

**HIT Policy Committee
Accountable Care Workgroup
Transcript
November 1, 2013**

Presentation

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

Thank you, good afternoon everyone, 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, please state your name before speaking as this meeting is being transcribed and recorded. I'll now take roll. Charles Kennedy?

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

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

Grace Terrell?

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

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

Shaun Alfreds?

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

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

Hal Baker?

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

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

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

Scott Gottlieb? Heather Jelonek?

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

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

David Kendrick? Joe Kimura?

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

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

Irene Koch?

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

Here.

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

Eun-Shim Nahm? Frank Ross? Cary Sennett? Bill Spooner? Sam VanNorman? Westley Clark? Akaki Lekiachvili? I'm sorry I always butcher that name. Mai Pham? John Pilotte? And 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

Hi Alex.

Kim Wilson – Health Communications Specialist – Centers for Disease Control and Prevention

Kim.

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

Hi Kim.

Kim Wilson – Health Communications Specialist – Centers for Disease Control and Prevention

Hi.

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

With that I'll turn it back to you Charles.

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

Very good, well, good afternoon everyone and thank you for making time on this lovely Friday afternoon. If we could go to the next slide for those of you who are on the WebEx, but this will largely be a conversation surrounding a hearing we would like to have on the intersection of Health IT and Accountable Care.

Specifically in this hearing what we are looking to do is to bring together a group of national experts, people who are not just perhaps academically expert but people really who have real world experience in using and being a part of an ACO and in trying to use health information technology within the ACO construct.

Now, you know, given that this is all fairly new we thought we would, you know, spend a fair amount of time trying to figure out who would be really strong panelists for the day. So, the purpose of this meeting is really to attempt to tap into the expertise on this phone call regarding how we should structure the hearing, what the panel topics might be, maybe some suggestions for people who could bring the kind of real world expertise that we're looking for and then talk a little bit about questions that we might ask of the witnesses. So, that's our objective for today. Before we dive right into it is there any question from the panel as to the intent of the hearing or our initial thoughts around structure? Okay, so let's go to the next slide where we'll talk through proposed hearing objectives.

And on this slide we thought to make this hearing productive there are several things we thought would be very important, first what are the priority of needs for health information technology and again we're defining that somewhat broadly. For organizations and individuals who are currently in an Accountable Care arrangement and most importantly what can the federal government do from a policy perspective in helping them be more successful through the application of Health IT in the participation of the an ACO arrangement?

The second objective would be to understand from them what are they doing that is working, what are they doing that is innovative and to the extent we can find things that are innovative and effective what might we be able to do from a policy perspective that could promote the spread, the dissemination and the replicability of those innovations and those successes?

The third topic we thought we would pursue would be to learn from them whether a certification program, perhaps broadly defined that might include EHRs but might go well beyond EHRs, maybe claim oriented applications, maybe registries other things, but Health IT technology defined broadly would certification provide any role that would be of value in helping to support and operationalize care management strategies that enable a population health type of approach. Certainly things like interoperability would be important but also other things such as usability, etcetera would be I think probably pretty important in getting that direct input from again people with real world experience might be valuable.

And then finally, a discussion around the MSSP Program really, and I would probably define it more broadly than that, maybe, you know, bundled payments and other strategies, but how could we help the MSSP Program or leverage the MSSP Program in helping to evolve Health IT so that it can be as effective and supportive of ACOs and population-based care management strategies as they can be.

So, with that I thought we might pause and ask this group, maybe I can open the floor up for discussion around are these the right objectives, what other thoughts come to mind, are we too broad, are we too narrow? And just open the floor for discussion.

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

Well, this is Karen; I'll jump in maybe to start the ball rolling over here. First off I think this is a great idea I'm so glad we're moving forward with this kind of an approach so we can begin to get input. I do talk a lot about the framework that we have, I've talked a lot about the fact that there is an ACO Workgroup that's moving forward with recommendations and really have tried to get people to think about what it is that they need and actually I have a number of delivery systems that would like to be able to participate so we'll talk a little bit more about that later.

One thing I would like to just – I would just wonder a little bit about is are we going to be asking these questions essentially de novo? Are we going to be giving them some background regarding the work we've already done? There was a list of discussions, recommendations, they weren't really recommendations but concepts that we discussed in mid October I think it was about possible – moving onto possible recommendations. Will we be giving them anything like that to build on or was the idea to basically start with a clean slate?

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

I think we haven't specifically – the CMS team might want to weigh in but I don't think we've specifically decided on that. I think we would certainly share, you know, some of the Workgroup materials that we have completed to date but I think the emphasis would be on getting, you know, real world, for lack of a better word, raw input into our process.

