NATIONAL QUALITY FORUM
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CARE COORDINATION STEERING COMMITTEE

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WEDNESDAY
OCTOBER 19, 2011
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The Steering Committee met at the Metropolitan Center, Liaison Hotel Capitol Hill, 415 New Jersey Avenue, N.W., Washington, D.C., at 9:00 a.m., Donald Casey and Gerri Lamb, Co-Chairs, presiding.

PRESENT:
DONALD CASEY, JR., MD, MPH, MBA, Co-Chair
GERRI LAMB, PhD, RN, FAAN, Co-Chair
DANA ALEXANDER, RN, MSN, MBA, GE Healthcare
KATHLEEN ALLER, MBA, McKesson Enterprise Intelligence
ANNE-MARIE AUDET, MD, MSc, The Commonwealth Fund

JUAN EMILIO CARRILLO, MD, MPH, New York-Presbyterian Hospital and Weill Medical College of Cornell University
JANN DORMAN, MA, PT, MBA, Kaiser Permanente
KAREN FARRIS, RPh, PhD, University of Michigan College of Pharmacy
PAMELA FOSTER, LCSW, MBA/HCM, ACM, Mayo

Clinic Health System
WILLIAM FROHNA, MD, FACEP, MedStar
JEFFREY GREENBERG, MD, MBA, Brigham and Women's Hospital
THOMAS HOWE, MD, Aetna
SUZANNE HEURTIN-ROBERTS, PhD, MSW, HRSA
CHRISTINE KLOTZ, MS, Community Health

Foundation of Western and Central New York
JAMES LEE, MD, The Everett Clinic
RUSSELL LEFTWICH, MD, State of Tennessee

PRESENT(Cont'd):
MARC L. LEIB, MD, JD, Arizona Health Care Cost Containment System, Arizona's Medicaid Program
JULIE L. LEWIS, MBA, Amedisys, Inc.
LINDA LINDEKE, PhD, RN, CNP, University of Minnesota School of Nursing and Amplatz University of Minnesota Children's Hospital Clinic
DENISE LOVE, MBA, RN, National Association of Health Data Organizations
LORNA LYNN, MD, American Board of Internal Medicine
JEAN MALOUIN, MD, MPH, University of Michigan
MATTHEW McNABNEY, MD, Hopkins ElderPlus and Johns Hopkins University
EVA M. POWELL, MSW, National Partnership for Women & Families
BONNIE WAKEFIELD, PhD, RN, FAAN, University of Missouri and Iowa City VA Medical Center
ALONZO WHITE, MD, MBA, FCCP, CPE, Anthem Care Management
NQF STAFF:
TAROON AMIN

HELEN BURSTIN, MD, MPH, Senior Vice President of Performance Measures
SHEILA CRAWFORD
LAURALEI DORIAN, Project Manager
ANN HAMMERSMITH, JD, NQF General Counsel
SARAH LASH
NICOLE McElveen, MPH, Senior Project Manager

SUZANNE THEBERGE
WENDY VERNON, MPH, MPT, Senior Director, National Priorities
ALSO PRESENT:
LIPIKA SAMAL, MD, Brigham and Women's Hospital
ARJUN VENKATESH, MD, MBA, Brigham and Women's Hospital

C-O-N-T-E-N-T-S

P-R-O-C-E-E-D-I-N-G-S

9:11 a.m.

MS. DORIAN: Good morning, everyone. Welcome to the Care Coordination Steering Committee meeting with NQF. I'm Lauralei Dorian, project manager for this project. And I can tell you we're very excited to have you here. We're really looking forward to this project. I think we've brought together a great group of people from many different backgrounds and looking forward to the day. I think before we get started I'll have the rest of the NQF team introduce themselves. Helen?

DR. BURSTIN: Hi, everybody. I'm Helen Burstin. I'm the senior vice president for performance measures at NQF. Welcome.

MS. MCELVEEN: Good morning, everyone. Nicole McElveen, senior project manager with the National Quality Forum.

MS. THEBERGE: Good morning, everyone. I'm Suzanne Theberge. I'm a

project manager at the National Quality Forum.

MS. VERNON: I'm Wendy Vernon, senior director with the National Priorities Partnership at the National Quality Forum.

MS. HAMMERSMITH: I'm Ann Hammersmith, NQF's general counsel.

MS. DORIAN: And Arjun, I might have you introduce yourself as well.

DR. VENKATESH: Arjun Venkatesh. I'm a resident in emergency medicine at Brigham and Women's and Mass General.

MS. DORIAN: Thank you. And now we're going to have you go around the room. We'll do our welcomes and introductions. And at the same time we'll have Ann do your disclosures of interest. So we might start down at this end and then go around.

MS. HAMMERSMITH: Lauralei.

MS. DORIAN: Oh, of course. Oh, the chair. Sorry.

MS. HAMMERSMITH: Well, I give a little introduction actually.

MS. DORIAN: Oh.

MS. HAMMERSMITH: An explanation.

MS. DORIAN: Okay, perfect.

MS. HAMMERSMITH: So if you recall, all of you received a disclosure of interest policy and form from us which you filled out and which we reviewed carefully. What we'd like to do now is have you go around and disclose anything that you feel needs to be disclosed. You don't have to recount your CV because that would take way too long and you don't need to go through the form and summarize every response. What we're looking for you to do is to disclose any of your activities that may be relevant to the work that this committee will do. We're particularly interested in your disclosure of consulting work that's relevant including any speakers fees. We're also interested in any grants or research support that you have that may be relevant to the work that's before the committee.

One thing that I want to talk about very briefly is when we do these disclosures people often say I don't have any financial conflict. In this context disclosures are not limited to financial conflicts. If you've worked on something and it's your baby a dime may not have passed hands but you could potentially have a conflict because you're very invested in it and you have a very, very strong point of view potentially. So I just want to remind you of that.

The last thing I want to remind you of is that you serve on this committee as an individual. We often have people say "I'm here representing the American Association of Healthy People," but you sit as individuals. So, you don't represent your employer, you don't represent any group. Even if they nominated you to serve on the committee you are not representing their interest. You're here because you're experts and that's what

we're after, your individual expertise. So if we could start with the chairs I'm going to ask everyone to introduce themselves, tell us who you're with and then do any disclosures.

CO-CHAIR CASEY: Good morning, everyone. I'm Don Casey. I'm the chief medical officer for Atlantic Health, vice president of quality. And I want to welcome you all and we're very happy that you're here. I have several disclosures to make. I think all of these are non-financial but they are relevant. I have served in the capacity of members of writing groups and technical development panels for the following organizations: American College of Physicians, the American College of Cardiology, the American Heart Association, the American Hospital Association, the American Medical Association, NCQA, the American Board of Medical Specialties and also CMS and NQF. I've received funding from AHRQ for research in care coordination but not recently. And I

think that summarizes it.

CO-CHAIR LAMB: Good morning, everyone, delighted you're here. I'm Gerri Lamb. I'm co-chairing with Don. I am a faculty member at Arizona State University and continuing that vein also have activities that I think are relevant although not all financially related. I am a consultant on the INTERACT program which is transitional care for older adults between nursing homes and hospitals. I just sat on the Board of Internal Medicine's PIM related to care coordination and I am on a working group at the American Academy of Nursing on care coordination.

DR. WHITE: I'm Alonzo White, managing medical director for Anthem Care Management. I work for WellPoint. My responsibilities are basically case management, disease management and the health and wellness programs. I volunteer with a group called Not One More Life which is an

inner-city program for people without insurance who have asthma and it's designed to reduce the asthma mortality rate in the inner-city populations, strictly voluntary. And my wife is director of Meaningful Use at McKesson and is a manager in their electronic medical records and practice management software division.

MR. FROHNA: Good morning. My name is Bill Frohna. I'm chairman of the department of emergency medicine at Washington Hospital Center here in the District and also work for MedStar Health. Our group of emergency physicians and PAs provide services to five hospitals in the nine-hospital MedStar Health system. I oversee the operations of those five departments and so 110 physicians, about 55 PAs. The only disclosure I have to make is that I come from a family with nine siblings and many of those are involved in health care and I have made those disclosures on the form, but nothing personal.

MS. FOSTER: Good morning. My name is Pam Foster. I am the director of care coordination at Mayo Clinic Health System currently in Eau Claire, Wisconsin. I just transferred from the Mayo Clinic in Arizona to that position. And my disclosures I think would include that I am a board member of the American Case Management Association and I am a client of McKesson as well as Executive Health Resources. And finally, since my application I am now involved in a grant application for CMS money for care coordination through the CBO and we're just in the early stages of that.

DR. LEFTWICH: Good morning, I'm Russell Leftwich. I'm the chief medical informatics officer for the state of Tennessee's Office of e-Health Initiatives, the agency responsible for promoting EHR and HIT adoption in Tennessee. I've spent a great deal of time the past eight months as a volunteer with the Office of National

Coordinator's Transitions of Care Initiative and their standards and interoperability framework and am the co-lead of the clinical information model group and the care planning work group. And I'm a physician advisor for the American College of Physician's web-based EHR information resource. I'm glad to be here and participate, thanks.

MS. KLOTZ: Hello, I'm Chris Klotz and I work as program advisor to the Community Health Foundation in Western and Central New York which is based out of Buffalo, New York. My role there, I have responsibility for designing and managing large projects and initiatives, and have had responsibility since 2005 with a series of projects under a care transitions initiative. And in that role I'm currently providing technical assistance for two rural applications for the community-based care transitions at CMS.

DR. FARRIS: I'm Karen Ferris. I'm a professor from the University of

Michigan College of Pharmacy and I have a few disclosures. I have worked for the past seven years on a volunteer basis doing work with the Pharmacy Quality Alliance where we develop measure concepts around medication use and pharmacist services. I'm co-PI on an NHLBI grant based back in Iowa where I was formerly and that is looking at care transitions and how pharmacists may improve that transition, I'll just leave it at that. And I'm initiating some work in the Battle Creek area with the Calhoun County group. And we are wanting to focus on who in fact manages the med list across their system. And hopefully we're going to come up with some different ways of doing that. And last year through PQA I was offered a speaking opportunity that was paid by Lilly and then most recently I've been in some discussions with Merck focused on medication adherence. And that's a very limited contract for five hours.

MS. DORMAN: HI, my name is Jann

Dorman. I work for Kaiser Permanente. I'm the senior director at our Care Management Institute and I oversee a portfolio of initiatives for care delivery improvement and innovation like palliative care, transitions, chronic disease management, et cetera. My disclosure is that takes more than all of my time and I have no other disclosures to make.

(Laughter)

MS. ALLER: Hi, I'm Kathleen Aller with McKesson Provider Technologies. I'm responsible for implementing quality measures developed by others within EHRs and for assisting providers in deploying and using those measures. But I have no involvement in creating them.

DR. HEURTIN-ROBERTS: Hello, I'm Suzanne Heurtin-Roberts. I'm with HRSA. My focus is quality improvement and cancer prevention and control. I'm on detail to HRSA from the National Cancer Institute. And the only thing I can think of that would be any

disclosure is I'm on an interagency HHS committee on quality cancer care and we're working on developing a pilot study of care coordination in cancer care. Otherwise no connections.

DR. LINDEKE: Good morning. I'm Linda Lindeke from Minnesota. I'm a pediatric nurse practitioner on faculty in the School of Nursing at the University of Minnesota in the Center for Children with Special Health Care Needs. It is funded by the Maternal Child Health Bureau and we have done a number of projects. I don't see any conflict. I'm not funded on any of these projects but I'm in an advisory capacity to the National Association of Pediatric Nurse Practitioners, a couple of AHRQ projects. I'm on the Medical Home Advisory Committee for the Academy of Pediatrics and also on an American Nurses Association Congress in Nursing Practice and Economics.

DR. AUDET: Anne-Marie Audet. I'm

vice president for the Program on Health Quality and Efficiency at the Commonwealth Fund. And my potential conflict is as a funder of many projects that are looking at care coordination. We have our state action to avoid rehospitalization which is looking at care transitions in over a hundred hospitals in three states. We're funding a lot of the -- we have funded measure development in the past, right now we're not doing that, but we're funding some investigators like Steve James, Jerry Anderson, Eric Coleman, so. And in that capacity sometimes I do sit on advisory committees for these projects but otherwise I have no other conflicts.

DR. WAKEFIELD: Bonnie Wakefield, I'm an investigator in the Health Services Research Center at the Iowa City VA where we focus on access, rural health and health information technologies. I'm also an associate research professor at the University of Missouri School of Nursing and I have no

disclosures.

MS. LEWIS: Good morning. I'm Julie Lewis. I work for Amedisys which is a national home health and hospice company. I'm their vice president of health policy so my work mostly focuses on developing and piloting alternative payment delivery models. Because I haven't been there long I should probably just add that my most recent job was with Dartmouth and Brookings working on the ACO model. So I probably would have had a lot of conflicts there but I think they're gone now. So nothing to disclose.

DR. CARRILLO: Good morning, Emilio Carrillo. I'm vice president for community health at New York Presbyterian Hospital where I'm very much involved with grants, contracts and programs in care coordination with CMS and the state of New York. I'm associate professor of medicine and public health at the Weill Cornell Medical School and sit on the boards of the National

Hispanic Medical Association and the United Way in New York where occasionally there are issues of care coordination that come my way. And I lecture and teach culture competency and cross-cultural communication. I was one of the founders of the quality interactions program.

MS. POWELL: I'm Eva Powell with the National Partnership for Women and Families. And just about everything I do these days is related to care coordination so I'll try to hit the high spots. I lead the health IT program at the National Partnership and through that role I provide significant support to ONC specifically on care planning. I also serve on the Quality Measures Work Group under the Health IT Policy Committee. I'm also the co-chair for the Care Coordination Council for the e-Health Initiative. I am serving with Russell on the S&I Framework Transitions of Care Group and have done a number of things with NQF

including the quality data model, structural measures and some other groups. I also have worked with the National Transitions of Care Collaborative specifically on elements related to health IT. And I serve on the Triple Aim faculty with IHI.

DR. MCNABNEY: My name is Matt McNabney and I'm a geriatrician at Johns Hopkins School of Medicine. And I'm the medical director of our PACE program which is the Program of All-Inclusive Care for the Elderly, an outstanding care coordination model which I must reveal is a bias I have. I'm also chair of the clinical practice committee with the American Geriatric Society and many of our efforts in that committee focus on care coordination and the health care home.

DR. LEE: Hi, I'm James Lee. I'm a practicing internist from the Everett Clinic. That's north of Seattle, Washington. My current involvement is with our local

hospital system, Providence Health, in coming up with a LEAN approach, taking care of patients from admission to home. And previously I was involved in the CMS physician group demonstration project with the Everett Clinic. And I don't have any conflict to disclose today.

MS. LOVE: I'm Denise Love. I'm executive director of the National Association of Health Data Organizations. I represent and work with states and private sector data agencies who are building large-scale claims databases to measure the cost, quality and access of care for market and policy purposes. And so my bias might be that I work with and promote claims databases for measurement for public reporting. And we are actively engaged with many states on all-payer claims databases and we are this week and going forward engaged with X12Ns who define implementation guides and core standards for payer-based reporting to state and local health departments. And I

have no other conflicts.

MS. ALEXANDER: Good morning. I'm Dana Alexander. I'm the chief nursing officer with GE Healthcare IT. I do represent GE with its membership for the National Quality Forum although I understand here I am an individual. I also chair the Nursing Informatics Working Group Public Policy Committee with AMIA. I am a member of the American Organization of Nurse Executives on their Technology Task Force and also a member of the HIMSS Nursing Committee. I do frequent speaking for each of those organizations but with no financial reimbursement. Thank you.

DR. MALOUIN: Good morning, I'm Jean Malouin with the University of Michigan. I'm the associate chair for clinical programs in family medicine, associate medical director for ambulatory care there. And most recently the medical director for our 450-practice statewide PCMH initiative in Michigan.

DR. HOWE: Good morning, Tom Howe,

medical director with Aetna with patient management responsibilities. But also was one of the organizers of our National Data Repository which uses existing measures for measurement of Aetna clinical management and referral of that information back to physicians. Also, piloted a PCMH project in New Jersey and an e-prescribing initiative. Other than that I don't think I have any conflicts.

DR. LYNN: Good morning, I'm Lorna Lynn. I work for the American Board of Internal Medicine where I have developed a number of practice improvement modules for physicians to use which put together data from charts and patient surveys to give them a picture of the quality of care they provide. Our ongoing initiative for this year is to develop a module on care coordination which Gerri serves on our committee for that. So that's an area of strong interest and we will have a viewpoint on that but are also looking

to learn from here. Other activities I have that might be relevant is I recently was a reviewer for the Pioneer ACO applications. I have a husband who is a consultant for some pharmaceutical companies but I honestly always have to call him and ask them which they are when I fill out a disclosure form.

DR. GREENBERG: Hi, I'm Jeff Greenberg. I'm associate medical director at the Brigham and Women's Physician's Organization, part of Brigham and Women's Hospital. I'm also a practicing general internist and I just started practicing at the Brigham's brand new medical home in Boston. And nothing else to disclose.

DR. SAMAL: I'm Lipika Samal. I'm also here from Boston, Brigham and Women's. I'm a primary care doctor and researcher, and I'm actually one of the speakers. I'm not a committee member. I have nothing to disclose.

MS. HAMMERSMITH: Okay, thank you, everyone. Are there any committee members on

the phone, Lauralei?

MS. DORIAN: Not yet. We're working on the phones but we'll check back in a few minutes.

MS. HAMMERSMITH: Oh, okay.

CO-CHAIR CASEY: The only one person I saw that wasn't here on my list was Mark Leib.

MS. HAMMERSMITH: Okay. All right.

MS. DORIAN: He'll be calling in. Yes.

MS. HAMMERSMITH: Thank you, everyone, for those disclosures. Is there anything that you, based on what you've heard that you want to discuss or any questions you have for each other or of me regarding the disclosures? Okay, thank you. Have a good meeting.

MS. DORIAN: Thanks, Ann. And thank you, everyone. We definitely have a very impressive group of people and we're

grateful to you for taking the time out of your obviously busy schedules. And thanks to Don and Gerri as well for the leadership you'll certainly be providing throughout the day.

So what I'm going to do now is just go through the agenda of our morning session and afternoon session. This morning you'll hear from Wendy Vernon who introduced herself earlier to talk a little bit about the NPP's relationship to care coordination endeavors in the past. And then you'll hear from Don and Gerri who we're lucky enough have been involved a lot in care coordination and performance measures in the past so they can touch upon some of the things that they've been involved in, some of the measures that came in, some of the measures that didn't come in. And then we are going to hear from Lipika who will give her presentation on her paper, her annotated outline. And then Arjun is going to talk about the findings of his

environmental scan.

And then during the afternoon session it'll be quite an interesting session I think. This is where you guys will really have the opportunity to set the pathway forward for the care coordination call for measures. We'll have a bunch of discussion questions that we can ask you and feel free to throw out questions of your own. We'll start detailing really the pathway forward and shape the specification within the call for measures and see what measures maybe are out there already that we want to encourage to come in. So it should be quite an interesting session.

We've already gone over the project with you on the orientation call and I think you've received a lot of documentation already, but just to remind you that this project is broken down into phases. That this first phase really gives you the opportunity to shape the future of care coordination measures and that's what's really exciting

about it. And so we really want to talk about where we want to be. And as you've heard in phase I the environmental scan and white paper. And then in phase II will be when we do receive measures and evaluate them through our CDP process. So does anybody have any questions so far about the schedule for the day or any questions about the project?

DR. BURSTIN: I just want to add a tiny bit of additional context. For some of you who have been on NQF committees for awhile this is actually quite different. We rarely have the luxury of sort of a prequel to a project. We really do see this as trying to get to that next set of care coordination measures and you will hear shortly from Don and Gerri about their efforts when they chaired the last committee. And we didn't get as robust a response to that call for measures as we had hoped so I think our thinking this time was let's take the chance. We have the time to actually work with you, think through

what we really need, try to sort of prime the pump of those out there to bring in the measures we think will really add value. So we'll talk more about this, but the idea would be can you help us collectively develop what we're calling a pathway towards getting those measures in which is why we're focusing for example as you'll hear shortly on the paper a lot of the emphasis is on HIT and it's not surprising many of you have experience in HIT. That obviously seems to be a key factor in bringing in measures that would actually get us that broader experience with care coordination.

So we'll really be, this is -- you're not going to have to evaluate measures today, you're not going to do a lot of the usual work of NQF. You will get to do that next time but this is really a chance to set the direction, signal to the measure development field what's needed and then also with the help of Lipika and David Bates and

the folks at the Brigham then think about what the HIT infrastructure needs that will help us get there. So we may not get all those measures in this cycle, but again you'll at least be priming that pathway to bringing in the measures we think really matter. And you'll hear much more about that from Gerri and Don, but for any of you who are used to usual NQF process this is a luxury and I hope we take good advantage of it.

MS. VERNON: Good morning, everyone. As Helen and Lauralei mentioned I'm Wendy Vernon and I introduced myself as part of the National Priorities Partnership group at NQF. I've been there since 2007 working with the National Priorities Partners on providing input most recently to HHS on the National Quality Strategy. And what we wanted to do this morning was just give you sort of an overview of that input so that you, as you go down this pathway of developing your pathway for measures that you have some sense

of sort of where HHS has been in terms of the National Quality Strategy as well as what NPP's most recent input was this past month. So with that let me just get started. Can you go to the next slide?

So this is just more broadly NQF's mission but I thought it was important to point out that NPP is convened by the National Quality Forum and has been since its inception. And really NQF's mission, you're really here addressing the second bullet around endorsing national consensus standards sort of leading the path there. But our first bullet there is on building consensus on national priorities and goals. And so at NQF what we really want to make sure is that our work is interconnected and that we're, you know, as these priorities are developed and as our partners support them and others that we make sure that internally we're also doing our best to make sure that those priorities and goals carry through all the work of our

steering committees and that it informs your work moving forward.

The third priority area or the third mission, sorry, piece was around then promoting the attainment of national goals through education and outreach. So not only do we need to set the priorities and goals but obviously to also help to achieve them through the work that we do at NQF. So the next slide.

So just a quick overview of NPP. Most of you are probably familiar, some of you have participated in a lot of the work that we've done over the past several years. Some of you are actually, or your organizations are on the National Priorities Partnership but again convened by the NQF. We have about 48 leaders, soon to be 51. We just had a call for nominations over the summer and we're waiting for board approval to add additional federal partners to this group as well as a couple of new partners. But really as with

all of NQF's work aims to be multi-stakeholder to the greatest extent possible so we include consumers, purchasers, various quality alliances. We want to make sure we have a healthy representation of health care professionals and providers, and really more recently have been looking to broaden our scope beyond the health care delivery system and really make sure that we're getting into more state-based organizations. We have the National Association of Medicaid Directors, also looking at engaging community work more fully, and then certainly health plans and industry representatives. And then you see our federal partners at the bottom there. NPP currently co-chaired by Bernie Rosof and Helen Darling. Next slide.

So initially when NPP was formed there wasn't any type of legislative mandate around priority-setting, it was -- really the NQF board felt that this was a void in the area, that we needed national priorities and

some type of common or shared goals to really help us identify what to measure, what was important, what we should all be working on. There are a lot of signals in the field of various sort of competing priorities. And so in 2008 NPP released its initial report with six priority areas but then in 2010 with the Affordable Care Act there was language in there about developing a National Quality Strategy with multi-stakeholder input. And so HHS contracted with NQF to convene the National Priorities Partnership with the goal of really having some type of national strategy that again would be able to coordinate and align public and private sector efforts to get everyone sort of rowing in the same direction so to speak. Next slide.

So with that late last year, so about a year ago HHS came to NQF again and said we need input on this National Quality Strategy that's to be released in early 2011. And so we provided input. We were pleased to

see that in March when the National Quality Strategy was released that there was pretty good -- that the priorities and the goals were fairly well informed by what NPP had recommended to HHS with a couple of exceptions which I can talk about sort of as we go through the different priority areas. But then this past year then after the release of the National Quality Strategy they came back to NPP and really wanted more information on some more specifics around goals and measures, some strategic opportunities for how we might get there and really again to help them make it more actionable. So they acknowledged that the first National Quality Strategy was a step in the right direction but that it really needed to be made a little more actionable. So that was where we focused our efforts this year. And the next slide.

And really before we get into the priorities and goals I just wanted to mention quickly there are three sets of strategies

that you might want to take a look at in your spare time. I know you've gotten a lot of reading for this meeting and you have plenty of other things to read but really wanted to make sure that we focused on sort of building these three areas out. And certainly they all hinge on the ability to measure well or support measurement. So really emphasizing that we need some type of national strategy for data collection and measurement and reporting, that we need supports for community infrastructure to be able to undertake improvement efforts, that we can't just, you know, say here are priorities and goals, everyone go forth and do this when we obviously have a lot of infrastructure needs that need to be met. And then third, recognizing that much of this will not come to fruition if we don't have payment delivery system reform that supports the achievement of these priorities and goals.

So as we sat down to do the work

over this past year of really looking at the six priority areas that were in the National Quality Strategy we had a lot of discussions about what the goals should look like. And these were sort of our guiding principles. They may help you as you think through your work as well. But one of the biggest things that we talked about was striking a balance between sort of more immediate and longer term priorities and goals. And what this really sort of boiled down to was aspirational versus achievable. Are we shooting for the moon, you know, are we asking for too much. And I think, you know, early on with NPP there really was this need to really let's aim for what we want and not be timid. This wasn't a time for timidity, that you know we do have some goals where I think the path is relatively clear of, you know, good evidence of success but it's still not widespread enough. And so we certainly want to continue to focus on some of those areas like around,

you know, safety and infections and things like that. But that there really is so much more that we could and should be doing. So I think you'll see as we go through the priorities and the goals that they really tend to take on, particularly I think in the care coordination and person- and family-centered care areas that they really tend to take on more of an aspirational where do we want to be. They really wanted to make sure that we focused more on health outcomes as opposed to processes, that we tend to a lot of the times and I think this came out in much of our care coordination work in 2010 when we had our Care Coordination Work Group convening meeting, you know, we tend to get in discussing a lot about adults and the elderly, and we really need to make sure that we're thinking across the entire life span and taking into account children and their needs.

Health equity was huge and is always a big point of discussion and we wanted

to make sure that we kept that front and center, that this wasn't just about improving averages, this was about also closing the gap between the best performing and those patients and populations that really need improvement desperately. Again, I think with the addition of the partners that extend beyond the walls of the health care system, wanted to make sure that we were thinking more broadly beyond health care delivery. So certainly in the priority areas that focus more on population health you'll see that a little bit more, that we tried to have goals that extended beyond health care which of course, you know, people don't live in the health care delivery system so it's important to meet them where they live. And then really emphasizing this need to have flexibility of approaches, that we can't dictate necessarily from the federal level how we will achieve these things, that states and communities really need to have the flexibility to be innovative and to meet the

needs of their specific populations depending on what their needs are.

So this is our rendition of the Triple Aim essentially, or the three aims. We're not allowed to call it the Triple Aim. But you're probably all very familiar with this, Better Care, Affordable Care, and Healthy People/Healthy Communities. And in the middle you'll see these are the priority areas of the National Quality Strategy. They are all in the middle because they are all -- they all have some impact on each of the three areas, they're all interrelated. We don't see plucking one priority out necessarily and just talking about the goals within that priority area. And you'll see sort of as -- I think this is the one area where I could dive into each and every one of these areas and figure out how it, you know, care coordination is so critically important in all of them. So what I'm going to focus on today a little more in detail is the person- and family-centered care

and the effective communication and care coordination priority areas, but you'll see how obviously all of these are impacted by care coordination. So the next slide.

