

**Meaningful Use Workgroup
Subgroup #3 Improve Care Coordination
Transcript
May 23, 2012**

Presentation

MacKenzie Robertson – Office of the National Coordinator

Good morning, everyone. This is MacKenzie Robertson in the Office of the National Coordinator. This is a meeting of the HIT Policy Committee's Meaningful Use Workgroup Subgroup #3: Improving Care Coordination. This is a public call and there will be time for public comment at the end. The call is also being transcribed, so please be sure you identify yourselves before speaking. I'll now go through roll and then ask if there are any staff members on the line as well. Charlene Underwood?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

I'm here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Charlene. Michael Barr?

Michael Barr – American College of Physicians

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Michael. Jessica Kahn? David Bates? George Hripcsak?

George Hripcsak – Columbia University

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, George. Eva Powell?

Eva Powell – National Partnership for Women & Families

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Eva. Leslie Kelly Hall?

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Leslie. Larry Wolf?

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Larry. Are there any workgroup members on the line?

Suzanne Mintz – National Family Caregivers Association – President and CEO

Suzanne Mintz is here.

MacKenzie Robertson – Office of the National Coordinator

Great, thanks, Suzanne.

Greg Pace – Social Security Administration – Deputy CIO

Greg Pace is here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Greg.

Marty Fattig – Nemaha County Hospital – CEO

Marty Fattig is here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Marty. Anyone else from the workgroup? Are there any staff members on the line?

Josh Seidman – Office of the National Coordinator

Josh Seidman, ONC.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Josh.

Michelle Nelson – Office of the National Coordinator

Michelle Nelson, ONC.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Michelle. Okay, I'll turn it over to you, Eva.

Eva Powell – National Partnership for Women & Families

Great, thank you. Thanks, everyone, for joining. I'm going to keep my remarks brief, because we really want to hear from our core experts in the field implementation of care coordination. As you all know, care coordination is really a people process, but it's one that certainly requires the support of technology, and so I think for purposes of meaningful use and specifically purposes of discussion about where to go with Stage 3 Meaningful Use what we would love to learn through these listening sessions is what are the most effective ways to use health IT to support care coordination to achieve the three-part aim, which is a reminder, I'm sure all of you know what that is, but to increase quality, which would include patient experience and increase population health and decrease cost. At the end of these sessions I think what we would love to have is at least a direction, if not some preliminary answers, to where ONC and CMS might focus their efforts for Stage 3 Meaningful Use in terms of what should be functional criteria for eligible providers to meet, what should be outcomes measures, and what should be key process measures.

I will now turn to our experts; I'll introduce them briefly. I'm not going to go through your whole bio, because I think folks have those, but if there are things that I leave out that you think would be useful for people to know, please just put those as part of your presentation. Our first speaker will be Suzanne Mintz. She leads the National Family Caregivers Association and has personal experience, which is really the main reason why she's on the call today, as a caregiver to her husband, Steven, who has MS and was diagnosed in 1974. The reason why we are starting with her today is because as the really only constant in any healthcare process the patient and their family caregiver will always have a very important role in this, so we'd like to start with her. And then we will go to Cheri Lattimer, who, let me get her bio, who is the Executive Director of the Case Management Society of America, as well as the National Transitions of Care Coalition. Then we will move to Jennifer Fels, who is a Nurse and Director of Health Resource Management, Social Services, and Clinical Documentation Improvement at Southwestern Vermont Health Care. And then wrapping up our expert panel will be Robert Fortini, who is Vice President and Chief Clinical Officer with Bon Secours Medical Group in Richmond.

I'll turn it over to Suzanne now. Suzanne does not have a presentation. I just wanted her to give her perspective on how technology has and can still be designed to improve her experience as a caregiver and her husband's experience as a patient. Suzanne, take it away.

Suzanne Mintz – National Family Caregivers Association – President and CEO

Technology has long been a part of our lives, very much on the practical side of things, from scooters, to wheelchairs, to hand controls in a car, to adapted mini vans, personal response systems, a lot of the typical kinds of functional equipment that we have. I guess the ... is probably the only thing that would fit into the category of monitoring. In terms of care coordination, I see a lot of space for technology to help. Our family doctor is right up there with the times. They do have electronic medical records and they have recently introduced a patient portal, which is still getting some of its sea legs, I think, but it allows us to e-mail directly and, what's the word, confidentially, communicate with him and him with us, we can make appointments through it, get results of labs, and eventually I know we'll have access to our records as well.

There are a number of Web sites, and more coming, that can assist patients and families in coordinating their healthcare information. One that actually is available to NFCA's members is a site called Saturating, S-A-T-U-R-I-N-G. The name comes from Saturn, the idea of rings, and it has something that has been long wanted and actually an interactive medication record. All the ones out there I think that you can download and fill in, but this one actually allows you to keep it live online, and other information specifically related to the coordination of your care. I know there must be others out there with similar functions, but every day there seems to be more and more stuff out there. I think it will be imperative, going forward, for people to have access to a computer in order to really play a role in their own care coordination.

Perhaps the biggest thing for care coordination may not be technological it may be financial, because until somebody is paid to do that work it still comes down to the patient or family caregiver to keep one doctor informed about what the other ones are doing. It seems that they just won't take the time to talk to each other, and that we are the conveyor of information. And I'm not sure that that's really the role we should be playing but until there is some financial reform I think it is the role we will continually have to play. Is that enough, Eva?

Eva Powell – National Partnership for Women & Families

Yes, I think that's great. For the most part, I think we'll hold questions to the end, but I just wanted to get from you, since you mentioned the patient portal and actually having access to your labs and anticipating access to your full information, if you can just describe briefly what that has meant for you and what difference has that made over when you didn't have those things.

Suzanne Mintz – National Family Caregivers Association – President and CEO

Okay. Well, for whatever it's worth, the site is called NextMD. We've been able to e-mail directly with our family doc for quite a while, just through regular e-mail, so having the portal isn't new in that sense. But the fact that this is really connected to the practice itself and that his assistant gets to see questions and everything as well means it's speedier to get responses, being able to set up the appointments, obviously you don't have to hang on the phone during regular hours, you can just ... three in the morning if you wanted to. So in that sense I see the advantages of it. When we can see our records I think that will make a big difference in being able to understand things. Also, with the movement toward open notes I think that will be really helpful in understanding what's going on, but also using it as a reminder for us if the notes I've taken are not complete or I can't read my own handwriting. So I see all of this as being very, very productive for transparency. I'm not sure if these portals will make it easier for our doctor to share information with other docs or not, I just don't know quite how all of that works, but I definitely see the benefit of it. And just psychologically I think it plays a role in knowing that you have this open communication ability with your doctor.

Eva Powell – National Partnership for Women & Families

Right. Okay, great. Well, that's really helpful, and certainly as we get to the end of the formal presentations, if you will... we'll have a lot of dialogue among the presenters and those of us on the call with questions, so hang on. Next, we'll move to Cheri. Cheri, are you there?

Cheri Lattimer, R.N. – CMI

I am, Eva.

Eva Powell – National Partnership for Women & Families

Great, go ahead with what you have to share with us.

