

**HIT Policy Committee
Accountable Care Workgroup
Clinical Quality Measures Subgroup
Transcript
November 8, 2013**

Presentation

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

Thank you. Good afternoon everyone. This is Michelle Consolazio with the Office of the National Coordinator. This is a meeting of the Health IT Policy Committee Quality Measure Subgroup, which is the Accountable Care Clinical Quality Measures Subgroup. This is a public call and there will be time for public comment at the end of the call. As a reminder, please state your name before speaking as this meeting is being transcribed and recorded. I'll now take roll. Terry Cullen?

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

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

Joe Kimura? Helen Burstin? David Kendrick? 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? Sam VanNorman?

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

Present.

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

And I know there are a number of ONC staff members so I'm going to call you all out. So Kim Wilson?

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

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

Lauren Wu?

Lauren Wu – Policy Analyst – Office of the National Coordinator

Here.

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

Heidi Bossley?

Heidi Bossley, MSN, MBA – Independent Healthcare Quality Consultant

Here.

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

Kevin Larsen? Well, I know Kevin's here.

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

Here, I was on mute, sorry.

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

And so I will turn it back to you Terry.

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

Great. So hopefully people are on the live meeting. We're going to give you an update of what happened at the HIT Policy Committee while we – when we presented and also give us some follow up work, which is basically what happened. So the – and hopefully, you guys have all looked at the last slides that we ended up presenting. I presented the first half Helen presented the second half. It was interesting because we followed up on data portability and interoperability, where I basically said how difficult it was, and then I ended up here saying, but we should definitely do it. So, it was a somewhat awkward moment for me, speaking out both ends of my mouth.

But they generally agreed with our proposal on deeming, remember, that was the major thing we focused on. And we had also given them some additional questions and recommendations, and we can talk about those, too. There were questions around how to operationalize, ensure top performance, that came up again and again about well – and Paul Tang reminded people that these – the people that will be eligible for deeming are groups that have passed Stage 1 and Stage 2. And already show that they are capable of doing this work, that's the only way that they become eligible for deeming. The Quality Measures Workgroup will continue to work on deeming and our subgroup will work on the original ACO charge for review at the December meeting. However, we were in – and next slide – we were also asked to look, and we'll talk about that as we go through, about what other options are available to work out for exemplars. And we can talk about that because we had some discussion yesterday.

Paul Tang subsequently sent Helen and I an email where he was specific about that the matrix was really an eye opener in that it shows that you can come up with a great idea. And as we've talked about previously here, the difficulty may be in the implementation and the execution of that. And you'll recall that one of our draft criteria really focused on the fact in a sense of doing no harm, that we didn't want the burden to be that great that people wouldn't be able to meet it. That the benefit would not be able to outweigh the burden, and you'll recall that was one of our criteria for deeming. So right here again you see the draft criteria for deeming that we presented and you see that benefit outweighs burden as number six. There wasn't a lot, and I'd be interested in the staff perception, but there wasn't a lot of pushback on any of these. In my opinion, there was an acceptance that these criteria were reasonable. Kevin or anyone?

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

Yeah, this is Kevin. I guess the thing I would say we heard maybe the most feedback about was whether or not our population focus was flexible enough to adequately capture some of the needs of the current marketplace. So was it flexible enough to think about service – and specialties, is it flexible enough to think about what an individual provider might do.

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

Right. Okay, next slide. So the recommendations for future work, as we talked about, for the Quality Measures Workgroup, some work to go with the group reporting option. It was interesting, there wasn't any negative feedback on that, but there wasn't a lot of discussion about it, I don't know if it kind of just slid through and people didn't know what to do with it. I don't recall any dialog around it. And then for us to look at this discussion by – I think by December, Kevin if I'm right, to look at population health, interoperability that matters, the measure coordination and the infrastructure and architecture for ACO measurement. If you'll remember, a lot of that was some of the original requests that we got for what this workgroup should be doing. And we actually have the original charge on the next slide. But there really was this desire for us to look at additional exemplars, and we're going to spend some of the meeting today talking about what those might be. Kevin, did you have any other comments on this from the meeting.

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

No, just to say that we didn't have much time to talk between meetings Terry, but what we've been thinking about from the staff standpoint is that the ACO Quality Measures Workgroup has really wanted to focus on these additional, non-deeming questions. And so you really have permission today to spend most of your time on that and the – and we as staff can work out some of the more deeming issues and then with the Quality Measures Workgroup. Because I think this group has felt that there was a lot to talk about, what do ACOs need from quality measurement? That's a kind of different question than deeming. So, just to say, spend as little or as much time as you want on the additional deeming questions, but we can table some or all of that to – and have the Quality Measures Workgroup address those if you guys want to just focus on the ACO measurement question.

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

Okay. Next slide. So this was our original ask, to develop recommendations for these measures, blah, blah, blah. I think we can go on. So review the preliminary framework for high stakes e-quality measures and identify known gaps in measurement, infrastructure next time, but also Kevin we want to make sure we get to those exemplars, right? We have that –

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

So we put together some exemplars, if you want to Terry, great. But we can have the Quality Measures Workgroup really flesh that out if this group wants to do what I thought I heard, which is really focus hard on what we need for ACO measurement that we don't have.

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

Okay. So why don't we go through the whole deck and then we'll come back to slide five, because it comes – we see that here. So once again, this was the – you may recall this but we did some changes to it at the last meeting and then they were made in here with this really primary focus on health. There was no – obviously no negative pushback on that, so I don't think that there are any concerns about it. I think there was some concern about how do we really make that happen, in terms of what are the measures that would go through there, but that was it. Okay, then the next slide. This is once again what you saw previously, we didn't have any modifications on this. So for all measures the intermediate outcome. Next slide. And the next slide once again is comparable to what we've seen previously where we actually have this building up from intermediate health care outcomes and then ultimately to health outcomes with some specific examples in there of what would be adequate for the health outcomes. Okay, next slide.

