

**HIT Policy Committee
Accountable Care Workgroup
Transcript
January 21, 2014**

Presentation

Operator

All lines are bridged.

Michelle Consolazio – Federal Advisory Committee Program Lead – 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 meaning, I'm sorry, Accountable Care Workgroup. This is a public call and there will be time for public comment. 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 Program Lead – 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 – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Hi Grace. Shaun Alfreds? Hal Baker?

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

Here.

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

Hi Hal. Karen Bell?

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

Here.

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

Hi Karen. Craig Brammer? Scott Gottlieb? David Kendrick? Joe Kimura? Irene Koch? Eun-Shim Nahm?

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

Here.

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

Frank Ross?

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

Here.

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

Hi Frank. Cary Sennett? Bill Spooner? Sam VanNorman? Westley Clark? Akaki Lekiachvili, I'm sorry every time? 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 for Health Information Technology

Alex Baker.

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

Kelly Cronin.

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

Hi Kelly and with that I will turn it back to you Charles and Grace.

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

Okay, great, thank you very much.

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

Hi, I'm sorry; this is Irene Koch I just want to say I joined right after roll call apparently, thanks.

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

Thank you and good afternoon everyone and thank you for calling in to this meeting of the Accountable Care Workgroup. This is our first real meeting since we had the hearing where we got some testimony from a wide variety of both individual segments of the industry and quite a few different perspectives on what the challenges are associated with the use of health information technology in supporting accountable care.

In the PowerPoint that was sent out earlier today titled Accountable Care Workgroup Hearing January 21, 2014 if you go to the second slide numbered, number one, there is a list of some of the key challenges –

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

Charles, I'm sorry, can I interrupt real quickly, there is – we're getting a lot of feedback somebody is breathing kind of heavily, if you're not speaking if you could please mute your lines we'd appreciate it. Thank you. Sorry, Charles.

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

Oh, no problem. So, if I could ask you to turn to the second slide which is slide number one in the deck there is a summary of some of the key challenges and messages that we heard from the hearing and I'm going to pause here. Grace I'm going to ask you maybe if you would kind of walk folks through the first slide and make some comments about, you know, what you heard as well as the summary here and then I'll do the same.

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

Absolutely, so if you're looking at the hearing key challenges and messages I thought that this was well summarized by our folks and we'll just go through it.

So, number one was data integration across EHR systems and with population health platforms is a major challenge for providers collaborating under the accountable care arrangements and those of you at the hearing or otherwise I think we've heard loud and clear the issues from providers, the importance not only of being able to integrate data not only internally but externally to the systems or ACOs themselves whether it's from technological issues related to interoperability with vendors or whether it's related to certain aspects of things as it pertains to just that there is not good population health management tools out there that are more comprehensive or integrated. So, this was a big theme, we heard it throughout the day.

The second point technical, strategic and financial considerations continue to inhibit providers from exchanging information to support care coordination this was in a lot of ways a – as I mentioned in bullet point one, partly related to technology.

From a strategic stand-point it was really interesting the emotion I thought that was heard around the concern that information was seen as a business asset and that even if it might be in a patient's interest to have the free flow of information it was not always in the strategic information of certain providers of healthcare which ended up being problematic if things got siloed in ways that were not helpful from the stand-point of ACOs and trying to be accountable for care.

And then there was some concern expressed by some of the providers in just the expense and technology that's related to the investments in this versus some concerns about the return on investment that might occur.

If we can go to the third point, there – while providers in accountable care arrangements are acutely experiencing these challenges today they do not have the leverage to drive solutions alone. There did seem to be a theme, although I don't think there was a lot of specificity about the how, that there would be a role whether from a policy stand-point at the level of the federal government in basically figuring out how to basically fix some of the problems that are out there when it comes to the financial, strategic and technical challenges.

There seemed to be some desire to make the interoperability issues something that could be thought about within the context of policy as well as a fair amount of discussion about where there ways of financially incentivizing to drive things in a more functional way.

The fourth point, HIEs are facilitating exchange for accountable care in select markets but sustainability and spread are still a major concern. We heard that throughout the day that there was not a business model out there at least that had been developed yet with any degree of breadth that people felt comfortable was going to be a long-term solution to health information exchange at a more than just local level in certain areas.

And then the fifth there is a lack of clarity and consensus around the key quality measures that are needed to effectively drive care to improve within ACOs. There seemed to be some frustration from some of the ones who gave testimony that some felt that the quality measures were helpful and others felt that they were just clicking the boxes to make sure they got Meaningful Use but were not necessarily doing what was actually meaningfully making a difference when it comes to quality. So, certainly we heard some various opinions as to how that was a problem.

Let me stop here before we go to the next slide in case anybody else wants to comment. All right, let's go onto the next slide then. Charles do you want to summarize the next point on the next page and then we can –

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

Grace E. Terrell, MD, MMM – President & Chief Executive Officer – Cornerstone Health Care, PA
Ping pong back and forth or do you want me to go ahead and keep going through here?

Charles Kennedy, MD, MBA – Chief Executive Officer, Accountable Care Solutions – Aetna
I'll take this one, give you a rest and we'll continue to ping pong.

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

Charles Kennedy, MD, MBA – Chief Executive Officer, Accountable Care Solutions – Aetna
I think the theme that Grace mentioned on that last point around quality measures, you know, a check the box mentality versus using it as a vehicle to transform a care process applied as well to the Meaningful Use requirements.

We heard a lot, and this was interesting because, you know, your first thought around number seven on ACOs aren't they mostly about population-based management techniques and so, you know, why did it come up that a patient-centered approach was necessary. And I recall that coming up in a couple of different discussions, the first was when we talked about the data and making the data less institution centric and more patient centric, again, pointing back to a consistent theme we heard around lack of health information exchange and interoperability.

And then finally, two last points, a point about smaller organizations really struggling and at times having actual business consequences in terms of needing to form alliances or mergers and whether that was really the best thing for healthcare delivery.

And then finally, an interest in broader data sets not just what we would typically define as clinical or clinically focused data sets but also beyond that behavioral health information and better strategies to understand, you know, other components of confidential or sensitive information.

So, that's a very quick summary of a long day of testimony. Let me just kind of jump to slide three and then we'll pause. We just want to highlight some of the report outs, but also kind of take this information and what you'll see us do in the next few slides is to try and get your input as to what kinds of recommendations we can begin to formulate to take to the HIT Policy Committee for their consideration as well as HHS.

So, some of the themes, again just to summarize things, we focused a lot – there was a perception we focused a lot on, you know, how information could be shared, standards, legal trust framework, etcetera, but in the case of ACOs you begin to introduce the element of business interests and how does the intersection of kind of business interests around for instance managing leakage outside of your ACO, what are the intersections with that and the desire to share data regardless of where the patient may seek to obtain care.

The cost component, given that ACOs, whether they're MSSP or private payers that efficiency, a modicum of efficiency requirements are successful in terms of making business endeavors successful how do we think about building in those requirements that cost reporting, you know, will require and are absolutely critical for success within an ACO.

