

**HIT Policy Committee
Accountable Care Workgroup
Transcript
September 11, 2013**

Presentation

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

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

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

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

David Kendrick? Cary Sennett? Karen Davis? Heather Jelonek? Bill Spooner? Sam VanNorman? Joe Kimura? Shaun Alfreds? Karen Bell?

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

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

Hal Baker? Irene Koch? Eun-Shim Nahm?

Eun-Shim Nahm, RN, PhD, FAAN – Associate Professor & Program Director – University of Maryland School of Nursing

Here.

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

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

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

Here.

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

Hi, John. Are there any ONC staff members on the line?

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

This is Alex Baker.

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

And I know Kelly Cronin is on as well. With that I'll turn it over to you Grace.

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

Well, good afternoon it sounds like we've got a very small number on the call this afternoon so maybe we can be relatively efficient and also get into a little more depth perhaps by having broader participation in the discussion, but the purpose today of the call was to essentially go over the next two or final three elements of the CCHIT framework as it's relevant to what our work is in front of us and I will be leading the discussion on element 5 and then Karen Bell will be leading it on element 6 and 7. If I could go to the next slide and the next, and the next.

So to kind of reiterate again what our task is to basically set up a group of recommendations on how we can advance the Health IT priorities to support care. We've chosen to look at some of the work that CCHIT has done and at the end of the discussion today we can decide how to further use what we've learned from the pulse that we've had to frame our discussions to see where we want to go forward. If I can go to the next slide please.

So, there were some framing statements that we thought that we would go over once again and then I'll get into some of the key discussion questions and we'll get into the elements. So, just to sort of show what's on the slide here. We really think that we need to be concerned with advancing the evolution of Health IT to something that's more congruent with value-based payment methods and we know that there is significant amount of action happening both in the public and private spheres including ACOs, bundled payments all these things and we're trying to come up with a common set of core IT capabilities that are relevant. So, go to the next slide.

And so what we have done is go through the CCHIT framework and we thought that as we go forward that we would go again to the 5 key discussion questions for each of the functions and to reiterate them once again. Do you concur with input received about importance to accountable care arrangements and prioritization needs of the particular element as it's listed?

Do you concur with the input received about the effectiveness of the market forces, effectiveness of regulation to advance the development? If appropriate what policy changes could incentivize further development of this function? Are there additional interoperability standards that are necessary to support the function? And what data could be collected or integrated to better support the function?

And so if you will go to the next slide I think a lot of the theme that we've had so far has been very relevant, which is, is there an appropriate strategy that the ONC could leverage through its regulatory authority that would be able to think about what's clinically relevant, what there is a business imperative to do based upon where the market is now as to where it needs to go, that the market will not do by itself and that regulation could help. And if such a strategy can exist I guess is our task to sort of render opinion to the ONC as to what that might be. So, if I can go to the next slide.

So, we've been doing this now for several meetings and we're now to the final 3 elements of the CCHIT framework and if you'll start with the financial management one and go to the next slide I thought that what we might do to begin with we would basically review the actual answers to the survey that was out there and let me ask Alex or somebody from the staff, how many people actually responded? What was the "n" on the survey could you all give me a sense of that?

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

I think we have different numbers for each of the, I think the 3 and 4 we had 9 folks and this one 7.

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

Okay, all right, so it's a relatively small number which means we need to think about that from a standpoint of relevance although, you know, from an expert panel as has been convened I think it does have more meaning than it otherwise would. So, if you'll look at the financial management piece in the slide that you're looking at you can really see maybe quite different than what we saw on the previous three and four and one and two that things are all not sort of blending in the middle.

You'll see that there is some performance reports for example that are seen as having a lot of importance for that function and then in terms of opinion as to whether federal policy would actually help those numbers and scores were quite low on the financial management piece in general which I think is very interesting. So, within the context of the slide we just previously looked at which said are there things that federal policy can help with, there does not seem to be a lot of opinion or at least it tends to be towards the negative on a lot of the financial stuff that policy can help. I'm not sure I personally agree with that, but let's hear what people are thinking about these numbers.

Karen, I know that you actually, before the call went public and we had everybody on the phone, you said that you had reviewed this and was asking my opinion as to what I thought. What do you think about this within the questions of the discussions of the functions and do you agree with these numbers or not?

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

Well, I think and thanks for the question Grace, I think that there is no question that the answer depends very much on what the ACO is looking at right now and where it intends to go. There are a lot of upsides to Medicare Shared Savings Programs a lot of patient centered medical homes that are not at significant risk for any downside to loss and for those groups really intensive financial management isn't going to be quite as important. Another factor is the degree to which those groups have a specific percent of their total membership under a risk contract.

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

Yes.

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

So, I think that, you know, when you look at those two things it's very, very hard to specifically say that a particular thing is going to be important or not. I would agree that everyone needs some sort of what I would call descriptive analytics to be able to monitor your costs, know where they're going, be able to monitor a whole set of dashboards of things and that can come pretty easily from the information that they have on costs and payment information that they should be able to get from their payers. So, I think that that's one thing everyone does need and that's why that very first one got a 3.0.

I also noticed that there wasn't a lot of emphasis on ONC or HHS helping in that direction but I would also comment on the fact that if CMS was very clear about making sure that it's claims data was available in a timely way and it was accurate, and that if there was some way that HHS in general could exert some leverage with states to assure that other payers could make claims data available for any of those other programs whether it be a patient centered medical home or alternative quality, or alternative payment contracts I think that could make a huge difference in assuring that everybody who needed information on total cost of care and this type of descriptive monitoring data would be able to have it.

So, I think that's really, probably to me, the most important thing that stands out here, because many of these other things don't become absolutely critical to a lot of groups until they get into significant downside risk or they take on capitation or bundled payments or something like that.

