting nurses home on time. I'm going to work on my core customer base and I'm going to be scratching my head wondering what I need to do for those customers be it hospitals or large clinics to help them on the margins. For example, when people come into the emergency room and they've just been at another hospital, perhaps with one of my competitor systems, what do I need to do there to make sure it's transmitted easier? I'm also going to spend a lot of time explaining why mine is the best. But indeed if you look at the evolution of vendors, all of the vendors are moving to

standards rapidly. I think if I'm a vendor, I'm going to be smart enough to know that I'm going to walk down that road. So I'm not too worried in the long-term. If I'm a small company trying to go into the small practices, I'm going to take heart with innovators dilemma. Talks about in many cases the steam shovels, for example, they knew about the backhoes, but they just said there's no money for me there, and the little guys with the backhoes won the day. And I'm going to take heart that I, as a small businessman, can provide value to the practitioner, that's going to require a certified occasion process, and it's also going to require, again, inexpensive access. If I get those things, I'm going to be successful. So I think that right now we're seeing tremendous interest in the vendor community, vendors in some assistance really want to take a fairly monopolistic view of this. And I can understand that, but even if you had a single vendor across your entire community, when you look at the problems throughout the country, technology's just again a small part of it. The legal, the organizational issues, the trust issues, the privacy, those have very little to do with vendors and a lot to do with community culture and organization.

Scott Very good, David any response to that?

David Yeah, I would just say that we can expect a lot of consolidation in this marketplace, and that as Mark said, the vendor community is now

recognizing they have to move towards standards and towards a representing data in ways that makes it easy to pull it in and out of systems.

Scott

Very good.

Well, David, while we have you there, at the end of the day purchases and payers must engage and endorse. In any substantial changes in the health care environment, having said that, many regional efforts are having difficulty engaging health plans and manage care organizations. Why is that? What is the view from the industry, such as industry HR departments or new development, or business development aspects of your local Blue Cross Blue Shield.

David

It's been a terrific leader in this regard. Blue Cross has taken the high road and said they recognize we can all be better off if we can come together and agree to work together around this issue. Now -- Massachusetts has been unusually fortunate in that regard, we only have four big payers, they've all agreed to plan this. In many other states, it's been a much harder conversation. And I think some of the reasons for that is that one or more of the big payers maybe headquartered out of state. It has been a little harder to engage some of the for-profit payers in some of these conversations, and there's a clear-cut first mover kind of effect. So that it may not be to your advantage to be the first plan to do something like this.

Because, you know, you could end up paying for it when everyone else benefits. Talk about efforts to try and bring together payer groups in different communities. I think that's one of the most important things to do if you want to really be successful. And yet, it's hard for the reasons that I mentioned. It's helped a lot to have the biggest payer in our neighborhood be such a leader in this regard.

Scott Thank you. Mark.

Mark The payers in Tennessee are leading as well, and I think it's a high road, but a little bit different high road. And that is that one payer in particular has created a subsidiary trying to address some of these problems, and as strange as that may sound at first blush, it's yet another effort in a very business sense to try and understand the value and business case for regional exchange. And I just think that I'm just very excited that payers are getting involved. At the end of the day, this is really about a shift in power by health care. Who people are, and how they pay. When I think payer, the first thing I think of is a self-employed individual or a small business or someone like that. I don't necessarily jump to the giant federal expresses of the world with that. And we're trying to build systems that affect all of these people, and again, if we had answers to that, I think we'd be in better shape. It does appear to me if we don't keep going down this path of trying different experiments and be open and honest, we'll never

get to the point where the ultimate payer which is us can make the kind of health care choice we want. And my guess is, over time, many of the plans are going to be more active in health savings accounts. They're going to be more active as consumer focused organizations. I would always want to work through some sort of a broker to manage my money and other things that I will no matter what kind of health care plan this country has, I will be looking for a robust organization with critical mass to help me navigate through the system. So I think we're starting at a different place here. I think a lot of people are threatened and it has to do with fundamentally about consumer choice. And what it means. If I'm a consumer and I have a $4,000 deductible health savings account, a lot of the payers are literally out of business. This is fundamentally disruptive. And that is a threat. But I've been fairly hardened although it seems slow and I have every reason to believe they're coming to the table even more.

