

**HIT Policy Committee
Accountable Care Workgroup
Accountable Care and Health IT Hearing
Transcript
December 5, 2013**

Attendance

Members present:

- Charles Kennedy
- Grace Terrell
- R. Hal Baker
- Karen Bell
- Craig Brammer
- Joe Kimura
- Irene Koch
- Frank Ross
- H. Wesley Clark

Invited present:

- Micky Tripathi
- Heather Jelonek
- Helen Burstin
- Hunt Blair
- Paul Tang
- George Hripcsak

Members absent:

- Shaun Alfreds
- Scott Gottlieb
- David Kendrick
- Eun-Shim Nahm
- Cary Sennett
- Bill Spooner
- Samuel VanNorman

Presentation

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

Thank you. Good morning everyone; this is Michelle Consolazio with the Office of the National Coordinator. This is a meeting from the Accountable Care Workgroup on Accountable Care. Today we're going to do roll call a little bit differently, we're going to go around the table, because this is the first time the Accountable Care Workgroup has met in person, so it would be for everybody to see whom each other is. I also – we have a few people trickling in because I know there is some confusion, there's the Marriott Gateway and this Marriott, I know people often go to the wrong hotel, I did myself. So, hopefully people will be trickling in as we do roll call.

As a reminder, today, for those giving testimony, you have five minutes. It's the worst part of my job; I hate having to cut you off, but I will cut you off. There will be a five minute clock set, some of you have experienced this before, so please don't make me have to tell you to stop talking, because I hate it. But, hopefully we'll have a great day. And with that, I'm going to start with Craig to introduce himself and we'll go around the table.

Craig Brammer – CEO – HealthBridge

Sure, thanks. Good morning, I'm Craig Brammer, the CEO of HealthBridge in Cincinnati.

Ahmed E. Haque – Project Officer – Office of the National Coordinator

I'm Ahmed Haque and I'm with ONC in the CMS Innovation Center,

Micky Tripathi, PhD – President and Chief Executive Officer – Massachusetts eHealth Collaborative

I'm Micky Tripathi with the Massachusetts eHealth Collaborative.

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

Frank Ross with Cumberland Center for Healthcare Innovation.

H. Westley Clark, MD, JD, MPH, CAS, FASAM – Director, Center for Substance Abuse Treatment – Substance Abuse & Mental Health Services Administration

Westley Clark from the Substance Abuse and Mental Health Service Administration in HHS.

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

Charles Kennedy, Aetna.

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

Grace Terrell with Cornerstone Healthcare.

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

Irene Koch with Healthix.

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

Joe Kimura with Atrius Health.

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

Heather Jelonek with the John C. Lincoln Accountable Care Organization.

Helen Burstin, MPH, MD, FACP – Senior Vice President for Performance Measures – National Quality Forum

Helen Burstin, National Quality Forum.

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

Karen Bell, Chair of the Certification Commission for HIT and Independent Consultant.

R. Hal Baker, MD – Vice President and Chief Information Officer – WellSpan Health

Hal Baker, WellSpan Health.

Hunt Blair – Principal Advisor, State HIT-enabled Care Transformation - Office of the National Coordinator

Hunt Blair, Office of the National Coordinator HIE Team.

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

Alex Baker with the Office of the National Coordinator, Beacon Program.

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

Thank you everyone. I should also mention, so this is an Accountable Care Workgroup Hearing, but we did invite the Chairs from other workgroups, so we have Micky Tripathi from the IE Workgroup, Paul Tang's coming from the Meaningful Use Workgroup and we have Helen Burstin from the Quality Measures Workgroup. So with that, I'll turn it over to you Charles.

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

Thank you. Good morning everyone and I'd like to welcome everyone to the first meeting of the HIT Policy Committee's subcommittee on accountable care. Just in a few opening remarks, let me just say when I joined the HIT Policy Committee back in 2009, 2010, we were very clear that the ultimate objective of the meaningful use activities was not just to deploy technology, but was to make it useful in achieving the Triple Aim, lower-cost, higher quality, greater convenience. And since that time, we've had tremendous success in the first step, which is getting the technology out there. Over 286,000 Medicare eligible professionals have registered for the program, over 139,000 Medicaid eligible professionals have registered and over 4600 hospitals.

But with that great success, our work, in my view, has really just begun; when you think about some of the challenges before us, for instance, the recent RAND study that documented the high level of dissatisfaction that physicians have with the current Health Information Technology. When you think about the relative paucity of proof points around improved financial performance or improved clinical performance, due to the use of technology, I think it becomes very clear that our work has just begun. I'm particularly excited about this subcommittee because it addresses one of the fundamental headwinds we've been facing, which is our fee-for-service payment system. The intersection of accountable care, the changes in reimbursement, and the technology that this organiza – this subcommittee is seeking to deploy, is a unique intersection, right here in this room for how we might actually be able to find a path forward for the transformation that we all seek. So it is with this perspective that I'm particularly interested in what individuals will say and our various panels will tell us.

Our objective, if I could have the – let's see, is this – here we go – is – the objective of the Accountable Care Workgroup is to make recommendations to the HIT Policy Committee on how we can advance the evolution of the HIT infrastructure that helps providers make the transition to population-based health care. And most importantly, do it in a high quality, lower-cost way. Our objective for today's hearing is really to hear from the experts we have invited, the stakeholders, as to how they use health IT to satisfy costs and quality business objectives under various accountable care arrangements. And we are really looking for an emphasis on real-world problems, real-world challenges, and things that HHS can do from a policy perspective to help address those fundamental challenges.

We're also looking for specific input on whether and how modular certification of health IT can be helpful in population health management functions and what we can do around the areas of interoperability or functionality that would help the transition to accountable care. And then finally, we're specifically looking for input on how the MSSP program can help accelerate and adapt the Health Information Technology solutions that are out there in support of population-based management approaches. So that's what we're trying to get out of the day, I'm very excited to hear what we will learn, and with that, let me turn it over to my Co-Chair, Grace Terrell.

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

Thanks very much. And I'm going to be the Howard Cosell color commentary, I think, just to liven things up. As you can tell from my voice, I'm from the South so I like to tell stories to sort of make my point, which is an unfortunate habit we have there. So my one-minute story is that in 1803, Napoleon Bonaparte was out of money, so he called up Thomas Jefferson and he sold him for \$3 million what became most of the United States territory, as part of the Louisiana Purchase.

And that was something that the federal government did that everybody questioned, and then about 34 years later, it ended up being very important as the railroad industry started. And the railroads were starting to build bridges in what ultimately became our industrial world, as we knew it by the end of the century. When they first started building those railroads though, everybody was doing it from their own perspective and different companies had different railroad tracks at different spaces apart and none of it fit together. And ultimately, there were certain decisions made by industry with a little prodding from policymakers that allowed there to be standard rails. And once they had those standard rails, we became the United States of America and a great industrial power because we had a new form of transportation.

So I think it's a metaphor for where we are right now in healthcare. My perspective comes from several places, I'm a practicing internist and I'm the CEO of a multi-specialty medical practice that has decided to basically morph all of its contract into value-based contracts. So we're in the Medicare Shared Savings Program, as well as all of our commercial contracts. We've invested heavily in IT through the years. I've been involved with the Certifying Commission of Health Information Technology where we've been looking from a private perspective on some of these same issues of what can we do about the fact that our railroad tracks just aren't fitting together? Because we've got some really important things that we need to do in this century for our new transportation system, particularly in healthcare.

So what I'm hoping will happen today is that we'll have a dialogue from all of the stakeholders who get it that we need to move forward together and that we're going to need everyone's perspective to understand and learn how to do that. My group participated in that RAND study and the other side of the study is that the physicians are very frustrated, but they see hope in what the possibilities are for health technology, they just know that we're not there yet. So, what I hope that we're able to accomplish today and what I welcome you all to do is for us to have a healthy dialogue in which we can learn from one another so we can get that railroad built.

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

Very good, Grace, thank you for that. I'd also like to mention that Paul Tang has joined us. Paul is the Vice Chair of the HIT Policy Committee.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

Very good.

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

And with that, I think we'll move right into our first presentation, which is from Clif Gaus, an overview of the accountable care landscape. Clif?

Clif Gaus – CEO – National Association of Accountable Care Organizations

Good morning, everybody. And I appreciate being invited to this very important committee's first committee meeting. This is an overview of what I'm going to talk about in 10 minutes. I'm going to talk very fast. A little bit about our organization, the National Association of ACOs and results about a recent survey, that have not been published yet, but they are going to be released shortly. And then I'll close with a few comments about what you and others could do to enhance the success of ACOs.

NAACOS is the only national organization owned and governed by ACOs. We were formed a little under a year ago. We advocate, we educate and we analyze problems and make suggestions, both on the policy side and the operations side. We have 77 ACO members and 54 business partners. And all our members now are Medicare Pioneers, MSSPs, managed payment; it's a good mix of the population. And we're expanding to the private payer ACOs in membership in 2014. Just a brief lay of the land, you probably – most of you may know all of this already, but we now have 23 Pioneers, down from 32. We have about 220 MSSPs, and I say about because there is a lot of merging and kind of consolidation that's under discussion now. So we'll probably end up with a little fewer ACOs in the current cohort, but of course we'll be adding new soon.

There's a total, therefore, of about 478 ACO contracts, 55 of these organizations have both private payer and Medicare, so net about 423 organizations, all building the railroads. The gross trend is that it appears from the – data, that the private growth, growth in private payer contracts is a little slower than Medicare for the last year or so. But I'm not sure that we know enough about what is going on in the private sector, it's a bit more difficult to gather that data. So my estimate is we'll see a total maybe of 150 new ACOs, so we'll be at almost the 600 level here in the very near future.

What are the success factors? Very little research around evaluating the ACO program, in fact, hardly any; we have the PGP demo and it's results. We have the Pioneer's first year, showed certainly improved quality and mixed financial results and leading to some of the dropouts. The 2012 April MSSPs have received interim financials and are not yet allowed to discuss those publicly and assume CMS and Terry may want to comment. I know we'll be releasing their results of that cohort of the first year – the first cohort of their performance in the first year. Across the spectrum, it's clear that the early targets the ACOs have are reducing readmissions, managing less SNF use, better coordination with specialists and managing chronic care to avoid the hospitals. There's also uniform agreement that current and good data and IT processing is essential for that success. The problem is, it's – we're not where we need to be.

We conducted a survey in the last month of the ACO population; the response rate was somewhat small, 35. We only had the survey for two weeks and it was a short survey. But it – the mix of the respondents was very encouraging because it was literally all across the spectrum of size, types, categories of Medicare. The average beneficiary count was 20,000 treated in the survey, so that's about probably the average of the Medicare ACOs. The predominance governance model was one legal medical group, sometimes with or without a hospital, but there are myriads of other operational legal affiliations. And we had actually several respondents that had over 100 different legal entities that defined their governance structure. We asked about what their anticipated financial expectations were, those results were mixed, about half – some had – were anticipating large savings, some were anticipating large losses, average gain and the average loss was about equal. But over half of them just didn't know and I think that is the bigger takeaway from this particular area, is that there is a huge gap in information that the managers of the ACOs have about how they're progressing and whether or not they are actually succeeding doing the tasks and the goals that they have.

We also asked about start-up costs, we've heard all kinds of estimates from consulting companies, from ACOs and we think the average of about \$2.2 million is pretty good. A third of those had acquired debt from a bank or line of credit or payments back to Medicare. And I think the important point here is that these organizations, small and big, are taking on a huge risk in creating these ACOs and we're worried that – how that can – how they can sustain the ongoing costs if of course savings don't come and come soon. We also dove deeper into the IT experiences of the ACOs because we wanted to better understand how they were fulfilling their needs and also what their satisfaction levels. We broke questions down in the internal staff costs and vendor contract cost. We defined the timeframe as the first year and we asked on satisfaction on a 10-point scale.

From internal costs the – you can see by size, they range from as low as average of \$200,000 up to 8-900,000. And similar for size varies, that expenses for external vendor costs also varied by size, and that's the grouping of the two. Not sure why the very largest of the ACOs whether this is an anomaly in our data or whether the very large ACOs are part of larger healthcare systems, who already have a platform and kind of are more making modifications to it than really starting from scratch. We also asked about how they process their claims and claims line fee data, this is the critical kind of flow of data from CMS. And we're surprised to see that actually a third – or I'm sorry, a fourth were external only, they relied solely on a vendor. A quarter did it themselves, had built the capacity internally. And then over half – slightly over half did it with a combination of both their own staff and IT vendors.

So we thought, well what about the satisfaction with IT? A 10-point scale, there was variation across certainly the cohorts in each of these categories, but I was pretty amazed at the fact that they all, whether they did it themselves, did it with a vendor or a combination, nobody was really very satisfied with where they were in their IT processing and systems. And I don't know six out of 10 is in my view certainly not a – what you expect from a high-performing organization, so. And then probably the most interesting question that we asked was what was the most vexing or frustrating problem in your first year of ACO implementation? And these were – these were text answers, which we categorized. In a few cases, there was more than one problem given, but pretty much single problem and the majority, more than half, of their major problems were around data and IT, not governance, not quality reporting. There were a few that essentially had unknown progress up there, 11 percent is a part of the group that just have no idea where they are in the costs and meeting their benchmarks. But I think this tells the story that we're not where we need to be in the ACO IT world.

Now, let me make a couple closing comments here about, just observations I guess I have from talking with our members and others. We all know that ACOs generally comprise at least several organizations and sometimes, like I said, over 100, and many of them have – most of those within the ACO governance will have a different EHR and in some cases, no EHR. So most of the times, they can't even communicate clinical data within their – the ACO network. It gets worse, the – probably half of the care of the ACOs is out of their ACO network and they have no idea until three to six months later from Medicare claims data, what the costs were, where the patients were treated and who were the treating physicians? So what that says is that these ACOs are handicapped from doing what we all think and all know they should be doing, which is coordinating care. If you look back on, why is that? I think as this country pushed forward with EHR adoption, we really favored speed over interoperability and we're now seeing the consequences of that big policy. We have a lot of adoption, but unfortunately, there are a lot of railroads being built. And even within one vendor and a hospital on the same system as another hospital typically can't communicate, because the variables are defined differently and major differently in the hospitals. So, I would say interoperability is the fundamental problem for ACOs. I think we've missed – we've built the EHR adoption model around fee-for-service and around providing good care in the facility that the patient is being treated in. This country is moving to population health and we don't have the IT infrastructure yet, I think, to support that movement.

Lastly, I want to comment on – there is one thing CMS could do, I think, that would help ACOs coordinate care better, and Karen knows about this, we've had discussions. And ACOs need to know when their aligned beneficiaries are being treated in a hospital or when they're going to – in an emergency room or being admitted to a SNF, because those are key drivers of cost and great opportunities to intervene on quality. And right now, there is no system except the Medicare system that can do that. And Medicare does know when a patient is – their eligibility is accessed by a hospital for an admission. It's complex and there's lots of false positives in this eligibility checking, but we think there's a way to filter out the impor – the extraneous eligibility checks and provide real-time data to the ACOs on where their aligned beneficiaries are hitting the emergency rooms, hitting the SNFs, and in some cases, knowing that in advance of the SNF stay actually. So anyway, I would encourage – I'm encouraging CMS, I encourage this committee to look into that aspect and see if there's something that could be done to accelerate that process of making that eligibility data available.

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

Thank you. We've got about 15 minutes for questions, so let me start and then I'll open it up to everyone else. So within the context of the concerns about interoperability and usability, what sort of policy type of approaches do you think would be helpful to move the industry along to where it needs to go?

Clif Gaus – CEO – National Association of Accountable Care Organizations

Well, I know that there's work afoot at least with meaningful use and Stage 2 and probably the – certainly the definition of a common data set and extract from clinical records would go a long way. It's not going to – it's not interoperability. HIEs I think on paper at least and in a few communities, have and are accomplishing the complex task here of walking – translating multiple, it's literally having a room full of people speaking, everyone speaking a different language and someone trying to simultaneously translate all of those languages into a common language.

And I think this committee and the government probably need to consider how – what kinds of incentives could be given to the EHR companies and systems to actually build the interoperability, agree to do that. I mean, I am told, and I don't know maybe somebody can answer – that the EHR vendors actually don't have a vested interest in interoperability. I don't know if that's true or not, but if that is the case, we've got a serious problem on our hands, so investigate that. What are the barriers to it? And bring them out into the light and let's see what we can do to improve that.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

Thanks, Clif, really appreciate your summary of the state of where we are, and I think you're absolutely correct in terms of care coo – the information in support of care coordination being a sore need. And you also know that meaningful use is pushing in one – are pushing the requirements for the technical health information exchange. We do describe it as a social technical challenge, so let's concentrate a little bit on the social side. You did mention sometimes there are some vendors who socially don't want to make that exchange. We've also heard that sometimes providers have that – are in that same situation, and as you pointed out, most of the A COs are a legal construct and do you – what amount of reluctance to you sense there is in terms of some providers not necessarily wanting to exchange? I mean, where would you put the social side of the challenges?

Clif Gaus – CEO – National Association of Accountable Care Organizations

Unfortunately, and fortunately, we've created a very competitive health system, and in some regions, there's a dominant provider, in others, there's not. Again, I think both – I think the federal government needs to explore incentives both provider incentives and EHR vendor incentives, to build the interoperability and allow it – basically allow it and encourage it. I don't think it's going to happen without either an incentive or someone has to pass regulation and I think in these days, probably forcing this through regulation is going beyond at least what we're doing with meaningful use, probably difficult. But once the public sees and the political world sees that we've now built these railroads, I mean Grace, you're absolutely right, we almost have built out the railroad system and they don't talk to one another. And there's just going to be an outcry.

If in my community, as a patient I'm admitted to one hospital and that hospital cannot get my records from another hospital. After we've invested all of this and now we flip the switch and say, hey, we're – we all have EHRs, I'm going to be really furious that I have to run across town to get the copy, or my wife does. So – and I think people don't – they aren't educated that what we're doin – about the building of the different railroads, I don't think public sees that. We think we're – it's like all problems are going to be solved when everybody has an EHR. And somebody needs to tell them, that's not the case.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

Follow up a little bit more on the railroad, I mean, you do have B&O coming down one end, and you have – I don't even know what the other railroads are, but they all think they have both the slickest train that goes the fastest and that they're going to win out. And that just not – just as soon not give in to the oth – and I think we have that, as you pointed out, both on the vendor and provider side. You talk about incentives, one thought that the ACO or MSSP was – had some built-in incentives, so what other things can we do? And I'm not even sure the "we" is the – on the government regulatory side, it's more the, how can we create the shared understanding that the best world for everybody would be if we did – or the uniform rules?

Clif Gaus – CEO – National Association of Accountable Care Organizations

I just – I don't see the ACOs as the solution to the interoperability or they are a voice in it, and interesting in the communities, they will become a more active voice, saying, hey, we can't do our job without this. But, the predominant number of the ACOs are small organizations learning the heavy lift of what care coordination is and redesign of care, undercapitalized, sometimes not even with an EHR and just in the process of implementing one, and they're not where we are right now. They're struggling just to close the books for December without having lost their shirt. So, they're not in a position, I think, to either invoke financial incentives from them, they don't have the money to do that. They have a voice and could argue in the community to do interoperability, but I just don't see them – we shouldn't look to them as a solution to this.

W

That was excellent, and really appreciate your testimony, Clif. My question has to do with backing up just a little bit. We're talking about interoperability, but there's a lot of data that we're also talking about that needs to remain interoperable. And I recognize that one ACO is not another ACO, so some are only doing upside risk and some are under full risk. With that in mind, is there a sufficient amount of data to really manage cost, particularly the high cost patients and quality to the degree to which one would need to do that under full risk? And I'm really talking about behavioral health data, I'm talking about social determinants of health, perhaps patient reported outcomes. Is that something that's a hot topic within the organization?

Clif Gaus – CEO – National Association of Accountable Care Organizations

I think there's, it's just my opinion, and it would be interesting to hear from some of the ACOs, what they feel about this, but I think there is ample data to really take down cost and really go after the low hanging fruit. I think there's – and there's a lot of that out there, the readmissions, the use of SNFs and the claims data can help, with good analysis, can help identify patterns, practice patterns that need to be changed, physician behaviors that need to be changed. Alliances between hospitals and SNF's that may be were working against the ACO success and so there is a lot of information that can be used, I think. As long as we continue and CMS can provide good claims data and there are some gaps that we're working on that I think need to be filled in that data to help us process. But that's a first stage in my view, and it's probably a stage that for the next few years, if we could just figure out how to use those data, to drive decisions in the ACOs and behavior of the providers, every ACO would succeed.

Beyond that, then there's another question about the whole realm of social care, patient engagement and long-term management of chronic conditions and non-healthcare impacts on that. And that's a kind of a – it takes a lot of other data that we don't see in the claims. And we don't see even in EHRs, so down the road I would say, we do need to expand that sphere of information, but we really have the possibility here if we could figure out how to process it well, pinpointing those low hanging fruit and really improving quality and lowering costs. Quality measures I think is a work in process and we do have a concern that not everybody's on the same page, not every payer's on the same page with their ACOs. As we move into the private world of ACOs, one of the things we think we can do is maybe facilitate agreements between the Medicare and the private payers around what are the quality metrics that should be used, so the ACO's not having to search their records for one payer, then search their records for another payer.

W

Thank you very much.

M

Your explanation of the problems resonates with I think many of our general experiences. And in your experience though, have you seen bright spots of anecdotal success that give you hope that there may be scalable successful Pioneers in this uncharted horizon?

Clif Gaus – CEO – National Association of Accountable Care Organizations

Yeah, absolutely, there's – not just Pioneers, there are MSSPs that have, for whatever reasons, been able to create the infrastructure, the IT infrastructure, to go after that low hanging fruit. And I think the – and they're going to show savings, so there are going to be some real success stories. There's also, on my one slide, I had that unknown, there's still a lot of unknowns about why an ACO is able to change patterns and reduce readmissions and reduce SNFs but for some reason, their claims or their costs and their reconciliations aren't showing savings. And there's – we need to understand more what's going on in the alignment of the patient and whether or not the current alignment formula, even for the MSSP world, is the best one, I'm not sure about that. But it's very difficult to manage a cohort of patients that's changing every quarter by a significant amount, and then adds up over the course of the year and your claims aren't in sync with your population. So at no point that I know of in an ACOs year of operation, do they have a good numerator of expenditures that is parallel to the denominator, the population. So most ACOs really do not really know an accurate PMPM from month-to-month or quarter to quarter.

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

Clif, I'd like to follow-up on a question Paul asked you. He talked about the need to change physician culture, physician behavior. I'd like to follow-up on that by exploring a little bit the need to change the financial culture and financial behavior of a delivery system. One of the things I've noticed is, when you have an ACO, and if it has any success in managing care better and reducing readmissions, you create a lack of volume within the hospital, within the delivery system, which has an immediate negative financial impact. And in order for the business model to make sense, I think you said for them to kind of not lose their shirts so to speak, you've got to replace that lost volume due to efficiency, and the only way to do that is either finding new patients or better leakage control. Or some people talk about keepage. Has your organization come across any innovative approaches that your members have used to address the leakage keepage problem? And how have their financial and administrative leaders thought about, they need to be thinking share of wallet now rather than just the traditional fee-for-service, how are they thinking about that transition?

Clif Gaus – CEO – National Association of Accountable Care Organizations

I think the hospital-based ACOs, and based is, I don't know, a vague term. But it's an ACO where the hospital is – it's in some way in the governance, in the shared savings. They certainly have a lot to risk and the better the ACO does, the more empty beds they have and there have been solutions. There are – the Geisinger system, and I happen to know it better than I do Intermountain and others. But, they over the years, took down utilization, hospital days per thousand, in both their health plan and the community at large and they figured out ways to fill the empty beds by expanding their market share. And now, that's at the detriment of somebody else's market share, but that's what competition is about. So unless a hospital administrator is ready to knock down a wing of the hospital, the solution to being in part of an ACO is you have to expand your market share. And that's what I think the successful population-centric hospitals are doing. At some point, there's a – you reach a point in a community where maybe there's no more – at some point there's going to be empty beds everywhere, and I'd love to see that day, I mean, I think that's the day we've succeeded.

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

Okay. Very good. Thank you, Clif. I think we're – oh, I'm sorry, Westley?

H. Westley Clark, MD, JD, MPH, CAS, FASAM – Director, Center for Substance Abuse Treatment – Substance Abuse & Mental Health Services Administration

Yes, I had a question – mentioned the issue of behavior health services or behavioral data, where does behavioral health fit in the ACOs that you know about?

Clif Gaus – CEO – National Association of Accountable Care Organizations

Well, I mean, it's an important element that they want to manage and have data on. There is a huge difficulty with not having substance abuse claims, a lot of those patients drive costs, drive big costs, but not even knowing who those patients are really handicaps them. And I think we've – we would love to see the two big HHS organizations figure out a way to provide those claims to the ACO.

H. Westley Clark, MD, JD, MPH, CAS, FASAM – Director, Center for Substance Abuse Treatment – Substance Abuse & Mental Health Services Administration

What about the mental health data?

Clif Gaus – CEO – National Association of Accountable Care Organizations

Say –

H. Westley Clark, MD, JD, MPH, CAS, FASAM – Director, Center for Substance Abuse Treatment – Substance Abuse & Mental Health Services Administration

– mental health data or parts of the substance abuse data? We're working on the former –

Clif Gaus – CEO – National Association of Accountable Care Organizations

I think it's mostly substance abuse, if I'm correct Terry, is that right? I mean, they have some mental

health claims, but the – so it's an important element and it's going to be a growing element, I think, because of the private sector's going to be mimicking and expanding benefits in behavioral health and mental health and the treatment. The understandings about how it drive costs are going to increase, but everybody that I talk to in ACOs says, we want more information about our patients in that arena. It's sensitive, and it touches on this privacy security side, but if we don't do it, we're again; your hands are tied behind your back.

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

Thank you very much. This has been a great way to start this and before Michelle gets nervous and has to ding us, we're going to thank you for your testimony and move now to the first of our panels, which is going to be the physician-led accountable care arrangements group. It's going to be a 90-minute panel where there's going to be some presentations first and then we're going to have about 65 minutes of discussion. So let me ask that the physician-led accountable care arrangements group come up, and as they are getting seated, we'll allow them to quickly introduce themselves and then we'll start letting them give some testimony. So why don't we start with Larry, and if you will, give a brief introduction as to who you all are and then we'll go back and have you each do your quick presentations.

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group

Thank you. I'm Larry Garber; I'm a practicing internist at Reliant Medical Group, part of Atrius Health in central Massachusetts.

Michael Weiss, DO, FAAP – Chief Medical Officer - Monarch Healthcare

Good morning. Mike Weiss, pediatrician, 22 years, now Chief Medical Officer at Monarch Healthcare, which is one of the Pioneer ACOs.

Stephen W. Nuckolls, MBA – CEO - Coastal Carolina Health Care, P.A.

Stephen Nuckolls with Coastal Carolina Health Care in New Bern, North Carolina. We are an advanced payment model ACO. I serve as their CEO for both medical practice and the ACO.

Troy Tyner, DO – Chairman, Quality Improvement; PHO Medical Director - Kettering Health Network

I'm Troy Tyner; I'm the Quality Improvement Chair for Dayton Ohio, and the PHO medical director.

Craig Behm – Executive Director, MedChi Network Services

Good morning. I'm Craig Behm. I'm the Executive Director of MedChi Network Services and the Executive Director of the three advanced payment MSSP Accountable Care Organizations that we own and manage.

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

Welcome to all of you and I'm presuming that the way you've got the slides teed up is by the – what's on my list here, so we're going to ask Larry Garber first from Reliant Medical Group to give us some comments.

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group

Thank you, thank you for having me here today on this important subject. So Atrius Health is an alliance of six multispecialty group practices in eastern central Massachusetts. We have 1,000 physicians, a Home Health Agency and we're a Pioneer ACO. And years before we became an ACO, we achieved the Triple Aim and we did this through advanced electronic health records with superb clinical decision support, health information exchange, patient engagement tools and home monitoring tools and very robust analytics and reporting tools, thank you Joe. And so I encourage everyone, if you would, to read my written testimony where I give the details of what we built and what we've achieved. I think will knock your socks off.

So the question is how do we achieve the same thing throughout the country? And I think the biggest pain point that we've fought through is the ability to automatically share information, have the information flow appropriately to the places it needs to go. I call that hassle-free HIE, and that's what we need to achieve in this country. So the pieces that we need to accomplish that are number 1, we need to have some standard codification of patient authorizations for release of information. EHRs need to know automatically if they're allowed to release information. The second thing they need is a place to store that, so in a community or in a state, we need to have relationship listing services like what Mickey's building in Massachusetts, where we can store these consents. So EHRs can automatically know who's authorized, who are the authorized members of a care team, so they know where they should and can send the information. Those relationship listing services should carry information about who the PCP is as well.

And then when they know where to send it, you need to have a national network of provider directories, standards for that, so that the EHRs now knowing where to send it, know how to send it to those locations. And those directories need to be automatically updated by the EHRs. The EHRs know where physicians work, they know when they're hired and they know when they're fired instantly. And they should be automatically updating these provider directories. We need to know what to send – EHRs need to know what to send and when. We've already been talking about sending summary documents and care plans, but we need to also know events such as when someone is scheduled for an appointment, when they arrive, when they're discharged from the offices, from emergency rooms, from hospitals, from skilled nursing facilities. Don't forget about long-term post-acute care providers. We also need to know when a PCP changes, so that we can know who to send information to, who's now caring for the patient and we need to know when patients die. Those events need to be passed to the care team members as well so that we can provide bereavement to the family and also not try to call these dead patients to come back for procedures.

We also need to have better standards for querying, so we can automate the process of querying. The recipient EHR – the EHRs that are the record holders need to be able to automatically decide if they should be responding to a query for information. So we need better standards surrounding that. Vocabulary standards are getting better, that's great, the one big hole right now is in the vocabulary for orderable tests and procedures. If you look it up, there's no single code, no single CPT, SNOMED or LOINC code for a thyroid cascade, so that's the kind of problem that's out there and we need to be able to standardize that to help us with our clinical decision support.

We also need better access to claims data. I've been getting – I've been receiving for the past 20 years, on a daily basis, claims data from the payer directly loaded into my EHR, so I know everything about – that happens to my patients and I know it in a clinically relevant and appropriate timeframe. It's great stuff, it's very valuable, it's easy to do, great standards for that and we need to make that available and supported by both the payers and the EHRs. We need to have EHRs also support standards for home monitoring devices. The integration of home monitoring devices is really so important for the future to be able to understand what's going on with our patients between visits, to identify – to treat them and obtain outcomes faster, as well as identify adverse trends that are happening between visits and act on them sooner. We also need to have better standards for prior authorization for medications, for tests, procedures. We need to be able to have EHRs automatically suggest the appropriate ones, gather the appropriate information and automatically obtain approval.

And then probably one of the most important things is we also need to harmonize the quality and safety metrics with what we use for billing, with the meaningful use measures. All of this needs to line up with what we are using clinically to take care of the patient, so that we are not trying to work twice to capture the same sort of information. And then in the last four seconds, stop the ICD-10 rollout because it's never going to achieve the Triple Aim. Thank you.

Grace Terrell, MD, MMM – President and Chief Executive Officer – Cornerstone Health Care, PA
Awesome. Thank you very much. So we're going to move on to Michael Weiss.

Michael Weiss, DO, FAAP – Chief Medical Officer – Monarch Healthcare

Thank you, and thank you very much for allowing us the opportunity to be here. I'm going to heed the opening comments of our Co-Chairs and really jump into the weeds of what the real world is like for a lot of our doctors. We are heading into year three of the Pioneer program and for those of you in the room that have been part of this; you know this is not for the faint of heart. I do thank many of you for all the hard work that you've done, and I bring those thanks from our organization.

Just as quick background, Monarch Healthcare is a physician led and governed IPA of 2500 primary care and specialty physicians scattered throughout all of Orange County in Southern California, 98 percent of the docs are paid under capitation arrangements, so population based payment. And we're at professional and institutional risk for about half of our senior patients. We do not own a hospital, we are quote, unquote "affiliated" with hospitals but in reality those hospitals are creating parallel ACOs and competing with us, so they do whatever they can to not help us receive data that would help to manage patients and provide better quality of care. Our docs see all lines of business, HMO, PPO, Medicare, Medicaid, adults, children, women's health, so Pioneer is, in many instances, a small percentage of their day-to-day work. So I think that's a very important point that we'll get back to.

We have about 250 of our doctors as part of our Pioneer ACO and about 21,000 aligned beneficiaries. Our current IT platform, we lovingly call it MacGyver, because it does a really good job and we're lucky to be one of the successful Pioneers, but it truly is homegrown and there's a lot of duct tape and paper clips. Half of our doctors are on an EMR of some kind, not the same one. We do sponsor an EMR within our organization, but that's only a small percentage of those doctors practicing. And as you can imagine, it's very expensive to put 2,500 doctors that may be in very small offices on EMRs, and they don't talk to each other to the comments of our first speaker. About 43 percent of our ACO population is encompassed within our ACO EMR.

We've created a proprietary software that has registry functions to be able to identify gaps in care and that is probably the most robust piece of what's used on a day-to-day basis. It's accessed via our EMR, but it is not fully integrated with the other EMRs. It's an office tool that's used by office staff, and I think that's really important for people to realize here, doctors do not sit at their computers and look at registries and say, Mrs. Jones needs a mammogram. They go in a room and take care of patients so all this stuff needs to be teed up and prepped and ready, so the EMR is a box. It's a program, it's about efficiencies and processes, and I think we need to be thinking about those efficiencies and processes as we move forward.

So to pain the picture for you, our typical doctor is in a one to two physician practice, they have three or four staff. They don't have any idea of what CPT 2 codes are, they've heard of ICD-10, but they're ignoring it and meaningful use may be something to do with a nine iron on a Saturday. This is how half the doctors in America practice and I think we need to keep that in mind that all too often, I believe we focus on these very tightly vertically integrated systems when we think about how to approach this and I think we need to be very careful about that.

So very quickly I'm going to go through three things, some of which have been touched upon. Provider and patient identification, it should be noted that about 87 percent of the care in our ACO was rendered by physicians who are not part of our ACO. This is the nature of the fee-for-service Medicare business. I would also mention that a big area where we have an opportunity is with specialist physicians, we've noticed that if you look at be spend in our ACO, 3.8 percent of the spend was with primary care physicians, the remaining was with specialists. So I think we need to be focusing on how we integrate HIT with our specialist physicians. The meaningful use metrics right now encourage – I'm sorry, the ACO metrics encourage PCPs to be on the EMR.

I'm rushing now. Timeliness of data, Mr. Gaus mentioned this, but encounter data versus claims data. If the docs don't know where the patients are, if we don't know where the patients are, we can't do anything. We need to work on that very, very carefully. And then the whole idea of chasing. Physicians in the grassroots really feel like they're just trying to keep their heads above water. So they're trying to avoid penalties, maybe work with PQRS, but that's very challenging. So we want to continue to support those independent doctors however we can and provide value to them and their patients. One second over.

Grace Terrell, MD, MMM – President and Chief Executive Officer – Cornerstone Health Care, PA
Awesome. Thank you very much. Steve Nuckolls?

Stephen W. Nuckolls, MBA – CEO – Coastal Carolina Health Care

Thank you once again for allowing me to testify here today. Coastal Carolina Health Care is a 50 provider, multi-specialty medical group based in eastern North Carolina. While the group is small in comparison to most here today, we are comprised of a good mix of providers with 60 percent specializing in adult primary care and remaining 40 percent specializing in internal medicine subspecialties. Our organization was selected by CMS in the first round of April 2012 as an advance payment model. The medical practice serve as the ACOs sole participant and it derives a significant portion of its revenue from its 11,000 Medicare beneficiaries.

