MS. EVANS: Great. We are on the agenda item at 10:45 on how health IT is actually used to specific recommendation from which we're building our discussion and future actionable recommendations from is listed here. It's state Medicaid agencies and state employee health plans in cooperation whenever possible to implement incentive programs and/or reimbursement policies such as pay for participation, rate adjustment and quality incentives that will urge provider adoption and use of health IT systems and participation in health information exchange.

So before we get into that discussion, Mr. Francois de Brantes is here. I'm delighted to introduce him. I don't think I've introduced you before, but Francois knows probably more about this topic than most. Francois, it's great that you're here to share this discussion.

I'll just say a few words about you, Francois. Francois is the CEO of Bridges to Excellence, which probably everybody knows about by now, rewarding physicians for better quality care.

Francois is responsible for setting and implementing the Bridges for Excellence strategy and he's also a national coordinator for PROMETHEUS payment, which maybe you can tell us more about. I know I'm anxious to hear a bit more about that in your presentation, Francois.
Prior to that, François was a program leader for various software initiatives at GE Corporate Health Care Programs responsible for GE's active consumer strategies. He's on lots of boards. He speaks a lot. He teaches. He really sort of spreads himself thin, which probably makes you all the more insightful when we're talking about these kinds of incentive programs. I would hand it over to you. Thank you.

MR. de BRANTES: Thank you. Thanks for having me here this morning. It's an honor and a privilege. What's interesting, as folks were going around the table introducing themselves, is some of the themes that keep coming up. At the taskforce I had the opportunity to chair the Foundation Health Initiative. What struck me think strikes me now.

All of these activities raise the demand for health information technology. And if there's no demand for health information exchange, it's all for not. Really what we've been focusing on over the past five years is trying to create that essential demand for health information technology and the demand for data exchange with a very, very specific purpose; and that purpose and that goal is centered around delivering the quality.

And actually, where we did visions and that's where the deployment of IT and the physician processes for key health care kick in, but it's
around that very specific goal, and that's really
essentially what we're going to spend the majority of
the time on, which is why we've had experience with
some of the lessons learned in helping engage in that
dialogue. Next slide.

(Slide.)

MR. de Brantes: It's a non-profit
organization. It still is a multi-stakeholder
organization. The bottom line is, as I look back
about five years of doing this, can we say that it's
worked well? This year we're going to be publishing	hree studies that say, yes, it has. We have
thousands and thousands of additions. They have
become recognized as a result of this, and I'll get
into that. Yes, incentives to creating demand for
change in information practices. There's no doubt
about that. We have concrete evidence that we
engineered practices to deliver better health care at
a lower cost and then finally, the last paper
centers around the central issue of the strengths of
the signal. It's almost a subdocument.

You need a strong signal and $10,000 is a
safe one, but I think you'll see in our charts that
it's not strong enough and that's why the private
sector and the public sector have to play a very
strong role in sending that signal and the signal has
to be a strong one in terms of the dollars at stake,
also in terms of the focus. He can have lots of
dollars and a distributed focus, which, of course, creates a lack of opportunity in the future.

(Slide.)

MR. de BRANTES: With that, we've grown fairly significantly. Many of you are in states where we have active organizations of Bridges to Excellence. Many of you are in states that don't have active implementation of Bridges to Excellence. Our results are spread not evenly across all the states, but they therefore have more to show for it. But I think the results we're seeing from state-to-state are very consistent. There are four essential programs, and the programs I'll get into a little bit, but really they're what I call the foundational program is the first one. Physician, obviously, designed five years ago is now called the Physician Practice Connections administered by NCQA, but that we paid NCQA to develop five years ago. It was always a foundational program for us because we felt very strongly that without assistance to deliver a good outcome folks don't know it's a good outcome that you couldn't have change. Essentially, you'd end up with micro-changes and centered around certain activities and they would not be sustained by systemic change in practice.

The other ones are additions that are
again focused on the management of the outcomes, the
appropriate management of the patients in practices.
(Slide.)

MR. de BRANTES: Many states are directly
involved as either purchasers, employers in North
Carolina, Colorado, Minnesota, and Georgia. The
State of Minnesota is actively participating and
paying rewards through their plan administrators. In
Maine and Minnesota, Bridge to Excellence
practitioners are used either as fee recognition or
they're used as part of physician chairmen -- another
way the state gets a benefit plan engaged. You
activate consumers by telling them, you're doing a
good job, predetermining the network and the kind of
market share. Many city and county employees'
benefit plans are also participating. In one city, the
Department of Health in New York City, is
partnering to try to create a citywide, quality
reporting system as part of the overall plan that I
talked about earlier. Next slide.
(Slide.)

MR. de BRANTES: The programs we're trying
to create demand in the physician office. How do you
do that? You do that by creating rewards if do
something. What we're asking them to do is to create
systems that do create demand for both adoption of
that system and as importantly, the use of those
systems to effectively manage patients. Again, the first one I talked about is what we think of again as foundational program. Interestingly, it's not deployed in all of our implementation areas.

Many of the foundation areas, like the folks on single need, you can have physician practices change their practice. You focus on multiple diseases. You've got a foundational program with a fundamental change on the way they practice, then you get--that's what I call a dividend yield study. So you're with them if they do certain things. The physicians, I think, if they adopt certain things they get a reward. The greater the level of systemness in the practice the greater the reward.

It's been very effective in engaging practices and adopting systems. We've got dozens and dozens that have adopted medical records and now are using them to get additional rewards. They're associated with good management in these two scenarios. So the idea is, again, you're asking them to do things that, without the system, it's going to be very difficult to do. When I say that, what I mean is we're looking at all of the conditions that--things that you can find in medical records that you cannot find that's been the foundation of our program. Let the claim data do what it's supposed to do, which is count dollars and let the medical record
participate as they're supposed to do, which is to look at what's happening to patients in the practices.

