

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

Presentation

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

Thank you. Good afternoon everybody. This is Michelle Consolazio with the Office of the National Coordinator. This is a meeting of the Accountable Care Clinical Quality Measures subgroup, which is a subgroup of the Health IT Policy Committee's 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 this meeting is being transcribed and recorded. I'll now take roll. Terry Cullen? Joe Kimura?

Joe Kimura – Atrius Health

Present.

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

David Hendrick? Eva Powell?

Eva Powell – Evolent Health

Here.

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

Helen Burstin? Mark Overhage? Paul Tang? Sam VanNorman? Ted von Glahn?

Ted von Glahn – Pacific Business Group

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 – Office of the National Coordinator

Kevin Larsen.

Alex Baker – Office of the National Coordinator

Alex Baker.

Kelly Cronin – Office of the National Coordinator

Kelly Cronin.

Lauren Wu – Office of the National Coordinator

Lauren Wu.

Heidi Bossley – Office of the National Coordinator

Heidi Bossley.

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

Okay. Thank you, everyone. I'll now turn it back to Joe.

Joe Kimura – Atrius Health

All right. So I want to thank everyone, and I'm going to start with a little bit of a preface, that I think we're busting through this relatively quickly. And I have to admit myself, I think Paul, Sam, and I were at Epiccare in Madison this past week, so I am going to rely a little bit on Kevin to help us through this discussion. We had a – we had some back and forth after our last call around where we were heading in terms of a framework, and I think we drafted a couple of things up along those lines, and I think we want to share that with our group, to make sure that directionally, we are again heading the right way, or in a way that's consistent with how all of us on the Committee are thinking about this. And I think we are also making sure that we have a deadline of October 2nd, I believe, that we're trying to drive towards, so we have about another week and a little bit or two weekends, if we put it that way, for trying to get something to the HIT Committee that they can actually use going forward. So is that –

Kevin Larsen – Office of the National Coordinator

Yep. That's great. This is Kevin.

Joe Kimura – Atrius Health

– where we're at? Kevin, help me out here a little bit. Yep.

Kevin Larsen – Office of the National Coordinator

No, I'm here. So thank you, Joe, and yeah, we'll go through kind of what we've been talking about behind the scenes. There was also a meeting earlier this week of the Quality Measures Workgroup, and the way that we've divided the charge of deeming between the two groups is that the ACO Quality Measures Workgroup is working on the framework as well as some of the core criteria and some population and group-based reporting exemplars, and the Quality Measures Workgroup is working on how this works in a individual provider, fee for service setting.

With – thinking in the same way, they looked at the framework that this group has been putting together. They also looked at some of the exemplars, but then started talking more specifically about not using this in the context of large-scale integrated system build, but what does it look like in an individual provider incentive program, or an individual hospital incentive program.

So for the purposes of this call, we don't have to focus very much or at all on individual providers and individual hospitals. We can think about the group reporting, ACO accountability kind of framework that we've been focused on all along.

So should we start going through the slides?

Joe Kimura – Atrius Health

I think that makes sense.

Kevin Larsen – Office of the National Coordinator

So we did the introductions, so we – overview of the previous call. I think all of the group members were here at the previous call, but as you remember from the previous call, we fleshed out some more the framework ideas, as well as how we wanted to focus on populations of patients as a guiding frame, as opposed to thinking about this from a condition-specific place, or a program-specific place. And so by that I mean a population might look something like the chronically ill or the frail elderly as a holistic patient care population, rather than how does this look in the PQRS program, or how does this look in the Planning Your ACO program?

And so we started some work and had a lot of great discussion about what would be criteria that would kind of define these populations. We came up with a few examples, and then behind the scenes, we've mapped some of that out, and we'll show some of that here for – to spur further discussion.

Other thoughts from Joe or others in the group about kind of where we are from the last call?

Joe Kimura – Atrius Health

No, I think, Kevin, that summarizes the trajectory we were heading towards, and I think reframing that to focus us on sort of an organizational level also adds, again, that aspect. I think we did have discussion last time around being sure that we're picking things that make sense, and with Paul's encouragement of some things that get used in the organizational incentivization elements, while conceptually we're all in agreement towards, may not be ready for primetime, where others are. And so we just need to be conscious of that as we go forward. But as we're talking, we're talking from the – as an organizational set of measures.

Kevin Larsen – Office of the National Coordinator

Absolutely. As an organizational set of measures, as a system of accountability, things that a group or an ACO or, you know, maybe even a hospital, that's something that – it's system level accountability as opposed to what – the Quality Measures Workgroup is looking at how does this fit into the current framework of fee for service incentive programs, which for the – for many people are still at an individual provider level.

Joe Kimura – Atrius Health

Yeah.

Kevin Larsen – Office of the National Coordinator

All right. Next slide.

Ted von Glahn – Pacific Business Group

And I'm sorry. This is Ted. I understand the distinction you just drew. I'm – I am confused about where the two lines converge. So it's your saying the charge here, the focus around system level accountability and the accompanying measure sets by populations, and then the charge of the other workgroup around the individual practitioner and so forth, and – but of course, at the end of the day, am I – there's going to be one measure set, so it's just to say that we're –

Kevin Larsen – Office of the National Coordinator

Well, I think – I think –

Ted von Glahn – Pacific Business Group

– feeding in some, you know, thinking along – you know, bounded by the parameters you just articulated, and the other workgroup is feeding in similarly thinking, for others to merge the two lines, the two strands of consideration?

Kevin Larsen – Office of the National Coordinator

Yeah. Absolutely. So remember, the deeming pathway is always going to be a pathway of optionality, right? So there will always be a standard pathway, and what the Policy Committee has described is deeming would be an optional pathway for groups or individuals to choose. And the goal for the deeming pathway has been choosing – has been – has been identifying important outcome measures that span a variety of kinds of desired outcomes, typically triple aim outcomes: better health, better healthcare, and lower costs.

And so as we think about the opportunities for those outcomes, the opportunities are different potentially for large systems or groups than they are for an individual. So for example, we have talked in depth about how a total cost of care measure might be really worthwhile at a large group level, but that a total cost of care measure would need some really different kind of thinking about how it applies at an individual provider level. Holding an individual dentist to a deeming pathway where they're responsible for total cost of care for a patient in a given calendar year, it's a further stretch than saying that that total cost of care measure in an ACO context is a – is an ideal measure for that kind of deeming outcome phrase. Does that make sense?

Ted von Glahn – Pacific Business Group

That's a good example. Thank you. Yes.

Joe Kimura – Atrius Health

Mm-hmm.

Kevin Larsen – Office of the National Coordinator

So you're right. They're – we're looking at ideally one measure set, but there may be – much like group reporting doesn't always look exactly like individual reporting, there may be a sort of articulation of how this happens in this kind of accountability system level framework that looks different than how it looks in a more individual provider fee for service kind of framework.

Ted von Glahn – Pacific Business Group

Yeah. So Kevin, I think to that point, I think in any report that goes forward, just being very transparent about those are some of the parameters we used when making these reqs, right, are going to be important, and sort of it's not that it can get flexed, and that our thinking was in this frame.