We were asked to provide an example of actionable quality metrics and to outline the role of health information in helping the organization improve this measure. I think a good example is the percentage of diabetic patients whose last hemoglobin A1c was greater than 9 percent. Health Information Technology was needed to help identify the entire population of these patients to obtain a complete list of patients. We used our problem list, medication list, laboratory values, from our EHR and then we matched that against the diagnosis in our billing system. We then made sure each patient had been assigned an accountable provider, not always specializing in primary care sometimes the specialists are attributed – have beneficiaries attributed to them.

The providers were then given a point-of-care dashboard that was made available by our advanced payment incentive payments and that is integrated in with our electronic health record and we update that nightly so that they have actionable information every morning when they come in. We combined the dashboard with a monthly, unblinded paper report that each doctor in each department is listed individually. We review that paper report at all meetings, Department meetings, our staff meetings, and of course at our Board of Directors. Our findings with this, most of the patients who did not have an A1c on file were receiving care from endocrinologist or another provider outside of our group. We corrected this by having the staff enter the values manually in our system. The second thing that we found were that some providers did not realize they were accountable for specific patients, they thought somebody else was doing it. But by having each provider listed, that showed that they were accountable and they had to look at the list monthly and they had to account to their partners during meetings.

Our claims data also helped identify many patients who were not diabetics. This resulted in having to re-file corrected claims with different insurance carriers and it's one reason we have found that using the claims data is not as helpful in helping us meet our quality metrics. With one exception, we did find that the flu shots were very valuable because a lot of patients were getting those from area pharmacies and other things and so inputting that was a timesaver. Since – by using the processes, we were able to demonstrate that 98 percent of our patients currently had an A1c in the last 12 months and that we've improved our percentage of patients with an A1c, we started around 20 percent that had an A1c above 9 and we have that down to 8.3 percent. This is all possible by the ACO and the focus on these quality measures. So, that is there are actionable things, when you have a list of patients, the doctors know who they are, they can assign the staff members, as Michael said. The staff are the people who are doing this, we've had to add extra labor to the point of care to help meet these quality metrics and to push things forward.

But one thing, we could have reached our goal more easily if our records could have talked to each other. As part of the clinical care summary, if the EHR vendors were incentivized or made it to be a requirement that we could have to send discrete data between the different systems. I think that would really help the specialists that we send referrals to and that we receive the data back in. Whenever we enter manual information, that's not helpful. Every time our patients go to another office, they have to fill out another health history form that's in paper, there should be some way once that data is entered once, we can transfer it when we're making referrals. Perhaps that could be a quality measure that could be used as part of a later version of meaningful use.

There are a number of challenges that we have encountered, I'm going to switch over to the claims data now of the ACO, with the claims data that we receive from CMS as part of this program. And the main problem is it's completeness. Complete data is needed for a number of purposes including accurate profiling of provider practice patterns, implementation of reliable physician incentive programs and number three, ability to determine detail changes in utilization between periods. And some complete data will enhance accountability and increase engagement in performance. Complete data sets have not been made available because of patient privacy concerns, but I believe that patient confidentiality can be protected if identifiable data such as the HICN is removed and providers are prohibited from linking these claims to other clinical and data sets. Lastly I want to thank CMS and the Innovation Center for creating the advanced payment model; we would not have been able to do this without them.

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

Thank you. Troy Tyner?

Troy Tyner, DO – Chairman, Quality Improvement; PHO Medical Director – Kettering Health Network

Thank you. I've been a physician in private practice for the last 25 years. I wear many different hats at our organization; I'm the quality improvement Chair and Physician Hospital Organization Medical Director. I've rolled out IT solutions in my own practice as well as coordinated the protection of hundreds of order sets throughout our Kettering Health Network and I've directed network-wide process improvement projects. These experiences have shown me the hurdles in regards to the difficulties of meeting budget as well as driving quality care. Let me walk you through a typical day in my life. My first patient is at 7:00 a.m.; his primary care doctor referred him over to me. He has no idea why he's there to see me and I do not have access to any information. His only complaint is problems with his hands and he's been told he has gout. Unfortunately, the lab at the family doctor's office is not yet open, so I have no access to any records. I nevertheless come up with a care plan and the patient's on his way.

I'm off to the hospital and I'm on the ICU service. Overnight a gentleman was admitted for pneumonia, he does not normally come to our hospital system, so I do not have easy access to his records. He informs me that he cannot be in the hospital long, since he has an appointment with a thoracic surgeon for his esophageal cancer. I start searching online for his records from other institutions, but I have to go through screens after screens of information or data that has no real clinical importance. I find no documented evidence of cancer. Eventually I get to the path report and it turned out not to be cancer at all, and I had to tell him he did not have cancer and then canceled his referral.

I go onto my next patient. She's on a ventilator with no family. The medication reconciliation form shows that she's on a multitude of medications, all with possible drug-drug interactions, including two blood thinners. She's anemic and her abdomen is firm, so she could be bleeding internally. We order a CT scan, it comes back fine. We finally get a hold of the family and they tell us all of those blood thinners were stopped last year because she had a total knee done, and she's not been on them for months. We all her family doctor who tells me an entirely different list of medications as well; the family finally brings all the medications from home and, of course, they don't coincide with anything we have on any EMR or HIE. Now my office calls me and informs me that very first patient I saw that morning for hand pain was not referred over to me for his gout, but rather for a colonoscopy because of Hemoccult positive stool.

The next day I have to supervise our internal medicine residents at our clinic. The clinic, one half of the building is a federally qualified health clinic in Dayton, Ohio with a nationally top-rated EMR. Unfortunately, it doesn't interface with a single practice or hospital network. My residents are across the hallway at our specialty clinic where just last week we installed another nationally rated EMR, which of course, doesn't talk to the HQC EMR. So literally we have to lean across the divider and ask the primary care physicians, now why am I seeing your patient and what labs have been done, because the EMRs don't interact. Even if you have two different practices with the same EMR, the vendor – with the same EMR vendor, the don't communicate in anything close to being seamless, to do any disease management is fraught with problems. Yes they're certified EMRs, yes they can send CCD documents, but to do this on any scale is very, very cumbersome.

Each EMR or HIE provides a different snapshot of the patient's care. For each physician a patient meets, they have a different portal to get their information. They have a PCP portal, they have a urologist portal, they have an orthopedic portal, etcetera. Each has a different username and password, all with a different story to tell with silos of misinformation. What is needed for successful ACO model is a single understanding of the patient, not multiple understandings of the patient. As circumstances are now, the meaningful use criteria drive things to a documented based model, connecting the data silos together does not drive quality, but raises costs, hampers data mining and efficiency. And striving to improve care communities have developed and launched health information exchanges utilizing the exiting criteria. Unfortunately they have failed to live up to that promise. They do not have all the data about the patient and if they did, they don't provide any actionable data for the individual patient, let alone as a community. Existing vendors do meet the meaningful use criteria as written, but they are not motivated to improve things, they are ignoring the issue. They're very slow to respond and their architectural requirements hamper and constrain their products. In my heart, I think they all realize they have a Potemkin Village and the answer really is a patient-centric model. Thank you.

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

Thank you. Craig Behm.

Craig Behm – Executive Director – MedChi Network Services

Great, well thank you very much. I agree with everyone, and so – including Clif, so thank you very much for the opportunity and I'm not going to probably dive too much into the barriers because I think that they've been very thoroughly outlined. So maybe, and I'm from Maryland, we're not quite the South so I'll tell a partial story.

So I'm the Executive Director of three different ACOs all in Maryland, but all have providers across state lines. There all three advance payment, which I need to say is a very, very positive program. It's the only reason that any of these physicians could even dream of any kind of initiative like this. So that's been a very, very bright spot in this program. We have about 40 practices across the three ACOs, we have about a dozen different EHRs across those 40 practices, of course none of the EHRs talk to each other. And even some of the EHRs, which seem to be the same, are different versions or using different data base structures or in other ways, not working together. So it best goes with one of the many barriers of interoperability.

In Maryland, we are a little bit fortunate, probably for two reasons, one is, as you may know, we have the Medicare – we have a Health Rate Setting Commission with a Medicare waiver. So we're very fortunate that the hospitals are equally incentivized to get people out, as our practices are. That's been a very, very important aspect to this because it's in alignment with the Goliaths that are working with our doctors. We also have a very positive health information exchange, the Chesapeake Regional Information System, for our Patients, CRISP, is providing us with their encounter notifications, so we do have ADT feeds and can act upon discharge or admission information, which has been very positive.

I think it's important to remember first that this is a process, we had two of the ACOs awarded in July of 2012 and one in January, I mean we are starting from the ground up. So these community physicians, many have never served on a board before, many are not used to regular board meetings. We are working with three different medical directors, two of which had never been medical directors before. So it is a brand-new experience and I think it's also important to remember that this is on top of the PQRS world and meaningful use and PCMH program and e-prescribing, even. Meaningful use Stage1, ICD-10, Meaningful Use Stage 2, so throwing in one more acronym was overwhelming, which we assumed it would be. That's framed a lot of our work to really show the ACO as a resource, not as ends to a means and not has a some panacea to solve all the world's problems.

I don't, quite frankly, that many of our physicians, if any, are expecting significant payments from savings. I think that they're all thrilled to have free support with meaningful use and free support with PQRS and a reason to interact with each other that they wouldn't have had before. In these areas, for example, in Garrett County, one of the very rural, very sparsely populated counties in Maryland all the way out west, probably near Ohio – closer to Ohio than to the rest of Maryland, we have all the primary care physicians in the county, so there are eight of them. And three of the practices are in the parking lot of the hospital. And I think it's important to remember, these physicians are neighbors, they're competitors, some I know don't like each other and they have assured me they're all above average, which, of course.

But the ACO Program was a reason to come together, to take a leap of faith and to figure, well, at least maybe if we share data a little bit better, maybe if we communicate a little bit better, maybe we have some best practices and workflows, then we can hit, I think as Clif mentioned the low hanging fruit. At some point if we can do predictive analytics that would be wonderful. And if we can capture people before they're admitted from the ED to the hospital and get them directly into a short-term rehab or somewhere else, that would be wonderful. But today, the transitions of care, the flu shots, preventing readmissions, trying to schedule same-day appointments for tummy aches instead of letting people use the ED, these are going to move the needle, I think, very significantly. And then in two, three, four, five years we can be at a, I think, much more positive place. So again, I'm looking forward to our conversation and thank you very much for this opportunity.

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

Well we got through all of the first five testimonies without making Michelle nervous at all. So you guys rock as a result of that. So I think that you all have received ahead of time 11 questions, is that correct? Well, we tricked you because there are four more that you haven't seen that we wanted to explore a little bit about additional questions related to quality, particularly since this was the physician-centric panel. So I'm doing math here and there are 15 questions and five of you all, and we've got a bit of time, but not huge amounts of time, about an hour. So it would seem to me the way to do this, as we also have to expand it for others, will be for us to start with these questions and let you all sort of decide who might want to respond or add to a particular issue, if that makes sense to you. Does that sound like the way to do it?

Okay. So let me start with the first one you've probably seen, which was to identify high-value clinical strategies you're focusing on in order to meet costs and quality targets under ACO arrangements over the next five years. What are the key process, workflow, care delivery changes you're implementing to execute on these objectives? What is the technology strategy that supports each of these objectives? You see why we're not going to have all five of you answer all 15 questions. So does anybody want to start on that one, we've already gotten some testimony about bad experience and challenges, this is what are your strategies?

Stephen W. Nuckolls, MBA – CEO – Coastal Carolina Health Care

I'll start with one. We're a relatively simple ACO with one medical practice practicing in one hospital in a rural community. One of the first things we did was we tracked all of our hospital emergency room visits and admissions. We get a feed, just the regular discharge summary that would normally come in on a fax. We created a little database out of that, we had our Medical Director review all of our admissions and ED summaries every day. We send a note out to the clinicians, we report on it monthly. And it's just one way we tried to create some physician engagement. The things that we found, this is on the cost savings side, it does not have as much to do with IT, but we do – you do have to have a database and you do have to have those things working. but it is – creates physician engagement just to have something that you're focused on and looking at on a monthly basis. Thanks.

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

Can I just quickly ask, before you speak if you could state your name again for the record? Thank you.

Michael Weiss, DO, FAAP – Chief Medical Officer – Monarch Healthcare

Sure, Mike Weiss, our number 1, 2, 3, 4, 5, 7, 12 and 50 initiative is to try to figure out where the patients are. So we're working very closely with our 20 hospitals that we are not in ownership of, to try to get daily feeds of those patients going to the hospital. The majority of the spend, as everyone in the room knows, is at the hospital and if we can get there early enough and have our case management teams and disease management teams work with the patients and the families on care transitions, we're going to be much more successful. So I think that's probably our biggest challenge right now.

Grace Terrell, MD, MMM – President and Chief Executive Officer – Cornerstone Health Care, PA
Dr. Garber.

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group

Thank you, Larry Garber. So I think probably the most important thing we did is we wanted to make sure that all of our alerts and registries are actually giving accurate information and not giving false positives. So that's why we spent so much effort in actually bringing the information from wherever we can grab it, directly into our EHR. Whether it's from claims, whether it's point-to-point interfaces that we build, whether it's through the state HIE, anything that we can do to pull the information in automatically increases the likelihood that our alerts are going to be actionable.

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

So I'm going to ask one of the questions you all haven't seen yet, just to mix it up. So there's a lot of attention given to creating actionable quality metrics. How do physicians define actionable? And can you provide a good example of an actionable quality metric? And how does your practice drive accountability for those quality metrics? Whatcha doing?

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group

So we – .oh, Larry Garber, thank you. So we came up with this concept of actionable deficiencies and so in our registry, we have the barometer of actionable deficiencies, which is the BAD score. And so we focus on – what we did is we looked at okay, for our diabetics, hypertensive patients and hyperlipidemia patients, what are the things that are actually actionable, that someone can make a difference? Okay, they're obese, but today I can't make them lose 50 pounds suddenly. But if they're due for a test, we can make that happen, if they're due for a visit or procedure, we can make that happen. And so we come up with a score based on how actionable each of these deficiencies are, add them up, sort the patients to the ones who are the most BAD and those are the ones we address first. So that's – so actionable means that we can actually do something now.

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

This side of the room over here, what about you?

Craig Behm – Executive Director – MedChi Network Services

I'll take a stab – Craig Behm. I think a really good example of all the systems working together is the transitions of care. If we get a notification someone's been discharged, and we know based on standing orders they deserve a phone call, do the follow-up research and schedule an appointment with 7 or 14 days, we're working to prevent the readmissions. If it's a Medicare claim that the practice is actually going to increase revenue from, so they're kind of double incentivized to do it, and we know that it's going to have a significant cost impact in the long-term if we can prevent that readmission. So that's, I think, one of the good examples of a metric that's completely in line with our goals and the practice goals. And then the ACO is essentially a service on top of the practice to give them the data on the discharge and to give them maybe the hospital summary that they wouldn't have time or the ability to get otherwise.

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

Troy, when you were speaking, I saw a lot of heads nodding about kind of your reflections on your daily practice, it sure sounded a lot like when I practice, my daily experience. You also said something profound, a single understanding of patients and typically where I've seen single understandings of the patients created, has been in more of an integrated delivery system kind of environment where you are

all on a single EMR, and therefore at least all of the data within that system is, to a degree, a single understanding. Is that something, Larry, I'm struck by kind of your comments on how kind of positive you are about your experiences with health IT, are you in more of an integrated system? Or how do you all think about the value of a single understanding of the patient and what is the data foundation upon which you're operating to create actionable interventions?

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group

So this is Larry Garber. So I'm in a highly integrated system of ambulatory physicians. So I – we don't own any hospitals, but what we do is we have hospitalists in the hospitals. We have SNF-ists in the SNF's in the skilled nursing facilities and we're good friends with the home health agency, so we've built interfaces to bring all that information into me. So, I'm not the classic integrated delivery network without the hospital, but I get into my EHR every lab result, procedure that's done in the hospital, dictated reports, discharge notes, admitting H&Ps, ER notes, those are all loaded into my EHR. Even though they occurred in the inpatient, in the hospital that I don't own, I get all of that. And the vast majority of it that happens on the inpatient, I file it silently in my EHR so that I can use it to help me with my – make sure my clinical decision support files correctly, things like that and I count on the discharge summaries, which do come to my in-basket to summarize those things. So we're not truly integrated, but we've created an integrated environment.

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

That's wonderful.

Michael Weiss, DO, FAAP – Chief Medical Officer – Monarch Healthcare

If I could jump on that one a little bit too. So we're very similar with hospitalists and SNF-ists and all that, but I think, again I'm going to go back to the grassroots. Put yourself in an office, this piece of your day, maybe 10 percent of your patients and so I've created a registry that has 10 percent of your world in it, how much time are you going to spend on that and how much effort are you going to put on that? We align incentives, there are bonus metrics, we do all those things, but when a physician is asked to take care of their HMO commercial metrics, their Pioneer metrics, their Medicare Advantage metrics, their Medicaid metrics, it's five different registries on a system, each of which comprises 10, 15, 20 percent and then they have PPO fee-for-service patients with no accountability. It's very challenging to engage them in a non-vertically integrated system, just point of reference.

Stephen W. Nuckolls, MBA – CEO – Coastal Carolina Health Care

And to add onto what they say, we are, I guess, somewhat of an integrated physician group in that we have multiple specialties, we do not have a hospital as part of ours, we have all of our data that feeds in, the same as Larry. But we view ourselves as the central repository of data, which allows us to report monthly for everybody. So that when we go to set the quality metrics, we not only are setting them for our Medicare patients, but for every patient we have, and so we have a common – we have – our reports are set up with what we call thematic overlay. So that when we go in and do the reporting for plan A through D, we still do the same thing for every patient when they come through, the reporting has to be different and we try to contact on the same things, but you have to have the thematic overlay so the computers know how to report it. But I don't know how Michael's groups do it, there's no way you could keep up with this plan, this plan and the others, it would just be too difficult and if you don't have the data every month, by being not – by having everybody separated, that's going to be a very difficult thing to move and change behaviors.

Troy Tyner, DO – Chairman, Quality Improvement; PHO Medical Director – Kettering Health Network

Troy Tyner. In Dayton, we have – all the hospitals are on the same EMR vendor and when we were exploring the different vendors, it was the idea from the doctor standpoint that gosh, it would be great that we're all on the same vendor and everything can talk to each other and trade information back and forth and that'll be our nirvana. Obviously, it doesn't work that way, as you know. So really, the single understanding of the patient is really a key point in regards to understanding. All these things from my standpoint as Quality Improvement Chair, going to my doctors saying, work harder, work faster, think smarter, don't forget, look at this field, look at that field really is not where I want to go as Quality Improvement Chair. I want to drive towards quality, I want to drive towards allowing the doc, the nurse practitioner, whatever provider's seeing that patient to do their best, not to work around IT infrastructure. So really driving towards that one understanding is a key component, not multiple understandings.

And then on top of that, what we're all forgetting is letting the patient take care of their lives as well, where we have all these portals and nobody's accessing them, and if they do, then they have all this disinformation going back-and-forth. And so it's really that one patient understanding is really critical. One thing, not to use the metaphor all the time, was the railroads, which I like that metaphor. Because it decreased variance and I'm all about decreasing variance, but the problem is what's in the boxcar? And that boxcar is where you're taking care of that patient. And when I go into a patient's room and the family's there and I'm talking about misinformation – an example, just this week I logged onto the HIE that's available, and it said this patient was a heroin addict. And so I went in and started talking to her about her diseases going on and she wasn't fessing up. And she had never been a heroin addict. So that put me in a very, very bad position as a physician.

So the one understanding is a key component about this and not just interoperability, transferring data back-and-forth and going screen after screen after screen of data telling my doctors, work harder and jump higher is not where I want to go.

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

As a follow-up to that, of the amount of work that your docs are doing right now, how much of it is work that could be done by somebody else just as effectively or efficiently if the system were designed differently?

Troy Tyner, DO – Chairman, Quality Improvement; PHO Medical Director – Kettering Health Network

Certainly as the physician in your private practice, you're going to have to hire more people and that's a budget issue. And my practice, I take care of everybody, I'm in private practice, we take care of self-pay, Medicaid, Medicare, we never look, so we still have to be in our budget and pay our staff, and that's very difficult. So just to hire more people, another body, another case manager and case managers are getting expensive these days, is not really where I would like to go. I want to look at the IT process, the one understanding allows everybody to take care of that patient much more efficiently in real time as well, obviously.

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

Dr. Weiss, you disagree?

Michael Weiss, DO, FAAP – Chief Medical Officer – Monarch Healthcare

I will respectfully comment on that, that I think that all too often when we have more work to do, we say, let's bring in more people. And I will submit to you that if you really look at healthcare today, at the point of care, we are tremendously inefficient. Physicians are not trained in how to run an office, most often, it's their wife's sibling, cousin, running the office. We have undertaken an entire lean redesign of our primary care offices and I think that this is something that – I know this is an IT discussion, but quite frankly, you can't do that without looking at the processes from a time a patient enters to the time the patient leaves.

Just anecdotally, we've done this now in a number of our offices and somewhere in the neighborhood of 75 percent to 80 percent of the time a patient is in the office, is non-value added time. We can fix that and we can create the bandwidth for our physicians at the point of care to be able to do a lot of the things that we're asking them to do. And to answer your question, there are studies, New England Journal Study that somewhere in the neighborhood of 60 percent to 70 percent of what a physician does on a daily basis can be done by someone other than a physician. So I think we need to not ignore that aspect of what we're doing when we talk about IT piece as well.

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

So you got in question 15, and you didn't even know what was, so that was awesome. Dr. Garber, what do you think?

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group

Thank you, Larry Garber. So I wanted to add onto that, is that so we've taken advantage of the power of the electronic health record to allow for substitutability to perform tasks. And so our registries are run by medical assistants who we've trained to become health coaches, so they're really very inexpensive. They do a great job managing the registry and working on those actionable deficiencies. We've got medical assistants who stage our prescriptions that are coming in for renewals, because we're using the power of the electronic health record to fill in all the information. Medication specific monitoring is automatically filled in for the MA, so they don't have to know what to monitor on lisinopril, it automatically populates that. And then when it comes to me, it's very easy for me to just see everything that I need to know about that, when's their last visit, next visit, is there a monitoring test done and then I just can sign it very efficiently. So we absolutely find that it's cost-effective to have people who cost less to do the work that doesn't have to be done by me.

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

Yes sir.

Craig Behm – Executive Director – MedChi Network Services

Yup, Craig Behm. I will say that I think one of the unintended consequences of the rapid rollout of IT is that physicians are doing a lot of data entry that they wouldn't have done before. And so in Dr. Garber's example, I think that's a perfect example of you have the right people documenting things and the right system and the workflows created well, then you are driving the care to the appropriate level and physicians can spend time with the patient. But in many cases because of the rapid rollout, you end up the physicians spending the same 15 minutes with the patient, but now is 10 minutes of point and click and checking boxes rather than 15 minutes of talking to the patient.

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

I want to open it up to the rest of our panel to sort of get in on this, does anybody want to sort of take this and change the format, you've got some questions you're bound to be.

Michael Weiss, DO, FAAP – Chief Medical Officer – Monarch Healthcare

I wonder what you can tell me about data and the way it's presented. To take it from Craig, being deniable, I know I'm above average, you're data says I'm not, it must be wrong, to informative, it tells me I need to get Mrs. Jones a mammogram, I'll try to remember that in three months when I see her, to motivational and actionable. And if it is motivational and actionable, is it done in the context of a visit or is it more between visits? What moves it from something I could do to something I will do and how have you seen that work?

Stephen W. Nuckolls, MBA – CEO – Coastal Carolina Health Care

I'm happy to answer that. This is we've used our point of care dashboard. So it updates every night so each doctor has a schedule when they come in that's duplicated in the dashboard, so the staff and in our preferred model, you have two mid-levels or nurses that are working with the doctor. One of them is going into the room helping document part of the visit, the other's getting the next one back to room. But at the beginning of the day they look at the gaps in care and the different registries that they are enrolled, so that they can see at the beginning of the day, oh, I see Mrs. Jones doesn't have this done, so they can look back in the chart, perhaps it was done somewhere else. But they're asking Mrs. Jones when she comes in, and the doctor's not having to remember, because its reminding them. And the staff know that they get red "Xs" if it's not done, and they can turn it to green if they get these done. So the goal is to try to turn the red into green.

Troy Tyner, DO – Chairman, Quality Improvement; PHO Medical Director – Kettering Health Network

A lot of the issues that he was talking about, our practice we had, before we went with EMR, we had the work processes down. We had a paper process where we had all the – healthcare metrics that we wanted to drive our care. And when the HMOs came in to give our report cards, they loved us because the very first page they opened up was their report card, and they went click, click, click, click and they were out of our office in literally minutes, in all their auditing. So really, it's not an IT issue, it's a process of care issue that everybody's talking about, workflow and identifying those things. Going from paper to EMR did not improve my quality, we had all the quality metrics there, our readmission rate is very, very low compared to everybody else in the nation and it's just – it's going from a paper process and plowing everything – the same thing into the EMR, and lots of clicking away, just to satisfy things. So if you had an efficient paper process and now you're just doing the same thing in the EMR. It really did not get us to that different level, and that's where the crux is.

Michael Weiss, DO, FAAP – Chief Medical Officer – Monarch Healthcare

Just very quickly to add on, that reactive approach is what many of us do, but the money is the proactive approach. So we have to remember the Mrs. Jones who's not coming in the office is the one we really have to be going after and so we use those registries proactively to remind those people to bring those people in for the services.

M

And are any of you in ordering those services without visits and moving away from a point of care service?

Michael Weiss, DO, FAAP – Chief Medical Officer – Monarch Healthcare

Exactly, I mean we try to touch with the patient's at three different points, one is when we're scheduling appointments, the smart set that the staff brings up shows them, based on rules and clinical decision support, what are the things that this patient is due for that they ought to be scheduling. So they're on the phone and we're booking those. When they come in for the visit, there are alerts to me as a physician showing me these are the things that need to be booked or have already been booked and you need to remind the patient to go to the lab to get them down. And then between visits, that's when we have the staff using registries to say, oh, these people are falling through the cracks, let me call them.

We also send birthday letters, so at the time of their birthday we say, happy birthday on your 50th birthday, oh by the way, you now need a colonoscopy, call the office and we'll book that for you. So we try to catch them all these different ways. And just to support what Troy said, we actually looked at our – scores from when we are paper to when we turned on EHR and it didn't change much. It was when we turned on all the clinical decision support and registries that we made the big difference.

Grace Terrell, MD, MMM – President and Chief Executive Officer – Cornerstone Health Care, PA
Karen.

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

Thank you. My question is related to how you approach patients in terms of a patient engagement point of view, because they are responsible for a lot of their healthcare as well. And we tend to think of ourselves as clinicians as being the key factor, but in fact we're only a small piece. So when it comes to things like shared care plans and engaging other providers outside of your particular organization, perhaps other specialists or even community-based services. How do you go about doing that and how do you use your HIT systems to really think about engaging patients, collaborating with patients, in all of the things that support them outside of your office visit or outside of your interaction with them?

Troy Tyner, DO – Chairman, Quality Improvement; PHO Medical Director – Kettering Health Network

The process that in Dayton that we're going through right now is because the hospitals have one vendor and all the private practices have multiple different vendors and that will be a very big struggle to get the EMRs or EHRs to interoperate and collect data together. But certainly that is a process that I'm pushing forward in regards to getting the practice to work together in a clinical integrated model, showing them the opportunities, showing them the advantages of data mining of what we have and looking towards the future for the better one patient understanding, where we're not at yet.

And so because we only started a year ago, we're not quite there yet, quite frankly, with the patients. We haven't come up with a strategy on patient portals, some of our physicians are implementing their own because they know they need to, others aren't. And I do think that's going to be a big roadblock in the future when you're asking – it's one thing for the physician to log into six different systems, to see a hospital record or payer records. But now the patient has to log into six different systems to see lab results and specialist referrals. So, I do think that's going to be a big issue and we just haven't gotten to it as the priority. A lot of the patient engagement that we're working on is really change management within the office to drive shared goals and different discussions and kind of how the staff engage between visits, it's really not an IT focus.

Stephen W. Nuckolls, MBA – CEO – Coastal Carolina Health Care

We have used our – this is Steve Nuckolls. We have used our system to help identify high-risk patients, those with two or three or more chronic comorbid conditions, higher risk scores using CMS' HCC model. We then use our care managers to reach out to them, we combine that with some of the cost data to look for high cost beneficiaries. And from that we found people whose self-care was very low. They are then assigned a care manager who gets to know them, they go to their house after every ED visit, they're calling them daily. We usually have them do the annual wellness visit so that we maintain continuity of care and relationships. We found that high-touch and talking to these patients, getting to know them, and then working – and then the care managers working with the doctor, in many cases we have just wonderful success stories that we love to hear every month from our care managers, who are really reaching out of these patients who haven't had good self-care before.

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group

Hi, Larry Garber. And one thing that we've done, we've got 200 patients with now with home blood pressure monitors. And they can – we used to have them call in their results, which was a pain in the neck them and also a pain in the neck for our staff. And what we do now is, they can actually plug it into their home computers, it uploads the results through Microsoft HealthVault into our EHR and then it shows up on my nurse's mailbox after a batched set of readings are loaded over a couple of weeks. If there's anything critically high or low, it's instantly sent to them and the patients love it just because it's so darn efficient and it allows us to do treatment between visits.

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

Any other questions? Yes.

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

Just a quick question to is, you guys have talked a lot about sort of the data and the single source of truth around what's happening with the patient and how that can lead to embarrassing conversations in some senses. As we talk about where we're going in the future, many of you guys have talked about automating processes driving information down to systems, right, that will be able to catch up when we don't have enough people do all the stuff that we need to do. Are you seeing examples where the inconsistencies in your current data systems are driving towards harm elements or iatrogenesis and things like that, based on the sophistication of what you've currently built out already.

Troy Tyner, DO – Chairman, Quality Improvement; PHO Medical Director – Kettering Health Network

Certainly when metrics are put out there by payers or by the federal government, it can drive quality in a direction that can be very dangerous. An example of using beta blockers perioperatively drove lots of hospitals and systems to put people on beta blockers and make adjustments in reality that didn't do anything for them, as a matter of fact, hurt them. Intensive insulin protocols in the ICU for open hearts, okay that was proven, but then it was said – Leapfrog had it – everybody had to do it and so all the hospitals hopped on to it and we killed people. So bad metrics can lead to – or leaping with faith can drive quality in a very bad way.

So getting back, I think looking at evidence-based medicine, there are only certain significant points where the quality data shows that if you hit those metrics and you do them perfectly all the time for every patient, you'll drive their quality. And so I look at it, and I have a phrase I don't know if I heard it from someplace else, I call the Disneyland effect. Doctors and nurses just want to take care of patients, when you go to Disneyland, how do they empty the trash, it's underground, you never see it, it's the Magic Kingdom. And so as we are doing processes and changes, I want to look at how we can look at how we can do the Disneyland effect for all our patients care, so that our doctors don't have to jump through hoops, click everywhere, pull up sheets and sheets of reams of data and sift through stuff, we just take care of it for them by looking at the processes. And to do that, you have to have that one understanding of the patient .

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group

We're also interested in actually the issues of the quality of the data and implications of that, because on – as I said, we low claims data right into our EHR so we learned very quickly that as you shine daylight on some things that had never been visibly seen by a human who has any context, things show up. So for instance, placenta previa, which has to do with pregnant women is one keystroke mistake away from an actinic keratosis, which is just a little thing on your skin. So my guy who had an actinic keratosis now had placenta previa, so, we learned to fix that. And so, it's important – for instance, we won't load any diagnoses that were tagged to a test or procedure, because there are all these rule out diagnoses that people throw in there, so it will only be with actual face-to-face visits that we'll load those diagnoses into past medical history. So I think the key thing is by reusing the data and doing it in the context of patient care, will allow us to keep cleaning up the data and fixing those mistakes.

Michael Weiss, DO, FAAP – Chief Medical Officer – Monarch Healthcare

Not also to be understated is, you can only go to a doctor so many times with bad data and none of this stuff works from the top down unless at the point of care they believe in it and they're doing the work. And we call it once and done, if you go there once and it's bad data, you're done. And so that's a very real thing that we face when we're going out on a daily basis of talking to doctors about gaps in care. You walk out there and say, Mrs. Jones hasn't had a mammogram and they go, yes she has, you're done. And so those things are extremely important to keep the doctors engaged so that we can get this all this done.

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

Actually, can I follow-up on that. Many of you have described an integrated clinical claim data world, Dr. Garber, you talked about that quite a bit. Dr. Weiss you talked about the MacGyver approach, but I'm also struck by Dr. Tyner's comments about all the screen flipping. I mean every time I've tried to go out and introduce a new technology program, my God, don't make me open up another screen. How – could you comment on a couple of things. One how have you designed your systems to deal with that problem? And two, this requires some changes in physician culture, right, being more not so much just the captain

of the ship, but part of the team. How have you dealt with kind of physician cultural issues in dealing with this new way of thinking about their role in population-based medicine?

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group

This is Larry Garber. So our EHR has a section for history of visits, it's got the medications the patients been taking, their lab tests, their cardiovascular procedures, their imaging studies, and if I do any of those in my office or in my clinics, they file to those places. I do an x-ray, it's on the imaging tab. When I get an x-ray report from the hospital through an electronic interface or something that I – or a mammogram that I've scanned, because it was done across town, I got the report, I had it scanned in. It files to the exact same place and it files as a mammogram or as a CT scan or a PET scan or whatever it is. And so when I go to – when I want to find some brain imaging study because my patient's getting loopy, I go to the imaging tab and I look for brain CTs and brain MRIs. And it doesn't matter where came from, whether it came from an interface, I did it at my place, it came from the paper I scanned or whether it came from claims data, it all files in the exact same place.

Now when I click on the claims data, all it tells me was that this is where it was done, so I know where to go find it, as opposed to actually having the report and something I can click on to see the image. But it's still all filed in same place and it's still searchable in the same way and still satisfies health maintenance in the same way. And so the fact – and immunizations, I file those on the immunization section. So, they don't really know where the data's coming from, they just want to know that when they want to look, there's only one place they ever have to look and it's no more complex than a regular EHR.

Craig Behm – Executive Director – MedChi Network Services

All right, so that's a much more integrated approach than what we have. So we have a central data warehouse that we're pulling claims data, we're pulling some clinical data, we're trying to pull lab results, and CRISP HIE values. But we've told our physicians that we will be flexible and get you the information however makes sense to get it to you. If it's a fax summary, we'll fax it, if it's a Direct message, we'll get it out there. If we can work with your vendor and put it into your table in your EHR, we'll try our best to do that.

We've also developed just a Web services interface that's simple and a login and we're understanding that today there are going to be some duplicate approaches to doing this. And so it might be a second sign on, but hopefully not a third or a fourth or a fifth or a sixth. And in five years, if we have full integration, everyone's at Stage 2 or Stage 3, then hopefully it's all in the EHR. But today we've had to develop parallel systems that are flexible and we're trying to do a modular approach that we can move things in and out as the technology inventors catch up.

