

**HIT Policy Committee
Accountable Care Workgroup
Transcript
September 20, 2013**

Presentation

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

Good afternoon, everyone. This is Michelle Consolazio with the Office of the National Coordinator. This is a meeting of the Health IT Policy Accountable Care Workgroup. This is a public call, and there will be time for public comment at the end of the call. As a reminder, please state your name before speaking, as the meeting is being transcribed and recorded, and if you are not speaking, please remember to mute your line. I'll now take roll call. 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

Akaki Lekiachvili? Bill Spooner? Cary Sennett? David Kendrick? Eun-Shim Nahm? Westley Clark?

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

Here.

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

Hal Baker? Heather Jelonek? Irene Koch? Joe Kimura?

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

Here.

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

John Pilotte? Karen Bell?

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

Right here.

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

Mai Pham? Sam Van Norman?

Samuel Van Norman, MBA, CPHQ – Director, Business Intelligence & Clinical Analytics – Park Nicollet Health Partners Care System

Here.

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

Scott Gottlieb?

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

Here.

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

Shaun Alfreds? Are there any ONC staff members on the line?

Kelly Cronin – Office of the National Coordinator

Kelly Cronin.

Alex Baker – Office of the National Coordinator

This is Alex Baker.

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

Elise Anthony.

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

Hi, Elise. Thank you. I'll now pass it back to you, Grace.

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

Well, good afternoon to everybody. We're having a nice fall, autumn day here in North Carolina and I hope that the weather is this pleasant where the rest of you are. Just to sort of go through where we are today, our agenda is such that we're going to begin with sort of an overview of the responses to the RFI and the strategy that we've had, and then there was a document that we worked off for quite some time that did come out of the CCHIT that we looked and discussed all the different types of things that they had put in their policy guideline recommendations at the CCHIT that we then prioritized.

The staff has created, and we've had some discussions, around what came out of that long discussion we've had over the last month or so, and we were gonna give a chance to look at the things that you all have been sent from the committee ahead of time, a summary of that today, and I'll lead that part of the discussion. In the meantime, let's go back to the overview of the responses to the RFI.

Kelly Cronin – Office of the National Coordinator

Great. This is Kelly. I'll just walk through quickly sort of some work that we've done over the last year. I've really been thinking about this for quite some time, recognizing that where we need to go at the health IT infrastructure and health information exchange in a more networked health care system is way beyond where we are today, of course, but even from a federal government perspective, we need to go way beyond the authorities and programs that we have from the Recovery Act, or HITECH, as we often refer to it.

We have the Meaningful Use incentives, which have been really helpful to hospitals and physicians, eligible professionals in terms of getting to EHR adoption and using them in ways that will improve care, but we need to go beyond it to reach a broader universe of providers and make sure that we have the kinds of functions and interoperability across the spectrum of care. We've been thinking a lot about how to really bake that in to delivery and payment reform. It's sort of timely, to sort of just give you an update on where we are, based on a lot of public input we got for our Request For Information on this, since some of the input we had, I think, is somewhat similar to what, some of the topics we've been discussing in the last two months. This might give you a little bit more context and a little more, maybe in some cases, validation of what we've been thinking and hearing.

Just to run through really quickly—I won't get into detail on any of these slides. A lot of them are sort of high level. We've always been looking at this as a way to support better care, better health and reduced cost, and it's sort of essential that it becomes much more of an ecosystem across all settings of care that are clearly necessary to support Accountable Care arrangements.

Next slide. Again, in getting to a much broader universe of providers, we really see adoption increase across post acute and long term care providers, institutional, home and community based. Behavioral health is an issue, labs, radiology—there's really a much broader number of providers that we're now thinking through very specifically how do we reach them through a variety of payment mechanisms, of the CMS regulations and Medicaid waivers, start planning them and sort of thinking through comprehensively what are all our levers to get through to these different parts of the system?

Next slide. We sort of clearly stated, this is our North Star that, from now on, we're gonna clearly encourage providers to retain or exchange information and use sort of technology through interoperable systems to support care coordination. I think HHS now is strategically very clear that they need to be much—we need to be really tightening our line in between standard certification and all of the payment and delivery reform activities. In essence, really, in doing that build the business case for this all to be sustainable over time.

Next slide. In doing that, we need to be thinking across Medicaid, all Medicare programs, I think we have our SAMHSA leaders on the call, through all other HHS agencies, it's sort of all hands on deck. What can we do to create this workable information infrastructure that's gonna support Accountable Care and value based payment?

When we got public input on this back last spring, we really got a terrific response from all kinds of providers across the spectrum and payers, consumer organizations, a lot of state responses, a lot of thoughtful suggestions. We heard a lot of different recommendations, well beyond the questions we asked which, a lot of them were sort of focused on sort of the payment business side of this, but we ended up getting a lot of feedback on the need for better standards, more interoperability, more certification, expanding our voluntary certification, and really trying to accelerate how we're implementing these payment models since that's really sort of the engine that's gonna drive this.

Next slide. We heard a lot of specific input and I would say, related to ACOs and Accountable Care broadly, there were some comments that directly supported just making health information exchange and having certain aspects of interoperability be a flat out requirement for all ACOs or those engaging in Accountable Care value based like arrangements. Then there's others that were saying, "No, let's be much more hands off. Let's be outcomes oriented and assume that interoperability will just be part of that over time."

