



Just Say No to Bolt-On Payment Reform IT:  
Value-Driven Disruptive Business & Operating Models  
and the Super-Charged, Agile, Enabling IT Infrastructure

Accountable Care and Health IT Strategies Summit  
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Dossia Consortium

What is the Dossia Consortium?

Meeting the expectations of consumer/patients in a transformed health experience

A 'tough love' employer assessment and expectation perspective of the health delivery industry

Business context and IT infrastructure roadmap for accountable *health* organizations (AHOs)

Health delivery CxO and CIO leadership implications

# What is the Dossia Consortium?



**Dossia Consortium** is a 501(c)(6) not-for-profit employer-led organization dedicated to improving health and health care in America by enabling information technology to address cost, quality, safety and access barriers

- Support the development of **health IT-enabled public policy** to facilitate the transformation of the health care industry like all other major U.S. industries have been
- Promote **ecosystem data transparency and liquidity** to reduce the enormous friction in the health care industry which is a major barrier to attaining more natural market dynamics
  - *Optimal well-being and care outcomes require decisions (clinician and/or consumer) to be made in the context of an aggregated, longitudinal person-centric health record* that transcends organizations, settings and data types (medical, dental, claims, observations of daily living) from systems, devices and self-entry
- Active within Institute of Medicine, Bipartisan Policy Center, ONC S&I Framework, Center for Health Value and Innovation, Markle Foundation, Patient-Centered Primary Care Collaborative, eHealth Initiative, National eHealth Collaborative, others

*Founders represent over **5 million** benefit-eligible employees, dependents and retirees*



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# Like Every Other Industry, Health Care Delivery Now Must ... Listen to the 'Actual Purchasers/Customers' of its Services



- Many of the market dynamic problems will be greatly reduced when the incentives in the health delivery market are realigned to focus intensely on the actual purchasers
- A much more “perfect market” **focuses on the needs of the true customers**, those that actually purchase the products and services, and in the case of the health care delivery market (in order of spending \$\$\$ amounts) they are:
  - Employers
  - Government Entities
  - Consumer/Patients
- **Extensive fundamental disruptive changes in the way the health care industry is organized and performs is required for successful payment reform**

*“Purchasers of care, whether individuals, employers, or government entities, must **preferentially purchase care of higher quality and value**. Failure by any of these groups to realign incentives around quality and value will limit progress for all toward the objective of high-quality, affordable care..”*

*Health Affairs, “At Virginia Mason, Collaboration Among Providers, Employers, And Health Plans To Transform Care Cut Costs And Improved Quality”, September 2011*

- **Well-being and health care industry should work for me on my terms**
  - Must work like all the rest of the products and services that are being offered to me today, fitting into my lifestyle and preferred communication channel(s)
  - *When* (e.g. same day appt., Sat. evening), *where* (e.g. mobile, home) and *how* (e.g. secure messaging, lay health worker at church) I need them
- **Services tailored to me**
  - Advice and decisions to be made by me (or my designated proxy) and/or my physician need to be in the context of my preferences, goals and my specific circumstances
  - **Includes leveraging everything 'the system' should already know about me**
- **Efficient and effective value-based services**
  - All service providers function as a coordinated team, including my PCP, specialists, pharmacists, mental health professionals, dieticians, therapists and any other entity/person that touches me
  - **Consumer/patient is a respected member of the care team – as with any good team, each member is provided with the information they need to perform their responsibility to the best of their ability**

# 5<sup>th</sup> Grade Class Project: Rational Market Explanation of a Transformed Health and Health Care Industry



**Economics**  
**LT: I can explain a business profile.**



## HEALTH and WELLNESS CENTER+

How can you **NOT** be interested in these well-paying jobs?

- Accountant
- Health Specialist
- Appointment manager
- Health and Wellness Administrator

- We make goods to protect your health.
- We make sure you can afford medical care when you're in need.
- And we keep citizens healthy + happy.

If you're not, maybe you're interested in our fine products! We have these products at extremely low prices!:

- Stress balls
- Health Insurance
- Medicines or drugs

- And we provide excellent services!
- Wellness Exams
  - Cardio Screening
  - Neck Massages
  - Exercise Classes
  - teaching P.E.

Cost structure understanding: activity-based accounting

Understanding that in a service industry people make a big difference

- Triple aim**
- \* Individual health
  - \* Lower cost
  - \* Pop health

'Health' not 'care' focused

Price transparency

Integrated well-being and care monitoring

Consumer needs and service quality focused

Products are services offered are not insurance coverage limiting

Preventative Focus

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Health reform related changes in the law to improve quality and cost ...

