NATIONAL QUALITY FORUM

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PRIORITY SETTING FOR HEALTH CARE PERFORMANCE MEASUREMENT: ADDRESSING PERFORMANCE MEASURE GAPS IN PRIORITY AREAS

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CARE COORDINATION COMMITTEE MEETING

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THURSDAY
APRIL 3, 2014

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The Care Coordination Committee met via teleconference at 9:00 a.m., Mark Redding and Susan Reinhard, Co-Chairs, presiding.

PRESENT:

MARK REDDING, MD, Community Health Access Project, Co-Chair
SUSAN REINHARD, PhD, RN, FAAN, AARP Public Policy Institute, Co-Chair
DAVID ACKMAN, MD, MPH, Amerigroup/WellPoint
RICHARD BIRKEL, PhD, MPA, National Council on Aging
DON CASEY, MD, MPH, MBA, American College of Medical Quality
DAVID CUSANO, JD, Georgetown Health Policy Institute
WOODY EISENBERG, MD, FACP, Pharmacy Quality Alliance
NANCY GIUNTA, PhD, MSW, Silberman School of Social Work at Hunter College, City University of New York
CAROLYN INGRAM, MBA, Center for Health Care Strategies, Inc.

CILLE KENNEDY, PhD, U.S. Department of Health and Human Services
GERRI LAMB, PhD, RN, FAAN, Arizona State University
RUSS LEFTWICH, MD, State of Tennessee, Office of eHealth Initiatives
LINDA LINDEKE, PhD, RN, CNP, School of Nursing, University of Minnesota
RITA MANGIONE-SMITH, MD, MPH, Seattle Children's Research Institute
SHARON McCAULEY, MS, MBA, RDN, LDN, FADA, Academy of Nutrition and Dietetics
SAMANTHA MEKLIR, MPAff, Health Resources and Services Administration
JUDY NG, PhD, MPH, National Committee for Quality Assurance
MICHAEL PARCHMAN, MD, MPH, MacColl Center for Health Care Innovation
FRED RACHMAN, MD, Alliance of Chicago Community Health Services
ROBERT ROCA, MD, MPH, MBA, Sheppard Pratt Health System
VIJA SEHGAL, MD, PhD, MPH Waianae Coast Comprehensive Health Center
ILENE STEIN, JD, Service Employees International Union

NQF STAFF:

KAREN ADAMS, Vice President of National Priorities
LAURALEI DORIAN, Project Manager
LAURA IBRAGIMOVA, Project Analyst
SARAH LASH, Senior Director
ELISA MUNTHALI, Managing Director
WENDY PRINS, Senior Director

ALSO PRESENT:

CONSTANCE BOHON, MD, American College of Obstetricians and Gynecologists
MAUREEN DAILEY, DNSc, RN, CWOCN, American Nurses Association
KAYTURA FELIX, Health Resources and Services Administration
ELLEN MAKAR, RN, MSN, Office of the National Coordinator
DEIRDRA STOCKMANN, PhD, Centers for Medicare and Medicaid Services

A-G-E-N-D-A

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

9:02 a.m.

DR. REINHARD: Good morning. This is Susan Reinhard. Welcome to everybody on the phone and of course those of you in the room traveling from snowy Minnesota to I hear Hawaii. I mean, we really have it all in the room.

I'd like to welcome you. Mark and I are co-chairing this meeting. It's really a privilege to chair this Care Coordination Committee for the National Quality Forum.

We're going to tag team a little bit. I will kick off the meeting and together facilitate different meeting portions of the agenda today. But I have to leave before the end of this meeting today. I'm really sorry about that. Heading to Vermont where I hope it's not going to snow. And then Mark will take over for tomorrow. So I think the opportunity to lead this pretty august group is pretty exciting I think.

I think first we just want to thank Sarah and your whole team. And you'll have an opportunity to introduce everybody later.

(Applause)

DR. REINHARD: But it's safe to say that they get all the credit for the organization of this meeting. They're very organized.

And we were just saying ahead of time, Mark and I, that it's great to see this organization but then a real openness to be flexible. And I think Sarah would say very honestly that it really is about you and about your thinking. So again, we'll wait to hear from Sarah in a little bit.

So, I was asked to just give a few personal reflections and then Mark will add his to this. And I don't want to take a lot of time.

But I come to this work as -- my very first job as a visiting nurse. And I

don't know how many of you have been in the field like that, probably many of you, and in many ways a visiting nurse is the care coordinator. You're trying to get things going and call the physician and the pharmacist.

And then observing how really the family caregivers, the person themselves and the family caregivers really have wound up dealing with more of the care coordination on their own.

We just completed a study about a year ago at AARP Public Policy Institute that I direct called "Home Alone." And the bottom line is that family caregivers are feeling that they have no choice but to do all of this on top of all of their other tasks that they're doing, including medical nursing tasks. And they're just overwhelmed by the whole thing.

It's just, you know, I had one family caregiver in a qualitative study

talking about how she was going to spend the whole day to get to appointments. And that was all she could do. And the woman works. So, most caregivers are working.

So this is an incredibly important thing that we are embarking on. There are others within the National Quality Forum community and outside of these meetings that are really trying to get their arms around it.

Samantha and I were just talking earlier and she'll have an opportunity to address you that the timing is really excellent for this. There is a lot going on on the ground, in academe, all over, and it's a good thing it is because it's time for us to get on there. So, I'm delighted to be here and to welcome all of you and I'll turn to Mark.

DR. REDDING: Thank you, Susan. So, it's wonderful to see you all here. My personal interest in care coordination started out with an idea that I wanted to be a

missionary. And so my fiancee and I, my wife's also a physician, were talking and I told her that actually when we finished our training we would be headed for Africa to be missionaries. And she essentially told me that we would not actually be doing that.

(Laughter)

DR. REDDING: And so we ended up in rural Alaska, in Kotzebue. So I thought I was there to change the whole world and make such a huge impact, but ended up really learning, sometimes in a difficult way but really learning. And mainly learning from care coordinators within the community.

And to be mentioned, although it hasn't been researched much Alaska started out with the worst basic health outcomes in the United States and now ranks among the top two or three, very much related to the way they do community care coordination.

This opportunity to improve care coordination that we launch today or in person

launch today is much greater because each of you have come from all over the United States to lend your wisdom and thought and guidance.

We live in a country with the greatest wealth and some of the most poor health outcomes in the developed world. The transformative power of care coordination has really been underestimated until now.

Recently we have begun to learn that those most likely to land in an ER or a hospital bed are the least likely to connect to basic prevention and early treatment.

With the support of HHS and NQF to begin to develop measures that could hold our system of care accountable so that it can reach beyond the bricks and mortar walls of our 19th century healthcare system and go to urban housing complexes and rural house trailers, to assure that individuals who are at greatest risk connect to and address critical individual risk factors like health and housing, food and clothing and education,

and even employment.

This I personally believe can have a dramatic effect and a quick effect on our outcome situation and our costs. And thank you for being here.

DR. REINHARD: Thank you, Mark. So, I think we're ready to move on and just start by review the objectives.

You had this. I hope you had an opportunity to prepare for the meeting so I won't belabor it, but we have four major objectives.

The first is to really pull together our own thinking, our own understanding of the environmental drivers of care coordination measurement activities.

And then the second is where I think a lot of our attention will be, refining the domains and sub-domains. We've had some work on this on our webinar last fall. I can't believe that it's already that long ago.

And we're focusing mainly on the

coordination between primary care and community-based services, and looking at developing potential measure concepts in these key areas.

The third is to consider the role of new data capabilities, that will be mainly tomorrow, and facilitating measurement of care coordination.

And most important I think is prioritizing the opportunities for care coordination measurement so that we can inform HHS.

So that is our mission over the next two days. And I just want to go over sort of a high view of the agenda for today, just today's agenda.

So we will first have Samantha which will be wonderful to give us from the Office of Planning, Analysis and Evaluation at HRSA will give us her opening remarks on the environmental context for the project.

Then we will have a review by

Sarah to set the stage, the progress to date that we have made both together and staff work in this area looking at the project elements and get some affirmation of the work that has been going so we can keep moving forward.

We will then turn to how does this work relate to endorsement measures. Again, I think we will hear from Lauralei for part of that, but also the -- I guess your co-chairs, right, Gerri Lamb and Don Casey on the Care Coordination Endorsement Steering Committee. They are the co-chairs of that very important steering committee.

Members of that steering committee will join us also. So I'll get to that too. So it's great to have this connection.

Then we will look at how does the work relate to connecting the National Quality Forum efforts on care coordination to improve population health outcomes. And we will hear from Elisa Munthali and Wendy Prins, both from NQF, on a number of areas that are currently

going on so that we know everything that is going on and try not to duplicate but to build on.

We'll have a break during that time. And after the break Mark will facilitate discussion to evaluate the draft domains and sub-domains for care coordination measurement. And that's about an hour. So I think that's going to be a very important component of your attention to which will then lead us into further work.

We'll have an opportunity for public comment. And right before lunch we'll give you some direction on what you're going to do during lunch.

So you can eat, but you know, you're not going to eat only during that time. You will have an exercise, a very important exercise that coming back we will spend a good 90 minutes with real activity building on the work that you've done individually but as a group really looking at elements of the impact

and feasibility for measurement. And that will take a good amount of our time I think. So we'll have good discussion on that.

Then we will of course have small group discussion, generating potential measure concepts. Lauralei will be leading that conversation.

And then finally, you'll have a fair amount of time for that too, about a little more than an hour. I think more than that.

And then Mark will be facilitating the report from these small groups, and again more opportunity for public comment, and then a summary of the day where you will just like sort of hopefully relax a little bit.

I understand some people might join for dinner. Others will go home. I'll be heading to Vermont. So that's kind of where we're going.

So before we start on this kind of ambitious agenda but I think this group is up

to it let's introduce ourselves. I guess start first with members of the committee and then, Sarah, I'll turn to you for members of your team. So, how about we go around this way. Gerri?

DR. LAMB: Good morning, everyone. I'm delighted to be here with you. I'm Gerri Lamb. I'm from Arizona State University, came in from Tucson. And as Susan mentioned already I co-chair the measures group with Don Casey.

DR. CASEY: Don Casey. I report to Gerri Lamb.

(Laughter)

DR. CASEY: I'm an internist and have recently relocated to Chicago to coordinate care for my 89-year-old dad and his wife. And am involved with a number of efforts like this.

Prior to that I was at NYU as a professor of medicine in the Department of Population Health.

And I've been involved with the trajectory of NQF on this topic since its inception in 2005. So, I was, thanks to Reva Winkler back then on the front end of this. And so I have that broad perspective of where we've been.

DR. REINHARD: Great. And now you're a caregiver to boot.

DR. CASEY: Well, I've been a caregiver but now I'm really in it with both feet.

DR. REINHARD: Russ?

DR. LEFTWICH: I am Russia Leftwich. I am a recovering internist as well and for the past three years have been the chief medical informatics officer for the State of Tennessee.

And I guess relevant to this committee I'm also on the Care Coordination Steering Committee that Don and Gerri chair. I'm one of the leads in the S&I Framework, so Longitudinal Coordination of Care Initiative.

And a patient care workgroup co-chair in HL7 which is the workgroup that's been responsible for the care plan domain analysis model and the new developing standards that are coming out of that.

DR. ACKMAN: Good morning, I'm David Ackman. I'm the medical director for WellPoint, formerly with Amerigroup before we were bought by WellPoint, working in Medicare.

Before coming to managed care I was a public health physician and worked primarily -- I worked for CDC and then for a state health department. And for six years I was a health commissioner in Nassau County.

And I think my background relating to this would be much relating to surveillance, public health systems, and measurement in public health practice.

DR. REINHARD: Thank you.

DR. EISENBERG: Good morning, I'm Woody Eisenberg. I'm with the Pharmacy

Quality Alliance. We're an organization that develops performance measures for medication use.

Prior to that I was the chief medical officer at Medco's Part D health plan. And I'm an internist by training.

DR. PARCHMAN: Good morning, I'm Michael Parchman. I'm a family physician by training and I work at Group Health in Seattle, Washington. It's a little early in the morning for me which is why I have a cup of coffee.

I am as I mentioned a family physician by training. Actually, before I went to work for Group Health, I've been there for a couple of years, I was actually here in D.C. with the Agency for Healthcare Research and Quality as a project officer and senior advisor for primary care within their Center for Primary Care Prevention and Partnership.

But most of my career has been spent in academic medicine running networks of

small primary care practices of one to two physicians who want to do research in their office in a partnership way. So I've spent much of my time working in those small offices.

Which harkens back to my first several years of practice when I opened a solo family practice in a small town in central Texas. So that's kind of my roots.

DR. REINHARD: Great, thank you.

MS. MCCAULEY: Good morning, Sharon McCauley. And I represent the Academy of Nutrition and Dietetics. And my background is also registered dietitian nutritionist.

Before coming to the academy over six years ago I have worked in a variety of practice settings, not only group purchasing with -- and also as academic medical center, clinician, worked in long-term care, retirement, behavioral health, mental health.

So with all that variety of different professional roles was able to bring

that to our academy to represent over the 94,000 credentialed practitioners to make sure that they are qualified to do what they are assigned to do.

And they do work in a variety of practice settings across the country one of which of course every day they handle their care coordination with all of the rest of the interdisciplinary team.

So thank you for having me and I've been working with my practitioners to make sure that I represent them well.

DR. REINHARD: Thank you.

DR. RACHMAN: Good morning. I'm Fred Rachman. I am a pediatrician. I still practice a little bit in a community health center in Chicago.

And the most part of my life is to lead an organization, a community health center controlled network. It's a HRSA-funded organization and we provide centrally hosted EMR and health information technologies

services for safety net health centers.

Centrally hosted in our data center are about 34 health centers operating out of about 200 delivery sites in 12 states.

And we grew out of an AHRQ demonstration project to embed clinical quality measurement and clinical decision support into an EMR. And we're very much still focused on evaluating, developing, testing quality measures through electronic health records.

And then relevant to care coordination of course working at a community health center, very dear to my heart. And actually the first grant project I ever wrote as a new physician just out of residency in a health center was to fund community workers to be embedded in our health center and be linking our services to the community.

Because as the rich funding of the 330 funding came to that small community organization it started to lose its community

ties so this is very close to my heart.

DR. REINHARD: Wow, when was that?

DR. RACHMAN: Pardon?

DR. REINHARD: When was that grant?

DR. RACHMAN: Oh my God.

(Laughter)

DR. RACHMAN: Thirty, almost thirty years ago.

DR. REINHARD: Wow, that's something. Thank you. Yes. I guess we'll start down this end.

DR. NG: I'm Judy Ng and my background is a little bit different from everyone who's spoken so far. I'm a health services researcher by training and I work now at the National Committee for Quality Assurance up the street.

However, I live in Princeton, New Jersey due to personal circumstance so I'm actually not a local technically.

As you know, NCQA is in the

business of developing quality of care measures of course. And at the moment oversee several projects related to care coordination, mainly the patient-centered medical home CAHPS survey.

We just finished a major public comment period to get feedback on how we can improve the measures in that survey.

We've also been collaborating with AHRQ on a new project, not a completely new project but a fairly new project for us to develop new care coordination measures in the primary care setting.

And earlier this year we were involved in helping the HHS with a community health center survey as well. So I've been involved in a lot of patient-reported outcomes in the survey setting there.

And I also grew up in Hawaii which I think someone mentioned which of course is a completely different setting from what we see here. I moved here to the east coast for

college and grad school and it was a very big change to see how community centers and community health is done here versus there.

DR. REINHARD: Great, welcome.

MS. ADAMS: Good morning, I'm Karen Adams. I'm vice president at National Quality Forum. And I really want to thank you all for your passion and your enthusiasm and support for this work around care coordination.

I know later on the agenda you're going to hear about other work across NQF which you're a very important part. And then of course we hope to hear from you how this can help work that we know that you're doing. Because we don't want to operate in a vacuum for sure.

But I know that Sarah and her team have you in good shape and so I just wanted to extend my thanks.

DR. REINHARD: Thank you for being here.

MR. CUSANO: Good morning, my name is David Cusano. I'm with the Georgetown University Health Policy Institute where I support 11 states on implementation of the Affordable Care Act under a Robert Wood Johnson Foundation grant.

Prior to joining Georgetown I served as in-house counsel with Coventry Healthcare where I provided legal counsel to the Coventry health plans and worked on health reform implementation and our medical home product.

And prior to going to law school I practiced as a registered nurse in Boston at Beth Israel in both administrative and clinical capacities.

DR. LINDEKE: Good morning, I'm Linda Lindeke. Greetings from Minnesota where it's snowing.

I'm a pediatric nurse practitioner and I care for the smallest and sickest premature babies. I do care coordination each

week for half a day. The rest of the time I am an academic.

And we have a center for children with special healthcare needs, federally funded MCHB money. And I bring you greetings from Minnesota.

DR. REINHARD: Great, thank you.

DR. MANGIONE-SMITH: Good morning. I'm Rita Mangione-Smith. I am a professor of pediatrics at the University of Washington and an investigator at Seattle Children's Research Institute.

I spend about 80 percent of my time doing research and around 20 percent doing clinical time both inpatient at Seattle Children's where we're very focused on children with complex healthcare needs.

So, very cognizant of the need for good care coordination for that population. And I also do some outpatient care with our residents.

My research currently is focused

on quality measure development for children with complex needs, specifically care coordination measures. I'm part of the Pediatric Quality Measures program. We have a center at Seattle Children's Research Institute. Linda is on our national advisory board so she's very familiar with what we've been doing. And hopefully we can bring some of that experience to the fore today.

DR. REINHARD: It's great to have you. Thanks.

DR. GIUNTA: Good morning, I'm Nancy Giunta from the Silverman School of Social Work at Hunter College. I may be the token social worker in the room which is fun. I'm glad I'm here representing social work.

I am also part of the Hartford Center of Excellence in Aging and Diversity at the School of Social Work at Hunter.

And my area of research is mostly around multicultural aging and what we call macro practice social work interventions to

design structural interventions to help improve access to older adults in community settings. So, thank you for inviting me.

DR. REINHARD: You're welcome.

DR. ROCA: Good morning, everyone, I'm Bob Roca. I'm trained as an internist and a psychiatrist and a geriatric psychiatrist. But my day job these days is primarily as a vice president and medical director of Sheppard Pratt Health System which is a freestanding psychiatric hospital up the road in Baltimore.

I've been involved with the American Psychiatric Association in a number of projects related to quality measurement. And I head up our quality and performance improvement effort at Sheppard Pratt. And this is an area of great interest to me.

And I'm also sort of I guess a consumer of quality measures as well as somebody who works in a health system and very interested in ensuring that the measures that

we develop are meaningful but also practical to use. And not just things that are complied with in a pro forma way in order to meet standards.

DR. REINHARD: Okay, great. Thank you.

DR. SEHGAL: Aloha, good morning. See, I'm still -- talk about early. I'm Vija Sehgal. I'm a pediatrician and a chief quality officer at the Waianae Coast Comprehensive Health Center in Hawaii.

And it's wonderful being close to the end because I can find so many connections between so many of you.

I did my pediatric training in Seattle at Seattle Children's. and my question to Judy is what school did you go to? This is a local Hawaii joke.

DR. NG: I went to McKinley.

DR. SEHGAL: McKinley, good girl.

(Laughter)

DR. SEHGAL: My nightmare is that

my daughter who's in Boston right now studying in college is not going to come home so we're not going to have her speak to Judy.

My day job is -- I do a lot of things. I'm still a practicing pediatrician about a quarter of the time, and the rest of the time I'm in administration.

I oversee a number of our payer contracts. Hawaii has been fortunate, our health center fortunate enough to develop payer contracts with our Medicaid providers where we are actually given increased money per member per month to provide increased care coordination and HIT services to a complex group of patients.

And our goal is with this increased investment to actually cut down on preventable costs such as we have seven financial measures that we're following which I'm sure you're all familiar with, basically hospital readmissions and low-acuity ER visits and such. So, as a quality officer I'm busy

tracking those things.

I'm also overseeing the entire group of care coordinators that we have working for us. So, it's really an endeavor and process.

I'm also involved in policy for the State of Hawaii. And we have just recently completed -- submitted an innovations grant. We're hoping that it includes a lot of obviously care coordination and whatnot. So it's a work in progress.

My background before I went into pediatrics and policy was actually in public health. I was an epidemiologist in Papua, New Guinea. So I have -- it's a long history and it's all kind of coming full circle which is fun and fascinating at the same time.

DR. REINHARD: You're wide awake.

DR. SEHGAL: Coffee.

DR. BIRKEL: I'm Richard Birkel with the National Council on Aging. And I direct the Self-Management Alliance.

I'm actually a community psychologist by training and I've spent most of my career on the community services side of things for a variety of populations across the life span.

I'm very -- I'm fascinated with the idea of the health neighborhood and the integration of those services, the capacity that exists, the robust capacity in this country that exists in the non-profit sector on the community side with health systems.

We've done a terrible job, I believe, and I think care coordination is one of the pieces that has to be solved for that integration to take place. Thanks.

DR. REINHARD: Thank you. Samantha?

MS. MEKLIR: Good morning, I'm Samantha Meklir and I'm with the Department of Health and Human Services with the Health Resources and Services Administration.

I've been with the Department for

14 years, 15, I don't know. It's amazing because I'm still only 22, so I'm not sure how that happened.

(Laughter)

MS. MEKLIR: And half my time with HRSA looking at health information technology and quality measurement, and then the other half of my time with HHS at CMS focused on Medicaid in different places within CMS, in Chicago, in the office in D.C. and then in Baltimore.

So I just again want to -- I'll have a chance in a few minutes to welcome and thank you all, but thank you again.

DR. REINHARD: Thank you, Samantha. So, Sarah, we'll turn to you.

MS. LASH: Sure. We'll move onto the next slide. Just to kick off staff introductions.

Good morning, everyone. I'm Sarah Lash, a senior director here at NQF where I've spent the past four years really focused on

quality and quality measurement issues for vulnerable populations specifically.

And it's been a pleasure to lead this team in developing the content for you in this meeting today. But we're going to try to sit back and stay out of your way and just hear all the good thinking and wisdom collected in this room.

MS. INGRAM: Sarah? This is Carolyn Ingram. I hate to interrupt you but are you guys going to also do introductions on the phone? I'm sorry if I missed that.

MS. LASH: No, this is great. Thanks, Carolyn. Why don't you go ahead.

MS. INGRAM: Sure. Maybe I'm the only committee member participating by phone so I apologize to others. I couldn't get there due to family issues.

But my name is Carolyn Ingram. I'm a senior vice president at the Center for Healthcare Strategies. And there I oversee our work on integrating care for people who

are on Medicare and Medicaid health reform. And I lead our Medicaid leadership projects.

Prior to this position I was Medicaid director in New Mexico for eight years. And actually my first position in Medicaid was running our care coordination and case management program a long, long time ago. I won't say how long ago because that will reveal my age.

And then on a personal basis I serve as the care coordination of my son who has special healthcare needs. Thank you, Sarah.

MS. LASH: Thanks, Carolyn.

DR. REINHARD: Welcome. Did you want to continue or just go to individuals? Lauralei?

MS. DORIAN: Good morning, everyone. My name is Lauralei Dorian. It's so good to finally be able to put faces to names. I'm the one you would have been receiving email from the majority of the time,

so welcome.

I've been at NQF now for about two and a half years and I've been fortunate to be working on care coordination with Don and Gerri and Russ and Linda as well.

And I think as you've already heard and as you'll hear in more detail later on there's just consistently been a lack of new measures and certainly of very impactful measures. So, I think that that's why this project is so important and promising. And so I'm really looking forward to working with everybody over the next two days.

DR. REINHARD: Thank you.

MS. DORIAN: And I'd also like to say that our analyst over there, Laura Ibragimova, if you want to just wave your hand? She's done a lot of work as well to help us prepare for this meeting. So if you need, she actually has all the meeting materials. So if you're having trouble accessing the internet or if you need those

materials she can get them to you.

DR. REINHARD: And Wendy?

MS. PRINS: Good morning, everyone. I'm Wendy Prins with NQF. I'm a senior director here. I've been here for about six years and primarily worked on the National Priorities Partnership work providing input to HHS on the National Quality Strategy.

Of course that group really elevated care coordination to the forefront grounding it of course in a lot of the work that you all have been involved in over the years.

But really excited to talk with you a little bit today about some of the other work that we have going on at NQF that supports this. So, happy to hear.

DR. REINHARD: Thank you.

MS. DORIAN: We also want to acknowledge our colleague Severa who is at home with a new baby girl. So, you might remember her name from previous emails. But

she's also contributed to bringing us here today.

DR. REINHARD: Lauralei?

MS. DORIAN: Great, thanks. So now we're just going to briefly go through some logistics. As you've already heard this is an open call. It's open to members of the public and committee members as well if they dial in. And we will have dedicated times throughout the day to have member and public comment. You'll see that listed in your agenda.

The meeting is being recorded and transcribed and a transcription and recording will be available following the meeting.

So the way that we've sort of figured that works the best to indicate that if you have a question or wanted to contribute to the conversation is to take your table tent and stand it on its side. I think those of you who've worked with NQF before know that this works pretty well.

So please always turn on your microphone when you're speaking so that everything will be recorded and turn it off after you're speaking.

And those of you on the phone, please mute your line when you're not speaking. Let's see, if you want our wi-fi password it's available from staff either outside or Laura can give that to you.

Restrooms are actually through here through the double doors to your right. And we have staff out there all the time as well so they can point you to anything.

Food will be served. We had breakfast back there and we'll have lunch. Food is for committee members only but we'd be happy to recommend to any members of the public who happen to be here some restaurants close by.

And also, that brings me to our next agenda item. If you're interested in everybody getting together for dinner tonight

we have a reservation at Mio which is a restaurant that's right around the corner, it's about two blocks away. And so if you'd be interested in that please let one of the staff members know during one of the breaks so we can indicate what the numbers will be.

And so now I'm pleased to introduce Sam Meklir who you've already heard from. Sam has been working really closely with our team to shape the project's vision and has also been proactively working with an interagency HHS team. And so we would like to invite Sam to provide some opening remarks.

MS. MEKLIR: Thank you so much, Lauralei. So, good morning, and just a special welcome and thank you to all of you who have traveled near and far to be here.

Especially thanks to Sarah and her team, to my HHS colleagues, to the public that is joining us by phone and we'll have a public comment period.

And a special thanks to Mark and

Susan who are co-chairing. We're just delighted. And thank you again for that extra work and responsibility.

So, as Lauralei indicated there's been a large team of HHS colleagues that have been part of this effort. And it's really been a privilege and honor for me to be the subject matter lead here.

What that means is I've had the task of working across HHS to engage and tap into all of the work across the Department from all the different agencies.