There was a variation in response. Interesting, in some of our public input sessions, we actually heard from some ACO CEOs that were saying, "If you don't actually make it a requirement, people won't prioritize it, and they won't do it in year one or year two." I think that's something for us to just keep in mind that it may be challenging to have some level of health information infrastructure up front. If your community doesn't already support it, you don't have good trading partners, you don't have a vendor that's ready to execute, whatever your situation is—that said, if it's not a clear priority from a program or a federal government perspective, then will that kind of architecture be created, will there be investments at the ACO level that will naturally happen? It's something we might want to explore a little bit more as we get into recommendations.

We were asked to include long term post acute care, direct incentives to try to bring along adoption and exchange for those kinds of providers. That is being addressed, to some extent already through the state innovations model. We have 6 states that have won testing awards and 19 in the design phase that could reapply and get testing awards. There are some opportunities through federal programs to advance adoption, but we recognize the need to do more.

We also had a lot of input on the need to expand certification to get to better interoperability across the spectrum of care; in particular, supporting certification for long term post acute care and behavioral health, and CCHIT is already doing, but I think they wanted the federal government to step up and have a clear direction there. Clearly, a lot of input on the need for more specific reimbursement to support care coordination or telehealth. To some extent, there are some policies that exist to support this and clearly ACOs and Clinical Care support it, but I guess there is some thinking that fee for service is not gonna disappear overnight and we need to do something else besides ACOs. Then a lot of other regulatory input on ... kickback, and those are rule making processes that are ongoing and will be finalized soon.

Next slide. Really, the next there slides just expand on some of the input. Whoever is advancing them can just keep going, and I'll try to give you the nuggets that are most important to our work. Essentially what we did, we took all these responses and tried to synthesize them and marry that to our own thinking, because we've had a lot of internal plans around this for a while across CMS. Just keep advancing the slides, whoever's doing that. *[Laughter]*

So we came up with a set of principles and strategies that laid out sort of how are we gonna phase this in to delivering payment reform? How are we going to think more systematically with the way that we reimburse hospitals, physicians, the way we implement value based purchasing, the way that we're going to move long term care, post acute care, home health payment—how do we think through the various Medicaid authorities about how to marry it to what we're doing with standard certification and health IT so that it does become more baked in and that we have a transparent and thoughtful way of doing all the coordination across these programs such that we reach the enhanced capacity in the market to be successful in all these programs.

We've said, through a paper that was released in August, that we're really committed to doing an incremental, comprehensive approach to this and we're gonna be looking through all our regulations to be having sort of a systematic way to get to more patient centered care and health information that follows the patient and really following through the logical life cycle where we start with rewards and incentives and then potentially move to penalties, like in the example of the Meaningful Use program or payment adjustments like in a readmission—reduction and readmission rates or high readmission rates for hospitals and then eventually having it be a standard of practice where it would be incorporated into our conditions of participation. It would follow that general spectrum, and that would be sort of along the trajectory of what we likely see happening in the market over the next several years as technology becomes a lot more mature and there's a lot of cost effective options and it's easy to exchange within a community of medical neighborhoods.

We also were clear about needing to just continue our work with the standards and interoperability framework, having a multi-stakeholder process for standards development and adoption and really being transparent in how that all maps out and how that all plays out together so we have a clear path to interoperability that's publicly communicated with the CMIOs of the world, for the developers, for anybody who's interested in trying to figure out where is this going over the next few years and how are the health, the delivery of transformation priorities around Accountable Care or around managing dual eligibles or whatever the specific priority or use case might be, how that all plays out in a road map and gets integrated into policies over time.

We also, more concretely, want to be figuring out how to align certification with payment policy. One example of this is the current proposed rule making for the physician fee schedule under Medicare Part B is proposing a new Complex Care Management fee that's tied to summary of record exchange and the regulatory advantage for Meaningful Use, the most recent standard. If it was to be finalized in a rule this year, then it would be tied to Meaningful Use stage two standards and certifications. We'd be looking for those kinds of opportunities more routinely to make sure that certified technology and the standards that are required as a part of that would be more uniformly adopted as a part of these various programs.

Clearly, we need to be continuing our work on privacy, developing standards and policies to enable electronic management of consent, particularly among patients that have sensitive health data and continuous guidance on the HIPAA mod. There's really a lot of ongoing work to be done with data provenance and any other things.

Next slide. It's an ongoing process. Joe and I and others were just on a call to figure out how do we continue to think about the next iteration or generation, if you will, of electronic clinical quality measures, and measures that more broadly get at value that would be more appropriate for organizations that are taking on transformation in the health of populations over time, but we have an awful lot of work ongoing to better align our standards and specifications and are really committed to improving that since we want to reduce burden and really get to measuring what matters in an automated way that drives improvement, and that consumer engagement, a variety of things are already going on there, but we're very committed to just continue on that trajectory.

Next slide. These are a variety of action steps that are being taken. I guess, in some ways, just relevant to what we're talking about today and our charge, a lot of the health care innovation awards and the state innovation model and even as just under fee for service physician payment is going to move to having physician be more accountable for total cost of care, just implementing the value based modifier fee for service is going to change the way physicians ideally would think and practice, being more mindful of what happens outside their practice and across the spectrum of care that is being delivered for patients that they primarily treat. All of these are really a lot of the spectrum of Accountable Care, and we're thinking very systematically about how to make sure all of the health IT needs and uses and exchange uses are being advanced through those programs, and that we have sort of continuous learning and improvement from that.

