

**HIT Policy Committee
Accountable Care Workgroup
Transcript
July 19, 2013**

Presentation

Michelle Consolazio – Office of the National Coordinator for Health Information Technology

Thank you, good afternoon everyone, this is Michelle Consolazio with the Office of the National Coordinator. This is a meeting of the Health IT Policy Committee's Accountable Care Workgroup. This is a public call and there will be time for public comment at the end of the call. As a reminder, for those on the phone, please announce yourself when speaking as this meeting is being transcribed. I'll now take roll. I apologize to you all this will be my first time saying some of your names so if you could just correct me if I say your name incorrectly so I know for the future. Charles Kennedy?

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

Yes, I'm here.

Michelle Consolazio – Office of the National Coordinator for Health Information Technology

Grace Terrell?

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

Here.

Michelle Consolazio – Office of the National Coordinator for Health Information Technology

David Kendrick? Cary Sennett? Karen Davis? Heather Jelonek?

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

I'm here.

Michelle Consolazio – Office of the National Coordinator for Health Information Technology

Karen Van Wagner? Bill Spooner? Judy Rich?

Judy Rich, RN – Chief Executive Officer – Tucson Medical Center

Here.

Michelle Consolazio – Office of the National Coordinator for Health Information Technology

Sam VanNorman?

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

Yes.

Michelle Consolazio – Office of the National Coordinator for Health Information Technology

Joe Kimura?

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

I'm here.

Michelle Consolazio – Office of the National Coordinator for Health Information Technology

Shaun Alfreds? Karen Bell?

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

Here.

Michelle Consolazio – Office of the National Coordinator for Health Information Technology

Susan Stuard? Hal Baker?

R. Hal Baker, MD – Vice President & Chief Medical Officer – WellSpan Health

Here.

Michelle Consolazio – Office of the National Coordinator for Health Information Technology

Irene Koch? Eun-Shim Nahm? John Fallon? Aaron McKethan? Scott Gottlieb?

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

Here.

Michelle Consolazio – Office of the National Coordinator for Health Information Technology

Westley Clark? Akaki Lekiachvili? Sorry. Mai Pham? And John Pilotte?

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

Here.

Michelle Consolazio – Office of the National Coordinator for Health Information Technology

And with that I will turn it over to you Charles and Grace.

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

Okay, great, well good morning or good afternoon everyone depending on where you are and we're going to continue on with the activities of the Accountable Care Workgroup of the HIT Policy Committee just let me say a few opening comments.

At our previous meeting we discussed the importance of being able to link various capabilities and functionalities of health information technology to value, because this is the underlying premise of an ACO delivering population-based healthcare that achieves the AAA. We established a framework using the work that CCHIT has done around the requirements, functionality requirements for accountable care, and we made the decision to follow that framework in our conversations moving forward with a specific perspective around are these the right kinds of categories for us to be successful in defining what public policy could do in furthering the creation of technologies and capabilities that serve the needs of emerging accountable care organizations.

So, we're going to use this framework to further that discussion today and the key discussion questions we have listed on the agenda that we would like you to comment on, first we'll spend some time discussing are these the right functional areas, the right functions for these areas and do, we as a group, see any gaps that CCHIT maybe has not identified.

Two, we'd like you to comment on what are the things that you would prioritize as essential or important baseline characteristics. And then finally three, bring a market perspective. Many of you on the phone certainly are looking at solutions that are available in the market today and so as we think about how to use public policy as a lever to further accountable care development we'd like you to have the perspective of what gaps do you see in the market today that we could potentially encourage or facilitate through the use of public policy levers.

With that as an introduction and a framework I'm going to turn it over to Grace who will walk us through CCHIT framework element number one which is care coordination but before we launch into that let me just pause to see if there are any questions? Okay, Grace, take it away.

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

Thank you, Charles, so when we were framing this up this week in a pre-meeting one of the suggestions I had, which I've always found helpful, is to have a clinical veniet that allows us to have a conversation that's not so abstract. So, I'm going to start the conversation since it's about the care coordination framing it around these questions that Charles delineated by an imaginary patient although I think I see her about every day in my internal medicine practice.

So, imagine that there is a 77-year-old patient who was seen in an internal medicine practice and then she is hospitalized for a hip fracture and she goes to a skilled nursing facility and then she goes back to home with some physical therapy and returns to a primary care practice for further management. So, the point of that is that it's care that's given at multiple locations possibly with multiple types of information systems or lack of information and how might we think and frame what types of care coordination is...how it relates to IT and whether there are some things that can be done to facilitate this in a way that's rational.

So, if you will look at the framing statements what we were going to do for about 30 minutes is to assume that we're concerned with advancing the evolution of IT infrastructure for value that it's going to be both public and private efforts, and that there are some common sets of core Health IT capabilities that might broadly be relevant to that and we were going to sort of go through the CCHIT framework initially with care coordination as it was spelled out on that expert panel's work to see if we can now look at these questions and delineate them. So, I'll stop for a minute. Okay, whoever is advancing the slides could go forward then to the care coordination piece.

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

Just a few more.

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

Okay.

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

...

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

There it is.

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

Great.

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

Okay, so go back to the one before that for the glidepath and I'll make one point. There is my imaginary patient I sort of made it up, yeah; I got it mostly the same, now go to the glidepath slide.

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

One more, there we go.

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

Okay. So, remember part of the concept between the CCHIT framework was that we were not where we needed to be and there may be different groups at different points and ultimately there may be an ideal point that we can impact federal policy one way or the other to get us there and so if you would then go to the next slide.

