Strengthening Medicaid with Health Information Technology (HIT): Are Providers and States Up to the Challenge?
Alliance for Health Reform
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ED HOWARD: My name's Ed Howard. I'm with the Alliance for Health Reform. I want to welcome you on behalf of Senator Rockefeller and our board of directors to this program on how health information technology, HIT — we won't do many acronyms, but you've got to master that one — how HIT can help and is helping improve both the quality and efficiency of Medicaid programs throughout the country.

These are pretty stormy times for the Medicaid program, for its beneficiaries and for those who run the program. On the one hand, in almost every state Medicaid has been under the budget-cutting knife as legislators and governors struggle to balance the books. Now it appears that the debt ceiling agreement spares the Medicaid program, at least for now, but we don't know what's going to happen in the fall. We do know that the enhanced federal matching funds provided under the stimulus bill are now history, and that's causing some problems in a bunch of places.

At the same time, though, we've got big changes that are happening now and even bigger ones that are coming down the pike in the years ahead for Medicaid, and states are scrambling to prepare for those changes or dealing with them in some cases. Here are just a couple of the present day developments.

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First of all, the so-called HITECH Act, and I'm not going to tell you what that acronym means because I don't know [laughter]. It's part of the 2009 stimulus law and it provided $27 billion, that's billion with a B, in incentives, the largest part to providers who are encouraged to make meaningful use of electronic health records. There's also a 90-percent federal match available to states to set up and run simplified and uniform eligibility and enrollment standards that came out of the patient protection and affordable care act. And those standards are going to be effective in 2014, but the preparation for them is going on right now and the federal funding is available right now.

There are also some cooperative agreements to help fund health information exchanges. These are not the insurance exchanges. They're health information exchanges in the states to build the capacity to share health information to the tune so far of about $550 million.

Now the reform law is scheduled to bring some further major changes, obvious, in 2014, including a major expansion of Medicaid enrollment. So the sheer volume represents some challenges all by itself including to state Medicaid information systems which can be, in some cases, decades old, what they call legacy system, but it's not much of an inheritance.

And Medicaid is going to have to interact with the new health insurance exchanges to make sure that people are assigned to the proper program and they get the subsidies that they're entitled to. The idea is that there'll be, as they say in Virginia, no wrong door through which to apply for insurance coverage and we're going to hear about the commonwealth's program in that area later.

HHS has awarded early innovator grants to several states to design and implement infrastructure that's needed to operate these health insurance exchanges and their interaction with Medicaid. That's another $240 million. More immediately, HIT offers an essential tool with which to improve both the quality of care being delivered in Medicaid and to keep cost increases at a minimum. We're going to hear today from a major Medicaid insurance plan about their work with providers to improve care delivery and reduce costs by reducing duplication of services, avoiding medical errors and improving billing efficiencies.

Also, we're going to look at a cutting-edge community health center based in Seattle about how they're harnessing HIT in their work to provide better and more efficient care for the uninsured and the underinsured. And we'll look at how HHS's Beacon Community Program has helped more than a dozen communities build on their HIT progress which has been

substantial to improve community health and serve as models that other states can learn from and other communities can learn from. So we're going to look at these and other issues. There are a bunch of them involving Medicaid and HIT with people directly involved in using HIT as a tool to improve care and effectiveness in Medicaid.

Now we're pleased to have as our partner in today's program, the Centene Corporation which contracts to provide Medicaid coverage in about a dozen states. It operates a number of related services like nurse call centers, and you're going to hear from their chief information officer, Don Imholz, in a few minutes. In fact, less than a few minutes [laughter] because I do want to get to this.

Well, there is one item that I want to cover. There are obvious a lot of information in your packets including a list of information we didn't run off that's available online at our website, allhealth.org. There are green question cards you can use at the appropriate time and a blue evaluation sheet, and I actually want to spend a minute talking about that evaluation sheet.

Let me see here. We really learn a great deal from reading your comments and suggestions and complaints and we'd like more of you to fill them out. So we're taking a new tack.

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We are giving up on volunteerism; we're going to go for pay-for-performance (laughter) device.

Normally about a fourth of you fill out the evaluation form. Here's our deal: if that number goes up to 35-percent of the people who are in attendance, the Alliance is going to donate $50 to Bread for the City. And if you don't know Bread for the City, they are a terrific group. It's not just anti-hunger. They have operated a no-cost clinic for low income children and adults using volunteer health professionals and a small staff for the better part of 30 years. If you get to 50-percent participation in filling out the form, we'll go to $100. So exert some peer pressure on your friends as we go along here and we'll do some good as well as doing the original chore that we're supposed to.

Now s I promised, we'll turn to Don Imholz who is representing the Centene Corporation. He's the executive vice president and the chief information officer for the Centene Corporation, and as I noted, they provide Medicaid coverage for about a million and a half beneficiaries in a dozen states. There's a one-pager in your kits that details where Centene operates and you'll note that the program has different names in different places.

So if you've not heard of Centene before, you shouldn't feel bad except that you missed the previous briefing that they

co-sponsored with the Alliance and that's a shame. But a word about Don, he — whereas the health sector generally has been dragged kicking into at least the 20th century with HIT, Don Imholz has spent his entire career specializing in information technology, including for more than 30 years at the Boeing Corporation. So we've got cutting-edge technology and skills involved in trying to update the $1 in $6, headed for $5, in our economy that's represented by healthcare. Don, thanks very much for being with us and thanks to Centene for being part of this program.

DON IMHOLZ: Thank you very much. On behalf of Centene, welcome and I appreciate the opportunity to talk today on a subject near and dear to my heart, the impact of IT on healthcare. I'd like to share with you over, of course, the next few minutes how Centene is making significant contributions to the subject, driving outcomes and processes, technology, and most importantly, driving improved outcomes.

Just a quick, and Ed touched on this, a quick summary of Centene, the services we provide our geographic footprint as mentioned and -- and again as Ed mentioned, some of our brand names. The brand names actually are significant because we have a very local model for delivering healthcare. We deliver our services with people in the states that we serve. As Ed mentioned, we're in 12 states. Although in the last three

weeks, we also won two additional contracts, one in Kentucky and one that we're — we're announced as a winner in Louisiana. So we're pleased to extend our services to those states and again, our overall mission is to improve health outcomes and lower costs.

This gives you a view of our membership and it's something that a lot of people perhaps don't understand, but our average member is about 19 years old. So while we have today some 1.6 million members, it's mostly children, women who are pregnant and so forth. I would note that that mix is shifting a little bit as we win additional contracts, so while we're heavily temporary assistant for needy family kind of contracts today, if you look at the last year and the contracts we've one, they're tilted toward aged, blind and disabled long-term care, SSI types of — those numbers grew by some 50-percent over the past year and TANF is relatively flat.

We do have today a proportionate number of members that are quite young. That creates some opportunities for us in terms of health IT and also some challenges which I'll touch on.

This next chart in pictures, I hope, is what I believe as I came in this industry since the historical relationship between payers and providers in the field. While this chart leaves out two important parties, certainly those organizations

developing products and the consumers who use health care, it summarizes, I think, the historical context of payers and providers. Simply stated, payers, established and verified eligible members, providers, whether they're primary care physicians, specialists, labs, pharmacies [inaudible] care. And then payers pay claims, and then in the early days of the industry, not a whole lot else.