So this is the first priority area and I'm going to go through these pretty quickly but you have them and certainly if you have any other questions about the specifics I'm happy to answer them. But essentially for the first two priority areas, for health and well-being and then for the preventing and treatment of the leading causes of mortality which will be on the next slide, the subcommittee that was focused on this really wanted to make sure that we got at three different levels of improvement, that we focused on things that could be done at the community level, community-level supports, policies, those types of things, things that could be achieved by individuals that were really focused on healthy lifestyle behaviors, and then things that could be impacted by the

delivery of clinical preventive services. And so obviously when you look at the measure concepts and some of the things that NPP was encouraging HHS to look to when selecting measures you can see things that very clearly need improved care coordination, mental health, oral health. So any type of prevention activity certainly you need to have effective care coordination.

So the next slide is really getting at the prevention and treatment of cardiovascular disease. HHS indicated and now they have a Million Hearts initiative that's geared at really improving cardiovascular disease. And so again you'll see that three-part goal strategy around community interventions, healthy lifestyle behaviors and clinical preventive services. And really emphasizing there addressing tobacco use, making sure that there's better control for patients who have high blood pressure and high cholesterol, that we address some of the

dietary problems that people have access to healthy foods, et cetera.

The next one is patient safety and I sort of wish that I'd flipped the slides again. I thought about that this morning when I woke up. But because the original NPP work included admissions or preventable readmissions in the care coordination priority area but as the National Quality Strategy came out HHS really framed this more under safety and so we included it there as well. And so this really mirrors the work of the Partnership for Patients that's currently underway through HHS and CMMI. And so NPP decided we really just need to reinforce the work that's going on there. But in addition to emphasizing hospital readmissions which is what the Partnership for Patients is focusing on, NPP really felt it was important to focus also on hospital admissions. So looking at admissions for ambulatory-sensitive conditions, obviously also a strong need for

care coordination there.

And then the other thing that we wanted to do was, in addition to the areas of safety, the healthcare-associated conditions that HHS had identified with the Partnership for Patients which are in very fine print at the bottom, but they're things like healthcare-associated infections and UTI and bloodstream infections and falls and pressure ulcers. Really wanted to make sure that we also tackled some of these areas of inappropriate care that can also be harmful to patients. So that's where you see the inappropriate medication use in polypharmacy, some of the inappropriate maternity care which was the work of NPP's earlier overuse work group.

And then before we launch into the two priority areas which I felt like were really important to this work in terms of affordable care this is a priority area on its own. HHS had not really got a lot of detail

in the National Quality Strategy around affordable care and so this group really spent a lot of time talking about what was going to be important to patients and to employers and to the federal government. And so we looked a lot at things that got at consumer affordability and insurance coverage and whether patients were able to obtain needed care in addition to sort of those bigger numbers around, you know, our continually escalating health care expenditures nationally and at the state level.

So as we looked to patient- and family-centered care this is really I think one of the areas where care coordination is obviously critically important. The care needs to be focused on the patient to ensure that they have a positive experience of care and that they're getting high-quality and safe care, that their care is accessible, all of those things very important for this group to consider I think. Using a shared decision-

making process and developing care plans, really enabling patients and their families to navigate and coordinate their care. And these actually mirror the original goals of NPP. It's things that NPP partners have really been espousing for several years and I think these really resonate with the field as things that are important. As we got into measure concepts, you know, we certainly had some areas around experience that we can look to. Really wanted to start to get into whether patients felt like they had the confidence to manage chronic conditions and I think before I even go to the next slide, these two really I think emphasize how interrelated these two priority areas are because it was really hard for the subcommittee that worked on this to sort of tease them apart. So it's kind of like where can we -- HHS asked us for three goals for priority area, two measures per goal, and it was sort of like where can we get in these various concepts that we feel are so

important while sticking to this, you know, wanting to have a parsimonious set and not really I think, you know, they really could have gone much broader and included a lot more goals, but really trying to keep it to a limited number -- used I think these two priority areas to really try to get in a lot of important concepts. And I think as you go through talking about what your pathway forward is I hope that this will be sort of helpful in seeing where NPP feels like the important areas are and how we might be able to get there. So the next slide.

This focuses on, and it's played out a lot more in detail in the report but certainly looking at some of the measure gap areas and where NPP felt like more nationally there were gaps. And this is probably an important place to stop and talk about the types of measures that NPP was really looking at. So HHS wanted measures to monitor national progress. So when we looked at what

types of measures to recommend back to them we really looked at things that were already reported in like AHRQ's health care and disparities report and some of the Commonwealth Fund reports that come out, things that are already out there that have been in use for awhile to look at some of these things. So, you know, as you go through your work obviously the -- and I have a slide that will play this out in a moment in a little more detail but you know, what types of things at the provider or the health care professional level when you're thinking about accountability could help to support those. So in terms of these measure gaps what NPP was really wanting to see was that we would have sort of this national composite of really how patients and families are experiencing their care, that we would have some national indicator of the breadth of use of experience surveys, and that we would have a national type of measure to really assess whether

patients have these longitudinal care plans across time that aren't just, you know, discharge plans as they're coming out of the hospital and that they integrate shared decision-making. So really in this area the NPP felt like there was a lot of room for measure development in terms of what we would want to measure progress by at a much bigger sort of population level which I think is different from what you will probably be looking at in your work, but I hope that this can help to sort of guide that a little bit.

So, for effective communication and care coordination got into a lot of discussion about the importance of the quality of care transitions and communications across settings. Wanted to ensure that we, and this is where the earlier work of NPP had a priority area focused on palliative and end of life care which did not make it into the National Quality Strategy. So NPP felt it was important to, you know, provide input to HHS

on the priority areas as they come out in the National Quality Strategy, but to continue to emphasize the importance of palliative care, end of life care, really looking at the care that patients with chronic illness and disability need. And so this was if you will sort of that got snuck in I guess you could say. So wanting to make sure that the care coordination, I think this came out in the NPP work that we did, was really in the eyes of the recipient, that it's not something -- care transitions or good care coordination is not what we say it is, it's what the patients experience and what they feel they have been prepared to do and to manage. And so you know a lot of that gets back to quality of life and experience.

And then the third goal area is really a challenging one and it was really trying to push this notion of how do we get at this shared accountability. And obviously there's a lot of work going on in this area

right now but really how do we determine whether there is better communication. How do we determine whether there's good coordination between the health care delivery system and the community resources and supports? How do monitor that and watch for improvement there? And so I think that again is an area of difficulty for measurement, I think, but hopefully we're starting to blaze new trails there.

So you can see some of the measure concepts again. We wanted to incorporate some of the earlier palliative work. NQF does have a palliative steering committee doing work there. So, but you can sort of see emphasizing again care transitions and control of chronic diseases, and really looking again at those outcomes.

In terms of measure gaps, again, you know, we have measures of experience of care transitions, Eric Coleman's measure, but it's not something that we're really able to

look at yet at a broader population level and so that's really what NPP was desirous to see, if there are measures out there that can sort of look more broadly at how as a nation we're doing. How as a nation are we doing with having complete transition records? Are we doing better with chronic disease control? How are we doing in providing care that's concordant with patient's wishes, whether end of life or other? And so a lot of work to be done here and a lot of blank spaces where, in some of the other areas, for the health and well-being areas for example we had a lot that we could pull from because there are a lot of measures that are being reported at the national level through Healthy People 2020 for example that we could sort of say these are things that we would like to emphasize as part of the National Quality Strategy. But in this area really still rather limited in what we could pull from. So, the next slide.

So, this is my very rudimentary

slide. And some of you may hear us talk about a measurement cascade, or rolling up and rolling down of measures. And it's very small print, but essentially what we're trying to demonstrate here is that we have these national goals. So if the national goal is around, you know, improving patient experience across the board, that nationally wouldn't it be great if a hundred percent of our patient population experienced positive care transitions. Then what does that mean needs to happen at a state level, at a health plan level? What would we need to measure at a provider level, at a clinician level or even at a patient consumer level? Which is, you know, the patient-consumer is sort of throughout this. But on the far right side all of those boxes going down really stem from that top one, that you know, states could measure how their patient populations are doing on care transitions. Health plans could look at their populations and how they're

doing. Providers, clinicians, all of those could look at that as sort of a guiding star of what's important. But then you might also think about are there standard things that are being included in care plans, and are health plans ensuring that their network providers are including those. I can't even read my own things there now, that's really sad. But essentially what we're trying to show here is that it may not be that what's measured at a national level is what we need to measure at a provider. I think there are opportunities where it could be. But what at a provider/clinician level would feed into that? So what are the most essential things that we would want to measure to ensure that we had positive care transitions for all of our patients? So again, very rudimentary and not in any way evidence-based, it was just my thought process. So if you go back to it keep that in mind.

This slide really just sort of

encompasses the sort of vision for the National Quality Strategy is that really we get on the same page. We're all working towards the same things, we're all rowing the same directions. And so I won't belabor this but just wanted to include it to demonstrate that we're really hoping that we start to see unified signals. We've seen some good evidence so far. I think, Helen, you were the one who discovered SAMHSA's framework that they had developed for their patient population which mirrored the National Quality Strategy to a tee. They basically took the goals of the National Quality Strategy and the work that we were doing at the time with our Healthy People/Healthy Communities subcommittee and looked at it for their population. So for care coordination or for the safety area, for example, for readmissions they wanted to see the patient populations that are most important to SAMHSA, how are they doing with readmissions and preventable

readmissions. How are they doing on some of these other areas. So it was really, really promising to see that and hope that we continue to see more examples of how, you know, federal but also the private sector is embracing this and starting to align behind it.

I think there's one more slide. This just essentially wanted to communicate sort of that at NQF and as part of the measurement enterprise sort of how we see the priorities kind of being the starting point of, you know, what are the goal areas that we want to make sure we emphasize. We also have a list of high-impact conditions. And then as we go through, how does that inform the endorsement process which is why we feel it's important to make sure that we sort of set up the work of these steering committees with just a brief overview of the NPP and the National Quality Strategy. And then how does that trickle down and how -- what's needed at

various levels with the electronic data platform and aligning environmental drivers. And you can see some of the other work that NQF is undertaking to try to get all of this sort of moving in this same direction, and that all of our various work is aligned around these. So I think with that I will stop. I've used all my time.

MS. DORIAN: Thank you. Does anybody have any questions for Wendy? And by the way, we have asked for the heat to be turned up in case of you are feeling chilly.

DR. CARRILLO: Very comprehensive and really aligns very nicely. I do have a comment. And you know, kind of like the horse is out of the barn so it's just probably a comment. It's that in, you know, almost 10 years ago the Institute of Medicine's Unequal Care showed that we have a huge problem in this country with inequities in care. And as the IOM pointed out a lot of that, a significant portion of that is driven by

communication. And so when we talk about effective communication and care coordination I really see very little if anything about cross-cultural communication, cultural competency, health literacy, language interpretation, translation which are huge, huge issues. So, again, there is mention of cultural sensitivity, there are the patient-centered goals, but I think that more attention to that would have been positive.

CO-CHAIR CASEY: I think that's a great point, Juan, and something that, you know, when we talked about it before in the previous steering committee it did come up in spades but I don't think it made it with the clarity that you're asking for, and I think that's something we've got to keep in mind throughout this deliberation, so thank you.

DR. BURSTIN: I'll also just add that Nicole is actually leading our parallel disparities committee which is doing a call for crosscutting measures. Actually, Emilio

was the chair of our Cultural Competency and Disparities Committee this last round so we actually specifically wanted him on this committee to make sure we made those connections as well to the disparities and cultural competency side. But again, you know, if you know of particular areas and measures that would be appropriate we could easily figure out which project to bring them to.

MS. DORIAN: Okay, I think with that thank you very much, Wendy. I'll hand it over to Don and Gerri now to go through some past work.

CO-CHAIR LAMB: Okay, we're entering now the background and context-setting which Wendy just started for us with the National Priorities Partnership. And again, I think as we look around the room we have tremendous expertise and diversity. And I think Don and I would like to emphasize what Helen started us out with. It is an

extraordinary opportunity here somewhat unusual. In NQF's usual processes is for us to be able to step back and look at the work that's gone on in care coordination and to rethink, reframe, revise if we need to, add to it in terms of setting a direction for a measurement of care coordination. Again, if we take a look at the stages of the work ahead of us today is really that process of what do we want in terms of setting that pathway towards the call for measures, the evaluation of measures and to invite all of us to think about what is meaningful measurement of care coordination. So where have we been, where do we want to go and to set the pathway.

So this morning what Don and I are going to start off with is a little bit of the background on the initial work on the steering committee. We have individuals in our group who sat on that steering committee and so we will also draw from that experience. But what we also want to do is lay out for you the

assumptions that we made and some of the general premises not so that we can put them in stone and say this is the way we need to proceed, but to open them up and say do they still make sense. In this stage of moving forward do we still support those premises, should they be guiding principles, do we want to add to them, and so forth. So we're going to do some context work here and invite all of you to join in. And then we will have the invited papers which will then lead into the afternoon and the afternoon will be our discussion of setting that pathway forward. So before I go through these slides, Don, would you like to?

CO-CHAIR CASEY: Well, I echo Gerri's sentiments about having you. This is a great group. And you know, I sort of view the work as in two parts, just to summarize. And I think if we could put Wendy's slide 28 back up that might help because I think that's an excellent sort of framework for us to think

about -- is that? I'm sorry, the next one. Yes.

So, there are really two parts to the work we're doing, and one is that there's going to be a very specific focus on that second set of boxes there around performance measurement and the NQF endorsement process. So that will be a major part of the work we will do. And as you know, one of the goals is to frame the request for measure submission. But then I think throughout the work now when we do the performance measure evaluation and afterward you're going to really sort of help us look at that entire slide vis-a-vis all the different moving parts that are up there, not to so much reconstruct everything, but to build on it, to enhance it, to add things like Emilio mentioned so the we continue to move forward with this for the future. I'm glad the room next door agrees with me.

(Laughter)

CO-CHAIR CASEY: I planned that

perfectly. That what you're really trying to do is to inform current and future measure developers in this field to bring forward new strategies, innovations, the implementation of information systems to help us achieve those goals that Wendy talked about. And I think those are really the two important priorities to keep in your mind throughout this. That first part will be very technical, that performance measure evaluation and we have certain rules and criteria that we use to evaluate that. So you'll, if you're not familiar with this, need to become very familiar with it. So I just think, Gerri, having that two-part mindset always in tow will be important throughout this process.

CO-CHAIR LAMB: We would encourage you as we go through these discussions this morning, jot down notes for yourselves so that when we get to the roadmap we can really kind of pull in all of those pieces as well. Can you move forward on the slides, please? Okay.

The earlier work that you have in your packets -- go back one, please. There we go. Okay. The previous consensus report, the 2010 report which you have was very much framed by the work that happened in 2006, the NQF definition and framework for measuring and reporting care coordination. And we'll hit the highlights of that in just a bit. The importance of that is it really did frame the call for measures and the evaluation of the measures. And Karen and Christine, as members of that committee if you want to jump in anywhere you just feel free. And so having that definition and the domains of care coordination was really foundational to the work in the 2010 report.

And then as we get into the 2010 report we're going to draw your attention not only to the measures that were submitted and the ones that were sent forward for recommendation but where some of the strengths and the gaps were as well, plus the premises.

And we in the first committee spent a lot of time talking about those premises, what would be the guiding principles that would assist us in the evaluation. So we wanted to highlight some of those for you as well. Next slide.

Okay, just a reminder, this is the NQF-endorsed definition and it goes with the framework. It is that in that document that guided the call for measures as well as the review of the measures care coordination is a function that helps ensure that the patient's needs and preferences for health services and information-sharing across people, functions and sites are met over time. And as I'm sure all of you know there's been a lot of writing and discussion on definitions of care coordination and we'll be hearing more about that later in the invited papers in terms of what are -- what are being looked at in terms of the components of care coordination, the domains, so that we can also look at do we want to add anything, think anything is

missing from the way that it has been defined in the past. As Don was saying, the intent here is not to start from scratch, it is really to build and refine on what has gone before. Next one.

CO-CHAIR CASEY: Gerri, could I just?

CO-CHAIR LAMB: Of course.

CO-CHAIR CASEY: Before you do that maybe as the, I guess, historian, go back. In 2006, if you could go back to the last slide. Thank you. We were actually what is referred to as a technical expert panel, not a steering committee, and we were subservient to a steering committee that was looking at a whole host of global measures. And as I think I mentioned on the call, when we put the call out for measures I think we got two or three and we adopted I think one or two. I think the CTM3 measure put forward by Eric Coleman was one of those. But it was very clear to us as, and I was the chair, not

the expert. There were a lot of experts as we went around the room thinking about this. Even the experts couldn't define very clearly amongst themselves what care coordination was and couldn't articulate where they thought real opportunities for measurement were that were explicitly available in the environment. So you know, I do think that this carried us forward into the steering committee that was the last one. But I think that's important to mention, that this has been a total work in progress, and the amount of work that we've accomplished in the past five years has been enormous but really still very much a starting point. So just recall that this is, again, thoughtfully put together with a lot of input from the membership, voted upon and agreed upon by NQF.

CO-CHAIR LAMB: To add to that too, those of you who are familiar with the AHRQ Atlas on care coordination measures probably remember that in the opening pages

they talked about reviewing more than 40 definitions of care coordination and creating an amalgam that we'll see later. So again, to echo this is emergent. It's also, as we all know, moving very quickly. Next slide.

Going back to the endorsed definition and framework. These are the five key domains that were identified in the 2006 work and these again were the domains that guided the call for measures as well as practices. We have health care home, plan of care, communication, information systems and transitions. Might note here in terms of the previous work there has been a lot of discussion of transitions and that focus has received a lot of attention. But as you can see the framework has five domains and we'll go into a little bit more about the measures that were received. Also, if you go back to the definition in framework there is a definition of each of these domains and a description of them. Those are also I

believe, and Nicole can correct me, are also in the consensus report. Next slide.

So the intent here as Don has said was to -- of the first committee that resulted in the 2010 report was to set the stage. It was also to accelerate future work so that it was meant as a base. And we have the benefit of having that work but not to be limited by it. Some of the areas that we wanted just to go through so that we could revisit them later, and if you have comments please, you know, make them, is that if you look on pages 39, 40 and 41 of the consensus report and we would encourage you to take a look at that, there were some foundational premises that the first committee established related to care coordination that also framed the review of the performance measures. And we'll hit just a couple of them here but they are outlined and described on 39, 40 and 41.

The first premise was that care coordination was relevant to all patients. So

that what drove the thinking was that all patients needed some aspect, some degree of care coordination, okay, and that it, number two, varied in intensity. So that there was considerable discussion as we'll get into later this afternoon about care coordination, case management, how do we titrate for risk levels and to be able to at least for this first kind of pass at this work we set the premise that care coordination existed on a continuum of intensity and that we were not going to segment out case management practice, okay? So that it allowed us to look at care coordination as a whole rather than beginning to say what's care coordination that everybody needs, what's case management, how are we going to risk adjust so that we could stay focused and look at care coordination, understanding that we really did not address case management and risk level in great detail. So far so good? Okay.

And that care coordination could

be a function that existed, could be delivered at the individual team and the organizational level. And so with all those implications for measurement. And consistent I think with what you heard Wendy say is that the first steering committee felt that the patient and family experience and perspective on care coordination had to be front and center, that that was absolutely critical to this work.

We also did have another assumption related to outcomes, the focus on outcomes and to guide the measurement work was to focus on those aspects of care coordination that had evidence linking them to important value-laden outcomes. We also had an area importantly that we affectionately labeled the gray zone in terms of what we wanted to start with in terms of care coordination measures. And as you'll see, after the call for measures 77 measures were submitted. And some of them were condition-specific, some of them were specifically about appointment-keeping or

making, some of them were following treatment guidelines. And to get our arms around what is this thing called care coordination because we agreed that it could be linked to so many things that, you know, making appointments, yes, it is part of it. However, where do we want to focus meaningful measurement? So for this starting work we established that the measures needed to cross providers and settings so that in some way it approached that whole aspect of care coordination that happens at the intersection between providers and settings. It's not merely following treatment guidelines. Important, but that was not the centrality of care coordination. And so you can see our effort and the struggle we had in terms of centering on what is important about care coordination. And so for the purposes of this first go-around we said the measures that were sent in, if they were only did we follow treatment guidelines, that didn't capture where we were going. If it was

making an appointment for somebody after they left the hospital, important, but it wasn't where we wanted to center, okay? And again, we're throwing out these assumptions and gray areas for your deliberation and our deliberation together about where do we want to be. Don or Karen or Chris?

CO-CHAIR CASEY: Well, I -- Gerri, thank you for putting this backdrop together because I think it helps. I would totally agree with this framework and I will say that to take your points ahead a little bit further this challenge of having very shall I say strong-willed experts around the table who are very good at what they do in their own context was something that we struggled with because everyone had their own perspective. And I think what we ended up trying to challenge the group with is to get out of that for the moment and try to put in the center what the team would look like and understand that for example, I'll make it up because I practiced

primary care for 20 years, that a primary care physician ought to be really, really good at some of the things that he or she thinks aren't necessarily part of their job to do to coordinate care. So I'm just giving you that example as something that we tried to think about in terms of making this crosscutting across the traditional boundaries of how we coordinate care now. And so it's not to say that one is not important than the other but to bring that sort of equality to the forefront so that at any moment in time whoever is dealing with the patient directly is in part taking the lead for helping the patient make decisions about how to coordinate care better.

DR. BURSTIN: I just one additional thing to add. I think many of the measures we saw last time that were condition-specific were actually more about referral to specialists. So if you've been seeing an ED and you've had a headache you should have seen

a neurologist. If you've had X you should see so-and-so. And I think our feeling with that did not feel care coordination-like at all and very far off scope for the people who are also around the table and the expertise they brought to the table. So we tabled, for the most part said those didn't fit. But I want to be a little careful about things like appointment-making or keeping because there actually may be really important aspects in there that would be really important. If you think about, you know, Bill's role from the ED, ensuring that follow-up got done, or ensuring that somebody leaves the hospital and has that appointment, or has some kind of follow-up may be generalizable enough and important enough that I think we'd want to even potentially consider those.

I know Anne-Marie supported some work that NCQA and Hopkins had done about closing the referral loop, very broad-based kinds of concepts. I don't want them to think

those are off the table, but you know, I think we're trying to stay out of the box of every condition, every specialty having a slightly different way to approach this and try to keep this sort of very important national quality strategy as very crosscutting.

CO-CHAIR CASEY: You know, Helen, that's a great example of one of the challenges we had. Because our discussion was okay, so you've made an appointment for this person and this person has the appointment. Now what? And so, you know, that was kind of like the measure didn't capture the now what, and so that's why I think what Helen is trying to say is appointments are really important to care coordination but we've got to know what else is going on to be sure things are carried forward. So we were trying to be intentionally I think thoughtful about being sure that we didn't make just the transactions in and of themselves the measure of care coordination alone, that it had to fit with

something else.

I also believe that the other part that I continually remind myself about was piqued by Emilio's challenge about disparities because I was scratching my head going damn, I thought we worked on that. And so let me refer to page 38 of the document. And Helen, this is something that I think we probably need to do a little bit more work with on the committee with Lauralei is that we started by also calling out existing NQF-endorsed measures and frameworks. And so you'll see, Emilio, that we looked very closely at the cultural competency measures that were in here, the preferred practices I should say, and included them in this document. So I just think we need to call out the continuous update of the NQF treasure trove now.

And you can see other examples of it. For example, on page 17 there are opportunities for measurement based upon existing measures that might not have been

initially endorsed specifically for care coordination but may actually fit the paradigm going forward of being supportive of that. So you know, we've got -- I think my final message here is we've got a lot of opportunity to look at what we've got and just try to coordinate that better. So.

MS. KLOTZ: Yes, I just wanted to, having participated in that steering committee just kind of reiterate what you're saying. There was some frustration, I think, amongst all of us as we looked at the number of measures that came in and realized how few really looked at the issue of care coordination. And I'm hopeful that in the couple of years that have gone by since those that maybe some people who were looking at those in a more narrow way have now really understood that they have to look at it for the full connection of that coordination loop and that maybe this time we'll get something good.

CO-CHAIR CASEY: You know, Chris, Chris was really great. I think we were in one of the subgroups together and I think that you know the other opportunity we had in that context was we didn't just sweep the measures away. What we did was we provided very thoughtful and constructive feedback to the measure developers who brought measures forward to say can you just go back and start re-framing this part of what you're looking at. And I think, Helen, that is another opportunity for us is to give constructive feedback to measure developers who bring things forward, who don't quite get across the threshold of us bringing them for endorsement, but could give them actual guidance by saying look at this or add this. So I think that's another rule to keep in mind here that's a little nuanced but is something that I think we should.

DR. BURSTIN: Well, and actually one very concrete example. Last year Brandeis

did some work for CMS as part of a measure they had put forward to us on readmissions, follow-up care and preventable ED use. And the committee at the time just looked at it and said, you know, we get the readmission part, we understand why you may want a composite that looks at ED use in follow-up but as stand-alones there are lots of issues with both those measures. So we agreed they were reasonable as sort of a control of the overall measure, but as an example of the measure that was follow-up I think it was within I think 10 days after the hospitalization. One of the main concerns actually raised by a lot of the leading people in care coordination said but you don't need a doctor visit. I mean, this could be in your home, this could be a home care visit. There's no way, that that measure just didn't reach the bar because they were so exclusively focused on was there a CPT code for an in-office visit. So those are opportunities for

us to go back to developers like that as well and say, you know, this actually could be a very useful measure if you thought more broadly and conceptually of what care coordination could really bring to the table.

DR. GREENBERG: Yes, I wonder if -- is there any thought to doing this in phases similar to the way meaningful use was done in phases with sort of low bars in phase I that get progressively more intensive over time? Some of the measures that you seem to be tossing off I think would do a lot of good in the short term. Making sure that sick patients do have a follow-up in a short period of time with the right provider would I think benefit a lot of patients and would force providers to improve their access which is a huge problem at least for I think many people. So sure, we'd rather know that they're doing medication reconciliation and filling out a care plan and doing all sorts of things, but you know, if by next year or a couple of years

we just knew that patients were getting appropriate follow-up I think we'd be in a much better place than we are right now. And maybe think about these other things down the road once IT systems are set up that we can use to ensure those things and hold people accountable.

CO-CHAIR LAMB: I think, you know, that's an excellent point. And if we think about this work in terms of opportunity and incremental build I would also suggest that if we begin to take a look at the patient-centeredness piece is what are those critical junctures that are important to the patient. Is, you know, perhaps from the flow of care getting an appointment is meaningful but from a patient's point of view is it the most meaningful piece. And I think that's some of the deliberation that we need to have is what would it mean to raise the bar and push this work forward to the next stage, understanding that this is going to evolve. Even the

thinking about care coordination has advanced dramatically since we started the work on the 2010. I think that there's so much national emphasis on it right now that people are really focused on what is this experience. And I think all of us have had the experience of family members coming to us and saying this did not feel coordinated, this was not a coherent experience, what is this all about. So, point well taken but let's also think about what that bar is from the patient.

