

**HIT Policy Committee  
Accountable Care Workgroup  
Transcript  
December 13, 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 Committee's Accountable Care Workgroup. This is a public call and there will be time for public comment at the end of the call. As a reminder this meeting is being transcribed and recorded so please state your name before speaking. I'll now take roll. Charles Kennedy? Grace Terrell?

**Grace Terrell, MD, MMM – President & Chief Executive Officer – Cornerstone Health Care, PA**  
Here.

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

Shaun Alfreds?

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

Here.

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

Hal Baker? Karen Bell? Craig Brammer? Scott Gottlieb? David Kendrick? 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**

Hi Joe. Irene Koch? Eun-Shim Nahm?

**Eun-Shim Nahm, RN, PhD, FAAN – Associate Professor & 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**

Frank Ross?

**Frank Ross, MSSP, AP, ACO – IS/IT Steward – Cumberland Center for Healthcare Innovation**

Here.

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

Hi Frank. Cary Sennett? Bill Spooner? Sam VanNorman? Westley Clark? Mai Pham? John Pilotte? And 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.

**Kim Wilson – Health Communications Specialist – Centers for Disease Control and Prevention**

Kim Wilson.

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

Thanks Kim and Alex. I'll turn it back to you Grace.

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

Well, thanks very much and let's just – it's good to have a chance to review what I thought was an excellent in face meeting last time where a lot of us got to meet each other for the first time and had what I thought was a very good day and a very good discussion with the public forum around some of the issues that we've all been working on now, I guess since early spring together.

So, the purpose today from an agenda stand-point is for us to essentially make sure that we can kind of review what all we had learned both from the public as well as from the other types of forums that we've had discussions with one another either through these types of meetings or some brief e-mails so that we can go ahead and get on with completing our work which is to understand the key messages and takeaways from the Accountable Care Workgroup Hearing some specific discussion items on strategies and actions moving forward from that and open discussions on strategies on what we can do from here on.

So, this is hopefully a meeting where we can sort of put some meat on the bones of the stuff that we've heard. I know that Karen Bell had wanted to be part of this but is on an airplane and she sent some comments in earlier, I don't know whether it went to the entire Workgroup or just part of us, but that I thought were also very pertinent in framing many of these types of things that we've also been talking about within our outline.

So, with that and until Charles shows up and otherwise directs me otherwise I'd like to go ahead and get into the Workgroup discussion at this point. Does anybody want to have any sort of opening comments before we sort of get into that?

So, hearing none let's move on forward. Could you all move forward with the slides and put up some of the types of outlines that you all had, there it is, okay. So, what you'll see on the slide show and I've got to put mine on full screen here because my eyes are too old, there we go, is what was really delineated as the key messages that we got out of the hearing. So, I thought I might just go through these right quick and then let us then go back and discuss sort of one at a time.

So, for those of you that have access to a computer and see it, it says number one data integration across EHR systems continues to be a major challenge for providers partnering under accountable care arrangements.

Number two, the reluctance to share data across providers is an ongoing challenge for care coordination.

Number three, at this stage most organizations are focused on a discrete of common strategies to succeed within accountable care arrangements.

Four, many providers are using Health IT solely to meet requirements rather than a means to support new models of care.

Five, we need to distinguish between tools for encounters which are the traditional focus of EHRs and tools for population health, which by definition takes place outside of the encounter.

I think there is another page of this or am I wrong about that?

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

Yes, one more page.

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

If we could turn to that slide. Five, HIEs or six HIEs are solving the interoperability problem in select markets, but sustainability and spread challenges are a major concern.

Seven, there is ongoing lack of clarity around the key measures that are needed to drive care improvement within ACOs.

Eight, ACOs need to do more to prioritize a patient centered approach and identify common HIT strategies.

Nine, technology solutions need to serve the care team not just physicians.

And ten smaller organizations unable to meet the administrative burden and IT requirements are going to be more challenged.

So, if we could now go back to the proceeding page I'm just going to – unless anybody objects just go back and just read that first statement and then open it up for discussion as to whether these and this is a key message and how we might approach it.

So, number one data integration across EHR systems continues to be a major challenge and we heard that all day long. Any comments from anybody about that?

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

Grace, this is Alex, I just want to just for a little more context in the way that we're thinking about this, you know, besides the specific recommendations that, you know, we're certainly driving towards I think we see this an opportunity to make sure that kind of the overarching messages we heard during the day are clear as we share this around internally at ONC with the HIT Policy Committee, with other colleagues at CMS.

So, as people are looking at these, you know, please sort of think about the kind of key statements that you would like to see people hearing coming out of this meeting on, you know, a 1-2 pager that would be shared with leadership around the department and within the FACA.

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

Thank you. So, with that what are people's observations on that first statement, we talked about that at the end of the hearing as being a pretty crucial message that we heard all day. Is there anything anybody else wants to say about it or what are the thoughts on how this needs to be clarified for the purposes that Alex is talking about which is a shared internal document and messaging from us to the ONC and the other stakeholders.

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

Grace, hi, this is Joe, I guess my one thought here would be around integration being sort of two parts, one being the actual exchange of information and then the second part being integrating that information that got exchanged into your own organization. So, I think there are two parts of why it's hard and I heard both of those from different panelists throughout the day.

**Frank Ross, MSSP, AP, ACO – IS/IT Steward – Cumberland Center for Healthcare Innovation**

This is Frank I agree with what Joe's saying but I guess to be a little bit more technical in that description. I'd say, you know, we're dealing with issues of big data with the HIEs and then we're dealing with issues of peer-to-peer which is what I think Meaningful Use is trying to drive and they necessarily are not the same solution, they are two different approaches to the exchange of information.

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

Yes, thanks, Frank.

**Frank Ross, MSSP, AP, ACO – IS/IT Steward – Cumberland Center for Healthcare Innovation**

Thanks, Joe.

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

Other comments? You make a good point about the way the theme of the day went because quite often we were talking about things at different levels and sometimes there was a complaint or concern about where we were within Meaningful Use or within the world it is as opposed to getting much more abstracted out into what we need for population health.

