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Operator: Hello, and welcome to today's conference call titled, "Healthcare and the Stimulus: Investing Wisely Matters."

As a reminder, all lines will be on listen-only mode, and we will conduct a Q&A session at the end of the call. If you need any assistance during this call, please press star-zero to speak to an operator.

At this time, I'd like to turn the call over to Mr. Bill Pierce from the Partnership to Fight Chronic Disease so that we may begin. Please go ahead.

Mr. Bill Pierce: Thank you, Eric, and thanks, everybody, for joining us this morning. I'm going to quickly introduce our speakers, as that's what you're here for.

The first, many of you probably familiar with, Ken Thorpe, who is executive director of the Partnership to Fight Chronic Disease. He's also executive director of the Emory Institute for Advanced Policy Solutions and chair of the Department of Health Policy and Management at the Rollins School of Public Health at Emory. And Ken, of course, is a former senior official with the Clinton administration at HHS.

We also have with us today Alan Aviles, who's president and chief executive officer of the New York City Health and Hospitals Corporation, which is the largest municipal healthcare system in the country. The reason he's here today is we're talking about health information technology, and, under Alan's leadership, the city's public healthcare system has gone and undertaken an extensive investment to

rebuild and modernize its infrastructure, and that includes an information technology system. So, Alan's really got some real-world experience with putting HIT in place and the benefits of doing so.

So, with that, I want to turn it over to Ken, who then will turn it over to Alan, and then we will open it up for Q&A.

Thank you.

Mr. Ken Thorpe: Okay, thanks, Bill, and good afternoon, everybody.

Let me just start out with some introductory comments on this issue. Our group, the Partnership to Fight Chronic Disease, has spent the last year-plus really focusing on issues around how to make healthcare more affordable and find ways to get the growth in healthcare spending so that it grows at a lower rate. And our two main messages on this have been that you've got to go to the heart of the problem, and the heart of the problem on both, where we spend the money and what's driving the growth, is chronic disease.

So, for example, we know that three-quarters of what we spend in healthcare is linked to chronically ill patients, and we know that the doubling of obesity over the last 15 years by itself accounts for 15 to 25 percent of the growth in spending. So, what that means as solutions is that we have to find more effective prevention methods, and, in particular, we've got to find more effective ways of managing patients that have multiple chronic healthcare conditions.

In order to do that, we're going to have to make some investments in restructuring our delivery system. And one of the key investments that we have to make in order to make this a reality is investing in electronic medical records. Very few small physician practices have them. Something on the order of 10

percent of physician practices in groups of five and under have any type of electronic medical record capacity. So, we know that, if we're going to manage patients more effectively across multiple sites and multiple settings, we've got to have the tools out there that link physicians and hospitals and other healthcare professionals in order to really more effectively manage healthcare.

So, it seems to me that, as we look at this debate about stimulus and then the upcoming debate about healthcare reform, that, in order in order to make healthcare less expensive, we have to make several initial investments in order to save money downstream. And perhaps the most important investment is to find ways to accelerate the diffusion of information technology out in the provider community. So, that's number one. It's a good infrastructure investment. It obviously is a--an investment that relates to providing additional jobs and capacity out there to the healthcare market.

We're going to have to make some other investments as well, and whether we do that as part of stimulus or we do it in health reform will be debated. But, I think that there's sort of a common--or at least a growing common agreement that--around the use of information technology--that we need to make this investment. And what better place to make it in the context--other than in the context of a stimulus package? So, we're hoping that the size of the package that has been going around, whether it's 10 to--$10 billion a year for two years perhaps--A, that would be consistent with what the President-elect talked about in the campaign, where he talked about a $50-billion commitment over five years.

But, clearly we need to start building the infrastructure around managing chronic disease, and our view is that the centerpiece of this is information technology. We'll also have to build some capacity, as well, on providing a--personnel in the traditional fee-for-service program, nurse practitioners and other healthcare providers, in order to manage more effectively healthcare for people in the traditional Medicare program in particular. But, that may or may not be part of the stimulus package. At the very least, if we want to get into it, I think it would be a major part of a healthcare reform initiative.

So, that's just a sort of brief overview. We think this is central in terms of making this investment now, as soon as possible, and we're hoping that, in the context of the stimulus bill, that the HIT component is a major piece of it.