I think we've got a lot of ONC things going on, but maybe most relevant to our conversation today is that we did hear a lot of variation of input in how to move the needle through the spread of ACOs and value based purchasing. There was not uniform consensus in our public responses that we got from a spectrum of providers around how federal government—how prescriptive federal government should be. For example, should anybody participating in a CMS ACO model or program, Medicare Shared Savings or any other models or innovations that are going to—should there be an up front requirement or maybe milestones, benchmarks that would have to be met related to health information exchange for care coordination? There are people who are clearly supporting then others that were really sort of shying away and just wanting to be completely outcome based.

I think that sort of the spectrum of stakeholder opinion is probably—I don't know if it's perfectly representative, but it's clearly consistent with things we've heard in recent years. That said, just sort of the general intelligence we get day to day about some of the ACOs and the Medicare Shared Savings programs, which would be physician led, it seems to be—at least in many cases we've heard, in the last few months, that it's not easy for them to get summary of care records from primary care physicians to specialists to do good referral management, to get the discharge summaries in a real time way, and there are some scalable services like notification alerts for admissions, discharge and transfers that are widely available in states like Maryland and increasingly in New York and North Carolina and Maine and elsewhere, but that kind of thing, if we think about whether it's a part of Meaningful Use stage three or whether it evolves to be an aspiration or a requirement in an ACO program, there could be very high return with that if it became more available.

I think if we think about what are the right policy levers to consider or even just anything for government to do to advance the sort of high value use cases, we may want to think about sort of the risk/benefit involved with whatever that option might be, having scalable ADT alerts across the country wherever there's an ACO could be very high value, but the best way to get there is a question mark.

I'll leave it at that. I think, if anybody has any specific questions about the kind of input we got relative to ACOs or sort of where we're going from here, I'm happy to elaborate, but I don't want to take a lot of time because I think we wanted to move on to the meat of our meeting.

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

Kelly, thank you. That was a great overview discussion and really speaks to a couple of things that we've been talking about for months now, and that is, we know we're not there yet, things are very fragmented. We have no consensus at the policy level from the various stakeholders as to how we might get there, although there are several themes that you articulated that we have over and over again related to various assets and capacities and constraints and all of that. We know that we've got to get to a much different place in order for us to be successful.

Let me open it up right now for any questions or discussion around the implications of the discussion you've heard before we start looking at the CCHIT framework discussions that we all did.

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

Grace, Kelly—this is Karen. One of the things that really impresses me is that you folks have done such a tremendous amount of work in terms of pulling input and feedback from all over the place. I'm wondering if, by any chance, you think it would be of further value to have a more structured way of getting input; i.e., an opportunity for a day of public input sessions or something of that nature, or is your gut feeling—and I'm addressing you on this one, Kelly—that you think you have a pretty good sense of really what's going on out there and have gotten really good input from pretty much everybody?

**Kelly Cronin – Office of the National Coordinator
Technology**

No, I think there's always more need to *[Laughter]* have more market intelligence about what's really happening. We try to do that on an ongoing basis the best we can, but yeah, there's no substitute for really talking to people or going on site visits or really getting data in any way you can. Because we feel like—but now there's so much traction with the Medicare Shared Savings program and commercial ACOs and while we have terrific representation on this workgroup, it would be really helpful for us to have an all day public hearing some time this fall to get a download on what people are really experiencing and where are the pain points, what do they see as very high, important opportunities that need to be pursued or better supported by federal policy.

We've been starting to think through how we might design that and have, I think, started to talk to Charles and Grace about it, but it would be great to get the workgroup's input on that, too.

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

Great. Thanks, Kelly.

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

So does anybody wanna input on that at this point, the rest of the workgroup that's out there?

Is there any other discussion points that people want to bring up now? Thanks, Karen, for your remarks.

Well, hearing none, let's go on, then, to the next part of the agenda, which is the review of the key themes from our previous discussion. The way that I was thinking this might be easily sort of organized would be to basically take the 13 themes that the group has been articulated and sort of talk very quickly about how this was put together in the way that you also, in the documents that were provided ahead in terms of these overall categories of the 13, and then let us go down one by one to essentially look at what they may provide with more in depth discussion right now.

If we can really kind of look at the wonderful organizational discussion theme draft that we were all sent, there was basically three aligning themes, and that is that it's critical for the entities operating under ACO arrangements to meet consistent quality targets really requires a fair amount of near term investment and attention from entities in these arrangements and it's gonna warrant further exploration of federal policy on how to support that.

What we did, obviously, as you all know is that we used the CCHIT framework and had a discussion around those things and then prioritized what they were. There were 13 themes that have been organized for us and they were, and I'll just read them out and then let's go back through it one by one:

Increase availability and access to information about patient functional status.

Number two, facilitate robust information sharing among care team members and other providers involved in patient care.

Number three, enhance cohort identification and management tools within EHRs or other HIT applications.

Number four, enhance capacity to conduct organization based clinical decision support.

Number five, improve effectiveness of the clinical decision support tools.

Number six, increase availability of coverage information for clinicians.

Number seven, increase availability of real time alerts for patient care in all settings.

Eight, encourage patient engagement.

Nine, increase provider insights into the financial metrics and cost data—and boy, that's a big one in our organization right now.

