

**HIT Policy Committee
Accountable Care Workgroup
Clinical Quality Measures Subgroup
Transcript
September 10, 2013**

Presentation

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

Good morning everyone, this is Michelle Consolazio from the Office of the National Coordinator. This is a meeting of the Accountable Care Clinical Quality Measures Subgroup it's a Subgroup underneath the Health IT Policy Quality Measures Workgroup. This is a public call and there will be time for public comment at the end of the call. As a reminder, please state your name before speaking as the 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
Joe Kimura?

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

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator
David Kendrick? Sam VanNorman? Helen Burstin? Ted von Glahn?

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

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator
Marc Overhage? 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
Paul Tang?

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

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator
And are there any ONC staff members on the line?

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

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

Thanks, Kevin.

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

Kelly Cronin.

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

Hi, Kelly.

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

Hi.

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

And I'll pass it back to you Terry.

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

Okay, we're going to modify the agenda a little so we're on this slide, we're going to move up Paul because of a conflict he has so we're going to go through slides 1 through 6 and then go to Paul's slides. So, next slide. So, these first slides are once again just reiterating our charge so I'm not going to read them to you but you'll recall that we have, by the October/November timeframe the need to develop these recommendations for the next generation of eMeasure constructs with the focus on their applicability into the ACO framework. Next slide.

In addition we were looking specifically about how the electronic clinical quality measures concepts could be used for deeming and Paul is actually going to talk about that this morning for both providers and hospitals for Meaningful Users. We also had this – wanted to be attentive to the HIT sensitive outcome measures which would be ideal and what groups would they affect. Next slide.

So, our goal here is really to finalize the preliminary framework for ACOs and Joe is going to go over a proposed framework review later in the call and discuss the measure concepts needed to move forward for deeming and Paul is going to speak to that. Next slide.

And this is the summary of the last call you guys did get the minutes in the attachment for the calendar announcements and what you see is the focus on the framework, exemplar measures, some proposed modifications to the framework that we had discussed and we're going to talk about that later this morning to broaden the perspective with really the focus on health versus healthcare, look at overarching measures, attention to community enablers and some attention to how we can incorporate them into the development of the appropriate measures and then decision quality in addition to shared decision making.

So, these are pretty significant modifications to the framework that we discussed last time and we will relook at them this morning as we go over the proposed framework with you. Next slide and then the next slide, remember the next steps, these are from the last call the one page document that looks at the framework how to include sub-domains and what exemplars should be included and identify the glide path and implementation. If you'll recall we do have some attention – we need to pay some attention to the IT – I'm not sure we'll get to the specifics but some of that glide path to implementation will include attention to that.

So, does anybody have any questions about where we are? Okay, so with that I think we'll just turn it over to Paul to be attentive to his time and Paul I'm assuming if we can flip to slide 13, which you are already there, and then we'll turn it over to Paul and let him present about the deeming.

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

Wonderful, thank you Terry and thanks for the summary of where we are and where we are headed because I thought that was excellent. I'm going to talk about deeming but the charge to this group and the interest that the HIT Policy Committee and general community are – the interest in quality measures are of the same type – the interest of quality measures for Stage 3 is sort of the same type as we're talking about for deeming.

So, in other words we are talking about a specific voluntary optional pathway and I'll explain more about that in just a minute. But the goal is for quality measures in the Meaningful Use Program overall is the same as for deeming so I just wanted to sort of clarify that. So your work is very important to the overall Meaningful Use Program as well as the deeming pathway. Next slide, please.

And the other comment I'll make is I know we've switched to sort of the value of health versus healthcare and one emphasis on value I think it was on a call of this group where someone pointed out that although cost is on the denominator you can certainly see if you over pay attention to cost alone you can swamp everything else and I don't think that was the intent of that original value equation and I think there are a lot of people who believe, probably the people on this call as well, that if we work truly on what's important to consumers and providers that the cost will also go down as you improve the quality.

Okay, so the recommendations on functional deeming and these are basically draft recommendations we've presented to the HIT Policy Committee a couple of times and gotten their feedback and part of it is the driver for the formation of this particular Tiger Team.

So, one is the realization, we're at Stage 3 and we've had Stage 1, 2 and now we're looking at Stage 3 the overarching goal for one was to get data into the EHR in structured form where that's appropriate. The overall goal for Stage 2 was to get it to the places where the patient receives care so that of course involves health information exchange and interoperability. And the intended focus from the very beginning for Stage 3 is really to move towards measuring and improving outcomes which is the overall goal for Meaningful Use Program in Toto.

So, if you step back and think, well gosh if by Stage 3 providers have already been through Stages 1 and 2, and we already know from some of the surveillance we've been doing about the Meaningful Use Program that first providers come in and we talked about 10%, 30% thresholds, well once you're in, once you've implemented a functionality people don't sort of stop at the threshold and they really blow it out of the water, they are up in the 80 and 90%, so that's one point.

The second point is year after year, and we do have a couple of years under our belt, then people don't slack off. So, once you've implemented something in Stage 1 we expect it to go through in Stage 2 and there is no reason that it shouldn't be going on in Stage 3 based on past experience and just the practicality of the matter.

So, with that as assumptions we'd like to – and another criticism of the program is how much effort it takes to actually – so you do something, the effort it takes to prove that you did something sometimes is actually more effort than actually doing it, people talked about that with documentation first you have to perform, either perform some procedure or cognitive decision making and then you've got to prove it in your documentation, the same similar principle. So, that burden of proving that you did something, you meaningfully used EHRs sometime is more than the effort required to actually do it and we want to relieve that burden.

So, the thought is, since we're in Stage 3 and we're trying to both encourage and reward good performance let's act that way. So, once you are achieving high performance or the other concept if you are significantly improved from the previous year then we would like to deem you in fulfillment of a subset of the Meaningful Use functional objectives, so that would relieve you of the reporting responsibility for that. This would be an optional pathway.

The people can take the traditional and prove that you've done these functional objectives and submitted these quality measures but as an optional pathway in order to reward good behavior, good performance we're proposing the creation of this separate pathway.

So, the other thing that deeming does is allow you to be more innovative. So, right now you have to perform and document your performance according to certain functional objectives and that maybe limiting. You basically – however your organization decides, you know, it needs to focus on in order to achieve good outcomes that should be the ultimate goal.

