

**HIT Policy Committee
Accountable Care Workgroup
Transcript
May 17, 2013**

Presentation

Operator

All lines are bridged.

Alexander Baker – Office of the National Coordinator

Great. Welcome everyone to the call this afternoon. This is a meeting of the Accountable Care Workgroup of the HIT Policy Committee. My name is Alex Baker. I am a project officer here at ONC with the Beacon Community Program and I'm starting this call on behalf of MacKenzie Robertson, who was not able to be here today. This call is a public call and will have public comment built into the agenda at the end of the call, so we'll leave a couple of minutes at the end for that. I just want to remind everyone that this call is being recorded and that it would be great if folks could just introduce themselves as they are speaking. And with that, I will move into roll call, so when you hear your name, just give me a confirmation. So, Shaun Alfreds?

Shaun T. Alfreds, MBA, CPHIT – HealthInfoNet – Chief Operating Officer

I am here.

Alexander Baker – Office of the National Coordinator

Hal Baker?

R. Hal Baker, MD – WellSpan Health – Vice President and Chief Information Officer

Here.

Alexander Baker – Office of the National Coordinator

Thanks. Karen Bell?

Karen M. Bell, MD, MMS – Certification Commission for Health Information Technology – Chair

I'm here.

Alexander Baker – Office of the National Coordinator

Thanks Karen. Karen Davis? John Fallon? Heather Jelonek?

Heather Jelonek, MS – John C. Lincoln Accountable Care Organization – Chief Operating Officer

Heather's here.

Alexander Baker – Office of the National Coordinator

Hi Heather. David Kendrick?

David Kendrick, MD, MPH – MyHealth Access Network – Chief Executive Officer

Present.

Alexander Baker – Office of the National Coordinator

Thanks David. Joe Kimura? Irene Koch?

Irene Koch, JD – Brooklyn Health Information Exchange (BHIX) – Executive Director

Here.

Alexander Baker – Office of the National Coordinator

Thanks Irene. Aaron McKethan? Eun-Shim Nahm? Judy Rich?

Judy Rich, RN – Tucson Medical Center – Chief Executive Officer

Here.

Alexander Baker – Office of the National Coordinator

Thanks Judy. Cary Sennett? Bill Spooner?

William A. Spooner, FCHIME – Sharp HealthCare – Senior Vice President and Chief Information Officer

Here.

Alexander Baker – Office of the National Coordinator

Thank you Bill. Susan Stuard? Grace Terrell?

Grace Terrell, MD – Cornerstone Health Care, PA – President and Chief Executive Officer

Here.

Alexander Baker – Office of the National Coordinator

Thanks Grace. Karen Van Wagner? Samuel VanNorman? Akaki Lekiachvili? Sorry?

Akaki Lekiachvili, MD, MBA – Centers for Disease Control and Prevention – Informatics Science Lead, National Center for Chronic Diseases, Office of the Medical Director

I'm here.

Alexander Baker – Office of the National Coordinator

Mai Pham?

Hoangmai H. Pham, MD, MPH – Centers for Medicare & Medicaid Services

Here.

Alexander Baker – Office of the National Coordinator

Thanks Mai. John Pilotte?

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

Here.

Alexander Baker – Office of the National Coordinator

Thanks John. And Westley Clark? All right. Thank you everyone for announcing yourselves. So, I think with that, if we could move to the next slide. So Charles has not been able to join us yet, but just wanted to quickly recap the last call and some of the themes that we heard and some of the items that we went over. So if you could move to the following slide. So here just wanted to reiterate the workgroup charter and scope that we discussed for this group, and I think we had some good discussions of what some work for the group could be in these different areas. If we could move to the next slide and then the following slide. And so here we just wanted to take down some of the major themes that we heard from that call.

So, around the access to Medicare data, that is an important part of the ACO program for many, but a lot of the challenges that come with standardization issues around that data and a lot of the challenges folks are facing currently and an interest in understanding how that data is going to evolve over time. I think we discussed a lot about broader interest among the workgroup in integrating claims and clinical data to support ACO success, how to develop a standard, scalable way to aggregate information about patients outside the system. Discussed, in addition, a number of issues with exchanging clinical data that continue and lots of different pieces of the HIT Policy Committee are looking at together.