So these are additional questions for discussion and then on the next call we'll be talking, like we said previously, about the infrastructure needs. So these really are comparable to what we see on slide 5, which was review the preliminary framework, high stakes e-Quality measures for ACOs. Your framework is on, let's see what slide, so the draft framework we had was slide 7. So why don't we go back to slide 7 and just take a little ti – wait, I have this wrong. Yeah, slide – no slide 8 I think is really where we worked out the framework and just to see if anybody has any comments on that – that concept. So it would help if these were printed out for you so you could see them all, the intermediate outcomes, the healthcare outcomes and health itself.

And are people still okay with this; are there any other concerns about it, especially from the ACO perspective? The one thing we tried to do at the Health IT Policy Committee is remind people that this was a subgroup that did include the ACOs and that the perspective from the ACOs, because of accountability, was critical and we wanted to ensure that any of their needs from the ACO perspective were included in the framework itself. Does anybody – I know you've seen this previously, any concerns, anything you think is missing, now that you've all thought about it again. There wasn't – Kevin, what do you think, there wasn't any disagreement about the framework. I don't think there was a long discussion about it. Actually, the discussion focused much more because of the exemplar, that's what really triggered the dialog at the meeting itself.

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

Yeah, I agree. So I think that like interaction with many groups, they want as much specific detail as they can have to respond to some kind of suggestion. And as we all know from working through this for the last couple of months, deeming has taken us a long time to get the shared meaning around. And so I think it's hard for anyone to react on their first pass and understand something as sort of conceptual as deeming and then something that's conceptual about criteria and framework. So they really want, hey, here's the policy proposal and, oh, I can see if that works or not. So I would agree that we didn't maybe give as much feedback and we expected about the framework, but we certainly didn't get anyone that disagreed with it fundamentally.

Just as I mentioned before, these questions about is it flexible enough to account for all of the possible ways that it might be used, and that's where Paul was terrific explaining that this is an optional program, was not intended that everyone would want it. But we do want to think about is it possible for everyone – who wanted to be able to participate. So I would say that this group doesn't need to – a lot of time kind of hashing this through, I don't know that we need to do that unless people want to.

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

I guess the one question Kevin is, is it important for us to, because of the ACO commitment to tease that out – when we presented this, we really basically said, this is where we are with these measures. And we didn't – while we recognized it was an accountable care clinical quality measure subgroup; there wasn't a lot of dialog around the ACO part itself. I guess that's because we're pushing into population health for everyone, kind of how we presented it, I think.

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

Yeah it is.

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

It wasn't well circumscribed.

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

Yeah, well one of the things that we talked about at staff is that maybe some clear language about when we're talking about a panel as the population versus when we're talking about some other kind of population with multiple providers.

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

Right.

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

And so I think what we're going to queue up for the Quality Measures Workgroup is some discussion about some more articulated definitions of population that we can then use when we're framing any particular measure set to say, this would apply to a single provider's panel, and it would apply to the patients that qualified. If their panel is the frail elderly, in this context, policy context, it would apply to a larger population, let's say an ACO population, and integrated delivery network or a, to David Kendrick's point, potentially a regional collaborative. And we could then use the language to more articulately call out what we mean by population in each context.

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

Okay. No, I think that that would be really helpful. So almost like a spreadsheet in some ways, in this case this is what happens and then you sub-domain here, you think?

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

Yeah, it's a little bit, like what we did for EP versus –

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

Right.

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

– ACO except it's to not just call out who is the accountable party, but it's also kind of what their accountable for, are they accountable for their panel, which is what we're sort of implying in EP. But some people do call that population management so it's to; I think articulate panel management in contradistinction to overall population health.

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

Yes. Okay. Okay. So it sounds like we're okay with the framework, we don't have any real need there to look at it. Are there any gaps in the measurements for accountable care, so any areas that we don't have. And Kevin, let me ask you one other thing. There was this, in the original ask, for us to push two measures into recommendations for measures that would be applicable at the ACO level. So we've developed a framework to look at measures, is there the ask to specifically, and I think – or maybe you're giving this to quality workgroup, to specifically look at some divis – developing new measures and/or – other measures in and evaluating them for applicability at the ACO level?

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

So –

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

Assuming that ACO level is a subpopulation somehow.

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

Yeah, so the thoughts that I've had based on our discussions before and the initial charge to this group, this group would now focus on what the ACOs need from health IT and how can the policy levers of meaningful use and EHR certification help advance the needs of ACOs for their quality measurement enterprise. And so that will likely eventually get us to specific measures and so we could start with specific measures and work our way back, or we can start at the sort of conceptual place like combination of claims and clinical and work our way forward. I think eventually get to specific measure recommendations both in overall general context and also in the deeming context. So if that's a good place to start, we could start there or if you want to start someplace else, we could do that, too.

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

Okay. So we definitely need to get there, that's the thing, right?

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

Yes, getting there would be fantastic, correct.

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

Right. So there – I think you are right, there are a couple of ways to do this. One is to look at what are the in a sense domains that need to be included, to make sure ACO measures are effective in the ACO framework. So that would be like, what parts are there, the physical information, this is blah or to look overall and go back down in. So I don't know if you guys have any ideas on the phone. If you thought, I really wish the measure had been this or I wish that we were at least looking at this area, this domain because I think it would be effectively – it could be used effectively to evaluate what ACOs are doing as opposed to what we're currently doing. And that's how I think we could get at the, what are the domains and subdomains of interest. Does anybody on the call have any ideas about that? We could drive it through the one question for discussion, which is at the bottom of nine or what exemplars best capture ACOs quality and really what exemplars best capture ACO work?

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

This is Eva. I'm trying to think along patient lines, like we've already laid out that our goal is to take a more patient focus, which I think we've done thus far. But I'm wondering if there is a patient focus exemplar or perhaps it's better to include, where it makes sense, patient-reported elements in the measurement strategy. And I guess part of my thinking is, I feel like when you look at overall what an ACO is all about, one of the things that we should be measuring is functional status. In other words, if you're balancing cost and quality, if you're – for certain things, not for everything, we – the – if you're not improving functional status, then you've not gotten your money's worth. But that of course is not the case for everything, but for things like total joints, any sort of elective surgery would probably fall in that category. But I don't know if that rises to the level of an exemplar itself or if that's a portion of certain exemplars.

