

**HIT Policy Committee  
Quality Measures Workgroup  
Accountable Care Clinical Quality Measures Subgroup  
Transcript  
February 28, 2014**

**Presentation**

**Operator**

All lines are bridged with the public.

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

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 Committee's Quality Measures subgroup, which is the Accountable Care Clinical Quality Measures Subgroup. This is a public call and there will be time for public comment at the end of the call. As a reminder, please state your name before speaking as this meeting is being transcribed and recorded. I'll now take roll. Terry Cullen?

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

Here.

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

Hey. Terry. Joe Kimura?

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

Present.

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

Hi, Joe. David Kendrick? Eva Powell?

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

Here.

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

Hey. Eva. Heather Jelonek? Helen Burstin? Marc Overhage? Paul Tang? Sam VanNorman? And for ONC staff members we have Lauren Wu.

**Lauren Wu, MHS – Policy Analyst – Office of the National Coordinator for Health Information Technology**

Here.

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

And is Kevin Larsen on the line?

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

I'm here.

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

Hi, Kevin. And with that I'll –

**Kim Wilson – Health Communications Specialist – Center for Disease Control and Prevention**

Kim Wilson's here.

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

I'm sorry, Kim Wilson.

**Kim Wilson – Health Communications Specialist – Center for Disease Control and Prevention**

Yes.

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

Thanks Kim. And with that, I'll turn it back to you Joe and Terry.

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

Joe, this is Terry. Joe, I'm just going to start so we can quickly go through the slides and then what we want to do is discuss some questions that you're going to see on one of the slides as we go through. So the goals of this meeting are listed here, really the major thing is for us to get through some of these questions and then do a wrap-up. This is planned to be the last meeting of the Accountable Care Clinical Quality Measure Subgroup, because we believe we, by and large, met what our mission is, the next slide. The next slide includes just a reference to the Word Document that we had, which was Recommendations for ACO Measurement Domains and Data Needs. You've probably hopefully seen this in the past and there were some questions that came out of this, and that's where we're going to spend the majority of our time.

So next slide. So I think we should just hop into these questions. One reason I'm speedy here is that one of our workgroup members needs to leave in about 20 minutes and we really want to get some feedback to these questions. Our plan would be to have some discussion right now on this call, then subsequently send out that discussion to the workgroup members, and ask them if they have any further input and/or comments on what we come up with here. So Joe, do you think we should just walk through each of these questions?

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

Yeah, I think the first two in policy kind of complement one another, so we can probably just, yeah, dive straight in.

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

Okay, so, should ACOs be required to report metrics at the individual physician level or should they be given the option to only report metrics at the group level. They are tied together.

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

Yeah.

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

What we really wanted to do is get the workgroup's opinion on this.

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

This is Eva I'll speak up. And I'll give the caveat to all these questions is that I have some input, but particularly when we get down to the technical aspects, I think other workgroup members probably have better input, just based on their knowledge base. But on the policy level, it would seem a beneficial policy to be able to have physicians report only at the ACO level, assuming that that's required on the A – if you're part of an ACO, that it would be a requirement that you report within the ACO and then that be one and done.

But I can say, wearing my consumer hat that the big caveat I would put to that is that an output from the ACO would need to be reporting at the physician level. And I know that we don't necessarily have that broadly right now, even outside the ACOs, but – and that there's some technical reasons for that. But, if we're going to have quality data that's useful for consumers, it really does need to be at the physician level, because patients don't make a choice on a group, they make a choice on the physician. So, I'm not sure from a policy level if the intent is to report at the ACO level and then have the ACO level metrics reported out publically and that be it. Because I think that would be problematic from a consumer, and probably a payer standpoint as well.

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

So you – get a summary down. So you're saying definitely that we should consider it at the individual physician level and that that – that those results should also be available, so they should be published, even if you published ACO overall level, you should – consumers should be able to find the individual provider metric.

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

Right, yeah, I mean I – the technical issues notwithstanding, there should be a way to allow – to help physicians by reducing their burden by – if they're part of an ACO, let them report at the ACO level and then not burden them with all of the other reporting programs. At the same time, if we do that, we need to not have any sort of loophole that they then escape any sort of accountability at their own personal physician level.

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

Okay.

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

Yeah. It is interesting to think about sort of the both on the clinical quality side as well as if we're thinking about efficiency and utilization measures in total as quality and performance measurement. And for pure accountability purposes, I think it's hard to – no individual provider would take financial risk, right, at a one person one panel level, and yet the performance of quality could potentially get reported down at that – at those levels. And when I think back to the types of measures and domains we talked a lot about in our committee, a lot of them are sort of that system domain element as well, that require collaboration of lots of physicians. So I'm struggling with the – I hear what you're saying Eva, around sort of at the consumer level, you're actually trying to find a physician that you can establish that kind of relationship with, so it would be nice to have that kind of information.

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

Um hmm.

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

But, as an ACO, I don't think we talk about ACOs as a single physician entity –

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

Right.

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

So that's where it – I can think of individual physician quality reporting for sure, but I'm not sure that's ACO quality reporting.