When you try to retrofit the latter to the former, you get a mess. So yes, it's complicated and that's why you need to have all of the dollar amounts here were based on actuarial studies conducted many years ago that looked at the relative effect of the right management of patients, appropriate management of patients and physicians in reducing their risks, avoiding complications—blood pressure, diabetics

ey're going to have strokes. They're going to have people with renal failure and as a result it increases the cost of care. We have said that these estimates hold true in terms of observed lower costs of care to patients with these conditions. Next.

(Slide.)

MR. de BRANTES: So it took us five years to get four programs. We're now in a pathway to create a lot more in the next year. That's primarily based on the use of electronic medical record data. What we're looking at now is tying into data sources and to leverage those data sources and having made systematically the ones at issue and to do it on a broad spectrum of issues so that we can start getting into continuous quality care evolution, not using data that's 18 months old but using data that's
quarter old so that as the physicians changes and improve their care the immediate effect of those changes, one quarter or two quarters down the road, you can get it as opposed to waiting a year and a half or two years. You can have a fairly significant increase in the adoption rates here and how we tap into those data to create better and better feedback.

On the core physicians and their performance, and these can be combined in a fashion that we're calling our medical home designation where physicians have adopted the systems and they to demonstrate they're also delivering good care. It's not just one or the other. They have to do both. And if they do so, it's $125 per patient per year up to $100,000. That's a lot of money. And I can tell you that in all of our models there isn't a physician that doesn't want to engage in significant practice re-engineering if there's $100,000 in rewards. But it's a tough criterion. It's not just about checking a box that says, yes, I've got an HER. It's doing that and demonstrating good outcomes from management.

Next slide.

(Slide.)

MR. de BRANTES: Why? Because when both conditions are met this is what we see. This will be in a paper that was published in September of this
year. What we did here is we looked at the differences between recognized physicians versus peer comparisons in Massachusetts where we have lots of recognized physicians. Essentially, what we found is that not only is the cost of care lower between the comparison group and the recognized group, but also using a standardized set of claim-based performance metrics. They score better on quality and we see that very systematically in all of our other studies as well. And where the money comes from is generally two places, reduced hospitalizations and reduced use of extraneous ancillary services. Those are your indications for your patients. Lori mentioned that one of my other job is the national coordinator this more fundamental reform program. In our early work around that what we found is the amount of money, for example, the patients with diabetes and out of money being spent today and potentially on complications is one and a half times the base. If you spend a buck on normal routine care, good care for patients for diabetes you're spending an additional 1.50 on potentially avoidable complications for a total of 2.50 per patient. All these have connotations--things that should never happen to patients with diabetes. The savings that
can be achieved in the system from good management of
patients are absolutely enormous, but you can't get
there if you don't have a good exchange system.
Again, a lot of it will be that we're trying to focus
on how do you create the report system that will
engage the provider in really rethinking the way they
provide care, about adopting systems.
If you look at these numbers, which are
about $300 per patient per year, that's what we're
using as the basis for where the justification in the
125 in the medical area. If you can save 300, you
can afford to give 125 to the doctor. That's what's
creating that drive. To achieve good care you adopt
this system. You get $125 per patient per year and
you don't need a lot of patients to really make this
case.
(Slide.)
MR. de BRANTES: So we haven't just done
it Massachusetts. We've actually done the study in a
number of the markets. The numbers always come out
pretty much the same and the savings come out the
same sources interestingly, again, and I think Tom is
going to talk later about the medical home concept.
Out of time spent talking about this part of it is
how do we solve the crisis?
First of all, it's a self-made thing--the
crisis. But secondly, you find in your practices
that they're behaving like that. You see the number
of ambulatory visits go up. Why? Because they're actually calling patients and having them call back. How can they call patients and have them come back in? Because they know which patients are out of control. And how do they know which patients are out of control? Because they have a system and they pull data from their information system that tells them, hey, here's my list of patients who's out of control, who's blood pressure is out of control and need them to come in; and they get back in the office and make sure they've been complying with their treatments.

All these things are together--those amounts pale in comparison to the things that you get from reduced hospitalizations. It doesn't take long to get a pretty decent quality yield from that, but you need to spend a fair amount of time getting it done. Next slide.

(Slide.)

MR. de BRANTES: In fact, when we look at the amount of time it takes for practice range, and mostly in smaller practices, it takes 18 months. There's nothing simple about this. It's not just about the system. It's changing the culture, the philosophy of how you manage patient. That doesn't happen overnight. Money helps. There's no doubt about it. But even if you have the money, even if you went out tomorrow and said every physician practice is eligible, you have everyone rising up
their hands, first of all. We wouldn't know what to do with that. There are no swat teams for practice re-engineering in the country as a result of which we wouldn't be able to respond to the small practices. There's no magic formula there. It's one practice at a time and you can deal with a couple of hundred practices in a state on your Medicare panel, not

unless you really think it takes time and it takes effort and it takes direct intervention.

Your wife's practice she's going to wake up and say how do I re-engineer? That's okay. She's going to call you and that's okay, but we can't do that for every physician. It's who you call and the ability to re-engineer and I think as you engage in thinking through how to create these things with the demand for re-engineering is practiced across the country once you get pass the larger practices who have the resources and the ability to empower change within their systems, it breaks down and you really need to think about how do you respond to that. Once you've created the demand for IT, now you've got another demand and there's no answer to it. So it takes a lot of effort.

