

**HIT Policy Committee
Accountable Care Workgroup
Transcript
June 28, 2013**

Presentation

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

Thank you. Good afternoon everybody; happy Friday. This is MacKenzie Robertson in the Office of the National Coordinator for Health IT. This is a meeting of the HIT Policy Committee's Accountable Care Workgroup. This is a public call and there is time for public comment on the agenda. The call is also being recorded so please make sure you identify yourself when speaking. I'll now take the roll call. Charles Kennedy?

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

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

Thanks Charles. Grace Terrell?

Grace Terrell, MD – President and Chief Executive Officer – Cornerstone Health Care
Here.

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

Thanks Grace. Shaun Alfreds?

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

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

Thanks Shaun. Hal Baker? Karen Bell?

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

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

Thanks Karen. Karen Davis? John Fallon? And our new Policy Committee member, Scott Gottlieb?

Scott Gottlieb, MD – Resident Fellow & Practicing Physician – American Enterprise Institute
Hi, here. Thanks.

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

Thanks Scott. Heather Jelonek?

Heather Jelonek, MS – Chief Operating Officer – John C. Lincoln Accountable Care Organization
I'm here.

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

Thanks Heather. David Kendrick? Joe Kimura?

Joe Kimura, MD, MPH – Medical Director – Analytics and Reporting Systems – Atrius Health
I'm here.

MacKenzie Robertson – Federal Advisory Committee Act Program Lead – Office of the National Coordinator
Thanks Joe. Irene Koch?

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

MacKenzie Robertson – Federal Advisory Committee Act Program Lead – Office of the National Coordinator
Thanks Irene, am I pronouncing that right?

Irene Koch, JD – Executive Director – Brooklyn Health Information Exchange (BHIX)
Koch and thank you.

MacKenzie Robertson – Federal Advisory Committee Act Program Lead – Office of the National Coordinator
Okay, sorry, Koch, thanks. Aaron McKethen? Eun-Shim Nam?

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

MacKenzie Robertson – Federal Advisory Committee Act Program Lead – Office of the National Coordinator
Judy Rich? Cary Sennett? Bill Spooner? Susan Stuard? Karen Van Wagner? Samuel VanNorman?

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

MacKenzie Robertson – Federal Advisory Committee Act Program Lead – Office of the National Coordinator
Thanks Sam. Westley Clark? Akaki Lechiavili? Mai Pham? John Pilotte? And any ONC staff members on the line?

Joseph Bormel, MD, MPH – Medical Officer, Director of Health Outcomes – Office of the National Coordinator
Joe Bormel.

MacKenzie Robertson – Federal Advisory Committee Act Program Lead – Office of the National Coordinator
Thanks Joe. Alex Baker, are you on the line?

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

MacKenzie Robertson – Federal Advisory Committee Act Program Lead – Office of the National Coordinator
Great, thanks.

Michelle Consolazio Nelson – Office of the National Coordinator
Michelle Consolazio Nelson and happy Friday to you too MacKenzie.

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

Thanks Michelle. And Kelly Cronin, are you on? Okay, with that I will turn the agenda back over to Charles.

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

MacKenzie, before you do, this is Cary Sennett, I was listening to muzak when you called my name.

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

All right, no problem. Thanks Cary.

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

All right, thanks.

Elise Anthony – Senior Policy Advisor for Meaningful Use – Office of the National Coordinator

Hi MacKenzie, this is Elise Anthony as well.

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

Thanks Elise. Over to you Charles.

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

Okay. Thank you. Why don't we start out with a brief overview of what we'd like to achieve on this phone call. First, what we want to do is we've had a series of meetings where we've begun to frame out our – the activities for this workgroup with an eye toward the deliverables and how they can potentially influence Meaningful Use, Phase 3. In this particular call, what we will do is spend some time talking about an overview of the strategy for this workgroup and make sure that all of the individuals on this call are appropriately bought off and supportive of the strategy and that we get a fair amount of input as we do so. We will also then use some of the work of Karen Bell and CCHIT to begin to review and prioritize HIT function specifically around the care coordination domain.