So, the deeming program is there to promote innovation, to reduce the burden of complying with the program requirements and to reward good performance. Now we recognize, and again this is the motivation for this group, that not all the CQMs, and that may be an overstatement, in other words, not a whole lot of the CQMs in current existence, because of our, you know, claims-based administrative-based QM definitions, are outcomes oriented.

So, we really are looking for, we the country and we the Meaningful Use Program, are looking for outcomes oriented HIT sensitive measures that would more accurately measure clinical performance and achievement of better health for the patients we serve. Next slide, please.

So, as an example, let's – we're putting together a framework for how would you create the criteria for deeming and so one we're trying to give a threshold for what's high performance and two what's good significant improvement?

So, high performance, as a draft, we put out there to say top quartile based on CMS data from the previous year. So, what does it take to perform at the top quartile or significantly improve performance? And in order to – so not everybody is starting at the same place and let's say there is a certain performance threshold, the top quartile, the difference between where you, your organization last year and your performance this year if you reduce that gap by 20% that's, you know, as a draft, considered significant improvement.

The second point – well, why don't you click through another please and one more? So, you would demonstrate, this is the proposal, that you are either a high performer or high improver by choosing from two high priority areas. Now, we've just given examples, this is all examples, one category for EPs could be prevention and another is control of high priority chronic health conditions. And then we would imagine you'd have some flexibility, you'd pick some measures that are most pertinent to your population thinking that this is both primary care and specialty care.

The second component of this program, click one more please, is reduction of disparities which is a priority for Stage 3. So, you would have picked, for example picked two from category one, picked two from category two that's a total of 4 measures, you need to prove that you're a high performer or high improver and for one of those four measures that you are closing the gap in a disparity between some disparity population and your performance with the rest of your population closing that disparity gap. So, that shows how we are moving towards better outcomes but also reducing disparities. Next slide, please, and click.

And the same would be true for EHs and we proposed a couple of categories, high priority categories, one is patient safety and another is care coordination. Again, it's pick two from each category and show in one of those four measures that you've also improved; you've reduced the disparity for your population. Next slide, please.

So, the idea, and these are things that are still in discussion by the Meaningful Use Workgroup, is that if you are – if you in this deeming pathway are a high achiever or a high improver then you would not have to go through the reporting requirements to prove that you've complied with certain functional objectives and in the left column are some examples.

So, in order to improve or achieve high performance it's our belief that you probably have used clinical decision support tools within your EHR, you've probably taken electronic notes, documentation, you are looking at your tests and you're tracking them. Those are examples of things that in general people who are high performers is because they're leveraging their tools and so we deem them as qualifying or satisfying a subset of the functional requirements. Next slide, please and click through please?

So, since there is an improvement option then we have to have a baseline reporting period, CMS would determine what that baseline is, and it would be for a full reporting period of 12 months and some of the reason for that is just logistics. And that you would have to show – so if you perform at the top quartile last reporting year then you would be deemed for the current reporting year in satisfaction of some subset of the functional objectives.

Now we recognize that for the quality measures a lot of them apply to primary care and not all of the specialties are fully covered and so it's possible that a specialty would not have four performance measures for which they qualify and because this is a voluntary program we just sort of have to live with some of those restrictions, constraints and of course encourage the measure developers to develop measures that cover the full gamut of specialties.

The other thing we're trying to do is align, as CMS is trying to align all of its programs, one of the programs is Meaningful Use and I think they are really doing an excellent job trying to align all of the requirements particularly with respect to clinical quality measures. The other thing we've heard is that even though you maybe measuring the same concept that when you tweak the denominator or numerator, or exclusions that requires a whole new investment of time by the providers.

So, as much as possible everything numerator, denominator, inclusion, exclusion should be the same and so we are trying to make sure that the MU Program uses appropriate things, potentially, from ACO Program as an example or vice versa, or I should say and vice versa, and some of that is already happening. Next slide, please.

So, let me go one more slide and I don't know whether that's my slide or – so this might – okay, so this goes to the charge for this Workgroup is that in order to fulfill the ideals or objectives of the deeming program, and as I mentioned at the beginning, and the Meaningful Use Program, the idea would be that we have HIT sensitive outcomes oriented electronic CQMs.

An example to help guide the development of these we're addressing both the measure developers as well as the people who will use the measures like CMS to look at what existing eCQMs might fit the attributes that you're developing. What are some in the pipeline as we heard last call and what are some that still have yet to be developed and could be cause to be developed through contracting for example?

Over a year ago the Quality Measure Group came up with concepts that are in this HIT sensitive outcomes oriented framework and proposed that and you may want to look at those and say, hey, look these are, when you have your attributes, these are some of the concepts that fit these attributes and we would recommend that CMS or other consumers of these measures work towards getting these contracted to be developed for example.

So, that's really – that's an overall – that's sort of the motivation for the work of this group and really more broadly the work to get better measures that matter in the eCQM domain. So, thanks, Terry, I'd be happy to answer any questions.

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

Thanks, Paul. Does anybody have any questions for Paul? Paul you can stay on until 9:00 right or whatever?

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

Yes, I can.

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

Whatever time?

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

Yes, whatever time –

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

This is Eva, just one quick question, I think this is implicit but I just wanted to be sure that in the slide that had the mapping of the measures and the deeming.

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

Yeah.

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

Or the functional criterion, the deeming that for a provider who in Stage 3 chose this voluntary path and was able to deem on those that were on the left side they would still though have to meet those on the right side is that correct?

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

Correct.

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

Okay.

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

Exactly right and the things that are listed are all just examples but yes.

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

Right, right, right.

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

Yes.

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

But this is not intended nor is there the expectation that we would come up with a deeming plan that would basically be, you know, one and done kind of you've deemed and now you don't have to worry about any functional criteria.

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

Correct and another thing to point out is the ones on the left have already been there in stages at least Stage 2 if not Stages 1 and 2.

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

Right.

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

So, people move along and there is no reason that we should keep chasing after the measurement of past accomplishments.

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

Yeah, yeah, yeah, yeah that's great.

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

So and the corollary then is we wouldn't have a new functional objective and then all of sudden deem out of it so that wouldn't make sense either.

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

Paul, this is Joe, thanks for that review. With respect to that same slide in terms of the left column and the right column has there been a mapping exercise of those functions related to the process for quality measures and outcomes going upwards to be sure that there is some alignment?

