

**HIT Policy Committee  
Accountable Care Workgroup  
Clinical Quality Measures Subgroup  
Transcript  
August 20, 2013**

**Presentation**

**Michelle Consolazio – 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 of the Health IT Policy Accountable Care Clinical Quality Measures Subgroup which is a Subgroup of the Quality Measures Workgroup. This is a public call and there will be time for public comment. Please remember to state your name when speaking as this call is being transcribed and recorded. I'll now take roll. Terry Cullen?

**Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration**

Here.

**Michelle Consolazio – Office of the National Coordinator**

Joe Kimura?

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

Here.

**Michelle Consolazio – Office of the National Coordinator**

David Kendrick? Sam VanNorman?

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

Present.

**Michelle Consolazio – Office of the National Coordinator**

Helen Burstin? Ted von Glahn? Marc Overhage? Eva Powell?

**Eva M. Powell, MSW, CPHQ – Senior Director, Quality, Improvement & Innovation – Evolent Health**

Here.

**Michelle Consolazio – Office of the National Coordinator**

Paul Tang?

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

Here.

**Michelle Consolazio – Office of the National Coordinator**

Are there any ONC staff members on the line?

**Kevin Larsen, MD – Medical Director for Meaningful Use – Office of the National Coordinator**

Kevin Larsen.

**Heidi Bossley, MSN, MBA – Independent Healthcare Quality Consultant**

Heidi Bossley.

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

Kelly Cronin.

**Amy Helwig, MD, MS – Medical Officer, Office of the Chief Medical Officer – Office of the National Coordinator**

Amy Helwig.

**Michelle Consolazio – Office of the National Coordinator**

Thanks, Amy. With that I will turn it over, Heidi will you be starting us off?

**Heidi Bossley, MSN, MBA – Independent Healthcare Quality Consultant**

Kevin would you like to?

**Kevin Larsen, MD – Medical Director for Meaningful Use – Office of the National Coordinator**

Certainly I can do it.

**Heidi Bossley, MSN, MBA – Independent Healthcare Quality Consultant**

Okay.

**Kevin Larsen, MD – Medical Director for Meaningful Use – Office of the National Coordinator**

So, this is Kevin Larsen from ONC and this is the newly formed Workgroup the ACO Quality Measures Workgroup that contains components and members of both the Quality Measures Workgroup as well as the ACO Workgroup and this is the first call with a planned series of calls of four. And we will go through the charge here in a little bit. The Policy Committee has asked this group to look at the clinical quality measures most appropriate for ACOs as well because ACOs are one of the new emerging care models that focus on care coordination and holistic patient centered care ideally, also to look at what quality measures might be appropriate to deem Meaningful Users. So, with that I will turn it over to our Chairs which are Joe Kimura and Terry Cullen.

**Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration**

Hey, this is Terry, I think we should spend just a little bit of time introducing everybody so I'm Terry, I'm the CMIO at the VA, I was previously the CIO at Indian Health Service, I'm actually a family medicine doctor but I practiced emergency room medicine. Joe do you just want to give a brief introduction to you?

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

Oh, I'm Joe Kimura, I'm from Atrius Health and I serve as our Medical Director for Analytics and Reporting Systems here at Atrius. I'm a general internist and mostly primary care internist at this point.

**Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration**

Okay, and then I think I got, who else is on Eva you're on do you want to –

**Eva M. Powell, MSW, CPHQ – Senior Director, Quality, Improvement & Innovation – Evolent Health**

Yes, hi, I'm Eva Powell I am the Senior Director of Quality, Improvement and Innovation at Evolent Health, sorry, getting some feedback here, but previously with the National Partnership for Women and Families. My role at Evolent is entirely focused on patient engagement and so I bring the kind of ACO perspective to that.

**Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration**

Great and Paul?

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

I'm Paul Tang, Palo Alto Medical Foundation and I Co-Chair the HIT Policy Committee.

**Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration**

And then I've got to admit, Sam were you on or Ted, or David? Somebody else is on.

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

Yeah, this is Sam VanNorman I'm from Park Nicollet Health Partners Care System. I'm the Director of Business Intelligence and Clinical Analytics and have had a lot of involvement with our population health work including Pioneer.

**Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration**

Great and is there anybody else on that we didn't get? Okay, so if we could advance the slides to the agenda slide as was mentioned we're hoping to complete this work in a series of four calls by the end of September with a due out in early October to the Health IT Policy Committee with recommendations. As we go through this you are going to see what the charge is and then the goals for this call.

We've mapped out the four calls, the first call will have presentations and time for dialogue and then as we go through the next three calls our hope is to be able to come to conclusion about the framework that you'll see in the goal. So, the next slide will go over what the goals are or the charge of the Workgroup.

And you can see here it's really to develop recommendations for the next generation of eMeasure constructs, I'm not going to go through this because you can read it, with the attempt to ensure that they are feasible to develop and implement in the next two to three years. So, on the Workgroup we have identified people who we believe can help identify the framework and also give us insight into the feasibility of what we're doing. And we are also going to do a use case for ACO, which we developed showing this.

The combination of this Workgroup are members from both the ACO Workgroup and the Clinical Quality Measures Workgroup, the Subgroup is under Clinical Quality because of the belief that this will help inform the Clinical Quality Group as we go forward. We also have the latitude that was identified earlier this week to tag the Clinical Quality Workgroup to do some detailed work if we identify areas where we believe it's important that additional work be done as it relates to clinical quality.

So, as we go through these four Workgroup calls one of the things we should be attentive to is the possibility that we know this is an area of import but we also recognize we're going to be unable to address it in the small time that's been allotted to this Subgroup and we can push that into the Clinical Quality Workgroup agenda for this coming year.

So, the next slide is within the next 3-4 months develop recommendations blah, blah, blah and part of this is the deeming and we're going to let Paul, because you are on I'm going to let you talk specifically about deeming, because I think you have the greatest understanding of it and you recently presented it at the Health IT Policy Committee. So, with that let's go to the next slide which is the goals for this call and what we're going to try to do is really look at some potential frameworks and previous experience with ACOs and the Medicare Shared Savings Program. I think this is ambitious but we want to really talk about what's the preliminary framework for high stakes e-quality measures and remember because the goal of this is really to develop that framework so that at the end of this what we report out to the Health IT Policy Committee is goals for the framework.

So, obviously it would be great if we had specific measures, we're reluctant to have committed to that so what we've committed to is really giving them the framework for what are e-quality measures that should be going forward, identify the gaps in measurements for accountable care and Joe's expertise is in that area. I actually sit on the Clinical Quality Measures Group and Joe is on the ACO group so he will be bringing that forte and insights into this discussion and then identifying measures for deeming. So, the next slide, and Paul would you be okay talking to this slide?

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

Sure, so what we're interested in for the Meaningful Use Program overall, as you know, there are three stages that are under consideration right now the program doesn't end with three stages but we are working on the third stage, and we've always been oriented towards one get these systems into place so that we can measure and improve outcomes.

So, the ideal measure, quality measure, performance measure are those measures that do in fact measure outcomes and for an EHR incentive program those that are HIT sensitive and Helen Burstin is probably the one that coined that term. So, in general those would be quality measures for which you almost depend on HIT in order to perform well on these measures.

So, if you think of the three, put three buckets of measures those that are currently in existence, in use, NQF endorsed of which there are over 800 of them, those that are in the pipeline to be one developed and two endorsed, and those that are yet to be even worked on yet, but may have been identified as concepts, valuable concepts by the Quality Measures Workgroup under HIT Policy Committee probably about 18 months ago and they were labeled as concepts at that time.

So, of these three groups, those in existence, those that are in the pipeline being developed and those where we still have gaps this Tiger Team would look at the latter two, hopefully it will be brought forward, I don't know whether it's on this call, that are in the pipeline for consideration of good measures to be used in the EHR Adoption Incentive Program.

And then the Quality Measures Workgroup would try to identify those that already exist and identify those as HIT sensitive outcome measures. The second part of this charge – so the output of this group, this Tiger Team goes over to a combination of the Quality Measures Workgroup but also the Meaningful Use Workgroup who is due to present its final recommendations to HHS in probably November. The ideal is – the original intent was for this group to present its first report in October related to these quality measures.

The second part of this charge has to do with group reporting and that is it certainly makes sense, certainly in the ACO world that we think about the whole group, the whole healthcare team and how it is able to manage the care of individual patients. So, should there be a group reporting sort of option in the Meaningful Use Program. So, as you know right now both eligible professionals and hospitals report as individuals, individual entities, should we consider a group and that's something that the ACO Workgroup would be well suited in order to render an opinion.

So, one, what would that look like? How would you – what constitutes a group and two, how would you consider that a provider is in that group is a provider in multiple groups and so how do you portion their responsibilities in each of their groups, but in other words it's one thing to talk about group reporting it's another to delve into a little bit of the details to give guidance or as part of recommendations to CMS. Thank you, Terry.

**Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration**

Thanks, Paul. Joe, do you want to add anything before we go into the presentation?

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

No, I think what we've just laid out in terms of the types of measures and I think these two slides definitely help us get to our true goal of trying to make recommendations around what is helpful for identifying value that would improve the health of our populations particularly in the ACO type model and I think the emphasis too, even though we're entitled the Clinical Quality Group, I think we are expanding that to include all elements of quality around value, so it is more inclusive than just clinical, sort of pure clinical quality type measures.