CO-CHAIR CASEY: Yes, I think your point is something we actually struggle with all the time at NQF. And let me say that the big challenge now in the criteria for evaluation is to be sure as best we can that there is evidentiary linkage to a patient-centered outcome. And so that is going to be the challenge. I think what you're talking about is a more fundamental paradigm and it's, this is oversimplified, but we talk about measures for what we call accountability which

includes public reporting and a whole host of other strategies that relate to trying to determine the focus of actually moving things forward. That is different from the measures for quality improvement where we're measuring it because it helps us identify opportunities in our practice to do X, Y and Z. And I think that, you know, ultimately the consensus development process is going to be much more focused on the accountability side of it. And that means the closer there are real proven linkages to patient-centered outcomes the better. So that's always the push and pull, and I don't think NQF ever says no to anything you're saying. I think it's just a challenge because of the scope of the work to be sure we have that counterbalancing understanding of what the work is.

DR. BURSTIN: Just to build on that, I'd also make the point that all of our measures are up for reevaluation every three years as part of our maintenance process. So

it clearly could be that a measure may work now and in three years it'll be like, whoa, that's certainly outlived its usefulness and the committee, especially as we -- and we talked about this a little on the orientation call, but we'll talk about this more as we get into actual measures. We've also been raising the bar of our criteria. It is harder to get a measure endorsed now certainly than it was three years ago. That old measure of discharge instructions for CHF which essentially became a checkbox measure was removed from endorsement several years ago by NQF saying it's not a valid indicator of -- or I guess it's being reviewed. It's being reviewed right now. We removed the smoking measure several years ago and it was not, obviously, not a valid indicator of did you actually do smoking cessation counseling.

Our surgery committee, for example, just looked at all the SCIP measures. There's a SCIP measure that says did you order

VTE prophylaxis and there's a measure that said did you administer VTE prophylaxis. Well they said ordering is gone. You know, we don't care anymore. We really only care if it's administered.

So it is a different model. I think we are moving towards measures that are really as much as we can proximal to the outcome, less distal, lots of narrow process steps. And there may be opportunities. If a measure meets the bar now, that's fine. It may not need to live forever. It's fine if a measure has a life and then a better measure or more advanced measure comes forward.

CO-CHAIR CASEY: Yes, and this is an example of where taking that discipline back to the measure developer by saying keep working on this is useful feedback still. So, yes.

DR. LEE: And on that subject of taking small steps, for us folks who are taking care of patients day to day with care

management program, currently the system is built around medical condition. You know, a complex patient with heart failure, for example. And there's been a lot of experience learned doing so and people are in the process of replicating across different conditions. You know, but of course more research needed to show that structure works. And so tiny steps sounds perfectly reasonable and perhaps even consider condition-based approach as our first step.

DR. MCNABNEY: I have another comment, sort of building on the type of outcomes that would be pursued with regard to patient preferences and patient accountability. So how might we measure how coordinatable a patient is? So we can establish -- we can establish outcomes that may be not achievable because the patients themselves either prefer or just are not manageable or are not capable of adhering to well-coordinated care. And I think we need to

not, certainly not let providers or systems off the hook by any stretch, but have a measure or strive for a measure that demonstrates that that was evaluated, you know, measured in some way and documented because, you know, like James, working with a lot of people that the best efforts, their care is not able to be coordinated and then the outcomes are therefore bad.

CO-CHAIR CASEY: Yes, I think it's a great question and really, really important. And something we struggled with before. And to the extent that you can define some sort of standardized elements that might relate to patient-level characteristics I think that may be important, especially if we get into this notion of risk adjustment. But for the, you know, experiential part of this we've all had patients who, you know, despite our best intention are upset with a lot of other things besides us and don't want to be bothered with anything that we ask them to do so it seems.

So I think you're talking to the choir here about this and I do think in the area of accountability it's a sensitivity to, from my perspective, being fair to the people that actually have to do the work, that at least in their own minds some of it is beyond their control, quote unquote. So I think having that sensitivity is important and will come into our discussions.

DR. WHITE: Can I ask a quick question also? We talked a little bit about special populations with cultural competency but what about behavioral health? Because in my experience that's a huge barrier that if you can't address that you can't address the rest of it.

DR. BURSTIN: There seems to be a lot of projects we're launching these days. We're also about to launch a behavioral health/mental health project. So, again, we've tried to keep this somewhat separate but I think this is very fair game particularly in

this committee about sort of the interstices. So people who sort of fall between mental health/primary care kinds of issues, those coordination approaches I think would be fine here as well. And we can you know have that other committee take a look at those as well. Those are obviously critically important and were a hallmark of that SAMHSA framework that they put forward as well.

CO-CHAIR LAMB: Just a request. I think Eva, is it Eva? Eva's idea of putting your card up so that we can kind of track people. The other thing is remember that after you finish speaking please turn off your mic because it blocks other people. I think Eva, you were next.

MS. POWELL: Thanks. I'll put out a suggestion and it's just something I've been thinking about lately. And it is relative to all of the other comments as well. Of course, the problem that we're trying to solve is how do we standardize something that will rarely

if ever be an actual standardized process because care coordination depends on all of the various and sundry individual needs of an individual patient. And I've thought for some time that one way to approach this that's a little bit different, it's still though I think a process measure would be to measure according to a care plan. In other words, I haven't been able to think of a scenario where a care plan would not be appropriate for a patient. And so even the healthiest patient still needs to go to the dentist twice a year, get a mammogram, get a pap smear. So, if that can be a point of standardization and then measure against the care plan then that might be a way to approach this.

Now, of course part of the problem with that is that there is no such thing as a longitudinal shared care plan yet. We tried to work that into the meaningful use stage II and I've never heard such weeping and gnashing of teeth in my life, so. So there's a lot of

work to be done there. But it seems like that would be a way to get at these issues of accountability because that would be something that would need to be built into a care plan as being very specific about this is the step, this is when it needs to be done by and this is the person who's responsible, and then using technology to assess at a certain point of time did this stuff happen and that can get it out of the manual mode of actual people having to go through and measure. But I don't know how to do that. But it seems like that's a little bit different approach while it's still kind of a process measure.

CO-CHAIR CASEY: So let me see if this helps because I think, again, that that's an excellent point and something we struggled with. I would say that it is difficult given the diversity as I'll call it of the way care coordination gets done now to expect that we're going to have a one-size-fits-all because communities are different in terms of

the resources they have as an example. I mean, Chris was very helpful in her mind in terms of helping us clarify that. But the outcomes, the expected outcomes should be the prize, do you see what I mean? So if there are five different ways to get to the expected outcomes that's really what we're looking for.

As far as the process goes, again I'm going to challenge you to think about whether the process that's in place could achieve the expected outcome. Do you know what I mean? In other words we have a lot of process that we think theoretically is a great idea and it sometimes makes people feel good, but is it necessarily tangibly proven to be a benefit. And we're not expecting perfection here, but to the extent that we can have that linkage then that can be a positive support of what we're trying to do.

DR. AUDET: So actually that was my point which was made before so I'm glad you brought it up right now. I distinguish

enablers and actual functions, and I think what I'm hearing is we're really not interested in enablers per se. Making an appointment is an enabler. If you don't make an appointment you cannot have care coordination. These are just the basic enabling capacity. But we really want to go to the next stages as I think what you were saying here, also have -- the relationship between having an enabler is essential but not sufficient. We need to see what else is there.

DR. CARRILLO: Yes, I wanted to build on some of the points that Matthew made about the issue of fairness and complexity and doing leveling. And you know, it's the old 20/80 rule. I mean, 20 percent of the patients bring about 80 percent of the cost. And we have to be mindful of health reform, we have to be mindful of the pickle that Medicare and CMS are in. So I think that for us to inform the nation we need to be mindful of

that and the most severely impaired and disadvantaged patients are something that we should be looking at. And it can be looked at. In New York state working with CMS there's a program that is called Health Home where there's a leveling in terms of care coordination for patients that are severely persistently mentally ill, patients that have three chronic conditions, two chronic conditions, all of the above, and different reimbursements for care management. I mean, there's actually a reimbursement for care management functions. So I think that we need to keep our eyes on the prize and think about the very high-need patients that need linking with housing resources, linking with rehab, et cetera, et cetera. So I wanted just to amend that to what Matthew said.

CO-CHAIR LAMB: Perhaps as we get into the afternoon we can come back to that because I think your point speaks to the issue that we were dealing with before which is how

does the high-risk individual fit into this measurement pattern. If we deal with an assumption that all patients require some aspect of care coordination but there are some groups that need very in-depth complex care coordination and how do we deal with that. And whether we would still adhere to that assumption of keeping it as a continuum versus separating it out. Can I get the next slide? We just have just a few more.

Okay, just so that you have a sense of where things ended with the first stage is that after the call for measures 77 measures were submitted, and ultimately 10 were recommended for endorsement and endorsed. And take a look there in terms of the five domains that came out of the framework. Only two domains were addressed in the new endorsed measures, plan of care which I think Eva was talking to before and transitions. There were no measures that were recommended for endorsement in the health care home, in

communication, and information systems. So that again this is fertile ground for discussion this afternoon in terms of where do we want to be going, what are the issues. And as you go back through the consensus report you'll see a lot of dialogue about what the issues were and what measures were submitted that were not recommended for endorsement. Last slide.

I think it's the last one, yes, is overall this work, the 2010 consensus report, really was establishing a foundation, beginning to build on the definition and framework and define an infrastructure for care coordination as in the health care home, the plan of care. And it did identify as we just talked about the need for high-risk care coordination measures although at that time we made a decision to keep them linked in. Process-wise it was seen as a start. There were a few measures that moved forward but it began to establish that context of what's

important, what isn't important, and now several years later the recommendations we may make may build on that, they may be different. And as you saw from the measures that went forward, transitional care measures have been better developed, better thought of, you know, in terms of the work that's been done in the past linking them to outcomes. And then again, outcomes is a start and if you looked at the paper that came out of the workshop on care coordination there are issues with some of the outcome measures like preventable hospitalization. That has been one that has been the focus of a lot of dialogue whether there is consistency in the way that that's being measured.

So overall a good start. I think we deliberated on lots of critical issues, tried to get our thinking down for future work. So hopefully it will be helpful as we go to this next stage in looking at how do we want to advance the field.

CO-CHAIR CASEY: Gerri, just let me make one more point and that relates to the preferred practices. I think that when we started working on this with Nicole we were getting lots of sort of quasi-anecdotal or published examples of strategies that didn't fit measurements. So I would encourage you all to really get seriously familiar with the preferred practices as well. I think obviously our focus here is on measures but part of the challenge was that we got lots of great ideas at least in terms of the things that you're doing as an example including some of the things Emilio was talking about like behavioral health, children with special needs, et cetera, et cetera. So embedded in the preferred practices is a lot of rich data on sort of the things that we pulled out of all this wisdom that actually was also quite extensive. So pay attention to that as well. I think we're at the break, Lauralei?

MS. DORIAN: Yes. Right in time

for morning tea.

CO-CHAIR CASEY: So what time do we want to be back? About 10 minutes?

MS. DORIAN: Yes, I'd say about 10 minutes.

CO-CHAIR CASEY: Okay, great. Thanks.

MS. DORIAN: Thank you.

(Whereupon, the foregoing matter went off the record at 10:51 a.m. and resumed at 11:12 a.m.)

MS. DORIAN: Okay. Lipika? Can you just test the mic for me quickly?

DR. SAMAL: Testing. Okay.

MS. DORIAN: Okay, so over to you.

DR. SAMAL: I didn't think I needed this but maybe I do, this is a big room.

MS. DORIAN: I'd like to remind everybody as well that you should have the annotated outline for the commission paper in your folders that you've received. Yes, in

your folders. So you might want to take that out and follow along. And feel free to start.

DR. SAMAL: Okay. So my name is Lipika Samal. I am a primary care doctor and researcher at Brigham and Women's Hospital. I'm working with David Bates who's the chief of my division and he's very involved with this project. He's unable to make it today. And the other three members of our team, one is going to present right after me, that's Arjun Venkatesh and there's also Omar Hasan who's a hospitalist in general medicine and Lynn Volk who is an expert in quality measurement.

So just to orient you to the process here, this is really meant to garner feedback from you. This report is going to be partially completed in a month. So basically the first draft is due in a month and the idea is for the paper to be available to you when you're evaluating measures in the next phase.

So what I'd like you to do is to

take out the outline which is in your folder, and I think you've located that, and I have 20 minutes. So I did not include all of the information in the outline in the slides but I'm going to ask you to write comments on this outline. I'm going to collect it from you afterward. You can also email me later but I just think this is a better way to make use of our 20 minutes that we have and then we'll have 30 minutes for questions but it will be combined between me and Arjun Venkatesh. So just to make sure that I get all of your comments so that we can make this as useful as possible.

So basically the goals here as I just said are to provide guidance to the steering committee and we want to identify areas where using clinical information systems or health information technology may improve upon existing measures. And so just this bullet point here, I just wanted to say basically you know we've up until now mostly

depended on insurance claims, patient-reported measures such as surveys and chart review which are, patient-reported and chart review are very costly, time-consuming. Insurance claims in lieu of a shared payer database you know are prone to measurement error from dual coverage or changes in coverage. So there are reasons why electronic measures could potentially be an improvement over our current measures. And then the last bullet point here, condition-specific. So many of our measures are condition-specific. And you know, we're talking about care coordination which can include the idea of a condition coordinated over time for an individual but also should include cross-condition coordination and cross-setting. But cross-setting as everyone has been saying has been emphasized.

So I really don't have time to do a background section unfortunately. Page 3 of your packet is kind of the, I mean it is the

outline of what I would envision as the background section. So if you could just, you know, take a look at that. If you have any ideas of other things that would help to set the stage or orient the reader let me know. I purposefully kept it really limited because I just felt like that was, it was too broad an area to really, to spend a lot of time on in the paper. So basically I'm just going to go through one slide on meaningful use and then I'll jump into the other areas. So I'll spend about five minutes talking about data needs and five minutes talking about current capabilities and then five minutes talking about each of these two sections.

So, many of the people in the room are very intimately aware of meaningful use and basically the things I wanted to just emphasize in this slide were that in the core set there's one explicit measure of care coordination and that is a measure of transfer of information across care transitions. And

you know, as we were just talking about, that's not all that there is to care coordination. And so there are a number of other measures that are related and they're categorized and they're under different headings. And I think that's really important to remember as people are talking about meaningful use and talking about care coordination in the same sentence. The stage 1 menu set includes medication reconciliation and a summary of care record which are two other I would say tasks/data needs. And as far as I know and if someone here was on the committee they could correct me. I believe these were initially part of the core set for stage 1. Who was it that was saying they were on the meaningful use committee? I couldn't see you. Okay. Do you know were these initially part of the core set? These two, medication reconciliation, summary of care record?

MS. POWELL: I believe that they

were. I think med rec was optional --

DR. SAMAL: Okay, yes. Because my understanding was there were a number of things that had started out as being not optional and had been moved to optional because organizations just did not feel they would be able to meet those. This is what we were talking about with the -- exactly. Okay, yes. Exactly. Exactly. So organizations did not feel that it was reasonable to include everything in the not optional and that's kind of what Jeff Greenberg was talking about before with an incremental approach.

And then what's exciting is the stage 2 proposed set does include measures for a number of other care coordination concepts. But once again, this is all going to be interplay between organizational priorities and you know of course all the things that guide that, and federal regulation. So that's all I'm going to say about that. Obviously it's a very truncated background section. And

if anyone wants to make any further comments about that or anyone? Okay. Let's go on then.

So the first section begins on page 4 of your outline. You know, as of right now it's titled Data Needs. So this is the area where we could shoot for the moon as Wendy Vernon was saying before. This is the area where we want to identify all of the different data elements and also what I consider to be aspects of data which are really important for care coordination measurement. So what I call core clinical data elements, I don't know if there's a better word for this. The problem was allergies and medication lists. It's sort of like very small set of information that you'd really want to have when transitioning care. It's obviously not enough information when you're talking about caring for the whole patient and across the life spectrum in care transitions. So comprehensive care planning,

I just put that bullet there to remind me to talk about the idea that we're talking across conditions, we're talking about a person's entire lifetime. And communication across settings is sort of one of the sticking points in health information systems.

So I just, on both of these slides cited these two papers which were two of the only ones that I felt they were, you know, this one is a primary research investigation and this one's a systematic review. I would be open to suggestions from others of other places in the literature where I could find primary data about these concepts. There's a lot of papers that are thought pieces. There are not a lot of papers that have really gone out to practices as they did in the Ann O'Malley paper, or looked at a number of different types of computer discharge summaries as they did in this paper. And so really that's what I'm looking for here is trying to find scientific data behind the data

needs and current capabilities.

So first of all, the top bullet and sub-bullets are related to this Motamedi paper where I thought it was interesting. When they looked across the literature and they did a systematic review of the literature they found these, what I consider aspects of high-quality discharge summaries which are somewhat subjective. Providers talked about discharge summaries being comprehensive, brief, brief is very important, and legible which is a problem that is solved by health information systems. Another thing that was discussed there and in other venues is the fact that there's often not a record of patient education in discharge summary and so that's a really important part of discharging a patient but there isn't really a place to record that in our records often. And that's I think an artifact of our paper charting methods.

The second bullet here is, you

know, just basically like a laundry list of functionality to support different tasks. So thinking about what we want to do with medication reconciliation. We want to really raise the bar there and go beyond what we've done in the past. We want to track laboratory tests from the time that they are even conceptualized to the time the order is written on paper or put into a computer system through the result coming back to the provider and the result being communicated to the patient. This is what people call loop closure. And we don't really have functionality to support all these tasks yet but that's something we're thinking ahead that we really like. And tracking referrals, I think we talked a lot about tracking referrals but once again, this is about loop closure. So making sure that all of the players, including the family and patient, understand what the specialist said, what the generalist is going to handle, what the specialist is

going to handle and all those concepts.

And then population-oriented tools which I think sometimes people don't include under care coordination but I think definitely should be because when you are talking about like a disease registry for example you know the action that you take once you have that information in front of you is actually care coordination on the individual level. So that's a tool to manage a population. But every time you look at that list and say this patient hasn't had such and such, that's the care coordination. So we need that data and then we also need tools to support those tasks. So, all right.

So just to stop before going into the current capabilities. Did anyone want to just right now let me know if I've missed any data needs that you think are important to cover? Or if there's other places in the literature, organizational experience. Are you raising your hand?

MS. LOVE: I think an emerging data source and under 1(b) I made a note that consideration or mention of the statewide all-payer claims databases.

DR. SAMAL: Yes.

MS. LOVE: Even though they may not be fruitful today I am hopeful that they should be encouraged in this document somewhere, but that the vision would include them for future measures. Because they do bring across payers and providers, all the data and all the utilization data.

DR. SAMAL: Yes, I understand what you're saying. Are there any sources either in academic literature or organizational experience that I could use to write about that?

MS. LOVE: I would refer you first to the APCDcouncil.org site where we have a lot of Commonwealth papers out there that states have been using to build that business case.

DR. SAMAL: Okay.

MS. LOVE: And then I can probably find some other papers and send you some links.

DR. SAMAL: Great.

MS. LOVE: But we're trying to put a compendium on the APCDcouncil.org site.

DR. SAMAL: Great. Great. Yes, I think that's very important, especially as we get into the barriers and we talk about lack of interoperability I think that's really important. Yes.

DR. AUDET: Two small items. One on your clinical information characteristics of desirable information, comprehensive, brief, legible.

DR. SAMAL: Yes.

DR. AUDET: I think it would be great to get a bit more specific about brief, such as really what's really important is what are the items that need followed up and by when.

DR. SAMAL: Okay.

DR. AUDET: And another source of -- it's not going to be scientific data because I think some of this is still in pilot but there's, there are two groups that I think you might want to touch base on that are doing a lot of testing of these measures. And one is the Premier. They're doing a lot of piloting of measures. And they're trying to get at some of these care coordination measures and patient-reported outcomes. And the other one is the Dartmouth collaborative on accountable care organizations. So these are two kind of test pools or test beds. So you may not, it's not published literature yet.

DR. SAMAL: Well, I mean, that's part of the problem I'm running into is there's not a lot of published literature. So whatever is out there, you know, it would be good to bring as much of that together as we can. All right. Great. I'm so glad people

are participating. Oh, yes.

CO-CHAIR LAMB: Just a point of clarification. In the section on data needs.

DR. SAMAL: Yes.

CO-CHAIR LAMB: It's framed as functionality to support care coordination tasks. And so if these are the supports I'm interpreting them as structural antecedents, that you have to have them in place to actually track whatever is measured related to care coordination. So is there also a section here in terms of what the data needs are going to be for the care coordination measures?

DR. SAMAL: Okay, I see what you're saying. So in other words, well, I'm not totally sure what you're saying. Are you saying if I talk about these as structure, like the Donabedian structure-process-outcome, then I also need to talk about the process that you go through and then from that would come all of the data elements that you would measure. Is that right?

CO-CHAIR LAMB: Not necessarily the process, but if these are the pieces that you need in place to be able to track what's important, what about the discussion about what is actually tracked related to the quality of care coordination and the outcome.

DR. SAMAL: Okay, I see what you're saying. So come out with all of the actual data elements from each of these. Okay. That makes sense.

DR. CARRILLO: Yes, in terms of data needs, thinking about the customer. Who is using the data and who needs to input the data. Particularly in dealing with the high-risk, high-cost patients the community-based resources are very important. Community-based organizations --

DR. SAMAL: Right.

DR. CARRILLO: -- behavioral services, social services. And it's a real challenge. I mean, clinicians have been, nurses and doctors and hospitals have been

working on this for a long, long time.

DR. SAMAL: Right.

DR. CARRILLO: But for us to be successful we need to be able to have interoperability with this whole sea of resources --

DR. SAMAL: Yes.

DR. CARRILLO: -- that are for the most part not very much technically oriented. So that's an important need that I don't know to what extent it's been looked at, but certainly in New York state people are wrestling with it at all levels of care.

DR. SAMAL: Yes, that's right. And so you're saying that even if it's not, if they don't have electronic records in those organizations we need to somehow be able to capture the information.

DR. CARRILLO: You know, a CDR, you know, how are we going to project the information. And also what information we need from them.

DR. SAMAL: Right, right.

DR. CARRILLO: I mean, could it just be faxing something that is secure? I mean, how are we going to get that information that may not be an EMR but that it's desperately important?

DR. SAMAL: Yes, definitely. And I know that some organizations are using electronic records. Like there's something called Efforts to Outcomes someone I know uses in their orientation, so.

DR. CARRILLO: So, I mean if fax technology is what's available to some of these critical services that we need to coordinate care with is there a way of integrating that kind of lower tech data into our data exchange?

DR. SAMAL: That makes sense, yes. Okay.

MS. KLOTZ: And one other thing here. You mentioned the importance of patient education, and that brings to my thought

patient understanding. I mean it's one thing to have done education but does the patient understand. I don't know if there are any measures of that. The only one that comes to mind might be the patient activation measure that would at least give you a sense of the individual's readiness to understand and take responsibility.

DR. SAMAL: Yes. I mean, there are actually a lot of validated measures about the patient-provider relationship, trust, communication, knowledge, efficacy and things like that. So I mean that's a really good point, that could be incorporated as well.

DR. LEFTWICH: In terms of what's coming or likely coming, the clinical information model work group in the S&I Framework that I co-chaired concluded that the medication list, the problem list, the allergy and intolerance list and patient demographics should be core data elements that are in every document that's part of a transition of care,

close loop referral, hospital discharge summary and the patient instructions from the hospital discharge. That was presented to the HIT Standards Committee two months ago and they indicated two weeks ago that that would be their recommendation for states to have meaningful use, that that functionality be part of the requirement for an EHR to be certified for that. So.

DR. SAMAL: Okay.

DR. LEFTWICH: And those are defined down to data elements that will make it interoperable between systems.

DR. SAMAL: Great.

DR. LEFTWICH: And include some additional data elements from what's been there previously like the date of reconciliation on the medication list, the problem list and who reconciled them. The identity of the primary care physician and the demographics.

DR. SAMAL: So now it's just been

approved. So where would I find that like online or what would I look under to find that?

DR. LEFTWICH: The Standards and Interoperability Framework has a wiki that's siframework.org with all of their work. The HIT Standards Committee and Policy Committees have recordings of all of their meetings.

DR. SAMAL: Right, I saw that on the website. Okay, great. So that was just approved because I'd seen some stuff from July and August. Okay, great, thank you. That's very useful.

DR. LYNN: Just one last thing over here. Hello. It may be implicit in what you're talking about but in terms of patient perspective I think you also, with care coordination you have to include family perspective.

DR. SAMAL: Yes, yes. Of course, yes.

MS. ALEXANDER: I'm sorry. I

wanted to make a point too to keep in mind regarding discharge summaries. And that thinking about the discharge summary from the perspective of the care team and based upon a plan of care, and not solely upon the perspective of the physician discharge summary.

DR. SAMAL: Right.

MS. ALEXANDER: Particularly in your previous slide when you were talking about the patient education is often not included in the discharge summary because it's not documented. Well often patient education is documented but it is not included in the physician discharge summary.

DR. SAMAL: Exactly, so it's in the nursing clinical documentation.

MS. ALEXANDER: Yes or it could be other clinicians too such as PT, speech, that type of thing.

DR. SAMAL: Right, right. Okay, that's a really good point. Okay. Yes.

MS. POWELL: Another comment just to go along with that is it may be helpful just to kind of take a step -- well, it depends. If you're looking at what is existing out there now this may not be the case, but to the degree you're trying to set a path forward part of the problem with this has been a lot of the same information is in a lot of various and sundry different documents and this is something we ran into in the context of meaningful use. The comment was made that there's really not a lot of value to a discharge summary without a plan. So the idea is let's have one document that's a discharge summary and plan, and that then brings value in and you've eliminated one document. So I guess the larger framing for my comment is I think part of what we need to do is not figure out how to put what we're doing now into electronic format but take a step back and say how is what we're doing now not helpful, and how is it a lot of rework.

And let's look at how can -- what information is necessary at what points in time to whom, and let's design as few documents or as few presentations of information as possible that can give that valuable information when and where it's needed. So that's my first point.

Then the second point would be on the comprehensive care plan, and this is another place where, again, my mind just naturally gravitates toward this as like the primo document from which pieces can be taken for specific purposes. But then I think part of the care plan really has to be and it really needs to start with a goal. And that needs probably to be an element of information that goes across whatever documents or whatever care settings there are. The high-level goals, not just clinical but also patient goals because those are two very different things. And then that can become a frame of reference for actual specific actions related to care coordination.

DR. SAMAL: And so when you say "goals" do you mean goals along the lines of like a clinical goal for the patient, or a goal like a very broad goal, like I want to be able to live on my own again?

MS. POWELL: Both. And I think that's part of what makes this hard. I think of this in a similar way to what Wendy talked about in terms of the cascading of measures. What is the ultimate clinical goal for this patient who has terminal cancer? It's not cure, it's palliative care. And so then what does that mean, and what does that mean for each member of the care team, who's responsible for what, what are the roles of the patient and family, and then what are the goals for the family in that circumstance. And then again kind of the cascading so that people understand this is the overall care plan but underneath that umbrella of the longitudinal shared care plan then each individual discipline or person or area of

focus however that might be for the patient will have its own kind of sub-plan.

DR. SAMAL: That makes sense. I think that's a really good example because I think a lot of times palliative care teams in the hospital are doing that. You know, they're cascading the patient's overall goals of care into various, you know, areas like ICU or whatever.

MS. POWELL: Right and that's just an example because it's an easy one because it kind of already exists. But that should be the approach I think for any particular person, whether or not they're palliative care or not.