Kevin Larsen – Office of the National Coordinator

Yeah. Absolutely. That's absolutely the case. You know, that's really been the charge from Paul and the Policy Committee all along, or the Meaningful Use Workgroup all along, that the meaningful use program is aimed at these new kinds of integrated, coordinated care, so he is really excited that this is the group that's focusing hard on thinking about this from that integrated system perspective.

Ted von Glahn – Pacific Business Group

Okay.

Kevin Larsen – Office of the National Coordinator

So the goals for this call are to develop the criteria for deeming at this population and sub-population level and identify some exemplar measure concepts. So the reason we are doing it in this way, we've thought that rather than articulating exactly how deeming would work, to really help flesh out what are some criteria by which the deeming would function, because it may look different applied to some different types of populations. So for example, if we say that the frail elderly is one type of population and chronically ill children are another type of population, we don't need this group to flesh out a whole measure set for each of those, but we would – what we're hoping for is what's a set of criteria to apply against those measure sets that we could use a check, as we might build what that looks like through a set of potential populations.

And then we thought it would be useful to work through some exemplar measure concepts, so that we could kind of test our framework and test our criteria, and also give some examples to the – to the Work – Meaningful Use Workgroup and the Policy Committee and others for people to sort of understand what we're talking about. Next slide.

So this is just reframing what we've already done, the current thoughts. They should be HIT sensitive measures, outcomes oriented, population focused. Ideally, this framework would support high or improved performance. It would support a reduction in disparities, encompass the aspects of the meaningful use stage two objectives, but not map necessarily to those. And then a kind of thought that came up in the Quality Measures Workgroup is maybe some special focus somewhere on patient-reported outcomes measures, as we want this to be really meaningful to consumers.

Questions or thoughts on this slide? All right. next slide.

So this was the draft framework that we talked through, based on the framework of Elliott Fisher and Janet Corrigan. Above the line is referring to the red and blue dots, and below the line refers to the gray. And by above the line, we mean kind of big dot, high level measurement of outcomes, and below the line is more process measures.

We then thought about how do we – can we characterize kind of health and healthcare as two different but interrelated or two related but slightly different ways of measurement and intervention? So blue here is healthcare, and red is public health or overall measures of health, and that we thought that the ideal place is this sweet spot in the middle. And then – next slide.

We've been thinking about how that framework helps us talk through measurement for deeming. So this is a reconceptualization of that that Joe put together, I think it's quite nice, where right now, what we have are very few measures of health outcomes, especially at the community level or at the population level. So that's that small red dot. We have a lot of measures of healthcare and healthcare outcomes, but maybe even more measures of healthcare processes, the below the line.

And what we really want to have happen is to move to have a more measurement framework that is aimed at health outcomes, the big red dot, with less emphasis on healthcare outcomes, and less emphasis on the below the line process measures. Next slide.

So here's I think the place where we'll spend a fair bit of our time today. This is trying to live out what that might look like specifically across a couple of populations. So as we talked through, we identified a few different populations to use as an example, and then Joe took and built out some examples about how this might work. So across the top, the columns are populations that might be used for deeming, and the reason we've chosen populations is because most providers, even if they're working in a group or in an accountable care space, are not going to be focused on a geographic population, or sort of all types of Americans. They will still be focused on some particular population of focus: children, adults, or elderly adults, or cancer patients. There will be some kind of focus.

And so we want to have a way to allow for that focus, but still think in that big red dot way of what are health outcomes for that population of focus, not just think about what are specific clinical care outcomes, like cancer outcomes, but if we're thinking about a population of cancer patients, what are the health outcomes we care about? Efficiency of patient satisfaction, of care coordination in – holistically for those consumers, rather than just putting a lot of cancer measures there.

So those are the populations in the columns, and then the rows are the different types of measure domains. And so the top is the health outcomes. These are the red, the thing we don't have enough of, and we want more of. Healthcare outcomes are the next row, and then intermediate outcomes are the below the line. The gray _____ we actually have a lot of in the current framework.

So questions about this? Comments, thoughts? Joe, you created this. Your kind of thoughts about how – what – you know, ideas that occurred to you as it – as you were doing it?

Joe Kimura – Atrius Health

Yeah. No. I think we sketched this out almost like the same day we had our last call, because I think we were talking about the fact that there's a lot of development in these columns or these sub-populations, where we span all the way down to a lot of process measures, but then within each specialty society, they're developing some healthcare outcomes, and then ultimately also starting to think of health outcome type measures, and that as an accountable care organization, we probably don't have as many of the global measure, but conceptually, we were thinking about each one of the measures in the gray columns in some senses holistically all drive to some set of global population type measures, again, within each one of the rows.

So I think we were trying to just make that distinction and say, there's a lot of information in each one of these columns, because that's where the work is happening, and that's probably where we're going to get some more concrete, actionable things faster, but by no means do we think that a single column is representative of the performance of an organization for an entire accountable care population.

Kevin Larsen – Office of the National Coordinator

So I'm curious about the rest of the group's thoughts about this. I know you're just seeing it, but, you know, initial impressions or how we can improve it?

Ted von Glahn – Pacific Business Group

This is Ted. I like this positioning of things. I think it's really a nice – a nice organization or template. Joe, I didn't understand your very last comment. So I'm looking at the same screen, so we've got these two examples of the HIV and the total joint.

Joe Kimura – Atrius Health

Yeah.

Ted von Glahn – Pacific Business Group

Yeah. And were you saying that this was not intended to be exhaustive? I missed your last point.

Joe Kimura – Atrius Health

Yeah.

Ted von Glahn – Pacific Business Group

For that particular sub-population?

Joe Kimura – Atrius Health

Yeah. So I – my – I think what I was trying to say was, and I might not have been clear, is sort of within each sub-domain, and I think – and the PDF that's attached to the email, there's – we said that there could be other sub-domains, right? Like that are defined in very different ways in terms of diversity, language, or other things that aren't sort of the classic disease-based sub-populations, and that here right now, we have a lot of science happening on sub-populations that will fill out a bunch of metrics, but that we do need to take a step back, because it's – ultimately, as an organization, we're hoping that there are sort of higher level accountable care measures that if you were somehow able to smush all of the gray columns together, together, they would actually be driving these overall population-type measures at the top.

And that right now, we probably don't have enough gray columns fleshed out to be able to do that comprehensively, and we may never actually get to it comprehensively, but the concept is that you're going to have possibly dozens of gray columns, right, about various sort of sub-populations that specialty societies and other groups are working on, trying to develop how do you capture these concepts of health outcomes, healthcare outcomes, and process outcomes in each one of these domains? Does that make sense?

Ted von Glahn – Pacific Business Group

Yeah. Yes, it does. So as you say, there is a challenge that we're not going to solve I think in the next ten days. That's not part of our charge, is to create a suggested framing for the global indicators of a system or an ACO performance? Is that –

Joe Kimura – Atrius Health

Yeah. I mean, I think – I'm sure Paul would love us to be able to name some of those, but I'm a little bit wary to say do we have enough information and is the science advanced enough to tie these kinds of measures – like for the HIV one, I think, Kevin, you brought that. That's done out of the Atlanta group or the Emory team, right?