We talked a little bit about the current state of clinical decision support tools on offer and where some of those fall short and discussed how some thinking on that topic could potentially be a place where this group could contribute, in terms about how to integrate patients fully as members of the care team within accountable care organizations. And then talked a little bit about the item in the charter around trying to improve connections with non-core care providers such as LTPAC organizations, mental health providers and what some of the potential options might be there to improve those connections and support different accountable care models.

So, if we could move to the next slide. Great. So I think what we wanted to start to get into on this call would be to return to a bit of a discussion around the key tasks for the group. I think maybe what might make the most sense is to see if Charles gets on the phone in a little bit and can introduce this piece that we had been discussing. And so maybe we'll change up the agenda a little bit. And Karen, would you be willing to talk a little bit about the CCHIT framework at this time and answer some questions about that first?

Karen M. Bell, MD. MMS – Certification Commission for Health Information Technology – Chair

Sure. I'd be more than happy to.

Alexander Baker – Office of the National Coordinator

Great.

Karen M. Bell, MD. MMS – Certification Commission for Health Information Technology – Chair

And I invite Grace Terrell, who was on the team that developed this and John Fallon, if he joins, to comment as well. The bottom line of all of this is that I have to apologize that I don't have any slides for you today, because the framework and the accompanying publication that's going to go with it is due out at the end of this month, so I can't really show it to you at this point, because this is a public venue. But I can tell you a little bit about what it is, it's level of detail and how we, and why, we went about developing it. So, I'm going to go back to about 8 or 9 months ago when our Commission and I do want to emphasize that some of this can be a little confusing. The Certification Commission for HIT or CCHIT as you all know is an ONC authorized certification body, and we also have been authorized by NIST as a testing lab for all of the ONC certifications. Separate from that, and I do mean separate, there is a firewall between that work and the work of the Commission, which is a group of 15 multi-stake holders who develop and – developed the programming based on some strategic work that CCHIT does independent of the work it does of ONC.

So, our Commission late in 2012 started thinking about what would be of most value that would be consistent with its mission to really help the delivery system and providers understand what type of HIT they needed to move forward. And since so many of the providers are moving into what we were calling the transformed health care arena through the accountable care pathway, and we were only too well aware that many of these provider groups, whether they were some of the Medicare Shared Savings Program, taking on upside risk or others, were quite confused about really what was the HIT that was supposed to really help them along this path.

So we decided we would try to create a framework that would be a good basis, a good structured basis of discussion for the delivery system moving forward, thinking also that payers would be interested in looking at this as they worked out their partnerships with providers. Vendors might be interested in it in thinking about, well, the ways we could probably fill in some gaps. So the Commission itself went through the first iteration, recognized that it was a first iteration, and needed the benefit of some other experts in the field. So the framework evolved significantly over the course of time, with a lot of wonderful input not only from the commissioners for starters, but also from a panel of experts that included not only providers who were in the ACO arena and some payers. As well as some of the major groups like the ACP and the AMA, but also people who were really at the top of their field in other areas that are really important for any provider in the accountable care arena.

And just to give you an idea, I'm not going to go through the whole list, but Charlotte Yeh, who is the CMO of AARP was quite adamant about assuring that we were always thinking about moving from where we are with doing things to patients through doing things for them, to doing things with them as a provider system. Joe Kvedar, who is probably one of the top people in the field around mobile health care was outstanding again in helping us in that area. And in terms of patient safety, Tejal Gandhi, who just last week was announced as the new president of the National Patient Safety Foundation, kept us focused on the patient safety aspects of what we would need. So, with – I apologize because I didn't go through the whole list of 15, but we did have a very robust, very good group of people. And as I say, this framework evolved significantly over the course of time.