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

So it's been what, maybe 13 or 14 years now since the Crossing the Quality Chasm came out and said that the free flow of information was going to be crucial to transforming the quality of healthcare in our country. And what I'm hearing is, we ain't there yet. So within that context, which you all have described in very helpful detail, let's now talk about policy and what we can do about it, 13 years later. Because that's why we're here today is to try to understand what's possible and what can be done from a policy standpoint, particularly within the context of ACOs, to move us to better healthcare. So that is a broad question . I invite all of you to think about it and start giving us some of your thoughts on how to make this better. Or what can be done from a federal policy standpoint through meaningful use or through Medicare Shared Savings or whatever that could actually make it not be another 14 years and we're here again having the same conversation.

Troy Tyner, DO – Chairman, Quality Improvement; PHO Medical Director – Kettering Health Network

Troy Tyner. First of all the vendors, when you approach them to look at interfaces, they put roadblocks up immediately. Number one, perhaps it's their strategic plan, but number two, their employees are switching all the time. In regards to my EMR and the hospital's EMR, every time we had a conference call, it was another IT interface engineer. And then I'd e-mail them, all of a sudden the e-mail would bounce back, they're no longer with that company, they're off to something else. And then I have to back to the VP for interface and work through the whole issue. So the process that is in place right now, getting the vendors to work together is just not there.

Michael Weiss, DO, FAAP – Chief Medical Officer – Monarch Healthcare

So this is not an easy one, but the whole concept of ACOs is groups of doctors caring for populations of patients. It's not independent practice taking care of these patients and the hospital system taking care of these patients. So I think that moving toward some type of requirement or regions to be working together to share data. So if a hospital system in a given county has a ACO and an independent practice organization has a ACO, there should be some requirement to participate in those programs that those organizations must share data. I think that's key because what we've created this competition, which is great, because we're going to drive down cost and drive up quality. But we're also keeping that behind curtains and we need to open it up so everybody's working together – the pediatricians singing Kumbaya.

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group

This is Larry Garber.

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

Go ahead.

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group

I think the federal government needs to have a Lean Kaizen event and I think what you guys need to do is think about what truly is efficient and what is not value added at all, which is where I got the ICD-10 issue, because I don't see that as value added at all. It really is taking away our resources from working on things that are truly important and truly valuable for achieving the Triple Aim and I think that goes towards – also to the harmonizing. CMS, all the different pieces of CMS need to talk together. And you need to have the meaning – ONC, everybody needs to get aligned so they were coming in one unified, efficient directives.

Micky Tripathi, PhD – President and Chief Executive Officer – Massachusetts eHealth

Collaborative

Yeah, Micky Tripathi. So, just a question for Troy Tyner. So – and it's actually Michael Weiss touched on it a little bit just when you were talking about the need for regional collaboration around this stuff. I mean it strikes me that where you are in Dayton, first, I think everyone's on Epic there, is that right?

Troy Tyner, DO – Chairman, Quality Improvement; PHO Medical Director – Kettering Health

Network

Correct.

Micky Tripathi, PhD – President and Chief Executive Officer – Massachusetts eHealth

Collaborative

Okay, so you've got the city, in the city, everyone on Epic and in some ways, you live in sort of the land of milk and honey with organized HIEs, right? You're like 100 miles away from Indianapolis, you're 50 miles away from Cincinnati and Epic itself is probably the most advanced platform for within platform interoperability as well with Care Everywhere, Care Anywhere. Everything Larry has described he's done on Epic. So I'm just wondering if you could go into a little more detail about why in that environment you still feel that there are serious barriers, particularly with HIEs because you have two very – two of the most advanced, if not the most advanced organized HIE activities in the country.

Troy Tyner, DO – Chairman, Quality Improvement; PHO Medical Director – Kettering Health

Network

When we first went down the path at Kettering Health Network, looking at what vendor to go with, that was the whole thing, our competing hospital system had Epic, our Children's Hospital had Epic, University of Cincinnati has Epic, OSU, Cleve – oh, this is going to be nirvana. We went down that path and they just don't interface with each other. So the data is static, so if I log onto Care Everywhere and I go to Miami Valley Hospital, I can pull up data, it's just data and I have to click, click, click through reams of screenshots just to find anything. That's number one.

Number two, if I want to import that into any meaningful opportunity to do disease management as a system, it's impossible, it cannot be done. You have to go to Premier Inc., our group purchasing organization where we go through Quest and process improvement projects and ask – and I go to presentations all the time, well what EMR do you have? And I don't want to be pure Epic bashing, but they don't use Epic. We don't use Epic for any data analysis whatsoever because it is inaccurate, cumbersome and we use other databases for our process improvement projects .

So from a network, disease management, we don't use that platform. It's just to take care of patients. And taking care of patients, it's screen after screen, pop-up alert and pop-up fatigue. So yes, we thought we were going to get into nirvana, Kumbaya, everybody together one platform, they don't interact. And when you try, and – when we're talking about vendors, it's not just Epic, it's every vendor I've talk – worked with, what is the Valley doing? You installed your system over at Miami Valley Hospital two years ago, how did they solve this problem? How did they get their skip processes in place? How do they do this? Oh, they won't tell you. Oh, how did you do at the Cleveland Clinic? They won't tell you. How did you do at OSU? They won't tell you.

And so you have to literally reinvent the wheel every single time. And now we're in the process of trying to change the process of care in the hospital part, in our ORs and we can't change, and we have to have paperwork around. And we are wanting to change the whole work process and the flow of throughput to improve our quality and they say, well, we can't do that yet. Wait possibly for the next upgrade in two years. And so that's where the biggest frustration is.

Micky Tripathi, PhD – President and Chief Executive Officer – Massachusetts eHealth

Collaborative

And what about the HIEs? I'm not asking to beat up on Craig or anything, I just want to understand, so where HealthBridge and where IHIE aren't able to –

Troy Tyner, DO – Chairman, Quality Improvement; PHO Medical Director – Kettering Health

Network

Well even – in Ohio, all politics are local and HealthBridge is working its way up. So lots of interaction with – HealthBridge is not there yet, it's coming, it's working. We were doing CPCI projects, CMS demonstration project and so I can't really comment in extreme detail about that, but I know the CPCI projects they're working with HealthBridge, but they really don't have much expectation.

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group

Can I – this is Larry...

Craig Brammer – CEO – HealthBridge

If I could just comment on this. It's fascinating, just a little study of America, but – the Dayton area. But what's happened in this market, and I'm new in this role, so, and we haven't met – nice to meet you – is that the physicians in your market, most of them, use us for HIE services. You guys chose to use the other HIE in Ohio, therein lies part of the rub that we'd like to work together to solve .

Troy Tyner, DO – Chairman, Quality Improvement; PHO Medical Director – Kettering Health

Network

Right, now, when I'm talking about Kettering Health Network, I'm in private practice as well and the practices that are using you are using you, but they don't have – it doesn't have all the data. And it's a process, but yes, our network decided to go with the other HIE.

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group

This is Larry Garber. I wanted to add to this, because Troy you brought up a great point that in Epic, when you get a CDA document that comes in, you have to manually reconcile all this. And I think one of the things that the EHR vendors haven't understood yet is that there are really two types of data that come to me, there are opinions and there are facts. So the medication list, the problem list, the allergies, those are opinions. Are they really allergic to this or not? And so that's something that does manually have to be reconciled. But there are facts out there, medication fills, did the patient pick up that prescription? Yeah, I mean they either did or they didn't, that's a fact. I can load that in and make that part of my medication list, whether they're taking it's another story, but the medication history is a fact.

The test results are facts, the cholesterol's the cholesterol, it's a fact. The note from the consultant is a fact. The immunization that was delivered is a fact. All those facts can be loaded without any human intervention, other than the mapping, to get those loaded into my system and this way I can take advantage of them and it should be automated, it should be hassle-free. And that's what they need to do, make the facts hassle-free, make the opinions something that you have to reconcile.

Micky Tripathi, PhD – President and Chief Executive Officer – Massachusetts eHealth

Collaborative

One other question of Michael Weiss, when you – in your introductory remarks, you referenced the fact that the hospitals are a part of competing ACOs, could you just describe that a little bit more and what sort of practical impact that's had for you?

Michael Weiss, DO, FAAP – Chief Medical Officer – Monarch Healthcare

Yeah, the – in Orange County – California's a corporate practice of medicine state so the hospitals can't employ physicians, but that they start foundations. And so as we're building our model, they too are building their model, so we're actually, as I walk in the office to try to talk to doctors, they're walking out of the office talking to the same doctors to try to recruit them to be part of their system. And therefore, that breeds a lack of cooperation, unfortunately and that's what I was talking about with regional cooperation, I think it should be mandated that if we're caring for these populations in a given geography, we should be working together .

Micky Tripathi, PhD – President and Chief Executive Officer – Massachusetts eHealth

Collaborative

Right, and that manifests itself in reluctance to share data? Reluctance to integrate workflows?

Michael Weiss, DO, FAAP – Chief Medical Officer – Monarch Healthcare

Yes, yes, yes and yes.

Stephen W. Nuckolls, MBA – CEO – Coastal Carolina Health Care

Getting back to some of the policy decisions, I'm not as familiar with meaningful use or perhaps the Stage 3 that are coming up. But if they were to address some of these competitions issues, perhaps if you put a percentage of – for primary care doctors, if you're sending referrals, you need to send these data sets so that system such as Larry's and others can reconcile. And hopefully there would be some sort of electronic reconciliation, in other words, you have these meds or these problems and it's the same, so you don't have to have everybody reentering the data if it's a new patient and you're sending a referral out. That if you just tied the percentages of patients sent for referral for those and results that are coming back in from specialists, so that when you're sharing these patients together, that those records move with them.

I think that HIEs are always going to be a challenge, just because doctors don't want to work in two systems. We've tried that at our local emergency room, we put our platform in there, we gave everybody access on the icons, it was four clicks to pull up the record for the patient, but four clicks was too much. It has to be right there in front of them. We put a person in there, have them print the clinical summaries and hand them to them, that seems to work, it makes their life easier and they like that. But anyway, we've got to make it easier and to make it easier is everybody wants to work in their own sandbox, so we just need to get the data in the sandbox.

Troy Tyner, DO – Chairman, Quality Improvement; PHO Medical Director – Kettering Health

Network

Troy Tyner. I want to go back to the interoperability. Having everything integrated, the data flowing in, we're looking in the United States. There are other countries in the world that have everything on one platform and they have the pharmacies on one platform, the nursing homes on platform, home nursing agencies on one platform, the physicians on a platform – the same platform. They have the hospitals, they're all linked together, they're all sending data back and forth, but they're now morphing, they're changing. They're looking for better opportunities because they now realize, yeah, you can have the same platform, everybody has – that's what we thought in Dayton, Ohio, put everybody on one platform and it'll be nirvana, everything will talk to each other. Now we don't talk to each other.

But in the UK they do talk to each other and they still have issues and they're looking for other improvements. And so from an evolutionary standpoint, we're going through this painful process, but I think we need to look at other parts of the world as well where they've been there, done it and they're going on to the next solution and that's where just having the rails the same, wants in the boxcar, wants that one patient understanding.

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

So I'm going to get back to some policy implications of what you guys are saying and make sure that I'm hearing this right. So you're ACOs and you're having difficulty with basically interoperability, the free flow of information, as a result of vendor constraints. And so within the context of policy, we think about what could be put on this as a constraint for meaningful use or for ACO participation, but is it going to be placed on the ACO? Because we've kind of been through that with meaningful use, right? Because with meaningful use, sometimes the vendors weren't ready for the Stage and then that created difficulty with our own ability to actually perform, at least that was some of the experience that we saw in our part of North Carolina. So, from a policy standpoint, what can we do about it within the context of ACOs?

Craig Behm – Executive Director – MedChi Network Services

This is Craig Behm. I'm not sure I have an answer and this is probably a very vague comment, but I – we were founded by the medical society in Maryland, so this might be a very physician-centric hat that I'm putting on, but it seems like with a lot of the measures, like meaningful use, we were looking at the what. And so, you have to do this report, you have to meet this measure, you have to enter this data, we didn't look at the how. So we get a lot of vendors that say, oh yeah, of course we can do that, we have that capability, it's either a \$10,000 upgrade or it's a series of clicks or this process, and it doesn't actually work at the point of care. And so that would be, I think, a perspective to look at from the policy standpoint, how do these things actually work in the real world, not just in one system on one database with infinite budgets?

Stephen W. Nuckolls, MBA – CEO – Coastal Carolina Health Care

This is Steve Nuckolls, I'm not a policy expert but perhaps there's some way in this new value based modifier for groups I guess that are non-ACOs have to jump through certain steps in order to get this money back. And I guess that's assuming that the House and the Senate pass SGR Fix Bill. But, if as part of the – there is a meaningful use measure as part of ACOs, so as long as that continues, maybe there's some type of Meaningful Use Stage 4. The vendors are not ready today, perhaps they will be if we put some pressure on them down the road to develop better transfer of information and reconciliations between different vendors and systems.

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group

This is Larry Garber, I'll just add one more thing that – I mean, we're allowed to dream here, right? I mean, so one of the issues that's coming up is the actual transaction fees that vendors are charging, including my Epic, is charging me transaction fees for transactions I receive and transactions I send. And I think that that will cause some interference with all the good things that we're trying to do. That will send just enough transactions to meet meaningful use, but no more because it's going to cost us too much money, I mean – and that shouldn't be that way. And so I don't know if there is any regulatory lever with the vendors to say, that's not how you charge for this and it's probably also with the health information exchanges as well, that that shouldn't be the model for supporting this.

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

Paul, do you want to take –

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

Sure. Thanks. I'm a lemonade person so I'm trying to look for the juicer in this. And maybe the metaphor I'm going to work off has something to do with horse and water. I'm going to play off some of the stories that Michael and Craig talked about. In your IPA group, you have half the folks, only half the folks on HER, you have small practices, some of which, in Craig's world, don't even like each other, and you control only 4 percent of the spend. And it's one o'clock in the morning and you don't know where your patients are, so why did you do this?

But, my underlying question is what motivates the community to do this and can we tap on that, what are the policy levers we can do? So, I'll rephrase some of the questions. So we talked about some – a couple of you mentioned, well, we could have done this on paper. Well, what couldn't you have done on paper that we can facilitate with HIT, if there is anybody in that. The other thing that was mentioned is some examples about where quality measures can misdirect efforts. Well, let me turn it around, what quality measures, what performance measures, could point people in the right direction and motivate the right behavior?

Michael Weiss, DO, FAAP – Chief Medical Officer – Monarch Healthcare

So, I'll answer the first question and it's cliché, but it's culture. In Southern California, as many of you know, we've been in a capitated HMO environment for 20 years and Monarch was one of the first groups to be heavily involved in that. So, our doctors have been working in a managed care, care coordination environment for many, many, many years. And this is how they practice medicine, whether it's a fee-for-service patient or a managed care patient. And so why we do this is because our doctors have really bought into a culture that we really believe in, it's part of our mission and vision, of care coordination, doing the right thing. And we've got data supports that this work has improved outcomes and lowered costs, so Triple Aim data. So I think very clearly, it's culture and that trumps the reality of some of these hurdles that we're talking about on a day-to-day basis. But I will add to that that we are in danger of losing that culture because of some of these hurdles and so it is incumbent upon us to make it less burdensome so that we can maintain that culture and they can continue to believe that this coordinated care provides good outcomes.

Craig Behm – Executive Director – MedChi Network Services

So – and I can't speak for – this is Craig Behm. I can't speak for my practices, I'm not a physician, independent, but I think in the community-based small practices, they knew they needed to do something. They know that sequestration and ePrescribing and PQRS, all the stuff we've talked about are all challenges. And so when we approached them with very positive ACO regulations and no risk and a possibility for advanced payment develop the infrastructure, it was a compelling enough case to say, you know what, it's worth a try. We've got to do something different, this seems like the right opportunity for us and at the end of the day, if it doesn't work, then they've tried to provide better care, tried to kind of integrate it, but they haven't really lost anything. So it was a big ask on our part, but I think they saw a compelling reason to do something.

The second part of your question, just very quickly, I like the word value and I think any quality metrics as we go forward, must demonstrate value. And that value is first and foremost to the patient, but secondly is to the physician. The physician at the point of care needs to feel that if I'm going to do this, it's going to help my patient and potentially going to help me and then in turn, that helps the organizations that are the umbrella over which all this occurs – or, under which all this occurs.

Claudia Williams – Director, State Health Information Exchange Program – Office of the National Coordinator

– can you hear me? I'd like to ask – actually ask a follow-up question on your quality statement. On the quality metrics, from a policy perspective, what we have seen in our ACO is that the universe is immense in terms of what a payer, whether it's the federal government or private payer can determine to be quality or determine to be a reasonable metric. If this workgroup came up with a standard list of metrics with physician input, would it make the process easier? Would it make compliance, would it make the IT build easier if those quality metrics were standardize?

Multiple speakers

From – we all say yes at the same time. One, two, three, yes.

Troy Tyner, DO – Chairman, Quality Improvement; PHO Medical Director – Kettering Health Network

But at same – this is Troy Tyner, but at the same time, and I'm just going to throw out some metrics that everybody loves to go after is hemoglobin A1cs. And the data behind driving hemoglobin A1cs really is not there, and as a matter of fact, if you have cardiovascular disease and you strive to get down to 6-6.5, the data shows that you're going to kill the patient. So, I've been down this pendulum before and I've seen in out ne – in our community how organizations have driven towards the metrics and knowing that it doesn't improve quality care, but they get the payment from the HMO and they just drive for the payment rather than driving for quality. I've been on the board or presenting to our board saying, we're not going to drive towards this metric because we don't feel, as clinicians that that is proper metric and that will hurt our patients. And the board says fine, don't drive for it and they will take the penalty for that and the payment penalty.

So, you have to be careful. Really, truly use evidence-based medicine that's been proven, tried and duplicated and then you can go for that. But there are lots of organizations out there that, just get one article and they throw that out and then they're off to the races, and then everybody else is doing things that really hurt patients.

Craig Behm – Executive Director – MedChi Network Services

So absolutely one set of metrics, no question, I don't think anybody will argue that, but I also want to make sure people understand, and I think this was lost quite frequently, is that the results that a non-vertically integrated system reports in no way, shape or form reflects the actual work that's being done. It becomes a data chasing exercise, not a clinical quality exercise. And that point is emphasized at the point of care, the doctors feel like this has nothing to do with me doing the right thing for my patient, it's you digging into my charts trying to find some number. And until we get past that, we're going to continue to be challenged. And I think from a policy standpoint, any way to work, and I don't have that answer, if I had that, I'd probably be sitting where you guys are sitting, but I think that's a huge, huge piece. That the doctor see it as data chasing and they don't see it as care delivery.

Troy Tyner, DO – Chairman, Quality Improvement; PHO Medical Director – Kettering Health Network

To give you one example of what I felt was a bad process, but you could take it and look at it like and look at it as a good process. There was a very large, multi – fully integrated horizontally/vertically healthcare organization that called me up saying, how can you drive your quality mortality index to such a low level as an organization? And we went through our processes and a process improvement project that we've been doing for years. Six months later they came back, they had dropped their mortality index, but they implemented one program, hospice, because it got them out of their database. It didn't improve their quality, it didn't change anything, they just installed a hospice program. That is not quality .

Claudia Williams – Director, State Health Information Exchange Program – Office of the National Coordinator

So my name is Claudia Williams. You referred Craig, to a sweet spot around patients getting discharged from the hospital where you have the technological ability to send an alert, the providers incented to then do follow up within 7-14 days and the ACOs incented to not have a readmission. But all of you also described a lot of other scenarios where the various folks that you need to figure out where the patients are going, to the SNF, to the hospital, to long-term care, to specialists, and those folks simply have no motivation to participate in managing care. And I guess my question is, are there other sweet spots where we're seeing that the other participants who aren't part of the ACO actually are very motivated? And what kind of policy interventions could you imagine to create a higher level of motivation to manage care, get better quality, reduce cost that maybe lie outside the AC – like we've seen that with value-based purchas – with the various other policy drivers kind of creating the right incentive, so that you guys can succeed. So, I guess two questions; one, other sweet spots and the other, what kind of policy solutions?

Craig Behm – Executive Director – MedChi Network Services

So just one other sweet spot that might be a Maryland-specific because of the waiver, is a three day rule. If we can move someone into short-term rehab in fewer than three days, we're going to save tons of money, like Medicare Advantage Plans do. So I would almost look at, if there are other things that are happening in other managed care worlds that can be transferred to a ACO. So that's the first example, off the top of my head.

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group

This is Larry Garber. We're actually also trying a hospital at home program and so that involves home health and incentivizing them to be available at a drop of a hat to be there, to be in the patient's home for 12 to 18 hours a day. And so incentives to have them participate would be useful. But one thing that I've found, I've been doing this Impact Project, so I've been engaging a whole bunch of nursing homes and home health agencies and trying to get them to participate in health information exchange. And one of the things I found the most interesting is that the reason why our skilled nursing facilities wanted to participate is because they wanted to become the preferred provider for ACOs. They knew there were a couple of ACOs in the region, they wanted to show that they were stepping up, getting information, sharing information, giving the best quality care, reducing readmission rates and that that's the place that everyone would want to send the patients. So they see the business in it.

Troy Tyner, DO – Chairman, Quality Improvement; PHO Medical Director – Kettering Health Network

So I think another example is the DRG program. A hospital is going to be more incentivized to lower length of stay if they're being paid under a DRG model. Now, if it is a fee-for-service or per diem program, fewer bed days is lower revenue for a hospital. So if they have a fixed payment for a given diagnosis, they are more incentivized work with us.

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

This is Michelle. We're quickly running for the end of time for this panel, but there are still a number of questions. So we're going to quickly – maybe we'll go over just a bit, go around the room, have everyone ask their questions, but please be very efficient and maybe only one person answer. So we'll start with Kelly .

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

Yeah, I just wanted to do get back to what specifically could the federal government do, or what we could do with our state partners, since many states are interested in advancing multi-payer accountable care arrangements or communities. And knowing that Reliant, Atrius and Maryland are really benefiting from real-time alerts on admissions, discharge and transfers, wondering what HHS could be doing, or again, with our state partners to facilitate scaling of those services? Particularly in California in the physician-led ACO models where you have very little insight into real-time movement of your patients across settings. And in large states like California, it can be quite complex to scale that across the state. But if you have some thoughts about whether it's greater standardization of HL7 messaging, which we could advance through certification potentially, or is there just some collaboration that needs to be done in scaling these with the federal/state partnership? Or should it be really an ACO level, vendor negotiation that you make sure those services are just available in your service area?

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group

HL7 standards for the EHR vendors, that's the key.

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

Okay.

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group

And all the stuff that I have in my testimony.

Troy Tyner, DO – Chairman, Quality Improvement; PHO Medical Director – Kettering Health Network

But one HL7 seven is another HL7 is another HL7, so they all say they're HL7 compliant and then you look at them and they're not.

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

So there has to be something around how is it being implemented, yeah. And a follow on to that, the dashboard concept is really helpful to a few of you and your EHR vendors are doing it, but it's not across the board. Would there be – we could – potentially waiting down the line for some further Meaningful Use Stage to address this, but would it be helpful for you to know in the market of a EHR vendors or registry vendors that are out there that may have point of care applications as well. Should there be some easy way for you to differentiate in the market who's really providing that data and should they be able to consume the cost data as they are with Epic in Reliant?

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group

So like a transparent modular certification –

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

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group

– to show what these ACO vendors, EHR vendors can specifically do in the population health world?

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

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group

I think it would be useful, but until there's more transparency a more transferability between data, a lot of practices are stuck on the EHR they're on and ACOs might run into the world where we're stuck on the vendor we're on. So, I think that would help advance where we need to go but there other things that need to happen as well.

Stephen W. Nuckolls, MBA – CEO – Coastal Carolina Health Care

This is Steve Nuckolls. The point of care dashboard certification, I don't think that would help us much. CMS is auditing our records with our quality reporting and so if we don't not meet it, I think there are other safeguards that the groups would then go back. Plus those measures change frequently from the measure stewards and I think it would be very difficult to do. Your second question as far as integrating the claims data into it, I think that's a great idea but to me it's almost two different things, having the quality dashboard and the claims dashboard.

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

And would you like to see North Carolina be able to support ADT alerts? Or would you think that's an ACO specific issue?

Stephen W. Nuckolls, MBA – CEO – Coastal Carolina Health Care

And I think North – I think having a statewide standard be a good thing.

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

Um hmm.

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

Very quickly, NIH and the NCI have what's called PROMS, the patient reported outcome measures information system. It's vast, its – lots of different measures on it, covers everything under sun, but they are validated and they're used a lot for research. So my question to you is, given the discussion we have just had about quality measures and all the problems that are associated with them, is the ACO environment ready for patient reported outcome measures yet? And would it be helpful if the federal government did something with this composite of measures and provide at least a core set that that might be of value to you?

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group

Hi, it's Larry Garber. Patients are people too, and so they're busy and they only want to do things that they see value in, just like a docs doesn't want to do something they don't see value in. And so I've been shocked at how – that there's clearly a limit that's fairly low, as how much patients want to use portals and being – do these engagement tools and things like that. So I think we have to be careful not to over emphasize the wonder and amazement of patient reported outcomes or patient entered information or any of that kind of stuff. There's a limit to its usefulness, there's a limit to how many people are going to want to do this, to how many people are going to want to actually send messages or enter information. So – and it's got to be of value to them. So I think if you can specifically find things that are valuable to patients and that there's a reasonably good reason for them to be doing it, then it may make sense to be taking advantage of those outcomes.

Michael Weiss, DO, FAAP – Chief Medical Officer – Monarch Healthcare

Yeah, I think if we do that, it needs to be on a much smaller scale for the patients. If you've ever looked at a CAHPS survey or a health outcome survey, it's kind of ridiculous, so we need to be very thoughtful about some pointed questions that will give us value.

Helen Burstin, MPH, MD, FACP – Senior Vice President for Performance Measures – National Quality Forum

Great, hi. Helen Burstin. Just a comment and a quick question. To Dr. Tyner's comment about the standards measures, they should be evidence-based and if they're not, we need to know because there's a problem there and there needs to be a feedback loop. And in fact, there is no standardized measure for example that A1cs of six or seven, hasn't been for years and that's really important that we begin to really wrap our head around some of this.

But, I guess my question is for some of you is, we've heard that some standardized measures really present too low a floor for some of these more integrated ACO kind of environments. Do you have better measures or do you have suggestions for how we might begin to think about harvesting or prospecting for some of the more innovative measures that are already in your space, share best practices – and some of this is important as we consider perhaps an innovative option for meaningful use going forward. Can you use a different set of really, really high quality, innovative measures and get credit?

Troy Tyner, DO – Chairman, Quality Improvement; PHO Medical Director – Kettering Health Network

This is Troy Tyner. I think one of the most straightforward measures I look all the time is hypertension. And having tele-medicine, having blood pressure monitors seamlessly downloading. One process that we're working on is when the hospital employee, since we're self-insured, goes into the pharmacy to pick up their prescription, they have to put their arm into that blood pressure that's at every pharmacy. They swipe their RFID badge through it and it downloads right into their database. So the "white coat syndrome" stuff is all out and its being done automatically. And so looking at hypertension as being the one major goal for the nation would drive a lot of healthcare. Number two would be lipids, and then – those two things. And those are data points and those are easily collected, easily downloaded into a database automatically without case managers, etcetera.

Michael Weiss, DO, FAAP – Chief Medical Officer – Monarch Healthcare

The other thing we've done in California with our commercial HMO program is the bundling of measures around a disease process. So in the ACO program we have the diabetes bundle, we have immunization bundles, those types of things so that people aren't just chasing a metric, they're caring for a disease in an appropriate manner.

Irene Koch, JD – Executive Vice President and General Counsel – Healthix, Inc. 2:18:43

So, I'm a little surprised that we have not heard more in terms of the barriers that privacy and consent issues may be posing to ACOs, and we don't have too much time to discuss it now. But I'm curious to know whether you've run into that and whether there are particular barriers that might have affected the sharing of data, either as an excuse for people not to do so or within your IT system? And what recommendations you might have for improving that?

Troy Tyner, DO – Chairman, Quality Improvement; PHO Medical Director – Kettering Health Network

Troy Tyner. In that barrier, privacy is now coming up much higher and I'm having physicians hitting me up because now – because we have Epic, we have Care Everywhere and patients are putting roadblocks up on their My Chart. And so we have to go through lots of hurdles now and I'm continuously having to have staff go in, can we have your data from the other hospitals, from everywhere else. And that is a definite issue popping up.

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group

I'll just add one more thing to that is that from what we've seen through the Mass eHealth Collaborative and other health information exchange initiatives, that in 95 percent of the – 95 percent of their patients want to share their information. They get their peace of mind knowing that when they go to the next provider, all their information is there, they did it without any hassles. And it's 5 percent of the population gets their peace of mind knowing they have absolute control over their data. And so we have to be careful not to design systems that are purely for the 5 percent, we need to design systems that work for the 95 percent and then exceptions to handle the 5 percent that don't want to play that game.

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

We've got a question over here on this side, is that right. Frank Ross.

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

Yes, I'm going to climb out on the limb and kind of paraphrase what I'm hearing every one of you say that EMRs are silos and HIEs are just bigger silos. If we're going to break down the barriers where information can flow, and I don't mean – not be extracted with a pick and shovel, but actually flow to where it's needed, when it's needed, and we want to incentivize the private sector to do that, how can we do that? In one sentence what would you do to incentivize your EMR vendors to stop playing games, stop trying to be the only EMR in the world and actually begin to exchange information? I'm not talking about interoperability, I'm just talking about exchange .

Troy Tyner, DO – Chairman, Quality Improvement; PHO Medical Director – Kettering Health Network

This is Troy Tyner. I think there is a technological gap. I look at other organizations, Amazon and Google, how they can predict what you are wanting to look at and understand data and transform that into information. And so looking at them, and I'm certainly not an IT person, but those organization use ontology and other techniques to understand data that is then actionable, that is specific. Just like patients come in all the time, oh, I need my colonoscopy. Well, you just had your colonoscopy six months ago because the data is there and a filter pops up. So looking at the next technological leap forward I think is looking at something with ontology.

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group

This is Larry Garber. I think that first of all, making it the standard such that one transaction can be used for multiple different purposes, for giving information to the primary care physician and also going to quality data warehouses and doing public health reporting and all the same things based on the same standards will be helpful. But the other thing that's probably key to getting the vendors to play the games is if CMS paid the transaction fee to that EHR vendors, so that the more transactions the EHR vendor does, the more they actually get paid from dollars that eventually found their way from patients, benefits the patients .

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

So you're saying CMS should build that network?

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group

No. There should be a reimbursement process, again I'm dreaming, a reimbursement process where the EMR vendors can report how many transactions they do outside of – to other vendors or HIEs, and that there should be a way that they can bill for those transactions.

Craig Behm – Executive Director – MedChi Network Services

I think it would be incredibly powerful if through policy or program regulation you can convince vendors that the value proposition is not by locking other people out, but by having a more usable system. If people can switch freely between systems and have access to data and transparency, then they'll choose the good ones, not the ones they are stuck with because they bought them in 2010, when they had to reach meaningful use.

Troy Tyner, DO – Chairman, Quality Improvement; PHO Medical Director – Kettering Health Network

The other issue that from a practice standpoint is your practice management system, so you have an EMR, if it's tagged with your practice management system, that's going to be very successful. If all of a sudden – if I went back to my partner and said, we're going to jettison our EMR in our practice and go with another EMR, and we're going to jettison our practice management system, that is really fraught with problems. So in regards to interoperability, practice management system is disconnected from your EMR that would allow us as physicians to go with the best product that is willing to work with us, from an EMR standpoint, but not the practice management.

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

So we need to wrap this very useful first session up. You mentioned the practice management system, so I'll end with that. I think there's been at least three stages of healthcare information over the last 30 years and the first one was practice management systems, and it was about billing and collecting and scheduling because that's how we got paid. And now we're about 25 percent through the clinical decision support EMR world and it's not mature technology yet, which is what we've mostly been talking about today. But we just started population health management and it's not been built yet because there's not been a market for it yet and ACOs are probably one of the tipping points to creating that market over the next few years, as the vendors become more mature. So it's going to be important that we have the right policy in place to encourage that, that ACOs are rewarded for moving it forward and that vendors are able to respond to the market that you all are creating. So, we appreciate you contributing today, all of you gentlemen, to this conversation and I think it will move us a little bit closer to getting the railroad built perhaps. Thank you. We'll now have a 10 minute break and –

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

Well wait, actually, we're 15 minutes behind schedule –

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

A five-minute break?

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

So, if you all are amenable, we'll just take a very, very quick 5 minute break and then we'll just keep going. So maybe just switch people and we'll get going .

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

If everybody could take their seats, we're going to get started. Please take your seats, we're going to get started. As you all know, we are already behind time, so we are hoping to make up some time now. As a reminder, please state your name before speaking as the meeting is being transcribed and recorded and we want to make sure that the transcript is correct. And that's for the panelists and also the workgroup members when you ask questions. So again, please take your seats, we're going to get started and go ahead, Charles.

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

Very good. Well, we're going to move rapidly into our second panel. This panel is composed of hospital and health system led ACOs. If you would all wouldn't mind just introducing yourself, we'll just, in the interest of efficiency, introduce yourself as you begin your 5-minute talk. So Michael, please let's begin with you.

Michael Sills, MD, FACC – Chief Medical Informatics Officer – Baylor Quality Alliance

Hi, I'm Michael Sills, I am the CM IO of the Baylor Quality Alliance. I have more prepared stuff, but I think rather than being repetitive, I'm going to make some observations and more specifically respond to some of the questions that have been asked as to what can this group do to help us, who are more the foot soldiers. As I said, I'm the CMIO of Baylor Quality Alliance and in my free time, which I don't have much of, I'm a cardiologist. Baylor Quality Alliance, as an introduction, is the ACO of the Baylor Health Care System, or what used to be the Baylor Health Care System.

Baylor has merged with Scott & White to make one of the largest healthcare systems in the country. We've got almost 30 hospitals, we have approximately 2000 employed doctors and we care for probably the better part of 6 million patients in the North and Central Texas area. Baylor Quality Alliance was started about 2-1/2 years ago to do population management. Initially we thought about doing an MSSP but didn't. Instead we put our 32,000 employees into the BQA and went live in January. We hope and expect that we will become the platform for the combined system, hopefully over the next year or so. We currently have about 70,000 lives and expect by the end of the year, we'll be about 100,000.

Also as an introduction to where I'm going to get to, we have a number of tools. We have an HIE, we have a EDW, we have a big data solution, we have clinical and financial analytic tools, we have a care coordination tool and we have also Epic and Allscripts across our system and, none of them talk to each other. My job is incredibly complicated and I spend an enormous amount of time just simply trying to deal with disparate, uncurated data sources that have both passive and active attempts to keep the data from being integrated. We find roadblocks, as people have mentioned. There are cost implications, who's going to pay for it? How many EMRs should we deal with? It's an impossible task.

The holy Grail, obviously, is how can we get the information into a repository that can be analyzed. As I just said to Frank, the best database is one that existed before the Internet, because they're the only ones that are curated and are usable. No analytic tool is any good at all without a good database. Right now, there is no incentive amongst our vendors to cooperate, and we're a big system. We're the largest Allscripts implementation, we will be one of the biggest Epic implementation and we can't seem to get them moved. And I don't know whether it's a legislative, financial, or what kind of incentive to get them to begin to share the information, but right now we're trying to come up with alternatives, workarounds, to help us get the information integrated. And right now it's turning out to be a very major problem.