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

No and we actually put as a notation, you might want to go back to that slide, I'm not sure it's probably about 4 back. We put a notation that it's not intended to be a one-to-one.

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

Okay.

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

Ideally you'd like to think of it approximately that way, but the bigger way to think of it is if you look at high performers and, you know, you can think of the usual suspects including people on this call, you know, when you want to do – when you're a high performing group or hospital you're looking at a lot of things and in particular you're paying attention to your local priorities and areas where you know you need to improve and you're just doing it. So, you're going to use all the tools that you have it's in your best interest to use all the tools.

So, we don't think that if people are going to like, oh, I'm only going to do this because I'm trying to meet the requirements for this program, so we're sort of taking much more of a holistic view that seems to be borne out.

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

Yes, so I'm thinking – so the reverse side of it then, so if an outcome measure gets proposed that then shouldn't there be at least a bullet that's a functional specification that's related to that outcome measure? Can you create an outcome measure that doesn't have any – that is in a new spot, isn't related to some these things.

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

Okay, it's a really good – can you, oh, I thought you were going to ask the other question, so your question is can you create an outcome measure that doesn't have an accompanying functional requirement or are you saying the opposite?

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

Well, I was saying, so I'm thinking based – where I think our discussion will go, if we're really thinking about pushing forward on patient reported outcomes –

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

Yes.

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

Think about functions that the infrastructure, IT infrastructures are going to need in order to make that with meeting your objectives of minimal burden, you know, in terms to be able to do this and be able to reward good care I can imagine us thinking about a measure and then the functional aspects about what it means to actually be able to do that with a low enough operational burden may not actually be on the list yet and it maybe my ignorance on all the stuff that's on the list, but would that pose a problem if we jumped ahead with that kind of measurement?

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

No, we want you to. We definitely want you to and in fact that's the kind of pull that we'd like to create and so let's use your PRO example.

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

Yes.

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

Right there, stay on this, so we would love, in Stage 3 actually we are proposing that we have mechanisms to get PROs back to the EHRs.

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

Right.

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

So, right now we seem to be limited just because the limitations of standards of doing a semi-structured questionnaire.

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

But that's a good start, that's a really good start for functional status for example.

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

We would also like to be able to upload things automatically from devices it's just that the standards are not there, certainly the adoption of standards are not there. But do not hesitate in recommending things for which we don't have functions, as I say, we would love to have more pull that would help the cause of generating pull for the measures that are important to consumers.

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

Paul, this is Kevin Larsen, another clarifying question. As this group thinks about the quality measures that they are interested in do you want them also considering which functional measures that they cover or would that be work for a different place in time?

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

We'll worry about that in the Meaningful Use Workgroup, you know, you have quite an agenda for this group. I think the most important thing is to get, and this is somewhat of a term that I think Eva coined, measures that matter for consumers and providers, and I think those are very well aligned actually, but so just concentrating on the important measures that in your mind also are practical to measure would be the most important thing you can contribute. And if it doesn't exist like Joe said we'll make it so in the functional objectives, but we'll worry about the mapping.

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

So, and Paul, this is Terry, the other –

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

So, this is Ted –

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

So, the question I had is so I think you were also saying that we don't need to be constrained, we shouldn't constrain our thinking around what we know there are standards for in terms of terminology, are you saying that?

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

I think for important concepts where we don't yet have the terminology – one of the ways we work in the Policy Committee and the Meaningful Use Workgroup is if it isn't there but it's a really good idea and would be very valuable then we pass that information onto HIT Standards Committee that starts driving the standards either identifying standards that are applicable or starts driving standards that are in development or need to be developed.

So, yes, I wouldn't offer too many constraints on this group. We can put them in different buckets, remember we have the existing, we have the in the pipeline, we have the future so you can put them in the appropriate bucket and we'll work on trying to get those to come to pass.

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

Okay.

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

Well, this is Ted, well when I'm thinking about patient reported outcomes and how they fit in this configuration in many instances they of course are captured in yet another system, a registry, an outreach to patient information system and ideally ultimately passed into the ambulatory EHR.

So, in that example can you connect the dots with the functional standard that you would see relating? It's clearly moving into the clinical decision support system so that practitioner has information about a total knee pain change score, etcetera, but again given the information circuit that it's on and how it's used just comment on how that fits with the functional standard?

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

That's a really good question. There are two approaches and we were actually asked that question, another data source could be claims for example, and we haven't discussed that fully, but I can imagine a couple of scenarios, one is claims for example the claim itself actually gets generated in most cases from the EHR but what payers have that an organization doesn't have are the claims from the other organizations to which the patient also – that the patient also visits. So, we have to figure out a way how to get that information useable by the provider organization that also participates in the care of this patient so that's one point.

The other your registry point is interesting as well. So, the example you raised is, well you might capture let's say pain or functional status in some joint replacement registry. One scenario is that gets fed into, because it is needed in the PRO measure for the EHR reporting so that would require interfaces between the registry coming back to the EHR in addition you'd like to have the EHR to registry interface.

So, those would be good things actually the bidirectional interfaces and we have to think through what is implicitly required then for the Meaningful Use Program, but that's a good issue.

As you know there is a reporting requirement to – well, in Stage 2 you have the choice of reporting to some different registries and you can see the synergy with that so that's say going from EHR to registry and then we might think about how to import data from the registry as part of their reporting and that would be encouraging a good function, you know, a good behavior activity to come about as part of care coordination. Did I address your question?

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

Yeah, that's good, thank you so much, yes.

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

Any other questions for Paul?

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

Yeah, this is Ted, one other thought, I'm wondering about examining I guess more closely the improvement standard and if there is a possibility to model that, you know, with some of the most common clinical outcomes as an example. My fear is that that could be a hair's breathe difference, that 20%, if I'm understanding the formula, but again, the evidence would be more useful than my guess. Any thoughts about modeling that?

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

You mean using some large database to figure out where, you know, when you say model, you're looking at –

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

Yes.

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

What's the real effort and what's the real gain for – that whatever threshold is set?

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

That's right, yes. Yes, I'm just thinking whether it's a national dataset or some of the regional collaboratives –

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

Right.

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

That I think it's in hand in various places, yes.