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

Right, right. And maybe one way to approach this, because I think you're right, for some of the metrics that are – and hopefully ultimately most of the metrics reported at the ACO level, would be these more collaborative metrics where it just really wouldn't make sense, necessarily, to report at the physician level. So, you could see maybe a scenario where the metrics are reported at the ACO level and not necessarily at the physician level, but there's transparency about which physicians are contributing to that score. And I don't – forgive me, I don't know exactly all the iterations of how ACOs are being rolled out as to whether there's visibility to the patient of that their part of an ACO and these are the contributing practices. I don't – so, it may be self-evident that if I know I'm part of an ACO and I can plainly see which docs are part of that ACO and these are the scores for the ACO, it may be kind of a moot point that will just happen.

But if the ACO was not necessarily an entity that's recognized by patients and consumers, then there would need to be some visibility as to who's contributing to this group metric. And I think what that also brings up in terms of physician reporting and trying to reduce their burden is – I don't know if that's – I don't know to what degree that's possible, because we still need physician metrics. And if the metrics at the ACO level really very much are systemic metrics, then there may be a limit to the decrease in burden we can accomplish there.

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

I guess part of the question here for us too is sort of, reporting in the sense, for what purpose, right. So –

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

Right, right.

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

– if it were for transparency to patients and consumers so they can make better decisions on who to choose, I think there's a very different standard than if we were talking about reporting to an entity like CMS for the purpose of evaluating and payment processes, right. So, I do see that there are different standards that one would be able to put in sort of an aspect of if you're hoping to give informative enough information so patients and consumers can have reasonable, accurate data to make an accurate and informed decision. I think there are a lot of areas that says, the measurement has to be pretty darn good to be able to not give people data that leads them down the wrong path to make a bad decision. So –

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

Right. Well, and I think, and this I think is fully in the camp of technically how do we do this, even though it sounds good. But, if there's a way to design these ACO metrics, many of the ones we've talked about just aren't there yet, it seems to me like there's a design issue, too. That to the degree we can have the individual physician and hospital and nursing home – all the individual provider setting measures, is there a way to have the best of the bunch of those somehow roll up and the data contributed for calculating those metrics roll up to be data contributing to whatever systemic measure there is. And that's kind of a utopia that achieves both the decrease in burden, but also achieves the systemic measure that we're all about that's kind of the shared accountability. Technically speaking, I have no idea how you do that, but maybe experts who – in measure development and some of the analytical statistical processes can figure that out, but –

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

So, I think it is technically difficult, it's not that it's not doable, I think it does go back – this is Terry. It does go back to which of these measures can be teased out for quality at the individual level and how much have such co-dependencies –

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

Yeah.

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

– that you probably don't want to push into it –

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

Right.

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

– at that level. But it's a very interesting framework to think about. So, what I hear us saying, we obviously think ACO metrics need to be reported at the group level, and I guess the caveat I would put in here is that some, as opposed to all, metrics may be appropriate for reporting at the individual physician level.

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

Um hmm. Yeah.

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

Would you guys be okay with that?

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

I would agree with that, and I think that the big question is the methodology –

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

Um hmm.

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

– and is it – if it's appropriate, it's not sort of appropriate for decision-making, but appropriate for fair sort of measurement at that level. So it is sort of a – the method is the open question there –

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

Right.

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

– can – do it technically. And once its set, then I think yeah, from a policy perspective, I think it would be really informative at the individual physician level, but I think we've got a lot of work to do there still.

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

Yeah.

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

And I guess the one thing then would be from an ACO level, because of the – Joe, I think what you said is really right, the fiscal risk is at the ACO level –

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

Correct.

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

So publishing at the individual physician level does that put the individual physician at any risk?

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

Yeah. I mean, I don't think anyone would report financial PMPM sort of levels at the physician – it doesn't make sense to break apart an ACO and report the individual PMPMs for doctors, because that...

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

Yeah.

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

– so again, I can see where it can happen from the quality side, but – the pure clinical quality side. So, I – there's an area there. So, and patient –

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

Okay. Yeah, and I would think, I don't know, I'm just trying to think about the fiscal risk at the ACO level, it would seem that it would be useful for internal purposes for the ACO to understand which docs are contributing positively to whatever scores they get and which docs are contributing not so positively to the scores they get. So, I do think that Joe's point about purpose is really important. And I agree with your statement in terms of how we should answer the question. I'm wondering, though, if that's specific enough for what ONC needs.

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

Well, I think – Lauren, do you think that's enough to sort of throw that question with that kind of structure out there to the rest of the committee to try to get some feedback on it?

**Lauren Wu, MHS – Policy Analyst – US Department of Health & Human Services**

Yes. This is Lauren I think that's enough. As you see, we do have a couple of technical questions on this slide that actually talk about how you would actually implement this so that if you had reporting at the individual level, how does that roll up actually occur. But as we are a group of the Policy Committee, one – if we feel that question needs to be taken back to those at the standards level, who are actually working on the data sets, to think about this some more, we could make that recommendation, if we don't feel we have that expertise here, but we do feel it's important to be addressed.

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

Yeah, this is Kevin; it could also go to the Quality Measures Workgroup, which has a lot of experience in the sort of technical components of quality measurement and what is likely going to retain its statistical significance and ability to differentiate in a measurement space.

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

Well –

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

So this is Michelle, just a reminder, this is a subgroup of the Quality Measures Workgroup, so anything that's discussed in this group will have to go to the Quality Measures Workgroup anyway. I would recommend, though, that as Lauren pointed out, this is a policy group and so as we get into technical and more standard related items, that really should be passed over to the Standards Committee.

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

Yeah.

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

Okay.

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

Yeah.