So, I think those points are well taken that we need to understand really how to basically have that articulated in ways that people don't just sort of get caught up in the weeds of the current situation which is where a lot of the hearing actually focused on.

**Frank Ross, MSSP, AP, ACO – IS/IT Steward – Cumberland Center for Healthcare Innovation**

Grace I wanted to make another comment, this is Frank again, in regard to the last line of that first item where it says, so far ACOs did not appear to have the purchasing power needed to influence the vendors. I think it's even more fundamental than that. I mean, even if they had all the money in the world there is no market out there to purchase from.

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

Yes.

**Frank Ross, MSSP, AP, ACO – IS/IT Steward – Cumberland Center for Healthcare Innovation**

And I think some of the things I was trying to say at the end of the gathering, I know we ran out of time, but I was trying to say that if we don't somehow start looking at the information that the providers have at their disposal now in the form of their EMR databases, if we don't start looking at that as a public domain issue where that information can be let out and bring market forces to bear to bring information exchange technology into play all the money in the world is not going to solve the problem.

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

Hear, hear. So, that probably is a good segue to the other one, so the comments that you're making about the frustration with the vendors and actually not having something that's going to solve it is on the provider side of things, the reluctance of providers to share information because they saw it as a strategic asset and, you know, we had a fair amount of discussion about that all day long and it was pretty passionate among many individuals who gave testimony as to how frustrated they were about this.

Does anybody want to make further comments on how we might want to articulate a statement that goes from just a frustration on the part of the providers about that to something that would be thought through from a stand-point of a recommendation or how we might discuss this in a paper?

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

Grace hi, this is Joe, so I guess my thought here would be – I mean, I think it is – you say it in the second line around incentives, there are conflicting incentives that are – particularly in a market like ours up here in Boston where you have five overlapping ACOs all utilizing each other's resources and the person, the organization that really understands their data better and can capture that and staying one step ahead of everybody else is probably going to be doing better from the business perspective.

I kind of feel like I'm wondering if the reluctance is a strong word to use there because it makes it sound a little bit like people are – I don't know I guess I'm backpedaling – words come out of my mouth in the sense that we are being reluctant but I don't think it's because we're trying to harm anything going through there around care coordination, but there are conflicting incentives that are – and the financial incentive is driving a little bit more than the clinical incentive. Maybe there's an imbalance of incentives maybe that's a more neutral way of saying it.

**Frank Ross, MSSP, AP, ACO – IS/IT Steward – Cumberland Center for Healthcare Innovation**

Joe, this is Frank –

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

Do you –

**Frank Ross, MSSP, AP, ACO – IS/IT Steward – Cumberland Center for Healthcare Innovation**

Grace sorry, Joe is right about the reluctance. We do see reluctance let's say from hospitals to share information but it's not a reluctance that they don't want to do care coordination I think they just don't know how, they just don't know how, they don't have the IT resources and they certainly don't have a master plan that tells them what they need to do to be able to share information.

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

Yeah.

**Frank Ross, MSSP, AP, ACO – IS/IT Steward – Cumberland Center for Healthcare Innovation**

Lack of guidance I think is the reluctance is the basis for most of the reluctance that I'm seeing.

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

Right, so that actually brings up another point Frank around sort of the reluctance maybe because if you don't have the internal infrastructure it's a big lift to be able to share.

**Frank Ross, MSSP, AP, ACO – IS/IT Steward – Cumberland Center for Healthcare Innovation**

Yes.

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

And that's actually a negative incentive again for you to be able to do that so I'm not just trying to keep your patients.

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

That's a different slant on this than I think we heard from some of the more passionate testimony around this. So, if there is not a consensus that it's related to competitive advantage, which is what this statement says, but mostly due to inadequacy or a system that's not been designed or permitted to be, you know, done safely or adequately do we want to make a change to this, because certainly, at least my impression is I was hearing from some of the people that were giving testimony that they thought it was far more of a strategic decision. What I'm hearing from you guys is that it may just be an inadequacy more than it is a strategic decision.

**Frank Ross, MSSP, AP, ACO – IS/IT Steward – Cumberland Center for Healthcare Innovation**

Grace, I think – this is Frank again, I think it just deals with the size of the organization.

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

Yes.

**Frank Ross, MSSP, AP, ACO – IS/IT Steward – Cumberland Center for Healthcare Innovation**

You know when we were talking to hospital-based ACOs they quite honestly didn't know how to do it and then when we were talking to the large HIEs the state level ones and bigger ones they didn't want to do it because they were trying to consolidate the market themselves, so, you know, there's two different things at play here I think.

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

I agree.

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

Okay.

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

Yes, I'm hearing two different things, Grace.

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

All right.

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

I don't think one is – but, you know –

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

So, let's make sure that when we're writing this up then that we have that well-articulated the distinction there.

**Frank Ross, MSSP, AP, ACO – IS/IT Steward – Cumberland Center for Healthcare Innovation**

Yeah, that's great.

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

Other comments around this particular statement before we go on? Okay, hearing none let's go to statement three, at this stage most organizations are focused more on discreet set of common strategies to succeed within accountable care arrangements and they're basically within early stages.

I didn't see anything in that controversial other than we're not very far along with the process yet. Are there other aspects of this that we need to flush out?

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

This is Alex, that one might not be totally clear, I think maybe the idea here was just to the degree we want to quickly communicate, you know, to CMS and others what we heard about really the common strategies or low hanging fruit sorts of things that ACOs are trying to address right now sort of to organize people's thinking about these are the, you know, major things that organizations are focused on in the near term and problems that they're trying to solve immediately.

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

Got it. Other comments?

**Frank Ross, MSSP, AP, ACO – IS/IT Steward – Cumberland Center for Healthcare Innovation**

Grace, Frank again, one of the things I didn't hear, sometimes you learn more from what you don't hear than what you do hear, is that all the ACOs that testified particularly the physician-led organizations were pretty much focused on the cost because they see that as the single most important challenge that they have is to lower their cost per beneficiary so they can actually realize shared savings.

What I didn't hear was the strategies to deal with population management, so when you actually do achieve shared savings how much of it are you going to be able to hang onto, because in EMS SP model if you don't achieve the benchmarks or within 90% of the benchmarks you don't get to keep a dollar for a dollar earned you get a percentage of that dollar and I think that's something that's really missing.