Cheri Lattimer, R.N. – CMI

I want to thank Eva and the HIT Committee and the Care Coordination Subgroup and ONC for asking us to just share our thoughts. The information that I'm sharing with you is derived not only from the National Transitions of Care Coalition, referred to as NTOCC, but also from the Case Management Society of America. Between our two groups we cover a significant amount of American lives in the healthcare system, over 30 million, and the information I'm sharing is somewhat from our literature reviews from some of the studies that we've produced, but also a little bit of, if you will, stories from members that call and talk to us about the care coordination and the issues that they are currently dealing with, with HIT and some of that care coordination.

So if we can move to that next slide, one of the things that we've looked at very significantly is where are sitting many of the barriers and the gaps, and I'm sure I'm not sharing anything that the committee hasn't seen, but the process becomes more and more complicated, and it isn't just about a transition from the hospital, it is throughout the continuum of care. And what we find is that we have so many different professionals throughout in our facilities, and sometimes we even have two and three payors involved in this process, that there is no consistency in how we share that information. And as we're looking at HIT we're hoping that that is going to help increase our ability to do that, but there's a lack of consistency, even among the professionals across the nation, about what's really needing to be shared, what's the process, and who needs to share that information. I will encourage the committee to simply think about it as a collaborative team effort including the patient and the family caregiver.

Suzanne brings out a very good point about patient portals and that sharing of information, whether it's about their medication history, whether it's about their current plan or treatment plan, even about their transition instructions, and to be able to read it, understand it, and get access to it and to be able to act upon it is really a discussion that needs to occur, couched in health literacy and the ability to be able to feel confident that patients can act upon that. As we've looked at many of these areas we also understand that coordination is well beyond where the particular professional practice is and each degree that you move away from that practice area, that scope of practice, you increase the risk of miscommunication, and in the process of doing that it is hoped that HIT will help us do that, but there still are some significant gaps and barriers in that process that we look at throughout the components of what we're dealing with.

I'd like to move to the next slide because NTOCC talked just recently on its home page brought out a transition of care compendium, and in that compendium are a number of articles, over 300 articles, about care coordination, transitions of care tools and resources that are available. And the Measures Group for NTOCC actually did a walkthrough of those articles and identified throughout many of the models that are showing tangible savings, and among those models Dr. Ari Coleman's model, Dr. Mary Naylor's, Dr. Chad Boltz, Project Red, Boost, and looked at what were the key interview points that showed savings. What you see in front of you are those seven key points that every one of the models and resources out there is addressing and are the areas that we feel pretty strongly need to be looked at as we develop HIT and care coordination. These things are being addressed and we are sharing the information appropriately.

You will notice on bullet two, it says “transition planning,” we at NTOCC no longer use that word “discharge.” We believe that that sets a very different stage or mindset for providers and payors, discharge being that the patient has gone out the door, we don’t need to worry about that anymore, and that definitely is not what we’re talking about today. We are talking about a transition, a transition that goes across the continuum of care, and so we have really begun to address it more from that aspect than the word “discharge.” But to put those components together, that patient and family engagement and education and support, as Suzanne said, is really to be able to give our patients and family caregivers the tools and resources that they can use, but also to give them the support that they have the confidence that they can move forward and be involved in that. Our information transfer, follow up care, health provider engagement, and shared accountability are key points that every model within the compendium has looked at and continues to enhance, has in place. So really strong support that these are the areas as we look at health information records, medical records, patient health records, these are key areas that really need to be defined clearly, and being able to share that information across the continuum of care.

But no matter how many tools or resources we’ve put into place, as we move to the next slide, this is a key concept that both NTOCC and CMSA believe, the tools will help us, they are a sift, but to make this all work we have to commit and learn how to communicate with each other. And in communicating with each other it’s more than just sending information.

Moving to the next slide is a concept that NTOCC has brought forth about bidirectional and accountable communication. We also looked at this with several other groups that are talking about improving communication, but to just send the information is not enough. That key information has to be received by someone and when they receive it the sender and the receiver have to have what we call this bidirectional accountability, in that they can verify and clarify that information because it isn’t always easily interpreted into the consistency of the quality that we want, whether it is transition –

(Audio interruption)

MacKenzie Robertson – Office of the National Coordinator

Hi. Sorry, this is MacKenzie. Can everyone just make sure they have their lines muted, because we’re getting a lot of background interference. Sorry, Cheri.

Cheri Lattimer, R.N. – CMI

No, that’s okay. I won’t mute my line, MacKenzie, if that’s okay.

MacKenzie Robertson – Office of the National Coordinator

No, please don’t.

Cheri Lattimer, R.N. – CMI

... to verify and clarify so that they can actually act upon it. But it’s not enough, between us as providers, we have to include, and we must put the patient and the family caregiver in this process of engagement, keep them informed about this process so that they too are able to be a willing partner and an active partner, an engaged partner, if you will, in the course of treatment and the process that they’re doing. I’m going to tie one more piece together, because of how silo’d and fragmented we are in how we deliver care, we support heavily a provider accountability, or what we’re referring to as the care coordination hub, whether this is the primary care physician, the family physician, or a specialist who has taken the role of primary care. Because we use so many different providers we have to have that consistency of that care coordination hub, so we encourage folks to think about this process of communicating.

The next slide is really an indication of how patients go through multiple layers of our continuum and how this all pulls together in what we’re doing. This sharing of information is really a rich, if you will, component of how HIT can support that sharing, because folks do a tremendous amount of work, as providers, as caregivers, as patients in this process, and a lot of information needs to be shared, just not coming from the physician, or the pharmacist, or the nurse or the case manager, but as a collaborative team; absolutely key in the delivery of that.

As we move to the next slide, we look a little bit at an integrated team on who all is involved as we talk with and do care coordination. And when we start to look at the depth of the individuals that are involved and the different formats of interaction, it begins to drive the question our next slide is asking, who is the connector, from a collaborative team within a hospital setting to the community team out there, and the question that you are looking and working to answer is, can HIT electronic health records really bridge the gap? And we believe they can as a tool and a resource, but there are a lot of gaps in that process that need to be addressed very, very clearly, as we looked at that first slide back there where we showed those gaps around medication management, that transition planning, that care plan, and the components of what needs to be delivered.

Our next slide actually sums up this process of HIT is the tool for care coordination, a powerful tool, but communication is the key to this being successful. And in being successful we have to include a collaborative team, which includes the patient and the family caregiver, in working together in the communication and the sharing of information. The collaborative team is interdisciplinary. It isn't one individual. It isn't two individuals. It is the combination of those folks that touch that patient and work with that patient, and they need to have a common workflow pathway so that in sharing that information from one transition to the next, one facility to the next, one provider to the next, people are able to use, if you will, longitudinally that information and continue to build on that.

Tremendous studies have been done that every time we ask the patient and the family caregiver to repeat a scenario, the risk of missed information or misinformation goes up, so how can we continue to work together and share that information so we're not duplicating efforts and we're not continuing to ask the same pieces? When we look at elements for care coordination they need to and must include both the medical and the behavioral side of the clinical aspects of this patient, a medication management at every transition and throughout that we can continue to clarify with the patient and the family caregiver not only the issues around the clinical but the psych social. The including of the healthcare experience for the patient also has a huge impact on how engaged that patient will be and how confident they feel they can interact. So as we create these patient portals we need to think about the information the patients can share with us about not only their experience, but their preference and their issues that will help us coordinate not only the care but the ability to be adherent with treatment plans and medication processes.