And so a special thanks to Cille Kennedy who is the GTL on this project who's in the Secretary's Office of Planning and Evaluation. And to Corette Byrd who is with CMS and is the contracting officer, the COR.

And I believe we have several HHS colleagues in person or on the phone and so I just want to pause and invite those folks to just stand up and reveal yourselves as a fed or introduce yourself just quickly.

MS. MAKAR: I'm Ellen Makar. I'm from ONC. I'm a senior policy advisor in the Office of Consumer eHealth.

DR. STOCKMANN: I'm Deirdra Stockmann, Center for Medicaid and CHIP Services at CMS. We're providing services in population health in Medicaid and CHIP.

DR. DAILEY: I'm Maureen Dailey, a senior policy fellow from the American Nurses Association. There are several people in this room who worked on ANA's care coordination measurement framework.

MS. FELIX: Good morning, I'm Kay Felix. My full name is Kaytura. I go by Kay. Hi, Mark, we finally meet.

And I work in the Office of Planning, Analysis and Evaluation and I've been working with Sam on this project and it's been fun. Thanks.

DR. BOHON: I'm Connie Bohon. I'm in private practice, an OB/GYN here in D.C. and I'm doing a fellowship with ACOG. So I

know nothing about what's going on and I am here to learn.

MS. MEKLIR: Thanks. And so I think you'll hear some additional HHS folks call in over the next two days and certainly hope they can chime in and introduce themselves.

So, again, it's an honor and pleasure to be able to kick off this two-day meeting by providing some brief remarks that speak to the timeliness of this effort and to the larger landscape within which we find ourselves undertaking this important work.

And as we work to further care coordination measurement and address critical measure gaps with primary care to community supports and services. So this effort really extends quality measurement beyond the clinical setting to support the whole person and the person-centered plan of care for improving health outcomes of an individual with his or her care team as part of the

broader health neighborhood.

So as you know and as we've heard from NQF and in an earlier presentation this work really supports and furthers the National Quality Strategy. The aims of the strategy particularly as it relates to Healthy People and to Healthy Communities.

And so since we began this project I kind of was talking to Mark and Susan about this this morning. And I think back to the days when we were writing the statement of work and all these drafts were going back and forth.

And then I think to like the last few months where Sarah and I would exchange all these emails like did you see this, did you read this. Because we kept seeing this work really everywhere. It is so needed and it's so timely.

And so here are just some of the things that I know. And it's not at all comprehensive or reflect any kind of priority

in any sense.

But there's a report that the Robert Wood Johnson Foundation Commission to Build a Healthier America just released. And when you look at their third recommendation in that report it really speaks to promoting health outside of the medical system. And NQS was kind enough to arrange for some of those hard copies to be here and they're in the side room.

We have the arrival of the term TACO which is very exciting because it's not only the only food my kids will eat that I make but it's also the Totally Accountable Care Organization that speaks to health systems creating and expanding partnerships to influence health to create a more robust ACO model that pushes accountability beyond medical care.

So there are the efforts of the IOM to recommend social and behavioral domains in measures for electronic health records and

to focus on applying a health lens to decision-making in non-health sectors. And again that's a report that just came out.

And there's also increasing coverage in the media about the role of social determinants in healthcare and the significance of an individual's zip code, especially in a post-ACO world and environment.

And there's a lot of momentum for community needs assessment requirements of certain hospitals per the ACA. And that is mandated and really gaining a lot of leverage across many different discussions especially here at NQF.

And then of course you have the recent approval by HHS to support authority to support Medicaid funding of front-loaded programs that improve quality of medical care and increase access to services and promote population-based prevention to keep people healthy.

And in that 1115 that was approved in Texas. They're partnering with organizations such as local schools and the YMCA.

So, having said all this and kind of the big picture and the landscape what we tried to do is create an agenda over the next two days that is balanced with enabling you to be very aspirational and yet very practical. And so you'll be having discussions where you're thinking 5 and 10 years down the road from now and then you'll be very practical where we'll ask you to vote.

And you'll hear from Russ about where the capabilities are today. And kind of be thinking within a year from now.

And you'll also hear from CMS tomorrow morning about intended measure use. And I think that will be valuable as well.

So, again, so we'll have you look at existing data sources, HIT challenges, infrastructure capabilities, and really focus

on the details to help define key concepts and domains.

And as you do this we know that these discussions and these efforts really are being watched by and are helpful to so many other undertakings.

So, on behalf of my colleagues with HHS and I just want to thank you and welcome you all. I think you are here after what could have been our final snow last week and before our cherry blossoms. But I trust that you'll appreciate having the lack of snow and the lack of tourists. So hopefully that will be a good balance for your. Thank you again.

DR. REINHARD: Good point. Sarah, can you tell us where we are in this progress?

MS. LASH: Absolutely. So, the next few minutes will be spent refreshing your memory and confirming our shared understanding of where the group is based on what we've heard from you so far. So we're going to try

to hold up a mirror to the group and see if this reflection is accurate.

So we'll begin at the beginning with our definition of care coordination. And when we spoke on the web meeting there was some split in the group about whether or not it needed editing. So as a balance we've decided to make some very small changes to address the most prominent comments. And so those edits are in green.

We added just a short phrase about improving health outcomes because that was I think the most prominent thing that folks thought were missing from the definition. And then substituted the term "care recipient" for "patient" to better match the scope of this project.

So, as you recall this is already based on some consensus definitions from AHRQ and NQF. And so I think this is something that we'll continue to use and reflect as the basis for this work.

You might also recall our conceptual framework also built on AHRQ's work and now re-illustrated. It has three key features. We have actors as care recipients and families, clinics and clinicians, and a third, community resources.

There's also three sets of one-to-one relationships among these actors and a sweet spot in the middle where all are interacting and there's great potential for crosscutting and highly impactful measurement.

So, these individuals are not isolated as care recipients. They're part of a much larger and complex system. And so we're hoping to reflect in the conceptual framework a dynamic and flexible model that will allow for lots of ideas to be applied.

So similarly the community resources are intended to be broad and inclusive of everything that would impact health. And our clinics and clinicians really could be any kind but we'll try to keep a

focus on primary care.

So we've continued to build on a foundation of existing work in care coordination and revising as necessary to fit this project scope.

So I won't read all of the preferred practices back to you, but to simply remind you that this is now a few years old but they remain highly relevant and in many cases are still fairly aspirational for the state of care coordination that we'd like to achieve in the system.

So, these practices note very central concepts like the existence of a healthcare home, a central point for coordination, continuity of care, managing a person-centered plan of care, that there's a system supporting these activities that can measure, report and improve coordinated services. And again, creating, documenting and executing care plans.

The practices go onto describe the

need for preventive follow-up tests and ongoing treatments, education of the care recipient and that person's caregivers, support for self-management and taking advantage of natural supports such as family caregivers. And also, that the plan of care should include the entire array of community non-clinical behavior and healthcare services to respond to individuals' needs.

And a few more preferred practices really central to our thinking are that the care recipient and his or her designees in the care team are working within a same shared plan of care where they're sharing responsibility for their contributions in the ultimate outcomes. And an electronic information system is really facilitating these activities.

We also heard from this group some additional concepts that weren't very strongly represented in the preferred practices in the next slide.

And so we're also incorporating these into our conceptual thinking. And so these would be additional measurement opportunities about interoperability, the care recipient's level of activation and their care, the role of social determinants and working in partnership to mitigate those social determinants, and two outcomes around reducing caregiver burden and duplication of care coordination services.

So, I'll try to walk you through a bit of a simplistic storyboard of how we think those preferred practices and conceptual ideas fit in this dynamic model.

So please meet Stuart up there on the upper left. He's an 8-year-old boy with asthma and ADHD neither of which is very well managed.

Stuart's mother Maria is very concerned that he's not doing well in school and he's having repeated visits to the ED for asthma attacks. And that's had a negative

impact on Maria's ability to hold down a job.

In addition, it's very frightening and expensive to be having those attacks. So Maria doesn't know much about how to improve Stuart's behavior or his asthma, but she's very motivated to do something about it.

So fortunately Stuart and Maria have a primary care medical home at a neighborhood clinic. And the clinic has a range of health professionals and support personnel on staff. And Stuart and Maria will work with both a pediatrician and a behavioral health counselor as a part of their care team.

And Stuart and Maria live in an average community. There's many resources available for people that need them, but the awareness of those resources might be limited or connecting to them might be sometimes difficult.

So we'll move to consider the interaction between the family and the clinic team. And here we would consider having a

comprehensive assessment that looks in both positive and negative aspects and challenges of the family's situation, a shared decision-making process to set goals for Stuart as a part of his care plan, and the beginning of ongoing monitoring of both clinical and behavioral outcomes and prescription of appropriate medications as applicable.

In the interaction between the clinics and the community resources we were hoping that the practice would have a relationship with a range of community-based services and that they might be able to get a community health worker on the phone to speak with Maria while she's at the clinic with Stuart for a checkup.

The community health worker might plan an asthma control education intervention and recognize that Maria could qualify for some nutrition benefits and initiate an application process.

The clinician might also know that

peer supports of help to other parents and suggest that Maria join a group that meets at the clinic once a month.

Looking now at the interaction between the family and the community, they might arrange for Stuart to have an individual education plan at his school.

Someone from the public health department might visit their apartment and train Maria about how to recognize environmental triggers for Stuart's asthma and reducing his exposure.

And the human services system will continue to process the family's application for food stamps and they can begin to access healthier foods.

And with Maria's increased time at work she'll start saving up for a new vacuum with a HEPA filter.

So, moving onto results. A person-centered process in a system that is well-connected and coordinated can produce

very good outcomes. Of course, the reality of this is somewhat disjointed from the ideal example I'm presenting.

But if all goes as planned Stuart would stop going to the ED with asthma attacks, Maria would miss fewer days at her job, Stuart would miss fewer days at school and he'd be in more control of his actions when he is there, and people on the care team, in the community and at the clinic and the family are all sort of pleased with the experience they have collaborating with each other and that they're actually able to create some positive change on behalf of this family.

So, I think we'll pause there to see if there are comments related to the care coordination definition or the three-part conceptual framework. Anything missing or inaccurately reflected from the group's thinking? Don?

DR. CASEY: So, I like the -- first of all, just to inform this committee,

the group two cycles before this really developed a list of the preferred practices. And I think it was incumbent upon the staff to spend some time in thoughtful reflection since that -- I think those came out in about 09 didn't they, Sarah? Something like that. So you know, the world has changed and continues to change.

And I think that that bespeaks our point about -- and the point in time being dynamic in the future in terms of whatever we come out of the box with today. So I think that's important.

I want to just ask a fundamental question. Because in your example which I think is a superb example you didn't talk specifically about the clinic/clinician side of that. I didn't see that depicted there.

You know, for example, one of the challenges I think we're facing, whether it's in the medical model or not, is whether, for example, there are good established guidelines

that are followed both by patients and physicians, and other people, behavioral health specialists.

ADHD, I'm sure some folks know better than I have some rough edges around them. But asthma in the pediatric population is a little bit more easy to delineate in terms of what is effective, i.e., not just prescriptions but the effective use and compliance with prescriptions in an 8-year-old. I'm not a pediatrician but you know, I can imagine.

So I'm just calling that out as a piece in this example that I'd like to have a little more emphasis on. Because I think these things then fit together more effectively.

And I think there are a lot of questions that sometimes we assume are taken care of in that space. And I am not so sure that that assumption is a good idea.

MS. LASH: Sure, certainly. We

can certainly add that detail. Gerri?

DR. LAMB: One of the things that I think is really helpful about this example is the intersections.

In many of the discussions we've had in past meetings the sentiment has been expressed that care coordination happens at the intersections.

And what this I think represents is helps us I think as we move forward to look at aspirational measures is what's foundational but can we capture these intersections. Because that's where the work of care coordination really happens. And that's been a significant gap.

MS. LASH: Great. Michael?

DR. PARCHMAN: I think --

DR. NG: I think something that jumped out at me about this model is of course the patient is right in the center. And a lot of times when we think about development of measures the patient voice is not always

represented, although of course they're always a part of the picture. So I think that aspect of it really jumped out at me.

Another thing you mentioned in giving examples about this model is things such as, for example, the mother would miss less days at work. The child would have less asthma episodes.

And that really speaks to this idea of maybe setting goals from the patient perspective as well. And this entire work around goal attainment these days was also another aspect that I thought was quite important in the model.

DR. PARCHMAN: I just wanted to go back to the great point that was just made about the intersection piece. Because the example, the story you provided really does point out the importance of looking at what I call interdependencies of tasks between agents or between individuals or between organizations.

And I'm concerned our definition doesn't capture that, to be honest with you. It talks about deliberate organization of activities and information, but there's no mention of this intersection piece.

And I think that's a major failing right now of our understanding of care coordination. Because I know as a primary care physician I can document care plans in my EHR till I'm blue in the face, but that doesn't mean good care coordination is going to occur.

And so I can organize information in the EHR which would be consistent with the definition here and develop a care plan. But that's not -- the care plan might be necessary, foundational for good care coordination to occur, but I don't think our definition goes far enough.

MS. LASH: I saw a lot of nodding. Are others in agreement with that addition?

DR. MANGIONE-SMITH: Yes. I think

the other thing to me that's missing that really resonates with what I've been thinking as we've been going through this example, there was no slide that looked at the clinician overlap with the community by itself.

And the reason I bring that to the fore is accountability. I mean, we've got the patient and family in the center and to me that's where the burden comes. Because we tell them oh, go do X, Y and Z, right? And then it's their responsibility to contact the school and figure out how do they get an IEP. And to go to the place that they have to go to figure out the food stamp thing.

I mean, so it's just -- I think that's to me also sort of missing here. Like where's the accountability. Who makes those connections? Is it the family's responsibility completely or not?

MS. LASH: Fred?

DR. RACHMAN: Yes. So, I guess

listening to this I've been struggling all along. I think to me there's a difference between care coordination and coordinated care.

And the difference in that to me is care coordination implies that we have a bunch of separate sort of services that need to then be glued together by some body or some process.

Whereas coordinated care implies that somehow intrinsically from the view of the care provider there is some way that that service is being provided contemplating the totality.

And if we're being aspirational I wonder if we could keep those two different concepts in mind. Because one requires, definitely requires this body to kind of glue all the pieces together. The other would allow us to be all operating from the same page.

And I do think that the way to get

there is to be viewing it from the eye of the patient rather than the way we tend to view things which is from the eye of the service provider.

DR. REDDING: I think building on what Fred has also stated in Ohio and Michigan and some of the other places that used Alaska as a basis for a community-based care coordinator and then organizing them and building measures. AHRQ has helped with that in what's called the Pathways Community Hub Initiative.

But in that model a family has a primary care coordinator and that care coordinator may -- is really only responsible for making sure connections are made and some basic education. So it can actually be someone who has a more limited education but substantial education.

So the role of the community health worker is such as in the slides, that community health worker would be faced with a

-- you know, if we did a holistic assessment it would be health, social, behavioral health. They might have 20 different connections for a very at-risk person.

And then their role would be to work with nurses and social workers and physicians sort of as that advocate friend, sometimes mother figure to help the family work through it.

In Ohio, interestingly, care coordination in this way and I think in other states can be very duplicative. And so you can have 8 or 10 people in the home trying to do the same thing. And that's another issue. But thank you. Appreciate these comments.

DR. LINDEKE: My comment is similar to Mark's, actually. I work with the prematurely born children whose plans of care are changing rapidly. And they involve social service in many cases because of the risk factors that caused the birth to be high-risk in the first place.

There's also the task now on families of coordinating the care coordinators, all well-intentioned, all in place because of all the initiatives that were mentioned in our introduction.

And so the irony of going from this being an unheard, unknown concept to being the word of the day, the job of the day.

And just for a little humor, we sent student nurses out to interview care coordinators. They came back and said some of these people didn't want this job and don't even like the job. So we have plunked a name tag on folks and well-intentioned, going the right direction, but I think we do have to recognize.

And then you add the Meaningful Use and all the mandates out there. We've got a real complex situation for all the players involved right now.

And it's good we're talking about this. It's a good example to start with. It

doesn't represent the multi-layering that is the experience of the families I work with quite fully.

MS. LASH: Russ?

DR. LEFTWICH: This is a great scenario and I think in thinking about it it illustrates the point that care coordination as a concept happens in different ways and different places around the country. And it's hard to pin it down to one prescribed role of different -- if this child is seeing a pediatric allergist who may employ a certified asthma educator they may be playing the role that the health department has described in this scenario.

In some families the mother may really take the role of the care coordinator. And so I think it really illustrates that care coordination happens in different ways in different situations around the country. And I think the measurement framework and certainly the health information technology

support has to recognize that as well. The data is the same but the roles may be played by different individuals.

MS. LASH: Richard?

DR. BIRKEL: Yes, I just want to suggest that Fred's distinction between coordinated care and care coordination I think is something we should keep in mind.

I agree that there's -- the development of a coordinated care plan is a very challenging event. It requires the multiple parties involved including the family and caregivers to be at the table at one time. And so there's a sequence of things that happened.

In the aging field there are no integrated protocols, for example, for a primary care physician or a healthcare team to sit down with anyone in the aging network and develop a coordinated care plan. So you end up with two care plans that now have to be coordinated.

And so this -- I think your point is really well taken. Both are necessary. But there's a sequence of things that has to happen.

And the development of those integrated care planning protocols has to be in here somewhere because otherwise you're just handing over a really -- a broken set of services that now you're asking a care coordinator to somehow glue together. And we've seen that.

MS. LASH: Michael.

DR. PARCHMAN: This is a really good point. I just want to tell a really quick story.

I was in Bellingham, Washington last week for a patients with complex healthcare needs conference.

They had done a community health assessment, identified 47 organizations in their community that had care management, someone in their organization that was a care

management person or a care coordinator.

This is not a large, large urban area, Bellingham, Washington, but there are 47 organizations. In many cases they identified patients who had five or six different care coordinators all working at a different aspect of the patient's care.

One was the care coordinator for their chronic kidney disease, the other one was their care coordinator for their mental health, the other was their care coordinator for their CHF, and the list went on and on.

So we're talking about now coordinating the coordinators at this point. I think that's an issue that we're going to have to face as a group as we think about measuring this.

DR. REINHARD: Thank you for raising that.

So, I had a suggestion. Listening to this commentary if we go back -- was somebody, maybe it was Fred who was

questioning the definition. Did somebody raise that? Yes.

So, listening to this conversation I do, Fred, I think when you were talking it really hit me, the linking, is it linking or it is proactive work here.

And I think we're trying to get to the more aspirational, Samantha. Is that right? We're trying to get -- because linking is care coordinating.

But anyway, for the definition, do we want care coordination as the deliberate integration of activities? Or do we want deliberate linking of activities? It's the organization that I think is vague.

DR. RACHMAN: So personally, I mean I don't think there's an "or" here. I think there's really an "and" and I think that this definition contemplates both. I just don't want to lose one or the other.

DR. REINHARD: You're suggesting organization and integration? What would you

suggest to improve this?

DR. PARCHMAN: I was the one who really challenged our definition. And yes, I think it's about both organization and integration of activities.

DR. REINHARD: Does everyone agree with that? Organization and integration. You're okay with that, Sarah?

MS. LASH: Gerri?

DR. LAMB: I think integration is a key piece of it. I'm hoping that in the discussions that we have there are other elements. It may have been Richard that said it's not just the integration. There's appropriate sequencing. There's a lot of kind of characteristics that go along with it.

And I think what we're going to have to deliberate on is how many of them do we put in there and how many do we represent in kind of the supporting documentation. Because that's what's been missing in the measurement is the plan of care is supposed to

magically get integrated, be put into place in a consistent way with feedback loops. And none of that is represented.

I think I was one of the people who said let's talk about what's important and then wordsmith, but not wordsmith in advance until we agree on where are we going.

MS. LASH: Bob, your card has been up for awhile. Did you have something to add?

DR. ROCA: As I read the definition I'm impressed and pleased with the primacy of family needs and preferences in the definition here.

But in the world that I operate in the family's preferences, the family's needs, the patient needs are difficult to meet not only because coordination is not optimal but because the services out there that would be required in order to meet those needs or preferences aren't available or are not accessible.

So that we may be, you know, we

may have children in the hospital who need certain kinds of community services and we would make every effort to try to connect with them, but in fact they don't exist. Or they don't exist where these people happen to live.

The same is true with our elderly patients. We may have -- we may be able to envision the perfect environment for an older person, but in fact the person can't afford being in that environment.

So somehow the -- I guess the question is how do we take into account the failure of care coordination because all the building blocks are not in place, all the elements are not in place that would really be the foundation upon which care coordination efforts would have to be based.

DR. REDDING: Very interesting point. And I think this may lend itself in further discussions about how care coordination at an individual level might help by identifying gaps and then being reported

across populations might lend itself to more accurate recognition of what's needed.

So that if 800 care coordinators can't find behavioral health services in their community that's reported at a population level.

MS. LASH: Sharon and then I'll come down here to Don and Russ.

MS. MCCAULEY: Thank you. I wanted to piggyback off on I think what Gerri was saying. That was my thought about the sequencing. Because I think that's what -- we don't know what we don't know. And what areas are we missing.

And I agree with you, maybe we shouldn't be starting to wordsmith a definition till we listen and hear everything. Because I think we're going to have to get specific.

I know, Susan, you had said something about linking, the links. And I think if we don't know, if we have missing

parts how do we know what we're linking? And the sequence of that.

So I just think I like those words but I'm not ready to go that route until I think we think it through. And then we can handle the definition.

MS. LASH: We can plan to maybe bring the definition back tomorrow morning after today's discussion and then firm up the next version.

Don?

DR. CASEY: Yes, I wanted to go back to just resonating with this question of integration. And somewhat of an expansion of this definition.

I think, too, based upon what Linda -- and I like the coordination of care as an important comparator to care coordination.

But Linda's comments made me wonder if we shouldn't start thinking about the word "standards" because I think your

story about the care coordination challenges and the fact that some of these people don't like their jobs I was joking to Gerri might be a symptom of the fact that they don't really understand what their job is, right, as one part of it.

And you know, part of our challenge is that a lot of this stuff that is expected doesn't have a lot of evidence around it. We're not sure how much time people spend doing whichever part of this they do based upon best evidence.

We don't have standards around what the expectations are around requisite knowledge, skills, experience, ability and requisite training. We haven't specified that.

We do believe that experiential learning is important but at this point there's a whole lot of variation out there. Witness the fact that in the readmissions project pretty much everyone is all over the

map in terms of what they do.

But it raises a question about innovation on one side and standards on another side of this equation.

So I just think that in the meantime people's roles aren't clear and that's because we don't have clarity on how to define the roles and how they should interact.

So, that's kind of gestalt but I hope maybe the word "standards" might be something we could consider talking about. I'm not sure it fits in the definition yet but I think that's what we should think through.

MS. LASH: Russ, then Judy. Then we'll move on, then continue to bring back some of these themes.

DR. LEFTWICH: I know there's a prohibition against wordsmithing but maybe "orchestration" would be a better word than "organization"?

MS. LASH: Judy, go ahead.

DR. NG: Just, two quick things.

The first is when talking about the missing linkages. This idea we -- I want to jump back to earlier about different integrated plans. You know, you can have several care plans out there. If they're not integrated that's a huge mess.

Even if you do have one integrated care plan if you don't have, as you said earlier, everyone at the table including the caregiver and the patient that care plan can be -- even if it's just one it's not the quantity alone. That care plan can be very confusing.

For example, this came out of a qualitative interview we did and then I read a similar example in the New York Times a week later the patient is suffering from some cognitive impairment. And the care plan keeps getting updated to adjust their medication. The caregiver is also an elderly spouse.

And so I think it's not just the quantity of the missing linkages but the

quality of what you have in the care plan. Something in that situation is very confusing for the patient.

The second piece is I know we talked about being aspirational and then we brought the word "standards". One thing of course coming from NCQA you want to think about ultimately down the line what entity are you trying to hold accountable and is it feasible.

So I think it's great to cast the net very wide right now and that will help us identify what gaps are out there. But ultimately you want to be -- if you want to measure something to improve it you want to measure something that is measurable and feasible, and maybe move out later to fulfill those gaps.

MS. LASH: Carolyn, did you want the chance to jump in this conversation at all?

MS. INGRAM: Thanks. You know,

it's been very helpful and I think the points made by most of the speakers, there's a lot of them that I would also agree with.

And I like your suggestion of having more discussion and then coming back to some of these topics throughout the day.

I can tell you from -- well, mostly from personal experience you can have lots of detailed plans but as one of our previous speakers said a lot of that ends up falling on the family members to take care of.

And with our more vulnerable populations, especially those in Medicaid and even those on Medicare they don't have the skills to do that. So I think it's important that we remember that those things have to be included in some regard so that there's some responsibility held back by the people who developed the care coordination plan so that outcomes are delivered.

And I know that's very hard to come up with those outcome measurements. Also

from the work that we do right now in integrating care for people who are Medicare and Medicaid, it's just very difficult to come up with those quality measures. But I think we should strive to try to push some of that forward.

MS. LASH: Great, thanks. Last comment, Richard.

DR. BIRKEL: Yes, I'm sorry. I wanted to capture some of the things Don said and connect back to some things that Robert said.

Because care coordination ultimately becomes probably someone's job description. And I think it's important to emphasize these points. There are some times when there are not appropriate services available, and what is the role responsibility of the care coordinator in such a case.

And what we find are the best care coordinators, whether in the aging or disabilities or whatever is that they go out

and they create a bridge, they create something that doesn't exist. They find something that suffices. And that's not in here either.

You can organize lots of stuff, but what about the creation of real natural supports? That's not here and I think we can't lose that.

MS. LASH: Great, thanks. Okay. Let's jump ahead back to what we found when we looked for measures as part of the environmental scan.

Just, you heard this on the web meeting but to recap. We reviewed close to 6,000 measures from various major databases like the Quality Measures Clearinghouse.

And we found 363 generally related to care coordination. But they were in general either very narrowly defined or very broadly defined. And they didn't translate well to this primary care community patient relationship that we're trying to measure.

So about half of those measures were at like this broad population level of the entire U.S. population. So it's more of a surveillance indicator than a performance measure.

And they would need significant work to be brought down to be used as performance measures, although some of them did hit on good topics.

So we noticed some patterns in the types of measures that are available related to care coordination. Many were condition-specific and age-specific. So, tend to be narrowly defined depending on what those conditions or age ranges are.

Many were from international sources where data sources and health system capabilities are different. And they might not translate to the U.S. system.

We found lots of measures where there's a one-way referral made but no follow-up or representation of the other half of that

handshake.

A variety of measures derived from surveys or research evaluations that aren't very easily replicated or expensive to field. And then as I said those population-level measures that aren't very actionable.

So, we confirmed that we are certainly operating within a large gap area for measurement. There's hardly anything usable as is for the purposes of the scope we're defining within this group.