Scott Thank you. Mark, while we have you. Industry officials pushes the importance of standards and certification of health information technology. How important are standards and certification -- and how far can an organization go in the absence of standards and certifications?

Mark I'm very optimistic about that, as well. First of all, I think because of processes put in place well over a year ago and other state and federal agencies, there's been a lot of work going on and what certification means

and what standards are. The standards people have been working at this there are several years, and the reason why. David pointed out some of the major issues in data sharing really have to do with the legal and organizational issues. One of the most exciting pieces of work that deserves more attention will be the materials coming out of the foundation connecting communities. We're connecting for health rather in the next month or two that are going to create backgrounds, almost like a tool kit if you will to help navigate through the issues surrounding data sharing. So, I think, if you, we are starting from scratch today, we can go pretty far without stronger standards. The other thing comforting, is Medicare part D. They're out there. There's enough consensus at least with a new differences on how to advance working with our communities, with our hospitals, vendors, this is going to be a 5-6 year revolutionary process no matter how fast we move and the optimist, I don't think standards are an impediment right now and I think they're going to align, and I really want to believe that's true.

Scott David -- your reaction.

David So I would agree, I mean, I think that certification is necessary, that it will be hugely positive, but that it won't be sufficient. I think that more records will get certified then, we'll end up having a big share in the marketplace, but I think that's going to help a lot. With respect to standardization, I'll

agree with Mark, we've come a long way on the standardization front and the work that HHS has really led has gotten us far enough along that it's safe to move forward. There are lots of details that still have to be worked out and some gaps we still don't have -- RX norm for example, but I think it's time to move ahead.

Scott In that regard, too, David, you mentioned RX norm. People should read the report, it's really nice and there is a pretty interesting discussion of what it would take to create a national prescription drug history data base for the country. And those kind of services, and it's a wonderful thought experiment to walk through about how all of these standards, at least one way they could come together and that's kind of nice. And the other thing is when we're thinking about standards, we've got to think about more than the practitioner's office, we've got to think how to beef up the departments. They're tremendous resources for community care. We have to think about home health care, and nursing homes and the transition of care between hospitals and nursing home which can be catastrophic. There's a huge problem out here right now. And getting a lot of these people to the table and understanding the potential that could be realized if these technologies happen, is a lot of good work for the next year or two.

David, in the past few years, leaders at all levels, the national level, state, and local level have expressed an interest and support for these efforts.

These community, regional and state information exchanges. Suppose you're the CEO of a large hospital system, how important is it to you to have this high level engagement? And particularly, would it influence you one way or another and in what way would it influence you?

David I think it's been clearly very useful. It has raised things up on CEO's radar screens. This is now higher on my radar screen as the CEO of a large hospital system, than it would have been otherwise. That being said, it only takes you so far. And, you know, the feds and state leaders are talking a good line here, but best I can tell, they're not putting as much money into the, into the system as I think that they might be. So, you know, based on the first principle, I'm excited. It's going to be a good thing for health care, but I'm also doing the calculation, mentally, and I'm nervous because my health system has invested a lot in a large clinical data depository and we did that to have a competitive advantage compared to other systems in our areas. A lot of CEOs are in that position. And still we don't have a good concept in this country of who really owns the data, as I see it, the ultimate challenge you're getting at here is who does own the data? And do I, as a large hospital system have the obligation to make that information available to outside entities? Partners has said we're going to lead on this, we're going to make information available to outside entity, but I think a lot of other organizations will not do that and they'll be quite rational in doing so.

I certainly see a change in the debate from ownership of data as a competitive advantage to efficiency and service as a competitive advantage. I like to believe that's very real, and that's certainly my hope. But I think if you look at how of these things have to evolve, until the community can get over the data possession issue, we have a real problem in moving forward. And I think that again, most competition is not really based on that. As Americans all we see is the frustration. As someone mentioned here on the net, at least, ownership is really ultimately a function of us as consumers, and I think as consumers get more frustrated with health care technology, our health care information, you'll see some forward movement as well. I am very sympathetic to the CEOs and CIOs of health care organizations they're best borderline any way. The problem isn't no money, as much as it is there's a lot of money in health care, and none of is going to the basic enablers of health care. And you have a product of such variable quality as we are producing, I would say that any good executive in their right mind is starting to think I'm not going to bet the farm here, but I sure, as heck, have to rethink how I'm going to be playing in a vast community role in terms of supporting the patients.