And so what you'll see in the CCHIT work is that the recommendations are broken out into a series of domains, and we like that work and the way it's structured, and so our thinking is we'll use that as a framework to further our discussions. Once that's done, we'll have some time for public comment and we'll move on from – and we'll close the meeting. So that's our activities for the day. There is a webcast and I'm hoping that folks have either logged on to the webcast or have the PowerPoint materials available to them, that's what we will be working from. Let me just pause there to see if anybody's having either communication difficulties or doesn't have the PowerPoint. Okay, very good. Then let's turn to – I'm on the web x-mail, let's turn to slide number 2, and then on to slide number 3.

Okay. So, for the initial part of this conversation, what we wanted to do was have a bit of a discussion around framing for this workgroup's activities and overall strategy. And what we want to do is talk specifically about how broad the scope of activities should be for this particular Accountable Care Workgroup, and really have a discussion around should we include, for instance, all components of value-based contracts, from things like bundles and maybe patient-centered medical homes or more specifically tailored to accountable care organizations and population-based health. So we're going to – I'm going to ask for some comments on that. If we could have the next slide.

So, our initial task statement boiled down to as simply – as simple as we can make it is to provide a set of recommendations to the Policy Committee regarding how healthcare policies from ONC and HHS can address HIT capabilities in making accountable care arrangements successful and more HIT-enabled. I'm now on slide I believe this is 3. So, let me just open the floor first to ask for some comments around, when we think about accountable care, there are a variety of definitions out there. Some people define it fairly narrowly as a group of physicians who come together to take accountability for the health, wellness and disease-management of a defined population of patients, and have financial reimbursement arrangements that reward them for achieving the triple aim within that population. Others could define it more broadly, as I mentioned, bundled payments and others. So when we think about the intersection of health information technology and the business objectives of accountable care. Let me just open the floor for comments around how broadly this workgroup should consider its set of activities.

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

So this is Karen Bell, maybe I'll start off the conversation just a bit by underscoring the fact that accountable care, however we choose to define it, is really about getting the entire delivery system in some size, shape or form to value-based care. And that that's an iterative process, it's an evolving process. And while I think probably a number of people, as you say Charles, will define accountable care in the terms that the federal government has defined it, in terms of the ACO legislation, out in the field and I think other people would obviously want to comment as well, we're seeing everything. We are seeing a lot of patient-centered medical homes as a first step towards increasing accountability and increasing – risk.

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

Sorry, this is MacKenzie. Can I just ask that everyone put their phone on mute who isn't currently speaking because we're getting some background noise. Thanks.

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

So I would suggest that we think a little bit about our ultimate goal is really to get to value-based care. And that that is an iterative process and that we as a workgroup could maybe think about at least some of the baseline health IT capabilities that are going to be necessary to get everyone on that glide path, so to speak. So, I would throw that out there for the start of the conversation.

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

Yeah, this is Joe Kimura from Atrius Health. I would concur around that concept of sort of HIT being functionality that pretty much bridges all the structural – the entire range of the structure and the delivery system and the financing system, particularly as data is now mixing as to where we're getting those sources. And as we move towards even patient-generated certain data, I think fixing ourselves in an area specifically by either physicians or hospitals or some kind of structural definition seems like we're going to miss the important objective that we just talked about, talking about trying to get the value for a population of patients.

Scott Gottlieb, MD – Resident Fellow & Practicing Physician – American Enterprise Institute

Yeah, this is Scott. I would just echo that as well. I don't think we should confine ourselves to the physical arrangements because I think of a lot of what's being called accountable care in the marketplace right now is more of a payment arrangement rather than some kind of physical change in how the providers are being organized right now. And also, if we confine ourselves to too narrow a definition and tie it too closely to some kind of physical arrangement, we're likely to have a definition that doesn't match what's actually happening in the marketplace. So I would want to be as broad as possible, and I think a lot of the changes, the new payment arrangements is what might really drive a lot of this change ultimately, and so we should incorporate that as well in how we define this.

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

Did we lose anybody?

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

I'm sorry, let me play the role of devil's advocate then, a little bit and let's take the case of bundled payments. If you do a payment bundle for, let's say a procedure, or maybe a disease state, you can manage that bundled payment set of financial incentive probably without a population-based management infrastructure of any type, without disease registries, without many of the components of what one would define as the enablers of success in value-based arrangements. So I guess what I'm wondering is, I understand defining it broadly, but would defining it too broadly have a downside as well?