Now how does that feed into this, Alex, I don't know if that was the intent of this statement or not was to kind of ferret out, you know, what the status of those Accountable Care Organizations was, but, you know, in terms of accountable care arrangements, but I didn't hear a lot of arrangements being put forward to deal with improving the quality of care that's delivered to the population that's being managed.

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

I think that would be a really important point to get in here.

**Frank Ross, MSSP, AP, ACO – IS/IT Steward – Cumberland Center for Healthcare Innovation**

Yes.

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

Do you think that was simply because of the direction of the questions and how we focused our discussion that day or do you think that's truly the case that there's not a lot of focus being placed on this?

Do we need to explore further whether there is a problem with folks not putting the quality in place or whether we just didn't flush it out?

I know there had been some desire on the part of the ONC for us to expand our questions about quality some and we may not have done an adequate job.

**Frank Ross, MSSP, AP, ACO – IS/IT Steward – Cumberland Center for Healthcare Innovation**

I think both of those cases are true, we certainly didn't ask that question and since I didn't hear anything in their general comments to that affect, now they did talk about very discrete steps that were being taken to, you know, fill gaps in care, preventive exams, I mean, those are all strategies for managing populations.

But at the same time I didn't hear a single testimony given that related to we need to focus on achieving higher quality as a way of hanging onto shared savings that we've earned and that's – you know, again, I think that's very important because if they're not focused on that it's going to backfire.

ACOs are going to be looking at payday and it's going to be significantly less than what they feel like they've earned.

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

You know my organization is in a medical care shared savings program and we're focusing on this quite extensively and have been measuring, you know, seeing how we're doing relative to where we need to achieve, we're tracking our progress on things and are looking at this quite extensively, because we have this concern a lot of it from our stand-point has to do with can we report it and are we putting things in process to do it.

So, it may be – I don't think we're unique in that, it may – I think that it is going to be a big problem if at the end of the day there is no money paid out it's going to potentially set back the provider community quite extensively. So, it's something that I think there has been a fair amount of talk about at the sort of association level. So, maybe we just didn't flush it out or maybe my perspective is skewed.

**Frank Ross, MSSP, AP, ACO – IS/IT Steward – Cumberland Center for Healthcare Innovation**

Well, I think the lack of conversation can be primarily attributed to one thing there are no benchmarks.

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

Right, it's very frustrating.

**Frank Ross, MSSP, AP, ACO – IS/IT Steward – Cumberland Center for Healthcare Innovation**

And that I think if we can point to one thing we can just say, why would you start a program that has no benchmarks?

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

Yes.

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

Yes.

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

One thing that had been a rumor I think among the provider community is that the benchmark for full savings was that you had to be at the – not that you had to meet 90% of the benchmarks but that you had to be at the 90<sup>th</sup> percentile of the ACO group to achieve all of that, that was one thing being proposed and I think there had been a lot of controversy about that, because the feeling being that those of us who are actually taking the investment and the efforts to do this are being really compared to a very different set of organizations then the rest of the medical community that's not doing it at all.

So, let's move on then, the fourth comment was that many providers are simply using Health IT solely to meet the requirements rather than as a means to support new models of care. From my stand-point this relates pretty closely to some of these earlier messages that there is just not products on the market yet or vendors out there who have been able to provide providers, at least at this level of Meaningful Use or this level of the market, that actually makes this particularly easy, but is it important for us to articulate this statement as a separate comment and not relate it back to a causation of where the market is?

**Frank Ross, MSSP, AP, ACO – IS/IT Steward – Cumberland Center for Healthcare Innovation**

Grace, Frank again, you're going to get tired of hearing from me I guess.

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

No, I just want somebody besides me to be out there talking.

**Frank Ross, MSSP, AP, ACO – IS/IT Steward – Cumberland Center for Healthcare Innovation**

I understand. I think to be quite honest with you once again it's a lack of leadership I think to a certain extent, leadership being that, you know, we all think we understand clinical decision support systems but if you dig into them and you look at as many EMRs as I've looked at over the past year in putting this ACO together you begin to realize very quickly that there is no consensus, there is no template, if you will, for building a clinical decision support system and then you throw an ACO model into the mix and it gets even muddier.

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

Yes.

**Frank Ross, MSSP, AP, ACO – IS/IT Steward – Cumberland Center for Healthcare Innovation**

So, for lack of any guidance from CMS again we have a program whereby we're trying to track and improve the quality and ultimately the care and the cost of our patients without any guidance whatsoever, you know, the EMR companies are not going to dream this stuff up on their own they're only going to dream it up when somebody tells them that they have to do something. Meaningful Use I think is a testimony to that fact.

And the limited success for Meaningful Use tells us that even with guidance, very specific guidance sometimes those targets aren't going to get met by all the EMR vendors and they have to deliver this product since they have a closed product and since they have a closed world and there is no body that they have to compete with, with their customers who are the physician providers. So, and I'll leave that for people to think about.

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

What I'm hearing, based on what you just said, is that one statement or one thing that may come out of our group would be a much more specific recommendation about actually providing the specificity for the benchmarks in ways that can move the market and do that sooner rather than later.

**Frank Ross, MSSP, AP, ACO – IS/IT Steward – Cumberland Center for Healthcare Innovation**

Yes.

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

So, that's not exactly in these messages but that might end up being one of the things that we end up making sure that is articulated in the document that we ultimately get out. Other comments?

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

Grace, so this is Joe, so I guess my thought of this one would be that if I would ever flip this into a slight positive we would say that people are using existing sort of out of the box Health IT solely to meet requirements, but that at least I did hear many people and even Heather next to me in the committee was saying that people are trying to build stuff on top of it themselves to meet that need.

So, it's not that Health IT is necessarily the issue because I think we all recognize the value of Health IT as Frank was saying around best practice alerts, but we're jerry-rigging things in order to make it work to give us what we need.

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

Yes. Other comments? All right let's go to statement five. We need to distinguish between tools for encounters and tools for population health which by definition take place outside the encounter, I'd say outside the encounter or possibly my thoughts are it may be inclusive of the encounter but that's only a portion of what population health is about.

