

NATIONAL QUALITY FORUM

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MEASURE APPLICATIONS PARTNERSHIP
DUAL ELIGIBLE BENEFICIARIES WORKGROUP

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THURSDAY
MARCH 5, 2015

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The Workgroup met at the National Quality Forum, 9th Floor Conference Room, 1030 15th Street, N.W., Washington, D.C., at 9:00 a.m., Jennie Chin Hansen, Vice-Chair, presiding.

PRESENT:

ALICE R. LIND, RN, MPH (Chair)*

JENNIE CHIN HANSEN, RN, MS, FAAN
(Vice-Chair)

RICHARD BRINGEWATT, SNP Alliance

GWENDOLEN BUHR, MD, MHS, Med, CMD, American
Medical Directors Association

ANNE COHEN, MPH, Subject Matter Expert

STEVEN R. COUNSELL, MD, America's Essential
Hospitals

VANESA DAY, MPA, CMS Medicare Medicaid
Coordination Office (Federal
Government Member)*

KATA KERTESZ, JD, Center for Medicare
Advocacy*

K. CHARLIE LAKIN, PhD, Subject Matter Expert

THOMAS H. LUTZOW, PhD, MBA, iCare

D.E.B. POTTER, MS, Office of the Assistant
Secretary for Planning and Evaluation
(Federal Government Member)*

SUSAN REINHARD, RN, PhD, FAAN, AARP Public
Policy Institute*

E. CLARKE ROSS, DPA, Consortium for Citizens
with Disabilities*

GAIL STUART, PhD, RN, Subject Matter Expert*
SHAWN TERRELL, Administration for Community
Living (Federal Government Member)
JOAN LEVY ZLOTNIK, PhD, ACSW, National
Association of Social Workers*

NQF STAFF:

TAROON AMIN, Consultant
MEGAN DUEVEL ANDERSON, Project Manager*
MITRA GHAZINOUR, Project Manager*
SARAH LASH, Senior Director
ZEHRA SHAHAB, Project Analyst

ALSO PRESENT:

GRETCHEN ALKEMA, SCAN Foundation*
PATRICK CURRAN, CareOregon

* present by teleconference

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

2 9:02 a.m.

3 MS. LASH: Good morning, everyone.

4 This is Sarah. Thank you all for those
5 especially who are here in person and those who
6 are hanging with us on the web meeting today.

7 Jennie is going to go over today's
8 agenda in just a moment, but I did want to
9 acknowledge that we are going to try to compress
10 the discussion just a little bit to try to end no
11 later than 2:30 today. So that might involve
12 working through lunch, flip-flopping a
13 presentation potentially here in the middle.
14 We'll have to play it a little bit by ear, but I
15 think many of the really critical decisions were
16 made yesterday, and today we have more synthesis
17 and high-level thinking to do, and we have some
18 great content prepared.

19 Jennie, I'll ask you to continue the
20 opening.

21 VICE CHAIR HANSEN: Sure. Again,
22 welcome everybody who's on the phone. Do we need

1 to take roll at all?

2 MS. LASH: Maybe we could have people
3 say hello that are on the phone, yes.

4 VICE CHAIR HANSEN: Yes. Okay. Why
5 don't we start with the people who happen to be
6 in our conference here, identify who's here, and
7 then we can go to people on the phone. And I'll
8 then have some summary comments.

9 Okay. Tom?

10 DR. LUTZOW: Tom Lutzow, iCare.

11 DR. BUHR: Gwen Buhr.

12 VICE CHAIR HANSEN: From?

13 DR. BUHR: Oh, representing AMDA, the
14 Society for Post-Acute and Long-Term Care
15 Medicine.

16 VICE CHAIR HANSEN: Thank you, Gwen.
17 Why don't we start with Charlie?

18 DR. LAKIN: Charlie Lakin.

19 MR. BRINGEWATT: Rich Bringewatt, SNP
20 Alliance.

21 MS. COHEN: Anne Cohen, MAP expert.

22 DR. COUNSELL: Steve Counsell,

1 American Essential Hospitals.

2 MR. TERRELL: Shawn Terrell, ACL. ACL
3 is closed today, so I don't know if I'm
4 representing them or not, but here we are.

5 VICE CHAIR HANSEN: Thanks for being
6 here, Shawn.

7 Alice, are you on the phone still?

8 CHAIR LIND: Yes, I am on the phone
9 for probably another half an hour. Thanks.

10 VICE CHAIR HANSEN: Okay. Thank you.
11 Many of you know that Alice is waiting on a
12 plane, and so we're glad that she's going to be
13 able to make her next commitment.

14 Who else is on the phone, please?

15 MS. REINHARD: Susan Reinhard.

16 VICE CHAIR HANSEN: Susan Reinhard
17 from AARP. Thank you. Anyone else on the phone?

18 MS. POTTER: D.E.B. Potter from ASPE.

19 VICE CHAIR HANSEN: Thanks, D.E.B.
20 And I'm sorry. I heard another voice.

21 DR. KERTESZ: Kata Kertesz, Center for
22 Medicare Advocacy.

1 VICE CHAIR HANSEN: Great. All right.
2 Thank you.

3 MR. ROSS: Hi, this is Clarke Ross,
4 Consortium for Citizens with Disabilities.

5 VICE CHAIR HANSEN: Thank you, Clarke,
6 and thank you for some of your added materials
7 last evening. Anyone else?

8 (No audible response)

9 VICE CHAIR HANSEN: Okay. So we at
10 this point are happy that we have --

11 MS. ANDERSON: Jennie, this is Megan
12 --

13 VICE CHAIR HANSEN: Sorry.

14 MS. ANDERSON: Jennie, this is Megan
15 Anderson, staff member.

16 VICE CHAIR HANSEN: Megan? Okay.
17 Thank you, Megan. All the way from Germany.
18 Thank you.

19 The fact that we have everyone here
20 includes the fact of what we're going to be doing
21 today, which is about a great deal related to the
22 MAP's core mission on person-centered care

1 relative to our populations.

2 I'd like to make about three little
3 comments from yesterday. One of the things
4 yesterday that we had a chance to do is really do
5 a significant amount of heavy lifting with many
6 of the measures. And, Alice, we appreciate the
7 significant and focused discussion in moving
8 this.

9 One of the things that as a follow-up
10 there -- I've had a chance to talk to Zehra as
11 well as Sarah -- people were very particularly
12 understandably focused on the measures that have
13 related to the four kind of groups that we
14 represent relative to older individuals, people
15 with mental illness, substance abuse and the
16 younger disabled. And there were great summaries
17 done by Zehra to say how many measures are there.

18 One of the things that staff will do
19 is build out those last four columns in
20 particular so that we'll have the exact numbers
21 and names of the different measures that have
22 been passed relative to those four groups so that

1 it allows us to see some of the measures that we
2 have moved ahead with.

3 And the other thing that came out
4 yesterday: Rich, I think you conveyed to the team
5 here that they do have staff recommendations when
6 they look through the measures, and that hearing
7 their thought process, because they've had a
8 chance to really plum into this, is something
9 that they will do when they do have measures
10 here.

11 And then the last comment I'd make is
12 really -- was the prelude into some of our work
13 today relative to what makes the MAP here so
14 different from some of the other more provider or
15 setting-focused on MAPs. And so, that really
16 leaves a great deal to today.

17 And then thinking through the final
18 opportunity that this is so broad. I mean, part
19 of this I think -- I forget who brought the
20 example, the metaphor that this is a sculpture.
21 We've had basically a raw block of marble and
22 this is an effort of shaping some of the framing

1 of an area that's not been approached this way.

2 And I picked up on this yesterday, but
3 Tom from iCare brought up an example of thinking
4 who happens to -- where is it that we can really
5 have some leverage and focus?

6 And, Tom, I believe you brought up
7 that readmissions is one -- an item in terms of a
8 measurement that everybody is focused on. So
9 there's all levels of interest in that, and
10 readmissions is a factor for our dual eligible
11 population regardless of what segment. So this
12 may be an opportunity. And the segment that we
13 had a chance to have; and Sarah shared with me
14 that there were quite a few, like more than half
15 the measures that we ended up looking at
16 yesterday only came to our own staff here just a
17 few days before. So they themselves didn't have
18 much time to do this.

19 But I think the opportunistic side of
20 that is a lot of it was around mental illness, so
21 it allows us as a leverage point to use that body
22 of measures that we agreed to yesterday show up

1 in the column in a way that will begin to have
2 another leverage point of thinking of one of our
3 four segments of a population to be wedged.

4 So I think we have some opportunities
5 as a result of the discussion yesterday to really
6 have greater shaping and focus as we move on.
7 And for those of you; I think almost everybody
8 here, this is their first physical meeting that
9 we've had and it just takes this opportunity to
10 have that kind of organic discussion that we had
11 yesterday.

12 So let me then get back into a focused
13 area here. On our slide 101 it speaks to what
14 we're planning to do. Sarah's going to give us a
15 history of the recommendations that have been
16 coming from NQF on person-centered care and
17 thinking about how do we move forward with this.

18 Another area that came up on our web
19 meeting is the whole element of what has occurred
20 at the NQF in the past year or so, really having
21 this discussion on how does SES factors relative
22 to all this discussion on risk adjustment fit

1 into the measurement process. So, we'll have a
2 chance to hear a summary of what the debate has
3 been, as well as where NQF is going to be
4 experimenting for the next couple of years.

5 The voices from the field, some of you
6 who are here this morning will be part of that,
7 giving some concrete examples how we have
8 beneficiary engagement from some of the health
9 plans. We appreciate the kind of on-the-ground
10 experience that people bring coupled with, Alice,
11 your example of what you're facing in Washington.
12 And then there are some strategies that we have
13 that are in play that will have a chance to also
14 have as a focus.

15 What was mentioned yesterday, we have
16 a half-an-hour presentation from the SCAN
17 Foundation from Gretchen Alkema. And she will do
18 this probably from 2:00 to 2:30, unless we find
19 that she is available earlier. And our goal is
20 to finish at 2:30.

21 Okay.

22 MS. SHAHAB: Before we start, D.E.B.

1 Potter, you have your hand raised. Did you want
2 to say something?

3 MS. POTTER: Yes, please. I wanted to
4 thank Jennie for her excellent summary of
5 yesterday and just follow on quickly with the use
6 of the alignment tool. Right now SAMHSA, ASPE
7 and CMS are doing working behind the scenes to
8 come up with a list of quality measures that will
9 be used by community mental health centers in a
10 demonstration across several states. And as part
11 of that alignment we actually use the alignment
12 tools. So wanted to thank NQF for all of your
13 efforts and how it's helped in ways you couldn't
14 even have imagined.

15 VICE CHAIR HANSEN: Excellent. Well,
16 I'm glad that the MAP's work is having a positive
17 impact on influencing this in the various
18 domains. Thank you.

19 MS. LASH: Wonderful. All right.
20 I'll be setting up today also by recapping a
21 little bit of what we heard yesterday. I think
22 that this group has laid a tremendous amount of

1 groundwork, not only within this meeting, but
2 over the course of the last several years. But
3 what's really now come to the forefront are more
4 articulate goals for what we want to accomplish
5 through quality measurement, and that we need to
6 accelerate change in the form of more innovative
7 measures.

8 So we heard a lot about using the
9 information gained from stakeholder feedback loop
10 conversations to decide what's actually
11 productive for quality improvement and
12 recognizing the need to potentially do away with
13 some of the requirements, because we're seeing a
14 lot of effort spent on measuring things that are
15 not particularly relevant to the unique needs of
16 dual eligible beneficiaries. So, Vanesa
17 challenged us to think about whether we need to
18 know about core medical issues like blood
19 pressure and cancer screenings through
20 stratification methods, or whether a change in
21 course is needed.

22 We also were checking ourselves going

1 down that path with understanding that we don't
2 have good evidence as to whether duals are
3 experiencing good or bad outcomes on these
4 measures yet. We haven't been able to really dig
5 into that except through anecdotes.

6 So there needs to be some advances in
7 science made before everyone around this table
8 and other advocacy groups start to throw their
9 full weight behind measure recommendations.

10 But maybe some fertile places to start
11 would be working on consumer response mechanisms
12 and issues of goal setting and attainment. We
13 had an interesting discussion yesterday about
14 proxies and other things like that.

15 There was also good discussion that
16 measures should advance continuity of care and
17 shared accountability and person-centeredness
18 with readmissions being an area where the focus
19 and the partnerships and the financial incentives
20 really started to connect some of those dots and
21 move the field.

22 So, let's see. There was another

1 common thread around communication being
2 extremely critical with good suggestions made
3 about use of cell phone technology, medical
4 interpreters, other methods of assessing consumer
5 experience like the adaptation of the CAHPS tool
6 for the IDD population, etcetera, etcetera. So I
7 think that is something we will build out as
8 well.

9 And then finally some other clusters
10 we'll represent in the report. First, looking
11 deeply at measure use patterns. For example,
12 there are many ways to connect the dots of
13 alignment, and we'll look into which health plan
14 measures aren't being used in demonstrations, but
15 are they conceptually covered by another measure,
16 and understanding more about root causes, why
17 measures are or are not used. Is it the measure
18 itself? Is it not a priority topic? Is there a
19 data issue?

20 And then secondly, understanding which
21 measures are working, why, and what people would
22 like to most measure, but can't as gap areas.

1 And further advancing evidence-based practices
2 and models to deliver high-quality care before
3 making some short and long-term recommendations
4 to CMS. Some of those also began to surface
5 yesterday. For example, piloting the use of our
6 more innovative measures with possibly some
7 funding or grant support behind that to begin to
8 gain traction on some of the measures that aren't
9 really going to get picked up otherwise and some
10 of the major federal programs.

11 And we heard from Vanesa just how
12 seriously CMS is taking MAP's work. And I think
13 that was really welcome news to everyone in the
14 room and energized the discussion quite a bit.

15 So I'll move quickly through the next
16 few slides because we already went over these on
17 the web meeting, but just to recap, MAP has set a
18 high bar for quality and what it expects in the
19 dual eligible population. And so this group has
20 tried to advance person-centered approaches
21 through its work and will continue that today.
22 This will be a forum for strategic discussions

1 with and on behalf of HHS. And as much as we can
2 make explicit what the unique characteristics are
3 of the dual eligible population for care and how
4 that affects measurement needs, that would be a
5 good contribution. The group will also continue
6 to identify and publicize the measures with the
7 best fit for purpose, talk about opportunities
8 for stratification and then plant the seeds for
9 development of new priority measures.

10 So at the end of the day we're very
11 interested in making progress and advancing this
12 agenda of high-quality person-centered care, and
13 it's the quality improvement that matters the
14 most, and measures are just indicators of whether
15 that's present or not. So, we'll hear a lot in
16 today's presentations about those quality
17 improvement strategies that need to work hand-in-
18 hand with the measures.

19 We also know very well that low-income
20 is one of the only common factors that all dual
21 eligibles share, and so that I think is -- it's
22 fair to say that duals experience disparities of

1 many types in quality and continuity of care
2 because of their medical and social complexity,
3 because of the fragmentation between payers and
4 different types of providers, and the fact that
5 most of them are still in a fee-for-service
6 system.

7 So, as measures help reveal the extent
8 of these disparities and the most important
9 opportunities for quality improvement, what on-
10 the-ground strategies would we like the delivery
11 system to adopt to better engage these consumers
12 and improve their health?

13 So, after our web meeting Dr. Adam
14 Burrows, who represents the PACE Association,
15 sent us an email follow-up where he sort of
16 challenged the thinking around this topic area.
17 And we wanted to share it with you because it
18 seems insightful and it might trigger some
19 interesting commentary.

20 So, Adam was curious; and I think he
21 might not have an answer to these questions
22 himself, but how consumer-directed services like

1 personal care can be introduced into more formal
2 integrated care models like some health plan
3 managed care and PACE but in a way that respects
4 the core philosophy of consumer direction and
5 honors the autonomy of the consumer as the
6 decision maker that is able to ground the medical
7 providers in person-centered principles and also
8 providing support for those professionals in
9 terms of training and community supports in a way
10 where there's accountability that doesn't
11 compromise many of the delicate tensions and the
12 setup. So we can reflect on that, and we'd be
13 interested in your thoughts.

14 Our first presentation this morning is
15 from a fellow NQF staff member, Mitra Ghazinour,
16 who was project manager on a completed effort
17 concluded last summer related to prioritizing
18 measure gap areas in the area of person and
19 family-centered care. So, there's been great
20 progress made in sort of thinking through some of
21 those approaches, although they didn't really
22 have a duals lens. So this group will certainly

1 have something to add. And I'll ask Mitra to go
2 ahead and share her thoughts.

3 MS. GHAZINOUR: Thank you, Sarah.
4 Good morning, everyone.

5 So, I would like to start with
6 providing a brief overview of the project and
7 then presenting the findings of the Person-
8 Centered Care and Outcomes Committee.

9 Here NQF convened a 19-member multi-
10 stakeholder committee comprised of various
11 stakeholders including patients and patient
12 advocates to provide guidance to meet the project
13 objectives, which were to envision ideal person
14 and family-centered care that is not constrained
15 by the current health care *model and used that
16 vision as a framework for performance measurement
17 and also make short-term and intermediate-term
18 recommendations to measure performance and
19 progress on ideal person and family-centered
20 care.

21 So, existing efforts by consumer
22 groups including the Institute for Patient- and

1 Family-Centered Care and PatientsLikeMe were
2 explored and used as a starting place to inform
3 the committee's recommendations. And actually,
4 we had those stakeholders as our committee
5 members. We had -- this committee was very heavy
6 on having patient representatives. We had
7 representatives from consumer, purchasers, PCORI,
8 PatientsLikeMe, Planetree. So, NQF conducted an
9 environmental estimate of CAHPS surveys and other
10 relevant performance measures, and also conducted
11 an outreach to a number of stakeholders to
12 identify examples of person-centered performance
13 measures.

14 The multi-stakeholder committee met in
15 person in April 2014 to create the vision of the
16 ideal state or the "north star" of person-
17 centered care and make recommendations for
18 measuring the progress and performance of systems
19 that support person and family-centered care.

20 Many pioneer organizations such as the
21 Picker Institute, the Commonwealth Fund, the
22 Institute for Patient- and Family-Centered Care

1 and Planetree have defined person and family-
2 centered care and what it entails. These efforts
3 have been grounded in extensive research and
4 informed by expert panels, focus groups and
5 numerous dialogues between persons, families and
6 providers of care.

7 So, this slide includes the frameworks
8 and common attributes of person-centered care
9 resulted from these efforts which have been
10 foundational to set the stage for current and
11 future measure development including the work of
12 this Committee. As you see, these frameworks are
13 closely intertwined, yet each offers a unique
14 perspective of the multidimensional concept of
15 person-centered care.

16 So in order to reach suggestions about
17 how to measure performance related to person and
18 family-centered care it was necessary to have a
19 clear picture of what it is and how to recognize
20 it. Building from the prior work that I just
21 mentioned the committee agreed to the following
22 definition and core concepts of an organizing

1 structure to identify a specific measure concept:

2 So, person and family-centered care is
3 an approach to the planning and delivery of care
4 across settings and time that is centered around
5 collaborative partnerships among individuals,
6 their defined family, and providers of care. It
7 supports health and well-being by being
8 consistent with, respectful of, and responsive to
9 an individual's priorities, goals, needs, and
10 values.

11 So notably there are a variety of
12 definitions and frameworks relevant to person and
13 family-centered care and various descriptions may
14 use different terminologies or grouping of
15 concepts, but they are fundamentally aligned.
16 The definition here was developed through this
17 work and also builds upon previous definitions
18 used by the Institute for Patient- and Family-
19 Centered Care and the Institute of Medicine.

20 So, this is a graphical representation
21 of the core concepts of person and family-
22 centered care. The committee identified these

1 core concepts as important components of ideal
2 person and family-centered care to guide
3 performance measurement. The committee noted
4 that all of the core concepts must be present and
5 that none of the core concepts alone signifies
6 person and family-centered care.

7 The committee also noted the
8 interrelationship among the core concepts as
9 shown in the graph, which all the core concepts
10 need to be moving in the same direction and all
11 have an important role in the system. For
12 example, the family concept specifically
13 addresses involvement in care and need for
14 support, but all the other concepts also extend
15 to the family.

16 So here we have each core concept and
17 there's definitions. And as you may notice, we
18 have used patient's voice to define each core
19 concept to illustrate that patients should be an
20 active participant in their own care.

21 So, individualized care, I work with
22 other members of my care team. And care team

1 indicates families, persons, individuals and the
2 providers of care and all support staff. So, I
3 work with other members of my care team so that
4 my needs, priorities and goals for my physical,
5 mental, spiritual and social health guide my
6 care.

7 Next, my family is supported and
8 involved in my care as I choose. Family could be
9 defined by each individual and reaches beyond
10 traditional family members. And patients who are
11 unable to direct their own care including
12 children rely heavily on a family member to make
13 decisions. So it is important that they are
14 supported.

15 The next one is respect, dignity and
16 compassion are always present.

17 Information sharing/communication.
18 There should be an open sharing and bidirectional
19 communication with patients, their families and
20 all other members of the care team.

21 Shared decision making. I am helped
22 to understand my choices and I make decisions

1 with my care team to the extent I want or am
2 able.

3 Self-management. I am prepared and
4 supported to care for myself to the extent I am
5 able.

6 And access to care/convenience. I can
7 obtain care and information and reach my care
8 team when I need and how I prefer. So, timely
9 and easy access to care and information have
10 shown positive effects on satisfaction, self-
11 management and outcomes. Systems that value
12 patients' time also convey respect such as
13 scheduling of multiple appointments on the same
14 day, minimal wait times and weekend and after
15 hours appointments.

16 So, next the committee developed a
17 framework for measuring person and family-
18 centered care which combines the core concepts
19 discussed earlier and the structure, process,
20 outcome framework for quality measurement.

21 So the committee identified three key
22 principles that should inform the identification

1 of measure concepts for person and family-
2 centered care. They should be selected and/or
3 developed in partnership with individuals to
4 ensure measures are meaningful to those receiving
5 care; should be focused on the person's entire
6 care experience rather than a single setting,
7 program or point in time; and it should be
8 measured from the person's perspective and
9 experience. And, so generally person-reported
10 unless the person/consumer is not the best source
11 of the information.

12 So, these considerations for
13 structure, process and outcome measures for
14 person and family-centered care. Outcome
15 indicates desired outcomes of person and family-
16 centered care, particularly the experience with
17 care. Process is interaction between
18 person/family and the care team that are intended
19 to facilitate achieving the experience reflected
20 in the core concepts. And structure indicates
21 organizational structure or systems that support
22 person and family-centered care.

1 So, the committee identified some key
2 structures, processes and outcomes related to
3 person and family-centered care, which is
4 included in the report. Although some structures
5 and processes that facilitated delivery of person
6 and family-centered care were identified, the
7 committee agreed that the priority is measuring
8 the person and family experience with care as
9 represented by the core concepts.

10 So, this is just an illustration of
11 measure concepts identified by the committee
12 regarding the core concepts of shared decision
13 making. An example of a structure concept would
14 be organization has clear requirements for
15 engagement or staff training engagement. A
16 process concept would be elicit preferences for
17 shared decision making or collaborate with
18 individuals to make decisions and to co-produce
19 and implement a care plan that has the best
20 chance of attaining the person's goals. And an
21 example of an outcome concept would be I was told
22 about treatment options and their pros and cons

1 and had time to review before making a decision.

2 The committee also recommended that
3 some of the structures that support person and
4 family-centered care should be incorporated into
5 a standard label, which is analogous to the
6 nutrition label concept. Key aspects of the
7 label concept would include the standardized list
8 of features and items, the standard definitions,
9 standard ways to present information and layout
10 as seen with the nutrition label.

11 So this slide introduce an example of
12 a standard label for person and family-centered
13 care, information about standard hours, time to
14 get an appointment, communication via email and
15 open visiting policy could be helpful in finding
16 health care services that best meet a person's
17 needs or preferences. Information provided in a
18 standardized format would allow individuals to
19 weigh various aspects in terms of what is most
20 important to them.

21 So, the committee offers
22 considerations for the staging and prioritization

1 of measure development to advance person and
2 family-centered care which I'll be going over in
3 the next few slides.

4 So, the overarching recommendations
5 included to ensure that the measures are
6 meaningful for patients integrate individual and
7 family input into the ongoing dialogue and
8 decisions as performance measures are developed.

9 Focus measurement on person-reported
10 experiences and other outcomes when possible over
11 structures and processes. So, experience with
12 care and other outcomes are generally of most
13 interest to individuals and families and
14 measuring performance on outcomes also allows
15 flexibility in the approaches used to deliver
16 care.

17 Highlight and build on work underway
18 whenever possible, as mentioned earlier.

19 Consider the evolving health care
20 system. So in a rapidly changing delivery system
21 the committee recommended that eyes should be on
22 where we are going as opposed to where we

1 currently stand.

2 Next, go beyond silos of
3 accountability and measurement. So, delivering
4 and improving person and family-centered care
5 should involve systems and we need to consider
6 all relevant units of analysis and settings.
7 Next, consider actionability by those being
8 measured.

9 So, moving on to the short-term
10 recommendations. So, the first one is to
11 consider starting with one simple question from
12 the individual's perspective such as how is your
13 care working out for you, or do you feel like you
14 were well taken care of? These type of questions
15 could be asked in any setting in any situation.

16 Next, consider initially focusing on
17 patients with higher levels of need such as
18 individuals with multiple comorbidities and
19 serious illnesses. So these individuals are most
20 in need of high-quality person-centered care that
21 emphasizes collaborative partnerships between the
22 individual, their family and the care team. And

1 if it can work with these patient groups, then it
2 could be adapted and used for the broader
3 population.

4 Consider available CAHPS measures.
5 So, many important performance measures based on
6 current CAHPS surveys address the identified core
7 concepts. However the issue of proxy responses
8 for individuals unable to complete the CAHPS will
9 need to be addressed.

10 Convene a group comprised of experts
11 on CAHPS and PROMIS, the Patient-Reported
12 Outcomes Measurement Information System, for
13 mutual learning and measure development. So,
14 this combines the CAHPS expertise in identifying
15 experience with care measures related to many
16 other core concepts and the PROMIS expertise in
17 applying new methods of measurement.

18 Explore the person-centered care label
19 concept, which I mentioned earlier.

20 And the intermediate-term
21 recommendations. So, explore developing a
22 "Person-Centered Care 10" measure similar to the

1 PROMIS global health scale, which is a global
2 assessment of health-related quality of life in
3 10 questions.

4 Incorporate the full health care
5 experience beyond a single setting. So,
6 currently experience of care measures are focused
7 on a person's experience in a single health care
8 setting. A fully realized person and family-
9 centered care occurs over time and across
10 settings and expands beyond the walls of
11 hospitals and physician offices.

12 Advance family experience measures.
13 So, this is very limited currently and presents a
14 significant gap particularly for family members
15 of patients with serious illness and complex care
16 needs.

17 And lastly, the committee recommended
18 to fund research to advance measurement of person
19 and family-centered care. And some potential
20 research topics included vetting these core
21 concepts with individuals and families,
22 developing patient-level measures of experience

1 with care measures such as the PROMIS 10 and so
2 forth.

3 So, this concludes my presentation and
4 I will turn it back over to Jennie for questions
5 and comments. Thank you.

6 VICE CHAIR HANSEN: Thank you, Mitra,
7 for explaining and giving some very specific
8 background and context for the work of this
9 particular MAP and how it relates to ours. So I
10 would entertain any comments and questions from
11 the Committee at this point.

12 Okay. We'll start with Tom.

13 DR. LUTZOW: Yes, I know that I'm
14 entering dangerous territory here, but I've
15 always been a little bit concerned about person-
16 centeredness as a criteria. I think future
17 generations will look back on that value and
18 raise questions about it.

19 I think in fact what we do practice is
20 not person-centered care so much as value-
21 centered care. Person-centered care starts
22 breaking down and it needs patches when you begin

1 getting in behavioral health conditions. Member
2 preferences and family preferences sometimes
3 can't be honored there because of behaviors. And
4 the other area where it starts breaking down is
5 in end-of-life care where family preferences and
6 individual preferences may lead to futile kinds
7 of care. And so, there again the consumer's
8 judgment and preferences need to be questioned.

9 The question even on the last slide,
10 how is your care working out for you, I
11 understand the need for that question and I
12 understand the need especially to keep person-
13 centeredness in place with the poor and the
14 vulnerable who need the protection of this
15 mantra, but my question would be since the
16 patient is the first member of the care planning
17 team but also the first member of the provider
18 delivery team in the sense that they have to care
19 for themselves, first of all -- and so my
20 question wouldn't be how is your care working out
21 for you. That would not be my first question.
22 My first question is are you taking care of

1 yourself? And if I don't keep responsibility in
2 the hands of the patient, it is not only
3 profoundly disrespectful, it is not going to get
4 me or the patient where they need to go.

5 So, I think person-centered care, I'm
6 not ready to give it up at all. Certainly it's
7 better than some alternative like payer-centric
8 or provider-centric. It certainly is better and
9 more valuable, critically more valuable than any
10 one of those. But I think in fact in the real
11 world what happens on the street is value-centric
12 care. And making sure the patient voice is heard
13 is one of many values.

14 And even sitting around this table you
15 as consumers of medical care, you are certainly
16 willing to give up your own preferences in
17 exchange for competency. You want to know what
18 the best care is, not what you prefer to be the
19 care. You want to be in front of a doctor who is
20 giving you choices and making recommendations as
21 to what the best solution is, not the one that
22 you prefer. And so, even in our own case our

1 care decision making is driven by values and it's
2 value-centric, not so much as person-centric.