With that, I think I'll turn it over to Al, who is--has actually--for those of you who don't know what's been going on at the Health and Hospitals Corporation in New York, not only are they national leaders in the use and diffusion of information technology, but they've also put into place I think some very effective and very novel chronic care management programs within the HHC to deal with the uninsured, Medicaid and other patients in that very, very large healthcare delivery system.

So, Al, I'll turn it over to you.

Mr. Alan Aviles: Thanks, Ken, and good afternoon, everyone. Ken's outlined very well the critical importance of facilitating a more rapid and more effective nationwide deployment of health IT as a centerpiece of both the healthcare reform agenda and the pending economic stimulus efforts.

But, before I elaborate briefly on the role that health IT has played in our public hospital system here in New York City, let me just take a step back to say that it's also critically important that stimulus funds be used to support the Medicaid program and our nation's public hospitals, both of which constitute a healthcare safety net for millions of low income or suddenly out of work Americans.

It's an unfortunate reality that both aspects of this safety net, our state Medicaid programs and our public hospitals, are under tremendous pressure as they struggle to meet the healthcare needs of growing numbers of Americans as the national economy and the state economies continue to flounder. And using stimulus dollars to support Medicaid and our public hospitals obviously boosts meaningful employment

as well as local economies while, at the same time, increasing our capacity to provide essential healthcare for otherwise uninsured Americans.

Now, having said that, let me turn to health IT. As Ken said, HHC has invested heavily over the years to build an award-winning health information technology infrastructure for a very large system. We serve roughly 1.3 million New Yorkers each year, including more than 400,000 uninsured patients. And we began to install an electronic medical record in parts of our system nearly 15 years ago, and we have had a comprehensive electronic medical record in use throughout our entire system for about the last six years.

We have more than 10,000 doctors and nurses online every day. The same electronic record is available to our clinicians whether a patient is seen in primary care, in specialty care, in one of our emergency departments, or in one of our inpatient units. Digital X-ray images, sonogram images, or EKG tracings are integrated into our electronic medical records and can be pulled up for viewing at any physician's workstation in any of our exam rooms or inpatient units.

We decided to make this very substantial investment in health IT for the very reasons that Ken outlined. We were convinced that it would help us drive safer, more efficient and more effective care, and that's proven to be the case.

So, for example, we've come close to eliminating medication errors because there are no more illegible prescriptions, no more confusing and often idiosyncratic abbreviations that are misread. Our system automatically checks to see if there might be an adverse drug reaction when a new drug is prescribed for a patient already taking other medications. It also calculates the appropriate medication dose for children based upon their weight and alerts the pediatrician if he or she tries to order a dosage that's outside of appropriate parameters. And our physicians don't reorder lab tests or X-rays for a patient that has had

that done recently elsewhere within our system, because they're always available as part of the electronic medical record.

Our electronic medical record also has enabled our system, which is comprised of 11 acute care hospitals, as a whole, to outperform the majority of hospitals across the country on publicly-reported federal quality indicators that measure how often our physicians follow clinical best practices in the treatment of heart attack, heart failure and pneumonia, and in the prevention of surgical infection. Those performance indicator results are actually available on the hospital compare website that HHS hosts. And some of our hospitals perform in the top 10 percent of the country on several of these quality measures, and it is our electronic medical record that helps us to guide care in conformity with these evidence-based clinical best practices.

Now, Ken mentioned specifically the benefits of health IT in better managing and coordinating the care of chronically ill patients, and, at HHC, we have absolutely seen the tangible proof of this. For example, our electronic medical record prompts our pediatricians to prescribe inhaled corticosteroids, the optimal medication for kids with persistent asthma. And it automatically prints an asthma action plan that helps kids and their parents correctly use a peak flow meter to self-manage asthma on a daily basis.

Over the last several years, we've seen more than a 30 percent reduction in the number of kids admitted to our hospitals because of their asthma. That's roughly 1,200 fewer asthma-related hospitals admissions and more than 4,000 fewer asthma-related emergency department visits on an annual basis.

Our EMR also has been invaluable in helping us to better manage the health status of our nearly 50,000 adult diabetics under regular care across our system. Every night, we download into a data warehouse key data elements from the electronic medical records of all patients with a diagnosis of diabetes. The data warehouse is then used to populate an electronic disease registry, which provides a real-time

snapshot of the health status of every diabetic patient under our care, with the most essential data highlighted: what is their most recent blood sugar level, their most recent blood pressure level, their most recent cholesterol level? Have they had an annual retinal eye exam? Have they had a recent foot exam to check for neuropathy? Have they been screened for depression, which can impede self-management efforts and necessary lifestyle changes around diet, exercise, or medication compliance?

