

**HIT Policy Committee
Accountable Care Workgroup
Transcript
August 27, 2013**

Presentation

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Thank you. Good afternoon everyone, this is Michelle Consolazio with the Office of the National Coordinator. This is a meeting of the Health IT Policy Accountable Care Workgroup. This is a public call and there will be time for public comment. Please remember this meeting is being transcribed and recorded, so please state your name before speaking. I'll now take roll. Charles Kennedy?

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

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Grace Terrell? David Kendrick? Cary Sennett? Karen Davis? Heather Jelonek? Bill Spooner? Sam VanNorman?

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

Yup.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Joe Kimura?

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

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Shaun Alfreds? Karen Bell?

Karen M. Bell, MD, MMS – Chair – Certification Commission for Health Information Technology
Here.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Hal Baker?

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

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Irene Koch?

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

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Eun-Shim Nahm?

Eun-Shim Nahm, RN, PhD, FAAN – Associate Professor and Program Director, Health Informatics Specialty Program – University of Maryland School of Nursing

Here.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

John Fallon? Aaron McKethan? Scott Gottlieb? Westley Clark? Akaki Lechiavilli? I'm so sorry. Mai Pham? John Pilotte?

John C. Pilotte – Director, Performance-Based Payment Policy Group – Centers for Medicare and Medicaid Services

Present.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Are there any ONC staff members on the line?

Alexander Baker – Project Officer, Beacon Community Program – Office of the National Coordinator

This is Alex Baker.

Kelly Cronin, MPH – Health Care Reform Coordinator – Office of the National Coordinator

And Kelly Cronin.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Okay, thank you all. With that, I'll pass it over to you Charles.

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

Okay, very good. Good afternoon everyone. Today we're going to continue our process of dialing through the necessary capabilities that we want to consider in the Accountable Care Workgroup. Today we have, just looking at the agenda, an update from the Clinical Quality Measures Subgroup from Joe Kimura and then we'll go into our normal routine of using the CCHIT Framework and the elements of that framework and walking and discussing the key questions that you see for both the patient and caregiver component of the framework and the clinician engagement component of the framework. So with that, can I turn it over to Joe to give us an update on the Accountable Care Clinical Quality Measures Subgroup.

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

Sure. So, we've met twice, and just to briefly outline who's a member of that subgroup, I think it's a mixture of the quality measures group as well as our group here, so overlapping with our team here is David Kendrick, Sam VanNorman and myself. Other people on that subgroup are Terry Cullen from the VA, Helen Burstin from the National Quality Forum, Ted von Glahn, from Pacific Business Group, Mark Overhage from Siemens, Eva Powell from Evolent and then Paul Tang from Palo Alto. Our charge was to really look at quality measurement, although more broadly speaking, value measurement for an accountable care organization. And I think we're still in the early stages of forming what that framework would begin to look like. We've looked at an academic model coming out of the previous ACO work that talked about looking at the value equation and thinking about sort of health and healthcare outcomes in two different ways. We've also looked at quality measurements coming out of the meaningful use framework, as well as the series of both currently existing and pipeline measures coming out of CMS and the National Quality Forum. We had Scott also join us last week, I think it was, we've only had two of these meetings, and gave us an update on CMS's process for developing the quality measures from the MSSP Program as well.

So, we're really early in this process and still trying to come up with our first major deliverable, which is thinking about a good framework for what types of measures would be most important. Paul has pushed us to say after that framework is set up, he would like us to also think about the deeming concept for whether or not certain measures can help an organization around meaningful use, if you meet certain top level measures, then you don't need to attest to the lower level measures. So, we're not there yet, and we're still thinking about the framework, but we have another two and a half months of meetings. And I'm not sure if Sam or I don't think David's on the line, has anything more to add from our previous meetings to date.

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

I couldn't say anything better than you Joe.

Karen M. Bell, MD, MMS – Chair – Certification Commission for Health Information Technology

This is Karen.

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

Thanks. Hi Karen.

Karen M. Bell, MD, MMS – Chair – Certification Commission for Health Information Technology

Joe, this is Karen. I'm just wondering what the timeframe is, would this be for Stage 3, is this for some time in the future, what are the timelines for developing these measures.

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

Yeah, so the – I don't think we're actually being asked to develop measures yet, there's – Paul would like us to have some exemplars as – for more concrete purposes for the HIT Policy Committee, but he's pushing us really to have a framework. And really when we're thinking about the big, big picture, the types of measures – the model that was proposed has a significant emphasis upon patient reported outcomes as well as sort of traditional healthcare intermediate outcomes and process measures. And we've been sifting through many of those different models, diving really deep into specific measures, but also thinking about top-level things around health measurement, measurement of health of populations. And it's been challenging in the first two meetings, trying to be sure that our scope is appropriate for what Paul would really like to bring forward into the HIT Policy Committee, so I would say that the immediate deliverable out of the framework isn't going – may guide some discussions for the next phase of meaningful use, but we're not recommending like a list of 25 measures or anything like that, that's not going to come out of the committee.

Karen M. Bell, MD, MMS – Chair – Certification Commission for Health Information Technology

Okay. Thanks.

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

This is Charles, a follow up Joe. So you said two things in your opening statement, you talked about quality, but you also talked about value.

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

Yeah.

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

And I've heard value be conceptualized in many ways in the healthcare industry and I guess being the health plan guy, we frequently think of value as quality over cost. And even though that's not a perfect framework, the notion of value begins to introduce the notion of cost into the equation as well. You might get a certain outcome, but you might be able to get an equivalent patient outcome in three or four different ways, all with widely varying cost implications, I mean lower back pain management comes to mind. How is the group thinking about the notion of value and how do you see that getting framed in the work?