There were 9 elements and the first one that we thought we would look at would be care coordination function. So, when we look at the 9 elements in here I'm going to open it up for discussion as to whether these are the right things and are there gaps and then how are we going to prioritize them. So, let's just look at them very quickly. Access to real-time health insurance coverage information, is that an appropriate function for care coordination?

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

Hi, this is Shaun Alfreds from Maine, my answer to this is yes it's something that we're seeing as driving us as a health information exchange here in Maine to collect more coverage information to support that transition of care so that the provider, the next provider in the handoff has the access and knows what coverage that person is on and can reconcile that with the treatment options that are being provided to that patient such as having access to the medication formulary for example from a particular payer.

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

High priority or low priority?

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

From my perspective that is a high priority.

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

Okay.

M

I agree.

R. Hal Baker, MD – Vice President & Chief Medical Officer – WellSpan Health

Hal Baker, Grace if we could put this in a way though so that the person making the decision for the referral knows who participates with that coverage to provide that service so that there isn't as much friction of blind dead ends trying to match up coverage services with accepting providers, that's a pretty difficult task to take on, but if it could be done would be tremendous.

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

Great and then move the conversation along pretty quickly and then hopefully we can circle back. So, one coordination care function 1.2 is establishing payer relationships, organization and health plan, having a relationship that's involved with care management and other services for selected patients.

So, within the context of the patient that I mentioned as we are creating new types of payer relationships and with ACOs certainly who does what and how that information is conveyed is becoming increasingly important.

I'm starting to hear some concerns from some patients that everybody is calling them after they get out of the hospital now, you know, or everybody is trying to do medicine reconciliation so the relationship can be at the financial level but we're talking about the care coordination level here and making sure that it's done in a way that's patient centric but also highly coordinated. Is that a high priority? Does that resonate with anybody else or not?

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

This is Scott, I don't mean to diminish the importance of this and certainly in today's environment understanding these payer relationships is very important both 1.1 and 1.2, but the underlying premise here is that we're going to be moving into a system where patients are going to be more captive within sort of semi-closed networks and so while this is very important today it might be less important in the future to understand what all the different payer relationships are or what all the different insurance schemes are because patients aren't going to have as much discretion to go outside of them. I just throw that out there not to diminish it, but it's probably going to be a little less important than the future that we're envisioning than it is in today's environment.

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

Hey, this is Charles, I don't know about that because when you look at the benefit designs, at least that we're creating and I know some of our competitors are creating, there is actually increased complexity coming with some of the benefit designs associated with trying to manage leakage, having varying degrees of benefits depending on which providers that you see and so it may diminish it in importance, it may also require a richer transaction set to be as actionable by the provider community in terms of optimizing the benefit use.

So, I'd be interested in if anyone has any comments on whether the existing transaction sets that give you the real-time eligibility data, have you found any gaps in the richness of that transaction set to give you the actionable information that you need.

W

This is...

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

This is Joe Kimura from Atrius Health, I think one of the things we found...so, I have two comments, one on Charles your point there, I think that the information we get from the payers not just the eligibility information but actually some of the payers with our risk contracts are giving us sort of daily ADT feeds when our patients are getting seen at hospitals and getting pinged around their patient eligibility, they're giving us that information back on a daily basis, which is coming from our payer to us and so that sort of information I think is very helpful.

I guess for 1.2 on my second point, my preference would be to broaden that out honestly, so payer is one relationship but we have a lot of other portions of the healthcare delivery system also starting to do this. We just came from a meeting here where the Boston Public Health Commission is also interested in helping us figure out how they can give us information around care coordination when their ambulances go out, they don't pick anyone up, there is no transport, but they get a glimpse into the home and they're realizing there is information there that can be helpful to the primary care doctor. So, I think there are more relationships than just payer that need to get thought about when we're thinking about IT capabilities.

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

So, the next one actually goes into some of the other provider relationships before I move onto the next slide to move the conversation along, any other comments on that before I do?

R. Hal Baker, MD – Vice President & Chief Medical Officer – WellSpan Health

Hal Baker from WellSpan, we're...

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

...go ahead.

R. Hal Baker, MD – Vice President & Chief Medical Officer – WellSpan Health

Go ahead. Okay, we're extending our case managers from the hospital into the medical home so they follow the patient in and out of the hospital. I think there is going to be a real tension between whether the case coordination is coming from the payer or coming from the medical home provider. I suspect for the patient Grace described the ability of a payer-driven case manager and Grace dealing with 20 of them for her various panel of patients is going to be less effective than a single case manager working from her medical office.

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

Shaun Alfreds from HealthInfoNet and I would second that what Hal just stated, we're seeing that here where we've got multiple case managers and care managers working from the payer side and the provider side and I see the potential for confusion on the patient as to which care manager is supporting them and how do they work with two different care managers supporting them for the same activity. So, it's something that we have to look at and throw some caution to here.

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

That was sort of where I was going with it before. Let's move to the provider, the next one please, establish provider relationships.

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

Before we go Grace...

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

What's that?

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

Grace, before we do...

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

This is Karen Bell and I just wanted to add that the last two speakers actually got to one of the points of this particular function because it was recognized that care management the types specifically that can be done around determining where the patient goes for the next level of care and what is that appropriate level of care can be done either in the delivery system or in the payer sector and depending on the type of a contract and depending on the ACO a decision has to be made about who does it and make sure that the communications exist between the payer and the provider to make sure only one body does it, but does it in a way that's effective.