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

This is Joe from Atrius again. I guess I would say that what I'm hearing about bundled payments too though – so the infrastructure, the IT infrastructure required to study those bundles and to talk about identifying which providers are more efficient, providing better care, etcetera, along those lines feels like that's – the capability of doing that kind of analysis is something that actually can – bridges from insurance entities to provider groups to hospitals all the way through the different structural areas we're talking about. And I guess I would submit and say, even though we might not call it population management from a registry perspective, I can absolutely think about variation analysis happening through a registry of all the events that are being measured with different dimensions around providers or hospitals, etcetera on that. So, I think it's the same kind of actions that are being taken, we might call it something different, and so it may not fit directly into those buckets of population management per se. But I actually see it being a common approach, common tactic that bridges all the structures.

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

And this is Karen Bell. I think when we're talking about bundled payment, we're talking about how payment can occur. When we're talking about accountable care, I think we're talking more about not only cost, but we're also talking about quality and we're talking about the need to really engage patients in some size, shape or form. So maybe we should be – we wouldn't put our boundaries on whether it's patient-centered medical home or whether it's a fully capitated Pioneer ACO, but what we could do is at least say that accountable care does include improved quality, improved cost structures and better access to care for patients, or something of that nature.

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

Okay. Great. To follow up on that discussion, let's touch base on a little bit of what's said previously and that was, you touched on the notion of claim and clinical data and integration of such. So I think what – again, thinking about scope and framing, I think what we are saying is even though Meaningful Use has had more of a clinical data and a clinical, I'll use the word enablement, flavor, that in the case of accountable care, the importance of claim data and it's use within the objectives of accountable care is important and foundational enough that when we say the word health IT capability we probably should – would people agree that we should be clear that that includes not just a clinical focus, but also a claim data focus as well?

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

Charles, this is Karen again. I would say it's not just claims and clinical, but it's also patient derived data.

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

All right, great.

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

This is Joe from Atrius. I would agree with that.

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

This is Eun-Shim –

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

This is Shaun from HealthInfoNet, I would also agree here. Within our 10 ACOs in Maine, as well as within our State Innovation Model testing award, patient derived data is going to be a very important factor.

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

Yeah, this is Eun-Shim as well, I would agree with Karen's comment. I think we should – we can do more to include patients and caregivers to this process.

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

This is Heather Jelonek with John C. Lincoln, I completely agree.

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

And I think we can't lose the nuance on not just the patient, but also the caregiver. This is Sam VanNorman with Park Nicollet. And I would also say – and probably the community derived input as well.

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

Okay. Great. Thank you. Wrapping up on slide 3, any other scope questions or term definitions in identifying our initial task, anything else come to mind that would in your view be important enough to put in our kind of single-sentence statement of what our initial task is.

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

I guess I'd have a question for the group to consider. We talk about health IT capabilities – and again, this is Shaun Alfreds from Maine. I'm challenged by the term capabilities, there's a lot of things that can fall under the term capabilities and some of which the federal government and policy can have a significant influence on and some they cannot. One of the things that I look at here is the fact that the needs that we're seeing in the community are really focused around data and around getting data from sources that traditionally have not been very easy to get data from. Whereas meaningful use has helped us, as folks earlier in the call said, on some clinical data, there's still a significant amount of information and data that's challenging to make available, standardize, aggregate and use for accountable care efforts. So I'm struggling with the terminology here so that we can get to a point where we can – this statement actually has a little bit of – has some teeth to it, to allow us to say that we're not only looking at capabilities, but we're looking at how do we accomplish what our policy levers can allow us to accomplish.

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

This is Charles, I think that's a really good point and I – certainly my experiences with setting up ACOs across the country echoed that. Specifically around the challenges – the need to be able to leverage data and the challenges with more of a data-centric interoperability challenge than more of a document-centric, which is so much of what we see out there today. Any other comments on our initial task statement?

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

Grace Terrell here. My thoughts are that the real issue is when you're looking at the functionality of information technology as it relates to the functionality of accountable care organizations, how do those things interact with policy? And what should the policy be? So by starting with what types of information as we have with this conversation, that kind of leads to scope or scope creep and where you go. I think that capabilities as it relates to functionality, which I think is perfectly well suited within the way this is written up, is the way that we probably ought to approach it. And a lot what our subsequent conversation is probably going to be today, around some of the framework stuff that CCHIT did and the crosswalk we were proposing, will get to that.