3 VICE CHAIR HANSEN: Thank you, Tom,
4 for raising kind of the much deeper component of
5 a frame of a category of use of language that
6 we've had to bringing up this dimension. And
7 we'll look at how we perhaps exchange our input
8 from the entire group as we wrap up our
9 conversation in a bit.

10 I know there are a number of you also
11 in the queue who have raised your hands, and
12 Zehra has kept track of that. Right now I think
13 we have four, five members of the audience here
14 that we'll call upon. I had initially -- I think
15 it was Charlie next, and then after Charlie we go
16 to Rich. Then we'll have three more people
17 before we go to the queue.

18 DR. LAKIN: Well, I'd just like to go
19 back to the basic person and family-centered care
20 core concept. And care always throws me off a
21 little bit. I'm never comfortable with that
22 term. It seems sort of one-dimensional. But the

1 one core concept that I feel is missing here is
2 that one of helping me live the life I want to
3 live, whether that's involving inclusion or self-
4 determination, maybe employing some sense of
5 productivity and independence. That whole range
6 of one might call quality of life kinds of
7 variables that I think are really core to serving
8 and supporting a person.

9 MS. COHEN: So, the concept of person-
10 centered care really originates in the disability
11 community, particularly the adult disability
12 community and the non-elderly community around
13 home and community-based services. And the
14 Administration on Community Living actually has a
15 really beautiful page that I could email the
16 group that kind of goes into the specifics of
17 that. And it's really looking at the role of the
18 staff, family and other team members to enable
19 someone to assist that person in identifying
20 access to a unique mix of paid and unpaid
21 services to meet their needs and to provide
22 support during planning and implementation for

1 those home and community-based services.

2 And the real core concept of that is
3 the idea of self-direction, that you should be
4 able to direct the amount of hours you receive,
5 how you receive care, the types of services that
6 you receive. And traditionally this has coined
7 the term "personal assistance services." So it's
8 not care. It's assistance in your daily needs.

9 And I think that when you start to get
10 into the more medical realm, that's where people
11 with disabilities get very uncomfortable with the
12 concept of person-centered care, because they're
13 used to the providers controlling those services
14 that someone receives. And in many cases person-
15 centered care on the medical side has more to do
16 with they want to control the types of services
17 that they receive and they also want to refuse
18 care.

19 So there's this concept that people
20 with disabilities want to access all this care
21 and in reality many adults with disabilities want
22 to avoid care as much as possible and want

1 preventative services that will allow them to
2 maximize their daily living in the best way
3 possible. And that's a very foreign concept to
4 providers that think they need to care and
5 caretake adults with disabilities. And so it's
6 something to really keep in mind.

7 And we talked about this previously,
8 the concept of dignity of risk. So we discussed
9 the idea that people with physical disabilities,
10 people with developmental disabilities may engage
11 in health and wellness activities like physical
12 activities that may not always be the things that
13 other people perceive that they should be doing.

14 And so I gave the example; it's not
15 necessarily a good health care example, although
16 it was interesting, a friend of mine who has
17 cerebral palsy went skydiving and he actually --
18 his parachute didn't fully open and he got a
19 little injured. And he was okay, but he went to
20 the ER. And the ER staff was harassing him for
21 skydiving, that he engaged in that dignity of
22 risk because he was disabled instead of at the

1 time of the ER visit asking him about his general
2 health and other health preventative things.

3 So that's not necessarily a perfect
4 health care example, but it's an example of how
5 dignity of daily risk that we all engage in
6 overlaps in the health care system and how we
7 need to be aware of that when we're doing person-
8 centered care.

9 VICE CHAIR HANSEN: Thank you, Anne.
10 Again, rich consumer and persons approach to
11 this.

12 Rich next, and then we'll go to Gwen
13 and we'll finish up with Shawn.

14 MR. BRINGEWATT: Yes, I really like a
15 lot of what I see here in the definition and the
16 kind of principles that are involved. And that
17 doesn't mean there aren't things that can and
18 shouldn't be added. I like the comment you made
19 here in terms of the value perspective there, but
20 part of what I like about what I see here is it
21 incorporates a sense of system-ness, and that's
22 particularly important for complex care

1 populations, frail, disabled, chronically ill
2 people.

3 I think, given the majority of costs
4 relating to duals, and duals is our lens, it's
5 related to people who are frail, related to
6 people who have disabilities, adults with
7 disabilities and has a focus on people with
8 complex medical conditions. And so that kind of
9 system-ness is important. That's, from a
10 measurement standpoint, a very difficult area to
11 move into because we really don't have system
12 measures. And so, where can we begin to nibble
13 at that in terms of how to deal with it?

14 As a general principle, I would
15 suggest that for the complex care beneficiary,
16 the system needs to mirror the conditions of the
17 person, meaning almost the opposite. It comes
18 back to the comment here that was made before, in
19 terms of people things for themselves. We need
20 to empower self-help. And so where somebody has
21 the capacity to do something for themselves, the
22 system needs to mirror that.

1 At the same time where they don't have
2 the capacity to do something for themselves, the
3 system needs to mirror that, and it needs to
4 mirror it in its multi-dimensional, inter-
5 dependent, ongoing nature of the condition that
6 exists. It's a systems problem so that the
7 system itself has to mirror the nature of that
8 problem.

9 In thinking about then where do you
10 focus that system thinking, from my standpoint
11 the most important point of focus is the group of
12 providers that serve the same person, either at
13 the same time or in sequence to one another. If
14 you have an individual who just needs hospital
15 care and is pretty self-sufficient, system-ness
16 isn't as much of a problem. Or if you go to the
17 doc, it isn't much of a problem. But where it
18 becomes a problem is is how those dots either
19 connect or don't connect and there needs to be
20 some flexibility in how you help those providers
21 do things differently for the individual.

22 Within the context of that, I think an

1 important context is the notion of continuity of
2 care as something different from transitional
3 care in the sense that in my mind, continuity of
4 care has mostly to do with you have a group of
5 people who are involved in a person's life and
6 helping them where they function as a team.

7 And that's different than care
8 management. That's beyond care management.
9 Sometimes I think care management becomes more an
10 excuse to not fix the system and just help people
11 through the maze. And so, we need to think about
12 how we re-engineer the system for the system
13 itself to be person-centered in its concept. And
14 so, that kind of continuity and extended care
15 pathways, if you will, I think become part of
16 that. I think I'll stop there for the moment.

17 VICE CHAIR HANSEN: So, your concept
18 of making it match so the system complexity
19 matches the need at the time and the degree of
20 multi-faceted-ness that's involved. Thank you.

21 Let's move to Gwen, and then we'll do
22 Shawn.

1 DR. BUHR: I agree with what Rich was
2 saying. And then I just wanted to call out the
3 spoke of the wheel in person-centered care on
4 shared decision making, because I think that
5 addresses some of what Tom was talking about,
6 that if we have robust, shared decision making,
7 which I think often we do not, then the families
8 will understand and the patients understand the
9 different options. And in my experience, they're
10 choosing the futile care because they're not
11 explained everything and they don't understand.
12 Because you can't just -- I think we've gone too
13 far. We used to be --- totally tell the patient
14 what to do and paternalism. And now we're
15 totally let the patient decide what to do and
16 we're missing the shared decision making. So if
17 we truly have great communication and shared
18 decision making, most of the time there's a
19 mutually -- it's more toward the value. Maybe
20 not completely what the -- completely value, but
21 it's what the patient wants, but it's also not
22 futile usually.

1 VICE CHAIR HANSEN: Right. So, this
2 blending of -- almost the concept of the three
3 bears. It's not going to be too much, it's not
4 going to be too little, but there's a mix here
5 that has a very deep matrix to this.

6 DR. BUHR: And it's also something
7 difficult to measure. I mean, how are you going
8 to measure whether somebody's talking the right
9 way to the patient and the family and they
10 totally understand? That's very difficult.

11 VICE CHAIR HANSEN: Thanks, Gwen.

12 Shawn, and then we will follow with
13 the people who are online.

14 MR. TERRELL: Thanks. In general I
15 think it's in the right direction and it sort of
16 supports in some ways what we're trying to do at
17 ACL and in our HCBS group that we're sort of
18 starting to get going.

19 I would second Charlie's point about
20 really building in as a core concept. It's
21 really about quality of life and why would we
22 have all this if we weren't helping people live a

1 better life in the end for them? So, that
2 extends to things beyond -- so, I mean, it's
3 interesting that this is health care, however,
4 health care is a domain, one of many domains
5 around quality of life, right, that we can all
6 identify in our lives.

7 And there are many lists of domains.
8 And IOM came up with a list that's connected to
9 social alternative health, which I think is --
10 it's useful, but social determinants of health is
11 health isn't in every -- and we talked about this
12 yesterday on the important two, important four
13 concept, health isn't always in every instance
14 the final or only important matter. We trade
15 things off all the time. This is what we do in
16 life and we need to recognize that. And the only
17 way to do that is in the context of each
18 individual person. And this does create a huge
19 challenge for everybody because we want to have
20 deductive top-down kinds of ways of thinking
21 about this stuff.

22 But if we start with at least a

1 recognition that there are multiple quality of
2 life domains that in some instances require some
3 trade-offs or -- that we all make and then we
4 start to think about it. And then on the concept
5 side, this is -- and the process stuff, structure
6 and process concepts, that we really see often
7 this skipped over kind of in a very cursory way,
8 but that's really the core is how you do this,
9 how you approach it, which I think you mentioned.
10 How you approach a person. What's the skill set?
11 We believe that's a high level of skill that's
12 necessary to engage an individual, a family,
13 other people in their lives and all the provider
14 systems in a person-centered way to help address
15 the full range of quality of life goals or
16 interests that a person has.

17 So, we don't have --- so what's
18 happened, and in the disability world this has
19 been around for a long time. Thirty years people
20 have been developing person-centered planning and
21 practice, the techniques, but there was never any
22 until very recently. We're just starting this

1 discussion about what are the core standards for
2 this, right?

3 So we have now the ACA section
4 2402(a). We have a department-wide set of
5 person-centered planning standards which have
6 been published and signed off by the Secretary.
7 They're not perfect, but they are a set of
8 standards that if you go through this list,
9 there's a set of process standards and plan
10 standards to say, okay, you've got to have this
11 stuff in place. It doesn't mean that you can
12 take this and all of a sudden you're doing
13 person-centered planning, but you could also --
14 because anybody could sit in a room and check off
15 all the boxes and not be very person-centered.
16 But it does at least give a foundation for some
17 discussion around what we should be looking at.

18 And then the other thing is how can we
19 start to build that into some credentialing
20 standards if we have zero, frankly? And we have
21 -- within some of the methodologies there are --
22 you can be certified in this particular training,

1 this particular planning method or that, but we
2 have not had a national discussion about this
3 whatsoever, and I think we need that again to
4 address this. And I think that it's very
5 important. We have to recognize that there are
6 experts out there.

7 Of course, obviously there's people --
8 if I want to get a neuropsychological exam, I'm
9 going to go to a neuropsychologist and get their
10 best neuropsychiatrist to get the right -- the
11 best information I can, right? But I'm still the
12 ultimate decision maker about whether I do
13 anything with that or not. I mean, that's just
14 foundational, right? So I don't know that we
15 have to be too concerned about this idea that
16 somebody else has to have a lot of sharing in my
17 decision making. I think it's important to have
18 that information and to offer the kinds of --
19 make sure the best information is out there.

20 One of the best quotes I heard on this
21 question of choice is don't take a vegetarian to
22 a butcher shop and tell him he has choice, right?

1 I mean, this is foundational stuff. This is
2 about the person --- this kind of --- ultimately
3 having control within the context of the best
4 information that we can.

5 So, I guess --- bottom line is how do
6 we engage in this process? What are our
7 standards for this? How do we start to have a
8 discussion about that? Don't skip that over.
9 It's not simple.

10 VICE CHAIR HANSEN: Well, thank you.
11 I think our colleagues here have laid out a
12 structure that we can use. How we go about doing
13 it is something that is going to be the
14 implementation side.

15 I'm going to turn this over to Zehra
16 to call upon people in the queue.

17 MS. SHAHAB: Thanks, Jennie. So
18 there's three work group members on the webinar.
19 First I saw Clarke Ross.

20 MR. ROSS: Hello.

21 MS. SHAHAB: Hi, Clarke.

22 MR. ROSS: When I raised my hand I had

1 two points, and now I have three or four.

2 One, I wanted to reinforce Charlie's
3 observation about the term care. Terminology has
4 very important side effects, implications in the
5 disability field. We tend to use services and
6 supports rather than care. Care tends to be a
7 medically-oriented, paternalistic kind of
8 concept. So I would suggest the use of services
9 and supports in place of care.

10 Number two, how do we measure this?
11 We had a presentation a couple years ago by the
12 Council of Quality Leadership on their personal
13 outcome measures. This is a 25-year-old national
14 accrediting organization of community-based
15 organizations in the intellectual and
16 developmental disability field. There are 21
17 domains of inquiry focused on the individual
18 beneficiary. So it might be helpful to crosswalk
19 those domains of questions with the work that the
20 National Quality Forum staff is doing.

21 I wanted to reinforce Anne's point and
22 Shawn's point about the historic work that's

1 done. In 1978 the Congress of the United States
2 created the Centers for Independent Living
3 programs that ACL now administers. So this
4 concept of personal autonomy and community
5 inclusion, in disability we've done this for
6 decades.

7 And then my last comment was when Tom
8 questioned the value, judgment and validity of
9 people with mental illness and behavioral health
10 conditions it was like fingernails on a
11 chalkboard to me. SAMHSA has funded for a decade
12 a peer recovery movement, people with mental
13 illness who do recover and focus on person-
14 centeredness and valuing their judgment. And our
15 former Committee member Dr. Robinson Beale was
16 the medical director of Optimum, a subsidiary of
17 UnitedHealthcare, a managed care company, who
18 have employed about 2,000 people with mental
19 illness or a history of mental illness as peer
20 recovery specialists because of the value of the
21 individual's perspective on what they want in
22 their life and how to build supports around that.

1 So I just wanted to reinforce basically
2 Charlie and Anne and Shawn, and address the issue
3 of preordained concepts of the ability of certain
4 people with disabilities. Thank you.

5 MS. SHAHAB: Thanks, Clarke. Gail
6 Stuart, you had raised your hand next.

7 MS. STUART: Yes, thank you. So first
8 of all I wanted to say that I thought this
9 presentation of the concept of patient and ---
10 care was one of the best I've seen. There's a
11 lot of ambiguity in the field about what this
12 means and how it's defined. And I particularly
13 liked that circle diagram.

14 I also wanted to point out that I
15 don't agree with moving the idea of patient-
16 centered to value-centered because the values
17 become those of the health care providers, not
18 the patient. And we see that in end-of-life care
19 and some of the research that's been done where
20 even when the patients have documents of their
21 express desires and communicate that to the
22 family, those wishes are overridden by the health

1 care team. So, I hesitate to move into the sense
2 that it would be someone else's values.

3 I do, however, agree with the notion
4 of patient responsibility, but it's hard to be
5 responsible when you feel like you're the object
6 of care rather than involved in the shared
7 decision making process, which gets back to
8 Gwen's point about that being the critical piece.
9 My concern is that we do not teach shared
10 decision making in the health professions. We in
11 fact teach about being confident in your
12 decisions, etcetera, etcetera. And so this is
13 going to be another culture shift. Thanks.

14 MS. SHAHAB: Thank you, Gail. D.E.B.
15 Potter?

16 MS. POTTER: Hi. First I'd like to
17 thank Mitra for her excellent presentation and
18 summary. I was actually a member of the
19 workgroup that did the work that she presented.
20 The excellent discussion that we're having today
21 mirrors the discussion that was held a year ago
22 on these same topics, and it was a lengthy

1 discussion.

2 I'd like to point out that the
3 definition also includes not just care, but
4 health --- the well-being of the person. Not
5 health alone, but also well-being. And there was
6 extensive discussion about, well, should that be
7 quality of life? Should that be well-being? And
8 we actually made a conscious decision that well-
9 being was actually broader than quality of life,
10 but it included quality of life. So it wasn't
11 that quality of life was not part of the
12 discussion.

13 And the last point, several people
14 have made comments about the long history of
15 person-centered care in the disability community.
16 Well, I'll echo that for long-term services and
17 support. And actually it probably actually was
18 the cornerstone for the foundation of a whole
19 industry that we call assisted living to give
20 people dignity and autonomy, rather than living
21 in an institutional setting. Thank you.

22 VICE CHAIR HANSEN: Thank you to all

1 of you for this contribution. I think, one,
2 having a core presentation of this nature and
3 having this topic brought up by NQF in the way
4 that it has and using the lens of this committee
5 group that does bring the different perspectives
6 of ability and wellness, as D.E.B. has just last
7 said, to think about people thriving, because
8 it's not all about care, yet it includes care.
9 So, I think again, the balance of putting our
10 lens on this -- and I'm sure that staff will
11 provide some feedback, cross-feedback to the
12 Committee to bring up our perspective.

13 So again, Mitra, thank you so much for
14 setting this up for us.

15 And, D.E.B., glad you are one of our
16 cross-links.

17 So, at this point we do have our next
18 speaker to bring up our discussion on risk
19 adjustment and sociodemographic factors here.
20 So, let me just --

21 MR. AMIN: Thank you very much.

22 VICE CHAIR HANSEN: -- get my notes

1 here again --- and introduce you. Is it Taroon?

2 MR. AMIN: Taroon. Thank you very
3 much.

4 VICE CHAIR HANSEN: Taroon Amin, who
5 is a consultant with NQF.

6 MR. AMIN: Yes, thank you very much.

7 VICE CHAIR HANSEN: Thank you.

8 MR. AMIN: Sarah, just a quick
9 question on the timing. We have until --

10 MS. LASH: We have until 11:00, maybe.

11 MR. AMIN: 11:00?

12 MS. LASH: Yes.

13 MR. AMIN: Okay. All right. Just to
14 know how to pace the discussion.

15 So, thank you very much. So far today
16 even this has been very rich conversation.

17 So, what I'd like to do, during this
18 next 45 minutes, is to have a discussion with
19 this group about a topic that has been really at
20 a core of some of our measurement science work
21 around the appropriateness of adjusting for SDS
22 factors and risk adjustment models, particularly

1 for outcome and resource use or economic outcome-
2 type measures and really talk about how this work
3 intersects with the work of the MAP Duals meeting
4 and really understand where the path forward is
5 with this work, particularly for this important
6 patient population.

7 So, the outline for this discussion is
8 really giving a little bit of a background on
9 where we've been with NQF's activities, the
10 various perspectives that exist on this topic
11 that came very clearly through our work through
12 this expert panel, which was looking at this
13 important question of the appropriateness of SDS
14 factors and risk adjustment, describing the
15 policy change that NQF has undertaken in the
16 context of other broader policy considerations
17 that's happening related to various payment
18 programs and programs in which these measures are
19 being used, a discussion at a high level about
20 our trial period, and then really moving into a
21 discussion more broadly about how this work
22 intersects with the work of the MAP Duals

1 Workgroup, which really has an important focus on
2 these activities for this important population.

3 So, why have we really undertaken this
4 work? NQF has really been working to identify
5 these issues related to risk adjustment for SDS
6 factors, and in particular we convened an expert
7 panel to consider the questions of if, when and
8 how outcome performance measures should be
9 adjusted for SES or other related demographic
10 factors.

11 I just want to point out that when we
12 talk about outcome performance measures, these
13 include economic outcome measures related to
14 resource use or cost. And the basic fundamental
15 reason why NQF has undertaken this work is that
16 overall quality, by and large, has improved,
17 however, disparities in care generally have not.
18 There is a growing evidence regarding the role of
19 SDS factors and the outcomes being measured and
20 there needs to be continued growth on evidence-
21 based interventions that could help close the
22 gap.

1 And as Sarah pointed out earlier in
2 this morning's conversation, there isn't great
3 evidence in terms of the appropriateness and the
4 methods used for stratification, and additionally
5 the use of these measures for quote/unquote
6 higher financial stakes uses has made this
7 particularly an acute issue, particularly for
8 safety net providers who are disproportionately
9 providing care for this population.

10 And so the question becomes, well, why
11 risk adjust? And the main reason for risk
12 adjustment, broadly, is that consumers aren't
13 randomly assigned to health care units or
14 providers or facilities, and those
15 characteristics of the consumers do vary across
16 health care units. In measurement we want to
17 make sure that we're avoiding any incorrect
18 inferences about provider performance. And in
19 the context of comparative performance we want to
20 really understand how would performance compare
21 across providers if they hypothetically had the
22 same mix of consumers.

1 So, the current policy -- I should say
2 before January 1, 2015, was that consumer patient
3 demographic factors influence outcomes through
4 various different pathways, and sociodemographic
5 factors may also be related to disparities in
6 care and health care. So, the NQF policy related
7 to including these factors was that we
8 essentially prohibited the inclusion of SDS
9 factors in risk adjustment models, rather
10 preferring including these measures as
11 stratification elements. And just defining what
12 we mean by sociodemographic factors, we include
13 socioeconomic factors, income, education,
14 occupation as examples, but also demographic
15 factors including ethnicity or primary language.

16 And again, just a little bit
17 definitionally what is really the difference
18 between risk adjustment and stratification? Risk
19 adjustment generally refers to statistical
20 methods to control or account for differences in
21 patient populations through various different
22 statistical approaches. They may include

1 multivariate modeling approaches, indirect
2 standardization, as most know it as, or direct
3 standardization through matching of patients
4 based on various different characteristics.
5 Generally these methods result in a method that
6 results in a ratio of observed to expected
7 outcomes.

8 Stratification on the other hand
9 computes performance differently, in which you're
10 actually looking at performance across different
11 strata or groupings based on some
12 characteristics. So you may look at the
13 performance of readmissions based on the
14 percentage of dual eligibles, for instance,
15 making it very acutely related to the
16 conversation we're having here.

17 I would just point out that what's a
18 little bit challenging is that while these are
19 sort of presented here as two options to the same
20 problem, increasingly many of these measures are
21 being used for accountability applications and
22 the option of stratification becomes increasingly

1 more complex given the small numbers of patients
2 in the various different strata. And also
3 interpretation of those results for the purposes
4 of calculating performance or, in some cases, a
5 penalty for the provider may become even more
6 complex than that.

7 So before we really get into the
8 change in policy, I just want to outline some of
9 the core principles that NQF had in undertaking
10 this work, because while there's a core-central
11 statistical question at hand, it actually
12 obviously, as it relates to this group, and more
13 broadly, is rested in a broader context of how
14 we're looking at this -- again statistical
15 problem in the context of policy.

16 First, that outcome performance
17 measure is -- performance measurement is critical
18 to the aims of the National Quality Strategy, so
19 it's important to keep these outcome performance
20 measures at the forefront of our work.

21 Secondly, disparities in health care
22 and health should be identified and reduced.

1 Just because we're moving into an outcome
2 environment doesn't mean that the focus on
3 disparities isn't continued to be central to our
4 work.

5 Third and very related to the second,
6 performance measures and measurement should never
7 result in an increasing of disparities and health
8 and health care, particularly for vulnerable
9 populations.

10 Fourth, outcomes may be influenced by
11 a number of patient health status factors,
12 clinical factors and patient demographic factors.

13 And as I go to the next slide, these
14 factors should be considered individually as it
15 relates to the individual measure focus. So I
16 just want to point out there that we don't want
17 to make broad statements about it's appropriate
18 to include language, for instance, primary
19 language as an appropriate risk adjustment factor
20 for all performance measures because that would
21 be in some cases very inappropriate. So, we'll
22 get into that in a little bit more detail.

1 But, when used in accountability
2 applications, performance measures that are
3 influenced by factors other than the care
4 received, particularly outcomes, need to be
5 adjusted for the relative differences in case mix
6 to avoid incorrect inferences about performance.
7 So we really want to be able to understand and
8 isolate to the extent that's actually
9 conceptually possible the amount of variation
10 that is attributed to the hospital or the
11 facility performance, and that may be underlying
12 conceptually with the patients themselves.

13 Additionally, risk adjustment may be
14 constrained by clear data limitations and data
15 collection burden. Many of these variables that
16 we've discussed are not routinely captured in
17 many of the data systems that exist, depending on
18 the facility in question, and we do need to
19 recognize that this field needs to continue to
20 evolve to move this forward.

21 And then finally and most importantly,
22 or equally importantly, the methods, factors and

1 rationale for risk adjustment should be
2 transparent for users.

3 I'll continue to go through even
4 though there are some questions being raised.

5 Okay. So, there are various different
6 perspectives.

7 VICE CHAIR HANSEN: Excuse me, Taroon.
8 If it's just a clarifying question, it might be
9 helpful here.

10 MR. AMIN: Okay.

11 VICE CHAIR HANSEN: Okay. Anne?

12 MS. COHEN: No.

13 VICE CHAIR HANSEN: No?

14 MR. AMIN: It's more broadly. Okay.

15 And I mean, I'm sure this will
16 generate a lot of conversations, so let me just
17 get through this and we can talk about it.

18 So there are various different
19 perspectives on this issue, and these
20 perspectives really sort of -- very much
21 contained the National Quality Forum for quite a
22 bit of time through 2014 to really sift through

1 these various perspectives and understand the
2 path forward. And so, I'll just outline the two
3 divergent views to set up sort of the extremes.
4 And obviously there's a middle ground between
5 these two.

6 The first is that adjusting for SDS
7 factors will mask disparities, and this, for
8 obvious different reasons, is undesirable.

9 The other counter-option or divergent
10 view is that adjusting for SDS factors is
11 necessary to avoid making incorrect inferences in
12 the context of comparative performance
13 assessment.

14 Those that oppose SDS factors have
15 noted that some providers may deliver worse
16 quality care to disadvantaged populations, and by
17 including these factors in the measure, we may
18 not really be able to understand these meaningful
19 differences in quality. And with the inclusion,
20 worse outcomes could be expected and there would
21 be limited -- that may be a little strong --
22 there may be limited expectations for

1 improvement. And the stratas themselves imply a
2 different standard of care. Additionally,
3 there's limited adequacy of SDS data and there
4 may be other preferred payment approaches to
5 actually improving the care, or maintaining the
6 safety net, rather than adjusting the underlying
7 measure itself. So, that's one perspective.

8 And then the counter-perspective is
9 that the purpose of risk adjustment is to allow
10 for comparative performance, and a performance
11 score alone, whether or not adjusted for SDS
12 factors, cannot simply identify disparities. And
13 further, in the particular case of -- hospitals
14 caring for disadvantaged populations are already
15 being penalized, based on specific federal
16 programs that are in place. For instance, the
17 Hospital Readmissions Reduction Program.

18 Further, there's no evidence that
19 disparities would be reduced through these
20 negative financial incentives, and the lack of
21 adjustment would continue to create disincentive
22 to care for the poor and other disadvantaged

1 populations. So again, this obviously interacts
2 with the work of this workgroup very directly.

3 So I just wanted to outline what the
4 NQF policy change is, is that each measure should
5 be assessed individually to determine whether SDS
6 adjustment is appropriate. So again, I just want
7 to really underline the fact that while we do
8 have a change, which is a change in removing this
9 restriction of SDS factors, it doesn't mean that
10 all SDS factors or many need to be included in
11 all measures. In a lot of cases, that would be
12 inappropriate.

13 And again, just highlighting that, not
14 all outcomes should be adjusted. There needs to
15 be a conceptual basis, a logical rationale, a
16 theory underlying the inclusion of the SDS factor
17 itself and empirical evidence that demonstrates
18 its relationship to the outcome. And again, not
19 all SDS factors are created equally, particularly
20 as it relates to the underlying theory.

21 And then finally, these
22 recommendations would apply to any level of

1 analysis, including health plans, facilities or
2 individual, clinician-based measurement. And the
3 individual measures as they're evaluated,
4 specifically looking at the question of risk
5 adjustment, should be selected based on existing
6 guidelines around how we select risk adjustment
7 factors.

8 Again, just want to reiterate the
9 first two, which are arguably some of the more
10 important around the conceptual rationale and the
11 empirical relationship, and then just pointing
12 out a number of others. They should be present
13 at the start of care. They should be resistant
14 to manipulation or gaming by providers. The data
15 should be accurate. We should be able to
16 calculate the data reliably and feasibly. It
17 should be able to contribute to unique variation
18 in the outcome, or not redundant. Again,
19 reiterating the importance of the empirical
20 analysis. And there should be face validity and
21 acceptability for multi-stakeholders in the
22 evaluation process.

1 So, in order to move this forward NQF
2 is undergoing a two-year trial period prior to a
3 permanent change in NQF policy. During this
4 trial period, if SDS adjustment is determined to
5 be appropriate for a given measure, NQF will
6 endorse one measure with specifications to
7 include the SDS-adjusted measure, the non-SDS
8 version of the measure and a stratification
9 approach. And the last two are the non-SDS
10 version of the measure and stratification
11 specifications are suggested or required as part
12 of the evaluation to allow for the ability to
13 stratify the measure and be able to see
14 differences in performance without the SDS factor
15 and the risk adjustment model.

16 So how does this interact with the MAP
17 Duals work? When measurement programs use a
18 national average, rather than peer groups to
19 determine a benchmark or a performance threshold,
20 and measures within the program are not risk
21 adjusted, entities that serve a higher proportion
22 of dual eligibles may be disadvantaged. Two

1 particular notable examples of that may be the
2 Medicare Advantage Star ratings and the Hospital
3 Readmissions Reduction Program.

4 So without clear adjustment you could
5 see the impact that it may have on these two
6 particular applications, but there may be others.
7 Now, whether that's appropriate or not again is
8 up for discussion. But employing risk
9 adjustment, and stratification for that matter,
10 will not address the underlying problem of
11 potentially poor care for complex consumers.