So the other thing that I think about, and again, I don't know exactly where this goes in our framework but the other thing I think about again from the patient perspective is this issue of decision quality and shared decision making. How do we capture that and I don't think there are existing measures that really get at that really well right now, but certainly from an ACO standpoint, from both a cost and a quality standpoint, there needs to be effective shared decision making. And how are we going to capture that, particularly from the patient perspective. And having just gone through a situation with my own father, who did not have cardiac issues, but ended up with a triple bypass, I am keenly aware of the fact that shared decision making is not happening right now, except for maybe some – in some very specific and special places and circumstances. And part of the reason for that is that it's really hard to know where in the process to do it. And when you think about – if we're talking about integrating care, presumably it would make it slightly easier to figure that out, or at least to do it proactively. But, I don't know, I'm kind of rambling. But those are my two main thoughts and from the patient perspective of what we need to be capturing somewhere, the issue of functional status and decision quality/shared decision making.

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

Hey Eva, this is Sam VanNorman, I'd just kind of like to rip off of those a little bit. I strongly support both of those domains. I think that with the patient reported outcomes piece, it's a struggle to get kind of that broad population one that is with – that really has a lot of good meaning. I know that there are a number of instruments out there; we've got PROMIS on ours. I think that the difficulty comes when we talk about a lot of those elective procedures and wanting to get some sort of – and how do we measure our success as a system, rather than just our success as a system at treating one or two conditions? So, I don't have an answer on that, I think it's just one of those open questions.

As far as the shared decision making, I think that that again has to come from the patient perspective. I think we'd get into a lot of danger when we say, hey, we're going to offer shared decision-making and we found that we had shared decision making because the doctor clicked that within the EMR or the nurse gave out this pamphlet and we get into some of the gaming of the system. So I'd really push for us, if we're going to go down that path, to have that be from our patient perspective as well, which is I think what you're saying.

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

Yeah, definitely. And to your first comment, I think that's part of why I'm thinking it could be an approach to how the – from the functional status standpoint. To have that as its own exemplar in that – part of what's difficult about that is you – the existing functional status metrics, which are actually fairly plentiful if you look at PROMIS, but they're very specific to pop – to subpopulation, which I don't know is –

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

Yes, yes.

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

– terribly helpful for an ACO on a population level, but perhaps we could think of buckets, saw functional – like physical function, mental function, I don't know, these are just things I'm pulling out of the top of my head. And then come up with exemplar measure for each of those and combine those as a set into our exemplar. But I don't know if pulling it out that way is the best approach, but it would help with this issue of specialty – specialized measures that are only meaningful for a very few people.

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

So Eva, this is Terry. So it sounds like there's this one pillar, I'm going to say it's a domain, which is patient reported needs, perspectives, whatever; I don't know what that last word is, and we get patient reported outcomes about functional status, shared decision making from the patient perspective. And then I think I got, might have been daydreaming a little about the exemplar. So the exemplar would be functional status for different disease states or different conditions or – where were you trying to go with that?

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

Well I think where I was going, and I'm not sure that this works because there are certain disease processes that you would not expect improvement. But I guess I'm thinking of it from an improvement standpoint, in other words, have the exemplar be improved functional status. And then within that, have the subcategories of functional – the physical function, psychological emotional function, kind of the broad buckets of kinds of functional status measures that we have, and then roll it up into, I don't know, maybe you would call this a composite rather than an exemplar. But what I don't know, and this may be kind of the – this may do this idea in, is that – is this issue of say for palliative care, you don't expect improvement in functional status or for a chronic disease; you don't necessarily expect improvement either. Maybe it's reasonable to expect maintenance, I don't know, I'm rambling a little bit, I'm just trying to get at –

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

I know, I think –

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

– go ahead.

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

Yeah, no, I think it's really helpful and perhaps the – because I think what it points out is there's this domain about patient wellbeing –

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

Yeah, yeah.

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

– and perhaps it's not improved functional status, but it's wellbeing or it's quality of life or something –

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

Yeah, yeah, yeah.

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

– that is kind of the overarching and then in a sense what I hear you saying is, independent of the condition that confronts the patients, there's some improvement. And it may not be functional status it may be –

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

Right.

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

– wellbeing, it may be mental resilience or whatever –

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

Yeah, yeah.

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

– and it's wrapped, so in that way you get the population is, it could be a subset of your panel, it could be the majority of your panel, anybody that's not well can fall in there. So I actually really like it conceptually.

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

Yeah, conceptually it's good, I'm just having trouble thinking through how we might structure it in a way that actually works. But it – I think referring to it as wellbeing or – I mean it's almost the ultimate patient reported outcome.

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

Yeah.

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

It encapsulates all possible outcomes from the patient perspective.

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

So we know that we would like – I mean, it sounds like there would be agreement that one of the domains we would call out for additional work and prioritization is that which is dependent on the patient, the patient producing the data about themselves –

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

Um hmm.

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

– and either functional status or how they're involved in the decision making or their perception of the integration of their care, or something like that, and that that's critical to the ACO population. I guess one of the hopes here is that if it's critical to the ACO population, at some point it will become critical to everybody.

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

Yeah.

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

But it would be something in the ACOs as a domain. Is there anything else in that patient focus area, patient reported, patient focused that we think we should include, other than what we've talked about? Decision making kind of, I would think, and I recognize that these might not be measures that exist out there, but decision-making obviously can capture some of the autonomy, at some point. I don't know that we can do that right now.

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

Yeah, yeah.

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

Anything else from the patient communication –

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

Well that's, yeah, that's what I was going to say is there's – it's almost to me the link between the patient reported and other more traditional kinds of measures, some of which would be traditional clinical measures, perhaps, and this issue of coordination, which I think includes communication. But given that the patient is really the only constant in the coordination process, it would seem that if we're really going to measure that effectively, we've got to have some sort of patient reported component to it.