DR. SAMAL: Okay, that makes sense.

CO-CHAIR CASEY: So I know Linda's got her card up but let me jump in here because Gerri and I were having deja vu all over again. And just emphasize for you and also the committee that for example if you

look on page 18 of Preferred Practices you can see a lot of what you're talking about. So I would again harken back to what's there. And some of the things you're talking about because I didn't process them all may actually not be all there so how do we enhance that. But I think both the committee and yourself should really use this as a structure to help inform what you're talking about.

DR. SAMAL: Yes, okay, definitely.

CO-CHAIR CASEY: So Linda had her hand up.

DR. LINDEKE: I wanted to raise one point. It's not, I haven't read about it here but in my clinician role working with premature infants at discharge I'm very fortunate compared to Gerri, we really do start at the beginning of this story with pregnancy and all that. But we talk a great deal and it does come into these summaries about risk because we're sending discharge summaries about unique physiology, a

combination of all sorts of rare events in some cases, multi-diagnoses that will take huge amounts of family and community resources. And we've realized we need to say eye condition, at risk for blindness, pulmonary condition, interventricular hemorrhage, at risk for, in order to get the clinicians whoever they might be, even sometimes the family attention, that this isn't just an eye screening you can do down the block. So I don't know if you see this in the literature. It's extremely important with multi-diagnosis special needs children and others I'm sure to, "at risk for."

DR. SAMAL: Okay. How am I doing on time? We're out of time. No, we have a little bit more time for questions. I guess we'll just move ahead to the next section which begins on page 5. Okay. So, this is, you know, now these are things that I identified from just these few papers as current capabilities and I think a major

overarching question that you guys, that you can help me on is should I be looking for the frontrunners in each area or am I trying to understand what the general, what's going on generally? So I mean for example, I've used a lot of, I've used the NEMSIS data set a lot and that does not have anything about care coordination that I know of in it. Maybe in a broad sense it does. But we don't have a lot of nationally representative data on care coordination so, you know, I would really just be going to things like there's a survey I quoted on the next slide and, you know, give me some idea of whether you want me to talk about like what's the best, what's the state of the art or you know what do we have generally. I think some of the points that I brought up here, so for example the first point is from the same paper in Journal of General Internal Medicine which was that they went to a number of practices that are fully electronic and they found out that continuity

with the PCP is not built into that system. They have a separate scheduling system and someone has to think, okay, who is their doctor, let me figure that out before scheduling them. Also for referrals I think this is like something everybody knows but, you know, fully electronic practices, they're communicating with non-electronic practices so often they're sending out their requests and receiving reports by fax and then they're scanning them in as a PDF which makes it, you know, at this point fairly useless for quality measurement and also for clinical care I would say. And then in multispecialty practices and this is something I can say from my experience, you know, we don't even really send a true referral request anymore because we're just expected to read each other's notes. And so you know, that really does not fit into the framework of making sure that the specialist understands what the question is and whether you want co-management or just

recommendations and then tracking the referral to completion. That really isn't, even fully electronic practices with very advanced electronic systems there's not necessarily a function for that. And so then just maybe, let's just go to the next slide and then we'll stop there.

So this is a survey of regional health information organizations or RIOs and they were able to survey I think the number for response for different questions was different, but for the first question can people in the inpatient setting access information from the ambulatory setting. Out of the 59 surveyed 44 said they could. And then vice versa, if a primary care provider is doing a follow-up visit and the discharge summary is not available at time of visit. Now remember, if you're having people follow up within a week that's really, that happens a lot. Only 32 out of the 43 surveyed had that. I say only because I mean, those are

not -- these are what I would think are some of the key things that you need for care transitions. So that's why I said only. But if you have other sources of information about either of these issues so the ambulatory settings, care transitions or ambulatory inpatient. Yes.

CO-CHAIR LAMB: If we kind of go back to the NQF framework and we take a look at those domains and then we also look at other definitions of care coordination it's -- care coordination happens at -- between, it's between the providers, between the patients. And you know, and I know that it becomes really complex but care coordination I think as Wendy said before is owned by the patient. Providers support it but virtually every provider in a health care setting is doing it. I think it's important to move beyond looking at the medical component and the PCP to specialist in the hospital or in the ambulatory care setting, to broaden out that

this is something that goes across every professional that is there because it doesn't work otherwise. And so it would be good to kind of broaden out that perspective and take a look at what is it going to take to share information that's being generated by virtually everyone in the health care system. And it makes it really complex and I know we need to start it, but if we stay so focused on just communication in one venue we're never really going to get to what the issues are and how to solve them.

DR. SAMAL: Okay, yes, that's very useful to know because there's a -- I didn't really, let's see here. What did I include about this. Under page 6 there's 1(e) is about personal health records. And I guess (f) also is related to this. Because you know, I think we were just, before this meeting we were talking about consumer health informatics and the question was whether or not that fits in here. You know, it's a huge

field and now people are generating all kinds of quantitative data at home which we need to figure out how to process in the health care system. So yes, I definitely think that's important. It's very helpful to know that we want to try to at least touch on that as well.

CO-CHAIR CASEY: So that's the nurse speaking. And as the doctor I defer to the nurse.

(Laughter)

DR. SAMAL: That's always a good idea because usually we're wrong. Okay.

CO-CHAIR LAMB: Not just the nurse, every health care professional, and we have many of them represented around the room as well.

DR. SAMAL: You know, definitely. And just to give an example from something I had worked on, I worked on a systematic review about consumer health informatics. And we had decided to really take that completely out of the health care setting. So we actually said

if a doctor, nurse or someone in the health care system had to be involved with the use of the technology then it wouldn't be included in our study. So that ruled out all patient portals, and it was very interesting to look at the literature. And this actually was funded by AHRQ and is on their website. But yes, there definitely are studies out there and there's information out there. So we can, if we're trying to do that, we're trying to cast a wide net, that's good to know. We can pull in examples from all of the different areas. So. Yes.

DR. MALOUIN: So I had a comment. I'm not sure exactly where this fits in but I think it just, it speaks to the biggest challenge that I've found in measuring care coordination. So what we're doing in the state of Michigan is we have a large, we're part of the CMS multi-payer advanced primary care demonstration project and we have about 450 practices that are across a wide

geographic region with a lot of different EMRs, a lot of different capabilities. And so we, one of our primary goals is care management, care coordination. That's one of the initiatives that we're implementing. And so we, the first thing we did was come up with a list of metrics of what we want to measure to sort of, you know, for quality, for patient satisfaction and what do we want to measure for care coordination. And it's hard enough to agree on the measures but it's impossible to try and measure them when you're going across multiple EHRs. And so I think what we have to think about is that everybody's doing a lot of great work in their own systems, but in order to do meta-analyses of this work and look at, sort of draw really broad conclusions you have to be measuring common things. And that's I think where the challenge is. So even if we come up with, you know, a great set of core measures, if we can't develop reproducible ways of capturing those I think

we're never going to be able to really add to the knowledge and the literature on this, in this area.

DR. SAMAL: Yes, definitely.

DR. MALOUIN: So that's my challenge. I'm sure it's all of our challenges.

DR. SAMAL: And that's why it's tough for me to decide whether we should look at sort of the front-runner systems which are very, which are isolated. You know, our system is very advanced but we're isolated. We are slowly trying to scoop in practices into our system but we can't really talk to other systems either.

DR. MALOUIN: Exactly.

DR. SAMAL: I don't know if we should focus there or if we should focus as you're saying more on like what is actually happening in real life and how hard is it for us to actually go across these.

DR. MALOUIN: Well, and how do we

get from where we are to where we want to be. Because I think that's the biggest challenge. And what we ended up doing is sort of taking these sort of indirect markers like, you know, reduced ED visits because that's all we've got and we're saying well, if you're coordinating care well then you're going to end up with X, Y or Z, but that's really not getting at the processes of care that got you to that outcome.

DR. SAMAL: And those measures then drive different systems such as ones where the ED tries to set up a care coordination program, or you know, and then that's not exactly what we're talking about here either. So okay, let's just keep going.

CO-CHAIR CASEY: I'm sorry, Emilio has his.

DR. SAMAL: Oh, I'm sorry. Yes.

DR. CARRILLO: Just to build on what Gerri said before. I think that rather than just an afterthought or a section 7 that

the whole idea of the communication at the patient-centered level, the patient and also communicating with the homeless shelter and the rehab center and the CBO and the visiting nurse. That, we may not have it but that has to be a destination. I mean, so maybe the organization of the paper needs to be in a way that reflects the gaps that we have rather than just like a summary, then we also need to work on the following. Because that just gets lost. I think that, you know, out in the field this is where the action is.

DR. SAMAL: Right.

DR. CARRILLO: That's where it's happening and we need to point towards that direction the way that Gerri said.

DR. SAMAL: Right, that makes sense. Okay, so let's see. So what's the next? Okay, so now we're moving to page -- well, it's really page 7. So you know, at this point I'm just basically listing some of the various -- and these actually, a lot have

come up now in our conversation which is great. And if you want to mention others that's great. I organized it under technical and organizational though some of them could fit under both, and we could go back and forth and discuss those, even those categorizations. So first of all, lack of data standards. So this is something that's being addressed and right now is slowly in the process of becoming a reality of having data standards that will allow the technical interoperability. Legacy homegrown systems. So like for example we have a system that's very advanced that we built that we want to keep using. And there's also older versions of commercial electronic health record systems that are not able to be - you know, you may hear that Epic, I shouldn't say Epic, but I'm just saying you may hear that a commercial system is interoperable with your system but the person you're communicating with may have an old version of that system. So that can be an

issue.

And then kind of going to a different area which is, you know, one that's sort of you know what I'm really interested from a research perspective, that's part of the reason I think about it a lot, clinical decision support tools which are tools for physicians, once again going back to physician focus, at the point of care. They don't support audit and feedback in a lot of cases and so you're doing double work, you're doing data entry but you're not getting a report back, and then if you do get the report back it's not necessarily in a time or place where you can react to that and provide care coordination for a patient.

And then the last part of that bullet is about risk stratification which I think is what you're talking about, right? Okay. I was thinking about it more from the perspective of, you know, providers often say don't give me these cookie-cutter

recommendations from clinical practice guidelines because they don't apply to this patient. So you know, being able to be more intelligent than that and providing recommendations for people is I think the next step.

Another issue is just encounter-based documentation. So in very short, acute hospitalizations having all the information kind of in one encounter and just kind of putting that on a shelf and starting the next one as a separate chart the next time the patient comes to the hospital makes sense but when you're talking about longitudinal care over someone's lifetime or collaboration then that type of system of organizing information does not make any sense. And then I think someone also talked about, well this is basically what you're talking about, measurement bias because information about care transitions is stored in different systems. So whether it be paper charts or

electronic that is a measurement issue. Any other thoughts or comments there? Okay. Yes, okay.

MS. ALLER: I would just comment that --

CO-CHAIR CASEY: Use your microphone.

MS. ALLER: The whole issue of data standards is just astronomical.

DR. SAMAL: Yes.

MS. ALLER: And when we talk about things like a care plan it's wonderful. But unless we not only have a very clear structure with implementation guidelines and it's had time to mature so that it's well-adopted and the bugs are worked out of it we're not going to have high-quality data for measurement.

DR. SAMAL: Yes.

MS. ALLER: So it's not good enough just to have a standard that somebody's put together if it hasn't had time to be out in the industry, be tested, be used and worked

through so that we mean the same thing when we use it.

DR. SAMAL: That makes sense. Then someone else had a comment? Yes.

MS. POWELL: This is apiece technical but it's actually I think a bigger organizational issue I guess. But the issue of just because you -- yes, data standards are a huge problem. But we do have a lot of standards and data still doesn't flow. So it's not just a problem of standards, it's also a problem of incentives both on the vendor end. Just from a market perspective if you are the Brigham and Women's you don't have a vendor issue. You'll get the attention of your vendor because of the volume that you produce for them, but if you're a very tiny one-doc shop out in rural Montana getting the attention of a vendor is going to take awhile if you get that.

DR. SAMAL: Yes.

MS. POWELL: Just, again, it's a

simple market kind of concept. So there's that issue. I don't want to take us away from this if we're not ready to leave it but I think part of the reason for that issue is the fact that there's also not always an incentive and often a disincentive on the organizational standpoint to share data. And that gets at what Gerri was talking about is that what we're really trying to get at is shared accountability. But if there's all kinds of disincentives for sharing information so that we can actually perform the functions that we need to perform to coordinate care for patients then we've really got a huge roadblock.

DR. SAMAL: Yes.

MS. POWELL: And that then in turn kind of I think affects vendors and market products because there's not a demand.

DR. SAMAL: Exactly. Exactly. And so, and I think that's part of the reason why I said that data needs really is driving

this is that what I want to try to do is encapsulate that concept coming from the other side and saying here's what we need so we want to drive development around that. And then you know, the whole piece of reimbursement and creating the incentives is kind of out of our control but maybe by driving the data needs and saying what we really need then we're able to push that forward. Yes.

DR. AUDET: About clinical decision support, I would also probably suggest adding that. Right now clinical decision support is really focused on a fragmented delivery system and what we really need is clinical decision support that supports the care team and the care plan. So an evidence-based care plan that everyone has available. So it's not only one person ordering a medication but it's really talking about care coordination underneath it.

DR. SAMAL: That makes sense, yes. Okay. So yes, we could just go to the next.

So I called this organizational and if, you know, if people would rather it be called policy or maybe taken out completely because it's not you know technical information let me know. But this is, a lot of these are kind of corollaries to the other bullet points because as I was thinking about it I was thinking we can't really leave that out. So resistance to changing legacy systems. I mean, that's because people like me are used to using a system and it's also because the organization doesn't really have an incentive to do that. Or I mean they do, but you know, the incentive has got to be weighed against a lot of other priorities as well. And it's tough to even know when you go into that process how much it's going to cost, how long it's going to take, what you're going to get from it. So that's an issue that is going to come up a lot I think in the future.

Then the next is, you know, this is once again kind of physician-centric I

think because it's about the resistance to mediating care plans between specialties. And we don't often do a good job with that. And finding ways to do that at an organizational level is really important before you can get buy-in into any technical solution to the problem. Yes.

DR. WHITE: Let me just add one other problem that you may not have considered because a lot of the carriers have a lot of claims information. It's very useful. They may also have members who are in case management and other health and wellness programs, disease management, et cetera. But when a member changes plans that information doesn't follow the member.

DR. SAMAL: Yes.

DR. WHITE: And is there a way that we could make sure that that information gets, you know, transmitted from one carrier to the next, or from one provider to the next so that they have that information?

DR. SAMAL: That makes a lot of sense. I mean, I think in lieu of having an interoperable solution that makes a lot of sense, yes. Yes. Okay. So, yes.

DR. LINDEKE: Can I make -- were you on the next slide? A very quick comment. Trying to educate the next generation of health care providers when the environment is click and drop-down menus really worries me. My colleagues and I talked about this yesterday, of engaging the thought process when the day is spent clicking rather than the clinical decision-making unique to this patient. I don't know where it is in the literature but it's a huge unintended consequence danger for care quality.

DR. SAMAL: And I guess the other things that relate to that are the patient-provider relationship is affected by the clicking and also just the human-computer interface affects your cognitive process as well. So I don't know if that's too broad to

get into at this report but we'll have to think about that further. Okay.

MS. KLOTZ: I'd also like to suggest thinking about the fact that as we know most care coordination is done by the patient and the family, and that we need to be careful that this isn't a process of taking that responsibility away from the patient and family.

DR. SAMAL: That's a good point. And I think that's where I also have to decide how much to talk about personally controlled health records or that type of technology which is actually trying to put the power back with the patient and family more.

DR. HEURTIN-ROBERTS: Can I follow up?

DR. SAMAL: Yes.

DR. HEURTIN-ROBERTS: On just what Linda said. I guess part of what's concerning me about this, or just a concern I have is that there's a real danger that we collect

information that is easily collectible through electronic health records and not necessarily what we really want to know. You know, it's like looking under the lamppost for keys you dropped somewhere else. And I think we need to be really mindful of this.

DR. SAMAL: That makes sense, that makes sense. And I think that's also what we were talking about before.

MS. POWELL: Can I just add something to what Christine said? I think it is important to consider the patient and family because they do certainly have a role in this and yet they're -- part of the reason why care coordination doesn't happen as well as it could or should is because the health system itself is not doing some of the things that it needs to do to help the patient and family be successful in that. And so I just want to be careful about not -- in places where this is really hard just kind of turfing it to the patient and family. Because things

such as making appointments and navigating the health care system, that's difficult for those of us who actually work in this all day every day and to think that a patient is going to be successful at that is, I just want to make sure that we're assigning responsibilities well.

DR. SAMAL: Right, right. I mean people have likened it to the banking industry or airline industry where now you as the consumer do all the work basically. We don't want to get to that point.

MS. POWELL: Yes. But there are certainly places where patients and families can be more involved or have, given the right tools.

DR. SAMAL: Right. That makes sense. Okay, so just --

MS. KLOTZ: To clarify what I was trying to say too is that the system should support the patient and the family, not push it off to them.

DR. SAMAL: Right. And yes. Right. I did put a bullet in and it's actually here on page, right next to the -- I'm sorry, let me see here. It's about personal health records. Where did I write that. It's page 8, the second bullet point. I wrote that because if we are going to talk about consumer health informatics there's a huge literature around that as a concern. And even, not just consumer health informatics. I mean, patients are concerned about electronic exchange of information in general. So I think that's definitely a huge issue that we should at least address. Okay.

So the last two bullet points here are actually kind of the same thing. The first one is from the paper in the Journal of General Internal Medicine which was that, you know, when they talked to clinicians providers were describing work-arounds for tasks where when they interviewed the vendors, the vendors said no, we actually have a function to do

that. So I think that's something we don't want to forget is that clinicians don't necessarily get the training and the support that they need to really use what's even available in the products. So that's an organizational problem. And then --

DR. WHITE: Excuse me. I wanted to make a comment about that.

DR. SAMAL: Yes.

DR. WHITE: That is true but some physicians are also -- clinicians are also resistant. And there's still a lot of resistance out there. I think we all sort of assume that everybody's on the same page and they aren't.

DR. SAMAL: Yes.

DR. WHITE: And there are a lot of providers out there who still don't want to use electronic medical records.

DR. SAMAL: That's right. That's definitely true. And people are talking about sort of the graying out, is that really going

to be a phenomenon where people gray out and the ones that aren't using are going to retire or not. Are there also people that are coming in that will be resistant.

DR. WHITE: The other thing is we need to remember that these systems are phenomenally expensive, especially if you're in a one- or two-provider practice setting.

DR. SAMAL: That's right. And I know that some of the efforts around the regional extension centers were meant to try to create community-wide resources, regional resources for clinicians, but I don't really know that that's really penetrated the market or if people really are even aware of that yet. So. Okay.

And then work flow redesign change management. So you know basically we now have moved to thinking that the health IT should fit the work flow but when we're talking about raising the bar and encouraging people to do things they haven't with care coordination we

have to remember that we're asking them to redesign their work flow to use the health IT that's supposed to encourage the care coordination. So concepts of change management are important I think.

DR. LEE: You know in some of the more successful stories we hear around using EHR I think the training is not just conditions but staff as well because then that defines a proper workload you know per member. So bullet number three, consider adding staff.

DR. SAMAL: Yes.

CO-CHAIR CASEY: So I just want to point out that it's noontime now.

DR. SAMAL: Okay.

CO-CHAIR CASEY: And I know that you've got some slides to cover and people still want to make comments, but I want to be mindful of our schedule because we're behind now, so.

DR. SAMAL: Yes, and we have more time for questions.

CO-CHAIR CASEY: And we'll probably bring Arjun after lunch.

DR. SAMAL: Oh, I see. Okay. That's fine. So let's just go to the next slide. So I'm not going to read through everything here but basically bullet 1 talks about problems with the way that documentation is -- well, we talked about some of that already, how documentation is optimized more for capturing information, for billing and capturing your decision-making process in a way that may not actually be helpful in this situation. We talked about bullet number 2 I think already and we talked about bullet number 3. Great. Okay. Could we go to the next one? Okay.

So, you know, really this is now sort of bullet points that respond to the other bullet points. So we don't have to go through each one. We talked about the first, the second, the third. I brought this up earlier saying there's not really electronic

tools for tracking the task. Even if you have a disease registry it may not help with that. We talked a little bit about insurance information flowing to other insurers, but we didn't talk much about that coming to the point of care coming into the care settings. So for example, you know, knowing if a patient has filled a prescription, that is something that really I think makes a huge difference in your decision-making process and your conversation with the patient. Talked about personal health records. What we didn't talk about is the fact that we haven't really gotten to a point where everyone has agreed upon bidirectional communication for many reasons, time, work flow, cost, liability. So that's a whole area that we could focus on in the future. And I think in the paper this really is going to be almost like a laundry list unless people feel like there is some data behind any of these that we could cite. Otherwise it'll sort of just be a discussion

section. Next slide, please.

And you know, these are just kind of responses to the issues with documentation, clinical decision support. And just another idea about being able to display information, quantitative data, longitudinal data to patients and providers in a way that is helpful to the patient to understand their self-management and to, rather than counter-based documentation that we have now which makes it very difficult I think to bring things together for patients. So that is really my last slide and if anyone has any other comments right now that's fine. I know that people probably don't because they'd like to eat lunch.

So, I'm going to collect your outlines and then if you want to email me that's fine. My email is just my first initial "L" and my last name S-A-M-A-L at partners.org. Or if you just write your name and email on your outline I will contact you.

Thank you.

CO-CHAIR CASEY: And Lipika, you'll be here through the rest of the meeting.

DR. SAMAL: Yes and I'll be here all day.

CO-CHAIR CASEY: So thank you very much.

DR. SAMAL: Thank you.

(Applause)

DR. BURSTIN: Just one comment. So, Lipika is just as you could tell at a fairly early stage of developing this paper. So this input has been great. You'll see a draft of this paper come back to you for review. We're hoping the paper serves two roles one of which is obviously to help inform the committee about what are the likely directions, but also I think it's -- we're also hoping this is part of that critical pathway of putting something like this out there that allows developers and others to

start thinking about where they potentially could go for the next generation of measures. So thank you, Lipika.

DR. SAMAL: Thank you.

CO-CHAIR CASEY: So Lauralei, is it lunchtime?

MS. DORIAN: It is lunchtime now. We'll have Arjun's presentation after lunch. I think what we might do is just maybe break for 10 minutes for lunch and then we can take lunch back to the table if that's okay with everyone?

CO-CHAIR CASEY: Have a working lunch then.

MS. DORIAN: A working lunch, does that sound good? Okay, thank you.

CO-CHAIR CASEY: Is everyone okay with that?

MS. DORIAN: Operator, are you there?

OPERATOR: Yes, I'm here.

MS. DORIAN: Can you see if there

are any public members on the phone for public comment, please?

OPERATOR: No one is on the phone yet.

MS. DORIAN: Okay, thank you very much.

OPERATOR: You're welcome.

(Whereupon, the foregoing matter went off the record at 12:05 p.m. and resumed at 12:25 p.m.)

CO-CHAIR CASEY: So let's kind of review while you're eating what we've done. We started off with sort of getting to know folks. We've reviewed some of the detail about the journey we're on vis-a-vis what this committee's going to try to accomplish in the next few months. We've had I think a very elegant presentation from Lipika on the work she's doing and I think she appreciates the feedback you've given. We're really going to look forward to having this paper in our hands during our deliberations.

We thought we'd change the agenda a little bit because we want to be sure to capture everyone's point of view in the room. We've noticed that some people are a little less shy than others so for those of you who are shy, get over it. You're going to be asked to talk. Because we really do want to be sure that everyone in the room is participating on this in this afternoon.

We are going to -- I'm going to say a few words, then Arjun is going to do his presentation. Arjun, about 20-25 minutes. And what we're going to do is ask him to go through his slides and then what we will do then is have a round table with your reaction to what he's talking about. And also, you know, what you've heard so far. We're going to ask you to be, try to be brief and if you've heard other ideas not to repeat them. And then Lauralei is actually going to be capturing a lot of the content of what your comments are in this process of going around

the room. Helen suggested too that in this process if you can think about sources of measures that are either in development or are in play. And if you can help us identify where those measures lie. We're thinking that a pull strategy of trying to reach out to these particular areas would be also useful in terms of our request. So I think that was a really good enhancement.

Then what we will do is I think we're going to then break into the questions that are in your agenda because we do want to really at a high level talk about these questions. The major goal is to help frame the call for measures which is a written document and will go out to the NQF membership and the public, the rest of the country, in terms of saying now is the time to submit. And it's in that document that we will really try to be guiding in terms of what it is we want. So we want your input about what we're going to be asking of those measure

developers. So, and then keep in mind again that we're in two levels. One is you're going to be doing the review of measures but also trying to reframe and redefine the current and future state around care coordination based upon all this stuff that's here. So again, please read the preferred practices several times and you know, you don't have to do it today, but after you get home, to be sure that you take advantage of the great work that's been done before. So did I do that okay? So, any questions about our agenda or any comments? Does that seem reasonable?

We're still on a goal to be done by 4:00. We know some people may actually have to leave a little bit early. So if that's the case and you feel like you're going to be missing something we could either make the phone available to you if you want to stay called in or we could be sure that if you missed something that we would give you a chance. How many people have to leave before

4:00? Just a show of hands. So only a couple. So, we'll be sure, 3:00, 3:00 or 4:00.

MS. DORIAN: Don?

CO-CHAIR CASEY: Yes.

MS. DORIAN: May I also call your attention to the fact that in your folders you have a sort of brief summary that includes all of the preferred practices from last year. So that might, it's just a two-pager. So that might be useful.

CO-CHAIR CASEY: That's a great point to just keep that over to the side so you can look at it when you're wondering if, you know, because it's a lot of stuff. So with that I want to introduce Arjun and thank him for his patience. And Arjun, we really look forward to this. I think what you've provided us already is very interesting and I think it will serve really as the foundation for our discussion about how to reframe the basis for what we're talking about. So it's

all yours, Arjun.

DR. VENKATESH: Just as a little background I'm a fourth-year resident right now in emergency medicine and I don't have much prior experience at all with care coordination. But I did have the opportunity to start a mini-fellowship with Helen at NQF this year and this seemed like a good project to start with. So, this kind of reflects a view maybe from the outside of care coordination. There's a lot more, many more experts in the room so it'll be interesting to get your perspectives when you see what I show you about where it seems like there's been a lot of measurement development and where some of the gaps are moving forward.

So as my disclosures I have some unrelated grant support from a variety of foundations. And then I do also have some consulting money related to 30-day readmissions from AHRQ but that's outside the scope of this project fortunately. Okay.

So my main goal is going to be to quickly outline the approach that I used and what the purpose of the environmental scan was as well as then to kind of describe the methods by which I conducted a bit of a systematic review, and then describe some of what the measure characteristics that are out there as well as what some of the subsequent measurement gaps are by doing some mapping of those measures. And then we can leave that then with the discussion that'll kind of flow into what we're going to do next which is to think about future measurement gaps and what may already be in development in those areas.

So my primary objective was to identify all current measures that are related to the NQF-endorsed definition which you already kind of reviewed earlier and I put it up there again. What's challenging about it is because the definition is so comprehensive and includes so many things, in order for this project to get done, in order to be efficient

it really became important to start drawing some more lines for what would be included within the environmental scan.