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

Right, so we've been counseled to say that worrying about threshold is something we should, we HIT Policy Committee and Meaningful Use Workgroup, should do less of and we're trying to put out the concept and I guess the main concept – because people like CMS can probably model that.

The main concept is some notion of high performer where you're saying once you've achieved that you've just got to be using these tools and the other is you can't just only have the high performers get recognized or rewarded by the program you've got to give credit to the people who work with different challenges, different patient populations, different social determinates and how are they using the tools to improve.

So, that's the concept and the concept wasn't like an absolute number or a percent because for example 20% of a very low performance is a lot smaller than 20% of a high performance. So, this was our attempt at a formula concept that would try to normalize the differences or at least somewhat accommodate for those different instances.

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

Right, understood and it sounds like a task for others. I'm just suggesting that 20% that ought to be pushed and pulled a bit.

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

Yeah, no that's a good thought. If you have either data or other input I'm certainly happy to receive that.

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

Okay, anything else? Paul, the one thing, if you look at the deeming and satisfaction in terms of the criteria that they are meeting I could speculate that we may come up with some measures that may actually cover more of that and I'm intrigued because of this reporting to registries stuff. So, is the – so I'm assuming this is just a notional list right now and if there were other measures that people – okay, so let me ask you a broader question.

Is the assumption that if you choose to deem you're only going to be able to hit stuff that's already on the left side? So, even if you had a deeming measure that you knew was dependent on another functionality you wouldn't get credit for it?

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

No, so that's the whole – this is just like a strawman.

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

And I would say the critical constraint on "the list" left or right side, left side in particular is the lack of quality measures that we're asking you to think about.

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

So, if you come up with good quality measures, you know, outcomes oriented HIT sensitive of measures we will put as much as we can on the left side. So, the goal of the program –

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

We need to put things on the left side; we are primarily limited by the existing quality measures.

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

So, that's your biggest opportunity, that's our biggest opportunity.

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

Okay, just because that's an additional incentive to the –

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

Yes.

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

Person deeming.

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

Exactly, in a sense that's –

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

The more you move to the left the better.

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

That's right, that's exactly right. So, the better the measures you have in rewarding exactly what consumers, patients and providers would like to be measured against the more we can put on the left.

Lisa Lentz, MBA, MPH – Health Insurance Specialist – Centers for Medicare & Medicaid Services

This is Lisa Lentz from CMS I just wanted to mention regarding the clinical quality measures, I do know in the 2012 shared savings program rule, you know, there was some language signaling further alignment with PQRS and Meaningful Use measures down the road. So, I think that will be, you know, a strong consideration when the shared savings program goes through rulemaking again. You know, right now of the 22 GPRO Web Interface Measures I believe just 7 of them do not, you know, directly correlate with the current Meaningful Use measure.

You know, but certainly I think this is an area that, you know, could be revisited as another opportunity for alignment in the next rule. You know, in addition to any additional eMeasure concepts that, you know, this group believes might be appropriate specific to ACOs.

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

Thanks, Lisa.

Lisa Lentz, MBA, MPH – Health Insurance Specialist – Centers for Medicare & Medicaid Services

I just wanted to mention that.

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

Yeah, I can't – you probably can tell this is such important work, so thanks for doing this and also second, everything I've heard about CMS's work they truly are trying to align all the programs we just need good measures to align them around.

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

Okay, anything else? Paul, thank you so much.

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

Well, thank you.

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

Joe, did you want to go back to the framework?

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

Yeah, I'm thinking so, in context though, the good things are the more times we talk through this I think I'm starting to get a clearer picture about where we could potentially land and I'd like to sort of just – there are three slides that we have that two are review and then one is the new sort of the diagram that Heidi and Kevin put together that I think would be helpful to spend most of our time on slide 10, but talk through this framework to see, based on the discussion, based on what we just learned from Paul around the deeming criteria and our work ahead of us, how the diagram actually talks to us along those lines.

So, we've got slide 8 here, this is I think the slide we started from and the concepts that we that we grab from here, the outcomes, experience, expenditures sort of the above the line and below the line sort of concepts here around health and healthcare oriented measures versus potentially some process and healthcare oriented metrics down below.

The next slide got us to this map where we're trying to bring together these context domains for particular measures and tried to cross map them to the bigger buckets in the previous diagram and I think trying to figure out where the gaps were, we did the color coding exercise here, but from those two discussions we then pushed to this next point, which would be the third slide.

Where in many senses I think this is what we're trying to check our summarization of where our discussion has gone so far where the above the line/below the line gets represented with sort of in the big Venn diagram up above as opposed to sort of the traditional measures that are below that are in gray at the moment and that those top measures are the focus of where we'd like to go around patient reported outcomes and global outcomes both oriented from health perspective as well as healthcare perspective, and that those are overlapping but there are also unique concepts within each one of those domains that we'd like to begin to capture.

But that a lot of the traditional healthcare measurements whether or not they're intermediate outcomes or even process measures underneath fit under the structure that's sort of supporting those two bubbles, but I think this is the first time we've shown this graph to the committee live, so would love to sort of hear some reactions to the visual here and whether or not it reflects our discussions to date.

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

This is Ted.

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

Yes?

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

I guess I'm thinking about the feeder into these slides. I have to say I'm struggling a bit because I don't think of these as individual measured decisions. I think of them as measure sets.

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

Yes.

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

And that brings me to of course the populations and I don't see any visual representation of the populations to be served. So, whether that population is a nice set of – measures that address those who are severely chronically ill as an example –

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

Yeah.

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

Or those who are total joint replacement candidates or so on and so forth. Where do we get at the construct of a set of measures that, you know, of course are through the filter of the NQS where we're thinking carefully about the domains and at the end of the day we may say, you know, out of those 6 domains for that population 3 of them are spot on for application in Meaningful Use, but I would find it very useful to see all 6 of those to see that organization for that population and then apply, you know, some of the finer grain criteria that we're discussing.

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

This is Kevin Larsen from ONC, we do have mapped all of the Meaningful Use quality measures to the National Quality Strategy and then we have where they've been chosen to be used in programs that have predominance of specific populations. So, for example, the State Medicaid Programs will choose certain measures that are important to the populations that matter for Medicaid in those states.

We haven't done a mapping of the measures that exist to some prototype population in part because the program is a national program and so there is a challenge how to think about this for everybody, but we're open to that, but that's what we have.

