

**HIT Policy Committee
Accountable Care Workgroup
Transcript
March 5, 2014**

Presentation

Operator

All lines are bridged with the public.

Michelle Consolazio – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

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

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

Here.

Michelle Consolazio – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Hi Grace. Craig Brammer? David Kendrick? Eun-Shim Nahm? Frank Ross?

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

Here.

Michelle Consolazio – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Hi Frank. Westley Clark? Hal Baker? Heather Jelonek? Irene Koch?

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

Here.

Michelle Consolazio – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Hi Irene. Joe Kimura? John Pilotte? Karen Bell?

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

Right here.

Michelle Consolazio – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Hi Karen. Mai Pham? Sam VanNorman? Scott Gottlieb? Shaun Alfreds?

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

Here.

Michelle Consolazio – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Hi Shaun. We have a small group today. From ONC do we have Alex Baker?

Alexander Baker – Project Officer, Beacon Community Program – Office of the National Coordinator for Health Information Technology

Yes.

Michelle Consolazio – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Is Kelly Cronin on the line? Okay, with that I'll turn it back to you Grace.

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

Well, good morning everybody and Happy Wednesday, and what we're hoping to get done this morning is to go and complete for what we didn't get completed our last call which is to go through the draft recommendations and make comments and tweaks and make sure we all have a chance to sort of think about them and vet them so that we can then move forward before our next meeting and get on with what we're trying to ultimately do which is to get our recommendations out in written format.

So, if we can just start looking at the slides and going through them, if I can have the next slide. The, you know, the way we've been thinking about this, just to review very quickly, the first two concepts of just sort of the principles is to see if we can come up with a policy as it relates to HIT in the context of ACOs and population health management that basically can be driven by regulation effectively, will not happen as a result of current market forces alone, is necessary from both a business stand-point and clinically important.

And I feel like we've done a pretty good job in our conversations over the last several weeks bringing out various focuses and approaches that really look at these four elements and hopefully we can continue that today. So, let's go to the next slide.

And the real efforts that we've got again to review the principles quickly before we get into the rest of it is, as was on that last diagram slide, is related to the value from all four contexts of both business clinical as well as policy, but it really also – we need to think about how we're going to prioritize that in terms of its impact on both the near-term or long-term priority.

And so as we go through the rest of this let's just keep this in mind. And does anybody want to make any further comments since we've gone through that part before, before we get down to business and go onto the next – to where we left off? Okay, well let's go on then. Next slide.

So, here's where we stopped last time which was access to encountered data and there were comments about eligibility and benefit data should be explored to make it real-time as much as possible. And then there were some comments or suggestions that access to the adjudication system rather than waiting for the CCFL Claims File would help expedite the timely sharing of information. That was just a comment that seemed to be a consensus comment. Other thoughts on this right now?

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

Grace, this is Karen, I will say that for those of us who were at HIMSS last week this had come up, this came up in a number of situations and the concern is that this kind of data is not available across the country right now, it is available in a few settings, but it is also, and this came out in a number of presentations I went to, it's also a good business model for HIE so that this actually is a twofer I think and incredibly important for ACOs, I heard that a lot last week, but it's also a good business model for HIEs. I don't know if anyone else wants to comment on that or not?

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

This is Irene Koch, I'll second that, you know, there was a lot of talk about that, that I heard as well, but I would also just add the extra frill of that there was some concern that sometimes, and I think we heard this also in the testimony day, that some of the information isn't entirely accurate or totally current, which is also frustrating. So, I think there needs to be a focus on making sure it's as clean as possible.

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

Within that context, as far as federal policy goes, it sounds like this was a high priority, it sounds like everybody agrees it's important. Other than just exploring strategies to make it real-time how from a policy stand-point do you all see this need being addressed? In what sort of policies would that make sense? I mean, it's sort of – this is almost a mom and apple pie statement that we all agree with and it sounds like there was a lot of consensus about that at HIMSS. What would put some teeth into this?

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

Hey Grace?

Grace E. Terrell, MD, MMM – President & Chief Executive Officer – Cornerstone Health Care, PA
Yeah?

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

Good, I just want to make sure that everybody could hear me my phone's acting kind of funky. I think the, you know, it's – that information is out there today, I agree with, you know, the testimony that said that it's questionable at times, but it's getting better. I mean, we do routine benefit requests on our Medicare patients at my wife's practice and we do it through NaviNet and it seems to be working fairly well.

The thing though that's not happening is that the federal government today farms out all of the claims processing to their MAC contractors and if those contracts were written to where those contractors had to make this information available as part of their contractual agreement then we would be a lot further down the road than simply saying we should explore strategies.

I think this is something that, you know, in the contracting side for CMS if the initiative was there they could make this happen in pretty short order.

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

Perfect so should we strengthen this, is there a consensus based on what you're saying, Frank, that we should – how do other people feel about strengthening it to actually saying something much more specific such as requirements to make it available through the contractors?

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

Yes.

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

Or possibly, I mean, I hate to go this far, but it might even need to be, this is Karen, conditions of participation.

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

On the contractor's part Karen?

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

On the provider's part that are participating in CMS reimbursement.

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

Okay, I'm missing your point.

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

If the various provider groups are to be providing encounter data to an HIE or something of that nature then they may be required to do so or they could be required to do so as part of a participation clause, conditions of participation clause.

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

You were talking more about the fact that they can't do it because the contractors won't supply it to them is that correct Frank?

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

Yeah, I'm just saying that my idea is probably a lot simpler than trying to route things through, you know, an HIE. What I'm trying to say is that the contractors are the ones who are actually processing the claims, if we simply make that a provision of their contract that they have to provide this data, you know, through whatever means CMS defines, but they have to provide it and ACOs could be one of the entities that benefit from that.

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

Then I absolutely apologize because I was thinking encounter data as being the ADT feeds as opposed to what's in claims.

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

Right, well, I reached out to the claims because that to me is the most directly accessible information, but it's all eligibility and it's also ADTs as well. You can bet, you can bet that Cahaba who is the MAC processor in Tennessee knows when somebody is being admitted and discharged, okay, and that data is there but it's not available, it's just not available at this time. And they could make it available, they have the resources and by the way they're doing things on a contractual basis where their cost plus so there is no reason for them not to be able to do this.

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

Well, except for the fact that there are a lot of health plans that actually don't get that data until they see their claims and that can be a long time down the line. So, it's not really real-time. So, I think the real differentiation here is real-time access to encounter data, maybe that would be an important – it would be important to clarify that and then eligibility and benefit data are a very different category.

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

Okay.

Alexander Baker – Project Officer, Beacon Community Program – Office of the National Coordinator for Health Information Technology

I think for the ADT feeds we have that I know it's not on these slides but that's to – we talked about that at the end of the last call so that is definitely in this section under a separate letter.

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

Oh, okay, apologize.

Alexander Baker – Project Officer, Beacon Community Program – Office of the National Coordinator for Health Information Technology

Yeah, yeah, that's at the top of this section.

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

Okay.

Alexander Baker – Project Officer, Beacon Community Program – Office of the National Coordinator for Health Information Technology

And then this was just specifically about the queries for eligibility.

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

All right then I stand corrected and I apologize for being confused.