Kevin Larsen – Office of the National Coordinator

Yeah.

Joe Kimura – Atrius Health

So, you know, we picked a lot of our discussion elements, so the stuff off to the left of this in green are some more sort of generic, quote/unquote, measures, but, you know, within the HIV realm, they're talking about viral load suppressions, etcetera. Does that – everything on the right actually correlate well to more generic measures to the left? I'm not confident that we've got that tied – those things tied together yet enough to be able to apply them. Again, I think this is the key for me, is by applying it in terms of incentivization and measurement of performance, to rank and/or to compare one organization's performance over the other.

Ted von Glahn – Pacific Business Group

Yeah. I – that's really well-stated.

[Crosstalk]

Kevin Larsen – Office of the National Coordinator

And just to – this is Kevin again. A clarification. For the meaningful use program, remember, the only reason that a ranking would be important in this context would be that would be – allow you to get into this deeming pathway and get you away from having to measure a lot of other things. There would be no additional payments to you as a higher performer. It would – it's just a way of saying you're doing so well that we don't – you don't have to show us your homework. Because you – you're able to, you know, calculate these things reliably on your math test, you don't have to do all the pages of math homework.

Ted von Glahn – Pacific Business Group

Right.

Eva Powell – Evolent Health

Yeah. Well, this is Eva. I think that this is helpful, and I think the previous – the discussion thus far has been a good way to talk about this. But I'm wondering if maybe part of the guidance that this group can offer is the need to – in order for this model to work down the line when we do have the more overarching outcome measures at a population level that we don't yet have, we need to move beyond, as you say, the disease specific columns and begin adding columns that are reflective of the other domains of the meaningful use criteria.

In other words, what strikes me about the slides – let's see what slide number the – I think slide 3 of the presentation, where it talks about the framework should support improved performance, reduction in disparities, you know, all those things are great and I agree with those, but then if you look at the grid of the different categories of meaningful use, that is only reflective of that first category, which in essence makes that first category more important than any of the others, which I don't think is A, the intent of the meaning – of the Policy Committee, and I don't think it's the intent of the group, either.

And so maybe part of our guidance on this issue is to lay out some exemplars in the sense that they're exemplar concepts that need to be developed more, say related to coordinated care, which is one of the priorities of meaningful use, that that could be measured across an organization more easily than some of these other things that are in that first category, because they by nature have to be disease specific. Does that make sense?

In other words, conceivably, you could measure coordination of care across an organization, because coordination of care is a universal goal that's a little more specific than like a quality outcome. Perhaps it could be done using the CTM3, which would be relevant to pretty much any patient, at least in the hospital setting. That's just an example. And part of the difficulty, of course, is that these things aren't yet built.

But I guess part of my concern about this is that we get down the road and we're rolling up all the priorities of meaningful use into this one category of improving quality, safety, efficiency, and reducing health disparities, which certainly is important, but it is no important than the others. And I would argue in an accountable care setting, coordination of care is more important than an individual disease quality measure. So I just don't want to lose that in all of the discussion about what we have already and what we can use going forward. Sorry. I'm babbling a little. I'll stop there, if that makes sense.

Joe Kimura – Atrius Health

No, I think that's – those are great points, Eva, because I think sort of like the coordination of care to me does feel like that's something that if you pick any sub-population where it's a disparity population, a SES population, a chronic disease or even age or payer group, you name it, we should be able to assess how care is coordinated in any of those subgroups. I think in some sense it takes us back to that original diagram, Elliott Fisher's diagram that had that top equation, right, that said ultimately, all of these things, whether it's quality outcome, coordination, we are trying to optimize the value equation at the top. And I'm not sure, again, if we have great science yet that absolutely has the weighting of each one of these, of what is more important, and it may be differential weighting based on what type of conditions you have, what combination of gray boxes you have.

Eva Powell – Evolent Health

Yes.

Joe Kimura – Atrius Health

But fully agree to the point that, you know, we want to think about a framework that says we're trying to drive towards value at the top, and balance that out with Paul's needs of something a little bit more concrete that we know that it's being developed, but granted, there's holes.

Eva Powell – Evolent Health

Yeah.

[Crosstalk]

Ted von Glahn – Pacific Business Group

So the thing I would add to this, I mean, I would like to see us be – exactly what you just said, Joe, be a little more concrete, even to use the term coordination, and Eva, you nicely singled out an example of, you know, the CPM, the sort of – but of course, that's a relatively limited population, and it wouldn't be my first candidate domain within coordination. I think as an example, coordination across practitioners if more of a cross-cutting concept, you know, in a system or ACO population, accountability. There are several other strands of coordination, so I'm fishing a little bit for is that – I think we could bring value to the larger effort, if we could be a bit more specific about, you know, within coordination, the lead horse in this context of system-wide accountability is X. There are other coordination constructs that bring value. They may not rise to the summary of the global indicator for that ACO of coordination, but, you know, they're darned important for some sub-populations. Something like that.

Eva Powell – Evolent Health

Right.

Joe Kimura – Atrius Health

Yeah. No. I agree. I mean, we can think about – so say we just take that and put coordination in the middle bucket, which would I guess be our blue circle in the previous diagram, and say, so in theory, you can calculate activation, patient activation scores. There may be inpatient specific or disease specific, but globally, we're trying to measure patient activation as an important construct to improving value. And similarly, coordination of care as a healthcare outcome, 1 system is trying to coordinate care for its entire population with potentially different interventions and different sub-pops, but if we can actually measure that either as an inpatient, outpatient, or global system measures, those kinds of things are what we think are going to be important.

Eva Powell – Evolent Health

Yeah.

Kevin Larsen – Office of the National Coordinator

So this is Kevin. I wonder if it would be helpful to kind of walk through an example, for you guys to pick a – you know, someplace that gets your more concrete, maybe that's a population or sub-population or maybe it's a program, and start articulating what would be in that place, and then think – let's think simultaneously about what kind of criteria we might use. And I think if we go to the next slide, I think the criteria that we discussed at the Quality Measures Workgroup, we pulled from previous work that was one for MU1, this thing called the Gretskey Group. Oh, this is – sorry, this is a – not quite yet.

So this is another framework that we have pulled together that, again, looks at this kind of shared accountability. So this is some work that CMS has been looking at for how we can share accountability across various actors in the system. Why don't you go to the next slide?

So these were some of the criteria that were discussed for e-measures in general from this Gretskey Group, and again, we talked through this in part at the Quality Measures Workgroup on Monday. So we looked at what – were the measures ready, either in the pipeline or likely to be able to happen? Are they HIT sensitive? And do they promote parsimony? And HIT sensitive is a specific one which I think deciding whether or not they're important for this is a thing to articulate. HIT sensitive was important to meaningful use because the goal was to show that with using electronic health record technology, this measure we think would be likely to move, not that there aren't other important things that you can do in healthcare that don't need HIT, but for the purposes of the EHR incentive program, it was felt that the measures actually measure parts of healthcare that we anticipate are improved with HIT. Next slide. I think there were a couple more criteria.