Payers obviously came up, a variety of strategies around, and measures and metrics around how the different gain share/risk share, quality measures from payers are implemented and used, and that perspective we really, you know, other than myself haven't had a lot of input from the payer community.

And then IT capabilities, there was an overriding statement that many of the things you need for accountable care you need for good high quality efficient care regardless. Many of the statements for instance revolved around care coordination and data sharing, decision support which are obviously contained in other parts of Meaningful Use and so there was a desire for us not to be too specific, in terms of recommendations, specific to the ACO model but rather try to focus on things that have broad capabilities, broad support and likely to be leveraged regardless of whether it's an ACO model, a PPO model, a risk model or whatever the case.

And then finally, we had a fairly rich discussion about the balance of innovation and public policy and/or regulation and a caution not to try to regulate our way to innovation but rather be very prudent in any recommendations so that they are not so specific and potentially burdensome that they might stifle out innovations that are necessary on the individual caregiver and care system level.

So, that's kind of a summary of what we heard. I know it was a day long and a very long day worth of testimony but that is a very quick summary. And before we begin our discussion on recommendations I'll just pause to see if anyone has any questions or additions?

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

Charles, let me – I'm not sure that everybody has seen Karen Bell's e-mail or whether it was just us, but I thought that it was very helpful and might, before we start getting into the specifics, help us think about how we might categorize these things.

So, Karen had sent an e-mail that was shared that basically said the way that we might be able to focus on these very complex and overlapping discussions would be to categorize them in ways that we could get around it both for the sake of our recommendations as well as the sake of our ability to talk about it this afternoon.

So, she came up with what I thought actually probably did encompass all the types of things that were talked about in these various formats. The first was issues around support financial or otherwise for developing new ACOs.

The second one was about data availability or accessibility, we certainly heard that. The third was about sharing of data and information, the fourth about the use of data and information and the fifth about administrative simplification.

And, you know, the more I read over her e-mail the more I liked it because I couldn't think of anything else that was actually said that you couldn't put in one of those five categories. So kudos to you Karen.

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

Thank you very much and I think it's just, you know, from having listened to all of those wonderful meetings over the last several years that the committees have presented, it just seems to me that to have a handful, maybe 5 or 6 basic categories and then think about all the recommendations underneath each one, might make it easier for the HIT Policy Committee to really understand a lot of the challenges that frankly our Workgroup has had dealing with all this wonderful rich input that's come in.

There has been just so many different aspects of things that have been shared that I think it would be helpful to sort of work for the HIT Policy Committee to really hear something that fits in a fairly smooth workflow category. So, thanks, Grace.

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

This is Hal Baker, just one comment on slide three, the first bullet, I don't know how others took it but when there seemed to be resistance to sharing it struck me that it wasn't so much a resistance to the concept of sharing but inadequate incentives or motivations, or drivers to overcome the barriers to adding sharing into a very complex workflow that really had no room for adding extra processes without strong incentives. So, it could be read by others that this is an attitudinal problem, but I didn't hear that as much in the conference.

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

Okay, very good, thank you, Hal, I think that's right. I don't think anyone – I don't think I heard anyone specifically say "I have an attitude against information sharing." I think you have it right that incentives were really – and the balance of that was really the issue.

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

And those areas we heard about where it was going on there were fairly unique drivers outside of the health system that either made it very easy to happen or provided incentives to make it happen.

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

Hi, this is Frank, I just wanted to make a comment there too about the second bullet on the panel in front of us right now. You know, we talk about cost, what the cost of care is for people, we've got to be careful, I think, and make sure we always use cost and utilization, because those two things if they're divorced from each other the real picture gets lost very quickly.

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

Yeah, I –

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

So, that's a – oh, go ahead?

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

I would add that what they were looking for was the total cost of care that very frequently, particularly in the Medicare arena, a Medicare patient can have a certain amount of data coming in or will be presented to the ACO, but the behavioral health costs are missing, the wraparound cost if someone has a wraparound product that's missing. So, the total cost of care aren't really available to the ACO that's taking on financial risk for that patient.

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

Okay, if there are no other comments on the report out and hearing pages and Grace I thought that was a very nice summary of, you know, the key themes per Karen, maybe we could move into the specific areas around, you know, specific hearing input and specific recommendations we should be considering as we look to our, you know, final set of recommendations in March. So, if we could turn to slide four?

You know the hearing input would be the more – and I won't just read it I'll let you read the quote yourself, but I think the point here was, you know, a tighter link between Meaningful Use and the ACO Program that is stronger or perhaps more flexible, or in some way, you know, advantage over the current waiting which is fairly light.

And then maybe we could start out by having people read the recommendations on the right and offer any comments on those.

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

And within Karen's categories I believe this one would be under the administrative simplification if I'm thinking about it the way she was.

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

I think so. I'm dragging all of my notes on this, it's Karen.

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

Yeah, this is Alex, I just want to make a quick framing comment about these slides, you know, just want to make sure that people understand that we're looking for, you know, broad reactions to what is here as an illustration of the kinds of things we heard which is why, you know, people should not feel this is in any way the sort of universe of types of recommendations or the way that we need to – you know, we're asking for clear approval of these things, this is material that we've heard from and looking for new ideas here based on these ways to edit these and additional input, thanks.

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

So this is Karen –

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

–

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

Go ahead?

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

Thanks, Karen, sorry it's Kelly I just wanted to just quickly say that I think some of you might remember back when the Medicare Shared Savings Program was initially proposed in a proposed regulation and they actually did initially think about a higher bar for Meaningful Use and Health IT adoption as a starting point to be an ACO but there was a lot of pushback through public comment at that time and that was what over three years ago before we really had a lot of experience with the Meaningful Use Program.

We're now at a point where at least with Stage 1, let's say hypothetically, you know, we advanced some recommendations and CMS were to address them over the next year, they probably wouldn't actually result in changes to the program realistically for, you know, another year at least and at that point we're going to have a lot of eligible professionals as Meaningful Users like hundreds of thousands.

So, I think when we think we might want to project about where is the market going to be a year or 18 months from now as we contemplate this and what might be a reasonable expectation or what would be helpful not burdensome but helpful to the overall success of the organization, because I think it was like 50% of provider networks should be Meaningful Users as an entry point last time around.

And so not that we have to reconsider that specifically but I just wanted to both, you know, have folks be mindful of the timeframe we're probably talking about and also just what the market might look like at that point.

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

Thanks, Kelly, and this is Karen again, and I think that's sort of what I was thinking when I developed my comments around this. There is a difference between a recommendation that's very strict about, you know, very clear adoption of certified EHR technology and then some of the underlying elements that this encompasses here.

So, for instance when we talk about long-term post acute care providers adopting certified EHR technology I think that entire community would have a concern that it be the same type of certified EHR technology that physicians and hospitals need to adopt because it's a very different workflow under those circumstances.