Alexander Baker – Project Officer, Beacon Community Program – Office of the National Coordinator for Health Information Technology

No.

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

Just retract everything I just said.

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

You're in good company though.

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

Okay, so in terms of where we are with our confusion, does it make sense to put more stronger language in it related to the recommendation to have claims data made available through the contracts that Medicare has with its subcontractors?

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

And my reference to claims was due to the comment on the side there, so –

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

Okay.

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

Yeah and –

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

And, you know, as an ACO too you have to realize the claims line feed is getting better, it's becoming more succinct, we generally get it on the third week of the month for the prior month that's pretty close, quite honestly with a 90 day run out most of our claims are being 95% complete by the time we get them. So, it's pretty amazing how far they've come and I don't know what brought that all about but I do believe that you're getting pretty close to having claims data that's going to be useful to you.

But, for me it's not so much the money in the claims that I'm looking for because that will get processed out, I'm just looking for the movement, the activity and in the healthcare community and I think that makes a big difference right there if you're looking at eligibility and claims.

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

And this is Shaun Alfreds, I would agree with the previous comments. I think there are a couple of pieces here for both the eligibility and the claims data, on the claims data side for the ACO there is a lot of data that's important there in the presence and absence of a functional health information exchange. So, I think getting that data and making that available is a key recommendation here.

I think in that recommendation, Grace, I think it would be very helpful to clearly state a standardized format for all contractors because if one contractor gives us a format and then we're having to map to another format for another contractor even in a small State like Maine we have multiple Medicare contractors. So, I think that would be a key piece for the claims side.

On the eligibility side I think that is growing in importance on the ACO front especially as new members come on board from the payer perspective, from the provider perspective the ACOs are quickly trying to assign risk and then bucket these individuals into different care management focus areas.

And so I think also on the eligibility side, and I think we should talk about that, and talk about claims and eligibility separately, I think as close to real-time as you can get with eligibility is helpful, that being said, eligibility is usually processed on a first of the month basis so it could be a monthly file.

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

And this is Karen, I think, you know, particularly on some Medicare patients who could have any one of a different – any one of probably a hundred different health plans with respect to medication, the drug benefit, knowing and being able to get the information on exactly what that benefit is for what drug is absolutely critical at the point of care. So, I think, you know, there are ways that Medicare could clearly make information available that really helps at point of care.

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

This is Irene and I guess just furthering that point, because I agree with what everyone is saying, as the patients are going to be getting more access to their own information and plans, you know, making sure that's in sync with what the providers have is going to be so important to just make sure the communication can happen as timely as possible.

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

Well, very good everybody, are there any other comments on this one or shall we move to the next slide and the next Roman numeral which is sharing clinical information across the healthcare neighborhood? Okay, well, let's move on then.

We've had a lot of themes that have been about administrative data in our last part of the discussion but now this is back to talking about sharing of clinical information. As you all know there was just a substantial amount of discussion about that at the hearing and so what we have here is A and B, A being identifying and encouraging exchange with ACO partners and B being public measures around the exchange.

And we've gotten some comments here, one is consider removing or adding additional detail, one is consider expanding to other types of services such as social services and if we could just start with A then and get some comments on that and more detail as to whether this language is correct, it sounds like there was a desire to make more detail here at least from a couple of commenters.

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

Hey, Grace, this is Shaun, in reading this, in the original text, it's unclear to me what is being recommended here except for maybe CMS should collect data on who the trading partners are and who is sharing data and who is not, it's not clear to me how that original language is driving a recommendation.

Is it – are we looking to make a recommendation that CMS should require local, regional trading partners to exchange data or are we saying that we're encouraging CMS to identify those areas where there are barriers to exchanging data?

Alexander Baker – Project Officer, Beacon Community Program – Office of the National Coordinator for Health Information Technology

Shaun, this is Alex, I think this is definitely something that's a little bit on the softer side, you know, we're trying to think about ways that HHS could use its leverage to get at issues of data hoarding, for lack of a better word, that we heard about. So, this is, you know, if ACOs had to identify their key trading partners and then HHS could use that as sort of a basis to identify bad actors that are inhibiting ACOs ability to trade across their markets.

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

Alex, this is Frank, let me be specific here, you know, one of the trading, one of the major trading partners are the hospitals. Is this what we're saying is that, you know, if I read the context of Part A, you know, that we would identify those hospitals in our networks and then report the hospitals that are not making an effort to notify us for discharges and things like that?

Alexander Baker – Project Officer, Beacon Community Program – Office of the National Coordinator for Health Information Technology

Yeah, I think that's trying to get at that, definitely not sort of fully formed yet probably but the idea would be raising awareness of those trading partners that ACOs are having problems with.

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

Okay. Shaun, I don't know if that helps, but –

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

Yeah, well, I guess, in thinking about what that means then I would suggest that we be very clear in the recommendation that CMS should require ACO partners to submit information on who their trading partners are in the local area and which organizations in that area are or are not sharing data.

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

This is Irene, I might even go a little farther or at least, you know, make sure we understand that trading partners can mean, you know, a bunch of different things. You can have folks participating directly in your own ACO or shared model but there could be other ACOs in the same region, particularly where I am in New York City there are many, many and the trading partners that you need information from in order to really improve care could be ones that aren't directly in your ACO. So, I think we just want to make sure the trading partner is defined expansively.

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

Is the word "trading partner" part of the problem in that that's a very provider centric approach to this whereas what we're really talking about, from a patient centered approach is all the potential the people in a healthcare delivery ecosystem that have an impact or information, or data that would be useful to an ACO at providing better care and I don't know how to actually then go around and from a regulatory stand-point talk about it as a trading partner because that's the provider centric approach to it, but maybe there are ways of formulating it that would get to that point.

If I were somebody that was hoarding information my concern with this might be that the information could be used by other federal regulators to assess for antitrust or other types of inappropriate behavior. So, we probably need to word this very carefully so that the intentions are what's right for the patient in terms of having secure, private, but accurate and expansive information to improve their overall healthcare delivery.

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

This is Frank again –

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

Grace, this is Karen –

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

Go ahead.

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

Grace, this is Karen, I was just thinking from the perspective that you've just articulated the goal very well and I'm just going to throw out there a slightly different take on that and that is that if Medicare is going to contract with organizations in the Medicare Shared Savings Program then they should or they could sign an agreement that they will participate in local regional, national health information exchange as that technology becomes available to them.

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

That's good.

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

Yeah, I would say just speaking from New York where we're really working on a lot of regulation in a parallel it's more local universe but really a complicated state that's sort of the model that's taking hold here that really everyone needs to participate.

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

Well, this is Frank again, I hate to keep bringing this up, but in the wonderful world of Tennessee where there are no HIEs, it gets a little bit more community driven in regard to, you know, this issue and Grace I think you're right, trading partners is kind of the scary word there.

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

Yes.

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

I think care coordination has to be worked into this somehow, because that's really what we're talking about here. Whether it's an HIE or an ADT feed it's all about care coordination and –

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

Frank, I'd agree too – oh, go ahead.

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

Hey, this is David Kendrick I was just going to ask Frank what happened with the State HIE funds in Tennessee did they not build a resource that could be used for HIE?

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

Well, our extremely knowledgeable legislators took a pass on it. So, you're in the land – you know, Boston is where the Tea Party was held but it's still being celebrated in Tennessee.