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

Yeah, so a big portion of that discussion has been coming. So the framework I referenced was the framework developed by, I think it was published by Bankowitz, Corrigan, Fisher and Gene Nelson I think in May of this year that has this concept of value being defined as outcomes plus experience over expenditures. And I can share the slide that we're looking at actually in the other committee meeting, as sort of a jump point for discussion. And so they are trying to – we are trying in the group, trying to look at how that gets balanced, although we've had some back and forth for sure on can you really balance those things, how do you optimize that kind of value equation? And is that really what we're try – do we think it's reasonable that we're going to achieve something like that.

That's kind of where we had the break between healthcare measures around outcomes experience and expenditures and health – population health outcomes, experience and expenditures. But, it is a good point, I think we're struggling to make sure that we create something that's actionable and operationally relevant, not in something that's going to get developed 10 to 15 years from now. Sam brought up some really good points at our last meeting around if we're going to create measures and recommend certain measures, we really do need to think about the operational consequences of any measure that gets proposed. So, we're in this zone where a lot of theoretical discussion is going forward, to see if the framework is correct, but we know part two of the theory has to get back down to very practical implications. But, we're still in part one at this point.

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

Okay, that's very helpful. And just one follow up. Another, I guess framing, I frequently use in thinking about ACO reporting and measurement needs, is to perhaps frame it from the perspective of there are population health measures, meaning here's a population of individuals and I might be able to use a data warehouse or other registry-like function to launch queries to identify anything from gaps in care to any kind of analysis on the quality of care that someone is receiving in more of a retrospective and population way. But then there's also the individual care of the patient who might be sitting in front of you and needs care individualized for that particular moment or that particular encounter. Quality and value have implications for both. Is the workgroup addressing kind of both areas or focusing more on one or the other or – how is the workgroup thinking about the need to look at a population of individuals versus the need to have some of those insights be managed in the office or wherever the care is occurring?

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

Yeah, I don't – I'm not sure if we necessarily addressed that point head on yet. I think the discussion points we've had so far have been around when we talk about healthcare measures, many of those are talking about system reliability, sort of your classic clinical intermediate outcomes, things that we can capture that have traditionally been reported out of data warehouses, either EMR or out of claims administrative data sets. So those are sort of elements around the delivery system that I think we're conceptualizing around healthcare measures. And I think making that distinction of those types of measures versus again, this world of patient reported outcomes, the promised global 10 and other kinds of scores that are a little bit – we may not even be capturing half of that data yet, but if it feels like those are the population level measures, not just aggregation of individual scores, but truly population level measures for a community, etcetera, how does that get looked at?

And Helen brought up the good point that many of those measures are still very early in academic vetting, so there's got to be a lot of work on that one before anything like that even comes close to being applied towards any kind of sort of performance rating comparison between organizations or anything like that. So, there's clearly certain measures that are more ready sooner and then others that need a lot more work and research before they're ready for primetime.

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

Thank you.

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

Sure.

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

Anyone else have any other questions for Joe? Joe, I'll just add one last one then. Do you think, just based on the scoping of the workgroup's activities, that they'll be any discussion of – I guess let me explain the term as I would use it, data architecture. In other words, the types of quality measures and the types of value measures you can create. As you were discussing during your last point, an EMR might not have all of it, in fact, it might only have representations of the care that was delivered at that particular facility. Whereas if you're going to do reporting on a population, you might either need multiple EMRs or EMR and claim data or a variety of inputs, you mentioned patient entered data, etcetera. Is the scope of the committee going to include any discussions around what the architecture needs to be or what the overall kind of framework –

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

Yeah.

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

– for all of this data to come together might be, in order for it to be maximally valuable to an ACO?

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

Yeah, that's a very good question. I would say that part two of the work, regardless of whatever framework and what sorts of exemplar measures get created, there is – the next part two really is to come up with maybe not the answers to how do you set up a very specific data architecture, but how do you make sure, what sorts of processes and steps does the Policy Committee have to go through once a measure is proposed, to be sure that it's operationally doable and fair. So those two elements we talked about, not only the application of the methodology, but the application of that method around high stakes measurement or other types of comparative aspects were things that needed to get tested beforehand.

And I think it was Sam that also brought up the fact that again, a lot of times measures get proposed and the cost of developing the data capture capability lands on the delivery system that needs to build something custom in the EMR to try to capture that information. And trying to be sure we think through that to give some guidance around what needs to additionally be thought through when a measure is proposed. I don't think we're going to get to, this is what an ideal architecture would look like, or these are all the variable components that every ACO delivery system should have in place. I don't think we're heading in that direction.

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

Okay, great. Thank you, that's very helpful.

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

All right.

W

Charles, there is a Data Intermediary Tiger Team that's been looking at sort of what's the middle layer that needs to be there, especially as we get into longitudinal measures, where data could be residing in multiple EHRs or multiple information systems or in some cases through claims or patient entered data. So they have been looking at that and I think there's probably going to be some intersection between the two workgroups that we're going to have to figure out as we get into phase 2.

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

Yeah, I think that makes a lot of sense, because it – I've been involved in so many informatics initiatives where we kind of didn't do a good job in understanding the underlying data versus the underlying apps or reports that we were trying to drive, and that can create some real gaps or misses in what you're trying to do. So I think that's going to be really important to provide those linkages.

W

Um hmm.

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

Okay, well Joe, thank you so much for that and let's continue on our agenda. For the next part of the agenda, Karen Bell is going to walk us through our next two CCHIT Framework elements and so Karen, I'll turn it over to you.

