Lessons from Memphis

Health Information Exchange

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Questions

Missouri 2020
- Our destiny lies in our demographics and our economy
- Radically different model for care delivery

Central elements - Patient-centered care
- Everybody pays something [1]
- Pay for the important things first
- Pay for what works

Barriers
- We compete over the wrong things
- Unnecessary complexity

The one big thing
- Build "Version 1.0" first – enable new markets

Metrics for success
- ABCDs

1. Governor Phil Bredesen. Medicaid 2.0: National Democratic Address: June 11, 2005 2005.

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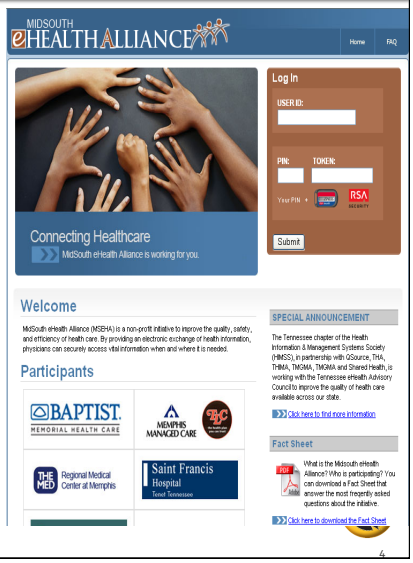
What are the "ABCDs" ?

- **A**dherence – medication reconciliation, integration with over-the counter meds (e.g., aspirin) from personal health records, polypharmacy, controlled substances (separate database would not longer be necessary)
- **B**lood pressure – weight (obesity, congestive heart failure management), height (needed for drug dosing), and integration with home technologies (blood glucose monitoring).
- **C**holesterol – any labs (along the lines of the Memphis work)
- **D**iabetes – same care coordination tools can be used for more extensive transitions in care (e.g., nursing home care, ambulatory follow-up) and for medical home pilots.
- **S**moking – other behavioral risk assessments and interventions

The Memphis Exchange

- Baptist Memorial Health Care Corp. (4 facilities)
- Christ Community Health (4 primary care clinics)
- Methodist Healthcare (7 facilities including Le Bonheur Children's Medical Center)
- The Regional Medical Center (The MED)
- Saint Francis Hospital & St. Francis Bartlett (Tenet Healthcare)
- St. Jude Children's Research Hospital
- Shelby County/Health Loop Clinics (11 primary care clinics)
- UT Medical Group (300+ clinicians)
- Memphis Managed Care/TLC (MCO)



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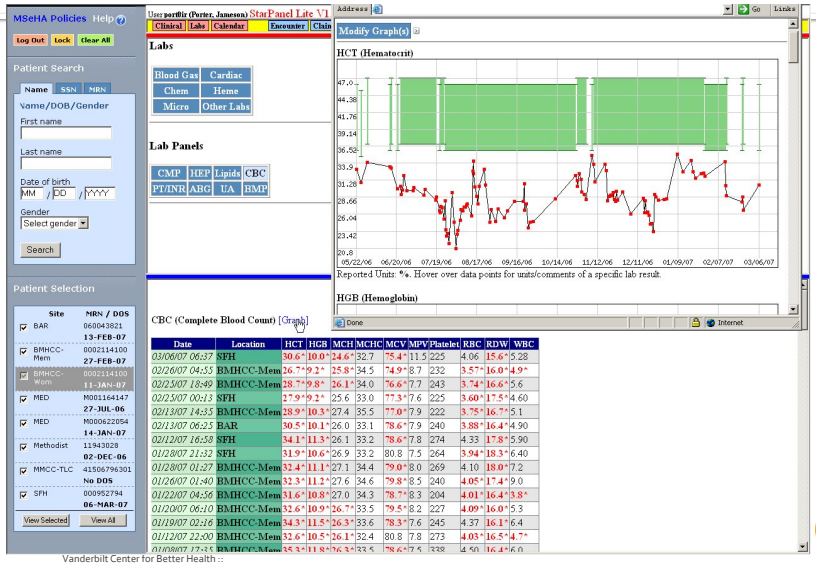
the Memphis Exchange- 2009