In fact, I think not that long ago, that was the sole mission of payers and that's how the name came about. Some would have characterized this relationship between providers and payers as somewhat historically at odds, as having different goals. My experience is that's way overstated and we know we can't accomplish our mission unless we make providers more successful as well. So it's much more of a teaming relationship as well.

So in today's context the managed care mission is way beyond claims. This is, I think, a more accurate depiction of the relationship today. Managed care companies such as Centene have direct interaction with members providing such diverse services as counseling, education, incentives for wellness, nurse triage lines that were mentioned and while still a counterbalance to some degree to providers, both work together to reduce wasteful procedures, substitute more cost effective options such as use of generic drugs. Both are focused on

improving quality care, believing that quality care is cost effective care.

At the bottom of the middle of this chart, detects managed care organizations, also have information analytical tools and often more holistic knowledge of the patient history across a spectrum of providers than would an individual provider. And as such, that history being analyzed, can identify gaps in care, risk and when that data's provided to members, can increase quality and lower costs, again, our mutual mission.

As we look to where IT can improve outcomes and lower cost, I believe if you look at the spectrum of opportunities, they really break down into three areas and I would say these things cut across industries. Certainly, we can automate routine and non routine operations. A simple example of that at Centene is the use of alphacharacteric recognition for entering paper claims into the system, much more effective in terms of quality and in terms of cost and key punch.

But we've also — to the second point, non-routine, we've designed dashboards to analyze trend data and point out exceptions rather than people poring over reports, our systems do a lot of that identification of adverse trends for them. The second broad area is speeding of information, having the

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right data late is many times the equivalent of not having the information at all.

The best example of speed in our uses, in our environment, is use of the web and electronic data interchange. To get data into our systems versus paper and fax. Last, the high quality of information at the source, the less checking, the less rework. By analogy, some of us may be old enough to remember the days when you go into a grocery store and there was a checker who was keying in prices. Nobody's seen that for years and years. There's Universal Product Code today. That Universal Product Code not only speeds that process, but provides rich analytical data that — to avoid stock outs and reorder automatically.

Healthcare is moving in the same direction with more information available to providers and payers and the whole community. If you break things down on this chart, there's four broad areas of health IT, I believe. And if I start in the lower right as I noted, the focus originally was on admin efforts, reducing paper files and cumbersome handling as well as risking not having the right information. Still work to be done here, but the industry's come a long way.

Once you digitize the information, these are those who share have need to know so down at the bottom left. Then you can provide and analyze that data in the upper left and last,

but not least the pointed care technology that's come into place in many organizations. That upper right's the technology at the point of care.

So moving to the next chart, just to give you some examples that Centene used in these areas. We've made many investments and starting at the lower right, chart shows our use of electronic data interchange for receiving claims. We're approaching some 90-percent. Every 1-percent means 20,000 fewer paper claims that has to be entered.

The lower left shows that we've taken claims data and turned it to information relative to gaps in care. So our nurses can get this information, contact members, contact providers and make sure that we have preventive care where appropriate. The upper left is an example using our data to understand opportunities for interventions and then validate that they made a difference.

We've won numerous awards from improving care in areas [inaudible] as premature births reduction, improving the care of diabetics, in this case, reducing use of the AR for children with asthma. This is not about denying care, but getting the right care at the right place, improved quality of the life of our members and families. In just one example in the upper right, we've given cell phones to members to [inaudible] them education and a bit of a lifeline in case of need.

As we move and look at particular phenomena today on electronic health records, this is an example of one we developed for a Texas foster care. There's a lot of press today about EHR and the MRs. We're strong supporters of them.

In this particular case, we worked with the state of Texas to design one for all their wards of the state in terms of foster children. Foster children with movement from foster home to foster home and getting the same care over and over again, whether it was a physical or whether it was additional immunizations. This information sharing reduces those costs and certainly improves outcomes.

Next page, touch on the HR challenges. I suspect other analysts will mention this as well, but given our history on the foregoing chart, we do understand the challenges, many of them listed here. Certainly, the article in Health Data Management magazine that's depicted on the right there raised one of the primary issues in terms of whether there's return on investment. We certainly believe that over time, there is a return on investment. We certainly see that with Medicaid. The average time frame of one of our members is about nine months. So we certainly see the value in having that information and being able to share it.

This next page then depicts some of those savings and benefits. As I noted before once you capture data, good things

happen. The experience we had with claims, taking data intended for proper payment and then mining it to determine opportunities for better care, reduced waste gives us a parallel opportunity for collecting more clinical data and having it shared appropriately.

As just one example in terms of quality here if you look at the script — I'm sorry. If you look at the script and kind of in the middle of the page in terms of quality, some of you will read that as Coumadin, some of you will read that as Avandia, I think some very different pharmaceuticals. So again, quite an emphasis there on quality.

I would note that progress on the HRs is accelerating. You can get many studies. Some will say it's moving fast, others not so. This particular study suggests a broad progress and adoption. I would also suggest that, um, the network effect as more and more data is shared, more and more members, more and more providers get value. And so the network effect is real.

As just a quick couple of observations, I know I'm running over time here, the stimulus bill is clearly making a difference in terms of adoption. Even more emphasis on standards needs to be put in place. Certainly, the industry is struggling with changing business while doing business and I think the importance of patient involvement in the lifestyle

and the foregoing charts indicate that those issues will be overcome.

And last but not least, just as one kind of conclusion, I believe health IT and EHRs in general will be adopted. It will take time. If you look at the history of things, things that mattered in terms of efficient outcomes in healthcare get adopted. They get overcome. In this particular case, the quote could have been from today, but it was actually many years ago with the introduction of the stethoscope. Thank you very much [applause].

ED HOWARD: Thank you, Don. Next we're going to hear from David Mix who's the HIT program manager for the Virginia Department of Medical Assistance Services. David Mix is also a 30 year IT veteran, the last ten years spent supporting the IT needs of the Virginia Medicaid program. He's also managing the program to reward Medicaid providers for achieving meaningful use of HIT and dealing with HIT issues for the entire state health and human services secretary. We're very pleased to have you make the trek up 95 or on the train to come visit us and share your experience, David. Thank you.

DAVID MIX: Thank you. We're looking at this relative to a puzzle. We've got a lot of pieces under the recovery act. There's HITECH, which is dealing with the health information exchange, certified EMRs, provider incentive program,

meaningful use and all that's targeting better outcomes and coordination of care. We've also got the affordable care act which introduces Medicaid expansion, the health benefit exchange, eligibility systems and again, that's targeted for better coordination of services. We've also as part of that health and human services efforts towards simplified enrollment standards and federal verification service with the IRS, homeland security and SSA and we got enhanced funding available for eligibility systems to support the benefits exchange.

Some of the other factors that our states are dealing with are the HIPAA transaction set standard upgrades, 50-10, ICD 10. We've got the national correct coding initiative along with provider screening regulations. There are state mandates and state budget challenges. The budget challenges, I think, are actually opportunity to look at major changes in direction and thinking out of the box.

