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

T-A-B-L-E O-F C-O-N-T-E-N-T-S

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

9:02 a.m.

MS. LASH: Good morning, everyone. This is Sarah. Thank you all for those especially who are here in person and those who are hanging with us on the web meeting today.

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

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

VICE CHAIR HANSEN: Sure. Again, welcome everybody who's on the phone. Do we need to take roll at all?

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

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

Okay. Tom?

DR. LUTZOW: Tom Lutzow, iCare.

DR. BUHR: Gwen Buhr.

VICE CHAIR HANSEN: From?

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

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

DR. LAKIN: Charlie Lakin.

MR. BRINGEWATT: Rich Bringewatt, SNP Alliance.

MS. COHEN: Anne Cohen, MAP expert.

DR. COUNSELL: Steve Counsell,

American Essential Hospitals.

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

VICE CHAIR HANSEN: Thanks for being here, Shawn.

Alice, are you on the phone still?

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

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

Who else is on the phone, please?

MS. REINHARD: Susan Reinhard.

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

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

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

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

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

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

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

(No audible response)

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

MS. ANDERSON: Jennie, this is Megan --

VICE CHAIR HANSEN: Sorry.

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

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

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

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

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

One of the things that staff will do is build out those last four columns in particular so that we'll have the exact numbers and names of the different measures that have been passed relative to those four groups so that it allows us to see some of the measures that we have moved ahead with.

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

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

And then thinking through the final opportunity that this is so broad. I mean, part of this I think -- I forget who brought the example, the metaphor that this is a sculpture. We've had basically a raw block of marble and this is an effort of shaping some of the framing of an area that's not been approached this way.

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

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

But I think the opportunistic side of that is a lot of it was around mental illness, so it allows us as a leverage point to use that body of measures that we agreed to yesterday show up in the column in a way that will begin to have another leverage point of thinking of one of our four segments of a population to be wedged.

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

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

Another area that came up on our web meeting is the whole element of what has occurred at the NQF in the past year or so, really having this discussion on how does SES factors relative to all this discussion on risk adjustment fit into the measurement process. So, we'll have a chance to hear a summary of what the debate has been, as well as where NQF is going to be experimenting for the next couple of years.

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

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

Okay.

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

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

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

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

MS. LASH: Wonderful. All right. I'll be setting up today also by recapping a little bit of what we heard yesterday. I think that this group has laid a tremendous amount of groundwork, not only within this meeting, but over the course of the last several years. But what's really now come to the forefront are more articulate goals for what we want to accomplish through quality measurement, and that we need to accelerate change in the form of more innovative measures.

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

We also were checking ourselves going

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

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

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

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

So, let's see. There was another

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

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

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

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

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

So I'll move quickly through the next few slides because we already went over these on the web meeting, but just to recap, MAP has set a high bar for quality and what it expects in the dual eligible population. And so this group has tried to advance person-centered approaches through its work and will continue that today. This will be a forum for strategic discussions with and on behalf of HHS. And as much as we can make explicit what the unique characteristics are of the dual eligible population for care and how that affects measurement needs, that would be a good contribution. The group will also continue to identify and publicize the measures with the best fit for purpose, talk about opportunities for stratification and then plant the seeds for development of new priority measures.

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

We also know very well that low-income is one of the only common factors that all dual eligibles share, and so that I think is -- it's fair to say that duals experience disparities of many types in quality and continuity of care because of their medical and social complexity, because of the fragmentation between payers and different types of providers, and the fact that most of them are still in a fee-for-service system.

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

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

So, Adam was curious; and I think he might not have an answer to these questions himself, but how consumer-directed services like personal care can be introduced into more formal integrated care models like some health plan managed care and PACE but in a way that respects the core philosophy of consumer direction and honors the autonomy of the consumer as the decision maker that is able to ground the medical providers in person-centered principles and also providing support for those professionals in terms of training and community supports in a way where there's accountability that doesn't compromise many of the delicate tensions and the setup. So we can reflect on that, and we'd be interested in your thoughts.

Our first presentation this morning is from a fellow NQF staff member, Mitra Ghazinour, who was project manager on a completed effort concluded last summer related to prioritizing measure gap areas in the area of person and family-centered care. So, there's been great progress made in sort of thinking through some of those approaches, although they didn't really have a duals lens. So this group will certainly have something to add. And I'll ask Mitra to go ahead and share her thoughts.

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

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

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

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

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

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

Many pioneer organizations such as the Picker Institute, the Commonwealth Fund, the Institute for Patient- and Family-Centered Care and Planetree have defined person and family-centered care and what it entails. These efforts have been grounded in extensive research and informed by expert panels, focus groups and numerous dialogues between persons, families and providers of care.

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

So in order to reach suggestions about how to measure performance related to person and family-centered care it was necessary to have a clear picture of what it is and how to recognize it. Building from the prior work that I just mentioned the committee agreed to the following definition and core concepts of an organizing structure to identify a specific measure concept:

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

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

So, this is a graphical representation of the core concepts of person and family-centered care. The committee identified these core concepts as important components of ideal person and family-centered care to guide performance measurement. The committee noted that all of the core concepts must be present and that none of the core concepts alone signifies person and family-centered care.

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

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

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

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

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

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

Shared decision making. I am helped to understand my choices and I make decisions with my care team to the extent I want or am able.

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

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

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

So the committee identified three key principles that should inform the identification of measure concepts for person and family-centered care. They should be selected and/or developed in partnership with individuals to ensure measures are meaningful to those receiving care; should be focused on the person's entire care experience rather than a single setting, program or point in time; and it should be measured from the person's perspective and experience. And, so generally person-reported unless the person/consumer is not the best source of the information.

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

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

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

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

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

So, the committee offers considerations for the staging and prioritization of measure development to advance person and family-centered care which I'll be going over in the next few slides.

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

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

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

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

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

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

Next, consider initially focusing on patients with higher levels of need such as individuals with multiple comorbidities and serious illnesses. So these individuals are most in need of high-quality person-centered care that emphasizes collaborative partnerships between the individual, their family and the care team. And if it can work with these patient groups, then it could be adapted and used for the broader population.

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

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

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

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

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

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

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

And lastly, the committee recommended to fund research to advance measurement of person and family-centered care. And some potential research topics included vetting these core concepts with individuals and families, developing patient-level measures of experience with care measures such as the PROMIS 10 and so forth.

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

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

Okay. We'll start with Tom.

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

I think in fact what we do practice is not person-centered care so much as value-centered care. Person-centered care starts breaking down and it needs patches when you begin getting in behavioral health conditions. Member preferences and family preferences sometimes can't be honored there because of behaviors. And the other area where it starts breaking down is in end-of-life care where family preferences and individual preferences may lead to futile kinds of care. And so, there again the consumer's judgment and preferences need to be questioned.

The question even on the last slide, how is your care working out for you, I understand the need for that question and I understand the need especially to keep person-centeredness in place with the poor and the vulnerable who need the protection of this mantra, but my question would be since the patient is the first member of the care planning team but also the first member of the provider delivery team in the sense that they have to care for themselves, first of all -- and so my question wouldn't be how is your care working out for you. That would not be my first question. My first question is are you taking care of yourself? And if I don't keep responsibility in the hands of the patient, it is not only profoundly disrespectful, it is not going to get me or the patient where they need to go.

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

And even sitting around this table you as consumers of medical care, you are certainly willing to give up your own preferences in exchange for competency. You want to know what the best care is, not what you prefer to be the care. You want to be in front of a doctor who is giving you choices and making recommendations as to what the best solution is, not the one that you prefer. And so, even in our own case our care decision making is driven by values and it's value-centric, not so much as person-centric.

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

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

DR. LAKIN: Well, I'd just like to go back to the basic person and family-centered care core concept. And care always throws me off a little bit. I'm never comfortable with that term. It seems sort of one-dimensional. But the one core concept that I feel is missing here is that one of helping me live the life I want to live, whether that's involving inclusion or self-determination, maybe employing some sense of productivity and independence. That whole range of one might call quality of life kinds of variables that I think are really core to serving and supporting a person.

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

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

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

So there's this concept that people with disabilities want to access all this care and in reality many adults with disabilities want to avoid care as much as possible and want preventative services that will allow them to maximize their daily living in the best way possible. And that's a very foreign concept to providers that think they need to care and caretake adults with disabilities. And so it's something to really keep in mind.

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

And so I gave the example; it's not necessarily a good health care example, although it was interesting, a friend of mine who has cerebral palsy went skydiving and he actually -- his parachute didn't fully open and he got a little injured. And he was okay, but he went to the ER. And the ER staff was harassing him for skydiving, that he engaged in that dignity of risk because he was disabled instead of at the time of the ER visit asking him about his general health and other health preventative things.

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

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

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

MR. BRINGEWATT: Yes, I really like a lot of what I see here in the definition and the kind of principles that are involved. And that doesn't mean there aren't things that can and shouldn't be added. I like the comment you made here in terms of the value perspective there, but part of what I like about what I see here is it incorporates a sense of system-ness, and that's particularly important for complex care populations, frail, disabled, chronically ill people.

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

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

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

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

Within the context of that, I think an

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

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

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

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

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

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

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

VICE CHAIR HANSEN: Thanks, Gwen.

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

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

I would second Charlie's point about really building in as a core concept. It's really about quality of life and why would we have all this if we weren't helping people live a better life in the end for them? So, that extends to things beyond -- so, I mean, it's interesting that this is health care, however, health care is a domain, one of many domains around quality of life, right, that we can all identify in our lives.

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

But if we start with at least a

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

So, we don't have --- so what's happened, and in the disability world this has been around for a long time. Thirty years people have been developing person-centered planning and practice, the techniques, but there was never any until very recently. We're just starting this discussion about what are the core standards for this, right?

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

And then the other thing is how can we start to build that into some credentialing standards if we have zero, frankly? And we have -- within some of the methodologies there are -- you can be certified in this particular training, this particular planning method or that, but we have not had a national discussion about this whatsoever, and I think we need that again to address this. And I think that it's very important. We have to recognize that there are experts out there.

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

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

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

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

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

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

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

MR. ROSS: Hello.

MS. SHAHAB: Hi, Clarke.

MR. ROSS: When I raised my hand I had

two points, and now I have three or four.

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

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

I wanted to reinforce Anne's point and Shawn's point about the historic work that's done. In 1978 the Congress of the United States created the Centers for Independent Living programs that ACL now administers. So this concept of personal autonomy and community inclusion, in disability we've done this for decades.

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

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

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

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

I also wanted to point out that I don't agree with moving the idea of patient-centered to value-centered because the values become those of the health care providers, not the patient. And we see that in end-of-life care and some of the research that's been done where even when the patients have documents of their express desires and communicate that to the family, those wishes are overridden by the health care team. So, I hesitate to move into the sense that it would be someone else's values.

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

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

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

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

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

VICE CHAIR HANSEN: Thank you to all

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

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

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

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

MR. AMIN: Thank you very much.

VICE CHAIR HANSEN: -- get my notes

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

MR. AMIN: Taroon. Thank you very much.

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

MR. AMIN: Yes, thank you very much.

VICE CHAIR HANSEN: Thank you.

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

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

MR. AMIN: 11:00?

MS. LASH: Yes.