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

Okay, so unless anybody has anything else – to ACOs report eCQMs once to qualify for multiple programs. What policy and program changes need to be considered to report once across programs? Any comments on that?

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

Obviously I think reporting once would be less of a burden.

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

Yeah, that would –

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

Yeah, definitely.

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

So we would strongly advocate for that.

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

Okay, I can't imagine anybody's going to disagree with reporting once.

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

Uh uhh.

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

But then, policy and program changes need to be considered, obviously there needs to be consistency in what people want reported. Anything else?

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

This is Kevin. I think one of the details here is that as a provider you may be part of an ACO and simultaneously you may be doing non-ACO activity, like pay-for-service activities. So if the unit of measure is the provider, that's I think where this question is kind of aimed.

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

So the second question is aimed at the provider. I mean, the first question is focused on the ACO; the second question really is more about providers. If we're allowing – provi – am I getting that right.

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

So this is Kevin. I think the question is yes, if I'm a provider and I have 30% of my activity is part of a Pioneer ACO and the other 70% of my Medicare activity is not part of Pioneer, if I report to Pioneer, should that count for everything?

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

I gotcha.

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

Across all these programs.

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

Ooh.

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

So the only – go ahead.

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

Go ahead. Well I was going to say

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

What I was going to say is –

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

Yeah, go ahead Terry.

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

Well the only think I was going to say is that if we're going to say we endorse the concept of reporting once –

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

Uh huh.

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

– then we have to obviously endorse –

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

Right.

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

– the concept that there's consistency with the measure.

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

Right.

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

Or there's a set of measures you choose from or something.

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

Yeah.

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

Act –

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

Well, and I think – I think it also goes back to that first question, I agree, I don't think anyone's going to disagree that ACOs should report once for multiple programs. But, that's focused on the ACO, not the doc and the second question is relative to the doc. And I could see having as a way to encourage participation in ACOs or if that's what we're – part of what we're wanting to do, having some sort of threshold, kind of like Kevin was saying. If you have at least – and – but then I think this gets to what's the reality in the market, but, if you have at least 50% of your activities as a physician as part of an ACO, then you meet the cut and you can report once through the ACO. But if you're split with a heavier – the heavier caseload on your fee-for-service side, then you have to report both. But, I do don't know what the right threshold is.

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

I don't – so Kevin, this is Joe. So thinking through this, too, I mean I can't imagine, I mean we're measuring for the point of assessing performance and you want to get organizational performance, but – so even at Atrius, right, we'll have different business rules impacting our Medicare Advantage, our fee-for-service, and our Pioneer ACO. So the rules that the organization is functioning in is going to be slightly different in all three populations, even though we can all call them the Medicare population as opposed to Medicaid or commercial.

So, it feels like the intent or use of the measure to do – to get an accurate look may be that the policy has to say, if it's just going to be under Medicare, and you want to have generic measurement that can cross-apply to all three types of populations. It may be – I mean if the rules are that different, it's going to be challenging to smash them all together, right, to say, utilization on this particular population of a fee-for-service versus the Medicare Advantage versus hybrid Pioneer look should be equivalent if we only take out of the Pioneer bucket. I do – we're seeing very different performance across those three populations, even though they're all three Medicare.

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

So I don't have some particular sort of answer to what this should be –

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

Right.

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

– the question here is for you guys to wrestle with that and then think about, are there programmatic changes you would recommend or policy changes that you would recommend to sort of achieve or move us more towards this report once goal.

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

Joe, were you saying that you're seeing different measures or different outcomes of the measures –

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

Different outcomes –

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

– in those populations?

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

– so we actually measure the same thing on all three populations internally here. But they're very, very different, right, because the business rules are different in terms of what providers you can see, there's no restrictions, right, in the Pioneer ACO population and fee-for-service. Pioneer gives you a little bit more structure, because there's some more aggressive communication coming out there, but it's very different than the Medicare Advantage population, right. And so that – the rules around how patients can engage the delivery system, absolutely impact quality scores, utilization, all those things, right.

So, I think it would be – it's almost as if you're going to dip into a commercial population versus Medicare, not just the patient population demographic disease burden elements, but just sort of the business rules in play for that population will impact performance. So, if we were going to do it, it feels like we need to again take a look at measures that will be less impacted by those kinds of differential sort of business rules. And if we can do that, then I think absolutely minimizing the burden should be a goal that we should strive for, for sure, but I could definitely imagine sampling off of one population and making some assumptions that are probably incorrect about the general population.

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

Okay, does anybody else have any other comments? I don't know that we've come to any specifics here. Obviously, like I stated, it sounds like everybody thinks reporting once would be less of a burden. To go back to what Kevin said to us, what policy and program changes need to be considered? I don't think we highlighted anything specifically –

**Lauren Wu, MHS – Policy Analyst – US Department of Health & Human Services**

This is Lauren. I guess the two things that I'm taking away that are suggestions that need to be fleshed out some more is one, to look at sort of a threshold if a proportion of your activities are focused on a particular – toward a particular group, like ACO. Then you could meet that threshold and then you could report once for ACO, but again, needs more fleshing out. And then Joe's second point about maybe we look first at measures that are less impacted by these different business rules, depending on the group, and look at those first and seeing if we could apply those for reporting once. Are those –

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

For Joe –

**Lauren Wu, MHS – Policy Analyst – Office of the National Coordinator for Health Information Technology**

– kind of the two ideas?