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

And North Carolina I must admit.

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

Yeah, we won't talk about Maine Texas of the North.

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

Oh, look I'm from Oklahoma you guys got nothing on us.

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

I have one comment, this is Shaun.

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

I think this is the point that's why I suggested that it would only be to the degree that the technology is available, you know, obviously if the technology is not available –

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

Right.

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

You couldn't do it, but if you had that little caveat at the end then that would accommodate an ACO like yours Frank where you don't have the technology at the same time if there are places like Maine where it is available then everybody's got to sign on.

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

You know, Karen, I'd agree, I'm cautious about the term HIE now it's become – I've seen it from HIMSS and we talked about this at the Accountable Care Group down in DC a couple of weeks ago too, the term HIE is getting pretty loaded now.

There is a lot of organizations or states like Tennessee that didn't use the HIE funds and there is talk in the industry that HIEs have failed and there is no sustainability model and that certainly, you know, we take that very seriously here in Maine at HealthInfoNet.

And so I've been trying to think about, you know, how do we reshape the conversation and use a different term than HIE to reflect appropriate information sharing for care coordination and population health purposes without using HIE.

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

Well, so the irony here of course is what we're discussing right now is the business model for HIE. I mean had people come to the recognition that they were going to need this when the funds were available early on people would probably not have failed to build something at the rate that they have.

I mean, we've built not one but three in Oklahoma and we're now finally having board members say "oh, this why you pushed us so hard to get in this direction." So, you know, it's amazing that they finally come to grips with why in the world we focused on this in the first place.

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

I would tend to agree, we had those same conversations here. So, I'm not opposed to using HIE I just want to be leery about those states where it's failed and again changing that perception of a failed state to a "hey, this is real and this is why it's needed."

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

So –

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

Well and it –

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

It sounds like it's more like the technology to support sharing of health information across disparate parties. So, we just basically use the definition rather than the term HIE.

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

But I think it's more than just sharing. I mean, there has got to be some centralization of that data for reporting, because, I mean if you think about the logistics of this when people want an ADT report say all of my admissions, discharges or transfers from any hospital in the region am I going to have every, you know, ACO and/or five doctor clinic approaching me at the hospital to build a feed to them? So, very quickly it becomes obvious to the CIO in that situation that they've got to have a hub of some kind.

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

Well, but the hub doesn't necessarily mean a data warehouse though. I mean, Massachusetts has got a federated model and I'm not saying that everyone else should but you can do – you can share information through a hub using a federated model or you can do it with the hub being a data warehouse. So, I think it would be agnostic as to what that hub is actively doing.

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

Yeah, I –

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

It still allows one place where the information passes through in order to be available to everyone who needs it.

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

Yeah, so I think we're all in agreement or it sounds like we're both in agreement that the hub concept is the right idea it needs to come to a central point so everybody is not making multiple connections.

But, I would suggest that it's not too many synopsis down the road that people start to say "gosh, why am I building a data warehouse and they're building a data warehouse, and they're building a data warehouse to aggregate all this data coming through that hub independently instead of just doing one" but maybe people would prefer to do that as part of their ACO.

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

Shall we move onto the next bullet point down there which is public measures around the exchange, it was also a comment for that about considering strengthening further as it relates to an ADT data should be highlighted, the comments said that this could be something addressed in Meaningful Use Stage 3.

The alternative language proposed was "CMS should explore ways that Meaningful Use and the EHR ATCB certification process can require all EHRs to be able to submit real-time HL7 ADT data to trading partners and others." Are we okay with that?

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

This is Karen Bell, actually I'm not and the reason I'm not is that there are various types of technology that are used in various clinic environments and in the hospital environment the information that goes to ADT feeds is actually coming from administrative sources and, you know, it may very well be that that's not part of the EHR that the clinicians are using. There will be possible hospital interfaces that can connect all types of data within the hospital system.

But right now EHRs under the ATCB rubric are essentially for clinical use and getting ADT feeds out there are an administrative process that happens in the admission office. So, putting this into the certification program maybe really problematic.

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

Karen, this is Shaun, I think you're right that a lot of the EMRs are – the ADT feed at least begins in registration but most EMRs today in the hospital system, certainly in the ones that we're connected to, are connected and integrated with a centralized registration system that's part of the whole movement towards integrating your entire workflow internal to your hospital and then also external to your outpatient practices.

I think we'd be remissive if we didn't try to have some level of push in the certification process to move away from a continuity of care document or a CDA because frankly they're not very helpful from an interoperability stand-point.

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

No, I –

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

And I think it was me that really pushed this HL7 ADT because right now we have 38 hospitals that are sending ADT feeds from the hospitals, well our biggest challenge is not those hospitals getting the ADTs it's actually the ambulatory providers, it's the small EMRs that have come out of Meaningful Use that have developed and began marketing, as a result of Meaningful Use, and are saying that they're not able to interoperate beyond a continuity of care document or as they move forward to a C-CDA.

And from that perspective their CDA looks different than everybody else's CDA and there is not a – the economics of interoperability go through the roof if we don't have standardized transactions.

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

So, this is Dave Kendrick, we've done a fair amount of both of those kinds of interfaces as well and I will tell you that if we go to a practice that has the capability of giving us a good CCD or even a bad CCD we'll take it because we get all the important rich clinical data and it does have within it, from many EHRs but not all, an encounters list that shows previous encounters but far and away if we can get it we'll take the HL7 feed out of their scheduling and appointment system.

Now I think there are other parts of Meaningful Use where the EHR vendor basically relies on the partners it interfaces with to meet requirements and so this would seem to me to be an appropriate place for that as well, but if you're interfacing with a schedule system if that's the place you rely on to do your ADT feed out it's really – what we're talking about here I think is the en bloc install it's not necessarily the specific three systems the clinic uses, it's how they work together to produce that ADT feed and there is not really certification for that which makes it a challenge.

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

Well, I tell you what, for our ACO the ADT feed data that we're getting from some of the hospitals but not others has been absolutely crucial to us being able to do any sort of management from the hospital side of things with our high risk patients and understanding whether we're actually making a difference with some of our programs. So, I think this is a pretty crucial piece regardless of how we end up wording it.

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

Yeah, I think, I think again that this – this is David again, I think the sensitivity is around whether you require it of a certified EHR or the certified EHR practice management system tandem or you put the requirement on the practice to be able to deliver it, you know, as part of their whole solution set and that's where I've always struggled. I think it's clear what we want to happen it's just not at what level you regulate it.

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

Well, that's an interesting idea I hadn't thought about but perhaps we don't look at Meaningful Use as a means here, perhaps this is a – we take on condition of participation in order to participate in the Medicare Shared Savings Program, etcetera, etcetera you need to be able to develop and release a standardized ADT feed.

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

And there are ADT feeds and ADT feeds right?

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

That's right.

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

The phone notes generate ADTs, no-shows generate ADTs all of those kinds of things need to be –

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

Well, I think we'd have to look into the details and define ADT because ADT for us can mean anything from having the basic demographics to including all the diagnosis from that particular encounter and everything in between. So, yeah, you're right, I think if we're going to make that recommendation we have to define it.