We can run reports that pinpoint whether there are physicians who are having a problem with keeping a reasonable percentage of their diabetic patients under control, and then we can focus attention on whether those physicians are following best clinical practices in their prescribing of medications, for example.

Several years ago, we ran a pilot with a prototype of our electronic disease registry, where we monitored the health status of 9,000 diabetics in one of our four boroughs in New York City, Queens. And at the start, only about 25 percent of these diabetics had well controlled blood sugar levels. But, within three years, nearly 50 percent of those 9,000 diabetics were brought under good control. This degree of improvement in a large population of diabetics has, of course, enormous implications in terms of averted adult blindness, amputation of limbs, stroke and end-stage kidney disease, all of which are linked to uncontrolled diabetes.

We rolled out the e-registry across our entire system in mid-2006, and we're now focused on steadily improving the health status of our entire population of roughly 50,000 diabetics. As of the end of the 2008, about 45 percent of our adult diabetics are under good control from the standpoint of their blood sugar levels, and we continue with slow but steady improvements. This year, we'll begin using an e-registry to monitor and focus on improving care for non-diabetic hypertensive patients across our system.

So, these are just some examples of the power of health information technology to drive improvements in care, and especially to enable more effective management of chronic disease, which is such a huge

contributor to overall healthcare costs in our nation. In our microcosm here in New York City, what we are accomplishing in a single large system gives some concrete indication of what would be possible with federal leadership and investment in bolstering health IT across the nation.

Mr. Bill Pierce: Great. Thank you very much, Al and Ken. That was terrific.

Eric, if you want to kick up the Q&A process, we'll be happy to take questions and answers. If you've got a specific question for either one, you know, ask them, or if it's just a general question, that's fine. If you've got a follow-up, that's okay too. Let us--you know, just say you've got a couple of questions, and we'll be happy to do that and certainly ask multiple--you know, ask questions at the end of the queue. We'll run it out until everybody's--feels they've had their questions answers.

So, with that, Eric, open it up.

Operator: Okay.

If anyone has a question or a comment, please press zero-one on your telephone keypad to enter into the queue. Again, that's zero-one on your telephone keypad.

All right, Bill, we have a few questions coming up.

Mr. Bill Pierce: Great.

Operator: First is Nancy Ferris with the Government Health IT. Go ahead, please.

Ms. Nancy Ferris: Excuse me. Good morning.

I'd like to ask Mr. Aviles, if there was a new program of federal loans or grants under the stimulus, what would you be doing next with some health IT money?

Mr. Alan Aviles: Well, actually, because we have a health IT platform that is now a very early generation, we would be very interested in transitioning to current-generation IT capabilities, particularly on the ambulatory care side. There are now some excellent products that have been developed that have very robust decision support to help guide care, both preventive care and chronic disease management care. In fact, here in New York City, our city health department has partnered with one of the vendors who provides such a product, and they are working collaboratively to develop more and more of that decision support into the ambulatory care record. I mean, I think that really is--.

Ms. Nancy Ferris: --It's the eClinicalWorks, right?

Mr. Alan Aviles: That's correct--.

Ms. Nancy Ferris: --Yeah--.

Mr. Alan Aviles: --eClinicalWorks. And I think that's really the future, is really being able to bake into the ambulatory care electronic medical record that type of cognitive support to guide the best clinical practices.

Ms. Nancy Ferris: Okay, good. Thank you.

Operator: Our next question comes from Tricia Cunningham with the #dontgo Movement on Social Media and Healthcare. Go ahead, please.

Ms. Tricia Cunningham: Hello, Alan and Ken. It was wonderful listening to both of you. And I think this is an absolutely fantastic program through the HIT network as far as everybody on the medical community side being in tune with one another.

My question is, once this funding is secured or, you know, we go forward on--you know, on these regulations, how are we to ensure the patient--I know this was a question that you guys were expecting--how are you going to ensure that the patient's privacy is ensured? We've seen this before even with the Pentagon, where their computers and their laptops have been infiltrated. How do we ensure the--you know, through the HIPAA laws, that their security is good?

Mr. Alan Aviles: Well, I can take a crack of answering that.

Obviously, as you reference, HIPAA has very stringent privacy and security requirements, and we expend a fair amount of money just ensuring security for our system. And, you know, the system tracks every single entry. Every single viewing creates a log that then can be kept at--and viewed at any time. It has restrictions in terms of who can access which charts. We even have a contract with an outside vendor that periodically attempts to hack into the system just so that we can keep abreast of any potential security [unintelligible]--.