Our HIE is not working, I think that's been the experience when I go around the country and I talk to other systems, sorry, but ours is just not working. CCDs are inadequate, they don't give us a lot of information that we need. Most of the EMRs in our system don't automate CCD production, we're trying to come up with workarounds to extract information, but they don't, so that without automatic CCD updates – I have my partners calling me and saying hey, my patient was just in the hospital, just got a cath, how come it's not in the EMR? Well, because we didn't know; and we have those kind of issues.

We have efficiency issues that arise, and I think that until data is usable, until it's actionable, until we can actually deliver it at the frontline to the clinicians, to the care coordinators, to the medical directors, it's – we're still stuck back in the Dark Ages of not being able to do adequate population management. We need to be able to integrate all this with narrow networks. We need to expand the use of patient-centered medical homes and all this information needs to be usable, specifically for those kind of uses. Let's see, what else did I not – I was talking so fast, I went through it faster than I thought.

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

Whoa.

Michael Sills, MD, FACC – Chief Medical Informatics Officer – Baylor Quality Alliance

I know, you get nervous. One of the big issues that I'd like very much to hear about is the discussion of, what will be the ultimate way that we store data? Will it be in EDW? What are the incentives going to be? Will it be an HIE? What can we do to modify HIEs to – who's going to pay for them? Right now, if we pull the funding for our HIE locally, it goes away, and we're not sure that it is worse continuing to fund. And lastly, what about big data solutions? There are no standards for big data solutions right now and until there is some sort of agreed format for how the information's going to be stored and reported, then we're still left using two cups and a string. I will give you eight seconds back.

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

Very good. Thank you, Dr. Sills. Dr. Chodroff.

Charles H. Chodroff, MD – Senior Vice President of Population Health – WellSpan Health

Hi, good morning. I'm Dr. Charles Chodroff, I'm with WellSpan Health. Thank you for the opportunity to share my organizations experience with accountable care arrangements and how you might help us better use IT technology to help us meet our objectives. I serve as a Senior Vice President of Population Health for WellSpan Health, an integrated delivery system that includes over 700 physicians, a homecare agency, a managed care plan and four hospitals, serving three quarters of a million people and South Central Pennsylvania.

WellSpan has determined that we will migrate our business model from fee-for-service payments to accountable care relationships. As such, we entered into an accountable care relationship with Aetna this fall, and anticipate additional ACO relationships with other payers over the next five years, with the expectation that most of our revenue will come from these types of payment arrangements. We hope that future requirements from ONC will provide incentives that help us succeed under accountable care payment arrangements. Many of the requirements of the HITECH Act have up until this point focused on providers. My comments will focus on efforts that might be undertaken to enhance coordination and build expectations with the other two key stakeholder groups, payers and consumers.

I would suggest three broad initiatives that could create leverage for mutual success by these three stakeholder groups. These initiatives involve better identification of specific individuals in the managed population who are at highest risk, improved ability to proactively identify patients covered by accountable care arrangements, and additional actions that will help patients and community support groups engage with us electronically to collaboratively manage high-risk individuals in the community.

The current meaningful use requirements do not segment the served populations according to their healthcare risks. The requirements for communication, coordination and automated interventions are the same, regardless of the severity of illness, absence or presence of social or community supports or anticipated resources needed by the patient. Yet the success in most accountable care arrangements depends upon the payers and providers assuring that those who are at most risk of unnecessary costs are quickly identified and managed. We suggest that ONC require providers and payers to adopt a standard methodology that defines a risk score to help categorize patients. Several methodologies are publicly available that can calculate and estimated risk of health deterioration.

A standard set of data fields and set of data definitions would enable both providers and payers to immediately focus on those in the case management services. Patients and their family members would recognize that they have been identified as being at risk for complications, such as a fall in the home or inability to properly self-manage without assistance, and might be more willing to accept care management services that otherwise would be wrongly dismissed as unnecessary or extravagant. These requirements, combined with case management tracking functionalities could be part of voluntary certification of HIT applications designed to help ACOs manage their population.

The second initiative would enable providers and payers to prospectively identify patients who are included in accountable populations. It is difficult to reliably monitor populations of patients when providers are unsure of who is in the mutually accountable population. Payers, particularly CMS under the Medicare Shared Savings Program, provide information on the population after services have been rendered and opportunities or intervene on the accountable population may have passed by. Providers can intervene on those patients for whom they directly provide services, but what happens if the assigned individual decides to seek care for another unaccountable provider. The services might proceed uncoordinated from the providers in the assigned ACO, who continue to bear the risk. Proactive identification of those in the assigned population using a universal patient identifier would help coordinate patients. We propose even though the benefit plans do not require selection of a network, that ONC work with payers and providers to facilitate the identification of individuals in the accountable care population, prior to the beginning of a risk period.

The third initiative we propose is a set of actions designed to better engage patients, families and community support groups and the coordination of patients, particularly palliative care plans and end-of-life interventions designed to support the individual in their homes and engage support for community agencies. Public information programs were highly successful in educating the public on the hazards of high blood pressure and high cholesterol. Could HHS do a better job of explaining to the public how they can expect act with providers who are committed to an e-engagement? The focus needs to begin to shift from incentives to providers to education of the public, helping to create the pull from patients for services offered virtually rather than as part of face-to-face visits.

Part of this effort would involve enhancing future meaningful use requirements such that providers have the requirement to collaborate in the management of a common, patient developed, shared care plan; managed by the patient electronically that could then be linked to faith-based organizations, community support agencies and other members of the public who are part of the individual's social support system. This common document promoted through public education could serve as a backbone for a broader communication program designed to engage the patient in an e-community of providers. We believe these changes focusing on the identification of vulnerable populations, prospective identification of individuals in ACO arrangements and enhanced patient engagement strategies will help advance our ACO ambitions.

Charles Kennedy, MD, MBA – Chief Executive Officer, Accountable Care Solutions – Aetna
Great. Thank you Dr. Chodroff. Dr. Bragg.

Franklin E. Bragg, MD, FACP – Eastern Maine Medical Center

Good morning; I'm Frank Bragg. I'm a family care internist in Bangor, Maine, been on the EMR for 17 years and had the privilege of serving as the Performance Improvement Coordinator for our Beacon Community Plan, which ended the three year program. We've morphed into a Pioneer ACO and next month will be our third year as a Pioneer ACO, and I have the privilege of serving in the same capacity there, namely Performance Improvement Coordinator. We've got 72 primary care practices, 600 providers, 42 Maine towns and cities, 55 nurse care coordinators and 60,000 patients, that's going to be in January 2014, and six different EMRs. Our first year we had one EMR, now we have six, which leads me into my comments.

Luckily in the state of Maine, we have a very – a statewide HIE which I'm finding very valuable. It sounds like in some states, the problem needs to be faxed, I would encourage you to nurture the HIEs. I think that's going to be our temporary salvation to get over this problem of six different EMRs. On the certification side, I don't think you do anything about usability; couldn't should get Consumer Reports to test drive the EMRs. I mean, I want to be able to on the fly put my personalized med list in, personalized problem list, I want to be able to personalize it, I don't want to be told by the vendor what I can or can't do, I want to make it mine .

External apps. We use a lot of apps, we have one app that when I order an MRI, it takes me out to a decision support site where it tells me whether I'm ordering the right MRI or not, with or without contrast, anybody in practice gets driven nuts by that. I have another app we use to link us to the HIE where it shows me problems, meds and allergies in one column and matches or mismatches in the medical record. I click a button, it pulls the meds into my medical record or the problem is added to my problem list. We use an app that records keystrokes so instead of 20 clicks to order a blood sugar, I just hit one button and it does all the keystrokes for me, it puts the order in and attaches a diagnosis. I use another app for patient registry and now we're moving towards having the patient registry push my data to Bridges to Excellence to get recognition for performance with Bridges of Excellence. And another one – app we used six years ago to create a patient portal, so we use e-mail lots and lots and lots, and the patients can request appointments and send me e-mails asking questions.

So I just think – I think the electronic medical record world should move towards maybe two or three platforms, think IOS or Android or something, and a whole bunch of apps, so if I'm practicing next to him in my office, I might use a different app from him for diabetes management. But on the backside it pushes out the same data, it's all HL7 on the backside, so – and we both like our app and I don't want to use his and he doesn't want to use mine.

Social media. As we move into commercial contracting, which we're doing in a big way, we've gone from being a regional Beacon, thanks to Craig, a Beacon Community around the Bangor area to statewide now. We're doing commercial contracting, as required in the Pioneer contracts. Guess what, they're younger and guess what, portal schmortal, they don't want another password and e – and new username, they want to do it on Facebook. They want to Skype me. They want to do it on Twitter. They want to do it on, the middle aged ones, want to do it on LinkedIn, maybe. We have patients already who are messaging in Facebook. You know what we have to do, we have to call them back and say we can't use that, you have to call us, we can't use that, you have to call the portal schmortal. Come on, we've got to be flexible.

I've got a minute, cool. We have another issue and that is, I'm not sure how much you incentivize nursing homes and SNFs to use electronic medical records, but classic scenario. Last week I was told one of our nurse managers called the nursing home and said, when is Mrs. Jones going home? And they said, she's doing fine, she'll be here another week, she's making progress. Fine, good. They call back a week later and guess what, she went on the next day, so she went six days with no contact from our care manager. We've really got to, I think encourage, and again, I'm ignorant in this area, but if you don't do it, we should encourage SNFs and nursing homes to use electronic medical records to push at least ADT information, but more than that, labs, etcetera.

And it goes without saying, we should demand of electronic medical records the integration of claims data with the quality data. Because we're not going to succeed in this ACO world without being able to integrate those and have quadrant graphs showing quality on one axis and cost on the others and say, all right, that's the doctor I'm going to visit next week. Time's up. Thank you.

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

Thank you Dr. Bragg. Dr. Slonim.

Anthony D. Slonim, MD, DrPH, CPE, FACPE – Executive Vice President and Chief Medical Officer – Barnabas Health

Good morning, my name is Dr. Tony Slonim and I'm honored to be presenting testimony this morning. I'm the Executive Vice President and Chief Medical Officer for Barnabas Health and I'm also the Executive Director over two ACOs, the Barnabas Health ACO North and the Central Jersey ACO, as well as President of our 900 member medical group. Barnabas Health is a three billion dollar system, 7 hospital system, one freestanding behavior health center in the state. We're the largest provider in the state of New Jersey. We provide a range of services from prevention and wellness up through and including quaternary care. And again, we support two of the nine ACOs in New Jersey.

We've conceptualized ACOs as an umbrella under which you plug and play programs. For the Barnabas Health ACO North, we have 400 doctors and 10,000 beneficiaries. We started that in July 2012, to a Medicare Shared Savings program and in October, we started Medicare Advantage Program, as another program under that ACO. The Central Jersey ACO is a joint venture with a non-Barnabas Health Facility, CentraState Medical Center, has 200 doctors, 20,000 beneficiaries and started in January 2013. They also took on Medicare Advantage in October. We have a commercial program under development and we've decided at this point not to get into the Medicaid business.

We also think about the way that we're providing care, and it's interesting as a health system, we have to always fall back to the hospital as a place where we understand what we are doing. And as we reflect on that, it's weird to think that the hospital is the place we go to for highly coordinated care. But nonetheless, it does help, especially in contrast to the outpatient arena. If you think about the interaction between doctors and patients, a doctor in the hospital will write a bunch of orders or type a bunch of orders that go to the lab, radiology, medications and the hospital's management team is responsible for delivering that care. The payer writes two checks, one to the doctor for professional fees and one to the hospital for the coordination of that care while the patient is hospitalized.

When you transition to the outpatient arena, you actually realize it becomes quite cumbersome and uncoordinated. The doctor and the patient relationship certainly continues to be sacrosanct, but as the doctor writes prescriptions or types orders for laboratory care or consultation or any other number of pieces of care, we leave the coordination aspects up to the patient or if they're lucky enough, to the patient's family. So the patient has to decide with their new batch of prescriptions, do I drop the prescriptions off before I pick the kids up from school or after? And if I drop the prescriptions off now, then after dinner I have to go back and pick up those medications. If I get a cardiology consult as an order, is that cardiologist on my panel and if so, which one do I go to? Important conversations that we need to understand how to coordinate in the outpatient arena.

What's also important is that the payer writes multiple, multiple checks, one to every intersection point of that conversation, the pharmacy, the consultant and when you go to the consultant, remember, they undo everything the primary care doctor did, so it just explodes the situation. We've identified this as a struggle with coordination, we often blame the physician, which is a problem, because they're often ill-equipped to manage this. And so we've focused on connectivity and coordination is a major part of our work. We've hired care coordinators and we look to emergency departments and the discharge from the hospital as an opportunity to coordinate care and make sure that patients have access.

While we've looked at specific diagnoses, we've often focused on the things that are on test, for the CMS MSSP Program, diabetes, the coronary disease work and the heart failure work. We've obviously looked at a couple of high utilizers, but as a system that struggles with readmissions, we've not found readmissions to be a problem in our ACO, which is interesting and important because we have to segregate the work that we're presented to physicians. From an IT perspective, we have just completed an inpatient and ED rollout and have 15 different EMRs represented in our ACOs. We have a Barnabas Health HIE and seven HIEs in the state of New Jersey. Why we need seven, I don't know.

We were focused on implementation, so we made a decision to completely outsource our ACO IT program. It prevented distractions from the implementation, it allowed us to have a quick startup, it was solutions that we are able to discover and got a whole bunch of stuff, including warehousing, claims, analytics, registries and opportunities to advance physician portals and interfaces that we never would have gotten if we would have done it on our own.

As I look on our ACO experience, we've often said, why the heck did we get in this business? And certainly we've looked at it as a learning example, everybody's learning, CMS is learning, we're learning, the physicians and the patients are learning. Three major challenges have hit us. The first one is this HIE thing. We have to be, because we are large system throughout the state, members of three different HIEs. They have their own way of doing things, it's really cumbersome. The second challenges is with our physicians. The MSSP program has put incentives that are temporally distinct from the behavior change that we're looking for in our physicians. That's a problem because you can't get them to coordinate and do the work that they need to. And finally, we don't have the answer for this, but we need to do better job on engaging our patients if we're going to be successful in this work. And right now, the patients are driving the kinds of care and the expenses that they think they need to be able to have appropriate care. Thank you for the opportunity to be here .

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

Very good, thank you Dr. Slonim. We're going to move into the Q&A section of the discussion. What I'm going to ask the panel, or anyone asking questions to do is to try and relate your question to the pre-established questions that we have and let us know which one you're addressing. I'm going to start out with a question that will hit question one, which is, in our previous panel, the clinical strategies that were implemented to improve quality and reduce cost didn't necessarily have a financial – a negative financial impact to the provider-based organizations, as all of them on that panel did not have hospitals. You all are in a very different situation. Would you please comment on the clinical strategies that you're planning or are deploying for a ACO success and relate those to the financial impact on how you're trying to navigate those two often conflicting objectives? And anyone, please start.

Michael Sills, MD, FACC – Chief Medical Informatics Officer – Baylor Quality Alliance

You're right, Charles, it's – we exist in a world where hospitals only make money if the beds are full and we take care of our own employees. So when I proposed, which we succeeded in getting through, protocol for wh – trying to eliminate the 70 percent to 80 percent of unnecessary MRIs for low back pain, everybody loved it except the CFO put up hands and said, you understand you're just about to kill me, because that's our leading source of revenue. So I think it's about trying to get incentives aligned. And as somebody mentioned it before, I think that there's going to be a dark side to population management and that will be that smaller systems that can't be efficient, that can't conform to some of the requirements of data and data reporting, will probably not exist.

I've heard – you hear amazing discrepancies that we're over-bedded, we're under-bedded; I think we're probably over-bedded. I think that systems that have a strong ability to use IT that can create narrow networks, can cross the care continuum will probably continue to exist, at the expense of smaller systems that can't. So, I think the impetus for us is to understand that we've got to do the best job, as somebody mentioned before. There will be competition and competition's not a bad thing, but it's going to change the landscape. I think there'll be fewer hospital beds, the ones that we have will be better utilized, but I think, I heard them talk a couple of months ago, somebody said that there may be 1000 hospitals that'll close in the next five years and more than 100 hospital systems over the next 10. And I think based on all that, that will align some of the incentives.

Charles H. Chodroff, MD – Senior Vice President of Population Health – WellSpan Health

This is Charles Chodroff. We've made a significant investments in patient-centered medical homes, augmenting staff in the physician practices that we own. We've also taken case managers and social workers who formerly were based in hospitals, moved them up to the corporate level and then aligned them with our patient-centered medical homes, as opposed to hospital wards. We have augmented staffing of that service. Each of – all of their concerted efforts of our medical homes and our case management staff, are designed to reduce unnecessary hospitalizations, readmissions, preventable hospitalizations, reduce ED admissions. And we've also put in place a number of programs to reduce unnecessary high-end imaging testing.

Up until the Aetna arrangement, which we signed in the fall, which will not go live until 2014, so at this point it's actually, we are 100 percent fee-for-service. And so you might ask, what psychotropic medications are we giving our CFO? Well, he's mentally intact and quite aware of everything we're doing and a co-planner with myself and Hal and a number of our management team on a deliberate on it strategy, which we call a glide path. And it will result in lowered inpatient revenues over the next several years and the balancing act we have to undertake is a reduction in cost in certain elements of our system, while we're simultaneously increasing costs in other elements. We think being highly integrated offers us the best opportunity to stay on that glide path and not fly into a mountain or hit the ground. That's a very challenging prospect for us.

Franklin E. Bragg, MD, FACP – Eastern Maine Medical Center

Yeah, I think it's the Wayne Gretzky thing, we sort of see where the puck's going to be and want to get ready for that, making significant investments. I mean I heard our CFO yesterday say that the first year was a six million dollar investment, the second year 12, the third year 12. Those are big bucks in Maine. And we were one of the Pioneer ACOs that actually saved money the first year. It didn't even pay for half of our investment, so it's pricey, it's pricey. But when you think in the world when we get paid on a risk-adjusted per member per month for global care, that means nursing home, hospital, primary care, da, da, da, da, we're building for that world and we think that world's coming and we're willing to make the investment to be ready for that world.

Yeah, I don't mean to be an outlier here, but don't give us too much credit, we're not that successful in the ACO world, at least at the moment. We've got 30,000 patients, we'll probably get to 50,000 in the next couple of months with other programs that we're putting in this. While theoretically I worry about the challenge, there are going to be plenty of other people over-utilizing services that I won't have to worry about. The ACO is a microcosm of the system and so I think that's the benefit of having a large system, and I really don't – while my CFO might – this isn't one of the top 10 things he's worried about we're not going to be that good that quickly.

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

Okay. Kelly?

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

At your request to tie back to the questions that we posed originally, so question four was, to what degree are you leveraging community-based infrastructures to support care coordination objectives? And there's also, I think, Dr. Bragg in your testimony, or one of the testimonies around what should be the federal governments clear expectation on e-engagement with patients. And I'm wondering, given those two things and what the other panel members have said, should there be a logical home for a longitudinal shared care plan or a longitudinal patient record and should it be at a community level? Given where Meaningful Use Stage 2 is going, which was commented on earlier, where there's going to be a lot of EHR-specific views, but you have a goal of supporting care coordination across the continuum. What are your thoughts about where is a logical home for that?

Franklin E. Bragg, MD, FACP – Eastern Maine Medical Center

My main answer would be, excuse me, with the HIE. But when I hear the chaos in some areas I'm not sure that's a practical answer. I think we do need to develop a community care plan to include everybody's plans in that document, where it resides, I'm not quite sure. I can answer for Maine, I think the HIE makes sense, because we're scattered and we're some thinly populated areas and some aren't really in a community in the sense of community. But I'm not sure nationwide, there ought to be some aggregator though, I agree.

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

Can I ask a follow up? Some people have talked about the idea of an information home because there's a lot of need to actually manage and reconcile information and identify who it needs to be share with, that could be the role of the PCP or kind of a medical home, but actually kind of curating information, not just storing it. And just wondering if that – which is different from the concept of an HIE being just sort of the aggregator of the information, but not necessarily kind of distilling it and managing it. Just wonder what your thoughts would be.

Franklin E. Bragg, MD, FACP – Eastern Maine Medical Center

In other words, who sort of takes responsibility for that aggregated data? The visiting nurse says one thing, the doctor says another and the home health – the primary care provider clearly.

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

Done.

Michael Sills, MD, FACC – Chief Medical Informatics Officer – Baylor Quality Alliance

I wrote down a couple of answers to your question. I mean, yeah, it's great to have it at the community level, but in the city of Dallas with 9 million people and a contiguous area in the state of Texas of gazillions, what defines the community? And who – it also opens up the bigger question, who's responsible for it and that's one of the things we wrestle with. In my office they're allergic to sulfa, in the hospital they're allergic to penicillin. Who can make changes to that? Who's responsible for the integrity of it? So, those are the kind of bigger questions that we would love some guidance as to the ultimate responsibility both for the integrity and the maintenance of that. Because then there's also, I've logged, I think, last I checked, nearly 80 hours with our legal and compliance people as to, who can access the information? What kinds of people – can a practice administrator look at information to see which of her docs or his docs aren't performing well? So we have those kinds of issues.

We also have the issues of attribution. As you guys know, in standard Medicare you can't force a Medicare patient to go with any one provider. Now Medicare Advantage we can, but without defined attribution, it becomes very difficult, once again, to establish responsibility for the integrity of the information. Those are – without a narrow network, in essence, it becomes very difficult to do exactly what we would like to see, which is the establishment at a local level of all the information about any one patient.

Anthony D. Slonim, MD, DrPH, CPE, FACPE – Executive Vice President and Chief Medical Officer – Barnabas Health

I would love to see a longitudinal care plan. I think we've got some other challenges that are facing us, right. We've talk – and the question about who should manage that care plan is important. When we're talking to doctors, right, they often think about the individual doctor-patient relationship as an important piece of work. Now we're asking them to think in a paradigm that's very public health oriented, population management, community, terms that are not resonating in the one-off kind of approach. And so as you move from individual to population, we also have to get to a conversation around, how do I provide physician level accountability, but also team-based care? Because the doctor can't do it alone and we need to make sure that not only the technology's there, but the team, the broader team is there to support the needs of the patient.

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

Craig Brammer – CEO – HealthBridge

Thank you. I will also tag off of question number four. HealthBridge, our organization started 15 years ago and has been slinging data around for a dozen years, it delivers about 5 million clinical results a month. Interesting point of background, we are, at this point, merging also our hospital and long-term care membership organization, that's been around since the 1960s, the membership trade group. Also with a third organization that is a quality improvement organization that has a contract to lead the Comprehensive Primary Care Initiative that does claims aggregation. The result of that is splicing Triple Aim objectives into an HIE that's used to just moving data and building HL7 interfaces.

And my question is around this notion of clinical leakage and wondering if you have data about the extent to which that is – how big of a problem that is and I want to tell you about a solution that we've tested and Secretary Sebelius and Dr. Mostashari were in Cincinnati about a year ago to learn more about this. But essentially what we've done is 30 competing hospitals and all their providers, have agreed to machine-to-machine upload their panels and then we listed the ADT feeds and we instantly alert, Kevin and I are two competing hospitals, I'll tell him if one of his patients hits mine and vice versa. Cincinnati Children's assume that there are tens of thousands of Medicaid asthma kids would come back to Children's when they had a problem, turned out they were right about 60 percent of the time, 40 percent of the time they went to community hospitals. And as part of this alerting intervention, they cut their time to failure, which for a kid with asthma is hitting the hospital. It was on an average 12 months – I'm sorry, it was on the average every six months the kids were hitting the hospital and they moved it to 12 months over an 18 month period, in large part because of this alert notification and the pooling assets. So I wonder if you have a sense of the magnitude of the problem that that kind of solution solves?

Charles H. Chodroff, MD – Senior Vice President of Population Health – WellSpan Health

I think – this is Charles Chodroff. I think there are several tactics that we undertake to assess keepage. And first it starts with benefit plan design. If the benefit plan is a CMS traditional Medicare, the patient is free to go anywhere they want, it's very, very difficult to control that. The second point of intervention would be in the electronic health record when the – if you have electronic referral management. And I've been to one health system where when the doctor orders a referral or a service outside of the ACO, they are prompted and they can't proceed without indicating why they are choosing that provider.

The third point of intervention would be on analysis of claims data and making that highly visible on dashboards. We've learned that physicians respond very readily when their practice patterns are displayed in a semi-public manner, with those of their colleagues. So, I think – and there probably are some other interventions, but those are just the ones that come to the top of mind. I think you pointed out another one, which is that the point of contact, so like an emergency department admission if I'm immediately notified. I don't think that's going to really help. Let me just share one story, I'm not from the South, but this is a good story.

So I have a patient of mine who is very complex, he is a Medicaid patient, Medicaid HMO and he had bariatric surgery, he's got atherosclerotic coronary artery disease and he consistently goes to the competitor hospital. Now we're not in an ACO arrangement yet, but at some point I envision he will be. And I asked him, I said, why do you keep going to that emergency department as opposed to coming to the office? This man is moderately mentally retarded. He says well, I can't drive and I call the office and they give me an appointment but, community transport can't get me here, so I call 911. They will take me to an emergency department. I said, yeah, I understand that but why do you constantly go to the other emergency department? He goes, well, because they're faster than yours. So, this – there's no skin in the game for the patient and the multiple social reasons why we have keepage, it's not a simple problem.

Michael Sills, MD, FACC – Chief Medical Informatics Officer – Baylor Quality Alliance

It's kind of our belief that that's not going to be a physician issue. We did a little bit of work to try to figure out who's using our ER, because all 32,000 of us have the same insurance and we were trying to ask that same question, why do some people go to the ER all of the time and why to some not? And we realized just a simple thing, when I need to go get my annual physical, because I have to now, I call up an admin and say next Thursday at a 8 o'clock block me out for an hour. Housekeeping can't do that, dietary people can't do that. They can go to the emergency room at 10 o'clock to get a refill on their blood pressure medications, but it's hard for them to take time off.

So we really believe, having said that, that it's going to be network redesigned, and like Charlie saying, it's going to be benefit redesign. It's saying to them fine, you want to go to the ER all of a sudden, that \$25.00 co-pay is now a \$200 co-pay and with that, we've seen about a 75 percent fall off on unnecessary ER visits. So, I think it's going to be about – kind of as a segue from her question, I think it's going to be about definitely attribution and identifying who your high risk patients are. But it's also about getting these kind of people into a PCMH, giving them like with Denver and Geisinger, when they call, they get an appointment within one to three days. They get three options and by the third option they're just put in. You've got to create access, so we believe it's about network rede – benefit redesign, narrow network and access, and that's along with attribution how we feel like leakage, keepage, steerage and all the – ages are going to be resolved. 31300

Franklin E. Bragg, MD, FACP – Eastern Maine Medical Center

When you say leakage reports, I think of providers ordering tests or consultations and it just made me realize we're a little schizophrenic in Bangor. I work for Eastern Maine Medical Center, which is a tertiary care hospital in Bangor and there's another Catholic hospital, St. Joseph's Hospital in Bangor. And I get a monthly report, a leakage report that tells me how many times I used non-EMMC services and yet, St. Joseph's Hospital, the other hospital in town, has now joined our ACO for our commercial contracts. And I wonder when that behavior's going to change, it's going to have to ultimately, I would think but, is that what you meant by leakage or –

Craig Brammer – CEO – HealthBridge

Yeah, it just seems to me that over time, in our world, we'll be likely we are to living less data because we're in an Epic environment, we're in a very competitive healthcare market, five adult systems for 2-1/2 million people, and we – and they're all on Epic. And yet the data for the patients that aren't sticky, that are going bouncing all over the place, which is very common in our market. Dartmouth has its 30 percent of the attributed population will get care outside of the traditional ACO. And I was just curious if you guys, in your experience so far, has any ballpark of how much – is that 30 percent close? High? Low?

Charles H. Chodroff, MD – Senior Vice President of Population Health – WellSpan Health

In our own employee benefit plan, which is in essence our first ACO because we pay all the bills, and it's a hundred million dollars spent, so it's a significant amount of money. We have adjusted the benefit plan and now – .and we pay all the claims, so we have very accurate data on that population. We have about 80 percent by dollar value is by our ACO network providers. Now when we look at the other 20 percent, there's a big chunk that is just unavoidable, college kids who are out of town, people who needed a referral beyond our capabilities. And then there are patient choice and I think the ACA, it puts limits on out-of-pocket maximums and – but if you're of reasonable means and you go, I've got a very, very serious illness, write a check for \$6000, I want to go wherever I want to go, so –

Anthony D. Slonim, MD, DrPH, CPE, FACPE – Executive Vice President and Chief Medical Officer – Barnabas Health

Tony Slonim. We had, as it relates to this conversation, we've had conversations with our contiguous ACOs to figure out what we might do together to be able to try to understand this. If our patients got admitted to one of their hospitals, what we would do, would we transfer the patient? If one of their patients got admitted to ours, what would we do, transfer the patient? And at the moment, we've just simply decided, let's do what's in the best interest of the patient and the family. If they happen to be contiguous there, where they live, and illness is important, you need to be surrounded by family. If that's more convenient for the family, leave the patient where they happen to present rather than shuffle them all around, particularly at this stage of the ACOs. Now we have our first convening panel, again, there are only nine ACOs in the state of New Jersey, we're going to get them all together, after the first of the year, to start talking about how we might do things differently as we start to think differently about populations and where they bump up against each other. New Jersey also happens to be a state where lots of the elder population goes to Florida for the winter, so thinking about what that's going to look like is a whole another story, we're not even ready for that conversation.

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

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

Thanks. I'm going to pick off of question eight primarily, data liquidity and also four, which is a "community infrastructure," and piggyback on what Anthony just talked about. Last I checked, New Jersey's a fairly small state and it has nine ACOs and seven HIEs. Is that really a community infrastructure? So, unfortunately we've heard a lot from both panels about at least what you all labeled as vendor barriers to getting the data to flow, even within the same vendor. So the question – well, one question is, is it that they come back and they say well, it's going to cost a million doll – is it the money? Is it that they just won't do it? Is it the time they don't have? I'd like to understand concretely what they tell you. But then move onto what we do about it? I think, in this morning's conversation and frequently we talk about HIE as – an HIE organization is an organization that's supposed to just move data around. I think originally designed, and perhaps we've lost track of the HIE organization is really a convenient forum to what you said, the nine ACOs, even though you only support two or three of them is, we really have to have discussions and with human beings work this thing out. And I'm not sure adding more technology or adding more certification is going to fix the problem that I've heard about all morning.

So, are we missing that spot and is that what we need – once we've done this homework, which is you've had the experience, doesn't it get down to we actually have to sit down next year and all sit down, work together, including the vendors, and work on how we exchange information? One of the initiatives that was thrown out as an RFI by ONC was on governance. And interestingly enough, the reason I think it didn't go forward is because the public said, oh don't bother us with that, don't do that, we'll do it ourselves. But I go back to this New Jersey example and it doesn't sound like it's happening on its own, so what's the magic? What can – it's not necessarily what can the government, what needs to happen and then how can we facilitate that to get important information to move around to be used for patient care or an ACO management of the patient care? And I don't know that it's standards. And so, hel – can you help us understand what is it, and then try to figure out what policy levers would support what it is.

Anthony D. Slonim, MD, DrPH, CPE, FACPE – Executive Vice President and Chief Medical Officer – Barnabas Health

Sure I can at least start –

Claudia Williams – Director, State Health Information Exchange Program – Office of the National Coordinator

– and actually, our second round of public input on this idea of what do we do to accelerate HIE and is certification or governance appropriate, we did actually get strong public input to do something.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

Okay.

Claudia Williams – Director, State Health Information Exchange Program – Office of the National Coordinator

And so, I think the tides have shifted since two years ago.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

Good. Thanks. Go ahead.

Anthony D. Slonim, MD, DrPH, CPE, FACPE – Executive Vice President and Chief Medical Officer – Barnabas Health

Tony Slonim. I can at least start the conversation. I think the good news about having nine ACOs and seven HIEs is you can put your arm around that, there's a quantifiable number. I can put 16 people in a room, 15 people in the room and have a conversation about what this might look like if we were to actually work together. I know that sounds surprising, right? But, one thin – I met with the board of the HIE not long ago and in an effort to try and be provocative said, what would it take? I mean, because let's realize, we're a big health the system but we're making, by virtue of the electronic work that we're doing, the IT work we're doing, we're making real public health investments from a private organization. Would it take three years and fifty million dollars? Would it take five years and a hundred million dollars? What does it take? And I couldn't I could really get an answer and that was a problem for me, because I really don't kn – I've got some of the smartest minds in the room and I've got to figure out how to get there. So I think, to step back, what are we trying to accomplish and how do we get the work done is part of what the vision statement is. And then, do we have the right people in the room to get us where we need to be? How much will it cost? And how do we get it done is where we need to go. We're certainly just starting the conversations – get there. Maybe it's a place where we could be helped by government intervention, maybe it's a place where we could be helped by other conveners who have more knowledge than we seem to have around the current table.

Franklin E. Bragg, MD, FACP – Eastern Maine Medical Center

Is there federal support still for HIEs or is that just –

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

It's over –

Claudia Williams – Director, State Health Information Exchange Program – Office of the National Coordinator

Yes, there's Medicaid HITECH funding that's ongoing, but the Cooperative Agreement Program is coming to a close over the next year – that had targets for states. There are other funding sources.

Franklin E. Bragg, MD, FACP – Eastern Maine Medical Center

So when I talked to Dev Culver, the director of our Maine HIE, he's worried about the viability in terms of funding. And I talked to my small rural hospitals who aren't yet hooked up and they say, well how much does it cost, and I tell them, well depends on how many provides, but it's \$5000 or \$10,000 then the annual fee. So, could you put some money on the table? To New Jersey say, we'll give you ten million dollars boys, get in the sandbox and play nice and come out with one HIE?

Claudia Williams – Director, State Health Information Exchange Program – Office of the National Coordinator

We did that three and a half years ago.

Franklin E. Bragg, MD, FACP – Eastern Maine Medical Center

Oh.

Claudia Williams – Director, State Health Information Exchange Program – Office of the National Coordinator

And it's been experimentation across the country with variable results.

Franklin E. Bragg, MD, FACP – Eastern Maine Medical Center

So put 20 on the table. I'm just –

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

So maybe just to follow up on Paul's question. I think one of the things that often the government struggles with is how not to become the arbiter of all the business relationships between all the people. So to the extent a market can exist that solves problems or the public utilities that aren't under the control of the government, that's far better than us saying, these are the fees you can charge, here's how it works. I guess one this is I've heard from a lot of folks, both HIEs and hospitals, for whatever set of reasons it's been hard to exert the normal market power by just going to – and saying we're not signing that contract unless – these are the things that we need in our relationship with you. And I have heard a lot of frustration that it's just – it's too expensive, it takes too long, we can't figure it out how to do it. But getting to the place, where what is a government role? What would be? Is it more money on the table? Is that a governance thing that voluntarily people can agree to that says we won't charge fees for simple message exchange within our like net neutrality kind of thing? Is a more transparency around prices? Because I think what we don't want is to jump quickly to an assumption that the government's now the – or the regulator of prices, that doesn't really operate very well. So – I would just love to like take Paul's question and just really tease it out a little more, what would be helpful?

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

– .obstruct your – yeah, how is that the vendors obstruct your attempts?

Charles H. Chodroff, MD – Senior Vice President of Population Health – WellSpan Health

Actually, it is an interesting question, where are the vendors today? The reality is they're not part of –

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

Yeah, I know.