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

And the coordination is a critical lynchpin for a successful ACO.

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

Yeah, oh yeah, absolutely.

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

So obviously, that's another domain that we want to call out, coordination of care, it's patient-centric and then something about the facility and the providers or – and coord – the care coordination experience. So if we look at slide, I think it's slide 8, so we call out under generic healthcare outcomes, experience of care coordination. But it's actually not just the experience, it's also the outcome that we have above that, which is measured by readmission rate and safety event and obviously there's probably some other measures. So – but it's not just outcomes, right? It's –

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

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

– its entry into care coordination, it's the access to care coordination, what happens in care coordination and then the outcome.

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

Yeah. Well, and I think it also has a hand in the expenditures column and this has been discussed in the past, but not recently. And so I'm not sure what the barriers are, but this notion of repeat tests that are unnecessary that if care was better coordinated and the information was where it needed to be, you would not need to do again. So that gets at your communication component, too, I think. But it's like a duplication of effort, which would be an efficiency measure.

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

Okay, so I think we should call that an efficiency measure, right? That would seem reasonable and efficiency – so efficiency with obviously expenditures, but it's also appropriate utilization of, one could look here at care centers and navigators as how do you make the healthcare –

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

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

– from a timing perspective, more efficient.

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

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

Okay. So we have patients experience of care or something like that with a lot of subs, we have coordination/communication with the patient as a constant and then the system itself, how that responds. And then we have efficiency, both fiscal, timing, probably outcome somehow. Okay, are there any other domains and thinking really from the ACO perspective that the ACOs would like or think are reasonable things to be measured on? Is it always that what's within your control versus what's not within your control?

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

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

This is Kevin. One way to potentially trigger thinking is to think about the six domains of the National Quality Strategy. I don't know if others use that or find that helpful, but that's often where we go to in HHS to sort of think across a variety. So that's patient care, cost, patient and family-centered care, population health, safety and – there somewhere.

Eva M. Powell, MSW, CPHQ – Senior Director, Quality, Improvement & Innovation – Evolent Health
Safety's an interesting one –

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

Yeah.

Eva M. Powell, MSW, CPHQ – Senior Director, Quality, Improvement & Innovation – Evolent Health
– because that has – is a component – there's an efficiency component to it, if you create the need for more care, that's certainly inefficient, but then it's its own thing, too.

Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration
Yeah, so I think we should pull out safety, too, as a domain that we think is really important, especially because of that transitions of care, the safety around transitions of care.

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

Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration
Okay, anything else in the – go ahead.

Kevin Larsen, MD – Medical Director for Meaningful Use – Office of the National Coordinator
No, go ahead Terry you go on.

Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration
Well, I actually want to go back to the efficiency one and think if there was anything else in the fiscal one. When we look at what we had on this slide, we have admits/1000, ED utilization/1000, total PMPM. I'm wondering if there is anything else. The one thing we want to do is make sure we're not having unintentional negative consequences that we're going to track "X" from a fiscal perspective, but in the long run it's going to make us do – to meet that measure, it'll make us do things that'll negatively impact the patient.

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

Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration
And we actually have it in this model as expenditures, I don't know why, but if we kind of flip that to efficiency, I wonder if that's – I don't know if that's a more loaded word or not.

Kevin Larsen, MD – Medical Director for Meaningful Use – Office of the National Coordinator
So this is Kevin. As I'm looking at this, we also had Cheryl Damberg, who's on the Quality Measures Workgroup, led a Rand Project looking at efficiency measures for health IT. And if at some future meeting you'd like to look that over or have her present it, I'm sure she'd be happy to. There was a significant section in there about overuse, and so some of these are kind of thinking about overuse, but they don't – they just sort of benchmark use, they don't actually try to highlight where is overuse. So, there was a significant discussion about some of those as maybe you call them choosing wisely areas where care that is above and beyond or more than a guideline or sometimes contrary to a guideline. I don't know if that's – if ACOs care about that at this point, if you're focused there, but that was at least some of the work that came out of that Rand Efficiency Measurement for HIT activity.

Eva M. Powell, MSW, CPHQ – Senior Director, Quality, Improvement & Innovation – Evolent Health
Yeah, so you're – what you're saying is there's something to standardization and consistency of care.

Kevin Larsen, MD – Medical Director for Meaningful Use – Office of the National Coordinator
Well, it's thinks like –

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

Kevin Larsen, MD – Medical Director for Meaningful Use – Office of the National Coordinator
– we have a couple of measures in the Meaningful Use 2 measures that aimed at the space like rate of MRI imaging for uncomplicated low back pain.

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

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

So the guideline says that people with uncomplicated low back pain shouldn't have an MRI, but we know that that happens a lot in the US. So the quality measure looks at your rate of potentially overuse of an MRI as a quality measure. And there are a number of those kinds of measures that are out there like appropriate use of antibiotics for children with ear infections or tonsillitis, that kind of stuff.

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

Yeah, yeah. Okay.

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

And maybe you don't care about those, I'm just sort of putting them out there as ones that have come up in this context before.

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

Well, I think from a cost perspective and efficiency and outcome, patient experience of care, they're really important. So I think that it would be helpful to look at them. And I think that that is – actually, what would be great is that while we're teasing out these specific domains, that what we have is, especially to go back to the deeming, which I'm trying to not focus on, but that they're cross-cutting, that they're something that really gets at all of that. If you look at efficiency from this lens, you're actually getting patient motivation as well as adherence and stuff like that. So I think efficiency, those kind of measures would be helpful to look at, and the guidelines, Kevin, the next time.

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

Yup.

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

Yeah, I think so, too. And the other thing that I think about relative to that is a connection to shared decision making because so often, at least in the examples you mentioned, there's a patient demand component to it. And the demand often comes from, I just don't want to be denied what I think is going to help me and a shared decision making, if done well, presumably would lead to fewer people demanding, or at least squelching the demand or answering the demand with, this is not what's best for you kind of thing. I don't want to –

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

No, you know what, I really like that, I mean, it's almost like in each of these measures, how could you push it back to the lowest element at which the patient's autonomy is respected?