The state assets that Virginia has, we have executive support, excellent executive support from Dr. Bill Hazel. He's the secretary of health and human resources. We have a cabinet level secretary of technology, Jim Duffy, and the Virginia IT agency which provides centralized IT for the executive branch agencies. The Virginia Department of Motor Vehicles is going through a technology modernization effort and we've also got

our state agency legacy system silos. So those are all the pieces of the puzzle that we have.

Now the puzzle picture — anybody that's worked on a large puzzle knows you need a picture of the puzzle in order to pull it together. And what we used as a picture was the Medicaid IT architecture, MITA, the concept of operations document. Now MITA is a CMS initiative and an enterprise framework has been around for a few years. And that provides us a picture of what the assembled puzzle should look like. That would include the health information exchange, the EHRs, the eligibility systems and while the focus is on Medicaid and CHP, it does reflect the interoperability with other social services programs. So the technology base on it is program agnostic and not specific to Medicaid.

Since I'm from a payer organization, the business case is very important. With Medicaid expansion, we're forecasting between 35- and 45-percent increase in enrollment. For our business case, we use 40-percent expansion. So if we expand 40-percent, we're going to have to deal with our technology. The platforms we have today, our eligibility systems are very fragmented and we're going to have to expand on the technology base.

What we're looking at is if we expand our operational base to meet that 40-percent that means that we're going to see

a 40-percent increase in our annual fixed cost. And that would be about $40 million a year, part of that's state and part of it's federal dollars.

So the business case here is really one of cost avoidance. So when Medicaid expands, we don't want our operational cost to go up by 40-percent and $40 million a year can provide a very fast return on the investment for what we're making. So our strategy is — I've got to make sure the right slide's up since I can't see it — we want to leverage MITA as the core strategy to address both recovery act and affordable care act requirements. We adopt the MITA vision for self-directed services to look at the requirements from an enterprise perspective and use the MITA state self assessment process to align our efforts to federal direction and thereby maximizing our federal funding assistance.

We are also leveraging Virginia's existing assets, VITA is our central IT organization and they already provide an enterprise infrastructure, governance, standards, a couple of new competency centers, disaster recovery and all the rest of the stuff that goes to support an enterprise. Strategic planning will be done at the secretariat level. That's how we're going to cement our alignment in with the strategic planning to bring the rest of the state agencies in the future

direction. And the legacy systems can interoperate on the enterprise using standards-based services and interfaces.

The enterprise technical infrastructure will become the enabler of business transformation. So the work that we've got in progress — this is funded work, the HIT MITA program office is being expanded. I'll be functioning at the secretariat level and I will fund and manage multiple HIT and MITA projects.

MITA projects are in the enrollment area. A couple of the initiatives that we've got to work on are data sharing and trust initiatives. We're looking at the DRSA, the same thing that's used on the HIE side as a primary data sharing agreement between state agencies. Right now, sharing data across state agencies is very difficult and everyone needs a business associate agreement in order to exchange data. So it's a many to many and we need to have forward enterprise get down to one agreement per agency, and then an IT strategic planning initiative to get everything synchronized with our forward planning.

The common physical technical architecture is compliant with the MITA technical architecture standards. It's a pay for use environment. It will be available to all federal, state and local programs and it's a foundation for the health information exchange and the benefit exchange interoperability

with state systems. It includes a master data management product for person and organization information. That's the MDM product is intended to improve our accuracy rates for enrollment which are very poor and that goes down because we can't identify people uniquely across our systems well.

We would establish a service oriented architecture and MDM master data management competency centers as well as establish an authentication service. Our Department of Motor Vehicles is working on this. We're expanding their effort to include needs of the HIE and the health benefit exchange in it, and it's used for public facing portals.

The planning and progress is we've requested funding for tying the interfaces of our health department and state lab systems to the enterprise by the HIE and we're planning to replace our multiple eligibility systems with an integrated solution. We looked — spent a good bit of time trying to figure out how we could layer the advance technology on top of what we got, but we've put enough lipstick on our pig and it's just not worth the investment.

So that's all reflected in the MITA transition plan. It meets the CMS seven conditions of standards for funding. So to kind of summarize on this, there's going to be a lot of policy shifting and changing that are going to be needed. The last slide on here is really the links to where you can find

additional information, but the key policy area is governance. Program interoperability requires standards and implementation guides. The health side of this does pretty good. There's a lot of standards and vocabularies available along with implementation guides, a lot of it through HL-7.

The member management side doesn't have very much in that area, so that's a challenge. And then the program data silos, the data sharing and trust agreements are key to making all of this work. For the health information exchange sustainability, the value to the payer looking at a subscription model where they pay in, what do the get out of it?

Well, one of the things we're looking to put in place is a publish and subscribe model to our birth and death registries so they can push out a birth or a death and the payers could basically subscribe to those and get those transactions so they can in turn trigger either enrollments or in the case of a death, disenrollment. That's a large administrative nightmare right now between payers and healthcare organizations.

The other thing that the state could do is take a look at the advance technology that we're putting in place. If the clinical world wants to access it, they would go through the

HIE to get to it and not allow outside of that sphere access to the advanced technologies and interfaces we've been providing.

Now what happens in like our health department right — our consolidated labs right now are building three separate interfaces for meaningful use using the same HL-7 standard. They're just a little bit different and it's not a good idea for the state to be building multiple one-off interfaces when we should be building one that hooks to the HIE for everybody to use.

So part of that is to curtail this. We have an organization called HITSAC, and — HIT Standard Advisory Committee chaired by Dr. Marshall Ruffin. They're advising the state on what standards and technologies to use. So that's — compressed in my timeframe, that's everything that we've got going and it's quite a bit of stuff. Thank you.

ED HOWARD: And there'll be a quiz on that later [applause]. Let me apologize to David and the other speakers. The lines of sight in this room are not great, you may have noticed. Particularly, you folks may have noticed, but we ask you to bear with us because there are very few big rooms, particularly on the house side where we can accommodate the kind of crowds who typically come to these briefings. So bear with us and for our remaining speakers, if you're looking for

your slides, stare right through that young man and you can almost see them.

Let me turn now to Judy Featherstone, our next speaker who's a family doctor at a community health center called HealthPoint operating at about a dozen locations around Seattle. HealthPoint's been serving the King County area for almost 40 years.

Dr. Featherstone has been part of HealthPoint for more than half of that time. She became medical director 11 years ago and she's in charge of putting HIT capability in place at HealthPoint and she's helping a collaboration of community health centers with that same challenge. It's an area that a lot of people don't understand, that community health centers are actually on the cutting edge of IT adapt — adoption and use in King County and a lot of places around the country. So we're very pleased to have you with us. Judy?

JUDY FEATHERSTONE: Thank you. I want to start by answering the question of the talk which is are providers up to the challenge of strengthening Medicaid with health information technology? I think the answer is yes, but there's some help needed.

So as many of you know, community health centers are serving about 20 million people and one in seven of the individuals on Medicaid are served in a community health

center. Community health centers are in rural and in urban areas and we also see many uninsured on a sliding scale based upon their income.

