

**HIT Policy Committee  
Accountable Care Workgroup  
Transcript  
April 19, 2013**

**Presentation**

**MacKenzie Robertson – Office of the National Coordinator – Federal Advisory Committee Act  
Program Lead**

Thank you. Good afternoon everybody. This is MacKenzie Robertson in the Office of the National Coordinator for Health Information Technology. This is the kick-off meeting of the HIT Policy Committee's Accountable Care Workgroup. This is a public call and there is time for public comment built into the agenda. The call is also being recorded, so please make sure you identify yourself when speaking for the record. I'll now take roll call. Charles Kennedy?

**Charles Kennedy, MD, MBA – Aetna – Chief Executive Officer, Accountable Care Solutions**

I'm here.

**MacKenzie Robertson – Office of the National Coordinator – Federal Advisory Committee Act  
Program Lead**

Thank you Charles. Shaun Alfreds?

**Shaun T. Alfreds, MBA, CPHIT – HealthInfoNet – Chief Operating Officer**

I'm here.

**MacKenzie Robertson – Office of the National Coordinator – Federal Advisory Committee Act  
Program Lead**

Thanks Shaun. Hal Baker?

**R. Hal Baker, MD – Vice President and Chief Information Officer – WellSpan Health**

Here.

**MacKenzie Robertson – Office of the National Coordinator – Federal Advisory Committee Act  
Program Lead**

Thanks Hal. Karen Bell? Karen Davis? John Fallon? Heather Jelonek?

**Heather Jelonek, MS – John C. Lincoln Accountable Care Organization – Chief Operating Officer**

I'm here.

**MacKenzie Robertson – Office of the National Coordinator – Federal Advisory Committee Act  
Program Lead**

Great. Thanks Heather. David Kendrick? Joe Kimura?

**Joe Kimura, MD, MPH – Atrius Health – Medical Director, Analytics and Reporting Systems**

I'm here.

**MacKenzie Robertson – Office of the National Coordinator – Federal Advisory Committee Act  
Program Lead**

Thanks Joe. Irene Koch? Aaron McKethan?

**Aaron McKethan, PhD – RxAnte, Inc – Co-Founder and Senior Vice President, Strategy and  
Business Development**

Hi, I'm here.

**MacKenzie Robertson – Office of the National Coordinator – Federal Advisory Committee Act  
Program Lead**

Thanks Aaron. Eun-Shim Nahm? Judy Rich? Cary Sennett? Bill Spooner? Susan Stuard? Grace Terrell?

**Grace Terrell, MD – Cornerstone Health Care, PA – President and Chief Executive Officer**

Here.

**MacKenzie Robertson – Office of the National Coordinator – Federal Advisory Committee Act  
Program Lead**

Thanks Grace. Karen Van Wagner?

**Natalie Wilkins – North Texas Specialty Physicians – Director, ACO Operations**

Hi, this is Natalie Wilkins in for Karen Van Wagner.

**MacKenzie Robertson – Office of the National Coordinator – Federal Advisory Committee Act  
Program Lead**

Thanks Natalie. Sam VanNorman?

**Samuel VanNorman, MBA, CPHQ – Park Nicollet Health Services – Director, Business Intelligence  
and Clinical Analytics**

I'm here.

**MacKenzie Robertson – Office of the National Coordinator – Federal Advisory Committee Act  
Program Lead**

Thanks Sam. Westley Clark? Akaki Lekiachvili? Mai Pham? And John Pilotte?

**John C. Pilotte – Centers for Medicare & Medicaid Services**

Here.

**MacKenzie Robertson – Office of the National Coordinator – Federal Advisory Committee Act  
Program Lead**

Thanks John. And are there any ONC staff members on the line, if you could please identify yourself?

**Kelly Cronin, MPH – Office of the National Coordinator**

Hi, Kelly Cronin's on.

**Alexander Baker – Office of the National Coordinator**

This is Alex Baker.

**MacKenzie Robertson – Office of the National Coordinator – Federal Advisory Committee Act  
Program Lead**

Thanks Alex.

**Michelle Consolazio Nelson – Office of the National Coordinator**

Michelle Consolazio Nelson.

**MacKenzie Robertson – Office of the National Coordinator – Federal Advisory Committee Act  
Program Lead**

Thanks Michelle. Okay with that, I will turn the agenda over to you Charles.

**Charles Kennedy, MD, MBA – Aetna – Chief Executive Officer, Accountable Care Solutions**

Very good. Thank you. And thanks everybody for joining on this Friday afternoon. What I'm hoping we could do is have general discussion, as this is our introductory and kick-off meeting, to talk a little bit about why we're here. What's the scope of our activities? What do we want to achieve when we're done? And a little bit about how we work together. So, I'll be working from the slide deck that ONC has passed around, and we will move judiciously through it. Could I have the next slide?

Okay, so just to, as the Chair, let me just introduce myself a little bit. I'm an internist and practiced medicine for many years. I have since moved into the business and technology side of healthcare, currently as the CEO of Aetna's Accountable Care Solutions Group. And what we are doing is building ACOs all over the nation; we have about 21 under contract and are growing very rapidly. I'm also on the HIT Policy Committee as the representative of the Health Insurance Industry. And just so we could maybe get a good understanding, as this is our kickoff meeting, of some of the members of the workgroup, if you could just briefly talk a little bit about your background, that would help me out a little bit. So maybe if we could take a few minutes to do that.

**Mackenzie Robertson – Office of the National Coordinator – Federal Advisory Committee Act Program Lead**

And I think on the next slide Charles, we can go just in order of the workgroup members listed. There we go.

**Charles Kennedy, MD, MBA – Aetna – Chief Executive Officer, Accountable Care Solutions**

Very good. I didn't hear quite who attended and who didn't, so maybe MacKenzie, if you could call out the names of who's on the line. Sure. Shaun Alfreds.

**Shaun T. Alfreds, MBA, CPHIT – HealthInfoNet – Chief Operating Officer**

Sure, this is Shaun Alfreds. I'm the Chief Operating Officer of HealthInfoNet, which is the statewide health information exchange organization and regional extension center for the state of Maine. We're a centralized repository model of a health information exchange with 97 percent of all the hospitals in the state connected and about 60 percent of all the ambulatory practices, submitting data into a centralized repository. And that we're using now to support ACO efforts around the state.

**Charles Kennedy, MD, MBA – Aetna – Chief Executive Officer, Accountable Care Solutions**

Great.