When we talk about a proactive care plan, we want to make sure that we understand the engagement of this with the patient and the family caregiver has to be different than what we as providers see as the clinical treatment plan, because from the health literacy perspective the ability to be able to interact with our patients and motivate are going to be absolutely key. So have we really thought about that process? And in moving all of this together is to encourage the accountability for both sending and receiving the information, both in our performance measures for the process and for workflows, but that we ensure that the valuable processes and components of treatment are shared appropriately and can be acted upon by other providers. I will encourage the committee to also look at, we've been asked a number of times how is this all going to flow with a lot of the HIPAA regulations and the interpretation of that. That is probably something that we need to go back and look at with the integration of technology. And although today we're talking about meaningful use in Phase 3, not far behind that are the things the next generations will be asking us for in HIT, which I'm already hearing can I have a mobile application, a mobile app for this, so I think our job is probably years down the road, but these are the things that I really encourage us to look at and think about.

I think that is my last slide, MacKenzie. Can we move one more slide? Yes. Thank you so much for your time, and I hope I've given you some information from our two organizations that will help in the process as you assess the Phase 3.

Eva Powell – National Partnership for Women & Families

Great, thanks so much, Cheri. That was very helpful. You touched on a lot of things at a high level that our next couple of speakers can impart some knowledge on how those things actually play out in real time. Jennifer, if you'll go ahead with your presentation.

Jennifer Fels, R.N. – Southwestern Vermont Health Care

Thank you. Joining me for some slides will be Gail Balch. She's an R.N. and she's the Director of Health Information Systems and Clinical Informatics, so she'll be joining me on some of the slides. Just as background, we're a very small facility. We have a hospital, a home health agency, a nursing home, and employed as well as independent physicians. The hospital has a daily census of about 50 patients. We're rural, and our nearest tertiary care is an hour away. Our population area, again, I said, we're small and rural, is about 55,000. You can go to the next slide.

We were starting to look at care coordination and it all started with the discharge process. We were in the original cohort of Project Boost. It was considered a grant, there was nothing financial tied to it, but we did have mentoring in implementing these best practices across all areas of the hospital. We used it for all of our patient discharges. Some of the key things that we did work on, I won't read all of these, but it was the development of a patient education packet that is electronic, it's Web based, and the patient actually receives a copy of their med reconciliation. And we were able to identify and target high risk medications, patients new to insulin, Coumadin, narcotics, and we were able to automatically have those patient education materials pulled into the discharge packet. This is available in our electronic record, and an electronic record is also accessible to our primary care physicians and any of the physicians involved in the care of that patient. So it is a permanent part of the record, and the patient does receive a copy. It's important that this information is readily available, and this is available upon discharge in the primary care practice, so there's not a lag in time since we have a hospitalist program. Certainly we don't want that primary care to be out of the loop.

Looking overall at our measures, I'll just tie one in here, before we started Project Boost with the Society of Hospital Medicine our readmission rate was 16% to 18% for all payors. Currently we're at 9%, and our organizational strategic goal was 8%. Even though our organization realizes they are hurt financially, there is no reward for having a low readmission rate, it cuts on your revenue, it's the right thing to do. We realize that healthcare reform is coming and we're certainly looking at other models of payment reform here in the state of Vermont, so it is definitely a statewide initiative. You can go to the next slide, please.

At the same time, in parallel while the hospital was doing work on readmissions there was a lot of cross-continuum of care activity. We have a cross-continuum team of the nursing home, home health physicians, medical home, as well as what we would call competitors, other nursing homes in the community and home health agencies, assisted living, all with a focus on how do we help that patient transition and what information is key. I guess I'd have to use the word the hospital was very arrogant in saying this is the information you need as patients transitioned, and when we interviewed our partners across the continuum that wasn't the information they needed. So it was really an aha as we gathered information from our partners and care coordination, what was really needed.

We do have medical homes, there are seven in our community. They're all NCQA certified. This covers a total population of about 20,000. In the medical home is the R.N. case manager, that is the key position in the medical home, the provider cannot possibly sort through all of this information, and she acts as triage and then she works as the referral network within the primary care practice to the other players in the medical home, those being the behavioral health specialists, the social worker, nutritionist, and we are piloting having a diabetes educator, so that R.N. is critical and a key role.

We are certainly shifting to population health, and that's where that disease registry for panel management comes in. The disease registry is allowing us to follow patients' best practices for their age and gender and interventions, and it helps us to keep track of the patient centered goals, and it allows us to measure outcomes. So without that panel, that disease registry, we wouldn't be able to do that panel management, and unfortunately, most EMRs in the practices do not have that functionality so we have to layer on another system for that registry function.

If you could go on to the next slide, please, this is just a graphic that shows this is our patient, and we've done a very good job whatever setting we are in, if we're in a VNA or assisted living and we have senior housing now engaged, working with care coordination with senior housing primary care and across the

continuum for the frail elderly. And the patient really has to navigate this alone and we're seeing that R.N. case manager in the medical home can be very effective, but their transition of information has to be accurate along this, I don't know, arduous course that the patient has to take. The next slide, please.

Answering the questions that were given to us by the subgroup how electronically we've been able to support care coordination, real time communication of patient transitions, processes of having nursing homes when a patient is referred to their setting that they can have access to the medical record here in the hospital setting so that they're able to see more accurately what information they need to care for the patient as the patient moves across to their facility. Transfer of critical patient information, reliability, check lists are great, forms, but really without that IT support we can't rely on people to remember to look for the appropriate form, and it's really been critical in the information transfer. We have systems in place where we're able to notify the case manager in the primary care setting when a patient ... comes to the emergency room or has a hospitalization, so that's been very helpful. Otherwise, the primary care practice is totally unaware of ... for that patient in the community and we couldn't do outcome measurement certainly without that capacity.

I'll turn this over to Gail, and on to the next slide.

Gail Balch, R.N. – Southwestern Vermont Health Care

How does the EHR hinder care, was one of the other questions that was asked of us, and what we're challenged with in our environment are disparate IT systems. We have a core healthcare information system at the hospital and we have a separate system at our provider office space, a separate billing system, a separate VNA and hospice care system, and a separate long term care information system, so bringing and integrating all of the information across those four areas is very, very challenging. And to do that we've struggled to provide the resources in our small, rural area to accommodate the information exchange between each of these. What we had hoped to be able to achieve was a connection with our state health information exchange and provide a transfer of this type of communication of all of the information that is required for a safe and quality transition, including physician orders, results, and care coordination items and a care plan, but our HIE is not ready for that, and so we are challenged now with making the decision, do we develop our own internal HIE within our own community and then figure out how we're going to integrate with a state HIE to meet some of the legislative and payment opportunities that we know we will face. Can you go on to the next slide, please.

What functionalities would be helpful to help to achieve better coordinated care? We've heard quite a bit about patient portals, and that's one of the items that we are looking to implement in our future vision within the next, probably, year and a half, although right now that is a challenge for us because of financial resources. But we do see the benefit of patients' ability to have their own personal health records, communicate with their providers and caregivers, and for them to access their medical records. And that transparency, I agree, is very, very important.

