



June 22, 2015

The Honorable Orrin Hatch
United States Senate
Washington, DC 20515

The Honorable Ron Wyden
United States Senate
Washington, DC 20515

The Honorable Johnny Isakson
United States Senate
Washington, DC 20515

The Honorable Mark Warner
United States Senate
Washington, DC 20515

<Submitted Electronically>

RE: Chronic Care Reform: Stakeholder Feedback

Dear Chairman Hatch, Ranking Member Wyden, Senator Isakson, and Senator Warner:

Cerner commends the U.S. Senate Committee on Finance for its recent formation of a bipartisan chronic care working group to analyze current law, discuss alternative policy options, and develop bipartisan legislative solutions. We appreciate the Committee's perspective to approach chronic care reform thoughtfully and critically, as well as its efforts to solicit feedback from public and private stakeholders before introducing legislation.

Cerner has a 35-year history of creating value for clients by providing innovative solutions and services that help health care providers around the world increase safety, improve quality and reduce waste. Our solution offerings span all hospital departments, ambulatory practices, employer sites and retail pharmacies. Cerner is well-positioned to help our clients be leaders in health care delivery and population health management today and tomorrow. We are dedicated to developing our vision of the next-generation platform above the EHR to manage the health of populations, and the next generation of clinical computing capabilities that include making insights from health data available and executable at the point of clinical judgment.

Beyond our role as a health IT company, Cerner is a health company. We understand managing a wellness-focused population through our experience with our own employee population. In 2002, we recognized that our healthcare costs were on an unsustainable path. In the following years, we created personalized plans for individuals and entire populations. Our health and wellness program encourages positive health behaviors; participation in the program has been shown help keep associates on track. Looking at a consistent population of 1,946 associates who were active in Cerner's wellness program for 5 years (2009 to 2013), 71.6% improved or maintained their health status on five clinical risk factors. In addition to improving the health of our employees, we have recognized \$110 million in cost avoidance. What ultimately matters with this work is that we are now predicting and managing chronic conditions in a more meaningful way for our employees.

As the Committee is fully aware, the Health Information Technology for Economic and Clinical Health (HITECH) Act outlined the nationwide adoption and meaningful use of interoperable electronic health records through the CMS Medicare and Medicaid EHR Incentive Program (Meaningful Use). This \$30B+ to-date investment has enabled providers and hospitals nationwide to digitize an astounding amount of clinical data, exchange critical patient data across organizational boundaries, and integrate decision support and chronic care management tools.

Rapid, smart technology innovations - such as mobile medical devices, home monitoring devices, consumer apps and wearables - allow patient data to be generated and captured outside of the EHR workflow or by non-provider sources. As government and industry evaluate next steps toward ensuring maximum value is attained from the investment in the nationwide adoption of EHRs, *Cerner encourages the Committee to adopt - as a core principle - policies that support private market-led innovation beyond the HITECH programs* to leverage valuable EHR data, realizing transformative innovations in patient care, including personalized health, clinical research, drug safety, and population health management.

Technology plays a critical role in supporting people and process. Without engaged users, real-world workflows and sustained value delivery, technology is not much more than an expensive shiny object. Overall, we encourage the Committee to resist focusing on technology features and functions singularly, independent of comprehensive actions involving the support of people and processes, to motivate providers toward chronic care management activities.

Please find attached brief comments to your May 22, 2015, open letter to stakeholders, focused on four key areas: people, processes, patients and technology.

Cerner applauds the efforts of the Committee to discuss and debate chronic care reform by seeking input from industry stakeholders. We welcome the opportunity for further discussions with you and your staff. Please do not hesitate to contact me at the information provided below for any additional information or to answer any questions.

Sincerely,

A handwritten signature in black ink that reads 'Meg Marshall'.

Meg Marshall, JD
Director, Cerner Health Policy
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People

Primary care providers are the front line of chronic disease prevention and management. Current fee-for-service reimbursement models have traditionally devalued that role, driven physicians away from primary care, and stretched the primary care workforce so thin that there is little capacity to do more than put out today's patient care fires.

Cerner recommends the Committee should recognize the need to support the primary care workforce through reinforcements, additional training related to complex chronic care management, and additional funding to provide some breathing room to implement and use systems to proactively manage patients and their health information.

Chronic disease management is an ongoing and time intensive process that cannot be achieved successfully by physicians and patients alone and often overwhelms the skills and resources of family members/caretakers.

Cerner recommends the redefinition of roles and responsibilities of the care team by placing patients, physicians, and coordinated care plans at the apex, and critically incorporating care managers, public and community health workers, facility and home-based nurses, and ancillary care providers in a collaborative team to deliver defined and measured outcomes.

Processes

Sustainable systems are complex with multiple competing influences constantly rebalancing one another. Fee-for-service and capitation models have not provided appropriate alignment of payment and desired health outcomes promoting over-utilization and under-utilization respectively. A "blended" payment model has been promoted by several interests and acts to create a self-balancing ecosystem.