**Mackenzie Robertson – Office of the National Coordinator – Federal Advisory Committee Act Program Lead**

Thanks Shaun. Hal Baker.

**R. Hal Baker, MD – WellSpan Health – Vice President and Chief Information Officer**

Hi, I'm Hal Baker. I'm the Vice President and Chief Information Officer of WellSpan Health. I'm also a primary care internal medicine physician with about 1000 RBUs a year. WellSpan Health is an integrated delivery system of about 9500 employees in South Central Pennsylvania.

**Mackenzie Robertson – Office of the National Coordinator – Federal Advisory Committee Act Program Lead**

Thanks Hal. Karen Bell is having issues calling in, so I know she'll be joining shortly. The next member who's on is Heather Jelonek.

**Heather Jelonek, MS – John C. Lincoln Accountable Care Organization – Chief Operating Officer**

Hi, this is Heather Jelonek. I am the Chief Operating Officer for the John C. Lincoln Accountable Care Organization. John C. Lincoln is a two-hospital health system in the North Phoenix area. We have about 145 employed physicians and we currently use a centralized electronic medical record.

**Mackenzie Robertson – Office of the National Coordinator – Federal Advisory Committee Act Program Lead**

Thanks Heather. Joe Kimura.

**Joe Kimura, MD, MPH – Atrius Health – Medical Director, Analytics and Reporting Systems**

Hi everyone. My name is Joe Kimura. I'm a general internist with Atrius Health here in Boston, Massachusetts. I serve as our medical director for analytics and reporting systems. Atrius is a physician group in Eastern Massachusetts with about 1,000 doctors and mid-level providers. And we are actually one of the Medicare CMMI pioneer ACOs.

**MacKenzie Robertson – Office of the National Coordinator – Federal Advisory Committee Act Program Lead**

Thanks Joe. We have Aaron McKethan next.

**Aaron McKethan, PhD – RxAnte, Inc – Co-Founder and Senior Vice President, Strategy and Business Development**

Hi there. I'm an academic by background and consultant. I was the research director at the Brookings Institution's Engelberg Center focusing on the conceptual design and piloting of accountable care organizations with Dartmouth before I went to the fabulous agency, ONC, and was the director of the Beacon Communities. I am now a co-founder and Senior Vice President of a company called RxAnte, which is a predictive analytics company focused in particular on medication adherence.

**MacKenzie Robertson – Office of the National Coordinator – Federal Advisory Committee Act Program Lead**

Thanks Aaron. Grace Terrell.

**Grace Terrell, MD – Cornerstone Health Care, PA – President and Chief Executive Officer**

Hi, it's Terrell by the way.

**MacKenzie Robertson – Office of the National Coordinator – Federal Advisory Committee Act Program Lead**

Thank you.

**Grace Terrell, MD – Cornerstone Health Care, PA – President and Chief Executive Officer**

I'm a general internist and President and CEO of a multi-specialty medical practice in North Carolina, called Cornerstone Health Care. We are a Medicare shared savings ACO and may well be the – as far as I know, the only medical group in the country now that has 100 percent of its contracts with all its payers in an ACO contract. And we have a lot of investment in IT. I also sit on the Board of Trustees of CCHIT.

**MacKenzie Robertson – Office of the National Coordinator – Federal Advisory Committee Act Program Lead**

Thanks Grace. I know Karen's not on the line. Natalie, do you just want to give an intro for Karen?

**Natalie Wilkins – Director of ACO Operations – North Texas Specialty Physicians**

Sure. Yes, Karen Van Wagner is the CEO of Plus Pioneer ACO, as well as North Texas Specialty Physicians. And we are located in Fort Worth, Texas and have approximately 700 physicians, about a third of those are primary care experienced in taking risk on Medicare Advantage lives. We have a PPO and our partnered with United Healthcare on Medicare Advantage as well.

**MacKenzie Robertson – Office of the National Coordinator – Federal Advisory Committee Act Program Lead**

Great. Thanks. Sam.

**Samuel VanNorman, MBA, CPHQ – Park Nicollet Health Partners Care System – Director, Business Intelligence and Clinical Analytics**

Hi, I'm Sam VanNorman with Park Nicollet Health Services, now Park Nicollet Health Partners Care System, since we merged earlier this year. We're an integrated delivery system in the western suburbs of Minneapolis. We've got about 1000 employed clinicians, one major hos – one and one-third hospitals, a large clinic presence. We are also one of the Pioneers and were previously in the PGP Transition Demo Project. My role is as the Director of the Business Intelligence and Clinical Analytics Team as well as the co-chair of our Ops Population Health, which is focusing on our Accountable Care Initiatives primarily.

**MacKenzie Robertson – Office of the National Coordinator – Federal Advisory Committee Act Program Lead**

Great. Thanks. I think Cary Sennett, have you joined the call?

**Cary Sennett, MD, PhD – IMPAQ, International, LLC – President**

I have. I'm sorry I was a couple of minutes late.

**MacKenzie Robertson – Office of the National Coordinator – Federal Advisory Committee Act  
Program Lead**

Sure. Thanks. Can you just give ...?

**Cary Sennett, MD, PhD – IMPAQ, International, LLC – President**

I'm Cary Sennett. I'm the President of IMPAQ, International, which is a policy research and evaluation firm in Columbia, Maryland and DC. IMPAQ does a lot of work in health, but also educational, labor, human services and international development. The health portfolio, we're primarily a company that provides research and evaluation services to the government and primarily to the federal government. We work for CMS, ARHQ, HRSA and others. Our CMS portfolio includes a couple of the projects, we're the primary evaluator of the ACE demonstration and also involved in the bundled payment for care improvement initiative model 1 evaluation. My background very briefly, I'm trained as an internist, also as an economist and I was at Brookings in the Engelberg Center working in healthcare finance reform before I came to IMPAQ.

**MacKenzie Robertson – Office of the National Coordinator – Federal Advisory Committee Act  
Program Lead**

Thanks. Susan Stuard, have you joined the call?

**Susan Stuard, MBA – Taconic Health Information Network & Community – Executive Director**

Yes. Yes, I'm on. I'm the Executive Director of THINC. We're a community-based organization working on healthcare quality and IT issues in the Hudson Valley region of New York State. We sponsor health information exchange activity in our region as part of the larger state network, in collaboration with the New York eHealth Collaborative. THINC also has taken a longstanding role with authoring collaboratives in the region with a medical home project that subsequently sort of graduated three large medical groups who have become ACOs in our region, and I continue to work closely with those medical directors. And THINC is also serving as a local market convener and facilitator for one of the markets for the Comprehensive Primary Care Initiative. There are 7 markets around the country, this being one of them, and as some folks may know, that project, a CPC project, has a shared savings component to it.