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

Yeah, I mean so for example like here in our market, Blue Cross, we – Blue Cross would not accept us to be able to report out our global population quality scores and have them imputed. And even though it's the exact same method, right, you're applying it to the entire population of our medical group, and impute that in and say, so this is what we assume the Blue Cross population is getting right now. So, I think –

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

Guys, I'm sorry, I've got to drop off. This is Eva.

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

Thanks, Eva.

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

Let me know if there's another call. Yeah, thanks. Bye.

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

So, I think that there's an assumption that you can take one subset and that it will be representative. And I think if you're again using it for performance assessment, that there – we've got to do a little bit more work to be sure that that's a fair thing. And I think we've seen – we see differential performance, even though the delivery system absolutely is trying to be reliable and consistent and do things in a payer-blind way, we just know that again, populations are going to be underlying different and we just have to be sure that that's taken into account. I'd love to be able to report once, and if we're going to report on the entire ACO, right, without just the ACO population of patients, so it's literally an organizational measure, I think that would be great and then apply that across all of various ACO contracts that may be overlapping for a particular delivery system.

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

So Joe, let me reframe that to see if I have captured what you said, that a proposal may be that to do all patient, all payer reporting –

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

Yup.

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

– in all cases where you need to do ACO reporting, and then use that all payer, all patient reporting as your report once and as you're evaluated for the various contracts and projects.

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

That's correct, that would be superior than doing narrow looks and assuming it's consistent across everything.

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

And Joe, would you say that – would you want that dictated at the – not really dictated, it's not the right word, but defined what's in the all payer reporting, that would just reflect what you're currently reporting in the ACOs or more or, how would you get –

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

The technical side of that, right, is so obviously we can only report on "products" if we have all the data, right, so right now it would be for populations that we take risk for, so for any ACO-type measurement, assuming that most delivery systems may not just be participating in a single ACO, right, so multiple overlapping programs. In those cases, the aggregate that we're getting similar claims data from everyone, etcetera, that we can report sort of global organizational performance on all of those ACOs once and say, there's not a difference the way we report it for Pioneer versus Blue Cross AQC, it's an ACO – well, that's a bad example, because it's commercial versus Medicare. But if there were two Medicare ACO-type products there that essentially performance on that population is organizational performance and we would submit that to all AC – po – Medicare type ACOs programs we were participating in.

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

Okay, I get it. That seems reasonable to me, so but that's a change.

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

Yeah, I think that would have to – there would have to be some agreement across ACOs, right, or the ACO over –

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

– yes.

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

– right, that we'll have to kind of agree on that.

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

Yes, okay.

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

And Joe, this is Kevin. Can you think a little bit, too, about how that might work if you're not like Atrius but you're like a multispecialty practice that might participate in different ACOs that have different makeups, so one – at one point they might be part of an Atrius ACO, but for another program, they're part of Partner's ACO.

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

Yeah, so, I would think that again, sort of it's – if the goal was to really think about organization and to define the organization that's common enough, right. So unless there was 80% overlap and that 20% that didn't overlap with a significant group, I think there has to be some kind of consensus around what are you reporting? So maybe you – even though that 20% isn't part of that ACO, you always report on everything in your organization, whether it's part of it or not. The challenge, of course, is that you're going to drop data on certain elements of it, right, that you're not getting because you're not overlapping on a certain population, and you can't – you miss some of that.

So that's going to be a method thing we're going to have to work out, for sure. I guess we could set some sort of threshold or things like that to be able to say, if you need to have at least "X" percentage of your population represented, in order for you to be able to qualify to be able to submit, like it's almost like a common application, right, common quality reporting on "X," "Y," "Z" ACO organizations, if you meet this particular threshold. I can see what you're saying, Kevin, there could be areas where you drop one practice or two practices because they're not overlapping in an ACO contract, therefore there's going to be data differences and performance – artificial performance variation, because you're just missing data.

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

Yeah, to my mind it's a question of, how do the granular parts roll up to the larger whole, and when the granular parts get to roll up to multiple different kind of roll up levels, that – then we've created a sort of network complexity question. And trying to figure out a policy and programmatic way to ease the burden but still be sophisticated about that kind of networked matrix.

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

Yeah. I guess it does seem that to do good comparative – to have good comparisons of various organizations, ACOs, there does need to be far more definition on the specifications on what is complete data that you are using to calculate. And probably having some level of threshold, right, you need to have complete data on at minimum this percentage of the sort of accountable population, in order for you to be able to say that this actually represents the care that's being given to that population. I don't know what those numbers are, but I would say that that sort of – those stipulations probably need to be going hand-in-hand with anything around doing single level reporting.

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

Yeah Joe, I would really agree with you and also what is the specific exclusion criteria if you're not going to be in the denominator.

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

Absolutely.

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

Yeah. So I don't think – anyway, I'm intrigued by this. I think that you hit on something that actually would be potentially the quality measures group could put forward, which is this policy change related to the ACO-type products and having similarity in the reporting on them. Anything else anybody else has or any other ideas? Okay, so our – to remind people, one of our goals here is to just get some stuff down on paper so we can send it out for the workgroup committee members that aren't on this call and for us who are on the call, to think about and to re-comment on before we close up the workgroup finally.

So then, I'm going to go to the technical, the roll up to the ACO level occur, how data interfaces are needed based on our list of metrics? These are pretty hard questions to do quickly –

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

Yeah.

