Hearing on Exploring the Use of Technology and Innovation to Create Efficiencies and Higher Quality in Health Care

---

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS

U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED FOURTEENTH CONGRESS

SECOND SESSION

September 14, 2016

SERIAL 114-HL11

Printed for the use of the Committee on Ways and Means

COMMITTEE ON WAYS AND MEANS Kevin Brady, Texas, *Chairman*	
SAM JOHNSON, Texas DEVIN NUNES, California PATRICK J. TIBERI, Ohio DAVID G. REICHERT, Washington CHARLES W. BOUSTANY, JR., Louisiana PETER J. ROSKAM, Illinois TOM PRICE, Georgia VERN BUCHANAN, Florida ADRIAN SMITH, Nebraska LYNN JENKINS, Kansas ERIK PAULSEN, Minnesota KENNY MARCHANT, Texas DIANE BLACK, Tennessee TOM REED, New York TODD YOUNG, Indiana MIKE KELLY, Pennsylvania JIM RENACCI, Ohio PAT MEEHAN, Pennsylvania KRISTI NOEM, South Dakota GEORGE HOLDING, North Carolina JASON SMITH, Missouri ROBERT J. DOLD, Illinois TOM RICE, South Carolina	SANDER M. LEVIN, Michigan CHARLES B. RANGEL, New York JIM MCDERMOTT, Washington JOHN LEWIS, Georgia RICHARD E. NEAL, Massachusetts XAVIER BECERRA, California LLOYD DOGGETT, Texas MIKE THOMPSON, California JOHN B. LARSON, Connecticut EARL BLUMENAUER, Oregon RON KIND, Wisconsin BILL PASCRELL, JR., New Jersey JOSEPH CROWLEY, New York DANNY DAVIS, Illinois LINDA SÁNCHEZ, California
DAVID STEWART, *Staff Director* NICK GWYN, *Minority Chief of Staff*	

SUBCOMMITTEE ON HEALTH PATRICK J. TIBERI, Ohio, *Chairman*	
SAM JOHNSON, Texas DEVIN NUNES, California PETER J. ROSKAM, Illinois TOM PRICE, Georgia VERN BUCHANAN, Florida ADRIAN SMITH, Nebraska LYNN JENKINS, Kansas KENNY MARCHANT, Texas DIANE BLACK, Tennessee ERIK PAULSEN, Minnesota	JIM MCDERMOTT, Washington MIKE THOMPSON, California RON KIND, Wisconsin EARL BLUMENAUER, Oregon BILL PASCRELL, JR., New Jersey DANNY DAVIS, Illinois JOHN LEWIS, Georgia

C O N T E N T S

WITNESSES

Paul Black
Chief Executive Officer, Allscripts
Witness Statement [PDF]

Michael Gallup
President, TeleTracking Technologiess
Witness Statement [PDF]

Greg Long
Chief Medical Officer, Senior Vice President, Systems of Care, Thedacare
Witness Statement [PDF]

Jared Short
President and Chief Operating Officer, Cambia Health Solutions
Witness Statement [PDF]

Hearing on Exploring the Use of Technology and Innovation to Create Efficiencies and Higher Quality in Health Care

U.S. House of Representatives,
Committee on Ways and Means,
Washington, D.C.

The subcommittee met, pursuant to call, at 10:05 a.m., in Room 1100, Longworth House Office Building, Hon. Pat Tiberi [chairman of the subcommittee] presiding.

Chairman Tiberi. The subcommittee will come to order. Welcome to the Ways and Means Subcommittee on Health hearing on exploring the use of technology and innovation to create efficiencies, higher quality, and better access for beneficiaries in our healthcare system.

Over the last decade, Congress has passed several pieces of legislation that would expand the use of health information technology on a wide scale, helping to spur a wave of innovation and technological advancement. While these advancements have, in part, been utilized under meaningful use in the Electronic Health Record Incentives Program, there are a myriad of companies out there inventing and developing and groundbreaking products that we do not yet see in Federal healthcare programs, like Medicare. The commercial sector of health care is utilizing many of these innovations on a yearly basis to improve systems, medical facilities, beneficiary care, and collaborative care efforts. To date, Medicare has fallen significantly behind these efforts.

We are here today to kick off discussions about the innovative and technological aspects of health care and explore how we can use already available emerging technologies to increase efficiency, reduce waste, improve outcomes, and create greater access to care for beneficiaries in the Medicare space. What I hope we can talk about today is not about increasing or decreasing Medicare spending but about using the existing dollars already in the program more efficiently, focusing on goals, like giving patients more time with their physicians, clinicians, and more control over their health information.

I have heard from providers back in Ohio about clinician shortages that are jeopardizing access for Medicare beneficiaries who need the care. That scenario is both unacceptable and untenable. There are better ways to deliver care if we can lift barriers and incentivize

greater efficiency among all providers. Partnering with those who share these goals, including those who are already developing innovative products to create these efficiencies, will be a positive step towards bolstering Medicare solvency.

It is important to recognize what steps have already been taken to bring these technologies into the Medicare space. We can learn lessons from the implementation of the HITECH Act. Additionally, we can build upon the Medicare Access and CHIP Reauthorization Act, or MACRA. Rather than create more bureaucratic layers, Congress should continue to remove some of the regulatory burdens and barriers constricting advanced partnerships between technology and health care.

During today's hearing, we will discuss the role of innovation in the healthcare industry, look at how providers are leveraging the power of technology to cut cost and improve care for all patients, and explore how Congress can apply these lessons in order to further break down barriers, rather than create them, to improve Medicare for beneficiaries and ensure that taxpayer dollars are being spent with these goals in mind.

I now yield to the distinguished ranking member, Dr. McDermott, for the purposes of an opening statement.

Mr. McDermott. Thank you, Mr. Chairman.

Thank you for calling this hearing. In my opinion, it could be one of the most important hearings we have held during my time as ranking member on the subcommittee.

Innovation will be central to our efforts to address rising healthcare costs. Currently, the United States spends 17.5 percent of our gross domestic product on health care, and it is still rising. And although the Affordable Care has helped slow that growth, we still have work to do.

Innovation through electronic health records, telemedicine and delivery system and payment reform must be part of our discussion. So I am interested in hearing from our witnesses about our progress in these areas.

I am also interested in hearing about the challenges we continue to face, because recent events suggest that turning an innovative idea into reality isn't always a straightforward process. We often point to Accountable Care Organizations as an example of an important tool in our effort to shift toward a value-based system. If successful, they are supposed to lead to better outcomes at a lower cost. Care will be coordinated. Unnecessary services will be reduced, and the patients will be healthier.

But recently, last week, the New York Times reported on the challenges facing Dartmouth, an innovator that has struggled to make their ACO model work in practice. Although Dartmouth was improving quality and reducing cost, it found that the ACO was unsustainable and had to withdraw from the program. This is just one data

point. You can't draw straight lines with one data point, and it certainly doesn't mean ACOs are failures. What it does mean is there are questions we need to ask.

We are trying to figure out where we are going as a country and how we can turn our investments and innovation into sustainable models moving forward. The process involves collecting data, trying new ideas, and learning from our experiences. My hope is that we can work together to do this in a bipartisan way. It hasn't always been easy. I know the Center for Medicare and Medicare Innovation, for example, has become embroiled in partisan politics. That is a shame. The work that the Innovation Center is doing will help us become more efficient and achieve our shared goals of containing costs. I am hopeful we can work together to support these efforts in the future.

We have a great panel today, and I would like to hear our witnesses speak about the things they are doing to innovate and improve care. And I look forward to hearing from them about what works, what hasn't worked, and where they think we are heading, because I know we can all agree that without meaningful action on cost containment, we will continue down an unsustainable path in health care in this country. I look forward to a productive discussion this morning, and I hope we can work together to find solutions.

Thank you, Mr. Chairman.

Chairman Tiberi. Without objection, other members' opening statements will be made part of the record.

Today's witness panel includes four experts. I would first like to yield to the gentleman from Pennsylvania, who will introduce our first witness.

Mr. Kelly. Thank you, Chairman.

I want to thank Chairman Tiberi for his leadership in convening today's hearing to improve health IT and innovation in today's healthcare field and to generate greater efficiency for America's seniors and patients as well as saving U.S. taxpayers an awful lot of money and doing it in the right way.

A leader in this field is TeleTracking, a company based in western Pennsylvania. In fact, it is in Pittsburgh, Pennsylvania. TeleTracking's president Michael Gallup is testifying before us today to share TeleTracking's success in transforming companies from a patient flow automation company to a real-time automated operations management provider. TeleTracking's winning strategy has helped healthcare providers achieve broad operational efficiencies and cost savings. Mr. Gallup is leading TeleTracking's transformative healthcare policies. I look forward to his testimony today.

And on a personal note, Mr. Chairman, I would like to just briefly talk about a man named Victor Phillips, who died March 21, 1991. Mr. Phillips had open heart surgery, was in the hospital. And after the event, he had to be taken downstairs to another room for another event to take place or some type of a healthcare thing. I think it was

dialysis. After they completed that, Mr. Phillips was on a gurney for almost 3 hours, because they forgot where he was. So he laid on this gurney for 3 or 4 hours. Finally, somebody came by and said: What is this patient doing here?

They said: We don't know. He had a procedure done.

They said: He needs to go upstairs. He just had open-heart surgery, and he has been disconnected from all his monitoring machines.

They got Mr. Phillips up to his room, but by that time, he had slipped into a coma. He lived for about a week. Now, this is a guy who was a World War II veteran. He survived the battlefield, but he did not survive his time in the hospital. And I can tell you that Mr. Phillips at that time was 77 years old. I knew him for about 10 years. And the way I met Mr. Phillips is he was the father of my wife. And I watched as he lay dying and thought, if somebody had known where he was, this never would have happened.

TeleTracking is a type of company that says: This isn't going to happen anymore. We are doing it more effectively, more efficiently. And I tell you what: There is not a day that goes by that I don't thank the private sector for coming in here and telling us how to solve problems. The solutions are there with you. You have done great work.

Chairman Tiberi, I mean this sincerely. Thank you so much for bringing this hearing up. And I really wish I could go back in time to see my father-in-law again, and I am sure I will see him again. But it was really -- to sit and watch that man, after going through open-heart surgery and then get lost, not because he wasn't able to survive the surgery; he was lost somewhere in the whole system.

So, Mr. Gallup, thanks for being here, and thanks for all of you being here. You do great work, and we look forward to your testimony. Thank you.

Chairman Tiberi. Thank you, Mr. Kelly, for sharing that story.

I would now like to yield to the gentleman from Oregon for our next introduction. Mr. Blumenauer.

Mr. Blumenauer. Thank you, Mr. Chairman.