What I knew that we had was kind of what was low-hanging fruit, things that were easy to identify. The 2010 NQF report had 10 measures and 25 preferred practices. In 2011 the AHRQ Atlas was done which many people in this room were part of in various advisory group or executive committee forms, and that had -- that identified 61 measures relevant to care coordination. And then as we kind of came into this project some of the initial work that had already been done by NQF had really identified some major themes. And that was the incorporation of health care information technology, broad-based measures and moving towards outcomes away from processes. And what that left me with at the end was the question was where are the current measurement gaps.

So my approach was a "system"-atic

review. The quotation marks are important because for the methodological purists in the room I'd be raked over the coals. But the primary sources for the information were the primary literature, the Grey Literature, and then to some degree expert opinion interviews. I've made those all different sizes to show you the relative importance that they played in terms of how I identified what measures were already out there and what they were actually measuring. The anticipated outcomes was an inventory of existing measures as well as then a mapping analysis of this to the NQF and AHRQ frameworks. And that is more of a thought exercise to think about measurement gaps as opposed to say that one of those frameworks is better or more appropriate for thinking about measurement frameworks. And then finally to draw some qualitative conclusions about trends in measurement.

The search itself from the primary literature was largely out of PubMed, Cochrane

Review, using things like review articles that were there and things like the AHRQ Atlas. Databases being primarily the federally available ones, and then the Grey Literature, things that had been identified at CMS, previous AHRQ projects from PCPI and a variety of other sources, including Google but not including Wikipedia.

So in order to draw some of those lines that I said before to figure out what we could and could not include I thought it was fairly important. Because care coordination is so comprehensive and includes so many things and touches on so many things across the care spectrum. So we made an early decision to include both broad-based measures and condition-specific measures. And the reason is that ultimately it's very likely that there is some balance between these two that allows better measurement of care coordination. To simply measure things at the broad level and avoid the clinical conditions

ignores a lot of what's happening underneath, but then to do just the clinical condition and miss the broad measures, we've talked about already a lot this morning as to why that can be problematic. And then included measures regardless of their data source. So had I limited this search to electronic measures I could have finished this project in a day but we included paper surveys, electronics measures as well as claims-based measures.

What I started excluding were things that I felt either were a little outside of the definition, were going to be outside the scope of the project that this steering committee would work with and that would also help make sure the project could get efficiently completed. Measures that were specific measures of team communication within one setting I excluded. Measures that had not either had any field testing at all or even any structured assessment of their face validity, also out. Measures of screening

practices, you know, percentage of patients that got colon cancer screening completed in the last year, I excluded those. Measures that looked at single intervention and response. So blood pressure response after initiation of anti-hypertensive therapy, I kept those out. And then measures that were designed for other health care systems specific to like a Swedish trust or something like that seemed like they wouldn't be really helpful to consider within this group. And then 30-day readmission and emergency department throughput I also kept out since those are within other projects. Lauralei.

So, abstracted key measures in all of these. Whether or not they've been NQF-endorsed, was there any basis to say that they could be electronically measured right now, when were they endorsed, and then map them to two frameworks. The NQF mapping was assigned by me and that was looking at the original six domains that we've mentioned, or five domains,

sorry, that we've mentioned before. And then when mapping it to the AHRQ framework when the project was done a lot of mapping was already done for those 61 measures they included. This analysis done includes 125 measures. So for that 61 where they were already mapped by AHRQ I left it as-is and then after that it's subject to my interpretation.

So in total I was able to identify 124 measures. What's important here is that only 86 of those actually have published specifications, meaning that they can be found in the primary literature or within a clearinghouse or that they are somewhere where if somebody wanted to identify measures for their use that they could go and find them. And that becomes more important when we start looking at what types of measures were the 30 percent will really start helping us understand some of the gaps.

About a quarter of these can be electronically measured or have some testing

around being electronically measured, and the vast majority of that falls in the unpublished category. There was only one outcome measure if we want to define "outcome" by a health-related outcome as opposed to something like preventable hospitalization or ED visitation or something like that. And about two-thirds of the measures would be considered kind of broad or crosscutting versus about a third being condition-specific. And then a quarter of these had NQF endorsement. And the reason this 30 number is very different than the 10 number we were talking about before is that there are measures that have NQF endorsement that have come through other projects. For example, follow-up after TIA would have come through a different project so it wouldn't have been part of the 2010 project but certainly falls within the purview of care coordination.

So data sources. My pie charts. Go ahead. Every presentation needs this but

I don't have any Venn diagrams. So like I said before, if you take a first glance at what data sources measures come from it's about a quarter being electronic and three-quarters being manual of some sort. Another way to cut this though -- go ahead and click -- is to start looking at what types of data it is that goes within it. So, measures that are coming from electronic medical records are about a fifth. Survey-based, and by that that means largely paper or telephone questionnaire is about a third. Chart review, two-fifths, and then a small amount are claims-based measures. And that could include both administrative billing claims as well as like pharmacy benefit type claims both within that.

Now, this is slightly different because what this starts to say is well, what about the measures that are published, that are available and that people could find and do something about. And what you start seeing here now is that the vast majority of measures

are surveys of patient experience and the next large vast majority is chart review, and there's very little in the scope of electronic measures that are available for people to find and be able to use.

And then there's an analysis looking at all the measures in terms of their level of measurement. And this was the level that was specified by the measure developer. And since, for those who have been through the NQF consensus development project before, measure developers can specify either one or multiple levels of measurement for a measure. So what I did first was in the aggregate which is the dark blue I took every measure and I classified it by whatever its highest level of measurement was. So if it could be measured at the provider level or the system level I assigned it to the system. And then the disaggregate which is the light blue shows measures that are, when -- that concern what the closest to the patient, the most distal

level is. And so obviously as you can see as you go from dark blue to light blue more measures are considered to be at the health care provider level. What I think is probably the bigger takeaway from this is that there are very few measures that are kind of at the hospital level which I thought was a little bit surprising. And the reason that there are so many practice-level and health care provider level measures is because when you remember that last slide, right, half that pie was patient experience surveys. That's all over there. And that's why it looks like there's so many measures but really what those are is that they're all various iterations on the same small sliver of measurement.

So frameworks for mapping. I think a handout came out before and that was something I just kind of prepared for my own as a mental exercise for myself to think about when I find all these measures how do I make that useful for you all to be able to

interpret. And I thought well the best thing to do is then to put it to some framework for the measurement of care coordination so that you can start to think about where the gaps are. There was the NQF framework that was essentially made up of five domains and then four principles and that's 2006. And then there was a framework that the AHRQ Atlas uses. And the way they originally organized it was as mechanisms and what they call those are coordination activities and then broad approaches which are fundamentals across all activities as well as effects. And they thought about effects from the perspective of the patient, the health care professional or the system. And, next slide. The way they also described it in the AHRQ Atlas was to think of broad approaches as the structures and the coordination activities as processes and the effects as outcomes if you want to put it in a Donabedian sense.

The way I kind of framed it for

the purpose of this activity is the next slide which is this. And looks really messy and really scary but it is kind of colorful. And what it largely is is that the blue up here is the AHRQ coordination activities. So those are all the processes. And then the red is the NQF care coordination domains. And to me those seem to be the most relevant. Most of these kind of green, broad approaches that were defined by AHRQ as crosscutting things that make sense is that all kind of map up almost to one domain each. So in general what I thought was the most valuable thing would be to look at what measures look like if you use one framework and then what if I re-map the measures using a different framework. How would that be different in terms of what kind of gaps you see. And that was the goal of doing this. Next slide.

So, first broad stroke is if we look at NQF domains and the number of measures per each domain there's clearly gaps with

information systems and health care home. Now, those are slightly newer concepts to some degree and there just hasn't been much that's been, there's really very little almost measurement-wise that can fall within either of those categories. Transitions and communications seem to have a little bit more, and then plan of care has the most, and the reason plan of care has the most again is that many of the patient experience surveys that have been developed since the late '80s, early '90s focus on various aspects of what's included in plan of care and the way the NQF domain is defined for plan of care is very comprehensive and very wide. It includes, you know, everything from patient assessment and self-assessment to needs assessment by the provider to follow-up and all that kind of collapsed within one group.

If we map it to the AHRQ definition you start to see that there's a little bit more granularity. So an example of

one would be looking at the transitions between settings and transitions of needs. And the difference there is that a transition between setting and the AHRQ definition is what you would think of traditionally, hospital to home, home between ambulatory provider and specialty provider, something like that. But transition needs is the development of measures that really think about patients as they move from one set of needs to another. Adolescent into an adult care setting, right? Early elderly into more of a geriatric population, whatever it may be. So there's much less measurement that's happening right there. Similarly when it comes to measures that try to attempt to measure whether or not resources are aligned or whether or not there's any linkage to the community, again, very few measures and that probably links to a lot of the things we were talking about before which is some of the data considerations and things like that where it

becomes difficult to really develop measures that are really capturing some of that. Next slide.

So, where are the gaps when we say electronic measurement? And the thing to think about here when I present this data is when you see electronic measures those are things that we've identified primarily through the Gray Literature or from other NQF projects and things like that. These aren't measures that are publicly easily found or for anybody to pick up and use but what it's start showing is that where we do see electronic measurement may be the potential for some of this pull strategy of people that would be willing to submit measures, but it also starts to show where there's not even in much electronic that's been proposed so far. So, these are hundred percent bars.

So this is according to the NQF definition. And what you find here is that where there are most electronic measures fits

within information systems and that would be what you would think which is essentially measures of structure, right? Do you have a medical record that does these four things? Do you have patient -- does the patient feel like they have a medical record that has covered these eight elements? Things like that would fall under the information systems and that's why there's a lot of electronic measures there because most measures are structure measures that fall within that. Otherwise, for virtually, for transitions, communication plan of care, health care home there's very few, right? The percentage of measures that are electronic become very small basically across all domains. If we do this by the AHRQ definition, again the same thing. Very few measures would be considered electronic in many domains and there's almost none in certain domains such as interpersonal communication or establishing accountability, aligning resources in the community. So, what

I think this starts to paint the picture of recognizing is that when -- this environmental scan will show that there's a variety of measures around care coordination, very, very few are electronic and the areas that we have measurement gaps in already when we think about electronic measurement gaps in those areas it's even a bigger problem.

And so this addresses the second question I had and I've alluded to before was does the availability of the measure help frame how we think about these gaps. And by availability I mean has it been published and is it available to somebody looking for a measure to use. So if we do this by the NQF domain you can see how big of a difference it is, right? The number of published measures is tremendous and plan of care again, very high, as I said before, because that includes all the patient experience work. But when you look at published electronic measures they're very small slivers, they're almost none for

most categories. And then the same thing holds true for the AHRQ framework on the next slide here. Which is, again, many, many measures will be published and may be available, but if you only take the published ones that are electronic, again, it's a very, very small number that are able to be -- that are available to anybody who's looking to do any measurement. Next slide.

So, how does the use of the framework alter the analysis? And this starts pointing to whether or not thinking about whether or not what framework is used to think about these measures in this current project affects whether or not you address measurement gaps that exist currently across the spectrum. So the first one I'll take as an example is that proactive plan of care, right, that big catch-all category that existed for the NQF framework was actually relevant and mapped out - and this was, AHRQ maps this out actually even in their document to these five

coordination activities as well as this one broad approach. So then if you start looking at measure mapping within each of these categories you start seeing why grouping it in that one large category starts to miss a lot, and that's the next slide.

If you look just at the proactive plan of care you'd see that there was 80-some measures that addressed it, that you know there's over NQF-endorsed measures for plan of care. And there's even, I think there was eight electronic measures that are -- fit within the plan of care. But then when you start doing it across all those subcategories, when you mapped it across the AHRQ, most of those measures are in monitoring, following up and assessing needs. And assessing needs tends to be patient experience of assessment of needs and monitoring follow-up tends to be kind of a general transition to a lot of claims-based measures of follow-up. You know, two week after TIA, cardiac rehab after AMI,

things like that that start falling in that group versus linkage to community, care management, much, much less measurement and almost no measurement when it comes to NQF endorsement or things that are published and electronic. I also did this then for the communication group. It was a very important ones, everybody's always mentioning it in a variety of ways and it mapped out to two, really three of AHRQ coordination activities because they separate what is interpersonal communication, face-to-face, interactions between individuals and informational communication which is the actual transfer of certain data elements, and then a care management broad approach. And again if you look here what happens in the next slide is that communication has 40 measures in the broad domain, very few NQF-endorsed and then I think only one is published in electronic. But then when you start comparing it to the subcategories we see that interpersonal

communication and information communication both, I guess, information communication, sorry, has the most number of measures and this really comes down to, again, things such as -- I'm trying to think of the best classic example of that measure that would fall into that. Data elements included at discharge from hospital. Some of the transitions measures that were included last time would fall into a lot of that. Very much less about care management and on establish accountability I think this is interesting and probably worth some discussion later. There's a lot of measures that map to establish accountability but that doesn't mean I think that it meets the way everybody in this room probably is thinking of establishing accountability. So for example, if you ask a patient if they can identify their clinician, right, then that type of a measure is considered an established accountability measure. But that really doesn't get at a lot

of ideas and themes that you guys have discussed with respect to care coordination. So I think when we see a lot of measures in establish accountability as you see these slides and if you look at these again in the future I would take it with a grain of salt because a lot of that is not necessarily getting to what really is an idea of shared accountability or negotiated responsibility and things like that. Next slide.

So I think this is the last question I asked which was do the gaps defer based on the focus of measurement. And that meant, by focus I mean whether or not it's condition-specific or broad. And so what you see here is that not entirely surprising, plan of care measures is the place where there's a lot more condition-specific measures than broad measures. And that I think is largely driven by a lot of the claims-based measures that look for follow-up. And that's just the easiest way to do that. And also not

surprising, any measure of the health care home is not really condition-specific in general. Actually, the one that's condition-specific here, it was specific to children with special health care needs and one other condition that I can't remember what it was offhand. But in general across these what we see is that most of the condition-specific measures are in a specific plan of care and I think that that'll probably hold true as future measures are proposed as well. If you do this by the AHRQ framework, again, most of the condition-specific measures are on monitored follow-up and monitored follow-up again is usually transitions between settings and there's very little when it comes down to alignment of resources, the linkage to the community. In general, most of the measures when you map it across this, I think it diffuses some of that plan of care and follow-up. So the reason there were so many in planned care by the NQF analysis now gets

diffused across four or five categories here. So that's why it starts to look like the number of condition-specific measures are about the same across the domains. Next slide.

So what are some of the key findings? So, from the descriptive analysis I would say that most electronic measures are not formally specified or published. So while I was able to map them, those electronic measures, that doesn't mean that there's a clear numerator, denominator statement, or a lot of things that we would think about in terms of traditional measure specification to make them usable for anybody. So the question becomes is there an electronic set of measures out there that we just don't know about. Almost all the measures are process measures and I think this then gets to both a semantic game as well as meaningful kind of thought game around what is an outcome measure for care coordination. The one that I include as

an example is drug-related morbidity associated with drugs that need a high amount of prescription drug monitoring. And so actually, the outcome that they used within the measure that's reported is the actual drug-related morbidity. But are some of these other processes, rehospitalization, emergency department visitation, are some of these other things also outcomes measures? And I think that that's worth thinking about because it really -- what kind of guidance a measure developer gets around that will have a big impact on what they feel they can submit or not submit into the consensus development process.

And then most measures right now are patient experience surveys. That's the vast, vast majority of it. And then, so given that, how can you comprehensively measure activities across the spectrum when the majority of available measures take only that small sliver of the whole process and there's

a lot of measures right there, there's a lot of overlapping work for that little bit of area. Next slide.

This is my kind of what I think has been the timeline of care coordination measurement is that the '80s and the '90s were a lot of patient experience surveys because that's what was kind of doable by data. Then that has started to move towards a lot of condition-specific claims and measurements. So I think that that actually will be where -- go ahead and click -- where we are right now is in that area. And that where this could move to is more of these medical record-based or activity and process thinking about different measures. But I'm not sure we're like, there's not really much to say that there is something to use out there right now. And what will be interesting to see is what happens if somebody proposes a patient experience survey in this consensus development project. You know, do you want to

continue to include those types of things in a discussion and review them, or should the process really move towards the other end of that spectrum? Next slide.

One thing I found challenging was where to put information systems in this. We have it in the 2006 framework as a separate domain but in reality I think the discussion is and a lot has happened since 2006 is that it's more of a crosscutting foundation. It's a type of infrastructure that is necessary for all these different kinds of measures. So to simply bucket measures in there I don't think is a very useful thing, or useful way to think about it. There's definitely the need to consider sub-activities. I think looking at that plan of care mapping shows you that, where you can miss things if we use too broad of a group. And then the other thing to think about is is there a model out there that is better suited for measure mapping. Is there something that is more sequential or more

comprehensive where you can actually take measures and put them into mutually exclusive buckets to understand how well you've covered care coordination as a whole? Next slide.

So, in conclusion, the main gaps would be a lack of electronic measures and in certain measure areas it would be those with respect to the health care home, transitions within the ambulatory setting. There's a lot between the hospital and the ambulatory setting. There's very little that goes at the referral loop that happens within the ambulatory setting and as more and more things happen outside of the hospital setting the importance of those measures becomes increasingly important. There's really nothing that starts to get at community linkage and understanding how community resources play into care coordination as well as transition needs.

And then I think the last kind of thing about gaps is how do you get beyond the

patient experience survey. And a lot of people have kind of mentioned this today which is instead of it just being did you do patient education or did the patient get an experience survey is did they actually understand it. So is that patient assessment, is that other forms or ways of measuring whether or not you're getting true person- and family-centered care. And I think that those are probably the areas that have the most room for improvement but it would be interesting to hear from everybody if they're aware of any measures there and particularly ones that are in the close term and being near the point of development where they'd be in the next project. I think that's it.

CO-CHAIR CASEY: So Arjun, thank you very much. This is a lot of hard work and we want to be able to be sure we get some questions here and comments. I think that we will do our round table after this but right now I want to focus on this presentation and

get your reaction and comments. And let's just spend a few minutes doing that. So, go ahead.

MS. ALEXANDER: So the eMeasures, the lower number of the eMeasures I don't fund surprising at all. Whether that's NQF-endorsed measures or other. And if we think about particularly right now in the industry as related to NQF-endorsed measures that we're in, you know, a process of retooling current NQF-endorsed measures into eMeasures. I mean this is a very huge undertaking. So were you I guess aware of that and was any consideration given to that in terms of the results here and what you're reporting in terms of gaps?

DR. VENKATESH: I think that that exactly is what makes sense, is that what -- I think that the industry right now. I mean, it's all very new. And so as these measures do get retooled I would anticipate that a lot of those measures that are currently

classified as not electronic would hopefully be then, could be classified as electronic and would change that. My guess is then is that then if you think about kind of globally where some of those measures are that those will be still some of the gaps. So we don't really have many measures, for example, to measure community linkage. So, as we retool current measures to go electronic we're still going to have a gap with community linkage afterwards. But I'm sure if I redid this in like 12 months it would be completely different.

MS. ALEXANDER: I would agree. And I think the other aspect that's going on in the industry too that will help support this initiative of retooling the eMeasures and creating standardization for some of the data and information-sharing that we were talking about earlier is the quality data model which I think there's actually a webinar on today from NQF, and then the measure authoring tool for stewards as well too. So I see all of

those activities supporting measure development and then particularly for eMeasures as well in the future. Thank you.

CO-CHAIR CASEY: Yes, Karen.

DR. FARRIS: I would just comment that the segmentation of the proactive plan of care is probably the most profound to me personally because I did serve with a few people in here on the first committee and that just became a big bucket. And maybe sometimes we weren't exactly sure, you know, we'd put it there. So I think that that's very insightful and I think helpful to this group.

CO-CHAIR LAMB: I'd like to echo that. First off, for somebody who isn't familiar with care coordination literature I think you did an astounding job. The other question is when we're going to get this so that we can see, you know, the groupings. But what struck me was the granularity, you know, and I think you pointed that out. And just based on your experience in working with the

hundred and some odd measures whether you think that the granularity in the AHRQ mapping will help us not just look at gaps but be clearer on where there's value in filling those gaps.

DR. VENKATESH: Yes, I think you know, from the developer of measures perspective I'm wondering if what you're alluding to now when it's more directed, it's more granular. If your measure fits within that it may almost to some degree drive more measurement development because people feel like it fits that bucket versus something like proactive plan of care can seem so broad and so much more difficult to capture within a measure. So I could see maybe using some of this language or even incorporating some of it into the call for measures to help guide measure developers so that it makes it easier for them. Having been on the measure development side I can totally see how it would be a lot easier to follow something that

helps categorize it for me as opposed to having to come to the table and try to categorize it when I know that there's 40 definitions, 55 frameworks in the whole world out there.

CO-CHAIR CASEY: So, I want to point out a nuance here that I think is important. And I think it may be obvious to some but I'm not sure it is to everyone. And that is distinguishing between what you call HIT and data standards. Because I think that somehow or another data standards sometimes get rolled into HIT and I think they're related but different. But that is probably symptomatic proof of your findings, that we don't have these data standards. So I wonder if you could comment on that distinction in your presentation and maybe call that out a little bit more clearly.

DR. VENKATESH: Yes, there's like a pool of measures sometimes that were probably classified as administrative claims

measures or got classified as chart review measures and the reason being is that to capture the information necessary to know if somebody had appropriate follow-up and something was done at that follow-up for example requires multiple data sources. And part of that is based on the data standards that I think go into each of those data sources. So you can always know that somebody saw a doctor of some sort after they were in one setting, or you can know that somebody went from a primary care doctor to a specialist and saw a primary care doctor again, but if you wanted to know was there a consult report mailed back you'd have to do a chart abstraction. And so I think that that is a place where to some degree there's, you're almost there with, you have part of the data standards or you have part of the data elements in something that is electronically abstractable but then a little bit more is not. And I guess what would be interesting is

if when you put it back to measure developers, you know, what's the standard going to be? To be considered a measure that's electronic, right, everything has to be found and how electronic I guess.

CO-CHAIR CASEY: Other questions? Anne-Marie.

DR. AUDET: It may just be me but I'm a bit confused about two things. One is the distinction between a measure where the source is electronic versus the information system that is the domain of a preferred practice. I'm having a hard time kind of putting this together but it may just be me.

CO-CHAIR CASEY: No, it's not about you.

DR. VENKATESH: I think it's challenging. If you go back and you look at the paragraph that's written after information systems from the 2006 document and then you look at even the discussion in this AHRQ document about health IT there's a lot of

evolution in there and that happened between '06 and '10. And I'm sure if you looked at it now, and I'm not by any means a meaningful use expert and knowledgeable about everything that's happened in that gap, that language has evolved even more.

I think the way I thought about it to some degree was there are measures of these kind of do you have an information system that is able, and these are just structural measures of, you know, can it help with care coordination. You could have this information system and these structural measures and be horrible at care coordination theoretically. And then there are measures that are measuring some coordination activity, follow-up, medication management, something like that that are abstractable electronically. And they're definitely two different things. My guess is the former group though -- it's very hard to have the latter without the former so maybe that's a way of having them both. But

I think that those, when you think about it in terms of like the NQF domain for information systems when I mapped it both those fall in the same bucket.

DR. AUDET: The reason I'm asking this is because if we're thinking of the path and trailing the path at some point are we looking for measures that would be only available if you had this domain of health information technology and not available, like having information about a patient from all team members at the point of care. That's going to be impossible with paper. So I'm just thinking about the path. Are we, you know, getting more -- calling for more advanced measures that are even, or there could be some that are only available if you have the information technology, or those that could be both.

CO-CHAIR CASEY: My guess would be -- Helen, help me out -- that if you had measures like that they would be highly

preferential in the endorsement process, not to the exclusion of the other measures.

DR. BURSTIN: Yes, it's a really interesting observation. I think that we want to make sure there are measures out there that people can use but we also want to recognize there are measures out there for systems that are capable of using them, that we don't want to push out measures that feel, I don't need this, I'm way beyond this. So I suspect we're going to wind up with sort of a binary set, one that's probably more suited to those who aren't quite -- finished that HIT journey. I don't know if you ever finish it. And ones that actually really are more for the advanced systems.

And just a follow-up comment as well about the retooling aspect of it because I think it's a really interesting comment. One of our concerns though is that when we retool measures developed for another data system is you are kind of doing that junk in

the -- looking for your keys under the lamplight. You're still sort of operating under the idea that this is what I have available and I'm just taking the measure as I had it and I'm using the data standards in an EHR to create it. And I think we kind of want to also get to measures where de novo you say like some of the advanced health systems who've created measures with their HIT systems, these are the ones you can only do, and I can develop this because I know what I have in front of me. We thought about what was most important and then we looked to see if our data model could support it as opposed to the other way around.

CO-CHAIR CASEY: Does that help? Okay, Jeff, were you going to?

DR. GREENBERG: I think Helen hit a lot of what I was thinking. I mean, it seems like having a domain of HIT would hopefully be obsolete soon, that we could just measure things electronically and you can't,

you know, it's hard to step up to the plate if you can't do that. And therefore it sort of assumes that you have electronic systems in place if that's how we're going to measure you. But I do see that you can't do that right away.

CO-CHAIR CASEY: So you could see like the patient having like the NFL quarterback, the care coordination on his arm there? That's still usable. You know, the quarterback's got all the plays, right? I'm kidding.

MS. POWELL: Thanks. Along the lines of what Helen was saying about -- and really using this as an opportunity to look at what do we really need to be measuring that's going to be helpful. I think Arjun in his presentation asked the question what do we mean by care coordination outcomes and that's been a question rolling around in my brain all morning. What are we really after? And I'm not sure we've answered the question. And it

seems to me like we really need to answer that question before we go much further if we're going to focus to any degree on outcomes. And it struck me as I was looking at some of the materials put together since a lot of great work has been put together to identify the domains. Perhaps there's a way to take the domains and look at them and say okay, what is one outcome for each of these domains that would really give a clear picture that the domain has been addressed as an outcome? And I don't know what those would be, but to me that would be a way to really start moving toward outcomes, some of which may be able to be measured using electronic means, others of which maybe not, and some of which may require multiple electronic data sources that we have no way to link at this point. But that to me seems a little bit more progressive and moves us away from looking at like some of the measures that were endorsed because that's what we had at the time. The cardiac rehab

and all of these things that are very, very specific to a very, very specific patient. I don't know, that just seems to me to be moving us a little bit closer to having these measures apply to all patients as opposed to just a very small subset.

CO-CHAIR CASEY: So it's a very good point, Eva. I mean I have this practice with my team of when people have great ideas putting them in charge of helping us to define what it is they are. But as I'm thinking of it I would guess things like improved health status, functional capacity, quality of life, obviously some clinical endpoints as well would just off the top of my head be things we would want to start thinking about. Knowing that probably none of these measures may actually have these as endpoints yet. But is that sort of what you're thinking?

MS. POWELL: I think so. And again, not having taken that specific a look at this yet, but like I say, perhaps looking

at those things, and if we needed to get more specific look at, say, health care home. What really is the outcome that we're after in having a health care home and make it very specific to that. And some of them may be some of the things you just mentioned. But there may be others. I think where I have trouble is defining what is really a care coordination outcome versus what is just an outcome measure that we should be measuring anyway. I don't know.

CO-CHAIR LAMB: Eva, that's a really critical point I think that we really need to deliberate on in the discussion. When we go around you'll have an opportunity to talk about that. But that moves us towards a premise that care coordination is really central to all outcomes and it runs the risk of if it achieves all outcomes what doesn't it achieve and how do we know it which just makes it really complex. It is such a central function but we've got to tease out some of

this. So we'll have that opportunity to go around and talk about it. Does anybody have any more questions about or comments? Jeff?