For the other one--and this is absolutely, critically important point and you'll see it in the next couple of slides--incentives have to be clear, predictable, and achievable. Physician practices are businesses and the beauty of that, of this new HHS
and I think they're also achievable. They're not sufficient, but they're clear, predictable, and achievable. If you don't have that, you're not going to have someone, any physician invest 20 grand to get a passive box. No one's going to do that. You need to have lots of clarity and predictability in how you set the incentives.

Ultimately, and again, I think our studies will show this pretty dramatically that a system that in better care response, better quality at lower costs, if you focus on the right stuff, which is outcomes, not microprocesses. So one of the things we did--and this will be in the paper that we're publishing at the end of this year--is to look at this relationship between the amount of money that it takes to engage physicians in transformation and to test out this idea of incentives. And so the one point, especially for those of you who have statewide initiatives, you talk about harmonization of your internal data, it's obviously critical once you start getting out into the delivery system if you don't give the vision an incredibly strong signal about what it is we're asking them to do they simply don't act. And they don't act because they're getting a
message from Medicaid and a message from Medicare and
you know, you're just not clear. They're just not
paying attention.

And what we found is that the
transformation in a practice occurs off of two
things. One is the credibility of the data that you
can put in front of them to get them to think about
practice transformation, and what does that mean?
Credible data means it has to be simple, on their
patients and it has to represent stuff that they can
act on. And so again, given the outcomes from
patients—I mean there are lots of others, but those
are very good examples. It's their patient. It's
not someone else's. It's actionable information.
Some might say there are other factors and variables
that play into it, but it's still actionable, and
the more you can do it on a regular basis—not just
once a year—then the more relevant and more timely
it is; and that's a credible thing and then the
critical mass, as always, the fact. I think what the

folks that are involved in the memo what you're going
to find is because you're focusing on smaller
practices, not large practices, but the smaller
practices $10,000 is not enough.
(Slide.)
MR. de BRANTES: It's not worth it,
especially since it's a one-timer. So you've got to
be able to think about it again. This is not just a
one-time investment. It's an initial investment, plus there are some potential down the road efficiencies that might be gained by those physician practices engaging in these HIT activities. But let's be honest, right, if they were significant we wouldn't be stuck in low adoption rates. Where you see high adoption rates is where you see those productive efficiencies from adoption of HIT can enlarge their practices. Where you've got economies of scale, you've got economies of scope. There are lots of things which you can do with IT that you cannot replicate in smaller practices.

Once you get down to that level, the economics are different. So how much juice do you need?

(Slide.)

MR. de BRANTES: It depends on the intensity of the squeeze. What we've done in our study is really track and you have in the same case what we've done is we've contrasted them--we've engaged physicians in this case better management of patients with diabetes versus the more fundamental adoption of systems and management processes.

(Slide.)

MR. de BRANTES: So if you go back to the prior, what you see is the first slope of the curve is, in fact, the same. But second the dollar volume to get docs engaged is also significant and here the...
$200 you get about 2 percent of physicians in community engagement looking at better managing patients with IT. But you know those are the folks who are already doing a good job. So therefore, for them, the incremental investment is pretty small. But again, and this is just on one condition, if you don't get all your other payers engaged--Georgia's a great example because we've got this data of an employer participating in this program. We've got lots of other employers participating in this program, but none of the fully insured businesses from any other health plans. They're sitting this one out on the backs of the employers. As a result of which, the volumes of patients in any physician's office on whom that patient can get a bonus is severely limited by just the participation of those employers. If the plan were to bring in their full use for this, we'd be at the top end of that. It would be on the majority of patients in that practice that a physician would be able to look for a bonus and many, many more participate in the program.

I'll get back into the collaboration and the importance of collaboration in any community, but this is a serious issue. If adoption gets stuck, if we don't get the critical mass of dollars--and when you start asking practices for more, which is what we do--then it goes all the way to EMR adoption. They give 10 percent adoption. You need $20,000. That's
why if you're thinking about 10 grand, you can see
that you're down in the 5 percent range. And in

order to get 25 to 30 percent of physicians in a
community engaged, you need somewhere around 30 or
$40,000 per physician practice. And again, the
economics are different, whether you're talking about
small practices versus larger ones. The larger
practices you'll be at the lower end of the
regression, while the smaller practices you're going
to have to be at the higher level of the regression
line in almost all states. The one in Wisconsin and
Minnesota you're dealing with small practices--15
percent patients in small practices. So you can't
get that level of transformation. You can't ask a
physician to stop everything they're doing today in
an offer-fee-for-service treadmill in order to re-
engineer their practice. It's just not going to
happen. The only way they're going to do that is if
the potential benefit is clear and significant.

Look, the good news is that our data are
really clear. The quality dividend that's yielded on
the transformation is significant. So it's not that
we can't afford to share this data with physicians.
We can. The issue is we've got to do it together,
and the reason why plans have a tendency to sit these out is because of the free ride. If I can get Medicare or Medicaid to foot the bill, why would I invest when I can basically piggyback on their investment? Conversely, if I'm a forward-looking plan and I want to do this, but I'm the only one, then all the other plans—the transformation of the practice doesn't declare with just the patients, with Medicare patients and Medicaid patients. They occur with everyone transformation is universal. It touches all the patients in that practice. We all need to be cognizant—I'm not saying this in disparaging terms. This is a legitimate important business reason for effort. Unless everyone jumps in, you're playing the bill for everyone else and everyone else is going to generate the savings on their patients without paying the incentive. Therefore, they can afford to cut their premiums. You can't. So your reward for being a good citizen is to increase the business for everyone else.

It really takes a consolidated leadership effort on the part of the states to say let's jump into this together. If we do, the adoption on the next slide—

(Slide.)