- **Replacing fee for service with bundled payments**

- 39% (47% of large) want it retained
- 20% want it modified
- 31% of all employers want this provision repealed

- **Quality and performance based payments**

- 55% (70% of large) want it retained

- **Using value-based designs and incentives to motivate change**

- 62% (74% of large) want it retained

- **Creating accountable care organizations**

- 45% (52% of large) want it retained

- **Creating medical homes**

- 50% (59% of large) want it retained

Employers are very *interested* in bundled payments but **don't believe the industry currently has the foundational pieces in place to support it**

Midwest Business Group on Health, "Key Findings of Employer Reaction To Health Reform Survey", December 2010

Note: Large employers defined as having employees > 500

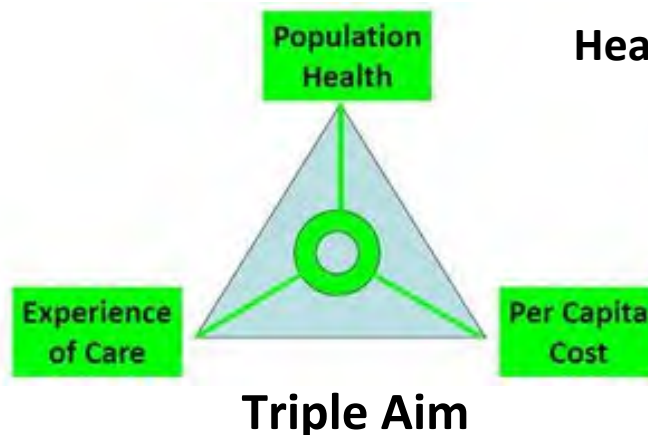
# Three Legs to the Employer Health Benefits Stool A Familiar Guiding Model to Health Care Delivery



***The brilliance of IHI and Dr. Berwick's Triple Aim model is that it extends nicely to employers in terms of key dimensions for optimizing their well-being and health care related programs and benefits***

“Research has consistently demonstrated that **patient experience correlates with clinical processes of care for prevention and disease management and with better health outcomes.**” *Health Affairs, “Measuring Patient Experience As A Strategy For Improving Primary Care”, April 2010*

“78% of all employers and 67% of large employers agree that the new [health reform] law makes it **more important than ever to keep workers healthy** to keep costs down” *Midwest Business Group on Health, “Key Findings of Employer Reaction To Health Reform Survey”, December 2010*