Scott Okay, Mark. I'm going to keep you on the hot seat for a minute. Suppose now you're the lead partner, managing partner in the practice. How

bullish or skeptical are you regarding the nature of these efforts? What financial challenges would you envision?

Mark Again, I am probably going to be focusing right now a lot of my own practice. I'm going to work very hard on linking my clinical care to frankly paying the bills. And I'm not going to be spending a lot of time on that, but as E-prescription and E-refilling and coming on the scene more as more and more hospitals reach out to me in clinical labs and others with unique portals, I'm going to say that I'm dealing with a dozen, I don't want a dozen interfaces in my information. So I'm going to be looking for a coherent market, if you will a utility to get information that's really information that belongs to my patient, brought into my office while caring for that patient. So I'm going to start, I think, after I get over transforming my own medical practice, pushing pretty hard for a low-cost means of accessing information. Without that I can have the best EHR in the world, if I have to retype information every time, I'm in a world of hurt. I'm concerned about -- I'm still the CEO of the hospital here, I'm concerned -- I have a bunch of complaints I want to bring up with you as a doctor, but that's a different story.

I want to know who's going to pay, and I want to know how it will all actually work. I don't want to be paying out a big fee to a big group that's moving data. Will my entity be better off if we participate in this and are there going to be a lot of costs with dealing with interfaces and dealing

with reconciliation problems, and so on. So that's what I would like to understand.

Scott All right. David, I'm going to keep you on the hook here for just another minute. The efforts in Massachusetts. I'm going to ask this to Mark too. Did you go to the lead partners of these organizations? Outside partners, of course, and say, what are your compelling issues? What are your barriers to ROI on this and did you endanger them on that dialogue?

David Absolutely, the RHIO in Massachusetts is called Mass Share and John is the CEO of it, and so he's got some capitalization right now and is struggling sorting out what the business model will be for Share. He has been to all of the individual organizations and had the kind of conversations we've just had. The big provider groups have contributed some to this, but asking just a set of questions that I'm asking now, and they want to know when is this going to pay for itself, and how is the transaction model going to work? We think that E-prescribing is going to be particularly important in this, and there's a large E-prescribing pilot starting in Massachusetts, and the hope is that that will be one of the places that it will be possible to generate some revenue, but it's far from being worked out at this point.

Scott Mark. How did it go in Tennessee with those conversations?

Mark

Well, let me follow up on the E-prescribing, because that's an interesting one. There's no doubt in my mind that there's tremendous savings to our health care system that will be incurred by more rational use of pharmaceuticals, specifically, move to generics where possible, finding the best low-cost alternative, offering more choices, streamlining the communications between the physician office and the pharmacy, lowering the cost of claims through third parties, there's clearly a lot of opportunity in E-prescribing. There's also a great opportunity in E-refilling. Refilling really gives practitioners for the first time in partnership and retail pharmacists in others the ability to manage chronic diseases with medications and not just worry about who's calling in but who's not getting it, which is an ability that many practices don't have. That said, I don't think 5 different groups in a community can have competing proposals and say we're going to make our money off of E-prescribing, it's something that's going to be happening over time and pharmaceutical trend management, and a little bit independent of technology, the degree I think will be increased because of this. In Tennessee, a very different situation. We've got a number of robust regional efforts. Each one originated for different reasons. Some very grass roots community based. Some plan based, some in our case based on the plight of large operations. They have several things in common. Facing a growing burden of the uninsured and a greater pressure on Medicaid providers and others, and

what our catalyst was really the health care financing crisis in our state, which again is not particularly unusual. Our catalyst was also the leadership of Governor Phil and his team in the state capital who really brought the attention to this challenge and has been advocating for several years the role information technology can play in lower cost care. So again, we have had strong leadership- it's in our health affairs article- leadership from the Governor's office. And that was really critical to convene. Because of the first few months of getting all of the executives and leaders together, it took a little while for them to start realizing the advantages of working together in these areas, but I think we're over that hump now, we have not gone out to the providers, we believe that these practitioners of physician or the consumers, we think that will come later. And that's done through a coordinating body, but instead through traditional relationships between hospitals, medical societies, community government, alike.