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

And you guys will remember what the metrics are because we pushed them out in an attachment to this. So, Joe, I don't know, do you have any insight into how you're rolling up right now that could help guide our response to that first one?

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

So I'm – I mean, I'm not sure Terry. So, I realize that if roll up is meaning, right, individual physician to some unit – business organizational unit to global ACO organization, and that's the sort of roll up levels versus business unit or service line, along those lines. It's technically, and Kevin, I don't know if that was where this question was targeted at, structuring – once the data's structured in that particular way and it's being captured, as long as the methodology is clear and we're making the appropriate adjustments along each level, it's not that challenging to roll up, it that's what we're talking about, literally from individual doctor to group of doctors to global organization.

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

Yeah Joe, this is back to that sort of thing I was talking about that if the doctor's trying to report once and the ACO is trying to report once –

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

Right.

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

– that might mean the doctor has some patients in the ACO and some not.

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

Right.

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

So those are the sorts of, I think, questions to – this is pointed to.

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

Yeah. So Terry, I think that then links back to our previous one of, if you could just say that the doctor – so similar questions at the doctor level that we would have at the organizational level. If a doctor has independent, overlapping ACO populations, at what point can you measure “the global performance” of that doctor as a proxy to report once. And then, can you roll that all the way up.

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

Right.

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

I mean, I think if the ans – if we can answer the questions at the ACO level, there may be some adjustments at the individual physician level, but I think similar principles would hold, to be sure that you are able to get a good assessment of the physician's performance by taking that subset. Or taking the complete – the “complete” view of that physician.

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

Right. Okay, so once again then really we do go back to similar concerns about how do we define what's in the denominator, what's the population that we're using as we roll it up.

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

Yup.

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

Okay. And then to go on, what data interfaces are needed based on our list of metrics?

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

This is hard.

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

Yeah, I think that's a hard question. I – I don't know, Kevin have you thought about that or have any –

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

Well, I mean I think you guys have articulated this already, that the need for claims data –

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

Yup.

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

– and ADT data, potentially along with the clinical data that we've already been talking about.

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

Yup.

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

And so I think it's just kind of making a formal report to the Quality Measures Workgroup about what you think those pieces are, but those are the ones I've heard this group talk about a number of times.

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

Yup.

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

Okay.

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

Kevin, this is Kelly.

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

And – we were also going to include those thoughts around some of the patient reported things, right.

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

Right.

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

We lumped it into that clinical side.

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

Yup. And Kelly, you had some comments, too?

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

Yeah, I was just – sorry I joined late, but I know there's been some concern that there isn't sort of a common data format for a lot of the various – for the commercial health plans providing data. And while maybe all payer claims databases are trying to work through that, it's still, I think, a work in progress. So I wonder, in terms of interfaces, whether there needs to be some kind of mechanism in the market to be having claims that are coming from multiple parties to be following some kind of common data format.

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

I think data format's one thing, Kelly – this is Joe. I think format's probably getting more – there is some variation, yes, but it's actually again, we're back down to the method that they're using to define those data elements is what we're finding to be variable, even with the commercial payers in our market here. So there's a lot of ETL transformation that tries to bring similar – exactly the same labeled field, like allowed amount coming in from all six of our payers, that have different business rules attached to them. So it's a dollar, so the field is clearly standardized, but it doesn't mean the same thing coming from all the payers. So that standardization would probably help on the claims side, that's a huge lift on the clinical side though for sure, right.

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

So – and Joe, some of that would be just what the definition is, what do you – what's an allowed amount mean in this –

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

Right and everyone use the same –

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

Yeah.

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

– definitions. So the field spec itself I think is pretty standardized –

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

Yeah.

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

– I mean, very few times – getting a string when it should be a variable, etcetera, or numeric –

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

Right. Yeah, it's probably a number. Yeah, so the constraints are good on the field, but the definition is what's unclear. Kelly, to go back to what you're saying, so is there anything you can think we would need to recommend – are you – is the claims databases starting to see consistent standards being pushed out there?

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

Well I just – I hear from some folks that are working like the group that Elizabeth Mitchell leads, the Network for Regional Health Improvement, has been trying to facilitate this across 40 regional health improvement efforts and they have found a lot of challenges in trying to get the multi-payer data to be sort of in a usable format.

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

Yeah.

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

I mean the QEs are struggling with the same thing and many of the QEs are in those 40 communities. But, I do wonder whether there has to be either it's a standardization of the definition or the business rules or something has to be addressed, maybe it's not at the interface level. But even to just efficiently be able to deliver this on a larger scale to a growing number of ACOs, I wonder if that needs to be addressed.

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

So I – this is Joe. So I would strongly advocate yes for that, because that's also one of the biggest reasons why when you slap a third-party vendor product on top of any kind of aggregated claims data warehouse, if that data is not normalized, the output – it's really hard for the output of that third-party analytics software to produce anything meaningful. So, if we were able to standardize it, I think we would better be able to leverage a lot of the third-party tools out there.

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

So – this is Kevin. I think that standardization of everything all at once is unlikely –

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

right.

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

– so is there some way that this group could help with the prioritization of which – where to start with standardization?

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

Well so is the financial claims files, is that – can we start there, Kevin?

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

You tell us.