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

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

So, what I'd like to do, during this next 45 minutes, is to have a discussion with this group about a topic that has been really at a core of some of our measurement science work around the appropriateness of adjusting for SDS factors and risk adjustment models, particularly for outcome and resource use or economic outcome-type measures and really talk about how this work intersects with the work of the MAP Duals meeting and really understand where the path forward is with this work, particularly for this important patient population.

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

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

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

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

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

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

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

And again, just a little bit definitionally what is really the difference between risk adjustment and stratification? Risk adjustment generally refers to statistical methods to control or account for differences in patient populations through various different statistical approaches. They may include multivariate modeling approaches, indirect standardization, as most know it as, or direct standardization through matching of patients based on various different characteristics. Generally these methods result in a method that results in a ratio of observed to expected outcomes.

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

I would just point out that what's a little bit challenging is that while these are sort of presented here as two options to the same problem, increasingly many of these measures are being used for accountability applications and the option of stratification becomes increasingly more complex given the small numbers of patients in the various different strata. And also interpretation of those results for the purposes of calculating performance or, in some cases, a penalty for the provider may become even more complex than that.

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

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

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

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

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

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

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

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

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

And then finally and most importantly, or equally importantly, the methods, factors and rationale for risk adjustment should be transparent for users.

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

Okay. So, there are various different perspectives.

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

MR. AMIN: Okay.

VICE CHAIR HANSEN: Okay. Anne?

MS. COHEN: No.

VICE CHAIR HANSEN: No?

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

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

So there are various different perspectives on this issue, and these perspectives really sort of -- very much contained the National Quality Forum for quite a bit of time through 2014 to really sift through these various perspectives and understand the path forward. And so, I'll just outline the two divergent views to set up sort of the extremes. And obviously there's a middle ground between these two.

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

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

Those that oppose SDS factors have noted that some providers may deliver worse quality care to disadvantaged populations, and by including these factors in the measure, we may not really be able to understand these meaningful differences in quality. And with the inclusion, worse outcomes could be expected and there would be limited -- that may be a little strong -- there may be limited expectations for improvement. And the stratas themselves imply a different standard of care. Additionally, there's limited adequacy of SDS data and there may be other preferred payment approaches to actually improving the care, or maintaining the safety net, rather than adjusting the underlying measure itself. So, that's one perspective.

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

Further, there's no evidence that disparities would be reduced through these negative financial incentives, and the lack of adjustment would continue to create disincentive to care for the poor and other disadvantaged populations. So again, this obviously interacts with the work of this workgroup very directly.

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

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

And then finally, these recommendations would apply to any level of analysis, including health plans, facilities or individual, clinician-based measurement. And the individual measures as they're evaluated, specifically looking at the question of risk adjustment, should be selected based on existing guidelines around how we select risk adjustment factors.

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

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

So how does this interact with the MAP Duals work? When measurement programs use a national average, rather than peer groups to determine a benchmark or a performance threshold, and measures within the program are not risk adjusted, entities that serve a higher proportion of dual eligibles may be disadvantaged. Two particular notable examples of that may be the Medicare Advantage Star ratings and the Hospital Readmissions Reduction Program.

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

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

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

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

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

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

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

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

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

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

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

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

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

Rich?

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

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

And so, the question becomes not whether to do something about this, but what to do about this. And that's the $64,000 question right now because we don't have the kind of research we would like to have in terms of measurement and how to approach this.

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

And where they looked at millions of people and looked at, not just duals and socioeconomic status in plans, but on an individual basis. And part of this study that's going to come out shortly is going to be their findings as it relates to individual-based factors in relation to social-economic status.

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

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

And there was a question as to whether risk adjustment makes a difference in relation to that, and so they looked at the only star measure that is risk-adjusted, which is hospital readmissions; and it's currently adjusted for age, gender and condition, and found that even with that measure there's a statistically significant difference between duals and non-duals in terms of their performance at an individual basis.

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

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

And then there's a long-term strategy here. And the long-term is going to take some time to really sort this out. There needs to be new research. There needs to be things -- a long-term fix. It's important to get started now, but we can't suddenly just have a short-term fix -- a long-fix overnight. And it's likely to involve factors that are underneath the social determinants. Like comorbidities can be a factor and other health-related issues in addition to some of the more demographic ones.

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

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

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

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

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

The thing about these measures, you'd like science to solve the problem, and certainly there is scientific evidence that SES has an impact on outcomes, but science doesn't seem to be winning the day. As we expand five-star measures through hospitals to nursing homes to home health agencies, the chorus of people speaking about SES will increase, and it seems like science is not going to win the day. It's going to be political action and legislation that's going to have to win the day. I think that's unfortunate. I think that this needs to be an evidence-based, truth-driven, as opposed to a political/economic-driven solution, but I don't see us moving fast enough to a solution from the scientific side.

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

So, something's wrong with us in our

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

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

Gwen, we'll go back to you.

DR. BUHR: (No audible response)

VICE CHAIR HANSEN: Okay. All right.

Then, Shawn?

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

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

So a lot of people are very isolated in these settings. They don't have a lot of connections outside of the provider system that's providing services and supports, the people that they know are the people that they -- they're providing personal assistance, and the people that they live with. And maybe at best, if there are a lot of people, it's a sheltered workshop kind of environment, getting sub-minimum wages.

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

How does this apply -- I'm sure it does. I just -- that's a huge question, I think. And it's back to, like Tom's point, that it's a different set of perhaps metrics and a different focus. Like for instance are there services to help a person do all these things? Get supportive employment services. There's plenty of evidence-based practices out there. Are they available? Are there services that whose -- the person's job it is to help that person integrate in a community in a way that they'd like? And so, can this -- I think it can, but I think that's sort of a challenge. How do we approach this idea of risk adjustment to push -- in most cases it's state systems to adopt the kinds of services and supports that will really honor the goals in these plans if we do them right. So, that's the question. And thanks for the time.

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

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

MS. SHAHAB: Kata Kertesz?

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

We have some concerns about this kind of risk adjustment potentially dis-incentivizing plans from adjusting the root of the disparities. And I think it's important to add to this discussion some things that have already been said that there is data to suggest that there are differences in performance in plans of duals and non-duals, but the causal relationship has not been established, which I think is a central question to determine how best to address this issue.

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

And I think sort of stressing the importance of providing services that would actually lead to improvements in care should be where our focus is. There are a lot of plans that do have a high dual population that do perform well. There's a plan in Denver that emphasizes these kinds of things, like having bus stops near their locations and having 24-hour call lines so that people can speak to someone, make appointments, cancel appointments after hours because of the unique needs that the dual population has that we're all aware of.

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

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

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

MR. AMIN: So this is Taroon.

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

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

The first is I just want to reiterate that again this change in policy is removing the restriction of including these SDS factors, and so that raises an interesting sort of challenge for us as we move forward, which is that these individual measures need to submit and consider and reflect on the conceptual rationale for how the SDS factor relates to the causal pathway for this outcome.

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

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

B, as it relates to the data, I think again one of the challenges that we've had in this disparities field for quite some time is that the data isn't systematically collected, but what's really opportunity for moving forward with this kind of trial period is that it sort of forces some systematic data collection for particular types of data elements. And if folks know that these data elements relate to the outcome and how they're being measured and how they're being profiled, I think that's a pretty good reason to collect that data going forward.

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

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

We still have other people on the queue?

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

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

sorry. I had to -- never mind.

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

VICE CHAIR HANSEN: We can hear you.

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

I had a couple of technical questions for the presenter.

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

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

The second stream includes guidance from the NQF Board that the measures that were under -- this is a little technical, but the measures that were under consideration for the readmissions and cost and resource use, the project that just completed in late 2014. Those measures should be considered in the trial period. So that's the second stream.

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

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

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

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

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

So, the way that we're thinking about this; and again, this is up for interpretation given that there's a lot of differences of opinion about this particular question about the variables that are included in these factors. We think about sociodemographic factors as a larger umbrella which includes sociodemographic -- or -- let me -- I'm going to start over again because there's no way that could get any more confusing than where I started.

(Laughter)

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

So, that's the construct in which we

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

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

VICE CHAIR HANSEN: Thank you, Taroon.

MS. POTTER: Thank you so much.

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

MS. SHAHAB: Clarke Ross, you had

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

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

And I think, Charlie, had you already spoken?

DR. LAKIN: I haven't.

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

DR. COUNSELL: Thanks very much. I just wanted to comment first on just the remarkable presentations, both this morning, and in particular to a really careful, succinct, really outstanding addressing and presentation in a short meaningful and understandable manner and the rich discussion that's going on. So I'm not disengaged. I'm just not commenting as much maybe as usual and really soaking it in.

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

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

And then third, just on the lighter side maybe, I'm just wondering where does functional status fit in? There's more and more data and research showing it's been highly understudied, but just recently last week in the JAMA Internal Medicine looking at I'm a geriatrician in geriatrics and just showing, oh, that people with ADL impairments prior to admission to hospital at higher risk of readmissions. Surprise, surprise. Something we all know. But again, not factored into these kind of situations.

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

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

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

DR. COUNSELL: Well, and this is where I think NQF and this initiative can really help drive quality improvement by collecting meaningful data, whether it's sociodemographic factors that aren't currently or functional status in particular, which we know is so important and useful in developing an individualized care plan, let alone measuring performance. So, thanks.

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

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

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

One of the things that people have

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

I was struck by Shawn's comment about people who live in group homes and that we don't know much about their outcomes. Actually we've had the chance to merge national core indicators data from about 15 states to look at that. And if you control for level of intellectual disability, behavior problems, physical impairments, which are highly associated with outcomes, you can then stratify that sample by service type and find out a lot about how people who live in their own homes, homes they own or rent, live with family members, live in small group homes with three or fewer people, four, six people, how they differ in outcomes like social inclusion and employment and things like that while controlling for those factors that are most associated with that and find really clear differences in those service types.

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

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

MS. COHEN: So when we talk about comorbidities or other kinds of clinical data, one rich resource kind of as a baseline would be Medicaid data -- or Social Security data for when people apply for Medicaid. And there's always been an issue with getting that data accessed by the plans to get that kind of baseline information when somebody enrolls in a plan. But there is a research study where Social Security data has been released to, I believe it's Mathematica, and they're doing -- I could be wrong.

Charlie, correct me if I'm wrong.

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

The second thing that strikes me is that; and forgive me, I have my personal disability hat on, you're always focused on the individual, the person with the disability, the senior, the member, as we call them. But really when we're talking about risk adjustment and stratification we should also be looking at the provider, because really if you're worried about controlling for having issues with understanding the impact of the provider differences, you're looking at socioeconomic data of the provider. What's the provider rate being paid? What group are they a part of? What demographic factors? Their age, the race, the language barrier of a particular provider.

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

VICE CHAIR HANSEN: Tom?

DR. LUTZOW: Yes, I would invite NQF to take the position that the same service needs to be reimbursed at the same level. You will lose that battle, but the mantra needs to be there. And part of the complexity here and the disparity is due to our reimbursement policy. Certainly the uninsured aren't reimbursed at all. The same service delivered to Medicaid individuals is reimbursed at a different level than Medicare, and Medicare is being -- providers to those folks are being reimbursed at a different level than the commercial service, but it's all the same service.

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

And I want to suggest that this problem is not going to be solved unless the duals get their own part, Part X. Unless we have a part that is sensitive to these conditions that are unique, where poverty and Medicare eligibility meet, we won't get a solution.

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

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

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

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

I think the one area I ask staff is to perhaps help us make sure, even though it's on the web site, putting back into our notes the three groups of areas that were going to be looked at relative to the topics just so that it brings it back to the Dual Eligibles Committee so that we know we can focus on that as well.