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

Yeah.

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

Okay.

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

Karen, this is Alex, I would agree with that. I mean, I think we'll definitely share what the group has done so far and I think, you know, the key place that we want to be building off all the discussions that the group has had to date are in those questions that we're talking about putting forward to the witnesses.

So, you know, we've tried to reflect some of those discussions in the questions so far, but definitely want to make sure that, you know, any of the group discussions so far that we want in there are accurately reflected so that we're getting a broader, you know, set of commentary on those.

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

Okay, because I think that, you know, the proposed objectives certainly make a huge amount of sense and like the way they've been set up and as I say I'm delighted that we're moving in this direction.

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

Charles, hi, this is Joe Kimura, can you hear me?

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

Yes, Joe?

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

Yeah, so one of the things, thoughts that come mind is as part of the Pioneer in the very beginning of that we did try to do a little bit of exploratory conversations with all the 32 Pioneers to get a sense of infrastructure, strategies and what we were doing around accountable care and one of the things that ended up happening was the people in the ACOs who really knew operationally what was going on and sort of cutting edge stuff around care, case management, population management weren't always the ones who knew a lot about the IT infrastructure and vice versa.

So, we would have these siloed conversations where you would have some very innovative ideas of what people really wanted to do but they had no idea whether EHRs were able to do it, what kinds of technologies, what were risk algorithms all these things on one side and then you had a whole series of very technical conversations on the other side where those individuals really didn't know much about case management, care management or the actual operational element. So did you envision balancing those two when we're trying to get a little bit of that and sort of the bridge between those two areas?

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

Well and that's – boy you described my daily life, that's a really good point and I think our initial thinking around that was to have a variety of perspectives available. You'll see later in the deck we talk about getting some representatives from the vendor community. I think in those circumstances we might weigh more heavily, you know, some of the technical expertise that you described.

And then we also talk about maybe getting some clinicians and some other individuals who might be more, you know, care management nurses, etcetera, who might be more from the functionality or programmatic side of the house and get both of those perspectives.

I think you raise an interesting question which is, you know, pretty much we struggle a lot as an industry I think bridging the perspectives of the two. I don't know if that's something we could bring out in this particular panel discussion but it certainly is a problem in the industry I've seen repeatedly.

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

Got it, thanks.

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

This is Karen Bell again, I think one other area that I didn't see on the list very much, but I think needs to be addressed is the fact that a lot of Medicaid Programs are moving into the ACO arena whether it's by law like Massachusetts or by strategic planning like Illinois, or through these CCOs like in Oregon it's happening, you know, coast-to-coast.

And safety net providers have some very specific challenges specifically around behavioral health integration, that's a huge piece that requires I think a lot more emphasis on how they can have access to behavioral health data, how they can use it and in multiple ways integrating behavioral health, particularly, as I say, for these Medicaid populations and all of the providers that are taking on Medicaid Accountable Care.

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

And this is Heather Jelonek with the John C. Lincoln Accountable Care Organization we're having that exact problem but with our Medicare patient population. We are unable to get complete medical histories because we are prohibited from receiving even the claims information as it relates to behavioral health, mental health and substance abuse and our ACO is actually struggling with this issue on a daily basis.

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

Great, that's very helpful. Behavioral health as well as making sure we have a breadth of perspectives from the various payer segments that are out there. I was wondering if I could ask for people's comments around something that we kind of talked about but left out of the objective and that is whether we should have any discussion around the financial component of being successful in an ACO.

Meaning, you know, as you develop population-based healthcare strategies as you begin to become more efficient on your use of institutional services or inpatient services in fact there are, I'm sure as all you know, revenue and financial complications from doing that and certainly the CFO or others within the hospital certainly have concern and look for technology solutions which might help them address some of those financial issues.

Is that something that the panel thinks – I'm just throwing it out there for discussion because we did exclude it at this point, but what are people's perspectives on whether we should perhaps extend the purview of the panel to financial implications and the technology in effect of that for this panel?

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

This is Hal Baker that's an absolutely critical issue and it's one we've had extremely explosive discussions about in our organization as we're transitioning from volume to value and what that will mean. As we talk about this it strikes me that this is all so relatively new and even places that inspire or seem ahead of where I see my own organization, when I talk to them seem to feel like they are just beginning to find their way in the wilderness here.

As we bring in a bunch of different people are we likely to see themes arise or is this just too immature a transition and we're still storming and we haven't started as a group norming yet? And will we have any themes arise?