My introduction is not quite as dramatic as my friend from Butler, but it is no less heartfelt. Welcoming Jared Short. Cambia is headquartered in Portland, Oregon. It is a collection of companies. Jared at one point managed their seven -- I can't keep track of all of them -- seven health insurance plans for the four northwest States. But, most recently, he has been focusing on areas of innovation, technology. They have services and technology, and Jared, as the chief operating officer, has been focused on that.

I have been pleased to work with his company with people who are there who are committed to the same sort of collaboration that my friend from Butler referenced. It has

helped me in my service, and I think we have been able to add some additional benefit for the legislative process. And I am looking forward to Jared's presentation today, and I think you will find it informative.

Thank you, Mr. Chairman.

Chairman Tiberi. Thank you, Mr. Blumenauer.

And, finally, I am going to recognize Mr. Kind from Wisconsin to introduce our third witness.

Mr. Kind. Thank you, Mr. Chairman.

Mr. Chairman, I especially want to welcome Dr. Long. He is the chief medical officer and vice president of systems at ThedaCare in Wisconsin. It is the third largest healthcare provider in the State of Wisconsin, I believe still the largest employer in the northeastern part of the State as well, and one of the leaders in Affordable Care Organizations, the coordination of care, one of the lowest cost, highest quality providers we have throughout the Nation. I have had, on occasion, the chance to stop by and visit Dr. Toussaint, the team there, and seeing the work up close, what they are doing. And they are really pioneering a lot of interesting, innovative programs, especially in the so-called super-utilizer category that I am sure Dr. Long will touch upon a little bit, hopefully, in his testimony. I know he did in his written testimony.

And it is one of the great challenges that we face, the fact that 20 percent of the population is consuming over 80 percent of the healthcare expenses, and how do we provide better coordination and quality of care at a better price for that high-risk population to begin with?

So, on behalf of our State, we are very proud of the work that ThedaCare does, and, Dr. Long, welcome to the committee today. Thanks for being here.

Thank you Mr. Chairman.

Chairman Tiberi. Thank you, Mr. Kind.

And, finally, I would like to recognize Paul Black, the chief executive officer of Allscripts. He will be third on our panel today. We welcome all four of you for this innovative hearing.

Mr. Gallup, you are going to go first. And it is great to see you again. We had a great visit at Ohio State, and my friends there are excited to work with you and have seen great results because of the work that you have done. So you are recognized for 5 minutes. Thanks for sharing your story with us today.

STATEMENT OF MICHAEL GALLUP, PRESIDENT, TELETRACKING TECHNOLOGIES (PITTSBURGH, PA)

Mr. Gallup. Thank you, Chairman Tiberi, Ranking Member McDermott, and distinguished members of the Subcommittee on Health. This is my first time doing this and could be my last, depending on how it goes, since my boss is sitting behind me. So be nice.

It is our great honor to be here today and discuss how innovations to drive efficiency in health care can increase access for all, provide a better experience for caregivers at a lower cost. Each year, nearly 2 million patients walk in and walk back out of an emergency department because they are tired and frustrated from waiting. Millions more find themselves waiting more than 6 hours to get a hospital bed. Every minute of every day an ambulance is diverted from its intended hospital, yet there are seven open beds for every two admitted patients. And why? Because there has been very little innovation or attention given to the logistical flow of patients, caregivers, assets and materials.

We are here today with evidence to show that complete visibility and automation of logistics for everything in health care -- beds, operating rooms, infusion chairs, patients, staff, equipment, et cetera -- through a centralized command center can fundamentally change access to timely care for beneficiaries and decrease the frustration for doctors and nurses that they are suffering today.

Efficiency and automation is not about cutting back on vital resources or labor. It is, however, about eliminating the documented waste of nearly $1 trillion annually. There are vital minutes, hours, and even days wasted in the system because we lack the necessary transparency and automation that is so prevalent in other service industries. Forty-six minutes was just enough time to save the life of a new mother suffering cardiac arrest. That is the amount of time it took for her to be transported from a regional hospital's emergency department to an intensive care unit at Baptist Memorial Hospital in Memphis, Tennessee, following an emergency C-section. A physician made one call to the Baptist operational command center. This coordination center automatically set up transport and secured on-call specialists in the matter of minutes. Upon her transfer, the specialists saved her life. This is efficiency.

What if that new mother's ambulance was redirected to another facility 15 minutes away, an occurrence that is all too common? We see a Nation in which every health system is enabled by an operational command center connecting care for doctors' offices to clinics to hospitals and beyond, one that places real-time data in the hands of clinicians and administrators, one that sees everything -- beds, patients, staff and equipment -- one that serves as a care traffic-control center. Dr. Joseph Underwood III at New York Presbyterian credits his coordination and command center with reducing the amount of time patients spend in the emergency department and allowing his doctors to spend more time with new patients. This is efficiency.

Recently, a senior hospital executive called me and shared two stories, one about a patient in rural Texas who had suffered a stroke in need of immediate care at the right facility. With one call, transport was on its way, doctors and clinicians were alerted, preparations were made in real time. And as a result, the patient returned to his family completely healed.

Even at 95 percent occupancy, this health system has been serving 2,000 more cases just like this every month without any added cost. The same executive went on to share, with this additional growth, his hospital system was able to serve thousands of community members without the means to pay for their care that they so desperately needed. This is efficiency.

Efficiency is more than digitizing medical records. While crucial to the information sharing, medical records are not built to facilitate the movement of patients through a system. We are not seeking a handout, but we are asking you to consider the possibility of a truly efficient care delivery system. Michael Zamagias, the majority shareholder of TeleTracking, has dedicated himself to it for 25 years -- who, mind you, pays 100 percent of his employees' health care and has invested nearly a billion dollars into making healthcare command centers a reality.

Through efficiencies and increased productivity, these care traffic-control centers are self-funding. No additional taxation is needed. Through these types of efficiencies, we can serve millions more patients by utilizing our underutilized assets, helping coordinate care so our doctors and nurses don't suffer from the wasted time. Less frustrated doctors and nurses are happier people. And by the way, those clinicians want this. I recently asked a nurse with a new command center what it meant to her, and she simply said: It changed my life. I spend my time with my patients now. This is efficiency.

And one last story. TeleTracking was built on the premise that too much money created this problem and too little money will solve it. As an example, a chief executive officer called and thanked me for saving 308 jobs in his hospital as he eliminated costs from his system through the command center that allowed him to keep more clinicians and provide better care. This is efficiency.

Thank you, Chairman Tiberi, Ranking Member McDermott, and members of the subcommittee.

Chairman Tiberi. Thank you, Mr. Gallup.

Mr. Short, you are recognized for 5 minutes.

STATEMENT OF JARED SHORT, CHIEF OPERATING OFFICER, CAMBIA HEALTH SOLUTIONS (PORTLAND, OR)

Mr. Short. Chairman Tiberi, Ranking Member McDermott, and members of the subcommittee, my name is Jared Short, and I am the chief operating officer for Cambia Health Solutions in Portland, Oregon. Cambia is a not-for-profit health solutions company that is committed to creating personalized experiences for people and improving the healthcare system. We are best known for creating the employer coverage insurance market a hundred years ago, but our footprint has grown. We are a family today of 20 companies, serving 80 million people, integrating technology to make health care simpler and more personalized. Cambia is making care simple for people by creating a consumer experience platform powered by technology. We are putting people at the center of everything and connecting the dots in health care that have not been connected before.

With our tools, people can search for treatments. They can find out how much they cost. They can schedule appointments. Lastly, they can have drugs and medical devices delivered to their homes. And if they need help, we can help them with a human being. In my written testimony, we give examples of our health solutions and list our entire set of direct health solutions companies.

For now, let me give you an example of one of our solutions, HealthSparq, a transparency tool that allows people to shop for healthcare services. It is a first-of-its-kind platform, launched in 2005, that shows individuals the price and quality of healthcare services, allowing them to comparison shop and make appointments. Think of it like an Amazon or Expedia experience, but for health care. HealthSparq is a simple one-stop-shopping experience.

We have another solution called MedSavvy that helps people understand whether a prescription medication will work for them. MedSavvy provides information about the effectiveness and cost of prescription medications at a personalized level. It assigns each drug a letter grade, like a report card we would receive in school, so people can more easily compare one drug to another. Both patients and prescribing doctors can access the MedSavvy data that is used to determine the grades and post ratings and reviews about their own medication experiences.

Another Cambia investment company, GNS Healthcare, is a company that collects patient data, analyzes it, and determines which treatments are the best match for individuals. GNS also has the capability to predict which patients are most likely to stop taking their medications. This process helps people have more success with their care plans and helps organizations lower cost related to medication adherence, diabetes, oncology and more.

At Cambia, we understand that health care is complex and it is personal, which is why we are focused on putting the consumer at the center of everything we do. Cambia's platform is all about making it easier for consumers to learn, decide, and pay for health care, without intruding on the important relationship with trusted doctors.

Elderly patients are frequent users of healthcare services. Today, there is an opportunity to expand these tools and capabilities into our senior population. We can help them save money, help the system save money, and it gives our seniors the health care they hope for and, quite frankly, they deserve.

The Medicare program, by the way, can modernize its systems just like the private sector is doing. Beneficiaries can access the same capabilities that will allow them to live healthier and better lives.

Cambia looks forward to helping the members of this committee transition Medicare into the next generation of data analytics, healthcare coordination, and patient engagement. Seniors are just as eager for timely, consumer-friendly access to care. They do not want to go in and out of hospitals when they do not need to, and our system can no longer afford this level of inefficiency.

Cambia is interested in partnering in a broader discussion about how to apply our innovations to the Medicare program to our seniors so they can have access to modern, high-quality experience.

Thank you for the opportunity to speak with you today. Cambia Health Solutions will be pleased to share additional information about our platform. Healthcare innovation is a work in progress, and we stand ready to assist the subcommittee as it continues its exploration of how technology can improve health care and the experience for Americans and their families. Thank you.

Chairman Tiberi. Thank you, Mr. Short.

Mr. Black, you are recognized for 5 minutes. Thank you for being here.

STATEMENT OF PAUL BLACK, CHIEF EXECUTIVE OFFICER, ALLSCRIPTS (CHICAGO, IL)

Mr. Black. Chairman Tiberi, Ranking Member McDermott, distinguished members of the committee, thank you for the opportunity to share my perspective on the innovations taking place in health care. It is a privilege to be here discussing how technology is changing the way we care for people, improving access, efficiency, and quality while reducing cost.

My name is Paul Black. I am the CEO of Allscripts. Allscripts is one of the largest developers of health information technology. We develop electronic health records, precision medicine solutions, and information exchange platforms. Nearly 180,000 physicians, 2,700 hospitals utilize Allscripts' solutions daily. We employ 7,000 people, with offices in 16 States, including Illinois, North Carolina, Vermont, Georgia, and Massachusetts. Allscripts' employees live in all 50 States. We are also majority owner of

Netsmart, the leading healthcare IT company serving the behavioral health and mental health and home-health industries.