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

So there may be some contextual background as well as the active PACE programs there are in 30 states now with this full capitation between Medicare and Medication, and not with the struggle per se of an individual given service, but the total amount of funds and how the provider ends up using it. So just a background of a system that has actually had this in legislation since 1983 to be able to look at it.

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

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

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

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

(No audible response)

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

MS. SHAHAB: So, I have a public

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

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

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

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

Okay.

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

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

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

Patrick, take it away.

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

I think the first thing that I have to

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

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

But really what I want to do is more tell a story and almost use this opportunity in your very packed agenda, discussing some very weighty topics and issues, almost as an interlude to paint a picture about what it looks like when a plan is actually trying to really redesign its work and look at things from a different perspective in serving the individuals that we're privileged to serve.

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

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

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

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

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

These -- each of these pictures are members. This is one of our members, Ruth Miles. Ruth is one of our favorite members for two reasons: one, she is on our Advisory Committee for our Medicare plan, and her daughter is to the left, Mya Ladd, who is in our Provider Service Department, so we have a definite connection with Ruth.

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

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

We have learned and are still learning a tremendous amount about this idea of us cultivating health in a community. I know to some of you it will sound very Pacific Northwest, and it is, but it's meant to conjure an image that it really is about us not solving problems, the whole paternalistic image, or us being passive, but trying to lay the groundwork, trying to put the elements in place that we can be part of a broader community effort to serve the population, and then our vision is one of -- of health equity.

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

That has changed over time. When we first started our SNP in 2006, it was about 65 percent under age 65, and then the graph in the lower left is meant to say that, that the members that joined us in 2006, in fact on average the members who are under 65 and disabled, have longer tenure with the plan, tend to be very stable. We have a very low disenrollment rate. It is something like two to three percent.

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

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

We are trying to figure out better ways of doing that, but the more and more we're working in these different programs that you'll see, the more we're seeing how under-reported that is. So it's really just as important what is not on here as what is on here, but as you see what's on here, mental health conditions are a significant amount for our plan.

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

Not only are we bringing it into CareOregon as being sustainable on an ongoing basis, but as you'll see, we're really building ---- we're actually rebuilding, redesigning, our whole care management model on this platform. So it's really a success of the CMMI program as well.

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

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

And then the social -- the social values is on there at the bottom, and what that is meant to say is as this program is developed during the CMMI grant, it has really been astounding what we've learned from, you know, some of the conversation about person-centered care. Some of what we have learned about being in the community and the incredible importance of being non-judgmental when working with individuals has been one of the most incredible learnings from this.

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

So they're a team, if you will, of social workers, 15, 20 people, but each of them are deployed out, and they are also not only health plan employees and members of that what we call community of practice, they are embedded within the primary health home and that care team, part of that care team, and have assigned case loads, if you will, where they're the primary responsible party linking back with primary care.

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

This is -- there's a lot of information on here. What I really want to show on this is one of the things that we are measuring are non-health-care things, and these are things where we're getting information directly from the member. Things like past trauma, things like their current living situation, about stability, and we've actually built software called Pop Intel, which is almost a type of -- of social determinant care management, if you will, platform, simply because it's almost creating new types of registries that you can also put EMR data and claims data in. So you can know medications they're taking and when they've gone to the ER, so you can use that information to help in the care, if you will, of the member, but it is really using a much broader base of information.

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

And these statistics show that we are keeping statistics of people's known trauma. We think though, when you see that yes, 55 percent and unknown, 42 percent, that much of that 42 percent is -- could potentially be that it is just not coming out yet, and just the high percentage of active trauma from this person's perspective in their -- in their life right now.

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

And there is a specific example of a story that just sticks with me that, again, we talk about, you know, population health and measuring and measuring, for example, someone who has diabetes and the diabetic care, that maybe they have other mental health conditions as well. And you're trying to create programs, individual plans of care, et cetera, for that person, but that person, you come to find out, doesn't go to the doctor.

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

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

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

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

So for us, the next step in this program is one, growing it, but two, growing it in a way that can be scaled. And so one of the big areas that we're looking at now is the use of peer support and leveraging peer support, leveraging patients existing and members, family members, and how can we expand this program?

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

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

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

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

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

And so this is kind of the map that we

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

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

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

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

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

One of the interesting tidbits is the process that we've gone through, I will talk about human-centered design, is to really look at how you can do things in a different way, and it's just a little amusing anecdote: one of the things they come up with as a model is like how do we get people to understand? There's pill boxes and all sorts of things, but one of the things they used -- I love it, they brought this to the presentation, was Richard Simmons, the like 80s fitness guru.

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

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

We -- we don't use the MEDS Chart in clinic, which is an interesting point, because one of the issues we faced was that each clinic has its own workflow and so we didn't want to disrupt workflow, we're very cognizant of that. And so what we are doing at the clinic level is we're actually embedding clinical pharmacists.

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

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

So it's this idea of plan-based

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

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

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

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

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

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

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

So really, what we had done, again, when I said this was really informed by the Health Resilience Program and these other programs that we've done, is really changing how we look at this. Really, from being population-based telephonic regulatory-based care management to one that is very different. It's almost a virtual -- virtual care management system.

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

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

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

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

So don't need to show this group the social determinants of health, and there's lots of different graphs that show this and different percentages, but just the reason I show it is that -- that it -- this has changed how we look at doing care management. It looks at how we serve the population because that ten percent medical care, we aren't -- we aren't really looking at building population health models based upon a medical care model, we're looking at it much broader, and again, with this thing of do we -- does our workforce change where we have more social workers, more people that work in housing and food and even economics, which I will get to in a second?

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

And we are -- again, we are embedding people in this and we're learning a tremendous amount. And one of the things is just an anecdote, but is we talk about greater integration and coordination and all these things, and it's all great. And then there are issues like HIPAA that we need to deal with, and sometimes that can be a barrier, but the other thing that we're, you know, encountering and managing, which is a good thing, is that people want their care to be integrated, but there are -- there are nuances of that.

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

Just a word on human-centered design, this is how we go about doing it. We worked with a company called IDEO, I don't know if people are familiar, but they have been wonderful working for us. We don't work with them anymore not because we don't like them, but because we're doing it ourself, and we are -- and this is what originated the MEDS Chart.

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

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

And what ends up happening is when you address the issues that are important to people, they are actually much more receptive and open to the issues that you think are important, and the health issues in going to primary care. And so we're trying to figure out, again, what we do with that and how we -- how we leverage that as well.

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

I have to admit we see these more as a regulatory element, and sometimes barrier, and for example, there are elements in here that are fine, but to be perfectly honest with you all, the idea that health risk assessment in an individualized plan of care the way it's currently structured I don't think adds a lot of value. There's a lot different types of assessments and care plans and ways to approach this that I think could be actually more cost-effective and better attuned to the needs of the population.

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

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

The Star ratings, again, I don't want to bash on this, but this is just meant to show we're a 3.5 Star plan, we've improved -- we've improved every year over the past three years, we have not cracked the 4 Star, and this is not meant -- the conversation, I love the conversation, we don't want to lower the standards, we don't want to change this.

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

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

So hopefully -- I have probably gone over a little bit, I want to make sure discussion -- this is Safa, he is one of our members as well. And really just what I wanted to end with, and again, hopefully we -- you can take away that I feel like we're just learning more about our members. There's a lot of data on dual-eligible members and such. I think we're just learning what the underlying causes of some of the costs and outcome issues that we're facing, and there's also a lot of absolute incredible creativity and amazing heroic stories such as his I won't get into.

But anyway, that is what keeps us going.

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

So our process here is that we have one of our committee members, Tom, who is from iCare, to be the reactor to this, and after he has had a chance to do that, we will take comments and questions.

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

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

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

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

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

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

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

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

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

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

ER, the results that you show for ER

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

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

Rx case management: we have a pharmacy also in Milwaukee, it's called Hayat, HayatRx.com, and they do home delivery of medications and send a pharmacist into the home to do comprehensive medication review. We don't pay them anything extra. They get everybody with ten or more meds, and the goal there is medication synchronization.

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

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

In this case, just as a highlight, Walgreens got very disturbed that they were losing iCare members to Hayat. They actually sent somebody out to Hayat to see what are you guys doing? You're taking all of our 30-med members.

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

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

MR. CURRAN: So just -- just quick responses on, hopefully I am hitting these, and not in detail, but in terms of the barriers to getting data, our barriers are mostly inertia. We don't have the payment, we don't -- we don't really have the same issues, it's more just getting the data and the completeness of the data is the main issue that we're facing.

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

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

The ER, you know, the -- what we found through some of these programs is actually that for the most part, people don't want to go to the ER. It ended up being -- it wasn't a choice issue or a restriction, it was -- it was the need for connection. And so when there's another connection, that need goes away.

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

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

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

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

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

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

And I think that the framing that you're offering is how do you still work within the system but start with an approach where people come to, and what helps them maintain their best ability? And part of the social connection discussion, and that kind of almost classic public health chart that shows that medical care is only 10 percent of this.

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

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

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

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

First is causality. There is no causal relationship here. We currently use age, gender, and condition to adjust for hospital readmission. There is nothing in the literature that says being old causes a person to go in the hospital. It's an association where you tend to have more factors associated with old -- being older, that is the driving force.

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

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

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

The second thing is we've got really

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

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

You know, so I think it's an issue that we have to address, whether, you know, if somebody is already a 4 Star plan, why shouldn't they be a 5 Star plan, if in fact they are putting in the kind of resources and addressing the kind of issues that are there?

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

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

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

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

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

VICE CHAIR HANSEN: Yes, thank you, Rich.

I think -- I so apologize you had to

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

Shawn?

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

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

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

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

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

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

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

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

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

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

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

And then last thing is on the software

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

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

So there is a complexity to this, and

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

VICE CHAIR HANSEN: Thank you, Shawn.

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

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

MS. ZLOTNIK: Hello?

VICE CHAIR HANSEN: Hi Joan.

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

MS. ZLOTNIK: Can you hear me?

MS. SHAHAB: Yes, we can hear you.

MS. ZLOTNIK: Oh, okay, great.

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

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

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

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

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

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

And the general --

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

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

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

So we didn't even -- the people that actually we started hiring weren't the people that we ended up hiring, and so it was -- it was really a mix, and really what happened, Joan, I think the best way to describe this is that what is really interesting is -- is how quickly people found out about it and how easy it was to recruit people.

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

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

MS. ZLOTNIK: Yes.

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

MS. ZLOTNIK: Great. That is really helpful.

I guess one of the questions is that a number of the CMMI grants actually use social workers as part of the intervention, particularly just because of the frame you provided where the issues aren't really medical, they're social and behavioral and such issues around access, but those data aren't -- there is no really easy way to get those data, so the other question, you might not be able to answer this one either, is the extent to which, you know, kind of as CMMI grantees, you kind of coalesced with some of the other grantees that were sort of using similar models, because I think some of the lessons learned that you've had around sort of who do you need the workforce to be are very important ones, so a lot of projects because it's cheaper are starting out with community health workers, but they're not -- they're like part of a team, but they may not be able to do all of the things that the expectations are for them to do, because these are dealing with people with complex problems.