And so we have encouraged use of NQF's measure pipeline tool for folks to log measures in development that are potentially coming to us. But again, we haven't found much in the way of promising measures.

So, as we presented this information to you on the web meeting what we heard in response was we would -- should keep a focus on coordination outside the traditional healthcare system and keep in mind the care recipient's engagement with community

resources and emphasize the role of social determinants.

Measurement should be agnostic to target populations or specific types of providers of care coordination. So that we would have measures that would work for many population groups.

Our approach should balance different types of measures like processes and outcomes to serve various purposes.

The care recipient and family's perspectives on how effective that care coordination is is probably among the most meaningful outcomes of the coordinated care process.

And an increase in the level of activation of the care recipient or family members is a desirable outcome in and of itself.

And then there was some feedback from the group about aspects of care coordination that could be developed into

meaningful measures.

Comprehensive assessment, the shared care plan, the extent of the patient's engagement, connection of services between clinical settings and the community, family's level of access to information and services, reduction of cost and overutilization, and improved patient safety as an outcome of successful care coordination.

So we'll continue to follow these and other threads through our two-day agenda. But were there further thoughts at this time about any topics we might be missing? Don?

DR. CASEY: This is just for the uninitiated what Gerri and I had been witnessing through our time as the chairs of the Care Coordination Steering Committee. You know, 180 measures are left. I don't know what percentage are NQF-endorsed. I would guess maybe about half, or a few, right?

So, again, this is the maybe chicken and egg challenge we can get to. But

what's the root cause or root causes of why after all this grand display of knowledge and wisdom we have nothing really to show.

And part of it, you know, which we'll get into is that we have to keep in mind the backdrop of the NQF endorsement criteria.

And one question in my mind and I'm sure even though Gerri and I haven't discussed this directly with Lauralei, it makes me wonder about if it's possible to consider a different set of endorsement criteria.

Not that we would throw out the endorsement criteria, but what we're learning is that it's hard to apply, unlike other measures, like asthma care. And then harmonization as well. So the ones that you summarized here perhaps maybe are things that we can begin to get to as a broad base.

But ultimately I think where I sit having written a number of guidelines and performance measures on a national level for

multiple diseases is that I don't think we're paying enough attention to pre-specifying the quality and strength of evidence that we want behind whatever we're going at in this case.

I just think it's very hard then to get to the finish line if what we're doing is sort of using things that have very soft or poor quality evidence.

DR. REINHARD: You've just given us a fabulous transition to the next session that we're turning over to Lauralei about how did the work that we're doing in this gap area relate to endorsement of measures. So thank you for that. Lauralei?

MS. DORIAN: Great. Thanks, Susan, and thanks, Don. We didn't plan that or anything.

So, I'll briefly go over sort of the history of care coordination at NQF though I think you've heard this already so I think it's more important to get into the current stuff over on the endorsement side.

But in 2006 we brought together for the first time a group of people which included Don and Gerri to start thinking about the complex area of care coordination measurement. There were a lack of measures at the time, really any measures to endorse. So it was a more strategic discussion about what the definitions should be and that's the version that we've updated and incorporated with the AHRQ definition.

And then five domains essential to measuring care coordination were also identified which sort of set the groundwork for future projects here at NQF.

In 2010 we brought a committee together again to review measures. If you're unfamiliar with NQF's endorsement process that's when we put out a call for measures in a certain topic area.

NQF is neutral but we bring together experts such as yourselves in that topic area and they evaluate these measures

based on a very rigorous set of criteria. And so at the end of the day they're either recommended for endorsement or not.

And so there were a lot of measures, I think 30 or 40 that were brought to NQF at that time but only 10 of them were really specified to the appropriate point where we could recommend them for endorsement.

So this is where the preferred practices came in, when the group really said, well, what's happening out there that's not exactly a measure but that could be aspirational for moving forward. What are some good practices.

In 2013 which is when I started on this work we had a two-phase project and it was sort of in response to this lack of measures. We had an environmental scan which said essentially the same thing that it does now, it hasn't changed since then. And we developed a pathway forward. And I think that sort of led the way to this project.

So, we did have a second phase of the CDP but unfortunately no new measures at all were submitted which is quite rare for NQF projects. But it was unsurprising at the time. And we had 12 measures that had been we call maintenance measures which means they had been endorsed before. They're required to undergo continuous review over three years. So we did review 12 of those and recommend them for endorsement.

So there's a current project that's occurring simultaneously to this one which Don and Gerri are co-chairs of and Russ is a member of. And they actually met just two days ago. Sarah and I were on the call with them. They've been reviewing measures. There was one new measure.

And the story, sort of similar to the one that we've been lamenting which is they're really, you know, we had seven structural measures which is just asking do you essentially do this or have this. We had

one e-prescribing measure from the City of New York Department of Health, three median time measures from CMS, and one new measure. It was a medication reconciliation measure which was actually an outcome measure so it was good to see that. And sorry this is so small.

But the committee is currently -- they've recommended most of them. They're currently still voting on those last four that you see. And the EHR one was actually not recommended for endorsement because it just failed to pass importance.

And it was this common theme as we've been mentioning is that, yes, these things are good to do but, as Don likes to say, it's only one side of the handshake and it's not really care coordination, is it, if it's just transmitted but not received or not acted upon.

So if you'd like to be involved with this work we actually did -- we'll talk about this a little bit later but we really

wanted to involve that committee in this work as well to make sure that it was a two-way process. So we spoke with them on a call on Monday and we'll be presenting that discussion later in the afternoon.

And if you'd like to follow their work we have the dates up there and the link to the committee's website is also in your agenda.

And I'd like to ask Don and Gerri to sort of reflect on this history and Russ as well. I know you've been a part of it. And Linda. And how this project maybe presents an opportunity to respond to this lack of measurement.

DR. LAMB: Okay, I've been voted to launch so I'm going to start.

I think what we've heard is the good news is that our thinking is and in this group certainly is progressing about getting closer and closer to what we think is important about care coordination.

But what you've heard from Lauralei is that we've now been through -- we're on our third measures committee with not only a lack of new measures as you heard which I think has been difficult for the committee because I think everybody's ready to see us move into more of the aspirational areas of care coordination.

But also really most of these measures as you heard are foundational. They are kind of establishing that groundwork for did you communicate.

And as Lauralei has mentioned often it's whether the information was collected and transmitted, not if it was received, not if there were feedback loops, not if it was acted on, not if there was integration, not if there was sequencing. We don't have any of that.

And so that's been a big piece of that dialogue is how can we move forward into these kinds of measures. So you can see the

connect between the discussions here and measurement are absolutely critical.

A lot of the motivation and commitment of our other committee is for the work we're talking about here and the desire to have those connects.

Because as many people have expressed to us on the committee they're impatient to see this move forward in terms of moving from foundational work which everybody accepts is really critical. Because it's what got us to the place of saying where do we need to go now. But everybody's ready to move to that place.

The other piece and I'll just throw it out and then turn it over to Don and to Russ is some of the difficulties that we're seeing as we apply the algorithms for the review of measures that go into the consensus process is that those are very rudimentary as well.

So that as we're looking at, say

for instance, importance the evidence base has built dramatically. But some of the measures that we're re-reviewing right now don't have that literature review, don't have the evidence. A lot of it is narrative support.

So that as we're looking for new measures we're also looking for really some key work going into developing the support for these measures in terms of importance.

Certainly the psychometrics. Almost everything that we're reviewing right now has a little bit of reliability, usually test/re-test, and almost totally limited to content validity.

And we really want to see as a group this area move forward in terms of the scientific merit.

And I think one of the things I'll leave for Don to talk about is as we move this forward and we really get to the guts of what we've been talking about, organization, integration, sequencing, kind of the feedback

loops that we're all talking about, the feasibility is going to get tougher as well.

And so these have been the dialogues but our group is impatient to move it forward and is really looking to collaborate with this group to see how can we accelerate what we know needs to happen.

DR. CASEY: Yes, and I think that the word that crops up to the sort of novices or the first-time participants in this process is frustration. And we're trying to lateralize that because anyone who jumps into this shakes their head and says what is this.

And so I think thinking more about impatience and trying to not let this turn into frustration would be a challenge.

You know, everything that Gerri said I agree with 110 percent. And we've witnessed this now for three cycles, not just the last one. So this has been a continuing theme. And it raises a big question in my mind for perhaps maybe HHS to think about.

And that is if we have incorrectly presupposed that measure developers understand what it is they're supposed to be developing.

And that gets back to my point about the fact that, for example, when we initiated the preferred practices our goal was to really begin to define -- we didn't call them standards, we called them preferred practices -- a list.

And unfortunately that list remains fairly arcane. And even to measure developers and people on the committee, they've never seen it before.

Now, I think it's right for NQF to go back and try to redesign it, but I think that what we don't have is a framework.

And so I would argue that the paucity of measures is symptomatic of our inability to express what it is we want. And so what we get is submissions -- no offense from certain measure developers who have their own pre-specified notion of what's important

to them. And we talk about those measures because that's all we have left.

Well, guess what? Med reconciliation and ED throughput and transmission of information is all we got out of this one.

And I think that part of this also in the evaluation side of it is that we're using the term "evidence-based" way too loosely. And still, even measure developers think that's a literature search.

And what I'd like to see us think about is, and I use my own term, "guideline-directed care." Because I think "guideline" the use of "guideline" assumes that someone has done a more thoughtful bit of work in terms of synthesizing the evidence, hopefully evaluating the quality of evidence and coming up with at least a consensus-based recommendation about the impact so that we can have a structured taxonomy.

I'm not sure that in thinking you

can just download the U.S. Preventive Services Task Force method and apply it here which I know some people try to do. But it just seems like we have to be a little more critical about the word "evidence-based" the phrase "evidence-based".

So those are my perceptions having done this about, you know, what we do. I mean, in the end we still have really good discussions but it's been now our third cycle, so, impatience.

DR. LEFTWICH: So, to reiterate something Don alluded to. The measures we looked at were really just measure the performance of a single organization and often only the coordination within that organization.

One of my favorite statistics is that the average Medicare beneficiary -- average, not complex -- average Medicare beneficiary sees seven different providers in four different organizations in a single year.

It's very aspirational to think we can measure the coordination between those seven providers who I like to say probably don't know who the other six are. But I think that's what we need to do. And that's the care that needs to be coordinated.

The other thing about the measures I would note is that they really don't leverage the information technology. They're really still more paper-based measures that we're looking at. Even the new one was not utilizing the information technology.

DR. LAMB: One observation that I think is useful is that what we're seeing in our group, and I don't know if the two of you would agree, is that there is kind of this growing comparison of measures in terms of moving towards what is aspirational for care coordination. And let me just give you an example.

Several of the measures that we reviewed were did this information get

collected and was it in the record. Clearly that's foundational for care coordination, but does it really capture what we're talking about? I think people were very comfortable saying no, it's not where we want to be at the end of the day.

But one of the discussions was about a new measure on really capturing medication errors between settings. And it really began to look at process of what data were being collected, what was being transferred across settings and were there gaps in that.

And so it became I think a really good example of, okay, this is really moving towards that communication link and how information either gets transferred accurately, not accurately and what people do with it.

The feasibility of that measure is really difficult. But so that I think we're going to have to really look at -- it's more

time-consuming to look at those connects.

But the committee had I think a fascinating discussion of, okay, this is closer to where we're going. And I think as we get new measures those kinds of discussions are possible.

DR. CASEY: And I agree with that. In fact, I think at a microsystem level, whatever you want to define the microsystem as, it's easier to get at a closer look within the microsystem.

For example, we naturally have hospitals coming together to talk about this or community-based resources. So I think having that connection is important.

I want to also throw in a different word than "integration" which is "synchrony" which now puts a time factor in here which I think we need to think about. I'm just giving you an overlay here.

But in the end I think that Russ is an expert in all of the health information

technologies.

I think what's also missing is we don't have a real explicit what I'll call data science approach to designing and evaluating studies that take us way past the traditional methods that researchers use to generate evidence so that we can get a causation and prediction much more quickly.

And then the last part of it which is kind of the gorilla in the room is what's going to be the shared accountability, especially as, for example, CMS tries to implement some sort of approach to a more synthesized and global evaluation of care coordination. So, you know, who is the accountable party or who are the accountable people. So these are things that are reflected in our discussions in our group as well as we go along.

DR. NG: I just want to quickly say that you really hit a nail on the head, especially with the idea of where we are now

with foundational measures. We face extreme frustration from recent -- this is not care coordination, but trying to develop a measure.

The Meaningful Use which is an eMeasure world of course has its own issues. But trying to come up with something around cognitive impairment and looking at issues of patient autonomy, driver safety.

We had a discussion about people talk about you need to have a situation where if you can educate the patient about driver safety. And that conversation took place and it's documented that's important.

But then of course it progressed onto but how do you know the patient actually understood the conversation. That's the important piece.

And the evidence -- I think because I'm a survey researcher the evidence behind how you can document that the patient understood and that that was good documentation, they really understood is so

lacking. We were so frustrated with the fact that we just couldn't find anything out there in peer-reviewed published literature. So that's one huge gap, just as you said.

The other thing is I think in the eMeasures world the kind of documentation you need is very specific, very prescribed. So that's another area altogether.

But I think coming from the survey research side, the lack of a lot of psychometrics and evidence is something as a measure developer I personally I have to say find extremely frustrating.

Because part of our end goal in this project which got ditched because there's not enough evidence is if you ultimately want this NQF-endorsed evidence is just not there. And there's only so much you can do as a measure developer to have the evidence out there. You want the independent researchers to do it. So I -- you just hit a nail on the head for me very recently.

DR. REINHARD: Thank you. One more comment, Rita? Oh, I'm sorry, there's a few more. We need to move on, but go ahead, Rita.

DR. MANGIONE-SMITH: So, this is -- I kind of feel like this is like good news/bad news, right? So we've spent the last three years in our center developing care coordination measures.

And we decided we were going to be aspirational and we were going to go for those information exchange measures and kind of the measures that we really felt had more teeth.

So, the first problem we ran into, and we've just recently published our synthesis of the evidence for individualized plans of care because everybody's talking about those. That's what we need, that's what everybody -- that's what's going to be the underpinning of care coordination.

And it's terrible. The evidence base is terrible. I'm a pediatrician. We

went to the adult literature. There was nothing in pediatrics. So then we went to the adult literature and there was very little there. So it makes us very nervous.

We've developed all these measures. Several of them are around individualized plans of care. But when I come to NQF and try to get any of those measures endorsed my concern is they're going to look at the evidence and say this is, you know, there's no evidence.

We have the content validity, the face validity thing that is easier to get. It's not a slam dunk but we've done that piece.

We're trying to look in a field test at associations between scores on the measures and parent missed work days and missed school days and functional status. You know, so we're trying to do some of that validation work ourselves.

The feasibility thing is huge.

It's just huge. So we've developed these measures. They are largely survey measures because we really came to the conclusion if you want to understand whether care is being well coordinated you have to go to the person who's supposed to be experiencing good coordination.

And so that puts a huge feasibility and cost issue into implementing these measures on a wide scale.

We've got medical records-based measures but they require manual review. There aren't fields in EHRs that allow us to do it in an automated fashion.

So I think that's the tension, right? There's this frustration. And I promise you, we will be putting some of our measures forward for potential NQF endorsement. But I think it's a steep climb for us for all the reasons I just said.

DR. REINHARD: I guess there's a reason why we're here.

(Laughter)

DR. REINHARD: Two more comments, Michael and then Fred.

DR. PARCHMAN: Yes, I just want to make two comments.

One, I think -- I'm a novice at this I have to admit in terms of working with the NQF on this, but I have a suspicion that NQF standards and endorsement criteria may be a really difficult challenge for us to work with.

Because a lot of the work we do with all the quality measures, this is an attribution issue. We can attribute quality to a provider, or we can attribute quality to an organization, but when you want to attribute a measure of care coordination we're talking about between or across organizations, between or across providers.

And it's hard, care coordination is relational. And good care coordination oftentimes is not about information systems,

it's about having sense-making conversations between real people. Those don't get documented in EHRs. And information systems don't gather that data.

So I think we need to think about the attribution issue when we think about measures of care coordination.

And going back to Rita's point, the only perspective we have I think that really captures where the care coordination is happening is the person for whom the care is supposed to be coordinated. There is no other perspective right now that tells us that.

You can't do it at an organizational level because that organization says yes, we tied off the bow on our end but you don't know whether the other organization received or even understands the information that the first organization sent. So it really is an attribution issue.

DR. REINHARD: That's a very good perspective. Thank you, Michael. Fred,

you're last.

DR. RACHMAN: Yes, actually I think following on that actually. I think the problem -- I think this concept that we're grappling with is very different from most that we look at developing measures for. And I wonder how often being truly aspirational is something that is part of a process of endorsing measures.

In this case we're trying to measure something that the reality is we don't do very well. And it's almost as though the ability to measure it is what we're really trying to measure, you know?

If you could -- in order to be able to measure care coordination you have to be able to do it. And it's probably the biggest challenge we're facing in this country right now. It's that fragmentation of services and the disconnect between medical services and other health and social determinants-related activities that are at

the core of the problem of our health system.

So one thought is, and I think you hinted at this. Could these measures be viewed somewhat differently?

I remember reading many, many years ago in a performance improvement book someone saying that we shouldn't measure performance to say how we're doing, but we should measure performance to say what's important.

And I can't help but think part of the fear of putting these measures forward is who are the consumers, how will that information be used, what are we setting ourselves up for, how much tolerance is there that a lot of the effort is going to have to be in putting together systems to collect the data to begin with.

And that maybe if we're truly trying to be aspirational we need to set the stage for how at least in the initial period these measures are to be used. And they're

not ones that would be, you know, punitive or have at least initially have heavy commercial implications.

But rather that we are really trying to establish a set of measures that are very different from what quality measures have been in the past. They are these aspirational measures. They are a set of standards against which we're hoping people will begin to develop systems and shape systems.

DR. REINHARD: That is very provocative. Will we have time later, Sarah, that we can address some of these?

MS. LASH: Oh yes, I think so. And David had his card up, just before we move on.

DR. REINHARD: Oh David, I'm sorry.

MS. LASH: Did you want to add?

DR. ACKMAN: I'm one of the novices here. But what I'm hearing is both from Don that we don't really know what works

in this, that there's not an evidence base for what works. So, I'm not sure, does that beg the question is it premature to develop measures for a lot of this?

Or if we're going to, you know, because the consequence of developing measures is creating work, creating costs, creating -- and rewards and punishments for things that maybe don't make a difference.

DR. REDDING: If I could jump in briefly on that. I think there's a growing and significant amount of evidence that care coordination works. It sounds to me like it has not been submitted to the committee in a manner that facilitates the development of measures. And I'm asking.

But with that sort of a translational thing like Michael is talking it hasn't been translated into measures.

MS. LASH: Rita has a burning comment.

DR. MANGIONE-SMITH: One follow-up

comment. I didn't mean to suggest when I said the thing about individualized plans of care. The biggest thing we ran into were the effective care coordination interventions were bundled. So, a care plan was just one piece of that intervention. So you didn't really know were there individual parts of it that were really driving the better outcomes that they were seeing.

But there is clear evidence that care coordination bundled interventions have decreased your hospitalizations, EDUs, increased medication adherence, all kinds of great outcomes that were very positive.

But when we peeled it down to that one particular thing that we wanted to make a measure about and feel good about that we feel like it's mushy. Because I don't know if that's what was really making the difference. Or was it the care coordinator that was really making the difference? And my hunch is it was the care coordinator who was making the

difference.

DR. REINHARD: So, these are very important provocative discussions. I think back to what Mark said in his comments about we're moving from a 19th century system. We are talking about transformation. We are seeing it. There's a lot going on.

Is it premature? Should it be more aspirational than our quality measures? Lots to take in here.

But I want to turn to other things that NQF is doing which is also aspirational around population health, duals and what have you. Again to keep setting this context for what we are going to be doing around domains and sub-domains.

So, let me turn to -- I think first we're going to have Elisa Munthali. Did I say it right? Yes, you're right there. Thank you, thank you. Who is going to talk about the efforts to improve population health outcomes. Are we ready for that? Good.

Thank you.

MS. MAKAR: Good morning, everyone, and thank you for this opportunity to talk about a project that we're really excited about. It's the multi-stakeholder input on the national priority of Improving Population Health While Working with Communities.

You might see this project also referred to as the Population Health Framework Project on our website if you're looking for any information.

Through a multi-stakeholder process and committee led by Kaye Bender who's at the Public Health Accreditation Board and Bruce Siegel who's at the America's Essential Hospitals we're developing a community action guide, a resource for communities at all levels including local, state and national that provides guidance on how they can improve population health.

It is intended to be practical.

It is written in plain language deliberately to make sure that we have broad application.

It introduces 10 key elements for improving population health from a readiness assessment to a plan for sustainability. And I'll talk about those further on in my presentation.

The guide also includes guidance on how communities can work with the public health system and clinical care delivery system. And it includes a subset of shared definitions so that there's better coordination and alignment.

This work is also funded by HHS and we're working very closely with Sam and Nancy Wilson.

And we're in the first year of what we hope and expect to be a three-year project. The first draft of the guide was posted for member and public comment just yesterday and it will be available until April 16.

And I think Lauralei has some hard copies that she'll be distributing to everyone. And I think we can follow up with a link to the guide online and also a link to the commenting tool. I would love to hear your feedback on that as well.

This work -- I've put up the National Quality Strategy's slide. And this work is really predicated on the three-part aim of better care, Healthy People, Healthy Communities, and affordable care.

And as reflected in its priorities it takes a comprehensive look at health and wellness. So it goes beyond the medical model. I know you've been having discussions this morning about that. And so it is promoting healthy living and well-being through community interventions that result in the improvement of socioeconomic and environmental factors. Those that result in the adoption of the most important health lifestyle behaviors across the life span. And

the receipt of effective clinical preventive services across the life span in clinical and community settings.

As you can see from the data that you see in front of you from the county health rankings of 2012 this also emphasizes the importance of looking beyond the medical model and really considering those upstream determinants of health, and looking at the considerable attribution that those upstream determinants have on illness and death.

The county health rankings adopted the model that you see here, the Health Outcome Logic Model, to demonstrate the relationship between health outcomes, their related determinants and the policies and programs that can be used to improve population health.

And so what I wanted to do on this slide is to just give you a brief overview about all of the work around population health that we're conducting at NQF.

And we're focusing with all of this work beyond the medical model, not just with the Population Health Community Action Guide but also with the project to your left which is the Health and Well-being Endorsement Measurement Project. That focuses on the endorsement of health and well-being performance measures.

And to the right you'll see the work around map families of population health measures which focuses on identifying and recommending aligned population health measures for inclusion in federal programs.

All of these projects will address an aspect of measurement gaps, the methodological challenges to population health measure development.

Some of the issues you talked about with attribution we've talked about them also in the endorsement project. Those are big concerns as well for that committee as well.

And we're hoping that we can create some opportunities for leveraging the work across these committees with the steering committees and also with you as well.

So, to further promote alignment between the work we've mapped out the major milestones of the three projects I just mentioned. And we'll focus on the third column which is the Population Health Action Guide.

And as I mentioned earlier we're in the first year of what we hope will be a three-year project. The draft as I mentioned is available for comment until April 16. And the committee will reconvene -- this is their second in-person meeting -- in June.

And we will culminate the first year of the project in August with the first draft of the Community Action Guide which we're calling version 1.0.

In year 2 we will select 10 local, state and national feedback communities to

pressure test the guide. So what we want to know is what did they think about it. What are their challenges with implementation or what are their successes. And that feedback will be included in the second iteration of the guide which we're calling version 2.0.

And in year 3 the committee will work very closely with the feedback communities to address any of the issues and concerns that were raised in year 2. And we will produce version 3.0 which will be the final Community Action Guide.

And so this is the final slide. We just wanted to let you know about in more detail the 10 key elements for improving population health.

And it ranges from various levels of readiness to begin population health programs to self-assessment, prioritizing health improvement activities and developing a plan for sustainability.

Each element in the guide provides

an explanation of the key step, why it's important and recommendations on how it can be achieved along with helpful examples and resources.

And so in closing I just wanted to thank you again for this opportunity to share this work. We have done quite a bit of outreach.

We realize that this is work that's traditionally not a part of NQF and so we're reaching out to many networks and we hope that you can do the same, letting people know about our comment period which opened yesterday and is available on the web until April 16.

DR. REINHARD: Thank you, Elisa. We are going to have all three presentations and then some time for discussion. So if you could just hold any comments.

Wendy Prins who is the senior director at the National Quality Forum is going to discuss four other sub-areas in this

kind of gap area that we're in. So let me turn it to you.

MS. PRINS: Great. So the conversation about coordination is really appropriate for what I'm going to present because there's a lot of work going on at NQF related to what you all are discussing today.

So, I think at your web meeting when you were first introduced to this project I presented a little bit of an overview about these five different content areas. So we have four parallel projects going along identifying priorities for -- in the measure gaps.

And I wanted to give you just a brief update today on how that work is progressing because they're all sort of working at the same time. But there are obviously a lot of interrelatedness areas. So we want to make sure that as staff we're helping to coordinate and inform one another. But I think it's also really important that

you all as committee members understand as well.

So, the first one I want to talk about, and this is just very briefly because it's a pretty confined project, but it's really around adult immunizations. And that group is focused on prioritizing opportunities to really increase vaccination rates and outcomes across adult populations.

So clearly there's a lot of good work that's gone on in childhood immunizations but there's a lot that really needs to be done in the area of adult vaccinations.

And the reason that I actually chose to offer you an update today on this one is because that group met earlier this week and had some pretty interesting conversations about sort of looking ahead on the horizon and really trying to figure out how immunizations could be part of a preventive service bundle.

So thinking again, I think, more aspirational is helpful here. But that group

also recognized that there are just simply some pretty significant limitations to that at this point.

They actually have immunization information systems, so registries that they're using, but those have limitations. And so thinking about the data needs and infrastructure was really important.

They were also talking about -- which may be important here for your conversations about the needs for provider-level measures as well as population-level measures. So, the population-level obviously to kind of see how we're doing more broadly as a nation or as a state or a community. But then also at the provider level to have those more actionable sort of process measures that can drive improvement so people can see how they perform and benchmark against others.

Another project that we have that's underway is related to Alzheimer's disease and related dementias. This project

is phased a little bit later in order to take advantage of the work that you're doing here today as well as some of the other projects.

But it's really timely. I think this work that you're doing will be very informative because of course a lot of caregiver issues, a lot of issues related to how to connect to community supports and services, the caregiver burden, end of life issues. So there's a lot wrapped up in this.

That group is if you're familiar with some of the earlier work at NQF that we've done around episodes of care, so they're sort of looking at it from that approach but not necessarily the medical model.