The community health center that I work for is in the suburbs around Seattle. We have seven medical, four dental. We have a school-based health center and a program for the homeless as well. We practice full spectrum family medicine, so we deliver babies. We see the families from birth till death. In addition to the primary medical and dental services, we also have behavioral health consultants at each of our sites. We have pharmacies in our clinics and we also offer the alternative of naturopathic medicine and acupuncture.

So HealthPoint is similar to many CHCs across the country with 95-percent of our patients below 200-percent of poverty and 55-percent of our patients are on Medicaid or Medicare, though the vast majority of that for us is in Medicaid and we're privileged to see patients in 80 different languages.

Health centers across the country are rapidly adopting electronic health records. In a recent survey, about three quarters of CHCs have adopted an EHR and are at some level of that adoption. In Washington State, I do know that the community health centers that are not yet electronic are planning to become so in this next year.

So at HealthPoint — alright, I'm going to just bring all this up [laughter]. Alright. So at HealthPoint, it's been — we instituted our practice management system and electronic health system six years ago, so in the world of health centers, that's sort of on the early side. We have not been bored since. There's always upgrades and things to work on.

Much of the information that is being talked about now to go across health information exchanges is what we extracted from the paper records to put into our electronic health system which makes it much better for acceptance by the staff that's using it and a much more useful tool to have that information. And I think that's why it's a focus in the HIEs as well.

After about a year of seeing patients in the electronic health record, we began to report on quality of care outcomes which has helped our staff to be more proactive in the management of their patients. The integration of the EHR with our pharmacy system and with our dental system has led to safety improvements and improvements in efficiencies as well. This year, we expect to be introducing a patient portal and will also start to share some information with the health information exchange. And I do think that this is all vital for our future as a health care home.

So there are numerous challenges to adopting health IT in the clinic setting. The hardware and software is expensive

and in many rural areas, it's really hard to find the expertise in how to manage those.

To be successful in the training, one has to know the software. You also have to know -- have the medical knowledge. You have to know the clinical work flows and I think more importantly, you have to know the changes in clinical workflow that have to happen to make an EHR work. So that takes leadership as well. All of those aspects take an investment in time and decreased productivity initially when people are doing that.

Providers are adapting to a lot of change in medicine at this time. So there's not only the adoption of the electronic health record, but there's a change in practice from being a reactive practice where you're just seeing the patient in front of you for whatever they come in and tell you they need to be seen for to a proactive practice where we're talking to people about preventive health, calling them in for visits and managing their chronic diseases. So that combination of all of that is very time demanding and is also leading to an understanding of providers that a team is really needed to be able to do this well.

Due to all the costs involved and all these challenges, it's been really important to have the Medicaid HIT incentive payments coming up and it's important that those are — those

payments are going to the organizations of community health centers that area paying for that work. So some of the help that's needed for providers to be up to this challenge. The meaningful use incentive payments will be instrumental in setting the structure for the full adoption of the health IT and of course helping with the investment.

Health center controlled networks which HealthPoint is a part of one are helping with those cost savings. Purchasing as a group is generally has better cost to it. And then sharing best practices across those organizations has been helpful.

Primary care associations of the state and regional level as well as the regional extension centers are really helping community health centers in understanding how to use the electronic health record in a meaningful way and to use the tool of technology to support becoming a healthcare home for our patients.

So technology is really helping to solve some risky times for patients. Transitions in care, either from a hospital to a primary care physician's office or from doctor to doctor in the community is a time of high risk of important pieces of information not going to all the right people. The health information exchanges will help with this, but even before those are really working well, an EHR allows us to track

better whether patients have made it to the specialist, whether we have a report back from the specialist and whether we're managing that information well.

Additionally, through Telehealth, our patients are able to avoid driving hundreds of miles and yet can still get quality care by seeing that physician through video conferencing. So at HealthPoint, we're working on a number of different things as well. We're really working to have technology assist us with the science of medicine so that the provider can focus on the art of caring for the individual patient.

We're building guidelines into the electronic health record to tell us when to refer to specialists and what those specialists want before they get there. And then we are running reports out of our programs to really help us know when to call people in for their health maintenance or chronic disease management.

We're also doing some innovations beyond electronic health record. We have pharmacists in just two of our pharmacies and in the other five, the patients are counseled about their medications through video camera and with 80 different languages to see patients in, we're starting to use some video interpretation which I expect is going to be better

than telephone interpretation and a lot more efficient than people driving all over the county.

So by using health information technology in a meaningful way and providing out patients, Medicaid and otherwise with a healthcare home, I think we're going to arrive at an improved value in healthcare with the improved quality and decreased costs, and I hope healthier communities.

REHR is allowing us to look at health disparities and choose targeted interventions, such as healthy eating classes in the right languages, and reports from our EHR are allowing us to analyze whether the interventions we're doing are really leading to improvements. So we're using HIT to meet the standards of a healthcare home and we're beginning to see some results. We've had an experience in the Seattle area in giving a state Medicaid population a healthcare home, and that's included medical care, mental health, behavioral health and these groups are of course, integrated through electronic health records.

Preliminary information on this population is showing improved depression scores, decreased costs for hospital care and decreased contacts with the criminal justice system. So I think health IT is really vital to our success in really improving the health of our — of individuals and in strengthening Medicaid. Thanks [applause].

ED HOWARD: Thanks so much, Judy. Finally, speaking of healthy communities, as Judy was describing, we're going to hear from Craig Bammer who is the deputy director of the office, the national coordinator for HIT within HHS. Craig's in charge of the Beacon Community Program which some of you may remember we showcased at a briefing in April. The beacon program provides funds for about 16 communities across the country to develop electronic health records and health information exchange capabilities.

I should mention that before coming to the Office of the National Coordinator, Craig ran the Aligning Forces for Quality Project in Cincinnati where it was chaired by none other than Bob Graham, the physician who also chairs the Alliance Board in the interest of full disclosure, so Craig we're happy to reunite you with Bob who's now over at the George Washington University running the Aligning Forces project and we're happy to have you here.

CRAIG BAMMER: Thanks, Ed. Wow, you guys are working hard. That's what I got — that's my take home from this panel so far is that IT is complicated, expensive, hard, confusing, but it's also exciting. Let me tell you a little story about my hometown. There's a doctor, Doug Magenheim, who's a solo doc, an internist out in practice by himself. Not long ago, he had a patient who had a concerning mammogram result and so he

sent her back for another mammogram and she was, of course, concerned. He was concerned. He called her up and he said "I have good news. Everything is great. You're in good shape." And not only was she happy to hear that, she was surprised. She said "Dr. Magenheim, I'm really surprised you called because I haven't left the parking lot of the facility yet." Her result had been read, had been routed through the health information exchange in Cincinnati which is one of the leaders in the country and then into her physicians electronic health record. He happened to be sitting there, picked up his phone and called her.

That doesn't happen in most markets in America. That's the kind of thing that we would like to see across America, but it's so — I guess in spite of the complexity, the cost, the confusing nature of all this stuff, I just wanted to give you some optimism, some excitement for this incredible time we're in when technology is just exploding. The mobile health applications that are just coming on the market day after day are incredible.

The potential of frontline clinicians like Dr. Featherstone and her team to understand populations, not individual patients one at a time, but their whole population and be able to accept accountability for managing those populations and be able to use advance predictive modeling to

identify patients most likely at risk for hospital readmissions or leg amputations or other adverse events.