12 So while this is related to the
13 conversation of disparities, it still doesn't
14 address the underlying causal area that we really
15 want to be focused on as a measurement community.

16 And so, moving forward for discussion,
17 none of the measures available for today's
18 discussion have been SDS-adjusted at present, and
19 these types of measures are expected to emerge
20 over the coming year and likely into the next
21 year as measure developers are quickly trying to
22 understand the relationship between these factors

1 and the outcome.

2 Are there considerations for this
3 project associated with the NQF policy change?
4 Given the unique focus of this workgroup, we are
5 interested as we move forward with this policy
6 change to understand what this group's
7 perspective on this topic is. And secondly, how
8 do we avoid misuse of measures for this
9 population, particularly for health plans that
10 enroll dual eligible beneficiaries or health
11 plans that are specifically structured for dual
12 eligible populations, and then also for hospitals
13 and other providers that may disproportionately
14 care for dual eligible beneficiaries.

15 And then finally, what delivery system
16 changes are needed to improve the underlying care
17 for populations, particularly those populations
18 with low SES, or particular SDS factors.

19 So with that, I'll turn it over to the
20 Chairs to lead a discussion.

21 VICE CHAIR HANSEN: Thank you, Taroon,
22 for a very thoughtful, very clear presentation.

1 I know we have three members here in
2 the conference room, four members in the
3 conference room ready for comment. And, Zehra,
4 how many people on the line here?

5 MS. SHAHAB: Currently there's one,
6 but I'm sure there will be more.

7 VICE CHAIR HANSEN: Okay. All right.
8 So let us start with, let's see, Anne and then
9 Rich.

10 MS. COHEN: So, I come from the pure
11 Medicaid health plan realm, and in that
12 perspective, the focus on risk adjustment for
13 them was always increased payment, of course, and
14 wanting to risk adjust for their disability
15 population and not really having tools to do so
16 other than the ATO and sort of constantly facing
17 there's more complexity in the disability
18 population than just their ATO. And so, when it
19 trickles down to the quality measurement role, I
20 think where this becomes kind of interesting -- I
21 don't know if it's problematic yet, but
22 interesting is where you have a health plan with

1 a multi-mix patient population that is joined in
2 the accountable care ---

3 So, I'm going to use the example; and
4 forgive me because he's in the room, but Patrick
5 Curran is with CareOregon who we'll be hearing
6 later, and they've joined a health co-op. And
7 so, a small -- and correct me if I'm wrong,
8 that's just what I've been reading -- but, so
9 they're enrolling different groups of folks,
10 different patient populations, different younger
11 populations in the Portland Metropolitan Area
12 that has very specific socioeconomic factors, has
13 a variant patient mix. And so, having a test
14 population like that, which is a very defined
15 healthcare market with very defined providers,
16 might be rather interesting to test the
17 differential between stratification and risk
18 adjustment.

19 VICE CHAIR HANSEN: Thank you very
20 much, Anne. Yes, it will be good to hear from
21 CareOregon in a little bit.

22 Rich?

1 MR. BRINGEWATT: Yes, I want to make
2 a couple of comments here. One is I think it's
3 important to start out with what we know and what
4 we don't know. And I think first in terms of
5 what we do know, from a dual perspective, the
6 only real characteristic that's present to all
7 duals is poverty. That's really what makes a
8 dual different from other Medicare beneficiaries
9 in the sense that there are relatively healthy
10 duals and there are sick duals and have all other
11 kind of characteristics present.

12 And secondly, it's real clear that
13 poverty is more than the absence of income. It's
14 not simply that somebody doesn't have the ability
15 to pay for needed care. There just are a host of
16 other factors that are involved. There are
17 decades of research that shows that social,
18 demographic, environmental factors affect health
19 and health outcomes. The presence of that
20 literature is clear.

21 And so, the question becomes not
22 whether to do something about this, but what to

1 do about this. And that's the \$64,000 question
2 right now because we don't have the kind of
3 research we would like to have in terms of
4 measurement and how to approach this.

5 I think it's important though to
6 recognize that there's -- and I loved your
7 presentation here. It was extremely helpful, I
8 think, for this discussion in kind of labeling
9 where we are and where we aren't. I want to just
10 lift up a little bit a study, a second study by
11 Inovalon that will be coming out probably within
12 the next week that I will make sure everybody
13 gets a copy of just to see that. But a first
14 study that Inovalon did; and Inovalon is a large
15 company that has the largest database of any
16 company in maybe the world, but clearly in the
17 United States as it relates to health care
18 quality measures.

19 And where they looked at millions of
20 people and looked at, not just duals and
21 socioeconomic status in plans, but on an
22 individual basis. And part of this study that's

1 going to come out shortly is going to be their
2 findings as it relates to individual-based
3 factors in relation to social-economic status.

4 One of the biggest questions has been
5 there is evidence that dual plans that serve all
6 duals on the same measures tend to have lower
7 scores than plans that don't serve lots of duals.
8 And one can say that's all about a dual plan
9 providing worse care than it is -- you know,
10 that's what the measure shows.

11 What Inovalon has shown is that if you
12 control for type of plan, whether it's a dual
13 that's part of a general MA plan or part of a SNP
14 plan, these SNP plans -- different parts of the
15 country, different characteristics -- that there
16 is a statistically significant difference between
17 duals and non-duals at an individual basis as it
18 relates to a star measure. And those differences
19 tend to be different depending upon the measure
20 that you look at, but there's clear difference.

21 And there was a question as to whether
22 risk adjustment makes a difference in relation to

1 that, and so they looked at the only star measure
2 that is risk-adjusted, which is hospital
3 readmissions; and it's currently adjusted for
4 age, gender and condition, and found that even
5 with that measure there's a statistically
6 significant difference between duals and non-
7 duals in terms of their performance at an
8 individual basis.

9 So, I think there's pretty solid
10 evidence here for the first time that kind of
11 moves clarity towards this being about the
12 individual, not about the plan. It doesn't mean
13 you don't have poor plan performance for certain
14 plans, and you don't want to take people off the
15 hook, and we're not suggesting anybody gets taken
16 off the hook and not suggest just compensate and
17 then don't worry about what happens. Don't just
18 compensate for the difference in status, but
19 people need to be accountable for what they do.
20 But if one plan has to jump a higher hurdle for
21 the same distance than another plan, then you
22 need to take that difference somehow into

1 account.

2 So, I'll just hit quickly and not go
3 into any detail, but we're looking at both --
4 there's a short-term problem here and there's a
5 long-term problem here. CMS has proposed some
6 strategies for dealing with both. We think that
7 there's a short-term problem where plans like
8 CareOregon are significantly affected by a
9 quality measurement, where there are really bonus
10 points and money involved, money on the table,
11 that if you don't get the money on the table, you
12 have an adverse effect, particularly if the cost
13 of caring for a high-risk population with these
14 socio-determinants is more expensive. It's kind
15 of a double whammy. There's a short-term effect.

16 And then there's a long-term strategy
17 here. And the long-term is going to take some
18 time to really sort this out. There needs to be
19 new research. There needs to be things -- a
20 long-term fix. It's important to get started
21 now, but we can't suddenly just have a short-term
22 fix -- a long-fix overnight. And it's likely to

1 involve factors that are underneath the social
2 determinants. Like comorbidities can be a factor
3 and other health-related issues in addition to
4 some of the more demographic ones.

5 But it's also I think helpful to know
6 that the Inovalon study is going to show some
7 factors that are -- what are the factors driving
8 the difference? And that also depends upon what
9 the measure is. But if you look at the hospital
10 readmission rate, one of the prominent factors
11 driving the difference is simply does a person
12 live in a poor community versus one that doesn't?

13 And so, this is a complicated issue,
14 but I really appreciate the fact that National
15 Quality Forum has this on our agenda and are
16 addressing it in a very thoughtful, careful way.
17 And Patrick is going to, I think, share some real
18 substance underneath all of this as we get to
19 him.

20 VICE CHAIR HANSEN: Thank you, Rich,
21 and we'll look forward to that resource that
22 you're going to share.

1 Okay. Let's move to Tom, and after
2 that Shawn. And when Gwen comes back, as well as
3 Anne. And, excuse me, I'll go to the people on
4 the waiting list.

5 DR. LUTZOW: Yes, first of all I think
6 it's remarkable that NQF did a 180. And I wish I
7 were a fly on the wall to understand the dialogue
8 that caused that 180 switch, because you have
9 here certainly a voice, a strong voice in the
10 discussion, and without NQF recognizing the
11 impact of SES the argument would be weaker. So,
12 I mean, it's almost unbelievable that that 180
13 switch occurred, but I'm grateful.

14 The thing about these measures, you'd
15 like science to solve the problem, and certainly
16 there is scientific evidence that SES has an
17 impact on outcomes, but science doesn't seem to
18 be winning the day. As we expand five-star
19 measures through hospitals to nursing homes to
20 home health agencies, the chorus of people
21 speaking about SES will increase, and it seems
22 like science is not going to win the day. It's

1 going to be political action and legislation
2 that's going to have to win the day. I think
3 that's unfortunate. I think that this needs to
4 be an evidence-based, truth-driven, as opposed to
5 a political/economic-driven solution, but I don't
6 see us moving fast enough to a solution from the
7 scientific side.

8 This idea of, for instance in
9 Milwaukee, the best heart surgeon has the highest
10 death rate among his patients. How is that
11 possible that the best cardiologist has the
12 highest death rate? It's because he gets the
13 impossible cases. Everybody else passes to him
14 the impossible cases. And yet from a metric
15 standpoint, he looks the worst. If we have a
16 metric system that discredits the best doctor in
17 the community, the problem is with our metrics.
18 And I think we are seeing a similar problem with
19 socioeconomic conditions. The best program may
20 be doing the worst because of who it's serving
21 and not because it's the worst plan.

22 So, something's wrong with us in our

1 thinking as social scientists. We do need to
2 accommodate those changes and conditions. And
3 everybody's worried about, well, we don't want to
4 reward a bad provider in a poor neighborhood
5 who's doing a bad job. I think that's a false
6 worry and we need to move more quickly to making
7 sure that those folks who are poor and
8 vulnerable, who don't have transportation on a
9 cold day like this and can't get to a doctor,
10 they should not be asked to compete on the same
11 level as some well elderly Medicare person who
12 lives in the suburbs and has two cars and a condo
13 in Florida. Those folks in the inner city cannot
14 compete on those same performance measures, and
15 let's stop asking them to do that.

16 VICE CHAIR HANSEN: Thank you for
17 acknowledging the thoughtfulness and the rigor
18 which NQF is taking on this very, very serious --
19 both science and contextual set of issues here.

20 Gwen, we'll go back to you.

21 DR. BUHR: (No audible response)

22 VICE CHAIR HANSEN: Okay. All right.

1 Then, Shawn?

2 MR. TERRELL: Thanks. I think I agree
3 with you on your points, Tom. I think that's
4 really important that we -- and this really does
5 get I think more complex, as Anne pointed out,
6 when talking about people with disabilities.

7 And I -- well, not a question. So the
8 application of this concept in that realm. So
9 just to take an example, you have a lot of people
10 with developmental disabilities living in small
11 group homes around the country, thousands and
12 thousands of group homes. And so they're not
13 technically institutional, although there are
14 many institutional sort of aspects to many of
15 these homes.

16 So a lot of people are very isolated
17 in these settings. They don't have a lot of
18 connections outside of the provider system that's
19 providing services and supports, the people that
20 they know are the people that they -- they're
21 providing personal assistance, and the people
22 that they live with. And maybe at best, if there

1 are a lot of people, it's a sheltered workshop
2 kind of environment, getting sub-minimum wages.

3 So if you go in there and you do
4 person-center planning as we all would like to
5 have it done, people start saying, well, I want
6 to meet some people outside of this group home
7 that I live in and the people that serve me. I
8 want to have real relationships. I want to
9 actually have a job where I get paid like anybody
10 else.

11 How does this apply -- I'm sure it
12 does. I just -- that's a huge question, I think.
13 And it's back to, like Tom's point, that it's a
14 different set of perhaps metrics and a different
15 focus. Like for instance are there services to
16 help a person do all these things? Get
17 supportive employment services. There's plenty
18 of evidence-based practices out there. Are they
19 available? Are there services that whose -- the
20 person's job it is to help that person integrate
21 in a community in a way that they'd like? And
22 so, can this -- I think it can, but I think

1 that's sort of a challenge. How do we approach
2 this idea of risk adjustment to push -- in most
3 cases it's state systems to adopt the kinds of
4 services and supports that will really honor the
5 goals in these plans if we do them right. So,
6 that's the question. And thanks for the time.

7 VICE CHAIR HANSEN: Thank you for
8 pointing that this is a crucial intersection
9 between care, medical, clinical system to
10 services and supports in terms of people's
11 ability to thrive.

12 I'll come back to you, Anne, but we
13 have somebody on the queue here.

14 MS. SHAHAB: Kata Kertesz?

15 DR. KERTESZ: Hi. Thank you for that
16 great presentation on such an important issue.

17 We have some concerns about this kind
18 of risk adjustment potentially dis-incentivizing
19 plans from adjusting the root of the disparities.
20 And I think it's important to add to this
21 discussion some things that have already been
22 said that there is data to suggest that there are

1 differences in performance in plans of duals and
2 non-duals, but the causal relationship has not
3 been established, which I think is a central
4 question to determine how best to address this
5 issue.

6 So to respond to something that I
7 think Tom mentioned earlier about a plan that has
8 wealthy Medicare beneficiaries who have access to
9 transportation and are able to go to their
10 appointments versus a plan that has a lot of
11 lower-income individuals who aren't able to get
12 transportation, that those plans shouldn't be
13 placed against each other in the star rating
14 system. And I think that the solution isn't
15 necessarily to increase the performance measure
16 for the plan that has the low-income individual
17 who isn't able to get to their appointment,
18 because by doing so we wouldn't actually be
19 improving their care. We'd just be sort of
20 giving a pass to that plan perhaps.

21 And I think sort of stressing the
22 importance of providing services that would

1 actually lead to improvements in care should be
2 where our focus is. There are a lot of plans
3 that do have a high dual population that do
4 perform well. There's a plan in Denver that
5 emphasizes these kinds of things, like having bus
6 stops near their locations and having 24-hour
7 call lines so that people can speak to someone,
8 make appointments, cancel appointments after
9 hours because of the unique needs that the dual
10 population has that we're all aware of.

11 So I just wanted to mention that, that
12 there are plans that are performing well and I
13 think we should also look at how to better
14 improve care through these services and not just
15 try to adjust the star ratings and the other
16 rating systems.

17 And then I had a question about --
18 with this lack of data that we've all
19 acknowledged and the issues with collecting data
20 in this area. There isn't really standardization
21 in how to ask these questions and how to
22 determine exactly these causal relationships.

1 How does that impact this two-year trial-period?
2 And when it becomes permanent how does NQF
3 envision determining if these are successful and
4 when they will become permanent with this extreme
5 lack of data? Thank you.

6 MR. AMIN: So this is Taroon.

7 VICE CHAIR HANSEN: Yes, Taroon is
8 going to respond here.

9 MR. AMIN: So, I think this point and
10 the point that Shawn raised right before this --
11 I think both raise some interesting questions.
12 And the spirit of what we know the answer to and
13 what we don't; there are some we don't know the
14 answer to, but I'll just reflect on a few of the
15 topics.

16 The first is I just want to reiterate
17 that again this change in policy is removing the
18 restriction of including these SDS factors, and
19 so that raises an interesting sort of challenge
20 for us as we move forward, which is that these
21 individual measures need to submit and consider
22 and reflect on the conceptual rationale for how

1 the SDS factor relates to the causal pathway for
2 this outcome.

3 And I think that in itself is actually
4 a very important contribution to be able to
5 understand and study how these factors really
6 influence the outcome and who ultimately is
7 responsible. Because some of the pathways may
8 actually require provider intervention or there
9 may be opportunities for provider intervention
10 that may not have been clear and transparent in
11 the past. And some may not have the opportunity
12 to be influenced by the provider, and they would
13 -- likely we would just include them and not
14 expect provider intervention at that point.

15 So, the examination of the causal
16 mechanism will be different for each of the
17 different measures that we're looking at and each
18 of the different outcomes, and obviously the
19 factors themselves. So that's A.

20 B, as it relates to the data, I think
21 again one of the challenges that we've had in
22 this disparities field for quite some time is

1 that the data isn't systematically collected, but
2 what's really opportunity for moving forward with
3 this kind of trial period is that it sort of
4 forces some systematic data collection for
5 particular types of data elements. And if folks
6 know that these data elements relate to the
7 outcome and how they're being measured and how
8 they're being profiled, I think that's a pretty
9 good reason to collect that data going forward.

10 Now again, we don't know that, but we
11 can at last assume that it will be an impetus on
12 an area that we've been trying to make progress
13 on for quite some time, and maybe this will help
14 advance it or accelerate it a little bit more
15 than it has in the past.

16 VICE CHAIR HANSEN: Thank you. We
17 know that we're only at the beginning.

18 We still have other people on the
19 queue?

20 MS. SHAHAB: So, D.E.B. Potter, you
21 had raised your hand earlier.

22 MS. POTTER: Can you hear me? I'm

1 sorry. I had to -- never mind.

2 MS. SHAHAB: We can hear you, D.E.B.

3 VICE CHAIR HANSEN: We can hear you.

4 MS. POTTER: Okay. Difficulty with
5 pushing the right mute button.

6 I had a couple of technical questions
7 for the presenter.

8 Thank you so much for your
9 presentation. On your slide on trial period, I
10 just want to make sure I understand this
11 completely. The trial period is for new measures
12 that are submitted to NQF? Because I've heard a
13 lot of discussion about the hospital readmission
14 measures, and so I'm confused about that.

15 MR. AMIN: Can I take that? So, the
16 trial period will sort of -- the way I've been
17 characterizing it has three different streams.
18 The first is new measures that are submitted
19 after April 1st, 2015. So those are completely
20 new measures.

21 The second stream includes guidance
22 from the NQF Board that the measures that were

1 under -- this is a little technical, but the
2 measures that were under consideration for the
3 readmissions and cost and resource use, the
4 project that just completed in late 2014. Those
5 measures should be considered in the trial
6 period. So that's the second stream.

7 The third stream is that any
8 stakeholder can raise a request for an ad hoc
9 review on an existing measure based on the fact
10 that the criteria has changed and that the change
11 in criteria would have a material impact on a
12 specific measure. And so, all that information
13 related to the ad hoc review process is available
14 on our web site.

15 So those are the three different
16 streams. How quickly measures get reviewed is
17 determined by the scope and the work load of the
18 individual standing committees. So readmissions
19 in particular, because of the volume of measures
20 that are within that steering committee's domain,
21 will likely require a multi-staged approach
22 toward individual review.

1 MS. POTTER: Okay. Thank you. That's
2 very helpful.

3 And my second question has to do with
4 -- you referred to SDS, and a lot of the
5 discussion today is around SES. And I guess I
6 would say that age and sex, while they're in the
7 SDS category aren't in the SES category. But we
8 know that a lot of the clinical guidelines and
9 the health in general is related to age and sex.
10 And so, a measure that only has age and sex would
11 be evaluated using the same criteria as the
12 measure that has age, sex and socioeconomic
13 status? I'm trying to understand where age and
14 sex are versus the other things on your list.

15 MR. AMIN: Thank you for that
16 clarification. And there's no question that it
17 -- I don't think you're the only one that's sort
18 of needs -- we all need some clarity on this
19 issue.

20 So, the way that we're thinking about
21 this; and again, this is up for interpretation
22 given that there's a lot of differences of

1 opinion about this particular question about the
2 variables that are included in these factors. We
3 think about sociodemographic factors as a larger
4 umbrella which includes sociodemographic -- or --
5 let me -- I'm going to start over again because
6 there's no way that could get any more confusing
7 than where I started.

8 (Laughter)

9 MR. AMIN: Okay. The way we're
10 thinking about this is that sociodemographic
11 factors is the larger umbrella underneath which
12 we include socioeconomic factors, which could
13 include income, education, things like that that
14 are related to economic factors. But it also
15 could include demographic factors, which are just
16 innate characteristics of the patient. Their
17 language, their age. And this is in addition to
18 clinical factors which are related to the
19 patient's health outcomes, which would include
20 their comorbidities that are present at the start
21 of care.

22 So, that's the construct in which we

1 think about this. I would say the overarching
2 summary statement is that the inclusion of any of
3 these variables: clinical, sociodemographic
4 factors, which include the two components, all
5 require the same evaluation process. They
6 require clear conceptual rationale and they
7 require an empirical relationship to the outcome
8 that's unique. And measure developers need to
9 consider that for each individual measure
10 construct that we're looking at. And that needs
11 to be transparent.

12 So, while there are a myriad of
13 different measures and the characterization of
14 these factors can be debated ad nauseam, the way
15 that we'll sort of implement it will be very
16 consistent. And we'll expect the same level of
17 rigor for all of these different variables.

18 VICE CHAIR HANSEN: Thank you, Taroon.

19 MS. POTTER: Thank you so much.

20 VICE CHAIR HANSEN: And do we have
21 anybody else on line?

22 MS. SHAHAB: Clarke Ross, you had

1 raised your hand earlier. Did you still want to
2 speak?

3 VICE CHAIR HANSEN: What we're going
4 to try to do is go a second round for some people
5 who haven't spoken yet. So Clarke's on line
6 again? Okay. Clarke, we're just going to --
7 there are a few people who haven't commented here
8 and so we're going to go through that process
9 again. Thanks.

10 And I think, Charlie, had you already
11 spoken?

12 DR. LAKIN: I haven't.

13 VICE CHAIR HANSEN: Oh, okay. Why
14 don't I go to Steve first then. He hasn't.

15 DR. COUNSELL: Thanks very much. I
16 just wanted to comment first on just the
17 remarkable presentations, both this morning, and
18 in particular to a really careful, succinct,
19 really outstanding addressing and presentation in
20 a short meaningful and understandable manner and
21 the rich discussion that's going on. So I'm not
22 disengaged. I'm just not commenting as much

1 maybe as usual and really soaking it in.

2 But I did want to make a couple
3 comments, that I agree with Rich's comments.
4 It's really not whether or not we deal with these
5 issues around sociodemographic factors, but how.
6 And I really laud the approach that NQF is taking
7 and the rigor in which it is doing it and the
8 courage really to lead in this area, which is
9 really quite controversial as we know.

10 Second, I think we do need to be
11 careful not to disadvantage providers who focus
12 their mission around caring for vulnerable
13 populations, and I think we have been lacking in
14 being more careful about that.

15 And then third, just on the lighter
16 side maybe, I'm just wondering where does
17 functional status fit in? There's more and more
18 data and research showing it's been highly
19 understudied, but just recently last week in the
20 JAMA Internal Medicine looking at I'm a
21 geriatrician in geriatrics and just showing, oh,
22 that people with ADL impairments prior to

1 admission to hospital at higher risk of
2 readmissions. Surprise, surprise. Something we
3 all know. But again, not factored into these
4 kind of situations.

5 And so, is that potentially one of the
6 clinical factors along with comorbidities, or is
7 that something that's not part of this
8 discussion? Thanks.

9 MR. AMIN: I would just say that I
10 think that's part of the evolving conversation
11 around the clinical factors that need to be
12 really considered in terms of risk adjustment.

13 I'm not necessarily an expert in terms
14 of how that data is collected and how that could
15 be characterized for the purposes of risk
16 adjustment, but that would certainly be a
17 question for the developers of these types of
18 measures and the standing committee that's
19 responsible for reviewing this, and certainly is
20 within the scope of what we're thinking about.

21 DR. COUNSELL: Well, and this is where
22 I think NQF and this initiative can really help

1 drive quality improvement by collecting
2 meaningful data, whether it's sociodemographic
3 factors that aren't currently or functional
4 status in particular, which we know is so
5 important and useful in developing an
6 individualized care plan, let alone measuring
7 performance. So, thanks.

8 VICE CHAIR HANSEN: Thank you, Steve.
9 And I'm just going to go off my hat for one word,
10 and that is to also -- perhaps it falls under
11 clinical, but cognitive and function oftentimes
12 kind of go hand in hand as well.

13 So, let me go back to Charlie. I
14 realize that we missed you here. Sorry.

15 DR. LAKIN: Well, I thought it was a
16 great presentation and I particularly appreciate
17 the sensitivity, both to providers who take on
18 more challenging people who need services and
19 also that we don't reinforce a social
20 disadvantage, that we don't diminish the
21 significance of social disadvantage.

22 One of the things that people have

1 been talking about that I just think is terribly
2 important and want to reinforce is that
3 sociodemographic factors are not often the most
4 appropriate factors for risk adjustment. They're
5 not the most important factors in the risk. And
6 I think stratification research is really
7 important in identifying those things and to
8 really promote that as we use what databases we
9 have to identify those factors that are across
10 plans and programs associated with outcomes.

11 I was struck by Shawn's comment about
12 people who live in group homes and that we don't
13 know much about their outcomes. Actually we've
14 had the chance to merge national core indicators
15 data from about 15 states to look at that. And
16 if you control for level of intellectual
17 disability, behavior problems, physical
18 impairments, which are highly associated with
19 outcomes, you can then stratify that sample by
20 service type and find out a lot about how people
21 who live in their own homes, homes they own or
22 rent, live with family members, live in small

1 group homes with three or fewer people, four, six
2 people, how they differ in outcomes like social
3 inclusion and employment and things like that
4 while controlling for those factors that are most
5 associated with that and find really clear
6 differences in those service types.

7 And so, I just think that we need to
8 be really creative about both stratification and
9 risk adjustment and use those opportunities to
10 really learn about our service system. But to
11 begin to do that we need measures of the type
12 we've been talking about for the last two days
13 that really get into the more social aspects of
14 daily life.

15 VICE CHAIR HANSEN: Thank you,
16 Charlie. We'll move to Anne and then Tom. And
17 we'll come back to Rich as well as --

18 MS. COHEN: So when we talk about
19 comorbidities or other kinds of clinical data,
20 one rich resource kind of as a baseline would be
21 Medicaid data -- or Social Security data for when
22 people apply for Medicaid. And there's always

1 been an issue with getting that data accessed by
2 the plans to get that kind of baseline
3 information when somebody enrolls in a plan. But
4 there is a research study where Social Security
5 data has been released to, I believe it's
6 Mathematica, and they're doing -- I could be
7 wrong.

8 Charlie, correct me if I'm wrong.

9 But they're doing all kinds of
10 analysis for the first time. And so, you might
11 turn to them; they got a lot of money to do this
12 work, to kind of see whether there's a
13 partnership here around the work that you're
14 doing. So that's the first thing.

15 The second thing that strikes me is
16 that; and forgive me, I have my personal
17 disability hat on, you're always focused on the
18 individual, the person with the disability, the
19 senior, the member, as we call them. But really
20 when we're talking about risk adjustment and
21 stratification we should also be looking at the
22 provider, because really if you're worried about

1 controlling for having issues with understanding
2 the impact of the provider differences, you're
3 looking at socioeconomic data of the provider.
4 What's the provider rate being paid? What group
5 are they a part of? What demographic factors?
6 Their age, the race, the language barrier of a
7 particular provider.

8 And so, I think rather than solely
9 focusing on stratification and adjustment on the
10 patient level, or the member level; not to use
11 completely clinical terms, it should be the
12 provider as well.

13 VICE CHAIR HANSEN: Tom?

14 DR. LUTZOW: Yes, I would invite NQF
15 to take the position that the same service needs
16 to be reimbursed at the same level. You will
17 lose that battle, but the mantra needs to be
18 there. And part of the complexity here and the
19 disparity is due to our reimbursement policy.
20 Certainly the uninsured aren't reimbursed at all.
21 The same service delivered to Medicaid
22 individuals is reimbursed at a different level

1 than Medicare, and Medicare is being -- providers
2 to those folks are being reimbursed at a
3 different level than the commercial service, but
4 it's all the same service.

5 And with the duals it's even more
6 complicated, because there states use "lesser of"
7 logic. If Medicare reimburses at a level higher
8 than the Medicaid fee schedule, then Medicaid
9 does not pay the co-pay. And so, the
10 reimbursement policy itself contributes to the
11 disparity in health apart from the
12 socioeconomic/sociodemographic factors and as a
13 matter of principle the policy should be to take
14 that noise out of it. The same service
15 regardless of what your social condition or
16 status is, the same service should be reimbursed
17 at the same level. It's not possible, but it's a
18 principle that we need to move the country
19 toward.

20 And I want to suggest that this
21 problem is not going to be solved unless the
22 duals get their own part, Part X. Unless we have

1 a part that is sensitive to these conditions that
2 are unique, where poverty and Medicare
3 eligibility meet, we won't get a solution.

4 VICE CHAIR HANSEN: Yes, thanks, Tom,
5 for pointing out payment policy, although we'll
6 have 50 states also to bring along, but your
7 point is to send a message.

8 Clarke, I know you're on the line
9 waiting.

10 MR. ROSS: I'll pass. Thank you.

11 VICE CHAIR HANSEN: Okay. I think we
12 have had this opportunity to have very robust
13 conversation and some input. It's one of those
14 areas that I think has caused everyone to take
15 notice. And your presentation in the manner that
16 you did as members of said has been extremely
17 effective and clear, and we appreciate the
18 feedback and clarity.

19 I think the one area I ask staff is to
20 perhaps help us make sure, even though it's on
21 the web site, putting back into our notes the
22 three groups of areas that were going to be

1 looked at relative to the topics just so that it
2 brings it back to the Dual Eligibles Committee so
3 that we know we can focus on that as well.