This is something that I think probably is part of the genesis for some of the critiques, criticisms we heard in message one through four is that the tools have been very specific around how providers get paid which of course makes sense from a vendor market stand-point, but now that we're being paid in theory for population health management those tools have not been re-engineered yet to allow any real population health management information tools. Comments?

**Frank Ross, MSSP, AP, ACO – IS/IT Steward – Cumberland Center for Healthcare Innovation**

This is Frank again, you know, even when you're managing populations you do it one encounter at a time. I don't think there's anything wrong with a basic arrangement as far as EHRs are concerned because the providers do have to get paid as you said Grace, but they're also building a registry, they're also building a database which is rich in information that is not being viewed from a population stand-point and again that information is locked up, it's not easily accessible even if you have the money to go out and do development on your own, understanding what's in that repository can be daunting at times if not impossible.

And now we're taking these repositories to the cloud where they're inaccessible in addition to being unfathomable, you know, I'm going to keep saying this over and over until somebody tells me they're tired of hearing it, but until we unlock this information make it a public health issue where the definition of the data can be defined where we can bring more market forces to bear on developing solutions for accessing and managing the information we're not going to see much progress.

EMR vendors have failed miserably in my opinion and even though I have a registry I can go in and do all kinds of wiz bang things on it doesn't help me manage my population to the extent that I need to manage it at an ACO level.

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

Other comments? Let's move onto the next page then. So, this really is getting into another theme which is the health information exchanges and the frustration that we were hearing about the interoperability issues between the different vendors, the multiple HIE problem from a complexity stand-point for many providers.

I personally was hearing a wistfulness in the audience that they wished there was an HIE platform out there that would allow, you know, something to occur in all markets efficiently and effectively across the vendors and across the population, but I did not hear anything that suggested that people had a solution for that other than some sort of federal mandate. It did not sound to me like they thought the market was going to do that. Would that be other people's impression or did I get that wrong?

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

Grace, this is Joe, so I would agree I heard the wistfulness as well and I also heard the general acknowledgment that they didn't think it was going to get there except for maybe a couple of places but it didn't feel like in general that the natural course of this was going to lead to anything useful.

**Frank Ross, MSSP, AP, ACO – IS/IT Steward – Cumberland Center for Healthcare Innovation**

I agree.

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

So based upon that I guess as we're writing up our documents to move the conversation forward I guess at some level there needs to be a federal policy decision as to whether they want to tackle that or not and so maybe if we can at least articulate as we move that forward with how the frustration we were hearing about the issue in the market that might be helpful. Alex, what are your thoughts on that?

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

Yeah, I think that would be really helpful, you know, I think the questions that we're especially hearing from CMS partners who are not sort of today focused on a lot of the issues that ONC is are things like to what degree are HIEs going to solve these problems and so to the degree we can isolate, you know, ways that – or a strong statement about how HIEs in some capacity need additional attention from policy levers, you know, that's the kind of statement that I think is powerful here.

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

And Grace and Alex this is Shaun Alfreds from Maine, you know, as one of those few HIEs that actually is sustaining itself based on the market, you know, one of the things that we've seen across the country is as we talk to other fledgling HIEs is the fact that there is no sustainability model and part of the reality of that is that, you know, there wasn't, you know, up until the Accountable Care Act there wasn't an incentive to exchanging of information.

Now, you know, with ACOs forming there is a perception of need of exchanging information across competing entities but the challenge is that we have this happening at the same time as Meaningful Use is promoting the use of really poorly designed discrete data standards like CCD and so, you know, one of the things that we see as really important is looking to the federal government and to promoting simplistic interoperability standards, HL7 standards, ADT standards to help make information more ubiquitous, to help to seed a market.

Because right now I don't believe there is a market for HIE but it's because of the perception that there is no interoperability standards available that can promote an amalgamation or a consolidation of data across competing entities. We know that's not true, we see that happening.

I mean, obviously there are claims databases across claims for multiple payers across the country because there is a standard 837 and 835 files, and I think that maybe a way in which we can help the federal government understand and create policy that promotes interoperability and as such then seeds a new market for the such services.

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

Shaun this is Kelly Cronin, I think that is really helpful to point to that issue in particular and just also pointing out, you know, we're moving into sort of post Recovery Act, post HITECH funding era where ONC has more limited resources yet a broad interoperability agenda and there is a lot of need to advance standards development and making sure those standards get adopted and the implementation guide is as good as it needs to be and, you know, it's re-enforced through certification and then through other policies, but that whole machine has to be driven by adequate resources, so, just sort of pointing out the obvious that the challenge is – not easier if anything more clarified and bigger in a challenging budget environment.

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

Oh, I tend to agree Kelly and just one final comment, you know, one thing I think we try too hard to get too much out of concepts like continuity of care document and what we found is that frankly in the marketplace that didn't promote interoperability, it actually dissuades interoperability and so I think going back and thinking through what's the 80/20 rule, how can we get 80% of the value with 20% of the work and 20% of the investment, and I think there are standards in use.

Every EMR has to talk to a laboratory and they're using HL7 ORU messaging, you know, that kind of specificity and that kind of simplicity where, you know, the vendor marketplace is familiar with these standards they're using them all the time but we're not integrating them into policy frameworks.

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

Yeah, it's starting but actually even re-enforcing that those standards have to be re-enforced through other policies is absolutely – it's good validation of a direction that we've started to take but it would be great to point that out again.

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

Well, you know, I'm finding this conversation very helpful because we're using these messages and we're coming up with things which are starting to sound like specificity to some recommendations, so I hope that other people are feeling it like I am that maybe we're going in the right direction.

I'm going to move us to number seven, lack of clarity around the key measures that are needed to drive care improvement within ACOs. This goes back to the question of the benchmarks that are not out there that we mentioned earlier.

Does anybody want to elaborate or clarify how this is different from those previous statements or how we could make this – something a little bit more precise as it relates to our previous conversation?