The components of the patient-centered care plan I think is the most critical component of sharing of the information across the continuum. Setting mutual goals is really one of the most effective ways that we can move patient outcomes to the level of quality that we're looking for to achieve, especially with some of our chronic care populations. And we struggle with that. It's something that we develop a care plan in the hospital setting, we develop a care plan in the long term care setting, the provider has a plan, but we don't always know what it is, and pulling all of that together is what ends up in the patient's lap to try to navigate and to communicate across all of those settings. And so we see that this is probably one of the most key components of Stage 3, the ability to develop an integrated patient-centered care plan.

Another item that's really important is our ability to integrate with pharmacies for the medication reconciliation component of the transition, and we are doing medication reconciliation at every point, but in our state it's a little bit difficult to do ePrescribing in some cases, and so we do still have a lot of concern about the validity of the data that we're actually providing. One of the key concepts here is the team-based care, and Jennifer is a great graphics person and she can talk a little bit more about the team-based care concept.

Jennifer Fels, R.N. – Southwestern Vermont Health Care

The concept here, and I'll read several examples, aviation, we're trying to learn from other industries how they come together, and this one being a race car I know it seems it's far-fetched related to this, but it's really all of the players, if you will, all of the staff, valuable resources that you have, we're really talking about safety and reliability in the healthcare setting, no matter where you are along the continuum ... along the team they're working together, so it's really being about effective care. It's focused around the patient for, as I said, that safety and reliability, it's just an example of small settings. It's been well demonstrated in the literature, this is one from *Anesthesia*, and certainly applicable to the team as a patient transitions, is that everyone has their role, they're responsible to each other to have that role and they're accountable so that they have a successful outcome. Next slide, please.

We believe that the most critical users of electronic systems are partners across every care setting, and that includes home health, hospice, senior housing, primary care medical home teams, rehab care, specialty care, hospitals, tertiary care, pharmacy, and on and on and on, and I think we all understand who the team players are. Next slide, please.

Something that we have used throughout our initiative across the continuum as well as in the individual settings is we are following the Triple Aim model, I heard that mentioned before. Our overall aims are to improve the patient experience, focus on population health, that is certainly a real transition of thinking just to your setting or just to your discipline, to shift to population thinking, and also to reduce costs. We've used the chronic care model as our theoretical framework. It's also being used across the state of Vermont. And the question being, what does the patient contribute? If you look at that lower level of the chronic care model with the ... informed activated patient, that's critical. So in this it's patient engagement and self-management goals, and shared decision making. I cannot emphasize the shared decision making enough. The patient has to be educated. The provider has to be comfortable, all partners across the setting, in helping that patient make decisions that work for them and not necessarily for the provider or in the discipline. And the care model is used very effectively when you look at the higher level of health systems and your community involvement, so that is the tool that we use and those are the two things that we find that are absolutely critical. The second to the last slide, please.

Outcome measures, we're certainly looking at probably what a lot of folks are doing across the country, hospitalizations, readmission ... goal attainment, and cost of care. Something else that I'm finding very useful and we're starting to use in the organization is using the Dartmouth Atlas of Health Care. That shows us where we are in looking at variation of practice across the country, so it's a very useful tool. It also looks at cost versus spending, which are very different definitions, so we're using that to analyze how we compare to peers. And then our process measures, certainly the chronic disease measures, using the registry for that and the use of best practices will all be process measures that you would be using in this setting, how effective are we in that. Also, I included, not as a slide but as a handout, is our care transition bundle. It shows our best practices, our partners in the community, and what our outcomes are across the continuum, so I'm happy to share that and certainly answer any questions.

The last slide is just a thank you for listening. If you have any questions, Gail and I are both happy to answer them. Thank you.

Eva Powell – National Partnership for Women & Families

Great. Thanks to both of you. First of all, it's really exciting for me to hear what's going on and I know that this is not easy and yet it sounds like you're making some really important progress as well as learning a lot. So thank you for sharing that. And I want to move now to Robert so that he can share what he has, particularly with regard to the patient portal that they're using and their emphasis on population health. Robert, take it away.

Robert Fortini – Bon Secours Medical Group, Richmond – Vice President and Chief Clinical Officer

First of all, thank you very much. I probably, going last, can simply say ditto. A lot of what you'll see in the next 15 minutes here is a repeat. We're certainly all on the same path and I think we all recognize that there's only so many creative ways that we can bend that cost curve, and certainly the more robust and aggressive views of different types of care providers and human resources is one. The more

aggressive use of technology from electronic record to portal to home telemonitoring equipment that should be transformative as we become more aggressive is two. And then changing healthcare delivery systems with getting away from that fee-for-service physician-based practice and develop team strategies up to and including group visits and creative methods of focusing on specific populations. So just a quick word, as opposed to Jennifer and Gail, I am in Virginia. I am part of the Bon Secours Health System, which is a seven hospital system in Virginia. The Bon Secours Medical Group is across the Commonwealth, has over 400 physicians at 80+ practice locations, multi-specialty, and serves about half a million people. Also, as opposed to their environment where they have disparate information systems, I have the luxury of having a single integrated system across the spectrum of care, and so it makes a lot of what has been discussed so far a reality for us and I hope to demonstrate some of that as we go forward. Next slide, please.

Our strategy around care coordination really echoes some of the things that Cheri talked about, and certainly using evidence-based guidelines for care with everything from best practice alerts and pop ups to ERX formulary checks, up to and including disease specific rooming protocols are hard wired into our system so it makes it very easy to use. Having our teams aware of what exists in the community and how to link patients to them helps with some of that navigation and transitional management, aggressive use of registries, of which I will show you a little bit, using the documentation tools we have resident in our electronic record to do predictive modeling and to help further identify a relative risk index score for hot spotters and patients who are going to be requiring more care, and then having that relative risk index dictate a level of management or intensity of outreach and frequency of touch for a patient is extremely valuable. And then certainly the whole transitional care management and broadband communication with all the different payors is extremely important and greatly facilitated by a single electronic record. Next slide, please.

This is a little hard to see, but what it is, is a screen shot of a documentation tool in a platform that allows us to do a calculation of risk on a patient. So primarily it's used for patients who are referred into case management and/or discharged from hospital or ED and literally it uses the LACE scoring index with logic built directly into the system so it calculates a risk score. And for those of you unfamiliar with LACE, you'll see the categories there. "L" stands for length of stay, so the number of days the patient was in the hospital; the acuity of the patient, was the patient admitted emergently or into an ICU situation; comorbidity index, which is calculated using the Charleston Comorbidity scale, which, by the way, is a hyperlink right inside of the tool; and then the number of ED visits in the last six months, which again is captured automatically. And that L-A-C-E calculates a risk category, so a patient who falls into a low risk category, 0-5, will receive a follow up phone call and med reconciliation and red flag rehearsal and discharge instruction reinforcement, and scheduled for a follow up visit, and maybe that's it. But a patient who falls into a high risk category of 11 or above might get daily telephone calls and be brought in for post-discharge visit within 24-48 hours of discharge. Again, those are the levels of management intensity of care that generated by that risk index that is built into the electronic system. Next slide, please.