So, one of the things that I think might be important for us to consider if we are really thinking a little bit about how certified EHR technology can better support ACOs and coordinated care it's what are those elements that are going to best support the ACOs.

And if we're going to be talking about certified EHR technology maybe we should be limiting that to certification around interoperability so that it really doesn't matter whether you are a nursing home, a physical therapist or a behavioral health psychologist, if everyone is using technology that is interoperable information can be shared even though every single one of those different types of providers would have a very different kind of an EHR with very different functionalities.

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

Yeah, this is Kelly again, that's an incredibly helpful distinction, just also to remind folks that we do actually have interoperability guidance out that applies to providers that aren't eligible for Meaningful Use incentives so that would include behavioral health and long-term care post acute care providers and there is no – I mean, it's just voluntary, it's just for people to be aware of.

So, you know, they have a choice of going to a CCHIT certified product if they're a long-term care provider or they can just ask, you know, that as a part of their procurement process and requisition process that the vendor complies with the standards and criteria in that interoperability guidance so that we do have everybody using the same C-CDA standard over the next few years that can enable transitions and follow some basic, you know, requirements or structured data that will allow for managing across the continuum of care.

So, that kind of guidance before...let's say we have a voluntary certification program for long-term post acute care and we have behavioral health over the next few years, that's not a done deal, but it's under consideration, in the interim we do actually have guidance that's public and out there that can be connected to a policy recommendation.

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

This is Eun-Shim, who is using those guidelines? And is this –

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

Well, they're available to the vendor community and to providers who find them useful.

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

Oh, so only selected volunteers are using it currently?

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

You know, that's a great question I think we have, in ONC, you know, we probably could be doing a better job of making sure that that guidance is well disseminated and understood. I don't think we have a good handle on who actually is using it.

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

Thank you.

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

Hi, this is Frank, I may be one of the few people that's going to say that, you know, the comment that we're hearing here, as far as the hearing input is concerned, dealing with, you know, making Meaningful Use a prerequisite to participating in an ACO I kind of view that as, at least in the short-term, and the short-term would be the next three years, as becoming somewhat punitive.

I mean, the SSP Program right now already took a double weight on that particular quality measure and I know, you know, our ACO in particular we would lose some of our providers. If that rule was in effect today we would have never acquired them even though we think and we feel like they are making progress as part of the accountable care organization they would have been precluded in the first place.

So, I caution that we recommend that you have to be a Meaningful Use attested provider to participate in a federally sponsored ACO.

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

Yeah, this is Charles, I think that's very well said. I think that's probably even strengthened by the, you know, the heterogeneity of the responses that we heard in terms of how much a Meaningful Use Certified EMR actually supported ACO success.

So, I would support what you're saying that the punitive action of the bullet on the left sets the wrong tone, but I guess, you know, I'm wondering if there is any – as you look at the detailed recommendations, is there a way we could make it more supportive or inclusive, or affirming rather than punitive or is the notion of, you know, a tighter link between MU and let's say the MSSP Program just, you know, a bridge too far in terms of public policy?

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

Well, possibly. You know I like some of the recommendations that are there, the detail, you know, the phase into Meaningful Use requirements, particularly the transition care measures are extremely important.

So, I think we've got the right recommendations in place, but I think when we look at Meaningful Use as a program versus the ACO as a program, the MSSP Program, we possibly ought to just consider that, you know, by participating and achieving results those particular measures that can be a certification within itself. I don't know if that makes any sense to everybody.

But I do know that if you successfully meet the benchmarks, you know, at a physician level, and that's another weakness of the MSSP Program right now is it doesn't really measure things at a provider level, it only measures at an ACO level, but if it were done that way certification could be by proxy as a member of the ACO and again that's just a thought.

I don't want to blow this out of the water but I do want to say that Meaningful Use is a supporting standard but it is not the accountable care standard and I think we lean on that way too hard sometimes. We look at it as the ACO Program is a layer on top of Meaningful Use. I don't see it as a layer on top I see it as something that blends in with it.

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

Thank you for that. Other comments on let's say bullet one or the hearing input quote?

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

This is Karen Bell, you know, I think one of the things that we heard a lot about is that the concept of primary care is absolutely critical to success in an ACO and in many ways it's not just primary care its primary care medical home from the perspective that there is a team that can coordinate care across the continuum for these various and – patients.

And I think that one of the problems that we run into is that Meaningful Use is very much individual physician focused but when we're talking about ACOs and patient-centered medical homes it's really about team focus and so that's why I have a little bit of angst about really pushing hard on a Meaningful Use requirement because so many individual doctors can have Meaningful Use, as a matter of fact we know that they do, but to be integral to an ACO that's really taking care of patients across the continuum you have to have much more of this team-based concept or patient-centered medical home type concept which we heard about but we didn't really call it out at the daylong session that we had.

So, I would just throw that out that it's – you know, there is Meaningful Use and that's an individual measure for individual physicians that brings them along to use their technology appropriately but in the ACO environment I would agree with you Frank it's just not enough.

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

This is Hal Baker, overall I think these are a variety of different incentives to move people from the old paradigm to the new one which is increasingly going to be team-based care and organizational-based care and less tied to an individual provider.

The one danger I see of linking these things and tying Meaningful Use to other requirements is that people may opt out because if the administrative burden of meeting all these things concurrently are tethered together sometimes it's tempting to just give it up and try to pick up 5% more efficiency by not doing that and make it up on volume and we already hear arguments of people doing that.

If they're separated then people may move on one and not another. Those who move on all of them will be further incentivized, but people may get involved in the ACO but not in Meaningful Use or vice versa. All are generally moving northward of where we want in transformation of care that I think the administration is pushing, just a counter point.

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

And this is Karen with one last comment, just from the perspective that I think what the real driver behind this recommendation is to get various people to share within their organizations and external to their organizations the information that's critical to take care of patients along the longitudinal spectrum.

So, I think, however, if there is some kind of agreement amongst us as to really what it is that we want this recommendation to accomplish then it might be a little bit easier to frame it.

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

Okay, well maybe we should move onto number two, but I think what I'm hearing pretty consistently is a concern about tying them together too closely, I think we heard that from several people, amongst the potential for folks to opt out.

The punitive nature avoiding that and maybe making the incentives simply more upside than in any way punitive, but I think I heard general support for a phase in of a Meaningful Use requirement linked to ACOs and getting to Stage 2 especially around certain pieces of functionality like transitions in care.

It sounds like folks were pretty much supportive in general as long as we met the aforementioned constraints. Maybe with that we can go to the second set of recommendations?

And this is around the notion of transparency, transparency when it comes to methodologies, when it comes to purchasing both, you know, providers purchasing tools I think is the main comment here and then the notion of needing to find ways to integrate the claims data as part of building a comprehensive view of the patient and being able to do a better job, you know, especially across silo type of job in quality reporting. So, reacting to that –

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

Can you please move it forward one slide? Sorry.