**MacKenzie Robertson – Office of the National Coordinator – Federal Advisory Committee Act  
Program Lead**

Thanks. John Pilotte.

**John C. Pilotte – Centers for Medicare and Medicaid Services**

Hi. I'm John Pilotte. I'm the Director of the Performance-Based Payment Policy Group in the Center for Medicare at CMS, and our group is responsible for the Medicare Shared Savings Program where we have 220 ACOs participating in that program currently around the country. We also, our group is involved with the policy and implementation of the physician value-based payment modifier, which seeks to recognize and reward large group practices on the basis of quality and efficiency of care they deliver as well. And we're involved in certain other aspects of value-based purchasing around the agency.

**MacKenzie Robertson – Office of the National Coordinator – Federal Advisory Committee Act  
Program Lead**

Great. Thanks. And it looks like Akaki, have you joined?

**Akaki Lekiachvili, MD, MBA – Centers for Disease Control and Prevention – Informatics Science  
Lead, National Center for Chronic Diseases**

Yes. I'm Akaki Lekiachvili, Informatics Science Lead here at the National Center for Chronic Diseases within the Office of the Medical Director. And I work at CDC and also with CMMI on new ... and the reimbursement models. My background is I'm an internist, also business background with health administration and informatics.

**MacKenzie Robertson – Office of the National Coordinator – Federal Advisory Committee Act  
Program Lead**

Thanks. And I do – I just wanted to let you know that Karen Bell is just having technical issues calling in, but she is listening to the workgroup call.

**Irene Koch, JD – Brooklyn Health Information Exchange (BHIX) – Executive Director**

Hi, this is Irene Koch. I just wanted to let you know I'm here as well.

**MacKenzie Robertson – Office of the National Coordinator – Federal Advisory Committee Act Program Lead**

Great. Thanks Irene. You want to give a brief introduction.

**Irene Koch, JD – Brooklyn Health Information Exchange (BHIX) – Executive Director**

Sure. Thanks. So, like my counterpart Susan Stuard, who has introduced herself, I am also the Executive Director of one of the RIOS in New York State, the Brooklyn Health Information Exchange or BHIX. I've been doing this since 2007 and have seen the evolution of our support for lots of different coordinated care models here, including some health homes and projects that are working under the CMI Project. In addition, the first part of my career was as a lawyer in health care, so, the consent and privacy issues related to coordinating care across boundaries interests me a lot and it's something we weave into all of our work here.

**MacKenzie Robertson – Office of the National Coordinator – Federal Advisory Committee Act Program Lead**

Is there anyone else who missed roll call whose name I haven't mentioned yet, to do an introduction?

**Charles Kennedy, MD, MBA – Chief Executive Officer – Accountable Care Solutions – Aetna**

Great. Thank you MacKenzie. If we could turn to the next slide. Let me just say that when I saw the names on this list of individuals who would be a part of this workgroup, I think we've got a very rich and diverse group. And we certainly have a strong foundation to have the necessary knowledge to come forth with some compelling recommendations around how we move forward with the HITECH Act and what the intersections are with accountable care organizations. On the next slide, what are our processes and procedures? Our job is to report into the HIT Policy Committee with a series of reports that will be ...

**MacKenzie Robertson – Office of the National Coordinator – Federal Advisory Committee Act Program Lead**

Hey Charles, it's MacKenzie. Do you want me to go ahead and cover these next few slides?

**Charles Kennedy, MD, MBA – Chief Executive Officer – Accountable Care Solutions – Aetna**

Sure.

**MacKenzie Robertson – Office of the National Coordinator – Federal Advisory Committee Act Program Lead**

Okay. So hi everyone, this is MacKenzie Robertson. I'm the Federal Advisory Committee Program Lead within ONC. If you could just go back one slide please. It's my role to manage both the HIT Policy and HIT Standards Committees within ONC. I just wanted to give you a little bit of a background on how the Accountable Care Workgroup fits into the larger federal advisory committees. The HIT Policy Committee is charged with making recommendations to the National Coordinator for a Health IT policy framework for the development and adoption of a nationwide health information infrastructure. It is an advisory committee, its advisory in nature. The recommendations that the committees transmit to the National Coordinator are just that, they're recommendations, they do not bind ONC in any way.

The HIT Policy Committee is a federal advisory committee, it's subject to the Federal Advisory Committee Act, also known as FACA, and the FACA was enacted to ensure that advice by various advisory committees formed over the years is both objective and accessible to the public. The act also formalized a process for establishing, operating, overseeing and terminating these advisory committees. The Policy Committee is allowed to develop subcommittees or workgroups to focus on specific tasks or charges that they are given. The Accountable Care Workgroup is obviously one of these workgroups that they've formed. The workgroup is not permitted to provide advice or recommendations to ONC. The workgroups are established to report back directly to the parent committee, so in this case, you'd be directing back to the Policy Committee and presenting your findings to the Policy Committee.

ONC values the public partnership that these advisory committees allow, and determined in the very beginning in the establishment of the committees that all of its workgroup meetings would be open to the public. And as you can see on the agenda, there is a public comment portion of the agenda, and that's something that's standard across all the workgroup meetings and the full committee meetings. The majority of the workgroup calls are held virtually, they are similar to this format. There may be opportunity for an in-person meeting, depending on the charge that's presented to the workgroup, but the majority of the workgroup calls are usually held monthly via teleconference and webinar, similar to this one here. Other mechanisms that the workgroup can use to gain outside expert input is do listening sessions, where you can invite invited experts to present to the workgroup. You could also hold hearings, and those can be either in-person or virtual, depending on the budget constraints that we may have. And those are other ways of gathering testimony or input from members outside the workgroup. We do also have a Health IT Buzz Blog that ONC hosts on its web page. We can post questions or documents that we want to get public feedback on and the public is allowed to directly comment to the blog posting.