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

But I know there was, and I know those were some of the exact issues that they talked about, so I think for you Joan, or for the whole group, I think if you would want more information, I'd love to put you in touch with people who are closer to it to answer the questions, because --

MS. ZLOTNIK: Yes --

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

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

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

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

I have a couple of sort of technical kinds of questions. If you could speak some more about the risk model or the health reliance, I am trying to understand how you went about identifying people who had trauma. Or was that something that got identified after you had identified a high-risk population, for example?

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

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

What we found, what the real learning was was really -- and that is similar to what a lot of health plans use, but again, the process that we went through and the people that we hired to do the work, that was the revelation about the past trauma, the incredible high prevalence of -- and that's what this community of practice found, that when they would get together and they would talk about these issues, both data-driven and also just anecdotal.

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

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

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

I just think the more that we're

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

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

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

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

MR. CURRAN: It's --

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

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

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

VICE CHAIR HANSEN: Thank you.

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

So Steve?

DR. COUNSELL: Yes, I will be brief.

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

But I have a similar one about what

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

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

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

MR. CURRAN: That's great.

I think it will continue to evolve,

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

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

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

So that -- it was more -- it was more that than the nuts and bolts of who pays benefits and are there union issues or things like that, it ended up being more the support.

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

MR. CURRAN: Yes, yes.

VICE CHAIR HANSEN: Thanks, Steve.

Tom, you have the last comment.

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

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

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

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

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

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

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

Portland and Oregon is very competitive in the MA market even though it's a low-payment area, and very -- the community advocacy community, everyone is very much open to managed care, so it's a -- it's a very competitive market.

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

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

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

I think there are some practical opportunities, and having providers like yourself, certainly having a board that committed, is helping us uncover learnings that perhaps all of us can learn from.

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

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

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

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

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

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

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

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

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

A-F-T-E-R-N-O-O-N S-E-S-S-I-O-N

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

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

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

So our second goal in developing the

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

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

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

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

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

And this is a sweet spot for geriatrics teams, because if you need help in functional activities of daily living and such, that automatically bridges into the social and a lot of the things that we have been talking about, so you're dependent on someone else to help with your activities of daily living. That automatically brings in -- and you are typically -- not have those functional limitations without multiple chronic illnesses, multiple medications, et cetera.

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

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

And then, finally, I'll tell you about some of our experience here over the last four or five years in helping 21 now different health systems in five different states implement and replicate the model and some reports around the return on investment.

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

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

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

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

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

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

I put this slide in right up front,

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

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

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

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

GRACE is involved in this patient.

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

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

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

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

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

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

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

And then, having specific care protocols to manage common geriatric conditions, these protocols are kind of like checklists. If you read Atul Gawande's Checklist Manifesto, this is sort of to make sure we are checking and not leaving it to chance whether or not we think of physical therapy for someone who has balance problems or other things. So checklist as to -- to help guide development of an individualized care plan.

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

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

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

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

The nurse practitioner goes through all of the medications, pulling them out and helping identify, and the social worker talks about advanced care planning and goals of care and meets with the caregiver, if that's present, and talks about what kind of advanced directives there might be and does a home safety check.

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

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

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

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

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

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

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

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

And the doctors may feel even more comfortable discharging sooner and maybe back home rather than to a nursing facility, knowing they have -- the GRACE nurse practitioner and social worker are going to see them in the home a day or two after discharge and really -- and have been a part of the transition planning. So if there is home and community-based services involved, that they have been alerted also that the person was in the hospital, and they may have some different needs, and the nurse practitioner will make sure that home health care shows up and they know what the, you know, plan of care is and -- or the physical therapy, and that the person has a new medication list that they understand, that they have that has been reconciled with prior to hospitalization and then hospital changes in their medications.

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

The weekly team conference, in addition to new patients and follow-up reviews, they will also -- it is a continuous quality improvement sort of model where if someone has been admitted to the hospital they will look at, well, hey, should we review, and are there any needed changes in the care plan? But just as importantly, well, what happened, and why were they admitted to the hospital? Was there anything we could have done to possibly prevent that? And, if so, we can implement that in the future for that person, if not other patients, too.

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

Over half the patients typically will get at least the falls or the depression or dementia, and you can see the other geriatric conditions that -- again, this is meant to complement and support primary care and not to duplicate what primary care is doing. And so you don't see hypertension, diabetes, heart failure. These kinds of things are well managed by the primary care physician typically, and we assume that is going on and our reviews usually confirm that.

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

This is a typical protocol that -- each one has -- comes with about 30 different suggestions for care, and we have identified in developing these with our primary care colleagues, things that the primary care doc kind of wants to know about and be on the loop with before -- just get done, and then other things that the team can do routinely.

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

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

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

We had an equal number of 500 people in this randomized controlled trial that were in the control group, and so after the two years this is a very brief, one slide summary of our results, what we showed from assessing care of vulnerable elders, the ACOVE Quality Indicators. You know, more people got their immunizations, they were able to identify their primary care physician by name, they had follow-up after hospitalization, they had standardized, best care for falls and depression. They were not placed on or taken off of high-risk medications. They had a medication list. So a number of things on the quality side.

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

Now, all patients across the group, we showed fewer emergency department visits. But in the high risk, the most complex 25 percent or so in the group, because we took all comers 65 and over in the community health centers, but when we did a subanalysis on the 25 percent more complex, it's in that group that we showed a substantial reduction in hospitalizations.

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

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

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

And this is costs -- we have pretty

good cost analysis. It's the Regenstrief Medical Records System, so most costs are actually included in here, including the cost of the intervention, which is about $2,100 per year. And you can see in the first year that a reduction in hospitalization rates about -- was a break-even, but in the second year when we really had the large reduction in hospitalization rates we started to see cost savings, about $1,500 per patient, and those savings persisted then after the team signed off with the continued lower hospitalization rates.

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

So if one doctor has 20 GRACE

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

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

Incorporating proven transition strategies. We think the home-based nature -- we initially were just going to start out with an initial home visit, and then go to subsequent follow-up by the social worker and nurse practitioner in the office. But we quickly learned that the offices are too busy and there is no room, and scheduling people was another nightmare, and then transportation and no-shows was already a big problem.

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

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

So that final piece -- integrating with community resources and social services, so that was really the job of the social worker, especially to interface. And we had strong relationships, and I'll have more on that with our Area Agency on Aging, CICOA Aging and In-Home Services, and -- but other -- you know, senior centers, discount fitness at the Y for older adults, et cetera, that are available in the community.

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

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

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

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

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

Now, the third one was our

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

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

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

And then we saw a similar -- at the VA, a 50 percent reduction in the 30-day readmission rate, and then over the subsequent year quite a substantial reduction in hospitalizations compared to the year prior in the patients followed by the GRACE team.

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

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

And then, this is at IU Health, and the Medicare Advantage plan there, similar type results in our first -- this next slide is actually data from the health plan in the first 50 or so patients that we followed for two years or longer. And you can see in the year before their hospital rates was over 1,200 per thousand, and afterwards a 43 percent reduction. So this is sort of seeing very similar type results from each of the different populations we're working with.

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

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

What was also interesting to see is the premium increase, so the revenue to the health plan was increased in the patients. So even though the costs were going down, the revenue was going up by an 11 percent improvement in the per member per month increase. And this is because the team is identifying previously undiagnosed depression or malnutrition or other things, and documenting those in the chart that then get a higher, you know, and more appropriate case mix payment.

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

And their analysis of our publications and data showed these results, that the return on analysis indicated that the GRACE model had close to 100 percent return on investment. The annual cost of the program was similar to what we had calculated -- $2,200. Annual savings per member about twice that. And so your return on investment, 95 percent, or two to one, or per member per month savings $174.

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

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

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

Reduction in readmission rates and the penalties that come across that, at least to the hospitals. Better performance on quality metrics and STAR ratings. One of the health plans we are working with really feels that this is improving their STAR rating score and, again, their reimbursement to do the things that they want to do in patient care.

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

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

Improved access to community resources

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

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

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

Medicare Advantage plan, and the VA is there.

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

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

And these are the three principles that they outline that are sort of overarching in the design and implementation of these kind of high-risk care management programs. One of the most effective programs have been those that are practice-based, and so where the care managers are integrated with the practice, much like what we did with GRACE and even what have been presented earlier.

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

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

So I have tried to give you an overview of the persons that benefit most from this kind of integrated care and person-centered, you know, integrating medical and social care, the evidence of the GRACE model and its replication and scalability with pretty consistent results.

Thanks.

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

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

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

VICE CHAIR HANSEN: Okay. Great. So

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

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

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

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

Also, with this age group, chaplain services. At iCare, we certainly, you know, talk about radial eye care, for our members to call in to have access to those kinds of communal events. And that is not a protocol, but I'm sure you have talked about it. And so what are your -- what is your thinking about those additional protocols?

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

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

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

The chaplain services and even palliative care and those kinds of things, we typically will -- if a palliative care team is already involved, we won't enroll them into GRACE, but -- or if hospice is already involved. But typically we will help facilitate and through the developing of trust and that shared decision-making help facilitate people move to hospice or palliative care.

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

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

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

Two quick questions. One, has the recent finalized home and community-based rule from -- that was finalized in 2014, has that -- has any of that -- you know, states have to do these statewide transition plans for the home and community-based services for (c) waivers and a few other authorities. Has that filtered over to any of your work?

And then, a question about -- do you run into conflicts in the home and with the family around, what a person may want to do, and what -- versus what the family may want to do? Like, for instance, a person may want to stay home, the family may want to say, let's go to assisted living. When you run into -- do you run into those questions?

DR. COUNSELL: Never.

MR. TERRELL: Never. Right.

(Laughter.)

I mean, how do you negotiate -- it seems as a -- I think this -- I mean, it seems -- I just wonder, this is a test, because it's sort of a -- I see this -- that there is -- people seem to jump to time to go, move, you know, before -- like our thinking around staying at home and getting in-home support doesn't seem to have penetrated the general population.

Is that -- is that accurate?

DR. COUNSELL: Yes, no. This is an important point, and in our introduction even of the program is that we are -- you know, they go out and their initial, you know, almost first thing out of their mouth is, we're here to do anything we can to help you, you know, stay at home and not have to -- so to kind of relieve that fear of, oh, somebody is coming out to check on me and put me in a nursing home kind of thing.

So, but those conflicts certainly do arise, but it's -- it is -- I'd like to think it is a very holistic and patient-centered, family-centered approach in terms of looking at weighing those. And in the weekly team conferences, the whole team sort of discusses that, and the social worker or the mental health people will sort of speak up, you know, from their side.

You know, if the nurse practitioner is saying, hey, this person has got to get to a nursing home; they are going to fall, well -- the social worker, well, maybe they'd prefer to stay at home. You can fall in nursing homes, too. So I think that dynamic goes on quite a bit, but this allows really a team approach and shared decision-making, I think, model.

The home and community-based services thing, that is really still in the hands primarily of the Area Agency on Aging and case managers. So we haven't really experienced a big change there.

VICE CHAIR HANSEN: Anne, and then Rich.

MS. COHEN: So hopefully this is a brief question and answer, but probably not. Just getting back to quality, since that's our mission, I was struck by the reduction of hospitalizations and our hospitalization readmission measures. So, clearly, that is a measure you can impact. What other measures do you feel like you have less ability to impact, and what measures do you wish you were measuring?

DR. COUNSELL: Yes. That is a good

one. That may not -- that may take a little thought, but we -- a lot of the process things I think we know that sort of help deliver the outcomes. You know, so having a medication list and having a health care representative identified.