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

Thank you, Karen, you know, part of the interesting part of the IT dynamics when it comes to care coordination has to do with whether you're pushing or pulling information and how you structure that information and who has it really is going to be crucial to some of the redesign that we have. So, I agree with you that this really does get to the heart of that. Is everybody okay with moving forward? We've got a lot to go through today so I'm going to drive fast here unless there are objections and feel free to just stop me like you're doing, but otherwise I'm going to push us forward.

So, if we can go to the next one, number three, which was establishing provider relationships. So, the idea there was that there were multiple providers, that's what I tried to use in the example I gave, and that was it rationale to put this as a high priority function?

R. Hal Baker, MD – Vice President & Chief Medical Officer – WellSpan Health

Is this the medical neighborhood?

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

This is under care coordination on the next slide.

R. Hal Baker, MD – Vice President & Chief Medical Officer – WellSpan Health

No, but I mean, is that essentially what this provider relationship is?

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

Yes.

R. Hal Baker, MD – Vice President & Chief Medical Officer – WellSpan Health

It's a medical neighborhood of all the providers around the home?

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

Yes, all those that would be touching the patient. So, if you kind of look at the detail they mention the various types of service providers, the ancillaries in multiple settings and facilities. Obviously, this is much more less about the payment, to go to where somebody's point was before, and more about the care and the coordination and the lack of duplication and the appropriate communication as it actually allows for the care coordination that we're all sort of trying to get to.

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

Shaun Alfreds from HealthInfoNet, I think this is a very high priority, because without having the established provider relationships and electronic messaging between them then there is no coordination of care, informed coordination of care using the data from each site.

R. Hal Baker, MD – Vice President & Chief Medical Officer – WellSpan Health

Hal Baker, I would agree with Shaun, especially if the NHIN Direct can take off and we actually have a method of knowing who to communicate to and being able to do it very easily.

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

So, there's an interesting pattern as we go down the list. So, we sort of started with insurance coverage and payer relationships and now we're looking at providers and I think as we go down the list further you'll see it gets more into settings and transitions, and management. So, there is some logic to it, which may help us understand how to prioritize these. If we went to number four next is everybody okay with that?

W

Yes.

M

Yes.

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

And it's about sharing data during transitions of care.

M

Are we looking to...oh, sorry, are we looking to prioritize these or just agree that they're all important? Because, I mean, in terms of priority I would place this very high.

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

Well, I think that was sort of the...what I believe I heard the questions were to be was, are these the right functions or are there gaps and how do you prioritize them and then we're hoping to circle back around to the market, so, you know, we might just go quickly through the rest of them, five was identify best settings for care, six was identify community and social supports, seven was referral management, eight was patient centric medication management and nine was clinical information reconciliation. So, back to the glidepath concepts I think we were trying to see are these the right functions, is something missing and how do you prioritize them?

Judy Rich, RN – Chief Executive Officer – Tucson Medical Center

This is Judy Rich from Tucson, I had the same question that was just asked, which is, are you trying to force a ranking here, because everything is a high priority or are you trying to force some kind of ranking? Because, I think our perspectives are different depending on...

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

Is there anybody here who thinks any of these things are not high priority or there are things...my personal perspective is if you start with the patient care and the coordination some of the other things like the financial, which are important because of the financial capabilities and necessity for accountability are important, but that may be a place to prioritize first, but other people may say that's not the case.

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

Yeah, this is Alex I'll just add, you know, the concept in that second question about trying to get to, you know, those essential baseline kinds of functions so thinking if this is kind of what CCHIT has done as sort of comprehensive trying to get at a whole landscape of functions, you know, to the degree that we can really think about what those things that any accountable care arrangement would need to accelerate success I think that was the distinction that we were going for a little bit.

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

Yes, is there anything missing? If we sort of look at these things comprehensively...one of the reasons I was sort of going through them one by one is because we don't quite have them all listed up there at the same time. So, I just sort of read them out because I've got them in front of me, but what's missing within the concept of these care coordination functions that we need to be thinking about from an IT stand-point?

R. Hal Baker, MD – Vice President & Chief Medical Officer – WellSpan Health

I would offer...Hal Baker again, I would offer that going from four from sharing data to clinical information reconciliation is tremendously difficult and we can get into a situation where we are data rich but information poor and essentially it becomes an unsortable mass of data missing might be some sort of natural language processing indexing that some of the vendors out there have developed a Google-like function to be able to get the core information using semantic ontology to get concepts.

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

This is Charles; I would agree that's a very important step forward. I'd be interested in the thinking of the group as to whether that area is mature enough for us to put a specific requirement in it or is it something we have to be guarded in terms of whether the solutions are mature and proven yet.

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

Shaun Alfreds from HealthInfoNet, I think the answer to that question is dependent upon the standards by which we're facilitating health information exchange between providers. If we're using concepts like the conduit of care document or the CDA architecture then I think that clinical information reconciliation is of critical importance because if that data is going to be used it needs to be reconciled. If we're using more of a discrete information exchange architecture like HL7 then I think the answer would be different.

R. Hal Baker, MD – Vice President & Chief Medical Officer – WellSpan Health

I would offer...Hal, again, Cerner has a chart search function that they've provided that really is pretty effective when you've got 10 years of data.