So what can you expect to see when it comes out, is probably your question. And I'll start by saying that I think we can all agree that everyone is focused on improving quality, making sure care is cost-efficient and doing this in an environment where patients, their families, all caregivers – with their care are living their lives in as – in optimal health for their given situation. Not everyone is in the same position, but clearly we would want to optimize their health, no matter where they are in the continuum of health and disease.

So, with that in mind, after a lot of discussion, we agreed on that we would focus on 7 key processes and for each of those key processes, and some of them are ones you all are familiar with, care coordination, cohort management and a few others. For each of those processes, we developed a list of functions that would make that process work in a way that would truly meet the aims of the provider group. Within each function, we then went back, and there were 64 of those functions, we then went back and said, well what other critical HIT capabilities that would best support that function. So, recognizing that it's not about the HIT, it's really about the care processes that are – will be necessary in the work group, and that the HIT is only there to support it, we outlined anywhere from maybe 5-to-10 HIT capabilities per function. So, we ended up with this very long, very robust document. And the reason it's not out yet is we've been putting a lot of effort into making it interactive and user friendly when it's posted on the web site.

So, the hope here is that people will understand that this is not proscriptive, we're not saying this has to be in an EHR. We're simply suggesting that if you are moving along the continuum of no risk to upside risk to most of your patients are under global payment or capitation or something of that nature, then you'll need to think about an HIT roadmap to support that transition. We went so far as to recommend a glide path in terms of where a group might stand with respect to not just risk around the accountable care transition curve, but also what they might think about in terms of how to change clinician culture, how to think about working with patients differently, etcetera.

So our glide path, granted will probably create quite a bit of discussion, as will the whole document, because again, it's not proscriptive. It's not a document that will lead to an ACO HIT certification, that's not what it's about. It's simply about trying to understand what those key HIT capabilities are that will help various provider groups, all of whom will have different goals, all of whom will have different approaches and are starting from different types of structure, move along and develop their own HIT roadmap. And again, hopefully will be helpful for the vendor community and payers as well, going forward. From a CCHIT perspective, right now we're very busy working on the ONC side, but ultimately there may be opportunities for certification of some of the newer products that will come out, apart from EHRs, down the line. So, it's all part and parcel of keeping us on mission to support the provider system, and also do it from the perspective of the HIT. But again recognizing that HIT is just a support here, and this is really about moving the delivery system from where we are now to a more value-based system.

So that in a nutshell is what we've been working on, and you can expect to see this, as I say, at the end of the month, and hopefully be able to present it at our next Accountable Care Workgroup meeting. So I'm going to leave it at that and turn it back to you, Alex. And if anyone has any questions or Alex I invite Grace Terrell to comment as well, because she was very much involved first as a Commissioner and then also on the expert panel. So maybe I'll open it up to you Grace, to see if you have any other comments first and then we can open it up for questions and comments Alex.

Alexander Baker – Office of the National Coordinator

Great. Thanks so much. Grace, if you have any comments or if anyone else wants to chime in.

Grace Terrell, MD – Cornerstone Health Care, PA – President and Chief Executive Officer

Thanks Karen, I don't know that I have anything else to add, per se, other than you've done a very thorough job sort of delineating our work. My perspective on it, as you know from the Commission and otherwise has been that I've been on the Commission, I've also been a provider in the middle of an organization trying to be and is an ACO. And within that context, realizing that the type of information technology decisions and policy and all that, that make sense from the world we've been in in the fee-for-service to the world we're going to is very different.

So the work that CCHIT did as it started to look at the framework, was very much within the context of my own thoughts about where we needed to go, and I think it did a very good job fleshing out all the aspects of it. The interoperability aspect of things and the need for it to work for various stakeholders, such as the vendors, but more importantly the providers within the context of how the technology needs to work in the new world was done very effectively and I'm looking forward to the document that we worked on coming out for everybody to comment on. Because I think, as you said, it's a first step, but it's going to hopefully move the conversation along quite well, really because health information technology in general has been very focused on the here and now of how we provide things. And we all know we're going to a new world, and it's going to take a lot of thought on a lot of our part, to understand how that technology's going to have to evolve to meet the needs of where we're going. So, thank you for summarizing what we've done. I think that there's going to be a lot of good thoughts to come out of it, not only from this group, but from others, to allow us to move forward now in a more effective health information technology for a world that's not so much based on fee-for-service.