So also looking at preventable burden, measures that were – that prevent a large amount of disease burden or population burden or cost. Outcome assessment, so that – we wanted measures that were outcome-oriented and looked at patient risks that actually helped to – that are known to lead to outcomes.

And finally, longitudinal measurement, enable assessment and measures that are longitudinal at the sort of care, patient-centric, rather than – or condition-specific longitudinal measurement that span a number of measurement periods or the various programs.

So what we did on Monday with the Meaningful Use Workgroup was talk through an example of a measure suite and applied these criteria to see how well we thought these criteria that have already been used worked, and we talked through the Million Hearts kind of measure suite as our set of examples that might potentially apply to eligible providers.

So I might suggest that this group think about picking a population or sub-population, thinking through some examples to go into the framework that we can keep iterating as exemplars, and at the same time, thinking about why the measures that are picked, what criteria you use to pick them were criteria that helps – that we could apply over and over again as we think about this in other contexts.

Joe Kimura – Atrius Health

So Kevin, when I think about this, and if you go to one, two, three, four, five, six, you know, it – clear – because we're driving into an HIT Policy Committee recommendation, it seems like the first thing is that we're not tasked to sort of globally assess accountable care. We're being asked to do HI – or specifically HIT-related measures. So it seems like that would be one of our highest priorities, to say, okay, narrow it down to those.

But then also, second, is we are talking about this value construct, and four and five seem to be the key criteria to those that says if you're going to prevent the burden, improve health risk status and outcomes, that seems to be the second big criteria. And then we get down to sort of are we using sort of the operationalization of those measures and saying, let's be sure that we're not making up measures on our own. There's some good literature behind it that ties it together. Six is also something about longitudinal measurement. I think Sam and I would absolutely insert another thing that may not be in here yet around the burden of actually generating those measures and/or the validity of being able to do – I realize we talked about the fairness concept, and even though it's just deeming, you're either in or not, in order to be able to skip through the proving of your math problems.

I think that leads to still a significant burden to the organizations that don't meet that criteria for being able to show all of their math. And so there is absolute real cost for us to not be able to cross that threshold, so I still think I would be framing it around this aspect, it needs to be fair to – to be able to make that line of above or below, you met criteria or not, as far as possible along those lines. I kind of forgot what three was here, so . . . so I'm not sure if we can introduce another measure or another criteria.

Kevin Larsen – Office of the National Coordinator

Oh, absolutely. These criteria were just a place to start from. We – this criteria was one that Helen Burstin suggested, because it had been used in the past.

Joe Kimura – Atrius Health

Yep.

Kevin Larsen – Office of the National Coordinator

We can throw it out, but – or we can modify it or add or whatever.

Joe Kimura – Atrius Health

Yeah. I guess I would think that there's a hierarchy to it, and we should – my recommendation, I'd like to hear what Eva and Ted and everyone on the Committee feels, seems like we should start a little bit with what the task – the scope of the Committee, and then talk about value, and then be sure that we're talking about how those things get operationalized. If they fit those three things, then we think that a measure potentially is eligible for something along those lines.

Ted von Glahn – Pacific Business Group

Could I ask a couple of clarifying questions on the criteria? This draft here, this state of readiness, and again, I plead some ignorance on this, but is it not the case that many of these e-measures are not quite right? So in the fine print, what are we really saying here? Are we saying that measures that have been, you know, well-specified and evidence-based and endorsed by NQF but not necessarily e-measures, is that distinction important or not? Is it assumed, or –

Kevin Larsen – Office of the National Coordinator

So this is Kevin Larsen. We have, for the purposes of this group, we have not said that the measures need to be limited to e-measures, that things like total cost of care are absolutely on the table. Readmissions are on the table. Things that are used already, you know, parsimony is really important.

And thinking beyond just what is measured only at the EHR. When we're talking readiness, it's more to what Eva was talking about. We all would love a well-tested, country-wide ability to say that we have global assessments of function that we can measure reliably and repeatedly as a patient-centered outcome measure that is part of our national measurement infrastructure. I would say that none of us are confident that that is ready right now.

Joe Kimura – Atrius Health

Yeah.

Kevin Larsen – Office of the National Coordinator

We have some pockets of functional status patient-centered outcome measurement, and some areas that are more ready than other areas. But implementation isn't there. The science is only just emerging. And so that's the kind of thing we're talking about.

Ted von Glahn – Pacific Business Group

So Kevin, just to extend what – again, for a concrete example of how – what this would mean if it was applied today, it means that in certain treatments, take the total joint, we have a functional – we have several functional measures, scales, that, you know, have good evidence behind them, so meets the test. But –

Kevin Larsen – Office of the National Coordinator

Correct.

Ted von Glahn – Pacific Business Group

– across the entire ACO population, so when we move up to those global ratings, we don't have a population-wide functional metric. Is that what you mean?

Kevin Larsen – Office of the National Coordinator

That is correct. And so that's where criteria help us, so as CMS and ONC would work to flesh this out, having criteria to think about where we would apply it across various populations would be – would be very helpful.

Ted von Glahn – Pacific Business Group

So part of where I'm taking this back, Joe, to your earlier comments about, you know, it's a longer road to get to some of these global all-population indicators, and somehow this – you know, the communications of this work is – I think you noted this, just really needs to draw that out, because if I was to apply that criteria today, you know, we could completely rule out functional outcome measures for the reasons we're talking about.

Joe Kimura – Atrius Health

Right.

Ted von Glahn – Pacific Business Group

But that's not really our intent, that they will work within sub-populations, and – and go forth, right?

Joe Kimura – Atrius Health

Right. If I think about sort of the application, and Kevin, I don't know if this is how we can write things, right? So in some senses, if we talk about the horizontal bands and just say that there are certain – like the criteria ought to be – well, maybe I'm jumping ahead on this one. I was trying to say like, you know, each organization is given the freedom to look at a couple, and we can say, to Eva's point there around, you know, don't just look at disease-based gray bars or gray columns. You need to have, you know, something that's a chronic disease, something that's sort of a little bit more SES or population – a patient population community-related, and stay within those two areas or three areas, pick whatever you need, but that needs to be within the outcomes, thinking about healthcare outcomes and thinking about intermediate outcomes, and giving the flexibility to be able to say like you have to pick stuff that's mature enough, right, that you have some kind of endorsement – NQF is a tough one to keep throwing out there as a concrete one, because I think, you know, many of the things that we're trying to push towards, it's going to be a long time before NQF endorses some of these things.

So I'm trying to figure out how this gets concretized, and whether or not we need to give exemplar specific measures or a specific example of how we see these things actually getting applied in an ACO.

[Crosstalk]

Eva Powell – Evolent Health

Yes. This is –

Kevin Larsen – Office of the National Coordinator

So this is Kevin. I think one idea that would be helpful is for you guys to pick something more concrete, and you all have done this, so you know more what that concrete would be. But it might be the kind of population, Joe, you see in a pioneer ACO, and then start laying it out as here is a proposal more of – as a way to test the criteria and build the criteria than it is here's exactly what we're going to commit to.

Joe Kimura – Atrius Health

Okay.