## Healthcare Costs for American Families Doubled in Less Than Nine Years

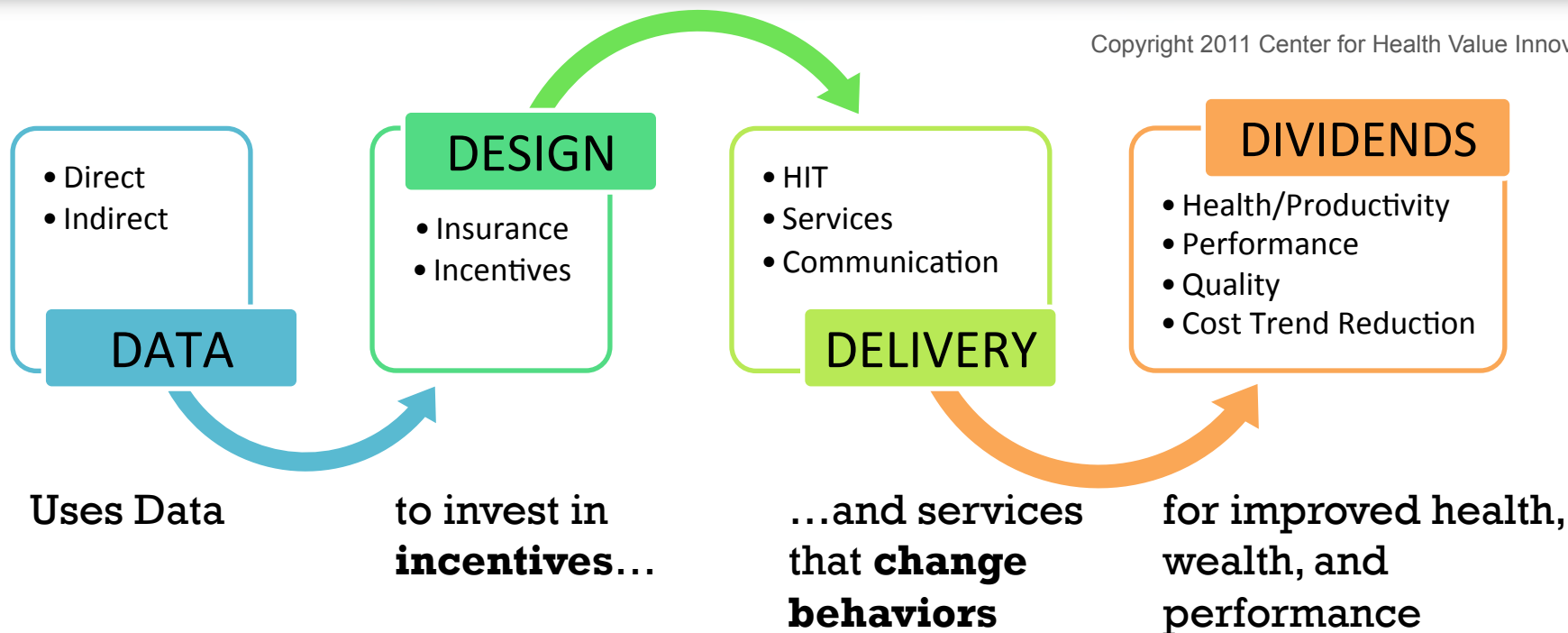


2011 Milliman Medical Index

- Should be “**Well-Being and Health Care Market**” – Wrongly self-defined market definition
  - Basic business principle is to **first** see if you can **avoid** buying something at all, and then when you have to, you optimize what you buy
- **Lack of Information Transparency** – The current health care market is what economists call a “*highly imperfect market*”
  - Unlike every other part of a business (with the possible exception of non-online marketing), ‘**I don’t know if I am buying the right stuff and if I happen to be buying the right stuff, I have no idea what the value equation is for that stuff**’
  - Because of its life/death elements it is certainly unique and will never be a “perfect market”, but the **health care market is not as unique as the health care industry makes it out to be – *this has been used as an excuse for far too long***

- **Lack of Information Liquidity** – IT is foundational to driving non-incremental cost reduction and service improvements
  - Unlike nearly every other major industry in this country, health care delivery has not undergone an IT-enabled transformation, deployed both within **and between** organizations, to create an efficient ecosystem
- **Lack of Customer Focused Continuous Improvement** – There is no health care industry without a patient!
  - Organizations in health care have been way too slow to adopt proven approaches from other industries as part of its core operating culture

*“Most physicians today receive virtually no meaningful information on their performance.”* Health Affairs, September 2011, “Medical Group Responses To Global Payment: Early Lessons From The ‘Alternative Quality Contract’ In Massachusetts”



Value-based design is an **ENGAGEMENT TOOL** for the CONSUMER/PATIENT, PLAN SPONSOR and **PROVIDER**



Representative Members  
of CHVI

State of Maine



JOHNS HOPKINS  
MEDICINE

# A Different Approach to Changing Behaviors

## Tracking & Reporting is a *By-Product* of Consumer Usage



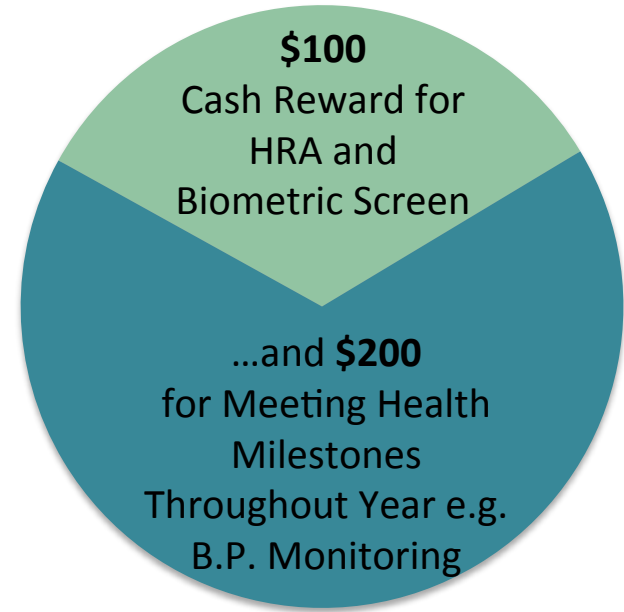
### The Old Way

Reward for Sign-Up:  
e.g. Join Health Club for Free/Reduced Price



### The Accountable Way

Reward for Behavior Change and Improved Health Outcomes:  
e.g. Reward for Regular Attendance and Exercise Reported by Integrated Devices