4 And I'm just going to take off my hat
5 for a bit. I happen to have a personal
6 background of working in full capitation in the
7 PACE model for over 25 years. And we now are at
8 a different generation of the ability to talk
9 about rate setting and risk adjustment. There
10 was some early work that was done by Brandeis
11 University on risk adjustment of multiplier
12 coming with a frailty factor, which is a very
13 different framing. And that had gone on probably
14 for about 20 years. And Minnesota used it as
15 well.

16 So there may be some contextual
17 background as well as the active PACE programs
18 there are in 30 states now with this full
19 capitation between Medicare and Medication, and
20 not with the struggle per se of an individual
21 given service, but the total amount of funds and
22 how the provider ends up using it. So just a

1 background of a system that has actually had this
2 in legislation since 1983 to be able to look at
3 it.

4 So, I think we're here at a stop here,
5 and I'm going to turn this over to Sarah.

6 MS. LASH: Yes, we wanted to take this
7 opportunity to ask if there are comments from the
8 public on the webinar that we should acknowledge
9 at this time, and then we'll -- following comment
10 take about a five-minute break here in the room
11 before moving on with the agenda. We're just a
12 slight bit behind, so not so much meeting the
13 goal of ending early at this point.

14 Any comments, operator, on the phone
15 or the web?

16 OPERATOR: Okay. At this time if
17 you'd like to make a public comment, please press
18 star, then the number one.

19 (No audible response)

20 OPERATOR: And there are no public
21 comments at this time.

22 MS. SHAHAB: So, I have a public

1 comment on the chat, and this is from Tom James.
2 He said, "Measures are largely drawn from
3 evidence-based guidelines. A conference this
4 week at the New York Academy of Medicine on new
5 directions for guidelines in light of their use
6 in policies and measurements adjusted that
7 current evidence-based guidelines consider only
8 the values of the scientific process so that
9 future guidelines must allow for variations in
10 algorithms which include patient preference-based
11 clinical decisions.

12 "Further, these patient preferences
13 may be value-based in terms of culture of
14 societal values. That means in the measurement
15 community there may not be a single point to
16 measure. There may be either multiple outcomes
17 acceptable to the persona and provider or the
18 measure is of a process by which decisions are
19 made. Sorry. I'm on the computer and not on the
20 phone. Tom James."

21 VICE CHAIR HANSEN: Well, Tom, this is
22 Jennie Chin Hansen. It's lovely to hear from

1 you.

2 For the rest of our Committee members,
3 he was on the MAP in a previous period.

4 Okay.

5 MS. LASH: All right. Let's take five
6 and resume shortly.

7 (Whereupon, the above-entitled matter
8 went off the record at 11:10 a.m. and resumed at
9 11:19 a.m.)

10 MS. LASH: Okay. Well our next
11 presenter, on the topic of what are the
12 strategies health plans can use to really engage
13 complex beneficiaries, like duals and others with
14 similar challenges, we've invited through some
15 networking of Rich Bringewatt, Patrick Curran,
16 the President and CEO of CareOregon, to come
17 share some perspective of the on-the-ground teams
18 working to provide high quality care.

19 Patrick, take it away.

20 MR. CURRAN: So hopefully now, people
21 can hear me on the phone. Thanks for having me.

22 I think the first thing that I have to

1 say as I have been sitting in the room here
2 listening to the conversation is just applauding
3 the work that you're doing, applauding the
4 approach that you're taking, the level of effort
5 and -- you're putting into this topic. It gives
6 me so much hope just listening to the last hour
7 and a half, two hours, and if this is what you
8 talk about during snowstorms, then I want to come
9 to the next one because it is just great.

10 What I hope to do over the next -- and
11 the -- there are several slides here, but I hope
12 to get through these in about 20 minutes, and we
13 can have questions during, however you want to
14 handle it, but is to really go through several
15 items, and I know this group would want to see
16 some information, a little bit of data on
17 performance and such, so we'll address that.

18 But really what I want to do is more
19 tell a story and almost use this opportunity in
20 your very packed agenda, discussing some very
21 weighty topics and issues, almost as an interlude
22 to paint a picture about what it looks like when

1 a plan is actually trying to really redesign its
2 work and look at things from a different
3 perspective in serving the individuals that we're
4 privileged to serve.

5 So I have been with CareOregon for 11
6 years and the CEO for the past two, two and a
7 half. So with the agenda, again, we'll go
8 through these items, but I want to just paint a
9 little bit of a picture about the company and the
10 members we serve. All of these I am going to go
11 through fairly quickly.

12 Two programs that really we have
13 implemented and have learned a tremendous amount
14 and actually are starting to see some results
15 from these programs. So I want to highlight a
16 couple programs, and then about how we're trying
17 to move upstream even further and some of the
18 methods and examples that we're using, and then
19 talk about that it does present some
20 opportunities, but some of the challenges we face
21 as being a dual-eligible SNP in the current
22 system, and then getting to discussion. So that

1 is the goal here.

2 So this is just a little bit about
3 CareOregon. We are 20 years in existence. We
4 are a 501(c)(3). 240,000 Medicaid members, in
5 the context, that's about 25 percent of the
6 people on Medicaid in Oregon. Oregon has gone
7 through its own health reform in the Medicaid
8 area, which isn't our topic today, but we have
9 been right in the middle of that.

10 We have 11,000 Medicare members. 9500
11 are dually eligible. We have two plans, but even
12 the plan that is not dually eligible, 70 percent
13 of the people receive the low-income subsidy, so
14 that -- this is what we're about.

15 We have grown quite a bit, have more
16 than 500 employees, and we started as a SNP when
17 the SNP program started in 2006, and we are a 3.5
18 Star plan and have been for the past few years,
19 and we'll go into that a little bit at the end.

20 These -- each of these pictures are
21 members. This is one of our members, Ruth Miles.
22 Ruth is one of our favorite members for two

1 reasons: one, she is on our Advisory Committee
2 for our Medicare plan, and her daughter is to the
3 left, Mya Ladd, who is in our Provider Service
4 Department, so we have a definite connection with
5 Ruth.

6 This is George Adams. George, I
7 served on a board with him in Southern Oregon for
8 actually our Medicaid program, and George is a
9 member of our health plan as well.

10 This is our mission vision. I just
11 wanted to highlight a couple things on here.
12 There were comments about well-being and health,
13 and this is a very live conversation for us. The
14 more and more we learn, and hopefully you'll see
15 through this discussion today, this broader sense
16 of it's not just about health care, it's about
17 health, and it's not even just about health, it's
18 about the person's own sense of well-being and
19 what's important to them and how they view the
20 world and their health through that lens.

21 We have learned and are still learning
22 a tremendous amount about this idea of us

1 cultivating health in a community. I know to
2 some of you it will sound very Pacific Northwest,
3 and it is, but it's meant to conjure an image
4 that it really is about us not solving problems,
5 the whole paternalistic image, or us being
6 passive, but trying to lay the groundwork, trying
7 to put the elements in place that we can be part
8 of a broader community effort to serve the
9 population, and then our vision is one of -- of
10 health equity.

11 The member demographics, I won't go
12 into this in detail, and a couple of these are
13 actually in hindsight a little bit confusing, but
14 what they're meant to do is show that we're about
15 45 percent of our membership are under age 65,
16 qualified due to disability, 55 percent over.

17 That has changed over time. When we
18 first started our SNP in 2006, it was about 65
19 percent under age 65, and then the graph in the
20 lower left is meant to say that, that the members
21 that joined us in 2006, in fact on average the
22 members who are under 65 and disabled, have

1 longer tenure with the plan, tend to be very
2 stable. We have a very low disenrollment rate.
3 It is something like two to three percent.

4 But what I don't show on here is just
5 our growth, and basically, we started at about
6 5000 members and have just had continued fairly
7 moderate growth and are now again at about 11,000
8 members. On the lower right are the conditions,
9 which I will go into in the next slide a little
10 bit. Those are based on HCCs, for anyone who
11 wants to know that.

12 This is -- this is our membership, and
13 I think that the takeaway from this slide is just
14 how this is different than a quote, unquote,
15 normal, Medicare Advantage Plan, and how --
16 what's also not on here, but we'll see a little
17 later on, is that what we're learning is the very
18 high amount of substance abuse conditions that is
19 really unreported, continues to be unreported, in
20 the HCCs.

21 We are trying to figure out better
22 ways of doing that, but the more and more we're

1 working in these different programs that you'll
2 see, the more we're seeing how under-reported
3 that is. So it's really just as important what
4 is not on here as what is on here, but as you see
5 what's on here, mental health conditions are a
6 significant amount for our plan.

7 So I am going to go into the first
8 program, which is called the Health Resilience
9 Program. This was actually funded through a CMMI
10 grant under the Affordable Care Act, and is -- I
11 didn't attend the conference, but when there was
12 a conference about the CMMI program, I think this
13 was and should be considered one of the big
14 successes because as the program started through
15 CMMI, and that funding will end July 2015, and
16 that staff now which will be about 20 people and
17 about \$2 million in cost, if you will, we are
18 completely bringing in to CareOregon.

19 Not only are we bringing it into
20 CareOregon as being sustainable on an ongoing
21 basis, but as you'll see, we're really building -
22 --- we're actually rebuilding, redesigning, our

1 whole care management model on this platform. So
2 it's really a success of the CMMI program as
3 well.

4 This is really looking -- and it
5 started as looking at community use of community
6 health workers, look at getting out in the
7 community, and this program evolved over time,
8 and it became one that was called Health
9 Resilience.

10 So on here, it's about looking at
11 those most complex members, and again, previous
12 approaches, telephonic case management, disease
13 management, even looking holistically at the
14 person, this was a very different approach in
15 terms of hiring social workers, which I'll get
16 into, to address the issues.

17 And then the social -- the social
18 values is on there at the bottom, and what that
19 is meant to say is as this program is developed
20 during the CMMI grant, it has really been
21 astounding what we've learned from, you know,
22 some of the conversation about person-centered

1 care. Some of what we have learned about being
2 in the community and the incredible importance of
3 being non-judgmental when working with
4 individuals has been one of the most incredible
5 learnings from this.

6 What we have essentially developed,
7 and this is what we think is a new primary care
8 workforce, and the way that this works, there was
9 kind of the hub and spoke, or the wheel, earlier,
10 on one of the slides. We use that term a lot
11 about hub and spoke, and this is one, where there
12 are essentially social workers, and as you see
13 here, they are embedded within primary care
14 homes. So they are health plan employees, they
15 have our benefits, and they meet together as a
16 community of practice.

17 So they're a team, if you will, of
18 social workers, 15, 20 people, but each of them
19 are deployed out, and they are also not only
20 health plan employees and members of that what we
21 call community of practice, they are embedded
22 within the primary health home and that care

1 team, part of that care team, and have assigned
2 case loads, if you will, where they're the
3 primary responsible party linking back with
4 primary care.

5 And that isn't all, though. What's
6 really the most important is the third component
7 of that, which is so health plan employee
8 embedded in primary care, but 70 to 80 percent of
9 their time is not at either location but actually
10 out in the community, whether it's at someone's
11 home or wherever they can meet people. Literally
12 the term meeting people where they are, takes
13 literal configuration with this program.

14 This is -- there's a lot of
15 information on here. What I really want to show
16 on this is one of the things that we are
17 measuring are non-health-care things, and these
18 are things where we're getting information
19 directly from the member. Things like past
20 trauma, things like their current living
21 situation, about stability, and we've actually
22 built software called Pop Intel, which is almost

1 a type of -- of social determinant care
2 management, if you will, platform, simply because
3 it's almost creating new types of registries that
4 you can also put EMR data and claims data in. So
5 you can know medications they're taking and when
6 they've gone to the ER, so you can use that
7 information to help in the care, if you will, of
8 the member, but it is really using a much broader
9 base of information.

10 And then the ED rates -- and actually,
11 I am going to go back to this before this. This
12 is probably a good time to talk about one of the
13 big learnings, because if you look on the bottom
14 two parts of this, it talks about trauma, and I
15 think in fact one of the -- one of the things
16 that I would hope for this group to take away
17 from this, and one of our huge learnings, has
18 been the area of past trauma and the whole
19 emerging area of trauma-informed care.

20 And these statistics show that we are
21 keeping statistics of people's known trauma. We
22 think though, when you see that yes, 55 percent

1 and unknown, 42 percent, that much of that 42
2 percent is -- could potentially be that it is
3 just not coming out yet, and just the high
4 percentage of active trauma from this person's
5 perspective in their -- in their life right now.

6 And what we're finding is that many of
7 the things you see on here: PTSD, anxiety,
8 depression, the addictions, that -- that those
9 elements that we know form high cost. People
10 with chronic disease and comorbid conditions,
11 that one of the profound things that we're
12 learning is that it's really due to past trauma
13 in that individual's life, whether it's adverse
14 childhood events and all the research in that
15 area about ACEs, but all different types of
16 trauma and the underlying effect of trying to
17 address that trauma.

18 And there is a specific example of a
19 story that just sticks with me that, again, we
20 talk about, you know, population health and
21 measuring and measuring, for example, someone who
22 has diabetes and the diabetic care, that maybe

1 they have other mental health conditions as well.
2 And you're trying to create programs, individual
3 plans of care, et cetera, for that person, but
4 that person, you come to find out, doesn't go to
5 the doctor.

6 And you find out why aren't they going
7 to the doctor, why can't we -- and you find out
8 that the reason they don't go to the doctor is
9 what happens when you go to the doctor is you go
10 into a room, you go into an exam room, you sit
11 down at the far end, and the doctor comes in and
12 closes the door and sits between you and the
13 door, and that triggers something in the
14 individual that they just -- they just won't go
15 to the doctor.

16 And so the reason for not going to the
17 doctor ---- and that's why this is so profound,
18 is the more we're learning, and we feel like
19 we're just starting to learn, the more we
20 understand about these underlying experiences,
21 the more it's changing how we look at things, so
22 that is why I wanted to pause there.

1 The nuts and bolts of this program is,
2 is it sustainable and does it show ROI for these
3 members? It convinced us pretty easily that the
4 ROI, there was no question for this cohort. This
5 is -- this was actually research done for the
6 CMMI grant, so we didn't even do it. It was done
7 by CORE, an organization that is affiliated with
8 Providence, which is a health system in the
9 Portland area.

10 They did this, and it has been
11 consistent with some of the other work, if people
12 have followed the work in Camden and other
13 places, that I am going to toggle back and forth,
14 but just ED visits and inpatient admissions
15 lowering for this high risk population, 35
16 percent or so, seems to be consistent, actually,
17 with what some other programs are seeing
18 throughout the country.

19 So for us, the next step in this
20 program is one, growing it, but two, growing it
21 in a way that can be scaled. And so one of the
22 big areas that we're looking at now is the use of

1 peer support and leveraging peer support,
2 leveraging patients existing and members, family
3 members, and how can we expand this program?

4 Because this is a case load of about
5 30, 40 people, so -- and you're going to see
6 another example of how we're trying to move
7 upstream from high cost to potentially high risk
8 in low-income housing, but as we move upstream,
9 if you will, the need to leverage existing
10 resources becomes much more acute.

11 So really, our next step is to
12 continue this program, grow this program, learn
13 more from what we're learning, and apply it to
14 all the other areas of our work, and as well as
15 trying to, again, leverage that peer support.

16 So the second program I wanted to go
17 into is called the MEDS Chart, and this is really
18 a program that generated from some of our human-
19 centered design, which I will touch on a little
20 bit later, and the statistic people have seen,
21 the idea of medication reconciliation is a huge
22 issue. And so what we did was we went through a

1 process of looking at that.

2 And one of the things that we found,
3 and I'll go through the process of what we used,
4 but I want to focus on this trauma aspect. This
5 is a term that I don't think was coined by our
6 pharmacy director, but we use it a lot, and
7 again, this word trauma, because what we're
8 actually seeing is the -- it's not really irony,
9 it's just that the lowest CAHPS score -- the
10 lowest issue we have in our Part D, are people
11 not feeling like they're getting their needed
12 medications.

13 What we actually see, though, is one
14 of the biggest issues is people getting too many
15 medications that they're not -- they're not
16 really understanding and taking appropriately,
17 and what we think is ---- almost in the eye of
18 the -- under the auspices of, first, do no harm,
19 that we think one of the first things we can do
20 is make sure that we're not doing harm by
21 prescribing medications.

22 And so this is kind of the map that we

1 drew to show how various elements of our program
2 are trying to address what is, again, you see the
3 big pills in the middle, that what we think in
4 many cases is too much medicine.

5 And this is the cycle that we go
6 through, and we see this through this Health
7 Resilience Program, through this program and
8 others, that it really is a vicious cycle, and
9 medication is a part of that, and it is not the
10 remedy, it's not the cause of it, but it plays a
11 fairly insidious role.

12 So we have a -- we have a predictive
13 risk model that we use, and what we see is that
14 for our Medicare plan, about 10 percent of our
15 membership falls into this category and these are
16 some of the statistics that we see. So you see
17 the monthly and also the 12 month. To me, the 12
18 months is the most stark, where in 12 months, for
19 these members, they have 30 different drug and
20 dosage combinations and 12 different prescribers.

21 So what we -- this is one of the
22 things that we use, and the MEDS Chart is

1 something that we created, again, rather than --
2 not rather than, we -- embedding this and new
3 tools and new processes and new ways of thinking
4 about it to our existing medication therapy
5 management. So it's not a replacement, but it's
6 a new way of looking at it, and the MEDS Chart is
7 one way.

8 And this is it, and as simple as this
9 looks, this is what we have come up with through
10 a lot of research, which is working with
11 individuals and caregivers, sometimes actually
12 resident coordinators in low-income housing, to
13 really try at a member level to figure out if
14 they understand what they're -- what they're
15 taking.

16 One of the interesting tidbits is the
17 process that we've gone through, I will talk
18 about human-centered design, is to really look at
19 how you can do things in a different way, and
20 it's just a little amusing anecdote: one of the
21 things they come up with as a model is like how
22 do we get people to understand? There's pill

1 boxes and all sorts of things, but one of the
2 things they used -- I love it, they brought this
3 to the presentation, was Richard Simmons, the
4 like 80s fitness guru.

5 He had this thing on eating from the
6 food pyramid that was like where you open the
7 doors or things like that, open and close the
8 doors and move things back and forth. So we use
9 those kinds of things as models. It's like, you
10 know, that was what he was selling to get people
11 to do stuff and get people motivated that maybe
12 weren't motivated. So it was kind of looking
13 outside to come back in.

14 So the way this program works is
15 essentially we use a predictive model to say who
16 do we focus on. We use the MEDS Chart and do a
17 lot of education with members and caregivers and
18 again low-income housing units, whoever we can
19 talk to.

20 We -- we don't use the MEDS Chart in
21 clinic, which is an interesting point, because
22 one of the issues we faced was that each clinic

1 has its own workflow and so we didn't want to
2 disrupt workflow, we're very cognizant of that.
3 And so what we are doing at the clinic level is
4 we're actually embedding clinical pharmacists.

5 So this hub-and-spoke model where we
6 have a health plan, a group of pharmacists, and
7 we're actually using residents. We're actually
8 offering a residency program in clinical
9 pharmacy, and we'll have ten residents that will
10 go out to safety-net clinics, and what they will
11 do is this hub and spoke.

12 We'll have data that we will use,
13 we'll have clinical pharmacists where we pay
14 pharmacists to do work, we pay pharmacists to
15 spend time with members. We're actually going to
16 be experimenting with paying retail pharmacy to
17 spend time with members because they don't have
18 the time to do that either. And as you can see,
19 our goal is to hit 10,000 people, so 1000 would
20 be in our Medicare plan, 9000 would be in our
21 Medicaid plan.

22 So it's this idea of plan-based

1 information and -- and staff embedded in primary
2 care, but also out in the community and working
3 with members, and then we'll measure the outcome
4 for that in 2016.

5 One of the things that I forgot to
6 mention at the beginning was kind of who we work
7 with with CareOregon, but the safety net made me
8 remember that. We -- CareOregon essentially
9 works in nine counties, but we work with --
10 Portland area is our largest area, but we work
11 with all providers.

12 So all hospitals participate in
13 CareOregon, we have a broad network of primary
14 care and specialty, and then the safety net. We
15 were founded by safety-net clinics, federally
16 qualified health centers, rural health centers.
17 They form the foundation of CareOregon, but
18 they're not the only part.

19 So when you look at our Medicare
20 membership, for example, 40 percent are assigned
21 to safety-net clinics, 30 percent to hospital-
22 based clinics, 30 percent to private practice.

1 So it's really a mixed model, but obviously we
2 were founded by and work closely with the safety-
3 net.

4 So the -- the cost savings that we're
5 looking for this, again, how does it pay for
6 itself? What is the return on investment? We do
7 think this will show a six-to-seven to one ROI,
8 but that's the one thing we're going to measure,
9 and then one of the questions, again, is going
10 back to scale, which is why we're going over the
11 next two years to use residents and seeing how we
12 can train people to use this MEDS Chart, how we
13 can perhaps leverage with already existing in
14 clinics.

15 We'd like to see more clinical
16 pharmacists in clinics in addition to
17 behaviorists as part of the primary care team,
18 we'd like to see more pharmacy, so we're going to
19 continue down that road.

20 So really, what we had done, again,
21 when I said this was really informed by the
22 Health Resilience Program and these other

1 programs that we've done, is really changing how
2 we look at this. Really, from being population-
3 based telephonic regulatory-based care management
4 to one that is very different. It's almost a
5 virtual -- virtual care management system.

6 So -- so we have almost all of our
7 staff actually re-applied for their jobs because
8 we took -- we took our existing plan and program
9 and we're flipping it. So we have people
10 employed now who do things like housing and food,
11 we have people who are embedded in low-income
12 housing units, we have again all these people at
13 the clinics. We're really changing our work
14 force.

15 We're doing that partly because we're
16 informed by this work and where we want to go,
17 but we're also doing it because when we look at
18 the financial -- and I'll get to this at the end.
19 We see that actually our utilization for hospital
20 services, emergency room et cetera, has
21 essentially been flat the last three years. The
22 number of scripts per member has basically been

1 flat.

2 Our costs have gone up two to three
3 percent in our Medicare plan, mostly due to just
4 case mix and payments, et cetera, and then in
5 pharmacy it's gone up due to specialty drugs,
6 Hepatitis C, and the increasing price of
7 generics, surprisingly, or maybe not surprisingly
8 to this group, has contributed almost 15 percent
9 increase in costs. So same number of scripts, 15
10 percent higher cost.

11 So we have just figured we're doing a
12 good job utilizing services for the population,
13 but we can't do that, that's -- the financial
14 model won't allow us to do it, and we also, what
15 we're learning from our members and from the
16 community in how we do things is that we can't
17 keep doing things the same way, even though one
18 could argue they have been -- they have been
19 working.

20 So don't need to show this group the
21 social determinants of health, and there's lots
22 of different graphs that show this and different

1 percentages, but just the reason I show it is
2 that -- that it -- this has changed how we look
3 at doing care management. It looks at how we
4 serve the population because that ten percent
5 medical care, we aren't -- we aren't really
6 looking at building population health models
7 based upon a medical care model, we're looking at
8 it much broader, and again, with this thing of do
9 we -- does our workforce change where we have
10 more social workers, more people that work in
11 housing and food and even economics, which I will
12 get to in a second?

13 This is kind of the moving upstream.
14 This is a partnership that we're involved with
15 with eleven low-income housing units where about
16 40 to 50 percent of the individuals that live
17 here are members of our either Medicare or
18 Medicaid plan, or both.

19 And we are -- again, we are embedding
20 people in this and we're learning a tremendous
21 amount. And one of the things is just an
22 anecdote, but is we talk about greater

1 integration and coordination and all these
2 things, and it's all great. And then there are
3 issues like HIPAA that we need to deal with, and
4 sometimes that can be a barrier, but the other
5 thing that we're, you know, encountering and
6 managing, which is a good thing, is that people
7 want their care to be integrated, but there are
8 -- there are nuances of that.

9 There are people who don't want their
10 resident housing person to know about their
11 addiction or something like that, so we're very
12 careful about this as well, and I think the whole
13 area we just need to share information and be
14 more integrated is a bit simplistic, and we're
15 realizing that, and it gets back to these social
16 values in the earlier part about how you go about
17 it is very important.

18 Just a word on human-centered design,
19 this is how we go about doing it. We worked with
20 a company called IDEO, I don't know if people are
21 familiar, but they have been wonderful working
22 for us. We don't work with them anymore not

1 because we don't like them, but because we're
2 doing it ourself, and we are -- and this is what
3 originated the MEDS Chart.

4 And just a brief tangent, and I want
5 to be cognizant of time, but it is to talk about
6 not Medicare, but one thing we've learned about
7 our Medicaid, the new population that's come in
8 through the Affordable Care Act: what we saw was
9 that people -- there were many members who
10 weren't accessing care at all, primary care,
11 emergency room, they weren't just accessing care.

12 We went to them, and rather than
13 saying how can we get you into primary care, what
14 are your access issues, what are your barriers,
15 we just said what are your needs? And their
16 needs were vastly about financial security and
17 economics, and so we're trying to figure out, if
18 that's the main issue for these people, how can
19 we help them address those issues?

20 And what ends up happening is when you
21 address the issues that are important to people,
22 they are actually much more receptive and open to

1 the issues that you think are important, and the
2 health issues in going to primary care. And so
3 we're trying to figure out, again, what we do
4 with that and how we -- how we leverage that as
5 well.

6 So this gets to the model of care and
7 some of the challenges. You know, these are the
8 elements of the model of care, and I don't want
9 to complain about these, but I think the more and
10 more work we do, the more I think -- I believe, I
11 firmly believe, these were intended as a
12 framework in being aspirational about how you
13 should better serve a population.

14 I have to admit we see these more as
15 a regulatory element, and sometimes barrier, and
16 for example, there are elements in here that are
17 fine, but to be perfectly honest with you all,
18 the idea that health risk assessment in an
19 individualized plan of care the way it's
20 currently structured I don't think adds a lot of
21 value. There's a lot different types of
22 assessments and care plans and ways to approach

1 this that I think could be actually more cost-
2 effective and better attuned to the needs of the
3 population.

4 The provider network having
5 specialized expertise, we totally have that. The
6 safety-net clinics, we have, you know,
7 geriatrics, internal medicine, all of that. I
8 think what we're learning is that neither we nor
9 the provider network have the experience in these
10 things like trauma-informed care, and in fact,
11 it's what is not existing -- not proving that you
12 do have a network, but it's what's not existing
13 in any parts of the system that we think are the
14 biggest gaps.

15 So this isn't the knock on the model
16 of care, it's just that it's a different -- I
17 wish I could create a new one. We would like to
18 create a new one.

19 The Star ratings, again, I don't want
20 to bash on this, but this is just meant to show
21 we're a 3.5 Star plan, we've improved -- we've
22 improved every year over the past three years, we

1 have not cracked the 4 Star, and this is not
2 meant -- the conversation, I love the
3 conversation, we don't want to lower the
4 standards, we don't want to change this.

5 It's -- the issue that we're having is
6 we have 46 different work plans to address these
7 things and we're trying our darnedest to make
8 sure that those work plans are aligned with what
9 we want to do anyway in our new care model, and
10 those are hard to -- those are hard to do. It's
11 hard to not do two types of work, which we don't
12 want to do.

13 So really we're -- we're -- we don't
14 want to dilute it, we want to have high
15 standards, but we think there are different
16 issues -- we just think there are fundamental --
17 what you have all said, there's fundamentally
18 different issues at play in how to address, for
19 example, a diabetes measure.

20 So hopefully -- I have probably gone
21 over a little bit, I want to make sure discussion
22 -- this is Safa, he is one of our members as

1 well. And really just what I wanted to end with,
2 and again, hopefully we -- you can take away that
3 I feel like we're just learning more about our
4 members. There's a lot of data on dual-eligible
5 members and such. I think we're just learning
6 what the underlying causes of some of the costs
7 and outcome issues that we're facing, and there's
8 also a lot of absolute incredible creativity and
9 amazing heroic stories such as his I won't get
10 into.

11 But anyway, that is what keeps us
12 going.

13 VICE CHAIR HANSEN: Well thank you,
14 Pat, for an inspiring as well as passion-driven
15 presentation relative to what you've done, and
16 really, helping to frame up a very different area
17 that is little-discussed, as you pointed out, and
18 what you've discovered about trauma being such an
19 underlying factor, that oftentimes is definitely
20 not recognized.

21 So our process here is that we have
22 one of our committee members, Tom, who is from

1 iCare, to be the reactor to this, and after he
2 has had a chance to do that, we will take
3 comments and questions.

4 MR. LUTZOW: There are a couple of
5 questions that hopefully you can respond to.

6 Going to the -- just I want to share
7 my experience bumped up against yours, and
8 certainly your passion is clear, and we need to
9 find a way to keep you alive, and all of that.

10 So this HCC documentation slide that
11 you -- that you referenced, I think this is an
12 important aspect even for approaching --
13 approaching the SES issue from a scientific
14 perspective.

15 There is a disconnect between
16 completeness of diagnosis and reimbursement.
17 Providers don't need, even within managed care,
18 don't need to reflect the patients' conditions
19 completely to get -- to get reimbursed. And of
20 course, that is why retrospective case file
21 reviews are done, to correct the claim stream
22 information because the claim stream information

1 is inadequate.

2 But we have run into situations where,
3 going back to the -- going back to the healthcare
4 system, we have been told well we're not going to
5 attest to those conditions unless you reimburse
6 us for the attestation, and so effectively, it's
7 extortion. And if CMS and those folks that want
8 good information don't protect the information
9 stream against that kind of extortion, monetizing
10 the information, we're never going to get to the
11 bottom of SES.