DR. GREENBERG: Yes, I totally agree with Eva and I'm glad she brought that up. I think we need not just outcomes but useful outcomes for this process. You know, something like quality of life is clearly an outcome but I'm not sure that's necessarily going to be useful in terms of how we evaluate measures. You know, that's, as you said, that's sort of an outcome of most of what we try to do in health care. So we need outcomes potentially, it's, you know, use of the emergency room, use of admissions, et cetera, that directly, you know more closely relate to these exact things we're talking about. Because some of the high-level outcomes that really do matter to patients may not necessarily guide us that well in terms of the processes we want to try to make standard.

CO-CHAIR CASEY: Tom.

DR. HOWE: Yes, before we start to assign outcomes to some of these domains I think it might be worth thinking about reordering some of these domains into the old paradigm of structure, process and outcome. And some of these domains I think as Jeff was alluding to are really just structural. You can't do care coordination that's essentially measurable or up to I think community standards without HIT. And some of these I think are enabling the process, that care coordination is a process and we need to define the subsets that allow us to measure that as I think we started to do. But once we define those then we can link outcomes to them.

CO-CHAIR CASEY: Yes, you know, Tom, very well put. The harkening back to this and Chris and Karen, maybe you can help us recall this. I think what we were, when we were sort of with a complete blank piece of paper on this we started defining it in terms

of what we thought critical elements of success might be from our own experience. And you know, obviously there was a lot there but things like community-based social services and the like were things that came to mind. But as you point out those are not outcomes. So, I think that balancing the structure process and outcome is going to be critical because you can never get to outcomes without knowing what it is you're trying to focus on with what you've got. So I think it's an elegant thing to keep in the back of our mind. Because it's very easy to jump to outcomes and just talk about that and not backfill with all the necessary ingredients needed to achieve improved whatever. So. Yes, one more question and then we're going to --

DR. AUDET: Well, I think in this, I really like also the process -- the structure, process, outcome. In reviewing the documents you sent there was a whole review of the literature on the impact of care

coordination. And I was struck by the fact that there's not a lot of evidence except maybe for transitional care. And so that is another challenge that this discussion you know poses is the evidence available to us. And there's another really great review of the literature on the cost of care coordination by Alfred Weit where he also shows, he's done a really comprehensive review of the literature, that we know about the cost of not providing good care coordination but we don't really know what the impact of good care coordination. So I think in this discussion maybe this structure/process/outcome will be a good way for us to anchor because if we base it on the evidence we're going to have some trouble.

DR. BURSTIN: And just one follow-up comment to that. That's actually really important. I think the other issue is that when you're going to get to look at measures, when that happens sometime this winter you're

going to need to look to see if you think there's evidence for the measure focus. So in some ways even if you may not necessarily be bringing in the outcomes of each of these domains and as I scan through it it was a very useful exercise. You're right, most of these do lend themselves to process, Tom. I think the issue still is going to be, it would be interesting, even if you think they're the right processes that are highly linked to outcomes we at least need to think through what those outcomes are to see if the evidence exists that that process is outcome-based. So it's going to come up anyway. I'm not sure they're going to be the ones that you're going to bring in in this project per se but I think you're going to want to be able to start thinking about how to judge those processes.

CO-CHAIR CASEY: So let me before I turn it over to Gerri say one last thing about evidence. Those of you who know Gordon Guyatt may have heard him teach this.

Gordon's a big master. He's one of the godfathers of the grade system, obviously, involved with Cochrane and the like. And what he taught me was that we have to be careful about saying there's no evidence. What we really mean is that the quality of evidence is very poor or low to support our hypothesis. And so there's a lot of good evidence -- I'm sorry, there's a lot of evidence that there's stuff going on. The quality of whether it actually achieves its intended effect is low or poor at best. So I just want to -- that's my pet peeve I realize but I get nervous when people say there's no evidence. I think we should just be mindful of that in our deliberations. So that's all I'll say.

CO-CHAIR LAMB: Okay. Here's your opportunity now to answer the question that we've been asking all morning which is what is really important to measure. So, if you would take just a few minutes and jot down you know what you believe is important on a go-forward

basis, keeping the theme here in terms of we're not retooling the same old, same old. We're trying to advance the thinking in this area. Is if you would jot down what do you think is important here, what should we move forward as we go from. This is stage 1 remember, where we're looking at what is important to measure to frame the call for measures. So take a few minutes, maybe just a couple and jot down. And then we're going to go around, everybody will have an opportunity, and Lauralei will be keeping track of these. So we're going to ask you if you can and we know this is difficult, keep your comments as brief as you can, but if somebody has already said what you think is important just kind of say "And I agree with" so that we can keep moving around. Because this hopefully will give us kind of the foundation for the discussion of framing the call for measures which will move us from this stage ultimately into stage 2.

The other thing is as you frame your comments about what's important, if you have any thoughts about this discussion about outcomes or available measures please bring that up then so that we can kind of use this as our chance to tap into your expertise. So just take a few minutes and write down what do you think is important. What should be on the table here.

CO-CHAIR CASEY: And Gerri, why don't we let our colleagues who have to leave early maybe go first.

CO-CHAIR LAMB: Everybody had a chance to jot down their ideas? We're good? Anybody need any more time? All right. Let's start down.

MS. LEWIS: So there's been so many great things said today and I'm going to try, because so much has already been said, to just try to add a little bit from my perspective on this. So the two things that come to mind for me, one is some sort of

metric of taking the whole person into account. And what I mean by that is that I think often that 10 minutes in the physician's office has very little to do with what is going on with that patient. And so as I said earlier, we work with patients in the home, from the home perspective. And what you learn in 10 minutes in a patient's home is very, very different than what you learn in the patient's office, or in the physician's office. You know, whether it's that, you know, the roof's falling in or there's no caregiver or, you know, there's shots being fired out in the street. You know, there has to be some mechanism in care coordination to understand that whole person perspective.

And that kind of leads into my second comment which is I think sometimes when we write performance measures we inadvertently keep ourselves inside the box of the current system. We don't mean to but it's how we all think and so that's what we end up doing. And

to that point I want to make sure, and I actually haven't heard this much today so I'm just, but this is just from my own -- so that I say it. I think it's really hard to look at the physician as the person who's going to do all this coordination. It's expensive, they don't have the time, they're in short supply. You know, they certainly, it's hard to get economies of scale in physician's offices. And so I guess I just want to make sure that as we think about who's going to do this care coordination that we're open to all the different, whether it's community, you know, home care, whatever it is that we leave that open and we don't kind of inadvertently put ourselves in that box.

DR. CARRILLO: I think that something that came up earlier this morning is that we're kind of limiting our vision to that narrow slice of the clinical interplay between hospital, home, you know, primary care physician. And I think that in terms of care

coordination we have to begin to define measures that go outside of the comfort zone that we all have because you know, we've all been around those institutions and have been patients. I think we need to figure out how we're going to capture the family involvement and how are we going to begin to capture the involvement of the homeless shelter, the CBO, the church activity, you know, whatever these other points of contact that are most important for the person. So I would widen that scope.

CO-CHAIR LAMB: And please remember, too, if you have thoughts about outcomes or measures to add that as well. Do either of you want to add anything to that? Eva, hang on just a sec because I think we're going to go over here just so that we can capture your input before you leave. Anything else from both of you that you wanted to just add?

DR. CARRILLO: Not right now.

CO-CHAIR LAMB: Okay.

DR. WAKEFIELD: So I just wanted to comment on the previous speaker's comment about HIT as a foundation rather than a measure. Because the chart has become a billing and legal document and not so good at telling the patient's story. And furthermore we've taken the paper record, a bad paper record, and translated it to a bad electronic record. And so you know, you really can't get the patient's story out of their record anymore. And I think it has the potential to both do that and allow for efficient data abstraction for measures. So, I think what's important to measure is this patient's story. So I would support this shared plan of care which is updated on an ongoing basis and I think by recommending measures like that it will force HIT to redesign, to be able to do that. Because as-is, you know, it's just done the way it is, the old paper record. So I think we need to look at how, what, sort of

shoot for the sky, decide what we want and then have the infrastructure respond to make it fit.

CO-CHAIR LAMB: Eva?

MS. POWELL: Thanks. I actually agree very much with Bonnie's comment. I hope that this group will really think outside the box because so much of what you said about EHRs is what we struggle with meaningful use, is what do we want to have happen versus what is possible today, and there's a huge chasm. And I also want to agree with Julie's point about, and I think this has been addressed a little bit today, but I think we do need to bear in mind that the vast majority of care coordination is really not a physician function, that it's certainly a multi-disciplinary function and at least in my experience working in a hospital very few of those functions actually get taken care of by physicians. And that's not to minimize their importance in creating, say, a care plan but

just, we will have totally missed the boat if we really zero in on physician activity here.

But in terms of what I think is really important to measure I tend to be a very concrete thinker sometimes and so I did kind of outline some measures that are out of the box. And I have no idea how we'd actually go about measuring these, but since we are where we are I'll throw them out there. One would be consistency in making necessary linkages to clinical and non-clinical supports. Another would be effectiveness of a continuous feedback loop between patient and caregiver and their care team members. And then the third that I came up with, and these certainly are not comprehensive, would be patient and caregiver experience of care coordination. And that's probably the one that's closest to being an actual measure, having actual capability of measuring. And forgive me for my lack of knowledge of details of what is out there, but I guess the

difference I see here is I think it's important to measure both patient and caregiver experience and to at least stratify the results by those two different categories, and then have that be overall care coordination, not just care transitions, although certainly care transitions I think would be an important point to stratify as well.

DR. MCNABNEY: So I'm going to build on a couple of these comments. So kind of along the non-clinical theme I think, when you think of care coordination over 99 percent of what patients do is by themselves and so to the extent that care coordination has an impact on that non-clinically supervised setting. So the carryover of clinical expertise and how we measure that I think is important. So I think the patient's understanding of what care coordination is and its value. One, conveying it, and then measuring that impact and its registering with

the patient.

And then going back to the statement of goals of care, something that we as clinicians and everybody in health care throw out which is very, in a real sense is quite a vague term. So I think of the ability to articulate in a structured way, or at least have documentation of goals of care and how that plays into the -- using care coordination techniques is important. So as far as outcomes I was thinking one process outcome would be tracking of adherence to goals of care with regard to self-management and patient preferences. And an outcome measure would be adherence to those. What they're collected and documented or noted in a care coordination model would be adherence to those as stated.

CO-CHAIR LAMB: Before you move on, for those outcomes are you aware of any measures out there that we can look at related to adherence to goals of care and self-

management?

DR. MCNABNEY: So, I think it's a real reflection of how -- I mean if you read, as all of us do, recommendations for patients they talk about, even in the documents we've looked at today, goals of care. And I think that that in itself is so vague. So I think if, I mean it could be as simple as a practice having a mechanism to establishing, you know, it could be an internal process and then a documentation of -- so to answer your question, I don't know of data that's shown that, but I think you could think of a practice- or a health plan-specific way of doing that and how well they adhere to it which I think would be more realistic than sort of a national plan.

DR. LEE: You know, looking at this issue I first asked myself the question, well, what do these domains mean. And it's kind of interesting. Health care home on page -- on one of the pages here it says "Patient

has an opportunity to select." Well, that means there's a selection process for this. This is not an outcome measure we're talking about just to have a home. And tomorrow it could be something else. So I think to me -- and I'm a very concrete person, I apologize -- having a plan for every patient, work on transitions to avoid quality and safety issues that happens along the way, and really ask the hard question how does IT help us to get there. Those are two pieces that have some concrete progress over time and it's likely we'll have more refined literature around how to look at these two issues. And then the IT issue really is about how to help with that. So that's my opinion, just to look at what we've got today and make improvements.

MS. LOVE: I think I'm coming at this from a different, way different perspective. So I'm just going to put it out there. My perspective is measurement precedes the science so many times. I mean, it's ahead

of, it's really a political statement and that's the arena I live in. And yet those political statements, the science should catch up and it will catch up but that's how we transform the system.

So when I think of all the discussion today I did some thoughts. If I were talking to legislators tomorrow in a state which I probably will do next week it's why should you invest in care coordination? Because they're cutting social services right and left. And so we're fighting a fight out there. So I need the measures to say this absolutely reduces the cost or the resource use, either upstream or downstream. So, you know, I'm fishing for that magic sweet spot where you can say, you know, by investing X dollars you can save. So, it really is that return on investment, but also reduction of complications and readmissions. So that begs some sort of person-centric linkage.

So then that begs sort of a

community capacity that I'm looking for. What's the community capacity assessment? If I have a patient in Kaiser that has nowhere to go out in the community, you know, am I talking to public health? Are those hubs and connections made so you can do tradeoffs in a more, maybe a non-traditional way outside of an ACO or health care setting. So some sort of capacity for what the linkages are within the community, maybe a score of this is a sharing community, or a collaborative community versus, you know, a siloed community, I don't know. I'm brainstorming again.

And then, you know, there's patient factors that I look at. And this gets back to if I see a failure of care or a bad outcome and medication not filled, or non-compliance, what is the patient's insurance like. You know, what's the socioeconomic. And so that begs sort of a patient risk score and we talked about that earlier today, or

just buckets of types of patients that might have extra care coordination considerations. And just like we worked for a decade to get present on admission on hospital coding and some of you can throw things at me, I foresee a day where maybe in these transitions we have a code for present with records on admission to a hospital. You know, so I really think that is possible in this new world. And so I keep thinking of Steve Jobs and saying there is an app for that, we just have to be creative and think a little outside the box. And so I'm not coming at it with absolute measures. Hopefully I'll come up to speed.

But I'm thinking more of the infrastructure needed both in the community, in the health care system and also if I were working with a provider system, just as an unpaid consultant, you know, is there an assessment of a provider capacity, you know, or a payer capacity system that, a checklist that they could do a self-assessment and say,

yes, we have the capacity to do these things or we don't and that's another measurable sort of thing that could get us along that way. So these are just some brainstorming ideas I came up with.

MS. ALEXANDER: So to build upon what has already been said is that, you know, why, first starting off, why we need care coordination. Because I really believe it is the function that is what is needed to manage and achieve not only individual health but population health. And care coordination is dynamic. The plan of care as I see a part of care coordination is dynamic and it's really based upon the patient needs and it is not owned by any one discipline but as what's been previously stated, that it really needs to be touched upon and driven by all of those care team delivery members that are actually touching and engaged with this patient across all care settings. And we need to think beyond the traditional settings into the

church and other community settings as well too. So again, at this point I don't have any specifics on specific measures, but I'm sure that will come soon here in my thinking as we continue discussion. Thank you.

DR. MALOUIN: Hi. So I think, you know, all of us in this room have spent a good deal of time looking at the evidence, sort of trying to come up with conclusions that are consistent and most us have probably found that there is a lot of inconsistency in the evidence. There's a lot of people doing a lot of things out there, but there's not always a common set of elements that is, you know, yes indeed this is what's shown to be successful. And now we're starting to get those. We're starting to get like with complex care coordination, you know, close to the doctor, medication reconciliation, attention to transitions. So anything that's moving forward needs to really emphasize the common elements of the literature that we've found.

And I have to tell you, you know, middle America, all of America, the people who are actually doing this stuff, they don't know the evidence. They don't read about this stuff. They just know what they've been doing for years. And so I think it'll be most helpful if we come up with measures that will actually, that aren't sufficiently vague that they're subject to a lot of different types of interpretation. For example, care plan. I think that's something that always comes up and it's been pointed out here that that can mean a number of different things. So what is it about a care plan that's important? It should be X, Y and Z. Obviously those things are hard to measure sometimes and that's I think what the barrier is. But I think the more we can use these measures to actually help drive the way people care for patients I think that will be in our best interest. Because we, because people really don't know what's -- they don't know what works, they

don't know what doesn't work. And I've been living this for the past year so I know this.

Measures such as transition care, you know, we all know now that transition care is thought to be helpful but what does that mean? It means a million different things to a million different people. And so you know, we look to things that are measurable. Like for instance, PCP visit after hospital discharge. And those of us who know there might be better ways to do that, but that's all we have because we have claims data. Can we come up with better ways to measure things that will be meaningful and that will also drive the behavior that we know does work?

I think, you know, one of the problems is that we've all talked -- I'm not going to elaborate on the EHR, the HIT problems that we have, but there's so much variability in what vendors are offering now that it's often impossible to try and come up with a common set of elements. And hopefully

I think the intention of meaningful use was to do that. And it sort of got caught up in the politics. And hopefully the next generation of meaningful use recommendations that come out will be more meaningful. But I think we really need to get EHR vendors onboard and perhaps that's a way to do that.

And lastly, as far as specific measures I'm probably going to kind of go against what I just said about being as specific as possible because I think that we also shouldn't ignore both the patient experience of care as well as the PCP experience of care. Because as a family physician I know when my patient's care has not been coordinated. I mean, I just know and the family knows too. They don't know exactly what went wrong but you can tell. When a patient leaves the hospital, you know, they know, or actually when they get back to their PCP they know whether or not their care was coordinated. They don't know what should have

been or what shouldn't have been done, they just know that they felt like they were thrown out into a big black hole. So I think that even though maybe we're trying to get away from those surveys I think we don't want to lose that patient experience.

CO-CHAIR CASEY: Let me just jump in and tell you a little anecdote that Wendy mentioned before. I have this fantasy of having a patient experience measure which relates to the patient satisfaction that they just had to be readmitted to the hospital. I wondered what the performance on that one would be. So I hear you.

DR. HOWE: I think we're at the point where we need to focus on measures that will enforce the process piece here. The coordination of care is really about the plan of care, or should be. And one of the highest priorities I think is to develop some standard elements that are part of that plan of care so you know one when you see one. And that would

be, the professional societies and other groups including community resources to decide what are the standard elements in a plan of care. Because you need that plan of care as the hub of the wheel of all these other spokes that we're talking about. Is there a transition plan from hospital to home? Is there a closed loop from that referral to the specialist back to the PCP? Is the family preference and the patient preference recorded and operated on in that plan of care? Are the conditions that are associated and certainly with the complex patients captured in that plan of care so that you have the total picture. And with that, once you've gotten and you need an accountable team leader. It doesn't have to be the physician, but somebody needs to be accountable for maintaining that plan of care and having that relationship with the patient and the family. From there you can then get to some outcomes I think.

You can certainly then focus on

what does the patient think happened to their plan of care and you should be able to structure that such that it's not a huge effort to capture. And you could also ask the providers did they think they met the plan of care. But there are metrics out there now that would essentially roll up to some sort of adherence score, medication adherence, referral completion, visits after some transition of care, lifestyle changes, preventive health adherence. I mean, there are a whole slew of measures that can be rolled into a bundle that indicate that somebody's care is being coordinated.

And we need to keep track of care coordination ability. There are going to be subsets, there are populations that don't trust their caregivers, they don't speak English, they don't have a relationship and working in the form of a team, they have, you know, outreach fatigue. They don't want to hear from anybody. Leave me alone. We need

some way to capture, you know, that there's a spectrum of impactability that's going to -- that might adversely affect a provider's measurement in their being able to achieve whatever this outcome goal is. So we need to capture that as well in some sort of risk adjustment. I have no clue how to do that.

CO-CHAIR CASEY: And Tom, you don't know of any particular sources that we could tap into that have anything near what you're talking about?

DR. HOWE: I do not.

DR. LYNN: So I can think of a couple of sources that might get at some of what Tom was just talking about. The Council of Medical Subspecialties of the American College of Physicians has had a group working on what they're calling the medical home neighbor where they have been defining what some of the elements should be in the correspondence between a primary care physician, a consultant and back again to make

sure that information is passed in a clear way. And they've been doing some on-the-ground testing of those. There's also a group out at UCSF in their safety net hospital at San Francisco General working on an e-referral system where they've done some publishing I think in JGIM. There's been some really nice stuff out there.

A couple of thought that I had build on what Eva and Matthew were saying. I think continuing to go to patients and to family caregivers to ask them if they have the knowledge and the resources that they need to provide care is something that's going to be important. And I really applaud NQF for moving to a more crosscutting measurement scheme so that it's not did your PCP give you a comprehensive nutrition plan for your diabetes which is really pretty focused, but do you have what you need to take care of your multiple chronic conditions is something that I think is important for all providers to

understand whether we're achieving that or not.

I've also been wondering if there are some adverse events that we could be measuring that would be sort of akin to hospital-acquired infections that would be markers of the failure of care coordination. So would failure to get needed follow-up be a marker of that that could be measured at a practice level, a group practice level perhaps, to see if that's something that we could see go down over time as we implemented more processes of care.

And the final thing I'd like to say is that a lot of what we're talking about talks about the medical home. And I think so much of what's defined in the patient-centered medical home is terrific. And the availability of that kind of care for many patients is just not there.

DR. GREENBERG: So I agree with a lot of that has already been said. A couple

things I would add is, one, I think care coordination does apply to all patients but I think there has to be an effort to identify high-risk patients. All these things cannot be done and should not be done for all patients. So I think we need to be able to promote sorting out through whatever means necessary, whether it's just a smart nurse looking at patients or you know a risk stratification software tool, who are the high-risk patients and then are appropriate pieces of infrastructure being put into place to help manage them better than a traditional, you know, solo doc can do.

The other thing I would add is on the subject of a medical home or health care home, you know, there's a lot of attention being put on the primary care practice in terms of being the center of coordinating care and it may be. But having one practice coordinating care is a bit like, you know, one hand clapping. There has to be the

involvement of other docs and specialists and community groups, but I think we've got to get the specialists involved. You know, if I'm a primary care doc and send my patient to a thoracic surgeon, you know, I shouldn't have to figure out what he's thinking so I can coordinate that care. He's got to be contributing to that plan of care too. So it puts a premium on integration, on the structure of a system and involving all of the parties in taking part in care coordination. And I think I'll stop there.

CO-CHAIR CASEY: So, not to disrupt the flow, but Jeff hit on an important point that reminded me of a discussion we had in the last steering committee vis-a-vis not just thinking of this from the standpoint of a disease. In other words, there should be a wellness plan of care like the preventive services and following the wellness guidelines that are, you know, put forth by the Heart Association that don't have to involve 25

people. And I think we were trying to build on that, but I think your point is as the condition of the patient, the individual gets more complex that's going to be a much different space than what I'm talking about. So I think I want to balance that to be sure that, you know, I capture clearly what you said in my mind but also remind people that we're talking about -- that's how "for everyone" got in there is to think about it that way.

DR. GREENBERG: And I fully agree that everyone needs, you know, this does apply to everyone. But certainly some patients need more intensive care. The folks that we're trying to keep out of the hospital and trying to keep out of the emergency room will need, you know, more intensive resources than others. But I agree that everyone needs something.

CO-CHAIR LAMB: Going back to what Lorna was saying, adding it to Jeff's is

perhaps if we look at the medical home neighbor and the tools that are coming out of that, maybe that'll give us some ideas in terms of not just the connectivity between physicians and specialists but between all providers, that we can kind of extrapolate to what would this look like if this worked across the system.

DR. WHITE: Okay. I was thinking about quality of life. But not only, you know, which is measurable and there are instruments which you can do that, but not only of the member or the patient but also for the caregiver. And I'm thinking in terms of some sort of patient satisfaction for the caregiver, quality of life, depression screening, that sort of thing because those are the things that lead to caregiver fatigue. And I think that leads to a lot of the coordination problems that we have.

The second thing that I thought about was, well, you know everybody's talking

about all these measures and all these wonderful things but I think only one other person mentioned the cost and I think that was Denise. And in my mind you've got to pay for these things. And so the reimbursement strategies have to support the work and they have to be aligned. And you have to be able to sell these to employers because I don't care what's happening with health care reform, most health care insurance is purchased by employers, not individuals. And even after the exchanges that's still going to be the case. And so you have to be able to sell this to that. So you have to be able to show cost avoidance, savings, reduction in utilization, return on investment, all of those things are important.

And then finally, people have talked about the plan of care. And I totally agree with that and there need to be standard elements, but you also need to have goals because goals lead to outcomes that are

measurable. So I think that's going to be critical to the success.

CO-CHAIR CASEY: Alonzo, from where you sit would it be tenable to reframe that context in terms of appropriate use of resources?

DR. WHITE: Absolutely.

CO-CHAIR CASEY: Okay. Rather than just it's lower cost.

DR. WHITE: No, no, no, but you're exactly right. I spent 22 years in Kaiser so I'm very familiar with those concepts. And in general if you give people better care it's lower cost. And so you want to do the right thing. And I think by framing it that way you can achieve that goal.

MR. FROHNA: I also agree with what Al was saying there about the cost, about the financial aspect, but also access I think is another key component that we haven't really mentioned a whole lot about. And specifically I'm going to expand I think what

Jeff was saying, the medical home neighbor. You think about it now it should be the medical home neighborhood. I mean, it really is more than just the medical home and a physician, it should be actually a whole group, a whole neighborhood providing the care and coordinating that.

Also that care coordination is not owned by any one discipline but I'll tell you, I think today the emergency department or emergency medicine has been mentioned about a half dozen times. As an emergency physician, just to kind of educate folks on this and maybe point out why patients seek us out may get to the point of access. And that is that over 130 million visits last year to the EDs, emergency physicians basically comprise about 4 percent of all physicians and really the health care costs associated with ED visits is about 2 percent of all health care costs. So actually relatively speaking, good deal. But when you look at what happens after hours, our

specialty provides greater than 60 percent, it's actually upwards of 66 percent of all after hours care. And maybe we're just not, you know, we hear so much about the patients and their access. Well, are we really getting to the root of what they're looking for and what they need and what they want? And so that's what I wanted to just point out there.

And then as far as some kind of a measure, taken along with Jeff's comment as well, the high-risk, the high-service utilizer of care and how can we measure that. And maybe it is -- you know, when I go in and I work I know if a patient -- how many prior visits they've been there, when the last visit that they've been to the ED. So I know, I can quickly filter on the high users. And in the district with the highest per capita dialysis patient population. I mean, there is a patient population that, boy, if we could get that under control and maybe we can reduce costs, reduce visits, et cetera there you may

have a real measurable goal. But that's just one small element.

MS. FOSTER: Okay. I was sort of coming at this as well from an outcome perspective and really thinking about how do we measure good care coordination. And in my mind that really does link to resource utilization. And if you have a patient that is utilizing a lot of resources can we say that we are really providing coordinated care. But there are, given the fact that there are dialysis patients, there are transplant patients, et cetera, I think that utilization resource has to be risk adjusted.

Another I guess idea that I had related to a lot of these evidentiary pieces of providing care coordination is outcomes. And I'm wondering if we've looked at the PQRI data and linked to that at all? And I don't know if you looked at that in your study. But I think the PQRI data is very good, it's very rich and I had the experience of abstracting

for that last year. And you know, for patients for heart failure, CAD, DM and hypertension there are very specific measures in there. So they look at the patient's A1C. So if the A1C is high are we doing a good job of coordinating diabetic care? So I think that might be something in terms of outcomes that we would want to look at.

And then just finally, a couple of other ideas that I had in terms of measuring the health information. In the report there was no measure recommendation for that and I had just jotted down on the way here, you know, patient's access to their own records. And you know, we give them education but is the education really adjusted for their health literacy. If they don't, if English isn't their primary language how well are we translating, what are we providing in their language of origin and how are we doing that. Because not every patient responds to written documentation. So I think somehow that has to

be assessed in all of this.