Kevin Larsen – Office of the National Coordinator

Eva, did I speak over you, I think?

Eva Powell – Evolent Health

Yeah. No. Well, I was just going to say the previous comment made a lot of sense to me, and I – yeah, I continue to struggle with this notion that we're trying to balance the need to have some – have an exemplar that we can implement more quickly than we will be able to develop measures that don't exist yet, but the very reason why we're having these conversations is the fact that those measures do not exist yet. And the measures that we currently have, particularly those that are NQS endorsed, are simply insufficient for an ACO environment.

And so I like the suggestion that whatever our recommendation is, whether it's at the level of criteria or maybe a combo of criteria and specific examples of how that would play out using more concrete – or measures that exist now, are ways to move beyond what we seem to be so strongly tied to, which we – everyone agrees does not work. It is insufficient. We do not have measures that support accountable care, and, you know, I feel like until we can take some little baby steps beyond the measures that we know do not work, we're just running around in circles.

And so from the specific standpoint using the care coordination example, when I think about some of these NQF criteria that we were just discussing, I agree. I think the notion that it should be electronic, but maybe not – but not tied to an EHR, gives us a lot of leeway. We can then look at measures that are being collected as part of HIDA and make a criteria that says, you know, for care coordination, you must combine – you know, you must show that you're using a measure that combines data from multiple data sources, or – you know, I don't know. That's just kind of off the top of my head example.

But I don't know. I just – I worry that we're tying ourselves unnecessarily to things that we've already agreed pretty broadly are insufficient, and the whole purpose of this is to move beyond that.

Kevin Larsen – Office of the National Coordinator

Yeah. So this is Kevin. One of the opportunities with the meaningful use program, because it is not a pay for performance program, is that it helps to ____ cause to mature and cause to create some of these things we need. So absolutely tell us what should be there, not just what currently exists that we'll have to settle with.

Eva Powell – Evolent Health

Yeah. So I'm just – let me go back to the gray bars. Let's see. Yeah. I'm trying to think of specific examples. Maybe that's one way we can spend our time today, is, you know, some other work beyond at least what I have in my own head would be necessary, but come back to the gray bars on the – the horizontal gray bars of health outcomes, healthcare outcomes, intermediate outcomes from say – you know, if we were to have a gray column that's labeled more generally care coordination – let's see. Health outcomes, we could have – I don't know. Is there a public health measure that's used in the public health arena to measure health of a community? You know, I don't know. I mean, that may be a little beyond the scope of –

Joe Kimura – Atrius Health

Right.

Eva Powell – Evolent Health

– meaningful use, what meaningful use is all about, but we – you know, if we could scale that back and identify something that is more public health in nature, because that's – part of the problem there I think is we are still dealing with healthcare providers who really are not – well, they're not currently concerned with health. They're currently concerned with healthcare.

Joe Kimura – Atrius Health

Right.

Eva Powell – Evolent Health

And so coming up with an existing measure that is health-oriented is going to be really difficult unless we can make use of what is being used in other arenas that are fully supported by meaningful use. There's the final priority of population and public health. And to date, it's been very public health heavy in terms of the criteria, and not so much on the population level. And so that, to me, from an accountable care standpoint, is a real area to look at. You know, what are – what are local public health departments or communities using to measure the health of their population. And so that would be – it's not really – it's a concrete thought of where we might go to get something more concrete to put in the actual box.

And then healthcare outcomes, I like the idea of longitudinal. And it may be too soon to expect people to have longitudinal data for X across – and you could leave that up to the entity, across multiple providers, but certainly, it should not be too soon to expect that within a certain accountable entity, that they have longitudinal data. That is the whole – one of the main purposes of accountable care.

So I don't know if this is making any sense or being helpful, but I just – I feel like we could do some – make some pretty helpful recommendations by consulting those who are working in some of these other areas, such as public health, that are involved in meaningful use, but have really been on the margins to this point.

Joe Kimura – Atrius Health

Yeah.

Kevin Larsen – Office of the National Coordinator

So this is Kevin. How about this as a – as an idea? Let's talk about the frail elderly.

Eva Powell – Evolent Health

Mm-hmm.

Kevin Larsen – Office of the National Coordinator

And the reason I picked that is because it's in the sweet spot of Medicare.

Eva Powell – Evolent Health

Yeah.

Kevin Larsen – Office of the National Coordinator

And it is specifically not focused on a particular condition.

Joe Kimura – Atrius Health

Yeah.

Kevin Larsen – Office of the National Coordinator

It's specifically focused on community integration. And it's a place where there's a lot of expense that I think many people feel there are opportunities for efficiencies. So if we would think about the frail elderly as an example population, how could we start filling out a grid of recommended outcome measures for deeming in a frail, elderly framework?

Joe Kimura – Atrius Health

Right. So if I think about that, Kevin, and say take Eva's concept of sort of care coordination, right, and again, completely off the top, and saying, so at the lowest level, how would you actually measure care coordination? And you could create, as we were talking about, saying, you need to have some kind of measure that looks at the sort of contacts that you've had with the particular population, whether it's using claims or EMR or ideally both, to be sure that you're able to measure accurately for your population of 20,000, 50,000, 100,000 frail elderly patients, how often they're actually contacting. The quality of that you can't tell. You're just real baseline, data available, get that kind of measure.

But then as you move up in the healthcare outcomes, I think then we do talk about things of if it's inpatient, is it CTM3? Is it some level of survey results? Or again, what are the tools that are available around the frail elderly population that measures that kind of continuity and care coordination from a population perspective. And then I too, unfortunately, then am lost at the top level of saying what is the right care coordination type healthy – health outcomes that would seem to be reflective of good care coordination down below? I don't know if I know of one at that point.

Ted von Glahn – Pacific Business Group

Hey, Joe, Ted. Where I'm struggling here a bit, and Eva, I thought you put your finger on it, too, part of the – I'm struggling between the measurement system and what actually – what it's related to in the functionality activities of the EMR.

Eva Powell – Evolent Health

Right.

Ted von Glahn – Pacific Business Group

So in the frail elderly world, as an example, several of the care coordination constructs – one clear construction is this whole notion of connecting the – you know, to community services.

Joe Kimura – Atrius Health

Sure.

Ted von Glahn – Pacific Business Group

And another construct is back to if someone actually – my medical home, if you will, is there – is there a primary care coordinator that's supporting me across the spectrum?

Joe Kimura – Atrius Health

Yeah.

Ted von Glahn – Pacific Business Group

So if you took those two constructs, you know, you – those, you're going to get through a patient experience report. So I thought that was a little bit of what, Eva, you were pointing to, but I wasn't quite sure. But imagine, you know, we're just conducting a CAHPS plus survey to get at those constructs.

Joe Kimura – Atrius Health

Yeah.

Ted von Glahn – Pacific Business Group

Those of course don't live directly in the EMR, but we point back to the EMR –

Eva Powell – Evolent Health

Right.

Ted von Glahn – Pacific Business Group

I guess the bridge back is so what's the functional activity in the EMR that supports, you know, community service coordination?

Joe Kimura – Atrius Health

Right.