MR. de BRANTES: The adoption curve is nonlinear. Why? Because you're trying to get a threshold. The threshold is somewhere around 30 or
$40,000 and so as a result of which once you--I hesitate to use this term on that tipping pointer, in the curve, the adoption is way up. The benefit accrues to everyone in the community because, again, change happens for all the physicians, all the patients in that physician's practice and the net benefit everyone in the community jumps up and everyone benefits. All the plans benefits--Medicare benefits, Medicaid benefits and you know what I tell them private sector persons don't care about the free ride effect. One reason now they don't care is because we all recognize that at the end of the day if Medicare and Medicaid piggyback on the private sector that's fine. All it means is you just won't have to pay for it later. Sooner or later, we have to pay for it. If you re-engineer practices and re-

engineer doing a better job of managing patients with Medicaid and Medicare today that might be the evitable. What we're looking at is the evitable tax increase today might not happen. We might be able to bend a little bit of that inflation curve over the years, but it does take leadership--I think strong leadership.

(Slide.)

MR. de BRANTES: In the next slide, it takes the strong leadership of the states to really get the employers and the plans together. Honestly, where we've seen the best effects of transformation,
the most amount of consolidation around the
activities with the greatest transformation is when
the state got involved. The employers can't carry
this weight by themselves. It's not going to happen.
But the stage, as a large pair, absolutely has the
clout.

There's a lot of talk about contracting
and contract terms in the managed care plans. As per
that's what the legislative branch are going to do--
convening, getting the employers together, getting

the plans together, agreeing on how is it that we can
create a good stimulus, not just for a couple of
hundred practices, but all the practices in the
state. It doesn't mean that everyone has to be the
same way. What it does mean is that there's a common
core that all of them agree to do. We can still do
lots of other things, but at least agree to a common
core, have a common core, strong signal that the
doctors can focus on at the end of the day.

If I'm Dr. Culver and I know that I'm
going to get a benefit from Signa and a benefit from
Medicaid, and focusing on these 20 things, then I'm
going to do that. No doubt about it as long as the
culmination of the reward ends up by getting me above
my threshold of what I need to fund my
transformation. Without that, there's not a whole
heck of a lot that we can do.

Living in Connecticut, I can easily afford
a health plan. I talk disparagingly about my own state because what I see in our state is a lack of leadership. It's almost absent--very different than in New York State, very different than in Massachusetts and it's a challenge in these types of discussions when you can make big change happen. But when you have an engaged governor, it makes big change happen. It is through collective action that we're going to get change.

MS. EVANS: Why don't we just have questions for Francois. Then we'll turn to how we can think about an actionable framework. I don't know how long we're charged for.

MR. LEVINE: Some states are in a better position to do it than others and certainly the federal government is in a better position to do it. The bottom line is trying to understand at the end of the day change happens because money--those of you who are physicians and those who are not--

MR. DE BRANTES: Money matters.

MR. LEVINE: It's understanding how the money matters and who those are in the industry that can actually effectuate change. If you think about Medicare, states that have Medicaid managed care, if you look at measures that are already out there, and which plans do them and have the best compliance with
diabetes management or what have you, we don't use
those measures to guy reimbursement. If we have
plans falling below a certain level, are we
penalizing their reimbursement or are we improving
their reimbursement based on their outcome for
Medicaid or Medicare? I don't know how you
effectuate that in the commercial market that the
large employers do when they're collaborating. But
it seems like if that is the threat of reduced
reimbursement is there on the front end with some of
these payers a lot of what you're talking about with
the $200 per member per year--was it for diabetes?
They're going to do this out of sheer survival, out
of the necessity of maintain their funding stream.
In our state we had an opportunity--some
are more progressive like Georgia. Louisiana is way
behind. But it seems like that is one of the things
we ought to have a dialogue about. It's really at
the upstream level.

MR. de BRANTES: Also, the state as an
employer. The employees of the state has a benefit
of that source, the state employee benefit plan, and

that sourcing process is changed so that the criteria
that are in the RFI's and in the contract terms with
the plan administrators stipulate that that plan has
to engage in health care reform. I can tell you they
do that. Massachusetts is a great example. It does
not contract with anyone that's not going to do that.

MR. MAGISTRO: The way we're addressing this in Pennsylvania is to actually tie a couple of things together. We're rolling out the implementation of chronic care where we tack on with six major payers in southeastern PA who are working with us and we are tying patients in our medical home standards for certification to incentives. We kind of pull these three together where we're missing some holes. We didn't go to the employers. We probably should have gone to them and we will as we go through the rest of the state. And our employee benefit trust fund is a separate entity and hasn't been at the table, which is a problem.

DR. MILLER: I'd like to congratulate you on an excellent program. I have one question and one comment. The question is what are exactly the reimbursement incentives for? Is it for improvement in hemoglobin A1C, hemoglobin A1C below 7, 6.5, control of lipids, or just ordering the tests or having the patients complete the tests? What is actually being done?

MR. de BRANTES: It's looking at the actual control and the percent of the patients that are under controls.

DR. MILLER: You have some levels?

MR. de BRANTES: And there are different
levels of achievement. You can gradually go from good, better to best.

DR. MILLER: The comments are, first, it seems that a program is having physicians focus on disease. In my mind that's after the horse is already out of the barn when they're not focusing on preventive measures. What about the patient who comes in who's starting to gain five pounds a year and is on a trajectory to become diabetic or a patient who's continuing to smoke or a patient who is really getting no exercise whatsoever because of their workaholic lifestyle, such as some people in this room?

(Laughter.)

DR. MILLER: Those are some things that I think are critically important that we start to reflect, particularly when you look at the weight of our children. That's one comment. The other comment is I do see a trend that I think is very exciting towards giving consumers or individuals rewards by their employers for achieving certain goals. These are very preventive. I don't see this partnership. I don't see the program really also reaching out to consumers and trying to give consumer money who are following the program.

