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Health Care Megabases®

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A SPECIAL
STUDY

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METHODOLOGY/DELIVERABLES

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more ☛

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Block B

HEALTH CARE MEGABASES®
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VII. Megabases: Third Party Providers

A. Government
   1. Descriptions of Major Databases Provided[1]
   2. Cost, if applicable
   3. Resources Devoted to Databases: 1995-2000
      a. Volume/Size Measures
      b. Spending
B. Non-Profit
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   7. Major Uses
   8. Benefits/Payoffs
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   1. Matrix of Classes and Individual Databases, by Characteristics
   2. 100+ Classified

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   2. Future
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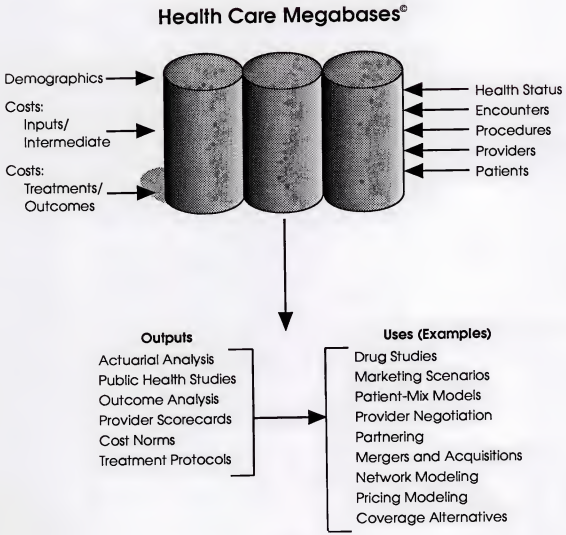

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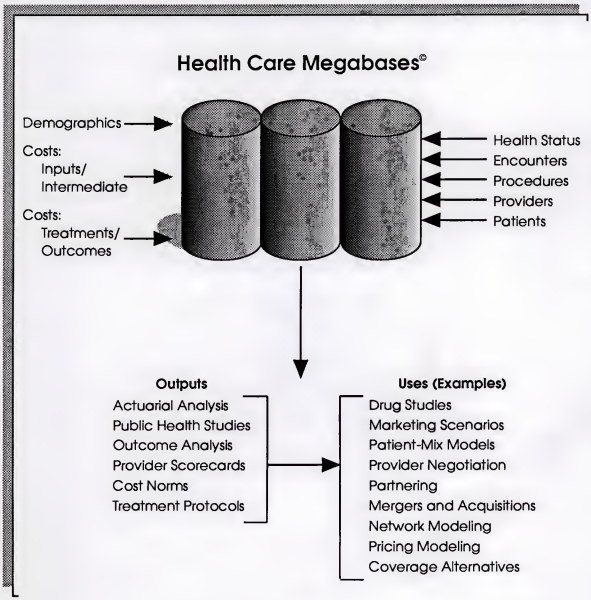

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(1) Look good - a few minor changes

(2) Is there a proofreader available who can look at it. My fear is a real word - that would slip by spellcheck - that is in fact a wrong word! I can't even see typos in this any more, as a matter of fact!

(3) Send me back a final proof on the "very fine" speed - we can use some for faxing before we get the printed copies

Thanks for all your work.

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↕ Close up slightly

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Preliminary Table of Contents (continued)

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Jan 16

To: Andrea

Fm: Tom

Re: Megabase Brochure Draft

Thanks for the effort.

I liked chapter VII so much I used it twice. I couldn't see any other content problems (but I'm probably too close to it by this time to really see any for a while).

I agree it needs a bit more work design-wise. My idea is to go from a 4-column to a 2-column page (except for bullets). I mocked it up on the attached to see how it fit/flows and it seems better; I was also afraid that I couldn't explain it in words well. In addition, two columns seem to utilize space more efficiently (both from an inch standpoint and focusing the reader's eyes).