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

There is a lot being mentioned right now out in the sort of conversation world about what's going to be the end game for Medicare Shared Savings Program or other ACOs that are doing, you know, gain share upside only and a lot of the rhetoric as well ultimately for this to be successful we're going to have to move everybody towards global payments, bundled payments and risk into its gradual process. So, part of what this was saying to me is people are still looking at the importance of these things relatively early along the glide path, which is no it may not be important right now why it's gain side only.

My personal opinion of that is that – and this is based upon my own role in our organization where we now have 100 percent of our contracts in these gain share arrangements or trying to learn very rapidly where our costs are and how to manage things is that it's going to be needed sooner than people realize.

Just before this meeting we were actually looking at some of our performance reporting from the Medicare Shared Savings Program data that we receive and that's our most complete information about payment because we have all the claims. One of the things that is on here about federal policy that people didn't seem was important was that federal policy could help with some of this.

But I can tell you in the private world with a lot of our commercial payers as much as they would like to give us financial information they cannot or will not, they're concerned about what it does from a stand-point of price fixing and they're also concerned about, you know, their ability to provide accurate information when they've really not had on their side, the payer's side, the IT structure set up to do any of this.

So, you know – and for a lot of the ACOs if they're going to move forward into more risk relationships over time it would not surprise me to hear far more emphasis in requests for regulation than this survey suggests right now anyway. Are there others that want to comment on this out there on the slide that's in front of us in terms of the way that this one sort of panned out from a stand-point of importance and emphasis?

Are these the right questions to be asking from a financial management stand-point? I guess that's the next thing that we need to pursue. This was obviously the CCHIT framework, but is this adequate? Is this what – are these the right things that we ought to be looking at? Shall we go to the next slide?

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

Yeah, just one comment, this is Kelly, I know from what we've heard in the past from some of the pioneers, pioneer ACOs it seems like most, if not all, were integrating claims and clinical data getting into sort of the 4th category of normalized and integrated data, and while that does seem to be common practice I wonder, you know, if there is a need for this kind of function or just generally speaking should we be thinking always in terms of the glide path, you know, what might be critical in having, you know, no downside risk versus two-sided risk or more capitative forms of payment.

And as we get into, you know, thinking through all this and making recommendations over the next few months be able to differentiate at what point does something become more important that you want to make it either, you know, more of an emphasis as an entry point to a program or have it part of something that could be addressed through certification or another mechanism, because, you know, a lot of folks had been managing, you know, risk-based contracting with just claims data for a while and doing it okay, but others are getting a lot more sophisticated with claims and clinical data, and the analytics to really, you know, make good use of the data.

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

This is Dave Kendrick; can you guys hear me now?

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

Yes, hi, David.

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

Oh, good, hey, I've been on but I was on the muted line apparently so I couldn't jump in. Something that appears to have caused in our communities pretty significantly around the ACO model is whether and how each different party meaning the provider and the payer can really trust the metrics around either the utilization or the performance metrics. And so what wasn't clear to me in answering these questions, and I have to say it was a pretty hard set for me to think through it took some time, what wasn't clear to me is whether there needs to be conversation or whether it's being considered as to whether or not, whether and how we would achieve some sort of a trusted third-party arrangement so that both parties could trust the measuring agency, has that been discussed at all in this?

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

Well, it's a very good question because obviously the payers and the providers are coming at it from a very, very different perspective and within the context of your – or the discussion in general about clinical data versus claims data some of the things that our organization is tracking right now we're looking at both and the data is very disparate because both of it has part of the information but not all of the information.

So, having – is not only going to be a question in the future of usability which I think has been part of a conversation for a long time, but it's also going to be a question of not just usability but translatability if you will between different types of data sets and what ends up being the standard for how financial decisions or clinical decisions are otherwise made. Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

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

Well, I think it also has a lot to do with, this is David again, I think it has a lot to do with whether the business model works or not.

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

Correct.

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

I mean, I'm dealing quite frequently with the Chicago issue with HCSC or Blue Cross in Illinois.

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

Yes.

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

And we have one of the largest ACOs and their embroiled in a battle right now with a provider group over what performance really was and it's because they didn't establish a trusted third-party for measurement to start at the beginning.

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

Yeah, you know, I think we've worked with states a lot on this issue and CMS is also trying to develop criteria to qualify clinical data entities or registries that could act as sort of that third-party and accept electronic clinical quality measures or data to do that calculation and then report onto CMS. And we've also in working with states we've been trying to figure out how might we scale that kind of capacity across payers so that you have, you know, one intermediary that could serve multiple payers.

So, I think there is a – we want to figure this out, but I think that also John Pilotte is on and there are operational, you know, realities of how MSSP is implemented and they're using this group practice reporting option and a web interface to capture data and that's really based on a sampling strategy which is a little bit different from the, you know, capturing and deriving quality measures from electronic health records which isn't necessarily based on sampling.

So, I think the need for this has been recognized for a while David. I mean, it's still sort of a work in progress about how do we scale it and how do we make it work across payers.

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

Great, I think one example is emerging in the comprehensive primary initiative side on those programs because they're having to push more quickly into at least multi-payer utilization reporting and hopefully we'll get to multi-payer and multi-provider quality reporting very soon.

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

Shall we go to the next slide now? So, this is just the rest of the financial management feedback and you see that we're starting to get into issues with the contract management predictive and adjusting consumption or utilization on a per patient basis.

One of the ones that I paid a lot of attention on here is the assignation of patients to a particular clinician or practice, it is – the attribution is becoming quite an issue in the ACO world where there is, you know, obviously an intention on the part of the federal policy to make sure that patients can go to whomever they want to within the context of choice but that has made for all these complex attribution models.