There's just tremendous opportunity, and once we move through this really difficult period I think there's no panacea, but I'm just — we're filled with optimism at ONC and we're like these guys slugging through some pretty heady stuff that I don't understand what we're talking about in half of our staff meetings, especially when the standards and interoperability guys get going. But it's an exciting time.

We think about healthcare — one way to think about this, let me see if this works for you guys, is to think about the tribes of healthcare being four major tribes. So we've tried for many, many years and will for the rest of our careers continue to try to improve our health sector. But to date, I would argue that there have been a few different tribes that have been pretty insular in their thinking and their interaction with one another.

There has been the quality improvement tribe. These are the folks who rightly say that if healthcare would just adopt some of the industrial motives from automotive industry, aircraft industry, from mass production sectors of our economy that include things like measurement; that include things like lean and six sigma and these are the black belt guys, karate

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guys, and we really applied industrial management techniques into healthcare we would be much further along.

These are the Berwickians if you will, the Don Berwick who, before he had his current job, ran Institute for Healthcare Improvement. And the QI tribe would go to Orlando every year for the big IHI conference; 100,000 lives and all that. They go to the same conferences and they read the same journals, those QI folks.

There's another tribe I would argue that are the payment tribes. These would be the folks who follow Mark McClellan and others who say of course our health sector is out of whack because we pay for volume and intensity and until we pay for value, we get what we pay for. These are the folks who drive pay for performance programs, who now are all amped up and working a lot on accountable care and bundled payments and medical homes. They go to their own conferences, read their own journals.

There's another tribe I would argue that are the consumer tribe that say that if Americans would purchase healthcare the way they purchase cell phones, we would drive the market. If we really had cost and quality information so we could shop like we do when we shop for a car, if we had some skin in the game, these would be consumer directed health plan advocates. If we had shared clinical decision-makings the

consumers really understood, the implications of varying treatments for the same condition and the cost implications, not just clinical; if folks had technology, a lot of mobile health technology I mentioned that helped them engage in their health and with their clinicians and their team, then surely the health sector would be more efficient and better.

Then finally there's the tribe I hang around with which is the IT tribe. This is the — these are the guys who said if we just wire the health sector. For crying out loud, how embarrassing is that we have these massive paper records. My father was in the hospital the other day; he's fine, but he had to go in and have tests done and he'd had the same test just done and they couldn't find the records and they — so they — you know, the cost, the — you understand. Surely, we could do better if we wire the system.

What we argue that these four tribes have at least something in common. That is a shared — a common enemy. There was a British anthropologist who wrote about in Northern Africa how tribes function — this was a long time ago, 80 years ago — and how when there's a large external threat, these tribes coalesce and essentially form a meta-tribe. And then when those external threats dissipate, then they break off into their tribes. I would argue that we're at the place right now, those guys over in the domed building over there are arguing

about a lot of this stuff, and we're at the point in this country where the tribes have to come together and are coming together and we would suggest that information, not technology, but information is one of the uniting themes that bring all these tribes together.

So HITECH was mentioned before. This is part of the stimulus bill. This is 30 billion or so of funding that goes out to providers for incentives to adopt and meaningfully use electronic health records. It goes to states for exchange. Regional extension centers which are like agricultural extension centers that helped farmers back in the day, they are now helping about 80,000 permanent care physicians across the country.

All of this is spread across the nation like peanut butter. Every square inch of the country has a regional extension center. The incentives are available. There's a state information exchange responsible for every square inch. The thing that excited myself and members of our Beacon team to join ONC was that there was a little pot carved out that said let's don't try to spread this across. Let's really try to find those advanced markets, markets that are doing novel things, and let's see if we can accelerate them and glean those learnings and spread that special sauce if you will.

These are not — this are micro chasms of America so sometimes reporters or others get the notion that if you go to a Beacon community, it's going to be like a George Jetson set. Everybody's got iPads and Bluetooth belts that report all their biometrics and it's just America. But it's from Maine to Hawaii, big integrated delivery systems like the Mayo Clinic, Geisinger, Intermountain and less advanced markets that have still nonetheless done impressive work like the Mississippi Delta where they're doing a diabetes project in a 12 county region and they don't have an endocrinologist in the entire region. For some reason because a lot of hard work, higher than expected adoption of electronic health records and they're a Beacon community now leveraging that information to infrastructure they've put in place for several years.

So what are these Beacon communities doing? They're doing a lot of work around care management, IT enabled care management. They're thinking about what is the essential architecture, information architecture in a region to support accountable care? Not just ACOs, but this whole notion of this era of accountability, whether it's bundled payments, medical homes, ACOs or what have you, all those require a lot of the same kind of stuff. They require aggregation of clinical and administrative data; they require sophisticate attribution models so we know this patient really belongs to that physician

or hospital; and analytics, advance analytics measuring performance in real time, not retrospectively like a lot of programs do where here's how you did a year and a half ago, Dr. Smith — not helpful — but in real time and then begin to look forward.

So in Tulsa, Oklahoma and Grand Junction, Colorado, they are deploying Archimedes which is a very sophisticated analytic model that helps look at risk profiles for patients using a whole host of clinical data and can actually show a patient here's your risk profile and your likelihood of stroke, your likelihood of all these adverse events. And more importantly, here's what your risk profile would look like if you did this, took a statin; if you did this, stopped smoking. So real time, lots of data aggregated together looking at hospital utilization as well as clinical factors.

Beacons are doing work on patient reported outcomes, so Geisinger and Mayo are looking at how do we electronically capture health status information from consumers. Functional status is very important as we enter this era of accountability because we really want to know how patients do, not that they get the clinical service that was indicated.

So the Beacon program, in closing, is about three things: it's about building and strengthening what's already going on in that market. So some markets are buying new

clinical data repositories, master patient indexes, using technology to connect to remote providers, doing remote monitoring of patients that are at home, doing e-monitoring of ICUs so that rural hospitals have an ICU physician expert that can monitor patients out in the rural hospital setting, build and strengthen.

The second is improve. A lot of communities are doing work on ambulatory care on improving like Dr. Featherstone mentioned around chronic disease management. Also on readmissions, a lot of great work on readmissions and how do clinicians hand off patients from one clinical setting to another one and have the data follow that that patient for efficient and effective care management in those very dangerous transitions of care.

Finally, innovate so we've got communities doing some really cool stuff around mobile health. New Orleans and Detroit just launched a — you may have read about a mobile health campaign where pre-diabetics in that market use their iPhone or a regular cell phone as well to identify their risk for diabetes and then there are tailored solutions for them that come through their phone that are customized to the local community. Here's the diabetes educator in your zip code; here's their number and their hours of availability based on your risk profile.

So I could go on and on about build and strengthen, improve and innovate. It's an investment we've all made. It's a non-trivial amount of money and we expect a lot out of these communities and in the year and a half to come that's left of the program, we'll be doing a lot more work to disseminate what they're learning. And it's not always great.

I will just add this final point. These are not — we're committed to not just telling all the good stories. So there are times when some of the things that communities think would work don't work and we learn a lot from that too. And so we're not interested in hiding any of that, so just watch this face. More to come and thanks again for the opportunity to talk about it.