**Frank Ross, MSSP, AP, ACO – IS/IT Steward – Cumberland Center for Healthcare Innovation**

This is Frank again, I just wanted to make a comment that the measures that the MSSP ACOs today are working with are an extremely rendered down set of measure, you know, the 22 that they actually report is a small fraction of where the recommendations started in the very beginning and that's okay you have to do that if you want to achieve any results at all.

But one comment specifically about the quality measures instead of just being something that has to be reported, you know, COPD is probably the biggest challenge that we have in this part of the country in the tobacco belt and yet the only COPD measure was the measure where we're being told how many of our patients are showing up at the hospital door and being diagnosed with COPD. In effect there is no quality measure at the practice level for COPD. Clinically that's a difficult thing to do I know that, I'm not a clinician but I do know a lot of clinicians who will tell you that COPD is a very tricky thing to deal with, but the very fact that it is tricky and the very fact that it is generating such a tremendous amount of cost in the healthcare community I would think would make it a higher target, value target than it seems to be in the current quality measures.

So, I'm just kind of throwing that out. We're not the quality measures committee but at the same time it does create problems when you're trying to incentivize physicians to treat populations by utilizing quality measures.

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

Your point is well taken, one of the nice things that we've found in our Medicare Shared Savings data that we're getting back from CMS is the ability for the first time to understand and quantitate the impact of various disease states on our cost and COPD is quite high as you articulate, you know, we are right here in the tobacco belt with you, and so your concepts of actually starting to correlate quality benchmarks around those things that also impact the cost of care with more specificity and also with that if you make the correlation that cost of care is related to disease burden among the population then that actually – you really start getting towards something that we haven't gotten to before, which is actual outcomes as opposed to surrogate quality benchmarks. Would you agree that this is a way to actually start getting the outcomes?

**Frank Ross, MSSP, AP, ACO – IS/IT Steward – Cumberland Center for Healthcare Innovation**

I do unless somebody has another idea. I mean, when we talk about managing populations how are we going to do it if we don't do it with quality measures. So, you know, the focus has to be on those quality measures, you know, what do they mean and I guess maybe even a little bit of assistance in the interpretation of the outcomes of the quality reporting.

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

Yes, this is Joe, so my take on this one too is the fact that I think part of it is, even in my organization, in terms of specific interventions to improve clinical performance around a particular quality measure if we're responding to a very specific quality measure the risk is particularly in these sort of ACO type environments that you're just going to significantly increase your operational expense and potentially your other medical expenses as you're trying to target a specific quality measure.

Now granted COPD admissions are very expensive and we've got a lot of them even though we're up here in Massachusetts as well, but I think that balance point is part of the aspects around picking quality measures that potentially are there but could target an organization in a way that's not balanced with the rest of "value performance measurement" and I think that's a tension that we have up here when you're operationalizing and building infrastructure to go after a quality measure that may not show up in other areas or maybe detrimental in other areas of performance.

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

Comments?

**Frank Ross, MSSP, AP, ACO – IS/IT Steward – Cumberland Center for Healthcare Innovation**

I mean, we're making the statement that providers do not see quality measures as critical to care that's a strong statement.

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

Yeah.

**Frank Ross, MSSP, AP, ACO – IS/IT Steward – Cumberland Center for Healthcare Innovation**

But I think it's accurate Joe, I agree with everything you just said, you know, we're not putting any – we're just not putting anything that has clinical value into the definition of the measures other than defining what the measure is.

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

Let's move to number eight, ACOs need to do more to prioritize a patient centered approach to care and identify common HIT strategies for engaging patients in their care.

We did not get, to my mind, deep enough into this conversation early enough in the day and one of the things that I felt by the end of the day is that it was pretty provider centric and vendor centric discussion as you might get from having providers and vendors giving the major portion of the testimony.

I did feel that when we got the community groups up there that some of the conversation turned towards more of a patient centered approach, that is a nice statement to say it needs to be more patient centered, but what do we do with it in terms of a specific recommendation that has something other than a wish in there? A triple Amish wish I would say.

**Frank Ross, MSSP, AP, ACO – IS/IT Steward – Cumberland Center for Healthcare Innovation**

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

Grace, this is Kelly – I'm sorry, go ahead?

**Frank Ross, MSSP, AP, ACO – IS/IT Steward – Cumberland Center for Healthcare Innovation**

No, go ahead Kelly.

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

Well, I was just going to say we could expand on this in describing one of the comments I think resonated with folks on the community panel was that we are not going – or accountable care will not be successful in sort of a traditional medical model and that we need to be thinking more about integration in the community and with social services.

And the other survey finding I think that sort of set the context for the day in some ways that Clif Gaus presented around one of the key strategies was to keep people out of institutional or long-term care. So, we're looking at more sort of community and home-based care than integration into a lot of other support services and coordination with them is much more patient centric engages the family and caregiver, and, you know, maybe we could be thinking along those lines like how do we support the patient outside of institutional care.

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

That actually, from a population health management stand-point becomes ability to also, depending on how it's approached and supported, a way that will actually give more strength to community-based HIEs if you've got the patients in the middle of it too.

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

The other thing that we've been just talking a lot about internally and it seems to be coming up in a lot of conversations lately is how to advance a care plan that really enables patient centered care that can be shared across a care team and the New York example of what they were doing was really compelling and so I thinking about how, you know, how that either an ACO-hosted care plan or a care plan that might reside out of any one given provider's EHR system or how, if it is tethered to an EHR, how does it get shared and updated and really become sort of a patient centered tool.

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

Very good. I'm going to move us to number nine, technology solutions need to serve the care team not the physicians because that's obviously part of what you were just commenting on. The – I mean, look at the sentences in here, ACOs are focusing on expanding the care team, MPI and provider directories all these other community entities they are not the physician all the time need to be incorporated into the standard. What you just articulated seemed to me to be exactly related to that. Do we need to discuss it in more detail here?

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

Yeah and we'll fix that I think that sentence got scrolled up a little bit.

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

Okay. All right, so the final piece of it here was the – number ten was about the real difficulty of smaller organizations to meet the requirements and administrative burden in ways that are going to be able to shift the market to value.