Some administrative matters related to the workgroup. Each workgroup call is recorded and the audio link is posted on the ONC website, along with all the meeting materials. So everything that's discussed in the workgroup call is in the public forum, all the materials are made public and that's again, just to make sure the public is actively engaged as we're deliberating and responding to different tasks and charges. Also, all the official workgroup appointments and the workgroup meeting materials will be distributed from the formal ONC FACA meetings email account, so if you're ever in a pinch and need to find workgroup meeting materials, you can just sort through your email and search by that ONC FACA email subject line. And, next slide.

So here's an org chart of the HIT Policy Committee as it stands now, with the different workgroups that have been established. As you can see, the Accountable Care Workgroup is on the top. We also have the Consumer Empowerment Workgroup, the Certification and Adoption Workgroup, Governance Workgroup, Information Exchange Workgroup, Meaningful Use Workgroup, Privacy & Security Tiger Team and the Quality Measures Workgroup. The workgroups are meeting – at least every day there is some sort of workgroup meeting going on, so there is a lot of activity going on in the Policy Committee. And next slide. This is the org chart for the HIT Standards Committee, which is a sister committee to the Policy Committee. This just gives you a snapshot of all the different workgroups that are currently active underneath the HIT Standards Committee. And I just wanted to include these two org charts because I know later in the slides, there is information on where different workgroups may be coordinating with this Accountable Care Workgroup, so I wanted to give you a lay of the land of how they all fit in currently.

So, are there any questions on the process for the workgroup or any administrative questions for me at the moment? Okay, with that, I will turn it back to you Charles.

**Charles Kennedy, MD, MBA – Chief Executive Officer – Accountable Care Solutions – Aetna**

Very good. Thank you for doing that. So now we get into more the meat of the discussion, which is, what are we going to do? How are we going to do it? And what will be the value of our work? And so if you look at this slide, the initial charge of what this subgroup has been given, is to make recommendations to the Policy Committee on how policies can help HIT and the infrastructure that comes with it, enable accountable care to be successful. And as we think about this charge, I think we have to think quite a bit about the environment, which we find ourselves in. If you look at meaningful use, certainly meaningful use has been successful in driving the adoption of HIT.

And so when I think about the objectives of this workgroup, certainly there is a growing infrastructure out there that could be leveraged to make accountable care types of initiatives more successful. That said, I think it's also pretty clear that there are a series of challenges that have been raised around meaningful use. There are things, anything from a republican effort to de-fund to the Rand Study backing away from the cost savings estimate. And so, I think this workgroup is being formed at a very interesting time, and that is, the marriage between some of the successes, but also some of the challenges associated with meaningful use, as well as what ACOs bring to the table. A rapidly growing business model that is growing by leaps and bounds and that is growing in quite a broad way. From where I sit, I'm seeing not just Pioneer and MSSP types of initiatives, but I'm very much also seeing commercial initiative from health plans like Aetna, but many others, Cigna, etcetera, who are also trying to find ways to make the ACO business model effective in a commercial environment as well.

So, I do think as I look at the ACO environment, the opportunity to marry up technology to the ACO business model and really create transformational change that we've all been talking about for so long. Actually, it makes itself more apparent when you merge the two together. I think the fundamental question though, that you're seeing in both the lay press as well as various peer review journals, is are ACOs going to work or are they destined to fail? And obviously, no one knows the answer to that question, but I think this workgroup could make a fundamental contribution in driving ACOs to success, because I think we represent the most direct and tangible linkage between deployment of technology and the generation of value that is necessary in order for the incentive structure with ACOs to be successful.

So, with that as a framework, perhaps we should talk a little bit about the scope of work that has been identified on this slide, and talk a little bit about is this the right scope, or are there things that have been left off of this scope that we think are important for us to address. So with that, let me just pause and see if anyone has any comments, either on what I said as an introduction, or if not, looking at that first bullet there around data aggregation and analytics. Okay, well I hope this isn't a shy group.

Let's go ahead and move forward into the first bullet and that is, aggregation and analytics. I think we – all of us involved in ACO activities recognize that if you're going to make population based medicine successful, you're going to have to be able to aggregate data across multiple individual and disparate data sources, bring it into a data warehouse and provide analytics. For purposes of identifying patients at high risk or risk stratification types of methodology, being able to identify patients who have gaps in their care associated with preventative medicine approaches. And a wide variety of efficiency and effectiveness and quality analyses that are necessary to make an ACO successful. So, comments on data aggregation and analytics as an area of focus for this workgroup, and what areas you might specifically call out, as we think about how to approach aggregation and analytics.

**Samuel VanNorman, MBA, CPHQ – Park Nicollet Health Partners Care System – Director, Business Intelligence and Clinical Analytics**

Hi, this is Sam VanNorman from Park Nicollet, and I'm not sure if this is the right point in the conversation to throw this in. One of the things that we've struggled with in both our national efforts as a Pioneer, as well as in negotiations with some of the commercial payers in our state, as well as with the state of Minnesota, is this idea of standardization around claims data and our ability to integrate that within our analytics infrastructure. I think it's absolutely key in accountable care arrangements for us to have a standard, scalable way to accommodate influx of information about all the care that's happening outside our systems, and a lot of that's going to necessarily come from our payers. So, I think that's an important part of the discussion, I'm not sure if that's important right now though.

**Charles Kennedy, MD, MBA – Aetna – Chief Executive Officer, Accountable Care Solutions**

Well no, that's exactly what I'm looking for and appreciate the comment. And could I ask you to talk a little bit about, there's multiple aspects of that. There's just simply receiving the claim data from the health plan, and I think we all know that there's varying degrees of either; a) willingness or b) ability for health plans to provide that data. So, could you talk a little bit about, or anyone, whether you've – what challenges you've had in accessing the data. Two, there's claim data, but there's also clinical data, and both of those may be mirrors of the same clinical event. So, are there issues that you've come across around trying to integrate the clinical and the claim data, or in some way use them in a collaborative fashion for better ACO success.

**Samuel VanNorman, MBA, CPHQ – Park Nicollet Health Partners Care System – Director, Business Intelligence and Clinical Analytics**

You know, those are two very good points. I think that talking to the first one, one of the things that's been just such a positive thing about our participation with the Pioneer Program is our access to the full level of claims data for our attributed members. And honestly, that's become a nice negotiating point in some of our discussions with commercial payers, as well as the state of Minnesota. However, as we get into these discussions, there is no standardization around the format or the level of content in these. I would love to see us, a year or two or three down the road, not even have to have that discussion because when we decide to open our kimonos to each other and get all this claims data, there is one format that we use. And, that I don't have to build a new ETL every time I have one of these new arrangements. So that – and that's been a – like I said, it's been a delight to get that information from CMMI and CMS as part of the Pioneer Program, but by the same token, it's been wildly unstable. And that's part of being a Pioneer, I

think, we get – that’s a cost of doing business, but what I would hope is, that at some point we get to the place where we don’t have to have that discussion. If we decide we’re sharing claims data, it’s the XYZ format and that’s that.