And then finally, the last thing I just wanted to say was in terms of talking about medical appointments this morning, you know, we were talking about having that as a standard because it's there and that's what we know. And you know, it really isn't -- Mayo Clinic did a study, I think it was published last year, that said that actually appointments have no, there's no evidence that they reduce readmissions. But what reduces readmissions is not the appointment but it's the handoff to the appointment. So if you -- because most of the time the PCP doesn't treat the patient in the hospital so the patient goes back to their PCP, a discharge summary gets faxed. That really doesn't, that tells just partial, you know, very little of the story. So it's the phone call. And at Mayo Clinic that's something that we are measuring. We are making sure that the patients have a phone call back to their, the treating

physician calls the accepting physician and the expectations for what has to happen in the ambulatory setting then occur that way. So you know, I think that that -- and I think that is measurable actually.

CO-CHAIR CASEY: So Pamela, just -- so it would be instinctive to believe that if you had a measure of success let's say for care coordination and you had one patient with one chronic illness as opposed to one with three, instinctively you would expect higher failure rates for perfection on the one with the three than the one in terms of successful care coordination. Or, if --

MS. FOSTER: Right.

CO-CHAIR CASEY: I'll make it up, a heart -- two heart failure patients. One had very poor muscle mass and was unable to exercise on a regular basis as opposed to that other one who could do that and was much more independent would probably require some adjustment to the measure.

MS. FOSTER: Exactly. Right. Some -- yes.

CO-CHAIR CASEY: I was using the disease model.

DR. LEFTWICH: You may have already caught on that I think HIT is foundational to all of it. So what I have is some more granular measures that are process and structure, and to -- under the category of patient involvement and engagement. And to reiterate some what Pam said I think there should be a measure of patients receiving enduring copies of instruction and education in their preferred language and format, and that patients should have access to their information including their master care plan in its current state. And that patients should have the ability, the mechanism to upload their observations and their data, home monitoring data for example, to their care plan and their record.

And under the topic of

communication and information transfer I think there should be measures of the right and appropriate information being transferred. Too much information is just as bad as no information at all. It needs to be the appropriate selected information. A measure of the completeness of those core data elements that we talked about, the medication lists, problem lists, allergies and intolerances, and the timeliness of the delivery of those transition of care documents. Do they get there before the patient does or at least with the patient. Otherwise their value is certainly degraded.

And along the lines of the one element that should be there in the care plan and aligned with that patient-centered medical home neighbor is the care team shouldn't be conceptual. There should be a roster, it should include contact information and it should include what their role is on the care team and that they have accepted that role,

including what level of involvement they are -- as a specialist. Whether they're assuming care of the patient or just doing a consult.

And I would ask your indulgence for about three minutes to talk about HIT innovation that's out of the blocks and that I found a couple of people are not aware of, something that's out of the blocks and into the pilot phase to demonstrate that it does work and I think it will likely revolutionize the HIT environment over the next few years. One aspect of it is the Direct Project which was begun about a year and a half ago which to be brief is secure email that can be exchanged between systems and even between individuals who don't have systems, who just have a secure Outlook email account and can include obviously a PDF file but could also include these standard documents, transition of care documents. And that is expected to be a requirement that certified EHR systems for stage 2 of meaningful use will be able to

create and receive those direct email messages between them.

Then aligned with that is the S&I Framework efforts that I already mentioned, the transition of care documents. But along with that there's an initiative to create provider directories in each state that would include not just physicians but the entire care team and the facilities and an in-point electronic address for those individuals as well as the traditional contact information, and an indication of what type of electronic documents they're able to receive, whether they have a system or not. There's another initiative that was launched less than two months ago that I spent much of yesterday on called Query Health that envisions creating a process and standards by which a query can be sent to any EHR system asking for a de-identified list of patients with condition X on medication Y and with lab result Z or whatever combination of data elements,

including quality measure, would be returned to the requester that originated that query. And those could obviously be aggregated into population health data including quality measures. And it's referred to as sending a question to the data instead of sending the data to a repository. And I would hope that we envision leveraging these innovations and expect that the measure developers leverage them as well anticipating that in the foreseeable future that will be a mechanism to gather information to communicate both between systems and with patients. If you sign up for a Microsoft HealthVault PHR today you get a direct address when you sign up so that anybody could send you a direct secure message be it patient instructions or your discharge summary.

DR. BURSTIN: Could I ask you a follow-up question? Specifically about your role in HIEs because I think the health information exchange aspect of this we haven't

really talked about. But it does seem like there would be a set of measures that would potentially emerge if you actually had an HIE where you could for example look at unnecessary repeated lab tests or unnecessary repeated imaging. Have you seen anything like that emerging?

DR. LEFTWICH: Yes, there is that potential but most of the HIEs I'm aware of, that sort of quality measurement if you will is not in their acceptable use policies. So they would have to be modified and that would be a challenge I think. Whereas the direct messaging type thing might -- would be much easier because it's up to the recipient of that query whether or not they respond. The other advantage to the direct at least in the use of patient care is that it's HIPAA-compliant in that it's a push transition and doesn't require patient consent as an HIE does.

MS. KLOTZ: Okay. Several of the

things I had jotted down have been well covered, things around the patient understanding and the connections to the non-medical and the inclusion of family. Thinking about patient goal versus the physician's goal I think has to be thought about. So I was trying to think about some of the potential measurement things and I was thinking about the CTM-3. And I don't know how many of you know that. I assume most everyone does and of course right now I can't think of the question specifically. But if you think about understanding your medications as you're moving from the hospital to home isn't that almost the same question we'd want to ask anytime somebody's looking at their medications. And wondering how that could be stimulated to do some slight modifications of the CTM-3 that really would not think just about transitions but about care coordination.

Another thought in terms of measurement, I'm wondering if the Stanford

Chronic Disease Management Program has come up with any kinds of measures that look at understanding of medical conditions and treatments, and you know, ability to kind of be involved with those themselves. Another thing, there's this discussion today about medical home neighborhood. I heard Ed Wagner speaking last week about, actually he was calling it medical neighborhood I believe. And you know, Ed Wagner is the developer in his group of the chronic disease model. Their group is now working on a model that relates to medical neighborhood and it's the same kinds of ideas we've just been talking about. And I wonder if his group is also thinking in terms of measurement in terms of that neighborhood idea that could potentially be addressed.

And then the last point I was thinking about is we're involved with some things that relate to fall prevention and the idea that you can't -- it's a pretty long time

span between measuring certain activities that reduce risk behaviors and then whether it results in a fall later. So thinking in terms of the idea of intermediate measures, that if people have, you know, using falls as the example, if people have reduced some of their risks in their home that are risk for falls, if they are working on strength and balance, if they're having their vision checked, those are kind of intermediate measures. That if those things are being done then there's very high probability you'll have fewer falls later. So if we could think of the same, maybe there's some evidence, you know, very tight research that can be done that say these particular processes around care coordination are indicators that it's a good job. So then we can look at those processes. And I guess I would just say think about process measures as intermediate measures, not throw them out because they're not really telling us the outcome.

DR. FARRIS: This will be quick. What Bonnie and Dana said about the plan of care. What Tom said about process measures and now just what Christine said about process measures. We can't just throw them out the window and maybe that's really where we are with this concept. And so while we all want outcome measures, maybe we're not quite there. What Bill and Jeff said about integration of all providers, and particularly what Jeff said about focusing on the most vulnerable. Everybody does need care coordination but we all know there are a set of people who need it more than others. And so figuring out measures specifically for those individuals I think is more important in the short term than -- in the short term.

And then finally, what Russell said about accountability in that there's a plan of care, but who's in charge of that plan of care? Are there providers and/or the patient who have different parts of it that

they're trying to achieve in terms of specific goals? And having the patient's input to say I want my physician to help me do this, my social worker's got to help me do this, my pharmacist has got to help me do this, or something like that.

And then my final comment is that a med list is only as good as the last patient interview, and/or follow-up with the community pharmacist, and/or follow-up with the primary care doc, and/or follow-up with the specialist. So I'll stop there.

CO-CHAIR LAMB: Clearly we know who's going to do our summary later.

MS. DORMAN: So I'm actually going to reference Eva. I was really heartened to hear that I wasn't the only one confused about what is care coordination and what could the outcomes possibly be. So it's been a great morning to think about that. And the way I typically start that thought is to go, well if there were patients in the room here what

would they be thinking about this conversation? And that led me to the thought in terms of outcomes. I mean, if I'm a patient my ultimate outcome is did I reach my goal? No matter what that goal is. And so that's my suggestion for an outcome, that care coordination we know is a meta process over the clinical process and that it has a meta goal, a meta outcome of achieving the patient's goal. The only measurement, the only place I know of, and I am sadly free of great expertise in care coordination literature, but the only thing I'm aware of is the gold standards framework in the UK that they use for palliative care. And it's more of a social patient engagement process where every patient is asked what their preferred setting of death is. They're asked what their first choice is and what their fallback. You know, if we can't get to that what would be the next choice. And they, the whole health care system works to make that happen

including the patient and family. So that care coordination is something that happens with the patient and family, not to them. And it's an interesting paradigm and I'll just offer that. I think it's, I don't think it approaches the level that it could be called measurement but it might be an interesting place to look.

Then my second set of thoughts was around coordination itself and really wondering if we're being ambitious enough. I hear us talking about coordination as a salvage process because of the bad health care system, but are we thinking enough about coordination as a way to deal with the inevitable complexities and tradeoffs in the best possibly provided health care. And what is that meta process and how would we measure that? As in addition to just the salvage kinds of activities that we know have to happen. So those are my thoughts. Thanks.

CO-CHAIR CASEY: Jann, can I ask a

little bit more about palliative care. You know, I personally think we did not do a very good job of calling that out in the last documents. And in specific what's called advanced care planning which is very easily mis-translated in my opinion to end of life care and DNR and all this other stuff. And those who have followed the work of Diane Meier and others understand this, especially in the early phase of chronic illness that advanced care planning is not about how you die but how you live.

MS. DORMAN: Right. We say it's about living well.

CO-CHAIR CASEY: And do you think that there could be more space in this context, knowing that we've got a palliative care group working on this to call that out in the structure of the?

MS. DORMAN: Well, I personally agree that it's useful to make a distinction between the medical-legal aspects of, you

know, quote, "advanced care planning for end of life" and the very real capabilities to get to, you know, to incorporate a patient's values and choices into the goals that are set. And that's relevant anytime, whether it's a 2-year-old with a cold or very complex illness. But I think it does provide a good place to look because those people, man, those people are skilled. They've been on the front lines for decades and they know a lot about how to do it and what really matters when you do it.

MS. ALLER: So there have been a lot of comments about how care coordination requires the whole team. And we as a nation are incenting health IT in the physician office and in the hospital, but we haven't done a good job of incenting it more broadly in long-term care, in home care and in the various community linkages. I've heard a lot of comments today about evidence and the lack thereof, or the quality of the evidence we

have. I heard a lot about needing to roll up measures. And so part of what I was noodling on is we have incented certain care transition type behaviors, med reconciliation for example, in the EHR incentive program. I would like to get a better measure of how is that changing patient experience, how is that changing outcome. I'd like to stratify against those who have had that reconciliation happen and those who haven't, get the evidence on which of those things we've incented are in fact changing outcomes and experience and then incent those technologies more across the rest of the care team. So what's the return on investment not just from a cost and a resource standpoint but from a patient outcome and experience standpoint. And then, okay, let's build on the things that really are moving the bar for the patients.

I think there's a real challenge as well between what we can measure and what we aspire to measure, and we have to maintain

that balance and take those baby steps that Jeff talked about earlier. And say okay, we're not going to have the perfect measure, let's at least get the few things, correlate that with what we can and take the next steps and keep moving that bar.

DR. HEURTIN-ROBERTS: I've been thinking about outcomes. And mostly I've been puzzling about outcomes because the question of measuring an outcome is determined, is based on what we call an outcome. And outcomes are rather ephemeral. We're talking about an outcome of what, an outcome when. We're thinking of, and maybe I'm thinking, maybe we should be thinking models and not measures. I don't want to throw that in. But we're thinking of care and care coordination as though it were just linear, you know, structure, process, outcome. In reality it's an ongoing process that occurs over time and at any point in time you could slice off a chunk of that continuum and say this is an

outcome. As far as I can tell the only universal outcome would be death. I mean that happens to everybody, nobody gets out alive. But if we're going to frame the question of measuring outcomes, we need to frame outcomes of what. What's an episode? Which chunk of care are we looking at? And that'll be an artificial demarcation no doubt, but I think we have to if we're going to be able to measure outcome effectively. Okay.

That being said I want to remind us all that care is not linear even though we think of it that way. It's pretty complex. It involves not only individuals, not only individual disciplines but involves a lot of different systems that come together. And we can frame it and think of it in terms of particular medical home or even a medical neighborhood, but what comes to bear in care coordination is, you know, different disciplines providing care, family systems, you know, financial systems, funding systems,

economic systems, social systems, geographic and all of that. And so when we're doing this I know we have to think of this in a more simplistic fashion in order to measure it, but I think we have to acknowledge the complexity that's involved. Otherwise we're trying to measure a process that we've artificially simplified and aren't really becoming cognizant of that. We need to realize that we're talking about something very complex. I have no doubt that statisticians will be able to deal with this complexity more and more. Not me, but statisticians. I mean, there's network analysis and so on. I think there are ways to study this. But I think we need to realize that it's there and deal with it.

DR. LINDEKE: I think we will have a very big debt in five years if we have not responded to the nation's hope for care coordination to deliver cost savings and quality. The fact that I think everyone here

is on multiple projects with the word "care coordination" somewhere in the title, it's astounding because five years ago it was just in the small print buried somewhere. We were talking about access at that point. So we spent a lot of time talking about access but we know that churning, which means you change your health plan multiple times, or ER where you might get, you know, 10 minutes of a hectic schedule with a person you'll never see again is not quality care. So the coordination piece has got to be measured. And to me we have to look at team, we have to see what is a high-functioning team and measure it, and the family is part of that team. It can't be done by the person whose name is on the bill and that primarily is the physician. That's not realistic in this country. We've also got a workforce of over 3 million nurses whose first course in nursing school is going to really be about care coordination. If we can get beyond turf, if

we can get a harness, really the bean-counting of HIT over meaningful data. And my concern is rehospitalization is probably not going to do it. A Canadian study this summer showed 15-20 percent of rehospitalization was preventable. The other 80 percent with, you know, universal access, had to be rehospitalized. That's not going to deliver what the nation is looking for.

So I have high hopes for this work. I will feel real bad in five years if we don't deliver. And it's got to be connected to -- to me some of the biggest heroes in our country are the Medicaid providers and those systems, the safety net providers. It's got to be connected to them or we're just doing more fancy stuff that the rest of the world that produces really darn good outcomes with less money looks at us, they just shrug and say, "Those Americans."

DR. AUDET: On the last, ditto. I was thinking of, you know, what is important

to measure to frame this call and I was thinking more on the principles. And those principles have been already clearly announced here. But the first one would be that why are we measuring. It has to be significant. It has to be a measure that shows that if you are a high performer on that measure you have had impact on the three-part aim. You've had impact on some aspect of outcomes, of quality of care, some impact on patient health and some impact on cost.

And the patient voice in this I think is really clear. An anecdote about the discussion we were having about discharge summaries being, you know, now being retired. It could be, and the discussion about calling people. In our current initiative on avoiding rehospitalization, calling after discharge is one of the best practice. So we would think it's a best practice but when we start to ask patients, they're getting calls by six different people. That is not care

coordination. So we have to be careful about, again, processes that are not linked to something else because we think it's a good thing.

The second principle, and here I was a bit challenged between a measure -- our discussion about whether a measure should apply to all patients versus condition-specific or even I think perhaps even more important, risk-specific as opposed to condition-specific. Whether we're talking about that being in one measure or are we talking about the NQF portfolio of measures. So that in the end we may need specific, you know, measures that are specific to a certain risk, you know, a population. And I'm thinking here of Joanne Lynn's Bridges to Health and her segmentation of the population. So in our portfolio it may be good if we could have a representation of these various segments of the population, not in one measure, in addition to measures that apply to

all people.

And just a comment on CTM-3. And we are currently, the visiting nurse of New York is actually piloting this measure in a home health setting. So they're adapting the measure and looking at whether they can use that measure in the transition between the hospital to the home health. So that's actually, that's happening right now and would be available to us to review some of the results.

CO-CHAIR LAMB: I think Don and I would like to add our thoughts to this too. So take off my co-chair hat for a second. I would like to just share with you what I've been thinking about in terms of the patient-centered measures as well as outcomes. In terms of -- and let me acknowledge a lot of this comes from months of coordinating care for my mother -- is the issue of perception of plan of care and whether there's one plan of care. And I think Russell said before is the

accountability for that plan of care, or does anybody, you know, do you believe that anyone, that everyone is working from that same plan of care and who would you go to if you felt the plan of care was off track. So, that whole idea of does anybody out there know me and is there one plan of care because my experience was I believed that if I had gone to any of the myriad of providers everyone would have said yes, there's one plan of care. Family member? No, there wasn't. And I was sleeping in the hospital trying to make sure it stayed on plan of care.

Another one is, and Russell I think touched on this, is the issue of how do we capture sequencing and timing of care. If you look at the AHRQ definition there's the whole element, the domain of organizing care, and it reminds me of, do you remember the mantra of managed care from the '90s? Right care, right time, right place, right cost. Is that care coordination is not time, at any

time we feel as providers it needs to happen, it's what's the right sequencing and timing. Do things happen when they need to happen to get you towards your goals? Whether it be tests, procedures, services, resources or whatever. So how do we capture that whole idea of sequencing of care?

The other one I would throw in, and again I think Russell, you spoke to it, I would name it a little bit differently, is a family burden care coordination measure. How much energy are family members putting into coordinating care for their family members and is it more or less? I mean, that's going to take us down the road than is reasonable. Another personal experience. I was spending probably 95 percent of my time trying to keep things on track and at some point not only got exhausted but got resentful that I was spending all my time coordinating care and not spending quality of time with my parent.

Outcomes. I think you've

mentioned things that speak to symptom management, self-care, functionality and was just at a conference at the American Academy of Nursing where people were suggesting that self-care and symptom management really should be some of the core outcome measures across the care continuum, and that I think the challenge is going to be, is getting good performance measures that really capture that in a meaningful way.

CO-CHAIR CASEY: Well, I've found this round table very enlightening and helpful and totally additive to what we've done. I want to harken back to my good friend Tom Howe though who I think points out that we've got to get real clear on what the elements are in the plan of care, knowing that it'll be flexible. It'll have to be. I'm in the midst of writing with a whole team of people a new ACCHA guideline on heart failure which we just had our first draft out on Monday. It's not public yet. And I was responsible for the

discharge planning. And I said I'm not going to write a section on discharge planning, I refuse. This is about care coordination and having a plan of care for heart failure patients. And while I can't share the specifics because this is embargoed, I have in here as a starting point for the physicians and nurses guideline-directed medical and device therapy being the first group. The second is management of comorbidities which includes preventive care, secondary and primary. Patient and family education which includes quality of life assessment, advanced care planning, CPR training for family members, social networks in addition to diet. Then physical activity and rehab, psychosocial factors such as depression, alcohol use, gender-specific issues, sexual activity. Clinician follow-up and care coordination which includes which doctor do I see next, is the advanced practice nurse better in this situation than the cardiologist and are there

other people like pharmacists who can help me with my medication. And how does that all fit together in my personal health record.

Then the last part is this business of health literacy, whether I have access to care, whether I have access to payment for care, whether I'm disabled, what other community resources there are. So it helped me to sort of share with you that vision of what we're trying to put in the guideline because I think that's what we're trying to get to. And it may not be perfect, but believe me, sitting with a group of cardiologists it's big progress. So. No offense to my colleagues the cardiologists.

CO-CHAIR LAMB: You know, that speaks to the issue of timing as well because -- and it's just, it's a conundrum of how to capture this. If you think about heart failure as your prototype, what gets people into problems that end up in the hospital is, you know, you think about it, late pickup of

warning signs. It is if they're getting into trouble they need to recognize them and they need to act on them. And how do we capture did -- were the systems in place that people not only were educated, because that's pretty straightforward about somebody taking their weight and recognizing they're gaining it, but did they take the right action and were the support systems there. Anybody in home care who tries to get somebody quickly into a PCP, whatever role that PCP is, often ends up sending that person into the ER because they can't get a response fast enough. So the timing of that whole kind of cascade of events becomes really critical to capture and how do we do that.

CO-CHAIR CASEY: Yes, Emilio.

DR. CARRILLO: Just one comment. One measure that wasn't mentioned, I think it should be put on the table, is a measure that helped, it's already an NQF-sponsored measure, that helps to capture issues of health

literacy, language and culture, which is teach-back. Something that's in the nursing world and in many different dimensions coming into increased use. And yes, is there a care plan and has there been a teach-back. I think that I would recommend that.

CO-CHAIR CASEY: So, why don't we take a well-earned break. And Gerri, what time do we want to come back?

CO-CHAIR LAMB: Let's just, when we come back what we're going to do is see if anybody has any reflections on this discussion quickly, and then move into the questions that Lauralei put together for us so that we can kind of frame it. Because we need to pull this into looking at what the framework is going to be for the call for measures. We've generated tons of critical issues and this is going to be kind of the grist for putting together a document for you to respond to. So how about, what is it, it's 2:30-ish? How about if we take 15 because we know we're not

going to come back before then anyway, and then we'll move into any comments, and then we'll go into kind of the final stages. Fifteen.

(Whereupon, the foregoing matter went off the record at 2:37 p.m. and resumed at 2:56 p.m.)

CO-CHAIR CASEY: We still have some work to do and we have to push through the rest of this agenda. So, yes. So what I'd like to do is before we get into the final phase of our discussion let's let Lauralei and Nicole sort of provide you with a teach-back as to what we think we heard so that we're capturing the elements. And we've all made copious notes so hopefully this will work. But I will turn it over to Lauralei.

MS. DORIAN: Well, I think we each took hundreds of pages of notes, and we'll have the transcripts afterwards so we'll go through them and come up with a document that we'll send to everybody for your feedback

that's much more thorough. But Nicole and Suzanne put this together. Do you want to say anything about it?

MS. MCELVEEN: So these are quickly some of the themes that we felt sort of rose to the top or that you had mentioned more often throughout the group as a whole. Of course, this isn't the whole comprehensive list. So, viewing the whole perspective of the entire patient there was a lot of discussion around support and education for the patient and the caregiver. Cost and resource use as a justification for care coordination. In addition, all other aspects related to cost. There was also a lot of talk about the possibilities and limitations around HIT infrastructure and health information exchanges, the involvement of the family, and coordination with organizations outside the traditional health care system. So there's a lot of discussion around resources within churches, community-based health organizations

and community centers. So again, these were just the few that we felt the group talked about most common, but certainly not the entire comprehensive list.

MS. DORIAN: And maybe one thing that I just remembered that would be important to add is asking the question for whom is care coordination most important. And so what are those high-risk populations? Are they necessarily the high-cost populations and should there be certain aspects of measurement that address those populations in particular? Are there any other major themes that you think we left off this list? We'll resend this through.

CO-CHAIR CASEY: Well, I think the notion of, and I think Julie spoke of this right off the bat, focusing on the whole person, i.e., not just the medical part of the person. The multidisciplinary nature of care coordination. I think Bonnie mentioned this with the need for the feedback about the plan

of care and its effectiveness being a continuous process. Matthew kind of reiterated the patient-centeredness. Dr. Lee spoke a lot about patient safety and HIT which I think you captured. And so, Denise I think also was in that space. Dana was reminding us about population health, measuring it not just at the individual patient level but also at the population level as well. The -- Tom talking about the standard elements of a plan of care and also, you know, the notion of a care coordination index which I think others mentioned. The -- some comments about the interactions with the specialties. Lorna and Jeff sort of spoke about the medical neighborhood and how people relate to each other. Al spoke about the quality of life and caregiver and incentives. Bill talked about access and availability being sort of key parts to this. And you don't need to write all this down, but I'm just. Pam brought up the resource utilization, talked about PQR

data risk adjustment. Russ talked about the master care plan, timely access. I wasn't here for your entire presentation, Russ, but I know you talked about several things. Accountability and the Direct Project, the S-9 framework. Chris was talking about some other models like Stanford and Ed Wagner and thinking about whether CTM could be modified in some ways to get at even more of what we're trying to accomplish. Karen summarized everything. She's an old pro. But I think Karen was really trying to pull all these things together for us and that was elegantly done. Jann among other things talked about palliative care. Kathleen talked about incentives. And the return on investment not just financially on patient outcomes and experience. I kind of got tired at that point, no offense to the rest of you.

Suzanne talked about non-linearity of care coordination. This isn't like a model where you try to fit a line through care

coordination. It's got many different dimensions and it will take certain types of sort of, I don't even know what the word is. You use the term statistical. I'm not even sure that's it. I think you used network. Model. Network models and things like that, where we look at the connections. Linda and Anne-Marie were also in there with a lot of this stuff. So I think we got everything in here. I think it's good.

So at this point I think what we want to do is let's go back to our agenda and let's look at the potential questions. These were meant as discussion questions related to both the foundation for the pathway which I think we've incorporated but this has to do now with informing the staff about how to put the call for measures together. So I want you to be real specific. Try not to repeat what we've done, but really look at these questions. And maybe we ought to step through them or you can pick one out and say, you

know, this was one I want to talk to. It might be better to do that.

I think in answer to the first question do the current domains adequately reflect care coordination I'll answer that for the staff and say they adequately partially reflect it. And that what we tried to do is now enhance that. We've got the AHRQ document and we've also got great input from Arjun and Lipika in terms of their enhancements to this. And we'll be working with you on this. But certainly they helped inform the framework and the way that we're going to ask the question of the environment about the presence of useful measures that could be considered by this group for consensus development.

So, you know, look at those questions. You may have already thought about it. There may be other questions as well. I think, would it be safe to say that we in general if we're talking about broad-based measures would generally agree that to the

last question of risk adjustment or stratification, that that would be a desirable trait? Do most people agree with that? I don't want to get into the details of how the risk adjustment is done, but given that I think we've identified that there are layers of complexity is it reasonable to agree with that statement? So.

DR. GREENBERG: Don, are you talking about risk-adjusting outcomes or actually using the process of risk-stratifying a population of patients as sort of part of the expected activities of the measure?

CO-CHAIR CASEY: I think it's both. It's got to be both, Jeff. I mean, what I mean is that, you know, you've got to have a way to risk-stratify and then you have to have a way to fairly measure the differences across these.

DR. GREENBERG: I think both are -- I'm clearly thinking of outcomes you need to be able to risk-stratify to be fair.

CO-CHAIR CASEY: Right.

DR. GREENBERG: But I think also we want to, I think we should be promoting risk-stratifying one's patients as a practice that we need to do.

CO-CHAIR CASEY: So that's a good point, that that's going to land in this other area of what do we want the future state to look like and we'll have to think about that. But surely -- yes, Anne-Marie.

DR. AUDET: Just a question. They would have to do both, not just risk adjustment without risk stratification.

CO-CHAIR CASEY: What's your opinion?

DR. AUDET: I would say yes, they would have to do both.

DR. WHITE: I think they're actually part and parcel of each other. They're sort of a -- you need one to do the other.

CO-CHAIR LAMB: I would suggest

too that we go back to the discussions we've had about what's the reason for this. Many of us have said there are populations within all of the people that are seen in the health care system that need, number one, more intense care coordination, and two is is risk -- we've got to keep in mind risk for what. And in this case it's risk for adverse outcomes of poor care coordination. It's not risk for everything in the health care system. So as we think about risk stratification and adjustment, I think part of the discussion on the go-forward basis is for what, and does it look like the same kind of risk adjustment and stratification for other outcomes like mortality, hospitalization and so forth because the parameters of risk may be different in this context.