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

Okay. Very good. Let's – with that, let's move on, in the interest of time, to the next slide, slide 4, where we talk about the very thing that you brought up, which is policy and program levers. Right now, as we move forward in this work, how can we actually influence the market, how can we actually influence the types of solutions that are likely to be brought to market. And we really see three levers. The first one is Meaningful Use Stage 3. The second one is through a certific – a modular certification program similar to how we have developed a certification program for EMRs. And then thirdly, recommendations that may come out of this workgroup around any other federal, and very importantly, private initiatives. I think you're seeing a variety of health plans, such as mine, but many others, work on accountable care

initiatives for the private sector. And our scope of activities should specifically not limit itself to just federal activities, but also how can complimentary private sector activities continue to further the agenda. Next slide. So here's how we see ourselves moving forward to do this work. I am now on slide 5, titled Strategy to Develop Recommendations. And what we are seeing as our set of activities moving forward is first spending some time around identification, looking at specifically from a capability/functionality perspective, what do we expect health IT to deliver to enable accountable care arrangements? Look at a degree of the current certification programs, where there are any gaps between the certification programs that exist today and a certification program we would propose for accountable care. Go through a prioritization process, certainly there is no end of functional requirements that would be nice to have within an accountable care solution set. But what are the ones that offer the greatest value and also are achievable within a reasonable timeframe. Have a discussion and an evaluation of each one of those capabilities, we will kind of gradually move forward, make sure we manage the granularity of the conversation so we can both create a high quality work product and also move forward in a judicious fashion.

And then finally, finalize our set of recommendations and consider specifically what will the HIT market do. How can we expect them to respond? And what are the cost and business impacts potentially having the ideal solution that perhaps is too expensive to acquire or takes too long to implement or is too costly to implement, may be suboptimal. Rather than something that's a bit more tactical, but maybe still rich enough from a functionality perspective, to track to value, which is our primary measure here. On to slide 6. And Karen, can I invite you to perhaps make a few comments on the CCHIT framework. This is the framework that we would like to use in advancing our discussions. And Karen is here from CCHIT and so maybe you could just say a few words on the framework and how it can structure our discussion.

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

Thank you very much, Charles. I think it will be helpful for a couple of reasons. Number 1, it does begin to organize and structure the key processes that accountable care organizations are going to need to consider as they move forward and take on greater amounts of risk. Not every organization is going to really get deep into knowledge management, but there are elements of literally all of those key processes that are at the bottom of the slide, that are going to be necessary to really meet the – what we've called the aim for the accountable provider organization. The part that I think is most important on this slide though, is the center bar, the primary HIT requirements. Because while we're interested and really would like to get into some of the functionalities and capabilities that are necessary, without these four things, then all of the ACOs, and it doesn't really matter if they're patient-centered medical care or something far more robust, will need to really – will really have to – think about whether or not they're going to be able to succeed.

So the information sharing between and among clinicians and with patients and their authorized caregivers, is going to be critical. And I know ONC is already doing a lot of work on that, but there may be other use cases that we might want to consider that will help foster that, because that's again, a very critical piece of success. We mentioned a little bit about data collection and integration. And without the ability to collect data from multiple clinical, financial, operational and patient derived sources, again, going to be very, very challenging to be successful in the evolution towards accountable care and value-based care. We highlighted patient safety specifically around the communication aspects that are necessary.

Without good communication internally and externally, patient safety is at risk and I would also add that there's been quite a bit of discussion in the literature lately about the fact that integration of information is also critical for patient safety. So patient safety, while we're not talking about the systems themselves necessarily being safe, other groups are working on that. There are things that can be included in the HIT infrastructure of an ACO that will enhance patient safety, but again, most of that's going to be very much dependent on really good information sharing, interoperability and the ability to integrate data. And then lastly, strong privacy and security is also going to be important and I know that there are other groups that are focusing on that.

So, I would come back to what the development group did on this particular framework and basically say that perhaps one of our goals might be to really look very carefully at possibly other use cases that are very ACO specific among all the processes that are defined and to assure that we've got good interoperability standards to support them. And then again, we've – a number of people have talked about it, how can we make some recommendations around data collection and integration. I think one of the concerns that people have had is that with the modular situation, if modules are not well integrated and there's no guarantee that they're integrated that can be a risk as well. So, I think those first two things in terms of primary HIT requirements, are things we can spend some time talking about as well.