Karen M. Bell, MD, MMS – Chair – Certification Commission for Health Information Technology

Thank you so much and I also want to thank Alex and Kelly and everyone else at ONC for having created this whole approach to allowing us to get some feedback on – to everyone online. There's absolutely no question that it's a whole lot easier to give feedback than create something de novo, so I'm hoping that we'll have some pretty rich discussion today because we've had the opportunity to think about this a little bit in advance. So again, thanks to the ONC team for teeing this up. So I guess you're going to move the slides forward for me Alex or someone there, because my system is coming up and down, so, I'll need you to do this for us.

So, I think the – to just sort of level set everybody, I just want to remind us all, or at least all of us who are in town and on the line today, a lot of folks are on vacation, being the last week of August I guess, that by the end of this year, we need to be providing a set of recommendations to the HIT Policy Council about how ONC and HHS can advance some priority health IT capabilities in a variety of accountable care arrangements. And here I think it's important to recognize that the accountable care arrangements that the federal government has include just upside risk, up and downside risk and then these more alternative payment mechanisms that can include everything from bundled payment to capitations and that sort of thing. And the, and Charles you can jump in here, that the commercial environment has those same kinds of arrangements, many ways, patient-centered medical home is a form of ACO with an upside risk based on ability to meet bonus targets. So the real question, I think here is, how can we develop some good recommendations that will be appropriate for all of the provider groups within the ACO environment. And then if there are some in particular that we think are going to be important for those organizations taking on greater amounts of risk, then maybe we could pull those out as well. But, this is our initial task, which you're all well aware of.

So if we move along, and in the slide deck we're really talking about these framing statements that we've had before, really advancing the evolution of the HIT infrastructure to get to those value-based payments. And as I said before, there are a lot of different ways that this can happen, but we really want to get to that common set of core capabilities. So, a lot of good work...next slide please Alex. A lot of good work has come out already with thinking about what we could do, based on again, the framework that CC – something else that's easy to react to. And I think it's important as we go through our discussion over the next hour or so, that we keep in mind these five element – five questions. Really, want to make sure that everybody is concurring with the input about the importance of these needs and the effectiveness of market forces.

And I think it's important to recognize that market forces are also diverse. They can include the pressure from the provider community as it grows in its evolution through accountable care and taking on increasing levels of risk. Market forces can also be the result of competition within the vendor community. There are different types of market forces that we need to be thinking about, and balancing those among – against the effectiveness of not just regulation, but any other type of federal policy that could be put in place to advance our goals here. And I think that's where the point 3 comes in, what other policy changes, besides regulation, could incentivize the development. We were talking a little bit earlier about other types of policy, one of them being related to dollars and cents. If there are specific incentives, then that's an approach that's taken, how the federal government chooses to pay, for instance, just creating the ACO environment creates a policy that will drive change, and there are others as well.

Conditions of doing business with the federal government could be another policy lever, so that there other policy levers that I think we'll probably get into, once we have a better understanding of where we might need federal intervention, i.e. where there is likely to be market failure for something that's really necessary for the ACO environment. Now we clearly, I think recognize that interoperability is absolutely critical in this environment, so we want to be thinking about additional interoperability standards as we go through this process. And again, we can concentrate more on that down the line. And then also the kinds of data that will need to be collected or integrated to better support the function. So, a lot of this we've talked about before, so we can go on to the next slide.

And begin to really pull it together, and again, I have to thank Hal Baker for this particular slide, because I think it's really important to recognize that there's this space in the middle where we may need policy and/or regulation. And that's where something needs to be clinically important, and I might add, and I hope you don't mind Hal, I might add that it also needs to be important from a business perspective or important from a business perspective, because the ACOs now are going to be functioning differently than just straight – from a straight clinical perspective. We also want to be sure that it's unlikely to arise from whatever market forces we've just talked about, and that whether it's regulation or other type of policy, it needs to be effective going forward, so it has to meet the needs of what we want. So, it's going to be an interesting juxtaposition of these three areas. But it's a great slide and I think that's one that we need to think about.

So, if we move along now, I think we'll probably now start getting into a little discussion on the key processes three and four, the patient and caregiver management and clinical management. And the next slide should be a slide that summarizes the results of all of the feedback that was gleaned from the survey that hopefully most of us had an opportunity to see and at least quickly pull out here. I'd like to start here by – start the discussion here by reminding us all that this is a really a very important process. It's not just about improving quality or improving the cost equation; it's also about ensuring that the patients and/or their designees are bonded to the particular ACO. This is all about the ACO environment now and, as we all know, it does not have any gatekeeping, patients are free to wander off the reservation if they choose if they think the grass is greener elsewhere. So, we really want to make sure that their needs are being met for their healthcare, but also for their personal needs as well. I think the interesting things that came out of this slide is that obviously there – our sample size wasn't particularly big and that the spread, particularly on the first column, how important is this function wasn't particularly big either.

So I thought it would be helpful to at least, with the group that's on the line, go over some of these, or at least go over some of these, just to make sure everybody understood where each of these was in perspective. And to validate that at least this order is, in fact, a priority list that we're comfortable with and in so doing, I'll mention many of the things that are on all of those ensuing slides that we got as part of the presentation. But I think it's easier just to concentrate on this particular slide, and I'll talk a little bit about the things that this entails and as I do, I will mention some of the HIT capabilities, and that's where you might want to think about how likely it is that current market trends may push that forward.

So as we go through this exercise, we'll stop and have chances for discussion along the way, I just want you to do two things for starters. Number one, make sure that the list and its descending order is how you would like it and if it's not, then think a little bit about what you might want to change or move around. And then secondly, to not so much worry about the scores, but put a little – in your own mind or on your own cheat sheet, mark off those where you really have some concern about the market forces not being able to support the development. Because those are the ones that we really will want to get into in greater detail with respect to federal support. And again, it's not just regulatory, even though that's what it says on the slide, there are the policy levers that ONC, HHS, CMS, etcetera can pull if need be, going forward, if we really think that there's going to be market failure in that the ACO – the drivers in the ACO environment itself might **27:43** – itself might not move this along.