Some of these kinds of things that are process measures I think would be -- I think the patient experience, so the satisfaction surveys and the CAHPS kinds of things can get at -- I think that one sentence question, you know, around patient-centered care, you know, how is your care going, or something, I think that first slide I gave about the -- from the VA experience starts to get at some of that kind of thing.

So I think the whole piece from sort of process, quality metrics, as well as the outcomes, are worthy of consideration.

VICE CHAIR HANSEN: It sounds like you are harkening back to, how do you start the conversation with what is important to them. And so doing that on a systematic basis as part of the meeting that goes on. And so having that be probably a new one as this person-centered work keeps coming, because it -- obviously, satisfaction and all, but there is probably an area of new deliberateness of --

DR. COUNSELL: Yes.

VICE CHAIR HANSEN: -- starting there. Okay. Rich?

MR. BRINGEWATT: I have a couple of plan change questions. How do you get this to work on the front end? So you drop -- drop you in the middle of an environment where you don't -- haven't existed before. There isn't something like what you had before.

How important is the selection of physicians that you work with? And given that selection process, what criteria do you use in order to identify some docs to work with you?

And then, the second question is, how important is critical mass to your success story, meaning percentage of patients that you help a physician or a clinic activity engage in this different kind of approach and similar kind of question as it relates to the degree to which you can affect a hospital's total population versus, you know, if you have only one or two, where you are really changing behavior, how big of a critical mass do you have to get before you change those behaviors?

DR. COUNSELL: Yes. These are key issues that we continue to, you know, work on. But the -- in just starting -- startup, our experience has shown that if you can start with a practice as a lot of older adults, and maybe a lot of higher risk patients, and a couple doctors who get it, and are sort of willing to or can, you know, take it on, and then we like to say we sort of develop and -- start with those two and develop the processes, and then build GRACE envy in the other doctors, and the other practices are then, wow, why can't we get that? And we want that for our patients.

There's another of our strategies, and then also your patient selection, so that you are identifying things that the doctors will agree that, oh, I could use help with that. You know, we are not identifying people by having diabetes or heart failure. We are identifying people by having depression or dementia or falls or 12 medications, those kinds of things, or being discharged from the hospital, where they typically will buy-in to the fact that, yes, okay, I could benefit from, you know, something else as a resource for my patient.

The critical mass question is -- varies, really, across settings. Certainly, I think we typically have an NP-social worker have a caseload of 100, and the ideal sort of unit of GRACE is to have three dyads, three nurse practitioner/social worker dyads, taking care of about 300 patients. And if you're looking at five percent, that's a population of maybe 6,000 people. So if you're looking at the five percent high risk, five or 10 percent in there.

I hope that gets at least a little bit to your question.

VICE CHAIR HANSEN: We have one last question.

MS. SHAHAB: We have one workgroup on the web, Joan Zlotnik.

VICE CHAIR HANSEN: Okay.

MS. ZLOTNIK: Yes. It was a great job/presentation. I have a question in terms of the social work/nurse practitioner teams. How are they being paid for? Or how are they billing Medicare? Are the social workers billing independently, or it's part of the institution where they are working for? How is it done?

DR. COUNSELL: Yes. This varies, too, depending on the environment. But like the VA, they just pay for the team as it's a -- you know, it's sort of their own --

MS. ZLOTNIK: Right.

DR. COUNSELL: -- system, and that's what Wishard Health Services is doing. The nurse practitioners -- since the patient is still going to the office practice for their primary care, we are not able to bill for a home visit in that setting. So that in a fee for service setting, it is more under an accountable care organization, looking at the accountable care organization paying for the program to then help in sharing, you know, savings.

The health plan in a Medicare Advantage plan world would be multi-faceted. At IU Health, they would pay for the team, and then the nurse practitioners, though, bill for their face-to-face visits. And so they just, at the end of the year, sort of true up what came in to cover the nurse practitioner costs from the visits, and they deduct that, and then the delta is covered.

Blue Cross/Blue Shield of Michigan is really covering, you know, that multi-faceted sort of payer for per member per month, also for face-to-face visits by the social worker or the nurse practitioner or a nurse, in addition to, you know, some face-to-face time for team meetings by the doctors.

MS. ZLOTNIK: That's great.

VICE CHAIR HANSEN: Yeah. That is very helpful to see how many different levels of systems and approaches, that you have been able to make it work in this multi-payer environment.

We thank you so much for presenting this. I think we have had a chance to see today with the various presentations the level of breadth, our cross-link to our colleagues on person-centered care, and some of the rigor of the work that they have started, that we have an opportunity as a group of us to interface, and then the ability to think about risk adjustment and stratification, the ability to see how a health plan that deals with the high risk does it differently and starts reframing and having such specific work here, Steve, of a model that starts off as a very important research program but now has diffused and really has some strong pickup from, you know, systems -- from health systems to the VA to private payers.

So I know we have our last segment here, and Dr. Gretchen Alkema is on the line and has been patiently available for us, knowing that we were hoping, Gretchen, to move on a little more quickly. We are having steady snow here in Washington, D.C. I imagine in Long Beach -- is that where you are right now?

MS. ALKEMA: No. But I am not where you are, so -- I got out last night, and I am grateful.

VICE CHAIR HANSEN: Okay. Great.

MS. ALKEMA: I am in San Francisco. I almost hesitate to say that for people who are on the East Coast.

VICE CHAIR HANSEN: Okay. Well, I know that the staff were great to invite you to present on behalf of the SCAN Foundation, with the title of our presentation as Person First or Measuring Quality in the New Era of Integrated Care Delivery. And we look forward to your comments. And in full disclosure to the rest of the Committee, I sit on the Board of the SCAN Foundation as well.

So, any other comments here, Sarah?

Okay. Gretchen, please, take it away. Thank you.

MS. ALKEMA: Great. Thank you so much. First, I will just do an audio check. Are you able to hear me okay?

VICE CHAIR HANSEN: Superbly.

MS. ALKEMA: Wonderful. Great. Thank you so much, Jennie, and to the whole NQF team for the opportunity to speak with you today. I was asked to set a little bit of a frame about thinking about some of the different vision points of how people perceive success in integrated systems of care, and hopefully with that kind of set a pallet for your discussion of thinking about what are quality measures to connect to those various visions of success.

I will also share a little bit of work that the foundation has been doing with NCQA in this regard, again, to continue a vision and one kind of framework to think about quality. There certainly can be many others. And it was lovely to step in on the conversation that Steve just provided the group, because I think he speaks a lot about how to -- how that kind of integrated system is operationalized, and that was a great follow on, that I have an opportunity to speak to you today.

So why don't we go ahead and move to the next slide.

So I am going to talk with you a little today about how the foundation thinks about success from different viewpoints. And I will start off with the concept of success from the consumer's vision, and this is based on focus group work that -- and polling work that we have done and lots and lots of conversations with consumers themselves, older people, family caregivers, as well as stakeholders.

And when we just kind of boil down, what are the three ways that our experience is that consumers are thinking about success in integrated systems of care, ultimately people are focused on, how can they live at the absolute highest functional level possible, and, frankly, with the least intervention.

I don't know anybody who wakes up in the morning and just can't wait to go to the hospital or end up in a doctor's appointment, particularly one that is unscheduled. And so thinking about that frame of people being able to live their lives fully, just like I would say most of us probably on this call would like to be -- I don't know anybody who is dying to go to the hospital today.

So, you know, kind of setting that frame about how much is the right amount of support and care and services for someone, so they can live at their best functional level.

Second in that is ensuring that there is a timely response by providers who are competent to know what their needs are. And in an integrated system of care, that obviously takes into account much more than just the acute care frame. And the third piece in that -- and we see -- is the opportunity for consumers and their families to feel confident in being able to navigate that system of care by themselves or to get support as needed in that, in whatever way that they choose.

So, you know, appropriate engagement, meeting people's needs through folks who have a sense of what they are doing.

Let's move on to the next slide.

So building on the consumer's vision, we take another kind of perspective about this. The system as a whole -- and this can be kind of at the 30,000-foot level, the system as a whole has a vision of success that has been articulated in many, many different kinds of documents, whether it be programmatic documents like, say, how the GRACE program has functioned or things coming out of CMS or out of the Affordable Care Act, taking that broad vision as the system often speaks about success in a couple of interrelated ways, but a little bit differently.

And that is focused on more about that the entities that are engaged in integrated care provide this range of services that meet the total care needs, that the financing mechanism supports integrated care delivery in its totality, so it thinks about what are those resources needed from kind of soup to nuts, acute care, all-inclusive to long-term services and supports in behavioral health. Some even think beyond that in terms of housing and other structures.

And that a quality strategy is focused around both improving consumer outcomes of care, meeting those objectives that we talked about on the last slide, but then also ensuring that there is an effective and efficient care delivery spectrum. So kind of putting all of those triple aim type pieces together.

On the next slide, I am going to start to break down some of the key players within that system who have variant visions of quality that are interrelated to that bigger system view, but kind of gets more specific based on what part of the system are we talking about.

And so I will first start off with the

entity itself who we call it generically a risk-bearing entity, who is the kind of point entity for bringing all of the pieces of the care delivery together in some way. That could be a managed care plan, that could be a health home, that could be an ACO, you know, lots of different places think about different structures. You know, it could be a pay site, et cetera.

And so thinking about the vision of success from that end, again, boiling it down to just three highlights is -- the first thing is that the financing structure sustains what is that contractual relationship that the entity has to deliver integrated care, which includes all of the facets from the enrollment to access to the design of care to having models like GRACE or others, all the way through implementation and being able to maintain the workforce capacity to execute this totality of integrated service platforms.

That -- another key vision of success is that grievances and appeals are minimal, meaning that people are getting their needs met, and so folks aren't feeling frustrated around what is happening in the process of care. And there are challenges, because there always will be some kind of challenge in some way, shape, or form, that they are fully solved, and my experience is is that plans or ACOs or other systems want to be able to solve that as much in-house as possible. So that's a measure of success when a challenge comes up, if they can address it internally with that individual and their family.

And that -- the third piece, that quality measures, frankly, make clinical and operational sense, and promote a system that embraces continuous quality improvement and allows for flexibility in that implementation to achieve this total outcome of care, which really puts function first in that person's life, knowing that, you know, most of the time these systems are dealing with people who have multiple chronic conditions and functional impairment, and it's not about meeting one disease measure metric of, say, decreasing hemoglobin A1c. I know that this group -- I'm preaching to the choir on that one, but so thinking about that vision of quality, both operationally as well as allowing for quality improvement.

So if we go to, in a sense, the opposite side of the spectrum in the system -- going to the next slide -- now I will speak to, you know, what we see as what the regulatory environment -- what is their vision of success, which is complementary, but a little bit different, from that larger system view.

And so this is the idea that the risk-bearing entity, whoever is responsible at the end of the day, ultimately meets all elements that are in that contract, including managing effectively all of those downstream relationships.

So all of the different kinds of vendors, the totality of care, that is really important in California where you have a delegated capitated model, by and large, within medical groups, where you may have multiple streams of responsibility, but there is ultimately, at the end of the day, one entity that is signing that contract, say, with the Feds or with the state, and that the buck stops there. So that the regulator wants to make sure that ultimate entity is responsible for the total package of care.

Additionally, the regulator is important for them as a vision of success, that consumer and advocate concerns are minimal and that any issues that come up are addressed fully and promptly within the construct of the appropriate party to address them.