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

Right.

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

And obviously some of them will have to have some times where that doesn't happen or it may be very difficult to get at. But I think if we approach this from an ACO perspective that the patient is the "n" of one in the whole thing, in the middle of this circle, you will end up in a different place.

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

Yeah, and –

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

But from an – go ahead.

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

Go ahead.

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

Well – but, we want to be respectful of the financial part of this related to ACOs.

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

Oh yeah, definitely. And I guess I would say, not necessarily as patient autonomy, although I think I understand what you're getting at with that, but it's actual engagement of the patient in the process of making decisions. And there are a number of articles out there that say if a patients offered clear and unbiased information about all the options, the tendency is for them to choose the less invasive option, which generally is the less expensive one. So, it's almost – it's a business case for shared decision making almost –

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

Yeah, yeah, yeah, yeah.

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

– sets the stage for patient engagement and it's also – there's a component of autonomy there, but there's also a component of physician leadership. And the idea is that there's a shared process, there's – and so, instead of going from what we largely have today of either physicians telling the patient what's best for them or caving in to patient demand, not to go necessarily to giving – making the patient completely autonomous. It's the shared process that is driven by information, which gets at the HIT component and certainly is important for ACOs, Because, and this kind of gets at my personal experience with shared decision making is, the point at which I knew all this stuff was happening with my dad, he was sitting in the hospital being prepped for surgery. Which is not the time to do a shared decision making process? But had the system been in place for – that that shared process, there might have been a greater likelihood that his outcome would have been just as good, but with a much less costly intervention than triple bypass surgery.

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

Yeah. Yeah. Okay, anybody else have any other comments in terms of what domains we might want to push on that we haven't identified or we've identified inadequately?

J. Marc Overhage, MD, PhD – Chief Medical Informatics Officer – Siemens Healthcare

This is Marc Overhage. I guess one that I always think about, but I'm not sure is there's sort of this domain of continuous self-improvement of the system. In other words, and this gets a little bit at the, what do you do with people who are at the top of whatever measure or whatever, shouldn't they be improving, too? But I mean it's kind of orthogonal to a lot of these others, but it's sort of the – if you look over time, shouldn't that ACO or whatever it is be getting better every year? So that's our monkey wrench.

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

This is Kevin. It's certainly in line with what the Policy Committee has talked about a number of times to try to build in incentives not just for being a high performer, but also having an acceleration curve of improvement.

J. Marc Overhage, MD, PhD – Chief Medical Informatics Officer – Siemens Healthcare

Would it ultimately worked for low performers, if you're a low performer, but you're improving, that's a good thing.

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

Yeah, Neil Calman says it's a way to incentivize people to take on patients with low scores, because –

J. Marc Overhage, MD, PhD – Chief Medical Informatics Officer – Siemens Healthcare

Sure.

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

– you have much more opportunity to actually improve the scores with low scores than you do if you're topped out.

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

Yeah I think that that's a really go – this is Sam. I think that's a really good point Kevin and I think that's been one of the things that we've struggled with is a Pioneer in a generally high quality state with a generally pretty well managed cost of care. I think that that's applicable across domains and I'd like to see some sort of acknowledgements of the greatest risers.

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

Yeah, I like that, too. This is Eva. And something that could be part of that bigger picture of continuous improvement, although it may warrant its own pulling out is the issue of health equity and disparities reduction. It's certainly a population based, well it may be a subpopulation based metric, depending on who you are. But, there are costs documented for health disparities, they're proven to be expensive, even for populations you wouldn't necessarily think of having disparities. But it would get at this concept of there's always something to improve and if you've improved your overall metrics over the entirety of your population and you're kind of where you need to be, can you then look at subpopulations and are you equally good for each of those.

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

Well and that – health equity did come up at the Health IT Policy Committee as a proposed additional criteria in the deeming criteria, right Kevin, that's my recollection. So we can add that here for –

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

Yes, absolutely.

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

– sure. Yeah, because it goes back to that definition of panel in some ways, what is your denominator? And then it could theoretically include the high performers and the recognition that within that high performing group, there are groups still at risk and the goal of helping them achieve equity with the other group, whatever the dominant group is. I think that's an important one, too, to include. Anything else, domains or subdomains?

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

I'm not sure if this is specific enough or easy enough to go in the direction of a measure, so I'll leave it to you guys, but, when I think about ACOs, I think about the need for an overarching care plan. I think care plans are difficult because you can define them in many different ways and they tend to be very specific to certainly the individual, but also to whatever discipline or condition. But if we're talking about population health and better coordinating care under the auspices of an ACO, then the proportion of your population that have a – it's not just an issue of having the care plan, but maybe it's the degree to which you, as an ACO, are able to share goals among the various players. I don't know, but it's – I don't know if it makes sense, first of all, or if you guys can come up with a more concise way to say that. Or maybe that just gets to the coordination of care and we can leave it at that.

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

Yeah Eva, that's where I think, if I was going to put it under this coordination of care where we have communication and the care plan. But what's interesting is that you can really push on that, which is once again the sharing of the care plan between the providers, and use that in a broad term, and also then between the patient and the patient's family –

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

Right, right.

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

– and the adherence part that comes from that.

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

Yeah.

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

Terry, this is Paul Tang, sorry I joined late, I've been in for the past half hour. But, I might add a few comments to some of the directions we've been talking about, I don't know –

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

Oh, please.

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

One is the experience as an outcome measure, do people experience care coordination or do we assess their feeling, let me take the example PCP as an example. One way to look at it is, is there somebody's name in the PCP slot? That's probably not an outcome, but if the patient had someone they could turn to that is in charge of their overall care, that would be the experience that means something to the patient as an outcome. Similarly, for care coordination the question, and I'm just making this up, if like my team has shared goals and a shared treatment plan for me that would be the outcome of the process of care coordination. Does that make any sense?

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

Yes.

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

Yeah.