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

Well, I guess I would underscore, I really don't think we can do the work well Kevin without that, because if we're talking about changing the behaviors of patients and practitioners I cannot imagine doing that without understanding that population, you know, fairly holistically.

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

Right.

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

You know, we can talk until the cows come home about shared decision making, you know, it's a nice term, but in fact it doesn't work in many instances. It doesn't work as something that we can detect let me put it that way in many populations.

So, we need to be very thoughtful about, you know, not general terminology around domains or constructs like shared decision making when in fact 9 times out of 10 it simply is, at least with the technology and our abilities today, we can't detect performance using SDM, we can in certain populations, but again, we have to be very, you know, particular about where it works and where it doesn't.

So, I would urge us to think about, again, if we're trying to provide patients and practitioners with information for improved health and affordability I cannot imagine doing that without thinking about, you know, the robust measures that apply to that particular population.

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

I think that's a great point, Ted. I think sort of – when I think through the balance of so if there is global accountability for just a generic population whether it's in the Medicare or a commercial ACO type arrangement and that's sort of the top level sort of a financial contractual population I guess I think of this, and I'm willing to go back and forth on this, I think of that as sort of the starting base population.

I don't know if we want to elevate it even further up and really talk about community-based sort of total populations of people living in a zip code arrangement or something like that, but if I start in that middle zone and then say within there obviously within your organization you will have sub-populations where the measurement is far more robust within those defined sub-populations underneath.

I guess I was hoping that the top level diagram that sort of talks about these general constructs would actually highlight which of those sub-populations there are very robust measures in and the other places where there are not so much robust measures in, but that doesn't mean that we can't be pushing development in those other sub-populations, but operationally I would fully agree as we get down to that next level that's where it's actually going to be helpful and useful because that's where the tools exist now that we can implement and apply.

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

Yeah, that sounds right, yes.

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

So, Joe if you're asking about input about this particular graphic I'm not sure it's highlighting the points – well, I'm not exactly sure what the points it tries to illustrate most. I think one of the messages is the difference between health and healthcare and potentially the other is the community context versus just individual, if that's correct it may not be coming through loud and clear.

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

Yeah, this is Kevin; I can speak a little to what we were trying to do. The committee at the last call had a discussion that we've done a lot work in measuring healthcare and we wanted to move into measuring health and how could we build our framework based on that Janet Corrigan's framework with the what we called "above the line" and articulate health and healthcare in a way that was illustrative and so we may not have hit that mark here, but that was the idea that we could use the framework to be able to see that some things are health and so therefore might be measured more at a community or a large population level and other things might be healthcare so therefore might be measured more at an individual level.

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

Okay, so may I make a couple of suggestions then in terms of responding to that? One is I think health is a super – is more the umbrella than just a co-equal of healthcare and probably community is also not a co-equal with individual. So, we – I mean, these are just a personal assertion, that indeed we probably need to spend certainly a lot more on health but certainly a lot more on community and I say that distinguished from population just sharing population in order to effect the behavior and the health of individuals, that's just a personal proposal I'm making and if people agree with that then I'm not sure that comes across with these co-equal bubbles.

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

Yeah, Paul, this is Kevin, one of the things that became clear as Heidi and I did this mapping is that we have a lot of measurement of healthcare but we have a goal for measuring health outcomes and a lot of health outcomes might not be best measured in a healthcare context.

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

Right.

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

They might be best measured outside of a healthcare context.

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

Well, so the subordinate – so this has two co-equal and I think actually care, and I'm just, you know, suggesting this, care is really both subservient to health and dominated by health. Does anybody else –

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

This is Terry, I would agree with you. I like conceptually what we're trying to show but I don't think – I think we probably need to play with the diagram a little in terms of the Venn part of it, what is the overarching and then what's subordinate, that's probably not the right words for it, but – and I would think from an ACO perspective, I'll actually defer to you guys, that the community part, and Paul I would agree with you I think in this case, well, it seems to me that community is the appropriate word, we have to somehow make it more overarching.

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

Yeah and this is Eva and I too like what we're working toward here but I'm wondering if a Venn is the right representation, because I think of these things as being relational in that with the community and more population-based emphasis being, yeah, overarching but I'm with you guys I'm not sure that's the right term, it's the broader term and I think what I mean by saying relational is there are some more population-based outcomes over which healthcare has more influence than others.

There are some outcomes that frankly healthcare has very little influence on and I think that probably is impacted pretty significantly by the previous point about population, you know, what population are you talking about and I feel like that's the concept or one of the concepts we're trying to get at is given that our focus is EHRs, which are fully in the healthcare camp, at least right now, to what degree can they be helpful in managing these more population-based issues.

And I think one thing that's already been discussed is that they simply must have the capacity to move beyond the walls of healthcare and that's where we've talked some about being able to receive data from other data sources which would be in the kind of outside bubble, which I think here is represented in red, but I don't know I think of this as more of a relational kind of thing that we're after as opposed to, you know, what is the overlap, which is I think – is the idea that whatever is in purple the patient centered value of health is kind of where we're targeting for this group in terms of identifying metrics?

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

This is Kevin, that was one of the ideas we were trying to convey and so Heidi and I played around for a while, but we're happy to take this back to the drawing board and anyone that wants to send us some ideas we would be happy to take them.

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

So, one of the things when I saw this first diagram, Kevin, and I think we talked a little bit about it, so it's – at least I see the three buckets, the blue dot, the red dot and the gray box and I see a left-hand side with current existing where actually the gray box dominates, right, in terms of what we do now, what we measure and what we are able to measure with a little bit more of the blue dot and then probably the smallest around the red dot, but that we're trying to move to the right side of a diagram where there is a little bit more balance.

Fully agree with Eva's point around, I don't know if the science is worked out fully of the red dot/blue dot and it maybe still content and sub-population dependent, but we're trying to move to that spot where that's a little bit more dominant and the gray box is a little bit or at least on equal footing with the top boxes rather than being so dominated by the gray box on the left side. To me that was kind of what my mind was trying to wrestle with.

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

This is Ted, I'm also wondering is the notion that the, I've forgotten the term you've used for the top, that earlier slide the blue I guess, the overarching measures, if you took the example of something like the CDC Healthy Days measure as a community outcomes metric.

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

Yes?