- 34 facilities; over 400 users
- 1.2 million unique patients with clinical data
- 140,000 monthly encounters
- 34,000monthly ICD-9 admission codes (chief complaints)
- 2.4 million laboratory tests monthly
- 26,000 monthly microbiology reports
- 35,000 monthly chest x-ray reports
- Saves money, saves lives

Total annual operational costs are less than $2.5 million

Measurable costs offsets in excess of $500,000
True economic benefit far greater, we believe

Looking at labs across facilities



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Prescription medication history

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Impact

Usage

- 5% to 15% of overall patient visits include detailed access

Economic Value

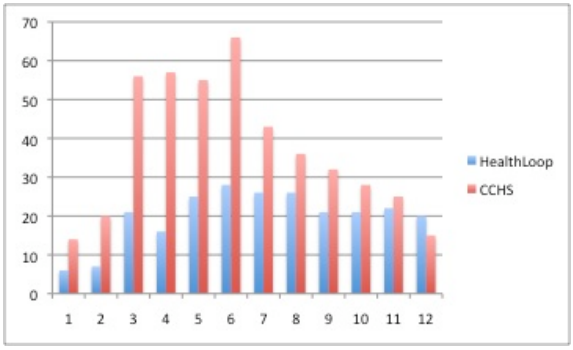
- Rigorous evaluation shows decreased utilization in the range of hundreds of thousands of dollars (i.e. can offset less than 50% of system cost); impact on transitions in care not completed
- Does not address price transparency
- Does not address claims fraud but simplifies investigation
- Does bring patient misuse into the open

Disease-specific utilization

- Addressing specific areas including abdominal pain, back pain, and headache

We have **saved lives** – and can prove it.

Potential: transitions in care



"Real time" query: when and where do patients seen in the Med ED seek follow-up care in a safety net clinic?

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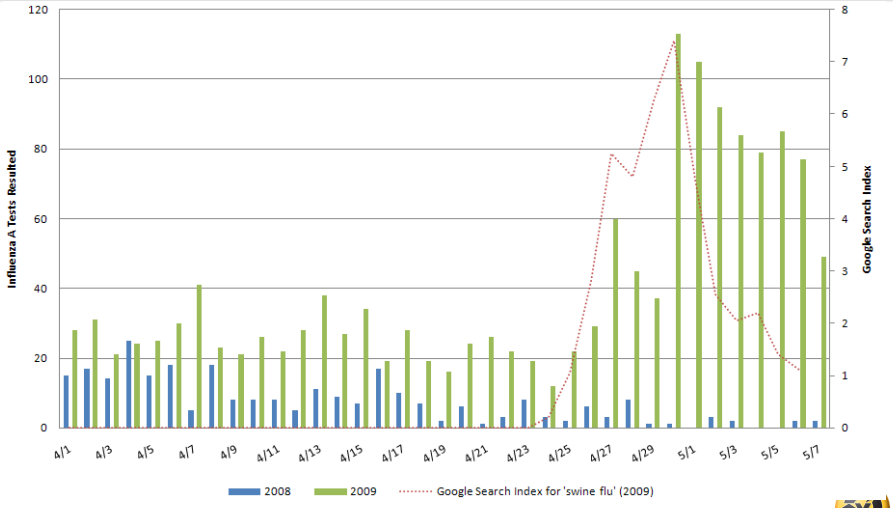
Potential: surveillance



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How we did it

Governance:
- Coercion & money
- Focused inclusion
- Minimal burden on participants
- Strong data sharing agreements (publicly available)

Technology:
- Built our approach on the Vanderbilt model- a "Version 1.0"
- We assumed standards would evolve
- We took data "as we got it"

Measuring impact
- Quick wins
- Meaningful metrics

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Lessons from Memphis

Leadership essential
Feasible
Inexpensive
Limited in scope
Can evolve
Hampered by
- Conflicting priorities
- Business perceptions
- Technical limitations and costs
- Privacy concerns
- "ROI"
- ? ARRA's HITECH provisions ?

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