Charles H. Chodroff, MD – Senior Vice President of Population Health – WellSpan Health

But I'm just saying, because the problem is for us, and we've got a lot of leverage, to be honest. I mean, we're the biggest Allscripts implementation the country, one of the biggest Epic. We can't get them even in the room to talk about data sharing. In the end, no the matter how much influence we might have as the hospital system, we don't have enough influence – to answer Claudia's question, to get them willing to share information because there is no incentive, there's zero incentive for them to do that for us right now.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

But there – I mean, meaningful use require – at least Stage 2 requires –

Charles H. Chodroff, MD – Senior Vice President of Population Health – WellSpan Health

Well, it requires certain things but, CCD production, sure. But, it's not all – there's not a free exchange of information, HIEs are limited. We would love just if everybody agreed, here's a format like a CCD, where all of your information is going to be. Let the analytics program decide what the format ought to be so that we can access it. But it's an enormous barrier right now for us – yes –

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

– what was the market failure, because you did have tremendous leverage and you could shop around. Was it not part of your requirement procurement process?

Charles H. Chodroff, MD – Senior Vice President of Population Health – WellSpan Health

Yes, good question. The answer is, we don't always know what we're going to need in a few years and moving a system like ours, with hundreds of millions of dollars of implementation costs over a five-year

Period, I wish we had better vision, quite honestly, than we did. But we didn't and I think ult – we're not unique, I mean, I just came back from California talking to a system there that's in the same dilemma. We probably don't have as much vision as probably is in this room and we could use a lot more guidance as to how this data interoperability is going to unfold.

Anthony D. Slonim, MD, DrPH, CPE, FACPE – Executive Vice President and Chief Medical Officer – Barnabas Health

Tony Slonim, I'd like to come back the question that was asked by Claudia over here. At the very granular level, one of the things that's hindered us has been the multiple fees that we need have to pay to each of the HIEs to be members. And one of the – because I believe in – so what happens – a couple of things happen. There's duplication, right, so I create my own HIE internally because I need to be able to move information within my own organization, a pretty big organization, we could just dump that, if you will, into HIW. Well I've got my hospitals, my member hospitals, I've got seven of them, participating in different HIEs, that doesn't make sense. So what does it take for me to move hospitals into one HIE?

One HIE in the state actually has more than half of the hospitals in it. Well there's a real opportunity for sharing. Well the way that they've structured the payment mechanisms, it's going to cost me a couple of extra million dollars because they charge by hospital, instead of as a system, okay, and I've got seven hospitals. So now I'm getting a fee per hospital, it's going to cause an excess couple of million dollars I just don't have to invest in that infrastructure to move people along. It's a very interesting to get important answers to the granular question, which is, we haven't organized the work in a way that allows us to get where we need to be in terms of integration.

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

What I'm hearing you say though is that at these HIEs get bigger there's less opportunity to get them to do anything different, because you're going to have to – you've got to adhere to their fee schedule, correct?

Anthony D. Slonim, MD, DrPH, CPE, FACPE – Executive Vice President and Chief Medical Officer – Barnabas Health

Absolutely.

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

Okay, so, unless something is brought into incentivize them or to bring about competition in the HIE market, funding HIEs is not a solution.

Anthony D. Slonim, MD, DrPH, CPE, FACPE – Executive Vice President and Chief Medical Officer – Barnabas Health

Right, and ultimately that becomes a sustainability issue for the HIEs, right? I mean, how do they go about continuing to do their work? One of the things that they could benefit though, I would think, is having three of my hospitals move from other HIEs in, because now they'll go from having half to having half plus. I mean there are only 70 hospitals in the state, so 35 of them are in one HIE, we should be able to figure this out.

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

What can make that market more competitive? Do you have any ideas?

Anthony D. Slonim, MD, DrPH, CPE, FACPE – Executive Vice President and Chief Medical Officer – Barnabas Health

No, I wish I could tell you. It's pretty – yeah, right.

M

– New Jersey, that's what's crazy.

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

Sounds like it's not competitive though.

Franklin E. Bragg, MD, FACP – Eastern Maine Medical Center

This is Frank Bragg. I haven't been saying my name, I'm sorry. Is there any move afoot to have a national HIE? Because I heard Tony talk about the snowbirds, we have snowbirds in Maine, too. They spend half their year in Florida and half in Maine, and I'm not sure if I can access an HIE in Florida, being a Maine doctor. So is there any thought of having a national HIE? And maybe if there is, then you can say, okay, we're going to have one HIE in each state plugged into the national, and that'll make them get the thing with statewide, or maybe region-wide.

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

Do you want to comment on that –

Claudia Williams – Director, State Health Information Exchange Program – Office of the National Coordinator

Maybe I'll just speak to that. I think experience in other countries like in Great Britain has shown that these complex problems don't become easier by elevating them to a larger geography. And also, that there's tons of exchange going on right now that's not funded by government. And our goal is to get it going for everyone, but I don't think there's either an appetite or experience from other places that shows that elevating it to a single point of failure and a the single point of opportunity necessarily is the path forward.

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

I would just also add that since 2005, it's been ONC's position that we're trying to accelerate a network of networks with a layer of governance as a – express, either through regulation, quasi-regulation or collaboration. And we're still working out the details, it's just hugely complex. And there's been a lot of failed experimentation, but we're now at a critical juncture where we've got to really advance something that's going to be workable.

Anthony D. Slonim, MD, DrPH, CPE, FACPE – Executive Vice President and Chief Medical Officer – Barnabas Health

I think that's an important point, right, so if we go back to a microeconomics approach, if the nine ACOs got together and say, we're important customers of the HIEs. Would that drive – and we took the nine ACOs and the five largest health systems in the state, which represents a good percentage of the market share and said wait a minute, we're your customer HIEs, here's what we need and see how that drives the market. I mean I think that could be a very powerful conversation.

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

Karen, you've had your card up for a while.

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

I almost forgot what I was going to – is this – but it's in a completely different direction. It has to do with the fact that the vulnerable populations that we all know about, the dually eligible, those with a lot of behavioral health comorbidities, the frail elderly constitute a high proportion of your high-cost patients in an ACO. And with Medicaid expansion, with some states like Oregon, Massachusetts, essentially putting all of their Medicaid patients in an ACO environments down the line. My real question comes down to, how are you going to manage these really high-cost, difficult patients outside of your specific delivery system? They don't always come to the hospital, they're not always coming to physician's office, they're going to senior centers, they're going to minute clinics, they're staying home, they're not going anyplace. And you can assign case managers to them, but they're still going to be using a lot of community-based services. So are you going to provide those services? Are you going to link with those services? How do you see this population being managed going forward and how can we help you?

Charles H. Chodroff, MD – Senior Vice President of Population Health – WellSpan Health

This is Charles Chodroff. This was a point I made in mine about that's where the money is, Sutton's law, and when you look at different payer groups, you find different populations. So you just talked about two different payer groups, the Medicare population that tends to be the frail elderly, the Medicaid is children with special needs or the dual eligibles. Commercial populations, it's what we call the whales and we look at claim streams, we see a lot of minnows, we seen an occasional bass and then you've got the whales. And the whales are two types, they are patients with chronic diseases that are being appropriately treated, but the treatments are incredibly expensive, so today, multiple sclerosis, some of the rheumatologic conditions, HIV, which can be a commercial population.

And I think you need, in terms of community linkage, it really depends or who you're linking with. So for the frail elderly and the children, absolutely, you've got to have linkages with area agencies on the aging, with the school districts and it just goes right on down the line, child and youth services. We've created those linkages in our health system and that is a key part of our strategy and to think that – it moves it away from the medical model of care and I think an ACO that stays in a traditional 19th or 20th century medical model of care delivery is doomed. It's going to be, like your comments, I think it's going to be ultimately understanding that patients, that particular patient's social system and then making sure your ACO can adapt to meet them. And again, how effective are our current health information systems at helping us understand those unique social systems, so that might be a question in terms of policy.

Anthony D. Slonim, MD, DrPH, CPE, FACPE – Executive Vice President and Chief Medical Officer – Barnabas Health

Yeah, Tony Slonim, I have a specific response on the behavioral health side. This is one of the areas we've thought about, we haven't executed on it yet but, a diagnosis or a disease specific ACO. So we happen to be the largest behavioral health provider in the state. We've got a 200 bed psychiatric facility, intensive outpatient treatment programs, inpatient treatment programs. We're in six emergency departments across the state for psychiatric services, etcetera. And so our model is, if you create a network of services, layer on top of that the physicians. We have ready 35 employed psychiatrists in mid-levels plus a whole bunch of employed community support, integrate them with IT platforms, shared protocols, guidelines, procedures and pathways, then you may be in a position to accept risk for a population across a broad geographic area. It's imperfect and it sounds really from a white paper perspective, it's not so good in implementation, obviously.

But that's the model that we've tried to start thinking about. And it represents, as we broaden that network of social support, how do we engage the primary care doctors? So for example, we've differentiated what we call the psych med patient, the patient who has a primarily psychiatric disorder, bipolar disease and might happen to have hypertension. Because a psychiatrist may not do as good of a job on hypertension as a primary care doctor, we've differentiated that patient group from the med psych patient, who happens to be a young 40 something year old who happened to have their first MI. Or had a new diagnosis of cancer who has situational depression or anxiety, who's primarily managed by the primary care doctor, but now needs support from a psychiatrist. Those two populations as a way to understand how we deliver broad-based support with two contiguous groups, we actually put the psychiatrist and the primaries in the same room to start having those conversations about shared protocols and guidelines.

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

Hal?

R. Hal Baker, MD – Vice President and Chief Information Officer – WellSpan Health

As you're looking at this and talk about HIEs, Michael you talked about unnecessary MRIs and their business case and Tony you're talking about your true investment. Clearly HIEs a social good, clearly it's a coordination good, is there a theoretical or actual business case that any of you have come up with to justify the expense on a care financial basis for your organizations?

Franklin E. Bragg, MD, FACP – Eastern Maine Medical Center

Could they get – this is Frank Bragg. Could they get in the business of data analytics do you think? In other words, get their hand on the claims data, and they've got all the quality data or globs of it, could they start marketing data analytics, risk stratification, risk predictive models?

R. Hal Baker, MD – Vice President and Chief Information Officer – WellSpan Health

So the HIE being something would be an investment for a value added of some other service that they would provide, but the HIE itself, it sounds like it's hard to come up with the business driver.

Michael Sills, MD, FACC – Chief Medical Informatics Officer – Baylor Quality Alliance 33601

I would agree, I mean, my short answer is no. We haven't – we've looked to see what the return on investment is and we – the old joke is it's more expensive to repeat the CT scan than pay for the HIE. I think – sorry – I think in response to what Frank's saying, I think whoever owns the data becomes the most powerful player in the environment. We firmly believe that our EMR/EHR data, coupled with claims gives us the potential to move forward in whatever environment we want to succeed at. And I think, we're not unique in thinking that we don't necessarily want to give all of that information away, that that's our greatest asset. And it's our ability to analyze it and use it that makes us most successful. So the problem is, right now we're putting information into an HIE that isn't always easy for us to get back and, quite honestly, isn't always correct. So, I don't – that's a long way of answering the thing 'no," but "no."

Anthony D. Slonim, MD, DrPH, CPE, FACPE – Executive Vice President and Chief Medical Officer – Barnabas Health

I would agree and in the last panel, there was this conversation about fact-based implementation of data versus data that needed to be reconciled. If the HIE functions as an aggregator, those data need to be reconciled and the reconciliation is the work. Who does that work is an important piece of the conversation.

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

I don't know who I'm doing metaphor commentary today, but I've got another one and its electricity, which is essentially, there's a business model out there for the wires and the lines, because everybody needs it to be in the 21st century. There was a time in our American history where we had to do things like the rural electrification project, which were government policy because there were areas of the country where you could not sustain a business model. But now we have communities, populations, all over the country on the grid. So, it's because the – it was needed.

And so, I guess my question for you, and there's – we've got to get quickly because there are some more is, why isn't this an electricity business model? Why don't want to pay for it? What would it take for you guys actually want to have electricity as a commodity.

Michael Sills, MD, FACC – Chief Medical Informatics Officer – Baylor Quality Alliance

We agree. This is Michael Sills. You're right, there was an era where the successful factories were by a river so they could use waterpower. And it is our belief, in extension of his question, that once we have good control of the data, we will deliver it to the end user. And that may be a smaller hospital system, it may be whoever, but we feel that's why it's important to have the power production facility or the data aggregated in a way that we can use it. That's exactly – that book recently, Game Change, I think, for Rewiring America is, that's what they talked about is taking information and creating a grid, that it's useful at the point of service. So, it's just a matter of getting all of the information together, normalizing it, making it useful, field validating it and then delivering it for a variety purposes, but we agree.

Franklin E. Bragg, MD, FACP – Eastern Maine Medical Center

And I agree as well and I think that it would be great to have it be usable, right? In my house when I plug the plug in, it works, just by doing that. The problem we've got at the moment is the data doesn't work when we try to plug it in.

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

All right, well in interest of time, we're going to have to just get these last two question in really quickly.

Westley?

H. Westley Clark, MD, JD, MPH, CAS, FASAM – Director, Center for Substance Abuse Treatment – Substance Abuse & Mental Health Services Administration

Well, I'm interested in the analytic capabilities of proprietary data in both the HIE and the ACO context. Michael, you talked about being able to use that data, but if the data gets fragmented and segmented based on proprietary interest, then that kind of defeats the whole HIE process. And then all – especially with the sort of out of the ACO network that also encumbers your ability to find out what's going on with client, particularly from the behavioral health point of view, given that, as Anthony pointed out, you need to be dealing with a wide array of social service agencies. So, how do you reconcile that and what do you suggest we do about it?

Charles H. Chodroff, MD – Senior Vice President of Population Health – WellSpan Health

I think the group that probably has the least amount of resources are the community agencies, and that's a real challenge for behavioral health patients, who are – they could be supported by Salvation Army and I think to get information from them electronically is just totally unrealistic. So I think maybe we need to be a little more circumspect in what we can expect, maybe we've been trying to do too much and in such, make it too complex. I just think about, in my practice, I haven't touched a piece of paper in several years, thank you Hal. Now, what I am seeing is a lot of faxed documents that are coming in, but I can still, myself and what we call our health coach in my practice, we can still manage that patient. Now it's not discrete data, so I may not be able to extract it out and be able to report it, but are we gilding the lily?

And I would love to see just a standard data interchange at a very simplistic level. Banks have been doing this, the transportation industry, I mean, you can – every different railroad company in the United States knows exactly where all of their boxcars are all over the country. They made it very simple. They didn't make it as complex as I think we're trying to make it, we may be trying to do more. And when I look at the vendors I understand why they're not changing, they've made billions of dollars in investment in 1990s for the technology that we have today. And that's their development cycle. They're probably working now on what we're going to see in the 2020s, and it'll be 10 years behind. Because I just don't think they have the development tools, the software development tools to do this as rapidly as we would love it to be. And I think we just may have gotten ahead of ourselves. Look at the evolution of the automobile, it took 70 years until you had an automobile that was safe, reliable and fast.

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

Okay. Well, with that – Frank did you have another question? Last one.

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

Okay. I want to go back with questions that we had and specifically number six and what made me think about this was the comments Dr. Bragg made. I know you want to app and I know you want to bump the guy next to get all of information you want. If a policy, set of standards were developed to support population management that relates to Accountable Care, so we talk about ACO measures now and in the future. Do think there's a market out there in your dealings with vendors, IT vendors, HIT vendors, is there a market out there that will voluntarily certify themselves to that – to those standards?

Franklin E. Bragg, MD, FACP – Eastern Maine Medical Center

Well, I think the vendors have to develop it before you can buy it and I guess that's the nature of the question is. Meaningful use the vendors had to go and provide you with meaningful use certified systems, whether you like them or not, it doesn't matter, they had to do that on their own dime. So I guess the question is, will they voluntarily take that next step to get to social media, to get to peer-to-peer networking?

Michael Sills, MD, FACC – Chief Medical Informatics Officer – Baylor Quality Alliance

Yeah the prob – it's Michael again.

Franklin E. Bragg, MD, FACP – Eastern Maine Medical Center

Go ahead.

Michael Sills, MD, FACC – Chief Medical Informatics Officer – Baylor Quality Alliance

The problem is, as a friend of mine once said, that our numerator – I'm sorry, our denominator is enormous, with boxcars with Amazon it's dollars and boxcars. Our denominator is an enormous number of different variables. And as Frank says, if we could get to one or two operating systems, then it's possible, the problem is, there's no point in having app if it doesn't interact with the data. And until the data is curated, then it doesn't matter, because if you have an app that only works for Epic or only works for Cerner or Allscripts, it's still going to come back to the same problem, we don't have access to all the information.

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

Well how do you break that barrier down?

Michael Sills, MD, FACC – Chief Medical Informatics Officer – Baylor Quality Alliance

We haven't succeeded.

Charles H. Chodroff, MD – Senior Vice President of Population Health – WellSpan Health

Doesn't feel like the different railroad grades?

Michael Sills, MD, FACC – Chief Medical Informatics Officer – Baylor Quality Alliance

Yeah.

Charles H. Chodroff, MD – Senior Vice President of Population Health – WellSpan Health

I'm not sure how that is resolved to get to one grade on the North American continent. Is that a government –

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

Lots of money. It was called the railroad barons and they put everybody else out of business.34449

Franklin E. Bragg, MD, FACP – Eastern Maine Medical Center

Frank, just to end on a light note. I think Lipitor ads is the answer to your question, that's how we fund it.

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

Touché. Yeah.

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

Very good. Well look, we're going to break for lunch. Thank you again for an excellent panel. We're running late. I think –

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

Yes, we're running late, we're going to need to adjust the back end of the agenda. We'll probably cut into the workgroup discussion time. So why don't we meet back here at 1:35 PM and we're going to get started right at 1:35 PM and you'll see an updated agenda. Thank you.

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

All right everyone. Thank you and welcome back from lunch. Hopefully you were able to not have to scarf down your food, although I did, and I was late getting back, even though I had told you all to get back here at 1:35 sharp. So I apologize. I'm going to turn it over to Joe Kimura, who's going to lead us through the next panel. So we have an hour for this panel, so this panel will end at 2:45 PM.

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

Thank you. Good afternoon everyone and thanks for engaging postprandially with us. It's my privilege to moderate this third panel of this hearing. And first I want to extend my thanks and welcome to Dr. Karen Nelson, Mr. John Lynch, Mr. Hunt Blair who joined us, as well as Dr. Troy Trygstad. And I'm excited about this discussion based on the conversations we have had this morning, as we turn our attention again from the physician and hospital health system led accountable organizations towards state and committee-based arrangements. I think we've started to hint at some of those interactions and where information needs to pass back and forth on some of our morning conversations.

So I think it's – it'll be interesting to hear your roles when you're sort of – together these pieces of information at the frontlines of our fragmented delivery systems. I am hoping that the panelists today will be able to provide us with a glimpse of realities in terms of their day-to-day work, and share with the panel some of their thoughts around how Health IT could really make their work more effective and efficient going forward. Based on the written responses that you folks have submitted, I think this opportunity is going to be great for you guys to share phenomenal work that you're doing, but also then to raise some questions and some challenges towards the committee. So without further ado, I think we can launch in, and I believe the order on the agenda starting with Community Care of North Carolina.

Troy Trygstad, PharmD, MBA, PhD – Vice President, Pharmacy Programs – Community Care of North Carolina

Great. Thank you for having me, I appreciate the invitation. I'll start with a very brief introduction to Community Care of North Carolina and save any details that you desire for the questions. Community Care of North Carolina is a community collaborative, I think that's a good sort of term for this type of an organization. It's 1700 practices modeled after medical homes. So some of those – most of those are primary care practices in the traditional mold, but there's also infectious disease and cardiology and endocrinology if they fashion themselves as population managers and medical homes. So, but it's a constellation of these 1700 practices, sort of a member owned and operated organization, across all 100 counties in North Carolina, almost 2,000,000 medical home enrollees. The goal of the organization is to provide wraparound supports to these medical homes on behalf of the sort of membership if you will or the collaboration and about 70 percent of patient panel currently is Medicaid.

I thought it might be instructive to provide maybe a vision for what a community collaborative is, I don't know that there's a Webster's definition of it currently. So, I thought it would be important to point out that, at least for us, collaboratives at current don't take risk on directly. I think that's an important feature, they really take on risk indirectly, they either take it on indirectly through payers or contracting with payers or through providers and contracting with providers or simultaneously. But really it's an indirect risk. The goal is to make the whole greater or more effective than sum of the constituent parts. Shared processes, shared IT, shared analytics and reporting, shared contracting, shared human resources, in my mind I call these sort of floaters. We have a need for navigators, not only within institutions but across the institutions as well.

It can exist at many levels, it could be two entities across the street from each other or it could be an entire state or region. I think the experience of CCNC or the advantages of a collaborative that make sense to express are, it really allows for the ability to completely serve patients across tax IDs and across geography. It allows for performance and benchmarking against peers in a manner directed by the members of the collaborative and the ability to trend with sufficient statistical power. From an IT perspective, we do try to take sort of the lowest common denominator approach. That's what collaborators are is to not to try to take the big perfect thing and apply that to everybody in the system, but really, what's that lowest common denominator's where the collaborative can effectively go about the business of its members or its federation.

An example of this, 50 percent of patients at least in our system right now, they're discharged from academic medical centers, get discharged to a medical home in a catchment area that's completely outside of their catchment area, so the need for collaboration is strong. The other is that it allows for a lot of ancillary service provider participation, personal-care services, committee pharmacies, public health departments, local initiatives around palliative care or substance abuse treatments and a lot of private entities. If you have some sentiment for the collaborative, you can sort of take a more medical neighborhood or it takes a village approach to population management.

I would say the recommendations that we would be – from experience, that make sense for us to promote would be, there really does need to be push for administrative data to be more readily available and freely available to providers. That is the best mechanism to get the 360° view of utilization quickly and make that assessment of where care is being delivered and how to coordinate it. It might make sense to consider to have Medicare, Medicaid, SCHIP claims repositories. If you're familiar ResDAC, you can imagine sort of a ResDAC real-time service where a provider attests to say, hey, I've got a patient that is Medicaid/Medicaid or S-CHIP and I'd really like to get one year look back on all their utilization to prepare for an encounter. I think we would say that avoid at all costs carving out data, it's really, really a critical feature. It's essential that behavioral health, prescription drugs and other types of claims data or other types of utilization are included in the whole. Utilization of just traditional data seems to fall short, particularly for that percentage of the population that drives so much of the cost.

And then also finally I would say, a need for a national push for a coherent and non-ambiguous interpretation of 42-CFR Part 2. Right now, it's very challenging not only to enhance substance abuse treatment but actually tangentially it has iatrogenic effect, if you will, on care for other conditions for those being treated for substance abuse. So it's not so much a policy position on what it should look like, but the need for an unambiguous national definition that everyone can abide by is important. Thank you.

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

Thank you very much. Dr. Nelson.

Karen Nelson, MD, MPH – Vice President – Maimonides Hospital; Executive Director - Brooklyn Health Home

Thank you for having me. I'm Karen Nelson. I'm a Vice President at Maimonides Hospital and I'm the Executive Director of the Brooklyn Health Home. And I think I'm going to focus most of my talk, after this morning, on our care coordination platform, which we've set up in Brooklyn, which is a borough that does not have a single health system that dominates it, there are many providers and social service organizations. Some are connected to our HIE, BHIX, now Healthix, some are not, some people have – there are multiple electronic medical records, and some are even using paper. So we have spent years building a platform that is on top of the HIE, so we can pull data from that HIE, but it's also Web based so people can participate and contribute to this dashboard from Internet.

And we also can accept claims data into this dashboard, so that we're trying to develop an analytics warehouse that we can then do population management. And we agree that we think the RHIO is too much information, it's too hard to sort through, so we're trying to build a clean dashboard that really has highly usable, very actual information for the team to work from.

So, the Brooklyn – so Maimonides is the lead agency in the health home, which is really 50 community-based organizations, health service providers, medical providers, the criminal justice system. We have payers, we have a union the works with us and we've been working for years on sort of refining this work with the dashboard. And Maimonides originally got involved in this work through – grants and then we got a CMMI award to do further work with patients with serious mental illness. So most of these are very high-risk, high-need patients throughout the borough.

So just to explain the Health Home a little, the state pays through the Medicaid program for care management services for patients who are complex. So that's HIV, substance use, serious mental illness, complex disease, that money goes to the community-based organizations providing the management and those people then – the care managers must use the dashboard to contribute to the care plan. They then help assess patients, they connect them to their PCPs and their psychiatrist. They document who the PCP is and psychiatrists are in the dashboard and they are – actually they can serve as sort of the hub for this dashboard with all of the electronic alerts and the things that are coming through from the RHIO. So essentially we're trying to virtually co-locate a team around these patients, because the providers are not in the same place, they're not in the same system and they're way across – often way across the borough.

So as I said, the crux of it is this dashboard and what we've done is it means that the dashboard allows the care managers and the team, this team, as I say, that can be any number of people. So they receive the patient summaries, they receive the continuity of care documents, messages, protocols. They get alerts when patients are in the ER or in the hospital admitted or discharged. That's now from BHIX/Healthix, soon we hope that's from the statewide SHIN-NY that will link all of the HIEs. But more important, what this does is it creates a dashboard where people can communicate with each other, so when you go onto the dashboard, you know who the PCP is, they can communicate either by phone or by text with the other members of the team. There are secure ways to PDF documents back and forth. The care plan itself actually will prompt the PCP if something's in it that's important. So we're trying to keep it again, so that it's high level information. And I just want to give a couple of examples of that, because it's really this consortium that has developed these clinical standards.

So if a patient is seen in the ER, within two hours, if there's no note in the dashboard from the care manager that they've called the ER or the PCP or the psychiatrist, there's a prompt and then the supervisor gets a text. So this is something that the organization, the consortium has agreed on and we're trying to agree on protocols like that. And recently, because so many of these patients are near homeless or homeless, they developed a standard where a lot of times in the houses there are a lot of notes about non-payment of rent. But the group said, if there's an eviction notice in the home, we want the supervisor to get a text and we want that to feed to the team so that the team knows that this patient is at risk of becoming homeless. So there's really a lot of opportunity for this group to create those kinds of social services and medical interactions that I think are often very fragmented.

It's been hard to get the providers on to the dashboard, because they don't get paid for it, they're not incentivized. The care managers must use it to get paid. So the providers, we credential them and do we get them on the platform, most become champions once they're on because they realize how much value add there is to be able to sort of speak to other people on the team without needing to call into an organization blindly. But that's been a little bit of an issue and then, of course, there are issues like everybody's been saying about some of the data flow from the HIE across to the dashboard. But I think this care coordination platform is really an opportunity for us to deal with some of these issues of interoperability, the HIE issues. And a way to take all the information that we're dealing with and try to focus it on people who are very complicated and very complex and marry some of the clinical and social service needs. Thank you.

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

Thank you very much. Mr. Blair?

Hunt Blair – Principal Advisor, State HIT-enabled Care Transformation - Office of the National Coordinator

Great. Good afternoon. Thanks for the opportunity to be here, I'm a bit of a pinch hitter, the state leaders that we asked to come today were not able to attend. I'm at ONC on a yearlong detail, I was previously the state HIT coordinator and Deputy Commissioner for Health Reform in the state of Vermont. At ONC I'm working really closely with the state innovation model grantees from the CMS Innovation Center funding and so I'm going to be speaking primarily from the perspective of those organiza – those states today.

If you're not aware, the scope of SIM is for states to use the array of policy levers that they can exercise at the state level to test approaches of delivery and payment system reform that will touch 80 percent of the state's population. So, by definition, those experiments are multi-payer in perspective. Six SIM testing states are actively moving toward that goal now, while the balance are currently in the designer planning phase. Not surprisingly, ACOs or something like them are key elements of SIM in almost all of the states. But for the states the key questions are, how the ACOs fit into the overall delivery system and payment reform ecosystem and how to bridge competing interest across ACOs and medical home projects that are often organized by different payers with different contracts and incentives, different measures and of course, different technologies.

As Cliff noted this morning, interoperability is a job that is larger than ACOs can take on alone and I'd expand on that to say it's also one that's bigger than states can take on alone. Just as one ACO coming up with a solution across its disparate providers and partners is not going to scale to overcome the kinds of barriers that we heard about earlier today. States can't do that by themselves either. So there's a real opportunity to align the needs of states and organizations operating within them with federal policy levers that can drive more constrained content standards to support interoperability, as well as a more sophisticated set of transport and security standards to enable uniform exchange across platforms.

States are looking at different model for how information is organized, that one understanding of the patient that was discussed this morning, through shared infrastructure. They're all at very different stages of understanding state to state, but the leaders are beginning to understand that they need to actively cultivate an environment in which health data and information can flow freely across organizational boundaries and that very much includes both public and private organizations. So one of the things we're seeing in the SIM states is evolution of the business and technical architecture that's needed to support the new payment models. The ecosystem of HIT is really bigger than individual EHR systems and that's becoming very clear to these states. So the functional components of HIT are becoming more discreet, distributed and componentized, so we're not just talking about EHRs but clinical registries for disease management in public health use cases, birth and death registries, consent directories – this was mentioned this morning, longitudinal care records, data repositories and analytic infrastructure. Meaning the lines between the parts of the system are blurring over time and so our regulation, our incentives and certification should meet and reflect that more sophisticated environment, than just EHR.

There's a huge degree of variation in technical capacity – I mean readiness for implementation state to state, but despite that, the variation and state – despite the variation in state approaches, there are some consistent themes that are emerging. All of the states are working on what I would call relationship transformations and along with those relationship transformations, they need the kind of IT support that was best described, cutting across the landscape. Skipping ahead, I already cut this down a lot this morning. All of the states – the SIM testing states, have an active – are actively pursuing links to providers in long-term care and long-term support services, mental health and behaviorally health and substance abuse. As we all know, it's challenging because not only their lack of the EHR infrastructure, but the policy barriers related to exchange of specially protected information. And I'm sure that were state people here, they would echo the comment from North Carolina.

So, I just want to close by telling a quick story about Oregon, because we think of Oregon as being one of the leading states for moving forward with health reform. And until very recently, what they call the CCO organizations in Oregon, which will evolve to become not just Medicaid organizations, but for all payers, were really pretty much said, we've all got the infrastructure we need to have and we don't need to work more closely together because we've got our infrastructure. And it was very interesting, Dr. Kevin Larsen and I took part in a meeting with them over the summer where during the three-hour course of the meeting, they really shifted their thinking from planning about how they could have basically discreet duplicative resources to thinking, hmm, maybe it would actually make sense if we pulled this stuff together. And that was on Wednesday, on a Friday, the CEOs of the CCOs came in to talk with the governor's staff. And for the first time, after quite a long time they were suddenly open to pooling actual funds, state resources collectively instead of having to be divided among them to actually accelerate by more than two years investments in common shared, statewide infrastructure to support all of their organizations collectively.

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

Thank you very much. Mr. Lynch.

John T. Lynch, MPH - Connecticut Center for Primary Care - ProHealth Physicians

ProHealth is the largest primary care group practice in Connecticut, 351 practitioners, 88 practice sites, 341,000 population we serve throughout Connecticut, meaning we deal with all the hospitals in the state. We NCQA Level 3 recognition NCQA medical homes in August of 2011, for all practice sites, and MSSP designation January 1, 2013. By January 2014, ProHealth plans to have ACO contracts in place with Medicare, Anthem, Aetna, Cigna, ConnectiCare, and United, covering probably 91.1 percent of ProHealth lives in theory, we'll talk about that more later. We are considering applying to be a dual lead care management agency for Medicare/Medicaid, we have approximately 5600 duals. I'm going to focus today on gaps, barriers and issues.

One, antiquated federal and state systems, NGS, PECOS, are major problems for provider supplier attribution. Paper processes can take up to eight months, beneficiaries are long delayed in getting attributed to the ACO. State agencies systems are unprepared to participate. The duals program will require lead care management to coordinate with the large number of state agencies, none of which have capability to integrate electronically with our PCP EHR. One of those components, as you'll see on the list there were paper card EHR vendors that they plan to introduce.

In terms of quality measures, each private payer chooses different metrics adding workflow challenges to the ACO. Benchmark for state metrics don't exist. Many metrics are outdated, we talked about lipids, A1cs changing in terms of patient risk components to them. Our ACO utilization metrics are down and that's good, but costs are up, bad. We fail – it looks like we'll fail to meet ACO criteria for shared savings therefore, because they're up. They're up because facility fees for physicians acquired by hospitals are being tacked on to overnight, over on to all of physician's fees and the hospitals are buying up.

Financing. Larger primary care practice driven ACOs are not qualifying for advance payment models, therefore we don't have the capitol to invest in the needed systems. The dual infrastructure being proposed in our state would go for like 1.5 years, it's not cost-effective to ramp up for a program, we need long-term Medicaid commitment to payment reform. We need standardized risk assignment methods, they're a black box to providers. We cannot project risks, savings, losses unless we open that black box. And we cannot depend on risk calculations based on claims, we need to move risk calculations to better data like medical record data.

Privacy issues. Approximately 50 percent of the duals population have behavioral health issues. CMS won't provide ACOs with behavioral health claims. Behavioral health providers are not able to send behavioral health data. Duals require greater care coordination, but these major gaps in data mean less quality and major patient safety issues. ACOs needs common language across all payers for various documents. CMS requires certain CMS language for handouts to the patients, we need to get away from that and go towards common language across all payers.

– attribution. Each payer has different approaches, different black boxes making it difficult to do anything in the ACO. We need real-time attribution, the physician is seeing the patient today, we need to know who we're dealing with as we see the patient. Payer restrictions. Beneficiary incentives are needed to align, we need the patient to be able to say, hey. we encourage you to use narrow networks, we encourage you to not utilize the high cost macular degeneration injections, whatever we want to try encourage them to do.

Information technology. HIE direct is currently insufficient, we need to trust fabric to create real-time credential issuance and revocation. We need all of that to go all the way down to the level of care coordinators, referral managers, ACO entities, etcetera. We need a community-wide master patient index. We need real-time hospital and SNF ADT messaging. The coordination of care coordination software, every payer, etcetera, has different care coordination systems, it's a whole new system that is totally distinct from EHRs and we need to figure out how to integrate them. And I think my time is up.

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

Thank you very much. So, I think we want to follow a similar format that we did this morning where we're trying to ground the questions coming from the committee with the submitted questions on panel three. And I'll kick us off a little bit by making a slight bridge over from the morning's conversation about bringing data together and adding value to it. Because what I heard from both Karen and Troy was there's activity that you guys were doing that was pulling information from various sources that the hospitals and the providers were talking about was what they were hoping people would do and perhaps HIEs would do. And it sounds like you started to layer on some of that on top. Can you talk about, I know Karen you said you're having challenges with adoption with the doctors on the opposite side. Can you talk a little bit about the value add that you guys are bringing to the table and what challenges you found bringing all that information together?

Karen Nelson, MD, MPH – Vice President – Maimonides Hospital; Executive Director – Brooklyn Health Home

So a lot of information that's coming in now to the dashboard actually is stored in a repository so you can always get whatever you want through the HIE. I think the challenge is both figuring out what's high-level enough, because we don't want to create another EMR that has too much information for everybody to be fussing through. So we're trying to create something that's more like an iPhone with apps, so people who have a particular – so the patients with serious mental illness have a lot of metabolic problems so we've embedded that in the IT system and there are alerts when the sugars start going up. Those alerts go to the care manager and the psychiatrist. So it's not prompting just the PCP about those things, it's trying to get the team involved in very high-level work.