So, there was some discussion, comments here that the advanced payment is a critical way to address this. We heard several groups, if memory serves me correctly, saying that the reason they were able to do this was because of the advanced payment. So, obviously that was a policy where we heard statements that it was helpful.

Based upon number ten being about specifically about smaller organizations do we need to broaden it beyond that or just make this statement about smaller organizations needing help to say different types of organizations may need different solutions from a help stand-point. Is this adequate the way we've written it up right here? Must be, okay.

Well, we've gone through the key messages now. Can we go to the next slide? Karen Bell sent an e-mail out; let me see if I can find it here on my computer, with some of her thoughts which I thought were a little different. Did everyone receive that or was it just – yeah, it was sent to everybody, I don't who all has seen it, but she had some overarching themes based on – and some of this is clearly related to the ten components that we've just discussed, but I like the way she organized hers which is access to needed data, support for data exchange and administrative simplification it seemed to be – it doesn't get into all the things that we just discussed but it certainly was a way of broadly categorizing it and then she got into some detail there.

Does anybody else have any comments on her e-mail because I thought it was quite helpful? So, are there any other overarching take away themes from the day that we need to be sharing that we haven't mentioned in either Karen's broad approach which many of you may not have seen, I'd encourage it as soon as you get a chance or from the ten themes that we've put up and discussed today, are there others?

Where do we go from here committee?

**Frank Ross, MSSP, AP, ACO – IS/IT Steward – Cumberland Center for Healthcare Innovation**

Hi, this is Frank, again, I'm kind of the newbie I guess since I've only been around for a couple of meetings, but I would love to see, you know, if not a draft at least a first pass at a recommendation's document and I say that constructively because I think it would help me understand a little bit better, you know, what are the challenges that we're actually making recommendations to improve and, you know, I don't know how this is normally submitted to the parent committee, to the HIT committee, but that would be how I would want to take a look at it and see if there were any omissions or discrepancies for the group to ferret out before it goes into a draft form.

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

This is Michelle; I just want to speak to a process. So, typically it's a good idea to present draft recommendations to the committee to get their feedback and then once you get their feedback you can either – if maybe they'll agree to everything and then you can submit a letter of transmittal or you can come back at a future meeting and update the recommendations per their feedback.

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

So, is this a burden that you all will be doing for us and providing back to us for us to look at in the next little while?

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

Yeah, I think, this is Alex, you know, our – today is sort of a relatively immediate debrief from last week but the plan from here would be to take, you know, the extensive list of things that we heard last Thursday as well as what came out of all of our discussions prior to that really talk about it internally because obviously, you know, we're covering a very wide waterfront with the discussions that we had last Thursday and elsewhere and, you know, many of these things are areas where there is work afoot in other committees or other parts of ONC or CMS, you know, where our position would more be re-enforcing current directions as opposed to areas where we want to make new recommendations in areas where there are clear gaps.

So, I think, you know, after today we're going to be continuing to work through that material internally and then in January, the next time we meet, which is still being scheduled, we would be trying to look at a refined version of that that sort of speaks to where we think the real gap recommendations are to where we think the re-enforcing type recommendations are and let the committee look at that material to compare it to.

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

Yeah, Alex, I'm wondering if it might be helpful because everybody will probably be, you know, busy doing other things over the holidays and we have so much – I feel like we have a lot more – in some ways a lot more clarity, we had so much good input last week and there are some really good ideas that are a little bit crisper than they were over the last six months and, you know, if Frank and a few others would be open to it, I wonder if we could be consulting with you in the next week to flush out some more specific ideas on recommendations and then we could take that, you know, we could take that input and refine a document to share with the Workgroup in January.

**Frank Ross, MSSP, AP, ACO – IS/IT Steward – Cumberland Center for Healthcare Innovation**

I'd be open to that, this is Frank.

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

I feel like we have a great opportunity now and we don't want to lose all the great thinking as we indulge ourselves over the holiday.

**Frank Ross, MSSP, AP, ACO – IS/IT Steward – Cumberland Center for Healthcare Innovation**

Great, so you planning on forgetting this committee exists come January?

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

Well, it's easy to kind of get everything else in an amnesiac way when you're going through the holidays and have to start off the New Year.

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

Right.

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

So, we don't want to, as part of our New Year's resolutions, to eliminate this from our collective consciousness. Well, I agree that the sooner we get something out that we can all react to the better it will be.

So, what I'm hearing you all say is that you're going to be working with some of the committee members to take everything we've done over the last year, take the clarity that we have received from the face-to-face with the discussion that's flushed out some of it today and get something back to us that we can react to after we've finished with our New Year's punch.

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

Yes, that sounds like a good plan.

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

Great.

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

Thanks a lot.

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

Yeah, Alex, sorry, I don't mean to load you up too much – but yeah, I mean, and anyone who is interested in helping with that let me know, I mean, Joe and Frank and Shaun and whoever really was part of the hearing and would like to, you know, contribute to this we'd really welcome your input, just let us know.

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

Sure you can count me in.

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

Okay.

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

Are there any other comments anybody wants to make? I think we've really played out through the agenda pretty rapidly today and it was good because we've clarified a very long and very fruitful meeting last week and then we need to be opening up to the public in a few minutes for comments, but before then does anybody else want to add any summary thoughts to where we need to go from here?

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

Can I just – before we leave, the one thing I just wanted to get the group's thoughts on before we go to start crafting something a little more specific, there was some discussion, recognition and this really validated a lot of public input we got earlier in the year around some hospital systems or hospitals just not wanting to share data because, you know, they are viewing their data and their analytics as sort of their crown jewels, you know, as a proprietary asset and this is in some ways a cultural thing that's been established over a long time but also now it's becoming maybe even more important as, you know, folks are going to be competing under accountable care arrangements and analytics really matters.

But, I wonder because we know this is an issue, it's been, you know, described in many ways to us over the last several years but there aren't any regulatory solutions that are sort of imminent and we got public input that we need to regulate on this issue earlier in the year but it's a difficult one to wrap our arms around because, you know, there is sort of the ultimate – just from a policy perspective, several policy perspectives there is the ultimate lever of a condition of participation, you know, to get any Medicare reimbursement you have to meet certain clinical and operational standards like for admissions, discharge and transfers. So, there is a whole lot of specification around what you need to do for discharge planning.