Ten is increasing the availability of claims data.

Eleven is increase ability to analyze integrated claims in clinical data.

Twelve is to simplify and clarify methods of patient attribution.

Thirteen is to enhance interoperability of systems to share clinical information.

I'm hearing a lot of similar themes to what we got from the input earlier, and I wanted to just sort of go through those 13 and then let us go back, one by one, within the context of these statements, so if we could move the slides forward a little bit.

Again, our whole concept is, can we basically take these themes and put policy and regulation in a sweet spot such that we have what's important, what cannot be done without policy, what can be effectively driven by policy and regulation and a business imperative to do it to sort of all be congruent with one another from the work we're doing. If we can do that, I guess we can run a country or do all sorts of other fancy things, because that's a pretty big total, although I think that the discussion has gone very well.

Let's go onto the next slide. These were the policy levers that we were thinking about before, which is, how can a voluntary certification address these issues? How can Medicare Shared Savings program requirements further address these? What are ways that the HHS programs and policies could advance these functions?

Next slide, please. Then you've got, there, the 13 themes that I've already just sort of read out to you. Let me stop for a minute so people can now read these themselves, because I was reading them off the draft, and I'm just gonna stop for a moment before we get into the individual, one by one discussions, and see if anybody wants to make any overarching comments before we dive in.

Okay, well, let's move forward, then. Let's start here with number one, which is, "Increase availability and access of information about patient functional status." There were sort of three underlined bullet points, which is whether there's a need for common standardized assessment, whether there was, how you could facilitate the integration of data from the home point of service labs and biometric monitoring and to provoke the development, validation, and provision of standardized, patient derived outcomes measures. Of all the things that were discussed, we sort of honed it down into these 13 themes. There was some discussion that sort of prioritized how much each was important, and then it sort of got distilled down into these 13 things.

Within the context of that, now that we've looked at it, to the Committee, I'm gonna ask, does that sound like, for number one—and these are not necessarily prioritized, it's just what the themes were—a lot of what cogently came out of that portion of the discussion?

That was a question—anybody got any thoughts on that?

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

Grace? Grace, it's Karen. I think there's the other multiple ways we can certainly move forward in this direction. I, for one, think this is really important to my priorities. I think what we have to do is really think about how this sort of thing could be funded. This is the sort of think that could be, it stresses again the development, it stresses developing kinds of standards, or are there things that could be ... to suggest, really—you mentioned that you have to pose to HHS if in fact ... that this is certainly a high priority item. I was just wondering if you've got little parking lots set aside for finding things that really help to assess in terms of what it has to take, what it would take ...

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

For those of you who may not have been able to hear Karen—Karen, you were a little bit difficult to hear—I'll summarize again that Karen is concerned about how we might think about the funding of this as it relates to either policy or otherwise as we're moving forward. Are there thoughts on the funding aspect of it? Should it be part of requirements? Do you think the market's gonna take care of it? How can you promote the development of these types of initiatives within the context of funding? Because the thing that most people hate the most in any of the sort of policy things is when there's unfunded mandates, and so what would be a funding for that?

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

This is Scott. It seems to me that this would be a core feature of what we'd want to enable, but it's gonna flow out from a lot of the other things that are on this list of 13. I'm not sure that I would necessarily break this out in this way and make this something that we work towards, because by working towards some of the other variables, it would seem to me that this would be what we're enabling.

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

That would take care of the funding, then, wouldn't it, because if we're able to do the others then, from a policy standpoint, then the market ought to take care of that. Is that sort of what—

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

Yeah, basically, it would enable the capability to do this, and then you're gonna have variation in the marketplace in terms of exactly what kinds of information the tool helps facilitate the transfer of as opposed to us getting in a discussion that could lead us on a prescriptive pathway around exactly what we'd want to see enabled. This is sort of second order from some of the other things, if we can achieve those other metrics and goals.

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

Do others have any—yeah, go ahead.

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

This is Shaun Alfreds from HealthInfoNet in Maine. I was thinking along the same lines as Karen when we're looking at this, and I certainly respect what Scott had to say.

There's a couple of pieces in here that I'm looking at, and as I was reading them, I was saying, I was asking myself, "How would we operationalize this?" To me, there's—A and C for this particular issue around the availability of accessing information about a patient, I really do think that there's still, there's some work that still needs to be done for us to understand what patient assessment tools we're gonna be using, what is a standardized patient outcome measure.

I think we're dealing with this, for example, on the ground today in the Innovation Grant here in Maine, trying to determine what patient dry metrics are we gonna have. There's a lot of things—there's a lot of examples available nationally, but no set standard. I guess one of the areas that I'd be looking at this from an operationalization standpoint and a funding standpoint would be to suggest that perhaps those two issues, at least, require some additional policy work and potentially, whether the federal government could make a grant or a contract available to convene some deeper dive discussions on that array, both what can be done and what's available today against what we're hoping to gather from patient derived data would be very helpful.

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

Thank you. Very helpful. Other comments? Okay. Hearing none, let's go to the next piece, which is taking it to sort of the cohort identification and management tools where you're basically breaking out population portions in registry functions. My personal bias to just start the conversation is, this is gonna be one of the crucial elements of population health from the provider side of things where we can start assessing risk and outreach and understand the cost and quality side of the equation. It's interesting that we really started talking, as we've gone on with this conversation, about a modular approach to that, again starting with the theme that we're not there yet and there's not gonna be any specific magic way of getting there, but that it's a crucial thing that perhaps a modular approach would be the way forward.