Again, a screen shot of the initial intake done upon case benefit, so we understand where the patient's coming from, where they're going to, what their demographics are, what the reason is for case management, what goals we're going to set with them, what literacy and learning approaches work best, what their functional status is, all captured as discrete data so that we can slice and dice and report it and measure our progress. And that's a critical element here, is capturing it all as discrete data instead of free form text in disparate systems. Next slide, please.

This is a screen shot of a link right from within the navigator that identifies all of the resources available in the community, we call it S-A-R-G, it stands for Services Area Resource Guide, and it's a searchable A-Z listing of over 4,000 goods and services that exist in each of our markets, Richmond and in the Hampton Roads market. So if you can read the detail, I know it's small print, the first one is Abuse, Adult and Child, so if you click on that it will give you all of the resources in Richmond and all of the resources in Hampton Roads that are available to the case manager for managing an abuse situation that might present. Again, that expediency and efficiency of accessing that information is key to making that transitional management as cost effective as possible. Someone looking through a phone book or doing a telephonic tracing of things could take hours of time, while with that SARG tool we've taken hours of time down to minutes of time improving effectiveness. Next slide, please.

These are a couple of illustrations of the registries that we use. We have diabetes, COPD, CHF, chronic renal failure, and a high risk registry as well as our daily discharge registry report, which identifies all of our patients discharged within the last 24 hours from hospital or ED visit. That registry is placed into the hands of the navigator who does follow up. If you look at this slide, this is a diabetes registry and the first person on the list is an 80-year-old male, a patient of Dr. Lee with an A1c of 13 and a BMI of 33.8, and hasn't had their A1c measured since February of 2011. Well, that person gets a phone call and they're brought in for a visit, so that's proactive management of a chronic disease driven by the registry. Next slide, please.

This is the daily hospital discharge registry, and again, by physician I know who's been in for what and outreach is done telephonically within 24-48 hours at discharge, and then all those things I mentioned earlier are accomplished, including the calculation of that risk index, including driving the intensity of management. Next slide, please.

This is some of the reporting and outcome measurement that we're capable of doing because of that documentation tool. And so if you look at the bottom line, the most recent data I have, 663 patient discharges at our medical home project sites in the month of March, with a 30 day all cause readmission rate of 2.48%, which compared to some national averages is awful darn good and we're very proud of. The reason you only see a couple of months worth of data here is that the discharge documentation tool is brand new and we've just started to use it. We were doing this in a very manual way for the last 10 months using an Excel spreadsheet, but I'll have to tell you something, our 30 day readmission rate, just because of the interaction and intervention on the part of the case manager, was still below 3%, so this seems to be very consistent with what we've seen even without the efficiency of this tool. Next slide, please.

This is some of the other reporting, so again, goal setting and goal attainment with those patients who are in case management. Of course we can track A1c improvements and blood pressure improvements and BMI improvements in all of those populations of patients that we apply this same strategy of aggressive proactive registry management to.

And now I'll wrap up the presentation with a little dive into what the portal looks like, so if you go to the next slide. This is a test patient, so don't be thrown by Patient 1 Test welcome sign there, but literally this is what you encounter when you enter, and so you have several options of navigation. I use it as a patient and I offered myself up as an illustration of patient satisfaction. I love it. I've got the iPhone app already and I do a lot of traveling, so I'm scheduling appointments and asking for refills and reading my test results and communicating with my physician and the care team seamlessly, no matter where I'm at. Next slide, please.

This is a snapshot of what a health summary would look like, and so you see patient 1 test has high cholesterol, high blood pressure, ADD, abnormal heart rhythm, and so on and so forth. The interesting caveat here is that if you click on the problem it launches educational material in our Health Wise library on that topic for the patient to read. And if you click on the date of the discharge it literally goes to the summary of the visit so you can see what medications were ordered at that time, what the physician's simple comments were, what the reason for visits were, what lab tests were done, and so on and so forth. You get the picture. Next slide, please.

This is the medication list that's available in My Chart. Again, if you click on the medication you have the option of refilling it, requesting a refill. You also have information about the medication. Obviously you've got the instructions on how to take it listed it clearly there, and the ordering physician and the date it was ordered, but it also says about this medication, again, that's specific information about what the medication is for or how it works, when you should take it, and so on and so forth. Next slide.

This is how we request an appointment online, you pick a day, you pick an a.m. or p.m. time session, the physician, give a reason for the visit, and we promise a response to this within two business days. And I think there's a slide here that shows that we have exceeded that promise pretty dramatically. Could you go to the next slide, please.

This is just an illustration of test results, so this is a urinalysis result that's done on test patient 1. Our results are released to the portal immediately. If they're a normal range result, as soon as the result comes off of the analyzer it is available to the patient. We hold abnormal results for 48 hours, which allows the provider time to review it, but then they're released automatically as well, and so the greatest length of time that you are separated from your test results, whether it's a radiologic study or a laboratory analysis, is 48 hours. Next slide, and this is the second to last slide.

These are some of the tracking tools that are available, so if I'm a hypertensive patient and my physician wants me to measure my blood pressure periodically I can go right online here and plug in my systolic and diastolic blood pressures over time and it notifies my physician immediately, who can then make medication adjustments via my chart.

And to summarize here, the last slide, these are the turnaround times and the volumes. Now, this is about a month old and our portal has been live for 12 months. We have over 40,000 patients, active users. We're adding 2,000 patients a month easily to that, and we have done no marketing it. As word of mouth spreads, the ease of use and the connectivity sells it. We're handling just under 2,000 electronic messages a week and we have turnaround times for prescription refills of 9 hours and 2 minutes, appointment requests of 4 hours and 42 minutes, and messaging just under 11 hours. And that doesn't sound impressive, but when you calculate into the fact that those are messages that are requested at 2:00 in the morning, or on Saturday afternoon at 7:00, or on Sunday morning at 8:00 a.m., and then averaged out over a 7 day period, those are very impressive numbers.

I heard it echoed a few times here, my last comment is that Human Resources technology and innovative delivery system designs will improve outcome and bend that cost curve, but right now there is no payment reform that supports it. And so a lot of what I've shown you here is simply an expense to those of us who are providing care, and until we move from fee-for-service to fee-for-value that's not going to change and these initiatives are not going to be sustainable. I'll stop there and thank you.

Eva Powell – National Partnership for Women & Families

Thank you, Robert. This was fabulous. I'd like to thank all of our panelists. It gives me great hope to know that folks like you are doing the hard work on the front lines of our healthcare system, and as has been mentioned, with the trust that the payment reform will come to support the sustainability of this.

I've got a few follow up questions, but before I ask those I wanted to give other folks who have been listening a chance to ask you questions. So I'll just open it for a few questions, if people have them.

Suzanne Mintz – National Family Caregivers Association – President and CEO

This is Suzanne. I do have some questions. Robert, this is extraordinarily impressive. I was wondering if you collect family caregiver information, not next of kin, but for patients with chronic conditions if they have a family caregiver, who that person is, how long they've been caring, what are the primary things they do, and then on the other side noting if somebody is a family caregiver on their own record and what impact that is having on them. We believe at NFCA that documenting who family caregivers are is the first step in giving respect to family caregivers and incorporating them into the healthcare team and so I was wondering if with all of your wonderful innovation you had considered that at all.