ONC has a limited role here in setting policy around healthcare technology, HHS can set some policy. The more interesting question to me is where can they have an effect and, you know, where is legislation, policy and certification requirements an effective tool to prod us along in this transition? That to me is a much – is an intimidating question but a much more manageable question rather than financially how do you stay afloat as you transition from volume to value? The answer to that one just is – I'm not sure we can get it.

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

Hi, this is Frank Ross, Cumberland Center for Healthcare Innovation; can everybody hear me?

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

Yes.

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

Okay. We – I represent kind of a niche ACO because we are a rural primary care independent practice provider network and quite frankly what the gentleman just said in regard to what is the roadmap that we're going to transition from fee for service to fee for performance that's a question I get asked every single day and without any guidance whatsoever either from CMS or hopefully this committee can address those kind of things as well so CMS can at least see the urgency in it and quite honestly without that guidance our ability to recruit and bring people into the ACO is going to be very, very difficult to do.

Because we just finished a recruitment program over the last three months and quite honestly it was very difficult to get people even interested enough to sit down and talk to us let alone when they started asking questions about what the financial model was going to be, you know, we could talk to them about what the ACO, shared savings format was all about, but we had absolutely no answers for them in regard to, you know, beyond what the additional fee for service components of CMS has added for things like care coordination and wellness, but beyond that we have no answers. So, I think that's an extremely critical component of this discussion. It is not a technical discussion but it is definitely critical.

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

And Hal here again, if anybody has the answers boy I'd love to hear it even a safe roadmap through it. We equally talk about it all the time and we have the same hesitancy of practices that are poised to be partnering with us who are just terrified of letting go of the safety of what they know.

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

Hey, this is Shaun Alfreds from HealthInfoNet, last week we participated in a meeting hosted by the Office of the National Coordinator for Health IT called the Modular Architecture for HIE Ecosystem. The meeting was pulled together by Hunt Blair out of ONC as a strategic advisor to the coordinator but also involved the health information exchange staff and the Chief Scientist, Doug Fridsma from ONC, and specifically brought forward or brought together multiple health information exchange organizations, provider-based organizations, federal agencies to talk about what are the key policy needs that we have in accountable communities, in accountable care organizations that health information exchange can support and also that ONC should focus on.

And coming out of that meeting the minutes haven't been released yet but I think tying some of this back to the results of that meeting and specifically some of the agreed upon needs that were brought forward at that meeting might be very positive and just quickly to go over there were 4 key areas that were brought up at that meeting that are critical to achieving a better infrastructure to support data interchange that is needed for accountable care and for care coordination moving into an accountable payment system.

The four areas that came up during the meeting where number one, standards for data interoperability and specifically doing better on discrete data standards rather than document-based data standards such as the continuity of care document or the CDA which is now coming forward to replace continuity of care document.

One of the areas that came up as a key example there was ADT notifications or admission, discharge and transfer notification so that care management staff can know when their patients were admitted to an emergency room or an inpatient setting or discharged from a skilled nursing facility so that care management can be initialized, that kind of data liquidity is really what we found being very important and an important driver to perceive success of the multiple ACOs operating in the State of Maine.

The second area that was called on for focus was master person identification both at the patient and the provider level and enabling certification criteria within the EMRs to do better at that and specifically looking to some of the ONC efforts that have been funded and that are going on right now on identifying key criteria that EMRs need to collect on patients not only their name and address information but for example for persons that do not have the US as their country of origin what is their country of origin, what is their language?

The third area that was a primary focus was around care management and specifically standardized means by which care plans can be shared. There are care plans – what we've seen certainly in our community in the primary care as well as the specialty community, we have a care plan for patients that is static. So when a patient transitions to a different provider that care plan is a static care plan and so their new care plan is developed and we're not seeing a single care plan or an opportunity for a single care plan in the community which is detrimental to that patient's care.

And then the fourth area was again focused on the ability of the certification program to not preclude or not make for a financial burden on certainly the HIE industry in order for them to be able to achieve or assist in this interoperability.

The concept of HIE certification came up and that was perceived as almost detrimental or at least not perceived as being financially sustainable because you're seeing one HIE and you're seeing one HIE. So, I'll stop there but I think that is an important piece of work that could feed into this group and also give the perspective of multiple other folks that weren't participating in this meeting.

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

I will second the –

M

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

Hal Baker I would second the ADT thought, that was a great one.

M

Excellent.

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

All right, well with that I'm looking at the time, I think we – Alex I think we collected a lot of good input, maybe we should move onto the next slide?

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

Sure.

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

All right and in this slide we wanted to talk – have a little bit of a discussion around how we might structure the day and what we're thinking about is to have a series of panels, and again this would – you know, there were some comments about this earlier around how we could pull our various perspectives.