Karen M. Bell, MD. MMS – Certification Commission for Health Information Technology – Chair

Thanks Grace.

Alexander Baker – Office of the National Coordinator

Any questions or comments from the group about the framework?

William A. Spooner, FCHIME – Sharp HealthCare – Senior Vice President and Chief Information Officer

Yes. This is Bill Spooner with Sharp HealthCare. I apologize that I wasn't on the first call, so I – and I hope I'm not wasting people's time by trying to catch up. But my question really relates to the Certification Commission's work as well as the summary from the first meeting and I'm wondering if our objective is to really to try to harmonize and identify gaps from the other programs that are in place, meaningful use, certification, harmonization of standards, HIE and so forth, so that we're really looking for the gaps, not trying to have a second flavor of them, so to speak. Could somebody –

Kelly Cronin, MPH – Office of the National Coordinator

Yeah Bill, this is Kelly Cronin. That's a great question and I think in some ways it would be great to hear from Karen and Grace, the crosswalk that they did to the current meaningful use criteria, because I think that in and of itself might sort of elucidate some of the gaps. But, yeah, I think it's a fair explanation to think about it in that light. I think we want to be thinking about where the market needs to be, where it is today, what is certification and other federal, or private sector programs doing to sort of get us there and what could be the role of Health and Human Services and ONC and trying to evolve that.

Is it expanded certification such as what was put forth recently from the Health IT Policy Committee in response to the CMS and ONC Request for Information on how do we accelerate health information exchange. So, should we be thinking in the context of expanded certification, should we be thinking about evolving the program requirements for the Medicare Shared Savings Program or are there other things that we haven't yet addressed for advanced primary care or quality measurement and reporting. So yeah, we want to be thinking broadly, but I think in the context of how do we get to this, to move along the health IT marketplace, so that it's going to meet these needs for accountable care.

William A. Spooner, FCHIME – Sharp HealthCare – Senior Vice President and Chief Information Officer

Thank you.

Alexander Baker – Office of the National Coordinator

Other comments from the group? Great. Well thank you so much Karen. I guess that's probably a pretty good segue into the previous topic. If you wouldn't mind going back to that previous slide with the initial task piece on it. There you go. So, unfortunately Charles isn't able to join today, but would just like to get some input on – some more thoughts on that topic that Kelly just teed up, which I think is the sort of what we're looking to continue to refine as an immediate task for this group. Grace, I don't know if you would be interested, I know we discussed a little bit about this, just wanted to let everyone on the group know that Grace has very graciously agreed to be a co-chair for this group, in addition to Charles. So, I don't know if you would be interested in maybe just teeing this piece up for the group or – so that we could have a little further discussion on how all the great work that CCHIT has done, and other folks have done, in terms of mapping those items – those functions, how this group could begin to think about how that overlaps with the federal policy framework.

Grace Terrell, MD – Cornerstone Health Care, PA – President and Chief Executive Officer

Sure, I'll give it a try, although as I told you earlier, I'm here on Maui, in my hotel room, calling in on vacation, so I think I might get around this. The way that I have personally thought about health information technology, maybe is where I'll start with this, because I think it helps me understand, at least for myself, what I think this group is about. I think health information technology has been, and there have been three stages of it, and the first was – is about a 30 year old mature technology, and it's related to our practice management systems and revenue cycle, and it was all about billing and collecting and scheduling. And there has not been a whole lot new related to that in a long time. And we're about 25% through probably related to the clinical information health information technology which is EHRs, it's clinical decision support and it's not yet a mature technology, although obviously it's evolving very quickly.