Despite some bumps in the road, as can be expected when times have changed, there has been a substantial progress in our industry that would never have happened had Congress not provided the impetus for ubiquitous adoption of electronic health records. These changes have disrupted paper systems that stood for decades, and the result is a new digital ecosystem of caregivers, software developers, and patients, allowing all to take a fresh look at how processes can be enhanced via automation. Fortunately, following disruption, there is innovation and opportunity.

In response, we have engineered solutions that sit on top of this new digital platform. We are leading the way in helping providers maximize the extensive data stores that have been created within their electronic health records. Our clients use these tools to harmonize volumes of data from the individuals' genomic story all the way up to the community's population health view. Allow me to give a few examples.

Allscripts' dbMotion interoperability platform, an information-exchange and patient-matching engine, brings together clinical content from across the community into a single patient view. We create access to this data from both within Allscripts and other electronic health records, all in the clinician's natural workflow. We connect over 350 different data sources, including electronic health records, developed by virtually all vendors, public health departments, and third-party claims systems. In fact, at the University of Pittsburgh Medical Center, the wait time for patient data decreased from as long as 20 hours down to 5 seconds, and the time physicians spent searching for information dropped from up to 40 minutes down to 1.

Importantly, when a physician clicks the community view of their patient at UPMC, they make a different clinical decision 60 percent of the time. At Baylor Scott and White Health in Dallas, a 12-year-old girl was spared a second CAT scan when images from her initial ER visit were available later at another hospital inside of a different electronic health record. The ability to pull up these images prevented unnecessary radiation and saved her family more than $3,000. We recognize that tomorrow's healthcare networks aren't being built by our company alone. Since 2007, before ONC regulatory requirements, Allscripts launched an open approach to our electronic health applications, allowing third parties to integrate with our solutions. This has grown to a network of over 4,000 certified developers and providers using apps that will exchange information over 1 billion times this year alone.

Program highlights include an app that helps connect diabetic patient data directly into their doctor's electronic health record, an app that helps patients quickly and accurately provide updates before a practice visit, an app that helps providers connect patients to relevant clinical trials while still onsite in their office, and an app that rapidly fills available appointments following a cancellation, avoiding lost practice revenue and creating accelerated access to care.

Beyond our own innovations, our clients have also capitalized on this open platform, building solutions to deliver results to their patients. As I described in detail in my written testimony, clients from Phoenix Children's, University Hospitals of Cleveland, and Orlando Health have all built tools on top of our electronic health records to almost eliminate errors in medication dosing and administration, noticeably decrease rates of sepsis, and dramatically reduce readmissions, all of which drove material cost savings and improved outcomes.

Allscripts was also the first in the industry to make significant investment in the area of precision medicine, aligning Congress' interest in this opportunity. We recently launched our 2bPrecise solution, which will help caregivers proactively identify optimal patients for genomic sequencing and make the results available, understandable and actionable at the point of care. The NIH will be an early adopter of the 2bPrecise solution.

We are early supporters of the Cancer Moonshot and among the first participants in the White House's Sync for Science effort, working with clients to contribute data to the NIH cohort of 1 million lives.

There have been many more recent examples of innovation improvements, both for providers and patients. We would be happy to speak with any of you about our specific work in your district. Thank you for the opportunity to be here today.

Chairman Tiberi. Thank you, Mr. Black.

Dr. Long, you are recognized for 5 minutes.

STATEMENT OF GREG LONG, M.D., CHIEF MEDICAL OFFICER, SENIOR VICE PRESIDENT, SYSTEMS OF CARE, THEDACARE (APPLETON, WI)

Dr. Long. Thank you. Chairman Tiberi, Ranking Member McDermott, and distinguished members of the subcommittee, my name is Greg Long. I am a family physician, and I serve as the chief medical officer and senior vice president for ThedaCare. Thank you for this invitation to appear today and discuss how technology and innovation can be leveraged to improve access to care and deliver better care at a lower cost. It is an honor to appear before you today alongside this distinguished panel.

As Mr. Kind had mentioned, ThedaCare is a not-for-profit, community-owned health system in northeastern Wisconsin, consisting of 7 hospitals, 34 health clinics, serving 8 counties. We are the third largest health system in the State, and we serve over 240,000 patients. Over a third of those are Medicare beneficiaries.

ThedaCare has for many years dedicated itself to advancing information technology to improve the way our professionals treat and engage with patients, expand access, and provide better, more coordinated care. In recognition of these efforts, ThedaCare has earned the Most Wired award for 15 straight years.

ThedaCare is also committed to delivering high-value care, and to us this means delivering the highest quality in a highly efficient manner, thereby lowering costs for patients and the overall health system at large. We are early adopters in healthcare quality improvement, having adopted lean methodologies in our care since 2003. And we have developed an embedded culture of continuous improvement with our team members. Additionally, our CMMI pioneer ACO excelled as the highest quality, lowest cost provider organization in the Nation for each of the 3 years that we participated. And we are now excited to participate in the Next Generation and Pioneer ACO.

ThedaCare is a member of the Healthcare Quality Coalition, a national group of leading health systems, hospital associations and medical societies that are striving to transition healthcare delivery to a value-based system.

With that background, let me first talk about how we are managing our complex patient care panel. In our service areas, as in many parts of the Nation, a growing percentage of the population is challenged by obesity, alcohol abuse, diabetes, high blood pressure, asthma, and lack of access to primary care. To meet these challenges, ThedaCare embarked on a pilot in 2014 to identify our most highly complex, sickest patients in our internal medicine population in Appleton. We screened, with a database tool that we developed through our Epic EMR, a risk stratification module that has looked at 7,000 patients and from it identified 600 of the most complex.

After we identified those patients, we enrolled almost 300 patients in our team-based care model and identified a team, which consisted of three care coordinators, one registered nurse, one clinical pharmacist, one behavioral health clinician, one nurse practitioner, and one medical assistant, plus three part-time staff in the same disciplines. And this was a decentralized model where we put these practitioners right at the bedside in those clinics with the patient. As a first step in the model, each patient met with the care team, completed an initial assessment of medical, psychosocial, and other needs. A customized care plan was developed and specific goals were identified. Each patient received supportive services and intensive management, including chronic disease monitoring, management skills, behavioral health screening, psychotherapy, and other behavioral health care. Patients also received assistance in obtaining housing and other basic needs through collaboration with community organizations, including LEAVEN, the United Way, the Aging and Disability Resource Center, and the housing authority of the Fox Cities.

The team provided home visits for patients with special needs and physical and mental incapacity. Team members would also accompany patients to specialist visits for health literacy and evaluate them in the hospital, when admitted, to help with their post-care planning, minimizing readmissions to the hospital.

The results from this first pilot were extremely positive. The percentage of patients with uncontrolled diabetes decreased from 12 percent to less than 4 percent. Improvement was also noted in the percentage of patients with controlled high blood pressure, which increased from 89 percent to nearly 92 percent. And the percentage of patients who

visited the emergency department more than 3 times in the previous 6 months fell from almost 50 percent to just below 19 percent. And for those patients with severe behavioral health symptoms, they were able to decrease their symptoms from 49 percent to 18 percent for anxiety and 53 percent to 40 percent for depression. And included in your written testimony, I give the table for other specifics on those results.

As far as technology goes, to improve access, we have incorporated e-visits. Patients now are able to consult with their ThedaCare primary care physicians on certain conditions. And for a flat fee of $35 and without having to leave work, a patient can get a diagnosis, prescription and/or a referral for followup with respect to 9 clinical conditions, and we are in the process of adding 11 more. And we have over a 98 percent satisfaction rate with our patients.

We also have tremendous experience with telepsychiatry. We have had a shortage of psychiatry, not only in our area but as recognized also in the country. We had a psychiatrist within ThedaCare that, for personal reasons, left our area and was still able to manage 2,000 patients from Utah to Wisconsin using telepsychiatry, having set up a remote clinic in the same office, and still sees, on average, 22 to 24 patients per day.

Lastly, for technology, we are implementing a telestroke program, which, as you know, stroke is much like a heart attack in that time is critically important. So, in our outlying hospitals in the rural settings, we can now connect those EDs with clinical specialists from our stroke and have clot-busting medication delivered within a few minutes as opposed to potentially hours.

So, again, in closing, from my perspective as a clinician, it is exciting to see the way that technology and innovation can transform care and improve outcomes for our patients. And, of course, like other healthcare providers, we continue to be challenged with the traditional reimbursement of fee-for-service that do not always support technology and innovation care models. And for this reason, we will and have continued to explore payment alternatives like Next Generation and private-payer contracting to better support these clearly improved models of care. Thank you again for this opportunity to testify.

Chairman Tiberi. Thank you, all four of you, for fascinating testimony. We have got a lot of member interest today. I am just going to have two quick questions here.

Mr. Gallup, I will start with you. I had an opportunity to take a look at your numbers, and the success that TeleTracking brings to every facility it contracts with. I obviously had an opportunity to view what you are doing at Ohio State and saw that nerve center or command center, which was amazing.

Is there a role for what you are doing on the commercial side under Federal healthcare programs? And do you have any experience with any government programs? Additionally, how can we utilize what you are doing for facilities out in our communities for Medicare, Medicaid, or other Federal programs?

Mr. Gallup. It's a good question. Let me start with one thing, as we all have these discussions up here, which is the care teams and people in the hospital are amazing. They are working as hard as they possibly can to deliver the best care. And I just want to make sure that that goes on record. A lot of this is a lack of tools that, frankly, we provide to them.

And to your question, yes, we have some experience. Probably the best example is we are currently working with NHS in England right now. There is a lot going on with them. And we have gone at that from a public-private partnership perspective. We are working with a group called NHSI, NHS Improvement. We found three different trusts over there that they are monitoring and that we are working in and putting this platform into place. And what we have done with them is created a 50/50 kind of investment model, where they put in a dollar, we put in a dollar, and we invest in helping them get this technology and be able to help their patients.

Obviously, as you all know, they are publicly funded totally, and that causes some significantly different behavior in the fact of it is a total zero-sum game. There isn't a lot more money to go get. And they have found that the way to do this is -- I mean, they have an aging population, as we do, and they have got to put more patients through the system than they have previously, and that is going to cost money. And so we help them see that you can get more patients through the system at the same rate, and that is what we have been working with them on. And we have a system -- a trust there. I have to keep translating between their language and our language. So that we have a trust there that we are able to help get 10 percent more patients through at the same cost, and as a matter of fact, they even shut down units and were able to get more patients through their system to show that this was the way to serve more of their people. So we could do the same, similar thing.