I think particularly we're talking about how we're making technology transformations. It's just as easy if I have a very good system to give an
alert to the physician that would also be given to
the patient in her home with personal health records.
Those are all things that I think we have to start
thinking about and tying them in here. And I would
courage that whatever programs we're recommending

that it really isn't just one-sided.

MR. ROMEO: I think that's a great point,
Holly. I think it takes the role of all of us.
Sixty-five percent of Americans get their insurance
from their employers, so if there were more employer
participation and wellness programs, you'd get more
reaction on that front. Medicaid is a big part of
it. They're forcing these behaviors. States, I
think every one of them is self-insured. Those
benefits come back with the state program if they
force it, but I think it's that level of focus and a
combined view on the problem is necessary.

DR. MILLER: We also have an opportunity
really for a transformation. At best, I might see a
diabetic four times a year. So what kind of message-
-how much can I really educate and bang them over the
head when they're not complying in four visits a
year? I can have automated programs running and a
finger stick that they're getting the message every
day. Or even if their glucometer is downloaded,
they'll get a message that you're not on track. So
really I can advocate for my patients, and I do 100
percent, that they are going to be their own best advocates. They care more about what happens to them, as much as I care about them, than I do. So I think this is really important.

MR. de BRANTES: This is no doubt patient engagement. It's the flip side to the coin.

DR. MILLER: We also have the data. We can move the data wherever we need to move it.

MR. de BRANTES: One of the decisions made very early on in this program was that it was tough enough to get employers compliance to agree on a common set of incentives, delivery systems and it became almost impossible to engage them in any discussion relative to commonality or anything to consumers because benefit designs change. Employers got collective bargaining agreements--a myriad of things that made that very challenging.

DR. MILLER: The other thing is you have education of consumers, engagement of consumers. Consumers will go to a provider who is going to provide that kind of tool, very much preferentially over a provider who does not. If you kick in some that they're going to get some money out of it or some benefits or pay less of their co-pay or anything less they're going to be engaged.
MS. THOMPSON: I just wanted to follow up on that point. In your data, do the physicians see any reward other than the money? In other words, are there any internal drivers to their practice, the way they want to identify as physicians or the way they want to interact with their patients?

MR. de BRANTES: Yes.

MS. THOMPSON: So you have data?

MR. de BRANTES: The professionalism is what drives them. What the one does is it breaks through all of the other toxic signals that are being delivered. If you think about the average practice and the service requirement, 95, 98 percent are coming from that. You're trying to send a signal that says time out. Let's do something different. Why should I do anything different? Well, because there's something here at stake that you really ought to pay attention to, so the money acts as a means to focus attention on there's something else than just the daily chart.

Once the transformational moment for a physician really comes when they get that first payment. That's the transformational moment, absolutely, at least in our experience. In 100 percent of the cases, the result is not as good as what they expected. That then creates the self-motivation to continue to do a great job and to try to reach out those patients. Hey, is there a way for...
me to hook up to a whole patient monitoring system so
the professionalism is what keeps this moving in the
quality improvement cycle.

MS. THOMPSON: A follow up on that point. Is there a point then at which the dollars are replaced by those values in terms of motivating?

MR. de BRANTES: Only if the economics work. You can't expect someone you couldn't say--and I'm not projecting 16 years down the road, but this is not just a one-time investment. We talked earlier about the maturation of the environment. If you're an environment for HRE at least you're not dealing with ad hoc requests from labs where your system is actually plugged into electronic receiving echometry system in which clearly there are going to be a fair amount of reductive issues that are put in the game. That might change the current economics. Today the current economics just don't support the idea of investment.

MR. CULVER: My question is in a different direction. I think a lot of us are assuming that the CCHIP initiative will drive them towards something. And yet it strikes me on two fronts that today, at least, the alignment incentive for the vendor community is out of alignment with what you're trying to do. Many of the systems do not have particularly strong skills in the area of reporting or the area of public understanding and yet, we're
assuming a great deal of this. How do you see your efforts also going over to realignment?

(Laughter.)

MR. de BRANTES: I don't.

(Laughter.)

MR. de BRANTES: The reason why I don't is because there are a fair amount of activities that are going on nationally. Part of it spurred by the Office of National Coordinator and the AMA, you know, a certain amount of good efforts. But think how of how do you create these incentives that are going—to me, in the short run, it's really about getting the provider feedback, whether it happens by information exchange or some other data aggregator. The critical thing is to give them that feedback, because that's what keeps the professional in the net.

And you know, certainly--

MS. EVANS: I think there's a much bigger infrastructure. I think there's an element of health information exchange that we're not being able to aggregate data and measure it. And there's an element on how those come together and what the implications are to drive, paying for prevention, paying for quality are significant. So I think--I'm just looking. We have two minutes left and I know that this was specifically directed at mitigate agencies. I know we were originally talking about having Medicaid here today and that didn't happen.
And we always complain why New York isn't allowed to participate in any E-H-R Medicare program.

(Laughter.)

MS. EVANS: But putting that aside, I was just putting down a couple of notes how we do our job as a taskforce and whether we want to--I don't know how long we're meeting and how many meetings we have. I know that I don't know that and this may be overlap, but I think we need to decide are we going to--we need to come up with actionable recommendations. This is a very complicated problem. We need to draw some boundaries around it so that we can be thoughtful and fulfill our charge, but do we want to categorize the practice in the incentive recommendations or do we really want offer them a framework that is rooted in how implementation happens at the state level. And if you believe the state, necessarily government, but the states collectively have an implementation responsibility, if you believe that, which I do, then how can we think about this more as a national strategy about something that's very rooted in the way we need to implement this.