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

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

If you could move the slides forward so people are looking at the slide.

Charles Kennedy, MD, MBA – Chief Executive Officer, Accountable Care Solutions – Aetna
Yeah, I'm now on slide five, suggested recommendations for discussion.

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

There we go, great.

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

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

Okay, all right and then I won't read through the detailed recommendation here I'll allow you all to read through it but it basically focuses on a standard methodology, data set and data definitions that would, I'm assuming, focus on the federal programs but also be encouraged around private sector programs as well. I'll open discussion around that?

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

Charles, from my stand-point part of this also segues into a bit of another theme that we heard which was the concept that once you had made a choice you were captured by your vendor and had, as we discussed in the earlier theme, very little power so there was – in terms of if you didn't get what you needed.

So, there seemed to be some cynicism over the day that a lot of what was bought was not actually able to accomplish what was necessary, which is why this theme of transparency is important, that seems, in my mind, to also beg the question of ought there to be certification that would permit some sort of ability to actually make sure that these things are functional when people buy them.

And then the other issue that we heard was once you made the investment the difficulty and the interoperability that was related to that. So, the way that this one is laid out in number two here, from my stand-point, depending on how we put in detail could perhaps get at several of those themes in ways that would bring them together.

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

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

Yeah and this is Karen, I think that the – it's not so much about the population health management solutions, which is important and I think you just mentioned that Grace, but I think it's also around transparency with respect to how the predictive models operate some of them are black boxes and no one really knows what's in that black box that will identify a particular patient as being high risk.

So, I think that there is the need also for that transparency that if you are creating algorithms to identify high risk patients then the purchaser of those algorithms should have some idea of how those algorithms are created it can't just be a black box. So, I would just add that to the discussion we've already had.

And I'm also not sure that the issue of the claims belongs here, it might belong someplace else, it's a very important piece but when it comes to really looking at these population management solutions I think a lot of it really just has to do with making sure that the black boxes are illuminated.

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

This is Eun-Shim, I was not sure whether the measure is transparency per se. I think someone mentioned dissemination methodology, perhaps we could do a better job in delivering the information or to the right person.

I couldn't be sure about the transparency or black box, whether the matter is the black box or we're not really delivering the right content or information to the right person, whether do we have a mechanism for the way how we do things is the right method.

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

I think that – I think the comments hit on really all the things you mentioned. I think there was a question about as you create a data input into calculations associated with population health management, you know, quality measures or other measures being used in the assessment of performance, I think the comments were around is the data being extracted through, you know, some kind of a detailed process that results in some kind of standard or consistent data set once that – and that would be driven by both the fields you choose and the definitions for the field and then once that is decided upon having, I guess, transparency in terms of the black box what are the methodologies that apply to that standard data extract so that you're outputs are as consistent as possible. So, I think the comments hit on all three of those components.

I get a little bit worried about this space myself as to whether this is something we can – how far we should go from a public policy perspective. I mean, if you're calculating a quality measure for, you know, reimbursement by the federal government or others, you know, I think some kind of transparency would be critical so that you could ensure that the measure that's being produced is being produced correct and in a consistent way and to get that output certainly you'd need to have standard data definitions and extracts.

So, I think there is some need for standardization but perhaps we might want to temper it to the specific ACO quality measures and have those ACO quality measures as appropriate align with, you know, Meaningful Use measures so that we're again, I think reinforcing a consistent theme. Other comments?

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

Why don't we go to the next slide then Charles?

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

Okay. Can we go to the next slide which is regional exchange of information and again, I think one of the loudest cries were heard was for the notion of better exchange not just within partners let's say who might be aggregated as an ACO but also across ACO partners. Again, there is some pretty sticky, you know, business implications to that to think through but certainly that was one area of recommendation we heard.

Explore ways to use a survey and certification process to survey outside the immediate institution that is being qualified to get feedback from the referring providers. So, I think this is the notion of an ACO having providers who are outside of that immediate institution trying to get feedback from them. This one I'm a little unclear on. I don't know Alex or others could you help me out on this one? I'm not sure I'm understanding this one.

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

Is this about the ADT feeds for re-admissions about the notification services?

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

I don't know.

W

Yeah, I think –

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

That's what I see.

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

I think the notion here was that if there was some room within that lever to ensure that exchange was occurring, again, you know, I think that this is definitely an area that we heard a lot of interest in but, you know, need to do more to crystallize what recommendations would be.

So, this was sort of a thought that came up in discussions over the past months could you somehow require through that process to ensure that information receivers were, you know, out in the community that were receiving discharges were also receiving information from referring hospitals but, you know, definitely –

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

I think – this is Kelly, I remember, I think it was Frank who said something during the hearing or in our follow up around sometimes having the community hospital not sharing discharge summaries or being willing to sort of, you know, enable the summaries of care to go in a timely way to the treating provider.

And this was perhaps one mechanism to make sure that as a part of their obligation to do good clinical quality care and there are requirements around transitions and discharge planning that are part of the – not only conditions of participation and Medicare but also through the survey and cert process they look at the very specific aspects of discharge planning and how the hospital complies with them or not and in that process there could be perhaps a more clear requirement to make sure that hospitals are not just doing a discharge summary but they're actually sharing that discharge summary with the responsible treating provider post discharge.

Because I think there is just the concern that there are some hospitals out there that are not actually getting to the responsible party after discharge.

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

This is Frank that is spot on in regard to what I was thinking when I made my comments and, you know, I just want to underscore it even more. Even though the ACO providers are really responsible for the patients that are attributed to them they have no way to compel hospitals to make sure they don't discharge those patients are even getting routed back to them and, you know, we have that situation it happens all the time when our local hospital is actually telling our patients who have identified themselves as our patients that they need to go visit one of their primary care physicians instead of coming back to us.

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

We're having the same experience with some of our local hospitals where they're actually putting policies in place to make sure that the patients do not get back to us.

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

Right. So, you know, unless you give the primary care physician – unless you actually put some teeth in that attribution it's not doing what it's intended to do, it's just not doing it.

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

So, would a fair way to summarize this be, you know, I think the wording here is a little tough or at least it was for me, maybe another way to word this might be, you know, explore ways to help ACOs manage patient "leakage" or "keepage" performance through, you know, feedback/notification of key clinical events like a hospital admission or a discharge or something like that. Is that kind of another way of saying what you all were summarizing?

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

Charles, this is Karen, I think that's exactly where I was going with this, you know, there is not much I think that the federal government can do to force community hospitals to share information, but if there is a of support for ADT feeds and various – particularly health information exchange organizations can make those available and make that data available to the ACOs so then that creates the opportunities that I don't think that the federal government can do otherwise. So, again, exploring ways to really scale ADT feed availability might be exactly where we want to go with this.

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

Just to clarify, I think, I mean, that makes a lot of sense because we heard so much input on scaling ADTs and I think it's also just becoming abundantly clear from a lot of our contacts across states and communities that this is a real priority and a lot of the pioneers and beacons have already implemented solutions, ADT services, really successfully with good results.