But really thinking about are there measurement areas or opportunities for identifying folks who may be at risk for developing dementia. Early screenings, things like that. How to really identify and become more aware of symptoms early on, early detection.

Again, evidence here is limited so that group will be grappling with some of these issues as well. Then progressing into evaluation and initial management, functional issues, cognitive issues, what type of measurement opportunities should they prioritize there.

And then finally moving into sort of the more intense care and treatment family supports and end of life, bereavement. So I know they're going to be really interested in your prioritization efforts and will probably draw on that as well as they move forward.

Then we have a really I think connected body of work for this project which is related to the health workforce. And that group will be meeting I think two weeks from now.

And they're focused on development and deployment of the health workforce to address prevention and care coordination. So, some very significant linkages here.

And I think some of the discussions already about care coordinators who really don't want to be care coordinators, and if they don't want to be care coordinators they're probably not trained to be care coordinators.

And so what are the needs in the workforce to really help us with prevention and care coordination, thinking sort of outside of the hospitals and the medical system itself.

And so they have nine domains that they're going to be talking about in terms of what are the measurement needs for training and development.

Experience of care. So, from the patient's perspective, from the family's perspective but also thinking about staff experience and how you would measure that and how that relates back to quality and safety and all of the things that we've been talking about.

Workforce capacity and productivity and infrastructure issues. So again, I think we're going to get into some really meaty conversations and probably also some areas where the evidence is really challenging and measurement may be particularly challenging.

I'll note here too, and when I finish with this I'll turn it over to Cille to see if she has any comments. Because she's helping to lead this entire body of work from the HHS side.

But we also have five sort of colleagues of Sam's who are helping us as subject matter leads on this work. And so both this project and the Health Workforce Project are being led by folks out of HRSA. So, there's definitely some coordination going on on the HRSA side that's really interested in this.

And for the Alzheimer's and related dementia we have D.E.B. Potter who's

out of AHRQ who's helping us with that work. And then I'll speak in a moment about our person- and family-centered care project. And that's being led by Kevin Larsen out of ONC.

So some interesting folks around the table from the HHS side and some very robust I think coordination efforts going on and input-gathering from HHS across the various agencies to help sort of get that perspective as we move forward with this work.

So, moving onto the last one here. This is our person-centered care and outcomes work. And they're going to be meeting next week on Monday and Tuesday. And that's really taking a look from the patient's perspective what are the measurement needs.

So, we've done a lot of talking about patient-centered care, person-centered care, what it is that we need. But this group is really trying to view it from the patient's lens. And we have a lot of patient advisors, patient advocates on that committee. And I

expect some really interesting conversations next week.

This is sort of their preliminary work. Their working definition is still evolving but I think you'll see some similarities to your definition in terms of preferences and values and planning and delivery and evaluation of care.

So that may offer a complement in terms of the patient's perceptions and perhaps that rises to a level of a recommendation around care coordination. So we'll kind of have to see how that work evolves.

Our core concepts are really, again, framed from the patient's lens in simple language. And this will again probably evolve but I think it's interesting to sort of take a look at is really wanting the medical community or people providing care to know the person and not just see them as a condition or as something specific to treat, but really moving beyond that into thinking about

physical, mental, emotional, spiritual, all of those types of issues when working with patients.

Giving me care when and how I need it. I think that speaks to the work that you're doing here today. Again, care that matches preferences, values, goals and decisions, and really having those important conversations so that the patient's perspectives are included.

And you'll see some other things related which I think to me the more humanistic elements in terms of respect and dignity and things that we probably don't regularly measure, but how patients feel that they're being treated as they're receiving their care.

So, let me stop there and then I have one more slide related to our Measure Applications Partnership work that we're doing.

But Cille, do you want to offer

any of your sort of big-picture visions for this work?

DR. KENNEDY: Well, let me speak a little more generally.

First of all, I apologize for having come late. The Red Line. I was sitting there pretending I was on a cruise ship so that I could at least enjoy it because it was taking that long.

(Laughter)

DR. KENNEDY: At any rate. Yes, I have the really good fortune of being sort of overseeing this contract with NQF with these five very interesting topics, very diverse topics, integrated and yet each its own entity and being.

And you will appreciate from the perspective of quality measures that my job sort of looks to the structure and the process in that -- for my good fortune the five different topic areas all will be doing the same sorts of things. The way they go about

is similar.

For example, each has a subject matter expert like Sam in charge. Because I can't be an expert, believe you me. And don't even pretend not on TV to be an expert in those five diverse topics.

And Sam worked very hard along with other colleagues and she's backed by key stakeholders. I don't want to mix languages but experts within the Department as well that she has behind her helping so that she isn't just singled out and standing alone.

Working with the NQF to lay the foundational work. And then when the co-chairs take over if you will what we need is the outside expertise to inform the government so that we're not busy talking to ourselves, that we're telling NQF to tell us what we wanted to know. And we tell them what that was.

So it's your outside expertise that we're relying on and we want to thank you

very much.

The great news is that progress to date has been pleasing the experts within the government. We now -- and you've heard yourself wanting more or slightly different shades of things and that's exactly the kinds of things that we need to hear.

I don't know what more I could say than that and the process itself very much appears to be working. And we're at the phase where you are the people, you are the experts that are making it work and I thank you.

MS. PRINS: So I have one more project that I have a hand or a finger on or something. I'm sort of bridging all of these trying to make sense. Perhaps I'm the care coordinator at NQF.

(Laughter)

MS. PRINS: But we have a Measure Applications Partnership and Sarah will talk a little bit more about some of that work. But the MAP is really charged with the

selection of measures for different programs for the federal government.

And we have in the past done what we've called families of measures. And these families are really sort of more topical focused and are intended to guide the selection of measures. So, we know we have -- I'll give a good example.

What I realized earlier this week with our immunizations work is that in effect about 10 percent our portfolio is actually fluid pneumo measures. So within all of those, you know, how would you choose which measure to use as we're working on sort of harmonizing and culling these potentially redundant measures, or streamlining them so they cover broader populations and can be harmonized.

The task is still there of what would you select for different programs. So these families of measures are intended to do just that and sort of highlight high-leverage

opportunities for measurement within these topic areas and then really sort of look to NQF-endorsed measures and also gaps which would overlap a little bit with this project.

But we have a couple of families underway. Elisa mentioned the pop health family of measures that the MAP is working on. We also have one focused on, and I realize it doesn't actually even say it on there, it just says draft high-leverage measures.

But this is for patient- and family-centered care, or person- and family-centered care. So these are the five areas that they'll be looking to identify measures for between now and June to go into that family.

And you'll see again some overlap here with the things that we've been talking about. But I think really importantly they had a call last week I believe or perhaps the week before and care coordination was not on this list. And they wanted to make sure that

it was because the experience of patients, and I think that probably what we'll see here as opposed to identifying a measure to put in that family is actually the identification of a gap.

So we'll probably just need to make sure that we're all sort of communicating that and really elevating this. If it is of high importance I think these multiple streams of work at NQF can really I think highlight maybe even the uber, uber gaps that sort of cut across all of these. And that may be helpful to HHS as well.

So, with that I'll stop and turn it over to you.

MS. LASH: And then going quickly through just a few more projects.

You've heard about the Measure Applications Partnership. There's also a workgroup focused on measures for dual eligible beneficiaries that several people in this room are involved in. And that group has

discussed care coordination at length. It is a huge gap area and they would be very much in support of the conversations happening here to create some forward momentum on filling those gaps.

So, just so that you're aware there's also a family of measures for dual eligible beneficiaries experience. And the group has recently discussed quality of life outcomes and shared accountability across the health system for contributing to better quality of life outcomes.

How can that possibly begin to be operationalized in measurement? It's even broader than care coordination.

And they're meeting next week to discuss different measure gap-filling opportunities related to their key topic areas which are quality of life, care coordination, screening and assessment, mental health/substance use and structural measures because of the fragmented nature of the care

they received.

So, really it's measures in these five topic areas that are expected to produce the most change for that population.

And last but not least we have some other related efforts inside NQF. A project on potentially changing the NQF policy on whether to risk-adjust outcome in some process measures for socioeconomic status and other demographic factors.

That report is available for comment if this is a topic of interest to you. Some people are rabid about it and others are really just happy to let others take care of the hard stuff. But please do look into that if it's of interest.

And the care coordination measures, this group would recommend for development would be subject to that policy whichever way it ends up. But I think the current recommendation is that risk adjustment would be recommended.

There's also -- I guess you heard Elisa mention the MAP Population Health Task Force and their family of measures.

And we're also interested if we've missed any connections just to make sure that we're fully integrating this work. One that was suggested by a steering committee member earlier this week from the care coordination group is the American College of Physicians High-Value Care Coordination Project.

So, that's specifically about making more appropriate referrals to reduce these missed coordination opportunities and the frustration resulting in wasted resources.

So, we can sort of open for any comments or questions from the other presenters or thoughts. Fred?

MS. INGRAM: This is Carolyn Ingram and I would like to just jump in on the last couple of slides you brought up about integrating care for people who are dually eligible.

And maybe you already are doing this coordination but there's a group, the Integrated Care Resource Center, that's funded by CMS to help states as they're moving forward in integrating care.

And a lot of the states involved in that project that get help from the center are looking at different quality measures. Some of those things that you listed on your slide are the exact things that they're considering.

So some of the states are creating their own. Some of the states are trying to look for best practices out there. So it might just be another area for coordination back to make sure to work with the Integrated Care Resource Center because they obviously, those states will be very interested in your work as you move it forward.

MS. LASH: Thanks, Carolyn. And if there is care coordination measures that the states are working on we really want to

bring them into our scan as well.

MS. INGRAM: Yes. And I can help get those back to you.

MS. LASH: Thanks so much. I didn't see what order the cards went up, but I guess Fred and then Don. Then we'll come over here.

DR. RACHMAN: So, great, thanks. Really, the synergy between this work is really apparent and very interesting.

A couple of questions come to mind. One is has it come up that there might be some unintended consequences of these measures?

For example, an immunization measure. If it's attributed to an individual organization, you know, we see this all the time. Kid comes in, we don't know if they got an immunization. We're going to be measured on whether it's up to date and so we give the immunization because that way we're compliant.

Meanwhile, that's not care coordination, right? Because that kid may have gotten an immunization twice.

So is there any thought about looking at that like overuse of some services tied to meeting the measure? That was one question.

And then related to that I'm really still thinking about this issue of attribution which I think is a really interesting one.

And one way to drive coordination is where the attribution is aimed. So, if it's an individual organization that's responsible that drives an individualized response.

If somehow, you know, and I don't know how you do this, but if somehow the penalty or the reward was at the individual level but the measure was attributed at a higher level and so everyone needed to be participating in helping that system achieve

that coordination goal, sort of like a shared risk model or something for a quality measure.

DR. CASEY: Yes. So, I think the attribution question fits in with the notion of how accountability is defined in the context of a vagary called "shared accountability." Perhaps maybe that could be parsed out.

I have a couple of comments and then a question for Sarah on the MAP family of measures slide.

The first is that when I hear the phrase "beyond the medical model" I think that's a normative construct and I think we ought to be very careful about using that phrase. Because I'm not sure it's been clearly defined or discussed. So, you know.

And again, I like to think of three categories of issues from my own perspective as a primary care internist. The one with chronic illness which is an episode that lasts forever. The next is an episode

where you're seeking curative care which could be, you know, I went and had my appendix out and now I'm better. Or, something that takes longer, like cancer. And then the third is prevention.

So, each of those domains that are just mine made up have different constructs about the relative importance of the quote unquote "medical model." So I'm just cautioning us to be very careful about using that as if everyone understands and agrees with what that means.

The second is that part of our problem may be that we tend to stay in aspirational space so long that we don't get real and start defining pre-specified methods and time frames for our hardcore evaluation of what it is we're going to do. So that maybe is a backdrop to not ditch the aspiration but to really think critically about how we're going to get these things done in the next, let's say, two to three years as an example.

I don't see, because I haven't looked at it, the plans out of HHS but it would be hopeful and pleasing to see some of this spelled out in as much gory detail as possible.

And then if you could put up, Sarah, the -- keep going -- yes, that one, the green one. Yes, that one.

So, my pet peeve about patient experience is that having been chair of the technical expert panel that basically approved back in 06 or 07 the clinician-level patient experience measures in great detail, would it be perhaps maybe foundational to think about that top line which is for lack of a better oversimplification very transactional in nature.

And make it subservient to all four of those other things that are actually not hierarchies or not separate boxes, but actually linked to each other, and try to frame not that transactional experiences

aren't important, but try to frame the patient experience in the context, the ring of those other four topics so we can get past the, you know, I like my doctrine, I understand it. Which again, don't get me wrong, I think is important.

But do I really understand what the heck I need to do next to make myself better in all these frameworks? And how is that going to make me better? I mean, I'm trying to push the envelope on that just to think about how we might frame patient experience a bit differently than it is framed now.

MS. PRINS: Don, I think that's a really good point. I think that's something that the committee has been sort of trying to figure out too.

Because some of the other things you could potentially get at or you would get at through a patient-reported outcome or something like this. So I think that's a

point well taken. I can take that back to the group. Thanks.

DR. CASEY: Thanks.

MS. LASH: Let's go to the left. Ilene, welcome.

MS. STEIN: Hi. My apologies that I was late, I had a conflict this morning that I couldn't get out of. So I'm Ilene Stein from SEIU since I was not here to introduce myself earlier.

I do not have a medical background. I am a lawyer by training so really thinking about this more from the social services aspect and the non-clinical care kind of part of the spectrum.

We've been talking about attribution and one of the things that I'm kind of curious about is how do you hold kind of the social service non-clinical side accountable.

The people providing those services are not -- do not have the same

business model as providers. And as a result probably do not -- cannot be penalized in the same way.

And I question whether they should be penalized at all given the fact that they tend to very low resources and are already unable to kind of meet the demand that exists for their services.

And I also just wanted to make a comment about SES. I know that it's a controversial area and I don't want to necessarily get into a debate about SES right now, but especially when we're talking about care coordination for dual eligibles there's a clear overlay thinking about risk adjustment and socioeconomic status. And how that affects the ability of providers and social service providers.

And frankly, we, SEIU represents mostly home care providers. How that affects their ability to coordinate care and provide treatment and be successful when they're

fighting against some of the cultural issues that exist in the communities in which they're operating.

So I just kind of wanted to say that I do think that there's clear overlap between the SES conversation and the care coordination.

MS. LASH: Very good points. Vija?

DR. SEHGAL: Yes. Coming from a community health center background I want to just -- I cannot begin to emphasize the importance of risk adjustment for social determinants of health. So I remain in that group that is really, really finds it very important. Thank you for working on that.

But that's not the comment I wanted to make. I actually really wanted to commend you for focusing on making one of your focuses on the healthcare workforce.

I think that as a so-called panel of experts we have to be very careful to not

appear patriarchal in assuming we know how the healthcare workforce feels and things.

We're doing better in terms of really trying to focus on patient-centeredness and yet in that -- the first comment here about the CAHPS survey.

I mean if you -- I just came from the National Association of Community Health Centers meeting and I sit on their clinical task force -- what is it, Clinical Practice Task Force.

And we spent the bulk of our meeting just two weeks ago -- I was here in D.C. as well -- talking about CAHPS and how CAHPS is not reflective of the true patient experience because of language barriers, et cetera. And this is despite so much effort in really trying to focus on how the patients think and feel and their experience and whatnot.

You know, Wendy said that something really resonated with me, that we

don't spend near enough time really focusing on the workforce. And maybe we're having such problems with care coordination because the people who are doing the care coordination don't like their job because they haven't been properly trained to do their job.

So this is something that we're really experiencing at our ground level. We have had incredible turnover in our care coordinators. And it's been something that I've been struggling with as I oversee this group. And I think it's just -- I think you really hit the nail on the head. So I think this really deserves a lot more thought.

MS. LASH: Great, thanks. Michael?

DR. PARCHMAN: Sarah, can I ask you about the charge to the committee? About our domain? Just to clarify.

MS. LASH: Sure.

DR. PARCHMAN: Because we've talked about a lot of different areas of care

coordination measure. And at some point earlier in the presentation you talked about a focus specifically on measures of coordination between the health home and community resources as being the boundary around which this group is supposed to work. Is that correct?

MS. LASH: I wouldn't say it's an extremely tight boundary. It's not an electrified fence from which you should not stray beyond.

But we do want to put a priority on those relationships because other areas of care coordination are relatively better studied and better measured. Such as transitions from an acute setting to the community. Very important care coordination opportunity.

But there was a desire for this group to unpack some of those primary care community-patient relationships specifically.

DR. PARCHMAN: So, right. So

linkages between the health home and resources in the community that are not a part of the traditional medical setting is what we're talking about here. Okay.

Because that gets back in my mind to your question just a few minutes ago about overlap between these other areas of work. Such as, say, the dual eligible population.

Because I know in my work with our state on this issue they're talking about how to create accountable communities of health in small regions within the state. And how do they observe or measure the degree to which patients are not only getting access to but are having services coordinated between community agencies. So it's not just between the health home and the community agencies, it's coordination between the community agencies.

Which gets back to the point of there's no standard information system or data being collected anywhere about that, that they

can find.

So there's no way that, for example, the state could -- and this gets back to the attribution issue -- attribute a measure of care coordination to a community level and say we're holding you as a community accountable for the degree to which care is being coordinated between your agencies and your community.

And in fact, as a state we're going to think about the way we disburse funds in this issue.

Now, that's accountability. When we start talking about money people start saying ooh, that's something we'd be accountable for.

So I just want to steer us to thinking of it at that level in terms of accountability and attribution.

MS. LASH: Sam, correct me if I'm wrong but I think that type of relationship would still be in scope as a measurement

opportunity.

DR. PARCHMAN: Okay.

MS. LASH: Don?

DR. CASEY: Just quickly that I think Michael was, you know, the magnetic brain waves were syncing in.

And you know, one thing in the model is that we haven't included this bundle of payment policies, payers and other resources as maybe the fourth leg of the stool and sort of backed that away and said something like this three-ring model should really occur first. It's hard for me to believe we can extract that.

So I think your point is really well taken and I think we need to -- especially for the government plans and commercial payers that are telling their shareholders that they provide services and healthcare. I mean, we're dealing with Walgreens now and places like that.

We need to think about the payment

policies and payers put broadly in the context of perhaps maybe redefining the model.

MS. LASH: That environment is certainly going to play a lot of factors. Russ? And then you'll have earned a break.

DR. LEFTWICH: So, I want to take the opportunity to bring up my favorite data gap while I've got a broad audience that I don't know if I'll have later that I think is foundational to care coordination and care planning and to several things that have been mentioned, communication, attribution, accountability.

And I think my best presentation is summarized in the title which is care coordination should work like an NFL team on Sunday afternoon, but what we've got is a pickup game at the park on Saturday.

And that analogy starts with the team has a roster and everybody has contact information and everybody has an assigned position. We don't have that in our data

structure.

The Meaningful Use stage 2 requirement is that the care team is the primary care physician of record, and the receiving provider and other care team members if known. There's no mention of contact information, there's no mention of family and community caregivers as part of the care team.

I think to do all this we have to have a requirement for a data structure. It should be part of a clinical summary just as much as a medication list, problem list, allergies are. And that I think is something that all of us need to argue for that has to be in place if we're going to measure care coordination at all.

MS. LASH: Great. I think you're anticipating the next session about what are those measurement opportunities more specifically. So, to take Susan's line from her. Go ahead.

DR. REINHARD: No, no, just that

you're ready for a break, right? I think we still have to take the 10 minutes even though we're running a little behind, right? Okay. Please come back in 10 minutes. Thanks.

(Whereupon, the foregoing matter went off the record at 11:34 a.m. and went back on the record at 11:45 a.m.)

DR. REINHARD: It's my pleasure to turn this over to Mark.

DR. REDDING: Okay, so our next section is a particularly critical one. And I don't know about your brain but my brain was quite bent by the last discussion in a very positive way.

I think as all of us can see we come together as a national group with many different perspectives. And what unbelievable value those perspectives are to trying to make sense out of this. And we heard from HHS and NQF that so many different perspectives are being considered and thought through and then coordinated. I think we have coordination on

more levels than I had realized was possible.

So, I guess in this section one of the things to request from you in addition to your wisdom and guidance is that we make sure to have heard the different -- one of the things I heard from HRSA years ago was -- and Kay's here who is connected to the folks who taught me this. But it's kind of a multi-level chess game.

And so I think we need to respect and understand each of our different chess fields that we've got some expertise and try to bind those together.

There's going to hopefully be good discussion in this. I was going to ask for the purposes of trying to manage time if you could -- if we could have our regular mode that we used earlier and then if Sarah tells me we're time-restricted, if I could just say a very brief synopsis or a very brief comment on your part. And that way if there were 10 cards up we could go person to person and

limit it to a few seconds. But otherwise this discussion is going fabulously.

So, with that I think we're now on the slide that you can see where we're going to evaluate the draft domains and sub-domains for care coordination measurement.

It's amazing how well the ones that we've got so far have fit into the discussion today. But we've got to start with looking at these domains and seeing what's missing at kind of a high level.

And then in our next activities we're going to get at a more specific level working from those domains.

So, are the draft domains and sub-domains for care coordination measurement on the page right now? And what do we need to change?

And then the other point is I get the sense that everybody in the room is talking. But if the person next to you isn't sharing much prod them a little bit because we

need to hear from everybody to get this correct, or as correct as possible.

MS. LASH: So without further ado I'll talk a little bit about the methodology for how the team created the domains and sub-domains based on your homework results from the web meeting.

So, this activity was introduced at that time and you were asked to rank possible domains of measurement for care coordination between primary care and community-based services.

Each of you had 10 votes out of 51 possible sample domains that we drew from three key sources, the Clinical Community Relationships Measures Atlas, the ANA framework and the patient-centered medical home standards.

So you also have the option to add your own domains or propose revised wording of the sample domains so that they fit your thinking.

We tallied your votes. We did a lot of grouping of similar concepts to reduce redundancy and ensure that the list was complete and organized and there was some consistency in the level of granularity we achieved.

So we found that our themes broke out in three main clusters. And they relate to one another across time.

So the first cluster of measure domains are related to the creation of a person-centered plan of care. Then there are a series of domains about utilizing the health neighborhood to execute the plan of care. And then finally, we'd look to achieving outcomes.

There are three measure domains under each. And I'll explain more of what they mean as illustrated by the sub-domains on the following slide.

But for the sake of, you know, being really clear here our domains under person-centered plan of care are a

comprehensive assessment, goal-setting process and shared accountability being established.

Then, under utilizing the health neighborhood to execute that plan of care the availability of services, the relationships present and continuous communication.

And finally, under outcomes, three general types. Experience, goal attainment and efficiency.

So, I hope everyone had a chance to digest this in advance of the meeting because there's a lot. And a lot of good thinking went into creating this which I think is why it's so detailed. And yet probably for many of you at the table not detailed enough.

So, the language is purposefully broad so that our categories will remain broadly applicable which is something that we heard from you as a desire from the outset of this project.

So, I'll sort of work my way through the sub-domains starting with the

creation of the person-centered plan of care to explain a little bit more of the logic. And then we'll open this for discussion about possible changes.

So the comprehensive assessment has a health focus but is very inclusive to other fields to capture relevant information about supports and assets, function, behavioral health, medication management, patient activation, et cetera.

It also estimates a person's risk level so that care coordination interventions can be targeted appropriately.

Under goal-setting, three sub-domains person-centered communication, shared decision-making and setting goals to address identified needs.

This is going to have a choice of the appropriate clinical and non-clinical interventions that weigh the risks and benefits.

On shared accountability we would

have a plan of care documenting who was a part of that care team, including community providers and the care recipient and family. Any care professional might be leading that team, a doctor, a nurse, a trained care coordinator or a case manager. It would be important to know who and who's doing what in support of meeting the patient's health goals.

Moving over to the health neighborhood to execute the plan of care. Under the availability of services, are those adequate? Are they nearby? How good are they? Open data I think might be part of the solution to mapping community assets in a more realtime way that gets away from every social worker having a giant binder of Xeroxed community resources and phone numbers. We can actually look to electronic infrastructure to assist with that.

Are those services able to be accessed in a timely way? Are they reliable? Something that's very important for our home-

and community-based services population.

And community health needs assessments might reveal a lack of services and we would sort of initiate a larger urban planning process to address that. Or non-urban, sorry.

Under relationships, is there knowledge of and comfort with other parts of the system? So looking at provider's awareness, the family's awareness and are the relationships collaborative to facilitate coordination.

Under communication we have both an initial linkage between primary care and community-based services and then follow-up to ensure the services are actually being received and communicating those results. So this is a circular set of processes.

And then finally under outcomes, looking to experience of the care recipient, the family and the other members of the care team within the provider community as to

whether that coordination was effective.

Goal attainment, very important. Have unmet needs been met as a result of these activities for the services in alignment with the person's goals and preferences? Did they get what was in their plan?

And then has their health status improved or been maintained if that was their goal?

Finally, efficiency. Is there a reduction of duplication in care coordination services? Something that was mentioned this morning, especially for high-risk individuals. Are we coordinating the care coordinators.

Have we avoided duplicative intake and assessment processes where people are being asked over and over for their medication list, forms and questions about their financial status.

And avoiding repeat testing or inappropriate use, like the vaccinations example, because we're now sharing information

about what someone has or has not received as a service.

So we would like to ask you three key questions about the domains and sub-domains for measurement. Is there anything very prominent that you can't find on this sheet? Is anything missing that needs to be added?

Is there a sub-domain or domain that we've inserted here that you don't think is appropriate for measurement? Perhaps there's not enough evidence? Or it doesn't seem like a priority to you at all.

Or are any of these domains or sub-domains really striking you the wrong way, you find it confusing and it needs to be re-framed to communicate something different.

So, I'll leave this up and Mark is going to facilitate this.

DR. REDDING: Thank you, Sarah. Woody? Make sure your mike's on.

DR. EISENBERG: My comment is that

the utilization column looks provider-centric. By providers under relationships do we mean designated healthcare providers? Or could that be anyone who's providing the care, whether they're included say in the Social Security Act or not?

DR. REDDING: Excellent point. So is the provider a care coordinator, a physician, or anyone else.

DR. EISENBERG: Right, thank you. And the next part of that question is under continuous communication there is an emphasis that the initial linkage between the primary care and community-based services exists but then down at the bottom, the communication of results, it looks like it's only going in one direction. And that's from the community-based services to primary care. I think they should be bidirectional.

DR. REDDING: Very good. Thank you. Yes, Don.

DR. CASEY: Quickly. I think that

I'm fine with the framework. What I would do would perhaps maybe under the first perhaps maybe specify a little more aggressively the notion of prioritizing those interventions linked with the highest probability of improving health in specific use, effective use of appropriate and available clinical practice guidelines that have the biggest impact on a patient's health status.