Does that sound like what other people heard us say in our previous discussion, and do you agree with it, those that are on the call?

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

Hi, Grace, it's Karen again.

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

Hi, Karen.

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

Just to get the ball rolling, the thing that really strikes me here is, not only do I agree with what you're saying, but I think that there may be ways to at least think about supporting how providers we generally don't think about could get engaged with this, and in particular, I think about end of life care and the post or most or whatever orders for the standing orders for end of life care that perhaps an emergency room or an emergency responder might need access to.

I'm thinking that we need to—I think it's important to do exactly what you are saying, so I think we need to really stress the fact that information is going to need to be available to a very wide range of providers, particularly in specific situations like I just mentioned.

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

I absolutely agree. Are there others out there who want to talk about it in a different way? For us, in our ACO and not to continue to be self-referential, but that's my referral point, I guess, for part of this is that this has become increasingly important, and the investments we are making in our own IT infrastructure. It's not easy to come by. Other comments before I move on, here?

Okay. Well, I'm gonna put number four and five together. You know, there are some themes, if you've got clinical decision support, it can be at the level of the individual patient as opposed to what we were talking about in three where you're looking at cohorts and portions of the population who may be at risk or require certain types of management or services. The ability to basically, to sort of further, again, what Karen was saying, enable each organization's ability to send appropriate information to clinicians when they need it about gaps in care or other things that will allow them to enhance their capabilities of clinical decision support in a way that's evidence based and meets the aims is gonna be absolutely crucial going forward.

A lot of these tools have been in their infancy and are being built as we speak, which goes to the them in 5, in my opinion, which is—at least 5A—which is, there's got to be some metrics involved that will allow these tools that are in their infancy now to become far more rigorous over time through metrics or otherwise. Is there more to five on the next slide we may need to look at? I was going to sort of group these two together, if you could go to the next slide. No, there's not, so let's go back. I couldn't remember. I'll go back to my handout so I don't have to worry about it.

Let's talk about capacity to conduct an organizational based clinical decision support and then effectiveness around those things. From a standpoint of policy, a standpoint of enablement for that, and thinking back to that slide where you're looking at the business case and what policy can do versus the market, are there things that policy, again, could impact here that needs to be honed in on the way that these themes were presented, or does this look good enough, in and of itself?

Well, I'm gonna move forward, then. Maybe—I mean, in a lot of ways, from my standpoint, I think things got very articulated well and some of it may simply be a no-brainer, and that's one reason that we're having some difficulty inducing more conversation this afternoon other than the fact that it's Friday afternoon, and that is that we've got, we've already really had it articulated nicely from the way that the committee wrote this up for us, how these things are done.

Let's go to the next two.

Samuel Van Norman, MBA, CPHQ – Director, Business Intelligence & Clinical Analytics – Park Nicollet Health Partners Care System

Yeah, I would agree. You know what, I think that this stuff is looking pretty good at this point, honestly.

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

Yep. Well, let's just go through the rest of it, and I'll just let us look at six, seven, and eight. Increase availability of coverage information for clinicians. You know, when I was thinking about that one, that's always been a case, even in fee for service. One of the biggest things in my organization is a report we've had in our practice management system for years, but we monitor the amount of denials up front that happen as a result of people not having appropriate insurance information at the point of service that's put in by our front desk staff. We can collect it on the back side once we get the information, but it's an increasing expense.

Yesterday I was looking at this, and although we're an Accountable Care Organization now, that's been an issue for us since 1995 when we first came together as an organization. In a lot of ways, that's not new, except that within the context of sort of upping the ante in the world of risk and Accountable Care, when you have to realize that there may be some constraints over time as to what people are eligible to receive and where.

My personal opinion with that was just a no-brainer in what's new about it. Then when you look at the real time alerts piece, that's different than reporting on the money piece in number seven, and when you look at number eight, "Encourage patient engagement in the health care system," that's almost the opposite of six, where you're looking at that standard information. I kind of look at these three things and say it all makes sense, but you're going from standard things that we still have in fee for service in number six to sort of the connectivity in number seven to really a much more patient centered approach in number eight. It all makes sense; it's kind of nice that they're grouped together here.

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

Basically—

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

Yeah, go ahead.

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

This is Shaun Alfreds from HealthInfoNet again. One of the areas that certainly—I think all three of these areas are incredibly important, and I think it's well stated here. I think one of the areas that we find important, and we're starting to see market drivers for, is the relationship between the payor, provider, and the HIE. We're seeing a significant evolution here in Maine regarding the payors becoming more involved in care management processes and care coordination processes with real care management staff on the ground working closely with provider care management staff, and the resulting impact, the business impact on the health information exchange environment and certainly on our state Innovation model environment is that we're seeing the business driver for the payor to ask for involvement in the HIE.

Now, I'm sure that's not happening to the same extent in other states based on maturity models of their HIE, but there is an area where I think the government could have an impact in encouraging payors to participate in HIEs. Now, because of the way ACO is rolling out, there is more of an incentive for that payor to be involved, because they're being involved in care management, they want to get access to the clinical information, but equivalently so, the providers are more open to providing that access to the payors because they want to get that coverage or eligibility information from the payor in return.