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

But I agree with what's been said, I mean, it is the critical data element, it's the starting point because obviously if you're doing good ADTs now and using them for your decision making it's not very long before you're going to want to know "well, what was the result of that visit" or "what were the lab results on that visit, are they better or worse and do I need to do a follow-up or to do a phone call."

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

Right, this is Frank, you know, when we start talking about Meaningful Use not being the appropriate place I would have to say that I have feelings in that direction myself, but for Stage 2 and the proposals for Stage 3, as far as the exchange of information is concerned, you know are we being responsible if we don't at least try to shore up Meaningful Use. I mean Stage 2 is going to require dissimilar systems exchanging information as a demonstration not as a production but as a demonstration. Stage 3 obviously will require certain thresholds.

If the hospitals, and again I'm looking at it from the context of an ACO or a practice trying to get information out of a hospital on an admit/transfer/discharge, so in that context why would Meaningful Use not be the appropriate place to strengthen the requirements on the EHR vendors, on any vendor that is selling a product that CMS information is going to be flowing through.

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

This is David again, I think, I agree we have to do something in Meaningful Use it just seems that – I think the challenge is that Meaningful Use certifies an individual product and nobody uses just one product in the clinical environment from a practical perspective.

Is there anything at ONC that has tackled this in terms of systems, I mean, other than an EHR sort of getting the certification by saying, well, we have these hooks out to a practice management system and that practice management system is what would cover our ADT feed requirement and then getting a stamp with the asterisk on it that says they're dependent on an external or ex-management system to meet this requirement. Is that appropriate? Is that the way it's done at this point?

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

As far as certification is concerned for the EHR vendors it's pretty weak actually because they only have to do a demonstration of compliance with the formats that ONC publishes. As far as the actual exchange –

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

This is Karen –

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

Go ahead.

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

Oh, I'm sorry Frank, I thought you were finished.

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

No go ahead that's fine.

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

This is Karen I think one of the other considerations here is that ACOs are being contracted on a regular basis they need this information now.

The concern that I have is that so many organizations are having difficulty to Meaningful Use Stage 2. A lot of the vendors are having difficulty with certification, I can attest to that, and as I think you were saying Frank the testing process really doesn't necessarily get to the fact that it really operates well in the clinical setting.

So, my concern is that if this is something that's included in Stage 3 we're not going to see it for several years and we need it now which is why I'm thinking that it might be important to come up with an alternative, perhaps such as what Shaun mentioned, to really get the ADT feeds moving because everyone does need them sooner rather than later.

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

This is Shaun I'd agree. I wonder if we should take a – I wonder if we should recommend both. I mean, I think making a recommendation to Meaningful Use is something that folks are looking to the FACAs to do, I mean, to address Meaningful Use, to address inadequacies or issues that we're learning in relation to the Stage of Meaningful Use we're in.

So, I think we should be compelled to make some recommendation towards Meaningful Use but I agree that we need to address this more in the immediate timeframe too. So, is it possible for us to do both here?

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

I see no reason why not. I mean, you're talking short-term, long-term.

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

Yeah.

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

Yeah, I mean, that's a simple concept. I mean, if someone doesn't sign off on that then they're not really thinking about the whole issue.

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

Very good discussion. More comments before we move on?

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

What are the conclusions then? So, we're going to try and make some recommendations about what should be required to sign up as an ACO in terms of your commitment but also or to apply to be an ACO and then also what we recommend for Stage 3 is that what the conclusion was?

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

I think so.

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

Yes.

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

I would think so.

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

I like it.

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

Okay, let's get to the next slide.

Alexander Baker – Project Officer, Beacon Community Program – Office of the National Coordinator for Health Information Technology

Just a – sorry, this is Alex, just want to – that was a great discussion adding more input on the ADT work. I don't know if that was quite the same as the recommendation on the left-hand side which we may not – we don't need to necessarily spend a lot of time on but just want to – if people want to comment at all I think that was sort of a different animal on B there, the public measures around exchange, this was another sort of HHS soft lever idea about increasing public transparency around whether people are exchanging data through using the hospital compare website or something similar.

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

This is Karen Bell I'm not sure that would actually change behavior very much. The hospital compare website isn't used by patients as much as it's used by other providers just to see how they compare with other providers.

So, I'm not sure the degree to which it actually would have an effect unless, you know, perhaps you could tell us to the contrary that in fact the public that does use the data website actually follows up and changes behavior because of it.

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

So, I mean, the way I look at that website is a little bit like the, you know, the coverage maps between Verizon and ADT or ATT that are always on their commercials now, you know, that's what that hospital compare should look like.

So, my hospital is connected meaningfully with all of these other hospitals and therefore you'd like to come to me because that's the biggest most comprehensive network. And if we can get folks into that frame of mind then HIE or whatever we want to label it would become the clearest and shortest pathway to success.

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

Hi, this is Frank again, you know, the thing that's becoming apparent to me very quickly is that there is a whole paradigm evolving right now around transitions of care and when I say that I say that it's something that has to be immediate, it has to be succinct and it has to have the information that the recipient, whatever healthcare provider that may be, needs to continue the proper care of the patient.

You know you look at something as simple as medication reconciliation and care one of the ACO measures it's loud and clear what they're trying to get you to do.

So, I think, Alex, to kind of maybe address what I think you're asking, is that, you know, do we carve out and plant a flag that says, hey, there has to be a different set of information evolved that provides exactly what I just described regarding transitions of care.

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

One of the – this is Shaun, one of the areas that this gets me thinking about is some commentary that we've had from some of our ACOs and their justification frankly of wanting to continue down the path of analytics through the HIE which is that they're right now focused, and they have data internally, plenty of data internally, to measure quality of care delivered to their patients and transitions of care internally but not externally. And that external side they're very interested not only in that transition of care but also the community quality of care delivery. So, how are we doing as a community in getting this patient what they need?

And so I wonder if there is an opportunity to add that term community measure in here that expands the concept from Meaningful Use where we're still focused on an individual provider providing care for their patient and rather how is the community doing in providing the patient with what they need across the continuum of care.

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

Yeah, we call that community-wide patient centric measure in our rubric which basically says, how comprehensive is the number you're reporting on this patient, is it all their hemoglobin A1c's or is it just the ones in your clinic.

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

Yeah.

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

And that's for the foundation of everything we're doing on the analytic side is providing that.

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

I think that's terrific.

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

Well, said.

Alexander Baker – Project Officer, Beacon Community Program – Office of the National Coordinator for Health Information Technology

Great.

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

All right guys I'm going to move us on, sorry, next slide. So, this is really more of the same about sharing clinical information across the spectrum of care, it really can be continued, from my perspective, of the conversation we've been having and it's specifically about hospital survey data and then wanting some guidance around behavioral health data that we, you know, talked about so much or at least it was starting to be articulated at the public hearing.

Is there, in light of the context of the conversation we just had, are there other things that we need to add to these text to clarify or flush it out in more detail that's what I'll put forth?

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

Grace, this is Karen, if we're talking about the behavioral health piece I don't know if everyone saw what I had sent out just before the last meeting, but there have been a lot of discussions, that at least I've had and I suspect a lot of you have had as well, around the fact that life has changed a lot since 42 CFR Part 2 was passed multiple decades ago and that was really around protecting information around substance abuse.