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

And Terry, I forgot to mention about the deeming which you asked me to talk about.

**Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration**

Yes.

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

The part of – so far the way you qualify for the Meaningful Use Program both for the incentives and avoid penalties is to satisfy the functional requirements of your EHR and its use and the clinical quality measures component. What's being recommended for Stage 3 is an optional deeming pathway and by that we mean if you perform at a certain level and right now the proposed recommendation is if you're in this top core tile in performance related to other groups and hospitals in the country or you're improving to close the gap between you and the top four tiles then you could be deemed in satisfaction of a subset of the Meaningful Use functional objectives.

So, because that is so important, and what we're trying to do is reduce the reporting burden and also to increase the opportunity for innovation, those measures that are used to deem people out of some of the functional requirements is really important and that reinforces the need for these HIT sensitive outcomes measures. So, thanks, Terry.

**Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration**

Great, so, what's important to note is our charge expanded this week thanks to Paul. Paul, thank you so much. So, you might not be familiar with the term deeming if you go back and you are looking at what your initial invitation included, it did not include that, we recognize that, we've expanded to accept this charge because it's exciting, could be revolutionary in terms of moving forward to Meaningful Use and it obviously falls within the purview of this small group. But, I don't want you to be confused if you are sitting there going "I didn't know about deeming, because it wasn't in there."

So, the one other thing I would like to just reiterate is what our real goals are. So, we're supposed to come up with a summary framework document that describes the quality measure framework criteria to use for the evaluation of measurement gaps and concepts, perhaps if we can an early list of existing and emerging measures that can be HIT enabled, also to look at this deeming criteria and ensure that we can address this new charge to the Workgroup. So, with that what we've done for today is schedule Janet, who I hope is on the line, to do a presentation. Janet are you there?

**Janet M. Corrigan, PhD, MBA – Distinguished Fellow - The Dartmouth Institute for Health Policy and Clinical Practice**

Yes I am, good morning.

**Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration**

Great, welcome, thank you so much for joining us.

**Janet M. Corrigan, PhD, MBA – Distinguished Fellow - The Dartmouth Institute for Health Policy and Clinical Practice**

Sure, it's my pleasure. Do you want me to go ahead and begin?

**Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration**

Yes.

**Janet M. Corrigan, PhD, MBA – Distinguished Fellow - The Dartmouth Institute for Health Policy and Clinical Practice**

Okay, great. Good morning everybody and if you could just flash to the first slide that would be great, the one and only slide. It's a real pleasure to be here today and have a chance to talk to you a little bit about some work that was actually done a couple of years ago and what I thought I would do is to provide you with background how the framework was developed by whom and why it was developed and then we can spend just a few minutes talking about the kind of measures that might be used to populate the framework.

And I think you all probably received copies of the Health Affairs Blog that describes this framework. By way of background when I was with the National Quality Forum a couple of years ago Elliott Fisher and I established a little group call the Gretzky Group, in fact it was actually almost 3 years ago I think, and the purpose of the Gretzky Group was to begin to look at what the measures of the future would likely be and needless to say named after Wayne Gretzky the hockey player who always said "you want to go where the puck is going and where it will be in the future."

And we were in the midst of really putting out a lot of measures especially at NQF endorsing many measures that were very appropriate for current programs, payment and publically reporting programs that were typically fee for service or DRG-based programs, but what we weren't focusing on was sort of the measures for groups like Accountable Care Organizations and they were just beginning to get off the ground.

So Gretzky started to focus on measures of value and we defined value to be outcomes plus patient experience over expenditures. And about almost two years ago we joined forces with Susan DeVore and Richard Bankowitz at Premier and with Christine Bechtel at the National Partnership and decided that it would be good to do sort of a deep dive into what a framework would look like for Accountable Care Organizations.

So, we convened a group of about 75 people for 2.5 days, it was a very in depth workshop and I would say that maybe 2/3 of the people there were from Accountable Care Organizations or emerging ACOs and they were typically CEOs, chief medical officers, chief nursing officers, Quality folks, chief financial officers and then the remaining 1/3 were sort of national representatives from employers, consumers, measurement experts and we spent the first day on the framework trying to reach agreement on a set of primary domains as well as subdomains for the framework.

And then on the second day the group divided up into working groups and shifted through many different measures to get illustrative examples of measures that might be used to populate the various domains and the subdomains. And in developing the framework there were a few sort of overarching principles or considerations I think that influenced every step of the way.

And the first was that we thought it was important to start to strike a balance between measures for accountability and measures for quality improvement and as we move into Accountable Care Organizations we have an opportunity to take measures up to the system level, and to begin to produce, make available probably a more parsimonious set of high level overall system indicators for ACOs that would really be most useful to consumers and to purchasers and others in assessing value and value really being outcomes plus experience over expenditures.

But then it needed to be the ability to roll down to the subdomain level and produce many, many more granular measures that would really be used for quality improvement and hopefully many of these measures producing real-time information at the point of care to inform decisions by clinicians and patients, and could also be used by ACOs for clinician or setting evaluation within their systems.

I think a second sort of guiding principle in developing this framework was that the measures that have to do with outcomes and experience really needed to be through the patient's voice. So, you will see here that there are a few political outcome measures whether it's hemoglobin A1c or things of that nature, but for the most part these measures really are patient reported measures of functional health and health risk, and their overall experience of care. So, that was a very significant movement to looking at outcomes and experience through the patient's eyes.

Another guiding principle here was that wherever possible when selecting measures we really wanted measures that were publically available and had been vetted. So, a lot of emphasis was placed on looking at the measures that are part of the NIH PROMIS item bank and measures that are NQF endorsed because those would be ones that would be already reviewed and we knew that they were good solid measures.

So, now let's turn for a minute to the framework and talk a little bit about what you see here. On the outcomes measures there are two primary domains under outcomes, functional health and health lists and then you see that that rolls down into subdomain areas that include more granular measures in both the functional health and the health risk area, but also includes measures that are disease or condition specific.

When it comes to the overall measures of functional health it seemed like a good instrument might be the PROMIS Global-10 but there are certainly other instruments and overall indicators of functional health that could be considered, the EuroQol measure has health status measure of mobility, self-care, pain, discomfort, anxiety and activities of daily living. We also took a look at the VR-12 that Veterans Health Affairs uses, certainly another possibility for the functional health index.

And then on the health risk side I think an excellent measurement instrument might be the avoidable risk of death by the Institute for Health Metrics and Evaluation, but there are certainly other competing measures there as well. When you roll down into the subdomain areas you see more granular measures coming out of the PROMIS database breaking out physical health, mental health, fatigue and pain.

And down in the disease and condition status area we looked in particular at measures for leading chronic conditions, some of those being clinical quality and outcome measures, but also thought that this might be an area where it would make a whole lot of sense to take a close look at things like knees and hips, and tapping into some of the measures there wanting to look longitudinally for these patients to actually get a handle on outcomes 3 months, 6 months down the road after things like hip and knee replacements.

And then turning a little bit to the patient experience of care, in this category the overall primary domain would have an overall patient experience rating and there we thought that the CAHPS indicator that was certainly probably the leading one and perhaps the best one.

But then in the subdomain categories you see they're breaking that out into more granular areas of activation and there one could use the HowsYourHealth measure or Judy Hibbard's Patient Activation measure would be a likely candidate to get a handle on how engaged the patient is. And then also access to care measures, which could be the patient centered medical home CAHPS questions from the PCMH CAPHS instrument and the same with communication with providers and support and empowerments and coordination and transitions. So, basically you just see the more granular detailed measures of particular parameters.

And then turning to the expenditure side here what seemed most appropriate for reporting out to the public would be the total cost per capita and that would need to be broken out not only by expenditures but also by the utilization, so wanting to adjust for differences in prices across regions to be able to break out utilization as well.

And then moving down into the subdomain categories you could see breaking that out by the over 65 and the under 65. And this was an area where there are right now two sort of competing measurement systems, there is a health partners measures for the under 65 and then there are those by the Dartmouth Atlas for the 65 and older and I think there are discussions underway to harmonize and try to get to one set of measures for all age groups.

Another area though in the subdomains that the group that we pulled together thought was particularly important was to begin to identify a whole set of overuse measures that target the areas where there is significant evidence already that there is a sizeable amount of overuse. And that's basically the framework.

It's important to say that the subdomains and the measures that are here, especially in the subdomain categories are really intended to be illustrative. There are other ways to populate this framework needless to say and there is also I think some flexibility here when it comes and some fluidity almost when it comes to measures that are in some of the subdomain categories, one might want to pull those up and use them for overall reporting out to the public and then perhaps if performance is particularly good move them into the subdomain category.

There was quite a bit of discussion around the experience of care and what belonged in the overall measures versus the subdomain categories and I think it is safe to say that quite a few that participated in the workshop felt that it might really be quite important for patients to have access to measures at the physician level that especially had to do with quality of the patient's physician or patient's clinician relationship.

So, not everyone was in agreement that reporting out the overall patient experience and then moving the others to the subdomain internal ACO category was the most appropriate split, so there was a very healthy debate around what belonged in the overall versus the subdomain internal quality improvement categories there.