So, if that's okay with everyone, I just want to start, before we start doing a slightly deeper dive, by reminding us all that this is about a relationship that's going from the delivery system, those of us doing things to patients to doing things for them and doing things with them, which will require a major change in how communication occurs between providers and their patients/designated caregivers. And even a more significant change in how patients and their designated caregivers can use technology to better care for themselves on multiple levels. So with that, we'll start with the functions first and as I said, I'll mention some HIT capabilities so you can get a sense of how you want to rate either good enough from the market or not on that second slide. And then we can begin to really think through what we need to think about with respect to the federal engagement.

So this part about the patient engagement on their own care was number one on everyone's list. I think that was pretty clear moving forward, and this includes things like remote monitoring options, the ability for a patient to amend and correct their own clinical records, to really be engaged in not only their care, but also with data around their care.

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

Sorry, can we just go back one slide – we're on number three, there we go. Good.

Karen M. Bell, MD, MMS – Chair – Certification Commission for Health Information Technology

Um hmm, oh, I'm sorry. We – yeah, that's where we need to be. We'll stay there. So, in addition to what I just mentioned, it also includes some interesting things like links to specific kinds of information, such as the end-of-life – the standing orders for end-of-life kinds of things that are available in most states. Things like access to organizational supported social media and games to encourage positive behaviors. And outbound motivational messages, reminders and opportunities to further engage in care. So it's a very robust set of HIT supports to move us in this direction. But many of them are not those that are currently used right now. So the real question here is, again, since this is so important, do we have enough going on – enough in the marketplace right now so that we can leave it be or whether or not that's something that we really would like ONC to work with us on, with respect to pushing that along. Any other comments or questions about that one?

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

Hal Baker. I noted there was a line in there about the ability for patients to schedule versus appointment request. That seemed like something that almost every other scheduled service industry has moved to, with healthcare being a laggard and –

Karen M. Bell, MD, MMS – Chair – Certification Commission for Health Information Technology

Absolutely, and I think that was part of administrative simplification for patients. So yeah, that was one that was included in the next batch down. So going to the next batch down then, if I may, the second thing we had on the list was some monitoring of the individual patients, and this was with respect to meeting their own long-term goals and their own self-reported outcomes. So this is where we would need good care plan, milestones and goals. We would want to be able to survey patients regarding their functional status, quality of life, and those sorts of things. And to be able to monitor not only ourselves, but – in terms of a delivery system, but have them be able to monitor their progress.

And we actually had some comments around this one, had to do with the fact that there's a paucity of tools to – or, paucity of tools that are standardized that could be used to regularly survey patients about their functional status or outcomes. There are some, but they're not available – easily available and they're expensive, and that there was a comment about web-based surveying that would be helpful for this as well. So, I think the gist of the comments was that there was some opportunity here for the development of some standardized approaches for gathering information on patient-specific outcomes. So the question is, is that something that the markets likely to do on its own, or again, will we need some sort of federal intervention to push that along. So, I'll let you all make your own little thoughts on that one.

And I'll quickly move on to the administrative simplification piece, because that, I think, is what you were referring to Hal. The administrative simplification for patients is really assuring that this is easy to use, patients can use the system easily, not only to be able to do their own online scheduling, but also to be able to assure that their billing is easily done. They have access to reliable and timely information – insurance information; they don't have any nasty surprises. Such as we just had reported in the Boston Globe this week when a couple or a gentleman – an elderly gentleman spent three days in the hospital with pneumonia and congestive heart failure and then was transferred to rehab, to pay out of pocket because no one ever told him that he was on observational status. He was in a regular room for three days under this IV therapy and all of that, but for some reason – well, we know the reason, CMS rules were interpreted as being outpa – observation. So those are the kinds of things that we really need to, I think – the reason we listed them here, make readily available that kind of information so it's really simple for them to navigate the system and they don't get any negative surprises out of there. So that's what that one was about.

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

Karen, I would just say, 3.5 actually had the scheduling ability in it, 3.2 contained the ability to access the scheduled information.

Karen M. Bell, MD, MMS – Chair – Certification Commission for Health Information Technology

Okay.

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

I'm not sure it matters.

Karen M. Bell, MD, MMS – Chair – Certification Commission for Health Information Technology

Okay – get them all over the place here, so thank you. So the next one down was patient communication that was number four on the list. And this was around the bi-directional communication electronically. And that's something that I know that Stage 2 and Stage 3 are attending to, in terms of secure messaging at least, so there's some of that that's coming, but it's also going to be important to think about giving patients access to their clinician's clinical notes and make it absolutely clear how they would like the communication to occur.

Basic information services are more the kinds of things that would allow a patient to really find it easy to get around the particular ACO, maps – directions to provider's offices, the provider directable – directory, available services, contact information as well as some transparency around cost information – reports, surveys, etcetera. So those kinds of informational services are about the ACO itself, very different from some of the patient education services we saw below, so I just wanted to make sure everyone was clear about that. And that the degree to which they felt that would be a high priority, and again, whether or not there needed to be any intervention. So we're halfway through the list, I'm going to stop right now just to get a sense of whether or not this is working, this is helpful. People have any comments about what we've done so far.

Eun-Shim Nahm, RN, PhD, FAAN – Associate Professor and Program Director, Health Informatics Specialty Program – University of Maryland School of Nursing

This is Eun-Shim Nahm.

Karen M. Bell, MD, MMS – Chair – Certification Commission for Health Information Technology

Um hmm.