**Charles Kennedy, MD, MBA – Chief Executive Officer – Accountable Care Solutions – Aetna**

Um hmm. Others, comments on claim data?

**Grace Terrell, MD – Cornerstone Health Care, PA – President and Chief Executive Officer**

It’s Grace Terrell here. We have very similar experience with the Medicare Shared Savings Program and the claims data from that because it’s so transparent, once we get it, as opposed to the commercial payers. One of the issues in our contractual negotiations that they payers have is, when you’re giving claims that are for things outside of your particular services, they fear that it can lead to some issues in contracting and market share information that they think is adverse to them. And so I guess that points...unfortunately all of the surrogate work-arounds they have in terms of what they give, is part of the complexity that’s being discussed and part of the reasons for it, I think.

**Aaron McKethan, PhD – RxAnte, Inc – Co-Founder and Senior Vice President, Strategy and Business Development**

This is Aaron McKethan. I’ll just build on this by saying, I think one element of value for the committee or the workgroup to consider as we take on this charge, going forward is to hear from CMS folks and ONC folks, to the extent they can talk about this publically, about not just statically where we are with the kind of data feeds, the timeliness of those feeds to ACOs and ACO-like organizations, but how they see those policies and data products evolving over time, in particular with the qualified entities data available through the separate program, and so on. I think it would help us to know how the market might respond if we had a better sense of what’s available now and what they envision to be available over time.

**Cary Sennett, MD, PhD – IMPAQ, International, LLC – President**

And Charles, this is Cary Sennett. I don’t want to pile on here; I think you’re hearing pretty strong validation of this bullet. But having cheated and read ahead, I would say that we’re maybe talking about some of the other bullets as well. The challenges, I think, what I’ve heard, really are on three fronts. There are the technical challenges of trying to aggregate data that are poorly standardized and in an environment where the pipes that are needed to permit data to flow, best case aren’t sufficiently capable, worse case, don’t exist. There are business – challenges on the business side, which is that entities that hold the data lose value in sharing them, the data have value that’s lost as they become available to others. And then obviously there are legal and sort of issues on the legal and regulatory front, the most compelling of which has to do with privacy and PHI.

So, I think those are probably the kinds of issues that the workgroup is going to have to address. And I guess the other challenge I would suggest is that there’s so much – these issues are being so much considered by other entities, including other agencies or other parts of the government, that one of the challenges will be to try to connect what this workgroup is doing with that other stuff.

**Charles Kennedy, MD, MBA – Aetna – Chief Executive Officer, Accountable Care Solutions**

Right, except, one of the things I haven’t heard anyone mention so far is data quality. And I’m just wondering, as you all work with claim data from various sources, what types of data quality issues have you run into, and is that something that the workgroup, you think, should focus on.

**R. Hal Baker, MD – WellSpan Health – Vice President and Chief Information Officer**

This is Hal Baker from WellSpan. As we function as an unofficial ACO, really trying to manage the populations we’re already accountable for, but not in a formal structure, we’ve really tried to leverage a data warehouse around our clinical data. And the disconnect between the administrative data which determines hyperkalemia by a physician writing the word down in the chart, versus the potassium level, makes a big difference. When we’ve been able to drive clinical dashboarding off of clinical data, it’s emotional motivation on providers to look at and improve their care, has been tremendously different. Because coding’s really precise, but coding is not always tied to the clinician as much as, or tied to the patient as much as it is tied to the way the clinician behaves in documentation. And that disconnect, we’ve found is really hard to drive improvement off of administrative data compared to clinical. Charles, I was really impressed by your statement about the warehouse, because it really comes almost to the

conclusion that population health is going to have to occur above the EHR in a data warehouse, which I don't know if you explicitly meant to say that, but that's what I took from that, and that makes sense to me.

**Shaun T. Alfreds, MBA, CPHIT – HealthInfoNet – Chief Operating Officer**

And this is Shaun Alfreds.

**Charles Kennedy, MD, MBA – Chief Executive Officer – Accountable Care Solutions – Aetna**

Yeah, that's what I was implying. I'm sorry, go ahead.

**Shaun T. Alfreds, MBA, CPHIT – HealthInfoNet – Chief Operating Officer**

Hi, this is Shaun. I just wanted to reiterate what the gentleman just said around clinical data. This is Shaun Alfreds from Maine. Here at the HIE level, we're working with two of the large ACOs and soon to be working with a, in a state innovation testing model grantee with our state, to help support the exchange and inclusion of clinical data within large data warehousing efforts to support ACO efforts. Both at the risk modeling level, but also at the clinical intervention level, using care management IT tools. And the challenge that we're seeing across the state, working with multiple EMRs still remains around the standards for exchange of clinical information. While we have multiple standards out there, the challenge is many of those standards still remain to be document based and are not discrete data and it becomes very challenging as we are supporting the inclusion of those data elements, such as lab results, such as vital signs within risk models, and advancing those efforts forward. So my hope is that this committee, working as another member mentioned, in tandem with some of the recommendations coming out of the other FACA committees, can help move the meaningful use standards and make recommendations to move meaningful use standards to support discrete data exchange. Sometimes very simplistic, frankly, using HL7 based exchange for example, in order to drive the necessary clinical data elements into the ACO model.

**Irene Koch, JD – Brooklyn Health Information Exchange (BHIX) – Executive Director**

This is Irene Koch. I think that's a great point and it's even, sometimes, more subtle than that, because even with discrete data, sometimes the way the clinicians are documenting, feel they're chunked together. And I think weaving together the workflow standards that would really more require the entry of data in a much more structured way, so it can come across and be analyzed. Ultimately, that way is really sort of the special sauce of putting it all together, taking the workflow, bringing it with the standards and then allowing it to be analyzed. Because there is a lot of clinical data, even in somewhat discrete formats that still can't be analyzed because of the documentation methodologies.