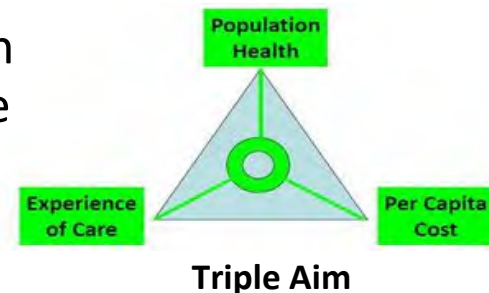
**Same \$300 Incentive,  
BUT Different Allocation**

### A Vision For Health Care

“We envision a culture that is open, transparent, supportive and committed to learning; where doctors, nurses and all health workers treat each other and their patients competently and with respect; where the patient’s interest is always paramount; and where patients and families are fully engaged in their care.”

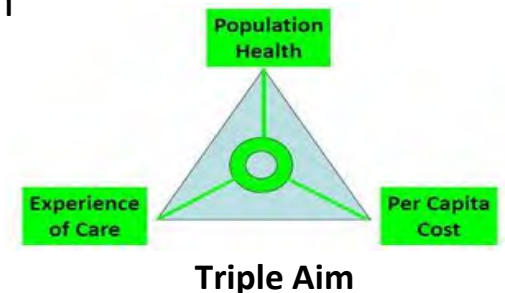
*BMJ Quality & Safety (Berwick et. al.), “Transforming Health Care: A Safety Imperative”, 2009*

- “Patient centeredness” at its core embraces the tenet that the **consumer/patient is a valuable member of the care team**
- **The most under-utilized resource in health care is the “free” patient** – Our nation’s ability to avoid a health care induced financial crisis demands that patients are engaged, jointly accountable and that *care happens with them, not to them*
- **There is a business model for HIE, it’s the patient!** It is in the patient’s best safety, quality and cost interest to have each clinical encounter to be informed by a comprehensive, relevant aggregation of previous health information



Understand and acknowledge the concept that **employers will increasingly focus on well-being** and is related but separate than health care

- Well-being is a core mission that employers *can have significant influence over* and thus want to control and own
- The goal for employers is, through well-being incentives and engagement, to minimize the number of employees that enter into the health care system, particularly for behavior-induced chronic diseases
- Even in an ACO and medical home environment, where there is a large incentive for care ownership and accountability, health care delivery will still need to externally coordinate with employer well-being initiatives
  - This will require the ACO/MH to robustly interface data with workplace well-being initiatives and related personal health management platform



# Triple Aim “To-Do List” From Employers to Health Care Delivery

## Transparency Is a Key To a More Efficient Market



Transparency in all aspects (both internally and externally) affecting consumer/patient care decision-making and direct care delivery:

### Value determination

- Quality reporting
- Price reporting

Insist your EHR vendor re-engineer their system to **capture the measurements required for quality reporting as a by-product of the clinical workflow** (not adding extra work by providers or requiring side analysis)

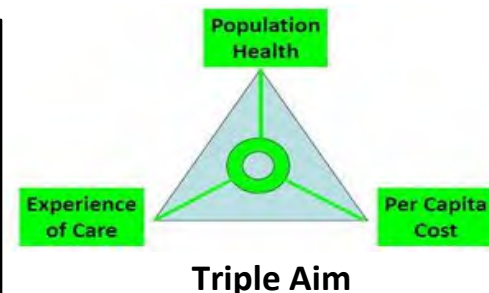
### Safety/defect reporting

- Cultivate a culture that embraces the same zero defect philosophy as other industries, rewarding identification of defects for input into continuous improvement process
- NTSB for Health Care: <http://www.safetyleaders.org/NTSBforHealthcare/home.jsp>

### Patient satisfaction

*“Transparency—the free, uninhibited sharing of information—is probably the most important single attribute of a culture of safety. In complex, tightly coupled systems like healthcare, **transparency is a precondition to safety.** Its absence inhibits learning from mistakes, distorts collegiality and erodes patient trust”.*

BMJ Quality & Safety (Berwick et. al.), “Transforming Health Care: A Safety Imperative”, 2009