I think some of what's happened is that the care managers working with these patient say to them, if I can't get you to somebody who can see this dashboard, it's very hard for me to take care of you. So there's sort of pressure from that line, I think, where patients are really saying, I don't understand, I just went there yesterday, how come this person doesn't know it? So I'm hoping for some shift in the provider community based on patient need, which is, I think – I think I've seen a little bit of that and so I think that's something that we're hoping will happen. Providers who use it because it is so simple and it's really not a lot of sort of fussing through different templates, really champion it. So it is – they don't know if a patient is a victim of domestic violence, that's something we consider a high-level alert that goes on that front page that they see when they open the dashboard. So I think it's partly keeping it simple and making it so that people can just communicate with each other better, which I'm hoping is actually by phone occasionally.

John T. Lynch, MPH – Connecticut Center for Primary Care – ProHealth Physicians

Yeah, I'd echo those sentiments. I think, drawing from the Connecticut experience, the notion of a community record becomes really important, which is one of the purposes of a collaborative, of course, is to share information. And I sort of – it's my personal view that I sort of view the information world in two buckets, bucket number one would be information not essential to the EMR, and bucket two is information essential to the EMR. And why would we try to send information not essential to the EMR from one to the next, right? But there is this need to have this information about, the patient has no transportation, they can't pick up their medication at the pharmacy because there's a prior authorization. That is non-essential to the EMR but it's critical that that gets shared between sort of all of the neighborhood of providers, right?

So I think it's one of those information elements that do, again, make the whole greater than the sum of the parts. And a lot of the information, I certainly hold the belief that it's a mistake to try to ship – we don't need to ship volumes of information so that we're replicating that information in a bunch of silos. What we do need is to ship the actionable information and then also have a community record or a community repository where you can get that nonessential EMR information utilized for the purpose of the care coordination, not medical legal documentation.

M

I'd like to react the little bit that what we're facing is the multiple portal issue and you can't expect the primary care physician to jump into a community portal, an Aetna portal, an Anthem portal, a Cigna portal, etcetera and – because they all have care coordinators and how do we coordinate the coordinators? And in the duals program, we have to coordinate HUD, beneficiary enrollment, care management, behavioral health, consumer ombudsman, transportation, dental, money follows the person, home care for the elders, etcetera. We need that coordination, but we've got to think of it more like the Internet where the messages are going to exchange, as opposed to needing to have a provider go to another portal, which they really will have difficulty doing.

H. Westley Clark, MD, JD, MPH, CAS, FASAM – Director, Center for Substance Abuse Treatment – Substance Abuse & Mental Health Services Administration

Yes, the issue – Troy, you mentioned the issue of 42 CFR Part 2, which we are looking at, but, you also asked for an unambiguous national definition. What did you mean by that?

Troy Trygstad, PharmD, MBA, PhD – Vice President, Pharmacy Programs – Community Care of North Carolina

I think if you asked all of the privacy and security task forces for all the state designated entities, they would probably say they all struggled with different interpretations of the law. So where is that common interpretation, that voice that says look, this – at an operational level, at an informatics level, this is the guidance that can be provided. And it certainly was our experiences that there are those that hold interpretations of the law that are more liberal with respect to sharing of information and what falls underneath that provision. And those that find that it to be a much more strict or more narrow encompassing of the types and amount of information and access and what's included as covered under that subpart. Does that answer the question?

H. Westley Clark, MD, JD, MPH, CAS, FASAM – Director, Center for Substance Abuse Treatment – Substance Abuse & Mental Health Services Administration

Not really, but – because basically the law is the law and the regs are the regs and we understand that indeed, because we've heard from others, that there are certain provisions that need to be modernized. But the other issue is that sometimes your lawyers need to read the law, because I've talked to some of the lawyers and they didn't bother to read the law, they sort of reached the conclusion that the law said "X," and it didn't, it clearly said "Y." So, that's why I was asking about the unambiguous, because if we change the regs, then the question is, who's going to read the new regs to – and if people aren't reading it, then that does create a problem. So – and we are very much interested in facilitating integrated care and the communications, but we need community providers who also make sure that whoever's working with the organizations, have a clear understanding of the law, which SAMHSA is in the position to help facilitate that. If – because again, every time you change a reg, then it's something else that someone's got to master and so, we don't want people getting lost in the mastering of –

Troy Trygstad, PharmD, MBA, PhD – Vice President, Pharmacy Programs – Community Care of North Carolina

I think that's a good way to put it, the maybe it's a push for mastery of the interpretation.

H. Westley Clark, MD, JD, MPH, CAS, FASAM – Director, Center for Substance Abuse Treatment – Substance Abuse & Mental Health Services Administration

Yeah, yeah. All right. Thank you.

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

So, I was feeling optimistic with you guys talking and it doesn't surprise me since some of the organizations I admire most in the universe are all sitting up there. But, one of the things that I was encouraged by was the relationship that you all were putting with your technology and your information to care coordination is a theme that I was hearing. And so, I though am wondering about, is it how do we need to think through push versus pull strategies with that? So I heard that a lot of times there were repositories of important information that somebody had to pull and obviously what we want is sometimes that information to be pushed so it's at the right point, to the right person at the right time. And that's something that seems to me to be a real area that you all could have some expertise in, based on your broad experience with sort of population health management before others were doing it in certain ways. It's certainly the case of CCNC in North Carolina, so, is that something that you all are taking into consideration?

John T. Lynch, MPH – Connecticut Center for Primary Care – ProHealth Physicians

The push becomes a problem, basically there is no health information exchange in Connecticut that's functioning and so we're going hospital to hospital. And part of the problem is they don't know who to push, they don't know who our doctors are necessarily, they don't know whose patient – what patient is assigned or linked to what doctor. So there's a major gap in both the master patient index as well as the provider kind of directory across the state in terms of enabling a push. A pull is possible. Part of the challenge, for example, in the care coordination is with all these care coordination across all these components, home care will stand up and say, oh, I've got a CMS grant to be the home care coordinator, etcetera. They have no access to our electronic record. How can they do a medication reconsolidation for us? They have no access to our medical records. So, somehow, I'm not sure it's a pull because where do I pull it from? I don't know my patient's been in the hospital? They don't know to push to me? So there's missing there somewhere between how do we push or pull.

Hunt Blair – Principal Advisor on State HIT-enabled Care Transformation – Office of the National Coordinator for Health Information Technology

I think that's a really important point and it's one that a lot of the states are realizing and that we're really coming to see that having that shared service of a master person index and provider directory, which you need to enable the ADT feed infrastructure that folks were talking about earlier. And that you also need to do attribution between patient and payer and provider and service type, right? So having those as essential components going forward, ideally on a state or in a big enough state a sub-state regional basis, I think is really essential to making this happen. Because really it's push and pull, like you want – I mean, this is really ultimately a very comp – as complex, a network of networks, as the Internet itself, more so given the sensitivity of the information that's transmitted.

And so I think one thing that we have to all sort of take a deep breath, having worked on HIT in Vermont starting in 2004 and still not being satisfied with the infrastructure that's operating there, it is long, hard slog to get this stuff to work. And I think we have to be realistic about that. But, by the same token, we're hitting the maturity level with all of this technology and as importantly, with what we want to do with it that I think is enabling it all to be a lot more clear about the sort of pieces parts that we need to enable the kinds of solutions that everybody's looking for.

Karen Nelson, MD, MPH – Vice President – Maimonides Hospital; Executive Director – Brooklyn Health Home

I would say that Brooklyn has been blessed by BHIX, so I'm – I sort of pretend that's just going to be, that we're going to have a borough-wide and then a statewide information system. I think without it, I can't really imagine how we could coordinate patients. We suffer from some not being connected to it,

but to me, that's a minor problem compared to places that don't have access to the HIE that way.

And I wanted to link this to last conversation about insurance claims, we have a pilot going where we've persuaded an insurance company to sort of serve as a care navigator on the backend. So that they really are doing the work that you would have a panel of 150 patients and the insurance company is really on the backend making sure people have gone to appointments, feeding that data into the dashboard. Because they do have the claims data and if we could get them to work behind the scenes with information we're not getting from BHIX, in a way it's a great way to marry that and I think it sol – it has the potential to solve this issue of too many people stepping on each other's toes. Care managers are on the ground, really out in the community, you do have people behind-the-scenes doing a lot of what disease management companies used to do in a silo.

Troy Trygstad, PharmD, MBA, PhD – Vice President, Pharmacy Programs – Community Care of North Carolina

So I'll use two biochemistry or biology examples. The first would be we don't want to forget that technology is a co-enzyme, it's not an enzyme. So we don't want to make perfect the enemy of the good and an example of this is, in the absence of a provider directory. Because I completely echo your sentiments about provider directories and the care coordinators being the least coordinated amongst themselves for a given patient, is that sometimes you can say, look, if I've got a relay system and maybe that ADT goes to of person and that person's making interpretation, and importantly, they're air – maybe they're adding a layer of information. We forget that one information source that's important to transmit across the collaborative is user imputed information. It's contextual information, it tends to be patient-specific information, so, that would be the first analogy.

The second would be the notion of practices and providers at-large of all types, needing sort of their own insulin. That is to say, what is that mechanism that says, here are the things I draw into my cell and here are the things I read and I benefit from that, but I don't bring into my native system of record. And so it becomes the question of where are you pushing it? And philosophically, for me at least, if we're focusing on population management versus here's what I'm doing versus in my encounter. When we say in workflow, we often say, look, it has to be in my EMR because it has to be in workflow. Well, that's the work that's done when you're in front of the patient during the encounter. Population health, by definition, is what happens to the right and to the left of the encounter. So the issue is, it's actually a different type of system of informatics. I'm pushing to a person or an entity or a machine on the other side that is not meant to be right there at the encounter.

So a lot of our experience is it's using sort of, you have to have the human HIE that's layered on top of your HIE to give it context and get it to the right person. Because the most sophisticated directory can't even say, in this circumstance it really needs to go to the rooming nurse instead of this person or that person. And so I think the simplest experience I can give you is the most popular way for us, a physician to receive a med reconciliation in our system right now is by e-mail because it's outside the encounter. I'm not in my EMR, I don't have a patient in front of me, but there's a patient that's been discharged and I need to do something about it. I'd rather go to some environment there through my e-mail and take care of that, because it isn't part of my encounter and, for better or worse, I'd probably argue worse, it's not billable.

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

Want to go to Karen and then back over to Paul, so –

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

Great, thanks Joe. And thank you all, it's a very, very interesting set of presentations today. I'm struck by the fact that we spent a lot of time earlier today talking about interoperability standards, data liquidity. I'm also hearing that there may be some opportunities for standardization of some processes. We talked a little bit about longitudinal shared care plans. I think I heard that there could be some standardized ways of doing the MPIs and a number of other things that would be helpful. Attribution algorithms, you're an ACO with five different payers, you've got five different attribution algorithms going on here. So, are those kinds of things, if the federal government were to step in an offer a standardized way of doing that helpful to you and what other kinds of processes could we address from the federal point of view that could really help you and decrease your administrative burden and confusion?

John T. Lynch, MPH – Connecticut Center for Primary Care – ProHealth Physicians

I have the struggle between the policy of stepping in at a national level and keeping your hands off. ONC jumped in to the HIE fray, in about five years messed up what was going on in the private sector, forcing it into the – a state which is bankrupt and can't afford or has no interest, etcetera, in that. It's struggled. It's coming back through the backdoor now because within the next two years we will probably have only have three major systems in the state, all 36 hospitals, a lot of the docs will have been bought up by either Hartford in the North, Yale in the South or Danbury in the West. We won't need an HIE in that environment because each of those major systems will have their own HIE kind of thing. So to us certain extent, there's let nature take its own course, on the other hand, we do need some level of standards and integration to make that happen. We don't have, like you mentioned, a care plan that's constant across. We have the old paper W-10, which everybody believes is horrendous, and it has to have all these signatures on paper going back and forth. Could we automate the care plan somehow with some standards, as an example? But not necessarily go to the level of creating standards that will inhibit the future invention, as we evolve?

We're talking about building systems to meet today's environment. Given three years from now, if we're all in a capitated environment in Connecticut, hopefully, we won't need claims. If we're building systems around claims, risk adjustment around claims, etcetera, hopefully in three years we won't need claims, because in a capitated environment we can be much more efficient, like you see with lora health. So we don't want to build those standards based on the old direction, we don't want to build the old film technology for Kodak and not go to the digital that they missed out on. And I think as we go forward, the options will be with value-based kind of health insurance kind of options.

Examples of changes in policy, today CMS inhibits certain things we can do. But if we're able to offer a value-based insurance plan in the future, where we say, hey, we can give the patient the right to incentives to adhere to their meds, they won't have co-pays or whatever. And it's in a capitated kind of world, maybe we've simplified the claims, maybe we've simplified, we're focusing on the patient in terms of getting them to goal. What's the system we need for that environment? Let's be thinking about the environment we're going to be coming up to as opposed to the one left behind.

Hunt Blair – Principal Advisor on State HIT-enabled Care Transformation – Office of the National Coordinator for Health Information Technology

I totally agree with that point of being very future oriented and thinking about these system's needs. But I would respectfully disagree with the statement that if you have those three systems you're not going to need an HIE. Or, let's not call it an HIE, let's just call it communication across different parts of the system and continuum, because it's not just going to be those organizations, but you're going to want to have your long-term care, your behavioral health, mental health, etcetera involved in that. And they're – it's ju – and ideally, you're also going to want data resources that a state would have that could contribute to more full understanding of the patients that you're trying to take care of, particularly in the capitated environment, right? So you're going to want to know as much as possible.

So I think that we have to embrace the complexity of the communication challenge of how broad and deep we ultimately want to go. Which back to your point, I think, is we're building an ultra-large-scale system of complex systems that interrelate, and just like the Internet, when it had beginning standards, nobody knew we were going to have Netflix, right? But we had the standards that enabled Netflix, so I think we need to be thinking about HIT in the same way.

John T. Lynch, MPH – Connecticut Center for Primary Care – ProHealth Physicians

Yeah, I would agree, it's really the communication that we need, it's not necessarily the HIE. If you think of the HIE as bricks and mortar or whatever. The Internet, you don't need the HIE for the Internet. And so if we can get back and forth like that with a standard. But let's be cautious, you might have to let the private sector get to a certain point before you standardize, because if you look at standards for the Internet, it too Microsoft or someone to get there first, create a monopoly or whatever before you tried to create the Internet kinds of standards in many ways. It's the same way here, I think, if some of these things like a care plan – which comes first, someone figuring out how to do it right first, and then that becoming the standard, or trying to create an imaginary standard that then people struggle with.

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

I think the one thing I would say is, I think our team feels that we've moved pretty far along the way of getting common elements for data sets and vocabularies, and for CCDs and some of that that's has been very valuable. There's been little sort of movement in behavioral health and some of the psychosocial documents that we need to transmit that tend now to be sort of free text. So I think our group would say, we need to start making progress on those elements, because there's not much that we know about that.

Troy Trygstad, PharmD, MBA, PhD – Vice President, Pharmacy Programs – Community Care of North Carolina

So I'll go back to Dr. Terrell's example this morning, I'm on the fence on this one. There are days I wake up and say, it would have been better to create a national standard to build the railroads and we'd have been better off. And then the next day I'll wake up and say, we should try this out first and find what way works best. So, it can be a real double edged sword, it's a hard question to answer. So I'm not going to attempt to answer it.

Hunt Blair – Principal Advisor on State HIT-enabled Care Transformation – Office of the National Coordinator for Health Information Technology

Just one final point on this, because ONC did, with CMS, do a request for information back in the spring that provided a lot of very positive feedback on just this question and what kind – like how much standard do you need to enable payment and delivery system reform? And particularly in the non-doctors and hospitals parts of the system, it was very, very consistent in terms of looking for more standardization, more federal guidance in that area.

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

Before I let you all good, could I just follow up just one little bit? In addition, to all of this around sharing of information, what about some of those standard other processes? This morning we were talking about standardized measures, so every payer uses the same measure? What about an attribution algorithm? I think I heard that, would that be of value? Shared care plan, are there – is there anything else that would be helpful without being a situation where it's going to squelch innovation?

John T. Lynch, MPH – Connecticut Center for Primary Care – ProHealth Physicians

When we talk about master indexes, for example, the provider directory, we've got to make sure it's not just "the physician." I don't know how many times this morning I heard about "the physician." We've got all these other community entities and they're not "the physician" all the time and we need to make sure they are incorporated into the standards of the caregiver directory that we try to develop as an example.

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

Just a follow-up to what you just said, I have a lot of interest in the unofficial safety net. We've got the ecosystem of the official health care system and then we've got the social services and the community. And then we've got things such as churches and friends and neighborhoods that are really part of our health system as well that's not really been part of our thought process as we're designing systems of care. It would seem to me that of all the ones that have spoken so far today, that the community systems are the place to do that. Are you all looking at things, I think of Camden, New Jersey where they have the embedded community people in physician's offices, which is one example of something that's very interesting. But within the context of the unofficial safety net, i.e., where people actually live and breathe and people that are around them, how is that or are you all even approaching that at this point?

Troy Trygstad, PharmD, MBA, PhD – Vice President, Pharmacy Programs – Community Care of North Carolina

I think you can best answer the question and then I'll reserve the right to come right back.

Karen Nelson, MD, MPH – Vice President – Maimonides Hospital; Executive Director – Brooklyn Health Home

So, it's interesting in New York City because the Department of Health has really done a lot with this and they've done a lot with the churches and blood pressure checks and that sort of thing. So really, what we've started to do is, as I said, we've start with the criminal justice system, a lot of the shelters now are connected to the dashboard, the community. So the question is really, access to what? And so with the dashboard there are different levels of access that we can give organizations. So the sort of a pilot is with the churches that are taking care of people and being able to use the dashboard again, to figure out who's taking care of somebody so that they can communicate with them, and it's been quite moving actually. I think the consortium that we have has been really very powerful, and so each of those community-based organizations that's really a sort of typical social service agency, then has its surrounding groups like churches.

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

Are you having any congregational nurses in these – like we've seen in some of the communities?

Karen Nelson, MD, MPH – Vice President – Maimonides Hospital; Executive Director – Brooklyn Health Home

So we haven't started – I mean, what's interesting also with the Health Home is it's kind of a transition structure, so there's actually – we're sort of nothing except the stream for this care management payment.

So all of the work that's going on behind the scenes is when we switch into more of an ACO-like payment structure, where we can do those kinds of things. But we've been able to pilot it because the Department of Health has so many of these initiatives, so we can sort of hook into those and use them.

John T. Lynch, MPH – Connecticut Center for Primary Care – ProHealth Physicians

I'd like to make the comment about the financing question there. And that is, as we switch from of fee-for-service environment, where are those community organizations going to get their dollar? And I don't think the ACOs at the moment are thinking of – I mean, to begin with, we're not going to get a shared savings, because we can't control it. But if we did, they probably were not necessary on the first line of the list of who we're talking about, but eventually those are really kind of getting a direct payment from the government to do certain kinds of services in today's environment. Where do we go in the future in terms of bundling all of that into a single capitation?

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

That's exactly what we're thinking about, actually. I think that's exactly where real population is going to go. Troy, you've been trying to talk for so long over there –

Troy Trygstad, PharmD, MBA, PhD – Vice President, Pharmacy Programs – Community Care of North Carolina

I echo your sentiments about having geographically-based risk rather than provider-specific risk, but – because if you're going to – it's really the community that's at risk, so they need to be the ones that are at risk, right, so to speak? But to tie the two issues together, I do sit on the fence on standards. But what I don't sit on the fence on is universal definition. So there's a difference between universal definitions and technical standards. You could have a standard that says, you could send us these five or these 10, we don't care, but please define them the same way. And we get into these team-based care and sort of non-clinician types of workers, my experience with trying to do med rec across what we call more than 40 actor-setting combinations. Literally 40 community pharmacists, hospital pharmacists, primary care physician in the clinic, hospitalists, is that when you say – you could have our room of 10 pharmacists and say, well what is med rec? And you might get seven or eight different answers and if you put 20 more nurses and 20 more physicians, you're going to get somewhere around 100 different definitions of what med rec means. So it's not about the standard so much as the definition of what that means. And so, as we sort of expand the care team, that universal definition or the mastery of interpretation becomes really, really important.

Hunt Blair – Principal Advisor on State HIT-enabled Care Transformation – Office of the National Coordinator for Health Information Technology

From the Vermont perspective on this, there's a really great program that grew out of our patients in our medical home program there, called SASH, which stands for support and services at home, and it's based in public housing sites. And so it serves residents of public housing, but then, because so much of Vermont is so rural, you've got little tiny public housing, so then it serves the surrounding community. They do assessments of everybody in their defined service area, have nurse care coordinators who are on-site and then visiting to the homes and doing wellness visits. They are tied into the longitudinal care record that is also shared by the medical homes and the community health team, so that you have that kind of connectivity among those different people with all those different versions of how to assess and describe people. And that has proven to be very effective and on the payment piece, it's actually included in the Vermont's Medicare payment as part of the Multi-Payer Advanced Primary Care Practice Demo, and it's showing very positive results. The evaluation is very positive.

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

Michelle's looking at me so I'm thinking we have 10 minutes?

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

So, we're getting very close to the end, so if we can quickly go to those who have questions and be as efficient as possible.

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

I think I saw Frank, Claudia, then Westley, and then Kevin and then let's limit it, if it's possible to one or two panelists responding. Frank?

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

I'll try to make mine as pointy as I can. Question number seven, how can HHS increased data liquidity and ya-da, ya-da, ya-da? The conversation you had a few minutes ago about push and pull, I kind of look at that as the chicken and egg kind of thing and quite frankly, to me the real value is that when you look at programs like meaningful use, which has established benchmarks for transfer of information. Do you have faith in those programs that they will bring about transformation by the way that information is exchanged? Because that's more of a peer-to-peer process than it is an HIE or a community-based solution. And I guess I want to know, do you see value in the meaningful use initiative from the standpoint of exchange of information? Anybody?

John T. Lynch, MPH – Connecticut Center for Primary Care – ProHealth Physicians

Part of the problem I have is with the metrics, we need to have transparency in the metrics. Current metrics we have problems, go back to the standard side, we can't fit our data into the continuity of care doc because the metrics require certain types of exceptions that aren't built into the current standards, so you extend it and therefore you're no longer compliant with the standards. So meaningful use is part of driving the metrics. I think we need the standards well-defined around the metrics so that we're all reporting the same thing and they're built in to how we report the data and you don't need extra data that doesn't fit standards to actually respond to the metrics. I think we need those transparent to the extent that meaningful use will make those metrics transparent. I think it's the transparency that's going to drive the change. It's going to be the patient seeing those metrics, the cost, the quality by provider etcetera, by ACO, whatever, that's going to drive the change. So, I think the good thing about meaningful use is therefore, driving toward transparency.

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

Claudia?

Claudia Williams – Director, State Health Information Exchange Program – Office of the National Coordinator

In areas like readmission, we've seen intense interventions like ACOs being paired with broad-based payment interventions that affect everyone, that really seem to drive to change more rapidly. States have huge power in their own hands to create of payment environments that promote exchange, care coordination, population health, etcetera, that we heard from Maryland this morning. There's the infrastructure payment in Vermont to pay for the HIE, they're, in other states paying for common infrastructure. And I'm just wondering what the most exciting things are from anyone of you in your state, where you're using state policy, state licensure, state funding to really create an new set of drivers across the board in the state?

John T. Lynch, MPH – Connecticut Center for Primary Care – ProHealth Physicians

I've got the opposite, there is no state funding, therefore it's private sector that's creating this excitement.

Hunt Blair – Principal Advisor on State HIT-enabled Care Transformation – Office of the National Coordinator for Health Information Technology

Yeah, I'd briefly go back to the Oregon example that I was giving before in that the state played such a catalyzing role – I mean, they had – like three years ago, I was on the panel out there where the folks basically said, we don't need your stinkin' HIEs, statewide H – like why would even do that? And yet, because now they have a law that gives of very clear definition of where they're going to transform their delivery system from medical home standards up through a full, integrated care delivery infrastructure and a vision for how that will work for all Oregonians. The implications of what that means and how it'll actually play out and why as an organization that's a Medicaid CCO and also has a – multiple commercial lines of business, but it actually, gosh darn, makes sense to think about applying the same – it's driving those organizations to think more systemically themselves through state policy.

Troy Trygstad, PharmD, MBA, PhD – Vice President, Pharmacy Programs – Community Care of North Carolina

It might be of good strategy rather than try to push states in a certain direction, use the natural experiment that's going on. I think there are a lot of states with a lot of differing opinions in this area, and one of the roles ONC could have is actually attempting to measure the effects of those different approaches. There are laboratories going on right now, let's make sure we capture those learning's rather than burn calories on pushing – there are going to be lots of different philosophies, and they're all sort of rational philosophies. And so, let's burn the calories on measuring this grand experiment, whether we agree to it or – liked it or not, it's there now, so let's measure it and learn from it.

And then the other comment, I think is, what can be done, I think Mr. Clark appropriately called me out for using lazy language this morning in definition versus mastery of interpretation. And so, when it comes to the policy, the words matter and one of the things we could about is, meaningful use I think is quite different from meaningful transmission. Maybe there should be a separate meaningful transmission and not call it meaningful use, use is I'm using the data, here's how I'm doing it, but maybe Stage 4 four is meaningful transmission, because that's really what we're talking about, right?

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

Westley, and then finally Kevin can close out.

H. Westley Clark, MD, JD, MPH, CAS, FASAM – Director, Center for Substance Abuse Treatment – Substance Abuse & Mental Health Services Administration

Maimonides has a mental health home kind of construct. So how do you, with question six, or how do you facilitate information exchange between such entities as Catholic Charities, Phoenix House or Village Care in a meaningful transmission way? Because they weren't edible entities under the HITECH Act. So, I don't know if in your system your mental health home bought the services for them so that they could facilitate the exchange or are you simply relying on faxes and messengers?

Karen Nelson, MD, MPH – Vice President – Maimonides Hospital; Executive Director – Brooklyn Health Home

No, yeah, that's what – the dashboard actually – so the care managers from those organizations input the data directly onto the dashboard. So the question is, how could we make their homegrown EMR interoperable with that dashboard. And actually, they're starting – there's a group that's starting to come up with a single care plan, because of course across all those organizations, most of the assessments are pretty much the same. So we're trying to identify how we could create a single care plan there that then would get pulled back into the home agency, so that they wouldn't have to do it obviously in both places. But some of them are connected, some of them do have electronic records and are connected to BHIX and Healthix, so that their data does flow and they have access to it. It's actually a reasonably good number of the 50 organizations we work with, like Catholic Charities and some of the bigger ones that are connected to it.

H. Westley Clark, MD, JD, MPH, CAS, FASAM – Director, Center for Substance Abuse Treatment – Substance Abuse & Mental Health Services Administration

Housing Works?

Karen Nelson, MD, MPH – Vice President – Maimonides Hospital; Executive Director – Brooklyn Health Home

Housing Works, definitely.

H. Westley Clark, MD, JD, MPH, CAS, FASAM – Director, Center for Substance Abuse Treatment – Substance Abuse & Mental Health Services Administration

Okay, they have an HMI system under HUD, how do you link your HMI system that HUD has, which is sort of a low-tech version of an EHR?

Karen Nelson, MD, MPH – Vice President – Maimonides Hospital; Executive Director – Brooklyn Health Home

So whatever data – so, and I'm looking at Irene because she probably knows this better than I do, from who's connected to our HIE. Whatever – whichever system they have that's connected to the HIE, they're still using for the care management, our platform. So they're still using that basically Internet-based piece of a template, but they can import that back, just as a PDF, into their own systems. So we are trying to deal with the fa – I think the horse that's out of the barn is that they're all sort of these homegrown different organizations have these different systems, so we're trying to coordinate it at the dashboard level.

H. Westley Clark, MD, JD, MPH, CAS, FASAM – Director, Center for Substance Abuse Treatment – Substance Abuse & Mental Health Services Administration – Health & Human Services

Thank you.

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

Kevin?

Kevin Larsen, MD – Medical Director for Meaningful Use – Office of the National Coordinator for Health Information Technology

So you guys have all done terrific work in integrated data from non-health sources, behavioral health data, data for care and service delivery. I've talked to a number of organizations that want to do this and feel like all they find are roadblocks and barriers and they don't seem to think there are a lot of successes. In fact, one organization said they started with one lawyer and a year later they had nine lawyers and still no data exchange. So I am curious what the strategies for success are and how can we help more organizations have that same success with this non-health integration – the non-health data integration and the behavioral health data integration?

Troy Trygstad, PharmD, MBA, PhD – Vice President, Pharmacy Programs – Community Care of North Carolina

I think in the absence of a perfectly functioning, elegant works for everybody exchange of information, you have to layer on a human HIE on top of your HIE. There has to be – context is so important when it comes to these care coordination – I mean, in any referral system, most people's complaint is where's the context, I need to know what the context is. So, it solves a lot of problems if that lowest common denominator pragmatic solution, I can't sent this as an electronic memo field, but I will go ahead and do a PDF image. So again, it goes back to the issue of do we let these things organically go and then figure out what works best or do we try to move people in a particular direction that all we think is best? And for my part, again, I don't know the answer to that. I think what would be the shame is, if we do have these things growing out there, that we do appropriately, in a qualitative and a quantitative way try to measure what's happening, so at least we get the benefit of learning from what's going on.

Hunt Blair – Principal Advisor on State HIT-enabled Care Transformation – Office of the National Coordinator for Health Information Technology

I'd just say that in Vermont, the longitudinal system that I mentioned. So we, and Kevin knows this, he's, as I've said, been in lots of conversations about this. But, it didn't work very well at first, like for a long time. And to the point that was raised earlier today, there were care reports on deceased people that went out to do calls, so really bad problem. However, we went through the painstaking process to identify why that sort of thing happened, to figure out how to hook it – the death registry of the state and have that feed there so that kind of thing wouldn't happen again. And what really made it successful is the fact that it started providing value to the people in the practices and their patients that they were trying to take care of and not just the physicians, but all the care coordinators and managers. And so, as there wa – the proof was in, oh, this is actually making our lives easier and improving patients.

So, I think you just – you have to have the fortitude, that's the real answer to this. And I really like the human HIE layered on top, I think that's really important. And meaningful use got us off the dime because it started digitizing health information so there can be exchange, right? So, meaningful use is – I think we should all celebrate it. I do not say this as an ONC employee, I've said this way before I ever came to ONC, or at least a while before. We should all be celebrating the success of meaningful use, because we wouldn't be having these conversations absent meaningful use. So, slowly but surely we are digitizing the last cottage industry in America. We're not going to go back.

John T. Lynch, MPH – Connecticut Center for Primary Care – ProHealth Physicians

ONC also got us off the dime by funding, which was sorely lacking and needed, and is still needed today to get all these other miscellaneous community components integrated, the SNFs, etcetera. We need the funding for that.

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

On that note, thank you very much panelists.

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

So, as we switch over to the next panel, I just want to give an update on the agenda. So we're going to end this panel at 3:45 PM, and then we're going to move to the closing remarks and then have our workgroup discussion after the closing remarks, so, just the little bit of an adjustment. Hopefully, we'll be all set in one minute. And Karen, are you all set to start to lead this panel?

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

I am. What I'm not sure about is whether Kris Gates case is calling in to do a presentation or not?

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

I don't believe she's on the phone, we're checking, but she had been in an accident, so –

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

Oh, I'm sorry.

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

– she may not be able to participate.

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

I'm sorry. Okay. All right, so, but she is okay?

M

Yes.

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

All right, so thank you. I feel better about that already. Well I do want to thank whoever is here and Kris, in your absence as well, this has been a fabulous day and by all stretch of the imagination, I think we saved the best for last. We did actually talk about this morning about where are the vendors, when a lot of discussion came up around interoperability and data liquidity. So, I'm delighted to see you all here and if we don't hear in from Kris, because she couldn't make it, then I know she has provided of very robust set of written testimony that we will have available to use going over. So, with that in mind, I'd like to just jump in and ask each of you to do your presentations and then we'll have some pretty robust discussion afterwards. So Matt, would you like to start off?

Matthew Eirich - Executive Director, New Product Development - The Advisory Board

Happy to, thank you. First of all, thank you for having us here, we are delighted to be here to discuss such an import topic with this group. My name is Matt Eirich, I'm the Executive Director for New Product Development from The Advisory Board. I identify and develop solutions for healthcare providers pursuing accountable care and have worked with a number of the organizations over the years as they've deployed information technology to better manage their patients. Okay, this thing is on, good.

For those of you that don't know, The Advisory Board is a global research, consulting and technology firm. We provide comprehensive performance improvement services, primarily in the healthcare sector, serving a membership of over 3000 provider organizations. Our technology solutions support our provider members, as we refer to them, in analyzing administrative, financial, clinical and claims data to improve quality and efficiency. Currently our technology has analyzed data covering over half of the US inpatient population. Our Crimson platform in particular provides support for organizations who are moving towards accountable care and that includes cost and quality profiles on 360,000 physicians in the US and details on the care of over 25 percent of all inpatient discharges and millions of outpatient encounters.

In our experience, providers depend on robust IT infrastructure to enable them to deliver better care to patients in the lowest cost setting possible in a timely manner. And in this experience, working with successful population health managers, we've realized that the need that they have around data and health IT tools to perform three primary functions. First, stratifying patients according to risk, using all available data, claims, clinical and even patient reported. Care management interventions can only be targeted after we know who the highest risk patients are. Second, population management means migrating from, as was mentioned in the last panel, moving from side-load care management towards a cross-enterprise, cross-continuum platform. And then finally, tools to actually allow providers and patients to share data with one another. After all, patients spend over, the vast majority of the lives, not being patients and instead being people and there's a lot of value in understanding what's going on when they're not in our facilities or our offices. And each of these elements that I just described requires timely access to reliable information, thus access to appropriate data is the most important issue that I'd like to discuss with you today.

As we know, we can only manage what we can measure and we can't measure without good data. The pioneering provider organizations that we've been fortunate enough to work with in deploying technology to enable population management, have been able to overcome many of the challenges that we articulated earlier in the current IT environment through a combination of smart and aggressive investment, determination and focus. But what concerns us and why we think that this is such an important discussion today is. when you think about the widespread adoption of population management models and the cost imperative presented by an aging and sicker population, we worry about the ability of the current infrastructure to scale quickly enough to deliver the kind of innovation that the healthcare system that we all imagine it is going to need.

So specifically we think providers face three data management challenges in managing at-risk populations. First is getting data from the EMRs in the first place. There are a host of technical, contractual, legal issues that make it difficult to get data out of the EMR that oftentimes retards or makes impossible the innovation that we seek. Second, oftentimes it's difficult getting data from the appropriate systems out into the appropriate activities in order to support interventions, especially on real-time basis. And then finally, and perhaps most importantly, even if we can derive insight from data, it's oftentimes difficult to get it back to whoever the care – the member of the care team is, to actually help them make an intervention or make an appropriate decision in how to care for a patient. Oftentimes we don't get access to additional data we need, or there isn't sort of real estate, as it were, in the workflow in order to deliver a particular insight.

Our written testimony goes into greater detail around what the challenges are around these areas, but in the last minute or so that I've got left, I want to just propose a couple of solutions that hopefully we can expand on during the discussion. A couple of things that we think would be helpful in making IT more useful in population management, first, having the EMR vendors provide standard APIs or a set of APIs to extract and input data into the EMR. Second, further specification of standards for data transport between systems. And third, as was mentioned in the last presentation, policies that move towards greater data sharing between and among providers and facilities who are engaged in population health. And then longer term, we think, as already has been mentioned, implementation of better patient management options and capabilities like the MPIs, increasing standardization around the data definitions and nomenclature. And not to be overlooked, the incentives for patients, as members of and participants in their care, to actually share data with us that allows us to be more effective in helping them to achieve a high quality of life and successful clinical outcomes. I see I'm over time here, so I will pause at this moment, but look forward to going into greater detail in the Q&A.