Ted von Glahn – Pacific Business Group

Or supports, you know, engaging caregivers, or whatever it happens to be. Is that – that's why I'm struggling. They are obviously very related, but the measurement system is not housed within the EMR.

Eva Powell – Evolent Health

Yeah. Yeah. That's a really good point.

Kevin Larsen – Office of the National Coordinator

And this is Kevin. We have permission not to just limit ourselves to the measurement system being in the EMR.

Joe Kimura – Atrius Health

Yeah.

Eva Powell – Evolent Health

So maybe it's production of a report that you can show is contributed to by EHR data, but that shows some of these more global population-based metrics.

Joe Kimura – Atrius Health

But so what – so I'm hearing it slightly differently, where – so that a uber CAHPS survey is somewhat at the top level around healthcare outcomes. There is a _____ we're not sure of yet that needs to be within the EHR that enables our ability to move the needle on the CAHPS survey around coordination. And in some senses, the process measure is whatever that structural element is, are you using it reliably across your delivery system on this population?

So there are a couple of unknowns there, but I guess I kind of heard it that way.

Eva Powell – Evolent Health

Sorry. Did you say CAHPS survey?

Joe Kimura – Atrius Health

Yeah. And things – the CAHPS survey or some addition to the CAHPS or some patient-directed survey element that collects the data that may or may not be in the EHR itself.

Eva Powell – Evolent Health

Right.

Joe Kimura – Atrius Health

But it's measuring that construction of continuity or care coordination.

Eva Powell – Evolent Health

Yeah.

Joe Kimura – Atrius Health

The assumption is an EHR delivery system or accountable care organization needs to have some structural IT thing in place that will support that, but it may be – that could be a very complex set of infrastructure underneath there.

Eva Powell – Evolent Health

Right.

Joe Kimura – Atrius Health

But the intermediate outcomes or the things that are underneath there really are how well do you use this thing that we know relates to improving your CAHPS survey score, right?

Eva Powell – Evolent Health

Yeah. Yeah. And I think part of what I'm thinking is consistent with that in that say – you know, say a provider or a hospital or whoever who's seeking meaningful use is part of a broader system that is accountable for care of a population, and as – this group that they're working with, they are contributing data using their EHR to something else that then generates the report back to those who have contributed pieces of the pie, pieces of data. They then get that report back. It's a much more useful thing than anything that you could ever get out of the EHR by itself, but the EHR has played a pivotal role in it, and the technology itself must have the capacity to send and receive the data in order to make it available to the provider.

So if it's – to me, if someone's doing that, that's exactly what we want them to do, not necessarily to be tied to the EHR. And it's – and it's useful from an accountable care perspective, because – for obvious reasons. You're measuring these things at a population level.

Joe Kimura – Atrius Health

Right. So Kevin, when we talk about it that way, we're obviously – we're articulating slightly more specific functional elements that we would expect an organization to be doing without really calling out what exactly it is in the frail elderly population. Is that – are we hitting a sufficient level of detail, or do we need to go further, you think?

Kevin Larsen – Office of the National Coordinator

Well, so I think we need to go further. So if I put my hat on and pretend I'm CMS writing a rule about how would deeming work in the frail elderly, I would need to be able to say, here's the frail elderly. Here's how I know I've got that population. And then here are the set of quality measures that if I – if scored well on, are deemed. So ____ –

[Crosstalk]

Ted von Glahn – Pacific Business Group

And Kevin, to take that – oh, mm-hmm.

Kevin Larsen – Office of the National Coordinator

– can sign up to do deeming via frail elderly, and here's the things that he – that organization would need to do well on to be able to know they're in the deeming pathway and eliminate a bunch of other functional measure requirements.

Ted von Glahn – Pacific Business Group

And let me offer one example, Kevin, and see if this is getting closer. So in this discussion about care coordination and sort of the – you know, the measurement system issue we just talked about, the functional requirement, the meaningful use functional requirement could be a care plan that has a home and community services whatever, module or some such thing. Is that what we're reaching to?

[Crosstalk]

Eva Powell – Evolent Health

This is Eva. I – I was just –

Kevin Larsen – Office of the National Coordinator

And that's a functional requirement. I – what we're reaching to is our readmissions one of the measures? And if you have really low readmissions, you don't have to measure care plans, because we assume you have them. It's maybe a bad example, but that's the kind of place that we're trying to get with deeming.

[Crosstalk]

Kelly Cronin – Office of the National Coordinator

Or mean number of falls prevented, or mean number of falls, or I think – yeah, we're moving more towards getting to specific outcomes that would be relevant to that population.

Eva Powell – Evolent Health

Right. And I could see the example, I forget who gave the example before, about touches to the healthcare system. I mean, that's something you can easily get from claims. You'll never get that from an EHR in today's world. But if you can show that you've tracked over time the number of system touches, whether it's admissions or what have you, but then couple that – so say that's a health outcome, and then couple that in this broader report that I've been talking about with the healthcare outcome, which may be falls prevention, or that could be something related to a care plan that's not just the checkbox presence or absence of a care plan. And then the intermediate outcomes, I don't know. I'm trying to think of what that would be. But I don't know. Does that help get us a little more close to the specificity you need?

Kevin Larsen – Office of the National Coordinator

Yeah. Well, this is Kevin. I don't think we need to go through all levels here, right? If we think there are great health outcomes, and that's all we want, we want to make this – we want to make this test as easy to do as possible from a measurement burden standpoint.

Eva Powell – Evolent Health

Right.

Kevin Larsen – Office of the National Coordinator

It might not be as easy to achieve, but we don't want to actually have you spend a lot of time filling out the tests.

Eva Powell – Evolent Health

Right.

Joe Kimura – Atrius Health

But Kevin, so let me ask this, though. So as a deeming criteria rather than a specific metric, I mean, I guess what's very attractive to me is that sort of process of there's an – there's a overall healthcare outcome in the frail elderly element, and you've identified that, and you've identified that there's a structural function that you need, and that being linked to your organization is measuring the use of that function across all of your providers, because you're committed to how that relates back up to that end outcome. To me, it's the connection of all of those things that shows me that they're meaningfully using their resources.

Eva Powell – Evolent Health

Right.

Joe Kimura – Atrius Health

And is – can we not frame it in that way, and say, look, it doesn't matter which con – which frail elderly, diabetes, you name it, you can pick one, but you have to show that you're using the constellation of stuff. Linking those concepts together, if you can demonstrate that, then we assume that things are going to get – head the right way.

Kevin Larsen – Office of the National Coordinator

So how does that work from a operational standpoint? So now you're going to sit down to attest to this. What do you send in as attestation?

Joe Kimura – Atrius Health

Yeah. So to me, that becomes – it's a lot more – I hate to say – I think I'm trying to figure out operational burden of reporting through and saying look, we're using this as our particular outcome, but say it is the patient experience outcome or care coordination reported through a patient experience survey. That's the end outcome. But just using that, I need to sort of demonstrate that there is some structure underneath there around care coordination, and to Eva's point around is there a report that I'm using, sort of attach the report that you're using that providers potentially get, and then show some kind of measurement monitoring system, etcetera that you've got going that says that your organization is managing that.