Atul Gawande had a video on the New England Journal website today talking about low-value versus high-value. So perhaps maybe in the context of migrating from the quality chasm word "efficiency" we might consider low-value and high-value which is what I think you're trying to clarify which is more congruent with this decade.

And then I still struggle with patient experience in its tradition being very transactionally based and not linked as I said to the other domains in that diagram that Wendy had.

So, to the extent that we can migrate past "I like my doctor" and "I understood my medication" and you know, "everything is hunky-dory" to all these things are getting done and I have a clear idea of how they're getting done or not getting done. And here's how I feel about it.

DR. REDDING: Very good. So, Don, a quick question back to you. In terms of creating a language where we can understand each other and it's definitely a question.

As we complete a comprehensive assessment of an individual who's at risk and we identify multiple risk factors or issues does it make sense that what you're saying in terms of the value proposition is that how we address those risks should be prioritized based on the potential impact of the person's risk and then future health and based on evidence as you mentioned before?

DR. CASEY: As one way of framing it. It's not to say that because there's no

evidence or it doesn't fit into someone else's view of what should be prioritized we shouldn't be sensitive to that.

But I do think that one of the goals is to apply evidence. I mean, I just personally had a lady who decided that for her stage II breast cancer she wasn't going to do anything but take herbal tea. And you know, I sort of had to live with that. That was her belief system. So, try as I might to bring her to an oncologist it was too late and she ended up dying. But that's what she chose. So, we have to be congruent with that as well.

DR. REDDING: Yes. And it's interesting how that ties to Rita's comment about bundles versus an individual. Thank you. Yes, Richard.

DR. BIRKEL: I just wanted to point out that in the creation of the person-centered plan of care there's really no specification about, again, who's at the table here.

How do we -- is this a plan of care that's created by the medical team and then shopped around to the social service providers? Or is it jointly created with the -- and this goes to the issue that we spoke about earlier, not care coordination but a coordinated care plan.

So, who -- the creation of a person-centered plan of care. Who is in that -- who's included? We don't see anything about that. Just to point that out. That that's -- it documents who's part of the team but I'm not sure we're really speaking to how do you even create a person-centered planning team.

DR. REDDING: Excellent. And it kind of fits with Russ's comment about the football team. Very good, thank you. Vija.

DR. SEHGAL: Vee-yah.

DR. REDDING: Did I say it -- Vija. I did it twice, I think once before.

DR. SEHGAL: Just building on what

Richard just said.

In terms of the measurement of the outcomes it would be good while we're working on improving patient-centered care is to include some element of patient empowerment.

And yes, it's not just achieving the outcomes, achieving the goals, it's to what extent does the patient feel empowered in the management of their own care.

And then in terms of the redundancy I like what you said about avoidance of redundant intake and assessment processes.

One of the things that we focus on, however, is actually creating redundancies in terms of who has the ability to bring a patient into care coordination.

So, is it we want to -- you know, it's the no wrong door philosophy of case management. So, anyone has the ability.

Now, this is where you rely on good HIT infrastructure so that if someone has

done an intake, for example, it's not redone by somebody else. But in some ways you do want to create redundancies.

DR. REDDING: Thank you. Vija, does your comment also point us to consider a person's strength? I know in pediatrics and parenting and that kind of stuff strengths-based approaches are very important. By making the person feel empowered, is that included in what you're saying?

DR. SEHGAL: Absolutely. Absolutely. I mean, the whole concept is, you know, again it goes into what you just said also about the herbal tea. You know, each patient deserves to take ownership of their illness and take ownership of their care.

And that right -- this goes along with what I said earlier, about we have to be careful about not being patriarchal. I mean we have to -- if a patient is going to be empowered to take care of their health we have to be respectful of what that patient's

decision is.

Not be, you know, traditionally especially in the medical model. I mean, it's this top-down kind of approach to healthcare.

DR. REDDING: Excellent, excellent, thank you. Rita.

DR. MANGIONE-SMITH: So, in the middle column, the utilization of a health neighborhood to execute the plan of care, I don't know why but I'm really bothered by the relationships box.

And I think it's the measure developer in me that I'm jumping to your next step which I know you're asking us at some point during this meeting to come up with measure concepts.

And to me the idea of trying to come up with a measure concept about provider's awareness of value of community-based services is mind-boggling. What does that mean? How would we ever operationalize that?

That one bothers me and the second bullet actually bothers me for the same reason. Just, they feel very qualitative, you know what I mean?

So I don't know -- and maybe that's okay. But I think with the next task you're going to give us and since I was assigned to that middle group it's making me a little squeamish.

MS. LASH: Is there something more concrete about connectedness you might suggest as an alternative?

DR. MANGIONE-SMITH: Let me think about that.

DR. REDDING: Thank you. I think there are opportunities. I'm looking at Sarah. But to become more -- I think there's a balance between specific and keeping it broad. And so there are opportunities to make things more specific within the strategy. David?

MR. CUSANO: Yes, thank you. On

the efficiency front I was just thinking, talking about reduction of duplication in care and avoidance of redundancies. But sort of goes back to what Richard and Russ were speaking about.

If an individual has multiple points of access into the system, you know, on the comprehensive assessment piece we really need to define who's going to be developing the care plan and taking the lead with that. So I think we need to think about the comprehensive assessment in connection with the efficiency outcomes.

Then also with respect to efficiency I was wondering if maybe you want to think about not only reduction in duplication of care in outcomes but also maybe the impact on total cost of care.

I mean, one of the themes that we heard earlier in the day was affordable healthcare. And I think one of the purposes of coordinated care is actually to reduce

utilization and cost. So maybe we should consider some financial measures around outcomes as well.

DR. REDDING: Wonderful. And I have no -- in several programs there's a significant private business influence which has been very beneficial and they've talked about this timeliness, production, timeliness and efficiency. Thank you. Judy.

DR. NG: One point under the outcomes column. The last bullet in goal attainment which is improvement of health status I would like us to consider that not just improvement but maintenance or slowing of decline of health status. Because ultimately the question is to what ends are we trying to coordinate care if we ultimately have measures in the entire Medicare program. Sometimes you can't improve health status for the elderly or disabled.

DR. REDDING: Thank you, very good. Fred.

DR. RACHMAN: Sorry. I do want to acknowledge what an amazing piece of work this is. It's easy for us to sit here and pick at it but amazing piece of work.

One thing just back to this discussion earlier about integration, that's a concept that maybe does not come through very clearly here. And just a couple of thoughts of where that could be.

You know, shared accountability, is that something that might be tweaked a little bit to have this idea of integration?

And then the continuous communication. Again, is that something that could be tweaked a little bit. Either one of those categories actually becoming integration or something that gets at that concept that, you know, this isn't a bunch of separate coordinated care plans, this is a single effort.

The other thing, just a little thing around the -- well, I mean not so

little, but in the goal-setting and in the assessment, this emerging emphasis on patient-reported outcomes. And our goals as providers may be very different or often very different from what a user would come up with.

I mean, you look at a lot of medication regimens, for example. Quality of life may actually deteriorate as someone is meeting our medical quality measures and somehow that should be contemplated. So, somehow calling that out specifically, that there's some attention to that.

And then the last thing, I like that idea of the financial. And I would pitch that we think about that on both sides. So, what is the impact on cost, both dollars and time on both sides.

Because sometimes I think our notion of coordinated care may actually be adding burdens unwittingly onto the person being coordinated.

DR. REDDING: Fred, just a

reiteration back to you for clarification. But on one level we've got measures of an individual and we're organized in that. On another level we've got measures on a system of care or a population of individuals and on from there. And all those are critical to care coordination.

And like Michael has talked about, the interfaces between those different areas. Thank you. Michael?

DR. PARCHMAN: Just a few points around the creation of the plan of care. I think in addition to thinking about evidence-based for outcomes which was mentioned earlier I think we also need to consider burden on the patient and on the caregiver in goal-setting.

And I know we say shared decision-making here, but I can tell you from having sat in a lot of exam rooms with a lot of patients who have very complex healthcare needs that oftentimes in developing a care plan the full implication of the amount of

burden on them that this care plan is going to create is not taken into consideration.

And patients walk out with this after-visit summary that's spit out by our EMR that can go on and on and on and on for what they're being asked to do.

So I think somehow in terms of the patient-centered care plan the burden needs to be considered.

Second, as a health services researcher and the health services research community, we make a real clear distinction between measuring patient satisfaction and measuring patient's experiences of care.

And so I know there's been some concern voiced in the room about measuring this. But we're getting a lot better now at coming up with ways to get patients to tell us about their experience of care instead of their satisfaction with care. And those are two very distinct domains. So I don't want to throw the baby out with the bath water here on

asking patients what they think about care coordination. Because we're getting really better at that.

And lastly, about the relationships. I agree with Rita, this awareness just doesn't do it for me. It's really about the linkage piece between the community agencies, the community resources, the providers between communities, and it's about things like frequency of communication, accuracy of communication, timeliness of communication, communication that is problem-solving communication about shared knowledge about what each other is capable of doing in terms of abilities and competencies.

And there are some measures to that out there. Survey measures mostly, still, surveys about the degree to which between me and you as a service provider our accuracy of communication, our timeliness, our problem-solving, our relationship in terms of shared goals and shared understanding about

what each other is capable of doing.

And we're getting a little bit better at measuring that relational coordination piece. So, I'd like us to flesh that out -- piece that a little bit better, perhaps in our workgroups.

DR. REDDING: Thank you, Michael. One point of clarification I think in terms of using the term "relationships." There is good data to show a completely different kind of relationship, but the supportive relationship that the care coordinator actually has with their patient.

And how it's a warm and fuzzy component but it actually has evidence behind it to make things go forward.

But I think you're using the term "relationships" in terms of the other system providers that are working together for that care. Very good, thank you. David.

One quick point, David, before you go on. I just wanted to mention your point

about premature versus aspirational versus now. That seemed like an important -- it took me a little while to get it through my brain, but yes, that seems to tap into what Don was saying, so thank you.

But, please.

DR. EISENBERG: I'm glad you said thank you. I wasn't sure if I did something wrong.

(Laughter)

DR. EISENBERG: I echo the prior comments about having a financial measure of this.

And I was interested, the idea of the financial consequences on the patient as well as -- or the person as opposed to the provider.

On the other hand you could be creating excess care that comes at a cost not only in time but also in a copay or out-of-pocket expense. So I think that would be important.

The other thing is that I don't see here is an appropriateness. That is, and I'm thinking about that either on an individual level or an organizational level or at a system level or a community level is the level of activity, is the level of effort appropriate to the needs of the group.

So you know, are we -- is there a lot of effort being given to coordinate care for someone who is just happy being left to their own resources?

DR. REDDING: Excellent comment. One quick builder on that is in Ohio as Medicaid managed care plans are paying for and paying higher for at-risk care coordination.

The newest proposal is to have an actually separate individual go out and assess their risk, take the data and determine the appropriateness of care coordination and then hand it over to someone else so that it's more objective. Because I think what you're saying does go on since care coordination brings

financing and it's based on individual caseloads. Excellent point.

DR. EISENBERG: And just to add on that. In the special needs plans, the Medicare, Medicaid, the dual eligibles, probably all of the special needs plans under CMS there's a requirement to do comprehensive evaluations and to have integrated care plans for everyone.

And sort of without I think an acknowledgment that there's -- that the level of effort, that the complexity of the plan should be different based upon the needs. And that's never been explicitly said.

DR. REDDING: It's also a question is when do they no longer intensive care coordination. When is there a level of need to a point they could make it on their own? Very excellent. Russ?

DR. LEFTWICH: Don and Vija may have touched on this, but under comprehensive assessment it seems like we're missing capture

patient preferences and priorities, patient family preferences and priorities.

And secondly, probably next to assess health literacy would be assess technology adoption level. Because we're really creating a framework in Meaningful Use of electronic access to your information.

Somebody in a state that I may live in suggested that we should give the Medicaid enrollees a free app for their smartphone to access their claims data. Really? You know. So I would say that should be part of the assessment.

DR. REDDING: Excellent, thank you. And my 15-year-old son would say he'd like to see that assessment applied to me because he feels I'm so backwards, but thank you.

(Laughter)

DR. REDDING: Yes, Don.

DR. CASEY: So, three really quick follow-ups that might help.

One is this I think someone mentioned cost and utilization. Someone else mentioned appropriateness.

But I think that low-value versus high-value moves us away on the cost and utilization side from this perception that that's an actuarial sort of evaluation as opposed to assigning expectation of outcome to the inputs.

And you know, low-value or no value versus high-value also encompasses appropriateness because high value is doing things that are appropriate and have an impact. So, we ought to think about being careful about how -- we're all trying to get at the same thing about how we frame it.

The second is, and again it's just my pet peeve so I'll repeat it. I think the phrase "evidence-based" is old and out of date. Just because you've done a systematic review doesn't mean you've crafted thoughtful guideline statements in accordance with

evidence.

So, the term that we're using in our ACCHA guidelines around heart failure and other cardiac care is not evidence-based but guideline-directed which implies that there's been a next level of evaluation of evidence which then turns it into specific statements about what has the highest impact.

And then maybe on this linkage thing, I mean so Russ and I are linked, right? But, we're not necessarily on the same page about everything. So linkage is kind of again this connection or handoff.

I sort of think of synchronization. And maybe it's timely synchronization of linkages, I don't know. But just trying to put that all into one knockout punch to say let's get it done and let's be sure everyone is on the same page. You know, linkage is still sort of a little wishy-washy to me.

DR. REDDING: Don, just

clarification. Back to you but I've heard it said that if our outcomes report could be the same as our invoice sheet where the value of the impact is directly tied to that -- and I know we're not there yet and so they need to be succinct. But that would be -- that's consistent with what you're saying, I think.

DR. CASEY: Well, I think that just looking at cost and not thinking about what the consequences, positive and negative, are, just thinking about cost is where I fall, so.

There are underutilized services which could cost us more that will impact all this stuff in a positive way. So just trying to be thoughtful about it rather than actuarially.

DR. REDDING: Very good, thank you. Gerri?

DR. LAMB: I think this is a great start. Just a couple of things to build on others.

Under comprehensive assessment the things that this raises for me is one of balance among the measures which may be premature but just to say it, that this is ripe for composite. But I'd rather not see 400 measures here and nothing anywhere else.

The other thing it raises for me in the discussion of patient engagement and whose goals is the taxonomy here which is whose language.

This is all provider language and all provider categories. Do consumers frame their health needs in the same language that we are? And I know that opens a can of worms but people who focused on patient engagement raised that.

And then the last one in that category is risk level. There's been a lot of work on thinking through not just risk adjustment but low-, moderate-, high-risk for what and we need to be more specific about risk for what and how do we titrate the rest

of this for that.

Under shared accountability, just to connect is we now have the National Center for Interprofessional Practice and Education and a huge focus on measurement. They just completed a review of all the team-based measures, team performance, team behaviors, team outcomes and that might be a place to look for that.

I too, the level of relationships is off for me. It's too low on the Bloom's Taxonomy. I think we need to up it to behavioral measures.

I'm not quite sure I have the same problem that Rita does. I'm not as concerned about whether you value it. Are you willing to use it and use it effectively?

And then I agree with the discussions about we need to move towards more integration. And I agree with Don, it's more the synchronicity is are you on the same page and can you move forward and how to capture

that. That's it.

DR. REDDING: Thank you, excellent. Wow. Susan?

DR. REINHARD: I tend to think in terms of multiple chronic conditions so I'm just going to put that out there. I just think everyone needs care coordination. Certainly those -- and I include preemies with this, not just older people, of course.

And so to Judy's point, the improvement of health status, it really needs to be at least health and functional status. And we do assess function under that. But it is about whether or not you can get through life and you can function day to day.

And that, by the way, is being confirmed by the SCAN Foundation who's putting a lot of emphasis on this.

And it also gets to the use of community resources. That's what you're trying to do there is link them to resources to help them function better.

And the second one is that there -- I'm trying to see whether this would be under goal-setting, or shared accountability, or continuous communication. But the care plan has -- it's not static. It has to keep changing.

So we talk about continuous communication, but this care plan has to be a living, breathing document kind of thing guiding the care.

DR. REDDING: Excellent. And it seems that that ties into the reevaluation of a person's risk and need and where they are, whether they've gotten worse, and then tracking their risk change over time, individual versus populations at risk. Excellent. Thank you.

I want to check in with Sarah really quick with our time. Or can we go over a little bit?

MS. LASH: Yes, let's keep going since we started the session a little late and

I think this is a really, really rich dialogue.

MS. INGRAM: This is Carolyn. If we have enough time I just have a couple of comments.

DR. REDDING: Please do, Carolyn. Thank you for speaking up.

MS. INGRAM: Okay, sure. So, on the right-hand column when you're going down and the bullets that are on there listing out primary care providers and community service providers. Maybe this comes when you do the definitions of how this is used but just to make sure that we include other than traditional primary care providers like community mental health centers sometimes serve as primary care entities. Sometimes in tribal communities there are tribal entities that serve as PCPS. So just to make sure we're sensitive to that.

And again, that can be captured maybe in the definition. I'm not saying it

has to all go on here.

And then I think some of the previous speakers talked about appropriate improved health status. And I just wanted to echo that I would agree with them on that.

A lot of our more vulnerable populations that we deal with may not always have improved health status. And maybe it's just appropriate to either maintain that health status or maintain some type of quality of life even while the health status is declining for our elders in the community. Thank you.

DR. REDDING: Excellent, thank you. Yes, I think to us medical providers the new JAMA article saying 10 percent of a person's health is related to healthcare was kind of a shock. So there are some other folks out there critical to communicate with. Richard?

DR. BIRKEL: Just one quick point and a question.

The point I want to make is back -- I'm trying to re-frame what I said earlier maybe a little bit more specifically.

But it seems to me that the patient needs to be engaged in the creation of the care team. In other words, who is at the table, and particularly in regard to community-based services. So, they may prefer to work through their church to get certain things done, or the YMCA, or the Alzheimer's Association. That needs to be assessed up front and those are the people who should be at the table.

My question goes to this issue. I was really impressed with what Sarah showed the person- and family-centered care group, the MAP that they were using. And how does our outcomes, achievement of outcomes, relate to the outcomes that they're defining?

For example, they had experience of care, health-related quality of life which we don't have. The burden of illness which

again isn't on here.

I'm just wondering why wouldn't we want to adopt a shared outcomes template of some kind? Are we inventing a whole separate set of outcomes that isn't going to relate to what that group is doing? So that's a question really.

DR. REDDING: Very good, thank you. Nancy.

DR. GIUNTA: Hi, thank you. I find myself agreeing with so many comments. I really want to underscore the question of who owns the person-centered plan of care and who drives it.

And I agree with Gerri where we need to make sure the listing of measures is not necessarily provider-focused in provider language.

There is a bullet point for documenting care recipient's strengths and assets and supports, but really incorporating that into the plan of care is I think

important.

Also, the area of relationships. I will be in that workgroup too. So really looking at not only knowledge of community-based services but what are the facilitators and barriers to patients or clients accessing those services.

Particularly I'm thinking about funding streams and funding sources and what helps people be eligible for community-based services.

And someone mentioned the bidirectionality piece. I think it's really important to be aware that this is not unidirectional, this is not one-directional, but it's multidirectional between clients and providers and community services.

DR. REDDING: Thank you. And as somebody who's on the ground doing this work we're glad you're here with others. Thank you. Rita?

DR. MANGIONE-SMITH: Getting back

to you asked me to think about some other things to put in that relationship bucket. And this may be getting too specific. Feel free to reject. These are just -- I'm trying to resonate some of what I've heard around the room.

So, appropriate community services identified and contacted based on a needs assessment. Care recipient and family successfully engages with and utilizes community services. Shared understanding by providers, community services and care recipients of care coordination goals.

So to me that's more the kinds of relationships that I would want to see come from executing a care plan.

And I just have to say this because it's been bothering me. Under the comprehensive assessment there's nothing about the goals of the care recipient in there which seem like should really drive how that care plan gets constructed.

DR. REDDING: Absolutely. It ought to be driven by the plan of care. Thank you. Linda?

DR. LINDEKE: Really good thinking going on here today. It's very encouraging.

Continuous holistic monitoring has to be in here. I've been searching to see where there's a nuance of it.

And then the question is who does that monitoring. The level of workforce. So I was very interested in searching on who was on the workforce work of NQF.

And I always remember tuning into a webcast and they were demonstrating their good care coordination. And they said, well who did you hire. Well, the phlebotomist really knew what families needed because she's got a child with blah blah.

And I thought oh my gosh, that's fine. That's not the skill set I hope that this phlebotomist -- anyway, you can finish the thought.

The other piece is a huge blossoming career of health coaches, health guides, health whatever they're calling them, navigators, whatever. What is their skill set for continuous holistic guideline-driven. But then I say whose guideline. So I like you're getting from evidence-based but then whose guideline? So, continuous holistic monitoring and then we can dig into that.

DR. REDDING: I think your point is particularly poignant for programs, for example, who pay and expend a lot of their employees' time training them and then have other programs pull in right next door, give them a 2-hour training and say they're doing the same thing. It really taps into the economics. Thank you. Judy?

MS. STEIN: I just wanted to say totally agree with the earlier comments about patients needing to be involved in determining the composition of their care team. It is something that's very personal.

And I'm not sure if any of these capture how you determine what the appropriate composition of the care team is, and if the right people are at the table. I guess the hope is that in choosing the outcomes you assume that -- if you have good outcomes you assume the right people were at the table and part of the team.

But I think that I have two other comments. One is we talked a little bit about the definition of providers and we talked a lot on the call about needing a good definition of community service providers as well. Because that is a pretty expansive category of services.

And then curious whether it includes things like people who help with activities of daily living. Those are certainly services that are provided in the community and community-based care and essential especially for people with complicated chronic diseases.

And lastly, in addition to updating the care plan I think that you also need to update the actual care team. I mean as the individuals' conditions evolve new people might need to be brought into the care team. And I'm not sure how exactly to capture that as well.

And some people might need to move off. But I think that underscores kind of the theme of flexibility in developing care plans over time, to meet the needs of patients.

DR. REDDING: Excellent. So that we have time to feed you, so that you can do more of this this afternoon I'll just ask for a high-speed if that's okay report-out. And feel free to put your sign up. Sharon?

MS. MCCAULEY: Yes. Just to reiterate a few of the ideas that have already percolated up.

The big thing is that monitoring that evaluation, that reassessment, I think that's what you just hit on, that we have to

have the right providers at the right table. And I still question who that healthcare worker is, that health neighborhood who's really going to be manning or coordinating.

Like who's going to be the person who's going to start that assessment and continue that and make sure we keep bringing the right people at the table at the right time.

And the big thing is to make sure their standards are set for the knowledge. This is the first base. Then you get into that practice experience to make sure that that individual is really the person who can do that work. Are they going to be able to handle -- do they want to be there.

And then the last point I wanted to make is I highly agree with the priority-based applying that evidence. Because many times we have so many different areas here that have to be addressed.

How do you prioritize what comes

first, second and third? You cannot overwhelm the care recipient. And I think so many times we do. And they're not going to be able to hear us. So we really need to make sure based on evidence what's the highest priority number one, two, three of the goals that we've set in that shared decision-making can we hit and then again go back and reassess, re-monitor and then, you know, then the next group of care providers come in to help out.

DR. REDDING: Excellent, thank you. Michael.

DR. PARCHMAN: Just real quick. For those of you who are going to be in the creation of person-centered plan of care group this afternoon I'd challenge you to think about the burden on the primary care team of doing everything in that lefthand column on every patient who comes in the door from 8 a.m. until 6 p.m.

DR. REDDING: Excellent. That's where you need that care coordinator.

DR. PARCHMAN: No, no. You need a way to risk-stratify your population and say who needs this and who doesn't.

DR. REDDING: Right.

DR. PARCHMAN: So how do you do that as a primary care organization.

Now, there are people that are developing ways of doing that and there's the famous Kaiser pyramid which many of you are familiar with about that top of the pyramid people who need what's in this lefthand column.

But that has got to be taken into account when we think about these issues in terms of developing measures. So enough said.

DR. REDDING: Excellent, thank you. David.

DR. ACKMAN: Also, in this first column I think is this always starting and is this always under the responsibility of the primary care team? Is it always coming out of the medical setting?

Probably -- I mean, certainly not when you're talking about chronically mentally ill persons who are primarily connected through the mental health system. And that probably should be sort of recognized.

DR. REDDING: Since there's others out in the community who know the social systems possibly better than the primary care physician, but the physician needs to be able to lean on somebody related to those aspects. Very good. Don?

DR. CASEY: Just quickly. I appreciate this discussion and evaluation and wonder if in the heading achievement and outcomes, embedded in that is an implication that the outcomes and performance measures have been used to measure the outcomes correctly.

So, achievement, you know, you're not describing a system of performance measurement. And maybe that needs to be more explicitly in this model. And maybe it's more

broadly writ evaluation which would include other things besides performance measurement. But getting at evaluation not just to the microsystem but also the community and then in aggregate at the macro level from an HHS standpoint seems to be an opportunity.

I think that right now we have lots of what I would call sort of loose innovation going on. So I don't want to discourage that, but the more we get standardized we have to be careful about not discouraging innovation.

We ultimately have to have generalizable and sustainable results and adoption in a knowledge-based system that promotes rapid dissemination independent of publication to get improvements more rapidly into place. Not that we don't want to be scientific about it.

So I'm just, I'm calling out whether evaluation, performance measurement methods ought to be either in a separate

column or embedded in here a little more discretely so that it's clear.

DR. REDDING: Seems like a very critical point. Just quick reiteration. We need measurement at the individual level and then we need it at a system level. And system-level particularly we don't have.

DR. CASEY: But evaluation too, you know, which includes performance measurement. So writ broadly.

DR. REDDING: Yes.

DR. CASEY: Program evaluation so to speak.

DR. REDDING: Gotcha. Thank you very much. Robert?

DR. ROCA: Very briefly. Having been a participant in creating plans of care and a witness to the creation of plans of care I know that it's often the case that the members of the team are not aware of what's in the plan of care.

(Laughter)

DR. ROCA: And I don't see any mention here of the extent to which the members of the team are -- and then that's the other one, do they use it.

I've seen many plans of care put on the shelf or created just for the sake of creating them. So it may be implied in all of this but some explicit mention of the extent to which members of the team know about the plan of care and the extent to which they use it I think would be important.

DR. REDDING: Thank you, excellent. Karen?

DR. GIUNTA: I also want to piggyback on Michael's comments about the primary care setting responsibility to collect all this information. It might not only be the primary care setting's responsibility.

If you look at access to information, that community-based services might already have that. And the role of community-based services in potentially

advocating for people, clients, patients, that could be used to inform information that you may need, that primary care settings may need for assessments.

DR. REDDING: Similar to that term "integration" in our definition somewhere, yes. Thank you.