12 So my question back to you is, you
13 know, are you, you know, running into those kinds
14 of data depressions?

15 An example on the plan side would be
16 there is a measure that calls for diabetes
17 control, there's an A1c test. To get a numerator
18 score there, we need the lab data. Well, we
19 can't get the lab data from some systems without
20 paying for the lab data even though we've already
21 paid for the lab tests. Well, that distorts the
22 data.

1 And CMS has not yet put in place
2 adequate protections of the data stream between
3 providers, especially where one provider or plan
4 has dependency on information held and controlled
5 by the other. That is a major weakness, I think.

6 The whole issue of person-centered
7 care, I think the reason it is important is
8 because it's clinically necessary. Unless I am
9 person-centered, I cannot get member engagement,
10 I can't get motivation, and so it's not a -- it's
11 not a casual value, it's a clinically required
12 value. I am not going to be able to work with
13 the member unless I am member-centric, so I would
14 like your comments on that.

15 Again, I don't want you to cause your
16 fingernails to screech on the blackboard here,
17 but I think the justification for person-
18 centeredness is it's clinically absolutely
19 important for me to get member engagement and
20 involvement and motivation and all of those
21 things.

22 ER, the results that you show for ER

1 utilization reduction are impressive. My
2 contention has always been that this move to move
3 patients away from the ER somewhat violates
4 person-centeredness and person-preference
5 principles, and there's very good reasons why
6 people want to go to the ER. It's open 24/7, it
7 has to see me, it can't reject me. It has the
8 best equipment around, many clinics in the
9 community don't have the kind of equipment. I
10 mean, there's many, many consumer reasons why
11 going to the ER is a very good choice.

12 And so rather than change that
13 behavior and violate the principles of person-
14 centeredness, we should insist that the ER also
15 be a medical home and provide primary care. That
16 is where folks want to go, that is where they
17 should get their primary care, and there could be
18 some triage there, but let's not fight city hall,
19 let's mine that behavior instead of fighting the
20 behavior, is the principle here.

21 Rx case management: we have a pharmacy
22 also in Milwaukee, it's called Hayat,

1 HayatRx.com, and they do home delivery of
2 medications and send a pharmacist into the home
3 to do comprehensive medication review. We don't
4 pay them anything extra. They get everybody with
5 ten or more meds, and the goal there is
6 medication synchronization.

7 We don't want the member going to the
8 pharmacy ten times a month, we want them maybe
9 going to the pharmacy once a month, so med sync,
10 making sure their refill date always lands on the
11 same date so their need to go to the pharmacy is
12 cut -- is cut down, but home delivery is also
13 important.

14 I am just -- I think there's
15 opportunities here within the reimbursement rate
16 for these high utilizing members to ask
17 pharmacies to do more than just dispense pills,
18 to do pharmacy case management and insist on
19 that.

20 In this case, just as a highlight,
21 Walgreens got very disturbed that they were
22 losing iCare members to Hayat. They actually

1 sent somebody out to Hayat to see what are you
2 guys doing? You're taking all of our 30-med
3 members.

4 Well, they were getting them because
5 Hayat has a car, will literally drive to the
6 home, work with the member, and there's a
7 pharmacist in that care, not a substitute, going
8 into that home to work with that member on their
9 meds, evaluating the dosage, the frequency, all
10 of those things, synchronizing the meds so the
11 fill rate is all due on the same day, and a host
12 of other things.

13 So I think there is an opportunity
14 here to reshape pharmacy services as a whole,
15 moving it from dispensing to a care management
16 kind of profile, so I -- just sort of a reaction
17 to some of the things you said.

18 MR. CURRAN: So just -- just quick
19 responses on, hopefully I am hitting these, and
20 not in detail, but in terms of the barriers to
21 getting data, our barriers are mostly inertia.
22 We don't have the payment, we don't -- we don't

1 really have the same issues, it's more just
2 getting the data and the completeness of the data
3 is the main issue that we're facing.

4 In terms of the person-centered and
5 the mesh with clinical, I think the best way that
6 I can describe that is -- is learning that we had
7 -- that the attempt, because it really is about
8 clinical outcomes and getting people to the -- it
9 is meeting them where they are to get them to
10 that place, I mean, that's the real learning, I
11 think, whether it's medication or someone who has
12 had lots of issues or -- it's -- it's how do you
13 get them to a place where they think that's the
14 most important thing for them?

15 And because then, once they're there,
16 then they're motivated -- they're a motivated
17 person.

18 The ER, you know, the -- what we found
19 through some of these programs is actually that
20 for the most part, people don't want to go to the
21 ER. It ended up being -- it wasn't a choice
22 issue or a restriction, it was -- it was the need

1 for connection. And so when there's another
2 connection, that need goes away.

3 But in terms of -- you know, that's
4 not everyone. In terms of that, I think there is
5 opportunity to use that. You know, we see it in
6 our Medicaid plan all the time. You know, it's
7 just if people -- if that is where people are
8 going to go for their care because that is what
9 fits their lives, then fit the care to their
10 lives, not vice versa. So we do see that issue
11 for actually more in our Medicaid than our
12 Medicare.

13 And on the Rx care management, totally
14 agree with everything. I think the piece that we
15 see the most missing is the care management,
16 we're building that, but it's still, you know,
17 and I don't know, I think we all experience this
18 on a personal basis, is you do all the right
19 things, but then the person still goes home, and
20 99 percent of the time is spent at home.

21 And how do you -- how do you do, you
22 know, that? And that's the idea of the MEDS

1 Chart, is trying to -- trying to engage in a
2 different way so that people feel more confident.
3 So little things like where the chart has numbers
4 and the numbers go on the bottom of the bottle
5 rather than the top, because the top, people put
6 -- you know, they take the caps off, but then
7 which one do they put back on?

8 So it's things like that that we're --
9 that we're really -- I mean, it seems simple, but
10 we're really spending a lot of time on those
11 kinds of things because it's that 99 percent that
12 bothers us the most.

13 VICE CHAIR HANSEN: Well, thank you,
14 Tom, and as well as Pat, for this exchange in
15 terms of the kinds of questions you come with
16 your background, Tom, of experience to raise
17 these.

18 And I think that the framing that
19 you're offering is how do you still work within
20 the system but start with an approach where
21 people come to, and what helps them maintain
22 their best ability? And part of the social

1 connection discussion, and that kind of almost
2 classic public health chart that shows that
3 medical care is only 10 percent of this.

4 So I -- we have two sets of questions
5 here. Do we have anybody in the queue? We have
6 one person. Okay. We will start with Rich, and
7 then we'll go to Shawn.

8 MR. BRINGEWATT: I apologize for being
9 out a little bit, I had -- there was something
10 else that I had to deal with at the time.

11 I also want to thank Pat, you, for
12 coming in, flying in in the middle of a storm,
13 it's literally and figuratively, perhaps. It's
14 a, you know, this is a tough issue to address.

15 I want to address three, quickly,
16 three issues that seem to be put forth as to why
17 we shouldn't do these, why we shouldn't address
18 this.

19 First is causality. There is no
20 causal relationship here. We currently use age,
21 gender, and condition to adjust for hospital
22 readmission. There is nothing in the literature

1 that says being old causes a person to go in the
2 hospital. It's an association where you tend to
3 have more factors associated with old -- being
4 older, that is the driving force.

5 If you're a man or a woman, you know,
6 these differences isn't because you are -- now
7 there may be some genetic factors, but it's
8 generally associated with something. It's
9 something down within the factor, not because of
10 the gender.

11 If -- if causality was the hurdle we
12 had to jump for smoking cessation or for dealing
13 with environment, we wouldn't do anything about
14 either one of those causes.

15 So I don't know why suddenly this
16 particular case can't live by the same rules that
17 have applied to virtually every other social
18 research effort that has complex social systemic
19 factors involved in looking at statistically
20 significant findings in terms of relationships as
21 something to address.

22 The second thing is we've got really

1 good plans that serve lots of poor people, and
2 they're getting high scores, you know, so why do
3 we need to do anything about it? You know, we
4 have plans, dual plans, have a 5 Star plan, so
5 why should we do -- they've got a 5 Star, why
6 should we do anything about that?

7 I -- I would suggest that if you talk
8 to those plans and talk to this guy right at the
9 corner here, they -- they experience things that
10 you just don't experience if you don't serve this
11 population, and if you look at the statistics,
12 plans that serve a high-risk population, that
13 serve -- have a lot of poor people in them, are
14 increasingly having a harder time maintaining the
15 Star rating, beginning to lose some ground, while
16 all of those plans that haven't -- don't serve a
17 higher-poverty population mix are moving up in
18 their Star.

19 You know, so I think it's an issue
20 that we have to address, whether, you know, if
21 somebody is already a 4 Star plan, why shouldn't
22 they be a 5 Star plan, if in fact they are

1 putting in the kind of resources and addressing
2 the kind of issues that are there?

3 The third issue that gets raised is
4 we're legitimizing disparity.

5 You know, I -- we have no business
6 kind of trying to say, okay, you can serve if --
7 you can have a different standard of care for
8 different -- on the issues of race, different
9 standards of care on issues of ethnicity, and
10 somehow it's okay to serve a poor -- provide a
11 poor kind of quality on the basis of those, and I
12 am fully supportive of not institutionalizing
13 anything, you know, that addresses those kind of
14 factors.

15 But that doesn't mean there aren't
16 ways that we can and need to address disparities
17 that help deal with some of the disparities on
18 the basis of -- of race and ethnicity, where you
19 look at the cultural factors, the -- relating to
20 poverty, and that have other higher kind of
21 prevalences, associations, where we can take them
22 into account.

1 You know, you don't have to be -- I
2 don't have a PhD in research, I am not a research
3 expert, I am not a data expert, but, you know, I
4 know that if -- if I have diabetes, and I don't
5 have diabetes, but if I have diabetes and I walk
6 into a physician's office and the physician gives
7 me a treatment plan, I am going to have a higher
8 probability of achieving a better outcome than
9 someone who is homeless who walks into the
10 physician's office with diabetes and -- and, you
11 know, the outcome is likely to be different
12 because of the kind of cultural factors and where
13 they live and what their habits are and the basic
14 kind of conditions that address that.

15 So, you know, we have to be careful to
16 not institutionalize disparity, and I respect and
17 support that. At the same time, it doesn't mean
18 that we don't address this particular problem,
19 you know, when the problem differences are real.

20 VICE CHAIR HANSEN: Yes, thank you,
21 Rich.

22 I think -- I so apologize you had to

1 miss the previous speaker because I think some of
2 the things that you're bringing up, you know, are
3 trying to be very thoughtfully, very carefully
4 evaluated so that we have a chance to do both,
5 you know, the best way to look at both the
6 science and the context together, so thank you.

7 Shawn?

8 MR. TERRELL: Thanks, that was an
9 excellent presentation, thank you.

10 So you mentioned, you know, the idea
11 of motivation and how you can sort of tap into an
12 individual's, you know, own sense of what's
13 important to them.

14 We talked about this yesterday, and
15 this question of person-centered planning and how
16 there's a skill set associated with doing that,
17 that, you know, one of the -- we -- talking about
18 how there's, you know, what's important to a
19 person, their life, their status in the
20 community, their job, their et cetera, their
21 social relationships, and what's important to
22 them in terms of health care and safety, et

1 cetera.

2 Sometimes there is a balance that
3 needs to be struck, right? At the same time,
4 though, from the perspective of doing good
5 planning and good, you know, skilled planning I
6 guess is a better way to put it, that you really
7 don't, as you point out, you don't really do
8 what's important for you, often, unless there is
9 something important to you in that, and that's
10 part of the discussion and the work that's really
11 built into a skilled person-centered planning
12 training program and an individual should have.

13 So it is -- it is plenty of work and
14 plenty of training can be done, and we're very,
15 you know, supportive of that this is a skill set
16 that you learn and maintain and develop over
17 time, so that's great.

18 And then another point, I guess, is
19 you mentioned you have peer supports and you
20 have, obviously, a high level of people with
21 mental health issues. Do you employ peers from
22 the mental health world in the recovery sense?

1 MR. CURRAN: So it is -- it is a great
2 question.

3 We have done a little bit, but it's an
4 area that I think we need to learn more about
5 because what we have -- what we have found is we
6 find that sometimes when we employ people, they
7 then lose their -- some of their benefits, and so
8 if we don't employ them full-time when they're on
9 our benefits -- so actually the biggest crux is
10 how do we do that in a way that helps them and
11 helps us?

12 That may sound simplistic, but that
13 has actually been the biggest challenge.

14 MR. TERRELL: That is a good point,
15 yes. And, you know, this Medicaid Buy-In, I
16 don't know if you have that, but still, you're
17 right, it's a big question, and it is an issue.

18 But just, you know, you have a ton of
19 really good advocates on the mental health side
20 in Oregon, so just, you know, I am sure they'd be
21 happy to talk to you about that.

22 And then last thing is on the software

1 question, I'd be really interested in that. You
2 know, there is an -- Department of Health and
3 Human Services over in the Office of the National
4 Coordinator is working toward an eLTSS model.
5 They have adopted the person-centered planning
6 standards that the Department has issued as the
7 foundation for that, and so we're obviously
8 always interested in finding places where things
9 are happening that could -- that are sort of in
10 that realm.

11 How do you -- how do you get, you
12 know, sort of do this in a person-centered way?
13 How do you, you know, allow people to own the
14 goals? It's their goals, it's their life. How
15 does that relate to the services and supports?
16 How do you map all of that together? How do you
17 build in, as you point out, questions about
18 permissions, who sees what? That is right in our
19 standards, you can't, you know -- not every
20 aspect of every plan needs to be seen by every
21 person.

22 So there is a complexity to this, and

1 then of course, there's all kinds of payer
2 questions. There's housing questions, you know,
3 it's a whole different realm. There's employment
4 questions, there's, you know -- so, but these are
5 the challenges, and so anything, if you, you
6 know, if you have any resources on that, you
7 know, we'd love to share them with our ONC
8 partners.

9 VICE CHAIR HANSEN: Thank you, Shawn.

10 We are going to go back to the person
11 who is on the queue and then come back to the
12 room.

13 MS. SHAHAB: There's two people on the
14 queue. First, Joan Zlotnik.

15 MS. ZLOTNIK: Hello?

16 VICE CHAIR HANSEN: Hi Joan.

17 MS. SHAHAB: Hi Joan, we can hear you.

18 MS. ZLOTNIK: Can you hear me?

19 MS. SHAHAB: Yes, we can hear you.

20 MS. ZLOTNIK: Oh, okay, great.

21 So I just wanted to say I was very
22 excited to hear the presentation about

1 OregonCares, having just been out in Oregon last
2 week and hearing some of the work of the
3 coordinated care organizations that are going on
4 there. It's really very exciting because it is
5 so focused on promoting well-being and having a
6 very multifaceted set of interventions and sort
7 of being really based in the community.

8 And I thought it was important,
9 Patrick, that you really addressed some of the
10 workforce issues, and I was wondering
11 particularly in your Health Resilience program,
12 where you are using the MSW-level supervisors,
13 social workers, to kind of lead those teams, were
14 those people who were specifically recruited for
15 those positions? Were they people who were
16 already working for you?

17 And maybe you could talk a little more
18 about the sort of issue of workforce development
19 and training, and how the teams were kind of put
20 together.

21 MR. CURRAN: So that's a great -- it's
22 a great point, and thanks for the question.

1 And I am going to have to admit at the
2 outset, I am not sure I am the best person to
3 answer it, so you are going to get probably a
4 broader, more general answer than you would be
5 looking for, but if, as a follow-up, if you want
6 to send me an email, I can put you in touch with
7 someone for more detail.

8 And the general --

9 MS. ZLOTNIK: Yes, that would be
10 great. I will listen to your answer now.

11 MR. CURRAN: Yes, yes. So do that,
12 and for anyone.

13 But the broad answer is that it's a
14 mix. And again, it didn't start out as being
15 master's level social work. This was more kind
16 of community health work where we actually
17 thought it was going to be kind of more basic,
18 fundamental, community college training, that
19 kind of thing, and it evolved to this, not that
20 there isn't a place for that.

21 So we didn't even -- the people that
22 actually we started hiring weren't the people

1 that we ended up hiring, and so it was -- it was
2 really a mix, and really what happened, Joan, I
3 think the best way to describe this is that what
4 is really interesting is -- is how quickly people
5 found out about it and how easy it was to recruit
6 people.

7 When they found out what was happening
8 and what they could do and what tools they had
9 available to them and kind of how the structure,
10 that it was, again, probably the supervisor doing
11 it, saying what's he saying, it was easy to
12 recruit. We had to do all the work, but -- but
13 it just -- it kind of spoke to a lot of people,
14 and you can see that when you talk to them.

15 But you bring up a good broader point
16 about workforce, and not to take this too
17 Pollyanna or too into the future, but I actually
18 do think that this -- that if I see our plan, and
19 again, our financial challenges with our Medicare
20 plan, I just want to have the time to sustain the
21 plan to do this for both our Medicare and our
22 Medicaid plan because I think it is a different

1 work force, and I think that --

2 MS. ZLOTNIK: Yes.

3 MR. CURRAN: -- what we're learning is
4 that our -- I think the CareOregon workforce of
5 the future is going to be a mix of health plan
6 people, clinical people, and social service
7 people, and basically, what we're doing is making
8 up for what other countries do, which is put more
9 money into social services, but that our new
10 workforce is going to be a blend of those things,
11 and that's going to be the model.

12 MS. ZLOTNIK: Great. That is really
13 helpful.

14 I guess one of the questions is that
15 a number of the CMMI grants actually use social
16 workers as part of the intervention, particularly
17 just because of the frame you provided where the
18 issues aren't really medical, they're social and
19 behavioral and such issues around access, but
20 those data aren't -- there is no really easy way
21 to get those data, so the other question, you
22 might not be able to answer this one either, is

1 the extent to which, you know, kind of as CMMI
2 grantees, you kind of coalesced with some of the
3 other grantees that were sort of using similar
4 models, because I think some of the lessons
5 learned that you've had around sort of who do you
6 need the workforce to be are very important ones,
7 so a lot of projects because it's cheaper are
8 starting out with community health workers, but
9 they're not -- they're like part of a team, but
10 they may not be able to do all of the things that
11 the expectations are for them to do, because
12 these are dealing with people with complex
13 problems.

14 MR. CURRAN: And that one is going to
15 be easier to answer because I really don't know
16 those learnings, because other people attended
17 those conferences.

18 But I know there was, and I know those
19 were some of the exact issues that they talked
20 about, so I think for you Joan, or for the whole
21 group, I think if you would want more
22 information, I'd love to put you in touch with

1 people who are closer to it to answer the
2 questions, because --

3 MS. ZLOTNIK: Yes --

4 MR. CURRAN: -- they have a lot of
5 great insight.

6 MS. ZLOTNIK: Right, because I -- you
7 know, I am sitting on the committees that are
8 representing the social work community, and the
9 presentations today are sort of really good
10 examples of, you know, highlighting ways in which
11 social workers are very beneficial to improving
12 services and outcomes, so I definitely will
13 follow up with you, and thanks so much for the
14 presentation.

15 MS. SHAHAB: Thank you. Next is
16 D.E.B. Potter.

17 MS. POTTER: Hi. I'll just reiterate
18 what everybody said about how exciting the
19 presentation is, and it's so exciting to see the
20 things that are going on in Oregon.

21 I have a couple of sort of technical
22 kinds of questions. If you could speak some more

1 about the risk model or the health reliance, I am
2 trying to understand how you went about
3 identifying people who had trauma. Or was that
4 something that got identified after you had
5 identified a high-risk population, for example?

6 MR. CURRAN: So it's going to sound
7 probably funny how simplistic it was.

8 We did not start out with a risk
9 model. What we really looked at -- and we've got
10 some people who have worked on this that have
11 done, you know, we used Johns Hopkins' ACG Model,
12 are very -- and actually, what they ended up
13 using was simply two or more inpatient admissions
14 or five or more emergency room visits in a year,
15 as simple as that sounds.

16 What we found, what the real learning
17 was was really -- and that is similar to what a
18 lot of health plans use, but again, the process
19 that we went through and the people that we hired
20 to do the work, that was the revelation about the
21 past trauma, the incredible high prevalence of --
22 and that's what this community of practice found,

1 that when they would get together and they would
2 talk about these issues, both data-driven and
3 also just anecdotal.

4 So it really wasn't that -- that
5 identification wasn't driven by the model, it was
6 driven by the experience.

7 MS. POTTER: Okay. And sort of a
8 follow-up, kind of related kind of question, when
9 you spoke about the sort of criteria or
10 principles of the Special Needs Plan, you spoke
11 to having difficulties with the assessment and
12 the person-centered planning, and that you
13 thought there might be other ways to go about
14 that. I wonder if you could elaborate a little
15 bit more on that?

16 MR. CURRAN: Well, I -- and I think
17 some people have spoken to this. The -- there's
18 -- you know, again, with many elements of the
19 Medicare Advantage program, it makes perfect
20 sense to do a health risk assessment, and then
21 for this population, an individual plan of care.

22 I just think the more that we're

1 learning, it's -- the more we want to know about
2 isn't about their health, and it isn't the
3 individual plan of care for their medical
4 treatment. Those -- those are things that for
5 the most part we either already know or we have
6 ideas that we can get from primary care.

7 97 percent of our members are in some
8 -- have engaged with primary care within the last
9 year, so it's not lack of access, and we've got
10 that information. I just think it's different
11 information we want to know.

12 I mean, I think it is things like
13 functional assessment. It is information about
14 their past life. It's about motivation. I don't
15 have the magical health risk assessment. I know
16 what I am most intrigued with is a homeless
17 organization that we work with called Central
18 City Concern. Their assessment is a self-
19 sufficiency tool, and I think it's more of that
20 than it is a health risk assessment.

21 MS. POTTER: So -- so it's not so much
22 that you don't need an assessment --

1 MR. CURRAN: It's --

2 MS. POTTER: -- but that the items on
3 the assessment need to be modified?

4 MR. CURRAN: I don't think it's
5 addressing the needs of the population.

6 MS. POTTER: Right, okay. Thank you.
7 That is very helpful.

8 VICE CHAIR HANSEN: Thank you.

9 Well, I have been informed that we're
10 running a little behind, and I know we have two
11 people ready to make comment and questions, so if
12 we could do that, and then wrap this segment up.

13 So Steve?

14 DR. COUNSELL: Yes, I will be brief.

15 I represent America's Essential
16 Hospitals as a geriatrician, and at Eskenazi
17 Health, used to be Wishard Health Services in
18 Indianapolis, so I really appreciate your
19 presentation and can relate to a lot of it there,
20 and I'm intrigued by your responses to some of
21 the questions.

22 But I have a similar one about what

1 would you change about the model of care under
2 SNP? I think we got some good input to that,
3 really more of a broader inclusiveness of more
4 than just the medical, which is something that
5 we've been really thinking is very important,
6 looking at psychosocial issues, living
7 arrangements, the whole, you know, functional
8 status, cognitive status, a broader assessment
9 than what's typically done in a typical health
10 risk assessment.

11 So I'll -- my one question, then,
12 would be more have you found issues around
13 whether the employees of the -- social workers,
14 for instance, the Health Resilience Program, are
15 employed by the plan versus being employed by the
16 practice?

17 And what -- tell us a little bit about
18 your experience between plan versus practice.
19 You know, integration of care and meetings
20 patients' needs and engaging with patients.

21 MR. CURRAN: That's great.

22 I think it will continue to evolve,

1 and I think we will have -- I can see a model in
2 the future where we'll have a mix of both we'll
3 be paying for, but what's interesting is that so
4 far, we started with plan, and then some clinics
5 very much wanted to hire their own, they wanted
6 that. And we got that.

7 And then they switched. And the main
8 reason was this community of practice, was that
9 with this type of work, it was almost like a
10 support group, that if you're just at the primary
11 care clinic and you're part of that team, so you
12 are part of that team, but then you're out in the
13 community working with these folks, you -- it can
14 be somewhat isolating.

15 And even though you're part of the
16 primary care team, so they would be at the health
17 plan, and they would feel like they're part of a
18 health plan that is serving hundreds of thousands
19 of people and a team of 20 that have similar
20 experiences.

21 So that -- it was more -- it was more
22 that than the nuts and bolts of who pays benefits

1 and are there union issues or things like that,
2 it ended up being more the support.

3 DR. COUNSELL: Or whether patients
4 would engage with them, you know, or whether the
5 doctors would allow, you know, the patients to
6 engage.

7 MR. CURRAN: Yes, yes.

8 VICE CHAIR HANSEN: Thanks, Steve.

9 Tom, you have the last comment.

10 MR. LUTZOW: Yes, it's not clear, I
11 don't know if you're a FIDA SNP or just a regular
12 D-SNP -- okay.

13 MR. CURRAN: We don't -- long-term
14 care isn't integrated.

15 MR. LUTZOW: The -- I am wondering how
16 you plan to get over the hump on the 5 Star
17 issue, and there are a number of strategies, for
18 instance, suggested.

19 One of them is to open up a regular
20 Medicare Advantage Plan of well-elderly because
21 your scores can be averaged into a population
22 that's doing pretty well. I wonder if that is on

1 your -- on your road map.

2 iCare happens to be owned by a large
3 national insurance company in part, in
4 partnership with a local rehabilitation facility
5 that I have worked for for a long time, and our
6 large national owner is a 4.5 Star plan, and one
7 thought that we've certainly talked about is just
8 selling to them totally, buying out the nonprofit
9 partner. And overnight, we become a 4.5 Star
10 plan.

11 I don't -- I don't see that as
12 complementary of the 5 Star program, you know.
13 Have you thought about selling out to somebody
14 that already has a high rating so that you get
15 averaged into that rating, and is that, you know,
16 your ultimate strategy of survival?

17 MR. CURRAN: Well, we haven't, but I
18 think it -- it's a great point, and we have
19 talked about do we grow the non-dual part.

20 Portland and Oregon is very
21 competitive in the MA market even though it's a
22 low-payment area, and very -- the community

1 advocacy community, everyone is very much open to
2 managed care, so it's a -- it's a very
3 competitive market.

4 I think it really boils down to -- to
5 mission, and that's why it has been such a tough
6 -- that is why this is -- we're in a touch
7 position right now, is our board is very mission-
8 driven, we primarily are involved in the Medicaid
9 program, and if they were here, I think what they
10 would say is this is what -- this is the work we
11 need to do for the community, and we need to be
12 convinced that the Medicare Star program and
13 payment system can fit that model, and that's our
14 challenge.

15 So rather than selling or diluting, if
16 you will, we're going to try and make a go of it,
17 and make it work.

18 VICE CHAIR HANSEN: This is an amazing
19 point on which to conclude this segment.

20 I think there are some practical
21 opportunities, and having providers like
22 yourself, certainly having a board that

1 committed, is helping us uncover learnings that
2 perhaps all of us can learn from.

3 And so we wish you well on the Star
4 rating, but at the same time, we especially wish
5 you well on your work.

6 So thank you so much for coming in, as
7 Rich said, on this snowy day.

8 MR. CURRAN: Well, thank you for
9 having me. You're doing great work. I love the
10 conversation that you're having. It's wonderful
11 that you're devoting your time and effort to
12 this.

13 VICE CHAIR HANSEN: Thank you very
14 much, Pat, and I'll turn this back to Sarah.

15 MS. LASH: That's all, and I'll add my
16 thanks as well, tremendous presentation.

17 I would like to request that the
18 committee just take ten minutes to get lunch, and
19 then I'd like to move forward with Steve's
20 presentation on the GRACE model, just, you know,
21 so we can all get out of here as quickly as
22 possible.

1 We did speak with Gretchen Alkema, and
2 she will be on the phone earlier than 2 o'clock,
3 so we can really just knock out the rest of the
4 agenda as best we can.

5 So for anyone on the web meeting,
6 please plan to reconnect at 20 of.

7 (Whereupon, the meeting went off the
8 record at 12:28 p.m. and resumed at 12:38 p.m.)
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(12:38 p.m.)

DR. COUNSELL: Well, thank you for the opportunity to tell you about some of the work here at Eskenazi Health, previously known as Wishard Health Services Safety Net Hospital and Health System in Indianapolis. I think we're the second or third largest safety net health system in the country by ambulatory visits standards.

And so I'll -- the GRACE program, the acronym there was a late-night acronym, but we were looking at developing a program that would really support primary care practices and physicians and their care of their older patients, and especially their complex older patients. And very busy community health centers where they were only accounting -- older adults only account for about 10 percent of the visits.

And so I was looking up words that start with G-R. And there's Geriatric Resources. I knew I wanted that, because this was really bringing -- trying to bring resources to the

1 practice to help with their older patients, and
2 for assessment and care. And so traditionally,
3 geriatrics is kind of known for doing these
4 great, big, nice assessments, and then, here you
5 go, Doctor. You know, here is what you should do
6 for your patients.

7 And so it was very important we know
8 that -- to then provide the resource to actually
9 follow up and get things done and implement
10 things. This is patients -- we have really tried
11 to make this a patient-centered model.

12 This was, first and foremost, a sort
13 of geriatrics, holistic, team-based, program, but
14 also we developed this about 10, 15 years ago,
15 and so this was on the heels of managed care
16 where doctors were reticent to work with a nurse
17 or something outside the practice where there was
18 disease management programs doing things with
19 their patients that they didn't even know they
20 were involved, and sometimes in conflict with
21 their own plan.

22 So our second goal in developing the

1 program was to really look at something that was
2 also physician, primary care centered, and
3 meeting their needs, looking for the synergies
4 between aligning patient-centered care with the
5 needs of what clinicians felt they could do a
6 better job with.