And then there is, you know, a lot of guidance and the survey and certification process that extends from those regulatory requirements. So, that's an ultimate lever that you could eventually – when the markets mature enough you could say it's a reasonable expectation that a hospital as a part of good discharge planning and good, you know, transition of care management you would send a summary of care record electronically to the follow-up treating provider. I mean, that's a reasonable expectation at the appropriate time, but it's a pretty high bar.

And then there's re-admission penalties, but under the current authority there really isn't anything you can do with re-admission penalties because it pertains to health information exchange. So, I just would – it would be great for folks to maybe think a little bit more and just get your input on if this is really an issue as we've been hearing about maybe not in all markets certainly and there's a lot of community-based hospitals that are very community oriented and have great trading partners, but in large urban areas where there are academic medical centers that are fighting tooth and nail with each other, how do we resolve this problem, is there – is part of it regulatory, is part of it just a realization that they're going to have to, you know, come to in their markets that it's more efficient for them to share, at least upon care transitions.

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

This is Grace; from my stand-point there may be a stepped approach the first one is related to some of our previous themes health information exchange needs to be made easier within the context of the technology and presumably in a way that would be less expensive.

So, the first thing is to make it easier for it to occur, because these systems, if they are seen as a strategic advantage are only able to have it as a strategic advantage within the context of the enormous investments that they are making right now because it's very costly in the current system.

So, after you've got the technology right, which could be step one of it, then from a policy stand-point making it easier obviously makes it better, but the second approach to it may be a second or third lever that's more regulatory at that point, but maybe part of the problem is so long as it's easy not to do health information exchange it's easy to hoard information.

**Irene Koch, JD – Executive Vice President & General Counsel – Healthix, Inc.**

Can you hear me? Hello?

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

Yes, we can hear you.

**Irene Koch, JD – Executive Vice President & General Counsel – Healthix, Inc.**

Excellent, sorry, this is Irene Koch, and I just wanted to sort of offer a little bit about our experience in New York State where in New York City, which is really competitive of course environment, I'm not really experiencing the hoarding situation here and we've had a lot of investment and a lot of champions of health information exchange and of course a pretty early start here in our state.

But at the same time with continued funding on the horizon potentially for the State Health Information Network of New York or the SHIN-NY it's going to be going along with a regulatory package including some provisions about how anyone participating in the network really does have a mandate to share data, it doesn't particularly call out discharge summaries or, you know, coordination of care documents, but, you know, there is going to be this regulatory punch and Kelly, I think that was Kelly who was speaking I'm sorry, you know, if you don't have a copy of that I can definitely share it with you or with the whole committee, but, you know, there is going to be some precedent here in our state for that kind of activity.

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

Yeah, thanks, that would be really helpful, thank you.

**Irene Koch, JD – Executive Vice President & General Counsel – Healthix, Inc.**

Okay, that's Kelly, I'll send it.

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

Yes.

**Irene Koch, JD – Executive Vice President & General Counsel – Healthix, Inc.**

Okay, excellent, thanks.

**Frank Ross, MSSP, AP, ACO – IS/IT Steward – Cumberland Center for Healthcare Innovation**

Hi, this is Frank, I just want to make a comment probably 180 degrees opposite of what my colleague just made that in Tennessee where there is no HIE and where there has been no effort whatsoever, successful effort anyway, to establish a state level or expanded community level exchange of information it is pretty much a wasteland and again I don't think we're seeing hoarding because hoarding takes place when people realize they've got something of value.

I'm not even sure that the value has been determined in our state for health information and I don't know if it's going to be an issue of public policy to mandate that it be assigned value or whether incentives like those being offered to ACOs are going to be enough of a financial stimulus to bring about a market driven desire to open up health care information for exchange.

So, you know, it's difficult to say when you live in the part of the country I live in what is going to be the spark that actually catches flame on driving the exchange of information when it comes to coordination of care which is what we're most concerned about.

I will say this though that conflicting regulations right now are causing problems in regard to the way the hospitals are being driven to make sure that upon discharge, you know, they're meeting certain Litmus tests for the patient at discharge but how they go about meeting those tests is not by necessarily handing the patient back to the primary care provider its handing him off to anybody that will take ownership of him and that is a very, very disjointed outcome for the most part.

And again, lack of guidance is a bigger issue because I don't think the hospitals are even thinking about primary care providers anymore because they own half of them in my neck of the woods and they feel like if they've got a majority share of primary care then they don't need to concern themselves with the remaining primary care, you know, community, which by the way my ACO is nothing but independent primary care physicians so you can see that we are definitely, you know, looking up out of the well when it comes to trying to get information out of hospitals in our neck of the woods.

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

What part of Tennessee are you in?

**Frank Ross, MSSP, AP, ACO – IS/IT Steward – Cumberland Center for Healthcare Innovation**

I'm in a place called Cookville, Home of Tennessee Tech the Fighting Eagles, and we're about half way –

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

What part of –

**Frank Ross, MSSP, AP, ACO – IS/IT Steward – Cumberland Center for Healthcare Innovation**

About halfway between Knoxville and Nashville.

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

I know that there is an effort in the eastern part of the State of Tennessee with the ACO Qualuable and Holston Medical Group where they're putting in their own health information exchange as a result of some of the issues that I think you've articulated to sort of go around the hospitals and it's a very, as far as I understand it a very interconnected group of mostly independent physicians, if that's the case it may suggest that being able to enable aggregations of non-hospital centric entities in some ways much like they are talking about the smaller ACOs needing some upfront funding maybe some sort of policy lever that could get things moving and may just make things more complex I don't know, but there seems to be some effort in your state to move around and beyond that.

**Frank Ross, MSSP, AP, ACO – IS/IT Steward – Cumberland Center for Healthcare Innovation**

There is but it's strictly driven by groups of physicians that have previously aggregated in ITAs and things of that nature.

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

Got it.