Eun-Shim Nahm, RN, PhD, FAAN – Associate Professor and Program Director, Health Informatics Specialty Program – University of Maryland School of Nursing

So maybe it could be me, but I'm having a little bit of trouble with the like definition a little bit, like ba – I mean all items seem to be ideal and very important, but there seems to be a difference between feasibility versus what is ideal. Or, like for example, like when you look at option number four, how likely is regulatory action to accelerate success? I mean, if we set it up as regulation or law, people are bound to follow, right, and try to meet the requirements, but – so to me, when I grade, I had a little bit of trouble with really ideal versus really, can I ask providers or patients, clearly ask them to do these things? Like for example, basic information services could be different in different settings. Am I off base here a little bit?

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

This is Hal Baker, I would agree with you. As I did my diagram, I was trying to get at what are the things that move along. I mean, I don't think we would be as far on patient portals if ONC hadn't nudged us all. And I'm sitting here wondering whether something like the Open Note Project will take off on its own momentum, or whether ONC needs to move it along. I think patients being motivated to take care of themselves is really important, but I think regulation is unlikely to make that happen and wh – so, I'm just trying to figure out how ONC uses its limited change capital most effectively, and which ones of these are – is in a sweet spot to make a difference. Because there's nothing in here that I disagree with eventually happening, they're all good things.

Karen M. Bell, MD, MMS – Chair – Certification Commission for Health Information Technology

Well, if the question though is whether or not the fact that we have an ACO market that's going to demand these things develop over time and vendors may be interested in competing in meeting the needs over time. That means that the market will get there eventually and probably – and it will be iterative I suspect. I think the real question is, and this is where I think it's important again to underscore in column four, it's not just regulatory action, and there are other actions that the federal government can take to affect policy, to move things along in a particular direction. It doesn't have to be regulatory. So, I think there – that's why the first question I – that we were addressing is whether or not the – we think the market, which is again, a combination of providers demanding it and vendors competing to try to meet provider demand, will eventually get the HIT infrastructure to where it needs to be to support all of these things. We can't force patients to do certain things, but we can certainly make it easier for them to do them if we have a good HIT infrastructure. So I think that's really the – that's really the push here, and maybe someone else would have a different viewpoint on that, but I'm just throwing that out from my own perspective and see if that's something you would agree with or not.

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

Yeah, this is Wes Clark from SAMHSA. We are particularly interested in empowering patients to participate in shared decision-making and to have information about the nature of their care so that they can make appropriate decisions, particularly for those, of course, who have behavioral health issues. So I think the agencies also have a partial responsibility, I agree with you that it's not all regulatory, we need to be promoting these patient-centered themes and at HRSA, SAMHSA, IHS and other places, the VA, DoD, other places where we want people to engage with care. The Washington Post had an article, a young man who suffers from PTSD making the pitch to others in the military to present early rather than later, when they have symptoms. And then the issue of medication adherence or treatment adherence is actually patient-dependent, patient's don't feel they have enough information, they won't comply which drives up the cost of care, they won't keep appointments which drives up the cost of care.

Karen M. Bell, MD, MMS – Chair – Certification Commission for Health Information Technology

Thank you. Any other comments on this, the direction that we're going here?

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

Well, as long as driving up the cost of care still drives up revenue, I think we're going to have a hard time with the model moving. While we're getting close to accountable care its, for most of us, not the majority of our business model, so some of these things, if we're going to get them going before we hit that tipping point where every additional study is additional cost, not additional revenue, that's where ONC and HIT can, I think, move things. This is Hal again.

Karen M. Bell, MD, MMS – Chair – Certification Commission for Health Information Technology

Thanks Hal. So, as we think through this, then any of the places there that we don't think the markets going to move fast enough would be, again, a place where ONC would be able to help us, using any one of its policy levers, and we can think about those on one of our subsequent calls. But right now, if we can identify those areas where it would be important and we don't – we think there's going to be market failure in a timely way, those are the areas we would want to move forward with ONC. So maybe the next step would be to look in greater detail at the various HIT capabilities within these functions, and really get a sense for whether or not we think they might be happening on their own or whether it's something ONC would need to intervene on.

Having said that, let's go back and just make sure that everybody is in agreement on the priority list here. There are a couple of things that were at the bottom of the list, such as – well, I guess it was – the last one on the list was number eight, that was the patient experience with care where the ACO would be doing surveys across the population, analyzing it, reporting it back out and capturing complaints and concerns. That was considered fairly low priority and also, not something that it was felt that there would be a lot of emphasis on if ONC was part of that as well. So, without reading too much then, is this list prioritized in a direction that everyone's comfortable with or would anyone want to move something around?

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

This is Joe. Actually, so one comment on that patient experience side of it, so recognizing that there is the real-time sort of patient experiences and complaint aspects of capturing information. But also the fact that patient experience of care is part of the seven quality measures in the Pioneer ACO sort of measurement of overall organizational performance, and it also is here in Massachusetts, right, part of the Blue Cross AQC contract. So as a domain of measure that's being tied to perf – organizational performance that's being tied to reimbursement, it has – it does have a little bit more immediacy, if that's going to continue in that direction and those are the types of measures that are going to be asked of ACOs in the future.

Eun-Shim Nahm, RN, PhD, FAAN – Associate Professor and Program Director, Health Informatics Specialty Program – University of Maryland School of Nursing

This is Eun-Shim, and I also agree with Joe, because we are making changes. I mean, the nation is making changes and I think we – it's important that we assess how those changes are perceived by the public. It may be soft data, but I think it's important to ask how they experience the changes over time. And it could be a very simple survey type, but it may be able to give some important data over time, I think.

Karen M. Bell, MD, MMS – Chair – Certification Commission for Health Information Technology

Um hmm.