Scott Thank you. We have about 153 attendees on the line right now, and maybe from various aspects of implementation of these kinds of organizations all the way from fully engaged to just planning it to maybe being a central or supporting role.

I'm going to ask both of our panelists to give me from their experience, kind of the one thing to avoid. This comes into the hard lessons category. The one thing to avoid and the one thing to definitely do while you're

assembling, planning, implementing, otherwise, designing one of these networks. I'm going to open it up with Mark, because I'm looking right at him, and David time to contemplate this -- to the attendees.

Mark I think the one thing I would avoid is the belief that I'm the first person to have any particular idea about health information technology or community practice or anything else, and that I'm the only -- I'm a member of the only organization that could possibly solve that idea. I think these are what we're talking about today is a number of incredible initiatives where there's no winners or losers across the unit. So the trap is to think you're the only act in town and to think you've got all of the answers, I urge you to listen as much as possible to everyone and always remember that the role of the person holding these things together is to enable others to be successful and not necessarily to in a sense run things. So don't think you're the first person to do it and listen real hard.

Scott David, one thing to avoid and one thing to definitely do.

David So my answers are really close to Mark's. I think the thing to avoid is to have too predefined plan. It's important to have negotiation and discussion around these things, we moved a lot on a variety of points. And on the definitely do side, I would say it's very important to bring everyone in. If you can get all of the stake holders to the table, this is a

situation in which people really will recognize that everyone's going to be better off if we can be successful.

Mark Yeah, but David, there's two schools of thought of that in my view, I absolutely believe everyone has to be in and at the end of the day it's all about us, it's patients it's about us and our kids and better health care. Don't you see a problem if you try to bring everybody in with a non-focused agenda then you end up with very few resources promising all things to everyone.

David Well, that's a tricky challenge, you have to decide where you're going and someone has to provide leadership around that. And there will be a few people who decide that they don't want to come to the party, and you have to be willing to proceed without them, but that being said, I think it's clear enough now from a variety of different experiences around the country what a purchaser going to be successful that -- it's possible to move forward without endless discussion, and haggling about what directions to take.

Mark Yeah, I also think that one way of being inclusive, David, is to take more of an educational focus rather than a project focus, and if you look, a lot of the successful, early initiatives have had a strong on education, and so particularly where consumers are concerned, one of the big challenges is

to help educate people on just how medical information is now. And another is, what technologies can and cannot do- open and honest discussions among health care providers because there's a lot of healthy reasons to be skeptical about the kind of -- if you're a one or two man practice or a small retail pharmacy. So there's a lot of education that can go on. I don't think most people understand the health care system very well. And I think there's advantages there. There's also trust, so what we've tried to do is create a number of different initial questions and then turn it over totally to the community leadership and I think that's helped us as well. So my approach is yes, get everyone involved in time but don't bring everyone into the same room. Because everybody's after a little bit different thing. Than if I'm a patient or home health nurse, we've got to find ways of making sure that everyone feels that this is something important and creates their own value proposition and sees how it fits. My sense is, that patients generally are a little ways, not as far along with this as the provider groups are, and that although we've included patient groups throughout in our effort, they haven't led with this, I think that the leadership needs to come from the health care community with this, at least for a time. I think the public is going to catch up.

David I would agree with that.

Scott All right. You've now heard from us, and now it's time for us to hear from you with your comments and questions.

Brian We'll call on Andrew.

Andrew Yeah, this is Andrew calling from the Alliance of Chicago Community Health Centers and we are involved in a formation of a small clinical data exchange with the community health care centers in Chicago, and one of the questions that I have been sort of mulling around as I've been listening to the speakers as regarding, who is really taking coordination and leadership over all of the clinical data exchanges that are happening nationally and I know that there's not a specific answer to that, but maybe what are the pros and cons of different groups, those being provider groups verses government groups, verses consumer groups, taking the lead of setting policy and other kinds of standards.