Another issue that was discussed quite extensively was whether or not the framework as it is currently fashioned pays adequate attention to safety measures and the argument can be made that if you are in an ACO that is not providing safe care that that would eventually be reflected in the overall measures and outcome measures as well as experience of care, but I think an argument can also be made that having more focused and specific measures around patient safety might be a good addition to the framework and one probably could develop an overall indicator of the occurrence of avoidable adverse events and then perhaps more granular measures of those within the subdomain categories.

I think the last thing that was recognized here, and then I'll stop and open this up for Q&A, was that in order to get to this kind of a framework it really is going to require a good deal of work and thought about how to capture patient reported measures and there was a strong sense that ACOs really do need to develop a common infrastructure that will capture this data across settings, it very much needs to be done longitudinally and that probably in the near term there is going to need to be a diverse array of methods for capturing the information and getting it into the EHRs, it will probably require things like both e-mail, interactive voice response, text, portals, comment cards just given the diversity of patients out there and their ability to use electronic devices.

There was some discussion about perhaps annual collection for payment and public reporting but that we really want to get to collecting this information on a routine basis and it's going to be really critical with all this data, especially the patient reported outcomes and experience, that we think through how best to do this as a part of the care process so the information is available in real-time for use by the clinician and the patient in making decisions and feedback.

And that it will be critical over the coming few years for AHRQ and others, and ONC, and others to not only work at further developing appropriate measures in this areas but evaluating how useful they are for care delivery, self-management by patients and then of course their accountability purposes in evaluating how well an ACO is doing. So, I think I'll stop there and take any questions, answer any questions that you might have.

**Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration**

Janet this is Terry how much time do you have?

**Janet M. Corrigan, PhD, MBA – Distinguished Fellow - The Dartmouth Institute for Health Policy and Clinical Practice**

Yeah, I'm good for another 15 minutes or so.

**Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration**

Okay, great, thank you. Does anybody have any comments or questions back to Janet? Janet in this deck there is another slide, is that your slide or somebody –

**Janet M. Corrigan, PhD, MBA – Distinguished Fellow - The Dartmouth Institute for Health Policy and Clinical Practice**

I don't think so.

**Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration**

Okay.

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

Janet, hi, this is Joe, I have a quick question, this is such a great framework, I'm wondering from two perspectives, particularly within our Workgroup one this aspect, you did talk about differentiating quality versus accountability and when we are thinking about high stakes measurement across those three domains was there conversation in the Workgroup about how those three domains get balanced out and, you know, how would one use performance measured organization A versus organization B, C, D, etcetera in terms of what was better based on these types of measures? In particular because I think with the outcomes you've got some interesting new areas in terms of what the population maybe presenting and I'm wondering if you had discussed that in any way?

**Janet M. Corrigan, PhD, MBA – Distinguished Fellow - The Dartmouth Institute for Health Policy and Clinical Practice**

Well there were certainly discussions around the importance of each of the three major domains and a very, very strong sentiment that we really need to move towards presenting a balanced picture of performance which means including all three domains of outcomes, experience and expenditures. There certainly wasn't any sort of rating of one as being more important than the other.

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

Okay.

**Janet M. Corrigan, PhD, MBA – Distinguished Fellow - The Dartmouth Institute for Health Policy and Clinical Practice**

And there was also a recognition that those interrelationships, so for example under expenditures there was actually quite a lively discussion around the importance of capturing not only direct healthcare expenditures but indirect expenditures and if you look over under the outcomes under functional health and the overall measures you'll see the CDC Healthy Days and that actually could be over under the expenditure column because it does provide, there are some very good questions in there about, you know, how many days in the last week or the last two weeks or I can't remember exactly the timeframe, you know, were you unable to function and carry out your activities. So, it begins to give an indicator of productivity loss.

So, there are interrelationships between the three categories and in some cases one provides useful information for the other but a very strong sentiment that we need to be looking and providing the more complete picture with all three domains.

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

Got it and then I guess my follow-up in terms of Paul's point around HIT sensitivity, it seems like a lot of these, what I'm inferring is this aspect around using the EMR to capture the data and therefore those types of measures would be HIT sensitive, but how would you sort of respond to the types of measures you would see particularly in the overall, the blue band around sensitivity? How would you integrate those concepts?

**Janet M. Corrigan, PhD, MBA – Distinguished Fellow - The Dartmouth Institute for Health Policy and Clinical Practice**

Well, certainly HIT sensitivity was not something that we focused on, you know, in this effort, but it seems to me that certainly the health risk would be HIT sensitive not only in the ability to capture but to begin to issue prompts and reminders and decision support to patients when it comes to health risk behaviors would be really critical.

And I think probably you can also make the case in terms of functional health too that capturing that information on a routine basis and beginning to feed it into the care process and looking much more carefully at whether or not a lot of what we are doing frankly in healthcare is resulting in better outcomes. So, the ability to do both of these really does require HIT to do it well and to make sense out of the data and to use it and apply it. So, I would say those two probably are HIT sensitive.

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

Thank you.

**Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration**

Janet this is Terry I have one question related to equation, so the outcomes plus experience over expenditures, was the feeling that you needed to come up with something that would allow you to calculate something from these three domains and was it intentional the way they ended up on top, on bottom whatever?

**Janet M. Corrigan, PhD, MBA – Distinguished Fellow - The Dartmouth Institute for Health Policy and Clinical Practice**

Yes there was sort of an aspirational concept here that wouldn't it be nice if at some point one could actually get to an overall indicator of value, but it was also recognized that we are not there and we probably are not going to be for a while so what we should really set our heights on here I think is having a parsimonious set of overall indicators for the three major domains, yes.

But there was sort of an aspirational concept there that, you know, five years from now or seven years from now it would be really nice to be able to actually relate all three concepts and get an overall indicator.

**Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration**

All right, thanks. Any other questions about this framework?

**Eva M. Powell, MSW, CPHQ – Senior Director, Quality, Improvement & Innovation – Evolent Health**

Oh, this is Eva, thanks Janet this is really great work and I'm sorry because I had to drop off a little bit so you may have already mentioned this, but am I interpreting it correctly that the overall measures in the blue band are the ones that are kind of being thought of in the direction of measures for accountability and then those in subdomains are being thought of as measures for improvement or was there discussion about there can be some mixing of the two?

**Janet M. Corrigan, PhD, MBA – Distinguished Fellow - The Dartmouth Institute for Health Policy and Clinical Practice**

You're correct that overall that's the basic idea here is that the most important ones for accountability and reporting are in the blue overall measures and that the others are probably more granular very, very appropriate need to be a part of the care process for ongoing improvement and to support decisions of clinicians and patients but also that we need to be reinforcing the responsibility as the ACO to have strong clinician evaluation and hospital setting and other setting evaluation programs and that these are the kinds of measures that they should be using a very robust set internal to the system.

Having said that, there is some fluidity here and there was quite a bit of debate around what belonged in the overall measure versus the subdomain measures and it was recognized that at times one might want to pull particular measures up into the overall measures and report them for a while and perhaps rotate on a rotating basis, pull up a few from the subdomain areas into the overall measures.

But there was a sense here that when it comes to accountability and public reporting, especially for the use by consumers that overwhelming people with a lot of measures isn't where we want to go, we do want to get a balance here and keep that set the most relevant and critical indicators for their decision-making process.

Now the one area you may not have been on when I mentioned Eva that there was really very healthy debate around whether or not a more robust set of individual clinician measures are needed that relate to the quality of the clinician/patient relationship, especially their communication between, you know, with providers those things that are very specific to the individual clinician/patient relationship. Some felt that that was important because patients often choose a primary care provider or another clinician for a specific purpose.

**Eva M. Powell, MSW, CPHQ – Senior Director, Quality, Improvement & Innovation – Evolent Health**

Great, yeah, that's helpful and was there any – I know that the need for kind of a level of robustness for purposes of accountability makes patient reported measures a little trickier, but was there discussion about potential for – with experience of a subdomain measure really across the board, but particularly relative to patient reported measures since there is I think a methodological component to that is worthy of some special attention. Was there discussion that one way of approaching this, without overwhelming people with a ton of measures, is to, after testing in the improvement kind of category, if there is the rigor there that warrants moving into the accountability area that that might be possible?

**Janet M. Corrigan, PhD, MBA – Distinguished Fellow - The Dartmouth Institute for Health Policy and Clinical Practice**

Yes, absolutely and the other issue that came up the group really called for AHRQ and CMS, and others to start putting, they already are, but putting adequate resources into both the approaches and methods, and infrastructure for collecting patient reported measures through a variety of different mechanisms which brings, you know, has a whole set of methodological challenges in and of itself, to then interpret the information, but to really begin to delve more deeply into this area not only providing resources as you said for testing measures internal to ACOs but perhaps using and building many of these measures and incentives into demonstration projects and others that CMMI is funding to encourage a lot of cutting edge work in this area and to get the measures ready for primetime so that they could move up into that blue area for the overall measures and public reporting, yes.

**Eva M. Powell, MSW, CPHQ – Senior Director, Quality, Improvement & Innovation – Evolent Health**

Great, thanks that's very helpful.