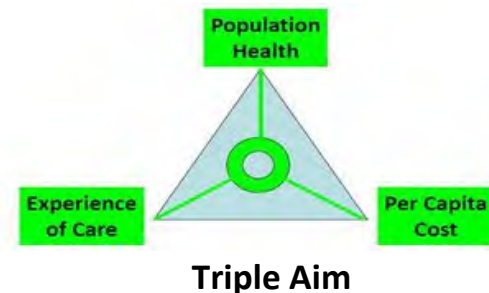
# Triple Aim “To-Do List” From Employers to Health Care Delivery

## Information Liquidity Is Foundational to Transformation



- Proactively (ahead of MU schedule) **provide discrete field level electronic copies of care summaries, discharge instructions and care plans** per the consumer/patient’s preference - *“Nothing about me, without me”*
  - As a member of the care team, the consumer/patient requires actionable information to do their part in both decision-making and post-care self-management
  - Insist EHR vendors not just support the proposed MU access & download “portal pull”, but also **support the much more cost effective and efficient “Direct project push” which automatically transfers data to entities identified within EHR-based consumer/patient preferences**: PCP, PHR, HIE, home health agency, proxy care giver, long-term care facility, etc.
- Proactively (ahead of MU schedule) **connect consumer/patient’s PHR to your IT platform so that remote self-management checkpoints can be optimized**
  - An information “closed loop” is required to make the transformational progress necessary which requires data-enhanced provider-patient communications

“Reimbursement models need to recognize and promote the interconnected nature of different ways providers and patients communicate to support the provision of care.”  
*Health Affairs, “Patient Experience Should Be Part Of Meaningful-Use Criteria”, April 2010*

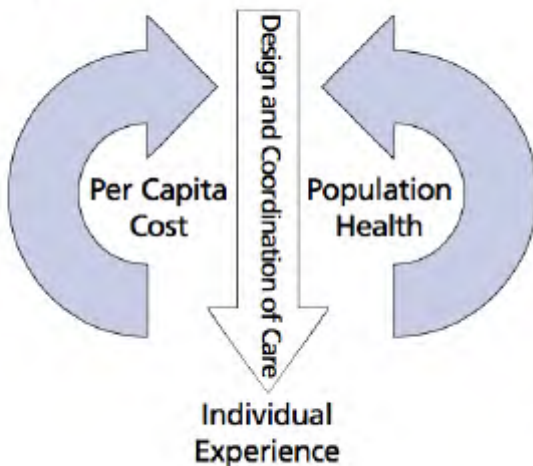


# Triple Aim “To-Do List” From Employers to Health Care Delivery Look To Outside Industries For Improvement Ideas



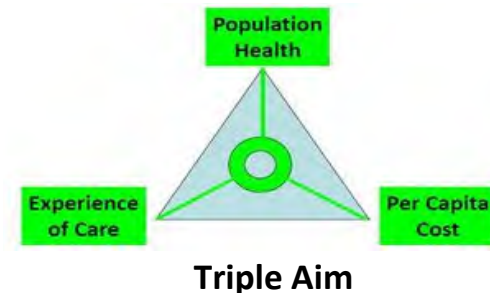
- **Fully embrace proven continuous process improvement** tools and approaches from other industries that can rapidly drive out safety, quality and cost problems
  - Lean value chain analysis & activity-based costing
  - Invite employers (and patients) to get directly involved as Virginia Mason does
- **Always ask: what is best for the patient? (or better yet actually ask the patient directly)**

- Act With the Individual and Family
- Learn for the Population



*“Much of the rapid escalation in health care costs can be attributed to the fact that **providers have an almost complete lack of understanding of how much it costs to deliver patient care.** Thus they lack the knowledge necessary to improve resource utilization, reduce delays, and eliminate activities that don’t improve outcomes.”*

*Harvard Business Review (M. Porter & R. Kaplan), “The Big Idea: How to Solve the Cost Crisis in Health Care”, September 2011*





## **Consumer/Patient Input**

- ✓ Well-being and health care delivery should work for me on my terms
- ✓ Services tailored to me
- ✓ Efficient and effective services

## **Employer Input**

- ✓ Adopt a consumer/patient-centric vision for health care
- ✓ Well-being is our focus and health care needs to fit around it
- ✓ Transparency is key to a more efficient market: value, safety, satisfaction
- ✓ Information liquidity is foundational to transformation
- ✓ Look to outside industries for improvement ideas

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# What is the Vision for the Health and Health Care Delivery System?