So, our initial thinking was to break it up into four panels, a clinician panel with the criteria being physicians who are participating in accountable care arrangements perhaps not very narrowly defined, you know, broadly defined in terms of value-based efforts.

A second panel around health systems that are participating in ACOs, a third pane around provider or physician led ACOs and then a last panel on the organizations which are enabling ACOs, those that are technology companies, maybe care management or other service providers who are presenting themselves as enablers of ACOs and have a set of panel discussions based on kind of who you are and where you stand within delivery of population-based care and ACOs.

Now, you know, there are some pros and cons to doing it that way, you know, we thought about mixing it up but just interested in the group's perspective on what you think the appropriate structure might be to get out the objective that we talked about on the previous slides?

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

This is Karen Bell, as you were looking at pros and cons one of the ways that this could have been set up as well and we can certainly work with this it's a very strong way of garnering information but another way of doing it could be looking at the type of accountable care arrangement and not necessarily focusing on clinicians but for instance if you have Medicare shared saving upside risk or patient centered medical homes you've got essentially the same kind of a basic infrastructure and we might want to hear from not just physicians but perhaps, again, maybe from some financial folks in that arena as well.

And then another level might be some of the groups that are doing upside risk and downside risk it's another type of the ACO and then obviously the last ones are the groups that are taking on substantial risk either through capitation or global payments that sort of thing sort of like the Pioneer ACOs.

So going back to the original question, did you consider doing it by kind of the level of risk that these groups have and then including more than just physicians or clinicians from each level and if so what were the disadvantages of that compared to any other way of doing it?

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

I didn't participate in all the calls so I'll defer to some of the CMS staff. I don't think we had, at least on the calls I was on, much discussion around doing it by, you know, level of risk, although there is certainly nothing wrong with approaching it that way.

We kind of came up with this as kind of the most, you know, the most obvious I think breakdown as just kind of where you sit within the institution but certainly, you know, risk and whether organizations who are assuming more risk might have different needs than organizations who might be only approaching it from a gain share perspective, you know, might offer some interesting perspectives as well. Other comments on that?

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

I would just share that the reason I thought of that is that, you know, when you read a lot of the literature whether it comes out in JAMA, New England Journal or Health Affairs usually the articles are around a particular type of risk like the patient centered medical home or the large organizations like yours Joe that take on significant financial risk and work in that venue and they seem to be very different in terms of how they function that's why I was sort of thinking that might be an alternative. But I'll defer to what my colleagues think as well.

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

This is Joe, so I think I hear that for sure in terms of level of risk, again I was seeing that and seeing – I was hearing it a little bit around also maturation of the – informatics of analytic infrastructure within the organization, because I think there is tremendous heterogeneity there, that seems to track with what sorts of risk organizations are going to take.

So, I guess I was sort of seeing it that way when you were saying that Karen around what level of risk is an organization willing to take on and is that reflective of the level of infrastructure and population management sort of for competency that an organization already has with them.

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

Yeah, yeah, I think we're tracking this on the same thought line.

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

Well, Karen, that also resonates with a bit because when we worked with delivery systems that are already like on the west coast have substantial and deep HMO capitation experience the path and the needs to get them to extend to an ACO and more of a PPO-based environment, you know, is pretty dramatically different than when we're starting with some of our east coast colleagues or others that have had less deep experience in the HMO capitation world. So, you know, I think that is an important distinction that you're making and something we should look at figuring out how to tease out of these panels.

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

Hi this is Frank Ross again, you know, I like the groupings the way there are the one, two, three, four that you have listed there and I guess I like it because quite honestly the whole – we talk about traditional models of risk but at the same time the ACO regardless of what flavor you are, whether you're at risk, two-sided, one-sided is an experiment in itself. They're still trying to figure out when to take risk and when not to take risk.

And, you know, I guess my ACO falls into the third category there the physician led organization private ACO and, you know, the way we look at risk is, you know, we're trying to minimize our downsides because of our advance payment funding and at the same time though we're trying to maximize shared savings, which I think everybody in the ACO world, the accountable care world right now is trying to do.

So, you know, the focus for risk has got to be toward how do you maximize shared savings and I'll just leave that comment for the rest of the group?

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

Hal Baker, the groups look good to me also. It seems a very reasonable way to break them apart.

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

Okay, very good.

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

This is Heather –

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

Well thanks for those comments. I'm sorry was there another comment?

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

I was just going to say, this is Heather Jelonek, I like the approach of looking at it by type of risk relationship or maturity within the ACO world as well.