**Janet M. Corrigan, PhD, MBA – Distinguished Fellow - The Dartmouth Institute for Health Policy and Clinical Practice**

This was seen very much as a three to five year effort and that was one of the reasons we started down this road a few years ago and then two years ago held this convening activity, this is actually a little bit old, it's a couple of years old now, was to try to get some of that jump started in hopes that we would be further along and being able to get them into the blue band as soon as possible.

**Eva M. Powell, MSW, CPHQ – Senior Director, Quality, Improvement & Innovation – Evolent Health**

Great, thanks, great work.

**Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration**

Janet this is Terry again, I'm stuck on the equation, so I have another question. Did you guys run any numbers through that to see if, in my head I'm trying to do it, there are unintended consequences like if you lowered your expenditures so much you would be able to tolerate less quality and less satisfaction with the patient experience and still look okay?

**Janet M. Corrigan, PhD, MBA – Distinguished Fellow - The Dartmouth Institute for Health Policy and Clinical Practice**

No, no didn't do anything of that nature. Yeah, yeah and I think those are good points if one actually were going to try to construct an overall indicator. I think we are quite a way from doing anything like that because we really don't know – we've got to get the individual metrics right in each of the major domains and then begin to understand the relationships between them.

**Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration**

Okay.

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

This is Paul, Terry, that was really an interesting and insightful comment, this equation is used a lot or something similar to it and if you map what you suggest it actually does map to reality in the sense of there is certainly experiences where people do that and we know that consumers actually weight it that way too, because they primarily make a choice on cost, so that's a very interesting unintended consequence that we need to figure out somehow how to put in this equation, some kind of balance measure that –

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

Yeah.

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

So, this equation does exactly what you just said.

**Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration**

Yeah. So, Janet, I'm intrigued by what you said because I think you are right though in terms of our – when I look at our report out obviously this is a temporally defined process but it maybe that we have to get the metrics right so the components right and then there may be a way to protect the measure within the equation to ensure that we don't do unintended harm.

**Janet M. Corrigan, PhD, MBA – Distinguished Fellow - The Dartmouth Institute for Health Policy and Clinical Practice**

Well, I think you could probably say for a given level of expenditures which ACOs are achieving the greatest outcomes and experience. If you wanted to hold expenditures constant or in difference bands of expenditures and then examine outcomes and experience relative to a given level of expenditure might be one way to deal with some of it.

**Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration**

Yeah, that's an interesting concept.

**Janet M. Corrigan, PhD, MBA – Distinguished Fellow - The Dartmouth Institute for Health Policy and Clinical Practice**

Yes.

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

Janet, hi, this is Joe, one question around sort of the expenditure bucket too, so the other two areas are very patient centric and population sort of measurement focused, were there any thoughts around is there any way of looking at the resources available to the population in respect to expenditures of the delivery system?

**Janet M. Corrigan, PhD, MBA – Distinguished Fellow - The Dartmouth Institute for Health Policy and Clinical Practice**

What do you mean by resources available to the population, beyond healthcare expenditures?

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

Yeah, well, so I'm trying to balance out the first two into the conversation we had around people looking at the top equation and that equation looks different if you have a lot of resources and what you can spend as opposed to what you are able to get in terms of outcomes and experience.

We have an absolute measure around sort of the actual dollars being spent but it is not – I'm trying to wonder if there was any ability to link that back to populations that have more resources versus populations who don't have a lot of resources and how that maps out with outcomes and experiences. Does that make sense?

**Janet M. Corrigan, PhD, MBA – Distinguished Fellow - The Dartmouth Institute for Health Policy and Clinical Practice**

Well, I think one of the things we know from the Dartmouth Atlas is that populations that have a lot of resources don't necessarily get better outcomes and indeed we may see that when it comes to healthcare resources there is clearly a point of diminishing returns where the excess waste and overuse from having so many resources spent leads to poor outcomes. So, I think from the Dartmouth Atlas work that becomes clear as you look across geographic areas and compare total cost per capita and then taking a look at some of the outcomes and the quality indicators.

**Eva M. Powell, MSW, CPHQ – Senior Director, Quality, Improvement & Innovation – Evolent Health**

Janet this is Eva, as a follow on where I think you might have been going when you asked for clarification is that more public policy connection to the things, particularly things that impact social determinates, you know, I don't know, is there a way to – even though we are not about public policy as a whole, much of this I think does reflect maybe an unbalance or a lack of balance in how public expenditures are allocated among what the real needs of the population are.

And so for example if we find that a population is having significant health issues or having bad outcomes and improving those outcomes doesn't necessarily require an increase in health expenditures or, you know, maybe the actual health system changes, which can be made will only go so far to addressing those things we may find that providing better transportation or having, you know, healthier foods or investing in infrastructure that supports a healthier lifestyle is really the thing that is going to lead to better population health down the road.

And while that is not necessarily the direct concern of ACOs ultimately when we get more fully into this new model of delivery and payment it will be their concern, and they certainly will be actors with the power to make a different there and, you know, we've got a lot of groundwork to cover before that becomes front and center but it seems like there could be some baby steps made toward that in our discussions now so that when the time comes we'll have something to build on. And I don't know if that is something you guys discussed or if it's completely out of scope or what.

**Janet M. Corrigan, PhD, MBA – Distinguished Fellow - The Dartmouth Institute for Health Policy and Clinical Practice**

That is a great comment and I couldn't agree with you more and I would love to see your group make some inroads in that direction. As I said this was a couple of years old, it was not discussed, it isn't my recollection that it was discussed at the conference but a good deal has happened in the last two years.

We've taken a few small steps toward looking at the total cost of health. This is the total per capita cost for healthcare, which is, granted in our country the total cost of healthcare healthcare consumes the lion's share of resources but it doesn't have to be that way and it shouldn't be that way if we want to get the best health of the population.

So, I think the first step to begin to take to look a bit more broadly is healthcare plus social supports and there you really can begin to look at the other supports that go to individuals, especially those with chronic conditions and to begin to capture some of those social supports whether it is transportation or it's Meals-on-Wheels or it's helping support making sure that you've got everything from home healthcare aids and others that are assisting people, taking one step in that direction.

Then even a bigger leap is to actually begin to move out in the community as you say, Eva, towards a more broader population level social determinants of health, everything from parks and recreation to healthy food, to environment, fresh air and all the rest of it. So, you get into a much more complicated measurement system for the cost of health.

David Kendrick has tried to do a little bit of work in this area, it's complicated because the data sources – we'd love to see this area of work begin to blossom so that one can actually look at the total cost of health across communities and some day as you said, maybe even for ACOs as well. So, I think that's a great point. There is some work as I said that's happened in the last couple of years and that is where some of this needs to go.

And I think you are absolutely right that if we could actually get to the total cost of health and relate that to the health of the population to their overall outcomes in terms of functional status as well as health risk we would find that if we could take some of those dollars, 25-30% of those dollars in healthcare and we could put them into the social determinates the health of that population in a community or an ACO that would be the best way to actually increase it as opposed to just decreasing dollars on the healthcare side.

We want to capture some of those and reinvest them out into the areas where we under spent that have a much greater impact on the health of the population. Now the challenge there is that investing in those social determinates typically doesn't have an impact within a year or two it may be more like 10-15, but that's the way over the long run to really improve the health of the population as well as to decrease healthcare costs, but it requires a much longer timeframe to be able to actually measure and assess.

**Eva M. Powell, MSW, CPHQ – Senior Director, Quality, Improvement & Innovation – Evolent Health**  
Okay, thanks that's helpful.

**Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration**  
Any other comments?

**Ted von Glahn, MS – Senior Director – Pacific Business Group on Health**

Janet this is Ted von Glahn at PBGH, I'm looking at the – wondering about the discussion you all had about why include the disease condition specific measures and I'm thinking about the relationship between them and the accountability measures in the blue there. Do we have an evidence-base of a relationship between those or is that work to be done?

**Janet M. Corrigan, PhD, MBA – Distinguished Fellow - The Dartmouth Institute for Health Policy and Clinical Practice**

Well, I think down in the disease and condition specific ones many of those measures are really very sensitive to interventions and you will see changes within a – you can actually see changes and results within a short time period. The relationship to the overall I would certainly hope so but I guess it would depend an awful lot on the prevalence of those conditions and procedures within your overall population. I'm not aware of anybody who has really analyzed that question. I think it's a very good one.

**Ted von Glahn, MS – Senior Director – Pacific Business Group on Health**  
Thank you.

**Janet M. Corrigan, PhD, MBA – Distinguished Fellow - The Dartmouth Institute for Health Policy and Clinical Practice**

And I should mention the individual who provided a lot of guidance to our overall group on the selection of particular items and measurement tools, and instruments, was Gene Nelson out at the Dartmouth Institute. Gene has really a tremendous amount of expertise in this area with very intimate and detailed knowledge on these various instruments so I encourage you to tap into his expertise if you choose to delve very deeply into these areas.

**Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration**

Great, any other questions for Janet? Janet, thank you so much for sharing your wisdom and this knowledge it's I think going to be incredibly helpful as we move forward. We may come back and ask you a few more questions in the next two months, hopefully that will be okay.

**Janet M. Corrigan, PhD, MBA – Distinguished Fellow - The Dartmouth Institute for Health Policy and Clinical Practice**

Sure, I'd be glad to help in any way I can and I'm very excited about the work you're doing it's critically important, it's wonderful to see this whole area moving forward. So, best of luck.

**Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration**

Great, thank you so much.

**Janet M. Corrigan, PhD, MBA – Distinguished Fellow - The Dartmouth Institute for Health Policy and Clinical Practice**

Sure.

**Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration**

Okay, with that should we go to the next slide, Kevin was this an ONC slide put together that you guys wanted to do?

**Kevin Larsen, MD – Medical Director for Meaningful Use – Office of the National Coordinator**

Yes, certainly. So, this is Kevin Larsen from ONC we've really had the luxury of having a terrific fellow from Yale who has been helping us with this committee, he is on vacation now, but he has done a lot of the background work, Arjun Venkatesh, who is a Robert Wood Johnson Fellow right now doing some time with CMS.

So, what Arjun did was took a framework that Janet built, that Janet and Team published in the Health Affairs Blog and did some work mapping that to the National Quality Strategy because we know that that is a framework that we are following at HHS and a commitment by the agency for framework for how we do our work.

So, he took the time to create this crosswalk between the framework that Janet presented and the National Quality Strategy and did some work to try to highlight the components within the National Quality Strategy that seemed to be most aligned with this patient centered measures of value. So, we don't need to spend a lot of time on this necessarily but we certainly can if this is a helpful way to think through a framework.

**Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration**

Does anybody have any questions for Kevin?

**Eva M. Powell, MSW, CPHQ – Senior Director, Quality, Improvement & Innovation – Evolent Health**

Kevin, this is Eva, so the intent in doing this other than mapping there is the intent that the things in red that are kind of additional over what has already been discussed as part of the Meaningful Use work that these be added to that discussion or is it just – is this just simply a mapping exercise to show similarities and differences?

**Kevin Larsen, MD – Medical Director for Meaningful Use – Office of the National Coordinator**

It's a mapping exercise to show similarities and differences, and it helps us to – we know that we are committed to the National Quality Strategy so whatever framework that this committee focuses in on we know that we have to be able to communicate and think through what that relationship is to the National Quality Strategy framework. So, this was to lie that out here at the first meeting.

**Eva M. Powell, MSW, CPHQ – Senior Director, Quality, Improvement & Innovation – Evolent Health**  
Gotcha, okay, thanks.

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

This is Kelly Cronin too, I think we are also just looking at this as a logical starting point since, you know, there is a good amount of work that's gone into both the National Quality Strategy framework where it is already validated and being used all the time and then to add in these other subdomains just made sense to call them out since they are obviously relevant to accountable care and they are categorized in such a way that we can look at this comprehensively across all the NQS domains.

**Eva M. Powell, MSW, CPHQ – Senior Director, Quality, Improvement & Innovation – Evolent Health**  
Yeah, okay, yeah that's helpful.

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

We can – you know, as a group you all can consider how to reorganize or call out additional subdomains, but if it is sort of – everybody agrees that this is a logical starting point we can, you know, use this for the basis of discussion on, you know, is this a logical way to organize a framework and if so is it capturing all the right concepts or subdomains, or are there other things that are missing.

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

So, this is Paul –

**Kevin Larsen, MD – Medical Director for Meaningful Use – Office of the National Coordinator**

This is Kevin; I think also looking at that rust area this was a way to highlight which parts of the framework that Janet just went through aren't really covered very robustly in our current National Quality Strategy.

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

So, just to get, this is Paul, just to get the legend correct, the bluish is National Quality Strategy only, the rust, the green is National Quality Strategy and the ACO framework, and the rust is ACO framework only, is that sort of what it means?

**Kevin Larsen, MD – Medical Director for Meaningful Use – Office of the National Coordinator**

That's correct.

**Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration**

And Kevin just to clarify too, so because the National Quality Strategy framework has been adopted, i.e., endorsed that should – I just want to clarify, so that should be the foundational work that we want to ensure we at least – that is the minimum to be addressed is that what you were saying?

**Kevin Larsen, MD – Medical Director for Meaningful Use – Office of the National Coordinator**

What I was saying is we know that whatever framework this committee decides on we have to be able to understand that in the context of the National Quality Strategy.

**Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration**

Okay.

**Kevin Larsen, MD – Medical Director for Meaningful Use – Office of the National Coordinator**

Because we're committed as an agency to the National Quality Strategy. It's not to say that we don't welcome other frameworks but it needs to relate in a way that we can describe and demonstrate.

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

So, this is Paul again, so obviously the devil is in the details, I mean, some of these words I certainly can see in like the things that are in rust overuse measures or patient activation seem to be in both – so I'm having a little trouble myself looking at the words and saying, well, gosh that's not at all covered in NQS or that's not – do you see what I'm saying?

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

**Kevin Larsen, MD – Medical Director for Meaningful Use – Office of the National Coordinator**  
I think Arjun's point here Paul was that these are – the rust was places we don't really have a measurement yet, so although the patient activation is covered under the National Quality Strategy we don't have patient activation measures in our current National Quality Strategy measurement framework.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**  
But that's a different point, I agree with that point, but I think actually that might be a clearer way to do that, to state that.

**Heidi Bossley, MSN, MBA – Independent Healthcare Quality Consultant**  
Right, this is Heidi, I was the one who actually added in the comparison yesterday and it was quite orderly and I did it knowing that you will make this better, a comparison of whether I saw something at a very high level mapped or not and I think a good example is the care transitions under care coordination. Coordination I pulled out as separate just because it was literally listed in the ACO framework slightly different but I just wanted to make sure you all saw that terminology may have been slightly different as well and interpretation could be viewed as different possibly. So, it was a very literal comparison.

**Joe Kimura, MD, MPH – Medical Director, Analytics and Reporting Systems – Atrius Health**  
Got it.

**Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration**  
So, Heidi that's helpful to know that we can massage this and if we want to move things.

**Heidi Bossley, MSN, MBA – Independent Healthcare Quality Consultant**  
I was hoping you would, yes.

**Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration**  
Yeah, okay.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**  
You know, there might be a different color for "Meaningful Use" I'm sure Michelle is thinking the same thing and see how we stack up. I think it would be favorable but I think – and it comes to the charge of this group, where is the measure gap and how can we improve upon that?

**Joe Kimura, MD, MPH – Medical Director, Analytics and Reporting Systems – Atrius Health**  
So would it help to translate this in a slightly bigger table format with the detailed measures underneath it rather than the domain names where the wording could overlap or we're not exactly sure what's underneath each bucket?

**M**  
I think that might be helpful, you know, just because there is so much that has been mentioned devil in the details.

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

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**  
So, the domain – we probably should leave the domains because that's the NQS.

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

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

And then maybe we need to label some of these or give examples or something – there needs to be some color that says “measure gap” because that’s sort of where we are targeting.

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

Right, so I can see the domains, absolutely – sorry, I misspoke there; the domains on top for sure are the subdomains but then if we can get the detail underneath that of the measures that are in each –

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

Yeah.

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

Then the reconciliation exercise of those two measures are pretty darn close to one another that’s not really a gap area as opposed to we’re not talking at all about this particular domain that would become much more apparent I believe.

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

Yeah, yeah.

**Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration**

Yeah, I think that that would be really helpful if we can work that, because when we were going to go over these frameworks if you had the deck, you know, one of the questions was what’s identified and named and is there something missing I think is really one of the major things we wanted to look at.

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

Right, right.

**Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration**

So, if we have some endorsement that at least this is the framework to start from and then we can tease it out over the next 3 sessions but by the next session if we can come back and say, even within this framework, we’ve already identified the what’s missing I think that that will help guide the discussion.

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

Well, the other two areas going from Janet’s slides to this one was there – is there an analog to the band overall measures versus QI measure type differentiation in the quality framework or is that unique to the ACO framework?

**Kevin Larsen, MD – Medical Director for Meaningful Use – Office of the National Coordinator**

This is Kevin; we don’t articulate that in our current measure inventory for CMS or for HHS but if that would be helpful we could take a stab at articulating what are outcome measures versus what are process measures.

**Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration**

I think it would be helpful, some of it is related to the deeming charge.

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

Right, exactly.

**Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration**

So, I think if we can get some sense of what’s in a sense an elevated measure to overall process versus outcome Kevin it would be helpful. I’m also struck –

**Kevin Larsen, MD – Medical Director for Meaningful Use – Office of the National Coordinator**

Yes.

**Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration**

By that discussion Eva you had and Janet had about, you know, we're saying these are patient centered measures of care the issue is because we are looking at ACOs are they really patient centered or are they population centered measures of care and then if we go into that next continuum are there community centered measures of care and I realize that is not in our charge, but I'm intrigued by the opportunity that we can seize to push on that a little in the national dialogue as we go from the cost to healthcare to the cost of health do we just see a continuum on the top two in terms of how we label it?

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

I think that's a great direction, I think that's where when we are thinking about that equation in the top two it seems like we're measuring outcomes of health, experience around global health but then expenditure specifically around healthcare. So, putting those together feels like we're missing some chunks.

**Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration**

Yeah.

**Eva M. Powell, MSW, CPHQ – Senior Director, Quality, Improvement & Innovation – Evolent Health**

Yeah and this is Eva, part of where I come from when I bring up the community and more public policy approach is just knowing what an impact those social determinates have and the fact that the healthcare system itself, at least as it is today, really isn't well equipped to the orthos in any fashion.