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

This is Hal on patient experience care. It's really important to us, we're spending a lot of time on it, and I just don't think ONC needs to put in regulation. Because if I've got to move my HCAHPS scores, I better figure out why my patients aren't happy and I need to do most of these things so you don't need to – I'm already externally motivated to do it.

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

I tend to agree on that. This is Sam VanNorman. It's just such a focus already that I don't think it adds anything and probably detracts some of the effort already going on in this area, if we have to mandate it.

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

Save your powder.

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

Yup. That's a good short way of putting it.

Kelly Cronin, MPH – Health Care Reform Coordinator – Office of the National Coordinator for Health Information Technology

This is Kelly. Just a reminder that our regulatory authority beyond governance of health information exchange, which we haven't really exercised, is really limited to voluntary certification of health IT software. So in terms of our leverage over the vendors, you just might want to think about what would you like the vendor's products to be doing more routinely and would a voluntary certification program support having that capability or those standards more widely available?

Karen M. Bell, MD, MMS – Chair – Certification Commission for Health Information Technology

But just to clarify, Kelly. Some of the other policy levers, we could make recommendations on and other parts of HHS might be interested in hearing those and perhaps doing something with them.

Kelly Cronin, MPH – Health Care Reform Coordinator – Office of the National Coordinator for Health Information Technology

Yeah, I mean, I think John Pilotte's on the phone, who oversees the part of CMS that's responsible for the Medicare Shared Savings Program and as that program evolves both through the experience and the Pioneer ACO model and the Advanced Payment model. And just the other experience of getting, as MSSP matures, there's potentially opportunity to inform their future actions. And in general, I think, since our charge is sort of accountable care more broadly, different types of value-based payment, or even accountable care arrangements that would be applicable to primary care or other types of providers, I think we could be thinking more broadly than the Medicare Shared Savings Program, potentially. But again, our lens is really around the health IT piece of it.

Karen M. Bell, MD. MMS – Chair – Certification Commission for Health Information Technology

Well one of the things that we might do, as a next step with this particular piece of work, is to – I think if everyone's in relative agreement that all of these, and there was a general comment that all of these really are important, all of these functions are important. Then perhaps a next step we could do would be to look at the HIT capabilities throughout the entire grouping of functions under the patient relationship piece. And then think about those from the perspective of whether or not that's something that is likely that the market will do in a timely way, or ONC might need to intervene in some way. And again I guess, if we are – we're thinking broadly, but if we're thinking about something that's going to be supportive of pretty much the entire environment, we're thinking primarily at the first rung, I would assume, kind of upside risk. Is that – would you a – is that right Kelly or should we be thinking beyond that? So many of these accountable care arrangements are upside only.

Kelly Cronin, MPH – Health Care Reform Coordinator – Office of the National Coordinator for Health Information Technology

Yeah. I mean, I think there's a lot in the market today that you all have a better understanding of than I probably do. I think we want to be looking at – inspecting what's happening today, but also think, a lot of what the federal government might do in response to your recommendations, would play out over several years. So, I think we're interested not only in what's happening or not happening in the market today, but also what you see unfolding over the next several years.

Karen M. Bell, MD. MMS – Chair – Certification Commission for Health Information Technology

So, ultimately our recommendations could be almost as a roadmap, things that are necessary now for upside risk only and then things that would be more important as these organizations grow and the amount of risk and how they take on that risk.

Kelly Cronin, MPH – Health Care Reform Coordinator – Office of the National Coordinator for Health Information Technology

Yeah, that would be incredibly helpful.

Karen M. Bell, MD. MMS – Chair – Certification Commission for Health Information Technology

Okay. So, I guess Alex, maybe the thing to do with this piece next would be to ask, and obviously we have a lot of members who are not on the call today. Ask them to look specifically at the HIT capabilities and rate each one of those as to whether or not it's something that the market will be doing fairly quickly for the current situation, whether it's likely to be doing it over the course of time. And if not, and then the if not would bump us over to the discussion about how ONC might be able to help. Does that make sense?

Alexander Baker – Project Officer, Beacon Community Program – Office of the National Coordinator

Yeah, I think we could think a little bit further about how we can, now that we have sort of this broad brush, think about what the implied specific sorts of capabilities are in here now. And as we pivot towards recommendations, think about what is sort of a feasible topic for digging in deeper and trying to formulate those specific recommendations.

Karen M. Bell, MD, MMS – Chair – Certification Commission for Health Information Technology

All right. Well then I think, maybe what we could do then is leave this slide and then have a little bit of discussion on the clinician engagement one. And whatever – we'll move – however we move forward with patient and caregiver relationship engagement will be similar to what we'll do here. I'd like to start this one off by reminding us all the culture each technology – unless that technology supports culture change by being easy to use and supportive of providing relevant information at the point of care. And I think with decreased administrative burden and some of the other approaches that technology can bring, we can begin to change the culture of delivery systems to one of greater collaboration and partnership. And really, I think that's what this one's all about.

So with that in mind, we had 11 – when we developed the framework, we had 11 different functions and again, there were some good comments on some – on many of these, which we can chat a little bit about. And then there was a pretty good, at least a 1-point spread between those that were considered most important and those that were perhaps least. And there's no question that I think everyone felt that user-friendly clinical decision support was probably the most important. And I want to stress, as did one of the comments that this really is about user-friendly clinical decision support that is non-intrusive, informative, timely, appropriately sensitive and specific and incorporated seamlessly into the workflow.

And one of the commenters talked about the need to assess the effectiveness of a lot of the alerts that are currently out there, to make sure that they are actually leading to helpful improvement and not just adding to the work of the clinician or causing alert fatigue. So I think that's an area that might be ripe for some discussion about whether or not market will get us there, which – or – which is something that I don't necessarily feel I can count on at the moment. Or whether we're going to need more in the way of federal intervention to really make the CDS something that will be more likely to meet the needs of both patients and providers. Anyone else like to comment on that?