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

Thank you very much. So you're up now Dan.

Dan Haley, JD – Vice President for Government and Regulatory Affairs – athenahealth, Inc.

Thank you for having me. I appreciate the opportunity to participate in this discussion. My name is

Dan Haley. I am Vice President for Government and Regulatory Affairs for athenahealth. For those of you who don't know, athenahealth is an cloud-based provider of health information technology services. I should mention right at the outset that I am not a tech guy. If you put questions to me during our conversation that include more than one or two acronyms, I will give you a blank stare. But, that fact affords me, I have found in these discussions, a perspective that is perhaps helpful in that it's more like that of the common patient who cannot understand why in 2013, the capabilities of health information technology are so inferior to the capabilities of information technology that we all carry around in our pockets.

A little bit of background on athenahealth for those of you who don't know, athenahealth was born 16 years ago in the care environment as a women's health clinic. And today provides EHR practice management, the care coordination, patient communication, data analytics and related services to physician practices on a network of over 40,000 care professionals in all 50 states, serving roughly 40 million patients in ambulatory care environments ranging from independent and small group practices to large medical groups and hospitals. All of our providers access our services on the same instance of continuously updated cloud-based software. And that cloud platform affords us a significant advantage over traditional static, software-based, health IT products as we work to realize our company vision, which has been the same for all 16 of those years. And that is, an information backbone, a national information backbone that allows healthcare to work the way it should. I would venture to guess that that is essentially a statement of – a good statement of the vision of this body.

Simply stated, the cloud enables us to coordinate care across providers and geographies, tracking patients, curating and transmitting patient information and providing granular data analysis enabling our care provider clients to achieve the benefits of 21st century information technologies that are common in most sectors of the economy, but still relatively rare, for many reasons, in healthcare. It's no exaggeration to say that our clients routinely express to us and to me directly, including very literally Monday of this week, confusion and frustration at the fact that they find themselves in the situation where they want to participate in value-based models like Medicare Shared Savings Program. But because many of them are independent and small practice docs, they literally cannot. Current policy requirements create administrative and financial burdens that independent and small practice doctors simply cannot meet in order to participate in these models and so they're forced into a situation where they're obligated either to become employed by large systems or to continue to muddle along in fee-for-service, in which they're drowning.

In a recent physician survey – physician sentiment survey that we conduct annually, fully 78 percent of physicians expressed deep skepticism of their ability to continue to practice in independent small practice context moving forward into the future. And as we start talking about proposals that are kicking around on Capitol Hill right now to address the SGR issue and to reform Medicare reimbursement, we're seeing more of a policy emphasis being put on moving providers into value-based models and away from the fee-for-service. Our fear is if the current policy gap persists, we will continue to have the inadvertent exclusion of still roughly half of the care providers in the country. I attached to my submitted testimony today, a proposal that athenahealth has been walking around Capitol Hill for the better part of a year now. We call it our independent risk manager proposal, or IRM, because nothing without a 3-letter acronym can be viewed as plausible in Washington, DC.

It is one proposal by which we believe technology providers, like athenahealth could leverage 21st century technology to enable independent and small practice physicians to share risk and share saving without having to become employed by a large group or a large hospital system. And we think by enabling that, we would address or would allow to be addressed, several of the unintended consequences of current shared savings models. Namely what we've got now is large groups who become ACOs, and I don't think it's any secret to anyone that a lot of those groups leverage the antitrust waivers that are part of the law in order to consolidate market share. And whether they actually achieve savings or not, savings achieved are frosting, but the real benefit is consolidation of market share, and it's a foundation principle of basic economics, market consolidation, whether it's in healthcare or widgets drives cost up of over time, not down.

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

I'm sorry, your time is up.

Dan Haley, JD – Vice President for Government and Regulatory Affairs – athenahealth, Inc.

Okay, I will be done then and I'll be happy to take questions. I would just add though, very quickly, with respect to the IRM proposal, based on some of the earlier questions I heard, it would be very important for any such model to be vendor neutral and for technologies to be able to interoperate across platforms in order for it to work. I'd urge you to read it and ask me any questions you might have. Thank you.

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

Thanks Dan. So now we get to move on to you, Josh.

Josh Seidman, PhD - Managing Director, Quality & Performance Improvement - Evolent Health

Hi, I'm Josh Seidman and I'm really talking from my experience of spending time with delivery systems around the country. I would say in certain cases, Stage 1 of Meaningful Use has really provided a great foundation for those delivery systems that are moving to value-based care. Particularly, those providers that have not only made the resource investments, but have really used meaningful use as an opportunity to change their care processes are much better prepared now for accountable care models. However, in places where providers really have contrived workarounds to basically check the boxes, they find themselves struggling from a data integration and a data infrastructure perspective. Specifically, they cannot find the data or integrate the data to do at least four things. One is to robustly measure performance, the second is identify individual needs of patients in order to tailor care management, the third is to right-size their population health resource investments to make sure that they're getting the right population health attention to the right people. And then finally, rewarding clinicians appropriately for the level of value that they are providing to the patients.

All that said, Stage 2 definitely cannot get here fast enough, particularly as it relates to accountability for population health. Many providers just cannot get the data they need, when they need it and how they need it in a Stage 1 world. Most notably, Stage 1 EHR really provides information basically about the care for a particular patient in a particular setting, rather than bringing in information from the person and from multiple settings. Once we have providers having robust access to transition of care summaries and patients ability to view, download and transmit their personal health information to where it needs to go, both for them and for the people that they're working with, that will really help to further effective population health management. But Stage 3 is also going to be necessary for managing accountable care. Especially if those Stage 3 requirements facilitate the addition and incorporation of patient-generated health data, really as part of broadening the definition of what constitutes data relevance to the patient's health.

And so I'll speak about a particular case in point. Many ACOs have focused their population health priorities extensively around managing care for people with complex needs. And as it turns out, probably not surprisingly to most of you, many of the issues that drive high-cost and inefficient care relate less to clinical needs and social needs. And yet the current data that are in most EHRs focus almost exclusively on the former. HIT systems really must incorporate social issues, or they really won't serve the needs of ACOs and management of populations. In the future, meaningful use really must evolve so that the EHR can be used in all parts of the care management team. And I heard some things today about where data is flowing to and from home health, to other health coaches that are outside of the clinic's four walls or the hospital's four walls and I think that that is going to be critically important going forward.

There are – there's been a lot made about data silos, and I'll just say amen, but beyond that, I would say that in addition to figuring out how to functionally integrate that data, all the different data sources, there also is an issue about how to make sense of it in real-time. And trying to figure out how to generate manageable reporting – tools for manageable reporting of that information is really a challenge for a lot of people right now. Specifically it's around how to balance the need for sufficient granularity so that people have the information that's actionable, with the demand for succinctness that today's leaders really demand.

And so I'll just close really with a word on payment, which is that although there are some places where, I was just talking with Joe about what's going on in Massachusetts, where things really have moved forward very quickly in accountable care. But in most places around the country, most of the progressive delivery systems are still operating in a situation where they have a small fraction of their revenue related to value-based care. And having a foot in each of those two worlds is really challenging thing for them and that transition is a really messy thing for them.

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

Thank you very much. Well, we're about ready to go into our question and answer session, and I would be remiss if I didn't stray, for just a moment from the list of questions that you all have in front of you, to the one that's still burning brightly from this morning. What exactly is the vendor community doing to address the problem that's out in front of us, the elephant in the room so to speak right now, why cannot EHRs not communicate with one another and what is being done to fix that?

Dan Haley, JD – Vice President for Government and Regulatory Affairs – athenahealth, Inc.

May I start?

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

Please. I was looking straight at you Dan.

Dan Haley, JD – Vice President for Government and Regulatory Affairs – athenahealth, Inc.

I appreciate that. There are a few answers to that; one is that there is still a market for non-interoperable health information technology. And another answer to that is the government is subsidizing the market for non-interoperable technology by paying subsidies to doctors who adopt and use technologies that either cannot or deliberately do not share information across disparate vendor platforms. We say over and over and over again, when we're asked on Capitol Hill, why is it that – members of Congress always ask the same question, why is it when I get referred down the street to another doctor I have to fill out the clipboard? And our answer is always, well, one reason is because the government is paying for that doctor down the street to use technology that can't speak to the technology from the doctor who sent you down the street. Meaningful use in 2013, at a minimum should require actual interoperability between vendor platforms, and that's a very simple concept, as far as we're concerned.

Another answer to that question is that large medical groups and hospital systems and ACOs have a market-based incentive to use technology that is ostensibly created to create data liquidity to do the opposite. To create data liquidity within the confines of deliberately constructed data silos and to use technology to essentially lock data into those silos, thereby locking patients into those silos and locking providers into those silos. And until policymakers recognize that, and at a minimum stop funding it, it will continue. By the same token, there is an increasing market demand for actual interoperability and our business is built on the expectation that that market demand will continue to increase. We interoperate with anyone who'll interoperate with us, we will build those interfaces, we will build them for free and we will do that because we believe there is a market demand for that and that is the future. We believe that absolutely and without a doubt.

The question of whether government should continue to create very specific standards for interoperability, I agree with a lot of what Mr. Lynch said in the last panel. We don't know what interoperability is going to mean five years down the road. We do not know via what technology the best and greatest interoperability will happen, a precept that we operate on at athenahealth all the time is, the smartest people in the world do not work for athenahealth, even though we have some very smart people working at athenahealth. We don't know whether today's certification standards are going to be obsolete next year, five years, ten years. It's much better to set outcome-based measures and standards than certifica – than very specific certification standards that may tomorrow be obsolete.

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

May I press you just the little bit more, Dan?

Dan Haley, JD – Vice President for Government and Regulatory Affairs – athenahealth, Inc.

I would love it if you would, Karen.

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

We go back a long way. There are a number of efforts around the country right now to actually improve the situation. And I know that athenahealth is part of CommonWell. Would you comment on that a little bit and some of the efforts that you know are happening?

Dan Haley, JD – Vice President for Government and Regulatory Affairs – athenahealth, Inc.

Yes.

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

And give us some idea of when we're likely to see results from them?

Dan Haley, JD – Vice President for Government and Regulatory Affairs – athenahealth, Inc.

Sure. Yeah, so thank you, I was remiss in not mentioning CommonWell and our CTO, Jeremy Delinsky, who's now Chair of CommonWell, would probably smack me upside the head if he heard that last answer. CommonWell is an industry initiative to increase interoperability between member vendor platforms. It is open to anyone in health IT and it is a legitimate, right now starting to function, effort to share information between disparate platforms, to do patient matching, to do query between the platforms, seamless query. As far as when we'll start seeing results, CommonWell, when it was established, when it was kicked off at HIMSS last year, gave itself a year to establish a pilot program, and every time I'm asked is that a legitimate effort, of is it all smoke and mirrors, my answer is twofold. My boss, Jonathan Bush, would not be involved in a smoke and mirrors effort intended to cover the industry's butt on interoperability. People who know him know that to be true, people who don't, don't have to take my word for it, but it is true. And second, CommonWell will be evaluated at the end of its year-long pilot program and it either will achieve results or it won't, but we're working very hard to make sure that it does.

Of course there are other efforts out there, some of them driven by ONC in which we're also participating. Direct, Blue Button, that kind of underscores my earlier point, there are infinite ways that we could achieve the goal of interoperability in healthcare, and letting a thousand of them bloom rather than saying this shall be the one big idea that government shall bless, is, in our view, the way to go.

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

Matt, Josh, can you jump into the fray?

Josh Seidman, PhD – Managing Director of Quality & Performance – Evolent Health

Well, I'll just say a couple of things. I mean, one is that when I said that Stage 3 cannot get here fast enough, part of it is because of the important things in Stage 2 that will help us down on the road around portability and around exchange across vendor and provider boundaries. So that was really what that comment was geared towards. That said, I mean I think that there really does need to be some very specific ways in which vendors have much more of an incentive to figure out how to easily share data. And that's been a huge barrier for many delivery systems across the country that not only are trying to integrate data from multiple EHRs, but really trying to figure out how to integrate the data from, even if it's a system that is using a single EHR, from that system into the broader population health technology platform.

Matthew Eirich - Executive Director, New Product Development – The Advisory Board

The only thing I would add to those two comments, and sort of echoes what Dan said is, when we talk with providers strategically, they just don't find the incentives to push their vendors necessarily for the level of interoperability. And I think we're discussing here today, they would like interoperability among certain sets of providers in certain markets but not necessarily full transparency everywhere for every bit of information. So I think the other side of that is the purchasing side, the demand side on the opposite end – side of table from the vendor community probably could be incented to push more as well.

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

Going to turn this over to you now Hal for just a moment, and then I'll come back with more questions, don't worry.

R. Hal Baker, MD – Vice President and Chief Information Officer – WellSpan Health

This morning we asked about business cases – Hal Baker – for HIE and you talked about subsidization of systems that don't allow it. But do you see a venue for a business case that drives it the way Surescripts with its transaction fee was able to move forward? We've heard concern about transaction fees being a disincentive. Being business people at athena is, how do you see this coming about by business forces? Or does it have to come about by regulatory fiat?

Dan Haley, JD – Vice President for Government and Regulatory Affairs – athenahealth, Inc.

I would never in any context say it would have to come about by regulatory fiat, ever, ever, ever. Opposite.

R. Hal Baker, MD – Vice President and Chief Information Officer – WellSpan Health

So, the alternative?

Dan Haley, JD – Vice President for Government and Regulatory Affairs – athenahealth, Inc.

Well, first of all, in order for value-based models to work, in order value-based models to be the future, in order for care to be coordinated, there has to be health information exchange, that is a necessary precondition. So a fee-for-service is to die, and we believe it is. There is a market case growing for health information exchange and frankly we believe that everyone in our industry, or at least everyone who is going to survive in our industry, I think everyone understands and it's kind of a common conception that there will eventually be of great EHR culling. There are a lot of EHRs that do – provide minimal functionality and they will not survive. But I think the viable long-term players in our industry all recognize that over time, interoperability will become the norm.

Again, we've kind we've staked our business on that, we've been cloud-based since the beginning, and the cloud platform affords us a platform to achieve interoperability that is – the difference between a jet airplane and a Buick in terms of travel. We believe that over time, the rest of our industry will move in that direction. We also believe that some government policy, well-intentioned, is slowing progress toward that day, one of them is by paying for adoption of technologies that don't do what the policy behind those subsidies is geared toward achieving. Another is the fact that anti-kick back and Stark laws prohibit in healthcare the fair market compensation for valuable data. In every other sector of our economy, the recipient of data that they find valuable is allowed to pay the sender of that data a fair market value for that data, that is illegal in healthcare and we believe that needs to be revisited. But to

answer your questions, I'm sorry, I do tend to go on once I start, market case, absolutely.

R. Hal Baker, MD – Vice President and Chief Information Officer – WellSpan Health

With the demise of the fee-for-service?

Dan Haley, JD – Vice President for Government and Regulatory Affairs – athenahealth, Inc.

Yeah.

R. Hal Baker, MD – Vice President and Chief Information Officer – WellSpan Health

Dan, you do have a model, don't you, where the – I forget how this works, but the recipient would pay the sender a dollar or something for every transaction?

Dan Haley, JD – Vice President for Government and Regulatory Affairs – athenahealth, Inc.

Yeah, we do and the reason we do, athenahealth does, is because we asked the HHS OIG for permission to do that, we laid our proposal on the table. And we said, we believe that in healthcare the recipient of information should be charged for a fair market value – the fair market value of that information, rather than forcing the sender to pay for that information, which it's not anecdotal for us. We go to – right now, because we're the only ones who can do that under our advisory opinion, we go to large hospital systems and say our ambulatory clients want to share information with your docs, and we will build an interface into your system in order to enable that. And we are told, that's great and we'd love that interface, but our docs won't use it because our vendor will charge them to send information outside of our system. And that is because the vendor is going to charge someone for the work necessary to curate and transmit that data, and if they can only charge their client, they're going to charge their client.

We believe, while you might think that that specific permission that we're given to do that is the great thing for athenahealth, that's not a sustainable business model, we lose a lot of money on that service, but we believe we're building a proof case for the proposition. That that is a viable model and that that permission should be extended through policy to everyone in our industry. We believe if that happens, then there will be a legitimate, two-sided function market for health information exchange, which will, actually goes to your question, what builds that – what builds that market; well, rational changes in policy. Thank you for that question.

R. Hal Baker, MD – Vice President and Chief Information Officer – WellSpan Health

What's been the uptake of that?

Dan Haley, JD – Vice President for Government and Regulatory Affairs – athenahealth, Inc.

It has grown at a faster rate than we expected. We're about two years into it now and over the last year, it's picked up considerably. We have most – all of the major national labs on the network, most of the major national imaging centers and a lot of other ancillary service providers. But it's slow, it's a hard sell to say to docs that something that lawyers would say is illegal is, in fact, permissible within – in the narrow confines of our services. And that's another reason that we don't want it to be within the narrow confines of our services.

Karen M. Bell, MD. MMS – Chair – Certification Commission for Health Information Technology
Craig and then Frank.

Craig Brammer – CEO – HealthBridge

You actually you addressed my initial question and that is, there's been vendor bashing this morning about –

Dan Haley, JD – Vice President for Government and Regulatory Affairs – athenahealth, Inc.
I wish I'd heard it.

Craig Brammer – CEO – HealthBridge

– interoperability, and just wanted pressure test the assumption that the provider community is really demanding it and you're not giving it to them. When – as mentioned, I run a hospital membership organization on 30 hospitals from Cincinnati Children's, the largest pediatric system in the world by revenue, down to rural hospitals and meet with CEOs a lot. And I've yet to have one of them say, Craig, my top priority is for you to make it easy for my patients to go to my competitors –

Dan Haley, JD – Vice President for Government and Regulatory Affairs – athenahealth, Inc.
Yeah.

Craig Brammer – CEO – HealthBridge

– and the data to flow. So, I'm always a little suspicious that the demand for interoperability, but it sounds like you're telling good story. So given that you've addressed that and done a nice job with that, I'd like to switch to Matt and ask you a question about claims data.

Matthew Eirich - Executive Director, New Product Development – The Advisory Board
Yeah.

Craig Brammer – CEO – HealthBridge

And, so – and about normalization of, or your thoughts on easier ways to extract – have APIs at the health plans or whatever, I know you consume claims data, it's a mess, and so we talk a lot about standardization around clinical data and what your thoughts would be.

Matthew Eirich - Executive Director, New Product Development – The Advisory Board

Yes, so the claims data that we are typically working is the paid claims data after it's gone through the adjudication process for a defined population that a provider organization has assumed responsibility for, so ACO environment, they're own self-funded employees, what have you. And so we're putting that into our risk models to use that for the purposes of identifying high-risk patients. And I think that represents largely sort of state of the art as to sort of what is being done with respect to insurance exchange – information with the health plans and providers with respect to data. Where we've heard a lot of interest, on both the payer and the provider side, again, in the right sort of economic circumstance and with the right business cases around things like ADT feeds. So just as a provider and a community might like to get an ADT notice about a patient that has been admitted, so too might a hospital. And under the right circumstances, those sorts of things are of interest. Similarly, health plans would have prior authorization notifications about say a surgery being scheduled. It could be of very great interest to a provider who is at risk for that patient and might have the conversation about whether that back surgery for instance, or that high-end imaging procedure is actually needed. And be willing to take on the responsibility for having that conversation to get to sort of a better outcome at a lower cost. So those are the sorts of things we're hearing people talk about right now, but I would say, right now what most people are using from health plans with respect to sort of data is that pay claims database.

Craig Brammer – CEO – HealthBridge

Is there any progress in terms of standardized extract from the carriers? So one of the complaints about all payer claims databases, for example, is United says, well, I don't want to do it special cut for 26 different states in America.

Matthew Eirich - Executive Director, New Product Development – The Advisory Board

Yeah, it's – we deal with most of the large, state-based as well as most of the large payers and typically, to be honest with you, the issue that we encounter, anyway, is not the claims forms themselves, it's literally just getting them. There's a reluctance to share the information for a whole host of reasons and so that's where we wind up spending a lot of our effort. Generally speaking, the data comes in, because it's on a pay claims form in a fairly standardized way, or they're using it fairly similarly, at least in our experience, across a lot of different markets. So, that isn't where we typically find ourselves trying to solve problems.

Josh Seidman, PhD – Managing Director of Quality & Performance – Evolent Health

You know, I think where I've seen this challenge of normalizing the data and the reliance on pay claims, I mean the biggest problem is that for organizations that are really trying to drive real-time improvement, the lag in claims it just doesn't lend itself to that. So if you're trying to be a responsive delivery system and trying to keep on top of managing health and keeping on top of improvement, it's very hard to do that. As they're integrating ADT feeds, that can be useful in certain circumstances, but then you're often then having to deal with the fact that they're comes from so many different places and it's often incomplete. And then you have this issue of reconciling 60 days later once you do have the paid claims with the ADT feeds, and often they're not the same. So that's where ultimately this integration of all the data sources is going to be really important for managing population health.

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

Before we move on, could we build on not just the little bit more? You mentioned all payer claims databases, there are 13 of them in the country, they're all state sponsored. Three of them are in New England, actually four of them. And ACOs are actually finding them quite hopeful because they can now access total cost of care, they can look at the cost of their programs, I mean, there are a number of things one can do to manage finances. And in these situations they are essentially performing an economy of scale function because every single ACO doesn't have to build their own. CMS, through its CMM I Program, has partially funded several of these. Is this something that you think would be of value for ACOs going forward if there was more emphasis in a – along with some very specific requirements on supporting these kinds of databases around the country?

Josh Seidman, PhD – Managing Director of Quality & Performance – Evolent Health

Yeah, absolutely. I think from the – for health systems that are con – especially contemplating getting into managing populations or taking on an additional population, oftentimes the biggest blind spot is what is actually the true underlying risk of the population that I will be assuming responsibility for. Oftentimes that information isn't known until the contract with whoever the risk bearing entity is signed and then it's sort of a basket of surprises. So being able to look at that information up front and sort of say, these are the folks that I think I could best take care of, for whatever reason, I think would actually help to eliminate some of the uncertainty that holds back moving into a more value-based care environment. I would also add that there are probably many other entities outside of formal ACOs that would be very interested in that information, which may have less relevance for the context that we have today around population management, but that could actually probably support the business case for building that data set and maintaining it.

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

Thank you. I think Frank, you've had your –

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

I want to direct everybody's attention to question number two on our syllabus here and I want to couch it in terms – it is, what are the major challenges you face in developing products that meet provider needs? And I want to address this to each member of the panel that's here. But I want to couch it in terms of, what major policy challenges do you see, whether it be existing policy or a lack of policy? We are policy group and we need your input. And I want to also add one little caveat to this, without exception, everyone who testified here today said that HIT technology was the largest impediment to their successful achievement of accountable care. So let's talk about policy in terms of what we're trying to do, is develop policy to facilitate accountable care.

And apparently the private market has not succeeded in reconciling its differences, no offense Mr. Haley, but I've heard your argument many times from other HIT executives. I can talk with anybody that can talk to me, that's the chicken and the egg again and that argument goes nowhere. So unfortunately, it looks like the government, in the form of the ONC, will have to step in and at least point direction and mandate some sort of vehicle for the exchange of information. Meaningful Use Stage 2 is the good step in that direction, but at the same time, if there are policies in place, Mr. Haley, that your company doesn't like, tell us what they are. If there is a lack of policy, gentlemen, tell us what you think that policy, and limit it to one thing if you don't mind.

Dan Haley, JD – Vice President for Government and Regulatory Affairs – athenahealth, Inc.

Yeah, okay. Limit it to one thing. All right, one thing with maybe two tiers. Meaningful use was conceptualized, in part, to incentivize, not only adoption of health information technology but, I don't mean to be trite, but meaningful use of that health information technology. I completely appreciate what you're saying about what you hear from our industry, and frankly, words are cheap. But, one of the things that happened with regard to Meaningful Use, first Stage 1 and then Stage 2 and now it's happening with Stage 3 is, representatives of our industry come up to Capitol Hill and they scream and yell that what you're of us is too hard and you're telling us to do it too fast. And unfortunately, policymakers respond to that by lowering standards and slowing down, lessening pressure on progress.

And I would say to you that when members of our industry come before you and say that it is not possible for health information technology to do what information technology does in all other sectors of the economy, that is untrue, that is baloney. And I would point to – and that's – those are just words, but I would point to results. Meaningful Use, year one, Stage 1, the attestation rates, successful attestation rate among participating providers nationwide was somewhere around order of 40 percent, meaning somewhere on the order of 60 percent of doctors who endeavored to successfully attest failed to do so. Athenahealth attestation rate year one, Stage 1 was north of 96 percent. And that delta is not illusory and it's not a coincidence, it's a different technological approach to achieving meaningful use. It's using a jet airplane to get across the country instead of using a Buick or a bicycle.

So, the policies that we would like to see are not necessarily, if I have to pick one, not necessarily different policy, but rather a little bit more steadfastness with regard to what policymakers are asking of our industry, and a little less inclination to adjust policy to accommodate technological laggards, which ultimately leaves doctors at a disadvantage. Because doctors adopt technologies based on the government stamp of approval, meaningful use certified. And when they find a year or two down the road that those technologies do not do what government is requiring them, the providers to do, they're the ones left hanging and now they're facing penalties and that is a direct result of, in our view, policy errors.

Josh Seidman, PhD – Managing Director of Quality & Performance – Evolent Health

Boy. So, it would be very hard to come up with one thing. I think if I had to go with one thing, I think I would return to what I was saying before about the need to go beyond the clinical data. And that future stages of meaningful use and other things, other policy from the federal government, really needs to ensure that the data that are being – that are ultimately going to flow, hopefully, through HIT and HIE are going to be data that are going to help organizations to really manage the overall needs of a population. And many of those data are not clinical in nature, and it also gets back to the types of data. The issue that Westley raised before about not having behavioral health data is another big part of that, because that's another huge issue in the management of patients with complex needs.

Matthew Eirich - Executive Director, New Product Development – The Advisory Board

One area that we thought about as we were preparing for today was starting with – sometimes it's hard to imagine the power dynamic between vendor and customer in this situation. It's all on the buyer side before the contract is signed, and then it's largely on the vendor side afterward. And here, I will now – I'm speaking primarily about core transaction systems, like EMRs, and the root impact of that, that I think is worth noting here is, it makes doing innovative things that are outside of what is offered by the vendor challenging. So as an example of something that The Advisory Boards has been attempting to do is to serve up real-time insights to clinicians in the EMR.

So, let us tell you in the golden hour before a patient suffers serious consequences from sepsis, which patients we think are trending towards sepsis. In attempting to do that in certain instances, certain vendors have said, if you do that, we may void your warranty on your \$100 million EMR investment. So, practical policy implication could be, this group could decide to indemnify organizations that endeavor to innovate in that sort of way, as a way of getting folks to actually meaningful use both the technology and the data that has been digitized to actually innovate and improve patient care. But I think that is a very important vector to understand and I can't presume to know what all of the policy elements could be, but we find that often times it's slowing things down.

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

Well as a follow-up, you promote the concept of the ownership of data belongs with the clinician?

Matthew Eirich - Executive Director, New Product Development – The Advisory Board

I'm sorry, is that to me? To Dan?

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

Yes, to you, Mr. Eirich.

Matthew Eirich - Executive Director, New Product Development – The Advisory Board

Yes.

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

Okay, Mr. Haley do you – .

Dan Haley, JD – Vice President for Government and Regulatory Affairs – athenahealth, Inc.

Yes.

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

Okay, so the owners of the information should have unfettered access to it, correct?

Dan Haley, JD – Vice President for Government and Regulatory Affairs – athenahealth, Inc.

Yes.

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

Mr. Seidman?

Josh Seidman, PhD – Managing Director of Quality & Performance – Evolent Health

No. I would say – so I think that clearly, some of the things in Stage 2, particularly around view, download and transmit, are really critical in making clear that those data also belong to the patient.

Dan Haley, JD – Vice President for Government and Regulatory Affairs – athenahealth, Inc.

Can I make one brief follow-up comment to my lengthy remarks? One way in which policy, we believe, could address this problem that's been created of doctors about to be penalized for the failings of their vendors, is by adjusting those penalties, so that they, in effect, penalize those vendors who are failing to meet the timelines that they either verbally, or in many cases contractually made to their clients. And you might ask how can policy do that? Well one way policy could do that is by waiving the penalties for doctors who replace their non-MU compliant now EMRs with EMRs that can meet the standards and timelines that the policymakers have set, rather than dumbing down and decelerating those standards and timelines.

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

Grace, I think you have a question and then we'll do a little bit of a wrap-up.

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

A couple of others have made them before mine, but the question I had was we haven't talked about big data; we mentioned it once today, which is going to be the game changer for you all, regardless of federal policy. What are you going to do about it?

Dan Haley, JD – Vice President for Government and Regulatory Affairs – athenahealth, Inc.

What are we going to do about big data?

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

Um hmm.

Matthew Eirich - Executive Director, New Product Development – The Advisory Board

We're doing it

Dan Haley, JD – Vice President for Government and Regulatory Affairs – athenahealth, Inc.

Well, we kind of are big data.

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

You're going to be the vendors?

Dan Haley, JD – Vice President for Government and Regulatory Affairs – athenahealth, Inc.

I'm sorry?

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

You're going to be the vendors?

Dan Haley, JD – Vice President for Government and Regulatory Affairs – athenahealth, Inc.

I'm sorry, I'm not understanding the question.

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

With data that's going to have different ways of basically giving information to people that we haven't had before quickly, point of service, are you going to be the vendors? Is that your plan? You said you're doing it now.

Matthew Eirich - Executive Director, New Product Development – The Advisory Board

Yes, we're attempting to do it many different ways. That example I just gave of sponsoring care registries, identify patient gaps in care when they're presenting at a primary care office, integrating that into care management workflows for when patients are being engaged when they're outside the office. Those are just – those are examples. I know those are not the most revolutionary ones, but those are certainly of the type that we're enabling today and with a claims database, that includes 25 percent of patients in the US, we've just begun to scratch the surface.

Dan Haley, JD – Vice President for Government and Regulatory Affairs – athenahealth, Inc.

Because we have – because of our cloud platform and the fact that we have 40 million patients on that platform, we have an enormous data set. One of the uses to which we just put that data set is when during the government shutdown; the CDC announced that it was unable, anymore, to track the flu. We used our 40 million, 50 state database to pick up that mantle and track the flu for a couple of weeks for CDC. That's just one small example. But when you talk about big data in healthcare, one of the – this actually goes to Frank's question about policy, I'm going to get in another answer. The biggest of big data in healthcare is the Medicaid paid claims database and everyone agrees that information is power, and that analysis of information in healthcare holds the key to revolutionizing healthcare. And yet, that paid claims database is largely kept under lock and key, subject to all sorts of restrictions as to who can see it and for purposes. Ostensibly under an injunction from the 1970s that was just lifted this year.

And so, another answer to the what policy changes could be made, and I know CMS is looking at this change, is opening of the paid claims database. Senator's Wyden and Grassley have a piece of legislation called the Data Act that would mandate the opening of the paid claims database. Combining that database with our 40 million patient database would provide an enormous resource for the kind of analysis to enable care coordination that everyone seems to believe is necessary.

Terri Postma, MD – Medical Officer – Performance-Based Payment Policy Group - Center for Medicare & Medicaid Services

Karen?

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

You have one quick question, and then Kelly, and then we'll wrap up.

Terri Postma, MD – Medical Officer – Performance-Based Payment Policy Group - Center for Medicare & Medicaid Services

Thanks. Terri Postma from CMS. And this sort of dovetails on some of the things that we've talked about today. I don't come from a health IT background or anything, so forgive me if I use the wrong verbage.

Dan Haley, JD – Vice President for Government and Regulatory Affairs – athenahealth, Inc.

Me neither.

Terri Postma, MD – Medical Officer – Performance-Based Payment Policy Group – Center for Medicare & Medicaid Services

But okay, so then we can talk, that's good. A lot of what I hear is Greek to me in some of these workgroups and things, but, I'm learning, I'm just a doctor. So, one of the questions I had was a question was posed earlier about what would it take to see vendors working on real-time health information exchange between providers? And, you raised the issue of death of beeper service. Well, given that we have a lot of ACOs, I work for Medicare Shared Savings Program and one of the things I constantly hear from ACOs is how valuable it would be for them to understand when a patient is admitted to the hospital, where they are receiving care at the site of care, that sort of thing. And so, given that that sort of health information exchange, real-time health information exchange is vitally important to care coordination for patients today and given that fee-for-service is alive and kicking today, what are things that the vendors are doing, today, to address that need?

Dan Haley, JD – Vice President for Government and Regulatory Affairs – athenahealth, Inc.

Sorry. So, there are a couple of answers to that one. One of them, mentioned earlier, CommonWell. Again, nobody needs to take our word for it now, because right now it's a concept that's being built into a reality. But within a year, actually within much less than a year, we are going to demonstrate that it is real and that is a real effort by industry to crack that nut and exchange information across disparate vendor platforms. Another example, not to turn this into a commercial, but that proposal that I attached to of my comments is an effort by us, a vendor, to respond directly to our clients stated needs. Our clients say to us all the time, they want to participate in value-based models, they want to coordinate care in the ways that you are describing, and they see what we do for them within their practices, and intuit that we should be able to do that for them more broadly. And there are current policy restrictions that prevent us from doing that. And that proposal that I attached to my comments lays out those policy restrictions and our proposal for changing them, essentially to allow us to do, us and others like us, again, the proposal assumes and would require vendor neutrality to do what technology, current technology, not future technology, can enable us to do.

M

(Indiscernible)

Dan Haley, JD – Vice President for Government and Regulatory Affairs – athenahealth, Inc.

We – Epic has been invited to participate in CommonWell on multiple occasions, and the hope is that Epic would participate in CommonWell. To date, they have not expressed an interest in participating in CommonWell, which we view as unfortunate.

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

Kelly, I believe you had a question as well.

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

I just wanted to go back to some of the things we heard on the first panel with the physician led ACOs, and what we have heard in the last two years from smaller physician led ACOs. Many of which don't have sort of an CMIO or a CIO, and they're not particularly very well versed on all the market offerings for population health management or data analytics. But yet, they all know they need to do something, invest in something. But they get quite nervous when they hear a lot of different consultants come and there's profit-sharing involved and sort of signing the contract is a big deal for them, particularly they're looking – they don't have capital. So we've been wondering, is there a way to sort of make it more – make these market offerings more transparent? Particularly when there's a lot of very young companies getting into this space, which is both exciting but perhaps risky for some organizations. And there's not lot known about how they are actually doing data transformation? Where are they getting their data? How are they doing mapping, normalization? What is the data quality actually that their population health is built upon?

And while we don't want – we want to be very careful about it, our approach to expanding certification and we don't want to do it where there's a lot of innovation it would hurt innovation. We also want to make it easier for organizations that really want to commit and get into this space, to make wise choices and to choose quality products that are based on some minimal set of expectations. So, what are your thoughts about what would be helpful to physician led ACOs, or really any ACO that may need some extra guidance about the market offerings?

Matthew Eirich - Executive Director, New Product Development – The Advisory Board

Yeah, I think it's a great question, and we do work with some – in addition to working with health system-based ACOs, we do work with some physician-based ACOs as well. And I think you're right, there is just a ton of innovation flying at them right now and they feel a ton of urgency to invest and be successful – in order to be successful. I'm not – I completely sympathize with the perspective that you're coming from, but I'm not sure that – I would love to learn more from them about what they – about what resources they need that they don't have right now.