I was surprised at the low level of federal policy intervention that was put on the or the prioritization that was put on that particular thing because I can tell you it's a huge issue not only to understand but to manage when it comes to understanding who your actual ACO population is.

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

I agree I mark that very important all across the board, because that's the number one thing our health systems are struggling with. But I would point out that this notion of having a trusted third-party for measurement would solve this issue as well.

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

This is Karen Bell; I think this issue of attribution is absolutely critical as well. I think we were all probably all unanimous on this one and having the ability to get the right data and get it from a complete source of data is important too.

So, there are two things that came to mind when I saw the survey, number one getting back to what I said a little bit earlier if there is some way HHS could leverage its influence to assure that the various ACOs have access to all payer claims data anyway and, you know, the reality, I think for me, is that if we're looking at financial management it's the business side of an organization and the claims are going to be absolutely critical on the business side.

And then I don't know whether if coming up with some really simple easy attribution algorithms is something that could be considered, some work that could be done either through a Workgroup or something else that could be examples of best approaches for developing attribution algorithms on an all payer database and so I would just throw that out as a possible intervention that federal policy might do.

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

This is David, I like those ideas, I think I would – one thing I'm not completely clear on is what's the intended size of an ACO in complexity? Because when you start asking an organization to be able to accept multi-payer databases all of which are in different structures put those together into something that they can work with and then apply algorithms of various complexity for patient attribution and which will be different for every payer of course you're not going to have, you know, a multi-specialty physician group able to do that, that's only going to be –

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

Well, that's what we're doing right now in our organization.

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

Yeah.

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

But it's costing an arm and a leg to try to actually, you know, build that in terms of a data warehouse and having to build the stuff ourselves. We are a multi-specialty group that's –

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

How much is it costing to do?

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

Oh, well our data warehouse alone was 6-7 million dollars, plus –

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

Yeah.

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

Well, but the State of Vermont is doing it for its ACOs.

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

Yeah.

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

So, they're doing it as a service? The state is doing it as a service?

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

Yeah it can be done at the state level on a state-based or a state developed all payer claims database. And 13 states have them, another 20 are in the process of building them, so it's becoming – you know, it's not immediately available to everyone, but again it's something that people are thinking about and from my perspective anything that HHS can do to underscore the importance of that and to encourage it in any size, shape or form would be helpful for the ACO environment.

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

I totally agree.

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

Yeah the only thing that I might add to that is that many of those, as far as I know, many of those state programs are not identified claims data and of course to do attribution you have to have it identified both the patient and the provider. So, it would have to be a specific kind of multi-payer claims database.

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

Exactly, exactly.

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

It could also be potentially linked in a financial sustainable model to health information exchange in that if you basically had an all claims database with a backbone that also allowed you to have clinical data information exchanged you might have some ability to really start linking some of these things together in more comprehensive ways, but it would require policy to do it because otherwise vendors and everybody else including payers are going to see a threat to having to share information from a competitive standpoint.

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

You know, it's interesting we actually tackled that very approach and managed to convince several of the largest payers that it was in their benefit to have this trusted third-party in existence because it turns out they don't particularly want to be the ones that have to call the performance number from providers.

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

Yeah.

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

They really like the notion of having sort of underwriters laboratory there, the community owned resource, they can say "hey you failed and you passed, and you get your payment and you don't."

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

Yes.

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

Yeah, they did that in Massachusetts actually, it seems to be something everyone really supports which is a good thing.

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

Yeah, I think there is a big barrier around both the legal restrictions and using the state, multi-payer databases and as David saying most of them are de-identified. I mean Maine and some others are trying to figure out ways to still do linking even though it's de-identified they have, you know, an algorithm to take a certain number of characteristics and basically re-identify them until they get to their clinical data repository, but it is tricky and I think some of them will have to actually go back to, you know, make statutory changes.

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

Yes.

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

Or fundamental legal changes around how they use the data and then they all have sustainability problems too, but if they could figure out uses to support, you know, scaling some of these models then that might be a sustainable business case.

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

Well, particularly in states that are moving forward with support of the ACO models, you know, you think of a State like Oregon that's just putting a tremendous amount of money in its CCOs and so there is a state that's going to have to find ways to get information on total cost of care to these organizations and I think that's really, you know, the ability to have information on total cost of care is going to be critical to these ACOs, the ability to do attribution is going to be critical.

The ability to even look at, and I again hesitate, but knowing, I don't want to use the word leakage, but knowing how much of your attributed patients care is going outside of your system is going to be critical, it will let you know whether you need to do things that will in essence delight your patients more so that they are more inclined to stay in house.

So, there is a lot that can only be done with that kind of data and I would just add one more thing and that's the vendors are all over this. There are a huge number of vendors who are doing descriptive types of analytics, a lot of them are doing predictive, you know, the predictive modeling that can tell you which of your patients are most likely to be high cost over the next year as one example of that.

And there are vendors that are even doing a lot of the really high grade logistic regression kinds of modeling that allow them to really think about what is the best way to plan for or structure the future, sort of if all of a sudden you're getting an influx of a lot more primary care patients how do you want to restructure your staff and your exam room to accommodate that and you can do that with the right tools, but you've got to have the data.

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

Yeah, I was just going to say, you concluded with the point I was just about to make which is having the claims data for a total cost of care analysis and attribution is okay, but it's going to be 60-90 days too late to do anything about it whereas if you are partnered with something like an HIE or other data sharing that's attaching clinical data and live feeds you could really do attribution on the fly multiple times a month if you needed to.

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

Yes, that's a very good point.

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

Let's move onto the next slide, please. So, it was interesting to me on this one again as the numbers go down if you look at cost accounting and otherwise, you know, we're right now in my organization engaging with some folks that really know what – their background and experience has been on the payer side and it's been on the risk side and the cost accounting aspects of things, the billing for revenue outside of contracts, all these types of things that have to do with really understanding the deep, deep aspects of financial management really become far more important as you move towards risk.