David This is Dave, and the approach that has been chosen so far is pretty much let each of the RHIOs set up their own rules and to do things in their own way. And the idea is that eventually it will be possible to link up data through the spine, sort of, approach. But there is not any single organization that's been responsible for coordinating and evaluates efforts.

Brian Mark?

Mark I think the politics is local. The key challenge in my view for the next couple of years is getting the local issues right. And there again, you kind of need a neutral convener, you need a sense of urgency. Most of the lessons from business review about why big projects fail is pretty applicable here, so I think it really depends on the organization and the need. Each of these issues is coming from different market forces or public forces if you will. Some are concerned more about consumer health. Some are more provider focused, some more physician focused. Public health wasn't mentioned. These are great questions about public health. There are very important drivers there, and I think you've got to look at what the resources and the market in your community is and try to fit everything else in.

Andrew Great, thanks very much.

Participant I'm calling from the U.S. Virgin Islands. One of the questions, is we've always had a cap for Medicaid, and we know now with some of the movements federally because of the difficulties with the deficit, that's -- faced with Medicaid issues and other issues related to funding. I'm wondering if you could shed some light as to how you could either convince the federal people with the power to somehow show the performance or IT to helping those less fortunate people be able to get

better services. I don't think there's a big enough emphasis on how it can help the population improve their services, and the reason I say that is that the physicians that are least likely to participant in IT are the people that are most likely to serve the population. I was wondering if this was addressed or any discussions going on about this issue?

David Certainly a lot of interest in our group is the question of whether or not implementing IT reduces disparities, investigators in my group that are particularly interested in that question, and our hope is that that it will. To do that, of course, you have to get providers who are caring for the disadvantaged to begin using IT. And that's why I think efforts like the collaborative are exciting and one of the communities we're studying is a disadvantaged population, and we'll be able to look and see does this make a difference for that, for that group? I think it's clear that providers who care for the disadvantage need special attention in terms of helping them get access to HIT.

Mark Mark here. I think the comforting thing here is when you take an approach to health care, you start seeing that all of the providers share a common interest in solving these problems regionally because, again, our inability to pay for the uninsured, our inability to reimburse providers, the enormous out of pocket expenses, these are issues that represent a hidden tax on the economy, and hence, the good news is, I believe, these kind of

discussions don't really separate into as much as understanding that everybody has to share a certain burden in this. But if you're looking for low-cost solutions to those providers, I think the Indiana experience is pretty relevant here. It's amazing what you can do with some secure e-mail and printers. Paper is still a pretty good form of communication and health care. And so there's a lot to be done without an EMR, where just getting reports any which way via fax even is a step above not having any information at all.

Brian One of the questions that came in via the Q and A text features was does the standard data format include any specific nurses languages?

Mark I would say that, the answer to that is no at the present time, but it doesn't even really -- there's no standard data format. The other question pointed out that despite great efforts by other organizations in the federal government, there really isn't a final public set of standards other than Medicare issues. So there aren't really that many standards, we're very early in the game. There aren't standards for allergies, no standards for problem lists, for a lot of common clinical information, so this is an area where as opposed to the inpatient setting where nursing vocabularies and standards are critical for patient care, we're in most communities dealing with real fundamentals, trying to get a function test from point A to point B. If we take an expansive view looking in terms of home care facilities

chronic disease management, we're not going to get really far without incorporating those standards down the road.

David I would agree, and I think nursing standards are one place where we have a significant gap, it's not that we don't have a standards for nursing terms.

Brian Speaking of standards, I think, a question from Gary, kind of speaks of that too, that we've talked a lot about standardization. He points out that Congress has been reluctant to pursue any national ID and he wonders aloud how can we securely exchange across the Nation?

David This is Dave again, I would prefer to have a national identifier, but I think it's not politically feasible at this time. And what David points out is that you can do pretty well with an identifier, there's not any unique identifier that we all have that gets our finances, and yet, you were able to get money out of ATMs all over the world at this point. I would suggest that we can do sufficiently well without the identification, although it is admittedly more expensive.