Fantastic work. Thank you very, very much. Sarah, anything else before lunch?

MS. LASH: We have two things to do before lunch. The first is to pause for public comment. The second is to actually preview the next part of the agenda so that you can do some individual work as you're eating.

So we'll do the public comment now. Operator, if you would queue the phone participants and in the meantime we'll see if there's any in the room.

OPERATOR: Okay. To make a public comment please press * and then the number 1 on your telephone keypad. No, no public

comments at this time.

DR. DAILEY: Hi, I'm Maureen Dailey from the American Nurses Association. And I know that you looked at ANA's framework for measuring nurses' contributions to care coordination.

And we all use the IOM six aims of care for the domains. Patient safety is missing here. And it's my personal experience with my daughter with a missed diagnosis of a massive tumor in two academic medical centers. And luckily we were able to get the right care. But it took a lot of care coordination to fill in the gaps of missed care.

And also being dismissed. So patient safety is important and I think that should be considered to be added. Thank you.

DR. REINHARD: So, you may have noticed that you got a little handout here during our break. And when we -- so while you're eating, as I said, this is not a free lunch. You really do have to do work. And

we're running behind, so together with that.

We're asking you to take these nine domains that we've been talking about that you have before you of course and take each one. You see these little stickies, right?

So you take each one and you consider that domain in two ways. The first is the extent to which it would be feasible to develop measures for that particular domain. So think about that first.

And then think about the impact it would have if we could develop those measures. So there's two ways of looking at this and you will individually use this sheet for your worksheet.

When we come back we'll have a discussion and I think Lauralei or others will be listening to us. And we will see if we can achieve consensus as a group on where these domains fit.

Obviously the high-impact, high-

feasibility is the sweet spot. You see it's in red. It would be great to get to there. We have some over there, but we know that they're not all going to be there.

But before we did that, if that's okay with you, Sarah, I just wanted to turn to Don and Gerri for a moment. They're going to have an opportunity to talk with members of their committee after we come back from lunch.

But in conversation beforehand it seemed like some of the thinking of that committee might influence some of your thinking for the individual work you're doing in terms of feasibility and impact, the tradeoffs.

Either one of you want to say anything? Just a few words to guide us.

DR. CASEY: Well, we know for a fact again that the group is highly emotionally charged and committed to these discussions. And so we promised the committee that we would include them.

But I think that relative to the comments we made before the current measures that come across are for the most part highly feasible, but they're only measuring a small amount.

And I think it was maybe Nancy and Rita who pointed out that as you get messier feasibility is going to fall apart. And maybe the part of this is sort of the ease of use of how the measures themselves let alone how the system works needs to really be thought through.

And without question I think that impact is again at a very focused level. So, I think we have to come up with an efficient way to help measure developers specify what outcomes would be the most important to evaluate.

As you get into outcome measurement it's extremely expensive and challenging to do that right. So that raises a question about whether, you know, how far we

want to push the research agenda given our current environment.

So, in the meantime I do think that there are things that systems can do a lot better on. And I think we heard lots of examples from our committee members about these examples of how we could do a much more robust and efficient way at the delivery point of evaluating without feeling like we're in a study.

So, you know, I just think we have to think through how that data gets compiled and brought together.

DR. LAMB: I think we've covered a lot of the concerns of our committee.

One thing I would add to it is as we look at putting these different domains on the diagram is to remember what I think several people here said is that they are not separate from each other.

And I think the challenge here is that many of these things may be what we're

dealing with right now in terms of the state of the art may be -- or a lower-impact, high-feasibility, and what we're dealing with is necessary but not sufficient.

So that it's going to really be I think the combination of things that we have to look at is where's the bang for the buck and what's going to really make this worth the time and effort to collect these data.

DR. CASEY: Could I just? I just got the announcement for today's Economist so this article says, "Is college worth it? Too many degrees are a waste of money. Return on higher education would be much better if college were cheaper." So maybe there are lessons learned in other sectors -- I'm being serious -- about how we might approach some thinking here.

DR. REINHARD: I'm thinking of the number of years of college education that occurred in this room alone, it's amazing.

Are there any questions about the

task head of us? Because when we return we're going to turn back to Don and Gerri and members of your committee who are I think going to join us on the phone. But I just wanted to have a teaser I guess of what you were thinking so you could apply that. Yes.

DR. GIUNTA: I know I'm sitting between you and lunch. But when we say impact is the ultimate goal, could you just give a one-sentence kind of description of what exactly we all mean by impact?

And if I'm the only person with that question -- then okay, okay.

DR. LAMB: I'm thinking about impact in terms of the review criteria for measurement which is does it lead to the outcomes. And what is the nature of the relationship between that activity and the achievement of the outcomes that we have in the right-hand column.

So is -- somebody that I work with frequently says is the juice worth the

squeeze. This is exactly that which is is the effort going to get us where we want to be.

DR. MANGIONE-SMITH: How do you apply that to the outcome domains that are on here?

DR. LAMB: Again, going back to the review criteria it's related to not only impact but importance which is do we have data that support the structure-process-outcome link both, you know, and I think we've talked about one of the algorithm is that narrative support is not considered evidence in the review criteria.

But we have a lot of narrative in care coordination and case management. So, how do we build the support that if we do this it's going to lead to the goal that we want.

DR. CASEY: Yes, and I would completely agree with Gerri.

What I'd say is that you've asked a key question and I think that's a journey, not a destination.

And part of the problem is, and I think Sarah pointed it out, endpoints in a lot of things that are out there as far as impact don't fit with each other. So we haven't sort of tried to set the agenda about what impact statements can be congruent through future work. And so I think we have to get through that. I hope that makes sense. I'm not -- there isn't a clear answer about exactly what impact, but we have to really think through it.

And I think this "Achievement of Outcomes" column is trying to get us to that point. But until we have consistency we're not going to be able to combine information.

DR. REINHARD: So, I'm going to give you two examples how I would think of it. And if anyone wants to push back they could.

In the long-term care arena the measurement of which CMS started a long time ago. I can't even tell you who developed these measures but it had to do with

restraints, physical restraints. Took years and a lot of data. People had to measure this, dah dah dah.

It has been so improved. The use of physical restraints in nursing homes has declined so much that we're not even including the measure in our long-term care scorecard that's coming out in June.

Instead we're replacing it with antipsychotic medication use. And we're hoping that the impact of it is really amazing.

In your field, Linda, I'm trying to think. Is it elective deliveries? It has to do with newborns. And that measure which I believe this group had something to do with that, the National Quality Forum, it's amazing what has happened with that. If you could just address that for a second, do you mind?

DR. LINDEKE: Well, the elective deliveries at late term which would have been 37 weeks-plus. And there's evidence and I

think the public is starting to listen to that and measurement, the quality of the outcome of the child. Some very physiologic measures. And they're paying attention, finally.

DR. REINHARD: I sit on the Leapfrog board of directors. I mean, this has been enormous. This is something that business has taken on as that measure.

So again, you've got to collect data, what was the feasibility of that. But the impact of it in a relatively short period of time has meant saved lives of babies and amazing drops in costs.

So those are just two examples that I would think of in terms of how hard is it to get to this measure or measure sets, and what impact would it have. And can you weigh that. Is that fair, Sarah? Is there anything else you want to add? Go ahead.

MS. PRINS: Can I -- I would love to add a little bit to this conversation because I think it's great that pretty much

every meeting that I go to now this EED example comes up.

And we were involved in sort of thinking about that because it's an endorsed measure. And when you think about the implications on the Triple-Aim, so cost, safety and health and outcomes of the baby. So there was evidence that it was being overused, that the cost to insurers was huge and that there were bad things that happened or that could happen to the baby.

So it was that sweet spot and it was, you know, it was just really we had a lot of people sort of working on it. And then it really, you know, everyone sort of came around it and it just exploded. And the results were amazing.

So, those types of things I think may be not as easy to find for this type of stuff, but where you feel like there may be those things that could really catapult us I think would be really important to highlight.

DR. REINHARD: Okay, Mark, and then we really want to eat.

DR. REDDING: One strategy, I think it just reiterates what you said. But obviously there's a huge amount of detail that could fall under each of these. And so if you have, and I'm asking this of you, Susan and Sarah.

If you have a sense that in those sub-units that would be there that there would be quite a few of them that would make this general item more feasible it may help you think through this scale. Because obviously there are big, broad brush strokes which is what we have to work with to begin. Does that make sense?

DR. REINHARD: All right, thank you. Enjoy your lunch.

(Whereupon, the foregoing matter went off the record at 12:54 p.m. and went back on the record at 1:23 p.m.)

DR. REINHARD: Okay, if you could

return to your seats. What we're going to do is Don and Gerri before they ate lunch kindly jumped in at my request to talk about what their committee has been doing to help inform your individual work and then our group work.

But we think there are members of your committee perhaps online. And so I just want to find out if they are and if you'd like to invite them for further comments.

DR. CASEY: They might be, I can't remember. Angela, do you remember if we cued any of the committee members as to what time to call in? Do you remember?

Okay, so anyone on the webinar from the steering committee who wants to make a comment identify yourself and let her rip.

DR. REINHARD: We heard a beep.

MS. LEATH: That may have been measure just un-muting my phone. This is Brenda Leath.

DR. REINHARD: Okay.

DR. CASEY: Are they on listen-

only? They're open lines? Okay, good.

DR. REINHARD: Okay. Yes?

MS. SCHULTZ: This is Ellen Schultz, a member of this other committee. I'd like to thank all of you for the opportunity to speak up and also just to listen and enjoy this really rich discussion.

I have something I kind of want to put out there to maybe provoke some thinking. Looking at this framework and thinking from a measure developer viewpoint what would be high-impact and what would be feasibility.

And one idea I had thinking especially how do we get to outcomes is thinking, you know, looking under this goal attainment box.

Instead of thinking of specific kinds of goals, even broad ones such as reducing unmet needs, or improving health status, or maintaining health status, what about just thinking, you know, did the patient achieve a goal. And keeping it really broad

to really be anchored in this person-centered care framework.

Now, I know that's a daunting prospect in terms of feasibility. But just for the purposes of discussion I kind of want to put that out there, that instead of trying to think about what goals people should have or what we think they might want, what if we could just look at did they achieve a goal?

And how would that really spur this process of assessment and shared decision-making and setting goals, and spur the process of helping supporting people in being able to achieve those goals.

DR. REINHARD: Can you identify yourself again and where you're from?

MS. SCHULTZ: This is Ellen Schultz. I'm a researcher at Stanford University and I'm a member of the Care Coordination Steering Committee.

DR. REINHARD: Great, thank you. You know, that statement made me think of

something Don said earlier where one of your patients had a goal. I don't know what her quality of life goal was but it was different than perhaps a physician might think of it. And she I guess attained her goal.

DR. CASEY: Well, I think it was a combination of me trying to be a physician without telling her what to do and letting her know my perspective. And then ultimately, you know, letting her follow her wishes. Being available to her at every step in case she had other information or changed her mind.

DR. REINHARD: Okay, all right. So then are we ready, Sarah, to move onto the exercise?

So, the goal here is that we're going to take one domain at a time and start with sort of a show of hands initially on, first, feasibility and then impact. And see if there's any consensus around each of these domains and where they fit on a quadrant.

This is in part preparation for

the next stage which will get us more into potential measure concepts.

So we are fine on time. We actually thought it would be an hour worth of this discussion. I think we're just fine. We don't mean to cut anyone short, but it will take away from the next section of the agenda. But I think an hour is a pretty substantial amount of time to have this conversation.

So, efficiency. I think that was the first one, was it? I lost track of where they were. No, which was the first one? Comprehensive assessment. Thank you.

So, feasibility. High, low? Anyone want to start? Well, just say whether you think it's high or low, feasibility. Okay, so we have one saying quite feasible.

Okay. Anyone disagree? No, not impact, feasibility. High feasibility? Everyone agree? Show of hands? Okay, good.

How about impact? Fred, it sounded like you had a thought about that.

I'm just guessing. Put your mike on, please, so we can hear you.

DR. RACHMAN: I'm really bad at this. I'm not coordinated.

It seems to me that it's almost a starting point. Because unless we're sure that we have defined all the domains and we're sure that we're able to use that as a lens to which we're judging how well everything is coordinated how are we going to measure it. So it seems like it's high impact to me.

DR. REINHARD: High impact. Anyone else agree? Rita?

DR. MANGIONE-SMITH: Actually, I'm in the bucket of low-impact.

And the only reason I say that, again, is our experience with this field test we just did where in the medical record we could many times find an assessment like this for a kid with complex medical needs.

And then we surveyed the parents of those same children. And only about half

of the time would they even endorse that they knew that they had a care plan.

So, I guess I'm a little hung up on how we measure this. So if it's measured based on what's documented and not really paying attention to do all the players actually know it exists and use it and update it then I think it's pretty low-impact.

DR. REINHARD: Okay. Don't forget to put up your -- and Gerri, I know you have a thought about this because you already gave us a clue early on.

DR. LAMB: I think this is one that for me falls smack in the necessary but not sufficient which means we need to do it.

I'm not sure that I would put it as high as some of the discussion in terms of feasibility because I think, Rita, you were speaking to this is depending on where you sit, what discipline, how you work with consumers, patients, you may define these categories differently.

I don't think there's tremendous agreement across disciplines on what we mean by some of these things. So I pushed feasibility to moderate.

And I also pushed impact. It's important but lacking everything else it's not where I'd hang my hat.

DR. REINHARD: Where did you put it?

DR. LAMB: Moderate, moderate.

DR. REINHARD: Moderate, moderate. I'll go right down then. Russ?

DR. LEFTWICH: So, I agree with Gerri. I think it's necessary but not sufficient. And if it's necessary I think it's high-impact. I think it's absolutely at the highest impact.

DR. REINHARD: So that's interesting because I keep -- I think I'm hearing a little bit like of course, like you've got to have this, right. But does that make it high-impact which gets back to your

original question, Nancy, about well, what is impact. Right? Yes.

DR. LEFTWICH: Somebody said earlier that we don't know what works. We know what doesn't work. And if there is no communication.

DR. REINHARD: Yes, okay. You have high feasibility, high impact?

DR. LEFTWICH: I had feasibility not quite up at the top, but impact, yes, up at the top.

DR. REINHARD: Interesting. Okay, well, keep going. Dave, then just keep going down the row. Could you put on your mike?

DR. ACKMAN: So you're saying we know that it does work. Is that?

DR. LEFTWICH: We know that care coordination can't work without it.

DR. REINHARD: It gets back to Gerri's necessary but not sufficient.

DR. LEFTWICH: If it's missing nothing else or --

DR. REINHARD: Okay.

DR. LEFTWICH: -- spontaneous care coordination.

DR. REINHARD: Okay, go ahead.

DR. EISENBERG: I think it's entirely dependent on if we're able to prioritize who gets this comprehensive assessment or not.

As David and Michael and others said earlier if we're going to have a comprehensive assessment of everyone it will be very high burden and very low impact and incredibly expensive.

So I would urge that we think about that as we're doing this exercise.

DR. REINHARD: Can I ask that question, Sarah? Because maybe I missed it early on in our discussions. Are we saying this care coordination work we're doing is for high-risk populations wherever they are, whether they're older adults or fragile babies or whatever. We're talking about risk.

MS. LASH: I think no one has made the explicit decision that we're targeting high-risk, but if you think about the populations that benefit most from care coordination interventions those come to mind.

There is a sub-domain about sort of tiering risk and matching people with the appropriate level of supports within this comprehensive assessment domain.

DR. REINHARD: Okay. Well, we'll keep going down. So, Michael and then Fred.

DR. PARCHMAN: I personally will probably find the next hour extraordinary painful.

(Laughter)

DR. REINHARD: Will find it what? An excellent --

DR. PARCHMAN: Extraordinary painful. Because we're doing such the traditional academic let's just break everything down into its individual pieces, reductionism, and that just is so counter to

care coordination in terms of what it actually is. It's just orthogonal.

And so I would agree with people, this by itself is low-impact. Right? But if you were to bundle it as your review found it's probably essential as a part of the bundle.

DR. REINHARD: Do we have an essential component?

DR. PARCHMAN: I don't know that I'm going to find this exercise very helpful, to be honest with you.

DR. REINHARD: Okay. But Fred, you were next.

DR. RACHMAN: So, that question that came up for whom, high-risk, low-risk, was something I've actually been struggling with through the day so far. And I wonder if we could maybe answer that question.

I could say the way I came to this thinking that it is everyone. And again, back to that bucket of care coordination versus

coordinated care.

And I think our health system needs coordinated care. And I'm a pediatrician. And I sit through all these meetings where we talk about that top whatever percent that's responsible for 90 percent of our cost and everything.

I see those people walk through my exam room as healthy babies. What happens between then and there? And if we really want to bend the curve that's the way we need to be thinking.

Because otherwise it's like managed care. We're going to keep skimming the top off but they're going to be replaced by the next wave and we're never going to really achieve any bend in the curve.

So I make the assumption that we're talking about everyone. And when we talk about care coordination, like care coordinators, clearly we can't afford to assign a care coordinator to every person in

the country. That's completely unaffordable. So, I think that's where that disconnect occurs. Because that is high-risk people.

And I guess I'm hoping that if everyone is on board with thinking more broadly we need some measures that are helping us track how the system evolves to be more efficient and effective at taking care of everybody.

DR. REINHARD: This is a pretty fundamental question. I think we're going to have to pause because it will affect every issue. You raised it early this morning to begin with. I wrote it down that that was an important thing.

So are we talking care coordination for everyone? Sarah, shall we start there? Is there any -- it's up to us? Okay. Go ahead, Mark.

DR. REDDING: You mentioned if risk screening is done appropriately and if everyone has some form of risk screening,

whether it's by geo-coding or other strategies, then that baby that is going to start out healthy and end up in significant trouble would have critical risk factors that might be related to environment or parenting. I'm so glad there's so many pediatricians here.

But if you risk-score that baby you certainly aren't going to find as many risk items as you would 30 years later. But there -- so for example, in Mansfield there are neighborhoods where 50 percent of the little boys go to prison.

And there's other neighborhoods where 80 to 90 percent of them finish college. So there are ways to look at currently healthy folks that have risk factors. It's not perfect.

I agree that there should be something related to the whole population, but I know for the contracts related to care coordination both in Ohio and nationally most

of the payers want some form of risk focus.

DR. RACHMAN: So just, again, you keep going to care coordination. I think you're absolutely right for that.

DR. REDDING: Coordinating care.

DR. RACHMAN: I'm really trying -- coordinated care.

DR. REDDING: I understand.

DR. RACHMAN: So how is it that we have systems in place? Because risk is dynamic and risk is continuous. How is it that we have systems in place where there is such a coordination amongst entitlements or things aimed at social determinants that we're catching people? So that's what I'm aiming at.

And so I think there are two separate things. One are measures of how the system is set up to be holistic, to be comprehensive, to be coordinated.

The other is how we deal with people that require intensive kinds of

services to manage. And there's not an --

DR. REDDING: Perfect.

DR. RACHMAN: -- here at all. And I'm just pleading with the group that we figure out a way to hold both because I think this exercise will look different for the two buckets.

DR. REINHARD: I agree with that. So Fred, I just want to be clear. It sounded to me you were saying coordinated care is the system level. Is that what you're saying? And that care coordination is more individual level.

DR. RACHMAN: I think we drift very quickly to that. And I'd submit to you it's very much a payer-based view of the world.

DR. REINHARD: Right.

DR. RACHMAN: And if we're trying to be aspirational I think, you know, we want to be thinking a little bit more preventive, a little bit more, you know.

DR. REINHARD: Yes, I tend to think of care coordination as the -- we need care coordination because we don't have integrated care. You know what I mean? It's like the solution we keep going to because of the fragmentation. And you're right to be thinking.

Gerri, I know you've been wiggling.

DR. LAMB: I wanted just to give kind of a historical perspective on that debate. Because it's something that in the first care coordination measurement group, and I think, Russ, you were on it as well. We kept debating should we split out case management, the more intense versions, transitional care.

And we made the decision to keep it fully integrated in care coordination for much the same reason that we're talking about here is to keep a broader, holistic view of care coordination.

And also the assumption that all patients, all individuals need coordinated care. And that it's a question of intensity and scope when you start risk-stratifying which has been around for 50 years.

So, that's actually one of my favorite parts of our report was our justification for really leaving them integrated.

DR. REINHARD: Which report?

DR. LAMB: Care Coordination 1. It was -- what year was that? Is that the 2006?

DR. REINHARD: Okay. So we should read that again. Yes, go ahead, Richard.

DR. BIRKEL: I'm wondering if a more fruitful approach to this exercise might be for each person to nominate two of their favorite domains for that high-impact, high-feasibility. Because if we go domain by domain we will have this debate at every single measure.

DR. REINHARD: Well, I think Fred might argue that we have to have this discussion anyway.

DR. RACHMAN: I agree it's been fruitful. But if we have it for the next measure as well I don't think we'll get through it.

DR. REINHARD: But can we think system and individual as we're talking about it? Or is that not fruitful? Gerri? Is that not fruitful?

I just want to hear what you said just now, that in 2006 you did this foundational work that we should be paying attention to. And what was the conclusion?

DR. LAMB: I think the conclusion was related to do we segment out according to risk stratification the care coordination and case management. And are we only talking about high-risk individuals. And that decision was not to segment them out.

I think the one that Richard's

raising is a different issue related to are we going to keep getting into this discussion of do we think about this as an effective bundle.

Because within that bundle, within that bundle -- and I think, Rita, that's what you were talking about is some of the difficulty with measurement is, you know, I know I'm going to sit here and say if I look at something within the context of all the domains then I'm going to place it.

But my thinking is never out of the context of the total. So it's, you know, I'm going to pretty much be a broken record in there because I do think of it as a bundle.

DR. REINHARD: But Gerri, I just want to be also clear. Is it both individual and system? I understand it was all, light touch to very focused, sustained care coordination, but did you think of the integrated care system and individual care coordination?

DR. LAMB: I'm going to need some

help remembering here. I think we reviewed -- we looked at both individual- and system-level measures. And it wasn't one or the other. It just became an issue related to feasibility and what level. But I think we came to the conclusion you have to have both. Because of the accountability issues.

DR. REINHARD: Okay. So Fred, what do you think about this? Put on your mike, please.

DR. RACHMAN: I'm somewhere in the sub-educable --

(Laughter)

DR. RACHMAN: I am really happy to hear that. I would bet that and I'm hoping that we can do that. And I do think it makes it challenging to do this exercise because we might rate certain ones of these things one way through one lens and one way through another lens and how would we balance them.

DR. REINHARD: Well, I think we could do both. Sarah, right? Couldn't we do

both? Make a note that it's -- she's trying to eat, the poor thing. So as you're chewing I'm just going to say what I think is being stated and then you can -- I know people have things up. I'm just trying to get to is there any stages of this that we do want to think globally or broadly, that everybody needs some degree of care coordination sometime in their life depending on what's going on.

And then there's this system versus -- not versus but system and individual level, family, there's probably all kinds of things in between, right?

And that I think what Fred is encouraging us to do is to articulate when we're saying it's at the individual level, when it's at the system level. And I heard Gerri say you talked about measures at both levels anyway and that we need to do that.

So can we do that, Sarah?

MS. LASH: I think you can. Maybe I want to take a step back and re-frame the

goal of what we're trying to get through torturing you with an exercise like this and that is an identification of the measure domains that are at the extremes. So what is both high-impact and high-feasibility.

As fertile ground let's go there first. Not to say that everything isn't a priority to someone for something, but if there are domains that we think are both low-impact and low-feasibility that would I think influence the prioritization of those relative to the others.

So, I liked the suggestion that we might want to just think about what goes in the upper right quadrant and why. And incorporate both system- and individual-level thinking there.

DR. REINHARD: Sounds good. Rita, I think you had yours up.

DR. MANGIONE-SMITH: Okay, so not I'm going to be the real measurement geek here.

I think what we're struggling with right now are what's the denominator. What's the denominator of any given quality measure that might come out of --

DR. REINHARD: Which we will get to. There's a whole section on that.

DR. MANGIONE-SMITH: Well, but it's really important because there's cognitive dissonance for me. If I'm thinking about some of these areas of domains of measurement and I think children with complex medical needs. Oh yes, that's high-impact for them. A kid who's healthy? Not such high impact for them.

Making sure a child gets an immunization every time they come to a sick visit when they're behind. High-impact for the complex kid? Absolutely. How about for the low-complex or the normal kid, the healthy kid? Absolutely. You know, so it's just that's the problem about not sort of knowing what we're talking about as we go through this

exercise. Because it changes my judgment depending on who my denominator population is.

And I think that denominator, that risk can be either medical risk or social risk. And whoever said it's dynamic and changes all through your life is absolutely right. So I think at any given point where we measure we have to figure out who's the at-risk population where we really think this measure matters.

DR. REINHARD: Okay. Anyone else? David? Could you put on your mike, please? Thank you.

DR. ACKMAN: Two thoughts. One is I hear this not so much as the distinction between individual and system, rather as sort of a program or an activity versus system.

So you know, on one hand you're sort of measuring the activities and that we are calling or putting into this group of services that we're calling care coordination. The other is sort of how the system is

functioning, whatever is in the mix.

I think your point, Rita, is a good one, particularly about the risk. I mean, the way we assign risk now is medical risk. It's cost -- it's prediction of future cost, prediction of future utilization.

That may not be really what is most impacted by some of these things. I mean I think about the nurse-family partnership. That's all about social risk. It has impact on medical spend but it's mostly about social risk.

DR. REINHARD: Good point. All right, can we -- is there another -- Judy, is that you up?

DR. NG: I just wanted to make another plug from the measure developer end of it to look at it in terms of denominator. Because someone who's healthy who's never had an encounter with the health system, what their care coordination is going to look like might be invisible and will be very different.

The other thing also is that if -- when you think about measurement, this goes back to the individual versus larger system. Also when you think about measurement you don't want to just measure only when a person is sick, you want to capture them somehow when they look healthy, maybe medically, but they might have other risk factors. So just another plug to think about that way too.

DR. REINHARD: Okay, go ahead.

DR. REDDING: When AHRQ pulled folks together this was also a point of major struggle. And they had care coordination programs from across the country.

And it really came down very clearly to what David said is although the two are part of one whole it's a different conversation if you're talking about the individual versus the system. The measures are going to be different. But they're both critical and interrelated.

And they ran into the same thing

and they ended up doing just what you're advising is to -- if you could put a little preface on the comment, are you talking about here or here, it suddenly makes it easier.

DR. REINHARD: Well, you know what? To just move us along I'm going to try something. David, is yours still up? Okay.

And that's to turn to Gerri. I'm sorry to put you on the spot but you have this history and you've been bringing a lot of that wisdom, and Don. Just that you happen to say it first I guess.

And that is which domain would you put in high-impact, high-feasibility? Just to get us started. Do you have any in that space?

