Politico Panel Discussion – Partial Transcript by CCHF

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Full descriptions and comments found here.

Outside, In: Will Population Health Solve What’s Ailing Our Health Care System?

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The W Hotel – 515 15th St. NW

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Moderators:

Arthur Allen, Politico
Joanne Kenen, Politico
Arthur Allen, Politico: Share your definition of population health...

WB: Population Health – “It’s another tool in my doctor’s bag; I can treat individual patients, but this is using systems, using data, engaging patients to keep them healthier and happier and out in the world and not in the health care environment....”

EH: (Researcher by background) “Population Health Management” (care for a subset of a population) vs. “Population Health” in general, “which is typically more about a community approach or geographic approach for providing care and keeping people healthy.”

Probst: “It really comes down to empowering and holding the patient accountable for care and their role in the care. I think historically as health care systems and providers of care, we’ve always said that’s our responsibility, and people came to us and we provided that care. We didn’t hold the patient responsible financially. And only to a small degree did we hold them responsible to take care of themselves better.

So to me, it’s about how do we have that patient be accountable in the care process? And that would make it as a population how we do a better job of caring for ourselves, the community and then the work that we do as health care providers. And it’s empowering them with data, It’s empowering them with a better education. It’s empowering them to understand the process and their role in that process.”

JS: “Well, I think of population health as the health of a community. That includes the people seeking care and the people not seeking care. It’s more than just adding up all the care that people get. It’s their overall health.

I particularly like when the community is geographic. If you go back to when the term “population health” was coined, it was coined to get at some of the non-clinical factors that underlie the health of communities, including access to safe food, access to safe communities, and prevention. So to me, it’s how you bridge from the care of the patient to the care and the health of the broader community.”
JK: **What's difference between “population health” and “public health”?**

JS: (former government official in MD, pediatrician; Hopkins): I think population health is the way that health care systems are thinking about public health now. Generally speaking, when people use the term, public health, they're thinking about public health departments. It doesn’t – Public health is sometimes seen as for public health people, but **when the clinical system gets into public health, they're talking about population health. I think it's a very similar concept. It's the term that people in health care use when they're doing some of the things that people in public health do.**

JK: At GW, when people talk about population health. We live in D.C. where there are lots of health disparities...GW...ACO...is it everybody that walks in the door? Is it public health for your patients?

Bill: Well I think all of that is going on. I think it depends on who you ask. We have, both in medical school and public health, people who are really thinking broadly about our community and the D.C. area, thinking a lot about disparities and trying to reduce those disparities. We have people who are sort of very operational who are thinking about our participation in the Medicare Shared Savings program and I think sort of building on the comments about what is population health. It's looking at the health of a population of people and you can define that population in different ways.

You can define it geographically. You can it by where they receive their primary care. Or you can define it by who the payer is. Right now, the way our Medicare Shared Savings program is structured is that it's defined by the payer – Medicare – and then that they’re connected to some doctor in our system. Where I would love to see things go in the future is that we move beyond that and we start to really fully engage our system, other health care systems in the D.C. area to move into that true geographic population health. And I think the way to do that is through coalitions.

AA: How many doctors are thinking about population health? Is it just another box in the bureaucratic things they have to think about?

JS: In Maryland, where I was the secretary of health, there are a lot of doctors who were excited about understanding the health of their patients more broadly than just the patients who are in the visit with them.

And the Maryland health information exchange gave a lot of tools to doctors to know what was happening to their patients even if they weren’t seeing them. So what I would say was very promising to me was when doctors would say I’m now realizing I’m not necessarily spending time with my sickest patients and I can see where they are in the system through the different information feeds that I’m getting and then I can make them healthier.'
They may not call that population health. They may not realize, but that is absolutely what that is. Then thinking about their whole population of patients, not just the ones in front of them, but the ones who are part of that population that really do need their help.

Bill: I think there is a real hunger amongst physicians and providers to want this sort of population health. And again, as we were trying to define it – our panel trying to define it -- there is not a clear one definition. But it’s just -- it’s very frustrating for us as providers when our patients are not getting the best possible care. Obviously it’s more frustrating and upsetting for the patients themselves, but we want their diabetes to be under control. We want their blood pressure to be controlled. We want them to feel well and be able to breathe well if they have COPD.