So there's a little bit more of a storyline submission rather than I'm just using this measure and I'm performing at 80 percent.

Eva Powell – Evolent Health

Yeah. And I'm trying to think also how this might work for smaller providers, not just for the larger providers, who very well by this point are probably going to be either in an ACO or functioning in some capacity where they'll have a broader technology capability than just their EHR that could generate this. But a smaller provider, I don't know – I don't know to what extent payers give data back to their providers, but if they aren't currently doing anything of that sort that would meet these requirements, that might be a way to loop them into this conversation. I don't – although this is just Medicare, sorry.

So this there a way – do providers currently get data back from CMS related to utilization for their patients?

Kevin Larsen – Office of the National Coordinator

So this is Kevin. They get some of that information back. You know, that is part of the promise of Physician Compare, that Physician Compare will be sending some reports back based on primarily PQRS, but also some claims data back to providers. That current system has a fair bit of time lag in it that CMS is working on, but yes, there is – there is some feedback, especially through the Physician Compare program.

Eva Powell – Evolent Health

Yeah. Yeah. So that might be something to build on to enable smaller providers in this – you know, I don't know what – to the degree they're getting it now. I don't know what the rates are that they actually look at it and use it. But it would tie – it would tie that benefit that's being improved on CMS's end to something larger, and also would serve to knit programs together.

Kevin Larsen – Office of the National Coordinator

So this is Kevin. I'm going to try to channel Paul a little bit. What I'm hearing from the group is that – a recommendation around making a narrative articulated, a rationale for how you're using health IT to improve outcomes in your population where there's a descriptive submission about the linkages between your health IT infrastructure and the key outcomes in your population.

So I'll submit that I think the goal of this is just to set the finish line. It's to say, what's the big dot at the end of the line, and really, CMS doesn't care how you got there. You got to the finish line, and you can – we'll trust you that your homework was good.

Joe Kimura – Atrius Health

Yeah.

Ted von Glahn – Pacific Business Group

Kevin, let me understand. You gave a couple of examples like, you know, the readmissions rate and fall prevention and so forth. That does not speak to a frail, elderly's person experience of care. It's really distal, in my mind, because what often happens in the real world is the health system fails that frail, elderly person, and it's all sorts of family and friends that fill in the gap.

Joe Kimura – Atrius Health

Right.

Ted von Glahn – Pacific Business Group

And I don't want to reward ACOs for family and friends filling in the gap, or at least then they should be paid for it. So I'm really stuck on, you know, we do need the uber CAHPS metric that says, you know what? The health system was there for me. It hit the high notes on these elements of care coordination that matter for frail elderly. I think that has to be an overarching indicator. I think that's one of the big dots. And – but I'm struggling. If you're saying if we can identify, again, constructs within that notion, you know, we can – have done our work and go home, that's great. I'm struggling with this next level, though, of what does that mean. Again, back to the functional or structural requirements of the EHR and what specificity you're asking for.

Kevin Larsen – Office of the National Coordinator

So we don't –

Eva Powell – Evolent Health

Yeah, well, I think –

[Crosstalk]

Kevin Larsen – Office of the National Coordinator

– this is Kevin. We don't need a lot of specificity about the – by collecting blood pressure routinely, you were able to improve the care of the frail elderly. We'll need a little bit of that to be able to articulate, you know, how do things like interoperability with transition of care documents play into something. But this is really to say what's the finish line? What's the target?

Joe Kimura – Atrius Health

Right. But to that, Kevin, doesn't it feel like – so I agree with Ted in the sense that the big dot is that uber measure, so if we had the big dot, I would actually be fine saying then let's not obsess about how we got there, because you're moving that big dot.

But because we don't have that big dot, I mean, we could write it and say, if this big dot were there, then great, let's use that for deeming, and it's apply it going forward along this line, and we can give suggestions on how we would write that question, blah blah blah. But that – if we're then fixed in terms of what we have available to us today, and it moves us down one level away from that big dot, then I feel like we're starting to – we lose that power of saying, just use that one measure, and if you qualify for that, then we assume you're doing your homework well.

Eva Powell – Evolent Health

Yeah. Well, and the other thing I would add is that it was clarified on the last call that we are not trying to deem all functional criteria in a smaller set, that part of our – either our work or the Meaningful Use Workgroup will be to come up with our – to take our recommendations and map them, so to speak, although not necessarily one to one, to the criteria that can be deemed. But other criteria of meaningful use functional criteria will still need to be in place, and as I've thought about this, I can't think – there's certain ones particularly in the patient engagement arena that I'm not sure we can really deem, such as access to information through a portal, or communication with your provider. You know, those kind of get at some of that uber CAHPS that we don't have yet, which would I agree totally that that is something we should shoot for.

But, you know, I hope that there's not going to be a move towards trying to deeming – deem people into meaningful use with a set of, you know, five measures or whatever that we come up with, that we are trying to reduce the burden, yeah, but that there's certain things that just aren't going to be able to be deemed at this point.

Kevin Larsen – Office of the National Coordinator

Yeah. No, that's true. There are – it's always been the case that it will only be a subset of the objective measures that would be under the deeming frame. So I hear you. We all agree that we don't have the perfect measure. But the question is, how can we continue to advance the measurement community using the meaningful use program, and also advance the sort of thinking around measurement to how can – what – how close can we get there, and articulate it in a way that people can understand.

Joe Kimura – Atrius Health

So it seems like, Kevin, that the big dot we have to choose has to be actually in existence today, with some level of acceptance, right? Or are we thinking that it needs to be there – we said 2017 or something like that. Right? So –

Kevin Larsen – Office of the National Coordinator

Right. And it could be – it could be a composite, right? So we could take five or six measures, ten measures, whatever it is, build a composite measure, if we're comfortable with that.

Joe Kimura – Atrius Health

Hmm.

Ted von Glahn – Pacific Business Group

Kevin, when you say a composite, are you cutting across dimensions now?

Kevin Larsen – Office of the National Coordinator

Yes.

Ted von Glahn – Pacific Business Group

You know, from clinical to patient experience and so forth, or –

Kevin Larsen – Office of the National Coordinator

Potentially. You know, it could be a frame. You have to score well in a frame. But eventually, you're going to need to know are you over the finish line of deeming or not. Right? You – as a system, you've got to know if you cross it. And so if we either kind of functionally build a composite, or we build a sort of series of not too many measures that you can tell if they're each individually over the line, and you know how they're weighted, to let you know that you're – you've made it or you haven't made it.

You know, so if I think about frail elderly, you could imagine us building a measure that has a readmissions scores, a CAHPS component, a total cost of care component, a falls component, something about number of days living in the community component, from public health information. So you could imagine building a series of those kinds of components that together form an imperfect but composite that's moving us towards the big dot we all want.

Joe Kimura – Atrius Health

So I think the idea of taking a – the frail elderly population as a very heterogeneous population and then using care coordination as the concept that we're going to try to push forward makes sense to me as sort of an example that people can use to say, this is how this framework is really going to work. When I hear about the things that we just threw out there and just – I don't know if we just need to acknowledge right now the uber CAHPS score is what we would really shoot for this construct, but in the absence of that right now, is it some portion of the existing CAHPS that's sitting at the health outcomes or the community-based measures? To me, those are where those things are as the big dot items.