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

Okay, well, very good, so we will take those comments and, you know, reflect the groups based on that input so that was very helpful. Let's spend the remainder of the discussion, if we could, on what is probably the most important piece which is what are we going to ask these people and what are we going to try to learn from them? And so if you go to the next slide please on the WebEx we have a series –

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

Charles this –

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

Yes?

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

I'm sorry, Charles, this is Karen, how are we going to recruit these people? Will we talk about that at the end or –

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

We will talk about that at the very end, I'm sorry.

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

Okay.

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

Yes, we will.

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

Thank you.

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

That is part of the agenda today, thanks. So, what will we ask these people and what are we seeking to learn and so if you look at the slide currently on the WebEx and for those of you who don't have access, we spent some time kind of going through some initial questions, so some of these, you know, are fairly obvious but we'd like you to take the time to read through them. I'll quickly just summarize for those who are not on line.

What are the Health IT capabilities that are most critical both from a cost as well as quality and a measurement perspective? What is your sense of the sophistication and success in adopting and using these tools in an ACO arrangement? Does the amount of risk impact the type of capabilities that you need? Are the current products meeting your needs and if not where are the gaps and what are the critical gaps in making an ACO successful? Innovations, what innovative products are you seeing out there?

And then lastly on – or question number five a discussion around to what degree population health management strategies are being used and kind of try to have a discussion around the linkage between the population health management strategy, the underlying cost and quality objective and then mapping that to the specific HIT capability that would support the functionality and the programmatic goals of the ACOs. So, those are kind of an initial five set of questions. Maybe I should just pick through all of them and if you all hear any gaps – so maybe we could go to the next slide.

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

I'll just – sorry, let me – this is Alex, just want to also remind people that you all have this in a Word document it's a little hard to kind of keep these all in your head going through the slides I know, but if folks are at their computer and want to open up that Word document you can see them, you know, all in one place.

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

Yeah and in fact, you know, there are quite a few here so let me just – I don't think it's an effective use of time for me to just read through them so why don't we on the WebEx show the next slide and just very quickly the key technology tools to strengthen information sharing across the continuum of care to integrate the care process, gaps in care and how physicians and patients might become aware of gaps in care and to what degree they've been used operationally, and how successful the technology is in identifying and closing gaps in care.

A discussion around claim data and how that might be used in a population health management strategy and then finally data integration, clinical and administrative data integration to create a truly comprehensive and longitudinal view of the patient, you know, what is the status of that and, you know, what might the government or the HIT industry do to try and improve performance there.

And then I think there is one more slide, a discussion around attribution methodologies which are commonly used in ACO arrangements, you know, strengths and weaknesses there. From a vendor perspective what are they doing, from a developmental perspective in developing and involving their tools to be successful in an ACO arrangement, some comments around the applicability of EHRs and probably HIEs as well in making ACOs successful.

And then finally, the Meaningful Use Program itself, perhaps some of the conversation around the Meaningful Use Stage 2 requirements and we might even delve into some of the discussion around the new deeming pathway that's being considered in Meaningful Use phase 3. So, that's kind of the corpora of knowledge that we're seeking to have an understanding of. I will throw the floor open for any gaps or any additions that people might see.

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

And I'll just make one more comment, so we sort of listed these questions in one place just to make it slightly more manageable but the processes that we will be creating customize lists of questions for each of the panels that then witnesses would be responding to. So, you know, these questions don't have to be one size fits all thinking about the different groupings we just talked about, you know, please think about questions that would be specifically for, you know, just certain types of panelists and we can include those in the customized list.

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

Yeah, this is Frank Ross again, maybe I missed something because I missed the first part of the intro that you guys did I had phone line problems, but there are additional questions on the document I got, was that addressed earlier? I've got 16 on my document.

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

Yeah, sorry, there is one more slide there.

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

Okay, sorry.

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

Oops, maybe we should flip to that on the WebEx?

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

Yes.

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

Okay, yeah, oh, so this is actually very important to mention and then finally what can we do about it, what can the government do from a policy perspective, a programmatic perspective, we all know data liquidity is going to be important in all of this discussion, a discussion on certification could that have a role? And then finally, existing programs MSSP, Meaningful Use 2 and 3, maybe even some of the bundled payment initiatives, are there any linkages there? So, thanks for that pick up.

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

This is Karen Bell, I think there is one huge gap that we're not addressing, when we talk about data liquidity we're primarily talking about data that exists clinically I think in the delivery system, some clinical data and the administrative data that exists in the payer system, but we're missing a lot of really I think what are the biggest determinants of the health of the population and those are the social determinants.