So, the interesting, I guess thing about it is again the feeling among those that were surveyed that federal policy intervention was not necessarily going to accelerate this. I suppose if the federal policy was to create a Medicare payment that was more risk-based as opposed to shared savings that might be the policy that would do that, but there seems to be a consensus in this that it is the market. I'm taking it that the market will be the ones to do this. Is that the way other people are reading this?

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

Yeah, this is David, when I read that I was trying to decide was there really a different pressure under a risk model than a fee for service model to be doing cost accounting. I guess there is mainly driven by the fact that money is coming out of the system and could be tighter margins, at least that's my read on it, but I didn't feel at all like policy could really effect the internal processes like cost accounting and that under a risk model people are going to sink or swim based on their ability to manage their internal systems.

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

Any other comments people want to make? Well, let's move onto the next then. So, there were some comments that were off of the survey that I thought we might just go through and let everybody see here. I think a lot of it we've said and some of our discussion here in our own way, but it might be good for us to take a look at it. You know the first one there is that the software industry has done a good job of filling the void on financial systems as they arise and didn't think the federal guidance would help.

The second one is the attribution models get a lot of attention but to really manage care you're going to have to have explicit assignment or responsibility to members of the care team, totally agree with that and then the third was, on this particular page was the strong role for federal policy in advancing the development and use of interoperability standards, that's been a theme that we've been hearing with all of our meetings I think on a regular basis is the concept that if there were interoperability standards from a federal policy level then a lot of the rest would happen as a result of how the industry would respond to that. Anyone want to –

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

I mean, all I can say about that last comment is a strong role being played right now isn't really working around interoperability.

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

Yes.

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

I'm in the business of interoperability; I can tell you I have yet to be able to have a CCD exported from an EHR passed NIST the first time from real practices. I mean, it just doesn't happen. So, the enforcement needs to be ratcheted up a little if we're going to do anything there.

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

Well, it certainly has not necessarily been in the vendor's interest in the short run for it to be too easy. So, that obviously will be an issue of tension between the vendors and policy because of the thing it does for competitive advantage. Can we get to the next slide?

Then the other two comments on this part was first that there were several capabilities that would be counterproductive to require software in excess of these specific requirements. Again, I think a fear of over regulating or over reaching from a policy stand-point, and then I think Karen mentioned earlier in her comments that if you only have a certain small portion of your patients in an ACO model you're not likely going to need the amount of financial resources that somebody who has a very high portion of their patients in a risk model would need.

So, one of the questions I guess we need to sort of wrestle with is are we going to give comments relative to where things are in the short future as it relates to ACOs as they're now construed for a recommendation stand-point or are we going to take sort of the approach that the CCHIT did that it's going to continue to be a progressive or continuous pathway and that there needs to be a glide path to something that sees an ACO as sort of a stopping point to where we are going over time.

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

This is Karen, I hesitate to put my bias out there, but it's clearly one that would encourage and educate people about what it takes to be on that glide path so that perhaps it would not be quite as intimidating as they move from a financial management perspective as they move from this kind of descriptive type of management using descriptive data to doing more predictive and then ultimately more planning, I guess you would call it prescriptive advanced analytics.

So, if there is some way that could even be articulated so that it becomes something that everyone understands and recognizes and that glide path is well flushed out, maybe that would be helpful. So, I'd throw that question out there.

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

Well, I would agree that it's a huge bite to move from nothing to full on ACO or any particular risk model where you can't contain patients. So, I would definitely endorse a path, you know, sort of a graduated plan of attack for many organizations.

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

Let's move onto the next slide. Let's see, I'm trying to remember what all this is or whether we even need to go into some of this. This is just more comments I think in more detail about the various aspects of the various bullet points. Does the staff out there think we need to go into detail with this?

I see that we're right on the 3:45 time on our agenda where we're going to move it on towards the – turn it over to Karen for the reporting and knowledge management. It seems like to me that we've been talking in very general terms but do we need to get to specificity here? There are some questions that they are asking here.

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

Yeah, it seems like, you know, we've touched on a number of these sort of issues with all payer databases and states and sort of what is happening around that level which will, you know, certainly be something we try to drill into and then the attribution algorithms on the last one.

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

All right well why don't we just move on towards Karen's part then?

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

All right and maybe it's a good thing there's a limited number of people on the call because this part is probably going to be quite short. This is primarily focusing on the knowledge management piece. A good deal of this knowledge management is pretty much focused on the far end of the glide path when the organization is large enough, robust enough and has the data sources necessary to really start doing the kind of development around personalized health and those sorts of things.

Having said that there is also the need to get information on the very first thing here and it falls in the reporting part of this. The reporting on the resource consumption, cost metrics and all of those other patient feedback aspects that are going to be important not just for managing the business but also for managing the care not only at the individual level but at the program level.

So, here again we're getting back to the analytical tools and programs and dashboards, and predicted programs, predicted analytics and prescriptive analytics, the advanced analytics that we talked about before but including the clinical information and including patient derived information as well recognizing that right now the latter two are even probably less specific than the financial information. I think probably everyone agreed that's really important.

I think the interesting thing is that because it's so important it seems as if the private sector, the vendors and others are quickly developing and trying to help out the ACOs in that venue and that perhaps it seems that an intervention from the feds is not going to be particularly helpful in terms of that type of reporting, internal reporting. So, I suspect that everyone would agree with that and I'll just stop for a moment to see if there are any other comments?

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

This is David; you probably could have guessed I would have a comment on this. One of the things that I had to think about carefully when I was answering these surveys was what's the perspective on taking them? Am I taking that of a community-based organization which is where I am or a university which is considering being an ACO? And so I instead took the perspective of Medicare and the government when I answered these and what would be best from their perspective and what outcome are they trying to achieve and I may not be in the best position to perceive their perspective but I certainly – the answers were different based on having taken that position on it.