Ms. Tricia Cunningham: --That was my question.

Mr. Alan Aviles: Yeah.

Ms. Tricia Cunningham: That was my question.

Now, is that under government control, or is that an outside vendor, or is that here within the United States?

Mr. Alan Aviles: In terms of who tests the security of our system for us?

Ms. Tricia Cunningham: Yes.

Mr. Alan Aviles: It's a--that's a private vendor, though we--our security team responsible for maintaining security of our technology infrastructure is largely directly employed by us.

Ms. Tricia Cunningham: Okay, so that's absolutely fantastic.

I have one more question, real quick. Now, when the--now, will the government have control over this if the national healthcare system is put into place along with this, or is it going to be maintained by the medical community?

Mr. Alan Aviles: Well, certainly, you know, our system is a system that is controlled entirely by our healthcare organization. I mean, I think the government's role is to establish, particularly, standards that would help to maximize the efficacy of electronic medical records and other clinical IT by trying to move us in the direction of interoperability, so that it would be possible to have clinical data exchange among providers and physicians even if they're not in the same system. And it's something that we're actively working on, because we want our community-based physicians who refer patients to our hospitals to be able to share clinical data with us, and us with them, in order to co-manage those patients better.

Ms. Tricia Cunningham: Perfect. Perfect. Thank you so much. Thank you very much.

Operator: Next is Bill Settlemyer with the Charleston Regional Business Journal. Go ahead, please.

Mr. Bill Settlemyer: Good afternoon.

I'm, as well as a reporter, a columnist, and also have led a number of regional discussions on healthcare issues and initiatives to try to pull things together in the Charleston region, which has about a 600,000 population. And so, I have a couple of comments/questions. I'll try to say them very quickly and then just invite comments back.

One of the issues is how to find the right system and not go down the wrong trail with the wrong system or one that doesn't have the right technology or the most modern technology. So, there's a question of how do we get help as a community trying to hook into the right kind of systems and don't go in the wrong direction? A second comment that came up in our own discussions is we've got to make sure we have a culture and a system which involves both the people and the procedures if we're going to use medical info technology. It's not enough just to have the programs. You've got to have the people willing to use them and trained to use them.

A third comment is that we're viewing, well, this is something that has to be extended into the community through schools, churches, other kinds of sources, and we also see that primary care, generally in our community through private providers, is not set up to work on wellness and managing chronic disease. They only react when you show up with a problem. So, we've got those issues.

And the final thing I wanted to toss out was the question on funding. One thing that occurred to me is the possibility of some sort of regional block grants where, in the stimulus program, a region like ours could get a large block grant to facilitate bringing the medical record system to the entire community on an

interoperable fashion, and we would put a community group of leaders together, including providers, to manage that. So, any thoughts on that idea and the other comments?

Mr. Ken Thorpe: Yeah, this is Ken. I'll just take some of the prevention pieces. And there's no question that as part of this legislation that's going to flow through stimulus, we're going to have to work through these issues of interoperability standards and compatible systems and some of the privacy issues that were raised, as well as the opportunities for training people on the systems.

But, on the prevention side, one of the other things that--if you look at Senator Baucus' draft reform proposal that he put out several weeks ago, a major piece of what he has in there goes exactly to your issue of how do you build that capacity out in the healthcare marketplace to do a better job of primary prevention and then treatments once patients are diagnosed with a chronic disease.

So, there's a whole concept out there that he has of community health teams. That would be teams of nurse practitioners and social workers and nutritionists, community outreach workers, a behavioral health specialist that would collaborate and, indeed, develop more formal relationships with primary care physician practices and hospitals to do a lot of the primary prevention and do a lot of the care management that, as you stated and I agree--that is not really being done today in the physician's office, largely because the capacity's not there to do it and the payment's not there to do it. And, you know, for--probably for the most part, they don't have the time to do it.

So, I think there's a recognition that we've got to make that investment in building that type of infrastructure as well. I had mentioned that--it would seem to me that that community health team approach might be another option to include in a stimulus package. But, at the very least, if it's not included in stimulus, I think it'll be a major part of what you see come out of a healthcare reform proposal.