So I think we'll see pretty quickly or actually I think most ACOs are already trying to figure out how can we start scratching the surface of that but my guess is that we'll pretty quickly run into a situation where ACOs are having to make a decision about, oh, my gosh, we really need x-service in the community and it does not exist because it's been cut from the budget, you know, whatever reasons that I think are plentiful in these economic times, and so now we're faced with either not having it or providing it ourselves, which then puts the healthcare system in the place of becoming all things to all people which obviously is not feasible.

And so, that's just at least the way I see this potentially playing out and why I do think pretty rapidly these kinds of community-based issues are going to be front burner issues for ACOs, I think we're still in that time of figuring out what are those very critical minimal lists of social services that are essential to population health and then once we figure out what's not there then it is going to be difficult to know how to manage that if we've not laid the groundwork for providing data of the nature that can be built into an ROI from a public policy stand-point or from, you know, even a business stand-point. If this is a community-based thing they can be – you know these services can be provided in any number of ways.

But, you know, I would love to see us move in that direction so that there is that groundwork because I do think that we will find pretty rapidly that it becomes a front burner issue for ACOs, because they are going to need resources that are not available period and then they are going to have to create those resources themselves, which is a really expensive proposition. So, yeah, I don't know that's just the...Eva, but that's based in my social work experience.

**Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration**

No, Eva, it's incredibly insightful and helpful and I think it goes back also to eMeasure readiness and what we – so I personally think we can do some leaps here and say, hey, you know, in the future or near term these are the areas where we know they impact care from social determinates of health and we're going to have to figure out how to get the data accessible and then obviously how to integrate it into measurement as we move ahead.

In the interest of time if we could go to the next slide I think we didn't discuss all of this but we've done a pretty good start and I want to make sure we have time for the next presentation. So, if people are okay, Joe are you okay if we just move on for now?

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

Absolutely.

**Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration**

Okay, so is John on?

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

Yes, I'm here.

**Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration**

Okay, do you have slides John because we don't have them in the – or maybe they are in the deck.

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

No, actually I don't have slides but I actually did forward – I think they hopefully made it into the packet and if not I can resend the links. We have two fact sheets on our Shared Savings Program webpage that provides sort of an overview of our quality measures and the reporting methodology and process and our performance measurement methodology as well in addition to the sort of pay for reporting process. So, that was what I was going to talk from today and that's what I sort of provided for background.

**Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration**

Okay, go ahead.

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

Okay, well, thank you for the opportunity to come and talk to you today about the Medicare Shared Savings Program and our quality reporting measures and methodology. This quality measurement approach actually applies both to the Shared Savings Program ACOs as well as the Pioneer ACOs as well and we actually just completed a round of quality reporting and have recently shared results with all the ACOs that participated with us for calendar year 2012 under either the program or the Pioneer model.

A little bit first about the Shared Savings Program ACOs, currently we have 220 ACOs participating in the program covering over 3.2 million assigned beneficiaries, they certainly touch a lot more patients than just that. They are located in 47 states across the country plus the District of Columbia and Puerto Rico. A lot of our Shared Savings Program ACOs are really what I would call sort of really provider networks.

So, we have some ACOs that are sort of large sort of single ten, Medicare enrolled ten entities, but for the most part probably over half of our ACOs are really provider or physician networks that are really made up of multiple Medicare enrolled providers ranging from maybe 15 physician practices that have come together to literally – we have some ACOs with a couple, you know, several hundred practices and other Medicare enrolled providers that participate in them.

So, I think when we sort of look at the Shared Savings Program and we look at sort of ACOs one of the things that it has provided us with is the ability to really engage providers in a new way through these provider networks to really measure not only their cost and sort of the efficiency of the care they provide but also its allowed us to bring together a lot of providers under a single sort of entity that we can aggregate up not only those financial results but also capture more broadly quality results.

I think, you know, together between Pioneer and the Shared Savings Program we are touching over 70,000 physicians that currently participate in the program and in addition to quality reporting as sort of an integral, fundamental part of the Shared Savings Program it's what qualifies you to share in any savings that you may generate, we've also aligned it with other quality reporting initiatives in the agency including the PQRS Incentive Program so physicians and other eligible professionals that are participating in an ACO can earn their PQRS incentive payments as a result of the ACO satisfactory reporting the PQRS GPRO measures through the web interface, they also avoid the PQRS payment adjustment for that and we also have a structural measure that I'll talk more about that aligns with Meaningful Use, it looks at the percentage of primary care physicians that are Meaningful Users.

So, our whole quality framework and approach to ACOs is really sort of to build out of the National Quality Strategy and align with that that we just finished talking about, but also to align with other Medicare quality initiatives both for the purposes of reducing burden on providers but also then to align those incentive structures so that they qualify and can receive those incentive payments.

All of the ACOs that satisfactorily reported the PQRS GPRO data for 2012 under the ACO approach qualified for their PQRS incentive payments this year. So, I think that's a real strength and a positive of the program.

A little bit about the measures, as you recall when we first proposed, going back with a little history here, when we first proposed our rule, I guess what is now probably a couple of years ago, we actually had a pretty – I guess we had a framework with our measurement approach that had a lot more measures in it. I think we proposed around 65 measures and 5 domains that included not only the ones we finalized, which are patient and caregiver experience, which includes our clinician and group practice CAHPS survey that we administer at least the first two years of the program we administer for the ACOs to capture measures around like the timeliness of care, access to care, access to specialists, but also information about shared decision making and health promotion, and education activities as well.

We have another domain that looks at care coordination and patient safety which is where we look at re-admissions and avoidable ambulatory sensitive condition admissions around COPD and congestive heart failure those measures align with AHRQ, PQI measures, the risk adjusted all condition re-admission measure is the same measure that we align with under the IQR Program for hospitals quality reporting. So there is another example where we sort of align this with other CMS quality initiatives.

And then of course our measure that looks at the percent of primary care physicians who have successfully qualified for an EHR incentive payment under the Meaningful Use Program as well. IT is obviously fundamental to what ACOs are about and moving toward population management but also being able to provide alerts to providers at the point of care to fill in the gaps in care that may exist and really work on quality improvement activities. So, that's a big part of why we've incorporated those measures into the program. We also have a medication reconciliation measure as well as a fall screen measure as well in that domain.

The next domain that we have looks at preventative health and it includes a series of vaccine, cancer prevention screening measures, mental health through depression screening which is a big factor in the Medicare population and especially for folks with a chronic disease. And then we look at tobacco use and BMI as well.

We also in aligning with the National Quality Strategy we also aligned with the Million Hearts measures as well and incorporated those measures into our quality reporting methodology as well, tobacco use, hypertension, cholesterol screening and so forth as well.

We also have an at risk population domain which is our fourth domain and that includes and focuses on chronic conditions that are high cost, high prevalence in the Medicare population, it also looks at measuring organizations not only on how well they are doing on those measures that look at diabetes, coronary artery disease, ischemic vascular disease, hypertension and so forth.

But we actually have two measures that are composite measures that look at did the patients get all of the recommended diabetes measures and we score the ACOs on a composite that is made up of all of those measures, the same thing with coronary artery disease where organizations have to report those measures and we look at them and provide them feedback individually. When we look to score them we look at the overall sort of all or nothing approach to the composite measures. So, that's something that is, you know, new for the shared savings program as well.

In terms of where we are with the program, as I mentioned earlier we just completed our first round of quality data submission through a sort of sister process to the PQRS GRPO web interface. We collect a lot of those preventive care, chronic disease measures through acquired clinical information from the ACOs and we collect that information through the web interface through a sampling approach to minimize burden but also to give us the data that is critical and fundamental to getting those intermediate outcome measures.

We administered a patient and caregiver experience survey as well, the clinical group practice CAHPS survey recently as well for 2012. And then the rest of the measures are measures we can actually capture through Medicare claims data or through our administrative databases to calculate and provide feedback to the ACOs.

ACOs just got feedback reports from us on the GPRO measures as well as the claims measures and they will be getting – they also got the initial information back on patient and caregiver CAHPS but there is a deep dive report that goes back that looks at the underlying responses to the questions that make up the broader CAHPS instrument and they will be getting that as well later this fall.

As I mentioned earlier, we align with PQRS so ACOs will be getting their PQRS incentive payments in November for those organizations that satisfactorily report and the first two years of the Shared Savings Program is a pay for reporting year. So, ACOs had to report that information in order to qualify for any interim Shared Savings payments that they may be getting but also for those ACOs that started in 2012 they have a long first performance year and they have to report for both 2012 and 2013 to qualify for Shared Savings.

While we're still in a pay for reporting approach under the Shared Savings Program, and it's not quite the same under the Pioneer model it phases the pay for performance much more quickly, our final rule for the Shared Savings Program laid out a phase in to bring us to pay for performance under that program. So, while all of the Shared Savings Program measures are pay for reporting the first year we move to performance on 25 of those measures in the second performance year and then to all 32 of those measures – for 32 of those measures in performance year three and then one measure retains pay for reporting the functional status measure, which is more of just a feedback measure that we capture through our CAHPS survey.