Cerner suggests four components must be positively incentivized to provide a sustainable balance and alignment with Medicare program goals: 1) care management; 2) direct services; 3) measured performance; 4) patient engagement [care plan compliance].

That Medicare beneficiaries have multiple conditions is the rule and not the exception. CMS and Congress may determine one thing or another about paying for individual services for specific conditions or for venue specific services, but strong recognition must be given to the point of coordination necessary to manage across them. Cerner understands there have been efforts at experimentation and demonstration projects with different forms of episode-based payment for chronic care conditions or for shared savings efforts for patient populations with chronic conditions, but current approaches to chronic care ultimately fragment the patient experience based on condition-specific, specialist driven care.

Cerner strongly recommends a well-defined model of paying for the value of chronic care management by an assigned point of responsibility that covers coordination of all of the multiple conditions a patient may have. More specifically, a focal point for care management that provides portability of a coherent record maintained on behalf of the multiple-chronic disease troubled Medicare beneficiary.

Patients

Greater patient engagement contributes toward improved health and health outcomes. We recognize that the industry has seen tremendous success from the requirements of the EHR Incentive Program's Stage 2 that provide patients the ability to view/transmit/or download their own health information; however, these specifications for patient engagement have fragmented the health information that a patient can access, since he or she is required to use a provider-specific access path to view a particular subset of their data. Just as interoperable health records enable providers to see the 'whole picture' when diagnosing and treating, they should also provide patients with the ability to view all of their information from one access point.

Broadly speaking, the industry should seek a more efficient point of aggregation for a patient's point of access than what has been achieved through this mechanism. The EHR Incentive Program focuses on provider-specific "slices" of data to be made available through a means provided and controlled by the provider, which is woefully inadequate for patients with multiple chronic conditions managed by multiple specialists.

Cerner recommends the Committee supports a beneficiary-focused aggregation point of information access as an appropriate role for the payer, including support for Medicare beneficiaries to change plans without major disruption.

Patients need access to cost, quality and safety data related to the providers and hospitals in their region in order to make effective decisions and create market pressure for safer, better quality care at a lower cost. In an effort to promote transparency among providers and consumers and encourage diligent use of health care resources, physicians' fee schedules/pricing and reimbursement data should be more transparent.

Cerner recommends that the Committee supports policies that require transparency of key data to patients, including appropriate tools and education to understand how to better their choices.

Inconsistencies in various state and federal privacy laws pertaining to sensitive health information such as that protected under 42 CFR Part 2, 38 CFR Part 1, emancipated minor-related data such as reproductive health, and other common sensitive data types and conditions, are obstacles to widespread health information exchange and may hinder a provider's ability to manage chronic conditions across all venues. A nationwide, privacy-focused legal framework is needed to create true interoperability across all venues of care and all types of health information.

Cerner urges support for the integration and exchange of all types of health information through efforts to support harmonization of state and federal privacy laws.

Accurate patient identification is crucial to ensuring the right health data is available to the right people (providers, organizations *and* patients) at the right place, and at the right time. Cerner strongly believes in the need for strong patient identity management. In March of 2013, Cerner co-founded the CommonWell Health Alliance, along with AllScripts, athenahealth, CPSI, Greenway, McKesson and Sunquest. Since then, CommonWell has aggressively facilitated the exchange of clinical data across EHR systems and care providers. A key feature of CommonWell's offering is a national patient identity management service, facilitated by a patient's voluntary decision to allow CommonWell providers to use one of the patient's "strong identity cards" (such as a driver's license) as the key to link the patients encounters together, no matter which provider they receive care from.

Cerner strongly urges Congress to remove the current prohibition on expenditures related to the study and development of a National Patient Identifier, and to support private market initiatives that address issues of patient identification, record locator services, and consent management.

In our experience, nursing homes and long term care or assisted living facilities generally lack the capital, the skills or the capacity to provide bedside services to the patients, and transporting sick and vulnerable can be painful and involve significant risks to the patient's physical health. Further, use of telehealth can overcome boundaries for those in rural and underserved areas.

Cerner strongly recommends strong support for access to remote and tele-health based solutions, particularly to address non-acute care and non-invasive care involving expensive procedures.

Focus on Technology

Data stored in today's medical records has been historically defined by reimbursement and regulatory requirements. Clinical relevance is contained but deeply submerged and often inextricable from lengthy, boiler-plate documentation created during face-to-face interactions. The true "patient story" must be collected and told through focused narrative and evidence-based clinical data elements that promote analysis, understanding, action, and authorized sharing. Tools must be available to not only collect and organize information from the patient (whether face-to-face or remotely) but to deliver best available evidence and optimized care plans to be applied to the patient.

Access to care, to data, to best evidence, to measured outcomes, and to each other must be delivered by innovative tools and technologies that are broadly available and intensely usable for all healthcare stakeholders.