Mr. Alan Aviles: And on the more technical issue of, for example, how you find the right system, I mean, I would say that certainly the federal government can play a very meaningful role in that regard. There is a commission on certification of health information technology that has begun to set standards. They're beginning to move in the direction of standards that help to create a foundation of interoperability going forward. I think that's absolutely essential and can help to winnow down the confusing field of competing systems at the moment and help ensure that purchasers are buying for long-term value in terms of the efficacy of clinical information technology.

And certainly, you know, the--your statement about it's both culture and systems, I mean, there's no question but that IT technology by itself does not automatically bring you improvement. It is a combination of using that technology to enable better care. And as Ken said, that really--in chronic disease management, that really focuses on its ability to empower a team-based approach to care with everyone having access to the same data and being able to coordinate care better among different providers and even across different settings. And it absolutely has to be thought of in that way.

Mr. Bill Settlemyer: Okay.

And if I could just do one quick follow-up and go back to that--I think the last thing I mentioned, about the idea of some sort of regional block grants or financial support that could help the community coordinate and pull together. For example, our United Way organization is highly well staffed and focuses on getting non-profits and other groups in alignment. We have three or four very good hospital systems. They do talk to each other, but there's a general feedback that we don't all talk to each other all the time, and we don't look at the whole region in a systemic way, as I think you've been able to do in New York City.

So, it just seems to me that some sort of federal block grant type money to a region, properly managed with local oversight, might be able to provide the WD-40, as I'd call it, to get people to work together and to create a real system, and I just wondered what you thought about that.

Mr. Ken Thorpe: I--.

Mr. Alan Aviles: --Well, I think--go ahead, Ken.

Mr. Ken Thorpe: Yeah, I was going to say that, on that issue of sort of community-based--and I'll just call them, you know, "prevention," for the lack of a better term--there--there's tremendous interest, certainly in the Senate Health Labor--Education, Labor and Pensions Committee, and Senator Kennedy's committee and Senator Harkin, to move towards providing that type of community-based challenge grants from the federal government to adopt, you know, state-of-the-art community-based interventions that we've seen in other jurisdictions that are very effective at promoting primary prevention and collaboration across regions and across cities. And I--my sense is that the--the transition team, I know, in particular has been talking about including an element of prevention--.

Mr. Bill Settlemyer: --Uh-huh--.

Mr. Ken Thorpe: --As part of the stimulus package. And I would think certainly a candidate to do that would be those federal grants to regions and states to put into place some of the very types of programs you're talking about.

Mr. Bill Settlemyer: Uh-huh. Thank you.

Mr. Alan Aviles: Yeah, and I think that the feds, I assume, will be looking to see, you know, to what extent there has been some progress at this point toward an infrastructure that is worth investing--.

Mr. Bill Settlemyer: --Uh-huh--.

Mr. Alan Aviles: --And so--.

Mr. Bill Settlemyer: --Right.

Mr. Alan Aviles: But, clearly we have that in various parts of the country. We have that here in New York State. It's in Massachusetts and other parts of the country.

Mr. Bill Settlemyer: Right.

Mr. Alan Aviles: There has been--work being done on what are called RIOs, these regional health information organizations, that focus on interoperability and clinical data exchange across communities. I mean, some of those have been--have gotten much more traction than others, but I think, at this point, the federal government has a number of models to look at to think about maybe that's not a bad way to begin investing these dollars.

Mr. Bill Settlemyer: Uh-huh.

Operator: Next is Amy Lotven with Insight Health Policy. Go ahead, please.

Ms. Amy Lotven: Hi, good afternoon.

Quick question on money. Ken, do you know how much they're looking to devote towards prevention? Have you heard any figures?

Mr. Ken Thorpe: Well I think that if you--you know, if you take the three pieces that I've heard talked about in the context of a stimulus package that are health related--the enhanced F map that Al talked about, which is obviously going to be the biggest part of this, the HIT piece, which I mentioned is sort of the 10 to--$10 billion for a couple of years--I would think, on the prevention side, that they're probably looking at something in the two to $5 billion range.

Ms. Amy Lotven: Okay.

Mr. Ken Thorpe: And, you know, I think a good candidate--although, I don't really know what the thinking is right now for sure, I do think a good candidate would be these community-based federal grants, in part because it obviously gets money out quickly to the communities. There are many communities that are already well positioned to implement community-based programs if they had the funding in place. So, I think that it meets a lot of the criteria for what a stimulus program is designed to do, which is create jobs. And, you know, I think a good candidate to do it would be this type of a program.

Ms. Amy Lotven: And also, the workforce training that you mentioned earlier, do you have any figures on that?