But the world that we're going to be going to very quickly I think is the third stage of information health technology, which has to do with population health management. And the types of things that we're going to need for that are very different than the way that our current EHRs were construed, which were around episodic care, the types things the clinicians need to do that and the information that we will need to exchange with one another. So, from my standpoint, a lot of the original work of CCHIT and a lot of the things that we've seen out of Meaningful Use and otherwise, have been about an industry that was in an immature technology phase. That needed some types of standardization that needed to be about more than just what perhaps vendors at the time were offering, but something that would be appropriate for patient safety, would be appropriate for the types of communication that needed to occur.

So I actually think that what we're getting ready to go into in our healthcare world, regardless of what's happening in Washington from a political standpoint, is going to be the result of a lot of the new ways that we exchange information in the world. And the whole aspect of what we'll need for that is very, very, very different and the technology needs may not be mature, the market may not be mature, but it's going to evolve very, very rapidly. So from that standpoint, my understanding of what our task was for this particular body was to think about where we are now, what's out there thus far with ONC standards for Meaningful Use and to basically think about where things are going to be 5, 10 years down the road. And make sure that we have policy in place that allows us to encourage technology that's going to get us to a place that we want, which presumably is a very, very efficient healthcare delivery system that's based on improved ways of using technology. And in ways that are not so much necessarily the way we're thinking about it now, but that will be patient-centered and based on interoperability and health information exchange, but new ways of understanding things, whether it's just registries as we've done now, or ways of really thinking about how we might tackle the...the things we do.

So within that context, if you look at our initial tasks, part of what I think that we're supposed to be doing is not thinking about where we are now and just filling in gaps, per se, because that would imply that this is a completed task. But to be thinking about what we actually might need for where we're going and can we take what we've been doing within the context of meaningful use and create appropriate policies, at the federal level, that would encourage that. And also at the same time, decide what does not need to be federal policy and can best be left to the vendors and the private market, from the standpoint of innovation to get us where we need to go. So, that's sort of the way that I think that we've had our discussion earlier and I hope that helps everybody understand at least my perspective on how we might move forward to think about where we are right now, as to where we need to go and what, not just the gaps, but how and what sort of federal policy would get us there.

Hoangmai H. Pham, MD, MPH – Centers for Medicare & Medicaid Services

This is Mai Pham from CMS, a question for clarification. I'm just reading through the initial task and under that number 1, talks about integration of clinical and care data. And I just want to make sure I understand the focus on the types of non-federal systems that are out there – that's really not what I mean. I mean systems that don't incorporate federal data at all, I don't see claims data and so I wasn't sure if that was an intentional omission in terms of data integration or not.

Kelly Cronin, MPH – Office of the National Coordinator

Mai, this is Kelly. I don't think it was intentionally left off. We had quite a bit of conversation about it last call around the need to have the ability to integrate claims and – just as all the pioneers are doing, and many of the MSSPs and ACOs and beyond. And I – there are, I guess, evolving competencies in that area, but there are still some challenges. And so that does seem to be an area that would be in scope and something we'd want to be talking about.

Alexander Baker – Office of the National Coordinator

Yeah, I think that care should definitely be claims there, I think that's just an error on the slide.

Karen M. Bell, MD, MMS – Certification Commission for Health Information Technology – Chair

This is Karen Bell. I also was thinking from the perspective that there are the Medicare ACO programs, but there are so many other payers that have programs that could be considered accountable care as well. So that when we're talking about integrating data between claims data for instance and clinical data, I think first we also need to think about the need to integrate claims data from multiple payers because many of the accountable care organizations that are out there will be having arrangements with multiple payers. So, I think that's going to be an important point, too.

Kelly Cronin, MPH – Office of the National Coordinator

Yeah, Karen, just to add on to that, I think that a lot of the states are finding it to be a bit challenging going from the all payer claims databases to figuring out both the data architecture and the legal and operational aspects of actually integrating the all payer claims databases with existing clinical data repositories.

Karen M. Bell, MD, MMS – Certification Commission for Health Information Technology – Chair

Right.