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

What it really means to have an outcome – the experience would be the outcome and from the patients I think we tend to look a little bit on still process measure, but yet if a patient knows who to call to query into care, like PCP. If they feel like everybody's on the same page, that's care coordination from the patients point of view. So one of the things I saw on you intermediate outcomes under experience for patients is face-to-face visit in 12 months, and I didn't understand what's good or bad in that. Whether the high number's good or bad or why that's an intermediate outcome.

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

This is Kevin. We just put those together I think as straw man things for people to talk through. This was really not a – that was not an attempt to say, here's a proposal, it was, here's an example of what you might talk through.

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

So, let me twist that then and say as an outcome measure, from the patient's point of view, I can get access to answers about health questions or advice about my health condition whenever I need to. That would be the outcome of care coordination access and it doesn't really count on one modality of getting my health needs and questions met. Are these sort of examples of another way of looking at health outcomes in the patient centric experience way?

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

I think so and the other thing it does, Paul, what we were trying to do is identify the areas or the domains where we might need to tease out, because they're more explicitly appropriate to ACOs.

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

Right.

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

And then we had a discussion about how really it would be great if all of them really sprung from having an impact on, or an engagement with the patient, so they were all patient engaged. And so these are both really the good examples that are pushing on the domains that we identified. And just to go over those again, so what we identified was patient, and we had functional status, but I think probably wellbeing or wellness or something, I don't know what the exact term is, communication, which then kind of morphed into coordination and a coordination plan. Efficiency, both fiscal efficiency as well as appropriate utilization of the healthcare system with the emphasis on appropriate; safety, which we haven't really dived into, but the recognition that safety definitely impacts at least the transitions of care, as we look for coordinated care. And then equity, which we were just talking about in the end. Eva pulled out care plan, which I think we can probably put under coordinated care. But now what you are doing, and I really appreciate it, is kind of forcing us then, if we look at those, to say okay, so what would be measures that would either cross these domains or involve these domains, that could be proposed explicitly for this population, as defined – as constrained by ACOs, obviously with further things.

So, what I captured from you and essentially a measure we used to use was, not is just there a PCP in the Health IT system where the slot is, which I think is a helpful measure in and of itself, because it means other people know it's there. But does the patient know who their primary contact would be, not necessarily even a physician. The experience of knowing what the shared goals or shared treatment are between that patient and that patient's family, and we haven't really talked about families here in this. And then finally that last one about access to answers, so we twist from face-to-face visits in 12 months more to, do you have access, when you need it, for what you need it for.

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

Right. Do you have access to professional advice, that's what you really want?

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

Right.

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

Another side comment is I know we put this in the context of ACO; ACO's a figment of our imagination. From the patient's point of view, they would just like to have a professional healthcare team that's got their act together, they have no idea what an ACO is or who can be or what the rule – we're – I think we're – that's the broader concept of what a better world would look like from a patient's point of view. So they're basically looking for a coordinated team to work with.

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

Right.

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

I also liked where the discussion went about improvement. So I think Eva talked about, well, does everybody have an absolute functional status and is that comparable from one health state to another? And so I think you move towards improvement, which I think is really nice because we can always improve – I mean I think we can always improve the state of someone's functional status from one time to another if we work on – and that doesn't necessarily involve medicine. But even if you have pain from arthritis, we can lessen your pain or improve your functional status with the existing – so there are ways we can improve and I think that was a really nice concept.

I think Marc talked about that as well and we used to call those delta measures. So you can always – so is it more meaningful for both the provider and the patient to say, hey, of my panel or of that physician's panel, what percent of their panel did they improve over the past year versus what's the mean population average, which really doesn't say anything, you have no idea what their patient mix, etcetera –

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

Right.

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

– but, regardless of the patient mix, you can certainly improve folks, and that would be, I think, more revealing. And the final comment sort of, I've sort of queued them up is, you talked about readmissions as an outcome measure, isn't that a process measure? So do we really have a rate that we want to have as an outcome, or do we want people to improve the control of their disease or the improvement of their functional status, the way we just talked about, as the outcome? And readmission happens to be a – one of the int – I wouldn't even call it an intermediate outcome; it's almost a process outcome. Sort of just introducing some challenges to the way we think about things and give us a chance to look at what are outcomes that really matter to the consumer patient.

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

Right. Yeah, those are really helpful Paul. Any other feedback from anybody?

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

Terry, could you go through the big buckets again, I've got equity, coordinated care, efficiency, continuous improvement and what am I missing?

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

Yeah, so I have – the first one that we talked about was functional status or wellbeing –

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

Right, right, okay.

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

– patient centric, then coordinated plan/communication and their efficiency, both fiscal as well as testing and things like that, and outcomes, we actually found some outcome stuff under efficiency.

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

Okay.

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

Safety, equity with continuous self-improvement under there, so I guess the other option is equity and then could another bucket just be improvement, continuous self-improvement of the system, like Marc talked about, improvement related to process itself and how that feeds equity. So, we could either leave that out, I kind of like the idea now of leaving it out now that I look at it, just because it think it's focused in and of itself. And from an ACO – so I think that one thing is from an ACO perspective, when ACOs look at what they're being tasked to do, is there something – is there anything else we're not getting through these buckets? And then Paul, you talked about outcome measures, but I think that tho – so that would kind of be what we imbue through all of these, when we listed them, we would like look at these and probably have some process, but also have outcome measures in each of these areas.

I think that one thing is, as we look towards wanting health, our general health outcomes, and we look at what we had once again on slide eight. We had some roll – presumptively roll up measures, though they kind of hit what we talked about, Healthy Days, which would be patient wellness, care coordination, which we explicitly pulled out, expenditures, which would fall under efficiency.

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

This is Kevin, I don't want to be too far out there, but I was just at a terrific talk yesterday by the CFO of Bon Secours and that they were talking about their goals as an ACO and hospital system, one of the things that they had was their commitment to healthy communities, which I found very interesting as an articulated goal by the ACO.