7 And then a third sort of background
8 piece was that we had visited a PACE site --
9 Indiana doesn't have a PACE site -- and saw some
10 barriers around developing a PACE site, the high
11 upfront costs of a building and capital. But
12 then, having -- patients having to typically
13 change doctors, instead of staying with their
14 current doctor, and you had to be nursing home
15 eligible, so you had to be quite disabled to get
16 into PACE.

17 So we wanted to see if we could go
18 upstream, help the current physician, help groom
19 that relationship with primary care, and to help
20 people maybe potentially avoid that kind of
21 disability that would lead them to qualifying for
22 PACE.

1 And the other piece was that --
2 looking at small geriatrics teams. We realize
3 that there is never going to be enough geriatrics
4 teams to take care of most older adults. So that
5 if we can divide -- have a small geriatrics
6 expert team relatively, and leverage that across
7 a broader population, that was another advantage
8 and where we -- what sort of led to the
9 development of the GRACE model.

10 So what I plan to cover here is just
11 -- and pretty briefly here, you know, the first
12 bullet point here, older persons, people with
13 multiple chronic illnesses and functional
14 limitations. That is really the combination that
15 gets people with high and complex health care
16 needs, but also high-cost hospitalizations,
17 nursing home, home health care, et cetera.

18 And this is a sweet spot for
19 geriatrics teams, because if you need help in
20 functional activities of daily living and such,
21 that automatically bridges into the social and a
22 lot of the things that we have been talking

1 about, so you're dependent on someone else to
2 help with your activities of daily living. That
3 automatically brings in -- and you are typically
4 -- not have those functional limitations without
5 multiple chronic illnesses, multiple medications,
6 et cetera.

7 The second point is that GRACE
8 provides -- certainly, this has been our intent,
9 to be very person-centered, holistic, in both the
10 planning of care and implementation of the care
11 plan. And then, right from the start we looked
12 at, how could we integrate medical and social
13 care?

14 GRACE, through our randomized trial,
15 published in the Journal of the American
16 Medication Association, now eight or nine years
17 ago, you know, a very rigorously tested, proven
18 higher quality of care, higher quality of life
19 outcomes, and lower total cost for the high-risk
20 patients.

21 And then, finally, I'll tell you about
22 some of our experience here over the last four or

1 five years in helping 21 now different health
2 systems in five different states implement and
3 replicate the model and some reports around the
4 return on investment.

5 So, first, older people. So the older
6 people with chronic diseases and functional
7 limitations, they need more services, oftentimes
8 have common geriatric conditions, dementia,
9 depression, falls that we all recognize don't get
10 the kind of attention or standardized approach in
11 a busy primary care practice that they would
12 benefit from.

13 And then, it's the socioeconomic
14 issues, especially in a safety net health system,
15 low health literacy, limited access, typically
16 very fragmented health care.

17 The group of older adults in the
18 community, the 20 percent that do require help
19 with instrumental and basic activities of daily
20 living account for about 40 percent of the health
21 care spending. And so this is the group they are
22 looking at trying to help.

1 And so an example of an older person
2 with chronic diseases and functional limitations,
3 someone who may be 83 years old, have high blood
4 pressure, heart failure, and diabetes, at the
5 same time they've got some mild to moderate
6 dementia, they've had a couple falls, and they
7 need help in bathing and dressing from a
8 caregiver.

9 So they have family and caregiver
10 support needs. They -- this person happened to
11 be on the Medicaid waiver program and was dual
12 eligible. And so getting a home health aide and
13 assistance in the home to avoid long-term
14 institutionalization. Eight different doctors,
15 you know, with specialists and primary care.

16 And then the whole system has limited
17 geriatrics expertise, you know, from the doctors
18 to the home health direct care workers, et
19 cetera. And typically, communication and
20 coordination of care between all the players is
21 limited.

22 I put this slide in right up front,

1 because this is -- and, really, it harkens on
2 this morning's presentations, but in terms of, as
3 a clinician, what do I see as a positive patient-
4 centered outcome.

5 And this is feedback after a couple of
6 years of getting GRACE going from some anecdotal
7 reports from the VA, the Indianapolis VA. This
8 is a veteran, older veteran. I'm amazed at how
9 you guys keep track of me. GRACE is amazing. I
10 surely do appreciate you guys. You are a great
11 team to have caring for me.

12 And then, from the caregiver, the
13 spouse, the GRACE team saved my husband's life
14 and my sanity. I had hit rock bottom when the
15 team came to our home and didn't know how we were
16 going to continue like this. The entire team is
17 warm and sensitive to our needs. I would like to
18 thank GRACE from the bottom of my heart for
19 giving me my old husband back.

20 And then, finally, consistent with
21 really teaming up with the primary care -- the
22 primary care physician commenting, thank goodness

1 GRACE is involved in this patient.

2 Okay. So where does GRACE fit in the
3 continuum here? You know, we have had -- in the
4 past, we've had office-based primary care, and we
5 see that that, you know, is the one-off with the
6 doctor, maybe with a receptionist or something,
7 is getting further and further away from
8 realizing -- thinking that that can meet the
9 needs of a lot of patients, especially the
10 patient population that we're talking about.

11 So we have had, over the last 10 years
12 maybe or so, a gradual infusion of patient-
13 centered medical home, again, an office-based
14 nurse care manager perhaps, maybe some
15 transitions help from a nurse or a social worker,
16 and where we moved and with some of our
17 replication sites they are identifying that that
18 is not enough for some of these complex-type
19 patients and that we need something that is home-
20 based and that is personal, and that even has a
21 higher skill set potentially than an office-based
22 nurse, to really be a help, to enhance and expand

1 the primary care reach.

2 So the Blue Cross/Blue Shield of
3 Michigan is referring to this as their high
4 intensity care management program, and they look
5 to GRACE -- and we are working with nine
6 different physician organizations in the State of
7 Michigan currently under Blue Cross/Blue Shield
8 of Michigan. And I will talk to you about that a
9 little bit later.

10 And I almost put on this slide, you
11 know, the next step really is PACE, where you
12 really have everything, you know, very intensive
13 around a person with complex needs.

14 So what is the model? Looking at this
15 conceptually, you know, people with unmet health
16 care needs, we want to improve diagnosis and
17 identification of issues that were previously
18 undiscovered and people could benefit from help
19 and improve the quality of care and outcomes.
20 Lots of barriers to doing that. And so GRACE
21 tries to get around those, and it has, in
22 general, been somewhat of a workaround, our

1 current health system.

2 And so it initially starts out with an
3 assessment in the home that is focused on
4 geriatric issues and things you can only really
5 get in the home rather than in an office, and
6 then to provide very proactive, ongoing
7 implementation of an individualized care plan and
8 follow-up and care management over a longitudinal
9 period of time, leading to better outcomes.

10 Some unique features from other home
11 programs is that it does have an in-home
12 assessment, but by a team of a nurse practitioner
13 and social worker. And similar to Pat's prior
14 presentation, our primary care system, their
15 biggest perceived need was the need for a social
16 worker. And so that was a critical part of this
17 team and matching them with a nurse practitioner,
18 as you will see, really we find has been
19 beneficial.

20 And then, having specific care
21 protocols to manage common geriatric conditions,
22 these protocols are kind of like checklists. If

1 you read Atul Gawande's Checklist Manifesto, this
2 is sort of to make sure we are checking and not
3 leaving it to chance whether or not we think of
4 physical therapy for someone who has balance
5 problems or other things. So checklist as to --
6 to help guide development of an individualized
7 care plan.

8 This is integrated with the electronic
9 medical records system there in the hospital, but
10 also a separate, web-based care management
11 tracking system for the care management team that
12 contains a lot of stuff that sometimes the
13 primary care providers, you know, it's too much
14 information and actually may get in the way
15 sometimes of efficient care or good relationships
16 with the doctors.

17 And then, finally, integrating in the
18 safety net health system there. We had our own
19 pharmacy, mental health -- there was mental
20 health center -- or an integrated hospital, home
21 health, community-based services, a big emphasis
22 on that.

1 The mental health, when we were -- and
2 still it goes on -- everybody had their own
3 electronic medical record. Pharmacy had their
4 own thing, mental health had their own thing, and
5 the hospital had their own thing, and the
6 outpatient had their own thing. And so -- so
7 trying to pull all of that together.

8 So there are seven kind of key
9 components that we call them to the GRACE model.
10 First is that in-home assessment by the nurse
11 practitioner and social worker. It takes about
12 an hour and a half, and it's right there in their
13 territory arranged at a time convenient for them,
14 and they focus on things you can't do in the
15 office so much, and geriatric issues that maybe
16 aren't identified. So they screen for depression
17 and dementia. They watch gait and balance.

18 The nurse practitioner goes through
19 all of the medications, pulling them out and
20 helping identify, and the social worker talks
21 about advanced care planning and goals of care
22 and meets with the caregiver, if that's present,

1 and talks about what kind of advanced directives
2 there might be and does a home safety check.

3 So they will bring that information
4 back to the office, and then develop an
5 individualized care plan using the GRACE
6 protocols. And the GRACE protocols are around
7 common geriatric conditions that typically they
8 identify during that assessment.

9 And then they will -- in the weekly
10 team conference, they will be joined by a
11 geriatrician, a pharmacist, and a mental health
12 liaison, all from this -- ideally from the same
13 health system, and they all have -- each have
14 about a 10 percent effort dedicated to GRACE.
15 And it is spread out throughout the week, except
16 for a two-hour team conference once weekly.

17 So they're available throughout the
18 week to support the nurse practitioner, social
19 worker, and review and prepare for the team
20 conference. But it's a part-time for that group
21 that don't see the patients; it's the nurse
22 practitioner and social worker who work with the

1 primary care doctor.

2 So at that weekly conference, they
3 will review new patients, and the
4 geriatrician/pharmacist/mental health will add
5 some of their input to the care plan that the
6 nurse practitioner and social worker have
7 drafted, and then that nurse practitioner and
8 social worker then will meet with the primary
9 care physician. So that's the next step is to
10 double back now and say, hey, here is what we
11 found in the home. Here is what the GRACE team
12 thinks might be helpful. What do you think? Is
13 there something we missed? Where do you think we
14 ought to prioritize our time? What do you want
15 to do? What do you want us to do?

16 And then it's a go, and the protocols
17 are written so that they are right at the level
18 of, you know, license and certification, so that
19 people can work at the top of their license. And
20 so if that's on board with the primary care
21 physician, really, everything in the care plan,
22 that nurse practitioner and social worker can go

1 and implement.

2 Sometimes we will have a doctor want
3 to, you know, change the medicine or start the
4 antidepressant instead of the nurse practitioner,
5 but over time the physician really sees this as a
6 big help and says, go, do. And so that is where
7 it is -- then becomes -- whatever it takes to
8 implement the plan of care consistent with that
9 participant's goals and their preferences, and so
10 they will go back out to the home, talk about the
11 ideas and suggestions for their care, and link
12 that, align that with their own personal
13 preferences and goals of care, and then provide
14 ongoing care management and support to caregivers
15 and the like.

16 The final piece of this is that they
17 do provide continuity of care between all
18 different providers, physicians, home health, you
19 know, et cetera, and also settings then, so
20 between hospital, nursing home, home health care,
21 et cetera, and really aim towards helping with
22 transitions.

1 This is a slide on transitional care
2 that we use, that we implemented a proven model.
3 Mary Naylor at the University of Pennsylvania, a
4 nurse practitioner driven model, that we'll get
5 hospital alerts if someone has been admitted to
6 the hospital, and this is where the hospitalists
7 really appreciate it, because we were able to
8 impact -- interact with the hospital team, give
9 them baseline functional status, information, and
10 cognitive status and living arrangements and
11 supports and medication lists and such, so that
12 the hospital can really have a broader view of
13 the person in the context of their acute illness,
14 but then engage with the GRACE team on planning
15 the transition back home.

16 And the doctors may feel even more
17 comfortable discharging sooner and maybe back
18 home rather than to a nursing facility, knowing
19 they have -- the GRACE nurse practitioner and
20 social worker are going to see them in the home a
21 day or two after discharge and really -- and have
22 been a part of the transition planning. So if

1 there is home and community-based services
2 involved, that they have been alerted also that
3 the person was in the hospital, and they may have
4 some different needs, and the nurse practitioner
5 will make sure that home health care shows up and
6 they know what the, you know, plan of care is and
7 -- or the physical therapy, and that the person
8 has a new medication list that they understand,
9 that they have that has been reconciled with
10 prior to hospitalization and then hospital
11 changes in their medications.

12 And then, certainly getting them back,
13 looped in with their primary care physician and
14 scheduled for a follow-up visit. So this does
15 not take the place of primary care; it enhances
16 and actually gives -- provides more primary care
17 and is ideally suited for people who still access
18 and visit with their office-based primary care
19 doctor.

20 The weekly team conference, in
21 addition to new patients and follow-up reviews,
22 they will also -- it is a continuous quality

1 improvement sort of model where if someone has
2 been admitted to the hospital they will look at,
3 well, hey, should we review, and are there any
4 needed changes in the care plan? But just as
5 importantly, well, what happened, and why were
6 they admitted to the hospital? Was there
7 anything we could have done to possibly prevent
8 that? And, if so, we can implement that in the
9 future for that person, if not other patients,
10 too.

11 This is a listing of protocols. I
12 think it is important to note what is there, but
13 also what is not there. We have advanced care
14 planning in every one, and health maintenance in
15 every one, and with complex patients typically on
16 multiple medications we use the medication
17 management protocol also. And each of these come
18 with various triggers or action plans that are
19 selected, independent, individualized to the
20 patient.

21 Over half the patients typically will
22 get at least the falls or the depression or

1 dementia, and you can see the other geriatric
2 conditions that -- again, this is meant to
3 complement and support primary care and not to
4 duplicate what primary care is doing. And so you
5 don't see hypertension, diabetes, heart failure.
6 These kinds of things are well managed by the
7 primary care physician typically, and we assume
8 that is going on and our reviews usually confirm
9 that.

10 When someone is getting admitted to
11 the hospital frequently, however, though, it is
12 not because the primary care team doesn't know
13 what they're doing. It's typically because the
14 person is depressed and that hasn't been
15 recognized, or they don't have transportation, or
16 they can't afford their medications, or they
17 can't read, these kinds of things that GRACE then
18 does wrap around and identify and help with.

19 This is a typical protocol that --
20 each one has -- comes with about 30 different
21 suggestions for care, and we have identified in
22 developing these with our primary care

1 colleagues, things that the primary care doc kind
2 of wants to know about and be on the loop with
3 before -- just get done, and then other things
4 that the team can do routinely.

5 And these are selected individually,
6 depending on if a person has already had the
7 blood tests to rule out, you know, reversible
8 causes of dementia, then they won't get those
9 blood tests, et cetera.

10 So some results from our -- this is
11 the original randomized controlled trial where we
12 had almost 1,000 people enrolled, 500 patients
13 served by six different community health centers
14 affiliated with Eskenazi Health. They are
15 serving an inner city, low income population.

16 We provided GRACE team care for two
17 years, funded by your tax dollars, the National
18 Institute on Aging, as well as a local foundation
19 and Wishard Health Services.

20 We had an equal number of 500 people
21 in this randomized controlled trial that were in
22 the control group, and so after the two years

1 this is a very brief, one slide summary of our
2 results, what we showed from assessing care of
3 vulnerable elders, the ACOVE Quality Indicators.
4 You know, more people got their immunizations,
5 they were able to identify their primary care
6 physician by name, they had follow-up after
7 hospitalization, they had standardized, best care
8 for falls and depression. They were not placed
9 on or taken off of high-risk medications. They
10 had a medication list. So a number of things on
11 the quality side.

12 What was most gratifying to the group
13 was the enhanced quality of life measures by the
14 SF-36 scales and general health, vitality, social
15 function, and mental health. Lower resource use
16 also in the high-risk group.

17 Now, all patients across the group, we
18 showed fewer emergency department visits. But in
19 the high risk, the most complex 25 percent or so
20 in the group, because we took all comers 65 and
21 over in the community health centers, but when we
22 did a subanalysis on the 25 percent more complex,

1 it's in that group that we showed a substantial
2 reduction in hospitalizations.

3 And that's where the money is here,
4 and so reducing the hospitalizations more than
5 offset the costs of the program, showing a return
6 on investment there that is really what is
7 getting the national attention.

8 This is a bar graph just of the
9 hospitalization rates, and the yellow is the
10 control group and green is the GRACE team group.
11 We had about a 12 percent reduction in the high-
12 risk patients in the first year, 44 percent
13 reduction in the second year. And then, because
14 this isn't supported under Medicare currently,
15 that we had to sign off -- the teams has to sign
16 off, but we still saw a persistent significant
17 impact on about a 40 percent reduction in
18 hospital utilization in the GRACE team.

19 And then, this is a slide --
20 similarly, we showed a pretty substantial
21 reduction in readmissions.

22 And this is costs -- we have pretty

1 good cost analysis. It's the Regenstrief Medical
2 Records System, so most costs are actually
3 included in here, including the cost of the
4 intervention, which is about \$2,100 per year.

5 And you can see in the first year that a
6 reduction in hospitalization rates about -- was a
7 break-even, but in the second year when we really
8 had the large reduction in hospitalization rates
9 we started to see cost savings, about \$1,500 per
10 patient, and those savings persisted then after
11 the team signed off with the continued lower
12 hospitalization rates.

13 So what do we think were the -- what's
14 the secret sauce? You know, people ask, well,
15 what is it that worked? So we think having that
16 nurse practitioner/social worker team was really
17 critical to looking at that holistic evaluation
18 and really getting at the patient level through
19 home visits and home-based intervention, and also
20 aligning that team with the physician and
21 practice.

22 So if one doctor has 20 GRACE

1 patients, they have one nurse practitioner/social
2 worker. So it's really -- they are really an
3 extension of the primary care practice. They may
4 not have an office or see patients there at the
5 practice, but they are part of the team and
6 invited to holiday parties and those kinds of
7 things.

8 They are focused on the geriatric
9 conditions and medication management, you know,
10 to complement primary care. Again, not detailing
11 doctors on how to do diabetes in an older person,
12 but looking at things that, you know, they are
13 often willing to say that they could use help
14 with. Providing recommendations and then the
15 resources to actually implement those
16 recommendations seems really key, and not having
17 accountability for implementation of the care
18 plan.

19 Incorporating proven transition
20 strategies. We think the home-based nature -- we
21 initially were just going to start out with an
22 initial home visit, and then go to subsequent

1 follow-up by the social worker and nurse
2 practitioner in the office. But we quickly
3 learned that the offices are too busy and there
4 is no room, and scheduling people was another
5 nightmare, and then transportation and no-shows
6 was already a big problem.

7 So, but first and foremost, we just
8 found out -- we learned so much. You know, you
9 really get the rest of the story and develop
10 relationships much faster in a home-based
11 program.

12 So we went, really, just to home
13 visits and telephonic. At times, the nurse
14 practitioner or social worker would accompany a
15 person to the oncology visit or other physician
16 or health care visits or visit with them in the
17 hospital or the emergency department.

18 So that final piece -- integrating
19 with community resources and social services, so
20 that was really the job of the social worker,
21 especially to interface. And we had strong
22 relationships, and I'll have more on that with

1 our Area Agency on Aging, CICOA Aging and In-Home
2 Services, and -- but other -- you know, senior
3 centers, discount fitness at the Y for older
4 adults, et cetera, that are available in the
5 community.

6 We probably think that the biggest
7 impact is this relationship-building, so it's not
8 a SWAT team that goes in for a month to prevent
9 the readmission, but it really is a group that
10 will go in, engage, assess, follow through. We
11 did see people really change behaviors and align
12 better after they built a trust with the team
13 over time. And so in that one-year assessment
14 suddenly we have people, oh okay. Maybe I'll try
15 this. I'll do this. And so that's where we see
16 the big impact in their outcomes, in the second
17 year and then even persisting beyond that.

18 So I'm going to give you just a brief
19 picture of four different -- our initial four
20 replications, some of which were supported by the
21 SCAN Foundation. HealthCare Partners is a large
22 Medicare risk-bearing managed care group in

1 Southern California. They had, at the time,
2 about 100,000 Medicare risk members that they
3 were responsible for, and they implemented GRACE
4 within their homebound population.

5 And I'll show you some results, but
6 they -- they had doctors, nurse practitioners,
7 and social workers already caring for homebound,
8 complex patients, but there was not an addressing
9 of these kind of holistic psychosocial issues.
10 The team roles were not well-defined, and so this
11 is where they really thought that GRACE brought
12 sort of a whole different approach for them.

13 At the VA, in Indianapolis, we looked
14 at enrolling people at time of discharge from
15 hospital to prevent the readmissions. The
16 hospital wanted -- it's a quicker way to show
17 return on investment from the program, and the
18 hospital wanted to really address readmissions,
19 but then we continued to follow patients there
20 after their readmission and longitudinally with
21 the primary care teams.

22 Now, the third one was our

1 collaboration, even closer with our Area Agency
2 on Aging, where the social worker from the Area
3 Agency on Aging, the case manager of the waiver
4 program joined the GRACE team and took on the
5 GRACE social worker role with the nurse
6 practitioner from the practice. And so it was a
7 really nice, integrated model there.

8 And then, finally, and some results
9 from the IU Health Medicare Advantage plan. This
10 is more of a typical Medicare Advantage plan
11 where we enrolled people from high-risk
12 stratification at discharge from hospital,
13 physician referral.

14 So this is the reduction, about a 35
15 percent reduction. These are before and after,
16 and hospitalizations and nursing facility
17 admissions, and then emergency department visits
18 in that homebound complex group by health care
19 partners.

20 And then we saw a similar -- at the
21 VA, a 50 percent reduction in the 30-day
22 readmission rate, and then over the subsequent

1 year quite a substantial reduction in
2 hospitalizations compared to the year prior in
3 the patients followed by the GRACE team.

4 And then this is that combined effort
5 with our local Area Agency on Aging with the
6 ADRC, the Aging and Disability Resource Center
7 social worker taking on the hat of both the
8 waiver case manager and the social worker for the
9 GRACE program, working with a nurse practitioner.
10 And this was under the care
11 transition/readmission prevention program, and so
12 that we were looking primarily at readmission
13 prevention there.

14 I should say that patients commented
15 that they had one social worker who is connected
16 with their primary care and their medical care,
17 and that sort of had the whole picture, and that
18 it was really well-received by the clients under
19 the duals and Medicaid waiver program.

20 And then, this is at IU Health, and
21 the Medicare Advantage plan there, similar type
22 results in our first -- this next slide is

1 actually data from the health plan in the first
2 50 or so patients that we followed for two years
3 or longer. And you can see in the year before
4 their hospital rates was over 1,200 per thousand,
5 and afterwards a 43 percent reduction. So this
6 is sort of seeing very similar type results from
7 each of the different populations we're working
8 with.

9 In-patient costs then reduced by just
10 about half over the two years following
11 implementation, and total costs and 30 percent
12 improvement, so lower costs per member per month
13 for two years after compared to the year before
14 GRACE involvement.

15 We know that we saved money mostly
16 around the hospital costs, but we -- GRACE does
17 increase the costs for things like behavioral
18 health and physical therapy and some of those
19 kinds of things.

20 What was also interesting to see is
21 the premium increase, so the revenue to the
22 health plan was increased in the patients. So

1 even though the costs were going down, the
2 revenue was going up by an 11 percent improvement
3 in the per member per month increase. And this
4 is because the team is identifying previously
5 undiagnosed depression or malnutrition or other
6 things, and documenting those in the chart that
7 then get a higher, you know, and more appropriate
8 case mix payment.

9 So this is a return on investment
10 analysis of the GRACE program by Avalere that
11 just came out about six months ago. And they did
12 a really nice report; I would recommend this to
13 everyone. Maybe we should send it to the group.
14 But they concluded that effective management of
15 key populations -- and, in particular, older
16 adults with multiple chronic conditions and
17 functional impairment -- not only improves
18 outcomes for the plan members but can yield a
19 positive return on investment.

20 And their analysis of our publications
21 and data showed these results, that the return on
22 analysis indicated that the GRACE model had close

1 to 100 percent return on investment. The annual
2 cost of the program was similar to what we had
3 calculated -- \$2,200. Annual savings per member
4 about twice that. And so your return on
5 investment, 95 percent, or two to one, or per
6 member per month savings \$174.

7 So that adds up pretty quickly, and so
8 this has been certainly strong evidence for the
9 health plan to continue to sustain and expand the
10 program.

11 I will -- how am I doing on time? All
12 right. I am just about -- okay.

13 So some less quantifiable benefits
14 that probably are important for this group to
15 hear that, you know, we -- it's easier to look at
16 the dollars, but things that aren't here that we
17 have had feedback from our replication sites --
18 improve patient experience and market patient
19 loyalty. So these are some other benefits to a
20 health plan per se for adopting the model.

21 Reduction in readmission rates and the
22 penalties that come across that, at least to the

1 hospitals. Better performance on quality metrics
2 and STAR ratings. One of the health plans we are
3 working with really feels that this is improving
4 their STAR rating score and, again, their
5 reimbursement to do the things that they want to
6 do in patient care.

7 Greater efficiency and job
8 satisfaction of the primary care teams. So when
9 patients show up for their visit, they are teed
10 up. The docs and such have something to back --
11 you know, to fall back on, and there is -- so
12 that the primary care teams really appreciate the
13 added help.

14 Increased revenue from identification
15 of geriatric conditions, as I mentioned, around
16 the premiums. Assistance to patients to help
17 optimize their health insurance. Sometimes
18 people qualify for Medicaid that aren't signed
19 up, or other benefits that they might be unaware
20 of, that can decrease their costs and help meet
21 their needs.

22 Improved access to community resources

1 and services, more appropriate utilization of
2 home and community-based services. At the VA, in
3 particular, we are seeing that some people are
4 getting more than they need because the person
5 overseeing the home and community services are
6 just being careful to make sure they get
7 everything. And some people aren't getting what
8 they need, and so I see it probably more of an
9 appropriate balancing of what people really --
10 matching because of the home visits by the GRACE
11 team. And then, prevention or delay of long-term
12 nursing home placement.

13 This is our replication and resource
14 center, and these are the groups that we are
15 currently working with. UCSF Medical Center,
16 they are working with patients under 65 and over
17 65, and we can talk about that and about how they
18 have adjusted the model for the younger
19 population.

20 University of Michigan, under an
21 accountable care organization. I mentioned the
22 Blue Cross/Blue Shield of Michigan and their

1 Medicare Advantage plan, and the VA is there.

2 We can talk some about the
3 dissemination kinds of things. I just -- I did
4 want to present this slide here. Optimizing
5 high-risk care management. This was just
6 published last week in the Journal of the
7 American Medical Association around, you know,
8 how do we get these kinds of programs out there?
9 And identifying that a coordinated strategy was
10 required between all of the players.

11 You've got purchasers, maybe in a
12 Medicare Advantage or special needs plan. You've
13 got -- that's CMS. You've got the payer is the
14 health plan, and then you've got the health care
15 organization or physician organization, what have
16 you, getting them all aligned and leverage the
17 unique capabilities of each to avoid redundancy
18 or duplication.

19 And these are the three principles
20 that they outline that are sort of overarching in
21 the design and implementation of these kind of
22 high-risk care management programs. One of the

1 most effective programs have been those that are
2 practice-based, and so where the care managers
3 are integrated with the practice, much like what
4 we did with GRACE and even what have been
5 presented earlier.

6 And then, catalyzed by the payer --
7 and so this is what we've really seen up in
8 Michigan by Blue Cross/Blue Shield of Michigan,
9 where they are actually paying a per member per
10 month for the care management, but also paying a
11 fee for service for the face-to-face visits, and
12 a fee for service to the physician for the team
13 meeting time.

14 So these are the kind of things that
15 can really be enabled by the health plan, and
16 then supported by CMS in the way they design the
17 Medicare Advantage program. So health plan
18 contracting at a powerful level.

19 So I have tried to give you an
20 overview of the persons that benefit most from
21 this kind of integrated care and person-centered,
22 you know, integrating medical and social care,

1 the evidence of the GRACE model and its
2 replication and scalability with pretty
3 consistent results.

4 Thanks.

5 VICE CHAIR HANSEN: Thank you very much,
6 Steve, to really show on such a granular and
7 operational level what it takes to achieve this
8 and to have a randomized control trial have the
9 impact that it has in a real pragmatic sense.

10 So we have some questions here from our
11 members, and we also -- let me just ask you,
12 Sarah, what's the best thing on time, since we
13 have Gretchen on the line.

14 MS. LASH: I think if the initial
15 round of comments and questions could be brief,
16 we'd like to ask Dr. Alkema to do her remarks
17 around 1:30, maybe a little bit later. And if
18 there are further questions and dialogue for
19 Steve, we can sort of continue that as we move
20 through our wrap-up and round robin on
21 recommendations.

22 VICE CHAIR HANSEN: Okay. Great. So

1 do we have people on the line? No. Okay. So
2 that's great.

3 Okay. Let's start with Tom on this
4 side.

5 MR. LUTZOW: Yes. I can see why the
6 hospitals are very nervous -- are made very
7 nervous by this program, and of course the GRACE
8 model is well-known in the Midwest and studied.
9 The protocol list that you -- I know you've
10 thought about these things, and I'm just kind of
11 curious as to what's not on the list.

12 And alternate -- you know, alternate
13 pharmaceuticals, if you will, almost -- for
14 instance, vitamin D has been related to falls
15 prevention as a strategy. And so I'm sure you've
16 thought about non-traditional protocols. Just
17 wondering what your thoughts are about that.

18 Also, with this age group, chaplain
19 services. At iCare, we certainly, you know, talk
20 about radial eye care, for our members to call in
21 to have access to those kinds of communal events.
22 And that is not a protocol, but I'm sure you have

1 talked about it. And so what are your -- what is
2 your thinking about those additional protocols?