So that could be at the managed care site or the ACO level. That could be within the ombuds structure. That could also be, say, with an enrollment contractor or broker that is working across multiple states where an issue is raised.

We work with what is formerly known as

the National Senior Citizens Law Center, now known as Justice in Aging, and they have in a sense called the fix-it list in California relative to demonstration, where they are identifying issues that are happening at kind of a more micro local level, but also some of them are macro system issues.

And so from a regulator's perspective, it is about, you know, making sure that that stuff, when it comes up, is addressed effectively and promptly.

And then, thirdly, that looking at those quality measures, that they function at a level where they are sensitive to change, they are specific, they are really addressing a particular process or a structure or performance outcome, as well as they are directional, so we can actually tell what is good, better, best, all within the guise of utilizing that information to guide any kind of decision that the regulator would have about enhancements or withholds. And that can be about payments, that can be about expansion, that -- lots of different ways that we can think about enhancements for that risk-bearing entity or withholds as well. So that quality really -- in the measurement realm speaks to that angle.

So if we go to the next slide, this is, again, just one vision. This is some work that we have been doing with NCQA of looking at, what is the way of thinking about an integrated system of care, and where are the juncture points for addressing quality measurement from a structure/process/outcome framework?

So this is part of a paper that they put out in 2013, and I'm happy to share that link with anyone on this call in the meeting who does not have access to this to get a sense of how they have been thinking about understanding structure and process, ultimately to get to a place of outcomes and, frankly, performance measurement at each level, which we are down the road from but that -- the vision is to move in that place.

So as NQF thinks about what might be its role, I think there is a lot of opportunity for dialogue and synergy from this framework as well as where NQF is going in its own regard.

If we move to the next slide, this is my expression of acknowledging that, you know, there is lots of ways of thinking about where we have been in quality measurement, and, frankly, where we need to go, I guess putting that person first perspective back at the center of our vision point.

You know, the old paradigm in health care, and I believe that quality measurement overall has reflected this, is a concept about acknowledging, you know, kind of the doctor or the provider saying, you know, "What's the matter with you?" It has been focused on single providers and the approach that single providers have been taking, and that the engagement, ultimately the improvement, is about do providers do things that are within their singular focus realm.

Personally, I don't see that these things function any more in a paradigm where we are looking at integrated systems of care that have multiple players that is focused on an individualized care plan for the member inside that risk-bearing entity, and that we really need to change our lens to focus on what matters to you, what matters to that individual who is receiving support, who is a member, and that what may matter to them may be really medical, and, frankly, it may not be.

It maybe I want to go to my granddaughter's graduation, which is six states away, which means I need to get on an airplane and I need to be healthy enough to do that. So how does the system support that kind of goal-setting? And that's how people are engaged in changing their own health care experience and working with providers when things are based on what matters to them.

I would love for health care, frankly, to change from the kind of paternalistic approach it does with all sorts of players, but particularly older people and people with disabilities, to more of a customer service approach, moving even away from dialogues about shared decision-making and really putting the decision-making back in the hands and the driver's seat of that person with adequate supports and engagement, so that they feel like they are a partner in understanding that information, but the decision still resides with the person and their family. And that is what a customer service approach really -- kind of takes that frame and transforms it.

And then, the third element, which we've talked about already, is the idea that consumer confidence and improvement in function, or at least maintenance and function for people who have aspects that are -- their function will not likely change due to a wide disability, that people can feel like they feel confident in getting their needs met and supported in a way that honors them for the whole person.

So I will move to the last slide, which is a photo that I took when I was out in Utah on a very beautiful day after a thunderstorm, but it's my expression of acknowledging that sometimes this may feel like we are chasing rainbows, and that what I really see it as is that we are seeking kind of a new pot of gold at the end of that rainbow, which may feel a little bit elusive, but the more and more we focus our lens towards putting people first, their confidence, their needs, their function first, then a value-based system wrapped around that will have improved outcomes in a way that meets that triple aim potential that we are all really striving for, even for people who have many, many health issues and functional challenges.

And so, with that, I will go ahead and pause. I am very happy to take any questions or comments from the group at this time. Thank you.

You can move to the next slide.

VICE CHAIR HANSEN: Thank you,

Gretchen, for that -- that comprehensive look through in terms of where the value equation is at all of these different levels.

Right now, we have one Committee member with a question. That's Anne Cohen. No? Okay. And we have nobody in the queue.

Gosh, you are remarkable, Gretchen.

MS. ALKEMA: Well, I don't know about that, but I am delighted to offer this up, and I just want to say that, you know, the leadership that you and so many members of this group have provided over the years I think really has set this vision, and I'm sure -- I feel like I'm preaching to the choir, and I'm glad to provide an orientation for the rest of your discussion.

VICE CHAIR HANSEN: Well, Anne does have a question. Hold on.

MS. COHEN: As your California colleague, I really feel like I should give you a good question before we conclude your wonderful talk. I am just --

MS. ALKEMA: Thank you.

MS. COHEN: -- from the SCAN Foundation's perspective, what recommendations would you make to the duals group in terms of future directions for quality measurement, and given the challenges that we have discussed in the past day? And given the potential change to the duals pilot, since they are in fact a pilot? And what funding priorities does the SCAN Foundation hope to fund in the future?

MS. ALKEMA: Thank you, Anne, for that comprehensive and wonderfully leading question on the last part of it. I appreciate it.

To be honest, I have not been part of the whole NQF discussions over the last two days. But just in reviewing the materials and the dialogue that you have been having, I think the more and more and more we can speak to the person's experience in getting their needs met and their confidence and connectivity to this integrated system of care, of thinking about that as an overall frame of measurement, knowing that there are clearly opportunities for structure and process specifics undergirding that, I think that is the way to go.

And the reason why I say that is when we are looking at the population being served through any kind of framework for integrating care for people who have both Medicare and Medicaid, the heterogeneity of that population is astounding. We often think about it in kind of quick and dirty cuts like, are they under, are they over 65, do they have dementia, do they have a spinal cord injury, you know, know, all of these different kind of basic cuts.

But what is undergirding that, and which I know this group is fully aware of, is that the life circumstance of that person, the supports that are around them -- the housing access, the connectivity and appreciation for medical treatment options -- all of those things are so individualized based on the complexity of their chronic conditions and the way that plays out in their daily function, that I think if we get too far down the road of kind of granular function or specific conditions-based measurement, we will miss the bigger picture, which is is this person and family having a care delivery system that is -- where it is asking about their needs, honoring those needs, helping set reasonable goals for them and the system of care to support them, and helping people live their lives.

And that may feel a little generic, but I think given the panoply of experiences that people have, that gets to the heart of that consumer-focused approach.

In relation to funding support, we certainly are engaged in lots of dialogue with NCQA. We have a problem with them right now that is moving to its completion, and we are in some dialogue about what might be next steps. I have certainly been in dialogue with NQF in some beginning ways of saying, "Are there things that this group is wanting to take forward? And are there ways that the foundation could be helpful there?"

In think in particular, is there a way in which we can articulate a framework of quality that all of the major quality players, particularly in Washington, can lay down as that base template, and moving forward, knowing that we know now about integrating systems for this population. I am happy to have a continued dialogue there.

VICE CHAIR HANSEN: We also have another question from Tom from iCare.

MR. LUTZOW: Yeah. The question has to do with a more global assessment of where we are on the timeline. And here is the thesis. We are -- part of the foundation here, the race toward metric-responsible care almost in a Deming-like way, we have a window of 15 years to get this right. And the reason I say 15 is because the baby boom generation is going to give way to the Generation X.

Generation X is roughly 47 million. We're in the 75 million range. There is an echo generation behind the Generation X of roughly 75, 80 million. But the reason for the 15-year window is the trust fund is going to be flush in that -- in 15 years, because of that generation dip. And so the heat is going to be off, and there won't be any pressure to do this good work.

So we have a limited timeframe to work out -- to work out these efficiencies, and I would like your thoughts about that.

MS. ALKEMA: Well, thank you so much for your question. I have to say, as someone who thinks in different time intervals, I love the idea that 15 years is the pressure point, but I think you are probably right on that, and I hadn't specifically thought about it that way.

I will say that in some respects the population demographic landscape has been forever transformed, and that while there may be, you know, fundamentally less people in the oldest ages because they ultimately have died off over many years, that the movement of population aging will not change. That is not -- I think as probably most of this group knows, like that's not a boomer phenomenon, and then it goes away, and that Gen Xers will continue to age, and then the question is: What is going to be the upper limit of that demographic relative to what we know about upper age limits in previous generations? And we will continue to learn about what is function going to be looking like.

One could make an argument that it also -- that the pressure may not be off because of other issues that are present in younger generations that were not as much present in generations who are substantially older today or will soon be, like diabetes and like patterns of substance abuse that have -- that are different kind of moving forward than what we have known, and obesity associated with that.

So I will say that there is no time like the present, that ultimately getting this right is both about improving care for the populations in need now and the soon-to-be populations in need who will connect with Medicare and Medicaid. But I will make the argument that as we move the entire health care system to something that is driving on value, not volume, we need to determine whose value are we talking about. And, personally, I am one of those who says it is about the value to the consumer that then bleeds into value to the system to function to improve the life of that consumer is where we need to put the emphasis.

I think it would be really easy for it to kind of punt the other way without us looking, that the value is that the system functions well, but we still don't take that consumer -- that customer service approach to care, which we have an opportunity to now, because of the pressure points that exist.

VICE CHAIR HANSEN: Well, thank you, Gretchen. You know, one of the things that you probably didn't get a chance to hear today fully is there is a whole MAP that is working on person-centered care, and the interface in some of the work that they have done that was presented probably has great consonance for the interest area that you cited relative to the consumer.

And the other piece of work relative to the sheer diversity of the population and some populations that are at greater risk. And, of course, this MAP is addressing that. So there probably are some very thoughtful materials that are coming out of NQF that would inform kind of the areas that you are thinking about right now.

So I see one final question here from Steve Counsell.

DR. COUNSELL: Gretchen, hi. It's great to hear from you.

MS. ALKEMA: Hi.

DR. COUNSELL: And really appreciate your insights on this. I just couldn't help but ask you about how -- how do you feel things are going with the dual eligible demonstration in California, and how this kind of patient-centered care concepts are penetrating into that movement, or is it too early to tell?

MS. ALKEMA: I would say it's probably

a bit too early to tell. I think that, you know, it is moving along. There are certainly lots of opt-out and enrollment issues that have been present in the state, in various ways for all sorts of sundry reasons. I think at the end of the day there is a commitment from the plans to move forward in a way that does meet the totality of care for targeted populations who have the most need, and I think getting under the hood on that relative to doing the risk assessment to evaluate and stratify that population in ways, frankly, that the Medicaid data haven't been able to do to date, you know, it's just another process of working through.

And I think we will have a better sense of how to fully answer your question probably in six months from now, once a number of the processes have moved through. January was an enormous enrollment month for California, and so what they are hoping -- you know, there was a lot going on before that. I think you all know that any time there is a whole new wave of people coming in, it tests the boundaries of your system's functioning at another level. And I think that the plans and the systems are still in the process of responding to that in an effective way.

So I have more to be revealed, Steve.

DR. COUNSELL: Thanks very much.

VICE CHAIR HANSEN: Thank you, Gretchen, and we will look forward to continuing to work with you and the foundation in this process and staying in touch.