Chairman Tiberi. So, for my colleagues, I was at Ohio State's Medical Center, the Wexner Medical Center, a couple years ago. And they had a challenge that many hospitals had that they had not enough space, at least they thought. Not enough space. And so they had people in the emergency room in the hallways. So I go back to Ohio State last month, maybe July, I can't remember, it all runs together now. And Mr. Gallup was there. Dr. Retchin, the CEO, took me to this command center. And if you can think about going to a restaurant. This is how Dr. Retchin described it to me. This command center has every room in the entire hospital in the command center. And I think green meant the room was empty; red meant the room was full; and orange meant it was being cleaned.

So the fact of the matter is, in this command center now, they can communicate with the emergency room or the entire hospital, actually. And so, if you are a doc in the emergency room, you can see on the board if there is a room that is being cleaned that is going to be ready and when, or if a room that is empty, much like a maitre d' in a restaurant can look at a computer screen to see what table is empty or what table is being cleaned. And so the efficiency that you have brought to this hospital in Columbus has been incredibly important. So thank you for your leadership.

Dr. Long, I have read a little bit about how your system has evolved over the years and how you have been cutting out the fat in the system. Kind of the same question I asked Mr. Gallup. Is there a way to apply this, and are there examples of what you have done through your experiences that could benefit Medicare or other Federal programs?

Dr. Long. Yes, absolutely. And really related to the last question, an interesting statistic that we found just in our organization alone, of our seven hospitals, we have 21,000 inpatient discharges. In all total, our ambulatory practice, you see over a million touches per year compared to 21,000. So what we really like to try to do is catch people before they even have to make it to the hospital. So, in light of the shortage of primary care, we feel that our team-based care model, as an example that I shared, is a way to leverage clinicians working at the top of their license to be able to support primary care, which still traditionally is the touch point for these chronically ill patients. And just sharing the statistics I did, we feel that we at least have a model, once spread, can actually be as cost-effective, because we can pay for other caregivers, not necessarily having to hire as many physicians, managing larger panels of patients.

And my future would be, can we get into some sort of a capitated model that is based on the risk of these patients, not in the old HMO way, but more customized for these panels, and certainly, Medicare falls into that category. And I think our experience with Pioneer would show that we were able to manage patients to the lowest spend per beneficiary, all while achieving the highest level of quality. So we think we have been able to do that for many years.

So I think the key is, how do you match the payment methodology at the same time you are improving care. I think that has probably been the biggest barrier for most healthcare systems is that, as we continue to do the right thing for patients, we are currently cutting our own revenue and not being able to pay in a manner that I think would be most beneficial in the future. So I am very confident that we can do it if we can sort of match payment methodologies as we make those improvements.

Chairman Tiberi. Great comments. Thank you.

I will yield 5 minutes to Dr. McDermott.

Mr. McDermott. Thank you, Mr. Chairman.

Mr. Kelly told a story at the beginning, which, you know, you would say to yourself, how could that happen in a modern hospital with all this technology? I was involved with the surgeons in their application of a checklist kind of system that is used in the airlines. When a pilot is going to take off a plane, he has got a checklist of stuff he has got to go through, including going out and walking around under the plane and looking to see whatever is under there.

Tell me what is in place in your system that protects the quality of care for patients. I am all for efficiency and saving money, but the bottom line, as far as I am concerned, is what

happens to patients. And what happened in Mr. Kelly's story is unacceptable, and I wonder how you deal with that. In trying to cut costs and cut people, how do you prevent that? Any one of you can --

Mr. Black. This is Paul Black. One of the things we try to do inside of our electronic medical records is provide a checklist set of capabilities that you are mentioning. The caregivers all are extraordinarily dedicated to the Hippocratic oath that they have taken, which is to do no harm. So there are a lot of people that are out there each and every day that are working as hard as they possibly can, and they are, in many cases, performing miracles. So I always try to start with that description first about these wonderful people that are out there.

Mr. McDermott. I am a physician, so I understand what you are talking about.

Mr. Black. Yes, you do. And, you know, they are busy. They have got a lot going on, and no one ever does anything to try to cut a corner that would cause any sort of avoidable medical error. There are checklist systems that you can have inside of the surgery suite, and there is bedside bar code administration. A lot of the errors that occur in the industry have to do with medication administration, and this thing you may have heard in the past about five rights: right bed, right patient, right dose, right caregiver, and right time. Those five doses -- those five rights, as it is called, are things that we also automate as part of our medication administration process as part of the physician and caregiver order entry, and to complete that entire loop is all monitored and checked by the computer.

Mr. Gallup. You can have all those checklists, especially when you go into an OR or whatnot or providing drugs. In Mr. Kelly's example, the patient got lost somewhere in the hospital. The hospital is a big plant. So that is exactly what we do. We know exactly where those patients are. We know exactly where the staff members are. We, in real time, say, this patient has been in this space too long. We can actually tell you if a patient has been in a bathroom too long and maybe has fallen down. Right. These are the technologies that aren't out there in health care right now, to let you know exactly what is going on.

And it even counts in the clinics. To the doctor's point, there is a lot more visits out in the clinics also, and these clinics could run more efficiently. We are working with a system, and I won't name the name, but they are very, very well-known for being one of the most efficient systems anywhere. And they thought their clinics were running at 80, 85 percent. When we went in and put in these technologies, that say, "Here's where people really are, here's what they are really doing," when they looked at it, they were at 35 percent utilization of all their assets, including the docs. So, imagine being a doctor, which you are, and you are being utilized at 35 percent, and you are told: You know what, if you did it this way, this way, this way, you could now do 30 percent more work. You know?

Mr. McDermott. Let me just follow up on that to ask you, if you have this system in place, who is monitoring and saying, "This person has been in the bathroom in their room too long"?

Mr. Gallup. The system will do that. The system will say --

Mr. McDermott. Who does it tell? I mean, the system has got to some people somewhere.

Mr. Gallup. Yeah, yeah. It will tell the nurse who is assigned to that patient: Hey, nurse, this is what is going on.

If the nurse is too busy, it will escalate to the charge nurse.

Mr. McDermott. On her cell phone --

Mr. Gallup. On their cell phone.

Mr. McDermott. -- monitor, or where?

Mr. Gallup. On a cell phone, monitor, exactly right. Both of them start to alarm and start to say: This patient has been there too long.

In all situations, you can send it to a pager, a phone. You can have it on a screen. You can have an audible alarm. You can do a lot of things to say: This has gone on too long.

And that counts for everything from that perspective, right. That counts from: I got to get my patient from point A to point B, and I know how long it is supposed to take to get to point A to point B, and this is an emergency. How do I then help them get there?

Does that make sense?

Mr. McDermott. Yes. Thank you, Mr. Chairman.

Chairman Tiberi. Thank you.

Mr. Roskam is recognized for 5 minutes.

Mr. Roskam. Thank you, Mr. Chairman.

Mr. Chairman, good job hosting this today and calling this. This is important work, and I really appreciate the perspective of all of the witnesses, and I am learning things by listening to you, and I really appreciate your taking the time.

Mr. Chairman, I have good news for you. You know what the good news is for you? The good news, Mr. Chairman, is that Mr. Blumenauer and I have been working on

a bill that fits right into this theme. Let me briefly tell you about it, and I think you will like it, and I think our panel will like it as well. And it has to do with this notion of using the technology that is already deployed at the Department of Defense, applying that into a common access card for Medicare patients to go right at this question of fraud.

And what Mr. Blumenauer and I are proposing is a pilot program, not a big rollout all across the country, but a pilot program to get at some of the waste and so forth and the actual fraudulent transactions that are being manipulated by criminals. So, in the Oversight Subcommittee that I chair, the fraud rate and erroneous payments last year was 12.7 percent. I just got a text from my staff that, hey, good news, it has dropped to 12.1 percent. So if you just do a quick back-of-the-napkin calculation, we are throwing away, literally throwing away about $60 billion a year, roughly. So there is some very significant work for us to do, and I commend this to your attention.

So let me just ask a couple of questions. Mr. Short, you were talking about, in your opening statement, about HealthSparq and MedSavvy. On HealthSparq, I assume it is kind of an app or a place that you can go online and so forth. How do you navigate through cost comparisons? Because one of the things that I think my constituents find frustrating is you go to a physician; there is a procedure that is done; and we have created this current system where the two people that should know the most about the cost of the transaction -- that is, the physician and the patient -- have no idea of the cost of the transaction. And our culture basically says: If you ask about the cost of a doctor, that is almost an offensive question. Try that. Hey, doc, what is this running me today? And your doctor will have an ashen-faced look. You got to talk to Mavis at the front desk. You go to Mavis at the front desk. She has no idea. So how is it that you have an idea?

Mr. Short. That is a great question. The institutions of health care have created this mirage of walls, where transparency isn't something that is an everyday occurrence in health care. And so what we established was we worked with 70 health plans across the country, and we took all of their provider registries. We took what their contractual rates are that they agreed to with providers, and we serve it up in what we call HealthSparq, our company, that allows a consumer, a member of any one of those 71 health plans covering 70-plus million Americans, to go in and do a search on their procedures, look at cost estimations, and actually look at what the cost is if they go to a particular doctor or a particular facility.

Mr. Roskam. Okay. So it is calibrated, based on who the health provider is or, I am sorry, who the carrier is?

Mr. Short. Yes.

Mr. Roskam. Okay. Time is short. Could I just ask you to contemplate, the four of you, and maybe give us some feedback later? Because we don't have time. Legislatures tend to lag real life. It is just the way it is. It is not an inherent criticism. Legislative bodies don't lead, by and large. It is the nature of them. So we are hearing from you. You are

hunting out ahead of the pack. And we are being urged, the theme today is we are being urged to catch up with you, which is what we should do.

Could you give some thought to sort of blue-skying us further out? Like what is the next thing that we should be thinking of? What are the things that you are thinking of, you and your boards and so forth are thinking of that are 5 years out and 10 years out, not just today, but that we should actually be broadening out? We don't have time for that now, but I would be very open to continuing the discussion, and I know I speak for everybody here that is interested in this longer view.

I yield back.

Chairman Tiberi. Thank you, Mr. Roskam.

Mr. Kind is recognized for 5 minutes.

Mr. Kind. Thank you, Mr. Chairman.

I would echo that sentiment. That would be a perfect tee-up for some future hearings to talk about the next 5, 10, 15 years and what is on the horizon and what we need to be thinking policywise to coordinate with the tremendous innovation that is taking place, because I agree with my good friend, Mr. McDermott. This is one of the more important and useful hearings that we are having this year, and inspiring, too, because of all the incredible innovation that is taking place in the healthcare field.

Dr. Long, I would be remiss if I didn't ask you a question about your participation, ThedaCare's participation in the Next Gen ACO and the success that you guys have realized, because there have been some ACOs that have decided the risk-sharing component that is involved is not worth it because they have already been high-quality, low-cost for some time, and it hasn't worked that well for them, so they opted not to participate.