DR. LAMB: I have efficiency.

DR. REINHARD: Efficiency. All right, so let's talk about that for a moment. Anyone agree? Oh, lots. Okay, David and then Ilene. David, can you say more about why you think it is?

DR. ACKMAN: I think it's been done on a large scale. People pay attention. It's -- my experience, the reference I'm making is to the health home program in New York State which they assigned I think hundreds of thousands of people to health homes. And there was a measure of -- I mean, it was really a cost-avoidance measure, an efficiency measure of reducing hospitalizations and I think overall spend. So, it's been done.

DR. REINHARD: I'll admit I had it in high-impact. I wasn't sure if it was feasible. So those who are more in the measurement area, then that's good news to me if that could be over there.

DR. ACKMAN: I haven't been part of it and I think there's a lot of discussion about whether it's because of the whole risk adjustment thing and accountability. So I remember those issues. I sort of walked away from it so I don't know how it resolved.

DR. REINHARD: Okay. Michael?

DR. PARCHMAN: I would agree. And I think it gets back to that comment I made earlier about who is the end user of the measurement. Who are the stakeholders that are most likely to use these measurements.

And it's probably going to be the health plans, the payers, the governmental groups that are looking across organizations, and across providers, and across clinics, and across clinics and hospitals, and across clinics and community resources. Because they're the ones who want this measure. And communities, and community groups, right? So I would say yes.

DR. REINHARD: You know, getting back to the system and individual, however you want to look at it, I do think the more integrated the system the less you'd need a care coordinator to make sure you don't get duplicative tasks and what have you.

Again, if the system -- you

brought that out earlier, Fred, with your example on immunizations. If you had the information because the system was integrated you would know I don't have to give the immunization rather than fear that you're going to get dinged because you didn't do it. So.

Anyone disagree with putting -- I'm just trying to move us along. Anyone disagree with the high-impact high-feasibility? Yes, okay. Vija.

DR. SEHGAL: Yes, I absolutely agree that it is extremely -- has incredibly high impact. But especially again this is where we go back to my world. It's very -- feasibility is not there. Yes, so I put it as high-impact and low-feasibility. Low feasibility because it's difficult to implement. And I'm thinking feasibility in terms of implementation.

So until you have -- I mean, if everything, if it was a perfect world and we

had those interfaces built up and we had that health information exchange then absolutely we would have a very efficient system which would yield high impact. But right now there's so much discordance.

DR. REINHARD: So you're questioning how feasible. David?

MR. CUSANO: I would actually agree with that. So, in thinking about the feasibility piece a lot of the successes we've seen, particularly coming from the industry side is the concept of the medical home which is really clinically focused.

And we're talking about care coordination. We're expanding the resources to include community resources and other resources that might not be integrated into the medical delivery model. And so I think when you're thinking about the feasibility you have to consider the new resources that we're trying to bring to the table and how that -- how those efficiencies will be measured from

a feasibility perspective. And being inclusive of the holistic set of resources that we're looking to include.

DR. REINHARD: Okay. Could I suggest -- go ahead. That you think it's less feasible than we thought? Okay.

So, should we put it in the middle? Sarah?

MS. LASH: Sure.

DR. REINHARD: You're okay with that? You said if we weren't sure you could put it on the line. I think so, I think there's a -- yes, just a little bit. We're not saying it's totally low. If something gets high we'll sort of put it in that zone. Okay.

Any other nominations for a high-impact high-feasibility? Any other? Yes, go ahead, Robert.

DR. ROCA: Well, I for better or for worse put experience in there. It seems like it's important. I think it has

potentially high impact.

I think asking people about, you know, whatever the complexities of measurement may be compared to many other things, asking people what their experience of how well organized things were doesn't seem all that difficult compared to some of the other things that we might be trying to measure here. So I would venture putting it in that category.

DR. REINHARD: Okay. Anyone agree? Oh, I'm seeing a lot. Experience would be high-impact, high-feasibility.

DR. ROCA: That's what I was proposing.

DR. REINHARD: That's what he's nominating.

DR. ROCA: That's what I'm nominating, yes.

DR. REINHARD: How many agree? Okay, who disagrees. Okay. So here's another one.

Okay, so let's start with

feasibility to separate what you agree and disagree with. How about feasibility? Who thinks it's high-feasibility? Okay. Low-feasibility? Okay, so Rita, I think you -- let me call on you.

DR. MANGIONE-SMITH: Yes. Just, I'm a very, I'm a proponent of survey measures so I don't want to come across as somebody who doesn't think -- and that's how we get at experience, right, is to survey people.

I'm a firm believer in the CAHPS measures and like I said before, most of our care coordination measures that we developed were survey-based measures.

My -- but my skepticism about feasibility comes from my experience as a survey researcher and working with the CAHPS group at RAND. Response rates are really low. And you traditionally get very biased samples of people who will actually respond to those surveys when they're mailed to them.

We had tons of problems with

response when we field-tested our survey. So, while I think you get very rich information that can really be impactful and drive quality improvement I'm very -- I'm much more skeptical about broad feasibility.

DR. REINHARD: So would you say high-impact low-feasibility?

DR. MANGIONE-SMITH: Right, that's where I have it.

DR. REINHARD: You put it over there.

DR. MANGIONE-SMITH: Yes.

DR. REINHARD: And you did too. Okay. Go ahead, Don.

DR. CASEY: Having, again, chaired the technical expert panel with Chuck Darby on this back eight years ago I just believe that the patient experience measures, especially those related to care coordination which I think there are only three and I think the CTM-3 from Colorado, Eric Coleman is I think the only other experienced measurement set

that's endorsed and is focused on the perception of care coordination.

But they're just, they're way too transactional for me. And that's why I think they're lower impact. I just had them -- I think they're feasible because you can at least implement if you're doing large-scale sample size estimates of organizations, but at the patient level, you're right, the feedback becomes less meaningful. Everyone seems to focus on the comment box as being where they get the biggest bang for their buck.

DR. REINHARD: So it sounds like Don and Rita would put it in the middle again, but for different reasons. Oh you put it squarely, squarely in the -- okay, you might put it more on the middle?

DR. CASEY: I'd put it lower down below the line and closer to the middle.

DR. REINHARD: Okay. Anyone else? Yes, Fred?

DR. RACHMAN: Well, just, you

know, a question. If there -- if we couldn't figure out a way to make it feasible with different methodologies. This is a question to you. And whether there's any way to adjust. You know, there's things that you can do to adjust the responses or weight them or whatever before we put it -- before we throw it out.

Just one more on the problem side. I'm concerned about subjectivity. And many of our patients are very tolerant by comparison to a lot of dysfunction. And I'm worried that they're not going to, you know, we're not going to capture.

You know, I actually take care of a pretty diverse population and I'll tell you, affluent patients or more-resource patients will tolerate a whole lot less than many.

DR. REINHARD: So it sounds -- I don't know, Don. It sounds like we do think experience is important. I mean, if you don't know how this is working for patients,

families, or the providers, the care team, that's a pretty serious thing.

I don't know how we'll change anything if we don't know what people are thinking about it.

I think whether it's satisfaction versus something more meaningful, meaty is a big issue, a measurement issue. But that we need it. Maybe it's this necessary component but we seem to have to have it.

DR. CASEY: No, I'm speaking specifically to the paradigm of experience. And also on the provider side of it there's very little margin to make on whether you can actually act in a sustainable way to improve against benchmarks.

So, you know, this notion of having a consistent way to take the data and actually do something different is still all over the map.

DR. REINHARD: So, it sounds like, Don, you've been consistent throughout the day

on this. We've challenged the whole notion of experience, how it is conceptualized and measured at this point.

But would you offer that it could be conceptualized and measured differently?

DR. CASEY: Yes, and then it would be higher impact if it was focused much more discretely on defining things in terms of what someone I think alluded to as patient-reported outcomes or quality of life or things like that which are --

DR. REINHARD: I don't think we're confined to current measures, are we? No.

DR. CASEY: Well, then it becomes lower feasibility because we have to develop the measure.

DR. REINHARD: Well, there you go. So that puts us back in higher impact but at least heading towards lower feasibility.

Anyone else on this topic? Yes, Fred.

DR. RACHMAN: Just to connect.

Part of what we're struggling is like we don't know precisely what it is, but we sort of do know what it isn't. And this experience measure is really, like you could get at that. When you get providers and patients to tell you, you know, it isn't.

And so I just wonder if we couldn't put some creative thought to this and figure out some way to measure. Because I then it just seems like it would be

DR. REINHARD: I think that's the next part, right? That will be the next exercise.

DR. RACHMAN: -- there would be the ultimate common denominator. And actually when you think about it it would bridge all the populations. Because you would be asking people who are low users or, you know, are at the preventive end. And you would also be asking users who are at the more acute end. So I would love us to try to keep that somehow.

DR. REINHARD: Yes. So, let's keep it -- is everyone comfortable with at least now keeping it here and then in the measure development or concept stage we can talk more about it?

Any other -- I see nods so I'm just going to keep moving. Any other recommendation for the high-impact, low -- high-feasibility?

DR. MANGIONE-SMITH: One quick response to something Fred said earlier. I was kind of -- when you said could we maybe do this somehow in the future and I think absolutely yes.

I think with the way being able to respond to surveys electronically is really taking off. I think that's going to make it much more feasible to do this kind of measurement. But we're not quite there yet. We're still using mail and phone.

DR. REINHARD: Well, that's encouraging. Thank you. I think -- did

someone have a recommendation? Russ?

DR. LEFTWICH: Goal-setting.

DR. REINHARD: Goal-setting. Okay. For high-impact, high-feasibility. How many believe that? Okay. Who does not agree with that? I think that's -- okay, Gerri?

DR. LAMB: I would agree with high impact. I'm not as optimistic about feasibility just because there's such diversity about what we mean by goal-setting.

DR. REINHARD: So that falls in like what do we mean by experience, what do we mean by goal. So we keep getting to this fundamental.

Did someone else before I go to Fred? No? Fred. Is that from the last time?

DR. RACHMAN: It feels like I'm talking too much but at least I'm getting practice in using the microphone.

(Laughter)

DR. REINHARD: You're really doing well.

DR. RACHMAN: I'm worried that this one, its feasibility is also its downfall. Because it's going to be very easy to check the box, put the goal in, okay, we're done.

And then, you know, the problem is is that really translated into anything that's really getting at care coordination. And maybe it's back to that bundled thing or whatever, but I'm really worried about if we're going to select a few I would put this low in terms of impact.

I think we're probably doing really well on that right now. All these patients that are in medical homes. I mean you go to the charts, there's all these beautiful goals and care plans. But it's not doing it.

DR. REINHARD: Ilene?

MS. STEIN: Just on the idea that something is low-feasibility because no measures exist. It strikes me that there are

very few measures that exist on any of it.

DR. REINHARD: I can't hear you too well. Can you move forward a little bit?

MS. STEIN: Oh, sorry. So we keep on going back to the fact that there's no measures that exist and that makes it low-feasibility.

DR. REINHARD: Well, this is to develop them.

MS. STEIN: Right, right. So, but that's my point is like there are actually very few measures developed in any of these areas. That doesn't necessarily make it low feasibility. So are we discussing the ability to develop measures?

DR. REINHARD: It's whether we think it's even possible.

MS. STEIN: Oh, to develop measures.

DR. REINHARD: Is it possible to get there. Knowing there's work to be done.

MS. STEIN: So, something could be

high-feasibility even though it has no measures --

DR. REINHARD: That's right.

MS. STEIN: -- it's just a matter of --

DR. REINHARD: Is that right? Yes.

MS. STEIN: -- the idea that you can --

DR. REINHARD: Right.

MS. STEIN: -- the ease of developing those measures and capturing --

DR. REINHARD: I mean, there may be some that we think it's impossible. We just can't -- or like this, what Fred was saying is well, it's feasible, but what -- it's so feasible. I think that's really interesting.

And who's checking the box attained the goal? Is it the nurse or doctors or somebody who's doing it? Is the person saying I attained my goal? How does that

work?

That's a very important -- because it could get misdirected. It could be the first thing we do and it could be really a problem.

There's a whole bunch over here. Russ, we'll just go down the island.

DR. LEFTWICH: So, I'm being aspirational and thinking that the care coordination will be done with the soon-to-be-published standards around the care plan that capture whether the patient either proposed that goal or acknowledged that goal, accepted that goal.

DR. REINHARD: Okay. Are you on goal-setting or goal attainment?

DR. LEFTWICH: I'm on goal-setting.

DR. REINHARD: Setting, okay. Sorry.

DR. LEFTWICH: And I have a different feeling about goal attainment. But

I'm on goal-setting.

DR. REINHARD: You're on goal-setting. Okay.

DR. LEFTWICH: Yes. And the patient did either propose that goal, set that goal, or endorse that goal.

DR. REINHARD: So you're saying that you are thinking it's possible to get to some kind of measurement system, that it's trustworthy --

DR. LEFTWICH: Right.

DR. REINHARD: -- to know that the patient or the person actually set that goal.

DR. LEFTWICH: Right. And not just the provider organization said yes, we set goals. No, not that. The goal is there and it was --

DR. REINHARD: Fred, he's trusting more than you are that we could get there. He's trusting more than you are that -- he's aspirational.

DR. RACHMAN: I'm still worried

about this thing about patients and what happens in the power dynamic with the provider and they say here's your goals and they'll say yes. And you ask them did you set the goal and they'll say yes. I don't know that we're really going to get at it.

DR. REINHARD: Kind of rote. Okay, did I get David?

DR. ACKMAN: Yes, the question who's checking the box. Often no one needs to check the box, it just gets spit out through a care plan's software. So the input comes in, you haven't gotten the colonoscopy so the goal is -- and so I think for some things it works. You know, the input says you're missing something, so get it. Or, the input says don't have an educational gap. And so it says that's a goal. So in some ways that's very --

DR. REINHARD: So you're skeptical too.

DR. ACKMAN: That's very feasible.

And for some things it's absolutely appropriate and it's the right thing to do. But to get to the more difficult things.

Either you don't know whether -- what the significance of the checked box, you don't really know how much thought is in. I think for the hard stuff it's probably not that good.

DR. REINHARD: Okay. Linda?

DR. LINDEKE: High-impact, low-feasibility with the example of children's dental caries. We would all agree with the impact. The measurement should be able to look in there and see if they've got them or not. And the feasibility of getting that basic care for every kid is just miserable in this country.

DR. REINHARD: Goal-setting.

DR. LINDEKE: Goal-setting to have -- the parents would agree the child doesn't want a toothache. We know it has health and behavior implications.

Feasibility in this system, this country makes me put it in the lower category.

DR. REINHARD: Robert?

DR. ROCA: Well, I think there are all of the problems that people have identified about gaming these kinds of measures and so forth.

But I honestly don't see how we can have anything called a person-centered plan of care without asking the patient what the goals of care would be. So I think acknowledging all of the complexities and pitfalls here, I think it has to be there.

And I think compared to many of the other things we're looking at it is relatively feasible.

DR. REINHARD: Okay. Vija? Is it Vija or Vie-ah?

DR. SEHGAL: It's Vee-ya.

DR. REINHARD: I said it right.

DR. SEHGAL: And actually he just echoed what I was going to say.

You know, I actually really agree with Fred's skepticism. And it's very difficult to for any of us who have aspired or attained PCMH certification, accreditation, recognition, you know, we have to go through the process of having our patients set their goals. And it's very easy to check a box.

That being said -- so I am skeptical and I appreciate the skepticism. That being said, I think it's something -- without setting a goal we will not be able to do anything else. So it's absolutely whether -- I mean I think it's our jobs as providers, as care coordinators, as people working with the clients we need to make sure that they buy into the goals that they're setting.

There may be some difficulty in doing so but it's still relatively compared to everything else feasible and we will never achieve those goals attained if we don't set them in the first place.

DR. REINHARD: Well, Richard, and

then I know, Russ, you're dying to jump in there.

DR. BIRKEL: On the community side we often set goals very differently. Not you need the colonoscopy, but patients might set a goal, a participant will set a goal that they want to attend their daughter's wedding in the fall, or they want to be able to walk down to the mailbox and get their mail on a regular basis. So we're really talking about a very different sort of set of goals.

And I agree with what Russ said. If you can get to that place where you're actually setting a patient-centered goal that makes -- and the PCMH defines that goal as meaningful to the patient. I can't believe a colonoscopy is meaningful in that way, to be honest.

(Laughter)

DR. BIRKEL: But, if the goal is that I want to live a cancer-free life, whatever, in order to be around for my

grandchildren which is the way a patient would honestly frame that, then the physician is in a position to say well, of course, then we need to do some preventive screening.

Now, getting to that, that process is what's so challenging. So anyway, I do think that the goal-setting is both high-impact. Not so sure about the feasibility.

DR. REINHARD: So it sounds -- at minimum feasibility is in the middle. It might even be tilting further over. But I'm hearing generally high-impact, yes? So it's the feasibility question. Russ?

DR. LEFTWICH: So, I'm one of the world's great skeptics, actually. You have no idea.

DR. REINHARD: That's good to know, Russ.

DR. LEFTWICH: But I am making the assumption that this is a shared care plan and that it's going to use the standards that I've worked very hard on developing in the past

couple of years that do include three kinds of goals and one of them is overarching goals that are -- that solely belong to the patient.

And I think we can measure whether that's there in a care plan or not.

DR. REINHARD: Okay. David, we're going to give you one last shot.

DR. LEFTWICH: I think we will be able to, yes. Not now, but soon.

DR. REINHARD: Okay. Can everyone live with where we put it? Okay, we're good.

Let me try the other way. How about low-feasibility, low-impact? Any in that quadrant? Yes. Relationships. Okay. Anyone agree? Okay, David did. Okay, I'm seeing heads.

Okay, who disagrees? Oh, lots. Okay. I'm going to start with Ilene and head over.

MS. STEIN: I mean, having, again, worked on the community service side I don't think providers have any clue what exists in

the community or how to connect to them.

No offense to any of the providers sitting around this table who probably have greater experience with care coordination and community services than most people within the community.

But having had to act as a care coordinator for clients with Medicare it's pretty apparent once you go through that process that there is a huge disconnect.

DR. REINHARD: Okay, but let me just -- I just want to make sure I'm clear on this. We're not talking about what is now.

We're talking about if -- can we measure and is it important. If you could measure this --

MS. STEIN: Right.

DR. REINHARD: -- and you could find out they know nothing, this group knows a little, this one knows a lot, would that have an impact on quality of life, on functioning, on meeting one's goals. So it's

not what's current.

MS. STEIN: Right, but currently it does. I mean, that's the whole point is that --

DR. REINHARD: Yes, right. Well, we know it sucks now.

MS. STEIN: Yes, that it doesn't exist and if you don't measure it --

DR. REINHARD: I agree with you.

MS. STEIN: -- and you don't create incentives for people to create those relationships then they won't exist.

DR. REINHARD: Right. Okay. Anyone else over here? Okay. Let me start in the middle here.

DR. EISENBERG: I think it's high-impact and it could be high-feasibility.

I think without relationships there is no coordination. You can define it in different ways but I think it's -- relationships are at the very heart of coordination. So I think it's very high.

DR. REINHARD: Okay, okay. Michael and then Russ and then Don.

DR. EISENBERG: And in terms of feasibility I think there are transactional ways to measure it.

DR. REINHARD: Transactional rates?

DR. EISENBERG: That may not be ideal. Numbers of referrals, numbers of feedback from the referrals, that sort of thing. Which gets at --

DR. REINHARD: Gets you started.

DR. EISENBERG: -- at the relationships actually working.

DR. REINHARD: Okay, good. Michael?

DR. PARCHMAN: I agree. I think it's high-impact for sure and definitely potentially highly feasible at a transactional level.

By gathering both secondary existing data sources, looking at secondary

existing data sources as well as talking to people who are involved in the care.

And I think it's easier sometimes to get better responses from them than it is from patients on this.

DR. REINHARD: This seems to be falling in the category of goal-setting, for example. You know, if we're not getting there then what are we talking about? If people are not talking to each other, there's no exchange, then there's no linking, there's nothing.

So in that vein it seems critical. I don't know, I guess high-impact. Does anyone disagree with that? Because who nominated -- okay, go ahead, Russ.

DR. LEFTWICH: I think it's high-importance, but that's different from high-impact. Because I don't think you can change. If it's going to be high-impact, you're going to have to be able to change it.

And I don't think you can change

it because I think a lot of times it's limited by what relationships could exist. If you don't have that service in your community.

DR. REINHARD: Okay, Michael. I'm going to let you because you're no-no'ing. Go ahead.

DR. PARCHMAN: Well, I see a lot of no-nos.

DR. REINHARD: I know but you said it out loud. We're going to go there and then we'll get some more.

DR. PARCHMAN: I'm representing the no, no, nos.

This is about building relationships. And yes, it is possible. This is a social networking phenomenon. And we do social networking all the time in our communities as a provider, as a family physician.

I'm always networking with people and building new relationships, trying to find out who's out there in the community. Oh, I

can no longer refer to them because they're no longer in business. Oh, I can refer to them because oh yes -- oh, that's a new resource. Okay, good. I didn't know about that. Let's figure that out.

But I spent a lot of time tracking community resources in the late-night hours after my clinic was closed because I couldn't figure out who was out there all the time.

But it is a matter of social networking and it is a relational process that you can develop.

DR. REINHARD: Don and then Linda.

DR. CASEY: Yes, I would echo that. I want to be careful we don't come across as seeming to make pejorative statements about the current state of nature with respect to, for example, this.

You know, as an example a friend of mine is in the White House as we speak all the way from Wichita, a physician advocating for harmonization of the Ryan White support

with the Affordable Care Act.

So, there's a perfect example of where providers wouldn't be able to do their business if they weren't emotionally and intellectually attached to community-based services. So, I'll just say that for the record.

But I think people were getting at my comment, but in the context of the roles and relationships of the people that are in the relationships, if those aren't clear then it's going to be lower impact and it gets back to I think what I'm hearing is being sure that these things are clearly defined in the context of everything else we've got going.

So that's why I ranked it a little lower.

DR. REINHARD: So you have to know what to measure, is that what you're saying, Don?

DR. CASEY: Well, I just, I think that measuring where roles and

responsibilities aren't clear in the relationships will lower the impact. I still think it's feasible to focus on. So it's maybe a nuance but I'm saying we've got to clearly define what the future state of the relationships would be in terms of clarity about who's doing what to who when.

DR. REINHARD: So are you in the middle of each?

DR. CASEY: No, I'm actually -- I'm actually on a higher feasibility.

DR. REINHARD: Higher feasibility, lower impact.

DR. CASEY: Yes. But I'm sort of a little bit below the line on low-impact.

DR. REINHARD: Okay. Linda?

DR. LINDEKE: I think some out-of-the-box thinking may develop. And I saw a poster about a study of dialing 211 and the impact that that had. We could measure who calls. And this was on actually doing screening using a standardized tool during

that call. It was acceptable to the people who called. They were in a teachable moment.

When we limit our measurement to what's in an electronic health record we are I think limiting the possibility to really show impact at a population and an individual basis.

And this was a relationship. That was in this study, that in that call at at teachable moment when they wanted help there was something powerful that could happen.

DR. REINHARD: Judy?

DR. NG: Just wanted to give an example of where the feasibility actually works for building relationships.

We just did a study of best practices where we looked at plans that did very well in a childhood immunization measure. Very high performance rates. We went and talked to providers, leadership in those plans, in-the-ground trench workers.

And a lot of it was about getting

to people whose children were not necessarily getting immunizations. A lot of them were on Medicaid, very low resource.

And what they all said to us was these people are not facing medical crises, they're facing social crises. Unless you can get them to the social resources they need and you know what they are they're not even going to come in for the care their child needs for immunizations.

So they built their resources up that way knowing they needed to achieve a particular measure. So it was feasible.

DR. REINHARD: Okay. I'm thinking -- okay, Mark. And then I'm going to suggest something. We'll move on.

DR. REDDING: So, if feasibility can be impacted in our thinking by some -- they may be oddball current examples, but oddball current examples that are out there.

What's interesting about relationships is that -- and again, so I don't

drive some people crazy I'm in a subset of the subsets of community-based care coordinator going out.

But if that care coordinator has strong relationships with the patient then they -- and then if there's a system in place, going back to Fred's comment to work as a sieve to find the people who are at risk and continuously look for them, get them to someone who can have a good relationship, that's the person that can do a comprehensive assessment that includes the patient's perspective, set goals and achieve goals.

And there are existing programs using a pay-for-performance model so it isn't just little checkoff boxes. You actually -- the managed care plan only pays if they are confirmed to connect to medical care, confirmed to connect to mental health.

But it's an oddball example. It's one of the reasons why I put those four things together.

DR. REINHARD: Carolyn, do you have any comments?

MS. INGRAM: Yes, this is of course harder to follow from being afar. And so I think you guys have moved onto some of the ones that I was looking at.

So I was thinking comprehensive assessment would have high-feasibility, high-impact. Goal-setting was the other one that I was putting into those two buckets.

DR. REINHARD: Okay, let's turn to assessment in a moment because I was --

MS. INGRAM: Okay, yes.

DR. REINHARD: So just hang in there for a second. I just want to finish with relationships.

MS. INGRAM: Okay.

DR. REINHARD: So, I'm hearing at least on the edge of impact how many think it's high-impact? High-impact? I'm talking about relationships, high-impact. Okay. Low-impact? Okay. So, we're going to put it on

high-impact. Can you live with that? Okay.

How about feasibility? High feasibility? Low feasibility? So that's sort of in the middle. So I think it's up higher on the impact and in the middle of feasibility. Okay.

So, Carolyn, can you speak to community assessment then? Or a comprehensive assessment? You were suggesting high-impact, high-feasibility.

MS. INGRAM: Yes, I'll just throw that out as a starting point. And the reason is I think by the list that we've been provided covering those different key areas I think and somewhat from personal experience as well it is, in terms of overseeing healthcare plans and that type of thing.

I think the feasibility of doing that and putting that into the plan of care is not hard to get done and measure.

I think the impact of that once it's in place may be, you know, I'll throw it

out as saying it's high-impact. I think it's harder to pull off, the delivery, after you've put those things into the plan of care.

But I think it's easier to at least measure that there's a high feasibility of getting it in there, easy to get to measurement, and I'll say maybe medium impact or something.

DR. REINHARD: All right. I'm just going to say something about this and then ask. I would have -- I put it there also. And I understand what you're saying, Gerri, about necessary but not sufficient.

But it seems if you could, and it depends on what's in the assessment, of course. But just asking some of these questions is unbelievable. People are not asked some of these things. So, again, it depends on what's in the comprehensive.

Like, family caregivers are never asked how they're doing. That's an example. Just asking them has an enormous consequence

for them.