Mr. Ken Thorpe: I don't, but I think that, you know, there's going to be a lot of opportunities for, you know, workforce training, both in terms of the technology side, because it's clear to me, as some of these states are already moving ahead of the federal government in adopting statewide health information technology platforms--Vermont's done it. West Virginia's on the verge of doing it, as well--that, in

addition to giving the physicians the hardware, you can't just drop it on their desk. There's got to be a training component to get people facile with using the equipment. And so, we really don't have that capacity to date, and we're going to have to create some additional expertise in terms of training people on these systems about how they work.

And the same's going to be true in terms of creating more primary care capacity, particular on the--I think the non-physician side--the nutritionists, the mental health workers, nurse practitioners, social workers and so on, that we're going to want to engage much more directly in managing chronically ill patients across different settings.

Ms. Amy Lotven: Okay.

Operator: Again--.

Ms. Amy Lotven: --All right, thank you--.

Operator: --As a reminder, to ask a question, please press zero-one on your telephone keypad.

And we do have one more coming up, though. That is Tricia Cunningham again. Go ahead, please.

Ms. Tricia Cunningham: Hi, guys. Again, just so, so many of these questions and answers is giving me a wonderful insight in the direction that the Partnership to Fight Chronic Disease and where they're supporting this stimulus agenda, and I think it's absolutely wonderful. I've actually been an advocate for the Partnership to Fight Chronic Disease for over a year in a--as a patient and, on the other side, as representing them through my non-profit organization, Reversing 4 Life. I'm affiliated with the #dontgo

Movement, which some of the questions that I had asked before, you know, we're promoting free markets and non-government control.

My question, as far as the money goes, are we looking to--or are you looking forward asking for money through the stimulus package as well for prevention and working with these healthcare groups in--you spoke, Ken, about the nutritionists and the obesity chronic epidemic that we have right now, you know, and I'm part of that. I'm also an author of The Reverse Diet. So, that's something that's very key in my life.

And so, when you're asking for two to $5 billion, is any of that money going to go towards that, or is there something you're looking forward to asking for referenced to the prevention of these chronic diseases that are already there?

Mr. Ken Thorpe: Well, my--if you look at a lot of the elements of what Senator Baucus has put in his white paper, we has three or four major areas in there that would deal with both prevention and chronic care management. You know, one are these community--what I call community challenge grants, which would be the types of grants I think the speaker from Charleston was talking about, that would really engage communities in primary care prevention and do better coordination of a lot of the services that are out there in communities, but they're not, perhaps, packaged as effectively as they could.

These community health teams that I've talked about really, I think, are an innovation, because they combine both primary prevention and treatment in the same setting, something that we don't do very well in our healthcare delivery system. And of course, then the technology piece. My preference--if it was up to me, I would like to see all three of these infrastructure components built into the stimulus package, because I think--let's face it, as you heard from Al, if we're going to prevent and manage chronic illness, we have got to have the right tools out there in the provider and public health community to do this.

So, I think these would all be wise investments. They would be, certainly, more than two to $5 billion to put in place. My sense of these community health teams that--if you did them to originally focus on Medicare patients, you're probably talking about $5 billion or so. And, you know, the community challenge grants are probably, again, in the two to $5 billion range. So, I would think that an effective prevention program built into the stimulus program would be something in the low double digits.

Mr. Alan Aviles: And I'm sure Ken would agree that the whole issue of making primary care more--elevating it in our system and trying to create more of a healthcare system versus a sick care system really requires that primary and prevention--primary care and prevention, and the reimbursement related to our healthcare system, be the cornerstone of the reform approach. And we need to reimburse healthcare providers differently so as to incent robust primary care and prevention and early screening of disease and effective chronic disease management, and that needs to be really embedded in the way we pay for these services on an ongoing basis.

Ms. Tricia Cunningham: Okay. One more question. Do you--to both of you. Do you feel that this could possibly be a way that we could lower the cost of medical malpractice lawsuits or reducing the cost for that insurance because you have such a great foundation on ensuring that that patient's well-being is taken care of through a network of people that are connected?

Mr. Ken Thorpe: You know, I don't know what the--what your experience with this is, but I've seen, in other systems that have put in very effective error reporting systems, error prevention systems, computer physician order entry systems, the types of things that was just described at HHC has two impacts. One is that we know that it reduces the number of adverse events in the system, and it reduces the number of negligent adverse events in the system.