Mark And I would agree with David on that too. Of course, we know even when we've got institutions with unique identifiers, we have a lot of transliteration errors, when we're doing mergers, we're seeing with internal identifiers some noise and introduced. It's not really a panacea, but I think

Gary asked a question, we've got to keep pushing on that, because there's so many ways I can create a unique identifier and tell you your life story, what is this country -- who are we kidding when we say that our identity is really hidden? I mean the broader question here is how do we really keep identity confidential in very unique situations? How do we treat each American as a unique VIP patient? And those working on efforts really have to worry about that. Because if somebody has X'ed out but there's enough data to put it together, all of a sudden with the linking algorhythm, you reconstruct information that was not supposed to be available. So there are a million things.

David I just wanted to respond. She's asked that as a CEO of a hospital, how do you get them to share primary care. And I think that's an easy one in that hospitals want providers, particularly primary care providers to refer patients to them. And if they do a good job of making data available to those providers, that will strengthen those linkages. There have been issues with not having hospitals pay for records for providers because of the Stark laws, but now that has been, that has been relaxed. In addition, hospitals sometimes have laboratories, and if providers get the data back, they're going to be more likely to make that information – to send their business to the hospital.

Scott David, that's right. I mean, this is Scott. Your traditional hospitals, by a variety of methods, want to find physicians and thereby bring patients to the hospital. This is all the way from creating an environment that physicians want to go through by having certain technologies, certain instruments, the ability to be for physician, it's going to be interesting in the future to see, you know, how data ability. These data interchanges play into that. Whether that's going to be another in that suite of service, or suite of capabilities that hospitals CEOs are going to deploy again to bind those physicians voluntarily to that hospital.

Speaker It may be, and Mark's comment about this too. I think it's a tricky thing. We don't see the -- I think there are a lot of down sides to have a hospital control your local RHIO. I think it makes more sense to have it be an entity that's not the hospital so that you can move information around without anyone having too vested on an interest.

Speaker I would agree, and it's kind of funny, if we look at our own personal health care, and I would have everyone think about their own health, and think about where do you get your health information? Your practitioner, your OB/GYN, your retail pharmacy, your relatives, from your friends, from your -- then the hospital saves your life. When you look at the overall health care, hospitals are critical because of the critical mass because of

their impact and it isn’t easy, because of their costs, but they're only a part of the whole thing, and I think the hospitals will prevail here.

Hospitals are becoming more than hospitals, systems of care.

Speaker Sure. And the larger the system, the better off you are. One aggressive market, multiple systems using the same vendors or by and large using the vendor, a regional data exchange are the same. A single vendor or a large system doesn't really get you off the hook. It simplifies the problem, but doesn't get you off the hook.

Brian Let's go back to the phones now, we have a question from Elizabeth. Are you there, Elizabeth?

Elizabeth Okay. I'd like to hear the panelists talk a little bit more about the concept of who owns the health care record. I think that a lot of the complexity that's involved is tied to this issue, and if I put on my consumer hat, you know, it makes a lot of sense that the consumer would own the health care record, I mean, every time the consumer gets some kind of medical service, they pay for that service in a sense, why don't they own it? You know, that's a model that we're very familiar with in almost every transaction we have in life. Someone mentioned the financial services analogy before. Even with financial services, even if you have providers

manage your accounts for you and stuff, you still as the consumer own the, you know, the records. But it just -- I'm just wondering, I know it's a huge shift from what we do. Why is it that the providers own every piece of information in today's multiple provider complex system?

Speakers — Say that the patient actually has access to their data, and I think we're going to eventually move to the concept that the patient will own their own data. But at the same time, the provider has certain obligations too and they have a legal obligation to keep a record, which includes the data. There are some efforts to make it possible to basically dump your data into a publicly available place. And one notable effort like that is the PING effort, which is something that Zach and Peter have put together. And PING is a personal health record that will hold your own health care data, and it will accept data that's sent in lots of different formats, and basically make it possible for you to look at it and access it. So there is interest in this area.

Elizabeth — Are any of the RHIOs or any of these prototypes? Are you exploring that at all?

David — They happen to in this neighborhood, our feeling is that we have to have some data moving around before that will actually make sense, but the thought is that we probably will move in that direction down the road.

And I'm sure that other organizations are thinking about it. Health collaborative elected not to make personal health records a high priority right out of the box, the feeling is we have to have some data there before it makes sense to work too much on making it accessible.