But, the survey and cert process is a federal mechanism that we could evolve to be more explicit about the discharge planning requirements as it pertains to hospitals responsibility to follow up with a treating provider. And the only reason I want to reinforce that this is an option you all can talk about and explore is that right now it's on ONC's radar, it's on the department's radar that this is a real problem that hospitals aren't sharing data is a serious policy issue that we're going to be doubling down on over the next year or two.

And this is going to be, you know, one of the things that will be, you know, it's under existing authority, it's something we can explore and it would be great to have everybody's thinking on is this something we should pursue?

I mean, it would be just a matter of probably, you know, refining an existing guidance that's sent to the state surveyors because they're already – in the last year they've already updated this guidance and it is more thorough with respect to discharge planning.

But there could be a more explicit expectation that the discharge plan actually does need to get in the hands of the treating provider and that treating provider needs to be known at the time of discharge.

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

I mean –

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

–

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

I just think that – oh, go ahead?

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

Well, I was wondering if what Karen was describing where people are being sent to another provider other than the primary care provider is partly incentivized by the re-admission penalties and people being uncertain about transition between systems and therefore trying to control it.

You know that you can manage people over the next 30 days if you keep them in your network. If you send them to someone else's network you're never quite sure whether they'll make it.

And really the concept of discharge summary versus transition of care is perhaps a little more than semantics here but re-admissions are providing strong incentives sometimes to keep people in network.

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

No, my personal experience is not that, my personal experience is that it's, as a physician led ACO it is seen as a market share grab, but, you know, perhaps there are environments out there –

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

Okay, I withdraw –

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

That are far gentler than Piedmont, North Carolina.

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

I withdraw my presumption of positive intent.

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

But, it sounds like though that everybody sees this as a major issue and something we need to include in the recommendation.

So, I think maybe to make it more manageable we might want to recommend that for all Medicare members who are attributed to an ACO that the hospital has to provide this information along the lines, I guess it was Kelly who was speaking, suggested.

So, how about we move onto number three on page six which is expand requirements as part of CMMI Programs to assure all subsequent innovations require evidence of behavioral health/physical health integration. Comments? I get a little nervous about the word “require” but others comments on that one?

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

Can we advance the slide?

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

This is Karen Bell, I’ve spent a lot of time talking to folks around the fact that without some integration of behavioral health and making sure that that’s really important and specified in the ACO environment and there is – huge opportunities are being missed and it doesn’t, you know, we’re not – we wouldn’t be specifying how you would integrate behavioral health, there are lots of different ways one can do that.

But, to not have behavioral health integrated into, particularly primary care, really is a problem for a lot of the ACOs going forward and it’s not just the care it’s also the behavioral health data. So, I think we do need something about integrating behavioral health, how we do that I’m not particularly sure about.

But, I think one of the problems that a lot of places have run into there have been these home health, CMMI innovation grants that are out there, and they are standalones, they don’t have to be integrated into regular care at all and it’s created some issues in some of the communities where there are health homes that are functioning completely independent from the physical health system and that just has been, as I say, problematic for some of the ACOs in those environments.

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

Many of us live in states where the public health rules were drafted in the 1950s and have never been revised to take into account electronic records or interoperability. So anything that – there may be some opportunity to force, from the federal level, re-evaluation of that which many legislators just haven’t gotten around to.

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

Hi, this is Shaun Alfreds, I would tend to agree with both the previous comments around behavioral health.

And I was thinking about a way in which a recommendation could come down that would have some means of being implemented and I’m wondering because of the high prevalence of behavioral health disorders and those persons who are receiving Medicaid coverage around the country, perhaps that’s a means by which we could make a recommendation that would be focused and implementable as related to perhaps the CMS 9107525 match funding related to Medicaid Health Homes Patient-Centered Medical Home Initiatives that they include a behavioral health component.

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

Very good suggestion. Any other comments on this bullet? Okay, let’s move to – if we could advance the slide to slide number seven, issue number four seamless data integration.

And just to kind of refresh our memories on the hearing input there were quite a few comments about the need for discrete data and comments around data liquidity that the more PROs based or document level sharing standards were really not sufficient for what was needed for success within an ACO and so this opens the door to a conversation about, you know, true data level interoperability.

And then there was a second area of discussion about even if you can extract the data then get an insight from the aggregated data how do you get it back in front of someone who is actually taking care of a patient to alter a behavior or alter a decision such that the care is more consistent with the evidence-base or more efficient or whatever the case may be.

So, you know, detailed recommendations to the right as well as any other recommendations people might have, but the first one is to require even greater Meaningful Use requirements around for instance notification and labs and then secondly require and promote data sharing by requiring the EMR vendors to provide APIs that enable specific Health IT programs to take out specific data from the EMR and then be able to put it back.

So, I think the notion of this recommendation is we saw the need for potentially analytic environments that might not be formally part of the EMR but are tool sets necessary for success in an ACO, developing some standardization around what the data extract would be and then finally, whether it's CCD or other some kind of standard way of getting the information back within the EMR. Comments?

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

This is Karen, I would agree I would just change the name of this recommendation because it's not just about data liquidity for population health it's about data liquidity for all aspects of patient care.

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

Thanks Karen. Other comments?

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

Well, the PROs is not great for managing a population but it's often very important for managing an individual so I think there's a balance between those. This is Hal.

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

This is Frank, we've got two recommendations on this and I applaud both of them, but I think, you know, something that is missing from this is that when we talk about developing these standards that are going to drive this that when we make a mention for notifications and labs I think we've got to be careful because that's kind of a limiting set of information that – you know one of things that comes to mind very quickly is for electronic prescription data to be pushed and pulled, and you know, there are some other things that should possibly go in there if we're going to actually itemize it, if not I'm not sure that this lends any support to the idea that we're trying to get across.

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

So, one of the things that we heard at the hearing also was the need to establish a common or shared understanding of the patient. I think it was – maybe it was Dr. Tyner or one of the other physicians talked about how if there are 20 physicians taking care of the patient and therefore, you know, 10 different EMRs potentially that may create 10 different understandings.

And the importance of creating that shared understanding through, and again I don't think we got specific solutions, but I think maybe if we include it in the recommendation something along the lines of, you know, promote data centric or discrete data enabled functionalities which promote a shared understanding of the patient across multiple care team users, something along those lines. I think we heard a fair amount of that.

Now whether that's the right words for the policy or not, I don't know, but I do think the notion of a shared understanding of the patient was something we heard pretty loudly in the hearing.

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

This is Eun-Shim, but to have a shared understanding of a patient we do need then some sort of data set right?

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

Yes.

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

The data set can reflect the changes of patients throughout the healthcare delivery system. I think that's going to be a challenge, but I think to formulate that understanding we do need the data set I think that were agreed by several individuals, I mean, several professionals actually.