Similarly, I think the TOC is less choppy using two columns and it's easier to navigate columns jumps (partially because fewer jumps are required).

I repeat the following phrase 6 times:

Includes
objectives, database
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implementation/man-
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performance characteris-
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building and operations,
as available.

I debated whether to footnote it, but couldn't tell how the footnotes would fall out in the draft. I <u>think</u> that we would just require the footnote twice, in the spots indicated, in the mock up. This would conserve space and reduce the repetition.

If you have questions/comments, please call.

HEALTH CARE INFORMATION A SPECIAL STUDY

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VII

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VIII

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To: Name: TOM

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Page: 1 of 5

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Contact
Other:

From: Name: ANDREA

Subject: MEGA

— for your Review

— Still needs work
Suggestions ?

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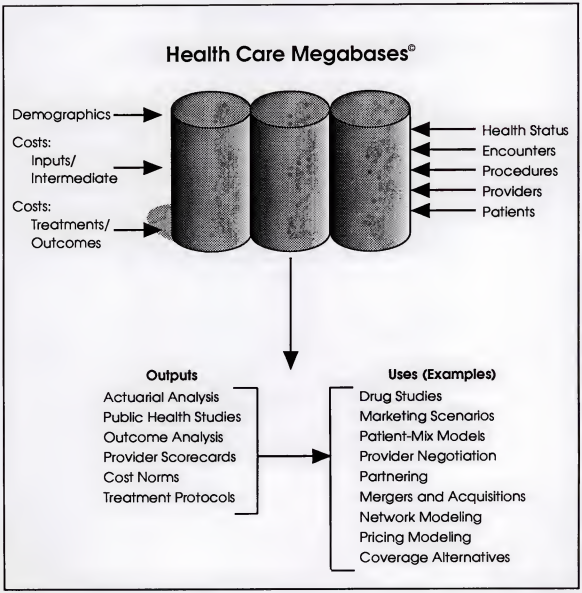
Health Care Megabases©



HEALTH CARE MEGABASES ©
A SPECIAL STUDY

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HEALTH CARE MEGABASES©
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■ Which government actions could impact health megabases? What are the most likely actions to occur?

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PRELIMINARY TABLE OF CONTENTS

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Suite 250
Vienna, VA 22182-3900
U.S.A.
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Fax 1 (703) 847-6872

HEALTH CARE MEGABASES

Preliminary Table Of Contents

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X. Recommendations

Jan 11, 1995

To: Andrea cc. BG

Fm: TOF

Re: Revised Health Care Multiclient Prospectus

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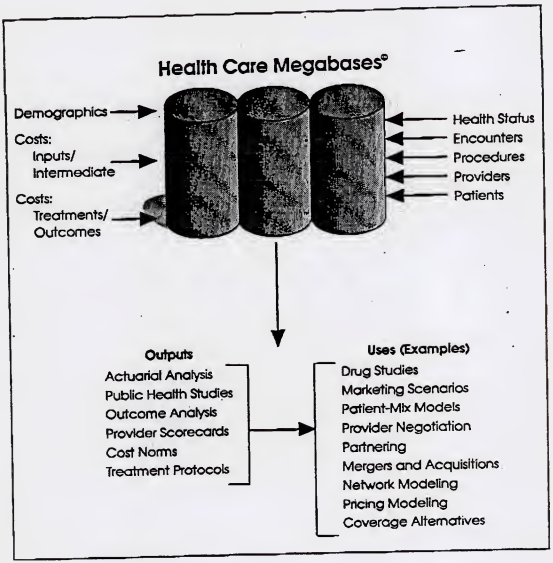
Health Care Megabases®



MEMORANDUM

To: Andrea

From: Jean

Subject: New Address - Notification

Date: January 10, 1995

Jan 30

Andrea, our new address is going to be

INPUT
1921 Gallows Road
Suite 250
Vienna, VA 22182 - ~~3700~~ 3900

(703) 847-6870
(703) 847-6872 (fax)