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

I think that seems like it's easier, because the structure of the files is probably close enough that we could probably come up with a common set of fields, and the specs for each of those fields, and just be sure that it's as comprehensive as possible and sort of regular. But I don't think that's that far to go. I think then the next step of beginning to define the data definitions for each of those fields may run into a little bit more sort of discussion points. But, to me it feels like we could do that, because that's essentially what all of the groups like the groups that you just mentioned with Elizabeth, that's what they're doing when they're writing their ETLs to transform everything to a common set. So it's already happening, but if we can do that on a more national level, that would actually eliminate a whole work step that many organizations are already undertaking on their own.

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

Yeah, that's re – that was really helpful.

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

Yeah, that is really, really helpful. And there's probably, we didn't look at it, but the assumption, Joe and Kelly and Kevin is that there are people doing this work as they're normalizing the data coming in to their databases.

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

Yeah, no, we do it and what's challenging is, a payer may change the rules on us, right, and so we pick it up as the data comes in and our QC process flags it and then we're saying, why, that seems weird, and then we have to have that ongoing conversation. So by setting the rules, you'd also begin to decrease individual insurers changing those rules sort of because they wanted to or their data system changed, so they've just adjusted it. So a lot of that noise starts to dampen down as well.

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

Yeah.

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

Joe, with the data dictionary that's changing with the Medicare files you're getting, does that need to be more transparent or does there need to be more collaboration in changing dictionaries?

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

I think it should, I mean, transparency is always good, right, because you don't want – you want to be able to see that before, like ideally like a month or two before that file comes forward, right.

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

Um hmm.

**Joe Kimura, MD, MPH – Medical Director, Analytics and Reporting Systems – Atrius Health** When it comes at the same time or just before, it's really – it's challenging and so, we can prep and develop methods in the ETL process, to make sure that it works with the rest of our data, if we knew it a head of time. But I mean, I guess if the goal is to not change it so frequently, because everyone's held to that standard that would be the best, for sure.

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

Yeah, so more transparency, change less frequency and earlier release of the changes.

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

Yes.

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

And probably change less frequently with predictable releases.

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

Correct. Correct.

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

So a related question, we've also heard that as groups are working to integrate clinical data with claims data, there's a lot of matching issues.

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

Yup.

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

Is there something in this space for us to consider there as well?

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

Umm.

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

Like a master –

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

Consider a patient ID, you mean, right Kevin?

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

I'm leaving it fairly wide open. What I've heard from a number of organizations that are trying to do this integrated claims and clinical measurement, is that the investment and the custom work they each have to do to integrate their claims and clinical data is very high.

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

Yes.

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

And I'm wondering if this group feels that way and if so, is that a priority for some solution and is there a proposed solution?

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

So Kevin, this is Joe. So I would say it is high, I think part of the challenge for sure is that match-over. So if we're talking about a national MPI that could be used one of the biggest challenges is obviously people switch jobs and switch insurance mid-year, so to be sure that you were creating a longitudinal look at a particular patient that matches with the EMR data. That ability is significantly hampered if you aren't able to capture that human being, right, that particular patient and stitch all of the claims data that are coming from one organization versus another organization and matching it with your EHR data. So, that's where it can get challenging if you're unable to do that well. So, if there was a standard out there that helped us, like an MPI now, that would definitely help make it easier. And everyone use that same MPI, so all the insurers use that same number that would be great.

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

So you probably know that the Congress has said that they're – we will not be creating a National Health ID number for all Americans.

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

Right.

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

So is there something short of that or something – an alternative to that that would be helpful.

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

Well there are a lot of states that have functional Master Patient Indexes, like CRISP in Maryland is leveraging that – I – but it's not scalable across every state, in our current form.

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

I mean every state is kind of like, that's what our Mass APCD is trying to create as well, right, so what's just short of that, everyone's essentially just building that to be able to do this work, so I don't know if it's just – I mean, I don't know if there's a more – a different way of doing it.

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

Yeah.

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

I mean all we're doing is sort of taking multiple fields and doing the match, right.

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

Yeah.

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

Trying to be sure that you're finding name, gender, social, date of birth, and all these other sort of fields in creating that match.

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

Where the states are really engaged in trying to figure out how to use sort of these core services to enable accountable care, like in Oregon and the SIM testing states, they are really thinking through how to federate provider directories and an MPI because for attribution and lots of other reasons, it's sort of an essential core service. So, I mean, it's realistic that this could play out in a good number of states, it's just not – it's not clear if it could be done across all states, just given sort of their priorities and what all – what they're all thinking about. But, if that's the logical point of organization we could be thinking about how to reinforce that.

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

Yeah, I mean, it's such a critical foundational step that again, I think, I mean we've articulated – everyone's already kind of doing it anyway, because they've all realize this – something like this has to be done if you're going to link the data together for usability.

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

Well and the multi-payer, I mean, MPCDs and the All Payer Claims Databases are not necessarily restricted to states and they're working on that, right.

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

Yeah, absolutely.

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

Yeah. So I guess the message for us is to just indicate that – I think we keep coming back to this, this is a problem that needs to be solved.

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

Right.

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

So just to put a name on it then, and tell me if I've said this correctly, summarized this. That the group recommends that their – that claims data be part of the measurement enterprise and that you recommend that there are patient matching processes that could be uniform and scaled across the country for patient matching of claims to clinical data. And you recommend that there is a process by which to do some standardization of data definition of clinical data elements in claims forms. Are those the kind of three key items that I heard?

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

Can you say that last bit again one more time, Kevin?

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

That there's a process for standardization of the data definitions for clinical data – or not for – for data elements within the claims forms. It wouldn't have to be clinical –

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

Got it. Yes.