And one of the things I'm worried that we create is a self-fulfilling prophecy here is that only large organizations can be participants as contractors in the future healthcare system and I think it was alluded to when I said, you know, no multi-specialty group could do it and then your example was "yes, my multi-specialty group is doing it" and then when I asked what you spent on analytics it was 6 or 7 million, well not very many multi-specialty groups in my part of the world have those kind of resources or are nearly that kind of size.

I live in a mostly rural state and I worry that we are forcing providers and groups into larger and larger organizations just simply because of the amount of overhead and burden we're creating for them. And so when I think about things like the financial systems "yes" and the multi-payer data sets "yes" but especially the clinical decision support and the analytics, and those tools that are going to be necessary these smaller practices are struggling just to deploy one EHR forget the rest of the advanced capabilities.

And so in that mindset I believe CMS and ONC have funded that infrastructure that should be able to do these things for – and the HIE work and other things, decision support and these advance tools could be applied but if we don't recognize that and include that as part of the equation then de facto the new healthcare system will be 5 enormous health systems nationwide running healthcare and if that's the intention of Medicare than that's great, but we're ambling towards that pretty quickly right now and the pace is picking up.

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

Could I – move that discussion a little bit further and off cue, if you can think of alternative ways to have those needs met in the rural environment and specifically I'm wondering if this could be a viable business model for health information exchanges for instance?

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

Yes.

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

Yeah, that's exactly where I'm going with it, that's the value proposition that HIE has landed on and this part of the world is to be sort of the HIT service agency for a lot of folks with smaller EHR vendors that are maybe not even going to survive Meaningful Use Stage 2 certification and instead, I guess the analogy I always use is we'd rather provide the public roads and bridges for all those practices, you know, we can do pretty advanced analytics like we use our community IndiGO and give it – use it on 850,000 patients every night on behalf of a lot of small practices that could never afford to do that individually. So, yes, indeed that's the business model we put out there.

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

And I guess that also begs the question of whether or not some of these HIEs can and should do this perhaps because it's a good business model for them without any type of federal or state interventions because ultimately if they're going to be successful they're going to have to find a sustainable business model.

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

Yes.

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

Yes.

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

Just to your comments, this is Grace, about the investment we put into it, we did that very specifically for the reasons that you articulated which is that we felt like if we did not make the investment, and it's been an extreme stretch for us, that we would not be able to continue to be an independent model and we were concerned about these large systems and whether they could actually move healthcare to where it needs to be which is more efficient and all the things that we all want.

One of the reasons we did it is because the type of infrastructure you're talking about there were policy decisions made at our state level and particularly as a result of the hospital association pulling out financial resources to having an HIE.

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

Oh, yeah, that's the killer. I mean, I will tell you that having been able to hold the hospitals in and then subsequently bring in all the payers in a very broad community coalition we spend about 2 million dollars a year and we're able to do the all the analytics, at least that I've heard about on this call, so far.

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

Okay.

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

Well, you know, I'm going to take this opportunity, presenter's privilege I guess or license, to continue this conversation in a slightly different direction around reporting, because we talked a little bit earlier around some State HIEs even getting into the business of doing quality reporting which is quite an administrative burden on a lot of the ACOs and while we didn't talk about – we didn't ask any questions on the survey or we were not asked questions on the survey about quality reporting I give a lot of talks around the country, which is why I'm in San Francisco at the moment with all the background noise, on what ACOs need to think about particularly ones that are just starting to move forward.

And some of the feedback I get is that we need to find some way to constrain all of the quality measures that are upon them and I know that ONC and CMS are talking about aligning some of the quality measures but when you have to do a plethora of Meaningful Use measures and then you add on another 33 or even more ACO measures the reporting burden is pretty significant.

So, I've been asked to put in a plea to really reconsider the numbers of measures that are used to make sure that they are absolutely relevant and that they also start moving in the direction of more patient derived measurements. So, we have measures around patient function whether or not care, you know, they're health improved after a particular point of care or whether or not their overall sense of health has improved or not improved or gotten worse.

So, I think that there is a lot of discussion and I think that's probably happening in other areas, but I would just put on the table that because there is a lot of discussion about more ACO measures that maybe our group thinks a little bit about from the ACO perspective that more is not necessarily better. So, I'm just going to throw that out there before we go through the rest of these and ask for everyone else's comment?

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

Amen.

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

Amen.

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

I think we, you know, we've got a comprehensive primary care initiative here, we've got a beacon, we've got a number of sort of federal initiatives and a bunch of Medicaid initiatives and the tendency was for all of them to come to the table for us with a different set of measures and one thing we were able to do by having sort of that community level governance is we got all the payers that were there, Medicare of course wasn't in the room, but everyone else was in the room, got them all to agree to a common set of measures which greatly relieved the burden on everyone.

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

Yeah, I –

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

One of the things that I heard is in a proposed final rule as it relates to ACOs and measurement and in fact we just turned in our comments to it was the concept that in order to get all the money that you would necessarily be allowed to have in the shared savings program that they were going to actually compare the ACOs to one another even though right now they're quite clustered around a mean when it comes to quality things that's going to end up being something that I think could be a real setback too which is we all need to be probably be meeting an absolute standard as opposed to be comparing ourselves to one another as we're going forward with this thing. So, part of it is not just complexity of regulatory policy but how it actually is being written or potentially written and regulated.

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

Yeah, I agree with that for sure.