We laid out, in our final rule, for the Shared Savings Program a quality scoring approach that basically would allow ACOs the opportunity to earn points for a range of performance on a measure. We looked at performance between either 30-90% or the 30<sup>th</sup> and 90<sup>th</sup> percentile of a measure to basically provide an opportunity for ACOs to get credit and to keep a portion of that shared savings no matter sort of where they were on currently in their level of quality performance in their organization, but then also to incentivize ACOs to improve care over time by recognizing those that do as well as obtain higher level of performance earn a higher quality score which then in turn allows them to keep a greater portion of the shared savings that they generate and that is sort of laid out in our rule and in these fact sheets.

Currently, I would point out that our physician fee schedule rule includes some proposals to change our quality benchmarking approach for ACOs and also would increase the weight of the patient experience clinician group CAHPS survey within the domain that it exists. All of these four domains we finalized as I talked about under the Shared Savings Program are sort of equally weighted but then the measures primarily are equally weighted within those domains as well and we would actually increase the weighting of the clinician and group practice CAHPS survey to about 75% of the patient experience domain.

We've also proposed changes to the way we would set the benchmark by our final rule for the Shared Savings Program that we would seek to incorporate ACOs actual performance on the quality measures in setting the benchmarks for future performance years and we have proposals out there now in the PFS rule that would incorporate for the second performance year data we just captured not only from the ACO programs, so we would be able to set performance benchmarks on actual performance for all three or all 33 of the measures if we finalize these proposals later this year for performance year two under the Shared Savings Program.

So, it would get us out of using these flat percentages for measures where we don't have a fee for service or MA data to establish the benchmark. So, I don't know if you folks have seen that but we encourage you to take a look at that and submit those comments, those comments are due the 1<sup>st</sup> week of September so we welcome your input and thoughts on that through the rulemaking process.

So, that's basically an overview of our quality reporting methodology and framework under the Shared Savings Program so I'm glad to take any questions you might have.

**Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration**

Does anybody have any questions for John?

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

So, John what – this is Sam VanNorman from Park Nicollet and I think that the letter that some of the Pioneers have put together regarding the quality measures has been circulated prior to this. What feedback are you hearing from the MSSP folks on the relevance of the measures for internal quality improvement efforts as well as the burden around doing this reporting, because I think that's been a very big concern for those of us participating in Pioneer?

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

Yeah, no, I mean, I think that – first for the CAHPS instrument, I mean, Medicare is underwriting that costs for the first two years of the Shared Savings Program participants for 2012 and 2013, so our SSP ACOs will have to select a vendor that we're in the process of certifying them for 2014.

We have the claims-based measures that we calculate and then our GPRO web interface approach, which is actually something that was developed actually under our physician group practice demonstration with groups that participated in that and helping really inform and shape the quality measures that were part of that as well as the sampling methodologies and approaches that were part of that as well and we've really sought to leverage that approach with the Shared Savings Program to address those burden issues.

I think, you know, I think one of the challenges, as I mentioned earlier, and what I sort of pointed out, is that if you look at ACOs, you know, they are not sort of – most of our ACOs aren't what I would call sort of single ten groups, so they're basically made up of multiple practices or providers.

So, you know, I think for those organizations that are more provider network based that are coming together for the first time potentially to participate as an ACO are still establishing linkages across those and I think it has been a challenge for those organizations to – since they don't really necessarily, out of the gate, have the information readily available they have to establish a lot of the processes and communication frameworks and feedback loops within their entities to do that. So, I think that has been a challenge for those provider network-based organizations.

I will say all of our Shared Savings Program ACOs were able to submit data to us under it which I think is 114 of them participated in quality reporting. So, I think that's huge and organizations should be commended for that that's a great step forward for us and for these organizations and I think they really should be applauded for that.

I think that really it gives us sort of a good sort of effort to sort of, you know, have sort of a baseline understanding of the quality that is being delivered in ACOs and how that compares to fee for service, how it compares to MA, how it compares to organizations participating in the group practice about interface process over the last several years under PQRS.

So, you know, I think it hopefully gives ACOs a baseline understanding and identifies areas where they can improve, but I think, you know, there has really also been sort of a – there is a landscape or a pretty wide range in capabilities as well I think that we saw across the ACOs as well. I know one ACO that's a single ten organization that was able to do this in three days and I know others, you know, struggled because of some of the issues I mentioned as well.

I know other ACOs who have given EHR technology to their practices and talking with some of their physicians it was basically seamless from their stand-point since the ACO had all the information in the EHR they were able to – it was complete back off of function that the physicians weren't even really aware or their staffs were only marginally bothered or if there was marginal follow-up with those organizations.

So, I think there is certainly a wide range across our ACOs, but, you know, I would expect that as the organizations get, you know, better at this, they get more experience with it that it will run more smoothly and more importantly they'll be able to use the information to improve care within their organizations.

**Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration**

Thanks, John, you know, in the interest of time I think we should move on and let Joe do the last part of his presentation. If people have additional questions for John we can collect them and try to get them back and/or send them to him by e-mail. John thanks a lot for your time and your information.

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

All right, thanks a lot.

**Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration**

Thanks, Joe do you want to start?

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

Before we move on can I just make one last comment?

**Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration**

Yes.

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

This is Sam VanNorman again from Park Nicollet. I would really urge all of the CMS agencies involved with these ACO Programs to be collecting some whether front office or back office effort numbers around participation. This is a – I think that a lot of the organizations we've spoken with did not have their eyes wide open on the cost of participation around especially the data collection burden. So, I think it's worth a study from CMS's stand-point whether it's a formal or informal study around this.

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

Yes, thanks I would be interested in those findings as well so I appreciate that.

**Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration**

Okay, thanks for that. Joe, do you want to go?

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

Sure. So, we're going to kind of dovetail right on John's talk actually and, you know, I think Sam and I are both coming from Pioneer ACO organizations, I think to John's point that maybe on one spectrum we both have an EMR, we both have good data warehousing sort of capabilities and have done lots of reporting before in the past. So, in some sense this next set of slides represents what sort of my experiences are and I will invite Sam to comment through this as well about what it was like trying to operationalize the things John had just mentioned from our perspective.

So, the first couple of slides actually just goes into details we can skip this one in the interest of time. So, these are specifically the patient experience questions that John was referencing. I think there is not – these are sort of generally accepted measures that I think we're not changing either. So, the next slide will probably be helpful.

As we get into the other measures there are going to be two slides that are particularly around clinical quality. I think it's an interesting point that we're going to get to a couple of slides from here around alignment versus actual, the exact same measure, because I think that's where we've had a fair amount of back and forth with CMMI just talking about the measures themselves and whether or not there were any adjustments made to them from sort of the NQF endorsed sort of measurement specificity towards what was actually being used in the field and I think particularly around eMetrics that becomes even more important as there was a fair amount of variability that I think we were beginning to recognize as we were trying to submit data through the GPRO system back to CMS.

And to John's point, I think that loops back into the challenge as they are thinking about how to use benchmarking and want to use real data collected from organizations to start setting those benchmarks clearly there is an evolution that is going to go on because I think the first level of data submitted may have tremendous variability because there is still a fair amount of uncertainty on some of these measures on how exactly are we supposed to be measuring and are we all reporting and submitting the same things. So, next slide.

Just again, the details are on the quality metrics, I think John talked about this the diabetes measures, the hypertension, the ischemic vascular disease, heart disease and CAD. And I think, at this level again, all of the measures seem pretty consistent with concepts at least that we've all seen in other measurement paradigms and so again as Sam would bring up there was very little sort of discussion/pushback/debate around the appropriateness necessarily of these concepts. I think it was only when we started to get into the details of the actual measurement, right, in terms of the numerator/denominator and exclusions that we began to wonder again if some of these measures themselves were capturing clinically appropriate sort of numerators and denominators.

The last slide is utilization because I think we want to get to this and again there was a set of both financial and utilization type measures that the CMMI and the Pioneer Program actually is generating and I think akin to the quality side we are in a process now amongst the Pioneers of working with CMMI to try to tune these measures again to useable measures that can be used both for quality improvement but then also for that upper above-the-line aspect of if we are going to use these to look at relative performance from one organization to another we need to be very sure that sort of the measurements are fair, accurate and feel like they are actually capturing the performance for the organization.

That is just a list of all the measures and again it is on these slides so I think this is what John's link would actually point to in terms of showing what these measures are. In the interest of time I think we are just going through the last three slides what our general reactions were if we can shift to this one.

I think around high stakes measurement there was a lot of discussion we had around, you know, how the metrics were applied and then about the actual operationalization of the metrics themselves and I think they go hand and hand because, again, as we talked about accountability versus quality improvement if the measures were going to be applied almost exclusively for internal performance improvement I think there would have been a little bit more leeway amongst the Pioneers around talking about, you know, whether or not this particular measure, sort of pushing the measurement specificity around those things.

And when we talk about benchmark versus reference groups I think the organizations again had some feedback around the approach of not only after you measure it how are you actually assessing relative performance, relative change across all the Pioneers or how you make that assessment in terms of linking it back to the high stakes elements of the Pioneer contract and I think John had talked about some of the changes and sort of suggested changes that were going forward that I think are reflected on some of the discussions that we've had over the past year.