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

Kevin that's interesting and that kind of gets to my soapbox a little bit, but I'm not – perhaps it's a little far advanced for this group, but since you mentioned that, I'll bring it up because it may not be. But this notion of – it goes beyond total cost of care and it's more a public cost that would include the total cost of health or non-health in the sense of, and I think Healthy Days starts to get at this. But my ultimate vision is that we would, as a society, look at how we're spending public dollars and are they pro-health or not. And I think we're pretty far from that in that if you look at all the money spent on healthcare, but then also look at the spending of money that helps facilitate good health, even outside of healthcare, which would be infrastructure like sidewalks, those kinds of things. How do we as a society allocate our public funding in a way that really promotes health? And I think the CFO that you mentioned, that's probably what he was starting to get at in a talk and is that a place we want to go with this or is that such a future state that it's beyond scope?

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

Well I'm with it, I want to go there, I think we get to decide, right?

(Indiscernible, multiple speakers)

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

And I would say that we are looking at that same thing. In other words, being a partner with the community instead of working only on individuals as a valid and very potent way of impacting health of individuals.

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

Right, by – go ahead.

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

Go ahead. Well, the one thing I would say is, we actually – we put it out there, because we said health in that big red circle –

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

Right.

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

– is what we want, so, it seems to me a logical handshake with that is the partnership with the community, a healthy community.

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

Yeah, yeah.

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

Can I introduce another concept that actually is impressionable from what Eva talked to us about at NCVHS over a year ago, and that's one way of looking at disparities. Is disparity a separate "condition," I put that in quotes, or is disparity a way you slice the data you have? So instead of reporting on a population mean, which doesn't fit anybody, if you stratify by disparity variables, that's one example, then you have a much better understanding on where – what are the disparities, but also a much better way of measuring what impact any of your interventions have. So that would be arguing for that as a way of stratifying outcomes in these various categories instead of as a separate topic. Another analogy is, instead of saying, oh let's work on user interface, well actually you should work on user interface as you design the whole system and the infrastructure instead of saying, okay, time to get to the user interface category, same thing. Disparity as an afterthought versus as a way of stratifying your population and making sure you hit each strata.

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

Yeah –

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

Yeah, so it's cross-cutting throughout.

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

Right, instead of being a category.

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

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

Eva M. Powell, MSW, CPHQ – Senior Director, Quality, Improvement & Innovation – Evolent Health
Yeah, this is Eva. I like that cross-cutting approach. I will offer, as a caveat to that is that I think that we would need to give at least a little bit of guidance as to what those categories would be. Not in an effort to prescribe them, but to be clearer about what we're really trying to do. So basically the goal is equity but instead of calling it out as its own condition, we are saying there should be equity in all these big buckets among race and ethnicity, perhaps we figure out the major categories of subpopulations, which would vary from community to community. And so the other way to do this is to go from a process standpoint and say, identify – I don't know that you necessarily do this through measurement, but the first step would be to identify what are the major subpopulations that your ACO is serving, and then stratify by them. So, I think I like the approach of the stratification and cross-cutting model, but I would worry that if we just leave it at that without any guidance. That people – I don't know, I guess they would come up with something that's meaningful to them, but I would hate not to get at racial and ethnic disparities, which are – as we know, are widespread and in many places pervasive, if we left it open and didn't get at that in a certain place. Does that make sense or do you think people would automatically go there?

Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration
I don't think people automatically stratify to look for – to achieve equity within populations.

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

So that was one of the examples you brought up the deeming conversation. We were thinking of it as cross-cutting, in other words, you pick some quality measures that you want to be deemed against, but another requirement was that there were actually four quality measures in our proposal, in one of the four you would have to stratify by disparity variables and show that you improved significantly in one of those.

Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration
So the cross-cutting is the stratification, but it's spelled out.

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

Right.

Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration
It's pretty explicit.

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

– there are “legal disparity variables,” so, it would be choosing –

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

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

– because it varies depending on where you are, right?

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

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

Right.

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

And the goal is, yeah, the goal is that what's important to you, we want to be a – the fulfilling this program requirement should be, ideally be a byproduct of what you need to do for your own – not something we dreamed up.

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

Right.

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

Yeah, I like that. I think labeling it disparity, but leaving it at that kind of begs the question of, well what are the disparities in our community or in our population for which we're accountable. So then, you have to do that first step of identification and then the second step of stratification so that you can then show how you've improved those.

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

Right.

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

I could see maybe at some potential far in the future day, maybe, kind of treating this almost like a really aggressive composite measure that if you look really good for your whole population, that's great. But in order to get your full payment or what have you, you have to look equally as good among all your subpopulations or something like that.

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

Right.

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

Yeah, or, I mean even the – once we get to the point of identifying populations, you could have kind of a secondary measure which is that difference between your top performing population and your lowest performing population.

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

Yeah, yeah and the measure –

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

I think that delta is an important piece of it.

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

And actually, that's the way we had proposed it, is that you would narrow the gap by, and I think we said 20%, between the disparity population and your mean population.

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

Yeah.

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

Again, it sort of self-normalizes because that's the only way to control for the patient mix.

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

Okay, so we have about 15 minutes left. So I think we've identified domains, subdomains. Any measure gaps, measure concepts that we could use to best capture an ACOs quality? Kevin, are you still on? I don't know if Kevin's still on, because we did come up with these exemplars, I'm trying to think if he thought that that part was now supposed to go to the Quality Measures Workgroup or if we were going to do that?

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

You know, I'm here, sorry I –

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

You're choking. I'm trying to think, did you – because I got a little confused Kev, did you want us to do the – come up with more exemplars for ACOs explicitly or are you kicking that all to the Quality Measures Workgroup?

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

If you want to, go to town. I know there was lots of work that these people wanted to do, not just around this kind of what are some areas of measurement. But also about what are some policy and infrastructure certification features that might be helpful. And so I wanted to be sure that you guys had time to talk about that, but if you would like to talk about some more exemplars that is also great that was – the Policy Committee wants that to happen. The Quality Measures Workgroup has two meetings this month where we plan to have that, so it will be tackled, but you could give the Quality Measures Workgroup some more examples from the ACO perspective if you'd like.

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

Okay, so clarify for me, we have one more meeting – how many more meetings do we have?