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

So, based upon that let me start trying to summarize here. I didn't hear that there were any of these functions that anybody thought was of lower priority, they all thought they were pretty important, but the integration of them in a way that you're able to prioritize it that you don't get information overload is important, doing that from a capacity of certain tools that are already on the market and that are allowing us to look at things from a coordinated stand-point maybe the way to go with that and the next question would follow, from my stand-point, would be where is the market in providing these things, is it there? Are these market solutions? Is there policy that could be put in place to get us where we need to be?

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

I would probably...this is Sam VanNorman from Park Nicollet, I think a lot of this, you know, is classified as maturing but not yet mature and I think that the market is trying to address this but interoperability continues to be the biggest bugaboo there.

Judy Rich, RN – Chief Executive Officer – Tucson Medical Center

I would agree, Judy.

W

As would I.

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

Are there policy issues, policy stances that could help that or is it simply something waiting for the market to figure it out for themselves?

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

I think policy could accelerate that or even some firm statements of, you know, you don't figure it out in the next time period we will come in and figure it out.

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

What would the policy look like that would help it?

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

I think...this is Charles, I think calling it out as either a requirement or maybe something short of a requirement could be meaningful to the points that were just previously made in terms of communicating to the vendor community that that semantic interoperability, clinical data interoperability in general is just critical to the success of getting value from HIT overall and specifically in the ACO market, so I think putting it on there and understanding maybe making it an optional requirement or a menu requirement but in some way indicating its importance I would agree is pretty valuable.

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

And I think just building upon that, Shaun Alfreds from Maine; I think it's important to make sure that that description of requirement is very granular describing interoperability. Many of our vendors have looked at these policies and taking them as written instead of looking at interoperability as being both the sending and the integration in digesting of information. So, I think, a policy should address both the standards for messaging, the standards for data collection as well as the standards for data incorporation within a patient's record.

R. Hal Baker, MD – Vice President & Chief Medical Officer – WellSpan Health

Hal Baker, policy's greatest advantage is where it can force technology to happen where the technology is the critical missing link to something that's already teed up to work because there is social and operational pressures that make people desirous of it, sometimes we can build these things and then nobody would use them and I think that's an important prioritization point that has to be estimated.

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

In the example of the railroads in the 19th Century and government policy once everybody had the right width of what the rails were going to look like then the trains could run and there was a need for the train, so I think what you're saying is there would be a need for a train and the standardization would have to do with how you actually created integration in a way that made things run seamlessly back and forth if you basically see this as being a railroad for information exchange otherwise. So, policy, from that stand-point looks like would go towards standardization then of a lot of these things in terms of the ability to exchange information, would that be a fair statement?

W

Yes.

R. Hal Baker, MD – Vice President & Chief Medical Officer – WellSpan Health

Yes.

M

Yes.

M

Yes.

R. Hal Baker, MD – Vice President & Chief Medical Officer – WellSpan Health

The railroad analogy is very nice.

W

Yeah, one of the things to take into consideration is whether or not...and maybe this is a little premature, we can get to this at the right point, but if there would be a requirement that would be expressed in some kind of optional certification that there be a way for the vendors to do more than sort of attest to the fact that they can do that, that there would have to be some kind of compliance testing to actually demonstrate the technical ability to not only send and receive but to actually make the data computable within other systems.

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

Well that's the Holy Grail I think we've all been looking for even early on with the EHR, the interoperability has been just a...it's been one of the real snags with healthcare coordination. The second half of this meeting we were going to turn over to Karen Bell who will take what we've been doing with the discussion here about care coordination and look at it as it relates to cohort management functions, which for my mind is sort of registry and otherwise gets at some of the real...not so much the individual patient like I was describing but the population of patients, so it's a different approach to the wider population as opposed to individual patients.

Before I turn it over to Karen, because I think what I'm hearing from everybody is that it's all important, it was pretty comprehensive, the market can only go so far and standards can be the policy that could help do this thing, I want to make sure that we're not missing anything else. Everybody ready to move?

M

Yes.

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

Okay, Karen it's all yours.

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

Okay, I'll jump right in then over here. I think you're absolutely right, Grace, of the 7 key processes that exist in the framework cohort management is probably where the rubber hits the road from a clinician's point-of-view because it really focuses on how one would take care of patients in this kind of an environment, in an accountable care environment rather than the traditional face-to-face encounter where that is the only moment of care.

Before we jump into the cohort management though I just wanted to remind you that on page 16 of the full framework is really I think a robust definition of how we approach this and maybe you might want to keep this in mind as we go through this particular section of the presentation.

Cohort management really is an assessment of the entire risk-based population in order to identify the specific cohort on which the organization will choose to function and that recognizes that many of the Medicare ACOs whether there are Medicare shared savings or pioneer ACOs also have alternative payment contracts with commercial payers, many of the MSS participants have patient centered medical home contracts and some of the pioneer ACOs actually have some capitated arrangements.

So, the risk population generally covers several payers in many situations, not all, but many. So, when we developed this cohort management piece we did it with that in mind. So, as we think about cohort management and we'll get into the details a little bit more, I think a good place to start is just the way we started with the care coordination piece.

We identified these 9 functions as critical to cohort management and before we go into the details of the HIT...go back, thanks, before we go into the details of the HIT that could support them and what kinds of recommendations could come forth I thought it would be helpful to just look at these larger groups in and of themselves and make sure that again, everyone agrees that they are important and if we are missing something to have the opportunity to pull it out here.