*Adapted From Landmark 2001 IOM Consensus Report*



Current State (Still Majority Today)	Future State (Adaptation in Italics/Cross-outs)
Care is based primarily on visits	Care is based on continuous healing relationships, <i>delivered when, where and how it is needed</i>
Professional autonomy drives variability	<i>Well-being and care are customized according to patient preferences which includes their needs and values</i>
Professionals control care	The patient <i>shares decision-making as a key informed member of the care team</i> <del>is the source of control</del>
Information is a record	Knowledge is shared <i>freely</i> and information flows <del>freely</del> <i>without friction on a as-needed consented basis</i>
Decision making is based on training and experience	Decision making is <i>foundationally</i> evidence-based <i>within the context of a continuous learning system</i>
'Do no harm' is an individual responsibility	<i>Safety and quality</i> are system properties
Secrecy is necessary	Transparency is necessary, <i>required and encouraged</i>
The system reacts to needs	Needs are anticipated <i>and meeting them continuously assessed</i>
Cost reduction is sought	Waste is continuously decreased <i>and quality continuously improved to improve value</i>
Preference is given to professional roles over the system	<i>Team-based care is essential to high value outcomes</i> <del>Cooperation among clinicians is a priority</del>

Adapted from: Institute of Medicine, Crossing the Quality Chasm, A New Health System for the 21<sup>st</sup> Century, 2001

# “Houston ... We Have a [M-a-j-o-r] Problem” ... The Classic Cart Before the Horse Issue



## Phase I: Laying the IT Foundation

ACO Core Competency	Progress	Representative IT-Enabled Capabilities
Network Interconnectivity		<ul style="list-style-type: none"> <li>Support for Direct Project and CCDs</li> <li>Physician portal</li> </ul>
Clinical Knowledge Management		<ul style="list-style-type: none"> <li>Inpatient and Ambulatory EMRs</li> <li>Site-specific CDS</li> </ul>
Patient Activation		<ul style="list-style-type: none"> <li>Patient portals and PHRs</li> <li>Contact center (inbound)</li> </ul>
Financial Operations		<ul style="list-style-type: none"> <li>BI capabilities for “drill down” reporting, dashboards</li> <li>Acute Care Episodes (ACE) billing</li> </ul>
Population Risk Management		<ul style="list-style-type: none"> <li>Basic employee analytics to identify cost-savings opportunities</li> <li>Site-specific disease registries</li> </ul>

## Phase II: Integrating and Delivering High-Impact Data

### Supporting Performance Risk Management

ACO Core Competency	Progress	Representative IT-Enabled Capabilities
Network Interconnectivity		<ul style="list-style-type: none"> <li>Private HIE</li> <li>Unified Communications</li> </ul>
Clinical Knowledge Management		<ul style="list-style-type: none"> <li>CDS – standardized and evidence-based, where possible</li> <li>Structured clinical documentation with CDS</li> </ul>
Patient Activation		<ul style="list-style-type: none"> <li>Patient education tools</li> <li>Contact center (outbound)</li> </ul>
Financial Operations		<ul style="list-style-type: none"> <li>RCM support for new payment approaches (e.g. bundled payments)</li> <li>Performance management tools for inpatient and outpatient</li> </ul>
Population Risk Management		<ul style="list-style-type: none"> <li>Readmission risk stratification tools</li> <li>Enterprise registries</li> </ul>

## Phase III: Leveraging Population Health Visibility

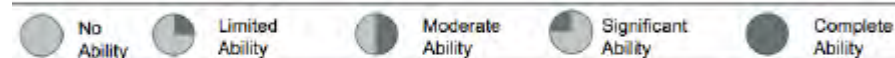
### Supporting Utilization Risk Management

ACO Core Competency	Progress	Representative IT-Enabled Capabilities
Network Interconnectivity		<ul style="list-style-type: none"> <li>Community HIEs</li> <li>Patient “connectivity”</li> <li>Semantic interoperability</li> </ul>
Clinical Knowledge Management		<ul style="list-style-type: none"> <li>Predictive analytics and advanced clinical decision support</li> <li>CDS across care venues</li> </ul>
Patient Activation		<ul style="list-style-type: none"> <li>Continuous passive monitoring of patient health status</li> <li>PHRs to support wellness</li> </ul>
Financial Operations		<ul style="list-style-type: none"> <li>Actuarial capabilities</li> <li>RCM support for new payment approaches (e.g. shared savings)</li> </ul>
Population Risk Management		<ul style="list-style-type: none"> <li>Clinical risk stratification, prediction and management</li> <li>Patient attribution</li> </ul>