R. Hal Baker, MD – WellSpan Health – Vice President and Chief Information Officer

This is Hal Baker. I'm wondering if there's a distinction between claims data in a model where you have restricted access accountable care where you're managing claims, but every transaction of care involves a claim to more of a global capitation where the transactional nature sort of disappear, business takes place in remote and telehealth ways, just like we're having this conference call, without physically seeing each other. And that those are very, very different and it seems to me there's a point of transition between a modified claims system, transaction-based accountable care and the more global capitation within the provider community is more freed up to accomplish the purpose without always generating a billable event. I don't know if that's what Grace was –

Grace Terrell, MD – Cornerstone Health Care, PA – President and Chief Executive Officer

Yes, it's Grace. That's exactly what I was talking about, which is not so much the system that we have in place now, but what we actually need. It's not so much claims, which is what we have as a tool to identify it now in our world, but it's the ability to measure the cost of care and the transaction cost of the various aspects of things that allow us to use the information we need to provide the care that we need to provide. So, claims obviously is our surrogate to get to cost, but there's other aspects of that too, such as how do you identify the patients with various levels of need.

I mean, we may do it right now in the Medicare Advantage world with RAP scores, which is allowing us to look at risk-adjusted types of factors as it relates to patient severity index. These are all types of information that we can use now and are doing in our ACO world to sort of get us where we need to go. But the real issue is how do we taken what we've got, all the systems in place, the vendors and what they've created for the current system, to really look at the overall aspect of things related to cost. And all we've got right now are claims, but what do we want it to look like in the future and what do we need to get there from a policy standpoint.

Shaun T. Alfreds, MBA, CPHIT – HealthInfoNet – Chief Operating Officer

This is Shaun Alfreds from HealthInfoNet. One of the areas that we're struggling with working with the ACOs here in Maine, I talked about this at the last meeting, is the data itself. We – in the good old days of managed care, even in capitation, the capitated insurers were collecting encounter information, and using it as a proxy to claims. And there are lots of algorithms built then to corroborate the encounter information against the clinical record, so that there was the means to hold the provider systems accountable for the capitation rates. And those systems are in place today need to address some of – or they can be used today to address some of the capitation pieces that we're talking about now, going into ACOs, as it very closely resembles that kind of managed care measurement.

But at the end of the day, we are talking about the need for having more robust clinical data, and I can't stress enough how important it is for the federal government to be focusing on discrete data standards for sharing clinical information. I'll be honest, the continuity care document is not a good standard. It's – even working with systems like the Veterans Administration, who pioneered the continuity of care document C-32 standard, what we're seeing is that we're having to map individual CCDs from – that we've been seeing from them testing their systems. And EMRs, you've seen one CCD, you've seen one CCD. So, our systems are built on an HL7 discrete data element exchange, because that's the only way we've found that we can accurately parse individual clinical data elements. And when it comes to ACO, what we're seeing here, certainly with our Medicare ACOs, which are fairly well developed now in Maine, is that they really – they're in need of discrete EMR-based data elements. Not only the ADT information, but also laboratory results, the BMI and vital signs and other data elements that are really difficult to get out of the EMR using the current standards that are being prescribed through meaningful use.

R. Hal Baker, MD – WellSpan Health – Vice President and Chief Information Officer

Hal Baker here again. Would you distinguish between – did you see a distinction between data elements and information that – because you can often have a lot of data elements that do not give the clinician the knowledge and information to understand how to manage that individual in the context of their life. The CCD is really structured around data to date, but lacks any ability to convey the broader information, I guess. And does that play a role or is that just beyond our scope at this point, if that distinction makes sense?

Shaun T. Alfreds, MBA, CPHIT – HealthInfoNet – Chief Operating Officer

I certainly think that distinction does make sense and it depends on how we're planning on supporting the ACOs. I always look at it at three different levels. There's the system-wide level for the ACO and looking at a population base and understanding how to drive policies across the ACO organization. And then there's the provider level, in looking at patient panels and understanding how we're doing on a patient panel basis on a disease state basis, doing your standard disease management activities. And then we look at it at the provider level and the individual patient level. And I think the information that we're deriving from the data is different if you're looking at those three levels.