And then I think, honestly, when I think about like readmissions and sort of falls and complication rates and all that, to me, those still feel like healthcare outcomes rather than sort of stuff at the health outcome level. So I feel like we want to – we really want to make the big dot in the healthcare outcome space. I don't know if we want to pull from a bunch of measures that currently exist that go all the way down into potentially some intermediate process things that we have readily available to us, and smush them together into a composite.

Kevin Larsen – Office of the National Coordinator

And that's why we've got you guys thinking about this. I just sort of threw something out there to get reactions. That was the – that was not some –

Joe Kimura – Atrius Health

Yeah. No, no, no.

Kevin Larsen – Office of the National Coordinator

– deeply thought through.

Joe Kimura – Atrius Health

So can we say, then, so as an example to – I don't know – if you keep your Paul hat on, Kevin, you know, can we say, look, let's think about frail and elderly. Let's think about care coordination. And if someone, an organization were to deem out of sort of proving all of these things in this care coordination space, the main elements of the composite score would be X, and to me, I don't know what – if the Committee feels this way. It's definitely at that – the proxies of health outcomes. And to me, that's still around the patient reported elements, around those – what the care coordination experience was like.

Ted von Glahn – Pacific Business Group

I like that.

Kevin Larsen – Office of the National Coordinator

So if – yeah, if I channel Paul, which I'll try to do. I don't know if I'll do a good job. So I think that's moving exactly in the right direction. But some more specificity, what is the question on the uber CAHPS that you really want? And how – and is there more than just that? Is there something about cost? Is there something that's about measurements of other types of care or other types of health? You know, health days was one of the things that Janet and Elliott Fisher suggested. Are there some other things on top of that patient perception of care coordination?

Joe Kimura – Atrius Health

So I would say there is. So would you force like an organ – if you – if you list five of those, it sort of forces the organization to absolutely measure those elements, right? And I don't know if I would feel comfortable saying, we're going to pick five that we're pretty sure everyone needs to be able to do. I – it feels like we're pushing our level of understanding on that. I don't know how to –

Ted von Glahn – Pacific Business Group

Yeah. As a follow-up, I'm happy – even this weekend, I can ____ on that question you just raised, Kevin. What I think are the – some of the candidates from our uber CAHPS world, including some non-CAHPS items that people, you know, are experimenting with that speak to care coordination, so – and maybe that would, you know, be a little bit of a spur for the other Committee members to weigh in.

Kevin Larsen – Office of the National Coordinator

Okay.

Joe Kimura – Atrius Health

So Kevin, recognizing we're at 1:25 –

Kevin Larsen – Office of the National Coordinator

Yeah.

Joe Kimura – Atrius Health

– are we done at 1:30?

Kevin Larsen – Office of the National Coordinator

We are.

Joe Kimura – Atrius Health

So our next meeting is at what time? I'm trying think what can we be thinking about and bringing back to it and what's the timeframe for the next one?

Kevin Larsen – Office of the National Coordinator

So Heidi or Michele, do you remember exactly what the next meeting date is? Let me look at my calendar and see if I can –

Heidi Bossley – Office of the National Coordinator

Sure. This is Heidi. The next meeting date is the 26th, so next Thursday.

Joe Kimura – Atrius Health

Okay. Then that takes us pretty darned close to our October 2nd turn into a pumpkin date.

Kevin Larsen – Office of the National Coordinator

Correct.

Heidi Bossley – Office of the National Coordinator

Yes.

Kevin Larsen – Office of the National Coordinator

Correct. And so I think that we're getting closer. We'll take this recommendation of frail elderly care coordination as a – as – so frail elderly is the population, care coordination is the domain, with a big dot in health as a patient-reported kind of H-CAHPS like assessment of their care coordination. And do some looking to see what else might go in there, and maybe send that around to the group for people to think through and comment on.

Joe Kimura – Atrius Health

Yeah.

Kevin Larsen – Office of the National Coordinator

The goal for our next meeting will be to come up with some finalized recommendations on criteria and exemplars. So what could we be doing to help support the group between now and Thursday in that direction?

Joe Kimura – Atrius Health

Well, I think a quick summarization of what we've talked about and how we're currently thinking about it. If we had some examples – Ted, I think you were going to – if you can send something out as to what we're thinking about there, it would be nice for all of the Committee members to have thought about criteria, just understand the framework and just sort of thought about what their general – how they would write some criteria around that to be able to share that in, because I think we need to have – to be working on actual examples by Thursday, right?

Kevin Larsen – Office of the National Coordinator

Yeah. We should have – we need to have something that the Policy Committee can have, and ideally that is here's a framework, here is – here is some criteria, here's some examples for you to think through.

Joe Kimura – Atrius Health

Yeah.

Ted von Glahn – Pacific Business Group

And, you know, Kevin, one of the things that would help at least me in the next go-round is as we use this example of care coordination, I immediately come up short with one of the criterion, which is the HIT sensitive. I'm – and again, I'm sorry if I missed a threat you all have pulled through this, but thinking to myself, okay, we have these – part of the big dot, care coordination, measure it through uber CAHPS, but we don't – as we're saying, we're not going to fill in the nits around the IT functionality, etcetera, that accompanies that.

We're not really speaking to the HIT sensitive element, are we? Or – and if we are, it would be helpful if in the recap of this discussion, if you could call that out.

Kevin Larsen – Office of the National Coordinator

Certainly. I mean, that's for this group to decide, if that's – how key that is. But yes, we can call that out. That was some discussion at the Quality Measures Workgroup as well.

I want to be sensitive to the time to make sure we have time for public comments, and we're getting down to the wire, so maybe, Michele, we should open for public comments?

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

Operator, can you please open the lines?

Diane Montella – Veterans Administration

Hello. This is Diane Montella from the VA. I'm not on for public comments, but I joined the meeting at the start of the meeting representing Terry Cullen, who at the last minute was not able to attend. And I'm a physician informaticist with the VA. I work several layers under Terry. And I just wanted to let you know that I've been participating, listening, and my role for Terry has been to follow the meeting and report back to her. So I apologize. I was unable to speak at the start of the meeting because I was on a line that was I guess muted by the operator.

Kevin Larsen – Office of the National Coordinator

Sorry about that. Thank you for participating.

Public Comment

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

Operator, can you please open the lines?

Ashley Griffin – Altarum Institute

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

Joe Kimura – Atrius Health

Okay.

Kevin Larsen – Office of the National Coordinator

This is Kevin. Thank you so much to the group.

Eva Powell – Evolent Health

Thanks.

Joe Kimura – Atrius Health

Absolutely. Thank you, everyone. I think we are making progress.

Kevin Larsen – Office of the National Coordinator

I know we are. Thank you so much.

Joe Kimura – Atrius Health

Absolutely.

Ted von Glahn – Pacific Business Group

Thank you. Bye bye.

Kevin Larsen – Office of the National Coordinator

Take care. Bye bye.

Joe Kimura – Atrius Health

Bye.