CO-CHAIR CASEY: Well, that raises -- Helen's going to kick me so if I jump. Raises the question about the NQF-endorsed outcome measures that have risk adjustment,

whether we think that -- and I know the answer, I'm answering my own question -- whether we think that the -- would those adequately reflect whether differences can be measured for improvements in care coordination based upon the way they're risk-adjusted now. In other words, I think they're very much driven by claims data that relate to clinical variables and not so much by some of these other -- I haven't jumped yet, so. So I think, Gerri, that's another perhaps futuristic question about how do we make some of the work that's done now related to outcomes like mortality and readmissions if that is an outcome more sensitive to the impact of care coordination. And that might take us in a different direction than the way the measures are currently calculated. My sense is I don't know but I'm guessing probably they don't do a very good job of that.

DR. BURSTIN: There's an article

in JAMA today for those of you who haven't seen it that specifically goes through the different risk models for readmissions showing they're actually not nearly as precise as we would certainly like. But I think in general, though, you know, risk adjustment for an outcome could be very well justified. We don't usually risk-adjust processes and much of what we're talking about here are processes. And I think there is also an opportunity to do the risk stratification. I think Alonzo's point and I think Jeff's earlier as well, thinking about stratifying for targeting, to think of, you know, who's high-risk. So I think there are sort of three very different models of how to use risk.

CO-CHAIR CASEY: Denise.

MS. LOVE: Risk adjustment is an interesting discussion. I'm for risk adjustment but sometimes risk adjustment that washes away all variation, especially for consumer information. And then thinking of

care coordination. Maybe the risk adjustment is to differentiate those populations and accentuate them. So it may be a different purpose. And so we don't want to just, you know, throw in the hierarchical modeling that I'm so fond of.

CO-CHAIR CASEY: Yes, certainly some of the work that I've been doing with the CMS-sponsored group out of the Colorado QIO that has developed these community-based readmission measures is doing risk adjustment for that precise reason which is to better understand the nature of the community. There are 14 of them. So that they can better try to define what the interventions might be that are different from, you know, the other communities.

MS. LOVE: If you're doing a hospital report card sometimes you wash away the differences because you want to be fair. So, again, it depends on the purpose.

CO-CHAIR CASEY: Well, again, and

so we always get into this sharp edge of CMS would like risk-adjusted measures for public reporting to help Medicare beneficiaries discriminate and perhaps become related to payment policy. And so, you know, you can, I know we don't have a CMS representative here. I'm not trying to be mean to them, I'm just trying to say that that is one of the goals of NQF is to support those efforts. So we have to expect that that type of thinking is going to persist. But your point is well taken. And when we endorse measures accountability is going to be something we're going to talk more about. So that's it.

My other, I'm just doing this because I'm a little tired of being in Washington so much but number 3, I think I heard should these measures be condition-specific or broadly applicable. And I think what I heard some people say is you shouldn't do one without the other. In other words, we should have broad measures and we should have,

for lack of a better phrase, condition-specific measures because practitioners can translate more easily. Did I get that, Dr. Lee? I think you were the one that brought that up.

DR. LEE: Yes, I like to think of it as how do we get its flywheel going. You know, get things started, more science, more integration. How do we get it going?

CO-CHAIR CASEY: So again the answer is kind of sort of both, right?

DR. LEE: Correct.

CO-CHAIR CASEY: Anne-Marie?

DR. AUDET: Just this JAMA paper that came out. Condition-specific is great and I will also stress, I'm not a lumper as you can tell. Population and risk-specific. Because if you look at this JAMA article actually the predictors of readmissions are not, you know, severity of illness, they're actually socioeconomic and all that other stuff. So that's more population and risk of

poor coordination than a condition. So I would stress both condition and population.

CO-CHAIR CASEY: Yes. So, but I think that the third nuance here is that we want patient-level measures that are more global too, right, Anne-Marie? So it's condition-specific, it's population and it's -- does that? Hey, that's pretty good. Other thoughts.

DR. LYNN: I'm wondering how this fits in with the NQF work on multiple chronic conditions.

DR. BURSTIN: So for those of you who don't know NQF has been doing some work trying to take the patient, the framework that was done a couple of years ago, this measure on framework to begin thinking about care longitudinally which was very oriented to longitudinal care of a single condition, and think about it differently in terms of care for patients with -- they're actually now calling it complex multiple chronic conditions

because sometimes one bad complex condition is enough. You don't need four of them if one of them is really bad. Alzheimer's, I mean there's some logic here. And what they've been trying to do, and I can't remember if the report is out for comment or completed comment, but we could share it with this group is they've at least tried to come up with some framework to think about what kind of measures you might bring in that might be crosscutting for all those kinds of patients. When condition-specific measures are appropriate and if so, is there better -- are there better ways to stratify by patient risk in terms of things like functional status and you know, end stage issues.

CO-CHAIR CASEY: So I'll just tell you a little anecdote because it's, you know, it's after 3:00. But my dad, he's going to be 87 in two weeks. He claims he's still in law practice. He's probably at his office now. And he goes to the doctor and he always calls

me up and says, well, I've got to tell you about this, this and this. And I'm like Dad, please, please make a list of these things so you won't forget when you go to the doctor, you know. Because he's got, I mean he's not seriously ill but he's got all these things going on. So he comes back from the doctor and I can't wait to call him and talk to him about how it went. And I said well? Did you talk about the list? He goes no, I forgot where I put the list.

(Laughter)

CO-CHAIR CASEY: So that's like, I give up. How do you adjust for that, you know what I mean? So I think we got some good traction on some of these. Let's see. Yes.

DR. LEE: Don, before we leave that question 3, something that fell out of the question set that's in the other documents is the level of measurement, how far down do we want to go. I really think we want to make sure we can measure populations but I'd really

emphasize at least from my point of view that we need measures that are specific at the physician or the office or the care team or the medical home or whatever that locus of care coordination is, that we be able to get at least some measures down to that level of specificity.

CO-CHAIR CASEY: Yes, I think for both accountability and quality improvement that's going to be critical. Because practitioners at that level need to know what's wrong in order to see if they can fix it in some way. And you know, one of the ways to do it is to say well we're going to, I'll put you on this website too and let people think about it. So, but I do think that that is really one of the levels of the goals here to inform the people on the ground doing the work. So. Eva?

MS. POWELL: Thanks. If it's okay I just want to back up really quickly to number 2, the assumptions. And I agree with

them on the one hand because I recognize that a call for measures is a call for measures that need to be specific and evidence-based, but I really, really worry that if we stick only to this notion of evidence-based in the same way that we've thought about it for the measures that we have now, that we're not going to end up with anything more than what we got before. Because as we've heard numerous times the evidence is not clear or it's lacking or however you want to put that. And so what made me think of this was, I think it was Jean that made the point about we need to somehow come up with measures that allow for latitude in terms of process. And then I can't remember what Christine said but she also made me think about this notion that as we make information electronic the line between quality improvement and research becomes very blurred. And so I'm wondering if since part of our task also is to develop a pathway toward implementation of emerging

measures, in addition to obviously the need to have a call for measures that are very specific and evidence-based could there be a part of this pathway that becomes part of the learning health care system where we design measures that are not necessarily evidence-based but are maybe based on pseudo-evidence, I don't know what you would call it, but something that makes someone think that it might be a good idea and then become part of a testing loop. Because I just really worry, I don't know how we're going to generate this evidence if we're stuck in our same way of thinking about evidence that we've been in relative to the measures that we have now. And this would seem to be a really good opportunity, particularly because so much is related to process in the world of care coordination, to put some latitude out there and have certain parameters, and I don't know what they would be, but have certain parameters that then provide more latitude

than what we've had before as a way of generating the evidence that we so need and want. I don't know, is there a possibility for that? Does that make any sense?

CO-CHAIR CASEY: No, it actually is, well, Helen and I have had this sort of ongoing discussion that I think has resulted in some positive change for how NQF evaluates evidence. And you know, let's be clear. There are sort of levels of measures now that exist that are well informed by lots of observational and clinical trial data like PCI within 90 minutes. I mean, we know that time is myocardium and we know that the faster you get an open vessel for a patient with an ST elevation MI the better likelihood there is for survival and improved quality of life and et cetera, et cetera. In this arena where it's so messy one could neither expect nor anticipate randomized controlled trials of that nature to describe, to attempt to describe the evidence. And I think that

that's where we're going to have to be very clear and careful about how we're going to think about as a group evaluating evidence as it comes in.

And I think it will boil down to making judgments like, you know, it's hard for us to be sure that care coordination has occurred if in fact the patient sees a physician in the office and there's a claim for it. So, on the other hand, if we know that in some of these measures that what the physician did was to actually provide an intervention that assured that a patient got the care that was needed for that particular problem, that that would be a higher level.

So I just want to harken back to Guyatt's mantra about not feeling as though it's a bad thing that there's limited evidence and that it has poor quality. I mean, I think we're going to be faced with that dilemma. So I want to be sensitive to it. But I don't, and I think your other point about informing

the future state will again be derived on what Suzanne talked about, developing these newer models to actually develop better ways to describe the outcomes. Because it isn't going to fit into a nice, neat, you know, generalized linear model usually I would guess.

So I hope that gets to the dilemma. It probably doesn't answer your question. We're going to get a lot of measures that we're going to look at right away that aren't going to really pass the sniff test that still may be worth it for us to bring forward to consensus development with the clear understanding that this is the first phase of what we're trying to accomplish. So, I don't want to throw the baby out with the bath water. And Helen, I hope you agree with that general philosophy here because I know when we started this Helen was like we don't have any measures and we've got to get some in here. You know, so she was just worried that

there would be nothing left after all this work and I don't think we anticipate having that occur this time. So I hope that makes you feel a little better. But it's going to be hard.

My philosophy is as long as we're transparent with saying here's the quality of the evidence and that people are clear about understanding that it may not be perfect but it's still worth a try that it's still okay. I don't know how we fit that into the consensus development process but I think this is one of these vague areas where it's going to take a different mindset I think.

DR. BURSTIN: Just one thing to add. People haven't seen that NQF in the last year did an evidence task force report which we could share with folks which really went through our perspectives of how evidence should be assessed. It is interesting in some of these emerging areas that are more crosscutting, not the clinical ones so much,

but some of these emerging areas where the evidentiary base may not be the classic sort of medical model. What's quality, quantity and consistency evidence is one we're really going to have to work through and that's what our new evidence task force requires. But there is still an element of allowing a steering committee to make a recommendation for a measure to go forward based on the expert opinion of the group where they feel like the benefits significantly outweigh the risks. And we actually just went through this in our palliative care committee. Again, the evidence on some things, these things are just not as clear, but they are so obvious to anybody that the benefits significantly exceed the risks. Some issues around sort of chaplaincy, for example, and palliative care. So I think we'll have the opportunity to work that through but that's why we're going to need to have that very structured process to go through the evidence.

CO-CHAIR CASEY: So, let me -- not to keep bringing up Guyatt, but Guyatt will say that if there is professional consensus that intervention X is useful that's evidence. It may not be of the quality. Do you see what I'm saying? So, I just want to be sure we don't get stuck on these terms evidence-based like we know what we're talking about. Sorry, Christine.

MS. KLOTZ: Is there any room for having something that's, I don't remember this, actually. Whether it could be provisional or labeled as promising? No. It's either endorsed or not.

DR. BURSTIN: At this point it's endorsed or not. I mean, I think a lot of those promising practices is what you guys did last round in terms of the practices. I think at this point if we're going to bring a measure forward it needs to be standardized sufficiently with a sufficient evidence base that it can be used for the various

accountability applications, including public reporting and pay-for-performance. So, no. But at the same time you can also make that assessment, that some of these things are kind of really obvious and you still think it should go forward because it's -- the benefits are really important.

CO-CHAIR CASEY: There is, though, Helen, this notion that there must be some field testing of the measure, right? Which in some ways is kind of sort of a level of evidence. And I think, Chris, we did find that there were some measures that really hadn't been adequately field tested and we actually gave the feedback back to the measure developer to do X, Y and Z. Do you remember this, Karen? So, I mean I think that it's never, like, you know, your measures didn't make the cut, they're bad. It's more like here's -- it's a continuum to get them in the shape where they can then succeed at the next round of endorsement.

DR. HEURTIN-ROBERTS: We're about trying to improve quality and care delivery. At the same time, if we want that to happen we want to have a better science of quality improvement. So I think that we can't only think about improving quality of delivery. I think that we need to at least see ourselves, or see this endeavor in the context of a research effort and be research-friendly knowing that this is going to generate huge amounts of data that you know we'd really like to be user-friendly for researchers. So you know we can't, we're not going to improve quality unless we also have a science of quality improvement that's functional and can use this data. I just think we need to keep that in mind.

CO-CHAIR CASEY: I've never been on a consensus development project that didn't have embedded in the deliverable a set of recommendations some of which would be very concrete for current and future researchers to

enhance. So that'll be part of our work for sure. But I think it's really important to emphasize it. So, yes, Anne-Marie?

DR. AUDET: Just a quick question for information. Last time you did this you sent signal to the field that this was, you know, something important. And you actually had a framework. So I'm just curious whether you at NQF, I know you have calls for measures, but do you hear from people who say oh, I'm now ready?

DR. BURSTIN: It's a great question and I think what we've seen is there are some measure developers who have made significant progress. Like NCQA of doing the work you funded. And one of the big issues here has been the continuing lack of sort of base support for measure development with some notable exceptions, thank you. They've developed a very nice model of what closing the referral loop will look like. When I talked to them a couple of weeks ago and said

so I'm really excited, you know, care coordination is starting up. When are we going to get that measure? And they went well, we're not actually sure we can spec it out because the EHRs don't exist yet that can do the measure. So it may be that there's work in place and I think there are some elements of that measure that we hope can come forward because they're really important. But sometimes I think the research work and the development work are not quite in synch.

I think there's more out there than we realize. Some of the work we did last summer supporting ONC on their potential measures for meaningful use 2013, I mean, there were some impressive measures out there that some of the leading health systems like Kaiser and Park Nicollet and others were using that were more sometimes transactional but did get at elements like did patients have access to their lab results within seven days. I mean, there may be some sort of baby step

measures out there that some of the leading IT systems could bring us, but we have tried to signal. I've talked about this everywhere. It's just, I think this is a really tough area to do without the data platform.

DR. GREENBERG: I think we need also to balance the need for standards with the need for innovation and the acknowledgment that we don't really know how to do this that well. And we want people to keep trying new things. And we run the risk, if we say everyone has to do X or Y that people are not going to try to do it differently. So, you know, I don't know if that's something that you come across in other areas where you've done this, but I wouldn't want to box people in too much because you know my hospital has done, you know, really well using nurse care coordinators for high-risk Medicare patients. But there are other ways of doing that. And I wouldn't want a measure that says you have to do that because you may be able to do it

many other ways. And I want to -- we should be able to give people credit for doing those things but yet of course we do need some standards also. So I just think it sounds like a tough balance to meet.

CO-CHAIR LAMB: One of the things that we might consider, it struck me as we were going through this day. If we look at number 5 which is, and those are probably two separate very important questions that we've been deliberating on is what are the priorities and if we can begin to flesh out all the stuff we were talking about as we went around the table and give some, you know, some bench posts to people about here's what we think is important to look at. What are you doing in this area? Because I agree with Helen, I think there is a ton of stuff going on out here but people are not necessarily framing it or seeing it as care coordination work. So that if we can begin to say for instance, I'm just going to make this up,

we're interested in looking at how patients are engaged in the care coordination process and it might look like A, B, C, D, E, if you're doing anything in this area and you're measuring it and you have some outcomes we want to hear from you. Because I think right now a lot of this work is invisible. So that if we can begin to put some, you know, some structure around this in terms of what is important. So I think somebody, it may have been Dana or Jean said before is the goal here is to help people understand what's important about care coordination to improve it. And the more we can begin to help that field I think it's going to be really useful and I think we may be surprised. But I think we're going to have to structure better than the last call for measures.

CO-CHAIR CASEY: So that's a good lead-in. What outcomes are relevant to care coordination? I mean, I think we talked about it but can you just punch a button and tell us

in a word or two? Tom.

DR. HOWE: Yes. I think we've kind of thrown up our hands that there is no easily obtainable outcome. I'm not sure that's correct. I think if the care coordination is focused on a patient-family set of goals were they met or not? And if somebody with some foundation money or if it's already been done can come up with a fairly concise standardized measurement tool that a patient and/or family could fill out, one, it would get you the level, at the practice level you'd get the level of engagement with folks that are actually paying attention to a care coordination plan. That's a significant metric right there.

CO-CHAIR CASEY: So, I know we're getting a little bit into syntax here but would a reasonable outcome be to measure successful achievement of a plan of care?

DR. HOWE: Right.

CO-CHAIR CASEY: Is that what

you're saying?

DR. HOWE: With specific goals on it.

CO-CHAIR CASEY: With specific goals, of course, right.

DR. HOWE: And did they get measured.

CO-CHAIR CASEY: Of the goals, achievement of the goals of the plan of care.

DR. HOWE: Right.

CO-CHAIR CASEY: Right.

DR. HOWE: And I don't know that there is a standardized tool out there.

CO-CHAIR CASEY: But I think if one would accept the word "outcome" in that statement that would be perhaps a way to phrase that. Is there anyone pushing back on that?

DR. BURSTIN: Well, it doesn't need to be only outcomes, though. I don't want us to think that this call for measures can't include really important processes,

evidence-based, linked to outcomes. I think we need to know what those outcomes are so we can judge the evidence of whether those processes in fact make sense but some of those outcomes are actually some of the ones we already have. I mean, you could argue readmission measures are one example. We've got all-cause readmission begins October 31st at NQF, the project. We're also in the midst of our resource use project. I mean, those may be the kind of outcomes you would use to judge the quality of care coordination. So I guess I don't want us to feel like we have to be only in the outcomes box.

MS. ALEXANDER: So I would agree that if we're, you know, asking the question what are measures of success for care coordination that it would include outcomes. Maybe not just only outcomes. And I do agree that that would include then the plan of care that which also would include then, you know, what are the outcomes that we're driving

towards, what are the goals that we're setting forth in order to drive towards those outcomes. Then how we achieve those. And measuring those achievement of those goals and outcomes not only from the care provider's perspective but also the patient's perspective as well too. And then earlier I think it was Pam that had mentioned I think another measure of success could be utilization if it was risk-adjusted as well.

CO-CHAIR CASEY: Yes, Matthew.

DR. MCNABNEY: Here's an example. This is a geriatrics example so it's somewhat limited but regarding care plans and goals of care, care plans. Joanne Lynn and Richard Schamp both in different articles on the same concept constructed these three pathways described as longevity, functional and palliative. And it had criteria, described criteria which a patient would declare which pathway they would want. It's complicated, more complicated than it sounds to help

somebody assign themselves into one of those pathways but you -- and they were used and we used them to prescribe care that fits into those pathways. But you could imagine that outcomes that would be appropriate for those pathways, you know. It could be different pathways for different populations but that you could then say, well, given that patient assigned themselves with help to a certain approach to care they met that care pathway, whether it's longevity, functional or palliative.

CO-CHAIR CASEY: Yes, I mean I think you really have hit some gold here in something that I hadn't thought of which is back to how does a patient decide what the correct plan of care is for him or her, right? So if I've got a risk of prostate cancer which I do and there are five different directions to go in to make my plan of care how does that get informed and is that -- that I think involves a certain level of, I don't know

whether it's exactly care coordination but it's a precedent too. Saying if I choose this pathway then what I'm going to try to do is coordinate my care in this direction. I mean, I think that's what you're saying, right? So, Helen and Gerri, that seems like a pretty good hierarchy of needs in terms of, I'll make it up, instruments that help shared decision-making to determine the pathway. Is that kind of what you're saying? So what do you think about that? That seems like it would be in play here.

CO-CHAIR LAMB: I would just suggest that when we start reviewing all the things that everybody has thrown out is to keep these questions in mind in terms of what is it we're trying to accomplish here which is really looking at, again, what's important in this process and how does it link to outcomes. Because I think to pull, you know, nascent measures and measures that we can actually look at that go beyond what we saw before,

we're going to have to define this for folks really clearly in terms of what we're looking for. So whether it be these outcomes and we've generated a list of several different outcomes. I'm thinking just in the interest of time here we're going to need to move into next steps soon.

DR. BURSTIN: Just one quick response to that as well and it's an important distinction between a tool and a measure. So NQF doesn't endorse the tool, we endorse the accountability measure that may be how you use the tool, what the results of the tool were. So in this area for example the Foundation for Informed Medical Decision-making has been doing some very elegant work on sort of measures of decision quality. Now those may be appropriate but we would be careful about avoiding, that we would not at least in the current environment be bringing in the tool that supports the SDM.

CO-CHAIR CASEY: Why don't we take

two final comments and then --

DR. HEURTIN-ROBERTS: Just the idea, outcomes are only meaningful relative to some antecedent. That's the only way you can evaluate it. So I think when we're thinking of defining an outcome and measuring it it has to be related to something that's come before, that's all.

CO-CHAIR CASEY: Which would include a process. Tom, did you have your?

DR. HOWE: Yes. I don't know if this is getting you into territory you don't want to get to but if we think patient engagement and feedback is critical to assessing at least a key outcome here in terms of how do they think they did with their goals with their care home there may need to be some thought to supplying an incentive. I mean, we have payers now paying for wellness incentives. This may be worth putting out there as a patient incentive.

CO-CHAIR CASEY: Lauralei?

MS. DORIAN: We did have some time set aside to specifically structure the call for measures but actually I think the round table did exactly that. So, and illuminated and elicited from you what you'd like to see in the call for measures. So in terms of next steps I do have some dates here. What we'll work on doing in the immediate next few weeks will be distilling all the information you've heard as I said and circulating it to you for comment. We did have, I'm trying to think here. Oh, we have the first draft of the white paper is due on November 22nd and then we have a tentative conference call scheduled with you between December 7th and 9th. So we're going to either poll you today or via email to see which of those days would work best for you. But perhaps during that meeting that would also be another good time to review the call for measures specifically and the paper that we've put together as a result of today's meeting.

And the other thing that I wanted to talk about, I don't know if you received the email with your information to access SharePoint but this is the first project that's using SharePoint at NQF and I think it'll be a really good way because care coordination is so big and you guys are a great group. And I feel like there's a lot of really good discussion that can take place on that site and so many documents. So rather than sending you emails with copious amounts of material all the time we can post it on there. So does that sound good to everybody?

DR. MCNABNEY: Does it alert you when there's a new post?

MS. DORIAN: You can set it to alert you for that. And I'll send through sort of instructions on how to use it. It's pretty straightforward but it can be a little bit confusing at first. But there's a discussion board, there's a calendar. We can post draft -- I can post a draft of the call

for measures for you to comment on. There's a forum. You can use it in a lot of different ways. So I think it'll be good to test how useful it is going forward.

MS. LOVE: I assume if there is something you'd post out there that you really want to call our attention to that you'll --

MS. DORIAN: I'll always alert you. Yes, I'll send you an email as well.

CO-CHAIR LAMB: Lauralei, could you go back to the previous slide in terms of next steps? Okay. So that, okay, here we are on October 19th. Are we going to get anything then in terms of responding to before the first draft of the white paper or is that the first request for a response?

MS. DORIAN: That will be the first date where you receive the white paper itself. But we'll send something to you about this meeting and the call for measures before that. Soon, yes, in the next couple of weeks. And then in terms of that conference call on

December 7th, 8th or 9th there's also a polling tool on that SharePoint site. So I might send that link to you tomorrow actually and you can poll to see which of those days works best for you.

CO-CHAIR LAMB: Okay. And the white paper is going to be in the form of a potential call for measures? Is that how it's going to look or no?

MS. DORIAN: The white paper is the commission paper that Lipika presented on.

CO-CHAIR LAMB: Oh, okay.

MS. DORIAN: Sorry, yes.

CO-CHAIR LAMB: So where's the call for measures in here? The development of the call for measures.

MS. DORIAN: The call for measures, well that closes, let's see. That closes on January 9th. There's an open call for measures right now but as soon as we have finalized our call for measures we can post that as soon as that's ready. So I was

thinking in the next few weeks if we can. Do you think that's doable?

DR. BURSTIN: We moved away from a 30-day call for measures and we let just developers know way in advance. They've known for months that this is coming and this is due in January. So and we can also modify that if we need to. But we'll go back, pull down the call that's up there now that's just very general and add the specificity and the prioritization you've put in today. And we'll repost that and send it out so people know what you really want to get in. We just wanted to at least let them know this is -- our submission form is now open at all times so people can start working on the forms early on. They are a lot of work to submit and pull together so we really want to give people at least three months to prepare.

CO-CHAIR CASEY: Would it be helpful to share with the committee maybe one such submission just so you can see it?

Because when you see it you're not going to be happy, it's a lot of work but we're going to be expecting all of you to really spend a lot of time and effort on this. So I think it might be, just to get your juices flowing. Karen?

DR. FARRIS: Are we expected to comment on the call for measures or you guys are just putting it together and it's going?

MS. DORIAN: No, we'll definitely expect you to comment on that. Within I guess let's see if -- I mean, we can give you a week to comment on it and then we'll send it out within the next week or two. But we'll send through all of these revised dates tomorrow as well so you know exactly what's expected of you. Are there any other questions on the project in general?

MS. ALEXANDER: Just to make mention while you're just conversing here that if we have -- however this week timeline comes for us to respond to build in Thanksgiving in

there too.

MS. DORIAN: Yes, definitely. That's a good point.

CO-CHAIR CASEY: And then Lauralei there will be, we will then, once the measures are in we will be doing some prep work for an actual another second face to face meeting.

MS. DORIAN: Yes, so that'll be part of when phase II officially kicks off. We'll have another conference call, orient you to phase II, to the details of the CDP process and then I think the in-person meeting is scheduled for the end of February.

DR. AUDET: So there are two public comments. Well, there are two public things. Public comment for the white paper and then there's going to be a submission, the submission of the measures. That's in phase II.

MS. DORIAN: Correct. The evaluation of the measures is in phase II. So the public comment period is on the commission

paper that was part of phase I.

DR. BURSTIN: We'll also have public comment on the measures in phase II, yes.

MS. DORIAN: Yes. That's a much longer process.

CO-CHAIR CASEY: That's when it really gets fun.

MS. DORIAN: Yes, exactly. Yes. Operator, are you there?

OPERATOR: Yes, I am here and there is no one on the phone.

MS. DORIAN: Okay. Thank you for checking. Well, before Don and Gerri say anything I would just like to say thank you all so much for today. I found it incredibly enlightening and I think it really will impact the future of this work, particularly the work you do in phase II. And thank you to our co-chairs. And look forward to working with you in the future.

CO-CHAIR LAMB: It's been a

pleasure having this conversation today. I just have so much more I'm going home thinking about now. So looking forward to working with you all on the reports and the feedback and seeing you again in February. So thank you so much for a great meeting. And notice we ended on time.

(Whereupon, the foregoing matter went off the record at 3:47 p.m.)

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C E R T I F I C A T E

This is to certify that the foregoing transcript

In the matter of: Care Coordination Steering Committee

Before: NQF

Date: 10-19-11

Place: Washington, DC

was duly recorded and accurately transcribed under my direction; further, that said transcript is a true and accurate record of the proceedings.

Neal R Gross

Court Reporter