We will need a variety of printing done for us. I am sure you are aware what we need, since there have been several of the offices move. I will list what I can think of, but I am sure there are more that you will be aware of:

1. Stationery
2. Envelopes, all sizes
3. Labels
4. Business cards for everyone who uses them
5. Noteheads
6. Purchase orders
7. News Release letterhead
8. Research Bulletin letterhead
9. Federal newsletter paper

P.O. #1130

500 copies

I woud like to get a change of address form to send out ASAP. I think it is time we started sending these now that the lease is signed and our move is only three weeks away. We will start moving on the 27th, continue on the 28th and be all set up by Monday, January 30th.

I will get a rubber stamp done here at Staples where we get our supplies. I have a supply of forms from the post office so we are on our way.

OTT

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Fax +49 (0) 6447-7327

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Fax 1 (703) 847-6872

METHODOLOGY

INPUT will interview 200 organizations that will be impacted by megabases — those that use, supply, interpret and mandate megabases. INPUT will interview:

- Hospitals and other provider groups
- Managed care organizations
- Insurers
- Pharmaceutical firms
- Federal and state policy makers, analysts and regulators
- Existing and potential health care megabase suppliers
- Health care information services and processing firms
- Health care consultants
- Health care applications software suppliers
- Systems integration firms
- DBMS software product and hardware suppliers

Clients who sign up before November 30, 1994 will be able to review and comment on the content and questions in the planned interviews.

INPUT will edit, tabulate and analyze the material obtained in the primary research and combine this with information obtained in prior research and analysis to prepare the report. *(See the preliminary Table of Contents of the report.)*

In addition to the report itself subscribers will receive:

- A disk containing the interview material in dBase III format for further client analysis. (Respondent identifiers and proprietary information will be masked.)
- Up to four hours of post-report inquiry per designated report recipient.

PRICING

The cost of one copy of the report with support and inquiry privileges is $6,950 [$8,500 after publication].

Each additional copy of the report may be ordered for other users at the address on the following terms:

- With support and inquiry privileges: $1,500
- Without support and inquiry privileges: $750

For an additional fee INPUT will provide an individualized presentation and/or assessment of a client's strategy, plans and offerings.

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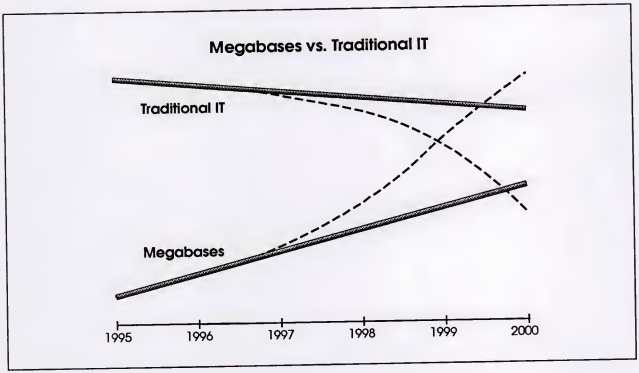

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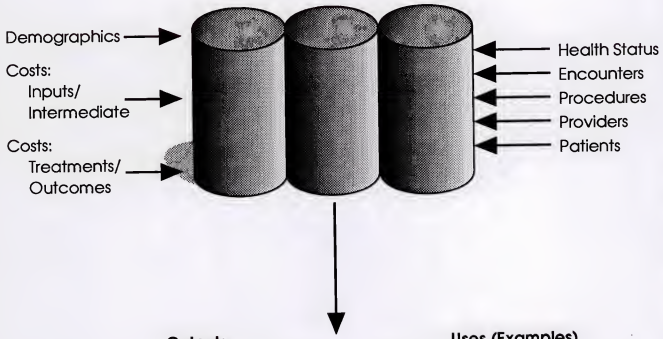