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

Great. Karen, thank you. So let me – what I'd like to do is pause here and try to get some conversation from the group on this, with just a couple of comments. First, the CCHIT framework is not just – we aren't just here to copy and paste, we're really here to add our own thinking and our own expertise to it. And so I do want to emphasize that we should be thinking about do we feel the need to change or to focus on certain components of this framework as we move forward in our activities. And then secondly, the – as we move forward, the definitions in here we can also change. So you kind of have a framework where you have the triple aim at the top, a series of requirements and then specific processes; these may or may not be what we choose to focus on. Because as Karen mentioned, there is a separate group focused on privacy and security and there may not be a need for the ACO committee to make any comments in that space, or perhaps make very minimal comments in that space. So I'd like to throw it open to the group to kind of begin to have some conversations around those two objectives and the framework overall.

Well, I'll offer an opening comment which is, I don't see called out specifically analytics. I do see reporting, but I do think of analytics a bit differently than just pure reporting. And so I think one of the things that we may want to either change or focus on might be that light blue, call it reporting and analytics column, as one area of focus. Another one that certainly I think is going to be critical for our activities are care coordination. But I'm not sure patient safety is one we particularly need to focus on, given that – or we could decide differently, but given that there are other workgroups focused on that as is privacy and security. So, I'll offer that to the group for an opening comment. Am I talking to myself? Hello, is anyone out there?

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

Hey Charles, this is Shaun from HealthInfoNet in Maine.

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

Okay.

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

So I guess I agree, I think a lot of – I think analytics and reporting is going to be a critical piece for any ACO moving forward. And when you think of analytics, and I think what I'd like to hear from the group and I think will be a good discussion is, how can ONC help to support analytics? I'll give an example of something that we're dealing with on the ground today here in Maine. We have a State Innovation Model Testing Grant here that we're beginning the implementation process on and one of our focal points is behavioral health. Right now, we know that 40% of our Medicaid population have a co-occurring behavioral health disorder with one or more chronic conditions and these represent our highest cost, highest risk individuals. Now on the commercial side, the percentage is a little bit less, but those – it's the same population that there's significant focus on for the commercial ACOs.

We have a challenge because the information for those individuals is not as readily available as it is for persons without mental illness, because we have state laws that resemble very, very similarly 42CFR Part 2 for substance abuse sharing, where consent is necessary for the sharing of information and to whom that information is being shared. So as we're looking at, as a state, the private sector and the patient-centered medical home practices are looking at this. We're looking at multiple different data sources and trying to bring them together, in order to get around the fact that we may not have the full breadth of information available to support the true analytics necessary to really drive for change for persons with these conditions. And this is an area of ongoing policy debate that we're having in the state.

We've actually had a state law that recognizes a state health information exchange and allows the exchange to have the capability of moving data outside of that state law, but it's in a very limited manner. And in order for those ACOs to be successful, we've got to find a way to help support these patients and to help drive change. And part of that is addressing the state law and the specifics around confidentiality, but at the same time, having enough information so that care management and interventions can be established when these persons with these disorders are being seen in inappropriate settings, whether it's the ED or whether it's in a primary care office when they should be in their behavioral health provider's office. So that's one area where we're seeing challenges and trying to develop policies to address, within the frameworks that we have available to us, and I think that that's something that I'd like to hear from some of the other folks that are working in other states, to see if that's a common issue.

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

This is Eun-Shim Nahm from the University of Maryland School of Nursing. I would like to get a clarification. When I look at the second layer, I see structure component and also the content component. For example, information sharing or data collection and integration, I think those components are focused on more on structure aspect of HIT. But when I look at the patient safety or privacy or behavioral health, I see that as more content oriented. So are we looking at both areas or do we focus more on structural piece. May I get a clarification on that?

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

This is Karen Bell and I just wanted to clarify that these were initially defined as some primary requirements that an ACO needed to consider as it started to develop its processes. You can't do analytics, for instance, without the data collection. You can't really do good care coordination or cohort management without information sharing. And that patient safety, while it isn't necessarily that same type of an infrastructure piece, was felt to be so important by the members of the advisory committee that we felt it was important enough to consider it a primary HIT requirement. If you are truly going to be an organization that's going to focus on value-based healthcare, you're going to want to assure that you're HIT infrastructure does have as much as it can possibly support in the way of patient safety, as well as privacy and security. So these were not looked at in terms of anything other than what the ACO really needed to start off with, was at baseline, if it was truly going to move deeper into accountable care.