So, since then we now have parity, parity is now the law both behavioral health and physical health are considered to be covered the same. We've learned a lot clinically and, you know, instead of separating out psychiatry and neurology we're now talking about neuropsych and more and more patients with substance abuse can now seek primary care with healthcare reform and even dentists are picking up cases of substance abuse.

And with all of that this whole concept of screening, basic screening and then referral for treatment or basic intervention and then referring for treatment is part of now primary care. So, that when we think about of this and about the fact that behavioral health and primary care integration are key to success in an ACO environment and that all of the guidance that we've had to date on CFR 42 is more about sharing of information through, I'll still use the term, health information exchange type organizations who really don't have guidance around sharing information within an ACO and it could be considered an administrative body in which case there could be some governance around that sharing of information or it could be considered a health information organization.

I mean, there are different things that could be defined that might allow information to be shared more openly so that the traditional problem that I think many of us have had or still have where someone now has become your new primary care patient and is presenting with back pain and you don't know and they haven't told you that they are on methadone or something of that nature.

So, we need to have at least sharing of information I believe with respect to medication if nothing else, but it would certainly be better to be able to share it across the board and from a technological point-of-view I know that there are some EHRs who basically don't want to get into the very complex type of consent that 42 CFR demands at the moment so we've got some technical issues with that as well.

So, that's in a nutshell why I had suggested that we maybe be a little more specific about the kind of guidance that we need around behavioral health and that we could at least get SAMHSA and some of these other organizations to work together to really define what an ACO is under 42 CFR and how information can be shared and integrated within it in order to get patients the best care they need and to be able to accommodate the needs of the ACO.

So, I'm sorry, I kind of went on a little long with this one but it's something that is near and dear to my heart so I wanted to present it and offer the opportunity for a little bit more discussion on it.

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

And this is Heather –

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

And this is Dave –

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

Hi, this is Heather Jelonek I'm, in addition to being part of an ACO I'm also a licensed professional counselor, my license is in the State of Illinois, and I can tell you there are a couple of issues that I see as not only a provider but an administrator and that is, again going back to CFR 42 Part 2, the information as a clinician that I want protected for my clients is the actual work that happened in a therapy session, you know, it's not the diagnosis code, it's not the medication and it's not the test results. I'm being irresponsible to my client if I am not aware of all of those situations but the actual work that goes on in therapy is what needs to be protected.

About a year ago I sat on a SAMHSA two day meeting where we talked about health information exchanges and how to bring behavioral health into, you know, the HIE arrangement and what we found through our discussion is that there are a large number of patients or clients that want to share their data, it's about 75%, but the limitations that exist within these HIEs provide barriers for us.

You know there is no ability to data segment so you can't say I want this piece of information always kept confidential but I want this piece of information to be shared. So that it's either an all or nothing. So, if a patient wants their data shared it has to be everything instead of just the pieces of information that are relevant, again, you know the diagnosis codes, the medications and the test results.

So, we've got a couple of different issues there but then also on the administrative side we've seen the impact when our patients, in your example, they're on methadone and they hurt their back and the primary care physician or the pain specialist has no idea, you know, we're causing more problems than I think need to happen.

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

If I can summarize it sounds like and I would agree with all of you that there is an incredibly intense need to change a lot of the ways that we've been thinking about behavioral health data and that it needs to be clarified as this statement says.

It would seem to me that putting some language in there specific to what kind of data would seem to be appropriate might actually help that, so to your point, you know, therapy notes ought to continue to be restricted because of various reasons, but diagnosis and medications, and other things could be specifically added to this in a way that might make sense here.

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

Grace, I couldn't agree more this is Shaun. Perhaps we flip that around and state it the other way is not what should be included but what shouldn't, 42 CFR is written to segment, literally segment substance abuse information.

SAMHSA has worked very hard and I was at that meeting last year, the two day meeting on HIE, they're working very hard to try to help facilitate the exchange of this information but the specificity that we just had in this conversation, you know, is not being brought to the table and perhaps that could be a very strong message coming out of this committee stating that information for substance abuse needs to be treated equally with all other patient information except for psychotherapy notes.

And be very specific because that gives SAMHSA something to run with and something, I think from a policy perspective, it gives them something to justify giving guidance very specific to allow for interoperability of substance abuse information absent the key pieces of information that we still deem necessary to keep private and only allow for it to be shared based on very specific insight mechanisms.

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

And there is one other thing we might be able to add to that and that is that perhaps in a certification process an EHR, an ONC certified EHR must be able to assure that this information isn't shared.

So, for instance if you've got a very large integrated system with a substance abuse center and a big hospital, etcetera, etcetera and everyone is on the same EHR then those notes can be sequestered.

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

Yeah.

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

Hi, this is Frank; I just wanted to comment too that I don't think we have to reach very far though to pull the string on this information. I mean, bear in mind CMS was giving out this information at the inception of the 2012 ACOs and then they unexplainably withdrew the information and had us destroy it.

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

Yes, it was a total pain too.

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

Well, besides the pain we never got a satisfactory response as to why.

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

Yes.

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

Now I don't think CMS would have released that information if they hadn't had the legal right to do it in the first place and again if you go and read the final rule they have the right to do that.

I think therefore instead of trying to reframe this I think we just say that, you know, I would agree with Shaun that, you know, we just have to say, this is what doesn't need to be shared, everything else should be shared by default.

And, you know, if a primary care physician doesn't know that one of their patients is in a drug and alcohol abuse program that's a problem for the primary care doctor.

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

And for the patient.

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

And for the patient as well, yes.

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

Yes.

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

And, you know, it's really two prongs because as you point out Frank what CMS was sharing were behavioral health claims and then they retracted the claims.

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

Yes.

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

So, that would be one side of the prong and then this other side of the prong is what is shared clinically from one provider to another.

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

Exactly.

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

And so I think we need to hit both of those prongs.

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

I just wanted to point that out because sometimes I think we're trying to reinvent the wheel, no offense guys, but we don't have to and the final rule pretty much gives CMS the right to do whatever they want to do if they decide they want to do it.

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

I agree.

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

Okay.

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

By the way, Grace?

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

Yes?

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

Don't change a word in C it's perfect.

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

Okay. I'm not changing anything. All right, let's go to the next slide if everybody is in consensus which is on data liquidity for accountable care and about interoperability standards moving on down then we get into common API.

So, let's start with the original text on interoperability standards and, you know, that's been a theme all along, it seems to be a consistent, you know, desire to do that for all sorts of reasons that we've discussed at infinitum but then there were some specific comments made that this would be one of those things that the market would not do by itself and I think there has been some discussion verbally that we all agreed to that and then a comment to add some specificity such as standards as potential requirements for certification to participate in programs such as Meaningful Use Stage 3. So, I'm going to stop there and see where the conversation takes us.

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

Grace I'll start, this is Shaun, one of the things when I look at this I'm thinking about some comments I got actually last week at HIMSS when I was explaining our HIE model here in Maine and when we say HL7 I think depending on who we're talking to people have different perspectives because frankly CCD and CDA are also exchangeable through HL7 version 3.

So, I'm wondering and I'd like to hear from other folks on the phone should we be being more specific and saying HL7 version 2.x here for these data elements and not v3?