Mark

It's a great question because there's several senses of ownership here. We as consumers own our health care information; I've already told you what it is. So why am I telling you again? Just a pure hassle factor, and this is my information, you should not play market games with my information by making it hard to transmit it if I choose to seek care elsewhere. I think that's an immediate and healthy thing, and I think it's why some of the people are responding to the initiatives in the absence of an immediate financial return for them because they see the consumer perception changes dramatically. The second set of ownership really has to do with what David had to talk about again, how you get your information and value. And again, there are signs that the world is changed, I don't want to mention specific products, plus but there is a product with income tax management software that has a personal health information management software package now. So, clearly, this notion that this is my health, this is my information, I have a right to know how it's used is coming forth both in the business plans and the vocalization privacy concerns.

Speaker So hack into our computer, and I can also download our personal health information --

Mark Absolutely, it's a much more efficient hack. Actually, of course, the technology models, most of the reluctance of this doesn't have anything to do with short-term standards, has to do with really how do I know that Dr. Smith is Dr. Smith. How do I know she has the right to see this patient? How do I know the patient has consented to that? Those are the kinds of things we need to bring forth. Some of those we are tested with the Katrina help.org initiative. But they showed we have problems.

Brian All right. Let's go back to the phone lines and see if Peter -- Peter are you there?

Peter Yes, I am. I have a comment and a question. The comment was about the terminology comments that were made earlier. There are national standards that have been adopted by NCHS -- that actually are quite useful. These have been used for diagnoses. There's RX norm now available for clinical drug naming, there's a new effort by the VA to create an allergy base that should be publicly available this year for everybody to use, and there are other notable examples, I just picked out a few, of where the government has sponsored or directly created or been involved in adopting national and international standards on the nursing side. There's

actually an international terminology model that's been passed and that's a big step forward in harmonizing things and as I'm sure Mark knows, there's been a terminology summit by the -- I think it will continue at Vanderbilt which has tried to harmonize the different flavors of nursing terminologies out there to get something going for this very purpose. My question is I think this is sort of the 800 pound guerrilla that's sitting in the back, from the point of view of health care providers and health provider organizations, is how will this all change referral patterns for these entities? I think that much of the problem that we've had has been either around ethical issues like security, or around economic issues like referral patterns and I wonder if the two participants can speak to how they expect it to change and is this for the better?

Speaker

Peter, that's a great question. I think it's unclear how referral patterns will change. My prior hypothesis would be that people will be more likely to refer to places that are good at accepting information and sending it back in ways that are intelligible. I think it's hard to predict how things will change in the longer term. If you asked people to predict how the Internet would affect shopping. I would have had a hard time predicting exactly what I would be doing on the Internet in terms of shopping a few years ago, and this maybe as profound as that.

Speaker I would agree, Peter, that we don't know. But here's my point, right now referral relationships are based often on trust, and pattern. I think that as we all age, consumers really are used to in a sense being part of a competitive economy that's based on results and quality rather than just on, this is where I've always went and bought my hammer. So I think that when you hear about Google possibly having Google maps it will tell you if there's a cheaper price a block away. Wouldn't it be a wonderful world if we as patients could see who is the best suited to manage my diabetes. So I think if that upsets referral patterns, but we have a more informed set of decision making, I'm all for it. And concerning the standards, you're right, but the problem with standards is there's so many. I mentioned because it's a fine example of how several pharmacy care standards are bought together with one idea. I think the challenge for all of us in the next couple of years is to take these incredible standards and support those people who are working so hard on the details and finding the ones that are really going to be adopted. Because there is a big guess between what people want to promote and the ideal approach is and the realities of some of ease at the current time. So we have to keep pushing.

Brian Okay. I think we'll go on to our next person. And that is Jason.

Jason I'm with the National Institute for Health Care Management Foundation. Earlier Scott asked about health care presentation and David in

Massachusetts but also noted in other areas that planned participation is not as forthcoming. What are the reasons why they aren't and how might they be encouraged?