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

Thank you.

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

I think there's a suggestion implicit in your statement, right, which is perhaps, I mean I don't think anyone has any concerns about the triple aim, but perhaps for our activities, the priority HIT requirements might have patient safety and privacy and security maybe as key processes rather than as primary HIT requirements. And perhaps there are some other things we might want to add to priority HIT requirements more as an infrastructure or capability perspective. Is that kind of what you're getting at there?

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

Is that question towards me, just want to clarify?

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

Yes.

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

Oh, I think you can go either way, but when I think about the whole component, I need to have some sort of framework, do I need to focus on processes when I think about the priorities or do I need to focus more on the structure aspect? That was my inquiry, because I think we need to have some sort of a framework to focus on. Did that answer your question?

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

You did. Yeah. So I think when we think about a framework, maybe for our purposes, and again, if others have an opinion, please weigh in. But I think information sharing, data collection and integration, I'm assuming Karen implicit in the – yeah, integration is some kind of normalization or some kind of ability to look across multiple data sets that may be coming from multiple sources so that you can build kind of a holistic patient perspective, is that kind of implicit in that?

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

Absolutely. Absolutely and – on which you can also put your analytics engines in order to be able to do your business intelligence and clinical analyses as well.

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

Um hmm.

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

All right.

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

Are there any other kind of infrastructure components that come to people's minds if we were to kind of move patient safety and privacy and security maybe to process level? We've talked about analytics and algorithms potentially as a capability. What are people's experience and expectations around kind of analytics and algorithms that support things like gaps in care identification or prevention and wellness interventions as kind of part of an enabling framework for analytics and algorithm use? Are you seeing much of that out in the community? Do you feel that those are critical foundational capabilities or more nice to have or maybe even future state?

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

This is Grace Terrell here. I mean that's absolutely crucial, at least with our organization and within ACOs is identifying gaps in care and the ability to analyze that data is absolutely crucial to making any difference whatsoever in terms of really moving the needle when it comes to trend on medical cost. So we've – we actually started there before we did some of the other things, because we found that that analytic capability was a way of moving the needle pretty quickly.

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

Okay. Well then, given that, maybe let's move into the next section of the discussion, and the final section of the discussion, which is drilling into one of these areas. If you look on slide 6, you'll see a key process being care coordination. So let's drill into care coordination a bit, by jumping to slide 8, entitled care coordination. And what this is are the more specific capabilities or processes – functionalities that would be listed under that care coordination bucket. And so what we'd like to do is have folks read through slide 8 and I'd like to get some reactions around, are we in agreement that these are the correct priorities – that these are all high priority functions for us to consider as part of a Meaningful Use Phase 3 set of recommendations. Or whether we're missing things that should be on this list or perhaps some of these things being nice to have. So what we have right now is kind of a list of things from CCHIT, what we're now trying to do is get some color and get some granularity around how people on this call feel about the prioritization of these various sets of functionalities. So, comments on slide number 8.

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

This is Karen with again another point of clarification. I think one of the things that's important for us all to recognize is that the group that developed this framework did not do it in a prescriptive way. It recognized that in order to truly be able to do the care coordination, one needed to in some size, shape or form, marry some traditional payer functions around utilization management and setting of care as well as some more clinical functions around communicating and understanding where care would be – with the information that could be gathered from care that was coming from multiple settings. So, this was actually an attempt to highlight the importance of both of those ways of thinking about care coordination and recognizing it could be done either by just a payer group, it could be done – I'm sorry, just a provider group, or it could be done through a payer-provider partnership. So – but again, we didn't want to be prescriptive, just wanted to leave the door open so that people would have those discussions around how

they could best manage those two aspects of care coordination.

M

Good afternoon –

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

And then let me just add one other thing, which is if we could jump to slide 9, there is some drill down information. So if you look on slide 9, what we've done is exploded each one so – of slide, into greater granularity, so 1.1 Access to real-time health insurance coverage information, what do we mean by that. And you see up-to-date eligibility and plan benefits, provider networks and co-pay and deductible information. I think you could look at that and say, well, those are things that have value in many, many contexts, accountable care or not. What might be more specifically linked to accountable care perhaps bundled payment functionality, and I'll leave it to the group to maybe describe any specific bundled payment functionality they might see as important, either on the kind of enablement side in allowing you to be successful in a bundled payment methodology. Or on the payment side, around a capability to perhaps reimburse or manage or reimbursement function associated with bundled payment. So, maybe in that first cat – maybe if we just take that first row, I'd be interested in anyone's comments on the functionality identified there, and what we might think might would be more important, or critical to add or delete.