3 DR. COUNSELL: Yes. In the interest
4 of time there, I didn't include much detail
5 around the protocols. But the medication
6 management protocol does have a number of kind of
7 different suggestions. The pharmacist sitting in
8 on the team conference will come prepared with
9 that person's list, at least what is known and
10 their fill rates and what alternatives might be
11 available, et cetera.

12 Also, we -- on the health maintenance
13 protocol, all the preventive services type
14 things, and actually that is where the Vitamin D
15 falls in in terms of vitamin D for falls
16 prevention and overall wellness.

17 So there is a number of things on the
18 health maintenance sort of checklist that address
19 that.

20 The chaplain services and even
21 palliative care and those kinds of things, we
22 typically will -- if a palliative care team is

1 already involved, we won't enroll them into
2 GRACE, but -- or if hospice is already involved.
3 But typically we will help facilitate and through
4 the developing of trust and that shared decision-
5 making help facilitate people move to hospice or
6 palliative care.

7 And the social worker would -- does do
8 a spiritual sort of brief assessment also at the
9 beginning to look at how those kinds of things
10 play into decision-making for that particular
11 person and would be able to refer them to other
12 resources.

13 VICE CHAIR HANSEN: Thank you. Let's
14 -- Shawn, we'll start on your end.

15 MR. TERRELL: Thank you. That was
16 excellent. I didn't know about you guys, but I'm
17 glad to see you work with the ADRC group there.
18 That's good.

19 Two quick questions. One, has the
20 recent finalized home and community-based rule
21 from -- that was finalized in 2014, has that --
22 has any of that -- you know, states have to do

1 these statewide transition plans for the home and
2 community-based services for (c) waivers and a
3 few other authorities. Has that filtered over to
4 any of your work?

5 And then, a question about -- do you
6 run into conflicts in the home and with the
7 family around, what a person may want to do, and
8 what -- versus what the family may want to do?
9 Like, for instance, a person may want to stay
10 home, the family may want to say, let's go to
11 assisted living. When you run into -- do you run
12 into those questions?

13 DR. COUNSELL: Never.

14 MR. TERRELL: Never. Right.

15 (Laughter.)

16 I mean, how do you negotiate -- it
17 seems as a -- I think this -- I mean, it seems --
18 I just wonder, this is a test, because it's sort
19 of a -- I see this -- that there is -- people
20 seem to jump to time to go, move, you know,
21 before -- like our thinking around staying at
22 home and getting in-home support doesn't seem to

1 have penetrated the general population.

2 Is that -- is that accurate?

3 DR. COUNSELL: Yes, no. This is an
4 important point, and in our introduction even of
5 the program is that we are -- you know, they go
6 out and their initial, you know, almost first
7 thing out of their mouth is, we're here to do
8 anything we can to help you, you know, stay at
9 home and not have to -- so to kind of relieve
10 that fear of, oh, somebody is coming out to check
11 on me and put me in a nursing home kind of thing.

12 So, but those conflicts certainly do
13 arise, but it's -- it is -- I'd like to think it
14 is a very holistic and patient-centered, family-
15 centered approach in terms of looking at weighing
16 those. And in the weekly team conferences, the
17 whole team sort of discusses that, and the social
18 worker or the mental health people will sort of
19 speak up, you know, from their side.

20 You know, if the nurse practitioner is
21 saying, hey, this person has got to get to a
22 nursing home; they are going to fall, well -- the

1 social worker, well, maybe they'd prefer to stay
2 at home. You can fall in nursing homes, too. So
3 I think that dynamic goes on quite a bit, but
4 this allows really a team approach and shared
5 decision-making, I think, model.

6 The home and community-based services
7 thing, that is really still in the hands
8 primarily of the Area Agency on Aging and case
9 managers. So we haven't really experienced a big
10 change there.

11 VICE CHAIR HANSEN: Anne, and then
12 Rich.

13 MS. COHEN: So hopefully this is a
14 brief question and answer, but probably not.
15 Just getting back to quality, since that's our
16 mission, I was struck by the reduction of
17 hospitalizations and our hospitalization
18 readmission measures. So, clearly, that is a
19 measure you can impact. What other measures do
20 you feel like you have less ability to impact,
21 and what measures do you wish you were measuring?

22 DR. COUNSELL: Yes. That is a good

1 one. That may not -- that may take a little
2 thought, but we -- a lot of the process things I
3 think we know that sort of help deliver the
4 outcomes. You know, so having a medication list
5 and having a health care representative
6 identified.

7 Some of these kinds of things that are
8 process measures I think would be -- I think the
9 patient experience, so the satisfaction surveys
10 and the CAHPS kinds of things can get at -- I
11 think that one sentence question, you know,
12 around patient-centered care, you know, how is
13 your care going, or something, I think that first
14 slide I gave about the -- from the VA experience
15 starts to get at some of that kind of thing.

16 So I think the whole piece from sort
17 of process, quality metrics, as well as the
18 outcomes, are worthy of consideration.

19 VICE CHAIR HANSEN: It sounds like you
20 are harkening back to, how do you start the
21 conversation with what is important to them. And
22 so doing that on a systematic basis as part of

1 the meeting that goes on. And so having that be
2 probably a new one as this person-centered work
3 keeps coming, because it -- obviously,
4 satisfaction and all, but there is probably an
5 area of new deliberateness of --

6 DR. COUNSELL: Yes.

7 VICE CHAIR HANSEN: -- starting there.
8 Okay. Rich?

9 MR. BRINGEWATT: I have a couple of
10 plan change questions. How do you get this to
11 work on the front end? So you drop -- drop you
12 in the middle of an environment where you don't -
13 - haven't existed before. There isn't something
14 like what you had before.

15 How important is the selection of
16 physicians that you work with? And given that
17 selection process, what criteria do you use in
18 order to identify some docs to work with you?

19 And then, the second question is, how
20 important is critical mass to your success story,
21 meaning percentage of patients that you help a
22 physician or a clinic activity engage in this

1 different kind of approach and similar kind of
2 question as it relates to the degree to which you
3 can affect a hospital's total population versus,
4 you know, if you have only one or two, where you
5 are really changing behavior, how big of a
6 critical mass do you have to get before you
7 change those behaviors?

8 DR. COUNSELL: Yes. These are key
9 issues that we continue to, you know, work on.
10 But the -- in just starting -- startup, our
11 experience has shown that if you can start with a
12 practice as a lot of older adults, and maybe a
13 lot of higher risk patients, and a couple doctors
14 who get it, and are sort of willing to or can,
15 you know, take it on, and then we like to say we
16 sort of develop and -- start with those two and
17 develop the processes, and then build GRACE envy
18 in the other doctors, and the other practices are
19 then, wow, why can't we get that? And we want
20 that for our patients.

21 There's another of our strategies, and
22 then also your patient selection, so that you are

1 identifying things that the doctors will agree
2 that, oh, I could use help with that. You know,
3 we are not identifying people by having diabetes
4 or heart failure. We are identifying people by
5 having depression or dementia or falls or 12
6 medications, those kinds of things, or being
7 discharged from the hospital, where they
8 typically will buy-in to the fact that, yes,
9 okay, I could benefit from, you know, something
10 else as a resource for my patient.

11 The critical mass question is --
12 varies, really, across settings. Certainly, I
13 think we typically have an NP-social worker have
14 a caseload of 100, and the ideal sort of unit of
15 GRACE is to have three dyads, three nurse
16 practitioner/social worker dyads, taking care of
17 about 300 patients. And if you're looking at
18 five percent, that's a population of maybe 6,000
19 people. So if you're looking at the five percent
20 high risk, five or 10 percent in there.

21 I hope that gets at least a little bit
22 to your question.

1 VICE CHAIR HANSEN: We have one last
2 question.

3 MS. SHAHAB: We have one workgroup on
4 the web, Joan Zlotnik.

5 VICE CHAIR HANSEN: Okay.

6 MS. ZLOTNIK: Yes. It was a great
7 job/presentation. I have a question in terms of
8 the social work/nurse practitioner teams. How
9 are they being paid for? Or how are they billing
10 Medicare? Are the social workers billing
11 independently, or it's part of the institution
12 where they are working for? How is it done?

13 DR. COUNSELL: Yes. This varies, too,
14 depending on the environment. But like the VA,
15 they just pay for the team as it's a -- you know,
16 it's sort of their own --

17 MS. ZLOTNIK: Right.

18 DR. COUNSELL: -- system, and that's
19 what Wishard Health Services is doing. The nurse
20 practitioners -- since the patient is still going
21 to the office practice for their primary care, we
22 are not able to bill for a home visit in that

1 setting. So that in a fee for service setting,
2 it is more under an accountable care
3 organization, looking at the accountable care
4 organization paying for the program to then help
5 in sharing, you know, savings.

6 The health plan in a Medicare
7 Advantage plan world would be multi-faceted. At
8 IU Health, they would pay for the team, and then
9 the nurse practitioners, though, bill for their
10 face-to-face visits. And so they just, at the
11 end of the year, sort of true up what came in to
12 cover the nurse practitioner costs from the
13 visits, and they deduct that, and then the delta
14 is covered.

15 Blue Cross/Blue Shield of Michigan is
16 really covering, you know, that multi-faceted
17 sort of payer for per member per month, also for
18 face-to-face visits by the social worker or the
19 nurse practitioner or a nurse, in addition to,
20 you know, some face-to-face time for team
21 meetings by the doctors.

22 MS. ZLOTNIK: That's great.

1 VICE CHAIR HANSEN: Yeah. That is
2 very helpful to see how many different levels of
3 systems and approaches, that you have been able
4 to make it work in this multi-payer environment.

5 We thank you so much for presenting
6 this. I think we have had a chance to see today
7 with the various presentations the level of
8 breadth, our cross-link to our colleagues on
9 person-centered care, and some of the rigor of
10 the work that they have started, that we have an
11 opportunity as a group of us to interface, and
12 then the ability to think about risk adjustment
13 and stratification, the ability to see how a
14 health plan that deals with the high risk does it
15 differently and starts reframing and having such
16 specific work here, Steve, of a model that starts
17 off as a very important research program but now
18 has diffused and really has some strong pickup
19 from, you know, systems -- from health systems to
20 the VA to private payers.

21 So I know we have our last segment
22 here, and Dr. Gretchen Alkema is on the line and

1 has been patiently available for us, knowing that
2 we were hoping, Gretchen, to move on a little
3 more quickly. We are having steady snow here in
4 Washington, D.C. I imagine in Long Beach -- is
5 that where you are right now?

6 MS. ALKEMA: No. But I am not where
7 you are, so -- I got out last night, and I am
8 grateful.

9 VICE CHAIR HANSEN: Okay. Great.

10 MS. ALKEMA: I am in San Francisco.
11 I almost hesitate to say that for people who are
12 on the East Coast.

13 VICE CHAIR HANSEN: Okay. Well, I
14 know that the staff were great to invite you to
15 present on behalf of the SCAN Foundation, with
16 the title of our presentation as Person First or
17 Measuring Quality in the New Era of Integrated
18 Care Delivery. And we look forward to your
19 comments. And in full disclosure to the rest of
20 the Committee, I sit on the Board of the SCAN
21 Foundation as well.

22 So, any other comments here, Sarah?

1 Okay. Gretchen, please, take it away. Thank
2 you.

3 MS. ALKEMA: Great. Thank you so
4 much. First, I will just do an audio check. Are
5 you able to hear me okay?

6 VICE CHAIR HANSEN: Superbly.

7 MS. ALKEMA: Wonderful. Great. Thank
8 you so much, Jennie, and to the whole NQF team
9 for the opportunity to speak with you today. I
10 was asked to set a little bit of a frame about
11 thinking about some of the different vision
12 points of how people perceive success in
13 integrated systems of care, and hopefully with
14 that kind of set a pallet for your discussion of
15 thinking about what are quality measures to
16 connect to those various visions of success.

17 I will also share a little bit of work
18 that the foundation has been doing with NCQA in
19 this regard, again, to continue a vision and one
20 kind of framework to think about quality. There
21 certainly can be many others. And it was lovely
22 to step in on the conversation that Steve just

1 provided the group, because I think he speaks a
2 lot about how to -- how that kind of integrated
3 system is operationalized, and that was a great
4 follow on, that I have an opportunity to speak to
5 you today.

6 So why don't we go ahead and move to
7 the next slide.

8 So I am going to talk with you a
9 little today about how the foundation thinks
10 about success from different viewpoints. And I
11 will start off with the concept of success from
12 the consumer's vision, and this is based on focus
13 group work that -- and polling work that we have
14 done and lots and lots of conversations with
15 consumers themselves, older people, family
16 caregivers, as well as stakeholders.

17 And when we just kind of boil down,
18 what are the three ways that our experience is
19 that consumers are thinking about success in
20 integrated systems of care, ultimately people are
21 focused on, how can they live at the absolute
22 highest functional level possible, and, frankly,

1 with the least intervention.

2 I don't know anybody who wakes up in
3 the morning and just can't wait to go to the
4 hospital or end up in a doctor's appointment,
5 particularly one that is unscheduled. And so
6 thinking about that frame of people being able to
7 live their lives fully, just like I would say
8 most of us probably on this call would like to be
9 -- I don't know anybody who is dying to go to the
10 hospital today.

11 So, you know, kind of setting that
12 frame about how much is the right amount of
13 support and care and services for someone, so
14 they can live at their best functional level.

15 Second in that is ensuring that there
16 is a timely response by providers who are
17 competent to know what their needs are. And in
18 an integrated system of care, that obviously
19 takes into account much more than just the acute
20 care frame. And the third piece in that -- and
21 we see -- is the opportunity for consumers and
22 their families to feel confident in being able to

1 navigate that system of care by themselves or to
2 get support as needed in that, in whatever way
3 that they choose.

4 So, you know, appropriate engagement,
5 meeting people's needs through folks who have a
6 sense of what they are doing.

7 Let's move on to the next slide.

8 So building on the consumer's vision,
9 we take another kind of perspective about this.
10 The system as a whole -- and this can be kind of
11 at the 30,000-foot level, the system as a whole
12 has a vision of success that has been articulated
13 in many, many different kinds of documents,
14 whether it be programmatic documents like, say,
15 how the GRACE program has functioned or things
16 coming out of CMS or out of the Affordable Care
17 Act, taking that broad vision as the system often
18 speaks about success in a couple of interrelated
19 ways, but a little bit differently.

20 And that is focused on more about that
21 the entities that are engaged in integrated care
22 provide this range of services that meet the

1 total care needs, that the financing mechanism
2 supports integrated care delivery in its
3 totality, so it thinks about what are those
4 resources needed from kind of soup to nuts, acute
5 care, all-inclusive to long-term services and
6 supports in behavioral health. Some even think
7 beyond that in terms of housing and other
8 structures.

9 And that a quality strategy is focused
10 around both improving consumer outcomes of care,
11 meeting those objectives that we talked about on
12 the last slide, but then also ensuring that there
13 is an effective and efficient care delivery
14 spectrum. So kind of putting all of those triple
15 aim type pieces together.

16 On the next slide, I am going to start
17 to break down some of the key players within that
18 system who have variant visions of quality that
19 are interrelated to that bigger system view, but
20 kind of gets more specific based on what part of
21 the system are we talking about.

22 And so I will first start off with the

1 entity itself who we call it generically a risk-
2 bearing entity, who is the kind of point entity
3 for bringing all of the pieces of the care
4 delivery together in some way. That could be a
5 managed care plan, that could be a health home,
6 that could be an ACO, you know, lots of different
7 places think about different structures. You
8 know, it could be a pay site, et cetera.

9 And so thinking about the vision of
10 success from that end, again, boiling it down to
11 just three highlights is -- the first thing is
12 that the financing structure sustains what is
13 that contractual relationship that the entity has
14 to deliver integrated care, which includes all of
15 the facets from the enrollment to access to the
16 design of care to having models like GRACE or
17 others, all the way through implementation and
18 being able to maintain the workforce capacity to
19 execute this totality of integrated service
20 platforms.

21 That -- another key vision of success
22 is that grievances and appeals are minimal,

1 meaning that people are getting their needs met,
2 and so folks aren't feeling frustrated around
3 what is happening in the process of care. And
4 there are challenges, because there always will
5 be some kind of challenge in some way, shape, or
6 form, that they are fully solved, and my
7 experience is is that plans or ACOs or other
8 systems want to be able to solve that as much in-
9 house as possible. So that's a measure of
10 success when a challenge comes up, if they can
11 address it internally with that individual and
12 their family.

13 And that -- the third piece, that
14 quality measures, frankly, make clinical and
15 operational sense, and promote a system that
16 embraces continuous quality improvement and
17 allows for flexibility in that implementation to
18 achieve this total outcome of care, which really
19 puts function first in that person's life,
20 knowing that, you know, most of the time these
21 systems are dealing with people who have multiple
22 chronic conditions and functional impairment, and

1 it's not about meeting one disease measure metric
2 of, say, decreasing hemoglobin A1c. I know that
3 this group -- I'm preaching to the choir on that
4 one, but so thinking about that vision of
5 quality, both operationally as well as allowing
6 for quality improvement.

7 So if we go to, in a sense, the
8 opposite side of the spectrum in the system --
9 going to the next slide -- now I will speak to,
10 you know, what we see as what the regulatory
11 environment -- what is their vision of success,
12 which is complementary, but a little bit
13 different, from that larger system view.

14 And so this is the idea that the risk-
15 bearing entity, whoever is responsible at the end
16 of the day, ultimately meets all elements that
17 are in that contract, including managing
18 effectively all of those downstream
19 relationships.

20 So all of the different kinds of
21 vendors, the totality of care, that is really
22 important in California where you have a

1 delegated capitated model, by and large, within
2 medical groups, where you may have multiple
3 streams of responsibility, but there is
4 ultimately, at the end of the day, one entity
5 that is signing that contract, say, with the Feds
6 or with the state, and that the buck stops there.
7 So that the regulator wants to make sure that
8 ultimate entity is responsible for the total
9 package of care.

10 Additionally, the regulator is
11 important for them as a vision of success, that
12 consumer and advocate concerns are minimal and
13 that any issues that come up are addressed fully
14 and promptly within the construct of the
15 appropriate party to address them.

16 So that could be at the managed care
17 site or the ACO level. That could be within the
18 ombuds structure. That could also be, say, with
19 an enrollment contractor or broker that is
20 working across multiple states where an issue is
21 raised.

22 We work with what is formerly known as

1 the National Senior Citizens Law Center, now
2 known as Justice in Aging, and they have in a
3 sense called the fix-it list in California
4 relative to demonstration, where they are
5 identifying issues that are happening at kind of
6 a more micro local level, but also some of them
7 are macro system issues.

8 And so from a regulator's perspective,
9 it is about, you know, making sure that that
10 stuff, when it comes up, is addressed effectively
11 and promptly.

12 And then, thirdly, that looking at
13 those quality measures, that they function at a
14 level where they are sensitive to change, they
15 are specific, they are really addressing a
16 particular process or a structure or performance
17 outcome, as well as they are directional, so we
18 can actually tell what is good, better, best, all
19 within the guise of utilizing that information to
20 guide any kind of decision that the regulator
21 would have about enhancements or withholds. And
22 that can be about payments, that can be about

1 expansion, that -- lots of different ways that we
2 can think about enhancements for that risk-
3 bearing entity or withholds as well. So that
4 quality really -- in the measurement realm speaks
5 to that angle.

6 So if we go to the next slide, this
7 is, again, just one vision. This is some work
8 that we have been doing with NCQA of looking at,
9 what is the way of thinking about an integrated
10 system of care, and where are the juncture points
11 for addressing quality measurement from a
12 structure/process/outcome framework?

13 So this is part of a paper that they
14 put out in 2013, and I'm happy to share that link
15 with anyone on this call in the meeting who does
16 not have access to this to get a sense of how
17 they have been thinking about understanding
18 structure and process, ultimately to get to a
19 place of outcomes and, frankly, performance
20 measurement at each level, which we are down the
21 road from but that -- the vision is to move in
22 that place.

1 So as NQF thinks about what might be
2 its role, I think there is a lot of opportunity
3 for dialogue and synergy from this framework as
4 well as where NQF is going in its own regard.

5 If we move to the next slide, this is
6 my expression of acknowledging that, you know,
7 there is lots of ways of thinking about where we
8 have been in quality measurement, and, frankly,
9 where we need to go, I guess putting that person
10 first perspective back at the center of our
11 vision point.

12 You know, the old paradigm in health
13 care, and I believe that quality measurement
14 overall has reflected this, is a concept about
15 acknowledging, you know, kind of the doctor or
16 the provider saying, you know, "What's the matter
17 with you?" It has been focused on single
18 providers and the approach that single providers
19 have been taking, and that the engagement,
20 ultimately the improvement, is about do providers
21 do things that are within their singular focus
22 realm.

1 Personally, I don't see that these
2 things function any more in a paradigm where we
3 are looking at integrated systems of care that
4 have multiple players that is focused on an
5 individualized care plan for the member inside
6 that risk-bearing entity, and that we really need
7 to change our lens to focus on what matters to
8 you, what matters to that individual who is
9 receiving support, who is a member, and that what
10 may matter to them may be really medical, and,
11 frankly, it may not be.

12 It maybe I want to go to my
13 granddaughter's graduation, which is six states
14 away, which means I need to get on an airplane
15 and I need to be healthy enough to do that. So
16 how does the system support that kind of goal-
17 setting? And that's how people are engaged in
18 changing their own health care experience and
19 working with providers when things are based on
20 what matters to them.

21 I would love for health care, frankly,
22 to change from the kind of paternalistic approach

1 it does with all sorts of players, but
2 particularly older people and people with
3 disabilities, to more of a customer service
4 approach, moving even away from dialogues about
5 shared decision-making and really putting the
6 decision-making back in the hands and the
7 driver's seat of that person with adequate
8 supports and engagement, so that they feel like
9 they are a partner in understanding that
10 information, but the decision still resides with
11 the person and their family. And that is what a
12 customer service approach really -- kind of takes
13 that frame and transforms it.

14 And then, the third element, which
15 we've talked about already, is the idea that
16 consumer confidence and improvement in function,
17 or at least maintenance and function for people
18 who have aspects that are -- their function will
19 not likely change due to a wide disability, that
20 people can feel like they feel confident in
21 getting their needs met and supported in a way
22 that honors them for the whole person.

1 So I will move to the last slide,
2 which is a photo that I took when I was out in
3 Utah on a very beautiful day after a
4 thunderstorm, but it's my expression of
5 acknowledging that sometimes this may feel like
6 we are chasing rainbows, and that what I really
7 see it as is that we are seeking kind of a new
8 pot of gold at the end of that rainbow, which may
9 feel a little bit elusive, but the more and more
10 we focus our lens towards putting people first,
11 their confidence, their needs, their function
12 first, then a value-based system wrapped around
13 that will have improved outcomes in a way that
14 meets that triple aim potential that we are all
15 really striving for, even for people who have
16 many, many health issues and functional
17 challenges.

18 And so, with that, I will go ahead and
19 pause. I am very happy to take any questions or
20 comments from the group at this time. Thank you.

21 You can move to the next slide.

22 VICE CHAIR HANSEN: Thank you,

1 Gretchen, for that -- that comprehensive look
2 through in terms of where the value equation is
3 at all of these different levels.

4 Right now, we have one Committee
5 member with a question. That's Anne Cohen. No?
6 Okay. And we have nobody in the queue.

7 Gosh, you are remarkable, Gretchen.

8 MS. ALKEMA: Well, I don't know about
9 that, but I am delighted to offer this up, and I
10 just want to say that, you know, the leadership
11 that you and so many members of this group have
12 provided over the years I think really has set
13 this vision, and I'm sure -- I feel like I'm
14 preaching to the choir, and I'm glad to provide
15 an orientation for the rest of your discussion.

16 VICE CHAIR HANSEN: Well, Anne does
17 have a question. Hold on.

18 MS. COHEN: As your California
19 colleague, I really feel like I should give you a
20 good question before we conclude your wonderful
21 talk. I am just --

22 MS. ALKEMA: Thank you.

1 MS. COHEN: -- from the SCAN
2 Foundation's perspective, what recommendations
3 would you make to the duals group in terms of
4 future directions for quality measurement, and
5 given the challenges that we have discussed in
6 the past day? And given the potential change to
7 the duals pilot, since they are in fact a pilot?
8 And what funding priorities does the SCAN
9 Foundation hope to fund in the future?

10 MS. ALKEMA: Thank you, Anne, for that
11 comprehensive and wonderfully leading question on
12 the last part of it. I appreciate it.

13 To be honest, I have not been part of
14 the whole NQF discussions over the last two days.
15 But just in reviewing the materials and the
16 dialogue that you have been having, I think the
17 more and more and more we can speak to the
18 person's experience in getting their needs met
19 and their confidence and connectivity to this
20 integrated system of care, of thinking about that
21 as an overall frame of measurement, knowing that
22 there are clearly opportunities for structure and

1 process specifics undergirding that, I think that
2 is the way to go.

3 And the reason why I say that is when
4 we are looking at the population being served
5 through any kind of framework for integrating
6 care for people who have both Medicare and
7 Medicaid, the heterogeneity of that population is
8 astounding. We often think about it in kind of
9 quick and dirty cuts like, are they under, are
10 they over 65, do they have dementia, do they have
11 a spinal cord injury, you know, know, all of
12 these different kind of basic cuts.

13 But what is undergirding that, and
14 which I know this group is fully aware of, is
15 that the life circumstance of that person, the
16 supports that are around them -- the housing
17 access, the connectivity and appreciation for
18 medical treatment options -- all of those things
19 are so individualized based on the complexity of
20 their chronic conditions and the way that plays
21 out in their daily function, that I think if we
22 get too far down the road of kind of granular

1 function or specific conditions-based
2 measurement, we will miss the bigger picture,
3 which is is this person and family having a care
4 delivery system that is -- where it is asking
5 about their needs, honoring those needs, helping
6 set reasonable goals for them and the system of
7 care to support them, and helping people live
8 their lives.

9 And that may feel a little generic,
10 but I think given the panoply of experiences that
11 people have, that gets to the heart of that
12 consumer-focused approach.

13 In relation to funding support, we
14 certainly are engaged in lots of dialogue with
15 NCQA. We have a problem with them right now that
16 is moving to its completion, and we are in some
17 dialogue about what might be next steps. I have
18 certainly been in dialogue with NQF in some
19 beginning ways of saying, "Are there things that
20 this group is wanting to take forward? And are
21 there ways that the foundation could be helpful
22 there?"

1 In think in particular, is there a way
2 in which we can articulate a framework of quality
3 that all of the major quality players,
4 particularly in Washington, can lay down as that
5 base template, and moving forward, knowing that
6 we know now about integrating systems for this
7 population. I am happy to have a continued
8 dialogue there.

9 VICE CHAIR HANSEN: We also have
10 another question from Tom from iCare.

11 MR. LUTZOW: Yeah. The question has
12 to do with a more global assessment of where we
13 are on the timeline. And here is the thesis. We
14 are -- part of the foundation here, the race
15 toward metric-responsible care almost in a
16 Deming-like way, we have a window of 15 years to
17 get this right. And the reason I say 15 is
18 because the baby boom generation is going to give
19 way to the Generation X.

20 Generation X is roughly 47 million.
21 We're in the 75 million range. There is an echo
22 generation behind the Generation X of roughly 75,

1 80 million. But the reason for the 15-year
2 window is the trust fund is going to be flush in
3 that -- in 15 years, because of that generation
4 dip. And so the heat is going to be off, and
5 there won't be any pressure to do this good work.

6 So we have a limited timeframe to work
7 out -- to work out these efficiencies, and I
8 would like your thoughts about that.

9 MS. ALKEMA: Well, thank you so much
10 for your question. I have to say, as someone who
11 thinks in different time intervals, I love the
12 idea that 15 years is the pressure point, but I
13 think you are probably right on that, and I
14 hadn't specifically thought about it that way.

15 I will say that in some respects the
16 population demographic landscape has been forever
17 transformed, and that while there may be, you
18 know, fundamentally less people in the oldest
19 ages because they ultimately have died off over
20 many years, that the movement of population aging
21 will not change. That is not -- I think as
22 probably most of this group knows, like that's

1 not a boomer phenomenon, and then it goes away,
2 and that Gen Xers will continue to age, and then
3 the question is: What is going to be the upper
4 limit of that demographic relative to what we
5 know about upper age limits in previous
6 generations? And we will continue to learn about
7 what is function going to be looking like.

8 One could make an argument that it
9 also -- that the pressure may not be off because
10 of other issues that are present in younger
11 generations that were not as much present in
12 generations who are substantially older today or
13 will soon be, like diabetes and like patterns of
14 substance abuse that have -- that are different
15 kind of moving forward than what we have known,
16 and obesity associated with that.

17 So I will say that there is no time
18 like the present, that ultimately getting this
19 right is both about improving care for the
20 populations in need now and the soon-to-be
21 populations in need who will connect with
22 Medicare and Medicaid. But I will make the

1 argument that as we move the entire health care
2 system to something that is driving on value, not
3 volume, we need to determine whose value are we
4 talking about. And, personally, I am one of
5 those who says it is about the value to the
6 consumer that then bleeds into value to the
7 system to function to improve the life of that
8 consumer is where we need to put the emphasis.

9 I think it would be really easy for it
10 to kind of punt the other way without us looking,
11 that the value is that the system functions well,
12 but we still don't take that consumer -- that
13 customer service approach to care, which we have
14 an opportunity to now, because of the pressure
15 points that exist.