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

This is Irene, I would push back on that because I think we don't want to stifle, you know, those that are moving farther which will, you know, although there could be a lowest, you know, common denominator but I don't know that we would want to thwart, you know, more innovation.

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

Okay.

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

This is Frank, I just wanted to throw in here too that, you know, in my mind what we're trying to do is decompose HL7 not make it even more of a conglomerate than it is and, you know, I think that if we start thinking in terms of transactional exchanges push/pull technology through transactional exchange and then we focus in on what is it that we're trying to exchange, what is the transaction that is actually taking place that's going to make this a lot easier.

I mean, if you read that little etcetera list at the end that just scratches the surface and a lot of that is taking place today prescriptions are there, labs are there and those have been very successfully transacted in the commercial market.

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

I like that Frank, could we add that term transactional to this recommendation?

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

I like it, this is Karen.

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

It sounds good to me.

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

So, this is David, you know, one of the things that we've observed in the interoperability space that has us quite concerned is that despite the sort of the written requirements for interoperability and specific document types no one really is tackling the trigger mechanism and the timing of it and so what we find is, yes and EHR vendor gets certified to be able to produce a document of type x but then the ability for the provider to control when and how they want to send that data out just doesn't exist unless it's in the most, you know, the newest versions that I haven't seen.

And so we wind up having to go in and work on behalf of the provider, the person who has paid for the EHR, and write all kinds of scripts and triggers in there and that ought to be something that's configurable by the user. You know I would like to send a CCD at the conclusion of signing every note on a patient or I would like to trigger lab results to go out after I sign them. I mean, those are things that to me are as critical to interoperability as having the document structure itself and yet somehow everything is silent on that.

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

This is Frank again, I, you know, in looking at a lot of different EHRs, EMRs those triggers are starting to show up, granted it's not the most organized thing I've ever seen, but they are starting to show up and where they're showing up most consistently is in the CDSS, the clinical decision support systems or subsystems that exist in most advanced EHRs today.

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

Can you give an example of how or what?

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

In eClinical, that's one my wife uses, we can go in there and actually say, we want to send this progress note upon completion to this provider, so, you know, it's one of those things that we can configure and actually send, now will it actually work probably not, most of what eClinical does doesn't work the first time they release it, but at the same time at least the thought process is there to let the clinicians or let the practices actually start pulling the trigger on these things as part of an overall process instead of having to go through a check list and say "I did this, I did this and I did that."

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

Yeah, I think it has to be in the workflow but in particular with the EHR you just mentioned the way we have to handle it –

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

Yeah?

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

When we get data from them is we have to go buy their hub for \$50,000 and then we have to pay them \$38.00 per month per provider to enable the feature and then they will send the CCD that's not complete over the wire whenever a patient gets seen. So, that's – just to give it to you from the perspective of the aggregator or the person doing the exchange they've – it's just a different approach.

I mean, I think sending the progress note when I see the patient is progress but it's got to be explicitly written that if a – you know, the provider owns this information, this EHR not the EHR vendor, and if the provider is participating in an ACO I see this as the biggest risk factor in accomplishing interoperability for ACO purposes is that the vendor won't be able to enable what the providers have agreed is important information sharing rules, whatever they are for that community, the providers won't be able to toe the line on it and that's the reason I'm suggesting, you know, a pretty specific comment about it.

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

Your comments are also related to the comments that were made in the public hearing about the capture of the providers by the vendors once you sign up with a particular product and by that I mean, at least our experience has been, every time we've needed anything we know it's always going to be a new charge and a new, you know, everything is always a \$10,000 or \$20,000 pop to sort of get various enhancements that we've needed through the years which you would think if it's part of Meaningful Use and the necessary requirements the specific vendor capture issues, as it relates to revenue models on their part, could certainly squash the ability to move forward if it ends up inhibiting providers from willing to be part of ACOs or part of these new systems of care.

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

Yeah and that's the general message we get from most of our practices is "boy, I wish I could participate more fully I need this information out there but I just can't my vendor can't get me there and I don't have the money to bridge the gap."

And it's sort of a notable gap I think in Meaningful Use because Meaningful Use said "here are the features and functions you have to prove to sell your EHR" but it didn't go to the next step to say "and once you've been certified you have to sell that as the package to the provider, the whole thing" because instead what I get is "well you got part of the Meaningful Use package now you've got to buy these other three modules and –

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

Yes.

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

And these other three vendor systems in order to get the full Meaningful Use module" and that's not helpful at all.

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

Well, it's certainly been a business model that the vendors have used probably to their advantage.

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

Unquestionably they've used it to their advantage.

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

Well, and again, you know, I think that it kind of segues into the next Part B there that we've got to break the monopoly. I mean, this is something I've been preaching since I joined this committee is that, you know, EHR vendors are a monopoly in their own right and if we can't figure out a way to break them up then we're not really addressing the issues that ACOs are facing.

Now, that said, you know, again the transactional component of Part A is at least defining what is it that we need to exchange discretely and then Part B is when you actually get in here and start saying, okay, let's bring a little bit of market pressure to bear here on this issue and let's let vendors who aren't interested in writing EHRs but are very, very good at writing Apps get into this marketplace and provide a little bit of competition.

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

Yeah, this is exactly – so we submitted our beacon report from our experience of the community and one of the things we really highlighted was the fact that, you know, purchasing an EHR for a practice is not like buying a car or even like buying a house, even though it's about the same price, you know, it's for life. If you want to have a functioning practice that's successful you need to not be changing EHR vendors because it's too painful to do so.

So, the EHR vendor once purchased has a particular influence and need we say "control" over that practice, they are sort of captive to that vendor. And given that, that's where I think the Meaningful Use Regs really have to start to protect the consumer a lot more than they do now because that consumer is stuck.

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

David, I totally agree I'm actually consulting with a doctor right now who is suing an EHR vendor because they will not provide him with a way to gain read only access to his information once he changes to another system. Now, under state law he has to maintain that information. He has to provide copies of those records upon request, but if he cancels his contract he has no option to continue to utilize that information because it's locked up in an EHR.

So, I think if there is any way to put into this and I don't know where it would go because we're not talking about interoperability standards, we're not talking about a common API except maybe that third-party vendors can develop read only access to proprietary EHRs. But I think there has to be something there.

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

But yet –

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

There has to be something that we recommend to CMS that says, hey, you've got to help doctors become a little bit more independent of these vendors because they're getting sucked dry out there right now and by the way you're not getting the results you're looking for, you know, because of what is taking place today.

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

Right and they're having doctors leave the practice of medicine in droves or get sucked up by big health systems because they can't deal with the mess. So, the way we suggest it and I think there are some concrete things that can be suggested under this that are, you know, the interoperability as you say and the others are specific issues to highlight under an overall recommendation I think that EHR vendors be required to have certain points of interoperability where they expose an API and full access to data to either outside systems or to the providers themselves and that they have to certify that those exist, those points of interoperability exist and every time they release a new version of their product they have to certify that this new version they have not broken those APIs because we see that as well.

And if you do that then you open the door for a couple of things, one the provider then has the ability to plug-and-play best of breed things and to choose. Two, other developers who don't want to do the full comprehensive EHR but instead want to do Apps and innovations and decision support tools have a way to play because otherwise they're closed out of the market right?