ED HOWARD: Great, thank you, Craig [applause]. Let me remind you that you have green question cards that you can fill out if you're hemmed in by other bodies. If you're adventurous or close to it, there are microphones on either side here where you can ask your question yourself. We'd ask you if you ask your question to identify yourself and direct your question and keep it as brief as you possibly can.

Let me also mention something that I neglected to mention before which is that by sometime tomorrow, you'll be able to watch a webcast of this briefing on Kaiser Family Foundation's website, KFF.org. You can get to it through ours

which is AllHealth.org and in a few days, we'll have a transcript available on our website as well.

Let me start off if I can. Craig, a couple of times folks mentioned the need for people to actually run these systems and the shortage of health IT professionals, if you will. Is the Office of National Coordinator concerned about that and if you are, are you doing anything about it?

CRAIG BAMMER: Yes, I think we're all concerned about that and we are doing something about it. Unfortunately, it's not something I know a whole lot about, but let me just mention through HITECH, one of the programs is with — is providing seed funding if you will to community colleges. So community colleges across the country are now training — have developed training programs for professionals in health IT. And so that is our contribution to this important challenge.

ED HOWARD: I remember reading about the graduation of the first class of graduates of that program just a couple of months ago. Let me ask David Mix. You're in charge of the provider incentive program in Virginia, the payments that are available to Medicaid providers and Medicare providers as well nationally, if they have HIT capacity in place and they're using it meaningfully. At what stage are you in that and what kind of reaction are you getting from providers? There's a lot of money at stake $60,000 or $70,000 potentially over a number

of years. Is that turning out to be a big draw or are there significant barriers that you're encountering or they're encountering?

DAVID MIX: Well, we've been — our particular program will launch in the first half of 2012. We've got a procurement going on right now to identify an administrative contractor that will handle the program. The proposals are due in in another week. Once we have the contractor in place, we've still got some more work to do to get the federal approval of the contracts and once all that's in place, then we'll have a better timeline.

We have been getting questions periodically from the provider communities. We used our industry associations to reach out and provide the information. We have our current status that we post on our HIT website, but there is a fair amount of interest in it. Some of the pediatricians probably won't be able to qualify, mostly because they can't count the CHP kids in with their counts. They do count on the FQACs and rural health clinic side, but —

ED HOWARD: Okay. That's good. And let me ask Don, you — your operating in a lot of different places. What's been the reaction to the providers you deal with?

DON IMHOLZ: Very positive. We see a significant uptake both in interest and in adoption. It does vary by

market, it varies for rural and urban, by type of specialty. But we see quite a bit of movement. We see more questions than we ever have and we've even worked with certain provider groups to help them where it makes sense.

ED HOWARD: And if I could just complete this, Judy, you talked about the potential loss of productivity as you put technology in place. And I know that the folks from Geisinger have occasionally said that when they install a new system in a small practice, that it might take them 18 months to get back to the level of productivity they had before the installation of the technology. Could you say a few more words about that and how you're trying to deal with that and continue the enterprise as an efficient operation?

JUDY FEATHERSTONE: Our big loss in productivity was in 2006 and into 2007. We definitely saw that 18 month time for going from paper to EMR. I also think that we learned a great deal, so as we share the learnings amongst community health centers in our state, the ones that have come on in the last two years have not had nearly as much productivity loss because we've learned ways to do it better and smarter. So I think the impact is getting less as we go through time, but it's still — as we go on to some of the new pieces like the portal and the information exchanges, I'm sure we'll see a little bit, but

we're trying to use our team to keep seeing the patients. There's a great need for the care our there.

ED HOWARD: Yes?

CARL POSER: Carl Poser, American Healthcare Association. My question's initially addressed to Mr. Imholz. You said your company had a lot of experience with moms and kids, but you've — in the recent round of contracts, you're seeing more of the long term care population. I just wondered how, as you move into this new market, how do you save money on moms and kids in comparison to is this a new challenge? Is it different? And how is money going to be saved in the long term care and disabled populations? And then how does IT play into that in the sense of — I mean long term care wasn't included in some of those stimulus efforts. Is it up for it? Thanks.

DON IMHOLZ: Well, what we're finding is that there are some systems and technologies that certainly help us cross populations in terms of identification of high risk members, gaps in care, et cetera. In other cases, long term care, as an example, if you can use technology and we have many cases of this to keep seniors out of nursing homes and in much more affordable care settings, people are happier and it's lower cost. So use of telemonitoring devices, use of other technologies that we collect information from the members in their homes and spot issues and not put them in a very

expensive care setting certainly are appropriate in long term care.

In the other high acuity populations, ABD, et cetera, certainly use of our tools to identify areas as mentioned in terms of diabetics and other persistent diseases to identify again gaps in care. A diabetic who's — who from our systems we know is a diabetic, but hasn't had an eye exam. We can get that person in to an eye exam, get it taken care of while it's low cost rather than down the line. So a variety of methods, but you have to tailor them to the population. But we've got quite a bit of experience across the spectrum of demographics now.

ED HOWARD: And I know the chart showed 70-odd-percent were moms and kids or pregnant women and kids. Do you have an idea that the classic chart that the Kaiser Family Foundation shows is the difference between that and the division of spending on those two groups. Do you have a comparable number for your system?

DON IMHOLZ: I don't have it off — with me. I can share with you that within both groups as you also have seen studies, there's a selective number of members that are responsible for most of the cost. And so focusing on the high risk members and targeting them with disease management and other programs is important.

ED HOWARD: Very good. Yes ma'am?

DEBORAH REID: Hi, I'm Deborah Reid from the National Health Law Program and since the patient is an important part of the health team, my question is whether the plans for incorporating existing technologies to help patients address those health disparities that are impacting them. And I'm looking particularly at underserved communities and also, of course, the Medicaid community who may not have access to smart phones or other means of technology that have been mentioned today. Thank you.

CRAIG BAMMER: Actually, that's a great question. I would say that interestingly, a lot of the mobile technologies has high penetration rates in underserved populations. They may not have computers, but pretty much everybody's got a — can do an SMS text strategy. In fact, most — well, many of these technologies have been tested in third world countries.

DON IMHOLZ: And I would add to that, I certainly agree with Craig and he mentioned a consumer thrust there. Centene has actually several programs where we actually provide our members with cell phones, with smart phones so we can push out educational material and also, as I mentioned provide a bit of a lifeline, that rather than go into the emergency room, the can hit a number that's preprogrammed in, get our nurse triage line and get the right help. In some cases, that's medication.

In some cases, that's heading to the ER. So we actually provide that technology to some of our members.

ED HOWARD: Here's a question directed at Craig Bammer. You identified four silos within the HIT community, but there's a greater chasm now, it is asserted, between clinical HIT work and HIT work related to implementation of eligibility and claims systems mentioned by Mr. Mix. What role can the Office of National Coordinator play in helping states bridge this gap to build streamlined efficient HIT systems?

CRAIG BAMMER: Good question. I wish I had a good answer. No, this is an important question. I actually — I think my colleague here to my left would probably be better positioned to address this and I hope that you will.

It's a big priority. It's an important topic and we're seeing states try to wrestle with this.