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

Just to let you know that Joe Kimura and San VanNorman from our group has been, you know, actively working on this issue with our new Accountable Care Measures Workgroup. So, the issue of alignment and patient reported outcomes has come up repeatedly and I think they're wanting to achieve that and it's clearly a CMS priority to have alignment across PQRS, Medicare Shares Savings Program, the EHR Incentive Program and, you know, as they considered more longitudinal measures that would be more, you know, in keeping with an ACO model I think they need to – you know, the same considerations around alignment would be, you know, in play and we're also, you know, doing this new group that Joe's helping to lead with Terry Cullen is looking to really leverage Health IT and the existing standards of technology.

So, hypothetically, you know, the burden – this is all well-coordinated and certified technology truly enabled it and we also had third-parties with the qualified data registries or, you know, whatever they're called, you know, if they could be enabling and then, you know, hope this all could come together. The other thing we are trying to do is really work with the states that are in the state innovation model to make sure they align around a core set of measures so that they're not driving the providers crazy.

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

Yeah and I think all of that is absolutely going in the right direction and I was just thinking, well maybe if nothing else in this Workgroup, and we can talk about it obviously when we go further down the line and truly get to recommendations, you know, might even make that line in the sand a little bit deeper by saying that, you know, don't impose or don't include, or don't offer any new measures until all of that happens. So, that might be one way we could sort of force the issue a little bit, make it happen a little bit quickly.

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

Yeah, this is David, I would agree and I would also just come back to the data source question as well, I mean, under the CPCI models there is a real push to have the Meaningful Use measures generated by EHRs be the quality measures for each practice and while that's okay with CMS at the moment none of the commercial payers who are participating are willing to consider those as quality measures because they've seen the high variability in the way those are calculated from EHRs.

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

And I think we're all well aware that whatever comes out of this Workgroup will obviously go to the Policy Committee and the Policy Committee may have very different ideas and might massage it very differently but it was a thought that comes from a lot of the feedback that I've been hearing around the country.

So, moving onto – and thank you for everyone's input on that. So, moving onto some of these other things that we have listed here. If we think about creating and sharing clinical knowledge some of these things are not in the reach of many practices, you know, going out and getting a search engine and document management systems when you barely can pull a reasonable warehouse together doesn't make a lot of sense.

On the other side of the coin there are some things in here that maybe, things like community as a practice and other types of ways of sharing clinical knowledge. So, I think unfortunately, when we, as a team, created the framework we talked about creating and sharing clinical knowledge and put the whole gamut in there recognizing that people would have to pick and choose to determine what was most important for them.

So, what ended up happening here, as you can see, is that everyone thought this was important and I think they probably picked and choose among the various options here, but again, recognized that the private sector is already going in that direction and federal intervention there, you know, probably would be unlikely to move things along.

And the same for the kind of clinical decision support that could be built into the ACO. There are ways that an ACO can create its own clinical decision support and granted these are primarily again margin to graded delivery systems, Partners does it, Vanderbilt does it – Intermountain does it lots of others that the major systems do it, but that doesn't necessarily mean that it's appropriate for everyone.

So, are there any thoughts about either of these at the moment in terms of whether or not there could be more opportunity for federal intervention on sharing clinical knowledge or CDS beyond what's already being done through Meaningful Use?

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

I'll just throw out one idea that we've heard from others and other discussions over the last year, you know, we are promoting standards for clinical decision support that could be more widely utilized, you know, across a variety of EHR platforms and making messages that are computable like say you have – like we heard from an ACO recently that they can produce really good analytics and care gap reports and they sometimes will even come up with, you know, some clinical decision support that could be, you know, supporting action within the practice, but they can't make the message computable within the EHR. So, I don't know if that's much of a barrier, but we are hearing about, you know, we need to make care gaps and information on care back computable so that it can be executed at the point of care.

And then the other thing that we've heard is that it would be useful to get cost data to inform referral decisions and this again may not be something that the federal government has a specific role in but it's a little bit beyond what's listed here, you know, the idea of having – being able to manage to a three-party and having data at the point of care – you know, related to cost and quality so you know who are the high cost providers for certain elective procedures or, you know, other ancillary services.

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

It would be huge from our stand-point, you know, one of the things that's been nice about the Medicare Shared Savings Program is that you are starting to be able to see where some of the costs are outside your own state of influence such as durable medical equipment, you know, long-term care things that have not necessarily been, for a multi-specialty group, part of our consciousness before, but it's a very small proportion of the overall dataset and price transparency is very early on right now with some of the federal efforts but as it becomes true transparency I think there is going to be some significant opportunity for improvement in overall cost control.

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

Yeah, I remember I think we talked about that when we were talking about the coordination of care question and I could be wrong but I think I remember that everyone agreed that that was an important part Kelly, so yeah, I will agree as well.

Okay, so I will continue on here with the personalize presentation of information. Again, this is an approach that is going to require a pretty strong search engine to be able to pull things together and some – around what's best for giving patients and also involves pulling in data from multiple sources that probably aren't available just yet. So, that's again, something that would be I think – and I think these numbers essentially articulate that by saying this is important, but it's not likely to be happening immediately.

The market will recognize that it's an important piece and is beginning to jump in and particularly around some of the larger customers that might be interested in this might not need a lot of intervention at this point.

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

Hey, David, this is Alex, I'd be interested in your thoughts on that care gap idea just given how much you've thought about this for MyHealth and, you know, the transfer of that care gap information automated transfer that Karen obviously you're doing it in the HIE context, but, you know, thinking about different ways that that sort of functionality could be encouraged elsewhere?

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

So, this is around the clinical decision support piece that you're talking about Charles?

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

Yeah, I was asking David about specifically the –

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

Oh, okay.

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

Being able to transfer care gaps and have those digested by, you know, what they're doing with MyHealth in Tulsa, but, you know, are there ways to transmit that information?

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

Okay, right.

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

I don't know did he drop off?