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

How does this fit with accountability? Is there any distinction between those overarching measures in that example you're measuring whatever total population as that practitioner or system is accountable for, so you're measuring their sort of Healthy Days, is explicitly what we're saying is, and you're being held accountable for a change in that metric over time or rather is it, you know, an environmental reference point and there are more discrete measures where the accountability kicks in?

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

Ted that's a really good point. So, I struggle with that in terms of thinking about, you know, ultimately under the accountable care framework right we're actually trying to optimize the value side of it.

There is a presumption that, and I think most of us would probably say it's probably true, right, in terms of the level of engagement, the number of healthy days in the community probably are some kind of not a process measure but a pre-measure towards on the pathway that could be a driver metric around the outcome changing.

But I'm not sure if the science of all of that has been worked out sufficiently for us to then apply it to a sense of saying, so if you increase that measure by 2% you're actually suggestive that that's actually something that you should get some kind of reward for one way or the other.

I don't – that still seems to me that there is a lot of work that needs to get done before a measure like that can get applied to that kind of what I would call high performance measurement. I don't know if others feel differently?

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

This is Terry, the one thing I'm intrigued by is, though I don't know that we're there yet, is overarching and then the – you know, in a sense the discrete measure that you talked about, discrete measure for accountability that presumptively has some kind of bidirectional relationship with the overarching one for the community and/or the population.

Because I think that that's where the pushback will be to some extent is that how can I be responsible for everything, but I'm willing to be responsible for this part of it. Because if we really want to elevate the conversation to health we have to talk about those larger umbrella things but we don't want to scare anybody with them.

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

Right.

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

Right, so, this is Ted, I mean, if I'm following, just as an example, if, you know, the bridge, if Healthy Days or, you know, the global – or whatever some global indicators of health are the overarching metric but is the, you know, is the money and the recognition and the public, you know, reporting consequences tied to, you know, the change score or the PHQ-9 or whatever it might be but something that we've gotten some evidence, you know, has got a relationship to those Healthy Days and a healthy population that's – I'm just fishing trying to understand if that's the construct or something totally different.

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

I guess I would say that that's what the ideal would be, right, that there is that kind of conceptual alignment of the types of measures that would be used and ideally they're all sort of on that driver diagram towards optimizing value for the target population.

I would say that I don't think a lot of it is probably established enough in the literature that most of us would feel comfortable talking with all of our doctors in our own organization about and this is what's going to get measured for us and to your point 2% improvement equals "x" right?

So, I'm not sure we're there yet as much as we are in a lot of the measures that are in the gray box, but I think, as an aspirational direction that's what we're hoping that we can start driving the work towards. Again, my opinion.

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

Yeah, and Joe this is Terry, I agree with you and I think that we probably have the opportunity to at least drive the conversation towards that through this work to talk about somehow embed in the framework these larger aspirational overarching, whatever the correct adjective would be, goals and then being cognizant of the need for HIT sensitive, achievable goals that once again don't overwhelm people.

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

Yeah.

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

Because, I think that that part of the conversation is missing a lot in that, you know, you look at hypertension without – not that I think that this happens at an individual provider level, but it may happen that, okay my drive is for hypertension control it's not because of the contribution that that makes in this larger community framework.

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

This is Kevin Larsen, I'm wondering if any of you are familiar with the HIV Treatment Cascade? The work they've been doing across the HIV community is an attempt to do this where there is a community-based total score, they're even looking at what would be the viral load in the community and then they have a series of measures that kind of span and bleed between public health and healthcare delivery, so it's number of people with HIV who know they have HIV, number of people in care, number of people retained in care, number of people on appropriate therapy and number of people who have their viral load in control.

And that's a guiding framework across the HIV community both public health and delivery and they can show you statistics city by city with organizations and community groups and public health agencies about how they are each playing a role in this goal of achieving HIV control, is that what we're talking about?

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

I think that's a good sub-population example, Kevin, but I would say, so I think we're pushing beyond even the viral load levels at the end right? Because I think you want to push into the blue and red dots or circles and I'm wondering whether or not that HIV construct was measuring sort of health outcomes as a whole for that population.

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

Yeah, I mean, it seems like they are probably using viral load as a surrogate marker –

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

Yes.

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

For the health population, but what's intriguing about that example is that if you say it's a surrogate marker and you're able to articulate what your real goal is, which is not just the HIV viral load; it's the health.

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

Right.

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

Presumably it's the health of your HIV, this subgroup of your population and then in a sense you have this HIT sensitive marker, which is a viral load measurement, because Joe I agree I think it's a good subgroup marker.

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

Yeah. I mean, it maybe that we create this framework sort of globally and then to Ted's point we have to give some good concrete examples of subpopulations where the literature and sort of the folks working within that domain have started to work out some of these. I don't know if – I mean, I don't know if they exist fully, it maybe that there are 5 or 7 sub-populations we can see all of them have some substantial gap somewhere in this framework, but if you put them together you can kind of see how all of them are trying to achieve this kind of global 3, two dots, plus gray box framework.

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

Right.

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

Joe, I don't, this is Kelly, I don't know if the pioneers have looked at their top common conditions in like say the top 10-20%, you know, of the populations that are driving their cost, but assuming that it might be CHF and some of the other complex chronic conditions I wonder if some of this could be applied to those populations where you're looking at a value equation or a total cost of care, or re-admission rates, or some of the utilization plus functional and outcome measures together almost in a composite way where you're applying it to the high cost conditions.

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

Yeah, so I think there are various pioneers who have looked at that I don't know if they've constructed the framework like that. I mean, so, in that narrow band of patient activation, right, and this may speak towards how we think about IT requirements, right, so we would look across both claims data and EHR data to see if anyone has had a face-to-face visit over the past 12 months as a sort of gray box kind of process measures around whether or not patients are engaged with us, but we'd love to be able to pair that with a PAM score right that says, okay, so just having them show up doesn't necessarily mean that they're activated, we'd like to be able to pair that with activation.

Then if you take that into a subgroup and say, within the CHF population, you know, we know that engagement is going to be very important because self-management is so important here, what are the sub-population type measures that are very specific to CHF that we'd like to be able to measure. So, we haven't gotten to that stage yet.

I mean, we could ask the pioneers if anyone has gotten there but within that framework it seems like there are some generic steps that we can start to see that we want an organization that's taking global risk for a population to be able to start to step through.