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

So this is Hal, I'll take responsibility for the comments that are on the later slide. I just came out of an all day long contracting situation and a lot of the vendor approach here is about reducing the liability. So they want to have as many alerts fire so that if the patient doesn't get some medicine that they it might possibly have been allergic to, it's not their fault. So, it's really trying to control their liability in the chain, which is a very logical pursuit of their self-contained interest, but unless we start measuring the efficacy, we get this – the effectiveness compared to the efficacy; we get this situation where we get over-alerting and fatigue. And I do think that the HIT Policy Committee is in a good situation to start putting in metrics of true effectiveness of how often the alert actually gets read, how often it stays open long enough, what's the yield of alerts. Because so many of the large sites I've seen, the systems I still use, we bypass them and if they were really important, it's often unlikely that we will have seen them before we close them. I think there's ample literature on that out there that increasing alert frequency is counterproductive.

Karen M. Bell, MD, MMS – Chair – Certification Commission for Health Information Technology

So that's clearly something that the market would not drive, that would definitely be a federally initiated endeavor.

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

Right, because the market is driven to alert efficacy as if they were all responded to, not effectiveness taking into account that users are imperfect and become fatigued.

Karen M. Bell, MD, MMS – Chair – Certification Commission for Health Information Technology

Yeah. So those are the – and I think that's a really nice example of the kinds of things that we're looking for as we go through all of this. There are, I'm sure, lots of other approaches here that the market really is not interested in doing and we're going to need some support to move that on. And again, just doing that kind of a measurement system might not be something that's regulatory, might not be something that's within a certification program, but certainly would be most helpful.

So I'll move on a little bit, I'm not going to go through every single one of these, but I think a couple of these are worth mentioning. The communication tools for use within the organization or within a patient's care team was second tier here, and there was a comment that went along with that as well that a lot of the ACOs are just getting into this and having some sort of a platform for community of practice for perhaps different groups of ACOs. Don't just have to be Medicare, obviously, or topic-related might be something that the federal government could in some size, shape or form provide as a tool. And I know some of that's already happening within some of the groups, so I think the Pioneer ACOs have something similar, but for many of the other groups just starting on this elevator, so to speak, it might be something that again, federal government could do to support a lot of the entry level groups I'll call them.

The third one was about communication tools for use in settings outside of the accountable organization. And again, this is a lot to do with the kinds of things that health information exchange will be supporting and will be needing interoperability standards to allow those kinds of communications to occur. We've already talked about shared care plans and accepting patient derived information. So those are things that we will probably want to spend a little bit more time thinking about, going forward.

I wanted to just underscore what the clinical education was at the point of care, for those who might not be aware of it. It has to do with those programs that are already out there, such as ACPs Peer Program or Up-to-Date, which is a proprietary program, but there are others, that physicians can, in very real time, get some guidance, scientifically-driven guidance about how they might approach a given patient. Again, it's something that will make the clinician's life easier and in many ways, create more loyalty to the organization if it can do that for them.

The remainder of these are I think pretty self-explanatory, not sure, necessarily, why administrative simplification was a little bit low on the list. Anytime you can use HIT to make – decrease administrative burden in the provider – from the provider's point of view, that's probably a good thing, will lead to culture change sooner rather than later. So I guess from my own perspective, I would have bumped that up a little bit higher than it is. But other than that, I think that the only other thing that might be worth talking about would be the standardized clinical assessment tools.

And I'd be interested in hearing what a lot of the folks on the line think about making more widely available things like Assess-36 and PI, the standardized approaches to evaluating patient function, as opposed to measuring a lab result or something of that nature, which are actually quite expensive. And a lot of physician's don't use them because of that reason, and whether or not there's something, or the group would think there's something that could be done by the federal government to, in some size, shape or form, make those more widely available. Or do the folks on the line that are actually working in this environment find that they are – their organizations are providing them and it's not a problem for them.

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

We're trying to figure out how to do the collection methodology passively through our portal from home, so that the patient is not taking up in-office time to be chaperoned to do the functional assessment. I think if we can figure out how to do it so that people can do this where it takes very little resource time on the healthcare provider, it will be interesting because then we'll start to get at which knee replacement done by which surgeon has people feeling like they're walking best 180 days out, without a huge amount of work, by using a survey methodology through a web-based assessment. That's our hope here, but it's based upon us – the payment model eventually supporting us doing that.

Karen M. Bell, MD, MMS – Chair – Certification Commission for Health Information Technology

Yeah. Well I think yeah, absolutely, it's a combination of getting support from the payment model and also whether or not one can incorporate that data easily, so again, having the interoperability standards so that the data can be transmitted and digested internally may be an important piece. So, is there anyone else that would change the order of how these are – these have been put together? So we're okay on the priorities then, we validated that. And our next step will be, I think, to really spend a little bit more time to determine whether or not the HIT capabilities that support each of these priorities, and maybe at least the top priorities, are things that the market is either doing. Or will likely do in the current environment, or it's unlikely that they will do or won't do it in a timely way and that ultimately we'll need to rely on some extra encouragement from the federal government to move it forward. Does that sound reasonable to everyone then? If that's the case, then I will cede my time here and go back to you Charles.

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

Very good. Thank you, Karen. Let's see, if we could have the next slide. We're now going to spend just a few minutes digesting and reviewing our previous conversation regarding Framework Elements #1 and #2, and we'll start with care coordination. And again, the purpose of this is just to make sure everyone sees how we distilled the conversation from the previous meeting. Next slide.