There is a huge amount of data that is locked up in social services and I don't mean just DSS but it's in housing, it's locked up in the educational programs, birth and death certificates, I mean, I could on and on, and those are different in every state, but I'm wondering if there might be something that could be done from a policy perspective and this is the real question, whether or not these groups that will be talking with us in December find that it would be important to have access to that data and the liquidity of that sort of data would be important for them in terms of their overall management of the health of their patient population.

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

Yeah, thank you Karen, you know, that would be an interesting discussion because on the one hand I think many of us intuitively see the value of it, on the other hand you get, you know – I've got enough of a documentation kind of overhead from my EMR that, you know, don't you dare add anymore work and so I think that might be, you know, having some folks who are in a real world environment, that might be a very interesting discussion to maybe understand how we might – whether the ACO makes that information more relevant and maybe understand how we might be able to in a – you know, semi-seamless way make use of it.

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

Yes.

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

Yeah, this is Joe, so actually a concrete example I would throw out is working with our state here even with getting accurate deceased data to be able to integrate particularly when we are thinking about improving care at the end of life, the palliative care initiatives, etcetera, it's a big challenge for us to identify accurately when patients stop coming to see us and you have an open net direct to the EMR and you're trying to figure out whether or not this patient actually was deceased or not if it's not marked by the clinician and so it's been a challenge. We've had multiple conversations with the National Death Registry, etcetera, but I think having the discussion open of can we get access more robustly to that kind of data would be helpful.

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

And this is Heather with John C. Lincoln, our entire health system both of our hospitals as well as all of our primary care clinics including our desert mission which is a food bank it has community services for folks who are uninsured or under insured, but we all share the same electronic medical record and I can tell you that from a clinical perspective knowing that one of our patients is also a client of our desert mission food bank has allowed us to intervene quickly and get the patient the necessary support system whether it was medications or home health in the home, but, you know, having those built in triggers has proved quite successful for us.

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

So, this is Hal Baker, I think those of us in the communities where there are shared records have ample demonstration that good information liquidity can be helpful. The enter EHR good data liquidity or more importantly information liquidity is pretty hard to find good examples of, it's something that everybody aspires to but if the information to data ratio isn't very good it becomes more clouding than clearing and so it's truly an aspiration I think we all have but I wonder whether there are practical examples of it working well on which we can anchor thoughts of policy and procedure.

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

This is Irene Koch, you know, maybe this sort of fits into the more suggesting witnesses rather, but it is responding to what you just said, but also weaving in what someone else said before about trying to include sort of Medicaid Health Homes.

Where I am here in New York City, you know, and New York has a pretty sophisticated Health Information Exchange framework including policy and consent and all that, there are some really excellent examples of sharing data across entities to support the health homes including social services and behavioral health providers.

So, you know, I think I might have more to say in terms of specific recommendations but that is definitely a piece I think we should try to include because it seems to address a lot of concerns that people have been raising.

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

Hal, again, it would be wonderful to hear from your front line physicians about how that in real world terms changes care for them.

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

Great, yeah, I can definitely recommend some folks.

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

This is Frank Ross again, you know, one of the things that I see here is a good thorough set of questions about the potential impacts. What I don't see is, is a question to the folks about what do they consider to be priority, you know, every ACO, depending on their venue, is going to have a different set of priorities. I mean, we have no clinical integration outside of the metrics that we are gathering as an ACO.

So, the primary care physicians in our rural network are truly living on their own islands out there and, you know, the priority for us right now is to simply know when people are actually in the hospital and when they get out and that's an impossible task in our area because the hospitals are making absolutely no effort whatsoever to do any sort of integration with the independent practitioners in the community and, you know, that to me is an extremely important question.

But, you know, I think it depends on, you know, what your venue is again, you've got to set priorities for, as an ACO what is the most important thing for me to do, and you know, our priorities are very simple, you know, we want to advance the care coordination as far as we can get it and it's going to take information in real time to do that.

And we want to get our patients in and start providing them with wellness and preventive care because we know that that's going to bend the cost curve down the road by keeping people out of the hospital but even more importantly we want to make sure that our patients have access to care 24/7 at some level, it doesn't mean they are going to get to see a doctor because right now they are going to emergency rooms.

We are producing what we call a frequent flyer's list right now and we have patients in our ACO, beneficiary or attributed beneficiaries that have in excess of 100 ER visits a year and that is just so far beyond any acceptable level of responsibility that, you know, if the primary care physicians knew or had an opportunity to intervene before those patients presented at the emergency room that would make a huge change in the direction though and I'll just leave it at that.