So I think that a lot of physicians have the hunger to learn about this and to be able to use these tools to help their patients. I think the challenge, and I think that’s something that’s been growing, is how to build that skill set. How to teach physicians, nurse practitioners, PAs about using data to look at their population, to say 'boy, on a whole my hemoglobin A1cs as a measure of diabetes control is not great. How can I use that to start making changes to improve that for my population of patients?"

Probst: “We never called it population health – and I’m not a doctor – but we’ve been, I think our physicians have been incredibly engaged in population health for probably 20 years, if we look back statistically at how we’ve used data to do a lot of things Bill's talking about. .... “And I really do think data is a really important component of achieving any level of population health so that you know where to focus your resources, but also you know how to modify your practice to best serve the community that you’re in. So I would say, I agree. I think physicians have been trying to practice that way....I think overall it’s a positive thing.”

JK: Intermountain doing this for a long time. ... It all comes down to technology. What are the tools that you have now...that are going from the individual patient to the population?

Probst: “That’s a big question. But I like what you said: everything comes down to technology. It is why we exist. It’s not different tools. It’s additional tools. We’re able to get aggregate data. We’ve been able to bring it together. We are incredibly unique.

Josh and I were having a conversation earlier about the exchange and the way data's able to flow in Maryland. That doesn’t happen in Utah, but it happens within Intermountain Health Care and because we have about 60 percent of the population that we serve, it's a big enough piece that we don't have to deal with a lot of the problems that many of the east coast hospitals have to.

But we’ve been able to bring that data together; we’ve been able to normalize it. We’ve been able to make it standard – I needed to be able to get that word in
somewhere – and make it usable for things like decision support, for analytics. They call them registries today. We never called them registries, but to do this kind of analytics.

The tools that we’re getting today that kind of fit in the conversation of population health, is now our ability to take that and engage the patient whether it’s the data from their FitBit, or any of their monitoring type things or their ability to interact with their own record and then push information back out to the patient in a meaningful way that can actually change their habits or change the way that they’re engaging in their care. So I think those are the new things that we have but if you don’t have that underlying data, I don’t think that next step makes a lot of sense.”

Erin: “Everyone’s been talking about is a systemness issue. We have a new perspective of what the health care is and how people want to be accountable in that system at multiple different level. ...You have to understand who’s in your population before you can figure out how best to serve them. That’s a lot of what the ability to aggregate data and then involve people on the individual level and that information can do.

There’s a fascinating example out of the NW, coming from Group Health and Kaiser Permanente looking at smoking cessation. [6 months ago]... Only recently, right, with a lot of the major investments that have been made in health IT was this group able to go back and say, OK, if you actually track people over a long enough period of time and use every trick in the book, all the data in there, not just the structured data but a lot of information from notes, can you see that if you offer nicotine replacement therapy... do people actually quit and stay quit for you know 12 to 18 months?” .... “It’s taken us that long to get the systemness perspective that’s possible under population health.”

AA: Crisp?

JS: So CRISP stands for the Cheasapeake Regional Information System for Patients (CRISP) – “CRISP is the health information exchange in Maryland. And Maryland is maybe more compact in some respects than Utah. And so we have a bunch of different hospital. I think there are 40 acute care hospitals. And what CRISP does is bring information together for all the patients. In fact, it’s now a verb in Maryland. If you che – If you look up your patient in the system, people say you’ve “crisped” the patient. And that – I talk to a lot of doctors who complain to me about a lot of things but they all really enjoy getting their data through CRISP.

In addition to that lookup function though, the exchange of data has really opened the doors to population health. And it starts with basic notifications that doctors can get when their patients are in emergency department that instant they’re registering. And a doctor can get a notice about their patients. In Maryland, we send about 800,000 or more notifications a month to providers, to case managers, to
mental health programs. So that people really know where their patients are. **That helps them with that part of population health: it’s not the patient in front of you; it’s where your patients are.**

Then you go to the next level and providers in Maryland can get an up to the minute dashboard of all of their patients hospitalization and emergency department use. So I could say, you know, I'm just wondering, who are the five patients that have been to the ER the most of all my patients.

Boom and I know who they are and I can integrate that into your medical record.