But before we do, I think we have got three great revolutions going on right now in healthcare reform. One is, obviously, the build-out of the health information technology systems. Before the American Recovery Act, before ACA, we were deplorably behind the ball when it came to electronic medical records and the meaningful use and interoperability, our ability to start collecting the data so we know what is working and what isn't, and then disseminating that information and driving that back into the hands of doctors and patients so they can make good decisions with it. And we see a lot of that exploding right now. And, of course, in Wisconsin, we have got Epic Systems too out of Middleton that has been doing tremendous work. So that is one aspect of the revolution that is happening.

Another is the delivery system reform that we are hearing about today, a more integrated, coordinated patient-centered healthcare delivery system that was long overdue. And, of course, being from Wisconsin, we have got providers of care, whether it is Theda,

whether it is Gundersen, the Mayo System, Dean, Marshfield, Aurora, that have been at the forefront of this revolution on delivery system reform for some time. And then, finally, and I think the big one is aligning the financial incentives the right way so we are rewarding outcome, value, quality, and no longer fee-for-service and just doing more, regardless of results. That was bankrupting us, because right now we are on a race against time as a Nation, whether we can get smart quick enough in the healthcare field before we grow too old. And with 70 million boomers about to enter retirement and join Medicare, it is a race against the clock.

But, Dr. Long, back to ThedaCare, the Next Gen ACO model that you are participating in, because I have heard, you know, some criticism, especially from the higher providers, the high-quality, lower cost providers, that there is not much incentive for them to be joining this program because of the risk-sharing component and the fact that they have already been hitting those marks for some time. How has ThedaCare managed that?

Dr. Long. Well, thanks for the question. And it gets back to what I said a little bit earlier. We were in for 3 years in the original CMMI Pioneer. And one of the reasons we got out is because we thought we had hit that ability to get some shared savings back. So, to your point, when you are a high-quality, low-cost provider, there is not much left to be able to get in shared savings. And that is why we think the next step and somewhat to the blue-sky comment is, how do we then go from the current model and escalate that into more of a risk-adjusted capitation model where the low-cost providers can get a lump of money that they know they can make the necessary margin on, but still offer extremely high-quality care? So we got out of the Pioneer 2 years early, because we were concerned about that very issue. So it is a leap of faith to try to move to that next model, which there is a lot of nervousness about because of the old HMO days, but we think we can do it differently.

Mr. Kind. Theda is also in a nine-county northeastern region of the State too, which includes a lot of rural areas. And, of course, I represent a large rural western Wisconsin area myself. But are there some unique challenges that rural providers are facing under the ACO model?

Dr. Long. Absolutely. And that is where I think we can connect with our community services. You know, we put together a rural health initiative that actually we supported and actually had a nurse going out to farmers in their homes and being able to help manage. So I think there are a lot of creative ways that you can put other clinicians with primary care physicians and expand the reach.

You know, to Mr. McDermott's point, I mean, regardless of technology, medicine is still a pretty high-touch industry. And it was interesting in the New York Times just this past Sunday, you know, they talk about the old-fashioned way of treating diabetes. You can connect and engage people with technology, but you still have to work on all the things that are barriers for them to receive care.

So I think it is very fitting to sort of get back to the basics, if you will, and help people through their psychosocial issues, their depression, their anxiety. And we have shown that we can manage that population.

Mr. Kind. It is also about the vanguard of telehealth too. But I am especially intrigued and excited about the e-visit program that you set up, making it easier for people --

Dr. Long. Another way to get access.

Mr. Kind. Electronic communication to get prescriptions and feedback without having to schedule an appointment, waiting time, and all the hassle that goes with that. So that is something more that we need to be exploring, I believe.

Thank you, Mr. Chairman.

Chairman Tiberi. Thank you, Mr. Kind.

Mr. Smith is recognized for 5 minutes.

Mr. Smith. Thank you, Mr. Chairman.

And thank you to our panel for sharing your insights and expertise. Obviously, a lot of taxpayer dollars are involved and the subject matter here today, and I certainly want to do my part in making sure that it is spent wisely.

A common refrain that I hear when I visit hospitals across rural Nebraska is that the providers and administrators are certainly proud of the equipment that they have, but they are also concerned about their inability to meet the meaningful-use requirements and that they can't even communicate effectively with other providers or hospitals.

And small hospitals have expressed concern that, after their upfront investment, they have to continue paying licensing and maintenance fees on their systems, which certainly can challenge each and every one of their budgets.

Now, based on these concerns, I do have a couple questions, so if you will help me out here.

I hesitate to suggest a one-size-fits-all system, because I doubt that that would work, and I don't know of anyone up here who would support that. But how can we ensure that this technology, which has been purchased, perhaps, can actually communicate one with another or even universally?

Mr. Black. That is fundamentally what we do when I talked about our interoperability platform. I agree that the dollars have been spent, and that is one of the other distinctions that we have as a company is that we don't advocate ripping and replacing electronic medical records. We say the investments have been made. If the record doesn't work or

if you have problems with your current supplier or they have decided not to go for MU3 compliance and you have a problem, go do that. But if you have one, make what you have work and have it be interoperable. And if your supplier does not have an open approach, then we will help you, as a client, get that data out. Everybody adheres to some level, to some form of standards. MU1 and MU2 guarantee that. So we can get the data, and I can emancipate that data, if you will, from the EMR if that needs to be done and there is some sort of effort on the other side from people not wanting to make that available.
Mr. Smith. So are you suggesting that, with relative ease, it can already be done -- ease and/or low cost?

Mr. Black. It is not necessarily easy, but it has been done at scale with a lot of very large organizations and some very small organizations. I have got people as large as HCA that uses our solution, and we have a client up in Vermont, a small 50-bed hospital, that is trying to connect to 45 different physician practices to make all the information in that community available to one another on five different electronic medical record platforms.

Mr. Smith. And I might suggest that facilities do actually get quite smaller than that.

Mr. Black. Yes, sir.

Mr. Smith. And yet I sense they are burdened even more so with the requirements and the mandates and the costs and the hoops, I mean, in very remote parts of our country.

Now, on the topic of cost and so forth, can you demonstrate that there is enough competition in place right now that there is actually downward pressure on these costs? Because, I mean, talking to providers, I take away from them that they are concerned that their costs are just spiraling out of control in an upward fashion rather than more competition, driving down the cost.

Mr. Black. Yeah. There is a lot of competition in these marketplaces. There are over 450 different electronic medical record suppliers that have been certified by the ONC, and there are various different models for pricing in that regard. There are license models. There are SaaS models, which is software as a service.

One of the companies actually offers software for free. They make you look at advertising from PhRMA, but it is a free electronic medical record. So there are lots of different models that have been put out there.

Over time, value, you know, gets displayed by what outcomes you are able to deliver with your client, and that is something we focus on very, very vehemently, which is we want to make sure our clients are successful in using these systems to connect, to transfer data, to look at it from a community standpoint, and then move that information once it has been analyzed back down to that caregiver so they can actually take action at the bedside, at the home, or wherever that might be.

Mr. Smith. Okay. Thank you.

Thank you to our witnesses.

Thank you, Mr. Chairman. I yield back.

Chairman Tiberi. Thank you.

Mr. Blumenauer is recognized for 5 minutes.

Mr. Blumenauer. Thank you, Mr. Chairman.

Mr. Short, I was probably derelict in not mentioning one item here that I think identifies can be as person-oriented approach to sustainable health care, because we have worked with your company, your CEO, Mark Ganz, for years on end-of-life care. And watching what you folks have done on so many different levels to raise awareness, help in terms of policy development, empowering patients is deeply appreciated and I think makes a big difference and illustrates your approach.

I wanted to just delve a little further into one point you made in the course of your testimony, where you are talking about having mechanisms to help people take prescription drugs that have been prescribed, presumably filled. My memory is that about half of them really are not taken.

Now, we can be concerned perhaps about some extraordinary predatory pricing mechanisms on behalf of a few drug companies that raise eyebrows, but this stuff needs to be taken to have the transformational effect. What is it that you are doing that you think is closing that gap?

Mr. Short. You know, in the space of pharmacy, it is the one place where transparency in health care today is absolutely possible right now. And so we started an effort that we call MedSavvy. I mentioned it in my own testimony.

If you think about it today, when someone goes to their physician and is prescribed a medication, a quarter of the time when they show up at the pharmacy, they do not fill it because they were not aware of the cost out of pocket. There is another significant percentage of individuals who do not fill that prescription because of the side effects that are described by the pharmacist. There is another percentage that get home and, because that is in the back of their mind, don't complete it.

And so we have done two things: One, with GNS Healthcare, through taking consumer lifestyle information by connecting with EMR claims data, by looking at just all of our claims data as an organization, we actually look and create predictors for which members, patients, consumers will not take their medications and will not likely show up at the pharmacy, who will stop 30 days later.

And instead of try to create rules-based engines on the back end of all that and reach out to a consumer or to a member to solve the problem after the fact, we have worked to put MedSavvy in the hands of both physicians and the patients that essentially allows all those conversations to be offered upfront when the prescription is being prescribed.

And so when I described the letter grades that we have talked about, literally looking at the effectiveness of medicine, which there is tremendous research on, to understand which drugs are most likely going to be successful and then actually allowing the physician at that time, through the MedSavvy application, to understand what that member's cost is going to be when they show up at the pharmacy, so there are no surprises, because that is the point to have the conversation, not to create lots of hoops downstream.

Now, in the event that a consumer or patient has done all the things right to go home with that medication, through the work that we do in our algorithms with GNS, we do an outreach program. And this is where the human touch comes in, because care is human. And we will have care managers reach out to patients that we know are at risk of discontinuing their medication, asking them how it is working, if there are any complications, so that we can reconnect them with their physician. So that is what we have started in 2015 and 2016.

Mr. Blumenauer. And what are the metrics in terms of the impact? How well does it work?

Mr. Short. Metrics, so the metrics today are that we are in three pilots. We are in a pilot in the State of Idaho. We are in the State of Oregon. So they are both in pilot phases today. We are doing them with delivery systems. And the metrics today are that the physicians that are prescribing medications, a significant portion of the time when they are looking at that are actually having a different conversation with members, and we see an increase.

It is early to tell you from a pilot standpoint what the actual metric will be, but today, there is about 79 percent engagement in the conversation, which is where we believe it starts.

Mr. Blumenauer. And do you involve pharmacists in this?

Mr. Short. We do. Actually, we employ pharmacists that do the work on the development of the programs and services. But from that point, we actually are all about enabling the patient physician conversation.

Mr. Blumenauer. Okay. Thank you very much.

Thank you, Mr. Chairman.

Chairman Tiberi. Thank you.

Ms. Jenkins is recognized for 5 minutes.

Ms. Jenkins. Thank you, Mr. Chairman. Thanks for holding this hearing.

We thank the panel for your testimony and for joining us.