One of the things I feel most acutely in New York is that regardless of the goals we want to
help, whether it's quality reporting or pricing or one of your value changes, whether you're health information exchange, whether you're trying to better organize the delivery system and support for Medicaid, whether we're putting E-H-R and whether we trying to really address this sort of quality reporting aspect, the building blocks are the same. With an implementation hat on, you're building blocks, not just technically but organizational from a policy perspective have to be the same. At least, I feel like I can't be central in New York. We don't have enough money in the first place and we're not able to really sort of drive and coordinate things the way we need to. So if we are trying to come up with more of a framework and a set of recommendations, accordingly, that's a pretty big task. But I think there are ways that we can try and draw some boundaries around that.

In order to do that I think there's a couple more things. There's, one, do we want to try and develop that framework, and I have some ideas about how to do that. We can talk about trying to define dates a little more in terms of the leadership opportunity that we have. Getting to your point, Francois and what the implications of that are, thinking about how to integrate this conversation with a group of state Medicaid directors that meet is something that we should think about because I know
that they're having a lot of these conversations as well.

Do we have an inventory of programs? Do we have an inventory of best practices yet? I don't know. I sort of covered the framework thing. And then, you know, I think this gets back to some of the implementation framework, which is we have a lot of national things. We do a lot of New York Medicare and Medicaid and the national plan and Medicare and Medicaid require, they demand a lot of commonality, a lot of cooperation. The regional plans in New York not as much and they're actually making--they have a lot more programs happening on the ground in New York than the national. So I think it really begs the question of accomplishing a Medicaid and Medicare strategy, even our calculus in New York we have--in a lot of places it's in there, from a state perspective, but we know we can't afford it without Medicare. We have a $50 billion Medicaid program.

We could try and focus the recommendations in that respect as well. I wasn't sure how ambitious we could be, but we wanted to be. So one line is sort of categorizing best practices and put across some recommendations as the other part is really sort of rooting it in more of a multi-state or a national framework than trying to put some boundaries around that framework.

I had a couple of ideas about how we can
do that when we see the spectra of incentives and the key drivers that we need to influence, both on the Medicaid and Medicare sides in terms of the enormous modernization it's going to take. And then in addition to the infrastructure in the health care community, the private sector. That really has to have a sort of shared services to drive the kind of reporting we need because any given doctors are going to have to help us. That's the reality. There are sort of measures—the whole measuring component. The methodology itself in terms of use versus prevention versus outcomes and how we target that and think about that, and then the use perspective begs the question of some states have another set of strategies when it comes to trying to pay for the build cost, of the upfront costs. They're sort of banking on trying to support the enforcement change and then there's a whole set of adoption.

Francois, you touched a lot on this—whether it's the medical home, helping physicians with that certification, re-engineering the practice and importantly, teaching the clinicians how to use the information consistently right from the start so that we actually have the hope of realizing all the quality goals that we want to realize from health IT and being able to wrap around things that we need. We should be paying for diabetes educators, for example. Why is that any less important than
thinking about specifically accessing the electronic health records? That's just a few of the drivers that will inform the way we think about incentives.

And then another dimension could be, again, to try to do this incrementally or pick where we think we can make progress. There's a lot of just high Medicaid areas. So if we think about the high Medicaid and think about those different drivers and be able to make recommendations there, that's one thought. The other is high Medicare because some places probably have that, and then there's the mix. Maybe there are some clusters of the mix. But at least in New York it's a big mix and then maybe you separate the employers out because you can really target--there's some low-hanging fruit there when it comes to the employers and then, though thinking about that kind of--is that the way to try and work toward specific recommendations. But again, it's an ambitious approach.

Maybe we can do one piece of it. Maybe we haven't at all cataloged best practices and maybe that's a worthwhile contribution as well. So those are my thoughts when I think about the problem holistically and try to understand what exactly we
want and how we want to go and I'm not sure if today in another meeting, if any, we can do that or how we're going to do that.

MR. RODGERS: As one of the key elements in this project and that is networking. I notice the states are all different in how the networks are set up. In our state, you have a mainstream network in Medicaid. About 85 percent of the physicians are contracted. In other states, it's concentrated around the health centers. So your impact, even between using both employers' health care benefits as well as Medicaid can be different by state.

So if the governors take the leadership, it has to look at it from the standpoint of where the network physicians are--sole practices, group practices--they have a very strong identity in the association. Have they accepted organized health care like managed care, et cetera, or are they independent? The kind of approach you take to get them to adopt is going to be different, based on what you start with.

MS. EVANS: I agree with that. There are a lot of implications to that in terms of what--it's hard to even catalog all the thoughts about it. One is to just internally list Medicaid. There are major implications just to the needs and the system and then our wait system is actually sort of separate from E-Med. But then, importantly, I think the
broaden infrastructure put the network design, in
addition to a lot of other things--and actually you
guys have done probably more than most, from what I
know, in terms of your Medicaid techniques and how
you're trying to build a broader record for doctors
and so on and so forth.

MR. RODGERS: I think when we think of the
work we have to do, we have to recognize how states
are coming at this from different places and where
states have a very strategic relationship with
different types of networks. Community health
centers and things like that you can build on that
and there are things you can do with federal
dollars. But then, beyond that, if we're trying to
get the governors how to more broadly adopt and
require strategies that are flexible. You may

actually have two different strategies going to
hopefully come together in some sort of common plan
in the future.

MR. LEVINE: I think as long as there's a
wider circle around this I think that's where we will
quickly run into trouble because of the national
fears. Medicaid wanting its own and Medicare,
unfortunately, it's a different framework. But it's
sort of gets to the point of how much can we think
about, how do we think about the framework so we can
have a set of common things that we can look through
that we know need to be common in that respect.
There's tremendous market variation and geographic variation on the line, the challenges on so many levels that's why I almost take a minimalist approach to try to figure out what the least common denominator for creating the infrastructure.