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

How do you feel about the fact that, from a market standpoint, although all the payors and all the various health systems won't access the information, there's been very, there's been the equal situation where they haven't wanted their competitors to have access to that information, so there's then, at least in our state, some slow down and some efforts that could be all payor as a result of the fear of some of the vendors and some of the payors with their own competitive advantage. Is that not a problem where you are, or is there aspects to it that you're saying that policy could sort of move us beyond that?

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

I think there are aspects of policy that can move us beyond that. Certainly that is the case, and it's certainly the case here where we see payor and provider alignments happening. The challenge that the provider systems are having that may elicit a market change in the involvement of payors is the fact that there is leakage out of their ACO. They can't control the behavior of all their patients, because their patients are not loyal, so therefore having this information may elicit a greater market advantage than keeping this information proprietary.

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

Thank you. Other comments?

To move on into, "Encourage patient engagement in the health care system," this is the sort of thing that, at least in all the discussions that I'm having, it seems to be this thing that, from the provider perspective that we have, tends to be the thing that leaves us both worried that it's not gonna happen and absolutely perplexed about what it will do if there's more patient engagement, particularly along the issues of information exchange and also within the context of all the HIPAA and privacy issues. A lot of this may end up being consumerism, but I'm wondering if others are finding this to be as difficult a conversation because it's sort of outside the provider framework as I am, or is this just—I see some tools that are starting to be built in from portals like we have that our patients are loving to some of these tools that sort of bypass the whole system.

Do other people find this to be difficult, or is that just me?

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

Hi. This is Karen again, and I probably should not, I'm probably the least qualified to be commenting on this, but kind of going back to—actually, you and I have talked a lot about, Grace, the fact that patient engagement is important not just for their own outcomes and for improving health, but it's also important in terms of the business case for an ACO that wants to keep its patients close to home.

From that perspective, I think that there's a lot that would be important as we focus on what—I think, we talked a lot about five different things of patient engagement. We talk about making it simple for them to use the system. There's a lot of simplification that HIT could support. We talked about providing them good information about a number of things, including how to use health information technology and why it's important. Then communicating more with them, educating, and then helping them really integrate in their own care, and all of those have different sets of health information technology support that could go forward.

I don't mean to turn the conversation dramatically back to the providers again, but I do think that the ACOs have every reason, from a business perspective, to do everything they can to do everything from simplify to integrate with their patients on the HIT level. Sometimes starting with simplification is not a bad thing.

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

Well, you're right about that. Go ahead.

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

This is Wes Clark, SAMHSA. We're also promoting patient engagement. We're clearly not as far along as the primary care delivery system with the hospitals, but we think that this is an important issue.

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

I would also say that simplification, in coming back to what the federal government can do, can be as basic as making sure that EOBs and how billing will occur is clear to the patient. We had some, I think I mentioned this on an earlier call, some issues when patient get, quote, admitted to the hospital, from their perspective and are sitting in a room, and it turns out that it isn't covering it as an admission, it's covering it as observational care, and that's very confusing to patients. Anything that I think CMS can do, particularly for its Medicare members that are in ACOs to really help them understand how billing works would be—and make that whole process much easier for them would be huge.

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

I think in that situation, that should be transparent to the patient when they're admitted. That situation is where people aren't communicating to the patient what's going on and what's the reality of the circumstances. It's not just CMS or payors, it's also the providers who need to be more candid and transparent about those realities.

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

Yeah, you're right about that, but one of the things that's so difficult about our system right now is, often the providers don't even know that. Within our own system, when things are—to go back to the example of observation stay versus inpatient stay, which was mentioned earlier, or the pricing of testing and all that, we've been so siloed that even in our best intentions of giving information about risk and price and all the types of things that can make for a better patient experience, quite often those that ought to be there to do exactly what you're saying don't have the information themselves. Perhaps again, patient engagement will benefit from transparency of the system, which is certainly something that policy can improve. In fact, the recent early efforts of Medicare to sort of open up some of the costs, even if it's just charge data, I think is a first step in some of that discussion.

Eun-Shim Nahm, Ph.D., RN, FAAN, Assistant Professor, University of Maryland School of Nursing

This is Eun-Shim Nahm from the University of Maryland. When we think about patient engagement, there seems to be a missing link, a shared vision between policy makers and patients and caregivers. We know that we need to educate our patients about HIT or the new, the Meaningful Use stage two or health patient portal, but the issue is, who is gonna take the role, and do we have enough resources? I think conveying those concepts to patients requires a certain expertise, I think, but I'm not sure whether the nation is prepared. We spent a lot of funding to educate clinicians, but I'm not sure we are doing a good job for patients, or whether we have even resources to really teach them correctly or make it easier for them.

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

You know, I think we're thinking and talking about the same—you're saying the same thing I was from a different standpoint, which is, it's not easy, and we don't necessarily have the information. It's gonna require a resource that we've got to understand.

Let's move on to the next slide. How nice, then, that immediately what comes up with nine is to increase the provider insights into the financial metrics and cost data, and then into the concepts of the availability of claims data and then the ability to integrate the claims and clinical data.