And as a result of, you know, that experience, which goes to the basis of what the malpractice system was trying to do in the first part, was--which is to deter substandard medical care, that you have lower malpractice claims. And so, there are certainly examples in Massachusetts and down in Florida where they've seen favorable medical claims that trend experience because they've done the type of patient safety innovation that we've been talking about.

Mr. Alan Aviles: And we've experienced some downward trend in the last three years in our number of malpractice claims. I'm a little hesitant to just say that that's directly related only to our use of clinical IT, because there are a lot of other things we're doing that are part of our patient safety agenda. But, there's no question but that the appropriate use of health information technology leads to safer care. And over the long term, that should reduce the number of adverse events and, therefore, reduce exposure for malpractice liabilities.

Ms. Tricia Cunningham: Fantastic. Thank you both.

Operator: Next is Bill Settlemyer. Go ahead, please.

Mr. Bill Settlemyer: Yes, I just want to loop back a little again to a couple of related issues.

One, there's been a lot of information in the press and--about the growing shortage of primary care physicians and those leaving the practice. And also, now, Wall Street Journal just had an article on general surgeons and how you can't get to--get them into rural areas. One of our discussions was about how the--maybe the federal government needs to cover the cost of education or some of the other related costs, or help pick up the business pieces of how to manage these practices to incent people to go into these professions and stay in them, because, as we look at our community--although, we're very fortunate that we--happily, a lot of very good medical people want to live in the Charleston area, and our medical

university is here, and we're pretty well supplied immediately. The further out rural you get, the worse it gets, but the long-term issue is facing all of us.

So, if there isn't some flow of funding that can support creating community health teams and managing healthcare at all these different stages, from prevention and prenatal through hospital, then getting the IT piece in there is going to help tremendously, but it's going to hit a wall in terms of funding for real care.

So, just to comment, I think the--I agree that the IT is an absolutely critical thing, but, if the package and further funding planning doesn't support the whole healthcare system, we're going to hit brick walls all over the place.

Mr. Ken Thorpe: I think you're right to--you know, to raise the issue about primary care capacity. I think that's--what you'll see happening this year, both in the health reform and also in the discussion about making some changes in the physician Medicare payment system, is--one is that, on the primary care side, I think we're going to try to attack this in two directions. One is that--having some increased payments and reimbursements flow into primary care physicians. And two, I think we're going to try to find some--you know, continue to work on ways to reduce the costs of running a physician's office practice.

Mr. Bill Settlemyer: Uh-huh.

Mr. Ken Thorpe: So--.

Mr. Bill Settlemyer: --Right--.

Mr. Ken Thorpe: --If we can get the administrative costs down so that, you know, you're not looking at 45 percent of your gross receipts tied up in administration and overhead, you know, that's one way to attack it.

Mr. Bill Settlemyer: Um-hmm.

Mr. Ken Thorpe: You know, the other part is I think we have to recognize that a lot of the primary care systems that you see in Europe, that are dealing with the same problem, really do a much better job of relying on nurses, nurse practitioners, other types of primary care providers, in much more organized ways than we do here in this country. So, I think in the near-term, we're going to have to just do a better job of integrating the capacity that we have with existing primary care physicians and, you know, the--these community health team-approach workers in order to make sure that we have the right capacity in the near-term to really effectively manage patients.

But, you know, over the long haul, I think you're going to see a vigorous debate this section--session of Congress about making some realignments in the payment rates across different types of CPT-4 codes in the Medicare program. And obviously, other payers would follow suit.

Mr. Bill Settlemyer: Right. And I think it's not just pay-for-performance, but, you know, a physician won't get paid for sending you an e-mail or for his nurse answering a phone call or filling a prescription or any number of things that need to be done. So, there's all kinds of things they don't get paid to do that would be helpful.

Mr. Ken Thorpe: Uh-huh. That's a good point.

Mr. Bill Pierce: If--we've got one for--time for probably one more question, Eric, if there are any left.

Operator: We actually have two. Can we--?

Mr. Bill Pierce: --Okay--.

Operator: --Do two? All right.

Next is Amy Lotven again. Go ahead, please.

Ms. Amy Lotven: Hi. I'm sorry, just a very quick question. I've talked to hospice people who suggest that the hospice model could be a good source for, I guess, expanding the community health, you know, coordination--change to that sort of thing. Do you guys agree?

