So this is my lay persons view of a healthcare environment that we need to be able to communicate about if we are going to get to the other side of this conversation where it is actually useful.

I gathered a very nascent glimpse of what the conversations have been about the last couple of weeks and think that I may have some small amount of clarity that I would like to confirm with the members of this group who are willing to teach an old dog new tricks.

Just to give some terms that we can anchor onto I want to make a very simple view of a kind of entity that will emerge in the coming years as the effects of the ACA and MACRA start the plate tectonic movements that we expect to happen as value based payments become a reality.

There is a story that goes like this.

A decade ago there was a hospital and a bunch of Clinics that all got together and became a single legal entity using a common Electronic Medical Record (EMR). For simplicity let’s call this entity **Germantown Regional Health**.

A few years later the behavioral health providers in the region all got together and formed an entity that they called **Serenity Health**. All of the behavioral health providers at Serenity got together and after much grossing and politicking agreed to migrate to the same Behavioral Health Record (BHR).

Around the same time as the formation of Serenity Health - seven of the local labs got together and decided to form a single legal entity that they chose to call **Sept Labs**. Combined these seven labs provided for the 80/20 rule related to labs and they could offer better services to their Care Delivery Clients at Germantown Regional Health and the other care providers in the region.

So about five years ago there were three separate entities each of whom had a separate Enterprise system that they used to capture data about each of the persons that they provided services to. Because of the overlap in Geography and other local determinants about 50% of the people that lived in Germantown had gotten services at Germantown Regional Health, Serenity Health and Sept Labs at one point or another. Just to put a number on it lets say that there are about 2 M people that live in the Germantown MSA and a million of them have gotten care at Regional, Serenity and Sept.

Now about 3 years ago each of these independent entities started offering an Authorization Service that sat on top of the independent organization’s Enterprise systems (a.k.a . Regional’s EMR; Serenities BHR and Sept’s LIMS – referred to in the vernacular as a Resource Server such that we might label them RS*regional*. RSserenity and RSlims.)

As the story goes, each of the three organizations was very progressive and had deployed an Authorization Server (AS) in association with their Resource servers. As the Nation’s largest payers started to signal that the future reimbursement model was going to be value based and driven by the total cost of care for a patient Regional, Serenity and Sept all merged into Germantown ACO.

At the time of formation the Germantown ACO had these components under ownership.

|  |  |  |
| --- | --- | --- |
| **Germantown Regional Health** | **Serenity Health** | **Sept Labs** |
| AS*regional*. | ASserenity | ASlims. |
| RS*regional*. | RSserenity | RSlims. |

**Single cross legacy-enterprise view of the records for a given patient.**

The CEO of Germantown ACO wanted to have a single query that gathered data for a given person across all three of the legacy RS and assign a URI to that view of the person’s data within the context of the newly formed ACO.

His DBAs were eager to impress and they made it happen such that given the right identifier (using an MPI to figure out what the equivalents were in the other two systems as necessary) he could get a single cross legacy-enterprise view of a given person’s prior treatments and maybe figure identify some people who would benefit from a holistic treatment intervention.

The software that was really good at matching these longitudinal records to new-age holistic interventions was another legal entity known as Mayo Health Clinic. The CEO of Germantown ACO wanted to send the results set from his cross legacy-enterprise view for his 100 historically highest cost patients but his CIO said before he could do that he’d have to get each patient to authorize the disclosure to Mayo because they couldn’t apply the multiple AS to the single cross legacy-enterprise view given the technical constraints.

This is the barrier that has been labeled the single AS for a given ~~RS\URI~~ R/URI.

Alternatively, the CIO suggest that these 100 people could all be asked to configure a single AS based on their sharing preferences in relation to the single cross legacy-enterprise view about them.

The root of the problem is that the AS’es cannot be combined because…?

Combining the AS’es is an enterprise-centered approach. It assumes that the entire universe is the ACO. In reality, the ACO’s patients have healthcare relationships outside of the ACO. Some of them might be snowbirds with care in a different region half the year, for example. Of the million patients in the ACO most will have authorization relationships that precede the Germantown ACO. This is particularly likely of the 100 high utilizers in this group. HEART is a patient-centered approach that seeks to avoid forcing the ACO’s AS onto patients that already have an AS died to a prior relationship. The ACO is free to suggest an ACO but it should not be able to force it. Therefore, given a single AS per R/URI, the ACO must accommodate a patient-specified AS.

<Is it that they are gathered at different times, they aren’t structured the same across the different RS? What? I am really asking why as I don’t know.>

Yes and yes. See the explanation above. This is why HEART is a patient-centered approach.

If the DBAs that created the single cross legacy-enterprise view allowed the user to enter the 100 Patient IDs for the top highest cost patients it would be in the Permission Type that Mr. Richer et al have been champion for us to include in the scope of HEART these last few meetings.

This way the guys at Mayo could get all hundred records at once and iterate through them to see if they had any new-age treatment intervention that would match a given patients unique health conditions.