Then you go another level back, and this is happening in Maryland, where we link that data to the discharge diagnosis and make that available to planning coalitions, just like William was talking about. So, in Maryland there are 18 planning coalitions. They have access to a dashboard that allows them to say, “in our geographic area, what’s happening to asthma admissions? What’s happening to asthma ER visits? What’s happening to overdose visits?

You can take that data and turn it into a **true geographic population** so you can bridge between what individual doctors are seeing with their patients and the ability of public health and coalitions that cover both health care and public health to make plans.”

AA: Compare the data he’s talking about and how used within Intermountain.

Marc: I'm amazed at what Maryland is doing in a very complex system. ... We're all on the same system. The data's there. ... network. We've been giving reports for about 15 years...out to physicians on a daily basis. I think we're in a far easier situation, because we're not dealing with so many systems.... The value has been proven.

JK: You have a heart patient. They end up at a hospital downtown. They don't call. Five years ago. When did CRISP start?

JS: all hooked up and going just a couple of years (CRISP)

Bill: Only would know if hospital called. We’re fortunate in the D.C. area that we have a relatively mature information exchange. It’s a powerful tool. Daily data feed all of our patients who have been admitted, discharged or transferred in the D.C. area. Operationalize that by having nurse to make follow-up calls.

JK: which is one of the keys to avoiding readmissions.

Bill: Absolutely. In terms of using the portal to look up data...Discontinuity here. If a patient gets admitted, have to send a fax. Log into the system. Last weekend on call
my residents use the word “to crisp” on a regular basis. And we can pull this information. It’s not all there, but often times you go in and you strike gold. (25:00)

JK: How do you get from individual patient; real-time notifications. How do you take that so it’s not just one patient? That improves the health of everyone you’re seeing.

Bill: It’s taking those data in aggregate and being able to look for patterns. It’s pattern recognition. It’s saying ‘either this individual patient is getting a lot of their care – they have COPD, emphesema – and they’re going into another hospital across town frequently. Maybe talking to the patient to understand why they’re being admitted frequently or talking to that hospital and saying can we share records with you? Can we work with you on this patient and trying to develop those connections.

And then it’s also perhaps seeing broader patterns. So if we’re looking at our patients with congestive heart failure, and if we initially only have the data from our hospital we’re not getting the full picture of patients that are getting readmitted to the hospital and are also going across town. So this broader view of the data allows us to be able to really understand our patient’s health conditions and where they’re receiving their care.

AA: Doesn’t it also...The availability of the information means that you are put in a position of knowing you have to act on it. ... That tells you something about their status. It’s all well and good to know that they went into the hospital again. How are you going to keep them out next time?

JS: What you’re saying really points to the importance of the reimbursement system. So if you’ve got all this information that people in your clinic are having preventable readmissions across town and you want to do something about it – and I think doctors want to do something about it – they somehow need to be able to be paid for that.

If they’re going to lose money by all the time that they spend and the staff that they hire to coordinate care, it’s very hard for them to be able to do it. On the other hand, if they’re able through Accountable Care Organizations or other mechanisms do better as their patients are healthier, than it’s a perfect match with these kind of IT tools because they can use them to be successful under different financial arrangements (28:00)

JK: Erin, as a researcher, what’s happening in your average town or city that doesn’t have CRISP and hasn’t been doing? Are they clueless?

Erin: I think we have to understand what’s been happened in terms of our changing infrastructure. We’ve had some major investments from the HITECH Act; we did a lot of work that actually Bill was involved in connected to understanding comparative effectiveness research, the exchanges, I mean, there’s just been a tremendous amount of investment in this space.
And so the groups that I’ve had the privilege to work with over the last five years of my work with the Agency for Healthcare Research and Quality [AHRQ], have been mostly more like the Intermountain folks or the really sophisticated academic medical centers that are really trying to figure out: How do you knit technology together so that it’s sticky, right, and people want to come back, rather than icky, which is what a lot of folks right now feel the user experience of health IT is.

And so I think that what we’re seeing are more flexible structures, um, interest in Application Programming Interfacing, APIs, right, to get people to pool their data, to try and use some of the emerging standards that we were talking about a little bit ago. About the FIRE standard. Trying to figure out how do you really integrate more of a flexible structure so that you don’t have to have all this huge institutional infrastructure behind you? And I think we’ve seen that in a lot of other industries and that’s clearly the direction that health care’s moving.