And in particular when we talk about the utilization and financial measurements again similar kind of parallel discussions as the clinical quality measurements but also in this aspect, because Pioneer is using a fixed cohort measurement approach over time how is that sort of impacting sort of the comparison and the use of risk adjustment is again something that has come up a fair amount when thinking about how do we look at Pioneers in comparison to one another to look at relative improvement over our benchmark or reference groups.

On the last slide probably operational issues I think when we talk about eMetrics specifically, actually if we go back, yeah this is fine, I think with the measures that didn't have benchmarks that John was talking about and a lot of these had to do with the follow-up clause in terms of the measure itself of, you know, we had depression screening did you do appropriate follow-up, we were finding some challenges in terms of taking that measure and trying to figure out exactly what counted and because the EMR has a tremendous amount of different places that one could put information and trying to figure out what rules counted for certain things led to some uncertainty when we were submitting things of whether or not we were submitting the same things from Atrius Health as we were potentially as Sam's group was submitting from Park Nicollet.

And so it feels like that level of uncertainty for ourselves raised some threat to the fairness of the measure itself and we were pushing to try to see if we could get a little bit more specificity around how exactly – what counts and what should be included in terms of the eMetrics.

The next slide will give a very concrete example of that so this is under the fall risk assessment. So, this is from the eMetric specifications I think from the CMS, if we click two slides, just two clicks, yes, so, you know, an organization like ours sort of would build out something that isn't covered much in the left hand side in terms of the code but again the fact that we were doing the get up and go tests and calculating a result out and that's the standard that we used in terms of submitting, yes follow-up was done or this was assessed, seems like that is a very different standard than a single procedure code being dropped that suggests a fall assessment was being done and again that range of what was done seemed to at least create some uncertainty and uneasiness actually from our side around what those benchmarks would look like or what our organizational performance would look like when then put up again other organizations.

And last slide, so just the aspect of integrating EMR and claims data I think many of us have definitely found that although they are supposed to be reflecting similar sort of events happening for the particular patient level we've done a fair amount of looks again, this is sort of just a quick comparison we had done earlier on Medicare Advantage population specifically with our EPIC data and trying to see how concordant it was in terms of diagnoses, patients with specific diagnoses and patients on specific drugs.

And unfortunately, there is a fair amount of heterogeneity and a lot of hit and miss between what is showing up on one data set versus the other, and a lot of times if it is just present in one or not in the other it's a relatively easy discussion but when the data is conflicting trying to figure out what is the right sort of answer for this particular patient to be able to submit for a quality report did generate again some more discussion and uncertainty on our side. So, Sam I don't know if you want to add anything to this? I realized I just blitzed through it.

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

I think you hit the really key points there Joe. I would also add that, you know, some of these measures a lot of our organizations have years of experience with and it's been a real frustration when the interpretations of these measures are not consistently applied. So, for example I'll throw out the diabetes measures, in Minnesota this was created by a Minnesota community measurement, we've been reporting on this for a long time and consider ourselves fairly experts in this in, you know, the extraction, interpretation of these results.

What we found is that when it came time to report around some of the Pioneer, on the Pioneer diabetes measure for example the interpretation we would get on the specifications, which were allegedly the same were inconsistent with the interpretations we'd gotten from the authoring body and as a result we have multiple indicators that we have to report internally and provide a lot of – you know, it's a lot rework for one thing but also a lot of, you know, calls into question some of the credibility about the Pioneer program at a higher level but also the credibility of the groups doing analytics within the organization.

I'd also say that there is tension within doing this reporting, we saw this both within PGP and now within Pioneer around how much effort do you put into measures that are part of the reporting period versus that of the performance period, none of the measures or at least not most of the measures are going to capture everything from the EMR.

We can, and I think legitimately go in and, you know, abstract to supplement a lot of the work catching things that are in scanned documents that would never be part of discrete fields, looking through notes that sort of thing that are never captured in discrete fields that wouldn't be reported electronically.

So, I think that that is also probably warping or potentially warping both the apples to apples comparison between organizations based on that internal discussion choice around that as well as the actual results when we get them. Is that a fair statement Joe?

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

Yes, I would say so and I think that links back to then applying the outputs of those measures and high stakes leads to queasiness.

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

Yes.

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

Because we know that there is that kind of noise creeping into the measurement.

**Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration**

Great, I want to be sensitive to the fact that we have to take public questions is that right, you guys from ONC? Do we have to do that or are people –

**Kevin Larsen, MD – Medical Director for Meaningful Use – Office of the National Coordinator**

This is Kevin, that's correct.

**Michelle Consolazio – Office of the National Coordinator**

Yes, you'll need time for public comment.

**Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration**

Okay, so Joe did you want to go to your next, I don't know if this is your next slide, but I think it kind of prods us into what are the questions remaining for discussion between you and what John presented. So, we have about 3 minutes if anybody on the call wants to comment on this.

The one question I had, so are the quality measures, if we go back to the framework, how we started today and we looked at how we had asked say can we put the Meaningful Use measures in here, I assume that crosswalk or perhaps I shouldn't assume that has also been done for the measures you guys have to report on for ACOs?

**Kevin Larsen, MD – Medical Director for Meaningful Use – Office of the National Coordinator**

Terry, this is Kevin, we can do that kind of work behind the scenes, the ACOs as they mentioned can do either claims reporting or in some cases some eMeasure reporting but a lot of these are not eMeasures a lot of these come from claims.

**Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration**

Okay, it might be helpful though if we just cross walked what we had because they are quality and financial which would be expenditures to some extent and patient experience.

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

So, I think one of the big themes on this one Terry was the fact that I think we are really trying to push for that consistency, which I don't think anyone disagrees around doing that, but one of the lessons learned from this for sure was, you know, even the AHRQ sort of preventable ambulatory sensitive care conditions, right for COPD, great measure I think it's appropriate, I think it's vetted pretty well, in the way that it got operationalized here, you know, even for that measure some of the major exclusions around cystic fibrosis cases or other respiratory anomalies weren't excluded in the denominator for the way this is being measured in Pioneer.

So, it's that kind of level of detail that at the top level it seems great and there seems to be alignment, but the details are what create a lot of the operational challenges, because when we go to start to report it we're obviously diving into those details and that is where we are starting to uncover things. So, as a theme just trying to be sure that we're consistent sticking with a single set of measurement specifications so that we can use it consistently across organizations.

**Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration**

And that they are defined enough in the granular fashion.

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

Absolutely.

**Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration**

To make sure that we have that guidance. Okay.

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

I know Michelle was on too and I think I just saw, I don't know if she had any comments too from CMMI's perspective.

**W**

No Joe I just appreciate hearing the perspective that you guys offer.

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

All right.

**Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration**

Okay with that Joe I think we should probably wrap it up so we can make time for public comment. So, could we go to the next slide, thank you very much? So, I'm not sure we have the potential framework so I'm not sure we can finalize, but in the next meeting we can start out with what we've come up with by relooking that the two frameworks we had ONC will do some work to make sure we have a crosswalk and look at Meaningful Use as well as some of the measures that the ACOs and Pioneer have been reporting on.

We do plan on having a presentation from CMS on their current and future measurement development work, we may want to cue that up asking them to respond to some of the specific issues that have been raised today related to granularity of measures, consistency of measures whether you should be using abstraction or not, how do they decide what is HIT sensitive and/or HIT ready before they include that in their measure domain that they promulgate and then finally beginning the discussion on the measure concepts needed for ACOs and obviously we've gotten at some of that today and then move into the deeming.

I think the one thing that we will need to have some, at least agreement on, hopefully by the conclusion of the next call, is really what is the "framework" with the understanding that we will continue to work that and make it more refined as we move through the rest of this small Workgroup time period. Joe do you want to finish up with any comments?

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

I think that's it, I think we do want to take this framework. I think the second half of the discussion we had today around operational burden, etcetera, I think that needs to come into the discussion but I would submit that I think we're trying to reach the conceptual framework first and then refract it through the operational elements of it. So, I think there is a sequence that I would recommend we follow there.

**Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration**

That sounds perfect. Okay, anybody else on the Workgroup want to make any comments before we open it up? Okay, so let's open it up for public comment if there are any.

**Public Comment**

**Michelle Consolazio – Office of the National Coordinator**

Operator can you please open the lines?

**Ashley Griffin – Management Assistant – Altarum Institute**

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

**Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration**

Okay, so I think Joe and I would really like to thank you as well as the ONC staff and everyone for participating on this and do you guys want to remind us when the next call is, because I don't recall?

**Kevin Larsen, MD – Medical Director for Meaningful Use – Office of the National Coordinator**

This is Kevin; I think the next call is next week on Monday morning at 10 Eastern.

**Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration**

Okay and we'll be sending out some notes between now and then Kevin is that right?

**Kevin Larsen, MD – Medical Director for Meaningful Use – Office of the National Coordinator**

Yes that's correct.

**Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration**

Okay, great.

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

Great.

**Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration**

Okay, thanks everybody for your time, for staying attentive and for your active engagement and we'll look forward to talking to you very soon.

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

Absolutely, thanks a lot everyone.

**W**

Thanks.

**M**

Okay.

**Michelle Consolazio – Office of the National Coordinator**

Thank you.

**Kevin Larsen, MD – Medical Director for Meaningful Use – Office of the National Coordinator**

Thank you.