These three things are what I spend, in my life right now, struggling with quite a bit, because we have to have increasing awareness on the part of our providers as to the impact their decisions are making on individuals, and we have to have access to claims, which is quite variable, depending on our various payors, and their ability to provide it or their willingness to provide it because of their own issues. That's been the nice thing with the Medicare Shared Savings program is, for the very first time, I have a payor that I'm able to see all claims on, and that's a very new experience and we're learning a lot from it. Then to basically integrate those things between the claims and the clinical data, our systems have not been set up to do that very effectively, and I know that there's vendors out there that are working on that right now, but it's certainly not in place yet.

I'm gonna shut up and let somebody else talk and see if these three things which, from my standpoint, where I am right now, these and an attribution which I'm gonna talk about in a minute are the most crucial things to my success.

Samuel Van Norman, MBA, CPHQ – Director, Business Intelligence & Clinical Analytics – Park Nicollet Health Partners Care System

Yeah, and I think that the value is sometimes muddled a bit by, I really see a number of perspectives that we've got to have introduced into these, you know, the financials and cost data where you've got the impacts—I'm sorry, this is Sam Van Norman from Park Nicollet—you've got the impacts from the perspective of the patient, you've got the impact from the perspective of the delivery system, and then you've got the impact from the perspective of the payor or public health or whatever other perspective. It starts getting really muddy there, and some of that's really icky, but each one of those is a crucial piece of the decision making that needs to go into this.

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

There is—go ahead.

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

This is Karen. Sorry, you guys. From a policy point of view, there are all kinds of Medicaid waivers that are being given. There's a Health Homes program that's available to states for their Medicaid participants; CMS funds quite a bit of it. I'm wondering if it might not be something—and we're not gonna solve the problems today or even probably by the end of the year on this—but if there might not be some way that CMS, through Medicaid, can, either through waivers or through how it funds various programs could include in those waivers some way that the state could—and I know some states already have this, and they have it by legislature—could either go through the DOI, the Department of Insurance, so that the payor has to contribute to an all payor database or would consider building one themselves. There must be one way to really have the kind of claims data that these organizations need for their business purposes, not their clinical purposes—that's a horse of a different color, here.

If they had that kind of access, they could do attribution much more easily, look at total cost of care much more easily, evaluate programs, figure out bundle payments, some of the things we talked about in the past. To get there, and I really do wonder if it might not be reasonable for a subgroup to explore with CMS, how it could support states going in that direction through its Medicaid initiatives, with the recommendation that CMS explore that in greater detail.

**Kelly Cronin – Office of the National Coordinator
Technology**

Yeah, Karen, I mean, that's something that we can follow up on. There are some existing guidance documents out. One recent one that came out over the summer on super utilizers clarifies ways in which states can spend money on claims in clinical data repositories and even connections to health information exchanges to build some capacity for this kind of work. We can follow up on it.

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

Yeah, that would be great. Thanks, Kelly.

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

Let's go to the last two. As I mentioned before, at least in my organization, attribution is the biggest, most complex, difficult, and talked about discussion as we're moving down this journey and as I'm talking to other ACO providers throughout the sort of national community, I get the same thing. When I'm talking to payors, I'm finding the same thing. With the old HMO systems, it was pretty easy to designate a primary care physician as a requirement and then subsequently be able to run from—at least from a claims standpoint—different types of algorithms than you do where you're having to look at the most likely person that you're seeing now is, from a likelihood standpoint, whether they're going to be attributed to these ACO models.

I'm gonna take this one separate from the 13th, which I think is a little bit different in sort of theme and tone as to where we're going. This one is crucial. It's not simple right now, and every month, with all of our payors and our ACO arrangements, we get a different number and a different group of people that are attributed to it, and it's very, very difficult for us to track what we think our calculated savings and cost are going to be so that we have any idea of what kind of gain share we may be getting at the end of the day from these types of contracts.

Others want to comment on their experience?

Are there others on the call besides me that are in an ACO right now?

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

Yeah, so this is Joe Kimura, too, from Atrius. I agree, in terms of, attribution, I think there is payor attribution and then there is attribution that we do internally to help us manage our populations and keep the sanity of our primary care docs as they're trying to make changes and improvements year over year, so I agree this is a challenging place, and I think with the PPO type ACO arrangements coming out, the attribution challenges are continuing to get bigger.

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

Are there federal policy things that could be done to sort of look at this in ways, even with the Medicare Shared Savings program or whatever payment systems going forward that we could talk about now that would make it easier, or should we just stay in general terms here?

Then my other question for everybody would be, for those that are on staff in particular, from a policy standpoint, is—what sorts of discussion, language, complaints, suggestions are you getting from the public at large on this issue? Because I think it's crucial that we understand that.

Well, let's go on to 13, then, which is the enhanced interoperability of systems to share clinical information. They're talking about some natural language processing. We certainly, some of that could be policy related decision—policy that could have impact on vendors and be encouraged in the interoperability by certification processes. Some of these things seem to be some of the easiest from my perspective that federal policy could help, and a lot of the discussion that we've had at CCHIT for the last several years, that commission has been about the just absolute need on the part of the providers just really asking for this.

I would just like to hear where the thoughts are on others as to how far we could go with actually getting these continued concerns addressed sort of ASAP within the context of where policy could put things.

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

We just had a—this is Wes Clark—we had a meeting on consent management, and one of the things we're looking at in behavioral health, this is for SAMHSA and ONC, is the issue of natural language processing in the vendors. The vendors were saying that it's not as easy all that, but I think we are promoting that as a way of dealing with psychotherapy notes and sort of the heuristic kind of behavioral health documentation that occurs.