### What Is Wrong With This Picture?? WE ARE UPSIDE DOWN!

The ‘imperfect market’ dynamics of the past have created a situation where **what is critically important today (see phase I ‘progress’ column) was least important in the health care market over the past decade**

The key to near term competitive advantage and success in the new world is how are **YOU** and YOUR ORGANIZATION going to **take advantage** of this disconnect in the market place



Source: Advisory Board Company, Jan. 2012

Predominant current hospital system market definition:

- *Insurance reimbursable health care services (and some services that look like them but are elective)*

- Implications

- No end in sight to cuts and increasing cost-sharing: “no money, no mission”

New AHO market definition:

- ***Well-being and health care products & services that meet the needs of consumers***

- Implications

- **Capture a portion of the enormous discretionary spending that consumers put towards products and services outside traditionally defined health care services**
- Ties vetted products and services into a consumer’s overall well-being and care plans and associated care team – a welcome change for both consumers and clinicians
- AHOs must provide the same level of ‘customer experience’ by having the same customer service and IT infrastructure that direct-to-consumer industries possess
- **Requires ‘true’ marketing and sales acumen**
- Hospitals in low-income areas will have to become part of systems with hospitals in wealthier areas to subsidize the lack of revenue diversification opportunity

# Exploring this Market Disruption *Point of View* Further Two Resources that Provide Additional Context & Perspective



Implication:  
AHOs are unprepared to support 'true' marketing and the required integrated IT related components



*"The value stream showed that 90% of what we did was no help at all" p. 137*

Implication: efficiently delivering high-value AHO services requires collecting quality data as a by-product of the IT-enabled processes

*"In today's market, with rising consumerism, increased competition, transparency and more, **successful marketing and brand building is vital to long-term sustainability**". Loc. 753*  
*"In one of the classic definitions of marketing, there are four "P's" – product, price, place and promotion. **Most healthcare marketers are only focused on one of those "P's" – promotion**" Loc. 714*



# Veterinarians Get It: Build Business Through Relationship Development at Consumer Touch Points Using Information



Emotional invoking mission communicated on every consumer interaction

Boarding is a related yet not direct pet health service (↑ rev)

Required service to meet consumer expectations (pet returned smelling good)

Constantly communicated 12+ month evidence-based medicine reminders to set action expectations with a subliminal budgeting prompt

Appointment reminder

## Blackbob Pet Hospital

15200 S. Black Bob Rd.  
Olathe, KS 66062  
(913) 829-7387

## INVOICE

Caring for your pets with Love and Kindness

FOR: [REDACTED]  
Olathe, KS 66062

Printed: 01-02-12 at 10:20a  
Date: 01-02-12  
Account: 8476 [REDACTED]  
Invoice: 2195 [REDACTED]

Date	For	Qty	Description	Price	Discount	Net Price
Services by Technician						
01-02-12	Daisy	3	Good dog Kennel			40.02
01-02-12		1	Board Bath <50#			13.98
Services by						
01-02-12			Visa payment			-54.00
<b>Old balance</b>		<b>Charges</b>	<b>Payments</b>			<b>New balance</b>
0.00		54.00	54.00			0.00
<b>Patient</b>			<b>Total charges</b>			
Daisy			54.00			

Reminders for: Daisy (Weight: 14.8 lbs - 4y)		Last done
07-29-14	Senior Wellness Bloodwork	
12-01-12	DA2PPV-COR(ANNUAL)	12-02-11
12-01-12	Lepto Annual	12-02-11
12-01-12	Well Pet Exam	12-02-11
12-01-12	Rabies	12-02-11
12-01-12	Lyme Vaccination, Annual	12-02-11
11-17-12	Fecal Flotation Bring Sample	11-18-11
07-14-12	Heartworm Test	07-15-11
05-04-12	Bordetella Semi-Annual	11-04-11
03-10-12	Dental Exam	03-11-11
12-24-11	Revolution 10.1 - 20lb 3pk	09-23-11

Next appointment for Daisy			Qty
01-13-12	At: 8:40a	With: Cindy Gastinger	

Boarding and grooming are by independent contractors yet appears integrated to consumer

Pricing is transparent, the price you call about is what is charged – no “75% off mini-blind” health care charge master equivalent

Overdue evidence-based medicine tasks are highlighted in ‘guilt-ridden’ bold

# Veterinarians Get It: Build Business Through Relationship Development *at Consumer Touch Points Using Information*



CONTINUED

Trusted communication: clarify service expectations

## Doctor's Instructions

### Board Bath <50#

Your pet must be free of external parasites to board with us. This is a requirement for our clinic so we are not housing fleas/ticks to be passed to your pet and taken to your home. This service does only charge you for bathing and dipping of Daisy and if you are needing any special services please inquire with the staff while scheduling or when you bring in Daisy to visit with us.