**Frank Ross, MSSP, AP, ACO – IS/IT Steward – Cumberland Center for Healthcare Innovation**

And, you know, we've talked to that group they've actually solicited our members to aggregate with them but the cost, the out of pocket cost to the individual physician, when we're talking about a solo provider their just not ever going to have that kind of money to get involved in those kinds of efforts unless there is some kind of funding through the ACO that would allow the ACOs to maybe collaborate, you know, an ACO collaborative to build a health information exchange might not be such a bad idea.

I would prefer that it be driven on a transactional level, you know, with distributive topography where you've got ACOs building and maintaining registries which is what we're doing and exchanging the information as required with other ACOs, but, you know, that's – here again we're in the infancy of this in my neck of the woods and I just wanted to let you know that the New York experience doesn't necessarily translate to the rest of the country.

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

Yeah, I wonder if it would be helpful to have, you know, as a part of the survey and certification process for hospitals to qualify for Medicare payment would it be helpful if they said, well, you know, as a part of appropriate discharge planning that the discharge planning, discharge summary goes to the treating provider of record as opposed to, you know, leaving it up to the hospital to determine any potentially appropriate – they're determining in some other way who is the treating provider. Does the treating provider need to be clarified?

**Frank Ross, MSSP, AP, ACO – IS/IT Steward – Cumberland Center for Healthcare Innovation**

This is Frank again, I think that's imperative, you know, within the ACO CMS is attributing patients to the ACO, in effect you're making us responsible for those patients whether we want to be or not. Therefore if you're going to give us that burden then you need to give us leverage to be able to actually manage those patients. Right now we just don't feel like we have that much leverage at all.

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

Right and in markets like you're describing in your area of Tennessee there is no real capability for the hospital to rely on to electronically send something, but where it is available they could encourage that it be electronically shared, you know, as feasible.

**Frank Ross, MSSP, AP, ACO – IS/IT Steward – Cumberland Center for Healthcare Innovation**

We can't even get the hospitals to fax us discharge summaries.

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

Yeah.

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

Wow.

**Frank Ross, MSSP, AP, ACO – IS/IT Steward – Cumberland Center for Healthcare Innovation**

Yeah.

**Irene Koch, JD – Executive Vice President & General Counsel – Healthix, Inc.**

But I think, it's Irene Koch again, I think you make an excellent point which is, you know, we need to start thinking about this sort of lever of certification and, you know, whether it's – or something else.

In New York we are doing a whole, you know, certification of the RHIOS the Health Information Exchanges and, you know, our flow down requirements for participants and, you know, I do think increasingly maybe not in one fell swoop but we do need to think about this as such a key component for operations that we do, you know, impose those kinds of obligations.

Having said that, you know, sometimes it is really hard to know from data, electronic data and otherwise who that responsible physician is so there is a flip side to it, you know, and a reality check, but I think that kind of thinking is probably required.

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

Yeah, it's interesting hearing Larry Garber's experience in Reliant and as part of Joe Kimura's system too where the hospitals that are sending them alerts upon admission or discharge they have obviously the list of the, you know, attributed population so they know they can trigger the alerts and that's all technically enabled but I wonder in the absence of sort of the ability to do ABP alerts in Tennessee or other markets, you know, is there at least a way that there could be more routine enabling or sharing of attributed populations so that it could be you take some steps toward a more routine bearing upon transfers or transitions.

**Irene Koch, JD – Executive Vice President & General Counsel – Healthix, Inc.**

Yeah, I think that kind of resource would be really important to make it all hang together for sure, electronically or otherwise.

**Frank Ross, MSSP, AP, ACO – IS/IT Steward – Cumberland Center for Healthcare Innovation**

I think it, this is Frank again, I think it warrants much more discussion, but the problem is that if that discussion takes place in a vacuum where all the stakeholders aren't sitting down and looking each other in the eye and talking about it in some capacity then you're not going to get to a working solution. You may come up with a solution but you're not going to get to a working one and I think CMS could probably ultimately mandate something that, you know, the hospitals have to report to CMS electronically and then CMS can share that with ACOs electronically.

But at the end of the day what – you know, that doesn't foster a sense of cooperation to achieve care coordination it just puts another mandate on the table and, you know, in my part of the world people are – you know, I get hammered every day, my foursome for golf threw me out because I worked for an ACO and –

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

My goodness.

**Frank Ross, MSSP, AP, ACO – IS/IT Steward – Cumberland Center for Healthcare Innovation**

Well, they're doctors and they're good guys but they take their golf very seriously and they definitely take their medicine even more seriously.

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

Well you can join my golf game it needs some improvement.

**Frank Ross, MSSP, AP, ACO – IS/IT Steward – Cumberland Center for Healthcare Innovation**

You know what my game is so bad right now I think I'm thinking about giving it up so I mean what difference does it make.

But, I'm just trying to make the point is that these things run deep, these issues run very deep and, you know, we've got – there's a joke that goes around in my part of the country that says, every 10 years the hospitals are going to buy me and then they're going to give me back to myself and then 10 years later they're going to buy me again and that's kind of the pattern that we're seeing in regard to hospitals and the aggregation of primary care services and unfortunately we're in an aggregating phase right now in my particular town and my particular part of Tennessee.

So, you know, it's just like trying to get everybody's attention in Grand Central Station at rush hour what are you going to say that's going to get everybody's attention I think that's really the message that has to be formulated to have the discussions that put together a collaborative effort to make these things happen and I don't know what the venue for that would be I just don't know.

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

Other comments or thoughts? Well, hearing none it sounds like our team there up in Washington has some homework to do before we're going to let them go home for the holidays. Is everybody comfortable at this point opening it up for public comment?

**Frank Ross, MSSP, AP, ACO – IS/IT Steward – Cumberland Center for Healthcare Innovation**

Yes.

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

Yes.

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

All right let's do that.

## **Public Comment**

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

Operator can you please open the lines?

**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're listening via your telephone you may press \*1 at this time to be entered into the queue. We have no comment at this time.

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

All right, well everybody have a good holiday season and I look forward to talking to all of you in January.

**Frank Ross, MSSP, AP, ACO – IS/IT Steward – Cumberland Center for Healthcare Innovation**

Happy Holidays to everyone.

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

Happy Holidays.

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

Happy Holidays.

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

Bye-bye.

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

Bye-bye.