When you think about that the Internet didn't exist. The Internet was created and access was there. All of a sudden everybody--most people have lap tops, computers and all the other stuff. So sort of the access point was created, the market responded to that. We even procured the new NMIS system. We actually put in the procurement that there has to be some module or plan for electronic records.

The problem is when you want to embark upon health information exchange statewide, we can only use Medicaid dollars for the Medicaid population and so we can't leverage. There are so many different levels that the system is not designed for us to move the infrastructure. And I know some states have already changed their alliance system and some are going through that fight.

MS. EVANS: Do the mitigate information program people know about that? I haven't looked at it in a long time, but I think that's going to come onto the CMS side. But I think they're just physical. They haven't gone further than that.

It's a start but the intention there was that that
would help plot at least the MNIS side in the context of interoperability and so forth.

MS. THOMAS: That's right. It's essentially to get some silos, transactional oriented
to spending those state dollars on interoperable, clinically focused component ties to architecture that will allow you to take advantage of all the things that the market will do in terms of the point solutions or communications and all those kinds of things.

MR. LEVINE: That's what EDS provided or is in the process of providing, which how many states have.

MS. EVANS: The implication is sort of cultural if you think about it. It depends of the mix, the payer mix across the state. It's a lot easier in highly concentrated areas. That when you start to look at the mix and understand the need for this sort of shared capability and the common report to the doctors and payers, that's a hard cultural shift for Medicaid directors. Thus saying so, I have to believe in this sort of shared infrastructure that hopefully the state is playing a leadership role. What's so wonderful is that there's some much is going on across so many states. When I come to meetings like this, I'm reminded of how amazing the
progress is, even though I think we have our
complaints. It's been remarkable. But being able to
say, wow, if I'm effective in a practice that has 13
percent Medicaid, which is very common in New York, I
need to be a part of this mix and my MITA strategy
needs to deal with that accordingly. But there's also
a great need for Medicaid to get the same data or
different data for other purposes or is the report
coming from Medicaid. And one of the dependencies on
the capability of the CMS.

MS. THOMPSON: The informatics issue, the
population health issue, the reporting issue medical
management issue—even in Florida, you know, there's
a struggle with, okay, so how does Medicaid play with
the VOs are doing and how do you just not check what
the private sector's doing. So you want to play the
leadership role. But then you want to be sure that
you're not creating a fragmentation. Where is the
sharing? Where does that place come that interface
and interaction occurs?

MS. EVANS: I think that gets to what your
implementation strategy is, what the overall vision

MR. MAGISTRO: What you talked about
earlier, the government is the only convening body.
If you put all the players and employers to the table
and talked about things and you mentioned about how it may be easier if you had a population, one payer at any rate, our experience is it's harder. If we go to western PA and there's one major Blue and one Medicaid payer, they're paying the bill. We go to southeastern PA where there are six payers. They're spreading it proportionately and it's easier to do.

MS. EVANS: What sort of Medicaid was that.

MR. MAGISTRO: There are three Medicaid payers there. They're sharing it in that area there. If there's one they don't want to pay. They don't have that money. They cut a billion dollars out of our budget.

MR. CULVER: The fundamental framework here is one that may or may not be--give better integration across those bounds, but clearly at the end of the day most of these programs are focused on--the patient is not in that program. It's in another program. So there are huge benefits here to sort of drive that point home where any one of those structures realizes that the same person tomorrow is either coming into their program as an unknown or going out of the program into somebody else's program as an unknown and dealing with that unknownness across this. That's the fundamental objective and yesterday's insured patient becomes your uninsured patient and that continuity is key.
MS. EVANS: And the continuing care, long-term care.

MR. LEVINE: You had a question, which was a very question, is what should we focus on in terms of our recommendations as a taskforce. We could get down in the weeds talking about our own perspective where we should go with this. We can fundamentally put it out there. I think we ought to focus on those things that will most generate the market conditions where the marketplace will get us there. I don't the government is a solution. Nobody's suggesting that this be a government solution. But to me, it's just the thing we talked about—the standards, the broadband. Those are the issues. If you lay that foundation on the medical legal issues, do we address those issues fundamentally? The marketplace is raring to go. It's actually ahead of us. We haven't figured out to catch up with it and create that. It wants to change—the market wants to change. We just haven't created a pathway.

MS. NOLAN: Let me just jump in on some underlying things to give you a context of where the Alliance has been and what they're asking for. In some ways the situation right now is they feel the best practices issues is kind of like pornography. We can't define it. Most of the time we don't even know when we're looking at it. The things that the State Alliance is asking for let's put that out
there. What they’re asking for are some organizational approaches, some ways of thinking about this category. I think you were starting to talk about can we set some goals, can we give some clear direction. These are the things you should be trying to get to. Then getting back to Janet’s point about all the roles the state has in their arsenal, so to speak, let them figure out which one of those to use in different cases. If you can provide—and I think it is the kind of framework piece—if you can provide a sense of what they’re trying to get to, what are the building blocks, what are the things they should see in their marketplace or should be building in their marketplace without a prescription of in this order with these methods and allow that to be what change is based on the state of their priorities and their directions. That is very much what the State Alliance or the governors and other legislatures are asking for because it is very convoluted and they’re not sure when they take a step that it’s getting them any closer to what they should be trying to attain.

So I think that is the kind of thing overarching that we’re trying to provide in this idea of framework that identifies the goals on what should be the target. Is it information or thoughts on how to get there, you know? Is it the regulatory
approach? We haven't been working the regulatory environment, but the incentive program, then that should be part of the dialogue. But I think it's less useful at this point in the environment we're working in. Then how--descriptive but not prescriptive?