This discussion regarding the use and future of healthcare technology and its ability to drive down the cost and increase access for Americans is a key discussion. I think most people know, in my home State of Kansas, we are one of the top agriculture and aerospace States. But what a lot of folks don't know is that we are a hub for health technology companies as well.

And it is also a very rural State and has many residents that are unable to access needed care to their location away from a major city. And so one of my priorities on this subcommittee has always been to help folks in rural parts of Kansas get the care that they need more easily than they can today.

So maybe my first question would be for Mr. Short. In your testimony, you touched on Cambia's investment in Carena and its ability to allow providers to extend their service area with virtual visits. How will that technology help folks in a place like rural Kansas get better access to better care and drive down the cost?

Mr. Short. Absolutely. It is a great question.

Telehealth today is a great extender outside of a traditional bricks-and-mortar setting in health care, especially in rural areas. There are pilots throughout the country -- we have them in the State of Oregon -- where rural county critical-access hospitals are doing telehealth with their patients that then enables a conversation to occur on whether or not they need to come into, if you will, Portland, a bigger city for more care.

You know, when you think about access itself, I will speak to just seniors -- 6 in 10 seniors today have flip phones, 30 percent have smartphones and mobile devices. And of that, things like Skyping, online chatting, are very, very common. When you think about seniors specifically when it comes to accessing care -- and I think about my grandfather myself -- transportation is a significant problem to get to a facility to have care.

I can remember being 16 years old and my grandfather needing to get to an office visit. And I would get out of school to take him. And guess what? He lay awake all night, worried, concerned, am I going to make it? I will tell you -- he is no longer alive, but I wish we had Carena 20 years ago because my grandfather wouldn't have had to lay awake wondering is a 16-year-old grandson going to show up or not.

And he could have done everything on his iPad. And they have iPads today. Because his conditions, his chronic conditions, which are prevalent in senior populations, he didn't have to go in and be seen firsthand. So when I think of rural areas -- and I grew up in a rural area -- what a great opportunity to extend care. What a great chance to connect

additional care extenders so that it can connect into EMRs to prepopulate, so that when someone, a senior or a patient, ends up in a more critical care setting, all of that relevant information is there so that their treatment plans are holistic in nature and not point specific. So I think Carena is a great opportunity to extend that.

Ms. Jenkins. Great. Thank you.

Mr. Black, it sounds to me like the private sector is working really, really hard to solve this problem exchanging information between providers that we have heard about for so long. Can you just briefly tell us more about the progress and information exchange and what you think Congress should be doing to increase adoption of what is working?

Mr. Black. I think that there is an awareness component here that is startling to me, quite frankly, because a lot of the things that people talk about with respect to the interoperability standards, the issues with regard to interoperability have been solved. And I think that there needs to be a greater awareness of what is happening out there in the small areas as well as the large areas, meaning the very small rural areas that need to have the connectivity as well as the larger organizations.

Unfortunately, there have been hearings and other discussion about data blocking and needed discussions about that because that has occurred in the past. And I think, because of some of these hearings, those issues have been removed, either behaviorally or economically, or in some cases, there has been a way to actually call a hotline and to report somebody that is actually doing data blocking. So I think there are a lot of reports and a lot of data that are out there that would suggest that that has broadly been solved.

I think that the work to be done through the ONC has also done a very good job and the new rules on MU3 actually create another layer of exposure into electronic medical record. So if I am a supplier of electronic medical records, the application program interface is a different layer by which somebody can get into. A third party can get into your record with permission, with security, et cetera, and pull data out. And that is a big component of what is inside the MU3 legislation that I think is very valuable.

The other piece that is inside the MU3 legislation that is very valuable is ability for patients to get access to their data. And at the end of the day, I think this discussion has to center more around the ownership of the data is not a large company, it is not a for-profit company, it is not an electronic medical record supplier, it is not the physician. It is the person. It is the patient. And that is the person that should own it, and everything should be engineered around that experience.

And I am telling you, now with the digital platform, there is going to be hundreds of people that understand that this platform is digital and this platform is accessible through APIs, and there is going to be a wealth of new innovation that sits on top of this thing when we look out over the next 5 years. There is going to be blue-sky efforts. There is going to be all sorts of wonderful things get created as a result of this new platform that this great country has funded in great part over the course of the last 4-1/2 years.

Thank you.

Chairman Tiberi. Good questions.

Mr. Davis, you are recognized for 5 minutes.

Mr. Davis. Thank you very much, Mr. Chairman.

And I also want to thank all of our witnesses for being here.

Dr. Black, it was indeed a pleasure to meet and have some discussion with you yesterday. And I know that Allscripts has made significant investment in finding more effective approaches to treating diabetes, which in some of the communities that I represent, has almost reached what I would call plague dimensions. Could you share a bit more indepth what it is that Allscripts has been looking at in terms of this.

Mr. Black. Yes, sir. Thank you for the question.

One of the things that we have as a byproduct of all this process automation is the data. And so we have, in our capability, over 40 million lives of humans that are out there that we have de-identified the data, and we actually perform a fair amount of research. There are all sorts of tools that data scientists can use to look at data.

I have a thesis. I am going to go in a look for a problem, or I am going to let the data talk to me, if you will. That is called machine learning. And what we are seeing with our 40 million people is, when we have specifically looked at the diabetes problem, is there are seven conditions, seven items or data elements that are out there that are predeterminants of a future diabetic problem.

And so what we are doing is looking for people who have those seven preconditions, where they may not yet be a diabetic, that we are working with them through cell phone alerts or other ways to score them on a health score basis to give caregivers or just the person themselves awareness that they actually are trending towards a diabetic condition.

So that is another use that we talked a little bit earlier. My colleague from Cambia talked about the predicting capability of before somebody becomes debilitized by something as horrible as diabetes. Some of it is genetically engineered, and you, unfortunately, chose your parents incorrectly. Some of it is preventable. And some of this that we are working on has a lot to do with what prevention we can do by the data that will show the actions that you can take to prevent it.

Mr. Davis. Thank you very much.

Dr. Long, you also mentioned high blood pressure and diabetes as an area of significant interest. Could you share a bit what you have been working on?

Dr. Long. Absolutely. Thank you.

Actually, to Mr. Black's point, I think this is a great example of where the technology and the high touch of medicine is still a great example. We are looking at, with this team-based care model, that these clinicians, especially the care coordinators, we have 150 complex care patients that are assigned to, by name, a care coordinator. So they literally develop a relationship.

What the data does is gives that care coordinator real-time point-of-care often information that if you have a diabetic, where are they in the system? Are they potentially going to be admitted to the hospital? Are they high risk for ED visits? So we can actually proactively reach out to these patients and oftentimes using technology in the rural areas, FaceTime, Skype, to interact with these folks and actually help them.

Because what I talked about too -- I didn't get into a lot of the details, but as most everybody knows, there is a lot of the psychosocial behavioral issues that actually prevent these high-risk patients from staying healthy or getting healthy. So this is a great marriage of data and our care coordination function team-based care model to reach out proactively and help those patients lose weight, get on the right diets, and get their chronic illness under control.

Mr. Davis. Thank you very much.

Dr. Black, you also mentioned a bit about clinical trials. And we know that there are some population groups that are reluctant to engage in clinical trials based upon historical acts that have occurred. Does Allscripts do anything to try and convince any of these groups to become more proactive relative to clinical trials?

Mr. Black. Yes, sir. We are very convinced that we can help people identify, if they have a condition that they are suffering from, that your last hope has been exhausted and you now need to look for an experimental clinical trial or to be -- am I a candidate for a clinical trial that is out there, that is something that people have somewhat changed their mind over time.

If I am sick and I have been to my primary care, I have been to my specialist, I am not getting any better, what else is out there? What conditions do I have that are so unique that I am not getting better?

And that is why a clinical trial for us to be able to identify for them a trial that is local, a trial that would meet the criteria that they are currently -- the conditions that they have, the medications they are on, and the, you know, even the behavioral health component. Here is a multifactorial complex problem that you are trying to navigate as a human, and to match them up electronically with a clinical trial is something that the PhRMA industry is eager to do that, and many patients, once we show them the evidence and the data, will be extraordinarily happy to become a participant in.

Mr. Davis. Thank you very much.

Mr. Chairman, I yield back.

Chairman Tiberi. Thank you.

The gentleman from Texas, Mr. Marchant, is recognized for 5 minutes.

Mr. Marchant. Thank you, Mr. Chairman.

I think my fear with all of this technology is that our government programs, Medicare and Medicaid, either have rules or regulations or there is legislation that is necessary to make it so that the doctors and hospitals can fully utilize these new technologies with these kinds of patients. Can I get each of the panel members to talk about that?

Mr. Gallup.

Mr. Gallup. Yeah. It is a great question.

What we see a lot of is a focus on the past. I really liked the comment before where it said, what are you going to do in the next 5 or 10 years? We even think of this idea of telehealth. Telehealth has to be coordinated in a way, and that is kind of where we want to go 5 or 10 years from now, is, how do you coordinate all that, right? So you can have a telehealth visit, but you might need to get them somewhere. How do you get them somewhere? Transportation is an issue. So how do you make that in real time and make that all easy?

So what we are seeing more is, hey, we are so concerned about the past of meaningful use and all these pieces that are going on now, that we are kind of stuck in trying to get to that future. You know, we are talking about $60 billion in fraud. Well, we have a $200 billion in waste just from inefficiencies, at least, that has been documented.

So how do we make all that work together? Our centers are seeing that we can help in the rural communities: 3,000 more patients on average are getting access to care that weren't at the same price, right. We are starting to see a day of length of stay decrease in these hospitals, but also that affects everything else. It means they are going somewhere else.

And so, as we see it, you are right, which is how do we get out of this. We are talking about the fact that we had all this meaningful use stuff and we are stuck in it and we keep talking abou how we should move to that next level. Mr. Black said, that we should start getting value from this. Let's start moving this forward. And these ideas of coordination and command centers that are bringing in telehealth, all the telemedicine pieces that are taking care of the rural communities.

In one of your areas in Texas, there is the greatest example of helping the rural communities and helping those hospitals that are small, working together with large hospitals that I have ever seen. It is amazing, and sometime, I would love to share it with you because there are many, many, many, many patients and beneficiaries in Texas who are getting access to care that they wouldn't have had by all this coordination.

Mr. Marchant. Thank you.

Mr. Short.

Mr. Short. I would just add, really moving to a place where we allow incentives to drive the innovations. Certainly, there are many capabilities that are coming to market that there are rules and there are regulations that make it challenging, especially when it comes to programs like Medicare.

What I would offer up is that because these are new, the rules aren't set yet, and we don't know necessarily how to think about how to approve new concepts that are coming to market. We have to ask ourselves those questions. We have to ask ourselves the questions on, how should we regulate them? How should we allow regulatory processes to put in place safeguards at the same time?