So we are at a point of wrap-up, and I think Sarah was saying that we were having a goal of leaving around 2:00. I think we are so close to this. Sarah is going to set up some questions that we will have a chance to each have one comment to.

MS. LASH: Sure. Actually, Zehra, if you could go back two slides. And I first want to acknowledge there was a small section of slide material on integrated behavioral health, which I didn't present because I think that we heard such a good case study from Care Oregon about how some of those practices are being integrated that I didn't want to devote the time to it.

I borrowed the slides from Jurgen Unutzer out of Washington State anyway, so it wasn't even my content to begin with. But I think that content area shows a lot of promise for further exploration in a future meeting. And I think hearing from our external presenters today -- well, external/internal -- Steve, Pat Curran, and now Gretchen, has brought in some of the dialogue in a really productive way.

And I will sort of challenge all of the Committee members to help connect us to innovations that you come across in your work over the course of, you know, tomorrow, to our next meeting, so that we can continue to build our dialogue off of these really promising practices.

So we had designed a series of discussion questions coming into the meeting, and I want to quickly review them all with you and give everybody the opportunity to kind of sum up their thoughts and offer a final reflection before closing. It can be on any of these topics, or something entirely differently, that has really risen to the top of your mind over the course of the meeting and that you want to make sure we understand as a team as we go into the report-writing process.

So, first, which measure gap areas have the most relevance to the broadest range of stakeholders, thinking about where these leverage points are. Are they quality of life outcomes, functional status outcomes, community residents, something else? What might be needed to accelerate the process of measure development in these or other areas?

Next slide.

Are there discussion themes that we began to talk about during this meeting but warrant further exploration in a next phase? Does MAP need to recommend any specific course of action to accelerate the adoption of evidence-based practices that support person-centered care, such as some of the things that we learned about today?

And knowing that CMS listens very closely to the input of the MAP, what is the role of HHS in these activities that you'd like to see moving forward versus some of the other stakeholders in quality that are also monitoring the work?

So I -- you know, we don't have to call on everyone, so volunteers or any final comments for the good of the order? Tom?

MR. LUTZOW: Yeah. This is just an observation from a plans perspective and it relates to the second item on the top, functional screens.

A functional assessment is contained in the PQRS set of measures, although it seems that a doctor has a choice or the physician group has a choice of -- to select from different measures, and they could select out functional -- the functional assessment. So that's a little disappointing.

But here is a case where there is a second -- there is a second platform to join the provider community around a common theme like readmission prevention, because that functional assessment, if it's -- functional needs assessment is -- if it has to be performed by the physician, it is already part of the MDS in the nursing home. It is already part of the OASIS system in the home health agency. And of course we, as a plan, have to do it, too. It's part of our five-star.

It is a basis for communication, and what -- what I am looking for in my dialogue with physician groups is, how can I help you do your job better? And if you are unable to do a complete functional assessment, because you don't ever get into the home, but I do, is my functional assessment of value to you? Because you are doing things -- you are doing other things that are of value to me. And so now we have a basis for dialogue.

I'm not the enemy as a plan; I'm your friend, and I want to -- I want you to do well. So I think, you know, it's an opportunity to create community within the provider stream, and more and more of that has to happen. All of the ships have to rise; they should not be competing with each other.

And how do we make them, you know, through common measures perhaps, how do we -- how do we make them co-dependent in some important ways? And unless they are co-dependent, they're going to be going in different directions, and Deming won't be happy.

MS. LASH: All right. Going to this side of the table, Charlie?

MR. LAKIN: Well, I -- first, I just want to thank you for including me. I learned an awful lot in the last couple of days. I'm awfully glad to have been invited.

Gretchen just brought up this notion of framework of quality kind of in passing, but I just think it's really important, at least for me, to kind of figure out what is happening. We have got so many measures in some areas, and many of the areas we have talked about over the last two days are just empty sets.

And I think if we just had even a cursory -- I'll call it outline -- but a set of categories where we need to look hard, maybe invest to better fill out a set of measures that really encompasses all that we have sort of talked about in the next couple of -- in the last couple of days, I think it would be really important.

And, finally, just to answer your question, I don't know if -- I think really focusing on personal life experience measures is important, and some of those are quality of life measures, some of those are really about the responsiveness of support providers to a person's daily life, and some of it is what you really want in life that you are not being helped to get.

But I think we have heard over and

over in the last couple of days that, whether you come at this from the medical end or the social service end, people are eager to attend more effectively both in delivering those things and measuring the outcomes of those things.

MS. LASH: Thanks so much. Rich?

MR. BRINGEWATT: Yeah. I also want to, you know, thank you for me being able to be a part of this. You know, this is -- what a great group of people, good people, smart people, have a common kind of vision. You know, it's fun to be a part of, and I think it's important to be a part of.

In terms of the first question, I think -- without taking away any of the bullets that are there, I think a huge gap here is system performance measurement. You know, we have talked a lot about today, over the last couple of days, the importance of the different component parts of the system having more -- being more representative of the nature of the problem that we are all trying to address.

And so I think getting at system performance measurement issues is a huge gap and a huge priority for dealing with this population.

In terms of what is needed to accelerate that, I would say one is continuing to push clarity on definition of population-based care. We -- you know, the duals group has helped everyone look across settings, across time, place, profession. I think we need more of that, and so what are those population segments that are most important, you know, like frail elderly, like adults with certain kinds of disabilities, whatever, but having some leadership around that area.

I think that we have made some good progress here in identifying a framework, to a certain degree, in terms of how to think about all of this. I think it needs more tweaking; I have some follow-up suggestions in relation to that that I won't get into now. And kind of what are the principles, really, that -- within some sort of framework that kind of moves us in this direction of more definition leading towards measurement about system performance.

Discussion theme raised that warrants further exploration -- you know, the National Quality Forum is committed to further exploration of SDS. I just want to underline the importance of that from a duals perspective. It is the only thing that is purely unique about duals is low sociodemographic status. And so what does that really mean, and how do we deal with that from a performance measurement standpoint?

And then, a specific course of action for moving ahead, one of the things that I think it would be useful for the Quality Forum to do is kind of on the flip side of what measures should we add? What are the most important ones to focus on to achieve the goal we are trying to achieve? You know, I find asking people the question: If you only could pick five measures, what would they be? And that is going to be a little bit different for the population you focus on; it is going to be a little different in terms of who you ask the question. You are going to get some different answers to that.

But, you know, if I look at the airline industry, and kind of changes that have occurred over the years with the airline industry, on-time arrival is a measure that everybody jumps to. Now, they move around on-time arrival in terms of changing what that really means and when they exit the gate and whatever, but that's -- you know, that's kind of operational mechanics behind the focus.

And so, you know, if we -- if we -- if National Quality Forum picked five measures that would really move the needle on improving quality for defined populations, what would they be?

MS. LASH: Great. Anne?

MS. COHEN: So a couple of things. One is, you know, it struck me while we are sitting here there has recently been a release of the long-term care project, and the Conference of Aging was this week. And in that budget, there are a lot of priorities, including continuing funding for aging at resource centers, family caregiver programs, programs for targeting elder abuse, broadening PACE to 18-year-olds to 54, and continued efforts to expand community first choice options.

And so there has been a lot of work in HCBS services -- more than there has ever been in this administration -- and it looks like hopefully it will continue. And with that, and knowing the new Committee that has been formed, I think there needs to be a continued focus and even a huge part of the meeting looking at HCBS, where they had managers looking at long-term care-related measures and what really are our priorities to make sure not only are we measuring that in a way that is meaningful, because there is a lack of measurement out there, and obviously that's a big need for measurement development. But also, how do you make that person-centered, which is always a challenge.

In terms of, you know, priorities and how can NQF move those forward? Again, I really feel strongly that -- in all of our work, but in particular that area, it is important to use the resources we have in this room and to really look at doing some pilot projects, because as we have seen there has been some issues with uptick in measurement. And I really feel like replication happens by having health systems and programs take up the work.

So, for instance, GRACE is a perfect example. Their work has been around for years and is being replicated, and so things get repeated over and over again. The way this Committee is going to get any traction -- NQF is going to get traction for this work, is by having it utilized.

So whether we, you know, ask the SCAN Foundation for money or another foundation for money, utilizing our federal partners to try to give us some money to do that work, I think it's going to be critical.

Thank you.

MS. LASH: Great. And we do intend to

I think marry the work of the HCBS Committee with the work of the Duals MAP. It was a very clear expectation of our funders that we would not rebuild the wheel.

Steve?

DR. COUNSELL: It has been a tremendous couple days here, and I really appreciate it.

I have two comments. I really like the idea of getting on the wave and the readmissions is really such a great example of -- it has brought to light the kind of issues that this group has been struggling with, and now everyone is kind of working on it? So if we could find something similar and the functional status may be another real driver.

I know under Medicare, looking at the Welcome to Medicare and the annual, you know, Medicare wellness visit, all have functional status measures in it, and this is just becoming increasingly, even in the physician world, I think recognized how important it is in many ways. So if we identify, you know, something like that to build on, maybe the readmissions, I think that would be really tremendous and get traction and further move the whole field up.

The second was in terms of the patient -- in terms of priority on the gaps, I think we have really come a long way in the patient-centered care. The presentation this morning was really quite something, and the various comments.

I was just reviewing -- there is one question on perceived health. You know, in general, you know, would you say your health is, and you rank it excellent, very good, good, fair, or poor. And that is predictive of outcomes. It is predictive and such, and whether we can do something similar as was suggested around the patient-centered care, if we could rally around.

And you would think it would be pretty quick that you'd be able to develop and validate, you know, a one question Likert scale like that, and you could just use it -- in general, would you say your health care services and supports are excellent, very good, good, fair, or poor? And just start to get at this kind of question. As broad as that is, starting to ask it and bring attention to it, I think would be -- it is the -- you know, I think this focus on one or two things as opposed to, you know, the next 30 quality measures might get us further, you know.

MS. LASH: Great suggestions. Shawn? People on the webinar, get ready. We've got two more people in the room.

MR. TERRELL: Thanks. So just I think three quick things.

One, to put a little bit finer point on what Anne was saying, to continue to really mine, as you go through the HCBS environmental SCAN work, to mine that for potential measures. You know, the problem is is that we don't have a lot of really -- we don't have a large stable of measures around HCBS in general, right? That is the basis of this project, and that some of the larger measure groups aren't necessarily poised to jump into an NQF endorsement process.

But there might be some of the smaller, you know, Mom-and-Poppy kind of shops, or individual researchers who have develop some good measures that might be -- and that needs -- we need to have like a concerted, you know, effort to try to sort of identify that and do some outreach and talk about that -- those measures. Those I think are there in some places. And look at other areas, like -- such as the whole -- you know, whole -- years and years of work on social support measures. Are there some social support measures that we might want to think about? This is obviously a huge area for HCBS.

Okay. So there's that, and then on and off for quality of life, you know, but -- and then there is a question of -- there is this continuous quality improvement or TQ -- you know, putting some emphasis on how you use measures around -- you know, how do we do -- you know, plan to study X cycles and, you know, process control charts, and et cetera. Can those things be a little more explicit in these processes, in these discussions?

And then the other third area that is really important to Kathy Greenlee, it's kind of a legacy thing, is abuse, neglect, and exploitation, which hasn't come up that much, but it's kind of an elephant in the room thing, and I think Pat, in his discussion about trauma-informed support services is -- speaks to that profoundly. And we need to work on not just the sort of reporting and the sort of legalistic approach, but some prevention models that we haven't done a lot around, I don't think.