16 VICE CHAIR HANSEN: Well, thank you,
17 Gretchen. You know, one of the things that you
18 probably didn't get a chance to hear today fully
19 is there is a whole MAP that is working on
20 person-centered care, and the interface in some
21 of the work that they have done that was
22 presented probably has great consonance for the

1 interest area that you cited relative to the
2 consumer.

3 And the other piece of work relative
4 to the sheer diversity of the population and some
5 populations that are at greater risk. And, of
6 course, this MAP is addressing that. So there
7 probably are some very thoughtful materials that
8 are coming out of NQF that would inform kind of
9 the areas that you are thinking about right now.

10 So I see one final question here from
11 Steve Counsell.

12 DR. COUNSELL: Gretchen, hi. It's
13 great to hear from you.

14 MS. ALKEMA: Hi.

15 DR. COUNSELL: And really appreciate
16 your insights on this. I just couldn't help but
17 ask you about how -- how do you feel things are
18 going with the dual eligible demonstration in
19 California, and how this kind of patient-centered
20 care concepts are penetrating into that movement,
21 or is it too early to tell?

22 MS. ALKEMA: I would say it's probably

1 a bit too early to tell. I think that, you know,
2 it is moving along. There are certainly lots of
3 opt-out and enrollment issues that have been
4 present in the state, in various ways for all
5 sorts of sundry reasons. I think at the end of
6 the day there is a commitment from the plans to
7 move forward in a way that does meet the totality
8 of care for targeted populations who have the
9 most need, and I think getting under the hood on
10 that relative to doing the risk assessment to
11 evaluate and stratify that population in ways,
12 frankly, that the Medicaid data haven't been able
13 to do to date, you know, it's just another
14 process of working through.

15 And I think we will have a better
16 sense of how to fully answer your question
17 probably in six months from now, once a number of
18 the processes have moved through. January was an
19 enormous enrollment month for California, and so
20 what they are hoping -- you know, there was a lot
21 going on before that. I think you all know that
22 any time there is a whole new wave of people

1 coming in, it tests the boundaries of your
2 system's functioning at another level. And I
3 think that the plans and the systems are still in
4 the process of responding to that in an effective
5 way.

6 So I have more to be revealed, Steve.

7 DR. COUNSELL: Thanks very much.

8 VICE CHAIR HANSEN: Thank you,
9 Gretchen, and we will look forward to continuing
10 to work with you and the foundation in this
11 process and staying in touch.

12 So we are at a point of wrap-up, and
13 I think Sarah was saying that we were having a
14 goal of leaving around 2:00. I think we are so
15 close to this. Sarah is going to set up some
16 questions that we will have a chance to each have
17 one comment to.

18 MS. LASH: Sure. Actually, Zehra, if
19 you could go back two slides. And I first want
20 to acknowledge there was a small section of slide
21 material on integrated behavioral health, which I
22 didn't present because I think that we heard such

1 a good case study from Care Oregon about how some
2 of those practices are being integrated that I
3 didn't want to devote the time to it.

4 I borrowed the slides from Jurgen
5 Unutzer out of Washington State anyway, so it
6 wasn't even my content to begin with. But I
7 think that content area shows a lot of promise
8 for further exploration in a future meeting. And
9 I think hearing from our external presenters
10 today -- well, external/internal -- Steve, Pat
11 Curran, and now Gretchen, has brought in some of
12 the dialogue in a really productive way.

13 And I will sort of challenge all of
14 the Committee members to help connect us to
15 innovations that you come across in your work
16 over the course of, you know, tomorrow, to our
17 next meeting, so that we can continue to build
18 our dialogue off of these really promising
19 practices.

20 So we had designed a series of
21 discussion questions coming into the meeting, and
22 I want to quickly review them all with you and

1 give everybody the opportunity to kind of sum up
2 their thoughts and offer a final reflection
3 before closing. It can be on any of these
4 topics, or something entirely differently, that
5 has really risen to the top of your mind over the
6 course of the meeting and that you want to make
7 sure we understand as a team as we go into the
8 report-writing process.

9 So, first, which measure gap areas
10 have the most relevance to the broadest range of
11 stakeholders, thinking about where these leverage
12 points are. Are they quality of life outcomes,
13 functional status outcomes, community residents,
14 something else? What might be needed to
15 accelerate the process of measure development in
16 these or other areas?

17 Next slide.

18 Are there discussion themes that we
19 began to talk about during this meeting but
20 warrant further exploration in a next phase?
21 Does MAP need to recommend any specific course of
22 action to accelerate the adoption of evidence-

1 based practices that support person-centered
2 care, such as some of the things that we learned
3 about today?

4 And knowing that CMS listens very
5 closely to the input of the MAP, what is the role
6 of HHS in these activities that you'd like to see
7 moving forward versus some of the other
8 stakeholders in quality that are also monitoring
9 the work?

10 So I -- you know, we don't have to
11 call on everyone, so volunteers or any final
12 comments for the good of the order? Tom?

13 MR. LUTZOW: Yeah. This is just an
14 observation from a plans perspective and it
15 relates to the second item on the top, functional
16 screens.

17 A functional assessment is contained
18 in the PQRS set of measures, although it seems
19 that a doctor has a choice or the physician group
20 has a choice of -- to select from different
21 measures, and they could select out functional --
22 the functional assessment. So that's a little

1 disappointing.

2 But here is a case where there is a
3 second -- there is a second platform to join the
4 provider community around a common theme like
5 readmission prevention, because that functional
6 assessment, if it's -- functional needs
7 assessment is -- if it has to be performed by the
8 physician, it is already part of the MDS in the
9 nursing home. It is already part of the OASIS
10 system in the home health agency. And of course
11 we, as a plan, have to do it, too. It's part of
12 our five-star.

13 It is a basis for communication, and
14 what -- what I am looking for in my dialogue with
15 physician groups is, how can I help you do your
16 job better? And if you are unable to do a
17 complete functional assessment, because you don't
18 ever get into the home, but I do, is my
19 functional assessment of value to you? Because
20 you are doing things -- you are doing other
21 things that are of value to me. And so now we
22 have a basis for dialogue.

1 I'm not the enemy as a plan; I'm your
2 friend, and I want to -- I want you to do well.
3 So I think, you know, it's an opportunity to
4 create community within the provider stream, and
5 more and more of that has to happen. All of the
6 ships have to rise; they should not be competing
7 with each other.

8 And how do we make them, you know,
9 through common measures perhaps, how do we -- how
10 do we make them co-dependent in some important
11 ways? And unless they are co-dependent, they're
12 going to be going in different directions, and
13 Deming won't be happy.

14 MS. LASH: All right. Going to this
15 side of the table, Charlie?

16 MR. LAKIN: Well, I -- first, I just
17 want to thank you for including me. I learned an
18 awful lot in the last couple of days. I'm
19 awfully glad to have been invited.

20 Gretchen just brought up this notion
21 of framework of quality kind of in passing, but I
22 just think it's really important, at least for

1 me, to kind of figure out what is happening. We
2 have got so many measures in some areas, and many
3 of the areas we have talked about over the last
4 two days are just empty sets.

5 And I think if we just had even a
6 cursory -- I'll call it outline -- but a set of
7 categories where we need to look hard, maybe
8 invest to better fill out a set of measures that
9 really encompasses all that we have sort of
10 talked about in the next couple of -- in the last
11 couple of days, I think it would be really
12 important.

13 And, finally, just to answer your
14 question, I don't know if -- I think really
15 focusing on personal life experience measures is
16 important, and some of those are quality of life
17 measures, some of those are really about the
18 responsiveness of support providers to a person's
19 daily life, and some of it is what you really
20 want in life that you are not being helped to
21 get.

22 But I think we have heard over and

1 over in the last couple of days that, whether you
2 come at this from the medical end or the social
3 service end, people are eager to attend more
4 effectively both in delivering those things and
5 measuring the outcomes of those things.

6 MS. LASH: Thanks so much. Rich?

7 MR. BRINGEWATT: Yeah. I also want
8 to, you know, thank you for me being able to be a
9 part of this. You know, this is -- what a great
10 group of people, good people, smart people, have
11 a common kind of vision. You know, it's fun to
12 be a part of, and I think it's important to be a
13 part of.

14 In terms of the first question, I
15 think -- without taking away any of the bullets
16 that are there, I think a huge gap here is system
17 performance measurement. You know, we have
18 talked a lot about today, over the last couple of
19 days, the importance of the different component
20 parts of the system having more -- being more
21 representative of the nature of the problem that
22 we are all trying to address.

1 And so I think getting at system
2 performance measurement issues is a huge gap and
3 a huge priority for dealing with this population.

4 In terms of what is needed to
5 accelerate that, I would say one is continuing to
6 push clarity on definition of population-based
7 care. We -- you know, the duals group has helped
8 everyone look across settings, across time,
9 place, profession. I think we need more of that,
10 and so what are those population segments that
11 are most important, you know, like frail elderly,
12 like adults with certain kinds of disabilities,
13 whatever, but having some leadership around that
14 area.

15 I think that we have made some good
16 progress here in identifying a framework, to a
17 certain degree, in terms of how to think about
18 all of this. I think it needs more tweaking; I
19 have some follow-up suggestions in relation to
20 that that I won't get into now. And kind of what
21 are the principles, really, that -- within some
22 sort of framework that kind of moves us in this

1 direction of more definition leading towards
2 measurement about system performance.

3 Discussion theme raised that warrants
4 further exploration -- you know, the National
5 Quality Forum is committed to further exploration
6 of SDS. I just want to underline the importance
7 of that from a duals perspective. It is the only
8 thing that is purely unique about duals is low
9 sociodemographic status. And so what does that
10 really mean, and how do we deal with that from a
11 performance measurement standpoint?

12 And then, a specific course of action
13 for moving ahead, one of the things that I think
14 it would be useful for the Quality Forum to do is
15 kind of on the flip side of what measures should
16 we add? What are the most important ones to
17 focus on to achieve the goal we are trying to
18 achieve? You know, I find asking people the
19 question: If you only could pick five measures,
20 what would they be? And that is going to be a
21 little bit different for the population you focus
22 on; it is going to be a little different in terms

1 of who you ask the question. You are going to
2 get some different answers to that.

3 But, you know, if I look at the
4 airline industry, and kind of changes that have
5 occurred over the years with the airline
6 industry, on-time arrival is a measure that
7 everybody jumps to. Now, they move around on-
8 time arrival in terms of changing what that
9 really means and when they exit the gate and
10 whatever, but that's -- you know, that's kind of
11 operational mechanics behind the focus.

12 And so, you know, if we -- if we -- if
13 National Quality Forum picked five measures that
14 would really move the needle on improving quality
15 for defined populations, what would they be?

16 MS. LASH: Great. Anne?

17 MS. COHEN: So a couple of things.
18 One is, you know, it struck me while we are
19 sitting here there has recently been a release of
20 the long-term care project, and the Conference of
21 Aging was this week. And in that budget, there
22 are a lot of priorities, including continuing

1 funding for aging at resource centers, family
2 caregiver programs, programs for targeting elder
3 abuse, broadening PACE to 18-year-olds to 54, and
4 continued efforts to expand community first
5 choice options.

6 And so there has been a lot of work in
7 HCBS services -- more than there has ever been in
8 this administration -- and it looks like
9 hopefully it will continue. And with that, and
10 knowing the new Committee that has been formed, I
11 think there needs to be a continued focus and
12 even a huge part of the meeting looking at HCBS,
13 where they had managers looking at long-term
14 care-related measures and what really are our
15 priorities to make sure not only are we measuring
16 that in a way that is meaningful, because there
17 is a lack of measurement out there, and obviously
18 that's a big need for measurement development.
19 But also, how do you make that person-centered,
20 which is always a challenge.

21 In terms of, you know, priorities and
22 how can NQF move those forward? Again, I really

1 feel strongly that -- in all of our work, but in
2 particular that area, it is important to use the
3 resources we have in this room and to really look
4 at doing some pilot projects, because as we have
5 seen there has been some issues with uptick in
6 measurement. And I really feel like replication
7 happens by having health systems and programs
8 take up the work.

9 So, for instance, GRACE is a perfect
10 example. Their work has been around for years
11 and is being replicated, and so things get
12 repeated over and over again. The way this
13 Committee is going to get any traction -- NQF is
14 going to get traction for this work, is by having
15 it utilized.

16 So whether we, you know, ask the SCAN
17 Foundation for money or another foundation for
18 money, utilizing our federal partners to try to
19 give us some money to do that work, I think it's
20 going to be critical.

21 Thank you.

22 MS. LASH: Great. And we do intend to

1 I think marry the work of the HCBS Committee with
2 the work of the Duals MAP. It was a very clear
3 expectation of our funders that we would not
4 rebuild the wheel.

5 Steve?

6 DR. COUNSELL: It has been a
7 tremendous couple days here, and I really
8 appreciate it.

9 I have two comments. I really like
10 the idea of getting on the wave and the
11 readmissions is really such a great example of --
12 it has brought to light the kind of issues that
13 this group has been struggling with, and now
14 everyone is kind of working on it? So if we
15 could find something similar and the functional
16 status may be another real driver.

17 I know under Medicare, looking at the
18 Welcome to Medicare and the annual, you know,
19 Medicare wellness visit, all have functional
20 status measures in it, and this is just becoming
21 increasingly, even in the physician world, I
22 think recognized how important it is in many

1 ways. So if we identify, you know, something
2 like that to build on, maybe the readmissions, I
3 think that would be really tremendous and get
4 traction and further move the whole field up.

5 The second was in terms of the patient
6 -- in terms of priority on the gaps, I think we
7 have really come a long way in the patient-
8 centered care. The presentation this morning was
9 really quite something, and the various comments.

10 I was just reviewing -- there is one
11 question on perceived health. You know, in
12 general, you know, would you say your health is,
13 and you rank it excellent, very good, good, fair,
14 or poor. And that is predictive of outcomes. It
15 is predictive and such, and whether we can do
16 something similar as was suggested around the
17 patient-centered care, if we could rally around.

18 And you would think it would be pretty
19 quick that you'd be able to develop and validate,
20 you know, a one question Likert scale like that,
21 and you could just use it -- in general, would
22 you say your health care services and supports

1 are excellent, very good, good, fair, or poor?
2 And just start to get at this kind of question.
3 As broad as that is, starting to ask it and bring
4 attention to it, I think would be -- it is the --
5 you know, I think this focus on one or two things
6 as opposed to, you know, the next 30 quality
7 measures might get us further, you know.

8 MS. LASH: Great suggestions. Shawn?
9 People on the webinar, get ready. We've got two
10 more people in the room.

11 MR. TERRELL: Thanks. So just I think
12 three quick things.

13 One, to put a little bit finer point
14 on what Anne was saying, to continue to really
15 mine, as you go through the HCBS environmental
16 SCAN work, to mine that for potential measures.
17 You know, the problem is is that we don't have a
18 lot of really -- we don't have a large stable of
19 measures around HCBS in general, right? That is
20 the basis of this project, and that some of the
21 larger measure groups aren't necessarily poised
22 to jump into an NQF endorsement process.

1 But there might be some of the
2 smaller, you know, Mom-and-Poppy kind of shops,
3 or individual researchers who have develop some
4 good measures that might be -- and that needs --
5 we need to have like a concerted, you know,
6 effort to try to sort of identify that and do
7 some outreach and talk about that -- those
8 measures. Those I think are there in some
9 places. And look at other areas, like -- such as
10 the whole -- you know, whole -- years and years
11 of work on social support measures. Are there
12 some social support measures that we might want
13 to think about? This is obviously a huge area
14 for HCBS.

15 Okay. So there's that, and then on
16 and off for quality of life, you know, but -- and
17 then there is a question of -- there is this
18 continuous quality improvement or TQ -- you know,
19 putting some emphasis on how you use measures
20 around -- you know, how do we do -- you know,
21 plan to study X cycles and, you know, process
22 control charts, and et cetera. Can those things

1 be a little more explicit in these processes, in
2 these discussions?

3 And then the other third area that is
4 really important to Kathy Greenlee, it's kind of
5 a legacy thing, is abuse, neglect, and
6 exploitation, which hasn't come up that much, but
7 it's kind of an elephant in the room thing, and I
8 think Pat, in his discussion about trauma-
9 informed support services is -- speaks to that
10 profoundly. And we need to work on not just the
11 sort of reporting and the sort of legalistic
12 approach, but some prevention models that we
13 haven't done a lot around, I don't think.

14 So those are quick three things.

15 Thanks.

16 MS. LASH: Thank you. Gwen?

17 DR. BUHR: So I was encouraged by the
18 last presentation, but generally all of this
19 discourages me because it seems like everything
20 is so fragmented. And how can we -- how can we
21 get something that -- where we are always or
22 where we are measuring the system and holding the

1 system accountable, instead of each individual
2 player in the system, who may not have control
3 over the other players, and then nobody can do
4 anything because -- I don't know.

5 So you know, I think that's the case
6 in the long-term care setting is that many of the
7 measures that physicians could use for their
8 different PQRS or meaningful use are not
9 appropriate for the long-term care setting and
10 you know -- or they are measuring more of the
11 system and they can't change the different things
12 that go into it. So you know, they don't want to
13 choose that measure, or they don't have the
14 resources to measure that measure.

15 So, anyway, I hope we can get to more
16 of a -- measuring the system and making the whole
17 system accountable somehow. How do you do that?
18 I don't really know. And I do like the
19 functional status as a measurement. So, you know
20 --

21 MS. LASH: Tom -- or let's go back to
22 the web, and then if there's anything else in the

1 room. Zehra?

2 MS. SHAHAB: Okay. So I see that
3 there is two workgroup members on the web that
4 would like to comment. First, Joan?

5 MS. ZLOTNIK: Okay. This is an
6 interesting process. It has been -- I don't
7 recall any time that I ever had the opportunity
8 to kind of have a snow day and actually ended up
9 listening to the entire day of a meeting.

10 This has just been quite interesting,
11 and I think really meaningful in terms of
12 directions that we really need to be thinking
13 about and is something that Gretchen, you know,
14 said when she started out in terms of, you know,
15 really wanting to sort of think about, you know,
16 in terms of being person-centered, asking the
17 person sort of what they needed. And I think
18 that really becomes sort of a driving piece in
19 what we need to think about.

20 And then I go back to sort of comments
21 that, you know, sort of over the last four years
22 I think, you know, Rhonda Robinson Beale has sort

1 of made a number of times, in really needing to
2 think about the workforce and sort of who is
3 doing this work and, you know, measures about,
4 you know -- one of the themes that I sort of
5 heard both from Patrick and Steve were, you know,
6 sort of the increased satisfaction for people who
7 are sort of working in sort of a more inclusive
8 team-based holistic system.

9 So if we can sort of integrate some of
10 those pieces together and, you know, look at some
11 of the system issues, I think it is important. I
12 was just kind of looking at -- maybe this was
13 quick and dirty, but looking at the spreadsheet
14 of our measures and just kind of searching on
15 some words, like social, and they don't come up
16 very much.

17 I don't know how -- not as much as
18 mental health does, but some of the issues that
19 got raised about sort of what people's histories
20 are and how that affects how they need services
21 delivered are also critical issues.

22 You know, the ACEs and sort of trauma-

1 informed care have -- are permeating a lot of
2 service delivery. But the fact that people come
3 to services and come to the health care system
4 with history and relationships, or perhaps
5 isolation, are really critical. So I think we
6 really need some more measure development in
7 those areas to really be successful.

8 MS. SHAHAB: Thank you, Joan. Also,
9 Clarke Ross?

10 MR. ROSS: Hello. I'd like to
11 reinforce everything that Joan just said. I want
12 to emphasize the importance of the seven high-
13 priority measure gaps that we developed in 2013
14 and in a final form was communicated to CMS in
15 February of 2014.

16 The disability consumer advocates and
17 family advocates, and actually a lot of providers
18 as well, are very critical of the measures we
19 have endorsed as too narrow, too many
20 limitations, and like age and setting,
21 limitations, and too clinical in nature. And so
22 the seven high-priority measure gaps allows the

1 disability community to focus both on things they
2 care about, but also to focus on the need for
3 investment funding for accelerated measure
4 development.

5 So -- and I loved Sarah saying it's
6 important that the Home and Community-Based
7 Services Committee and the Duals Workgroup
8 complement each other's work, because from the
9 disability community perspective those are the
10 two entities within the National Quality Forum
11 that are most like home.

12 And then the last thing I just wanted
13 to say, Steve's presentation and Patrick's Oregon
14 presentation I just thought were outstanding,
15 because those of us who work on the Hill and
16 other similar kinds of forums, we are always
17 asked, well, where does it work? Who is
18 practicing what you are talking about?

19 And these were just outstanding and
20 data-based and doing a lot of all of the
21 philosophical things that we think should be
22 done. So thank you very much. It has been a

1 great learning opportunity.

2 MS. SHAHAB: Thanks, Clarke. I also
3 see that Vanesa wanted to say a few words.

4 MS. DAY: Yes. Thank you. I, too --
5 I want to echo that I learned so much during --
6 in the last two days in this process, about like
7 what has been done, what we certainly at CMS need
8 to continue to do. And so I just want to say I
9 appreciate everybody for being so open and honest
10 about their opinions on things, and giving us
11 this guidance.

12 I would, just in thinking about this
13 and thinking about what we talk about at CMS.
14 Carolyn always -- Carolyn has experience working
15 in the field as a provider, and the one thing
16 that she says always is we don't want to have --
17 we don't want to limit access. We don't want --
18 whatever our good intentions are, we don't want
19 to put providers in a situation where they don't
20 want to treat duals because there is so much
21 additional work in regard to quality measurement
22 and everything else that we know goes along with

1 being able to treat this population well.

2 And so that, combined with everything
3 else that it means for us to be doing this work,
4 is certainly a big charge. I think we are
5 definitely up to the challenge and looking
6 forward to letting the science meet the policy as
7 we move forward, in a good way.

8 MS. LASH: Thanks so much, Vanesa.
9 One last comment from Tom, then we'll conclude.

10 MR. LUTZOW: Yes. This concept of
11 self-management is certainly part of the
12 discussion. And, you know, along the lines of
13 accountability, I -- certainly the member has a
14 primary role in the planning process and needs to
15 have a primary role in the planning process for
16 all the reasons, for engagement, for relevancy,
17 for motivation, to get to self-management. So
18 there is important reasons why the member has a
19 primary role in the planning process.

20 But their role as a provider also
21 needs to be emphasized, and that is the self-
22 management piece. There is -- you know, are we

1 measuring accountability on the part of the
2 member to be the first provider? And are we
3 really getting at self-management and emphasizing
4 it enough?

5 And certainly there is degrees of
6 ability, and at some point the ability to self-
7 management -- to self-manage isn't there, and
8 then supports and so on, are needed. All of that
9 is true, but we first need to get to that -- that
10 role as a self-provider somehow is missed.

11 And I know that NCQA is about to start
12 a five-year study on the ability of plans to get
13 to service of member preferences. And I am sure
14 that in this study it is not just any old
15 preferences, because some preferences aren't
16 supportable. I prefer to smoke two packs of
17 cigarettes a day is, from a health perspective,
18 not a supportable preference.

19 Their concern is, I am sure, about our
20 plans satisfying supportable preferences, and how
21 do we get to supportable preferences from a
22 health systems perspective?

1 All of that is good, and where we need
2 to go. But, again, you know, have we adequately
3 defined the member's role? Certainly, there is a
4 push toward -- first order role in the planning
5 process is, have we emphasized enough their first
6 order responsibility in the providing process?

7 MS. LASH: Great. Thank you. Anyone
8 else on the web needs to make a comment? Okay.
9 We have one I guess last --

10 MS. COHEN: One last quick thing, I
11 wanted to --

12 MS. LASH: -- Anne, and then we'll go
13 to public comment.

14 MS. COHEN: I wanted to thank Sarah
15 and everybody at NQF for staying, even though the
16 offices are closed today, and all of your hard
17 work at this meeting. It is not easy, and come
18 sleet or snow, quality has to go.

19 MS. LASH: I like that motto, and we
20 have many other thank-yous. So we will get to
21 those in just a second.

22 Operator, could you give the

1 instructions for public comment over the line,
2 please?

3 OPERATOR: Yes, ma'am. At this time,
4 if you'd like to make a comment, please press
5 star and then the number one.

6 There are no public comments at this
7 time.

8 MS. LASH: There are also no public
9 comments in the room, which is not a surprise to
10 anyone here.

11 On the vein of thanks-yous, I want to
12 begin our closing by thanking our CMS partners
13 for supporting such important work, and the
14 opportunity to come together and have such a rich
15 face-to-face discussion, and virtual today as
16 well. And thank you for being so open to the
17 input you received from the MAP.

18 To our stalwart Committee members and
19 your top-notch thinking over the past couple of
20 days, to our guest panelists for making time in
21 their very busy schedules to expand our thinking,
22 to our members of the public who have hung in

1 there over the course of a long and complex
2 meeting, our chairs for ever skillful
3 facilitation, and Alice in an airplane, we'll be
4 sure to thank her later.

5 And especially my NQF colleagues:
6 Megan, who was so sick yesterday, presenting for
7 three or four hours. Zehra trudging through
8 snowbanks, our meeting staff and IT support, who
9 have helped keep us all fed and plugged in and
10 dry today, and I think that probably covers it.
11 A big round of applause for everyone.

12 As next steps, we plan to give the
13 workgroup the opportunity to review at least an
14 outline, if not a draft, of our report sometime
15 in the next several months. It is not due for
16 quite a while. We do need to have the
17 Coordinating Committee bless it at some point as
18 well, and then there will of course be a public
19 comment period of about 30 days. So we will be
20 in touch about those next steps as they begin to
21 formulate with exact dates.

22 Jennie, over to you.

1 VICE CHAIR HANSEN: Again, I think we
2 have been summarizing along the way, but it was
3 really very helpful to have everybody have a
4 chance to articulate their reflections, which I
5 know are just kind of -- probably just the top
6 part of it relative to all that we have had a
7 chance to absorb.

8 You know, we have talked about this
9 particular MAP. The common denominator to this
10 is not only these four populations that we have
11 identified, but the factor of low income or
12 poverty. And I am reminded, you know, by the
13 complexity that we deal with.

14 The last example I think, Tom, you
15 brought up about self-management -- it's one of
16 those things that when poverty is a factor, you
17 know, just one segment of an example, many of you
18 know that people who reach the end of the month,
19 have run out of their money, end up in the ER.
20 And there is -- it's very predictable in terms of
21 that.

22 So this system is both fragmented,

1 complicated, but it is so interrelated. So it's
2 -- but somehow we have to find these common
3 denominators of aligning things that are already
4 -- you know, trains that have left the track that
5 have some opportunities for us to put our various
6 cars onto in order to move this.

7 I started this -- we started the day
8 yesterday really looking at very specific
9 measures. And as I said, and I know poor, you
10 know, Vanesa representing CMS felt that, oh, my
11 gosh, you know, there was such dissatisfaction,
12 but we know that that's where we started.

13 The conversation we have had this
14 year, this particular set of two days, has now
15 allowed us to think about if we are to
16 understand, say, the measures that have gone
17 ahead at this point, coming out of this Committee
18 based on tools and scientific work being done.
19 Now we have had actually a much more robust
20 discussion about a lot of the social factors and
21 how do we do that?

22 And I think one of the things that is

1 a key takeaway is our alignment with the home and
2 community-based group that many of you have
3 brought up, as well as the person-centered care
4 group, as a whole other kind of linkage in a way
5 that we can come across to think about this
6 framing, I think that, Charlie, you asked for.

7 And going back to this wish for all of
8 us, for parsimony, so that people who select
9 measures and people who are being measured see
10 that there is honest alignment to it. And when
11 you do have that, you have a joy that it makes
12 sense that we are doing what we are doing.

13 So I think this is -- you know, again,
14 the MAP of literally what we need to do is, are
15 there a few questions that start differently?

16 Somebody asked Steve, what other
17 questions might you have thought about? I think,
18 Anne, you asked. And maybe the question that
19 came out of the person-centered group wasn't
20 quite on target, but there were some
21 conversations.

22 So one of the things I leave as a

1 wish, are there one or two core questions that
2 anybody would understand more or less, you know,
3 with some context that make it really a way that
4 we can shift the framing so that it gets back to
5 what people feel strongly about, right down to
6 the alignment in physicians, providers, that have
7 some sense-making to this, and that it isn't so
8 fragmented.

9 So, again, it has been a privilege to
10 work with you. I bless our chair, Alice, for the
11 experience that she has with this, and your
12 forbearance of my working alongside of her. But
13 at the same time, this has been such substantive
14 work.

15 And I think, Joan, I compliment you on
16 the fact that here you had a snow day but you
17 spent the whole day hanging on with us.

18 And, D.E.B., if you're still there, we
19 so appreciate the technical clarity that you
20 always ask for in the course of our questions.

21 So, again, I --

22 MS. POTTER: I'm still here.

1 VICE CHAIR HANSEN: I don't doubt that
2 whatsoever. But as a group here, I do think the
3 hard work behind the scenes that Sarah has led,
4 and Zehra being a part of it now. She shared
5 with us as I kind of said, when you saw the
6 voluminous things, they only got it like a few
7 days before, you know, we did, you know, and so
8 they've been working on it to try to do some
9 sense-making.

10 So this is a once a year, in-person
11 face time. It's an important time that we see
12 each other. And with that, we will have, you
13 know, scheduled meetings and reports that we can
14 comment on.

15 But thank you. It is a privilege to
16 be with you all. Thank you.

17 (Whereupon, the above-entitled matter
18 went off the record at 2:38 p.m.)
19
20
21
22

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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: Measure Applications Partnership

Before: NQF

Date: 03-05-15

Place: Washington, DC

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Court Reporter

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