Robert Fortini – Bon Secours Medical Group, Richmond – Vice President and Chief Clinical Officer

Oh, without a doubt. And it's all captured discretely in that documentation tool, not just the contact information for the caregiver and their relationship, but also the best way to contact them, whether via e-mail or text message or telephone, land line, cell phone. And the other part of that that we're pretty aggressive about is when we activate a patient who has a well defined caregiver and support strategy in the home, we encourage proxy access to the medical record so that if they may be incapable of logging in and navigating My Chart on their own, their caregiver can do it and they can be the voice of communication to the physician and the care team at the practice.

Suzanne Mintz – National Family Caregivers Association – President and CEO

I'd love to follow up with you about that.

Robert Fortini – Bon Secours Medical Group, Richmond – Vice President and Chief Clinical Officer

Sure, I'd be delighted to.

Eva Powell – National Partnership for Women & Families

Great. First of all, I'd like to support that comment that Suzanne made about the documentation of family caregivers. I think that's something that is important for us to continue to look at in terms of supporting those at home. So I'm glad, Suzanne, that you're going to follow up with Robert and we'll definitely do some follow up in the committee on that topic. Are there other questions that folks have?

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

This is Leslie. I'm sorry if there's background noise. I have a question from the Transitions of Care Group, first of all, this has been really great. I love all the speakers' ... different perspectives and it's very appreciated. In the transitions of care it seems as if the gap points and transitions that we all know have significant cost of quality impact when things aren't coordinated, and I wonder if there had been any work done to determine what the cost of transition is when done correctly and the cost of transition when not done correctly. We hear over and over again on the Triple Aim that tests are repeated, that information is not shared, and although it's hard to quantify a gap or manage ..., I wondered if you had any number that you could help us with.

Cheri Lattimer, R.N. – CMI

Thank you for that question. There are several studies that have been completed and actually have been validated on the models that some of you were talking about, even Boost, not only about the savings and the reduction in duplication of resources, but the actual cost of the case manager, nurse, social worker, whoever is the focus of that transition in the team, based against that. We produced, on the NTOCC Web site, a tangible savings document, we actually pulled those studies off and highlight, I think it's seven or eight of those models. I'll be happy to send that to you or, like I said, it's on the NTOCC Web site. All of the resources from NTOCC are absolutely free to the industry and folks are able to use them in a number of ways, so whichever is easiest for you I'll be happy to share that.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

I'd love to see that as part of the record at this meeting that we have available to us for follow up and anyone who's listening into the call, so it's easy for them to get to. That would be wonderful. Thank you.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

This is Charlene. Again, I want to echo Leslie's comment that the content of the presentations, all of them were excellent and very complementary. A question, one of the challenges that we heard at the hearing when we first talked about care coordination is when you talk about things like the integrated patient care plan or sharing data and coordinating care across the continuum and/or implementing an aggressive ... manage populations at risk ... financial incentives, there's a whole culture change that has to go with that, so there are really two dimensions of this. I've got two ... of this question, but I really want to talk to you, first, to get your views in terms of how fast do you view, is it going to be tools that drive this transition, or will it be payment that drives the transition, how do we support, if you will, creating that on ramp to get what you guys are doing to actually happen, recognizing there's process change and cultural change that also has to happen concurrently. I don't know, Jennifer and Gail, maybe in a small community it's not so much an issue, but any of your views on that and certainly also Bon Secours' experience here.

Jennifer Fels, R.N. – Southwestern Vermont Health Care

This is Jennifer. I'll take a stab at that. Gail and I are together, we're just ... Certainly, payment will drive this. We're certainly driven by reimbursement methodologies. Leadership has to be engaged. We could have not done any of this work if it wasn't a part of our strategic goals. And you have to have all of leadership on board and you have to demonstrate your outcomes. I think that the quality outcomes showing value for what we're spending in healthcare, if we can't demonstrate our outcomes I don't see where we would be very effective in making any changes.

Gail Balch, R.N. – Southwestern Vermont Health Care

This is Gail. I think the other thing that I see is trying to create the culture to eliminate the silo mentalities within a hospital setting we still have silos of practice, of care experts, and it really has to move from being it's about my specialty, to it's about the patient and having really patient-centered goals for all care areas. And we have a leadership team here who is very supportive of helping us shift that, and one of the ways that we're doing that is to focus on patient safety. So that really helps everyone come to the table with it's about patient safety, so that's one tactic that we've used.

Robert Fortini – Bon Secours Medical Group, Richmond – Vice President and Chief Clinical Officer

This is Robert. Absolutely, patient outcomes, breaking down silos, but I'm going to forget the fact that I'm a nurse practitioner for the moment and I'm going to put my business hat on and say if there is no payment reform and if that doesn't occur that this is not sustainable. It is certainly not going to drive it. At the end of the day in order for me to provide care to the community and the patients I have to be able to pay my light bill, rent, and feed my children, and if I can't do that I have to close my doors. And so that's the sad reality of things. But I'd like to say that we're altruistic and interested in patient outcome above all, but I can't ignore the business case.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

That's great.

Suzanne Mintz – National Family Caregivers Association – President and CEO

This is Suzanne. I've got a question for Jennifer and Gail. Are you familiar with, or in some ways involved with the Medicaid program with the community health teams –

Jennifer Fels, R.N. – Southwestern Vermont Health Care

Yes.

Suzanne Mintz – National Family Caregivers Association – President and CEO

... that have gone on in Vermont?

Jennifer Fels, R.N. – Southwestern Vermont Health Care

Yes, we're actively involved in that.

Suzanne Mintz – National Family Caregivers Association – President and CEO

I think that the community care teams, especially in rural areas, hold so much promise as the mechanism for being the connectors, being the navigators, and unfortunately those pilots or ... in CMMI have not been funded and I think the more stories or the more data that comes out about them is so critical in moving that program forward.

Jennifer Fels, R.N. – Southwestern Vermont Health Care

Something about that program I would like to address for the rest of the group is that it's a team that comes together and looks at the high risk population and works with the patient directly for interventions. It is under-funded, and you cannot have one person have a broad scope, a broad geography. My fear is that we won't be able to demonstrate good outcomes and it will be seen as a failure. So I think that's a risk in under estimating the resources that it takes for the chronically ill ... those resources.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

This is Leslie. I have a question, back to the business model. I agree that this is a challenge for all, but one of the things I'm struck by in the Bon Secours model is this wonderful rate for appointment scheduling and the great ways that you're getting messaging back to the patients I wondered whether or not you've done any modeling on the cost of or the benefits of patient retention. Bon Secours is in a very competitive environment and does admission based care quite well, I've been to your sites, but every organization has been fee-for-service and patient retention is an important part of their model regardless of health reform, and I wondered if you had done anything that really demonstrated how this technology

has allowed you to retain patients within the Bon Secours system and what benefits you thought that might have brought to your organization from a business point of view?