David — As I've mentioned before, I think the biggest single reason is this first mover affect. It may also be that they don't really believe that the benefits are real or really accrue to them, but I don't know about that. I think that the kind of approach that advocated involves bringing together of plans in regions is the one that makes the most sense. In Massachusetts the plans have had a lot of experiences in coming together so they're sort of relatively unusual. We have a group called the Massachusetts Quality Partnership in which the plans got together and agreed about what the quality measures would be for the state. And that's been tremendously beneficial for the providers in the state. But in that kind of arrangement and organization is relatively unusual.

Mark — And we have multiple kinds of plans, fundamentally aggregators who have an incredible amount of thrashes to and from. And plans everyone knows their names that have a much stronger commitment to disease management and long-term care. I think the same issue that comes down to the hospital, comes down to plans. Right now, there's a desire to distinguish on the basis of data to establish a greater market share and I'm sympathetic to those concerns, but over time, I think the only thing that's

going to get the other plans are getting in. I think at the end of the day, it's really going to boil down to a first mover getting in and everybody else following. And I can think of no better reason, but as I've said there are some planned-based experiments and plenty of experiences and, I think plans are going to learn a lot from that, plans are going to learn a lot from the consumer experience and they're going to teach us a lot, and I suspect it may be in some areas and not the other way around. I wasn't trying to be evasive, but that's the best I can come up with.

Brian We'll go on to our next caller. Tom, are you there?

Tom Yes, I am. I'm working with the Washington State Hospital Association out in Seattle. I've got two questions, the first would be to David, I think congratulations, first of all, on being in a state where a health plan has dug deep to get things moving. The question I have for you is, do you have any sense for how far $50 million gets you if the goal is to establish a RHIO in the state of Massachusetts? And then the second question for both of you has to do with earlier you talked about some of the issues that come up when exchange of data is among providers, you talk about privacy and security. One of the things you didn't mention was the issue of liability, provider liability, when they incorporate information from someone that isn't part of their entity and act upon that information.

David So both great questions, in terms of how far the $50 million goes, we're not just implementing a RHIO. The costs we've looked at are the costs of the health records and implementing clinical data exchange, and we estimate that the net cost is about $1 billion. So the $50 million is a small down payment on that, but that gives you a sense of how big a down payment it is. The liability question is a very big one, and that has actually come up a lot. And it's an important problem. So there are all kinds of issues that come up that would not have come up before. What happens if you're practicing using an electronic health record ordered by someone else gets populated into your record? Are you liable for that? How is that handled? And those kinds of questions have to be answered.

Mark Let me pick up the second one first, Connecting for Health mentioned it's at least going to give guidelines and raise questions of great legal talent -- a lot more coming from that. But there are again, community precedents you've got to work through on this, and there are some legal precedents, but not many. We can spend all day talking about those, maybe we should some time talk about how that can be addressed. In terms of where the money goes, I'm with David. Every street and sidewalk is a toll road owned by someone else. I mean, at some point, you've got to say, you know, we're investing 18% of the GDP on health care in America. In terms of our hospitals call facilities, the problem isn't that we don't have money, it's how we think about the problem. In the absence of

mainstreaming focused health care and data exchange into what we defined as a the health care infrastructure of America, as we're playing that game, we're not going to get very far, which is why I'm hoping we get basically a change in awareness or a change in some sort of reimbursement to enforce or to reward those who take this fairly ambitious path. I would not want a third party to finance my health care system; I would like to own my own store, thank you very much. And I would say with 50% overhead, there's got to be a way to do something to make my practice more efficient if I get the kind of help from others.

David — And so one other comment I would make, the Massachusetts technology collaboration is doing something important, which is basically trying to get all of the hospitals in the state to begin using computers -- I think that's the other big chunk with the three big pieces being electronic health records, the outpatient setting and the third piece, CPOE in hospitals.

Brian — We're near time. The questions we haven't been able to answer, folks are going to get answers to these, there are great questions here.

Scott — Thanks for pointing that out, we are nearing time, and there are no hands raised in the Q, so if you have a final question, feel free to raise your hand in the last couple of minutes. And the other thing, I'll put a plug for if the poll that I started. Just 5-6 questions that we ask at all of our

teleconferences, your feedback is extremely important to us as we put on these events to ensure high-quality, to please do fill that out and submit it before you leave today.

Brian Thank you all very much for your time today.

Scott Best wishes all. Bye.