So, I think that, you know, the part about identifying your patients is pretty self-explanatory. The second one, the monitoring the individual patients, and I'm just going to go through all of them first and then go back and see what you all think really is about those registry functions knowing that not all of the ONC certified EHR systems have the kinds of registry functions that will be outlined here and while that is perfectly okay the ACO itself will need to find some way to include them.

Clinical decision support we felt is important; we'll talk a little bit more about that later. The patient engagement piece here, I just wanted to underscore that we also have a key process of patient engagement that's much more robust than the patient engagement that's defined here under cohort management, so not to get confused and there will be some overlap between the two. In terms of engaging the preferred providers and clinicians that's to make sure that the right team is together that's not only clinically appropriate but meets the patient's preferences for cultural sensitivity and that all of these providers are aligned with a team-based case or the principles of the ACO.

The shared care management plan is pretty self-explanatory as are interventions but I do want to point out here that these interventions go beyond those of evidence-based medicine and include the kinds of things that would be important in terms of diagnosing and treating patients not just assuring that the EBM is addressed.

And then follow-up, and we'll get more into this later, isn't just follow-up on the things that have been ordered in making sure you get the results, but if someone doesn't follow through with what's been ordered want to make sure that the ordering clinician whether it's a medication, a referral or a radiological exam is informed that that doesn't occur so that the physician can follow-up and the patient isn't left hanging and the physician isn't left hanging.

And then ultimately, when we monitor the cohort we'll talk a little bit more about that as well, but it's not just monitoring in terms of quality it's going to be monitoring in patient's identified outcomes as well and clearly around cost.

So, those are the 9 and I'm going to stop for a moment and see what you all think about that list, is it appropriate, did we miss something, is there something there that you think maybe doesn't belong?

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

I just want to note, you know, if folks want to look at the more detailed ones we can move to those subsequent slides if we want to zero in on one or two of them.

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

Yes, I thought we would go through those after we just started the big overview.

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

Yeah, yeah, yeah no problem, just wanted to...

R. Hal Baker, MD – Vice President & Chief Medical Officer – WellSpan Health

Hal Baker again, I'm concerned about follow-up when it comes to laboratory orders if every lipid profile or hemoglobin A1c that every provider writes to be done 6, 9 months in advance has to be tracked, there is just so much duplicate ordering that goes on from different providers co-managing a condition that could be dramatically complex.

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

So, if we were...so, if we keep that in mind, that's a good point, Hal, if we keep that in mind there may be ways that that can be mitigated as we work this through. So, I'm going...yeah, I've just written this down as an important point to come back to and we'll see if that can be mitigated with some of the deeper analysis over here. Can we go down to the next slide please then?

In the same way that Grace had a particular patient we have a patient over here, this is one that's a little bit more complicated and this is a situation where the medical director is very concerned about cost, he notes that re-admissions are going to be a key cost driver in this particular population as are admissions in general and will want to be able to identify a cohort to be managed with respect to decreasing hospitalizations. So, please bear that in mind as we go through and I think the next slide is another view of the HIT glidepath is that right?

It is, which gives me the opportunity to point out two things, number one, there is a glidepath here an organization that is only taking on upside risk, maybe only a little bit of it will have a very different set of needs that an organization taking on a lot of upside risks or downside risk.

So, managing cost for instance is going to be important across the board but clearly much more important than the transitioning in the transformed environment where there is downside risk. Upside risk alone may not be quite as critical, which was one of the reasons that there is a difference in some of the things that were recommended on the bottom half of this slide.

I do want to take the opportunity to also point out that in addition to having ONC certified technology for 2014 I want to again underscore and I apologize if I sound a bit like a hammer pounding a nail on this, but we had primary HIT requirements that are absolutely based on which all of this builds and the two that I think we agreed upon last time that were most important were health information exchange and the need for data integration. And that data integration really is not just clinical information that's integrating but being able to integrate that with financial, claims-based information, patient derived information and operations information as well.

So, keeping that in mind, you've got a lot on your mind here, I think it's time to maybe dive into some of the specifics here so we get a sense of where the market really fits or what the market has to offer here and perhaps where the federal government can help in terms of policy or other support. So, could we move to the next slide?

We talked already about identifying desired cohorts and here I would like to just start a discussion going on what is absolutely critical here. We felt that no matter what level the ACO...of risk the ACO was taking on at least four things here were going to be critical and that was the ability to ID patients by demographic information, diagnosis, medications, etcetera, to generate those patient lists, to populate the monitoring technology or the registry function and then to add the newly eligible patients.

If downside risk or if there was a lot of concern about the risk then some of these others would then come to the floor. The very first one was the ability to extract data from the multiple sources particularly from an all payer claims database where one could or the ACO could really get a feel for the total cost of care and identify patients that might ultimately be brought forth through predictive modeling algorithms which as you can see is the 4th item down there and obviously the data would be integrated.

So, I do know that not all of this is available to all ACOs, the market is not there for everyone and not every state has all payer databases for instance, but I'd like to open up a little discussion here about whether or not what is in the market right now is sufficient to truly identify the desired cohort that the ACOs might be needing or whether there is something here that can be...drive the policy or technology use to enhance this particular function.

R. Hal Baker, MD – Vice President & Chief Medical Officer – WellSpan Health

Hal, again, as we've done cohort management it's been much more effective when we've driven it out of clinical data rather than administrative billing data because of the chain of custody to the work area where the provider is working and the finite number of codes that can be used in billing compared to what a complex patient may actually have. I realize right now we're probably constrained many times, but I think there will be an increasing tension in favor of the clinical data.