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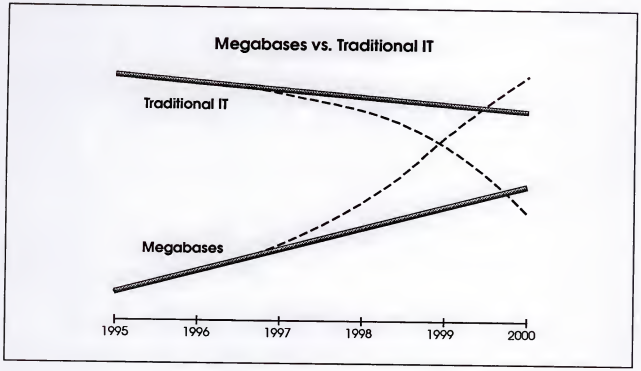

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The Impact of Changes in Health Care IT

The thesis of this paper is that changes are underway in U.S. health care information technology (IT) that will dwarf all prior changes.

- These changes are directly driven by changes in the health care system itself.
- The IT changes will, in turn, act as accelerants to further changes in health care, which will feed back to health care IT.

Health Care Changes

For the past two years a discussion of any health care changes revolved around politically sponsored changes.

Change in health care via federal-level politics is more-or-less dead.

- "Health care reform" turned into the politics of painlessly increasing health insurance coverage.
- Since there are no ways to significantly increase health insurance coverage without pain, the various efforts canceled out.
- The resulting turmoil and political burnt fingers will probably delay significant political initiatives in health insurance or health care for several political generations (i.e., five or six years).

A common conclusion, then, is that it's back to business as usual in health care (and health care IT). That is, relations between patients and

providers of care will be essentially unchanged, and the health care proportion of the GNP will continue its inexorable climb.

However, business-as-usual includes the "quiet revolution" of managed care organizations:

- The "pure" HMOs and IPAs, now account for over 25% of patients with insurance coverage.
- In addition, there are ever-growing numbers of pseudo-HMOs and other networks responding to the challenge of HMOs.

The marketplace critical mass is now shifting from traditional fee-for-service medicine to the managed care environment.

INPUT believes there will be significant changes in health care, health insurance and health care IT as a result of market-based changes. Ironically, these changes may very well be larger than politically inspired changes.

"Traditional" Health Care IT

Traditional health care IT has been primarily driven by the demands of fee-for-service reimbursement.

- Health insurers are in the middle of a very complex system of submitting claims for reimbursement of specific services.
- Much of the activity of insurers is focused on establishing whether a specific service for a specific patient should be reimbursed (either to the patient or the provider of care).
- Providers (generally hospitals) have set up (or are forced to set up by cost-driven reimbursers) very elaborate cost-finding systems that measure every provider activity and allocate costs accordingly. Providers, in turn, seek to "tweak" the systems to maximize their reimbursements.
- These activities place an administrative "tax" of about 8% on health care expenditures without much, or possibly any, positive impact on patient care, outcomes or efficiency.

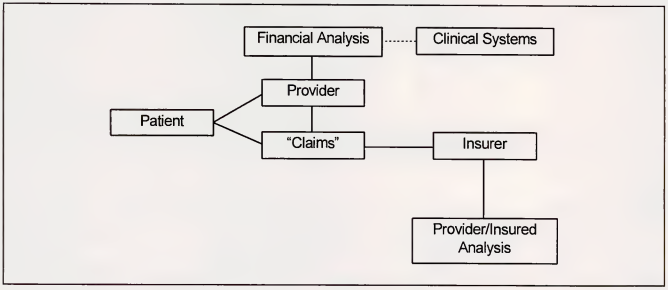
A considerable amount of this "tax" (between one third and one half) is spent on IT (either in-house or supplied by an information services provider).

There is also considerable IT activity in clinical systems (e.g., orders, lab, inventory management). However, these so far have not demonstrated significant impacts on efficiency or patient care; clinical systems have not been central to providers' well-being the way that reimbursement systems are.