Mr. Ken Thorpe: Well, I think that what's true is that, if you look at what's out there in the healthcare system now, in health--home health agencies, in hospitals, in nursing homes, in hospices, in each of those settings, we have discharge planners and nurse practitioners and nurses and social workers and nutritionists. You know, they exist in these silo-based operations. The problem is that they don't interact in a collaborative way across settings. So, I think our challenge is to do a better job of coordinating across these settings by, perhaps, pooling the capacity in a more effective way.

I think you're right, it's--you know, we don't need to, in the near-term, you know, I don't think, really, really be concerned about having a massive shortage here, because a lot of that capacity that would build a community health team already exists. It's just that they're bottled up in settings that aren't particularly effective.

Ms. Amy Lotven: Right, but--and I guess with--the hospice model is the only one that really exists outside of a--an actual setting, although I guess home health [unintelligible]--.

Mr. Ken Thorpe: --Well, I mean, a home health does--you know, if you think about the way that home health works in the context of Medicare, they're already dealing with very complicated patients post-discharge.

Ms. Amy Lotven: Uh-huh.

Mr. Ken Thorpe: And they really do have the--you know, the range of capacities that--for the most part, that I talked about.

Ms. Amy Lotven: Right. Okay. Thanks.

Operator: And our final question is from Victoria Knight with the Dow Jones Newswires. Go ahead, please.

Ms. Victoria Knight: Hi.

You mentioned the importance of using any stimulus funds to develop common standards so that electronic medical record systems are interoperable, but what funding [inaudible] to put in place in order to encourage healthcare providers to adopt the technology? And how should be funds be structured? Should they be structured through grants? Through payment incentives such as high reimbursements for Medicaid--Medicare, sorry? I'm a bit unclear on this point.

Mr. Ken Thorpe: Well, I think the--you know, the method in which the dollars are paid out is certainly very much of what is going on in the discussion right now. My personal preference--and this is just me speaking--.

Ms. Victoria Knight: --Okay--.

Mr. Ken Thorpe: --Would be to, you know, do two things at once. You know, we know that we want to build this integration between primary care physicians and, you know, what I'm calling community health teams and hospitals. So, to the extent we can build that type of integration out there, I think that's going to be critically important. And what I'd like to see is that, for smaller physician practices, let's say in groups of five, six or so and under, that, if they develop those types of collaborative arrangements, that we provide essentially full funding of a interoperable electronic medical record.

Ms. Victoria Knight: Okay.

Mr. Ken Thorpe: So, I think if you can--if you use the money strategically to not only get the technology out, but also to encourage and build the integrated systems that we know we're going to have to build in the--build anyways, I think that that would be a creative and useful way of paying the money out.

Ms. Victoria Knight: Okay. Okay.

Mr. Alan Aviles: We actually have a pilot going on here in New York City, which is being directed by our city department of health, and they're using a combination of city and state dollars to help subsidize electronic medical record technologies, a standard system for community-based physicians who serve as--a minimum percentage of Medicaid patients as part of their patient panel. And I think they've already got

about 1,000 physicians online with that one system, and their goal is to have 3,000 physicians online by the end of this calendar year. So, certainly, I don't know that it has to be completed subsidized, but certainly subsidies together with some assurances that there's additional value in the system because it will be interoperable seems to be an attractive package.

Ms. Victoria Knight: Okay. Okay.

Do you envision any problems about arriving at kind of--sort of interoperability standards given that there are various groups out there, a whole bunch of them, that are developing different standards, in terms of who decides what the standards are?

Mr. Ken Thorpe: You know, I think it depends upon who you ask. I imagine--.

Ms. Victoria Knight: --Okay--.

Mr. Ken Thorpe: --There are members of the vendor community that are pretty invested in the same way--.

Ms. Victoria Knight: --Right--.

Mr. Ken Thorpe: --That GM was invested--had troubles changing and innovating. So, I--you know, it--I think at the end of the day, drive has to be [inaudible] interoperability. It's obviously nothing that can happen overnight.

Ms. Victoria Knight: Right. Okay.

Thank you very much.

Mr. Bill Pierce: Well, I want to thank everybody for joining the call. We will have a transcript of this available tomorrow morning, a written transcript, as well as a audio transcript some time tomorrow as well. So, look--you can look for that on the PFCD website. If you want to get ahold of Ken Thorpe for any follow up, you can call Anne Kott, who's listed on the advisory, but that's (202) 778-6321. If you want to get ahold of Alan Aviles for any follow up, Brigette Settle Scott, at (202) 585-0102, can get you in that direction.

So, thank you very much, and until next time.

Operator: Thank you, ladies and gentlemen. This call has been concluded.