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

Now you touched on something that really resonated with me which is we all recognize the importance of, you know, interoperability or data liquidity or even just, you know, basic information sharing, but you talked about the hospital making no effort to I think reach out to the physicians who are in private practice to support data sharing is there a topic worth discussing around motivations or what the government might be able to do to, you know, encourage the data sources to share information more readily, more completely with the data consumers as part of an ACO, is there a topic worthy of discussion there?

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

This is Hal again, hasn't ONC already done that by the transition of care requirements for communication and hand offs somewhat? Doesn't that obligate a hospital to let the next provider know what is going on presuming that they are discharging with the intent that they follow-up with somebody?

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

Unfortunately in our community what that is translated into is that they have to notify somebody they don't have to notify the beneficiary's primary care physician and what we're seeing is we are seeing dumping, wholesale dumping onto home health and onto skilled nursing facilities and other outpatient facilities that isn't even being coordinated with primary care.

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

Okay.

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

And so, you know, the home health agencies are taking the patients at discharge and then they're eventually finding out who their primary care physician is or who their doctor is as they say here and then they come back to us after these plans have been written and handed out and we can't even provide oversight for those plans because we didn't order the plans.

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

Sure, yes.

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

So the patient is completely caught in limbo, home health agencies are so gun shy right now about taking anything, you know, we, I say "we" the physicians in our ACO which I happen to be married to one of them so I have a lot of bedtime conversations with her about these things and, you know, our biggest concern right now is that if the hospitals are not forced in some form or fashion to stay actively engaged with the primary care physician for that patient, and Medicare is telling us we're that primary care physician, they're attributing that patient to us, so there has to be some way that the hospitals have to follow some guidelines and they're not doing that, they're simply doing – they're taking what they think is a step to keep that re-admission from taking place because that's the only stick that they're getting beat with right now is a re-admission.

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

You know this, this is Karen again, conversation really I think underlines for me the importance of, and I look to ONC to do this, the importance of having literally everyone who does any type of a presentation to present a structured list of things that describe their own specific infrastructure and organization.

You know very frequently people will get up, and I'm guilty of this myself, and talk about what their organization does, but in this situation I think it would be helpful if every speaker was very clear about exactly how big their organization is whether it's a physician primary care physician ACO or multiple physician, or a number of parameters and characteristics that everyone could present so that when the information comes in and they do tell us what their thoughts are about these questions we have some idea of what their infrastructure is and how they're structured and how they function and I think that's going to be very helpful as well.

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

What you're describing is a profile and I agree wholeheartedly.

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

Frank Ross, MSSP, AP, ACO – IS/IT Steward – Cumberland Center for Healthcare Innovation
They need to be profiled before we, you know, they are addressed.

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

Charles Kennedy, MD, MBA – Chief Executive Officer, Accountable Care Solutions – Aetna
Very good, now in the interest of time that was – we got a lot of good information there, in the interest of time let's jump to really the closing topics which are suggestions for witnesses and maybe if we could on the WebEx go back to the slide that had the various panels. Alex did you have a specific process in mind as to how we might get input on specific witnesses for these various panels?

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

Yeah, so, you know, we're definitely going to be collecting a lot of suggestions from different places both internally at ONC and from all of you and then trying to rapidly narrow these down based on the final categories.

I think I would encourage folks just in the interest of time, you know, if you have some clear ideas about panelists who you think would be, you know, great articulate people to participate in this that we would welcome any of those suggestions so that we can start building that big list.

And then, you know, obviously we're going to be doing some changing around of the structure based on all the great input we've received here and so, you know, we'll be trying to match up that big list with the final structure of the panels, but so, you know, if folks want to mention any ideas here or otherwise please e-mail me with some initial thoughts about individuals.

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

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

This is Michelle, I would just add when you e-mail Alex please make sure that you include contact information so that we can reach out to those people as well.

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

Yes.

Frank Ross, MSSP, AP, ACO – IS/IT Steward – Cumberland Center for Healthcare Innovation
Again, the question I would have is there any preference in regard to the witness, I mean, are we – do we want to target any particular type of organization, you know, any particular profile of an organization? Does anybody have any thoughts about where the best value is going to lie?

Charles Kennedy, MD, MBA – Chief Executive Officer, Accountable Care Solutions – Aetna
Well, this is Charles, I would simply say I think we would default toward real world expertise and people who have actually, you know, faced these problems in their management of an ACO to the degree – I mean, who is also new and so immature I think what we said is we would, you know, value that real world perspective.

Karen M. Bell, MD, MMS – Chair – Certification Commission for Health Information Technology
Would it make sense, just a question, Karen again, would it make sense to reach out to groups that represent multiple ACOs, I think Joe you mentioned that the Pioneers has gotten together on a number of things, would it make sense to reach out to someone who could represent the experience of multiple Pioneer ACOs or something like the Northern New England Collaborative ACO Collaborative or something like that that's happening on the west coast?