**Joe Kimura, MD, MPH – Atrius Health – Medical Director, Analytics and Reporting Systems**

This is Joe Kimura actually, from Atrius Health. The one point that I would also add here is sort of the timing of the claims data. We too, as I think many of you on the call are also integrating sort of our clinical Epic data with our claims data, and I know John Fallon's on our committee, too. We work with Blue Cross as part of the AQC contract and doing a lot of the population management elements, the differential between claims lag and the data that's coming from the claims side and how we actually try to bring that data together with almost real-time EMR data, to help our population managers and our case managers do the work to improve clinical care, always ends up being challenging. And we've talked about that lag and create work-arounds to try to get around that, but that contributes to some of the challenges of bringing together both the financial administrative claims data with EHR data.

**Charles Kennedy, MD, MBA – Chief Executive Officer – Accountable Care Solutions – Aetna**

Some very good points there. Let me throw out a couple of questions, then we'll move on to the next section. Does anybody have any experience – I think that claim lag point is a very good one. Does anyone have any experience with trying to get the claim data on the outbound leg, meaning, taking it from the practice management system before it gets to the health plan, and has anyone had any success or found that to be a partially effective strategy in trying to resolve that issue?

**Joe Kimura, MD, MPH – Atrius Health – Medical Director, Analytics and Reporting Systems**

This is Joe again, from Atrius Health. We have tried, but I think one of the challenges for us, we're an ambulatory practice group without hospitals, and so a lot of what we use our claims data for our risk patients is for activities that are happening outside of our four walls, and obviously doesn't go through our practice management system. So, it doesn't quite fill the gap that we're looking to fill with the claims data.

**Charles Kennedy, MD, MBA – Aetna – Chief Executive Officer, Accountable Care Solutions**

Yes.

**Grace Terrell, MD – Cornerstone Health Care, PA – President and Chief Executive Officer**

This is Grace Terrell. We use some of the same type of outgoing claims data from the practice management system to sort of do some early analytics for purposes of demographics and that type of thing, but you really can't do very much with it when it comes to predictive modeling.

**Charles Kennedy, MD, MBA – Aetna – Chief Executive Officer, Accountable Care Solutions**

Great. Okay, that was very helpful. Let's move on, in the interest of time, to the second bullet. We kind of touched on this a little bit in the previous bullet, when we began to talk about information exchange and discrete versus document based exchange. But if we're going to aggregate data for analytic and/or other purposes, that implies some level of information exchange, and claim data, even if it is, even if there is no standard format per se. At least it's almost always discrete or largely discrete, and at least you do have ANSI and other standards, so that has helped you to a degree. But when we get into the clinical world, I think we run into the same set of challenges that the Information Exchange Workgroup finds around the complete, I'll call it a nightmare, of trying to make clinical data interoperable. Are there any particular activities that this workgroup could put forth around the information exchange/interoperability problem. For instance, I don't know, doesn't ACO as a narrow network, in some way constrain the problem. Are there a certain set of data elements that would be particularly more valuable to focus on from an ACO perspective or any other thoughts people might have around being able to resolve the, or partially resolve, the information exchange interoperability challenge.

**Shaun T. Alfreds, MBA, CPHIT – HealthInfoNet – Chief Operating Officer**

Charles, this is Shaun from HealthInfoNet in Maine. One of the areas that we found here, especially in addressing some of the provider types that have not been incented through the Meaningful Use Program, such as long-term care. We found that the concept of a care plan exists in all of these organizations and while it's a document, this care plan is used to support transitions of care and to support care management activities and as we're moving forward through the ACO models here, care management is a critical connection back down with the patient. And what we've begun to do is support a document-level format, in lieu of having discrete data from that care plan, in order to drive the participation from the long-term care community and the relevant data coming out of the care, long-term care community, as patients transition out of skilled nursing facilities or home health, into other care settings. So that would be one example of an area that I think could be focused on very concretely and bring some value to the ACO marketplace.

**Charles Kennedy, MD, MBA – Aetna – Chief Executive Officer, Accountable Care Solutions**

And before we go on to another comment, could I ask you, what standard...are you using the CCD or how are you – what standards are you embracing to make that possible?

**Shaun T. Alfreds, MBA, CPHIT – HealthInfoNet – Chief Operating Officer**

We are using an HL7 standard format, so we're using HL7 to support ADT in the submission of discrete demographic information and then using HL7 ORU messaging to support the submission of the care plan.

**H. Westley Clark, MD, JD, MPH, CAS, FASAM – Substance Abuse & Mental Health Services**

**Administration**

This is Wes Clark from SAMHSA. I was wondering: Are you having any difficulty getting mental health data in your analysis?

**Shaun T. Alfreds, MBA, CPHIT – HealthInfoNet – Chief Operating Officer**

Well, absolutely Wes. Certainly here in Maine, we've been working closely with SAMHSA on the mental health side and there are many issues on the mental health side, mostly on the legal rather than the interoperability solution. Although we had the same problem with EMRs on the behavioral health side as we do with EMRs on the general medical side, which is the availability of their interoperability standards. However, here, and I think in many states that we're encountering, the challenge is around consent and consent for making that information available, and the ability of the IT systems and the providers at those settings to be able to integrate that consent methodology within their programs.

**Charles Kennedy, MD, MBA – Aetna – Chief Executive Officer, Accountable Care Solutions**

Thanks. Other comments on information exchange as an area of focus for our ACO workgroup?

**Kelly Cronin, MPH – Office of the National Coordinator**

Charles, this is Kelly Cronin from ONC. Just FYI for the workgroup, the Health IT Policy Committee is submitting comments to a joint CMS/ONC Request for Information around policy levers to drive interoperable health information exchange. The RFI closes on Monday, and we've got a lot of good input so far, and the Policy Committee comments did address the issue of voluntary certification for health information exchange that would enable new, value-based payment models such as ACOs. So, they already did put forth that comment, and it's something – we could build on their deliberations or discuss in more detail if that's one viable solution that the workgroup thinks is worth pursuing.

**Charles Kennedy, MD, MBA – Chief Executive Officer – Accountable Care Solutions – Aetna**

Yeah, let's make sure we get those documents so we can make it available for the team. Moving on then to patient activation as a member of the defined care team, I mean, I don't know, to me this is one area where I haven't seen anybody really get it right. If you look at the health plans who have tried to create PHR, the utilization rates are pretty dismal. If you look at delivery systems, many of them have had greater success, but even the Kaiser's of the world, who I think probably have some of the greatest success, a lot of that is transactional in nature. Here's a lab result, here you can set up an appointment, not necessarily what this bullet is implying, which is making the patient an active member of the overall care team. And so, I'm wondering what thoughts people, and experiences people have around using technology to help patients become more involved in their care. And specifically tying that to chronic disease management, given that is a critical objective for success in an ACO.