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

– but that – you agree that there is – that you feel that the standards exist for the field and what the field contains, but that the meaning of what's in the field has not been well standardized.

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

Yes, I don't want to over – I think it's 80-90% standardized, the fields, there definitely are difference, like certain fields – I mean, even – we have this with CMS, too, right, in terms of discharge date, right. So it's a calculable field that other insurers will just give us the date, but within the CMS file, we have to calculate that and then impute that into that column that we get from other insurers. So, there's a little bit of that that's actually happening, it's not – I think those are easily rectifiable.

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

And then I think we – you also said start with the financial claims files.

**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 for Health Information Technology**

And then we've heard from this group other times also patient-reported outcome and ADT files, can you talk about those a little bit and priorities for those.

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

Well I think the issue, how we started the response to this question was really that claims, ADT, any other fiscal data, quality measures, patient-generated data needs to all be interfaced somehow, with obviously tied to a patient or a cohort, so that you can do the full analysis related to health.

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

Yeah. I think that similar thing shows up, right for ADT data for being sure that we've got the right patient, right, so all of us using ADT data right now, are doing matching algorithms, right, because the host institution sends their EMR and record number, and that doesn't mean anything to us. So we take it and try to figure out, so there's a lot of additional work happening there that would again be facilitated and that transfer information accurately and safely would be facilitated again with this – with more of a unique identifier number. I think the ADT format's actually pretty straightforward right now, so we're not seeing a tremendous variation on that, and at least here in Massachusetts, and I think – I mean, I wouldn't expand it too much to say there's a lot more information, I think there's potential there. If you're going to send an ADT file, you could probably add a little more value-added fields there, but that seems like I'm overstretching the ask.

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

I think the ask though is pretty overwhelming what we just said, actually to claims, ADT, fiscal, quality, patient-reported data, that's a lot of interfaces. And so there's probably a logical step-wise approach to this, not that I know what it is, but I would agree with Joe, I think ADT files tend to be pretty clean. So maybe it's ADT, claims then quality is where you start or – and then you add the patient-generated – patient reported data later. I think if we just move ahead with that huge lump, people will be like, we won't move. So, to me the other thing is prioritization of these asks –

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

**Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration**  
– into a logical, temporal –

**Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology**  
Just a reminder, if you're not –

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

**Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology**  
– speaking, please mute your line.

**Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration**  
– that we could propose. So where do we think the low hanging fruit is that could be done in the next two or three years.

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

**Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration**  
Okay, umm – go ahead Joe.

**Joe Kimura, MD, MPH – Medical Director, Analytics and Reporting Systems – Atrius Health**  
Oh sorry, Terry. So I was going to just say, so I just think, yeah, with that priority with the group, I think – I do think financial claims data makes sense and will really open up, I know we've talked at times too about how this workgroup interfaces and trying to get the private sector involved and be able to build better tools. I think there would be a tremendous, exponential gain in terms of a lot of activity going on. You know Terry, you and I were just at HIMSS and there's a lot of activity there, right. And all of that – a lot of that technology could be harnessed and used much more effectively if financial claims information started to be in a very standardized format. So to me, that's – there's a huge lever points and it's not like we're waiting for the third-party or the private sector to gear up, they're already there, they're just struggling with it.

**Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration**  
Yeah, I would really agree with you and I – we were both at HIMSS and I think many of you were there, too, with this sense of the big data, the analytics seems to be really taking off. And Joe I think you're right, that if just those two could be harnessed and combined somehow, made available, patient matching is resolved, specific definitions are there, there could be a tremendous impact.

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

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

Okay, any other data sets or standards that we need to be identified or developed? You know, I think that there were some of these we talked about that in the measures subgroup, domain and data needs handout and we already identified some of them. So I guess I'm thinking as we go forward, if we're going to send this out to the group that we can ask them once again, and I know we already did this, but are there any other specific data standards that we didn't identify in here. We did, just so people remember, when we sent this out last time, there was a sense that we wanted to focus on, from a data set perspective, things that had non-proprietary scores, but we also wanted to ensure that they had a scientifically sound basis. So, we'll probably include that as we move forward that comment. Okay. Joe, anything – anybody else from the workgroup have any other comments or anything they think we haven't discussed. I think the best thing that we could do is to put this together and really ask people to comment and prioritize the work we've done –

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

Terry, one thought that might be helpful as this gets refined, and that thinking's refined, is how – what are the opportunities to sort of test this reporting of – across payers and using your entire empaneled or attributed populations across accountable care arrangements? Could it – should it be for the State Innovations model, Accountable Care Communities, there's some sort of more – there are efforts at the model stage that aren't nationally scaled, just like the Pioneer ACO Program, and is that the right vehicle to test this or is there something else? It would be helpful for HHS to know a little bit more about what would be a way to test and scale some of these ideas. Or maybe not, maybe going faster, whatever the group would think would be the best way to proceed.

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

Well the one thing we didn't look at was those examples that you alluded to, that there are people out there already doing this, there are facilities or communities that may be doing this, what have the lessons been learned from the multi-payer claims database or the all payer claims database. Are they already doing this? Have they worked out the definitions? And so, I guess my question is, are there already de facto pilots and/or specific pilots on this, what are the lessons learned and can they help inform moving this rapidly? I think what – Joe, and I don't want to put words in your mouth, but I think at least what I would say is that I think that this is a real need. And while we may want to be in a place to test it, I wonder if the testing – I wonder if there's already enough lessons learned that if we pulled them together it could help inform how to accelerate this. Joe –

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

Yeah, I would agree. I think there are enough people now that have spent time in this space and if we pulled together that learning overall. And it would be from the insurer community in terms of what they're choosing to produce, as well as the delivery system community of people pulling together to statewide APCD type activities to collaborative organizations trying to do what that group up in Northern New England, too, is another great example –

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

Um hmm.