Exhibit 1 illustrates this traditional processing environment.

EXHIBIT 1

Traditional Processing



IT in a Managed Care Environment

In a managed care environment the traditional, reimbursement-driven processing more-or-less goes away. Does IT also shrink? INPUT sees the reverse occurring: the role of IT changes from event-driven *processing* to the management of very large *databases*.

There are several key characteristics of IT in this database environment:

- The "underwriting" function becomes critical for a managed care organization.
  - Each managed care organization must have group selection criteria that maximize its position in the marketplace.
  - This applies equally to understanding the characteristics of each covered family/person.
- The database of past services, demographics and provider characteristics will enable managed care organizations to design service packages that are both cost-effective and appeal to the largest number of prospective customers ("customers" are a combination of individuals, employer units and other insurers).
- Providers of service must be rigorously tracked and monitored. (This monitoring applies equally to providers controlled by the managed care organization and those that it contracts with.) Monitoring includes such activities as:
  - Costs
  - Outcomes
  - Patient care practices
  - Efficiency of delivery
  - Patient satisfaction

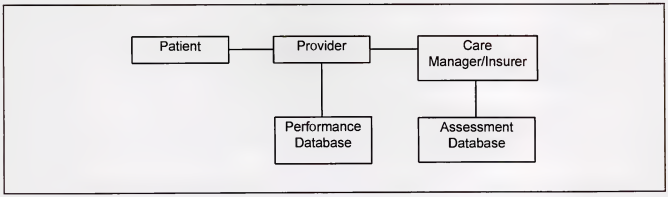
At the least, providers must have access to the same kind of information and analysis, if only to defend themselves at the time of negotiation with managed care organizations. The more advanced providers (i.e., the survivors) will want to be more proactive in their use of databases. E.g.:

- Unification of "financial" and "clinical" systems
- Cost/profitability modeling
- Provider network modeling
- Marketing

This new environment in deceptively simple in schematic form (Exhibit 2). In practice, initiating, maintaining and mining these databases will be complex and difficult.

Exhibit 2

Managed Care



Health Care Megabases

As these databases develop further, they will become very large as:

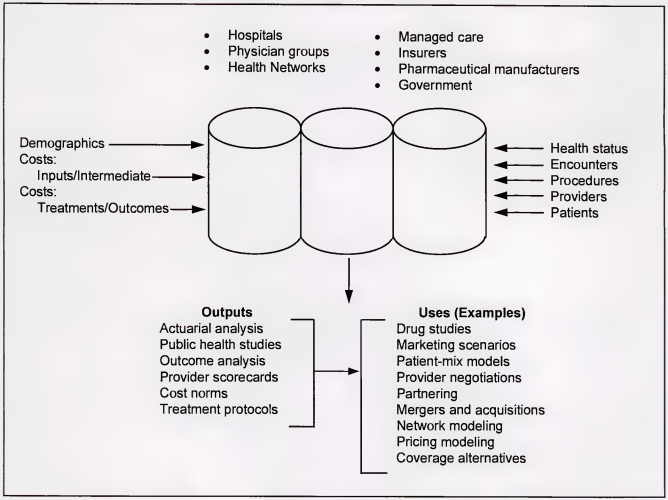
- Data becomes more available.
- Users understand better how to "mine" and apply the data.
- Competition increases the use of data.

There are some analogous databases already well established in other business areas, such as credit or insurance databases.

However, managed care-driven databases will be several orders of magnitude larger and more complex. Because of this, INPUT has coined the term, *health care megabase*© to bring home the level of change that is underway. A schematic is shown in Exhibit 3.

Exhibit 3

Health Care Megabases©



The megabase-driven world will have both winners and losers with, hopefully, the winners predominating. The period of transition itself promises to be a painful one for both users, creators and operators of health care megabases since the journey will, in large part, be into uncharted territory.