William A. Spooner, FCHIME – Senior Vice President and Chief Information Officer – Sharp HealthCare

This is Bill Spooner with Sharp HealthCare. I apologize for coming onto the call late, but I just wanted to make a couple of comments in general. As I look through the suggested items, in terms of ACO capabilities, I'd say yeah, they all seem useful. But as the previous speaker said, organizations accomplish these functions in so many different ways that a particular provider may not have that responsibility in their ACO arrangement. And so you have to question – wonder why they would need this IT capability if they're not actually doing the function. That's sort of like comment one.

Comment two is, then given comment one, does this really need to be in Meaningful Use? Because not everyone is using it, it's not really universal, it's certainly not an EHR function either. And then when I get to comment three, picking up on that, the functions they're describing are happening in totally different computer systems than your EHR and that really expands the universe of certified products that you have to have, thus increasing your cost of operation, increasing cost of healthcare, not going the other way. So I just – it really troubles me a little bit in terms of what we're doing from a macro level perspective.

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

This is Grace. Karen Bell may want to jump in here in a minute, but when we were approaching this at the CCHIT, when it came to the framework, we started with what would be the ideal. And then it was a second document, which I think you all of have seen, was then the glide path and a lot of it had to do very much with the fact that different people would be – different organizations would be at different levels of capabilities at any one time. And as we're going down this path, it wasn't to come up with a very prescriptive way of getting there, but again, starting with the functionality and then going to the – what might be the glide path to get to where we need to be one day. So the real question for me is, this was – CCHIT is a private body that basically said, this is what we think the way that it needs to be thought through from a process and function standpoint. And to speak very much to your question, what ought a regulatory body, like the ONC do, if anything or to what extent when it comes to meaningful use or otherwise from the standpoint of policies that pertains to these things. So, I think you're really getting at the meat of things, but again remember, we started off with a glide path, which basically says, if this is the ideal state, here might be the way of getting there. But it was certainly not to create a prescriptive state.

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

That's absolutely correct and it's – and not only prescriptive in terms of what the ACO specifically would need, but again, not prescriptive as to who does it. And if you are in a partnership with a payer who can make sure that this information is available at the time that you are essentially trying to make a referral or in some size, shape or form provide services that will be cost-efficient for your patient, then all of this will come together. But it was certainly not designed to be prescriptive in that ACO absolutely had to have this and it certainly isn't prescriptive in terms of the type of technology. We've – these are not things that EHRs are supposed to do.

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

And Bill, this is Charles. Appreciate your comments and let me just say, at the beginning of the call, we kind of had a discussion around so many of the things that an ACO needs to do to be successful would be outside of the bounds of what a traditional EMR, even a very advanced EMR might do. And so the question we asked ourselves early on was, well should we kind of confine our comments to that, which might have limited utility and value. Or should we kind of take it from a holistic perspective and say, what are the things that are necessary for an ACO to be successful period, and kind of come to some level of consensus around that. And then once we have that consensus, we can then come back and say, okay, what are the things that are appropriate for federal policy to do, and that may be a very constraining factor in what we ultimately recommend. But it was a bit of a challenge to figure out how to create a framework around this to have the discussion.

So our thinking was to start out broad, kind of create some consensus around what's necessary and then as a second phase, get into okay, now what are the specific policy levers we can use. They may not all be meaningful use, they may be simply recommendations that we put forward that may or may not tie to meaningful use and may or may not tie to certification. And so that discussion would happen a little bit later on in this workgroup's process. Does that make sense to you or what are your thoughts.

William A. Spooner, FCHIME – Senior Vice President and Chief Information Officer – Sharp HealthCare

I understand where you're going, I'm just not sure that – when you put – when you check a box that says Meaningful Use Stage 2 or Stage 3 implies another regulation and I'm not sure that regulation is really the – is really necessary. Given that really an ACO agreement between a group of providers and a payer is kind of a competitive business venture and it's up to them to ensure that they get the results that they get the best care for the best price and different agreements will take different approaches in terms of achieving those aims. So I'm just not sure – I appreciate that it's not prescriptive, but when you see a check mark in the box that sounds like a – going off and something more that I've got to pay for, whether I use it or not.