So there’s really a wide spectrum of experience and I think we’re starting to see the lessons learned from these early adopters, now moving back out and also some really innovative new approaches. But I would just add, I think one of the critical elements in population health is trying to figure out this user experience piece. We have to figure out how to bring the patient in in a way that facilitates interactions and discussions between providers and their patients and we just don’t I think have quite the right tools to do that yet. It’s a really exciting opportunity but we have a long way to go.

JK: How do physicians deal with this data overload? Even without with engaged patients also going to be sending stuff in. There’s all these different doctors. They’re all gathering data. We have all these fields to fit in.

Probst: Yeah, well, they don’t deal with it well. As a CIO, they all have my email. They’re always kind – “these systems are so good”-- No, I mean it’s very difficult and I have tremendous -- We’re just rolling out an EHR now., replacing our self-developed stuff - and I have tremendous empathy for them and what we’re asking physicians to do. Right now, with just the EMR. And then you start adding in all this other data that can come to them.

But we have had a lot of success where we take it and make it meaningful information that’s part of the flow of their practice and what they’re doing. And as we do that it becomes useable, palatable. But to ask them to make two more clicks to go to a separate website. I’m finding it incredibly difficult. It’d be interesting, because CRISPing doesn’t sound like it happens within EPIC or CERNER. It sounds like something external.

But right now, The appetite of our physicians is one of if it just doesn’t happen as part of our workflow, we’re going to have a difficult time using it.
JK: Are you overloaded? Does the useful stuff wave and say here I am?

Bill: **The data overload is a real issue.** There are different pieces to work on this. Part of this is provider education and training and how to use data in a meaningful way that’s actionable. I think another piece is what Erin mentioned, which is a useable user interface. I mean, the EHRs have gotten a lot better, but there’s a lot that you can do, or opportunities for improvement or how you display a lot of complex data in a way that’s usable.

And then the other piece I just wanted to mention because I think it’s really important is **patient-generated information.** So whether this be from Fitbits, or home blood pressure monitors or patient-reported outcomes, say you know a patient with fibromyalgia talking about this is what their pain or mobility score is on any particular given day and how to incorporate those data, and I think the opportunity there lies in **being smart about it, having algorithms that say, again looking for patterns, looking to extract the data** so that you get the key information to the provider in a timely manner so that they can act upon it, rather than just ‘here’s 30 days of blood pressure measurements’ because that’s too hard to integrate in a busy schedule.

Probst: And having that data come from just anywhere... I went and did 23 and Me and I thought I was being really smart, and took it to my family physician. He quickly put it in the file... if they don’t know the source or it or how to use it, it becomes really difficult for these physicians.

Erin: There’s a really terrific example... American Heart Association has the Simple Seven steps to a healthy life (e-gems journal)... Hb1c and BMI... Did a supplement on clinical decision support. A group took the simple seven and embedded it in a very well known EHR ... and presents it in one interface for a physician to engage with a patient at the point of care. "We forget how dispersed all this information is for shared decision-making." So that’s clearly an issue that we have a tremendous opportunity to address.

AA: On one hand, bringing in new info and on the other hand, streamlining it, making it simpler. Does this tell us anything about the meaningful use program? Has a lot of requirements. **Is it time to retire it, do you think?**

Marc Probst: Yes

Erin: **Well, the Merit-based incentive payment system, which CMS is working on, is going to do lots of this work for us.** So I think that’s a really tremendous opportunity for everyone in this room and listening to really pay attention to and think how to inform what are those new measures going to look like.

JS: **I would say the meaningful use program has been incredibly important for the adoption of EHRs, you know, across the country.** And it’s now at the point
where people really want to see the value of that investment for population health and public health. And I think that it’s really important to think of the meaningful use program and changes that could be made to it in that light. If it allows people to do more things to improve the health of the people that they are caring for, then I think that’s the real value for it. It shouldn’t just be, because you can do a discharge summary; it’s because you’re able to improve the health of people that you’re caring for. And I think what you’re starting to see in different settings is that possibility that you’re seeing that electronic data used at the population level.