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

Yes, so from the perspective of the group is it fair to say that right now things are working well in this arena and there would be no need to really think forward more about all of the technology to really support patient identification.

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

It's Shaun from Maine, I don't necessarily agree that all the technology is there today to support this kind of integration, I think the conversation we had around care coordination follows through here in regard to the lack of standards used to support both the discrete and the analytics necessary to support cohort and population management but also as you just mentioned, Karen, that determination of a common identifier across multiple disparate systems, that's a very complex process, we've got multiple health information exchanges out there nationally that are doing this and some EMR vendors are doing this now.

We see system level organizations building enterprise master person indices, but without the use of discrete data, even on the demographic side, such as ADT, we won't be able to do that identification for population health purposes.

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

I would agree with that, this is Joe from Atrius and also the issue with looking at just either clinical or administrative data, at least is, so we get our claims data and then identifying patients who actually haven't seen us yet that are utilizing systems outside of ours in terms of emergency or hospital, we only see that in claims and so we wouldn't actually identify them in our internal algorithms if we use just our EMR data.

So, I do see a gap in the sense we see cohort identification algorithms on either administrative and/or clinical data, but we find more and more in order to be truly population centric we need to integrate those two and I don't see as many people trying to do that as effectively.

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

So, maybe what I'll do is we'll take away from this discussion that one of the things, and these are all possibilities we're just talking about right now, is to pursue a possible recommendation in the particular area about integrating claims and clinical information and how that could be more useful for the ACO environment. Anything else on this list that anyone would like to comment on? Then maybe we could go to the next slide.

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

Karen, before you go to the next slide one other comment I had, this is Shaun Alfreds, the shared care management plan.

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

Yes?

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

I think this is one area that we have yet to realize nationally is a shared care management plan, we have situations where you've got multiple medical homes popping up all over the country, health homes and then the ACOs driving this as well on the patient centered medical home side, but yet what's happening, at least in our marketplace is that one patient may have 4 different care plans that are not shared and to date there is not a standard out there for a true care plan. There is a care summary record standard, but not a care plan record.

So, my recommendation here is that that is one of the policy recommendations that this group could provide is to explore a concrete standard for a shared care plan that goes across the continuity of care for the patient.

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

Oh, that's an excellent point, Shaun, I appreciate that and maybe we could have a little bit more discussion about that and someone who knows more about this than I do can talk about what HL7 is doing around this as we move forward unless someone would like to bring that up now. This is item 2.6 maybe we could just go to that right now. So, is anyone aware of the progress that HL7 is making around a functional model for a shared care plan at the moment?

Kelly Cronin, MS, MPH – Health Reform Coordinator – Office of the National Coordinator for Health Information Technology – Health & Human Services

Karen, this is Kelly, there is a Longitudinal Care Plan Workgroup under the Standards and Interoperability Framework and they've identified sort of an initial draft standard that they wanted to put through in HL7 ballot and I think it's going to happen over the next several months. So, that's some preliminary work. It is based on one of the CMS care plans that's used more commonly in long-term care settings.

I think there is, you know, a lot of sort of work that needs to be done to think about sort of a wiki-like care plan that could work in a variety of settings, you know, with a virtual care team. So, we could have another conversation about that since it's sort of a different...there are a lot of considerations that we probably don't want to get into today.

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

Well, that's a very good point, but we'll take this 2.6 as an area that we'll have further discussion on and as I look at some of the things that we had included here in the list of capabilities it does include patient directed goals and I don't know the degree to which that's included and information on MOLST, the medical orders for life-sustaining treatment. There is a lot here that we might want to bring to the floor. So, thank you for bringing that up Shaun, thank you Kelly for your response and maybe we should go back now to 2.2, the slide starts at 2.2.

And this is where we are talking about the true registry function in terms of monitoring the individual patient and the individual care plan shows up here as well in the definition and that it does need to be individualized with respect to outcomes and maybe there is an opportunity here again, and I'm just going to throw this out there, because all of you can read the 5 possibilities underneath here, is there some way that we could make some recommendations on how to capture outcome data whether it's functional from some form of the SF-36 or some of the other tools that are out there, would that be something that's important in terms of this environment. So, I'll start with that question. And then I ask anyone else to comment on the 5 pieces underneath it. Really talking about patient derived information in terms of their outcomes.

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

Shaun Alfreds from Maine again, I think this is an important area there doesn't seem to be a lot of maturity in the marketplace for patient derived data but yet what we're seeing is a strong interest in our ACO marketplace to look at patient derived data as another outcomes, as a critical outcomes measure.

We have a physician group here whose CEO is always talking about how the outcome measured by the clinical outcome and the clinical data for example for a prostatectomy can be great but do we really know if the patient is satisfied at home, are they really reporting that information and that's something that has come loud and clear to all of the ACO Workgroups that we have happening here in the State of Maine and I think there are a lot of options on the table for getting that patient derived data to date within the policies of Meaningful Use.

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

Thank you, Shaun. Would the rest of the group agree that this is something we might want to think about in terms of possible recommendations down the line?

R. Hal Baker, MD – Vice President & Chief Medical Officer – WellSpan Health

I just wonder...Hal, again, I wonder if we're ready, we're just pushing on patient access to information and this and the prior discussion about goals are both talking about patient's entering information into the record and care plan stating how they're doing, stating what's important to them that's a big cultural barrier of control that I hope we will let go of quickly but I'm not sure how quickly the industry is ready to embrace it.