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

So, I'm going to move right along here if that's okay? There are a few more and then we can have some discussion at the end here. This last one is about creating and sharing process knowledge. This is more not about clinical information this is more about understanding what kind of programming may work and bringing that to the point of care and it's almost like having – you know, having a pub net or having some sort of a search engine that allows you to really look at well how can I provide care in different ways, different care processes that might work given my patient population, given our structure, given a whole bunch of other things.

So, I'm not sure that that came out through, you know, as understandable as it might be but I do throw out that there might be some possibility that there could be some central information points where ACOs can go to really learn about these kinds of things and I'm wondering can I throw this to Kelly and Alex whether that's something that AHRQ is thinking about, whether you guys are thinking about, is there some central repository on successful ACO care processes?

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

You know, that's a great question. I do know that the Innovation Center has been interested in supporting shared learning among Medicare ACOs and clearly has been supporting that with the pioneer ACOs and I think advanced payment model participants in Medicare Shared Savings and I think there is an intention to do that more broadly so that they could potentially play a role there.

I'm sure AHRQ would probably be interested and we've been interested in helping with, you know, learning and diffusion in this area too. So, I imagine between a combination of efforts we probably could facilitate in some way.

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

And open it up to any organization that's taking on any type of risk upside, downside whatever that would be helpful not just the Medicare ACOs that would be great actually. Thank you. Going onto the next slide we have three more left one of them is supporting comparative effectiveness research and this is the ability to incorporate and integrate data from multiple sources and then feed it into someone, i.e., AHRQ who is doing the effectiveness research themselves.

So, I think we already have a structure to do that in terms of doing the comparative effectiveness research. I'm not sure we have an easy way for the ACO groups or provider groups to feed information into it. So, I'm just going to throw that out as a thought based on this and see what people think if there is any agreements or disagreements with the numbers or what you would think about that approach?

Okay, well in that case I'll just go back to the final two then registry reporting and reporting information to patient safety organizations. Certainly getting information to the patient safety organizations would be high priority for the federal government, probably even more so than for provider groups who won't see the results of that for some long time, but I think that there is movement in that direction to try to encourage access to the common formats when they become available.

And I just wonder whether though and I'm going to ask this question of my colleagues on the Workgroup, is this something that would require more federal input or i.e., assuring that they're baked into EHRs as a certification system or is this something that would make more sense for the ACOs to do and have them collect this information in any way that's most appropriate for them? So, the question comes down to should this be something that an individual clinician is responsible for or the organization?

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

You know, it seems to me that as we start really getting into improvement in care all sorts of types of reporting are going to continue to be a real aspect of that. The more burden we put on the individual provider or whatever the more difficult it is to actually provide care to people. Most of these types of things from my stand-point work far better if it's through a registry function at the level of an institution as opposed to an individual.

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

Yes. So, with that in mind I think that would help guide any policy or whatever that the federal government might want to take with respect to registry reporting or reporting on patient safety, because to insist that it be done at the individual level or at the practitioner level may not be the appropriate approach.

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

Yeah, yeah.

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

But doing it at the organization level would make more sense.

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

Well, you know, a good example of this would be in the PQRS reporting the year that it had to be done by an individual G-Code we just, as an organization, could not do a very effective job with that. A few of the individuals in our organization reported a little stuff. Once we were able to do that by registry we were able to very quickly participate in a way that was meaningful.

So, I think we've had experience of that already with federal policy and I don't know, you know, at the level of the money that was paid out in 2009, 2010, 2011 for the PQRS whether they know how much of that was through registry participants as opposed to individual G-Codes, but it would be probably illuminating to that and probably partly answers your question Karen.

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

Yes, yes, any other comments on that? Okay, well thank you and we will move onto the last two slides we have here which are some of the comments that came through. The first one basically pointed out that the survey has been pretty effective about informing on the perceived needs but that the market right now is abounding with products that are performing many of the described functions that were in the reporting and knowledge management comments.

So, again there are a few things we talked about that federal intervention might help but for the most part this is a market issue. We also talked in the past about the size of the organization and the more robust the risk the more important all the functions become so that's been said multiple times before.

And the last comment here addresses the fact that many of today's EHRs actually have very poor registry functions and while some of the things that are – some of the criteria currently in certification are helping it maybe that revisiting certification specifically for some that are respective of a registry function might be helpful.

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

Karen, with respect to that I wonder if, you know, when we have the larger group and we start to think about how to, you know, craft recommendations it might be helpful to think about, you know, the modular approach to certifying health information technology where it doesn't necessarily have to be an electronic health record, you know, as we've called it or thought about it in the past but that, you know, it's a Health IT application that has registry functions whether you call it a population health management tool or registry, or an EHR the name is less important than the set of functions that needs to be there for clinical care and population health management.

And it might be useful to think, you know, across sort of the continuum of functions that are right now part of the Health IT certification program how might these be grouped such that any ACO or provider that feels they need to be managing population health would have a core set of functions that would allow them to do that.

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

Yeah, no I think that's a very good point and I suspect that's what was meant here by these comments not so much just the EHR but the fact that there is a well described set of registry functions and people know when they will have them. Okay, I think that's it in terms of that part of the discussion and I guess I turn this back to you Grace for elements 3 and 4?

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

Okay, let's –

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

Karen I think we were going to see if you wanted to do that just because Grace was not able to join that call?

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

Yeah, that's right.

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

Thank you, thank you, Charles I had forgotten you had joined us.

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

Oh, it's Alex not Charles.

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

You sound similar.

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

Yeah, no problem.

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

Hello?

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

Hello, so is Karen there? I think the idea was Karen if you could lead that since I wasn't there to actually summarize what happened.

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

Oh, I'm sorry; I thought Charles was taking this.

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

Charles isn't here, so –

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

Oh, okay.