R. Hal Baker, MD – WellSpan Health – Vice President and Chief Information Officer

Absolutely.

Shaun T. Alfreds, MBA, CPHIT – Chief Operating Officer – HealthInfoNet

On the patient level, you're looking for that discrete information at the point of care that's going to impact the care coordination at that point of care. And for an ACO, what we're seeing is very important is understanding the potential risk of that patient, the relative health of that patient, the potential risk of them entering into or decompensating or entering into a higher cost bracket because of lack of management. On the provider level, it's really looking at the panel and assessing the relative health of the panel, and understanding the impact of that relative health of the panel on the ability of that provider to take on risk, and also entering into care management strategies with community care teams. And then on the system level, you're looking at developing your risk models, so that developing a relative risk for the population that the ACOs looking to manage.

R. Hal Baker, MD – WellSpan Health – Vice President and Chief Information Officer

Thank you.

Grace Terrell, MD – Cornerstone Health Care, PA – President and Chief Executive Officer

Other thoughts from the group.

William A. Spooner, FCHIME – Sharp HealthCare – Senior Vice President and Chief Information Officer

This is Bill Spooner again. I'll pipe in and endorse what I heard both from Hal and the other gentleman. We have a lot of experience in San Diego. We are 25 years into capitated managed care, including Medicare Advantage and commercial health plans. We're in three different ACOs and if there's anything that we really need is better standards, harmonized standards, more specific standards and it's not only for exchange of data internally, but in terms of exchange of data from our payer partners, whether it be a commercial health plan or CMS. There is woeful inaccuracy in the data and inconsistency from payer to payer in terms of what is being defined, and if there's anything that we need to do better its standards, it's the performance indicators. We spend so much time collecting differently defined performance indicators that it takes away from the time to that into action, which is what this program is really about.

Heather Jelonek, MS – John C. Lincoln Accountable Care Organization – Chief Operating Officer

And this is Heather Jelonek with John C. Lincoln. One of the areas that we're finding the biggest need and the absolute worst data source is the psychosocial and socioeconomic needs of the community that we have been charged with taking care of. In the Food Bank and the area Agency on Aging aren't necessarily going to generate any claims information, so therefore we're not going to receive information back from CMS on them. However, what we've identified with patients who are repeat frequent fliers in the ED, instead of – the psychosocial and the socioeconomic factors that are driving a lot of the clinical decision making. And until you actually dig down and actually speak with the patients or see where other needs are out there, we're spending a lot of time and resources on areas that aren't proving effective to the overall care of the patient. So, I would also like to be able to see a way that we can tap into some of those non-traditional medical care provider types, to be able to extract data in a meaningful way.

Alexander Baker – Office of the National Coordinator

Thanks Heather. Any other thoughts on that point, folks who see key pieces of data that could better inform work of accountable care models from those providers. All right. I guess in our last couple of minutes, I wonder if we want to just briefly touch on another task that we have been in discussions about with the leadership of the HIT Policy Committee. Kelly, are you still on the line?

Kelly Cronin, MPH – Office of the National Coordinator

Yes. Sorry, I might have a little bit of background noise here, so you wanted to talk about the quality measurement and reporting piece.

Alexander Baker – Office of the National Coordinator

Yeah. If you could move to the next slide, we have just a little bit of that on there. Great

Kelly Cronin, MPH – Office of the National Coordinator

Yeah. I think in talking with Paul Tang and planning this new workgroup, I know he and some others working in the quality workgroup under the Health IT Policy Committee, were interested in making sure that clinical quality measures that are coming out of Stage 3 Meaningful Use can be perhaps meeting the needs of accountable care. Looking at patient-centered, longitudinal measures that are eSpecified, perhaps eCoordinate care coordination measures and really just getting to sort of the next generation of quality measures that would be computable. And we'd certainly have certification and software testing tools and value sets to enable all of the numerator and denominator – data elements the numerators and denominators to be exported out of EHRs. And then we have a lot of things going on to try to also improve the sort of real-time feedback on performance back to EHRs or back to clinicians.