I think there are multiple kind of reports that have come out, our products have been featured in them as to serve who's better, who's worse, why and what dimensions. They make lots of other purchases where sometimes the – things are a little unclear or things are uncertain. So I think in order to really answer kind of what would be helpful to them, I need to hear more from them. Our experience with physician groups in general has been that actually they're pretty savvy and sometimes they're the toughest to convince. They are the ones that ask the better questions so our experience is that it isn't necessarily that they're may be kind of the babes in the woods, that they sometimes feel that they are.

Dan Haley, JD – Vice President for Government and Regulatory Affairs – athenahealth, Inc.

I am going to echo myself. One of the things that policymakers can do is be more deliberate about a) what is required for certification, and b) certification itself. Because I do think that one of the reasons that so many providers, whether they're grouped together into an ACO or not, find themselves making bad technology decisions is because they do rely on that stamp of approval, that government stamp of approval, certified. MU certified. This will – they have a right, it's legitimate to expect that the products that the government has ostensibly looked at and deemed worthy will in fact be worthy.

And then, part of it is on our industry to do a better job of breaking through this notion that what is long since obsolete in the rest of the economy still makes sense in healthcare. What immediately comes to mind is the notion of multi-year, multi-hundred million or even billion-dollar implementations of software. That's insane in 2013, it doesn't make any sense, it's hugely wasteful. And yet a lot of systems still do it and if I knew the answer to that question, I'd be paid a lot more by my employer.

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

Just a point of clarification, too, I'm sort of referencing like the data analytics and the data warehousing infrastructure that's not really covered under certification now, it's really sort of – there's a lot of maybe mystery almost in the market about what's really happening. And there are probably very different approaches to natural language processing, in some instances, where they're getting a lot of unstructured data and different kinds of mapping going on. So, is that important, I mean, is that something that we should be having some baseline expectations across all market products because there's risk. They're saying – whether we call them technology laggards or just the folks that are really offering something that might be subpar and could be a risky investment for any ACO.

Dan Haley, JD – Vice President for Government and Regulatory Affairs – athenahealth, Inc.

That is very important. I think it's very important for the users of data to be able to know where it has come from and who is responsible for curating it. That is certainly our paradigm. I think one of the reasons that a lot of health information exchanges are struggling is because they become what my boss refers to as big black boxes full of data, where for various reasons, incentives and otherwise, providers pour their data in, but nobody pulls it out because they don't know if they can trust it. They don't know where it came from, they don't know who's responsible for curating it, they don't know if it's current. And so, I know it's only a partial answer, but the answer to your question is, yes, it's important to rectify that.

Matthew Eirich - Executive Director, New Product Development – The Advisory Board

So specifically then around the analytics basis, we're talking about integrating things like EHR data and claims data, and knowing that you have lots of – we talked this morning as well, that the data conflicts, right? So, what is true? And as you're feeding them into predictive analytics, etcetera, what do you feel about sort of the transparencies in the methodologies and publishing those more transparently, such that people can make those comparisons. I mean, not pushing all the way down to say, give me the sensitivity and specificity of how you're defining registries. But a little bit more in terms of the performance of these tools in a more public way before people actually commit to them, and then run them for two years and realize these are not the patients I care about.

Josh Seidman, PhD – Managing Director of Quality & Performance – Evolent Health

It's a great – I think it's a great point. And it's funny, when we talk with primarily the larger health systems, but I think would apply to any provider organization about that point. For better or worse they actually want to keep that very close to the vest, so often times they'll say, we are going to be the ones that define who's a diabetic and who's an uncontrolled diabetic and we're going to titrate – based on kind of what we think is right for our area. So they're actually keeping some of that reconciliation and definition of truth is not source of truth to themselves. But – and I think I would also sort of say the other consideration that's the flipside of that is there is real value in the standardization, when we think about benchmarking and being able to do big data type things, having everyone use the same definitions is extraordinarily useful from that perspective, so there's that inherent tension.

I think, what I guess, as you start making things public, I think from our perspective we would consider if you have a better way of doing that that is, in fact, more accurate, we'd need to find some way to protect the intellectual property that goes into the algorithm versus the transparency that would allow individuals to compare that. Oftentimes what we're finding ourselves doing is taking in a data set and actually kind of running it through our algorithms and showing the perspective, a customer what the answer is and then they can decide for themselves whether they are satisfied with that.

M

– that required you to publish your data dictionary for your repository that you sell as part of your EHR? Would you oppose that?

Dan Haley, JD – Vice President for Government and Regulatory Affairs – athenahealth, Inc.

That's one of those questions on which I am out of my depth, but –

M

It is the single biggest impediment to opening up to third-party development of software, you have a lock on the information. We may own it as a physician, but you have a lock on it. If we can't read it and translate it effectively.

Dan Haley, JD – Vice President for Government and Regulatory Affairs – athenahealth, Inc.

Well I would say from a business philosophy perspective, we are very much dedicated to openness and transparency in our data, our methodologies, how we do business, to the extent that we have an initiative at athena that we call More Disruption Please where we identify third-party developers, building essentially apps in our industry space. And twice a year we gather groups of them together and they give panels of provider's elevator pitches and the ones that win inclusion in our program are given the access to our 40,000 care provider network. And that's how we incubate those services. So, we don't just commit ourselves to transparency and to working with third-party developers, we actually affirmatively, incubate third-party developers in our space. Again, as part of the general philosophy that the smartest people in the world don't work for athenahealth. They're out there doing crazy innovative things in this space.

M

But remember, accountable care organizations are collaboratives of disassociated practices in many cases, and the only thing they have in common is the desired test the desire to obtain information, analyze and report, that is the incentive.

Dan Haley, JD – Vice President for Government and Regulatory Affairs – athenahealth, Inc.

Yes.

M

So, if you don't have an open source, not so much in the sense of what you're programming code looks like, but simply a data dictionary so I can open up my database, read it and know that what I'm reading is what it really says it is. Do you believe that that would facilitate a greater fostering of the development of applications in the HIT industry?

Dan Haley, JD – Vice President for Government and Regulatory Affairs – athenahealth, Inc.

And what I would say is, and I guarantee I will respond more fulsomely to you on this. I am out of my depth in responding to that question. My inclination is to answer that question yes, because my understanding of the way we approach our business leads me inexorably to the answer yes. But, I need to talk to smarter people at my company in order to answer that question, and I will do that and I will get back to you all.

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

Interesting. I'm sitting here thinking that for physicians, ethically we – we can't ethically hoard a particular surgery that we do, it's considered unethical, because you want to share that for the benefit of all patients. And we interestingly now, we have a new type of operation within the world of information that needs to be there for all patients, which is the information for accountable care and population health. And so, I'm going to muse, just for a moment, and ask or at least philosophically muse on, what's the difference between me the inventing a new type of laparoscopic surgery and ethically be obligated so that all patients can be helped from that, and an HIT vendor who has some technology that can help all patients? I'm just saying.

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

And there – this panel has already gone over, I'm sorry. And, it's been a very long day for people, so I just want to thank all of our panelists for taking time out of their very busy schedules to share their thoughtful insights with us. I also want to thank Alex Baker and Kim Wilson who have done a tremendous amount of work to put this hearing together. Thank you both very much. We are going to move over to Grace, Charles and Paul for some closing remarks, and then we'll decide if we want to give people a two-minute break and start the workgroup discussion, but, I'll turn it over to you Charles.

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

Oh. Well, I think I started the day saying I am looking forward – with a lot of enthusiasm looking forward to what we would hear. I think a sobering dose of reality was what we heard throughout the day. But, I did hear some themes that perhaps the HIT Policy Committee can act upon, specifically around how can we get the vendors to share information more aggressively, I think that was a theme we heard throughout the day. And a fundamental point of obstruction for what we're trying to achieve in accountable care. And so, I'm just going to be real brief and say, we're going to have, I think, some dialogue after this, and I look forward to that dialogue and trying to form some recommendations that we could take to the HIT Policy Committee.

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

So I started off the day saying that I was going to be your Howard Cosell. Anyway, I just want to express my appreciation for all of our testimonies today. And the amount of thought and effort that they put into it to help us learn how we can, basically, deal with what was the common theme for the day, as someone said not just too long ago, that the biggest pain point in accountable care is information integration. So, I think of the whole accountable care organizations having to have three things, and one is a new payment system, and the second is information integration, and the third is clinical integration or new forms of care models that will benefit patients. So, interestingly, from my perspective, most of the conversation, as you would expect perhaps, did not lead down the road of payment system or clinical information or care transformation being the pain points. There seemed to be some feelings that that was still creative space, as opposed to barriers. So, with that, I think that what we learned today, that this committee hopefully can help inform how we might approach, from a policy standpoint, as a nation, the pain point of lack of information integration.

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

Paul?

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

Yeah, I share a little bit of Charles' concerns, in regards – I mean, I might summarize some of the things we heard today. One is the need for longitudinal, really, a longitudinal shared record for an individual. We didn't hear as much emphasis on the patient, and I guess I did miss that a little bit, heard that a little bit, but. People wanted to know who they were dealing with, some asked for a UH a universal health identifier I was asked for "an MPI or community MPI." They wanted to know where they're getting care and notification was part of the way to figure that out and that actually is part of meaningful use. What care are they getting, the "medical record," the clinical care record. And what are they not getting, and people were using registries as a – largely a manual way of figuring this out. And what was also mentioned is, what are the social determinants that need to be considered, the nonmedical and nonclinical information? So those seem to be things that people wanted in the longitudinal basis.

The barriers, wow, this is sort of a screaming barrier about – the testifiers reported that vendors are really either impeding, charging for or obstructing the flow of data from system to system and we're, I think, searching for a way to try to address it, if not attenuate that. Standards were mentioned a whole lot, and I think reading between the lines, people were talking more about the content standards rather than the messaging or the containers. So, I think that's what I heard from the panelists.

An observation is that it sounds like, at least in this early stages of ACO, a lot of folks are working on ACO checklists. And what I mean by that is working on the reporting compliance rather – more than the transformation that it was intended to be. So, people are working on ACO function, rather than

the new ACO model of care. Josh actually brought that up, his analogy was a Meaningful Use in Stage 1, I think it probably – one would expect that to be almost a checklist, but the danger is if you follow a

checklist, then you're actually not redesigning for the information infrastructure you need for the new model of care. So, his observation was that the folks who got it and were trying to build their infrastructure and satisfy Stage 1 were on their way. And the folks who were more building check – operating off of checklists, may have a tougher challenge getting to the data infrastructure they need.

So it looked like folks were...it was almost like an aggregated provider group around a checklist, rather than a new model of care, at this point. I mean, we're all learning and so it was a little surprising to me. So consequently the challenge of us trying to figure out how to support them is tough and we asked multiple times to try to get some ideas. I think one of the ideas that kept – I'm sort of restating what I heard is, we need to move data with meaning, that's a whole content standards, but also and mean it. And I think the part we're missing is "and mean it." So, the closest thing was, I think, reinterpreting HIE to be a human information exchange organization. So they don't – I'm not sure that we – I think there are enough standards to get us started, and I think we're not fulfilling the human information exchange to take care of either patients or populations.

So the question is, why didn't the private sec – why hasn't the private sector created this yet? Or what policy levers could we employ to support it? And maybe go back to this – the governance model, not that the government would enforce it, but could produce a model that could star – it's really hard to gather together – one, it's hard to get together, as some of the folks actually have said. And two, and get started on a way to operate with each other. So, even a model that's a draft could be an excuse to get started and let's go critique or tweak this. It just seems like there needs to be some kind of stimulus or catalyst or seed to get the crystallization of people, humans and organizations getting together as organizations.

There was some mention about somehow using meaningful use, I wonder if meaningful use could be a condition of participation in at least the government – the federally sponsored things, like the big – the Capitol ACO. I know there's a small amount of waiting, I mean, it's two times the small amount for MU qualification, but maybe MU Stage 2, as was pointed out, is a condition of participation in the big ACO. I'm just trying to think and where we're trying to listen to what people are saying what their problem is and look towards where the model was trying to take everyone, and say how can we help there? Because it looked like it was not something was happening organically in these early models.

So that's sort of – and I guess I would say, my biggest regret is we have not had a discussion about the measures that would motivate. Or one way to describe it is the measures that matter. So, what would really jazz both the patients and the providers, I suspect we don't have those things right now, anything that comes close to jazzing people. And what's the true North that could motivate people to go in a direction and seek the systems that would support the data that goes in that direction? That's a bit long-winded, but I am try – really struggling to try to figure out what it is we can glean across all the panels and where it might take us.

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

Well you know, and just on that, we even heard some challenges as to whether measures matter today, right?

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

Correct.

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

Which is really an even tougher conversation to have. But anyway, we're going to what, take a few minute break and then –

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

Yeah, we will take a 5 minute break? And then come back and regroup with the workgroup.

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

– reconvene. Okay.

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

Let's get started. The quicker we get started, the quicker you can all go home.

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

So Michelle, could you bring up the slide deck where we talked about the objectives for the day, for the hearing?

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

Sure, it might take a minute, but we'll get it out.

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

Maybe I can get it quicker. We began the day, we had a series of objectives and maybe the best way to close the day would be to review those hearing objectives and talk a little bit about what we heard. The first objective was to understand how stakeholders use health IT to satisfy cost and quality business objectives under different accountable care arrangements, to learn about the innovative solutions, which should be replicated, and spread, and understand the key challenges to adoption and implementation.

I didn't, I mean I heard some, but I can't say I was overwhelmed by the number of innovative solutions throughout the day. But we did hear, I think, a fair amount of key challenges to adoption and implementation, right? And maybe we should just start by summarizing what we all collectively heard. Would that be good? I mean, clearly the vendor piece, I think, jumped out of the page for everyone. I think we heard from every panel, including in some ways even the vendor panel, about the challenges of sharing information. And I was surprised a bit at the size of the challenge, even when we weren't talking about complicated, true, critical interoperability, but things that are fairly discreet and more straightforward to share, like ADT information. That is not complicated to share, there aren't a million ways of representing an admission, a discharge or a transfer. So, that was one of the real takeaways for me was the difficulty in doing what I would consider even some of the more basic aspects of information sharing.

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

As I was hearing that today, I was thinking about concepts such as value migration and profit capture, which I think has specific implications for accountable care when we are trying to lower the cost of care. And if, as we heard on a couple occasions today, that he or she owns the data has advantage whether by that it gives you market advantage or too much market advantage, that seemed to be what was really underneath. It's always about the money. And so, if we're talking about accountable care where an organization is taking financial risks for a population of patients, it's a really important issue who owns the inter – who has the ability to access appropriate information at the right time. And so, it really, from a – we need to understand what it means about who has the right or the access to that information as it relates to financial modeling as we're trying to put accountable care in place. And, I'm not suggesting we got an answer today, we got opinions today based on where a parti – an individual was in the place and space of the market, but that's really something that we need to understand because anything we do will have policy – market implications for somebody. So, to go back to the crossing the quality chasm remark that I made earlier, it was about the free flow of information and most of what we heard today was the difficulty of actually having to free flow information for the sake of better care.

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

Other comments?

Micky Tripathi, PhD – President and Chief Executive Officer – Massachusetts eHealth Collaborative

Sorry, to jump in, I have to catch a 4:30 PM plane, it's just – and I guess just a couple of – no, I mean a 5:30 PM plane, sorry. Oh, wow, I really have to run. I have to leave at 4:30 PM, that's what I was going to say. So I guess the one thought that just sort of struck me as we're going to this, and it think it's important for us to all realize, it's really premature, I think, for any of us to really panic about this right now. Because the ACO business model, as we heard, even though we have an association of ACOs now that's sort of here, acting with ACOs now as an interest group who need more incentives of their own, right, that was an interesting part of the conversation. But that's very, very new and as we heard from most people, it's a small share of their business, right? I mean we heard anywhere from 10 to maybe 20 percent of their business and not really affecting a whole bunch of their business. Right? So on that side, on the demand side, it's very early.

On the supply side, same thing, I mean Meaningful Use Stage 2, are all of us here live in a bubble and we think, oh, Stage 2's done, we're off to Stage 3. The market is barely getting over of Stage 1, right? And Stage 2, even though attestation has started for hospitals, very few hospitals are even starting attestation. So – and most vendors haven't fielded the Stage 2 – the 2014 edition versions of their software yet. So, it's very, very early and I think it's really early for us to be thinking about, wow, what do we need to do to correct this situation, when we haven't allowed the things that are in place to really start to develop. That's one thought. And we, in Massachusetts, we have a statewide HIE where we had assumed it's essentially going to be, essentially the idea of connecting up the silos as it were. So, it's not about providing an HIE solution to solve accountable care needs for any individual organization, but really about Direct-based transport to allow those silos to develop on their own, to solve their ACOs needs, their local ACO needs, but connect them up at a higher level.

And what we found, and the thought was, we'll just leverage the Stage 2 or the 2014 edition capabilities that are going to be built into the EHRs. Well, what we found is that very few EHR systems have those capabilities in place yet. So we've built a whole bunch of adapters and now we accept any kind of transactions, HL7, file drop of a text file, wrap it up in a Direct message, as Joe knows. And then send it off on its way where the HIE is performing that function with the hope that as the systems get fielded that we'll have to do less and less of it. But – so my point is just that we have to continue, even in places where we thought that we could leverage that, we've found that we just have to adapt to the market and essentially meet the market where it is and then slowly sort of mature as the market matures.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

– I mean, I think it's a very fair comment, and I meant to say something like that, these are all early adopters. With meaningful use, we had that swish and even said, where are we going but still, I guess, that wasn't how people were planning it, they took one at a time and just did it. I'm a little nervous because of how fast we're doing it. I mean, what your comment is, where it's just a beginning, we've got to do all of these things whether it was meaningful use or ACO, and the future's not clear. So I thi – don't even know how to prepare for the future. But, we can't also – it's like the rule of trends, you can't not see the flu coming, it's going to be reported on and like, what do we do? Is there any way we can make things a little clearer, either about the future or the value of doing certain things to improve your own future . So that's sort of – yeah, I mean, it's a very fair comment.

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

Well I think you are right, though, we did hear a couple of bright spots, right? I mean one bright spot was, I think the physician panel that talked about it an EMR with integrated clinical and claim data in it, which is still quite uncommon. And I'm wondering if there are some meaningful use policies we could think about that would promote or encourage the integration of clinical and claims. Even if it's not integrated clinical and claim data, because what he described wasn't integration of the data, it was presentation of data derived from a claim in a file folder, an electronic file folder, in that essence, integrated in with other things. So, if it was radiology, he could see a CT scan let's say was done somewhere, but it wouldn't have the actual information, right? So that physician seemed particularly enthused. And another bright spot we heard was statewide claim data repositories being very helpful in the access of information. So maybe that's a theme we could build upon, which is the integration and leverage of claim data within the HIT infrastructure for ACOs and may be more broadly. Karen or Hal or..?

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

– build on a lot of what's been said. I think that there's no question that, and since we all know this anyway, that the groups that are large, fairly well-integrated, have been doing this for some time, have been under risk for some time, have figured a lot of this out. We heard from Reliant and Larry Garber and Atrius and you folks have been doing this for over 50 years, with an EHR actually for over 50 years. So – and Massachusetts has been essentially under risk since the 1990s. So large groups like that are going to do well, but what really stands out to me are the smaller groups, are the people just starting and just getting into upside risk, which is the big majority of these 400 or 600 ACOs that are now out there.

And in many ways, what I was hearing is remove some of the extraneous burden from them, remove some of the administrative burden from them or just make it easier for them to do what they normally would do. And I was out of CMS for a while, too, there are some pretty strict rules about what you give to patients, but not every other payer has those rules. So you have to do things multiple times over. So finding ways to harmonize among all of the payers – work – CMS could certainly do a lot of work on that, I think would be huge. Finding ways, and this came out in a couple of ways, to make sure that the CDS is effective, that the quality measures are actually effective, I think would help a lot. So, removing a lot of the extraneous burden might be helpful and that will take a lot of energy to really actually look to see where it is, but I think that's another piece that we could include.

R. Hal Baker, MD – Vice President and Chief Information Officer – WellSpan Health

We heard a lot about people dipping their toe into ACO, but not being fully committed, they haven't dove in yet. And I was actually encouraged because what we heard was a lot of people doing a lot of initial exchange, not because of a compelling business plan, but in spite of the complete absence or at times a disincentive from a business perspective. But, for this to go forward, for the pilot initiatives that are 5 percent or 10 percent of a business to move to 50 percent, there's got to be a compelling business case. I wonder if the ADT feed with readmissions, with beneficiary adjusted, the 30-day window, maybe something that will provide a business case to clear the rail bed where we can build a railway here. Because the ADT seemed to be the one thing that everybody, where it was, said that thing is working, we know the readmission that we didn't know was happening across town, now happening, now we can intervene with that patient and try to get them out of the hospital and back in their home, reducing our costs. That may be an opportunity but, there's a danger here, there are so many people trying to do good things for the right reason, even if it's not good business, that we can think that things are going to take off. But it seems to me the business and the mission they have to align for it to explode.

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

I was going to say that. Actually, maybe my expectations were lower coming in, because I actually thought this was pretty realistic the entire day, of the world that we play in and work in. And so, part of it is, yes, I think there is, in the accountable care organizations, I think many organizations are fully invested in the thought that as you get global accountability, you have to be innovative and improve, right? And trying to figure out what tools do I need to be able to do that well, which I think may explain part of the reasons why we were not hearing tremendously innovative care delivery solutions out there. Because people are realizing, I could – now that I'm taking risk for this, I've got to be able to understand what this experiment that I'm doing in my own organization is, and really understand that well. That's for the early slides that we had in the very beginning that said, what was it, like 11 percent of the pie had no idea what was happening to them? I think that – that's really frightening, right?

But, getting to a place you begin to understand that and I think with a lot of the EHR technology and information technologies exist, when I talk to my peers around, a lot of it is focused on internal operational improvements, because that's what they can do. It doesn't matter that I don't have information coming around, because I know I can pull this information from my system today. And I think there's a lot of activity there to try to learn about how to use data and intelligent ways to drive improvement, etcetera, to get going.

But I do think as the financial market starts to sort of come to play, I think ADT, I agree, I think ADT presents an interesting spot, because it's not just around readmissions and hospitalizations, but it's – those are trigger point and transition that key off so many other care processes that happen for the patient. And not only from a safety perspective, but a cost perspective, so many of those, just from those three little elements that we're trying to get, you're transferring your discharging and ED visits, those are critical points. And if we can just do that as the next step, I really do think, and I agree, I don't think it's a comp – I don't think that technology is that complicated to figure out how to do that. But I think the incentives and the barriers etcetera around how to get everyone to start sharing that information more robustly would be very, very eye-opening. And I think would actually start to open some new doors in terms of innovations.

M

– to be able to get –

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

Yeah. Agree.

M

– proposed in Stage 3 or something and not create a backlash.

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

I think so.

Craig Brammer – CEO – HealthBridge

I was just going to follow up on this ADT issue if I could, which is – I was a little surprised that they kind of pooh-pooed this thing that we're doing in Cincinnati where 30 hospitals are alerting each other instantly. And also by the way alerting, I didn't mention it, but alerting the Council on Aging and Social Service agencies when their consumers or whatever hit the ED. And our folks locally, the health systems, are just eating it up, they think it's magic. So, I think it's a good lean, minimally viable product.

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

I mean, I think there's – we've heard huge interest among a lot of states that are advancing either some multi-payer ACO models or just really interested in supporting various forms of accountable care. So, there are CRISP-like services happening in many states. A lot of its – actually Pioneer ACOs are doing many of them, many of the Beacons are pursuing this. So on a community level and a state level it's happening, it's just not being scaled. And so it's like, what's the secret sauce and how do you get at the – because I think that the CMO for Monarch was representing a much larger view that we got a lot of public input on earlier – early in the year with the RFI. Where there are just – hospitals are – many, many are still at a point where they just don't want to share the data.

And so, what exactly – is that a regulatory fix? I mean, we did specific public input to say, you have to regulate them to do that. Well we can't go forward easily with a condition – I mean, it's CMS' call, but it would be very challenging for them to move forward on a condition of participation around, e-discharge planning or they would – in the next few years say, you have to send an electronic summary to get paid by Medicare. That's a really high bar. But maybe there are some other ways that we can more distinctly influence, and meaningful use is sort of a soft way of doing it and may not reach everybody, but it could be – clearly could be considered, I guess in Stage 3.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

Well, it actually is in our draft so far. I mean, we're going to have our final next month, but our draft does include notification of trigger events.

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

Yeah, I think the other thing is, is the state one area to organize and scale some of these services? I mean, where it's clearly worked in Maryland and they've done it really efficiently, cost-wise it's been incredibly efficient way they have done it. And I think Larry spoke – Larry Garber spoke to maybe a better HL7 standard that could be consumable by EHRs. So there might be a standards evolution issue, because there's a lot of variation in the way that the ADTs are being implemented right now. But anyway, I just – maybe we can think a little bit more about how exactly to scale, and I don't think there's an explicit Medicaid policy on whether or not that kind of service would be supported under the 90:10 match under HITECH. So maybe some clarification around whether or not that would be allowable, if in fact there might be some other payer support.

R. Hal Baker, MD – Vice President and Chief Information Officer – WellSpan Health

(Indiscernible) – out of turn, but just – to just not just think about states.

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

Yeah.

R. Hal Baker, MD – Vice President and Chief Information Officer – WellSpan Health

Because I think part of the thing that we from here, the problems we cause is when we just think about states. So we sit on a corner of three states and our patients bounce back and forth across –

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

Totally get it. As we know, we've had many conversations over the years about that. And so one of our things is that Medicaid is one of the potential big policy, arms that can address this. And they do have authority to approve funding to Medicaid programs to help support it. So, in terms of, if there's a need for federal government to be supporting it in some way, that's one avenue, potentially. And I guess it's – there are so many parts of the country that don't have it now, so when you think about scaling, is there a need for that federal support to scale?

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

Frank?

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

Again, on the number one objective, when we talk about using HIT information, leveraging technology, I heard a couple of things here today. The first thing I heard from everybody, except for the lady from Brooklyn, she's in heaven, she's got one system, she can see whatever she wants, whenever she wants. I need to move to Brooklyn. But what I heard – no, I've been there, it's a great place to visit, but I don't think –

M

Move through Brooklyn.

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

Real quick. One thing I heard from everybody was that, even a little bit from the state level folks was, you can't integrate information, you can't do it. You can't reach out and pull it in, because there are walls between me and that information, between you and the information that you need. And those walls are constructed on purpose. We are being held hostage to the information that is in silos, it doesn't matter whether that is silo's in my wife's primary care practice or whether it's in the Massachusetts collaborative. It doesn't matter, it's still in a silo. And the other part is, is when we talk about ACOs, we're not talking about these folks, really. I belong to a small ACO 10,000 attributed beneficiaries, 39 docs, 14 EMRs and we're getting the job done, but we're having to overcome it one single barrier, and it's called the EMR vendor.

Now, I got pretty pushy at the end about the whole thing about data dictionary, but the fact of the matter is, that one thing right there, in one fell swoop, if it was determined that we are trying to provide better public health care, an ACO has got – (Indiscernible) – we want to improve public health care, we've got to open up these databases. And if you do that, I can go down to Georgia Tech in Atlanta, go to their incubator, their start-up incubator and in the three months, I'll have you more apps than you can shake a stick at that'll do anything you want to do. So, when we talk about – we spent the whole day talking about transferring information, shooting sparks into the night sky and they generally are sparks because no fires are getting started.

We've got mandated things under meaningful use that have gone nowhere. Stage 2 is going to go nowhere because there's nothing there that aligns itself with the physician who's the one that has to pull the trigger on that exchange of information. There's nothing in meaningful use that supports him. There's a mandate that he has to do it, but it does not support him in trying to leverage his EMR vendor to open up that system, so he can do it the way he wants to do it, instead of the way he's being dictated he has to do it by his EMR vendor. Let the market come into play, there is no market. If you belong to an EMR vendor, you belong to them and if you don't believe me, do it and then try to change EMRs and see what you're up against.

So I'm saying I heard two things today. One, nobody likes the way that their information is being held hostage. And the second thing was the silence, nobody wanted to talk about what it would take to do it, other than just transmitting data. My background is IT, there are a lot of ways that you can get information from one point to another without doing it the way that it's attempting to be done today. So, I'll leave with that comment.

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

Heather?

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

I have a couple of thoughts. We are a small ACO in Phoenix. So, all of your problems with patients leaving the state, they come to us. So, I'm responsible for them for about nine months out of the year. And yes, ADT messaging is critically important. We're seeing it within our patient population and within our market. But, there are a couple of other things though that I think folks really didn't touch on and the next one is pharmaceuticals. What we're getting back from Surescripts, I think it was, is yes the prescription was received by the pharmacist, that's the extent. What our physicians are interested in is, did the patient in fact pick up that prescription and if so, how many pills? Because what we're finding are barriers are actually the cost of the medications. That – we have been able to tackle that through a PBM relationship, but we've seen drastic changes in the way our patients are receiving care by just having access to that information.

As it relates to the excuses that we heard about vendors not wanting to cooperate, I can tell you I'm an Epic client and I can tell you that I refuse to accept Epic's "no," and I went ahead and did it anyway. So, there may be some obstacles that are put in place and there are some folks who don't want to take a risk in infuriating the – angering their vendor, but that hasn't gotten in my way. So I find it to be just an excuse for not pushing the envelope, because we have, in fact, started to add claims data into Epic at the direct opposition of Epic's direction, but our physicians have insisted on it. So, I think a lot of what we heard today is frustration that I think it's also excuses.

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

Great. You know, I'm looking at the time here. We had a couple of other objectives here today, one was to look at certification and whether that would be helpful in the creation and management of population health IT management functions and interoperability. We didn't really get a lot of comments or support on certification. Karen?

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

Yeah, I was actually going to close my panel with that question, but we didn't have enough time. So I did check in with Kelly and we're going to do that online through e-mail, because I think it's important for us to hear from everyone, where they see certification going. Is it just around interoperability large over every form of HIT or is a more intensive around functions in the EHR arena? There are many different ways it could go right now.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

But I didn't hear people complain about the products, I think they complained about the behaviors. So, how do you certify behaviors, yeah?

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

Oh, I think they complained about the products, too. The products don't do what they expect them to do. They – I think we heard multiple times over, people saying that the products are certified for meaningful use measures, they're not certified necessarily for their needs around caring for patients in accountable care in an integrated systems.

R. Hal Baker, MD – Vice President and Chief Information Officer – WellSpan Health

I've had vendors say, this is how we certified the product, but we wouldn't expect anybody to ever use it this way. So they've achieved technical compliance with it being unrealistic in reality.

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

Well and I'm wondering, can we use certification or maybe even threatening loss of certification for modifying certain behaviors? In other words, we heard today, gee, I want to get data out of my EMR and the vendor comes in and it's a year later before I can get anything or there are five different software engineers I've got to work with. Is there some way we could monitor that in some way or, have some process where we look at that and say, if we see this, because it sounds like it is pretty widespread, just based on what I have heard in the industry. Is there some way of kind of tracking that and saying to a vendor, this is unacceptable performance for what we're trying to achieve through certification? And then the last topic we had – oh.

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

Hal's comment was really interesting – or, I'm sorry, Heather's and we heard it a couple of times today, where cost data is being integrated successfully. And maybe Epic is just one of the examples, I don't know if it's been done by Cerner or others. But is that also something that could also be considered as either future certification in Stage 3 or otherwise?

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

Yup, okay.

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

I think the other question is, does that belong in an EHR or does it – we've had modular certification or is that a data warehouse function that might be independent of an EHR? So, I mean, I think it's – there are so many different ways one can do this. So I'm not sure it's –

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

And I think that's the argument that Epic had with me during our journey, which is a patient gets a flu shot at a pharmacy, they don't want that in their database, because Epic owns the database, we don't. We own the data that goes into it, but we don't own the database. But, when you put that question from a clinical perspective of, do I need to know that as a physician, absolutely. So, there are things that don't really belong in the electronic medical record, but they are clinically relevant pieces of information, and from my perspective and our doc's perspective, it's not a vendor's choice or a vendor's decision. It's the clinician's decision as to what they want to bring into that record.

W

– used to say over and over again, which really influenced my thinking a few years ago, to change the culture attitudes about managing to the three-partying is, they've got to wake up every morning and look at their dashboard. And you really need to own that data to manage your populations and your patients.

You've got to know the cost data at the point of care, so not just at your registry level or your database level, but it has to be visible and part of your thinking and your approach to everything. So, it does strike me that we need maybe a deeper conversation and input from them about what all is underneath it, because it can't just be the EHR we're concerned about. But should we at least be sure that if the data's available, that it's visible on a dashboard?

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

Yup. All right, and the last topic we had was receive specific input on how the MSSP program can encourage development of health IT infrastructure and capabilities. I really didn't hear much at all on that topic, did anyone?

M

– was a key item for success, and so, they were I think saying, without quite saying that large organizations with capital that can do prospective investment had a leg up.

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

And to that point, several of the smaller ones said the only reason that they were able to get into the space at all is because of the upfront capital that was allowed the small ones. So, that needs to be thought through probably, particularly to Frank's points about that not all ACOs are large multi-specialty integrated systems and that capital continues to be, in some form or another, an increasing need for performance.

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

All right, it is an increasing need, but it is not limiting. When we went live on Epic and had to do our first MSSP reporting in the spring, we hadn't been on the system for a full year. So what we were doing was actually manual tracking of information that was in various systems and then uploading it into a master record. So it's possible to do it without the financial support, it really is.

M

– that athena brought forward that small doctor's offices independently are not going to be able to get to the capital and for investment to be able to do this, and it is going to necessitate a larger organization.

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

I think it's time for public comment.

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

Yeah, it's time for public comment. Thank you all. There is a meeting next Friday where we can continue the conversation. So, anything you weren't able to share today, quickly write it down so you don't forget. And with that, if there's anyone in the room who would like to make it public comment, I don't think there is, but please come up to the table. And while we do that, we'll open it up to the operator. And as a reminder, if you do have a public comment, it is limited to 3 minutes.

Public Comment

Alan Merritt – Altarum Institute

And if you'd like to make a comment and you're listening via your computer speakers, please dial 1-877-705-2976 and press *1. Or if you're listening via your telephone, you may press *1 at this time to be entered into the queue.

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

We do have a public comment from Katie Boyer.

Katie Boyer, MPPA - Manager, Federal Affairs - HIMSS

Hi and thank you so much for the opportunity to provide public comment on the important topic of health IT support for care coordination, payment reform and health care transformation. We at HIMSS have been working to expand our support for education, training and dialogue on health IT support for ACOs. In fact, we've recently established a provider-payer community of profession to advance the dialogue between these important stakeholders in the ACO model. Additionally, in August of this year, the HIMSS Accountable Care Task Force identified the core capabilities of accountable care organizations and cross-walked these capabilities against necessary enabling technology. This crosswalk, along with some additional observations and activities that we believe are relevant to this discussion, are included in written testimony that we provided to ONC, that will later be distributed to you, all the members of this workgroup. That's all and you again for the opportunity to provide public comment.

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

Thank you. And it looks like there is no one else. So, thank you everyone. We really appreciate you spending your time with us today. It was a very long day but hopefully everyone who traveled in has safe travels and if there's anyone left in the room, again, thank you for taking the time to share your insights with us.

Public Comment Received During the Meeting

1. Regarding the discussion at 12:32 AM ET: the HIE should be considered as member of or part of the ACO. The HIE should also share in risk. It is likely an ACO is not sustainable without a HIE.