I think we have to rethink how we do that so that the innovations can get into the marketplace, and this is new ground.

Mr. Marchant. Mr. Black.

Mr. Black. We have 45,000 physician office practices, small group practices throughout the United States. One of the things that they are worried about today is the macrolegislation with respect to the reporting requirements that they are going to have on their end.

And what I would hope is that, as we pass this legislation and as we are monitoring and measuring the compliance with it, that we don't make the reporting burden such that a small group physician practice participant says: I am out of here. I am done. I am going to retire early. I don't want that to be the last straw, if you will, that broke the camel's back.

So great legislation, great capabilities, technologywise, et cetera, that are in that really will help suppose this digital layer better that is out there. But we also need to make sure, from a workflow standpoint, we don't add additional burden to that small physician office practice, who is already very, very stressed today to take care of the patients that they have and to do the important clinical reporting. But for a small office, that is a burden that we have to be very, very careful about the tipping point of asking too much from a regulatory standpoint for these folks to report.

In this country, there are a lot of independent farmers, there are a lot of independent physicians that are out there, and it is a noun and a verb, as we call say with regard to these guys. They are still independent after, you know, the last 6 or 7 years. That is something they absolutely want to be. And I hate to have anything that we have collectively done force them to have to either quit the practice or I have to be employed by a large local organization, a large health system, or a large clinic practice if that is not really what I wanted to do.

Chairman Tiberi. Thank you.

The pride of Paterson, New Jersey, is recognized for 5 minutes, Mr. Pascrell.

Mr. Pascrell. Thank you, Mr. Chairman.

Mr. Chairman, the panel is great, and thank you for putting us together.

Our healthcare system is undergoing a very fundamental shift right now by revolutionizing the way we pay for and the way we deliver health care. The Affordable Care Act laid the foundation for building a healthcare system that rewards quality outcomes and smart spending rather than the volume of services provided. And I am glad that the innovators are here today.

The next step is promoting what I would consider further integration of innovative technology into the healthcare system. Health and medical technology has evolved rapidly over the recent years, which has resulted in, I believe, an improvement of patient care. I believe we must think critically about how to force their technology in order to improve the patient's experience.

Mr. Short, one of your company's technologies, which you wrote about in your written testimony, the Caremerge tool, allows everyone in a patient's life, from the doctor to the insurer to the family member, to access information about the patient's care. Over the years, I have met with a lot of constituents, by the way, who have told me their stories about caring for family members and the hazards of it and the problems of it, challenges.

Can you briefly discuss some of the benefits that the technology your company has developed can have in supporting family caregivers -- very important, there is more and more of them -- in possibly making a very difficult job a little bit easier?

Mr. Short. Thank you. It is a great question.

And I would say on two fronts: You know, first, Congressman Blumenauer a few minutes ago talked about our palliative care, end-of-life work. One of the places that we acknowledge is that palliative care is best between family members and physicians.

So the first thing we did was we actually, through the Cambia Foundation, funded grants all around the country to delivery systems to actually rethink about the holistic

end-to-end care, including how you bring family members into that process. It eliminates confusion. It eliminates waste. And it allows you to focus on outcomes.

So we have done that through our grants. It is something that we are several years into now and it is working very well. At the same time, we recognize that capabilities, like Caremerge, are necessary so that, depending on where people live and where they work and where they call home, and family can be connected with the physicians.

So, in the case of Caremerge, we are actually working with acute-care facilities, who are working many times with frail situations and allowing everyone to be on a common page, if you will, about where a patient's or family member's care is currently at.

Mr. Pascrell. One of the shortcomings of the Affordable Care Act was dealing with the acute care and everything extending from that. And we could have done a much better job. We tried, but it didn't work.

Mr. Long, in your testimony, you outlined a care model, ThedaCare, in using what couples team-based coordinated health care with additional support services in intensive case management for complex patients. That is not easy. I know that. That includes providing assistance with basic needs, as I understand it, like housing and life skills to manage stress, to manage anxiety, and addressing emotional support needs of caregivers, many times not even discussed.

So, in your experience, has helping connect patients with these types of resources, would you consider that a positive impact on what we are talking about here today?

Dr. Long. Oh, thank you for the question.

Absolutely. As you mentioned though, it is resource-intensive, and I think that is where the challenge comes in, is, how do we support the resources to decentralize what has typically been central care coordination, central social workers, and actually putting them where these complex patients are in the healthcare system.

So we have had an incredible impact. And if you think about population health, I think of it, you know, as three concentric circles: We have our clinic. We have our specialty caregivers. And then we have the community at large. We are probably remiss in not taking advantage of all the community resources that actually can help our patients quite dramatically, so that is a fundamental thing that we are focusing on to help leverage being able to care for them.

Mr. Pascrell. Thank you.

I yield, Mr. Chairman.

Chairman Tiberi. Thank you.

The gentlelady from Tennessee, Mrs. Black, is recognized for 5 minutes.

Mrs. Black of Tennessee. Thank you, Mr. Chairman. I want to thank you for holding this very important meeting today, because it really does encapsulate the future of health care, the things that we are talking about here today. So many times we argue across the aisle, but I think this is one that we can all agree on that is the future of health care and that we need to get behind and make sure that we are listening to people like you that are out in the field and are so creative and innovative.

I want to say, Mr. Gallup, I am really excited about your TeleTracking because I am an emergency room nurse who would call the floor and say, "I have a patient ready for you," and they would say, "That bed is not ready yet." And you would call an hour later, and they would say, "That bed is still not ready yet." Boy, the thought that I could look on some screen and say, "Wait a minute, there is a green light there so I am bringing the patient to you," it is exciting.

I think, Mr. Chairman, we probably ought to take a road trip so we can see all this technology actually working, so I am all in for that.

One aspect, a major aspect of health IT that I have been particularly engaged in is the telehealth. And I know that Ms. Jenkins started to talk about that and worked very closely with one of my colleagues here on Ways and Means, Mr. Thompson, on this topic. Earlier this year, we introduced a comprehensive bipartisan, bicameral piece of legislation once again showing that this is an issue that both sides care about.

The bill, called CONNECT for Health Act, was endorsed by about 100 organizations from all over the spectrum in health care. It actually showed a study that was done by Avalere that you would actually save about $1.8 billion over 10 years if we were able to put this into place.

And, Mr. Short, you talked about how you wish that your grandfather would've had access to some of the kind of telehealth that would have given him more assurances. And having two parents that are 91 years old and seeing what kind of technology is there and available for them is exciting. But it has got a lot of barriers there.

And until this comprehensive bill actually is able to be passed, what I would like to ask of you all, in particular looking at remote patient monitoring, which is one that is really near and dear to my heart because I do have a rural district where I know this would really help -- getting patients 45 minutes to an hour and a half to a facility is very, very difficult, on windy roads, especially, when they need to be seen several times a month or whatever by different practitioners. What I would like to have each of you talk about, until we can get to that point where we can pass comprehensive legislation, what are some of the small but constructive steps that we could take today to begin this process of putting in and expanding life-changing telehealth services?

And, Mr. Long, if I can start with you, since we seem to start at the other end, and just go down the aisle. And I know I don't have a lot of time left, so Mr. Long, briefly.

Dr. Long. Yes, thank you.

Well, I think, as I mentioned both in my verbal and written testimony, the things aren't really that complicated that can get us a lot of leverage. So, whether it is the simple things like a low-cost e-visit to the very complex telestroke, it is all about keeping people where they are and not having to have them travel.

Interestingly, I found in some of our rural areas, though, one of our simple barriers is that people are still on dial-up Internet, and it was somewhat surprising to me that there are still pockets of our remote areas that don't have the luxury of the high-speed Internet. And I know there is some talk about, how can we change that?

Mrs. Black of Tennessee. Yeah.

Dr. Long. But I think the technology exists, and I think providers and patients are eager for it. So some of it is just kind of fixing some of those infrastructure --

Mrs. Black of Tennessee. Get CMS to agree to pay for it.

Mr. Black.

Mr. Black. I think there has been a lot of discussion about telemedicine and the fact that people haven't been paying for it. I think a lot of innovators have bypassed the payment component. Obviously, folks to the left and to my right have actually figured out to way to do that.

And the dollars that people spend on a visit, whether it is a consumer or their practitioner, they quickly get passed the, "I have got to bring the patient in order to see them, in order to get paid," if, in fact, they are taking care of the patient in the way that they want or it is some sort of financial risk for them.

There are lots of different ways you can connect to these people. The wearable component as well is another thing we haven't talked about today. When you talk about remote patient monitoring, that is a big piece. You can connect that to the caregiver or some sort of central facility. There are a lot of clients that are out there that are doing that today in a hub-and-spoke environment.

I have got a brother who farms. I have got uncles who farm. I grew up in Iowa, so I know a fair amount about what it is like for people who don't want to get in a car, who are scared. They don't want to go to a big city. You know, when they get there, they are lost. You know, they don't like it.

And so I have been actually, just through the years of knowing what is out there in the marketplace, I also have been having some preliminary discussions about how about repurposing some of the room inside the ASCS office. There is one ASCS office in every single county in the entire country. They have broadband. They have got this. They have got that. And it is a familiar place.

People like the ASCS office because they know that is where people have historically given them money; they go for education, et cetera. And you could have a quick clinic, perhaps, there, and you might have a place where you could go plug in to get monitored or have your televisit at that facility if you don't have broadband at home. We are not going to get broadband in the entire country like we put the Rural Electricity Act in the 1930s. That is not going to happen for a while.

Mrs. Black of Tennessee. Well, thank you.

And I know I have run out of time, so Mr. Short, Mr. Gallup, if you have other suggestions, would you just jot them down and send them back here to the committee? I certainly would appreciate that.

Great suggestion.

Mr. Black. Thank you.

Mrs. Black of Tennessee. I yield back.

Chairman Tiberi. Thank you.

The gentleman from Minnesota, Mr. Paulsen, is recognized for 5 minutes.

Mr. Paulsen. Thank you, Mr. Chairman, for holding this hearing. This has been a great panel, very interesting.

We talked earlier about and heard some comments about the legislature and Congress lagging behind innovation. It is interesting because a technology entrepreneur once said that innovation is the ability to challenge authority and break rules. And as a result, there is often this conflict between what government does and what innovators do. Government, of course, makes rules, and innovators are all about breaking the rules to create something new.

And innovation, when it is happening in such a fast pace and rapid pace, if we are not paying attention, if government is not paying attention, when, where, and how this innovation is happening, we are missing out on the opportunities.

I will start with Mr. Short, but others may have comments -- you know, just from a cost perspective and the challenges we have within Medicare where there are so many regulations, for instance, what can the Medicare program be doing to collaborate better

with the private sector, for instance, to support better engagement, to have more superior results? Or vice versa, how can Medicare adopt what the private sector might be doing in this respect as well?