Robert Fortini – Bon Secours Medical Group, Richmond – Vice President and Chief Clinical Officer

Yes, actually, and maybe not specifically in terms of patient retention, but total number of lives served and unique individuals visited in the last three years, our rate of growth has been dramatic, to the tune of about 15,000 new patients a month, and that, without adding new physicians, but rather improving our ease of access and using some of this technology. So there's no question about the fact that we're now over half a million lives served and that's up from about 350,000 just a year or 18 months ago.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

And it seems to me that if you can equate 2,000 patients a month being added to your portals just based on word of mouth and that you can also demonstrate that ... in an ongoing manner of about 11,000 times or more a month, not including results given, that if you could really demonstrate a causal effect of implementing patient engagement strategies to the real business opportunities that you realized in that dramatic growth.

Robert Fortini – Bon Secours Medical Group, Richmond – Vice President and Chief Clinical Officer

Agreed. And those numbers speak typically to our bottom line in ambulatory services, so in primary care, that's where our growth emphasis is now, but also in specialty care. The contradiction that I'm faced with here, however, is that Bon Secours ultimately is a hospital system, and as I improve all of my ability and patient access and effect outcomes and decrease ED utilization and improve generic drug utilization and drive down 30 day readmission rates, our hospital system takes a hit, so it's transition management. Until we get into a payment structure that rewards the system as a whole for improving the health of the community, it's just difficult to manage.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

So really your growth becomes then taking patients away from the competing organizations, and I guess your point is at some point in time when that starts to equalize, that without payment reform that it's not sustainable. Is that a correct assumption?

Robert Fortini – Bon Secours Medical Group, Richmond – Vice President and Chief Clinical Officer

Yes, absolutely. If you drive through Virginia right now you have several large health systems, and the billboards on the highways are advertising cardiothoracic surgery and emergency room wait times. We shouldn't be doing that, okay? We should be putting emergency rooms out of business. And I might be getting myself into trouble by making that remark, but I should be building a primary care delivery system and especially a care delivery system that gives patients multiple points of access so they don't have to rely on the ED or call 911 and an ambulance transport.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

So in the event that payment reform is still a long way off, or could be, it sounds like your patient engagement strategy, by seeing good transitions of care and access to the patient portal and coordinating of the record, has been good for business.

Robert Fortini – Bon Secours Medical Group, Richmond – Vice President and Chief Clinical Officer

It has been good for ambulatory business, yes.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

But even in your hospital stay, for instance, if you have, let's say, 30% of the patients you see today have also been hospitalized in competing organizations and as a result of your strategy to retain that patient and now you go from 30% of the patients to only 10% of your patients have been seen by another hospital, it would indicate that you're retaining more patients in your system, so –

Robert Fortini – Bon Secours Medical Group, Richmond – Vice President and Chief Clinical Officer

And growing a larger market share perhaps.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

Right.

Robert Fortini – Bon Secours Medical Group, Richmond – Vice President and Chief Clinical Officer

Yes.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

So it would be interesting to see if your market share numbers overall also demonstrate the same kind of growth, and I think it would be wonderful information to know because in the interim between now and payment reform just getting people to appropriate care coordinated well seems to be a good business model based upon what you've just shown. Is that true?

Robert Fortini – Bon Secours Medical Group, Richmond – Vice President and Chief Clinical Officer

Yes, absolutely I would agree with that. Again, we're a little boggled by our own growth at times, but there is no question about it. And the numbers are hard to refute, so we're doing something right.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

Thank you.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

This is Larry. Can I jump in with a question?

Eva Powell – National Partnership for Women & Families

Go ahead.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Cycling back out of big policy issues and some more handoff issues, there was some discussion about integrated patient centered care plans earlier. I wonder if we could pick that up for each of the folks to comment on in terms of how you see that playing out both in terms of the human logistics of communicating across settings, and any kind of specific technical assistance in actually creating an integrated plan.

Gail Balch, R.N. – Southwestern Vermont Health Care

This is Gail. I don't really have any answer. I have desires, and I think by creating a personal health record, so to speak, with the patient and the focus of that so that the patient health records, so to speak, or patient care plan that they contribute to, and if that means that the medical home managers or the case managers advocate with the patient to help and assist them to develop that record, that that one single record travels with them wherever they go. And I think at the hospital level we need to have more standardized approaches to how we communicate our nursing care plans. I'm a nurse, so I am really understanding the need for an interdisciplinary care plan, but I think that each discipline adds to that and we need to really focus on goal attainment.

Cheri Lattimer, R.N. – CMI

This is Cheri with NTOCC. We couldn't agree more. We also believe that from that collaborative team the integration of the information gathered from the nurse's perspective, the social worker, the case management perspective, is very inclusive and often has further details around the patient's interaction and the family caregiver's processes, on top of the clinical aspect that needs to be and it needs to travel with the patient. The concern that we have is that the patient's information is from the patient and their specific health literacy, so how do we combine that to really be a continuum of information that is gone through, and in the process of that to make sure that we're able to share that no matter where the transition is occurring, so just not from the facility, but from the primary care to the specialty office, to the rehab, skilled nursing, assisted living, hospice, wherever that component may be. And HIT offers us the avenue to do that, the process is the information that needs to be taken. We may also want to look at what we've been able to see from some of the information coming from the health story project, where

narrative notes can actually be incorporated and I think that it can have a huge impact from the patient's perspective, and that may be something we want to consider.

Suzanne Mintz – National Family Caregivers Association – President and CEO

This is Suzanne. Cheri brought up the term "health literacy" and I was thinking more broadly that obviously patients cover the entire spectrum of education and socioeconomic situations, and it's one thing to have all of this engagement at higher levels, but how do we make all of this work for people who are uneducated and don't have consistent relationships with the healthcare system and all of that?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Cheri, I wanted to add one more, and Cheri and Gail you've probably got some perspectives on it, Gail and Jennifer, because we've been talking about where is this done. This is Charlene. From personal experience one of the things I did with my parents, the first thing I did was hire a care manager and we developed a care plan. My parents own that care plan and it's not stored any place except the care manager owns it, right, so Cheri this is your domain space, where it happens and where it just goes to long term care is where they're living, which is in assisted care. So when I see care management it's happening in the home, the patient's home, the EHR is resident as part of a system of care, but that system of care really is supportive of care that has to be coordinated, if you will, from a patient centric view that happens at the home or at the long term care center, so how do we make this transition, if you will, to this integrated care plan, which is everything you guys talk about but at the end of the day it's really a complete upturning, currently everything ... health system upside down to where it's centered around the patient, with everyone contributing to it? And what role does EHRs, as they're defined today, do to support that?

Jennifer Fels, R.N. – Southwestern Vermont Health Care

This is Jennifer. I think you've summed it up very well. We've been very hospital-centric, considering that's healthcare and it's not, and I think it's really a culture change for our entire health system. We could have a great electronic patient care plan but if it just lives in our system here at Southwestern Vermont Health Care it's really quite useless to the patient who's going to see specialists and look at other providers of care. So it does definitely have to be revolved and live with the patient, not with a hospital, not with a physician group even, or assisted living, and I'm not sure how we do that.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Yes.