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

It's Grace Terrell, to your point, an interim step in that might be some of these home point of service labs everything from hemoglobin A1c and fingersticks to pro-time levels and/or the weights, the daily weights that are there on some of the monitoring equipment such as the electronic scales. It may be an industry mover because it's not subjective about patient experience, which is what we're actually talking about here, but it's really the interaction of patients with objective data in a place that's not a usual setting.

So, I don't know if it's helpful to bring that up, but I suspect that if we get to where we're talking about with monitoring individual patients we will likely start, as we usually do, with discrete data that is something that is measurable.

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

But again, there could be a computer office validated format or survey that can be made available on a national basis for patients to fill out and then send to...via health information exchange or directly to a provider with that specific data within it that can then be incorporated if they choose.

So, let's move onto clinical decision support, I think we've spent a lot of time on this, there is a lot of clinical decision support in current systems, I'm not sure that there is anything much to add to it at this point. Any comments there?

I would just add that in terms of the capability of prompts and alerts going to health plans as appropriate, again this depends on the relationship between the health plan involved and the provider group. These aren't clear as to who is going to do what, but if the provider group chooses to send or have a health plan perform a particular function on behalf of its patients then that just has to be clear and the ability to share that information with the plan would be there.

So, let's move onto the next slide which is 2.4, patient engagement and again, as I said before, this is a subset of the larger key process of patient engagement and the...I think the piece here that I wanted to just spend a moment on is the on-line availability of shared decision making tools and information. This is fairly new. Remote monitoring devices or programs are beginning to mature in the market and some ACOs are including them, but the actual inclusion of shared decision making tools and information may be not be quite as robust yet.

So, I'm wondering what folks are thinking about some of the things here that are more aspirational? When it comes to the particular patient we were thinking about and it's obviously someone with multiple problems who at some point may be looking at a joint replacement, might be looking at a prostatectomy, actually it was a woman, but a prostatectomy or something of that nature, so there are programs out there that essentially help patients through that decision making process about whether or not the surgery is specifically appropriate to them.

R. Hal Baker, MD – Vice President & Chief Medical Officer – WellSpan Health

The data...Hal here again, the data I've seen in most of these circumstances is that decision support tools drive patients toward lower utilization of highly expensive or invasive procedures. So, as an ACO I would think there could be tremendous market interest in that. I wonder whether it needs to be externally required. I think as we get into this people will be less likely to do dialysis, less likely to do a prostatectomy versus watchful waiting if we give them that education. So, it will be a market forces.

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

Yes.

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

Grace Terrell here, you know, if you think about it from a patient's perspective the very first thing that happened when the Internet occurred as a phenomenon was the hunger they had for information about all sorts of things related to their healthcare and we all remember when they came in with the sheets of paper where they printed off things from the Internet from all sorts of resources.

So, even though you framed this appropriately, Karen, within the context of linking it back to the provider as being new or not there yet I'm not sure that from a patient's perspective that it hasn't been part of what they've been craving all along and tried to create on their own or explore on their own.

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

Yeah, I was thinking more from the technology point-of-view, all of these little blue lines in the HIT capabilities and I'm not sure that the technology is there embedded in our HIT systems right now to make this readily available, but maybe it is.

R. Hal Baker, MD – Vice President & Chief Medical Officer – WellSpan Health

...certification...

M

This is...sorry, go ahead.

R. Hal Baker, MD – Vice President & Chief Medical Officer – WellSpan Health

I was just going to say, some certification of the objectivity would be of greater interest to me than a technical certification that the presentation is not biased and gives a neutral presentation to the patient.

M

I think another area that could be fairly valuable is aligning...is helping patients engage the healthcare system itself in support of leakage management for ACOs and there could be some, you know, capabilities we might want to signal there as to helping ACOs manage the leakage challenge.

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

That's an interesting point because that gets back to the fact that you have to know where the leakage is. So, either if you're not providing the care itself you need to know that it is being provided which gets us back to relationships with payers or access to an all payer claims database. So, interesting point too.

M

Well and you may not need to know where the care is actually occurring, you can actually just simply provide a service, one of your ACO members needs access to care and there are at least a couple of companies that are out there that are saying "I'm going to find a way to engage that patient at the moment they're making that decision so that I channel them" and some of those programs do that even without any kind of access to claims data to understand how frequently those patients are doing that.

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

Okay, thank you for clarifying, good point.

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

And Shaun from Maine again, this is one of the business models for health information exchange isn't it? As an exchange one of the reasons why ACOs are purchasing our services is because we provide access for that ACO for their ACO covered patients is as they leak out of the system, and not only do we provide access to all that clinical data but we also provide real-time alerts when their patients show up at another unaffiliated emergency room or inpatient setting. So, when we think about recommendations in the policy levers here and we think about the impact on health information exchanges this is one of the business models.

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

That's an excellent point, thank you very much for bringing that up Shaun. I don't know that all HIEs are doing that but it's nice to know that it's happening there. Okay, so let me move right along here. We're down to engaging the preferred providers and clinicians, and as I said before, this is to make sure that we have the right team in place and that it's done through formal agreements, and that not only can the providers be engaged in the team but the patients and their authorized care team be there as well.