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

Karen M. Bell, MD, MMS – Chair – Certification Commission for Health Information Technology
Or should we do it specifically to individual organizations?

Joe Kimura, MD, MPH – Medical Director, Analytics and Reporting Systems – Atrius Health
I think there are sort of selective groups I think even within the Pioneers I think there are sort of the New England folks definitely in Massachusetts, the Minnesota groups and the California groups that I think get together and talk a lot. So, in that sense I think you could get a little bit broader perspective representative of that. I'm not sure if there is any one group that would represent – the majority of Pioneers but I do think that there are some structures like that that we could tap into for sure.

Heather Jelonek, MS – Chief Operating Officer – John C. Lincoln Accountable Care Organization
Yeah, there is the National Association of ACOs, NAACOS, which is led by Cliff –

Charles Kennedy, MD, MBA – Chief Executive Officer, Accountable Care Solutions – Aetna
Okay, well very good, Alex is there anything else we need to cover?

Alexander Baker – Project Officer, Beacon Community Program – Office of the National Coordinator for Health Information Technology
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R. Hal Baker, MD – Vice President & Chief Medical Officer – WellSpan Health
Can I ask a – this is Hal, can I ask a quick question. We have 16 questions and witnesses are we – I've only testified once and it was I think three questions. Is there a paring down process or is each witness going to write to 16 and talk to one or how does that work?

Alexander Baker – Project Officer, Beacon Community Program – Office of the National Coordinator for Health Information Technology
I think these 16 would cross multiple panels and so we have four panels so we'd probably have on the order of 3 to 4, you know, questions per panel.

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

Frank Ross, MSSP, AP, ACO – IS/IT Steward – Cumberland Center for Healthcare Innovation
This is Frank Ross again, I'm the newbie on the committee so I have no clue as to how these things normally proceed but if somebody could just thumbnail what is going to actually take place, you know, I saw that it was a gathering, a face-to-face in Washington, but beyond what I got in the invitation for this meeting here I don't really know what's taking place, could somebody do that for me?

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator
Hi, this is Michelle, I apologize my phone is about to die, hopefully I make it through, so past hearings what typically happens is we have a number of different panels, for this one they're looking at four different panels, each panelist is only given 5 minutes to make oral remarks, so we ask them to speak to all of the questions that are sent out and provide a written testimony.

So, we'll send the written testimony prior to the hearing for all of you to take a look at and have as background information. We also typically ask for their Bio's as background information so you have all that and they don't have to spend their 5 minutes going through who they are and where they're from so we'll just have to think through, I know you had asked for some of that, we can just think through that.

But the 5 minutes goes very fast and we stick to the 5 minutes very closely. I think personally what most of the committees have gotten the most out of is actually when they are able to ask questions. So, on each panel, let's say there are 4 panelists on a panel, the 4 panelists will go, give their 5 minute remarks and then we open it up to questions from the committee and that is typically where you get a lot of good conversation and some great questions are asked, at least that has been my experience in the past few hearings. Does that help a little bit?

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

Yes, thank you.

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

One of the things I think that we might need to do though, this is Karen, is at least give everyone the list of questions and they will find some of them that will resonate much more with their own particular concerns than others, but at least giving them the list of things that we're interested in hearing about will give them an opportunity to share with us their responses on the things that are most important to them rather than limit maybe who gets what in terms of questions.

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

Agreed.

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

We could also delve deeper in the question period at the end as you mentioned Michelle.

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

Yes, exactly.

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

Great and I just, you know, want to invite folks, as always if you have the chance to dig a little deeper into that discussion document and want to send any other comments via e-mail or, you know, if you are sending along some panelists suggestions want to include a couple of additional comments we would welcome that.

M

Yeah, I'll e-mail you suggestions.

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

When – this is Frank again, when would the final composition of the panels be determined?

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

We'll be looking to do this as quickly as possible. I expect it would not be before the end of next week or beginning of the following week given that we'll need to receive all the suggestions and organize them.

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

Charles, this is Michelle, if there aren't any other questions are we ready to open up for public comment?

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

I think so.

Public Comment

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

Okay, operator can we 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 comments at this time.

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

Thank you all for joining later in the day on a Friday afternoon.

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

Well, thank you all and thanks to the staff who did all this work to bring us to this point in spite of the fact that you had two weeks of furlough.

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

Thanks everyone, have a great weekend.

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

Thank you, bye.

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

You know too, bye.