Robert Fortini – Bon Secours Medical Group, Richmond – Vice President and Chief Clinical Officer

This is Robert. Yes, we've got a long way to go, no question about it. I think a bidirectional patient portal is one answer. That doesn't reach everyone in the population, but it's a start. And then I think we're all looking to our state health information exchanges to help us tie all those disparate systems together, and it seems to me that we've got a long way to go there. And some of it is political in nature, for example, in Virginia we charge physicians for access to the health information exchange and we make the registration process rather tedious, and the adoption rate, my suspicion, is not going to be tremendous. The other thing is we have an opt-in approach to patients, so a patient has to apply to be included in the exchange, and states like Kansas have an all-in, opt out approach in which automatically everyone is in the system and then as they do not want to be a part they can opt out, which is going to capture many more lives and be a much more functional database. So some of the HIE work that's going on as we speak in the background I think has got to be part and parcel of the focus for Stage 3 Meaningful Use.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

This is Larry. Let me ask a focus question about some of the content of these integrated care plans. The thing that struck me in some conversations around this is the shift in language I'm hearing in terms of the goal. So it's not uncommon for care plans to have goals in them, but really a shift to actually start with the goals that are patient-centric, so rather than starting with a list of diagnoses or problems, starting with what's the patient trying to accomplish in their lives, where are their values. It begins with that kind of discussion and those kinds of statements, and then it leads to, and because this is what we're trying to accomplish this is what we're going to do. And that includes addressing certain diagnoses and conditions

but it also includes choosing not to address some, because the patient would rather live with said condition and live with the side effects of the treatments. And I think those conversations often get lost in just the normal discussion and certainly seem to get lost in the electronic exchange. I'm wondering if any of you have tried using any of the exchange tools, or thought about using them, and how well they actually work at communicating care plans.

Cheri Lattimer, R.N. – CMI

Larry, this is Cheri. One of the issues that I hear from many of our members is that the definition of a care plan and the aspects of a care plan, again, are not consistent, and I think we all agree on that, and the process of doing that doesn't always cover, the information that we're talking about often is gleaned from the nurses, social worker, case manager around the patient's preference, their ideas, their culture, their religious aspects, and the things that we're looking to help move and work with the patient and family caregiver, both towards adherence and towards following the process of that. And so we're hearing pretty significantly that there are some significant omissions of information that is really pertinent to working collaboratively with the patient and the family in achieving the treatment goals, if you will, from the clinical side of the physicians who lead the team, but all of that has to come together and play into this patient centered model of delivery because without that we still will have those barriers, as all of us know, and these gaps of where patients either are not motivated, don't feel confident to go through this, don't want to go through this, and feel like we haven't heard or we haven't coordinated this appropriately. So as I said, one of the issues that I hear quite often from nurses, social workers, and our case managers along this line, care managers also, is the ability not to include much of this information that really comes from the patient within the electronic medical record or health record.

Eva Powell – National Partnership for Women & Families

Thanks, Cheri. I apologize for having to cut us off here. This has been such a fabulous conversation, but we do need to make time for public comment and we're actually right on time, so we'll be just a couple of seconds over. But what I would like to suggest, and MacKenzie and ONC staff let me know if this is allowable, but I had a number of questions specifically related to Stage 3 Meaningful Use but didn't want to stifle the conversation because I think the conversation we've had is really critical to being able to discuss specifics about meaningful use, so if it's allowable under the FACA rules I would like to send those to all discussants and participants in this conversation for an e-mail response that would then become part of the public record of the session. Is that allowable?

MacKenzie Robertson – Office of the National Coordinator

Sure, you can have them e-mail information back and forth to you directly, and then if you want we can just post it to the FACA portal just as a reference.

Eva Powell – National Partnership for Women & Families

Okay, great. Well then that's what I'll do, because I feel like this is the crux of health reform, what we've been talking about today, and the experiences of those of you who have been on the panel are just invaluable and you've brought up so many important issues that have been discussed at a very high level in the Policy Committee, but we really are not sure exactly where to head. And your input thus far has been very helpful and so I'd like to get an opportunity to get some answers from you on those two specific questions, so I'll send those out.

And with that, and one minute over, I will turn it over for public comment.

MacKenzie Robertson – Office of the National Coordinator

Operator, can you please open the line for public comment?

Public Comment

Operator

Yes, if you would like to make a public comment and you are listening via your computer speakers please dial 1 877-705-2976 and press star-1, or if you are listening via your telephone you may press star-1 at this time to be entered into the queue. We do have a question.

MacKenzie Robertson – Office of the National Coordinator

Does someone have a question?

Operator

Margaret Leonard, your line is live.

Margaret Leonard – Hudson Valley Care Coalition

This is Margaret Leonard from the Hudson Valley Care Coalition. I want to thank the committee for bringing this information to the public and to all of us on the line today. This is the way we are going to make a difference. The presenters were outstanding and their efforts are to be commended and of course supported. In New York we are, I just wanted to let you know that what's happening and what people are doing and talking about today, we are trying to incorporate. In New York we're working on the health home initiative and being forced to bring all the players together that haven't been together in the natural, normal settings, and trying to figure out what the representative from Bon Secours said of how do we keep all of the players alive, or is it necessary to keep all of the stakeholders alive, all of those different businesses, and how do we transition acute care beds and hospitals to other settings that we may need, maybe even apartments for homeless; the tools that were mentioned by Cheri Lattimer, National Transitions of Care Coalition, those medication adherence tools, the questions to ask when you go to the hospital or to your doctor, they've all been downloaded and used by many, many of the hospitals in the major systems here in New York. Those are the kinds of tools that you can download and put your own name, template on it, your own logos, and it really helps getting the information, working with your local RHIOs to get that platform so that you can have information, and I just love the speaker who talked about the app on their phone, and I think Cheri Lattimer spoke about having an app as well. That's critical so that the patient is walking around with their information on hand.

When we take a care plan and the point that we brought up about a care plan, the patient in the home or the patient in the private setting not having the same access, I think if we go to global, or some way of getting into this app for everyone at all ages is how we're going to move this forward. But the point about the dollars and how do you keep making your business sense, I think what New York has done, and this sounds very crude, but they've put everybody in the arena together and said figure it out, fight it out, here's a dollar, folks, figure out what portion of you ... deserve, what portion of ... the others in the community are willing to say you should get paid for this, and I think that forcing of the unnatural relationship between the different operating businesses, because the natural relationship, the intertwiner of course is the patient, but forcing that to happen and the different payment reforms will do that, but in the meantime we have to find mechanisms to support the different pilots that are going on until we can get to the major pilot, and some of these CMS innovators' money will help along the way, but having these types of meetings and then I'm assuming this will be posted and I can then share this with our whole coalition to listen to, is very important and I thank you all, thank all the presenters, and thank the committee for making this opportunity available.

Operator

We have another comment from Carol Bickford.

Carol Bickford – American Nurses Association – Senior Policy Fellow

This is Carol Bickford from the American Nurses Association. Accolades to all the participants for their great presentations and also their identification of key resources that many of us may not know about that are in the public domain. Thanks.

Operator

We have no more questions at this time.

Eva Powell – National Partnership for Women & Families

Great, thank you. Thank you all. This is Eva. I'm turning it back over to whoever I should turn it over to, or I guess we should just end the call since we're over. I apologize for being over, but I think the six minutes was time well spent.

W

Thank you very much. It was excellent.

W

Thank you so much. It was great. Thanks, Eva, great job.

Eva Powell – National Partnership for Women & Families

Thanks to you all and we'll be in touch. I'll send out an e-mail.

MacKenzie Robertson – Office of the National Coordinator

Thanks, everybody.

W

Thank you.