DAVID MIX: The basic answer is the MITA framework that CMS has already laid out that provides the direction and the strategy for pulling all this together. That's the common picture to build the puzzle with.

We could use assistance with standards, though. Technical folks need the standards, the vocabularies, and most specifically, the implementation guides in order to make this interoperable across all the states.

ED HOWARD: Yes, sir?

STEVE REDHEAD: Hi, Steve Redhead from the Congressional Research Service, CRS. A question for Judy; could you say a few more words about where you are at your clinics with implementation? Do you expect to qualify for money this year? How many providers, what are they grumbling about most? How much money if you — give us a sense of what the money would mean to you, how much you think you can reasonably expect this year or whether it's going to be another year.

JUDY FEATHERSTONE: Sure. We have about 50 providers at our health center and we expect — we will be going the route of the Medicaid and expect to get our investment money this year. That means that this year, we are implementing, so upgrading to a certified version September 12th. And we expect to also easily meet all of the measurements next year. So even if we were having to do the — all of the measurements that Medicare has to do, I think we would be able to do that this year.

At this point when I use paper in the clinic, it is only to hand a patient their after-visit summary and to give them other handouts that may be in different languages. So at this point, it's looking good.

ED HOWARD: And my back of the green card calculation says that over six years, your professionals might qualify for

somewhere north of $3 million worth of these subsidies. And I wonder, do you have plans for upgrading the hardware, for doing training, for recruiting some of those junior college, community college people Craig was talking about? And how are you going to use the money? Yes. Let me just repeat that so the folks around the room can hear it.

The incentives go toward the individual providers and not necessarily the institution. Is that the way it's working in practice and how will the money get spent, whether it's your decision or somebody else's?

JUDY FEATHERSTONE: In a community health center, the investment made into the hardware, the software, the training is all made by the organization and all of us physicians and nurse practitioners are employed and paid a salary. So the — though the incentive payment is going to the individual, we're all signing them over to the organization cause that's who's made the investment and that's important. And that's where it should be going because that's where the expenses come from.

With the cuts that have been happening at the state and federal level, that money is very much needed in order to keep functioning as well as we are, to be able to do the portal work and to really do our health information exchange, to continue to pay our licensing fees with the other shortages that health centers are all seeing. It's very much needed. It has been

top priority for every community health center I know to be getting to meaningful use.

ED HOWARD: I've got a question here pointing out that at the local level, particularly in small safety net community clinics, there are often funding threats that make long term planning difficult. I don't know where that might be coming from. I've never heard of that before. Are there existing efforts to incentivize the uptake and use of HIT and EMRs in areas that are struggling to keep the doors open? How do you do that? Feel free, because you don't want me answering this question.

Fortunately, the person wrote a second question on the bottom of the card. You can think about the first one while I ask the second one. How do you transition from pilot programs to long term implementation of QI initiatives or these other programs we've been talking about?

CRAIG BAMMER: Alright, that one's slightly easier. I think that we'll always have pilot programs, so we never want to just make a decision and do something on a dime. So the trick is getting the best practices out of some of these pilots and accelerating them. We think that you're not going to — back to this tribe metaphor, if you will, but you're not going to — these QI projects are not going to be sustained if there's not a recognition and reward for them. It's not — pay for

performance and a lot of the accountability work that we talk about is not about is not about dangling carrots in front of clinicians and saying if you jump through this hoop that you may not want to jump through and take better care of your patients, then we'll give you a little carrot. It's not about that at all. It's about recognizing there is legitimate expense, real expense associated with improvement.

And to do improvement work, the best — a great example is when Brent James was on the front cover of the New Yorker a couple of years ago and talked about at Intermountain how they got really serious about babies on ventilators and that's a bad thing. You don't want a kid on a vent, a preemie on a vent's bad. So they reduced it by 75-percent. Unbelievable success and they lost their shirt. It cost them hundreds of thousands of dollars. In fact, Brent James who's very -- pretty conservative, straight-laced guy, the last quote of his in this New Yorker article is he said "We pretty much got screwed on that deal." Until that stops happening, there are a lot of clinicians who want to do improvement work, but it's just too expensive. And so meaningful use is again, not a — I don't think of it as a carrot. OF course, it is in some ways, but it's really a recognition that it's expensive to improve, that we have a market failure, the market doesn't reward

improvement. And so until we get to that point, we need to stimulate improvement.

So I guess the answer is these things won't move beyond pilot until they're recognized and rewarded and those who do the heavy lifting are able to sustain it.

ED HOWARD: And I think — did you just move to the payment tribe [laughter]?

CRAIG BAMMER: I try to vacillate.

JUDY FEATHERSTONE: Can I add something to that?

ED HOWARD: Please.

JUDY FEATHERSTONE: I think that it's also important to look at just outside the physicians as we do quality improvement. It's often the physicians who just keep moving back into a pattern and it takes us a while to learn something new. So by continuing to put data and information in front of people that reminds them and that works in the flow of the day, so I think one of the big areas that technology in the EHRs is going towards is to put reminders right in front of you. And when that's there, that's in evidenced based medicine, then we're more likely to see things continue to change. But when you're in a busy day, it's really hard to just remember it all.

ED HOWARD: By the way, if I can slip in a small commercial, the descriptions of all of the Beacon communities and the aligning forces for quality projects and a parallel

technical assistance program being run by the agency for healthcare research and quality are on an interactive map on our website at AllHealth.org. If you search for quality map, it pops up and you can see where these are and what each of the communities is doing in each of these projects. I think you'll find it interesting and informative.

I've got a question that actually several of our panelists could have a view on. It has to do with special problems in rural areas. We've talked a little about telemedicine, the shortage of professionals. Maybe we'll start with Don Imholz. Are you when you're dealing with small practices and many different parts of the country finding a need to give rural providers more time to get this stuff in place? Or are those coming at about the same rate?

DON IMHOLZ: We're seeing — and it's at best anecdotal data, but we see some reluctance there and it comes down to size of practice and economics and rural areas. We're actually very successful in rural areas and as I mentioned, cell phones, we also have done some provider assistance in terms of technology. But we do see quite a bit of uptake in that area as well with a lot more interest in the past year or so than we had previously.

ED HOWARD: David, I don't know whether that — certainly, Virginia has its rural parts, but I'm not sure

that's part of your portfolio. Is there scuttlebutt about special problems with rural parts of the Commonwealth?

DAVID MIX: Well, one of the challenges is broadband out in the rural communities. We've got a lot of white space all over the place and it — outside of our major interstate corridors, there's not a lot of broadband available. And even if the practice wants to do this, if they don't have broadband, even for hosted solutions, they're in trouble especially when you get into any image heavy things like x-rays and other types of graphics. So that's going to be a real challenge to us is to try and get affordable broadband out to all the rural docs and some of them aren't really all that rural, they're just 15 miles to either side of the interstate corridors.

ED HOWARD: Good point. Yes, go right ahead.