If I could just make one other related point, which is that there’s a lot that doctors and nurses and physician assistants can do in the clinic for patients. But then **there’s also a lot of health that goes on outside the health care system.** And one of the incredible opportunities made possible by the meaningful use program and by electronic health data is that it can **show a picture of community health** and it can bring partners and some access to some other kind of tools. You could show where the asthma is in a community and then the health department can go in and do environmental health and clean up, you know, apartment buildings that are in bad shape or you can realize that you need to put better places to get healthy food in a particular part of town.

And all that’s kind of free to the health system. You know you bas – I’ve heard ah – someone refer to this as cheating by the health care system. You show people where there’s a problem. You have other people come in and improve the health. And then the improved health helps the health care system. It’s a good kind of cheating. It’s really made possible by access to electronic health data that can be put forward in a way that really reveals the health of a community. (38:32)

**Q&A with Audience**

JK – turn to audience questions

David Pittman: For Josh. About the role of payers in accelerating this system. In Maryland you have a unique system by which hospitals are paid. How much do you think that attributes to the Maryland success (the all-payer system). Should other states move to MD system.

JS: I would say not only that our unique system played an absolutely critical role, but it’s the reverse that’s true also. **I think one of the reasons health information exchange has struggled in other places is that there hasn’t been a fundamental financial alignment with the health care system.** In MD, the hospitals are paid on global budgets. I won’t go into it in great detail, but **basically the hospitals do better financially when there are fewer preventable admissions.** Some people call that like the Shangrila of health care. You actually do better. You’re paid more when your patients are healthier. That is the case in Maryland for hospitals and that creates this enormous incentive to share data through CRISP and in other ways.
As one example, I was saying, in Maryland, if a patient gets readmitted to the hospital, the instant they're registered at the hospital, a notice goes to the previous hospital saying, 'hey, your patient just got readmitted' and to the current hospital, 'op this patient was over there two weeks ago'. And it's that kind of collaboration that the hospitals are working on which allows the system to succeed. And I do think that variations on this model – maybe not this model exactly -- are very promising for other places. The reason to do it won't be health IT. It will be because of the cost of health care. But when they do it, they’ll find a very fierce need for effective health IT and information exchange. (42:00)

Julie Canter-Weinberg (independent consultant): I was wondering about patient privacy. I was faced with my first authorization to join the CRISPER and because I was a policy geek, I kind of knew what it was about but even then I was a little hesitant with the idea that my health information could be flowing all over Maryland and D.C. And I don’t know if it goes to Virginia as well. So can you address whether patient privacy concerns and the fact that HIPAA’s a bit dated now and only covers certain entities is a barrier to the takeoff of HIEs and population health more broadly.

JS: I can speak briefly. CRISP has a set of privacy policies. People can opt out. And some people, not many of them, have. Generally speaking the principle is that, in the health care system under HIPAA, -- you know it’s totally compliant with HIPAA -- if someone is part of your care team, you have access to that information. And so for example if someone is at Bill’s hospital they can call over and get the records from my hospital, even without health IT. So it just allows something that could otherwise be done to be done more efficiently. In general, I think people in Maryland are happy to know that their doctors have access to their other records that they can provide better care.

[JK: But it’s restrained to the other doctors treating that patient] Correct. It’s absolutely inappropriate and, you know, big problem if you’re like, if you’re not part of the care team you can’t use that information. [JK: And do we know that that’s adhered to. We know that HIPAA violations are... ] Well, there’s a process within to complain and sanctions to be taken.

But it’s sort of like, in a hospital where there are records all over the place, you just can’t go poking through the records You know paper records had all kinds of problems like that. Here there’s a trail. You know it’s a lot, in some respects, safer than a paper record system where nobody really is dusting for fingerprints on the folder.

Erin: I would just like to note that most Americans think this type of exchange is probably already happening. We’re so used to information flowing ... CRISP is still among a subset of systems that has done this very well. So it’s not necessarily the norm.
Probst: And it might vary by parts of the country. In Utah, it’s completely opt-in, which is one of the reasons we’re not doing so well in our health information exchange. It comes right back to privacy. And I can just tell you my wife said, if it was an opt-out state, she would opt out day one, because she didn’t have confidence in the overall system. And I probably would too.

Bill: I think it’s something that as we move forward it has to be top lined in all of these systems. I think what I’ve seen as a patient and a physician, I’m comfortable with, but I agree that that depends on individual preferences. I think, you know, one of the bigger issues is that these data belong to you. **Your health data is yours. And you should have it with you when you need it.** So if you’re admitted to a hospital, you’re in a doctor’s office, to me it’s ridiculous that the data’s not there. And so I think we need to move in that direction but while we do we have to do it very cautiously to be concerned about these privacy issues.