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

Any other comments around data integration? Okay onto –

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

Sorry, this is Alex, just one question on this item about the API recommendation which is something that we heard in the hearing, but I think, you know, an issue that has arisen is to what degree this is really realistic in terms of a requirement that would be – vendors would be willing to meet or if there is some sort of lesser version of this that could move folks more in this direction. I don't know if there are thoughts about the feasibility of that API piece?

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

Hi, this is –

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

Well, this is Charles...

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

Go ahead, I'm sorry.

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

No, go ahead please Frank?

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

I think that there is a tremendous amount of feasibility and I think the problem is that you almost have to walk away from an EHR, I don't know how many of you actually work with EHRs, but they're just – they're wastelands when it comes to managing process and I think they're wastelands because they don't allow the various groups in the clinical process to focus on what their jobs are, they force everybody to go through the entire process with everybody else which is very counterproductive.

And I think if you look at some of the things that are taking place, I mean, something as simple as a concierge's application that a lot of EMRs now are farming out, they essentially are partnering up with other IT firms to develop this, because this is kind of a standard set of technology out there that they can't master very readily on top of their somewhat bloated EHR so their allowing third-party companies to come in and obviously team up with them in a proprietary sense.

But I think that's what I see as potential that we can look at companies developing innovative new process management functions that don't have to be an entire EHR they just simply have to be, you know, be able to sit on top of the data source that drives the EHR so everybody that's in the clinical process then can focus on their functions and also handing off information to each other as necessary instead of forcing everybody to go through reams and reams, and reams of information the way the EHR vendors are doing it today.

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

So, Frank, I think that's a great point. Could you imagine some kind of a scenario, you know, if we get pushback on the API point to leverage something like a CCD, you know, create a use case or a standard somewhat similar to the CCD specifically thinking about the machine readable component that we might leverage to kind of achieve a somewhat similar end or do you think we'd have to go all the way to specifically defining an API?

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

I think we just – what we would have to do is we would have to come up with some means of declaring that the content of the EHR database, because it contains public health information, has to be definable. So, there has to be at least a standardized definition which HL7 I think does quite a bit of it already.

But at the same time as far as APIs are concerned once you open up a vendor's data dictionary, once you understand what the vendor has in there and how it maps to standardized discrete data components the APIs then those are just ways of getting information out and putting information in a structured format instead of just doing it willy-nilly.

So, the API is really just a tool. The true thing that you've got to have is the data definition, you've got to have the data definition.

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

This is Hal –

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

This is Karen – go ahead Charles?

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

Hal, I was about to follow on what Frank said and to Alex question, I think it's – you may want a subsequent slide, it's very hard for us as individual clients to push a vendor to take on this task and add it to their process and they have intellectual property, reasons of wanting to keep everything closed, but Frank made a very good case for why innovation and freeing the data is so critical.

I do think that the feds, federal platform for pushing for an API is appropriate though it may be politically hard from a vendor and CIO, and clinician point-of-view. It would be tremendously liberating to give us that kind of freedom.

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

And this is Karen, I would agree. I think that the vendor community is going to push back very hard on that on the API concept at least in the short-term. There are so many vendors who are entrenched particularly in the hospital situation almost with a monopolistic point-of-view that it's going to be very difficult to get them to change.

Having said that, however, the vendor community is innovating and there are some that are moving towards the API model and I think that as time goes on – excuse me –

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

God bless you.

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

As time goes on I think that, you know, people are not married to their technology forever, people are – both hospital systems and physicians are changing EHRs over time and I think that we are in a situation in short-term where the API model is not going to be very strong, but I think ultimately, over the next, I would say, maybe 5-6 years I think that we are going to go in that direction but the market will drive it there not so much policy.

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

This is Irene Koch, I think maybe along the lines of what we've been discussing perhaps it's also important to think about, not just for this recommendation, but for some of the other ones that we've been batting around we need to split the baby and maybe it's not so much about the API or the technical mechanism of how the data gets there but rethinking even how much does one provider's EMR need to do and absorb completely in and of itself versus thinking about, you know, using components from other places which of course are part of what's envisioned in Meaningful Use anyway.

And maybe part of the pushback we get from vendors is the thought of them taking in the data it's not so much technically taking it in but having to absorb it into their EMR as if it's this own provider's data that's a lot of the pushback that I hear and maybe if there is a way to sort of phrase it in such a way to have an option of a separate HIE repository vendor, you know, component that does some of this work of population health report or other types of aggregated patient centric view maybe that's a little bit more palatable.

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

Well, I do think – while I agree with the comments regarding the vendor community I think there have been, as Karen as you indicated, some movements away from or I guess I should say some positive indications that what we're thinking about might be both doable and palatable although I'm not sure how palatable it is to the vendor community should rank particularly highly on our concerns.

But you will recall at HIMSS that CommonWell was formed as an alliance across multiple EMR vendors and although, you know, we can debate how much of it was marketing and how much of it was, you know, a deep intent to really promote information sharing it does seem like – I'll use that as a reference point that the vendor community is at least showing signs of starting to come around to this way of thinking and, you know, maybe that's something that they could build on should we pursue with this recommendation.

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

Yeah and this is Irene again, I'm not, you know, as familiar with what they're going to show this year in terms of what they've achieved, but, you know, there is interoperability in terms of being able to send data from one record to the other as a document but then absorbing it and having it available for analytics and population health of course is, you know, even deeper integration.

And maybe what I'm – you know, what I'm suggesting is maybe that part can be done elsewhere and not within the EHR that's the main, you know, documentation tool or maybe it's done in a separate new type of forward thinking EMR that is a shared EMR among different types of providers who are jointly coordinating care like some of the providers that talked about solutions that they're using for their ACOs, but maybe, you know, in the beginning phase where we can get the benefit of shared data across silos but not have it have to live simultaneously in everyone's EMR when it's shared.

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

So, I think Alex, I think what we're hearing –

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

Can we –

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

Oh, sorry, did someone have a comment? Please go ahead.

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

Oh, this is just Grace saying that if there were no comment we could go onto the next, but it sounds like you're getting ready to do some brilliant summary, so go for it.

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

Let's see, onto patient centric shared care plan. So, you know, you'll see the input on the left but I think the notion of within an ACO having a care plan on a per patient basis that is shared across the care team where the information is appropriately integrated and that the care plan is updated as, you know, the care of the patient and new data sets are acquired.

And the second bullet point we see below is a point around the nature of team-based care that we need to think of in an ACO environment not just the care of the physician but the care team itself and that in an ACO environment you are likely to have various individuals with various skill sets be they healthcare coaches, nurses who might facilitate, you know, care coordination, transitions of care, chronic disease, management prevention, mitigation, training, behavioral health, etcetera that we are really talking about a larger definition of a care team.

And that as we think about managing patients in that kind of environment a care plan that is centered on the patient but shared across the team is something that the people providing testimony at the hearing indicated a need for.