ALICE WEISS: Thanks. Alice Weiss from the National Academy for State Health Policy. This is a great presentation, so thank you all for your time. I think — one of the things I was thinking about when I heard Judy Featherstone's discussion about the video translation interpretation is that this issue of translation and interpretation is going to be critically important for states as they implement new eligibility and enrollment systems making sure that they're accessible to the new populations they're going to have to reach. That's been a challenge for states in the past. Are there any models from

the clinical side of HIT that states should be adopting or any best practices in video conferencing that states could be thinking about as they are thinking about planning for HIT improvements as they have a 90-10 match on the table?

JUDY FEATHERSTONE: I don't know about best practices, but we're in a coalition with a number of other organizations called Global to Local trying to use some of the techniques of international medical, of world health in the local communities and actually giving these patients mobile phones so that when they're in places where they need an interpreter, they have a number they can call and it will be a rapid dial number to get an interpreter on the phone.

ED HOWARD: I've got a question that rises out of a Office of the Inspector General report and Craig, I don't want to put you on the spot because it may also be outside your area of jurisdiction, but in that report, the IT said that a lot of states who are making payments to providers don't have the information to verify the fact that the providers are actually doing the stuff that they're getting the payments for. And there was an announcement just last week by State of Florida which said we're about to give out a $200 million, and you've got to go through this clearance, and you've got to go through the federal clearance, and then we're going to circle back to make sure that you actively did what we gave you the money for.

Is that a problem that has come to the attention of the ONC and how serious is it, and are you working with states to try to do something about it?

CRAIG BAMMER: You know, Ed, it is a problem that ONC is working on but it's frankly not in my bucket.

ED HOWARD: Okay.

CRAIG BAMMER: I defer. And it's a little dicey so that's the other reason I'm going to defer [laughter].

ED HOWARD: It is a lot of money and I guess the information tribe would be most directly involved in trying to get that situation resolved. Before I take this gentleman's question, let me just remind you we're going to end this at 2:00 and so we have only a couple of minutes left. If you will recall, we have a special incentive program going which someone is trying to put back up on the screen. So don't forget to fill out your evaluation form as you leave. It's for the — not only the good of the Alliance and the good of the programs that you're going to come to, but it's for the good of a lot of people who are going to get care as a result of it in the District of Columbia.

CRAIG BAMMER: Maybe we should all fill out two. Would that be alright [laughter]?

ED HOWARD: Yes, sir. Thank you for your patience.

MALE SPEAKER: Yes. [Inaudible] instead of each provider and state coming up with a health IT format, why not devise a national health IT format? I think this may be effectual for the task.

ED HOWARD: Good question.

MALE SPEAKER: Correct all the current things and come out with what should be formed in it and also define the terminology. I think now as everybody comes out with a different thing, we are later going to have big problems. I think we should devise a national standard for health IT. Thank you.

ED HOWARD: Craig, you're from the Office of the National Coordinator [laughter]. How does that work?

CRAIG BAMMER: Good point, and so to my mind, my simple mind, one of the most important things that the office does is to work on standards. And so —

MALE SPEAKER: [Inaudible].

CRAIG BAMMER: Well, I can assure that some of the private sector folks don't take that view. The trick is —

MALE SPEAKER: But you [inaudible].

CRAIG BAMMER: Right. I understand your point. So we have a nontrivial amount of investment in this area. As a matter of fact, there's a whole floor of the building that the standards and interoperability guys hang out in, and I frankly

don't understand what they're talking about half the time, but it's a very aggressive part of our portfolio of work, actually. And it is a very aggressive partnership with the private sector which is the way it ultimately — we believe it needs to be.

And so you might have heard of the Direct Project, for example, which is a set of protocols for secure messaging. That has now been adopted by hundreds of private sector vendors including from Google to smaller EHR vendors and so that's the role that we play is to coordinate this and push it forward. I take your point that it needs to move quickly. We agree.

ED HOWARD: And are there areas where there's been resistance to the standard setting group or trouble within a standard setting group where someone wanted not to be uniform or — it's pretty clear I don't know what I'm talking about, but you get the idea.

CRAIG BAMMER: Sure. You can understand reticence based on legacy systems. So I think it's most often the case that people haven't made tremendous investments over time to re-tour or take left instead of right has financial implications for them and strategic implications.

ED HOWARD: I was in a meeting, and I was just talking with someone about, in which the person setting up the exchange and figuring out the relationship with Medicaid in the state of Vermont said that their legacy system involved, even with

current law before the 2014 provisions get implemented, something like 150 workarounds that were built in to this system and that they couldn't possibly build in enough workarounds to do the next level they were gonna have to do, so they planned on scrapping and starting from scratch. I suspect that's experience that a lot of states are having at this point. Did you have to start from scratch, David?

DAVID MIX: We're going to rip and replace. That's they only thing we can do. Our systems are way too out of date to even attempt this.

ED HOWARD: Sobering thought. 2014 is not that far away and a lot of things have to happen before 2014 as all of you know. Was that a question insipiently moving toward a microphone?

MICHAEL DANIUS: Yes, I have one question for Mr. Mix —

ED HOWARD: You want to identify yourself?

MICHAEL DANIUS: — Mr. Imholz. My name is Michael Danius. I work for the Health Resources and Services Administration and this question is also directed to Dr. Featherstone. One thing that we're currently working on in our technical assistance efforts is ICD-10 and it's impact on the safety net community. Since you each come from a different provider area, I thought it would be easy — I would like to hear your thoughts on how you're providing either your

practice, your providers or your state providers for this conversion on which the deadline's ticking down very soon. Thank you very much.

ED HOWARD: And I wonder whoever starts, could you explain to the poor country lawyers in the audience what an ICD-10 is?

DAVID MIX: It's procedure codes that's used on claims coding to identify what procedures the practice was doing.

MICHAEL DANIUS: Essentially, CMS has set a deadline for providers to move from ICD-9, which we've been — to ICD-10 which the rest of the developed world has been using for about 10 years, and the deadline is, I think, January 1st, 2012 and it's going to affect reimbursements dramatically [interposing].

DAVID MIX: Basically we're working with our trading partners to get the testing phases in place, so that's how we handle it. It's usually not at the individual provider level, the large providers that submit claims to us will be working with a trading partner. There's a number that go through the clearinghouses, which we work with the clearinghouses to handle this. That — Ed?

ED HOWARD: Don, you want to have a go?

DON IMHOLZ: Yes, we're — we have it in work. We are aware of the deadline and we'll be there. We're working with trading partners as well as we expect to handle both ICD-9 and

ICD-10 codes concurrent for a period of time. So we're in the final throes of selecting some translation tools that will help us operate in that mixed environment. It's a sizeable project, but not anything we're particularly worried about at this stage.

ED HOWARD: Well, we have — Judy, go ahead.

JUDY FEATHERSTONE: Oh, we just — it's certainly on the radar screen, and planning our work for this next year, we had to slate it in as part of the work we're doing hoping that our EHR vendor will do most of it and we can just do a little bit of it.

ED HOWARD: I hope that's right. We have been grappling with a very difficult series of issues this afternoon and I want to thank you for staying with it. I want to thank our friends from Centene for supporting and participating quite noticeably in this program. Thank you for filling out that blue evaluation form I see a few of you clutching and pressuring the person next to you who isn't clutching it. And also, just finally ask you to join me in thanking our panel for answering a lot of tough questions and asking even more [applause].

[END RECORDING]

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