AA: **Wait a second. The CIO of the major hospital system in Utah doesn’t trust sharing data?** I’m sorry. Can you explain?

Probst: Can I explain? Do I not trust data? I do within Intermountain health care. I don’t opt out of my own system that I know what the security protocols that are in place and what we’re spending on it. **But I would opt out of the statewide network** because I have less confidence in that.

Linda Mulhouser (mental health): I’m a health practitioner. Again, I’m wondering how mental health fits in with privacy. I have a few things. The Opt-out system requires a level of sophistication that people may not have, so I wonder how you deal with those populations who wouldn’t know to opt out unless it’s very clear. [The other thing is the patient and the practitioners. ] Many of the practitioners may like the CRISP system but when you’re in an office with them, they have to do all the data and so they’re not doing the eye contact with the patient. I hear that a lot from my patients as well. So you’ve got the individual piece and you’ve got the aggregate piece and the privacy that she just talked about. How’s that dealt with?

Bill: I’ll take the individual piece cuz I deal with this every day, which is wanting to make contact with my patients. My solution is that I do a lot of my charting after the visit. But that’s inefficient and that’s not...That slows me down. For a very busy practitioner that’s not realistic. I think that, to my earlier comments, **I think that the user interface needs to be improved dramatically** in order to allow a much easier input of data so that you’re not disrupting that patient-provider relationship.

JS: And of course, what CRISP is doing is saving the provider an enormous amount of time. So the provider can get the information right away rather than be calling around. My medical school roommate teaches at Harvard and he did a tweet that was, ‘I can’t believe this is 2014 and I’m still calling around to outside ERs to get the record to figure out what’s going on with my patient’ and I responded back to his
tweet, ‘I just met an ER doctor in Maryland who can’t remember the last time he had to do that.’ So he didn’t tweet back after that. I probably should give him a call. ...

I think we’ve got to keep in mind, health care in the United States for a lot of people doesn’t work. Critical information isn’t being put at the point of care. People’s lives may be on the line, so when you’re dealing with that type of situation and generally people want their doctor to know whether they’re admitted somewhere, the consent issue is complex. I could make a very strong case that it’s very much in people’s interest for the default should be to participate in the system like this because it could save their lives if they’re doing it. Having said that, there are a lot of different efforts to assess, to make sure people understand their ability to opt out, but in general people don’t. What I would say to Marc is, you know, you have confidence in your 60% of the market. Well in Maryland, nobody’s got 60% of the market. And you can’t get that level of confidence about the health you’re going to get unless you’re participating in a system like this. And so I think it’s a very rational approach that the state has taken, giving the people the ability to decide not to participate but frankly, offering a huge amount of help for their health if they’re able to.”

Erin: Individual institutions interpret the privacy rule in different ways and what that means in terms of the flow of information. Individual patients, this data is their data. And so some of the work that we’ve done is focus on portable consent. Sage Bionetworks to develop an icon app. How to help people who don’t want to read through a whole complicated consent structure and all that legalese. Icon-based system. (49:00) Apple – incorporated into the first 5 research kit apps released. Extraordinarily successful. Still problems with linking those apps back to the system.

Mike Miller, M.D., Foley-Hoak (sp?) – coroner data; how’s that coded? Pharmacy data?

JS: in Maryland we’re just implementing electronic death reporting. Suicide. If we were able to link into the coroner database, you could do a study and get consent from people upfront... I think it really is an interesting idea. In general, in Maryland we took the approach, and Governor O’Malley said this all the time, to use CRISP as a so we have the prescription drug monitoring data in CRISP. So it’s just one click and you get into that. We’re moving to put the immunization registry in there. A whole bunch of different things in the same place and eventually it opens the door to better understanding and better services for patients.

Probst: Aren’t all these sources of data? Coroner data is one source. Family history data. I mean there’s all kinds of data out there that when we can access it, when we can bring it into the system we can make a massive difference in population health. We’re just scratching the surface right now.” [...]

Transcribed by Twila Brase, president and co-founder, CCHF, November 23, 2015.