**R. Hal Baker, MD – WellSpan Health – Vice President and Chief Information Officer**

Well, Hal Baker from WellSpan again. We're rolling out our own portal and are approaching 20 percent sign up in many of our practices. It's anecdotal, but you get the stories of the patients who find the nodule on their chest x-ray that nobody mentioned, or have reviewed their lab results before they came in the office because they're released automatically to them. We certainly believe that it is an activation, but it involves being much more – it involves being as transparent in giving patients access to their information as we would want to be treated, not as we're comfortable doing as providers. And a lot of places only give the patient what they want, and we're really trying to do more in a patient driven way, kind of asking what we would want if we were the patient. And when the patient has access to their information, I think the OpenNotes Project also showed that they seem to be more participatory.

**Charles Kennedy, MD, MBA – Aetna – Chief Executive Officer, Accountable Care Solutions**

Great. Other comments?

**Grace Terrell, MD – Cornerstone Health Care, PA – President and Chief Executive Officer**

It's Grace Terrell here. There's – I think there's some innovation out there that's happening in this space right now, Avado out in the Seattle area, which is really looking at it from a patient-centric standpoint as opposed to from the provider-centric standpoint. So it becomes a question of push versus pull when it comes to who's got the information as it relates to patient engagement, and I'm not sure that an ACO or the providers, the way we're constructed right now, are going to get it right anyway. But I think there there's some other innovations that are happening that are going to probably get us there.

**Charles Kennedy, MD, MBA – Chief Executive Officer – Accountable Care Solutions – Aetna**

Okay. Well maybe what we could do is get some documentation, such as the OpenNotes, maybe get a summary of activities there. I think there's some other, PHR and advice and recommendations being generated and given to patients, that we could look at. One of the things that I've found kind of frustrating is, if you look at many of the leading EMRs have then begun to have PHRs or portal for patient access. I've been really disappointed at the level of...and accuracy of information that is provided. For instance, I've looked at one EMR vendor who, because they weren't connected to an HIE, didn't really have a comprehensive record of what was going on with the patient. And so, many of the recommendations around prevention and wellness were simply wrong, because some of those interventions were done at another site, where that data wasn't part of that EMR. Perhaps an ACO might offer some strategy...some structural strategies around that.

And I think the other thing I've seen is, you look at the recommendations themselves and as a physician, I found them wrong, on occasion. I think we see some EMRs kind of saying, okay, here's your problem list, and they may pull out of the EMR itself a problem list that they share with the patient. And I'll give you one example I saw, colonic polyps. The EMR clearly said the patient had colonic polyps. Well then, it got into the prevention and wellness component, and because the patient had polyps, I was anticipating that the recommendation for a repeat colonoscopy would be more in the three-to-five year time frame and in fact, they just showed the standard 10-year time frame. And so, I'm not sure how many of the EMR vendors are out there are actually making these recommendations based on an individual's health status, and rather maybe just kind of more in a document-centric kind of way, here's the general recommendations for what you should do around a repeat colon analysis. And I don't know if others have seen similar things or if others have seen vendors who have reached that level of sophistication.

**Joe Kimura, MD, MPH – Atrius Health – Medical Director, Analytics and Reporting Systems**

This is Joe from Atrius Health. So I think having third-party vendors, as there are a lot of third-party vendors that provide decision support services, that plug into the EMRs and look for discrete data within the system, that tries to sort of feed into their algorithms for when alerts get fired, etcetera. We've tried to do both ways, both building our own internally as well as trying to bring in third-party software. And both of them are still challenging, even as we try to get our own sort of gastroenterologist to document very clearly what the recommendations are, such that that data can then be used by our own organization to fire more accurate decision support.

I think it's a big challenge. I'm not sure necessarily it's the data challenge per se, maybe it is in terms of capturing the correct data in terms of clinical recommendations to be sure it feeds back into the patient level record sufficiently to drive that kind of decision support. I think the algorithms can work, if they can find it. We have a lot of challenges getting our clinicians to document that in a way that allows the system to grab it.

**R. Hal Baker, MD – WellSpan Health – Vice President and Chief Information Officer**

We're doing it ourselves and it's extremely complex and when you're doing it in a patient-facing way, you've got to be extremely sensitive. You do not want to recommend foot exams to people with bilateral amputations, you do not want to recommend mammograms to people who have gone through bilateral mastectomies. It is really complex to try to weave in the administrative and billing data into reliable algorithms that pull up a hyperplastic polyp while changing the recommendation on the adenomatous polyp. So, it's hard...at least it's been extremely hard for us to do it, and it's taken a lot of effort.

**Charles Kennedy, MD, MBA – Aetna – Chief Executive Officer, Accountable Care Solutions**

But it sounds like you've made some level of progress, right. I mean, could you talk a little bit about what you have been able to do?

**R. Hal Baker, MD – WellSpan Health – Vice President and Chief Information Officer**

Absolutely. We have devised...taken our data warehouse and devised a daily printout for each patient coming in the office with a coordinated care plan of what's supposed to happen and what's missing. We haven't put it to our portal yet, but it's driven off some very complex algorithms that we try to work out to do this. And certain times we just pull back our hands and say, your situation falls outside the routine screening, please discuss this with your doctor at today's visit. But, we've differentiated the exclusions that we need to meet the quality reporting data, which don't take into account the patient has a bilateral amputation from the exclusions that we want to put in there from a customer service recommendation, because we do not want to tell a hospice patient they need to get their cholesterol checked.

**Charles Kennedy, MD, MBA – Chief Executive Officer – Accountable Care Solutions – Aetna**

Right, makes a lot of sense. Thank you for that. All right, well let's move on to the last two bullets on this page, which is – I want to kind of handle them together.

**Akaki Lekiachvili, MD, MBA – Centers for Disease Control and Prevention – Informatics Science Lead, National Center for Chronic Diseases**

Can I – hi, yes, can I interject quickly. This is Akaki. Going back to slide 7 in the scope, we talked about the interoperable data integration, but then there's a mention of recommending inclusion of quality measures critical to ACOs. And I know that this work is still ongoing in different venues, is this group expected to make recommendations on specific quality measures for ACOs?