So, if you look the right the detailed recommendations, let's see, you know, should we have an HIT Policy Committee Tiger Team just specifically focused on this issue of care plans, how do they work, who accesses it, how is it updated, what does it need to do in order to be value generating and used across all of the different people with different skill sets and different requirements or different functions in support of the patient. So, kind of, you know, a deep dive on what a shared care plan should be, could be and would generate value around.

Second bullet, consider a requirement that providers have to collaborate around a care plan and is there a way to use the policy lever to actually promote these kinds of ways for patient management and is that in fact appropriate.

And then finally, and this one is a little bit out of my field so I'm going to defer to everyone else on the call, standardize the building blocks for social determinates of health data and I will defer to others as to the appropriateness of that one. But comments on the detailed recommendation section?

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

Well, this is Karen, so maybe I'll jump in with the last one that you mentioned Charles then I'll preface it by saying I think that probably we all heard the same things from everyone whether they were at those meetings or another venue set that having a shared care plan is absolutely critical in this environment for all the teams taking care of the patients.

The issue on the building blocks for social determinates of health data in the end this comes down to the fact that everyone's health and the population's health is much more defined and driven by social determinants than frankly what the delivery system has been doing.

So, again if the group is accountable for the overall health of the patient having some information around those social determinates is going to be critical and in the same vein that having data around total cost of care is critical, having data from ADT feeds is critical it's another data source that's going to be important for managing patient populations.

I'm not sure it actually belongs under this particular recommendation because I think it's a separate piece of work that would have to get done. There would need to be some agreement on exactly what are the social determinates of health that would be important to know and what can be done to bring that information together because it currently exists in lots of different silos and lots of different states, it's in social services, it's in corrections, it's in housing, you know, there are so many different areas that one would find this data and to really think about making it available to people who are taking care of patients and taking care of populations is going to require a lot of thought and guidance perhaps independent of what it takes to do a shared care plan.

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

Hi, this is Frank, you know, I read this and I just – I think about primary care as being the inner ring of healthcare delivery and we've got every ring that exists in this here and I wonder, you know, I wonder how much of – you know, we're working on the basic mechanics of being able to simply share information between providers that need to be talking to each other on a day-to-day basis and then we're going to branch out and try to bring in all the social aspects of it as well.

I don't deny that it needs to be done but we don't even know what the problems are out there, because those people haven't participated in this discussion. So, I'm not sure number three is something that needs to be in there either.

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

This is Hal, my take is that these aspects that impact health are all details of care and amount to our ability to manage them and select them is not terribly robust yet we're more into sick care than the healthcare paradigm still and we're transitioning.

I'm wondering whether that may be, you know, an IT generation down the road, you know, the higher ones are more about treat me like you know me and having more than just the primary care provider know what the values and the goals of the patient are, POLST and other activities trying to make sure that those are well coordinated and that we're taking care of the people who have the biological problems and not just their biological medical problems, I think they're two different things and one of them may be more reachable at this stage in our transformation as a country and the other one is noble but I think a bit further out from our current – system.

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

I think in that – this is Karen again, I think in that vein, you know, separating the third one from the first two is probably something most people are addressing and that makes a lot of sense to me as well as I said before.

I think that the challenges of bringing information around the social determinants of health are such that it will take several years before this starts to become available whereas we could certainly move forward with a shared care plan platform much quicker than that.

I think, you know, the real issue comes down to, as ACOs move forward and become more and more responsible for reining in the cost of care, a lot of the high risk, high cost patients that will exist will be Medicaid, will be dual eligible, will be a lot of the vulnerable populations that right now may not be on their radar screen but as they move forward, you know, managing a diabetic who is suddenly homeless is going to be very different and much more difficult than managing one that is comfortably situated in their own home.

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

And this is Kelly –

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

And that's where the social determinates will become important.

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

Yeah, I completely agree with all of your comments and I just wanted to note that I think while it is a few years out before this becomes anything that could be, you know, considered that would be really readily available or scaled, this kind of data, I think it will be increasingly and important part of risk adjustment as well.

So, there is probably several different, both sort of clinical, you know, need for this over time, but also I think it's going to be increasingly important for both payers and providers to have, you know, some of these data elements available to be able to appropriately risk adjust.

And there is some work that is starting and I think – I don't know if it's being contemplated in Stage 3 but in some future part of Meaningful Use to try to have some data capture in EHRs that would allow for these kinds of data elements to be more routinely part of the EHR.

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

This is Irene Koch, yeah, I just want to reiterate that the experience that we have in New York, and Karen Nelson testified at the hearing and talked a little bit about this, is very much based on Medicaid patients many of whom are homeless and so forth and the social determinates are a really important factor in what they're trying to collaborate around.

And while I understand and maybe even agree that certainly this can't be, you know, a required component of what we recommend I think it would be a missed opportunity to not at least include it as a recommendation of something to really explore and build toward standardizing.

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

Okay, very good, I think we're hearing a lot of comments on the social determinates, we didn't spend too much time on the care team, sorry on the care plan comments, numbers one and two, any comments on those before we move on? Are people generally in agreement or any concerns or additions?

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

This is Alex, I'll just throw in, you know, I think what we heard is that while there are definitely a lot of efforts afoot to try to get to greater standardization around care plan elements and some of the things going on in the S&I Initiative, you know, maybe the area where the most challenge was, was around the policy issues and the issues of rural-based access that, you know, a couple of places have clearly figured out very well, but, you know, in other parts of the country that model is not clear.

And so to what degree the group could move the ball or the Policy Committee or other group could move the ball of understanding those models better was perhaps the sweet spot for a recommendation at this stage of the game rather than where not a huge amount is known on that front.

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

Okay, very good, thank you Alex. Why don't we go ahead and move to the next slide and this was a comment, this is slide nine, vendor compliance, and to just summarize it here we heard a lot of frustration and abrasion between the vendor community and their customers with very strong language used, I mean, Dark Ages or, you know, not having enough leverage to get vendors in the same room to talk about data sharing even when you're one of the largest hospital systems and have one of the largest EMR/EHR implementations in the country.

So, any couple of comments here around the detailed recommendation? The first one being we have created a system of certification from an EHR and here we would introduce the notion of potentially revoking that certification based on performance.

I might say it a little differently and that is perhaps moving away from a system focused on certification or maybe supplementing our current system based on – which in my mind is do you have the capability yes or no to one of accreditation meaning maybe we supplement the certification process with an ACO accreditation process and that accreditation process might be based on ACO customers of the EMR vendor and would look at things like performance.

For instance, as we've heard today data sharing is critical to ACO success and yet we heard a lot at the hearing about vendors dragging their feet and requiring expensive upgrades or other performance oriented or financially oriented issues. Perhaps those kinds of things maybe are accredited at a certain level if you do data sharing at all maybe you're accredited at a higher level if you're able to, you know, within 30 days have a data sharing utility up, maybe if it costs, you know, hundreds of dollars or single digit thousands versus, you know, tens of thousands or hundreds of thousands. But issues like that and create an accreditation system which would allow you to kind of have a more educated perspective as you look at vendors to partner with.