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

Yeah, I was sort of thinking that, you know, when Elliott Fisher did that re-analysis of the PGP data and showed that the real cost savings were coming from the duals it does seem like if we were to look at certain, whether it's condition specific or cohort specific outcomes that maybe it would actually be, you know, reinforcing the concept of measuring what matters.

And it's not that the other populations aren't important but I'm thinking that if we're looking at, you know, high impact measures and sort of applying the value construct across the cohorts that we know are high end or where intervention leads to high impact that could be one way to try to carve this or get this a little more specific.

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

Yeah, I guess my reaction to that would be that, so, I think as a framework when you're talking about – so you need to look at these sub-populations and do some kind of ranking to figure out what provides the best bang for the buck, but I'm not sure whether or not we want to specifically name sub-populations except for the point of illustrating seeing that there is an exemplar there, like HIV, if the construct is there it's a great exemplar to help educate people what we're trying to say, but it may not be the number one driver that you want everyone to focus all their resources on and if you set that as the measurement you're kind of fixing people to say, we have to commit to improve the population here because that's what the measures are, right?

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

Yeah.

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

You know, though, I think that there is – one way to push this and we've talked about this previously is to really look at capabilities. So, if we used the HIV as an example and push it up because I don't really think it's about viral load and Kevin I'm not familiar with that work so I don't know if they even say viral load is just a surrogate marker for this other stuff, but then you look at, it kind of goes back to the whole concept of deeming again.

You look at what's the capability within the measure that's required to get the measure value out of it so that you make it more in a sense generic and I think Joe it's what you were, just in the interest of time, to go to what you wanted to do about these measure concepts, in some ways I think that that's what where we're going is that we're looking for this more generic but at some point we have to be specific and that's why if we recall what Paul said about, especially for specialists, they may not have four measures so they can't deem.

But if we look at it from a capability perspective too, which I think is inherent in the concept of deeming, it may help us get there. I agree with you, I think if we came out of here and said "oh and the example we want to use is HIV" and only did that we would not be meeting what the objectives were.

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

This is Ted –

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

Did we lose you? Hello?

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

Hello, I'm here.

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

This is Kevin, I'm here.

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

Was that Ted that we lost?

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

I think so.

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

Yes, I think we just lost Ted.

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

Okay, well, I mean, so Terry if I look at the examples that we prepped and said, so we had – and sort of dovetailing on the conversation so far it seems like, you know, we have depression, we have re-admissions, we have the CG CAHPS score and then total cost of care.

In the way our conversation has been going it seems like depression would be or patients with depression becomes the sub-population and in theory you can have re-admissions in that population, you obviously have CAHPS scores for that population and you have a total cost of care type concept for that sub-population.

Does it make sense to sort of orient to the sub-population mode or still kind of treat these as standalones and think how we would think about these and what the levels of above the line/below the line would be?

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

Well, I think my concern is that we have to do both.

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

Okay.

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

And the reason is I do think we have this opportunity to push that conversation to that higher level and so if we don't do that larger work above the line – and I think we're getting there I think we just need a new schema, a new graphic.

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

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

So, that we're most explicit about where we want to go and then we can say that all the work below the line is only important, not only important, but is critical to the above the line.

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

Yeah.

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

So, we have to do both. I think my concern is that we have to somehow wrap the below the line in the above the line. So, for instance, we have depression and I'll go back to HIV, really what's the goal of depression it's to make whatever, pick some way to describe a healthier population, but that that's the goal and I think that that should resonate, Joe, with the ACOs, right? I mean, conceptually at least.

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

Oh, absolutely, I mean, so in the – at least what I'm seeing visually in my mind, right, so if there is a total population and things like total cost of care maybe at that top level from the healthcare perspective and if there is an expense measure there around whether it's, you know, absenteeism or presenteeism or the sort of total days of health etcetera, those kinds of measures at the top but then in some sub-population around depression you also have the above the line kind of concepts around related specifically to depression patients and that actually allows you to go really deep down right into the gray box as well.

But, you know, in that framework I can actually see a future state where there is that capability to say there is global population type measures but in that same subgroup like one would think that total absenteeism would probably be related to whatever health and healthcare outcome around depression we had because it is sort of – they are related whether or not the literature has demonstrated that definitively it feels like those things should be conceptually related in that kind of generic measure for the global population and then some more specific measures for the sub-populations. I'm starting to see something like that, but –

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

Yes.

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

Yeah, this is Eva, I think that's – I like where this is headed because when I think about managing a total population, yes you need to have those high level metrics that apply to everyone, but I'm not sure how you do that without understanding exactly who is in that population and that requires us to figure out what those sub-populations are.

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

Yeah.

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

And this gives equal credence to both of those perspectives.

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

This is Kevin, a question for the group; we've been talking about sub-population in terms of diagnostic category where Kelly brought up a program enrollment. I could also imagine sub-populations defined in different ways by age bands or disparity experience. Talk a little bit about what you think those sub-populations – what we should explore, what kind of work we could do as staff behind the scenes to help bring the right kind of sub-population examples to you?

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

Well –

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

Yeah, I –

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

Go ahead.

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

Go ahead.

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

Oh, this is Ted, Kevin just to echo I think where you're pointing, it does strike me that the chronically ill as, you know, a general sub-population is worth plumbing and whether that line is drawn, you know, around a particular severity level, that's of course one approach or just diagnostically, but it certainly lends itself to a lot of, you know, very important crosscutting measures clinically and also to some of the patient report of experience and engagement. So, I can see a broad swath of measures and of course the cost measures, but readily applying to that population.

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

Yes.

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

And related to that, is there more work that we could look into that tries to look at among those chronically ill have ACOs refined their methods and their analytic approaches to better carve out who is most at risk for hospitalization or higher utilization of services and looking forward. So, they're not maybe already in the top 20% of the near cost cohorts but they're at risk for getting there. So, is there more clinical or diagnostic, or sort of analytic know how on how to figure out who is at the cusp of becoming high risk?

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

Well, I think that knowledge is growing for sure. I think that becomes more challenging, right, so that crosscuts because it's not a single diagnosis that tends to be driving risk for each individual patient's risk for either re-hospitalization or high cost in 6 months or even mortality in 6 months is very dependent upon the sort of the constellation of diseases or whatever gets put into that risk algorithm.