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

Sorry.

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

I thought he had just jumped in, I thought it was his voice I was hearing. Okay, I'll move on here. This was about some of the discussion highlights that we had on the last go around with patient engagement everyone recognizes this is a high priority and that there are many aspects of this including the ones that are listed here. So, we talked about leveraging social media, remote monitoring and then ways that we can follow-up on missed appointments and other patient behaviors that really are problematic.

We also recognized or we were informed that SAMSHA and other federal agencies are very interested in this as well and this whole concept of empowering patients would be absolutely critical to include patients with behavioral health so that would need to be emphasized and maybe the sort of take home here is that those of us on the physical health side tend to focus much more on that and that we need to perhaps highlight more the need to include amongst all of our caregivers and amongst our even our primary groups people with expertise in behavioral health.

We've, on this call, spent a lot of time talking about monitoring patients and making sure we have good data and patient specific outcomes so that's something we've talked about on multiple calls actually. So, we highlighted that then, continue to highlight it and the question still remains whether or not that is something the market will do or whether there is a role for regulation and maybe again it's going to be anything if not regulation but perhaps leadership from the federal government on these patients, specific patient derived outcomes.

Patient experience was relatively low on the list but it is important for the ACOs and so I think the other thing that we talked about is that from an ACO perspective because patients can go pretty much wherever they like ACOs really do need to concentrate on this so it maybe more emphasizing their motivation to really engage patients more and make the patient's experience a delight as opposed to a frustration. So, this may again be as more risk is taken on this maybe something that the ACOs themselves will perform well on. Next slide.

And then the other set of highlights around patient and caregiver had to do with better communication two-way, bidirectional. There are multiple ways this can be done of course but we also talked about giving patient's access to the clinical notes themselves and how they would like to communicate in a way that's culturally sensitive for them.

And then another way of just making it easy for them to navigate the system, the systems are not necessarily, our healthcare systems are not necessarily the best things in the world for us but then that's something again that would be important for the ACOs themselves to work on because that will keep their patients and their customers closer to their own organizations. So, again, we talked about the greater the risk the more these organizations are going to be assuming responsibility for a lot of these things themselves.

So, the final piece had to do with the clinician engagement but before we go into that are there any other comments that anyone remembers about the patient engagement piece?

Well, we had a lot of discussion around user friendly CDS clearly it needs to be timely, situation specific, etcetera but there was also the necessity that was outlined of assessing its impact or assessing the impact of what we're doing right now to assure that it truly is improving the care and is leading to the better outcomes we're hoping to be getting, because there is a lot of emphasis that's being placed on these types of alerts, reminders, etcetera, etcetera without any true evidence that they're making a huge difference. So, that was I think an important point that was made by one of our colleagues last time around.

And then we also talked about the importance of maybe having some standardized approaches to evaluating the patient outcomes, again, this is something we've talked about on many calls and again some simple tools that can evaluate a patient's function whether or not the care has been an improvement for them or led to improvement or their overall site of care would be important. And we did not talk however about whether this should be information that would be gathered by the ACO or whether it would be information that could perhaps be gathered directly by the payer, by Medicare or another payer.

And lastly, we talked about the importance of getting good clinical education tools at the point of care and we know that programs exist, some ACOs, many actually make them available to their clinicians today, but having those programs more widely available and I think particularly and this was made by – the point was made earlier on our call today, particularly by some of the smaller groups or the smaller organizations that are in rural settings sometimes the cost of these programs can be a bit prohibitive.

So, there may be some way under certain circumstances either rural practices or rural hospitals that are in this shared savings agreement that might be able to have access to some of these programs without the cost that is usually incurred by them. So, anyone else who was on that call would like to comment on these then please do so? If not I think I have to thank ONC for pulling these highlights together. I think they did a great job. And I guess I turn it back to you now Grace for any final comments.

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

Okay, so this has been a great discussion today and I thank everybody's participation. We have now been through all of the elements I believe, have we not, of the CCHIT framework or do we have some more left? We've done them haven't we?

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

No that's it.

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

So, it's really time for us to think about what our next steps will be in moving forward with recommendations. I think we've had some very substantial conversations from a large thoughtful group of people over the last several weeks. So, I'm just going to open it up to everybody and say where do we go from here as we complete our work?

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

So, just –

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

I guess –

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

I'm sorry, go ahead?

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

No you go ahead I didn't mean to interrupt.

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

Oh, no just from our end at ONC, you know, we're going to be working to consolidate the different things that have been mentioned on calls and things we've gotten through the process and other inputs into, you know, a consolidated format that we can look at and start to work through. So, we'll certainly be putting that together and trying to circulate that with folks soon so that we can start getting to a document that can guide that discussion on the upcoming calls.

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

And just to clarify our recommendations are due to the Policy Committee when?

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

We're currently still looking at the beginning of December meeting of the Policy Committee.

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

Okay. So, the next step is to begin to draft the – send out a draft of some of the areas that we've talked about and kind of – not actually made the recommendation, but talked about a possibility for a recommendation and then we can get into a deeper dive on whether or not it would be a recommendation and how to craft it is that correct?

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

Yes.

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

So, based on that then I think what we need then is to – we will await with bated breath your write up of the conversations and then at that point I presume we'll be – Charles and I will be meeting with you to set forth an agenda to continue the discussion after what I presume will be another round of electronic communication prior to any meeting. Are there any other things that we need to talk about today before we turn it over for public comment? Well, if not shall we open it for public comment?

Public Comment

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

Sure, operator can you please open the lines?

Ashley Griffin – Management Assistant – Altarum Institute

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

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

All right everybody well thank you for your kind attention this afternoon and I look forward to the next step of our work together. Bye-bye now.

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

Thanks, all.

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

Thank you, bye-bye.

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

Bye now.