So, care coordination. What we're – our conclusions from that discussion, and obviously when you're talking about care coordination, you're usually talking about multiple individuals involved in the care of the patient and coordinating the care across them, be they physicians, nurses or other staff. And of course interoperability and the challenges associated with that immediately loom large. The conversation also included a fair amount of discussion around data. We are in an environment, I heard one vendor characterize much of what we're doing today as email with attachments. And as unappealing as that sounds, there is a certain truth to it, but we recognize the importance of structured and discrete data in making interoperability both technical interoperability and clinical interoperability as powerful as it can be.

With that we talked a little bit about the importance of semantic interoperability, not just having systems communicate to one another based on syntactic or where you put various characters within the data stream, but rather ways of organizing the information so that the meaning is maintained and shared. Certainly one way of trying to certify or ensure that various systems have this capability is by trying to assess, or have them attest, to these capabilities such as a demonstration of their use.

So that you could do something like have your compliance testing process not only include the ability to generate and send a transaction, say a CCD, but also receive it, as well as to make it – make the resulting data a part of the receiving system's database. And demonstrate that that receiving data – that receiving system is using the data in computations, such as algorithms or other data queries. So, that was kind of our initial summary of the challenges associated with coordinating care and the need for interoperability, semantic interoperability and how to verify that systems have some level of capability there. Next slide.

We then had a discussion about some specific points. One area we talked about was the importance of health insurance coverage information. Now obviously that's important in PPOs and HMOs and all kinds of health plan product constructs, but it's probably more important in ACOs because patients will increasingly buy their health insurance from a closed or relatively narrow network, which means that they will face substantial financial penalties from not understanding that narrow network and not using it to its fullest. And so being able to access that health insurance coverage information wherever it's needed, wherever it can add value, is very important.

Also payer relationships, we talked a lot about whether the care coordination function that many health plans are doing because they see the benefit associated with care coordination. And that also many delivery systems are doing, in fact can create conflicts and incompatibilities where more than one person is trying to do the same function. So understanding those payer relationships is critically important to making the ACO business model a success. Also provider relationships are also very important. If we're going to try and coordinate care amongst multiple members of a care team, those members of that care team might not work within the same institution and the need to identify the patient's virtual care team can be absolutely critical to making their care as seamless and as coordinated as it can be. Next slide.

We then got into a discussion about cohorts, cohorts management. Obviously if you're going to do population management, being able to identify and/or manage patients within various cohorts is very, very important. In this conversation, the team talked a lot about how clinicians take care of patients in an accountable care environment versus a traditional model. And the importance of not just the face-to-face encounter, but also the ability to either track, manage or assess patients or part of a population and maybe, let's say at risk for diabetes due to non-compliance, not visiting their physician. And so there may not be a chance to intervene right at the point of care, you may need to have population-based techniques that would act upon a certain cohort of poorly managed diabetics.

The discussion also included an assessment of current tool mix. Most of us felt the suites were – the suite of tools currently available are inadequate to really do the cohort managing function well. And we've got to move toward – encourage the industry to move toward algorithms which can run on integration of cohort identification algorithm, because they tend to run either on administrative or clinical data and really both data sets are complimentary, and so a desire to have the algorithms and capabilities operate on integrated data. And then finally, around cohort management, patient derived data. Increasingly with chronic disease being managed in the home, and the ability let's say to refine and define what a good quali – high quality patient outcome is, patient derived data becomes increasingly important. We were not really clear whether the industry was prepared to take this on, and it may be an area ripe for federal intervention because of the lack of progress so far in the private sector. Next slide.

A couple of other points around the patient. Again, as with chronic disease management in mind, patient engagement is critical from multiple perspectives. First, utilization management, instead of relying on health plan utilization management function, providing tools for the patient that help them interact with the healthcare system as efficiently and effectively as possible may be a more powerful lever. And also, it's very valuable to the ACO because they have to manage the leakage. And so the notion of engaging the patient around anything from shared decision making tools to appointment setting tools that channel patients to providers within your ACO, are all very important capabilities. And then finally we spent some time discussing the importance of a commonly – of a single, common care management plan that is shared across multiple individuals taking care of the patient. This would be more of a shared care plan, meaning prospective in looking to the future as opposed to a care summary record, which is more retrospective and therefore looking in the past. Next slide.

And that was it. I think our concluding comments around there was also to talk about engaging patients requires a certain level of customization. Some people react better to the web, some people use instant messaging. There's a variety of potential channels for us, and we're going to have to do a – we're going to have to, as the industry evolves, figure out how to provide standards so that all of those channels can be used and be used in the most appropriate fashion to get the highest level of patient engagement we can. So that was a quick review of our previous discussion around our first two topic areas from the CCHIT Framework. With that, let me pause, see if there is any comment, and if not, I believe we have the public comment section next.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Not hearing any comments, or, sorry, go ahead.

Alexander Baker – Project Officer, Beacon Community Program – Office of the National Coordinator

Sorry, I just wanted to note that those were some highlights, but attached you'll find the complete meeting minutes, where we made sure to register all the discussion items that happened during that call, which we are continuing to look through.

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

Great. So with that, shall we open the phones for any public comment?

Public Comment

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Operator, can you please open the line?

Caitlin Collins – Project Coordinator – Altarum Institute

If you are on the phone and would like to make a public comment please press *1 at this time. If you are listening via your computer speakers you may dial 1-877-705-2976 and press *1 to be placed in the comment queue. We do not have any comment at this time.

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

Very good. Well, Alex, I guess with that we can adjourn the meeting.

Alexander Baker – Project Officer, Beacon Community Program – Office of the National Coordinator

Yup and you all can look out for some – an additional request for feedback on the last couple of elements of the framework which we will be looking forward to discussing on our last call, as part of this exercise.

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

Very good. Thanks everyone for your contributions.