MS. WARNER: I think you might also mention some of the things that we realize we're talking about in terms of what is the proposed plan or idea for the next phase of the Alliance--which is they always talk about this--we've got to be able to demonstrate some of the stuff that we're talking about, the recommendations that were already developed. The staff is in the process of drafting the first report, trying to bring it altogether and laying out the various recommendations along with the strategy for those options and approaches that were advanced by the previous taskforces and this taskforce will certainly build upon. But the idea is that there will be an effort to begin to demonstrate and actually implement some of the recommendations that are generated from the work of the State Alliance. So we can learn from those as well and try to identify again what are the challenges that a company--the implementation
activities.

So thinking realistically about the application of these recommendations and thinking about just the framework, framing it in terms of goals, framing the target will always be asked. As a generalized level, what are we trying to shoot for here--you know, what is my checklist? I'm shooting for the goal. What's my checklist as a legislator, as a governor? What is the agent's role? What is the insurance commissioner's role and the state? Those are the people at that level--what they're trying to do in their efforts to try to shepherd implementation.

MS. NOLAN: This is about the doing not the talking. That's always been the goal of the overall Alliance. It will move towards doing and responding to that doing. We're working on trying to do that, but I think the other thing, in addition to the checklist, of actions to some extent. It's also how do I know what I'm looking at and the issue of maturity that's come up. The first question we're going to get, you're going to get is how do I know? How do I say what should I be looking for in order to be able to say, okay, this is what I need to do next. I've done the last, so I think that in trying to encapsulate--and this is the struggle of every taskforce--is to take and parse it out and figure out where it is. It is very much about how to be
relevant now and how to help them judge their environment as much as it is to figure out where to change that environment. I think those are two questions nobody really has a good answer to, and if we're able to move that agenda on both what is the environment now and what am I looking at, but then where do I go from here. Those are the two questions that we get the most, so I think it's about how do we get to implementation now because we're all champing at the bit. We're all doing it already. Then how do we really make critical decisions in the more educated environment? Furthermore, one of our goals should be prescriptive.

DR. MILLER: And overall that we really want states to be having estimates to be able to build on in the future as dollars are spent. They're not going to be one-act projects.

MS. NOLAN: Part of the strategy it is absolutely not a single point. I don't know if that helps.

MS. EVANS: I think it does.

MS. NOLAN: I think we can probably come up with a good framework.

MS. EVANS: And then we start with piece and choose. I don't know what our time is.

MS. WARNER: You have two meetings right now.

(Laughter.)
MS. WARNER: But those are the meetings we have currently scheduled. We've always been flexible. This is not about process. It's about the outcome and we want those outcomes to be as best as possible as they can be. If you all need more information, if you need us to bring Lida in, or Rick.

MS. NOLAN: Also, if there's a desire to break off into smaller groups to work on something over time, there's a lot of different ways it can work to make sure that, although it's a limited number of meetings, we don't expect miracles. But we do want to be able to support whatever the group has come up with as well. And if there's a need to do offline, there is something that can move forward. And in fact, all of those we would willingly support that.

MS. EVANS: I guess the question is how do we proceed.

MS. NOLAN: Do you want to talk about the agenda--where we are in this?

MS. WARNER: Yes, we should probably break for lunch because I'm getting hungry and in the afternoon, we'll hear from a couple of state programs. Rhonda Meadows has offered to share a little bit more about Georgia's experience and the adoption in the state. Other states in the room are invited to also share their efforts and Tom will lead
but really the rest of the afternoon following that is devoted to having taskforce conversations about maybe a framework or different strategies. And Dr. Meadows and Tony Rodgers will help moderate that question. They've done this in the past and will be able to help get to a concrete plan for moving forward our tangible strategies. And then, the following day we're going to be flexible. If you all need more time to talk about it and wrap up the discussions here, we'll switch on bi-directional exchange and go through the same process. Our intent was in putting this agenda together it's really a starting point for those recommendations to provide you with speakers that can help you think about ideas and approaches, and then be able to generate some activity.

MR. LEVINE: Maybe I'm wrong, but I don't see anybody here from academia.

MR. ALFREDS: We're here.

MR. LEVINE: The reason I say this--

DR. MILLER: I'm from an academic medical school.

MR. LEVINE: I stand corrected. I should probably phrase it this way. Maybe there's not
enough. If we really want to try to change the behavior patterns of physicians, the place it starts is where they are trained. These young guys and women coming out of medical school today are more adept at technology and we've got 50 percent of the population practicing, certainly, in the South that are over the age of 55. So there's going to be a very big demographic shift in the physician community. So I think maybe if we could get some of the top medical schools in the country as part of the discussion, maybe they can adapt their platform of education to work that technology. Frankly, I would dedicate state dollars, if the legislature would go along with it, directed towards that LSU and Tulane in Louisiana if they really dedicate it to training tomorrow's physician.

MS. OLSZEWSKI: LSU have committed to those students now that they have to learn and practice and train or they can't go on to be licensed.

MR. MAGISTRO: It's probably the fact that the residency programs are dying because there's no money in family practice.

MR. RODGERS: I do think one of the things to talk about is how they provide leadership in terms of their training programs and to provide members in the Medicaid program and leveraging that.

MS. OLSZEWSKI: Other than historically.
MR. RODGERS: But they're waiting.

MS. WARNER: I would suggest that--just keeping some of these strategies and thoughts--you know, write them down, get them ready for discussion later this afternoon. Let's break for lunch. Lunch for the taskforce members is in Room 233 down the hall. Why don't we get back here at 1:15 to give you guys a little bit of time to take a break?

(Lunch recess.)