Cerner recommends the Committee supports - as a core principle – ongoing private market-led innovations in health IT that support provider workflow, without prescriptive regulations detailed features and functions.

As the health care industry shifts to a value-based payment system and healthcare providers take on more risk, the need for access to accurate information from a variety of sources increases significantly. New risk-sharing models continue to replace fee-for-service plans, meaning physicians are compensated based on patient outcomes or total cost control. Consequently, if they do not have access to data that demonstrates their ability to deliver effective patient outcomes, their reimbursement and patient volume levels decrease.

Data critical to chronic care encompasses many technology types and sources, a list of which is included below for the Committee's consideration as it approaches support of technology thoughtfully and with an eye toward the future.

Electronic Health Records: A patient's electronic health record (EHR) is more than a digital version of his or her paper chart. An EHR contains codified medical history, diagnoses, medications, treatment plans, immunization dates, allergies, radiology images and laboratory and test results, and also allows access to evidence-based tools that support providers as they make real-time care decisions. EHRs are built to be interoperable – to exchange critical information with providers and organizations across the patient's entire continuum of care, including with laboratories, specialists, pharmacies, workplace clinics, behavioral health clinics and long-term care facilities. *Clinical data should always flow unimpeded to wherever it is needed for direct clinical care/treatment of the patient.*

Traditional Medical Devices: It is our experience that currently only a small percentage of the data from the medical device ecosystem is captured in the EHR. Innovative technologies meaningfully integrate the deep information from diagnostic and monitoring devices with the EHR in order to advance the precision of therapeutic medicine. *The integration of devices with EHRs allows the awareness of clinical context across devices, leading to a positive impact on patient outcomes, such as smarter alerts and algorithms.*

Mobile Medical Devices/Consumer Apps: Not all information is stored in an EHR or captured during a patient encounter. Rapid innovations in technology allow useful data to be generated and captured outside of the EHR workflow and by non-provider sources, such as mobile medical devices and consumer mobile apps. For example, devices that individuals carry or wear, such as heart rate monitors and pedometers, generate information that can be valuable indicators of a patient's health status, especially when the patient is managing a chronic condition. Health apps directed at consumers enable individuals to capture additional data, such as diet, exercise and blood sugar levels. *Device technologies that enable patients to share captured or generated information with their providers permits providers to engage more effectively with their patients.*

Patient-Reported Outcomes and Satisfaction Data: Patient-reported outcomes and satisfaction are key aspects of everything from finding the right treatment, providing feedback on the patient experience with the provider, to facilitating comparative effectiveness research. *Government-funded research efforts such as that underway at the Patient-Centered Outcomes Research Institute (PCORI) will help to advance the capture and analysis of patient-centered outcomes, which will help patients and their providers make informed decisions.*

Hospital and Physician Outcomes Data: Public reporting of health outcomes motivates internal quality improvement, as well as steers individuals (and payers) toward high performers. Whereas the need to capture quality data is clear, in our experience the existing quality measurement programs can be very confusing or even contradictory, with overlapping and inconsistent reporting requirements between different programs, and with redundant and burdensome data collection requirements. Providers face demands to support venue-specific measures, episode-based measures and population-based measures for many of the same high cost, high prevalence - in the Medicare population - conditions. *To make these data sources more usable and provider*

efforts leveraged as to their collection, we encourage harmonization of quality measurement requirements, and encourage measurement systems that focus on quality of care measures that span venues of care to better measure the continuum of care.

Patient Safety Related Incident Data: Data related to patient safety events and near misses are not reported, aggregated or made available consistently or in a transparent manner. Currently, FDA MedWatch collects information related to medical devices, and some provider entities share patient safety information with Patient Safety Organizations. Efforts such as the LeapFrog's Hospital Safety Score™ rate hospitals based on voluntary survey responses; however, *more needs to be done to make this data available to patients, providers and payers in a standard manner.*

Payer Data: Both government payers (such as Medicare, Medicaid, Veterans Affairs and Department of Defense) and private payers hold valuable data relative to cost, quality and utilization. Claims-based data can also help employers, providers and hospitals know, manage and ultimately improve the health of their populations more effectively. Oftentimes, payers are reluctant to release data related to their patients, plans and providers, or the availability of the data is hindered by proprietary technology or expensive business requirements. *Cerner strongly believes that, like HIPAA-mandated provider-captured data, payer data should also flow unimpeded for treatment and payment purposes, including population health activities.*

Social Determinants of Health: We are increasingly finding the value of incorporating an individual's social determinants of health (the conditions in which a person is born, grows, lives, works and ages) with clinical data. This data can be found in community-based sources such as churches, schools and workplaces, but also in government data sources. *Cerner strongly supports activities that encourage integration and utilization of data from these non-provider sources.*

Social Media Sources: Platforms such as Facebook and Twitter allow individuals to reach across geographical boundaries to share and access information that may indicate or affect an individual's health or a community/public health occurrence. Providers are increasingly monitoring their patients through social media, leveraging it as an additional communication mechanism and source of data.