So, in thinking through sort of overall – from a business and clinical perspective, we're wondering if the workgroup would want to spend time trying to think through the intersections of, and the needs for accountable care – clinical quality measurement that supports ACOs needs. And whether or not the Stage 3 in Meaningful Use will be perhaps one way – like one way to do that.

R. Hal Baker, MD – WellSpan Health – Vice President and Chief Information Officer

Hal Baker from WellSpan again. I think there's a distinction between the needs of managing a population and the needs of evaluating a program evaluating a population. A lot of our quality measures are for ages 18 to 75, if you're in a truly accountable care organization, you're concerned with the diabetic patient from age 76 to 80, but you don't use that for your evaluative measures. In managing lipids in a demented man, you might pull back on the Lipitor and let them not try to treat that at that point in their life, given their life context, but it probably should show up in your quality measures, because you can't account for everything in quality measures. There are certainly some arbitrary constraints for quality measurement that are different and distinct, we're finding, as we start to get into truly managing a population and individuals. And so, they really serve somewhat different purposes and I think that has to be acknowledged.

David Kendrick, MD, MPH – MyHealth Access Network – Chief Executive Officer

This is David Kendrick from Tulsa. One thing that I've been struck by on measures is how many of them – there are two kinds, I would put them in two major buckets. One is measures that we believe are important and measures that actually generate return on investment savings or improvements in quality or qualities. And, I wonder if the work has been done yet to identify the real measures that an ACO should use to drive itself from a bottom-line perspective but also from an outcomes perspective. I mean, I can think of a few, but it would seem that those become the KPIs for the operation once they get embedded and I worry that's a lot of noise out there –

Kelly Cronin, MPH – Office of the National Coordinator

That's perhaps one area that maybe this group could uniquely address is the need to be able to better measure efficiency or value. And I'm sure a lot of people have probably saw the Health Affairs Blog last week, Janet Corrigan and Elliott Fisher and others had put together sort of a new framework for measurement for accountable care. It was really based on value and how to create – thinking about numerators and denominators in the context of value, probably not so dissimilar from where Medicare Part B payments going to be going with a value-based modifier. But going beyond sort of that concept to maybe measurement domains or specific measure concepts is perhaps something we could do, although also wanted to point out when we talked to Charles and Grace about this, I think they were interested in focusing on the "how" of quality measurement, not so much the what. So, it would be good to understand where folks think we could most contribute, is it more on the what or more on the how or is it a combination of both?

David Kendrick, MD, MPH – MyHealth Access Network – Chief Executive Officer

This is David again. I think that's a great distinction to make and I would agree wholeheartedly. I think the how is really a relevant topic for this group, because what I hear, at least from commercial payers who consider – are considering ACO-like models is, they find it difficult to trust measures generated by an organization on its own behalf. And I think the opposite is also true for providers, trusting measures generated by payers and how do we get beyond that to some sort of a trusted third-party arrangement.

Alexander Baker – Office of the National Coordinator

Any other thoughts from the group? Well, we are getting close to the end of our time here. I just wanted to thank everyone for your input today. I think that we are working towards being able to get a finer point on the task for this group and we will definitely do some work in the interim and revisit this on the next call. Unless there are any other final items that folks want to raise, I think we can open the phone lines for public comment. Does anyone else have any other items? All right. If there are any public comments from the operator, that would be great.

Public Comment

Rebecca Armendariz – Altarum Institute

If you would like to make a public comment and you are listening via your computer speakers, please dial 1-877-705-2976 and press *1. Or if you are listening via your telephone, you may press *1 at this time to be entered into the queue. We have no comment at this time.

Alexander Baker – Office of the National Coordinator

Great. Well again, just want to thank everyone for joining and especially want to thank Karen for giving us a little preview of the CCHIT work and also, of course to thank Grace and Kelly Cronin as well for teeing up some of those tasks for us. So, I think that will do it for today and we will talk to you in a couple of weeks. Thanks.