And, you know, then combination of those two means that we can do our work better as advisors around accountable care and around measurement with CMS because they're actually – there is actually some ability to move and to make adjustments in the plan.

Whereas the current pathway has us saying, all right, well we've got essentially eight vendors or ten vendors and they all have basically closed borders, and the only interface point is to get a CCD out without having any specific trigger to it, you know, but that each practice has to buy their own trigger and their own interfaces and that doesn't feel very satisfactory to me.

Alexander Baker – Project Officer, Beacon Community Program – Office of the National Coordinator for Health Information Technology

So, I know we need to move on, this is Alex, I'll just say, you know, one way that we may be able to address this and we can check in a little bit more about this and try to bring it back on the 18th for more discussion but sort of another S&I Framework Initiative that is not addressing this question directly yet, but, you know, could be a place where this group recommends further work is that structured data capture work, you know, focusing on right now how to ensure that EHRs can capture customized data for secondary research but, you know, future stages of work could try to build on that for other standards about what the EHR systems are required to capture.

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

Yeah I think that's a starting point, but I would stress again that this is not just about sort of quality reporting at the end of a time period but sort of day to day interoperability between my EHR and other systems.

The other thing I forgot to mention when we were talking about this is do you – does everyone realize that in most EHR vendor contracts when you sign them they have the right to take your data and resell it –

Grace E. Terrell, MD, MMM – President & Chief Executive Officer – Cornerstone Health Care, PA
Not in mine.

David Kendrick, MD, MPH – Chief Executive Officer – MyHealth Access Network
And that they do that and that is a big business model for a lot of these big vendors.

Grace E. Terrell, MD, MMM – President & Chief Executive Officer – Cornerstone Health Care, PA
Not in mine, yeah we were very concerned about that. Yeah, that's obviously something that a lot of them have been doing since day one.

David Kendrick, MD, MPH – Chief Executive Officer – MyHealth Access Network
Yes and so it's a default in most contracts.

Grace E. Terrell, MD, MMM – President & Chief Executive Officer – Cornerstone Health Care, PA
Are we ready to move on? We're not going to get through the rest of this today although the discussion is really rich, but I think if we can move a little bit further on maybe we can get us ready for where we can continue to get our work done.

Frank Ross, MSSP, AP, ACO – IS/IT Steward – Cumberland Center for Healthcare Innovation
Grace, I just want to say that, to Alex in particular, that the wording on A and B is good. I don't –

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

Frank Ross, MSSP, AP, ACO – IS/IT Steward – Cumberland Center for Healthcare Innovation
I would cringe to see that changed considerably, but again, just, you know, the transactional component in A I think is the only thing I would add there. I think the common API is something that obviously you guys know is near and dear to me, but I think it's critically important and Alex your comment about being able to access the information, you know, for – the ability to share information in a, I guess you were saying in a way that it's confidential for research and things like that, I don't know how you get that into this, but I think that would certainly be a byproduct of what we're talking about.

Because you have to pay, you have to pay to sanitize your data. We're trying to put together a deal right now with Tennessee Tech right here and we're just – it's like pulling teeth to try to get this done because we have to go through and we have to sanitize the data, if there is a common interface that allows research organizations that are doing really good work quick access to data instead of having to take a year to get it done then that makes – that's a lot of justification right there in my opinion.

David Kendrick, MD, MPH – Chief Executive Officer – MyHealth Access Network
This is David; the only thing I would like to see added to that statement is that, you know, the provider or the customer configurable triggers for data exchange. I think that has to be included in our conversation or they can provide the ability to do it but – I mean, the capability to generate the files but no reasonable way within the workflow to get it done.

Alexander Baker – Project Officer, Beacon Community Program – Office of the National Coordinator for Health Information Technology
Yes.

Grace E. Terrell, MD, MMM – President & Chief Executive Officer – Cornerstone Health Care, PA
Well, let's move on then to the next slide which is about, continued the liquidity comment about measures for cross vendor exchange and then also on this slide is remote monitoring devices. Let's look at C and someone made the remark that this may not be appropriate because they thought if a large delivery system had a single vendor they might not need to demonstrate cross vendor exchange particularly if the vendor has a HISP.

I'm not sure I agree with that statement. I think that there is probably not a single patient that can always be presumed to only be within one large system that doesn't have some sort of ability to or need to sometimes interface with other folks, but maybe I'm missing the point on the comment there.

Alexander Baker – Project Officer, Beacon Community Program – Office of the National Coordinator for Health Information Technology

Michelle, I don't know if you can chime in here, I know this was in Stage 2 and I think it is not in the Stage 3 recommendations right? This did not get included?

Michelle Consolazio – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

It is not.

Alexander Baker – Project Officer, Beacon Community Program – Office of the National Coordinator for Health Information Technology

Okay.

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

So, this is –

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

Well, in Stage 2 you do have to demonstrate.

Alexander Baker – Project Officer, Beacon Community Program – Office of the National Coordinator for Health Information Technology

Right, but –

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

Why would CMS, so this is David again, I mean, I can show you a map that will absolutely knock your socks off, but we've got data flowing into our health information exchange just from Oklahoma Hospitals and Clinics and we have patients whose home addresses are from nearly 50% of the zip codes in the United States –

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

Yes.

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

Who receive care, how can anybody not – I mean, even imagine that you wouldn't require systems with system interoperability at least demonstration but let's make it real with this requirement, because these patients are moving and they're getting not just failed health but potential harm by not having this level of interoperability required.

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

This is Karen, you know, I think one of the concerns I have with this is that, as you pointed out, we already have measures for cross vendor exchange in Stage 2. So, when we're talking about future stages for Meaningful Use are we talking about information that goes above and beyond what's already available? What exactly – my concern here is that I'm not clear about what this recommendation was intended to actually do.

Alexander Baker – Project Officer, Beacon Community Program – Office of the National Coordinator for Health Information Technology

Yeah, Karen, I think when this initially got included, and again this is something that may have been overtaken by events, but the idea was that, you know, should we think about strengthening that in Stage 3 or a future stage that the, you know, piece that had been initially introduced in Stage 2.

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

Yeah, I mean, that was one of the reasons I wasn't sure it was particularly relevant or appropriate right now because we already do have something and then we do have very large integrated systems that, you know, if you're in Kaiser you stay in Kaiser you don't go outside of Kaiser. At the VA –

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

Unless you go to Florida on vacation.

Grace E. Terrell, MD, MMM – President & Chief Executive Officer – Cornerstone Health Care, PA
Yeah...that's true.

Karen M. Bell, MD, MMS – Chair – Certification Commission for Health Information Technology
Yeah unless there is a Kaiser in Florida there too.

David Kendrick, MD, MPH – Chief Executive Officer – MyHealth Access Network
Well, but they're not in Oklahoma then.

Karen M. Bell, MD, MMS – Chair – Certification Commission for Health Information Technology
I know. The VA I know gets a lot of care outside of the VA and that's a big issue for VA. But I think that, you know, the real – I just don't know that it's appropriate or relevant given what we already have and I don't know what we might be able to do to really strengthen it at this point. So, I just needed something a little bit more specific here. I think more specificity about what this would actually accomplish.