Secondly, compliance testing, be more specific to not only send and receive but again emphasizing the importance of data for instance maybe in the CCD requirement, requiring the machine readable component to be tested at a lower level of granularity.

And then thirdly, strengthening the measure threshold about cross vendor exchange so, you know, instead of perhaps, I think in Meaningful Use Stage 1 you had to only produce one eScript but make those requirements deeper, more comprehensive and more aligned with ACO success. So, comments on those three columns?

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

This is Hal, I love the idea of accreditation because we can find ourselves at times, like I am right now, with an uncertified code that's not capable of being used to meet Meaningful Use and so you get this kind of paradox situation. Accreditation sounds like it would meet a functional reality for the end-user client.

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

I think, this is Karen, I think, you know, when it comes to the actual working of the technology itself certification is a system that can work and you could certainly decertify, you know, you'd have to change how certification is constructed at the moment, but certification certainly would work from that perspective.

The concept of accreditation on the other hand I think is very interesting and I actually have a question back for you on this one Charles because as you know in NCQA does have an ACO accreditation program, it's not particularly strong around health information technology, but it has not been very popular.

There are certainly a number of organizations, including Grace's, who have been accredited, so, congratulations Grace, but in general it hasn't been that popular because there is not very much teeth that goes into it.

So, I guess the question I would have Charles is as you talk with other payers is the payer community interested in an accreditation like the ACO Accreditation Program that NCQA has and from the perspective that in order to have a contract with a prospective ACO that you might require?

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

A point of clarification Karen, we did not choose to do NCQA recognition for ACO we have it in all of our medical home level three's and many of their other programs, but to your point, we did not think that at this point it gave us utility.

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

Oh, well, thank you, well that probably makes the point even greater because it seems like most groups are not finding that it's very useful, but it is a program that is out there, it's accreditation and it looks at all of all the pieces that an ACO needs to do, but when it comes to just the technology alone a certification program, if it's created appropriately and designed appropriately, would probably fill this bill.

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

Well and I may be – I may be over using some semantics here, I think, you know, the notion of certifying an organization and then decertifying them based on customer evaluation/performance as to how they are in a real world performing I think would largely accomplish the same thing.

I had always thought of, you know, certification as something closer to, you know, the, I don't know, Good Homemaker's Seal of Approval or something, we've tested this thing in a lab, it does what it says it does, it's performance is – and then, you know, again I'm using the word "accreditation" but certainly, you know, you could look at a certify/decertify approach.

In the real world with real customers, you know, I am, I'll just make it up, an Epic customer, I signed an ACO contract, I need to enable data sharing across EMRs 1, 2, 3 through 10, does it take me a day, a week, a month, a year, 5 years, does it cost, you know, and maybe think about some level of performance standardization.

But, I don't want to get too caught up on accreditation versus certification I think that the notion is more of the principle of kind of a grading system around real world performance and let's say real customers who are trying to drive down the ACO path.

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

Got it, so whether we were just looking at the technology, i.e., a vendor certification would take care of driving them in the right direction and what you're talking about is more how an organization functions. I guess the real –

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

No, no, no.

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

No?

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

No I'm actually still focusing this all on a vendor although we should have that discussion, but I think from a – we were – what I was trying to articulate is how does the vendor, meaning the HIT vendor, perform in supporting their organization, their customers who are organizations walking down the path from volume to value or from fee for service to an ACO. So, I meant this in a – and I think what we heard from the hearing was in a vendor specific meaning HIT vendor specific direction.

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

Got it, thank you.

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

Hi, this is Frank –

Caitlin Collins – Project Coordinator – Altarum Institute

...everyone, I'm very sorry to interrupt the conversation but we're passed our scheduled end time and we still haven't gotten to public comment.

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

Okay, well we'll have to pick this up at the next meeting. I apologize to everyone, maybe if you do have comments is there a place they can e-mail those comments?

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

Yes, please share any other comments you had with me and we'll be working to incorporate all the great input today and reaching out between now and the next meeting to further evolve these.

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

Alex, this is Karen, can we share comments with each other?

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

Yes, by all means.

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

Okay, so legally we could sort of just reply all and share comments amongst us all?

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

Yeah, I believe so.

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

Okay, thank you.

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

So, shall we go to – and that's Hal is your e-mail address correct? Hal Baker or –

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

Yes.

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

Yeah, okay.

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

I'm sorry –

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

Shall we open up the phones to public comment?

Public Comment

Caitlin Collins – Project Coordinator – Altarum Institute

If you are listening via your computer speakers please dial 1-877-705-2976 and press *1 to be placed in the comment queue. If you are listening via your phone please press *1 at this time to be entered into the queue. We do have a comment from David Tao.

David Tao – Technical Advisor - ICSA Labs

Hi, David Tao from ICSA Labs thanks for the opportunity. I wanted to comment on the bullet about APIs in recommendation number four. Standardized APIs to extract data from EHRs is very actively being discussed in the S&I Framework Data Access Framework Initiative, also called DAF, and many vendors are participating in that and it's also collaborating with the IHE organization that many vendors are part of.

However, the APIs to put data into an EHR aren't within the scope of that initiative and to my knowledge they would be much more challenging. One exception is patient generated health data because the recommendations from the Consumer Technology Workgroup proposes getting patient generated data into EHRs as a Consolidated CDA document with a clear identification as to the patient's source and vendors are already accustomed to processing Consolidated CDA.

However, granting data input privileges to some third-party application through an API seems like a much bigger stretch and I expect that if there is pushback it would probably be on that. Thank you.

Caitlin Collins – Project Coordinator – Altarum Institute

We have no further comment at this time.

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

Okay, very good, well look I'd like to thank everyone for sticking through what was a long call. I think Hal will have to pick up some time at the next meeting to finish up and I look forward to talking with everyone at the next ACO Subcommittee meeting. Thanks for your contribution.

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

Charles one clarification, Alex –

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

I'm sorry, I said Hal and I should have said Alex.

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

Oh, well.

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

Got it, thanks everyone.

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

Thanks, goodbye.

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

Thanks.

Public Comment Received During the Meeting

1. Here's a public comment I would like to make on the phone at the end of the call, included here for the record. This is David Tao from ICSA Labs. Thanks for the opportunity to comment. Regarding the bullet about APIs in recommendation #4, this concept of standardized APIs to extract data from EHR is actively being discussed in the ONC S&I Framework "DATA ACCESS FRAMEWORK" initiative, with participation from many vendors and collaboration with the IHE organization. However, APIs to put data into an EHR are not within the scope of that initiative and, to my knowledge, would face many challenges. An exception is Patient-Generated Health Data: recommendations from the Consumer Technology Workgroup propose getting patient generated data in as a Consolidated CDA document, clearly identified as to its source: vendors are already accustomed to processing CCDA. Granting data input privileges to another application through an API would probably meet much more pushback.