Mr. Short. It is a great question.

Medicare has the ability and is frequently a significant influencer of care practices that are adopted across this country. And so, to the extent Medicare in a rural setting allows for innovations, even on a pilot basis, to be launched, deployed, that then again we could come back to and say, "Well, how should we think about rules and regulations that would allow for the further adoption of those capabilities," could really ignite greater levels of innovation when it comes to, you know, creating access.

But most importantly, I think what we can continue to do, certainly with the amount of baby boomers who are aging into Medicare, certainly with cost challenges of Medicare, there is going to be tremendous institutional focus, whether it is about payers or providers or delivery systems.

I would just encourage all of us to remember at the end of every one of these institutions is the patient or the consumer. And every one of us in this room have a story that we face when it comes to a loved one, and a family, a friend. And so many times, if we would put ourselves in the shoes of understanding that situation, the innovation becomes bright, and it becomes clear on what needs to be done. And I would encourage us at each and every day to do that first and foremost, because good things come from that.

Mr. Paulsen. Good. Any other comments off that?

Mr. Black. Although, Medicare, the payer, that everybody pays attention to, so you have the economic club, if you will. And I think that the innovation that has been attempted through many of the different -- whether it is the Pioneer ACOs or those other structures have been set up over the course of the last 5 to 10 years -- have been, I think, very influential in moving from a value-based or pay-for-performance or pay for quantity to pay-for-performance methodology.

We have got a lot of folks in Tennessee. The folks got together there to get 22,000 people to be part of their cohort. They have got one primary practice, 160 docs. Now they have 1,200 docs in the State of Tennessee that have got together through an interoperability platform, and they connect the information to take care of these 22,000 people in remote areas. And they are one of the top five in cost and one of the top 30 in quality in the State like Tennessee, where they have very little infrastructure in place.

So there is a lot of innovation that is out there. I think that the structure that has been set up by Medicare is very valuable, and what has gone with CMS on the payment side has been incredibly influential in the innovation that has been spurred. And I would suggest that that rate of innovation and funding continues.

Mr. Paulsen. And, Mr. Short, you commented earlier about chronic care. And I think, obviously, with the demographics as you mentioned, 10,000 baby boomers retiring every day, chronic care management and coordinated care is the solution or the answer we need to focus on if we are going to be able to redirect dollars in a more cost-effective manner within Medicare.

And, Mr. Short, you said let incentives drive innovation. And obviously, piloting, letting Medicare pilot things is a good way to do so. Is there anything else that we can do to actually incentivize innovation in the market?

Mr. Short. I think there is always a lot to be thought of around innovation. I would say, top of mind, when you think about payment reforms that have passed to date and what is to come of that, I think continuing to see those through when it comes to how payers and providers collectively pay for service, I would say, looking over the next 2 to 3 years -- we talked about ACOs earlier today, in terms of how they perform and what is working, what is not working -- many times we will run on to the next innovation before we complete a current one. And I would say see through the current innovations as well in making sure that we deploy and scale some of them. Because many of these have the ability to be scaled, especially as my colleague, Mr. Black, talks about the interoperability. I think there are tremendous innovations on interoperability to come in terms of chronic care management across the population.

Mr. Paulsen. Thank you, Mr. Chairman. I yield back.

Chairman Tiberi. Thank you.

And last but not least, the pride of Butler, Pennsylvania, Mr. Kelly, is recognized for 5 minutes.

Mr. Kelly. Thank you, Mr. Chairman.

I want to thank all of you for being here today.

I think it is interesting. When I first ran for office I was really trying to champion what we do in the private sector. And I had people constantly tell me: You know your problem, Kelly, is you don't get it. Look, the government can't be run the way the private sector is run.

And I have said: No, it is just the opposite. That is the antithesis. The private sector can't possibly be run the way a government does.

There is a handout. I think, Mr. Gallup, you provided it. Here is where the rubber meets the road: It is not about the money that we spend; it is about the money we spend that is used inefficiently and ineffectively.

So, if you could, just kind of walk us through this, because I really don't understand how people can indulge in deficit spending, not year after year but decade after decade, and build a long-term debt that we know is going to sink our country, and say: You know, the problem is we are just not extracting enough money from hardworking American taxpayers. These people are going to have to cough up more money to support our inefficiencies.

I think this is really stunning, and this really gets to the thing. Listen, is it about policy? Yes. But more importantly, it is about people. It is about people.

Mr. Short, your grandfather, my father-in-law, this didn't have to happen. You know, it wasn't because they weren't spending money. It is because they were ineffective and inefficient, something we can't tolerate in the private sector. Well, you can, but you can't do it long because you go broke.

Mr. Gallup, when I look at this, this is incredible. The United States of America -- now, Pat, listen to this -- out of 51 countries, the United States of America ranks 44th out of 51, and we have really worked hard. We have been able to beat Bulgaria, who is number 45, and we are just about catching up with the Dominican Republic at 43.

And it is hard for me to sit here and look at who we are and what we have been and how we have led the world in everything. Gosh, we can put a guy on the moon, but we can't get him through the emergency room. We can invent the Internet, but we can't get people through the hospital system. What the heck is wrong with us?

But look at the spending. It isn't for lack of investment. Mr. Gallup, kind of walk us through this, because this is stunning, and it is also damning. It will ruin this country. If you can. This is incredible.

Mr. Gallup. I think you just did a great job of it. I mean, I think the best thing I would do is quote our clients, right. They know what is going on. And I think even the last Medicare question is very interesting where, what should we do about innovation? We shouldn't penalize people for coming up with innovations, right, number one. So if someone figures out how to do something better, the first thing we are going to do is cut, right, and that kind of scares people.

But as we quote our clients, they will tell you the money is in the system, right. They will say that. It is exactly what you are saying. There is enough money in the system to get the patients through and give them the care that they need if we cut out the inefficiencies.

To your point, we know that the CBO says 41 percent of the future of our hospitals are going to be running in the red. Why? Is it the funding issue? Or is it the fact that we don't have the right models in place, that we don't have the right efficiencies put in place, and we haven't decreased the cost of an adjusted discharge, right? We have enough.

And I think Chairman Tiberi saw this, right. There are enough bricks and mortars. There is enough out there to be able to go and do this. This isn't about cutting resources. You know, we have a doctor shortage. We have a nurse shortage. We have all these shortages out there. How do we fix that? Well, let's get them more productive.

Every study you see out there, a nurse is 30 percent productive. The other 30 percent we have got them stuck documenting. The other 30 percent they are out there trying to -- and I know that isn't at 100, so it is 33, 33. But the point being is they are out there finding stuff, wasting their time.

So, if we can take labor and help them become more productive, we can help doctors become more productive and not doing things they don't want to do, we then get more patients through at the same price. And that is what we have proven to NHS. That is what we have proved that many clients will stand up and say this is working for them.

We are seeing thousands of more patients not just in the clinics, not just in the hospitals but in the clinics also. And that is what is going to cut the cost, right. If we can get more through at the same price, we have solved a lot of our problems.

Mr. Kelly. Anybody else? Because you all have the answers. You have the answers. It is just, are we listening, and can we come up with a legislative fix to it? And I am saying, we have to do it, or we bankrupt our Nation.

Dr. Long. Mr. Kelly, I am not sure if I am allowed to say "hallelujah," but I am thinking it with your comments. But I think if you piece together all the great work that many organizations like these folks represent, I think the roadmap is out there. We all see the waste. We are all trying to improve it.

My impression, even if you look at what the Pioneer has done, it is trying to look at where everybody is delivering care and try to do something that will work equally for everybody, and that is where you probably leave out those that are doing the best work and not trying to figure out how they could help create the roadmap that really needs to be the long-term blue sky.

So I think the information is out there if we can piece it together with folks like that are at this table. You know, I don't think it would be that hard to do. But I appreciate your comments.

Mr. Kelly. Well, I can't tell you how much I appreciate your being here.

And, Mr. Short, we are going to run out of time. But let me just say this to you: It is only over when we decide it is over. It is our ability to stick to the message and stick on course and make sure that we fight this to the very end. This is a win for every single American. It does not matter to me how they are registered, by the way. We can win this battle. The big thing is we just have to refuse to lose. We can win, and we can win for every single American.

Thank you all for being here.

Mr. Chairman, thank you so much.

Chairman Tiberi. Mr. Kelly, would you like to submit those statistics for the record?

Mr. Kelly. Yes, I would love to submit them for the record. Thank you.

Chairman Tiberi. Without objection.

Chairman Tiberi. Thank you, Mr. Kelly.

I want to thank the four of you today for spending some time with us. To just piggyback on what Mr. Kelly said, you give us hope. You give me hope. These are such important issues. And innovation is a key, I think, to solving this problem, and you guys are the forefront of that. We have only begun to touch these issues, and we are going to dig deeper into these issues in the future, and I hope you stay in touch with us as we do that.

Before we adjourn, not knowing exactly what the calendar looks like the rest of the year -- and I am not in the prediction business -- and not knowing then if we might have another hearing or not, I want to take this opportunity to thank Dr. McDermott for, yes, your distinguished service to this Congress over the years, 14 terms to be exact. It has truly been -- underline, bold -- an adventure working with you.

I hope that, as you leave this body, that you believe that our disagreements -- and there have been many -- are heartfelt. I believe that your views are heartfelt, sir. And I also wish you the very best in your next steps.

You may.

Mr. McDermott. Mr. Chairman, I didn't know this was my swan song.

Chairman Tiberi. It may not be. There may be another one.

Mr. McDermott. I know sometimes you hope it would be my swan song, but it has been a pleasure serving on this committee. When I came to Congress 28 years ago, I made up my mind I was going one place, which was to the Health Subcommittee, the Ways and Means Committee. It took me a while to get there, and then it took me a while to get next to you.

But I believe that this area is such a large part of our economy as well as such a large part of our question of national security and how we take care of Americans that it is central to making decisions that affect every single American.

Leaving the Congress, I don't leave eagerly or glad to get away from it or anything else. I am sorry I am not going to stay because the development that we are talking about here today is going to go on and on, and it is going faster and faster.

When I went to medical school and graduated in 1963, the only thing that was left was anatomy. And even that has been changed by now. They are changing so many body parts that it is hardly the medical school I went to. But this committee has the potential of doing more good for the American people than perhaps any other single subcommittee in the Congress.

Chairman Tiberi. We agree.

Mr. McDermott. It has been a pleasure to serve here with you, even though sometimes you are wrong.

Chairman Tiberi. I will let that go.

Please be advised that members will have 2 weeks to submit written questions to be answered later in writing. Those questions and your answers will be made part of our formal hearing, as is your testimony. Thank you.

With that, the subcommittee stands adjourned.

[Whereupon, at 11:57 p.m., the subcommittee was adjourned.]

Questions for the Record

Public Submissions for the Record