David Kendrick, MD, MPH – Chief Executive Officer – MyHealth Access Network
Well, this is David, I would agree that it's very generic and it only requires a demonstration, but I think it needs to be focused on specific capabilities for cross system data exchange and, you know, put down to at almost a workflow level in order to do the measurements.

But, I think it's – I mean, I've been a Kaiser patient in California and I can tell you that during that time I had records in an emergency room in Oklahoma and in Florida and they weren't Kaiser facilities, and that's a big percentage of people in America at one point or another with mobility the way it is, travel the way it is, jobs the way they are.

I think if we fail to create – I mean, I view this sort of like a – I know this is going to localize me but I view it sort of like a tractor pull what was generic and simple in Stage 2 needs to be built upon on in Stage 3 and Stage 3 should be very specific this is the kind of information you exchange and on what timeframe and via what trigger between health systems.

Frank Ross, MSSP, AP, ACO – IS/IT Steward – Cumberland Center for Healthcare Innovation
Yeah, and I – just to remind everybody originally in the proposal for Stage 2 this was going to happen. There was so much pushback that it got relegated to a demonstration in Stage 2.

Grace E. Terrell, MD, MMM – President & Chief Executive Officer – Cornerstone Health Care, PA
Why was there so much pushback?

Frank Ross, MSSP, AP, ACO – IS/IT Steward – Cumberland Center for Healthcare Innovation
Pushback because the EHR vendors are doing everything they can to defeat it.

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

Frank Ross, MSSP, AP, ACO – IS/IT Steward – Cumberland Center for Healthcare Innovation
They want you, as David said earlier, if you want to exchange with eClinical you've got to go buy their \$50,000 community health system. So, you know, here we go, I hate to say that, you know, the dark force is out there but it is and the dark force is there are EHRs that, again, have a monopoly on your information if you're a provider.

So, I think, and Alex you're the only one who knows, I think the intent here was to make sure that we draw a line in the sand and we say "look this has got to take place." I would make this even stronger. I'd say that, you know, there has to be benchmarks, there has to be demonstratable benchmarks in Stage 3.

Karen M. Bell, MD, MMS – Chair – Certification Commission for Health Information Technology
Well, my only concern and, you know, I'm not against data exchange by any stretch of the imagination, but my only concern is how do we really want to make this happen? Do we want to support whatever we're willing to call health information exchange going forward because that's an ideal way to make this exchange happen? Does it have to be direct vendor to vendor exchange? I think that's fairly limited and the direct exchange process is a nice way to begin health information exchange but it's not what ultimately we need as a nation or as a country, or patients, or as providers.

So, I think the real issue for me here isn't that I don't believe in exchange and we don't need it, it's really how are we going to make a relevant recommendation that will push or will support efforts that are already going in the direction for ultimately nationwide exchange.

And, you know, as Karen DeSalvo said last week, what she is envisioning is a network of networks. Ultimately there will be networks for information as exchanged and they will come together and ultimately be a nationwide exchange.

So, I just am unclear about how a recommendation that will get to that goal can be defined here and I'm not sure that measures for cross vendor exchange are the way to do it that's really my concern.

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

So, this is David, I mean, I would – I think you've hit on something that has been a concern for me in Meaningful Use from the beginning which is it lacks a clearly articulate goal to guide the operationalization of some process and instead we go straight to operationalizing these things and then we wind up throwing out good important things just because they're hard to do or we wind up failing to do something that could have been easy to do because we lack the objective to guide it.

And to me the objective here is wherever a patient presents for care their comprehensive records should be available period. And then in terms of operationalizing it I would agree whether it's point to point between vendors which is less efficient than having some centralized network, you know, those are things that we should come to grips with within the overall objective, but we can't not – we can't I think come to the conclusion that it's hard or that there is no clear answer and therefore we should sort give it a pass or ignore it for another round.

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

David Kendrick, MD, MPH – Chief Executive Officer – MyHealth Access Network
Because patients are suffering while we do that.

Karen M. Bell, MD, MMS – Chair – Certification Commission for Health Information Technology
Yes, so I'm with you on that.

Grace E. Terrell, MD, MMM – President & Chief Executive Officer – Cornerstone Health Care, PA
Well, what kind of language would the two of you propose? We've got about 5 minutes before the end of the hour here and so I want to probably end here on this slide so that we can go forward with the rest of this on another day and really get into how we might think about this and data liquidity throughout all the rest of – is going to be 2, 3, 4 more slides in here.

How would you propose we actually do what you all just said which is get to our goal and put language in there that would actually help?

Karen M. Bell, MD, MMS – Chair – Certification Commission for Health Information Technology
I would propose that we think a little bit about that and in the next maybe 24 hours send out e-mails to each other and when the next iteration comes around we can pop it up there. Does that make sense? Because I can tell you I don't think I can come up with the best language in the next minute and we have one more thing to go.

David Kendrick, MD, MPH – Chief Executive Officer – MyHealth Access Network
Yeah, this is at least an hour at the marker board for me, but I can definitely chime in with e-mail.

Grace E. Terrell, MD, MMM – President & Chief Executive Officer – Cornerstone Health Care, PA
Okay. All right. So, let's – is there anything on the remote monitoring that we ought to add to it? I mean, obviously there is nothing other than that's just one more specific piece of information, piece of data out there that we're trying to bring into the equation of information exchange. Are there any comments on this that anybody wants to make?

Frank Ross, MSSP, AP, ACO – IS/IT Steward – Cumberland Center for Healthcare Innovation
I think it's a good first shot Grace.

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

Okay. All right. Is this helpful the way that I'm doing this in terms of trying to lead the discussion? I'm trying to sort of make sure we have time to really get into the details as well as push us forward. Do people feel like they've had enough time today to really make it useful conversation?

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

I like it.

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

This is David, I really enjoyed the conversation part because I've monopolized a bunch of it and I apologize for that, but I would add sometimes it's useful to have the language on screen and have somebody whoever is taking notes or something making edits to it or adding additional key words so that we know what we've left as an indelible take away before we leave the call. I don't know who is responsible for doing that.

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

Hey, David, next time leave your forklift at home okay?

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

Sorry.

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

I was wondering if before our next meeting, Alex I'm looking to you, I'm sorry, but if you could take all of the input that you've gotten both on this call and the previous one and essentially redo the recommendations based on all of that so we might be able to get a little bit of a leg up on what we've already talked about and then we can move forward with the remainder of them because we don't have much time left.

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

Coordinator for Health Information Technology

Right.

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

So, maybe you – the sooner we can move forward the better.

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

Coordinator for Health Information Technology

Yeah, definitely and, you know, would love to in the next week and a half or so before the following call to invite more input off line from people on a new draft. So, we'll try to turn around that quickly so that people have a chance to dig in one more time before the 18th.

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

Thank you.

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

Okay.

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

All right sounds good.

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

All right so I'm going to let us adjourn now and open it up for public comment if everybody has a consensus that we're at a good stopping point for today.

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

I agree.

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

Okay.

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

Great.

Public Comment

Michelle Consolazio – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Operator can you please open the lines?

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.

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

All right well I look forward to some off line continued interaction and everybody have a good work day, thank you.

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

Thanks, Grace, bye.

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

Thank you Grace. Thanks everyone.

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

Bye.

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

Thanks.