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

– I'm sure they're doing this as well. So, I think we probably could come to a relatively quick agreement of the areas that we see the most heterogeneity and then if we could use that forum to blast forward and say, okay, so let's try to get into a standardized format. It feels like it's there, I again, sort of from my perspective, I don't really know what the insurer perspective is as to why they do need to change some of these things, so – and are they overcome-able. But it seems like we could do that and use that to jump forward. I think there are enough people, it's not just one or two places, I think there are a fair number of organizations that are probably in mid-stream, if not tried to solve it for their own local market. So I think that if we get enough people there, you'd get pretty good representation across the country.

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

And do you all feel the same way about sort of the eCQMs to move to sort of multi-payer or all payer, all population definition for numerator and denominator?

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

You mean if we polled people and saw what they had done and aggregated their lessons learned, would there be enough to jumpstart this. Is that the question?

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

Yeah, I – for the claims and clinical side, do we want to –

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

Yeah.

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

Yeah.

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

I would agree with Joe. I just think we haven't – this is really intriguing to me right now, to think about the – to put those people, those organizations in a room together and say, hey, give us your lessons learned, your pitfalls. Is there agreement? How do you think we can move forward rapidly? And I think you could do that for the eCQMs, too.

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

Agreed.

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

It would be cool to do that. Is anybody doing that?

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

This is Kevin, I am not aware of it. I was on the Governance Board for the Multi-Payer Claims Database, the one for the country, and it did not get into that level of detail really. It was a lot more about the operational issues of – and governance rather than –

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

Right.

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

– the de – the lessons learned sharing and standardization creation.

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

I think there is some interest in this now, I've been hearing from some folks who want to start more public-private collaboration around this area. But I think this is pointing out some very specific detailed areas that would have to be fleshed out through the existing experience across regions and providers that are already doing this.

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

So it would be I think to reiterate what Joe said, I think the time has come. I almost think we're at this tipping point with this, that if we could – and Kevin, I agree with you that the focus was on governance a lot and that obviously we don't want to discount that. But perhaps many people are just waiting for these more – for this specific guidance, what's the data? How do I define it? How do I normalize it? Can we all get agreement on that? In some ways this feels to me independent of Meaningful Use and all that, I mean, it's not independent of it, but it could have its own path going forward, because it's so critical. Okay, from an ONC perspective, is there anything else you guys would like us to discuss today or focus on?

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

This is Kevin, not that I can think of. I want to really thank this group. This is – you ended up having to do more work than I think you thought when you signed up. And the group was very willing to tackle difficult problems that were coming rather quickly, like deeming, and so I just want to thank you for your devotion and dedication to this important work.

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

And it was a pleasure working with all of you guys.

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

Yeah, I would echo that. And thanks everybody for their time and commitment. Could somebody – could a staff person give us some idea in terms of logistics now as we move forward, wrapping it up, sending it out for additional comment, final report out to Quality group.

**Lauren Wu, MHS – Policy Analyst – Office of the National Coordinator for Health Information Technology**

Yeah.

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

Just give us some idea, timing.

**Lauren Wu, MHS – Policy Analyst – Office of the National Coordinator for Health Information Technology**

This is Lauren, Terry. So here is what I could propose. I've been taking notes about this discussion and I know we have some kind of high-level recommendations that we could bring. So maybe let me summarize those into a draft document, share with you and Joe and this group here for any last feedback, and then we can send it out to the larger workgroup and ask them to provide written feedback. And then at the same time, we do need to make our recommendations back up to the Quality Measures working group. So probably at a future Quality Measures working group Joe and Terry, would you be willing to present these back to the larger group, and maybe – one thing we could do, Kelly, since you're on is, try to find time where also the ACO working group members can be on, since this affects both of their topic areas.

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

Yeah, I think they'd be really interested in supporting and being part of that.

**Lauren Wu, MHS – Policy Analyst – US Department of Health & Human Services**

Great.

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

So the one comment I would make, or not that I only make ever one comment, but one thing would be for us to come out of here with some action, some recommended action. So, and I think we tend to – we do these recommendations, but there really may be some early next 12-18 month wins that we believe, and I think some of that is based on that last discussion we had. Like how can we actualize this?

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

Yeah, Terry, I couldn't agree more, having done this for a long time now. Yeah, no, it would be so helpful and that's why I was sort of referring to some programs that are either actively being planned or are already in the field, where there's multi-payer collaboration. And it would be an easy implementation step – or not easy, but it would just be a quicker vehicle to – we already have the mechanism in place and it could be facilitated through federal partners, but really done in the field, because there's work ongoing that it can be piggybacked off of.

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

Yeah.

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

Right.

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

Okay, anything else? Okay, thanks everybody.

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

Thank you much.

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

And we're ready to open for public comment.

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

Oh yeah, sorry. Thank you.

**Public Comment**

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

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, great.

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

Okay thanks everybody, have a great day.

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

Thank you everyone, have a nice weekend.