A few of additional services we provide are:

- \* Nail Trim
- \* Grooming
- \* Administering prescription medications

Cross-selling products & services

Confirmation of product/service level purchased – in plain English!

### Good dog Kennel

### Daisy's weight history (in lbs)

10-21-11	14.70
10-07-11	14.70
09-23-11	14.70
07-15-11	14.60
07-01-11	14.50
06-17-11	15.00
06-03-11	15.00
05-20-11	15.00
05-06-11	14.80
04-22-11	14.90

Trending feedback on key health status biometric

Taking advantage of the customer relationship to solicit supplies free of charge that otherwise would cost the business money

We need your newspapers!!

Get a \$20 Target gift card for making a referral to our hospital!!! Ask our staff for details.

Proactively seeking referrals from customers (not just provider network process)?



- ✓ Develop an **enterprise service oriented architecture (SOA)** that wraps and loosely couples legacy applications and new components for agile portfolio capability management
  - Move the EHR from the center of the HIT universe to a key component level
- ✓ Add robust **data management** capabilities to facilitate both internal and external data exchange, staging and integration – create a *‘data firewall’*
  - This is much more comprehensive than traditional HIT interface engines
- ✓ Add/ensure access to **“universal health record” (UHR)** capabilities
  - *Optimal well-being and care outcomes require decisions (clinician and/or consumer) to be made in the context of an aggregated, longitudinal person-centric health record* that transcends organizations, settings and data types (medical, dental, behavioral health, claims, observations of daily living) from systems, devices and self-entry – *EHRs are not designed to handle this*
  - The one go-to data source to support the virtual health and health care team and related stakeholders - key place for data transformation and consent-based sharing
  - UHR may live in a community “DMZ” as opposed to entirely within one organization where the AHO does not own/employ a majority of the care entities



- ✓ Add **customer relationship/engagement management** (CRM/CEM) capabilities to intelligently manage communications & build loyalty
- ✓ Add **data virtualization** capabilities to power a **business intelligence** component that is independent of current EHR, ERP, etc. vendor offerings
- ✓ Add **business process management** (BPM) capabilities to allow your entity to quickly deploy new services using flexible rules-based components as new business opportunities present themselves

*Many of the tasks above can be done in parallel*

- ✓ **THEN** select '**triple aim**' enabling components as outlined in your favorite analyst/consultant ACO capability roadmap that best fits within this SOA framework context
- ✓ More advanced and market aggressive organizations will add a robust **retail point of sale (POS) and e-commerce** component to enable a diversifying revenue stream from new products and services

What is the Dossia Consortium?

Meeting the expectations of consumer/patients in a transformed health experience

A 'tough love' employer assessment and expectation perspective of the health delivery industry

Business context and IT infrastructure roadmap for *accountable health organizations* (AHOs)

**Health delivery CxO and CIO leadership implications**

The *unprecedented market change and disruption* outlined requires very high performance by the executive teams and supporting IT groups (already with a full plate of existing mandates and now the urgent need to bring their architecture in line with other industries), unfortunately ...

- Assessment from those outside of the health care industry is that a **significant percentage of the executive teams in hospitals across the U.S. are currently not equipped with the required business acumen to be successful in other industries (and thus also not in a transformed health care delivery market)**
- **If the role of CIO is not ‘within the inner executive circle’, they are NOT positioned to be a strategic leader to play a critical business-enabling role**
  - CIO must have/obtain academic and/or non-health care business exposure to possess the skills to provide proactive strategic input into business planning
  - If the CEO/COO/CFO views the CIO function as primarily a cost management role going forward, neither the organization nor the CIO will likely have success in a transforming marketplace
  - *Successful CIOs in the future will be **business capability-enabling portfolio managers** with just the right blend of business and technical skills*



# Thank You

*Questions, Comments, Challenges - All Welcome*

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