So those are quick three things. Thanks.

MS. LASH: Thank you. Gwen?

DR. BUHR: So I was encouraged by the last presentation, but generally all of this discourages me because it seems like everything is so fragmented. And how can we -- how can we get something that -- where we are always or where we are measuring the system and holding the system accountable, instead of each individual player in the system, who may not have control over the other players, and then nobody can do anything because -- I don't know.

So you know, I think that's the case in the long-term care setting is that many of the measures that physicians could use for their different PQRS or meaningful use are not appropriate for the long-term care setting and you know -- or they are measuring more of the system and they can't change the different things that go into it. So you know, they don't want to choose that measure, or they don't have the resources to measure that measure.

So, anyway, I hope we can get to more of a -- measuring the system and making the whole system accountable somehow. How do you do that? I don't really know. And I do like the functional status as a measurement. So, you know --

MS. LASH: Tom -- or let's go back to the web, and then if there's anything else in the room. Zehra?

MS. SHAHAB: Okay. So I see that there is two workgroup members on the web that would like to comment. First, Joan?

MS. ZLOTNIK: Okay. This is an interesting process. It has been -- I don't recall any time that I ever had the opportunity to kind of have a snow day and actually ended up listening to the entire day of a meeting.

This has just been quite interesting, and I think really meaningful in terms of directions that we really need to be thinking about and is something that Gretchen, you know, said when she started out in terms of, you know, really wanting to sort of think about, you know, in terms of being person-centered, asking the person sort of what they needed. And I think that really becomes sort of a driving piece in what we need to think about.

And then I go back to sort of comments that, you know, sort of over the last four years I think, you know, Rhonda Robinson Beale has sort of made a number of times, in really needing to think about the workforce and sort of who is doing this work and, you know, measures about, you know -- one of the themes that I sort of heard both from Patrick and Steve were, you know, sort of the increased satisfaction for people who are sort of working in sort of a more inclusive team-based holistic system.

So if we can sort of integrate some of those pieces together and, you know, look at some of the system issues, I think it is important. I was just kind of looking at -- maybe this was quick and dirty, but looking at the spreadsheet of our measures and just kind of searching on some words, like social, and they don't come up very much.

I don't know how -- not as much as mental health does, but some of the issues that got raised about sort of what people's histories are and how that affects how they need services delivered are also critical issues.

You know, the ACEs and sort of trauma-informed care have -- are permeating a lot of service delivery. But the fact that people come to services and come to the health care system with history and relationships, or perhaps isolation, are really critical. So I think we really need some more measure development in those areas to really be successful.

MS. SHAHAB: Thank you, Joan. Also, Clarke Ross?

MR. ROSS: Hello. I'd like to reinforce everything that Joan just said. I want to emphasize the importance of the seven high-priority measure gaps that we developed in 2013 and in a final form was communicated to CMS in February of 2014.

The disability consumer advocates and family advocates, and actually a lot of providers as well, are very critical of the measures we have endorsed as too narrow, too many limitations, and like age and setting, limitations, and too clinical in nature. And so the seven high-priority measure gaps allows the disability community to focus both on things they care about, but also to focus on the need for investment funding for accelerated measure development.

So -- and I loved Sarah saying it's important that the Home and Community-Based Services Committee and the Duals Workgroup complement each other's work, because from the disability community perspective those are the two entities within the National Quality Forum that are most like home.

And then the last thing I just wanted to say, Steve's presentation and Patrick's Oregon presentation I just thought were outstanding, because those of us who work on the Hill and other similar kinds of forums, we are always asked, well, where does it work? Who is practicing what you are talking about?

And these were just outstanding and data-based and doing a lot of all of the philosophical things that we think should be done. So thank you very much. It has been a great learning opportunity.

MS. SHAHAB: Thanks, Clarke. I also see that Vanesa wanted to say a few words.

MS. DAY: Yes. Thank you. I, too -- I want to echo that I learned so much during -- in the last two days in this process, about like what has been done, what we certainly at CMS need to continue to do. And so I just want to say I appreciate everybody for being so open and honest about their opinions on things, and giving us this guidance.

I would, just in thinking about this and thinking about what we talk about at CMS. Carolyn always -- Carolyn has experience working in the field as a provider, and the one thing that she says always is we don't want to have -- we don't want to limit access. We don't want -- whatever our good intentions are, we don't want to put providers in a situation where they don't want to treat duals because there is so much additional work in regard to quality measurement and everything else that we know goes along with being able to treat this population well.

And so that, combined with everything else that it means for us to be doing this work, is certainly a big charge. I think we are definitely up to the challenge and looking forward to letting the science meet the policy as we move forward, in a good way.

MS. LASH: Thanks so much, Vanesa. One last comment from Tom, then we'll conclude.

MR. LUTZOW: Yes. This concept of self-management is certainly part of the discussion. And, you know, along the lines of accountability, I -- certainly the member has a primary role in the planning process and needs to have a primary role in the planning process for all the reasons, for engagement, for relevancy, for motivation, to get to self-management. So there is important reasons why the member has a primary role in the planning process.

But their role as a provider also needs to be emphasized, and that is the self-management piece. There is -- you know, are we measuring accountability on the part of the member to be the first provider? And are we really getting at self-management and emphasizing it enough?

And certainly there is degrees of ability, and at some point the ability to self-management -- to self-manage isn't there, and then supports and so on, are needed. All of that is true, but we first need to get to that -- that role as a self-provider somehow is missed.

And I know that NCQA is about to start a five-year study on the ability of plans to get to service of member preferences. And I am sure that in this study it is not just any old preferences, because some preferences aren't supportable. I prefer to smoke two packs of cigarettes a day is, from a health perspective, not a supportable preference.

Their concern is, I am sure, about our plans satisfying supportable preferences, and how do we get to supportable preferences from a health systems perspective?

All of that is good, and where we need to go. But, again, you know, have we adequately defined the member's role? Certainly, there is a push toward -- first order role in the planning process is, have we emphasized enough their first order responsibility in the providing process?

MS. LASH: Great. Thank you. Anyone else on the web needs to make a comment? Okay. We have one I guess last --

MS. COHEN: One last quick thing, I wanted to --

MS. LASH: -- Anne, and then we'll go to public comment.

MS. COHEN: I wanted to thank Sarah and everybody at NQF for staying, even though the offices are closed today, and all of your hard work at this meeting. It is not easy, and come sleet or snow, quality has to go.

MS. LASH: I like that motto, and we have many other thank-yous. So we will get to those in just a second.

Operator, could you give the

instructions for public comment over the line, please?

OPERATOR: Yes, ma'am. At this time, if you'd like to make a comment, please press star and then the number one.

There are no public comments at this time.

MS. LASH: There are also no public comments in the room, which is not a surprise to anyone here.

On the vein of thanks-yous, I want to begin our closing by thanking our CMS partners for supporting such important work, and the opportunity to come together and have such a rich face-to-face discussion, and virtual today as well. And thank you for being so open to the input you received from the MAP.

To our stalwart Committee members and your top-notch thinking over the past couple of days, to our guest panelists for making time in their very busy schedules to expand our thinking, to our members of the public who have hung in there over the course of a long and complex meeting, our chairs for ever skillful facilitation, and Alice in an airplane, we'll be sure to thank her later.

And especially my NQF colleagues: Megan, who was so sick yesterday, presenting for three or four hours. Zehra trudging through snowbanks, our meeting staff and IT support, who have helped keep us all fed and plugged in and dry today, and I think that probably covers it. A big round of applause for everyone.

As next steps, we plan to give the workgroup the opportunity to review at least an outline, if not a draft, of our report sometime in the next several months. It is not due for quite a while. We do need to have the Coordinating Committee bless it at some point as well, and then there will of course be a public comment period of about 30 days. So we will be in touch about those next steps as they begin to formulate with exact dates.

Jennie, over to you.

VICE CHAIR HANSEN: Again, I think we have been summarizing along the way, but it was really very helpful to have everybody have a chance to articulate their reflections, which I know are just kind of -- probably just the top part of it relative to all that we have had a chance to absorb.

You know, we have talked about this particular MAP. The common denominator to this is not only these four populations that we have identified, but the factor of low income or poverty. And I am reminded, you know, by the complexity that we deal with.

The last example I think, Tom, you brought up about self-management -- it's one of those things that when poverty is a factor, you know, just one segment of an example, many of you know that people who reach the end of the month, have run out of their money, end up in the ER. And there is -- it's very predictable in terms of that.

So this system is both fragmented,

complicated, but it is so interrelated. So it's -- but somehow we have to find these common denominators of aligning things that are already -- you know, trains that have left the track that have some opportunities for us to put our various cars onto in order to move this.

I started this -- we started the day yesterday really looking at very specific measures. And as I said, and I know poor, you know, Vanesa representing CMS felt that, oh, my gosh, you know, there was such dissatisfaction, but we know that that's where we started.

The conversation we have had this year, this particular set of two days, has now allowed us to think about if we are to understand, say, the measures that have gone ahead at this point, coming out of this Committee based on tools and scientific work being done. Now we have had actually a much more robust discussion about a lot of the social factors and how do we do that?

And I think one of the things that is

a key takeaway is our alignment with the home and community-based group that many of you have brought up, as well as the person-centered care group, as a whole other kind of linkage in a way that we can come across to think about this framing, I think that, Charlie, you asked for.

And going back to this wish for all of us, for parsimony, so that people who select measures and people who are being measured see that there is honest alignment to it. And when you do have that, you have a joy that it makes sense that we are doing what we are doing.

So I think this is -- you know, again, the MAP of literally what we need to do is, are there a few questions that start differently?

Somebody asked Steve, what other questions might you have thought about? I think, Anne, you asked. And maybe the question that came out of the person-centered group wasn't quite on target, but there were some conversations.

So one of the things I leave as a

wish, are there one or two core questions that anybody would understand more or less, you know, with some context that make it really a way that we can shift the framing so that it gets back to what people feel strongly about, right down to the alignment in physicians, providers, that have some sense-making to this, and that it isn't so fragmented.

So, again, it has been a privilege to work with you. I bless our chair, Alice, for the experience that she has with this, and your forbearance of my working alongside of her. But at the same time, this has been such substantive work.

And I think, Joan, I compliment you on the fact that here you had a snow day but you spent the whole day hanging on with us.

And, D.E.B., if you're still there, we so appreciate the technical clarity that you always ask for in the course of our questions. So, again, I --

MS. POTTER: I'm still here.

VICE CHAIR HANSEN: I don't doubt that whatsoever. But as a group here, I do think the hard work behind the scenes that Sarah has led, and Zehra being a part of it now. She shared with us as I kind of said, when you saw the voluminous things, they only got it like a few days before, you know, we did, you know, and so they've been working on it to try to do some sense-making.

So this is a once a year, in-person face time. It's an important time that we see each other. And with that, we will have, you know, scheduled meetings and reports that we can comment on.

But thank you. It is a privilege to be with you all. Thank you.

(Whereupon, the above-entitled matter went off the record at 2:38 p.m.)

CERTIFICATE

This is to certify that the foregoing transcript

In the matter of: Measure Applications Partnership

Before: NQF

Date: 03-05-15

Place: Washington, DC

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

Neal R Gross

Court Reporter