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

Correct, one more meeting in November before we give information. So we thought that that meeting would talk about some of these infrastructure questions kind of in depth.

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

Okay. So Kevin, when you look at what we've done today, do you think we've answered – I feel like we've answered the domains and subdomains, obviously we need to tease them out and get them out to people to comment on. I don't know that we have prioritized them, I'm not sure any of us would want to prioritize them, does anybody have any comments on that, on the areas we talked about? If you think you want to prioritize it, I don't think it's that big a list. Personally, I think they could all go forward.

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

And you could maybe then – maybe there are a couple kind of priorities, not just what you think is most important, but what do you think is first. So is it more important to you that we start at the beginning with efficiency measures or with care coordination measures? Because we might eventually have to get to a place where we can't push them both at the – in the same time sequence, so is there order to them an ordinality and not that one is ultimately more important than the other.

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

Okay. So does anybody on the call have any sense of that to pick what one first?

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

Well, I mean the whole construct of "ACO," we're just getting our act together on the professional side is care coordination and the outcome from that.

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

Right.

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

That's one way to look at it.

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

I agree.

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

It's certainly a huge pain point for the patient.

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

Yeah.

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

And it would have tremendous impact far beyond just ACOs, too.

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

Yeah.

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

Yes, right. And it all automatically invokes interoperability and so on and so forth.

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

Yeah. So it sounds like we've got the number one done. Anybody want to – at the rest? We had wellbeing, efficiency, safety, we still have equity in their, improvement, healthy communities.

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

Well, I started talking – wellbeing, that concept of if there's anything that matters a whole lot to the patient it would be how do I get better?

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

Right.

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

How do I feel better?

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

Right, that was going to be what I would say, because I think in some ways, with the first one, the coordinated care, you make progress on the others. But I think this notion of patient-reported outcomes is so – we're so behind in figuring out how to do that and also, it's a compliment it's not the same thing as, but it's a compliment to like the work that Kory is doing to know, what really is best for me. But if we, on our end of things, start measuring this notion of wellbeing and functional status, whatever we want to say, it's like a patient goal. Everything else is very clinical goal oriented. I think that's a great place to go.

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

Yeah.

J. Marc Overhage, MD, PhD – Chief Medical Informatics Officer – Siemens Healthcare

So you've highlighted – this is Marc, one of the things that makes me anxious, which is, there's nascent work – there's a lot of work to be done to create something that's measurable.

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

Yeah.

J. Marc Overhage, MD, PhD – Chief Medical Informatics Officer – Siemens Healthcare

And the timeframe makes me anxious about, can we create good measures between now and then that are defensible and doable and all that good stuff. It's just like a cautionary note; little alarm bells in my head going, good stuff, but is it doable in this timeframe, given the state of the arts?

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

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

I don't think there's a timeframe – yes, we – well, actually the other way the charge went was, what's needed and then what exists that could be tapped and then what needs to be made to exist? So just –

J. Marc Overhage, MD, PhD – Chief Medical Informatics Officer – Siemens Healthcare
Exactly.

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

– yeah.

J. Marc Overhage, MD, PhD – Chief Medical Informatics Officer – Siemens Healthcare

So I guess that's a better way to put it is, there – I would feel better if we make it clear that this is an area where there is significant work to be done to see if these measures can be created to fill this need –

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

Yeah.

J. Marc Overhage, MD, PhD – Chief Medical Informatics Officer – Siemens Healthcare
– in whatever timeframe it is.

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

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

Okay, I got that. Anything else then, do you guys want to prioritize the rest or just think this is enough?

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

Yeah, this is Kevin. That's enough and we may not need it, but I do know that it is sometimes helpful when it comes down to so what actually do we do?

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

So the one thing we didn't get to, and I don't think we're going to do now is, potential specific measures, Marc, to go to your exact point. So – ideas how we're going to move on that, so perhaps that could be partially covered at the next meeting, once we get the minutes up so it's clearer to people. And then the infrastructure needs to ensure successful measurements of the ACOs, predicated on this framework – the identification of these domains that we've come up with.

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

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

Yeah, and I might suggest we spend a little bit of time thinking about specifics, because that will, I think, help inform the infrastructure rather than being just generic about the infrastructure.

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

Okay.

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

And the other thing I would suggest, and it goes to Marc's point, which I think is exactly right. But if there's a – for things like this functional status/wellbeing, which is probably one of the ones that's going to require the most work, maybe if we can create, dare I say, a glide path such that we could at least get started on like the first step. Because I feel like in every conversation about this we get to this point where there's so much work to be done and then there's never any progress on the things that really need to be done, but there's a lot of work to be done. And so, that would be my suggestion.

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

So at the next meeting we add on some – so we have some pre-work done ourselves reflecting on what we believe infrastructure needs may be and some idea about the glide path to push out on measurements themselves, as well as some conceptual work that we each do related to what are some potential measures.

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

Right, right.

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

Yeah I mean – this is Kevin. It sounds to me like we'll probably be talking about some global functional status measurements. We're probably talking about some kind of care coordination measurement, maybe related to care plans. And then some kind of wellbeing measure potentially in addition to the functional status measure. So those will be some – we'll iterate a little bit behind the scene, but that's what I'm hearing from today, there may be others there, too.

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

Yeah and I also think we should make sure, Kevin, in the minutes or whoever's doing the minutes that we capture the specific ones that Paul proposed.

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

Yup.

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

I have them so we can make sure we do them. And those, I think, are great triggers for other ones we may want to think about –

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

Um hmm. Yeah.

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

– as we go on. So, I'm sensitive to time. Unless anybody has any other comments, I think we should open the phones. Any last comments from anybody? Okay, do you guys want to open the phones for a few minutes?

Public Comment

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

Sure. 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. There are no public comments at this time.

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

Great. Okay, thanks everybody, thanks for all your time. We didn't know that when we had our last meeting you'd be coming back for now and one more meeting. And so, we appreciate your sticking with us as we try to work through this. So, everybody have a great weekend and great Veteran's Day.

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

Thanks. Same to you guys.

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

Thank you.