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

This is Karen Bell. Along those lines, I think Kelly alluded to some of the work that's going on right now with consent around data segmentation where patients can determine exactly which information for which data points can be transmitted and shared and which cannot. I'm wondering if there is a—if it would be helpful if we made a recommendation to move that agenda forward as quickly as possible as well. That perhaps could lead to more sharing of the kinds of information that everyone needs.

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

This is Wes Clark again. Since our meeting was on consent management, I agree.

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

Yep. Well, I think that there's nothing more crucial right now that could be done to help us that could bring that market forward. Perhaps what I'm hearing is that if others agree as well that this could be an early consent priority that comes out of this committee is what we could basically, say, prioritize and accelerate. Does anybody, from a consensus standpoint, object to that?

Didn't think so. *[Laughter]* Well, we usually—

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

[Laughter] You phrased that correctly.

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

Yeah. *[Laughter]* We have now been through these 13 themes. I hope that what we've done here is had a discussion—I'm hearing a lot of consensus as to what's important, how we might approach these things, and how to prioritize it that goes along very well with where the strategies that Kelly talked about earlier with, for health information exchange acceleration were going.

I guess, at this point, we're running a little early. I can open it up for more general discussion, but also, let's turn that towards where our next steps are. What I just heard is, "Let's make number 13 a very early focused priority to accelerate." If that is the case, what would be next? Is it around some of these issues around attribution, or what? What would people think would be the next, if anything, that we would want to prioritize?

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

Here's a quick question. It's Karen again. Is this the sort of thing where, if we could put things together, it might be helpful for the whole workgroup to look at it and do some prioritization? I think we have a pretty strong input when we were doing the SurveyMonkey tools and maybe it would be helpful to do the same sort of thing here because I'm afraid, not actually being in an ACO at the moment, just listening to a lot of them all the time, *[Laughter]* to really think that my vote would be worth more than someone who's not on the line at the moment.

I'm wondering if we might, to tighten these up a little bit, put them on SurveyMonkey and have everyone prioritize them there.

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

We ought to certainly get a larger amount of input from that—excuse me, somebody else was talking?

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

Administration

This is Wes Clark. I wanted to agree with that statement. I think, as you were about to suggest, having a broader input, particularly for the people who are in ACOs, that could help us as we figure out what the large public policy should be.

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

This is Karen again. Maybe one of the other things we could spend a little bit more time on is, kind of going back to, I think it was Shaun's comments a little bit earlier—how would we operationalize? How would public policy actually roll out? What type of public policy would be most helpful to move each one of these along? Because, as I'm thinking to myself, whatever I might think might be highest priority—and I certainly agree with the group about 13 being the highest priority—but it's also important to understand what it would take to move it along. Because sometimes there might be some that are a lower priority, but they're lower hanging fruit with respect to being able to actually move forward.

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

I'm seeing a pretty simple SurveyMonkey that could be sent out, Karen, which is, "Name your top 5, or rank all 13 in terms of if you were prioritizing it," with the second column being what part of the community you come from, a vendor versus an ACO versus somebody in policy or otherwise might have a different point of view. It would be nice to see if there were clusters of that. Then a third one being, how easy do you think it would be and then a fourth one being, how do you think it would get there?

Maybe that would be a simple thing to do. What does the staff think? Do you think this is something that could be put together pretty quickly and sent out and be useful, or are you just sort of SurveyMonkeyed to death?

Samuel Van Norman, MBA, CPHQ – Director, Business Intelligence & Clinical Analytics – Park Nicollet Health Partners Care System

No, we can definitely think about that. I guess we would just want to maybe think a little bit about other things we would want to include in there if we have, just to minimize the number of times we try to go out to the group, so if there are other items that we could add for input in there before we send it out, we'll just have to think about that a little bit.

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

Wonderful. We're a little bit early in terms of our time together here, but I'm certainly willing to keep this going for further comment. Does anybody want to add to where we've been so far today in this? It sounds like we've got some things that we've, at least on the call, come out with as a consensus and a tool that might help us broaden that, that can be put forth after a little more thought, and a lot of consensus that the right things were discussed. Anything, any of the rest of us want to add to that before we close or open to public comment?

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

This is Karen again. I'd just like to thank everyone at ONC who worked on getting us to this point. We've really come a long way, and I really appreciate it. I actually do have to jump off the call right now, so thanks to everyone.

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

Thanks, Karen, for all your input. You've been absolutely invaluable as usual.

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

Thanks, Karen.

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

Okay, are we ready to open for public comment?

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

Yep.

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

Yep, let's open it up.

Public Comment

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

Okay, thank you. Operator, can we please open the lines?

Ashley Griffin – Altarum Institute

If you are on the phone and would like to make a public comment, please press *1 at this time. If you are listening via your computer speakers, you may dial 1-877-705-2976 and press *1 to be placed in the comment queue. We have no public comment.

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

All right, everybody. Well, I think we've bought an extra 10 minutes to our Friday afternoon, so we'll look forward to continuing with the next steps and I certainly appreciate all the attention that we are all giving to this issue as we move forward. Thank you.

Samuel Van Norman, MBA, CPHQ – Director, Business Intelligence & Clinical Analytics – Park Nicollet Health Partners Care System

Thank you. Bye.

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

Thank you.

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

Bye bye.