**Charles Kennedy, MD, MBA – Chief Executive Officer – Accountable Care Solutions – Aetna**

Well, our charge is not to be focused on quality measures per se, our charge is really to be focused on ACOs, and there are other workgroups focused on quality measures per se. That said, if there's something specific to quality that an ACO could do or could do in some way uniquely that the other workgroup wouldn't cover, I would think that would be fair game.

**Kelly Cronin, MPH – Office of the National Coordinator**

Yeah Charles, we've talked to Paul Tang and some of the Health IT Policy Committee folks that are involved on the Quality Measures Workgroup side, and I think there's a – no one's currently addressing the issue of are the quality measures that are currently being used as a part of the requirements and tying to benchmarks for shared savings, are they the appropriate measures for accountable care models. And, there has been some sort of input from various sources around the need to potentially evolve measures to be more patient-centric, more in line with care coordination models, perhaps longitudinal and more outcome based over time. So I think that the thinking is that there could be a healthy discussion around how does that happen and how does it potentially factor in to Meaningful Use Stage 3 and the clinical quality measures that are being developed and tested for Stage 3, since there's a big push with CMS to really align across programs.

**Charles Kennedy, MD, MBA – Aetna – Chief Executive Officer, Accountable Care Solutions**

Great. Well that makes a lot of sense. I mean, I do recall, I think it was the Pioneer award winners writing a letter to CMS around the quality measures. So, I do recognize it's an important target, especially because it has reimbursement implications. So, it sounds like it's something we should put on the radar screen then.

Moving back to the last two bullets here, before we run out of time, aligning payment policy and health information exchange for ACO success, and improving the linkage between functionality and value creation. And I guess what I was trying to get out with these bullets is, if you recall the discussion we just had, we've had a lot of discussion about EDWs and data warehousing and analytics, health information exchange, haven't had as much discussion about electronic medical records. And so as we think about Meaningful Use Stage 3, and as we think about ways to align the financial incentives, are there things we should be thinking about that maybe aren't directly tied to an EMR deployment, but are tied to all of these other infrastructures that we've been talking about, that are critical for ACO success.

**Shaun T. Alfreds, MBA, CPHIT – HealthInfoNet – Chief Operating Officer**

Charles, this is Shaun Alfreds from HealthInfoNet in Maine. One of the areas that we're seeing is of significant value on the ACO side, and of a financial alignment area is around the patient identification. What we see is a significant amount of what we call "leakage" across for patients that are assigned to one ACO and are being seen by providers who are not part of that ACO. And the value proposition here on the data warehousing side, but also on the health information exchange and data movement side, is the ability to be able to identify patients as they move across health care systems and across ACOs, so that data and information can be gathered for those patients, as they move across the health care system. As much as we think that patients are loyal, they're actually...we're seeing more movement of patients as of late rather than less, because they're becoming more activated. So driving a means by which identifying patients across a health care sector through standards, supporting standards, as well as financial incentives, can support the sustainability of both sides.

**Charles Kennedy, MD, MBA – Aetna – Chief Executive Officer, Accountable Care Solutions**

A great comment. I'm wondering, have you used – have you tried at all to use claim data at all as a vehicle and if you've had any experience or success with that.

**Shaun T. Alfreds, MBA, CPHIT – HealthInfoNet – Chief Operating Officer**

Yeah, here in Maine we are doing an analysis. What we have is a statewide, all payer claims database legislated. That database includes claims on both Medicare, Medicaid, as well as commercials. And what we've gone through over the last six months is an analysis of the linkage between the identified data in the health information exchange as well as the data that's coming out of the all payer claims database. And we're finding a high degree of linkage across the two data sets, which is certainly helpful in linking the claims and the clinical data; however, and our exchange is a little bit different as a centralized repository model. And what allows us to be able to bring value back to the ACOs is that shared EMPI that is statewide.

And we're able to, when working with the ACOs, they're able to give us their eligibility files and we're able to pass down to them, in real time, the ADT and laboratory information, as well as other clinical documentation for their patients, whether their being seen locally within the owned or affiliated facilities for the ACO but also outside of that ACO as those patients land there. That's a unique value that the exchange brings to the table that many states don't have, and so, thinking through how we can build policy, build incentives to drive for some standardization around patient identification can bring that same value to other states that don't have, or other location's regions ACOs that don't have a shared EMPI.

**Charles Kennedy, MD, MBA – Aetna – Chief Executive Officer, Accountable Care Solutions**

Great. Thanks. Other comments?

**David Kendrick, MD, MPH – Chief Executive Officer – MyHealth Access Network**

This is David Kendrick in Tulsa, can you hear me?

**Charles Kennedy, MD, MBA – Aetna – Chief Executive Officer, Accountable Care Solutions**

Yes.

**David Kendrick, MD, MPH – Chief Executive Officer – MyHealth Access Network**

Oh good. I was just going to sort of add to that that we are a health information exchange with extensive analytics on the back-end, as you may remember from the last call. But we have encountered a similar situation, but with claims, of course the age of the claim makes it not useful – makes it useful for understanding patterns long after the fact, but not as useful for intervening to redirect the patient back into their ACO for care, which would actually make the difference in cost and service. So, that's the only thing I would add on claims data.

**Charles Kennedy, MD, MBA – Chief Executive Officer – Accountable Care Solutions – Aetna**

Great. I'm looking at the time. MacKenzie, I think we're just about out of time here. Any other comments people want to make around these last two bullets? Okay, well, this was a robust discussion, I think we got a lot of good topics out on the table. What we'll do is, review all of these comments, try to put them into themes and then at the next meeting we can talk about a work plan to address these themes, and also talk a little bit about what's the most valuable output we can create from this committee, to influence HIT Policy Committee in subsequent discussions. So with that, MacKenzie, is there anything you wanted to say before we close?

**Public Comment**

**MacKenzie Robertson – Office of the National Coordinator – Federal Advisory Committee Act Program Lead**

I'll just open the lines. Operator, if you could please open the lines for any public comment?

**Rebecca Armendariz – Altarum Institute**

If you would like to make a public comment and you are listening via your computer speakers, please dial 1-877-705-2976 and press \*1. Or if you are listening via your telephone, you may press \*1 at this time to be entered into the queue. We have no comment at this time.

**MacKenzie Robertson – Office of the National Coordinator – Federal Advisory Committee Act Program Lead**

Okay. The only other thing I'll add is that we'll be scheduling more meetings and having them on the calendar, so please look out for the calendar appointments.