And when we talk about escalation paths it means if you can't get a hold of the immediate care giver then who do you call next? So, it's really a way of assuring that everyone who you want to have engaged is engaged, is with the program and can be reached if necessary and will participate as appropriate. So, maybe we could go onto the next slide? Well, actually I'm going to skip 2.6 we've done that and go to 2.7 which are the interventions.

And again, this is important from the perspective that it's not just the interventions that are part of the EBM but also assuring that all of the right diagnostic and treatment care is included. So, in addition to the CPOE, which I know is part of ONC certification I want to make sure that whenever the CDS is available is appropriately sensitive and specific, and focused on a particular patient, patient centric. Here we also have links to programs such as ACPs Program or some of the other more proprietary programs that provide information at the point of care such as up-to-date and here we also talk about incorporating the shared decisions if those become available in capturing patient consent for a lot of the interventions that come through.

And there is one thing that is at the bottom of the list here that I know some programs do or some ACOs can do and that's schedule care on behalf of the patient, you don't let them out the door until you've scheduled the referral or scheduled the particular radiological test or lab test that they need to have done. So, is this a reasonable set of HIT capabilities for cohort management under the interventions category? And please don't be afraid to say "no."

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

Hi this is Joe, I have just a quick question on this, because this to me dovetails with the patient engagement where whenever we're doing population management and trying to do interventions a lot of times it butts up directly against sort of is the patient engaged ready to do these things that we're recommending.

So, is there some aspect of this that links, it's not articulated specifically here, but that element of looking at an entire cohort and there is 10% of your population from the delivery provider side we would love to have them go ahead and do their A1c and that's on our side, but we all know that doesn't happen to everyone that we outreach to etcetera and that back and forth there is a lot of churn and a lot of activity and effort in that back and forth. So, is there a role anywhere...I guess this is kind of question, is there a role of somehow matching those interventions with engagement sort of assessments?

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

Well, I have to think a little bit about...yeah, so I think that's a very good point and how can we think about a recommendation around either the HIT or policy that could make that happen better. So, let's star that one as one to think about and come back to it as we think about our list of developing recommendations down the line.

Okay, now if we go to 2.8 and hang on there we're almost done, this is where the point that was brought up earlier, I think by you Hal, about the concern of follow-up and what happens when you have everybody trying to order something at the same time might be addressed. While we certainly want to know that all the results are in and that they haven't been acted on want to be able to do something about that, there needs to be some way of assuring that everyone is looking at this comprehensively.

So, if we were to move forward with some recommendations on this or even to say that this is acceptable the way it is I would suggest that it be within the context of everything else that's being done around cohort management, around the shared care plan, around authorized access to the registry so everyone is using the same basis and we don't run into problems with multiple testing or multiple tests for a particular measurement.

R. Hal Baker, MD – Vice President & Chief Medical Officer – WellSpan Health

Hal, again, the patient centered medical home requires us, for one of the scoring levels, to track every individual lab result, but frequently an endocrinologist and a primary care physician and maybe even some other specialist might order the same test, it's important that the patient get the test done but it's not important that each particular order be completed and the way these are written often it's about tracking each order.

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

Okay.

R. Hal Baker, MD – Vice President & Chief Medical Officer – WellSpan Health

Rather than what the order was intended to have accomplished is accomplished.

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

All right, so I was thinking of it from the point-of-view that if everyone is working from the same registry or everyone is working from the same care plan, shared care plan and you don't have multiple orders being written, but that's not the real world, so we'll need to be very...you know, we may need to make some changes to this to make sure that that accommodates the real world. So, that's very helpful.

R. Hal Baker, MD – Vice President & Chief Medical Officer – WellSpan Health

And with ambulatory duplicate order checking and I don't how you do that across multiple EHRs.

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

Yeah, okay, another one of my little stars that we'll think a little bit more about, because we do need to get through this and then have some public comment time. I think we have one more slide, is that right? Yeah, this is monitoring the whole cohort. This was to ascertain that the overall quality measures were on track, but as I said earlier, this isn't just monitoring for the standard quality measures, this is really about some tracking outcome measures as well, so this is where we would need some standardized form or format to look at the functions or goals, or something of that nature in some way to look at total cost of care so that if you are managing a particular cohort, a particular way and you have implemented some very specific programmatic elements you'll want to know whether in fact you are meeting your financial targets. So, there is going to be need for being able to access total cost of care information on this as well.

So, I just want to make sure everybody would agree with that stance that is taken? Well, I guess if there are no further comments I think Charles that we've come away with a little bit more than a handful of possible recommendations to explore once we get to the recommendation phase, but I think we have pretty much covered the entire cohort management section and a lot of the HIT capabilities in it and want to thank everybody for their input and we'll go back to the drawing board and think through a little bit more about these possible recommendations. So, Charles, I guess it goes back to you.

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

Okay, great, well, thank you Karen and first of all I want to add my thanks to everyone who participated on this phone call, I thought the discussion was very rich and we and the Chairs of the Workgroup, I know I speak for Grace as well, we really appreciate all the thoughtful comments that we received. Let me turn it back over to the ONC leaders for the public comment section and then we can wrap up the call and we'll look forward to speaking with many of you at the next Workgroup meeting.

Public Comment

Michelle Consolazio – Office of the National Coordinator for Health Information Technology

Operator, can you please open the lines for public comment?

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 comment at this time.

Michelle Consolazio – Office of the National Coordinator for Health Information Technology

Thank you everyone.

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

Thank you.

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

Thanks, everyone.

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

Thank you all.

M

Thanks a lot.

W

Have a cool weekend.

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

Bye-bye.