I think that's when it starts to bridge in saying, so is – I guess I'm stepping back and thinking who's doing quality measures and I'm not sure if there is a body out there with, a, we don't have a common definition of what exactly high risk is and then who's developing either below the line or above the line measures specifically for a high risk sub-population. It feels like a lot of the activity right now is still related, whether or not it's the right way yet, but it's still disease and sort of specialty related that's where a lot of the activity is right?

So, I'm a little bit worried if we tack away into another direction while potentially important I'm not sure if there were – the infrastructure there is to build quality measures around those kinds of sup-populations yet.

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

Yeah, I'm wondering if we could have some limited set of a variety of sub-populations in order to both push those areas where we are not sure that there is really much, if any activity right now, such as chronically ill. We might could also identify certain sub-populations that are disease specific that have the most opportunity both in terms of volume and cost that might be another thing to focus on.

But I think also we need to, and this gets us a little into the red bubble on the Venn diagram, to look at non-clinical factors such as, this is a place where we could begin some emphasis on disparities if we chose to focus on race, ethnicity, because I feel like those are things that are critical to understanding how you impact your population from an engagement perspective, but then both in terms of identifying disparities for those groups, but then in understanding how to close that disparity gap we need to understand what those specific factors – how they impact health.

So, you know, is it a health belief or language or what have you, but then another possibility might be socioeconomic which seems very strongly related to outcomes in someone who has say multiple chronic illnesses who is at a higher economic status I don't think necessarily responds or has the same kind of need in terms of quality in non-clinical instances as someone who say has a low socioeconomic status with multiple chronic conditions.

And so, you know, it maybe that we can figure out a limited set of a variety of things that begins to move us toward this understanding of the relationship between clinical care and the healthcare system broadly speaking with the number of domains that we've got in Meaningful Use and the broader outcomes on a population level that we all are after.

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

Yeah, this is Ted, I would agree with that. Again, just as another example of a nice crosscutting measure for the chronically ill particularly, you know, the moderate to severe is something, you know, one of the PROMIS batteries, I mean, this is a population where you actually can detect changes in health status. So, I would just encourage, again, those are examples of fairly large and important populations both health impact and cost where the measure set could be tailored.

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

So, I agree with you, so maybe the next step would be to first reframe up the big picture with the bubbles, the red, blue and then the gray, but then come up with a set of sub-population examples where we get into some more detail around what currently exists in each of those sub-populations and from that it kind of was what we thought about doing in this session with a couple of examples here, but now orienting around those sub-populations and using that to be able to talk about the HIT requirements that we see in common as we look across all of these sub-populations and the bigger picture. Does that sound like where we're heading to?

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

This is Terry; that seems like a reasonable place for us to tease it out and see what it looks like.

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

This is Kevin, I jotted down some ideas about sub-populations and I just want to get a sense from the group if I'm on the right track or if we should head in another direction. So, I wrote down that we could think about chronically ill, frail elderly, Million Hearts, mental health, asthma, HIV as some kind of examples of populations that we either talked about or sort of skirted around. Is that what people are thinking of as sub-populations or are we thinking of something different?

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

I think that's a broad set. I guess I would include Ted's total joint because I think that's a narrow sort of episode type population that adds an additional flavor to this.

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

I think that's right too, but, I would advocate strongly for some sort of non-clinical division.

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

Right, yeah. So one could –

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

And I'll add to that, that this could be a potential way to use the data that we know is already being collected because the previous Stage 1 and Stage 2 Meaningful Use requires collection of race, ethnicity and language, and thus far we aren't sure of whether or not that data is actually being used, this is a good way to make use of data that we've set the stage for in previous stages.

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

Yeah and this is Kevin just an FYI the IOM is just launching a new study with us as a partner looking at routine collection of social determinate of health data and so with that hopefully there is some output there in time for us to consider for MU3.

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

Well I think some kind of racial cultural sub-population or a language sub-population I think would be a valuable frame as well. Whatever, I don't know who has the most information on that, but –

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

Okay, in the interest of time, I think we're ending at 10:30 right, is that right?

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

Correct.

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

And we need to do public comment. I think we've had a lot of information and dialogue; we'll get out some minutes to you. We didn't go over the framework Joe.

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

Yeah.

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

So, I think we kind of need to regroup a little. I think we only have one more call, is that right?

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

This is Kevin; we do need to give some deeming recommendations to the Meaningful Use Workgroup in time for them to give it to the Policy Committee. So, the goal is to get this other call and give some basic deeming recommendations for the October Policy Committee meeting. We will have some additional time in October and potentially November to work out some further details.

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

Okay.

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

But we do need some larger recommendations including potentially some exemplars much in the way sort of as Paul framed this for us. We need enough that they can understand what it is we're talking about.

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

Okay, but you're going to, Kevin, you wrote some stuff down.

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

Yes.

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

There will obviously be minutes. We'll come back together; our next call is next week is that right?

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

That sounds correct to me but I'd have to double check.

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

So, we still have another hour and a half to work in order to get the stuff to the deeming Workgroup and then what I'm hearing you say, which I think would be positive, if people on the Workgroup are willing to continue to do this, is that we can push a little bit more on this by adding on one or two more meetings?

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

Correct, we can.

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

Okay.

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

We need some high level recommendations but we can push on some of the more specific details which would be really helpful to the policy creation.

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

Okay.

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

Kevin, I've got our next meeting on September 26th.

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

You could be correct.

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

Okay.

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

Yeah, it is.

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

Okay.

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

This is Michelle what I think I'm hearing is perhaps there could be some more meetings scheduled before then to keep moving is that possible?

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

Let's try.

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

Yeah, I would try for one between now and September 26th. I think some of it was related to the support that ONC could give us so I'll let you guys figure that out internally.

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

Yeah, it was around the change in year for contracts for support for the call, so we now have a new contract which makes it much easier for us to be flexible around calls.

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

Okay. So, let's try to do one additional call if people can make it, it would be great, if not we'll have everybody or as many people as can be back on the 26th. Okay, I want to be sensitive to public comment, so should we move to that now?

Public Comment

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

Sure, thanks, Terry. 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 comments at this time.

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

Okay, Joe any final words?

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

No, I think we're – the momentum is building, I like it.

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

Okay, thanks everybody for your time, we'll be sending out more information.

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

Thank you.

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

Thank you.

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

Thanks.

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

Bye.