Charles Kennedy, MD, MBA – Chief Executive Officer, Accountable Care Solutions – Aetna
(Indiscernible) – go ahead.

Michelle Consolazio Nelson – Office of the National Coordinator

I'm sorry, this is Michelle from ONC. I do want to clarify, because this slide does make it look like all of those items from 1.1 are suggested from the Meaningful Use Workgroup that they be in Stage 3, and that is actually not the case. They're suggested to be in a future stage of Meaningful Use. There was some clarification in the last slide that described that, but it's not on this slide, so I do just want to make that clarification as well.

William A. Spooner, FCHIME – Senior Vice President and Chief Information Officer – Sharp HealthCare

Oh, okay. Thank you.

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

Yeah, I think moving forward we'll pull off the Meaningful Use 2 and 3 and maybe change the framework around, because it is kind of an obvious conclusion looking at this document. So, Bill, we'll take that as feedback and change it appropriately.

William A. Spooner, FCHIME – Senior Vice President and Chief Information Officer – Sharp HealthCare

I appreciate it.

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

This is Eun-Shim, may I ask one more question? Does the number 1.1, 1.2, does the order represent some priority or just it doesn't have any order on this slide? The items, do they have any order?

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

No, it does not – this is not priority, this is somewhat in the kind of workflow of how one might go about checking on things and then figuring out how to get a particular set of services ordered. But there's not priority to them.

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

Okay, thank you.

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

So, I think we need to do a little bit more work in the framework of how we have this discussion. I'm looking at the time and we're actually running up against the public comment section. I think what we will do, the co-chairs will do is, we will work with ONC to kind of clean this up a bit, but what we were trying to do in the introduction of this is to simply show you we think we have a framework that is leverageable. And at the next call, what we'll do is dive right in to care coordination specifically. We'll change the framework of the discussion so that it's less meaningful use-centric and more capability and functionality centric and then hopefully I think that'll make it easier for people to see what we're trying to get out of this discussion. Is it time to open up for public comments at this point?

Public Comment

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

Sure. Operator, can you please open the line for public comment?

Rebecca Armendariz – Project Coordinator, 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.

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

Okay. Very good. Well then, Grace unless you have any comments, I think we've got some good feedback from the group. I think we need to kind of look at these CCHIT requirements and frame – refine how we have these discussions a bit. This is an iterative process and it'll get better with each meeting. I didn't know if you had any closing comments you would like to make.

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

Sure. I'd – thank everybody for the discussion. This has been an interesting experience for me to be on this, as well as be part of the CCHIT and part of the committee that helped create that framework. But, hopefully my perspective will mostly come from a provider organization that decided to go down this road very aggressively and then had to figure out, before there was anything out there, what kind of capabilities we would need to be successful as an ACO. And both with the Medicare Shared Savings Program as well as with many other contracted payers, and so I'm very pleased with the direction that this is going. Like some of the other speakers, I don't want it to be about more money, more rules and more regs that constrain me or constrain us as a nation from sort of going where we need to go from a value-based delivery system.

But it will, I think, be useful from a federal policy standpoint for us to decide as a committee what we would recommend as an approach to what I think's going to be a very rapidly evolving part of the healthcare industry. Where there really is going to be a need to have a concept of what capabilities you're going to need to be successful, so that people can get there. It may be that what we decide to do is keep it entirely to a negative within the context of federal policy and say, use what CCHIT or other bodies come up with as a way of approaching it, consultants or otherwise. Or it may be that we need to think very narrowly about the Medicare Shared Savings Program and some of the federal policy. But either way, it's very heartening that there are other folks out there thinking through this now, as opposed to when we were trying to figure out all this on our own a couple of years ago.

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

Very good. Well with that, what I'll commit to the group is we'll take the comments that you've made and incorporate them into the task description and the framing discussion. We will make some modifications to the CCHIT framework and then at the next meeting, we'll refine the discussion template so that it's a little bit more clear on how we move forward in the discussion we'd like to have, and a little less focused on what's the specific regulatory intervention. So, thanks for everyone's time and input and I look forward to speaking with you at the next meeting.

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

Thanks everybody.

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

Thank you.

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

Thank you.