So, I was pitching for that but again it depends on what "it" is. Similar to experience and goal-setting what it exactly is and then how you measure it. It seemed like it was pretty feasible, but again, I'm not a measurement expert.

So, anyone want to disagree with Carolyn and I? On feasibility. Let's take feasibility first. Anyone think this is low-feasibility? Okay, how about impact, low-impact? Oh, did you, David? Okay.

MR. CUSANO: Yes, on the feasibility front, again, it's just thinking about the broad continuum of individuals that would be providing services in the coordinated care model.

So you know, this assessment, you know, I wonder how feasible it would be to implement and say if someone started it through their church looking for services or through a more community-based organization

that might not have the training or skill set to do this level of assessment. So I worry about the feasibility depending on where the point of entry is into the coordinated care framework.

DR. REINHARD: Okay. The feasibility of doing it, or of measuring it?

MR. CUSANO: The feasibility of measuring, of both, actually I would say.

DR. REINHARD: Okay. But it sounds like most think it's feasible. Okay. How about impact? High-impact. Carolyn and I thought high-impact. We might be alone. There's a couple of us.

Okay, Carolyn, I think there's like maybe six -- one, two, three, four, five, six. Oh, I got it, six people. Seven.

How about low-impact? Okay. So there's moderate, okay moderate impact? Okay. I'm thinking this is falling in the moderate impact, high feasibility. Does that sound right? Yes? Okay.

MS. INGRAM: I'm good with that.

DR. REINHARD: Okay. Any other nominations? We're getting there and we have a little time left. Yes, Don.

DR. CASEY: I have availability of services.

DR. REINHARD: Okay, and where did you put it?

DR. CASEY: High and high.

DR. REINHARD: High and high? Okay.

DR. CASEY: Yes. Because I think that, you know, the way I perceive this is to facilitate access. And I think that while some people might not know about it I think there's a lot out there. It's not coordinated, it could be coordinated better.

But you know, I can think of 10 examples of where when I looked I found a lot more than was there.

So, all I'm saying is that while it's not perfect and it could vary by

community, you know, in New York City it's going to look a lot different than it is in let's say Mansfield, Ohio. We would hope. But that's neither here nor there.

The point of this is that I just sort of feel like this is a no-brainer to just work on.

DR. REINHARD: I just want to -- this is only community services? Because it says adequacy of community services. Are we focusing only on community services?

MS. LASH: I guess that might assume that the primary care network is adequate. We could re-frame.

But I think we would want to include things like behavioral health, specialty type care, in addition to non-medical community services.

DR. REINHARD: And we also think of adequacy of primary care?

MS. LASH: Let's do that.

DR. REINHARD: Yes, okay.

DR. CASEY: Well, I mean if you think of what hospitals are accountable for, especially if they're not-for-profit it's community benefit. So, you know, to that extent this should be easy to grab onto.

DR. REINHARD: Okay. So how many agree with high-high for availability of services? Okay. Who disagrees on either end?

Okay, Fred, and then I'm going to come to Vija. Fred? Can you say why? Is it feasibility, or impact, or both?

DR. RACHMAN: I think it's probably more feasibility. Because I don't think we're very good at -- I mean, I know we're good at a provider saying they know what the availability is. But how do we judge the quality or the --

DR. REINHARD: This is who does this.

DR. RACHMAN: Yes, right. So how would you measure whether what you're getting there is accurate?

And then there's also an impact question which is -- and it gets back to something, somebody said this earlier on like are we contributing to the identification of gaps and the filling of gaps in this process.

And I'm worried that if you're going to judge people based on how well they're saying all these things are available, you know, what are people going to do to pass the test.

DR. REINHARD: Is this about providers passing a test?

DR. RACHMAN: Yes, anyone. Like considering we put a measure up there. You're going to be judged on whether you are providing availability for all of these services. People are going to play to that test, right? And how are you going to judge. So it's both a feasibility and an impact for me.

DR. REINHARD: I guess I was thinking system level. So this gets us back

to the individual and system. Are the services there.

DR. CASEY: Well, it is under the health neighborhood.

DR. REINHARD: Yes. I wasn't thinking individual would be, but it is an important question. Vija? Oh, you put it down? Robert?

DR. ROCA: Well, my concern was sort of a level of measurement, who's being measured kind of question. So maybe that's -- because certainly the services that might be critical to somebody's well-being and wellness in the broader sense of the term may not be health services. There may be all kinds of other services that health systems normally don't dabble in or have any control over.

So I guess if you're looking at communities in the broadest sense maybe this is a very important and meaningful measure. But I'm not sure it's a meaningful measure at least for health systems.

DR. REINHARD: Sarah, do you want to say anything about this, whether this was providers being measured?

MS. LASH: Personally I would agree that it seems to operationalize better at a community level, yes.

DR. REINHARD: Okay.

MS. LASH: Because we had talked about the linkage to whether community health needs assessments could be informed by sort of these needs identified in care plans and then sort of elevated up to local decision-makers who would be more in control of influencing the total availability of different types of services in their communities.

DR. REINHARD: So who's held accountable is the question. This is an accountability --

MS. LASH: Yes, I think it's -- the accountability makes more sense to me at a community level. But I'm definitely open to others' opinions.

DR. REINHARD: Okay. Vija?

DR. SEHGAL: Again, from the community health center perspective it's very easy -- a lot of people now are jumping on the bandwagon saying that they have all these services available. And yet the impact that these services provide may be questionable at this point in time.

The actual -- so in that case I actually put it kind of on the low-impact area right now, the jury's still out kind of thing.

In terms of feasibility of actually coordinating to access all these services, again from a community health center world it's very, very difficult. Even if you know they're out there it's very easy for a provider to say you need this, this and this. But you know, it's just like the case study we did in the very beginning. Unless you have someone really helping the patient, the client get to all these services it's very low feasibility to make it happen.

DR. REINHARD: All right. Can I just pause on a time check? What do you want to do?

MS. LASH: We don't have to finish.

DR. REINHARD: Should we just finish this one? I'll finish this one and then leave it at that? Okay. Yes.

DR. LEFTWICH: So I would say high-impact very strongly, but feasibility -- the feasibility of measuring the existence of services is one thing but the availability, and even if it's a system measure it's availability for individuals.

So you may have a service that exists, but they don't have a new patient opening for nine months. And that's going to be very hard. Or they're not covered under this individual's --

DR. REINHARD: -- particular thing.

DR. LEFTWICH: So that is why I

said the feasibility I put as low. Because you just can't -- existence, yes. Availability. It would be hard to measure across. You know, you could pick one service and do it.

DR. REINHARD: Okay, Michael?

DR. PARCHMAN: I'm having a little cognitive dissonance with the concept and maybe you can help me connect the dots.

I mean, I know that in order for the care coordination to occur the service has to be available. But if we're measuring -- we're developing a measure that just measures availability of service how does that measure the degree to which care coordination is happening. So I'm not sure how it fits into the framework.

DR. REINHARD: So you're thinking we don't need this domain? Is that what you're saying, Michael? You're wondering about the domain?

DR. PARCHMAN: Yes, that's what

this conversation is making me think. I mean, it's a fundamental essential that the service has to be available for there to be care coordination. But if we're measuring just the availability of service aren't we measuring more access, not coordination?

DR. REINHARD: Well, that's a pretty fundamental question. That goes back to the earlier discussion should we take any of these off the table as domains. So Michael is now raising that issue. Go ahead, Sharon.

MS. MCCAULEY: So now you're making me think a little bit more. I was going to try to -- I had it at high-impact, high-feasibility. But now that you've mentioned that and I was listening to Russ availability of services, but look at the -- saw the indicators underneath there. It's not really anything about available. It is adequacy, timeliness, reliability and accessibility. But exactly what Michael just said. You've got to have the service. If we

don't have the service we're not going to be able to even begin to measure it.

But I don't think that the availability of services is the right term. For those three descriptors that are underneath that.

DR. REINHARD: You could add to it. We could add availability? Yes, so we could. So if we added availability would you think it should be a domain? How many believe this should be a domain?

MS. MCCAULEY: I think it has to be a domain but -- you're saying have like a --

DR. REINHARD: You would like more underneath that, I understand.

MS. MCCAULEY: Right.

DR. REINHARD: Like availability. How many do not think this is a domain? As titled, how would you change it? Okay, okay.

MS. MCCAULEY: -- need to have an extra sub-domain about availability. I like

what's underneath there, I just don't like the name "availability of services" now that Michael brought that up.

DR. REINHARD: How about just services?

MS. LASH: Quality of services? Go ahead, Don.

DR. CASEY: I had access to available services.

DR. REINHARD: Access to available services.

MS. MCCAULEY: Yes.

DR. REDDING: My thing to throw out in this is it actually -- it's not impossible that this could be one of the most important domains for a data collection.

If you do a comprehensive assessment and you connect the person to each of the risk factors or other things identified. And again, I'm still down in the weeds. In different communities you'll see different trends of what's not available.

And if we do what Fred's got we've got a system to measure not just individual but hundreds of individuals together. It empowers that system of care to say hey, we've got 800 people in this community that cannot connect to mental health services.

So, actually, availability of services is a measure at both the individual and the system level could quite possibly be the most important one. And according to legislators in Ohio it's the one that they don't know how to administer funding because folks come forward for 180 million but they can't document the need or the individuals.

DR. REINHARD: So, I'm just going to -- because we have to move on. I'm just going to put my duals hat on for a moment. Who else is in the duals workgroup? Is everyone here? Yes, okay.

So, if we don't -- if you are talking about duals you're talking about behavioral health, long-term care, you're

talking about a lot of different things a lot of which is not medical. It may not even be primary care. A lot of it is community-based services.

And I would think the duals workgroup when talking about coordination would very much want to see something about services in there, whether we think it's high-impact, low-impact. But without it what are you coordinating? You're only coordinating within primary care. You're not care coordinating anywhere outside the health system.

So, it seems pretty fundamental to the vision that we had from the beginning that there needs to be something about services more at a systems level it seems. Although the relationships gets to the interaction between providers and what they're doing with referrals and all that kind of stuff. But if there's nothing to refer to, or there's no availability or access to it it's sort of a

moot point which gets you to the community planning that the ACA has the hospitals do. I mean, there are levers to get to it. But if you don't have the data it's hard to advocate for anything.

So, I can't speak to how feasible this is. Again, I'm not the measurement expert in this area. But I would speak to very high-impact.

So, what -- so my recommendation so we can move on is that anyone who has ideas for the name of this, if you could -- Sarah, can we give them to you? Okay.

And how many want to lead it as high-impact? Low-impact? Okay, so we move it a little bit away from the very highest impact. A little bit closer but not quite on the line. Okay.

And feasibility? High feasibility? I don't even know what to say about this. Low feasibility? Okay. So we've got to move it closer to low feasibility.

Into low feasibility. So should it be over there? Higher up but over the lower end? Lower? Move to the left. Move it to the left.

Say high-impact but higher up. There you go. How do you like that? Okay. She wants it down. All right, you're right over there, you could just sneak it down, it'll be fine. We won't even know.

So, I'm sorry we weren't able to complete it but you got a lot of input in the general thinking. So maybe you can direct us what we should do next, Sarah.

MS. LASH: Sure.

DR. REINHARD: We didn't do goal attainment.

DR. CASEY: I think that was higher impact.

DR. REINHARD: It was higher impact. But that's what that is, it's high -- she just -- they want it higher. Of course Fred's going to move it down when we leave.

We're good?

MS. LASH: We can think less about their relative placement and just look at the pattern which is that we have a lot of impactful measurement domains with varying levels of feasibility of measurement but a lot of challenges have been voiced in this discussion that were very important and will inform HHS.

DR. CASEY: I don't think low-feasibility means impossible. I think it means --

MS. LASH: Relatively --

DR. REINHARD: Yes, that's right. Okay, any last words? I heard goal attainment. Is that a slam dunk? What would you say?

DR. SEHGAL: I would put goal attainment in the high-impact, low-feasibility group.

DR. REINHARD: Does everybody agree with that? Yes, okay. You only had one

down. We did pretty good.

All right, thank you for your attention and your help and we're going to move onto your break I think, Sarah?

MS. LASH: Yes, we'll take about a 10-minute break instead of a 15 and then we'll reconvene and learn about the next activity.

DR. REINHARD: Okay, good.

DR. CASEY: Can I just make one comment about goal attainment? I think it's the progress towards the goal.

DR. REINHARD: That's interesting.

(Whereupon, the foregoing matter went off the record at 2:42 p.m. and went back on the record at 2:57 p.m.)

DR. REINHARD: I think we're ready to start if you could head back to your seats.

MS. DORIAN: I think, Cathy, if you could open the lines up to anyone who might want to make a comment. That includes members of HHS and I know the other Care Coordination Steering Committee, certain

members might be on the phone or members of the public.

OPERATOR: Okay, all the lines are open.

MS. DORIAN: Is there anybody on the line or even here who'd like to feed back on that last session or ask us any questions? Okay. Well, then I think we're good to wrap that last session up and move on.

Before we get started I'd just like to take a poll to see who would be interested. We have dinner reservations as I mentioned at 6:30 two blocks away. Great, we'll be there. Sarah and I will be there. We look forward to it.

Okay, so we've come to our next exercise. As many of you have already anticipated now that we've had this last brainstorming session although we didn't get through all of the concepts I think it was still really helpful to iron some of those major issues out, or to at least start

wrestling with them.

So, now we'd like to talk about, we'd like to get a little bit more granular and start thinking about specific measure concepts that the group could potentially recommend.

So to do this we have divided you into three small groups each of which has been assigned to one of the major domains that you see on the screen.

So you'll be given -- each of these groups will go to a different room. I'll bring that up on the screen shortly. And either Sarah, myself or Laura will accompany you. And we'll give you sheets that look like this that essentially ask you to fill in by sub-domain. And we've updated this to reflect the comments that we had before when you fed back on the domains initially. So, to start really thinking about a denominator and a numerator statement and what potential data sources you might be drawing from.

So, we ask that you consider what you know about the evidence out there, what it's pointing towards. And you might consider other data sources and what information might be pulled from them too for more impactful measurement.

So we do have an example at the top. If you look at it -- you can't see it now, I know -- but we say that the denominator is all children ages 10 and up seen in the primary care measurement year. And then the numerator is the number of children age 10 and up who screen positive for risk factors for poor educational outcomes and for whom a community referral is completed.

So the denominator of course will be the entire population that you're interested in screening or measuring and the numerator is what you want to know about that denominator population.

So, Sarah, did you want to add anymore detail?

MS. LASH: I don't think so. We'd like you to try to, for one, measure a concept in each sub-domain. But don't restrict yourselves to picking system or individual or some of the other continuums that we've raised.

This is really a blank slate for you to try to operationalize the domain and sub-domain concepts for what might actually work.

And so we'll have these worksheets and staff facilitation to guide you. And we've got a few tricks in our back pocket if you get stuck. But we do want to encourage a lot of creativity here.

MS. DORIAN: So if you look at this slide these are the breakout sessions. The Group 1 will go with Laura and you're going to go to a meeting room that's down this way. Group 2 is going to stay here with Sarah. And the third group is going to come downstairs with me. And maybe if we could

just meet back there because you will need me to swipe you in when we get to the lower level.

Yes, Carolyn will be -- that's why we kept her -- oh wait -- yes, yes, Laura -- yes, they've set that up. She's expecting that.

Are there any questions?

MS. LASH: As a preview for what we'd like to hear from you when you come back to share your progress, some of your strongest potential measure concepts, the types of measures your group thought might be most important, the domains where it was easy for you to come up with ideas, and then the data sources that you think you're looking at.

Is everyone caffeinated enough for this? Okay.

(Whereupon, the foregoing matter went off the record at 3:03 p.m. and went back on the record at 4:09 p.m.)

DR. REDDING: So let's call

everybody together. Everybody has got lots of energy, right? It's been amazing energy and thought today.

We're just going to start with -- could the report-out individuals raise their hands? We've got Rita and where are the other two groups for the reporters. Three reporters? Okay.

So what about the third group?

MS. DORIAN: Any volunteers from the third group?

DR. REDDING: Or you can think about it for a minute. We'll start with your three reporters, Fred.

MR. CUSANO: So yes, we split up our work into -- we split up the domains. So we split up comprehensive assessment, goal-setting and shared accountability. So, we each worked separately on that.

So, Fred and I worked on the comprehensive assessment. And so our first approach was in defining comprehensive

assessment was to take the term "comprehensive assessment" and include in that assessment the measure sub-domains.

So, what would be included in a comprehensive assessment would be the measure sub-domains lead up to risk level and customized care. So that would be inclusive of the comprehensive assessment. That was our thought process there.

And in terms of the measurement for the numerator it would be anyone for whom an assessment is documented crossing domains. And the denominator would be anyone enrolled in the reporting entity.

So with that, I don't know if, Fred, if you had anything you wanted to add.

DR. REDDING: Very good. Okay, that's it?

MR. CUSANO: And then on the second measurement we looked at was the continuous holistic monitoring. And the numerator would be patients for whom a shared

care plan is in place. And the denominator would be that the care plan is visible and continuously updated by any service provider named in the care plan in the centralized database if possible.

DR. REDDING: Excellent. Great. Any other reporters from your group?

DR. SEHGAL: So Carolyn and I worked on goal-setting within the person-centered goals. And we had several examples. We found it best to talk about examples. And I think that really, now that I look at it they really do all tie together.

So I'm going to use one example that we used which was patients at high risk for falling and the adverse consequences of falling. And so we placed that as our denominator in each of the different groups and then we focused on our data source was always the care plan which is noted within the EMR ideally with appropriate checkboxes on the care plan so that this data can be pulled out

of the EMR easily rather than having to do chart audits manually.

The numerator would be, for example, in person-centered communication would be communicating with the patients that are at high risk for falling and coming up with some goals. And this kind of went into the setting goals.

So, for example, a goal could be that the patient wanted to live at home. But if they wanted to be really specific we needed to focus on what would be -- what actions would need to be taken into place to make these goals realistic. For example, working with social service organizations to help them install non-slip bars and whatnot in their house and ramps and whatnot.

This would have to be a shared decision-making because by definition you can't really invade a person's home without their sharing the decision.

So, again, the whole purpose was

to get away from the cynical thinking that we were discussing most of this morning to really assume that the patients are involved in setting their own goals, assuming that when the checkbox is checked off within their care plan that the patient actually played a part in setting these goals.

And really, I think they all tied together in order to be effective, in order to move from the highly feasible to the high feasibility and high-impact box they need to actually be shared when being made.

DR. LAMB: Okay, Woody and I looked at shared accountability. And we decided to start at the level of the individual practitioner but thought it could also be at the practice level. And so for the shared accountability, taking into thinking that the patient family is part of that shared accountability. We had two different measures for the plan of care documents who was a part of the care team including community

providers.

The first one that the provider would do is in their caseload the percent of patients with a completed checklist of team members including, or a checklist of roles including we would create a list of who the roles might be.

The concern being is if it's -- if it's just who's involved we would have no way of knowing whether that was ever considered and whether the team list was complete. So we were envisioning a checklist that would go, you know, who's the PCP, the pharm, nurse, educator and so forth. If it's non-applicable that would be identified.

And then for the patient is the percent of patients who were asked who assists them in their healthcare or caring for themselves. And then we could figure, then we could picture a lot of different other questions related to how these people were invited to the team.

We also looked at the plan of care assigns responsibilities for meeting the care recipient's goal. And we struggled a bit with this one because the issue of feasibility. There are a lot of people involved. If you think about even the one that was just suggested for falls or for diabetes education there could be multiple interventions with a variety of providers.

And what's meaningful versus this lengthy checklist of you got this one, I got that one and the other person has that. So, we started with percent of plans of care that identifies a primary accountable person, but we never could figure out -- we didn't get to the place of how do we really figure out what are the core interventions and who's accountable for them so that we didn't have this really humongous thing about, you know, a list of 9,000 interventions and accountability.

Woody, anything else? Okay.

DR. REDDING: That fit into Russ's concept of having a football team, possibly a quarterback and figure out who was going to be quarterback. Is that?

DR. LAMB: Well, you know, that's somewhat of the elephant in the room is we really are looking at shared accountability. And if we have one quarterback and there's no dialogue about that, you know, is it really reflective of who the quarterback actually is.

DR. REDDING: If we could have Rita from utilization of the health neighborhood.

DR. MANGIONE-SMITH: Okay, so we had a lively discussion in our group. So we didn't split up so we might not have gotten quite as much done.

But the first thing we really struggled with was the label of availability of services. And we talked a bit about how that might be re-labeled as a domain, either availability of appropriate services,

availability of needed services.

And once actually we found ourselves moving from that domain column to the sub-domain column we were able to kind of get our juices flowing and come up with some measure concepts or ideas.

So, I'm going to just pick a couple of examples from the different domains. But before I do that, the other thing I should tell you we kind of globally decided to do among the domains was to collapse what is now relationships, linkages and synchronization with continuous communication. Because we really came to the conclusion that the whole reason you need these linkages and relationships was so that there would be good communication.

And there was such a strong overlap in those two Venn diagram circles it seemed like they really were becoming one circle and so we collapsed them into one domain.

So, within the availability of services the sub-domain of adequacy of community services to support self-management. Wellness.

One of the measurement ideas we came up with denominator was, and I apologize, I always think of denominators first because that's just what quality measurement people do. But overweight care recipients who wish to lose weight would be the denominator. Numerator is reportability to access a weight loss program within their community. So that was one idea we had. There's several more so I won't tell you all of them.

In the domain of relationships, linkages, synchronization, one thing that our group wanted to do was have one structural measure. So that last one was obviously a process measure. We would use survey data to get at that last measure.

This next one is a structural measure and we would use EHR as the data

source. The denominator would be care recipients and families with a plan of care in place that lists all care team members. So that's what you need to get into the denominator, pretty specific.

Numerator is the care plan is accessible to all care team members including the family and all community service providers. So again, just really trying to have those successful connections and communication.

DR. EISENBERG: So, were the care team members the same for every patient?

DR. MANGIONE-SMITH: The care team members always have the patient themselves and their family or support system within their home, their caregivers. And then --

DR. EISENBERG: For example, if I -- the care team --

DR. MANGIONE-SMITH: No. So, it's individualized plan of care. Right. So as you structure that team and you structure that

care plan the people listed on that care plan are the people that that person needs, right? And those are all the people who need to have access to the plan for communication purposes.

And then the last one was again falling under that realm that we mushed together, the communication and relationships, follow-up protocol to ensure receipt of services.

So, our denominator there was care recipients with plans of care that include needed services documented. And the numerator is services obtained within two months of the identified need. So, and again we would say EHR for that particular measure.

So those were some of the ones we liked the best and felt like they might have some implications for Meaningful Use down the way and all of that.

I think I already talked about types of measures. We had some process, one structure. I don't think we found any of them

particularly easy. And I talked about the data sources. And the only other important thing was the fact that we decided to combine two of the domains.

DR. REDDING: And I think you mentioned that some of them you could see fitting in at an individual as well as a system coordination level.

DR. MANGIONE-SMITH: Right, you might measure at the individual level but they could be likely rolled up to the systems level.

DR. REDDING: Excellent. All right. And our outcomes team. Somebody has got to report out or we can't go to dinner.

DR. ACKMAN: So, we did not get that far down the list and I think we had a lot of sort of germs of ideas rather than fully formed ones. But I'll tell you what we thought.

In terms of -- the first one, experience, care recipients' experience. We

thought this was a survey, a care recipient survey.

There was some discussion about whether the denominator would be everyone or whether it would be a subset of people who had had either encounters or contact with more than one caregiver.

We talked about whether that would be encounter-based or whether there would be other ways to determine whether they had more than one.

But the thought was that the -- the question or what we were trying to get at was that did people -- and then there was discussion about what the question was. Did people work together? Did you have a sense that people worked together? Did you have a sense that people communicated and that people knew more than -- that your problems and issues and needs were shared among different people.

I think that's -- when we talked

about empowerment we had even more difficulty with that because we weren't quite sure what that meant. We talked about -- there was a discussion as to whether this was some ability to solve problems on your own, maybe an ability to work with your providers. We weren't certain what that exactly was getting at.

The family experience, I think a good idea came up on that was a hassle, the hassle survey which is an existing tool about whether the family experienced hassles with getting certain things done. So that's something that we may want to look at.

Again, the denominator on that would be I think in the hassle survey was people with multiple complex chronic illnesses with I think substantial interaction with healthcare providers. Empowerment I think again we sort of skipped over that.

We had some difficulty with the care team's experience of coordination.

Michael, I think you had the best sort of ideas on that. Do you want to just share those?

DR. PARCHMAN: Yes. This was about focusing on the experiences of care providers and service agencies and being able to coordinate care between each other within the community and thinking about.

And there are some beginning scales out there in which people are establishing compacts between each other about what I agree to do, what you agree to do and then we'll score each other, we'll give each other report cards. There are communities in which this is going on as a way of thinking about ways to improve. But it's also a way of saying how well are we performing and working together around meeting patients' needs.

But it's all about my experience as a care provider in being able to meet the needs of my patient and working with other agencies or other groups.

DR. ACKMAN: And then the last one we touched on was goal attainment. And at the simplest level we could think about this as a series of HEDIS measures, that a need would be defined based upon the patient's age, condition. And you could identify what the expectation was in terms of care.

But then sort of going back at it again we sort of paid attention to the goal attainment and as documented in the assessment. And so I think we sort of came around to the idea that these would be goals that were documented either in assessment or in a care plan and that they would -- and that meeting goals would be an indication of a reduction in their unmet needs.

The denominator here either could be everyone with a care plan or an assessment, or it might be a subset of those who have complex needs.

And I think that's as far as we went down the list.

DR. REDDING: Very good. I think that's just the information that was being requested. That's awesome.

In terms of hassles, does that fit with a concept of barriers to connecting to care? Was it in the same context? Just for clarity. Could be anything from transportation to a rude appointment clerk.

DR. PARCHMAN: Or hassles getting refills three times a week because the end date expiration on the bottle expires for the 16 medications they're on. So they're spending three days a week in the pharmacy getting refills.

DR. REDDING: Very good, thank you.

DR. LINDEKE: We touched on one other thing which was the goal attainment. Perhaps a better wording came up from before we broke which was progression towards goals. Maybe you said that and I --

DR. REDDING: Very good. So, with

Sarah's permission we're actually -- now we're finally doing better with time. If we could do one of those rapid things.

Could I check back in with each group. By hearing each other's presentations there may be just a few additional comments that each of the groups would like to say.

So if I could first check in with the person-centered plan of care group. Do you have any additional comments to make based on the discussion?

I know it's been a comprehensive discussion.

And what about Rita and your team, is there anyone else who'd like to say anything?

DR. LEFTWICH: We discussed the possibility that in the Meaningful Use promoted concept of electronic summaries coming back from a provider who a patient has been referred to, that piece of data that's generated in the course of care could be used

to document that a referral that was made was completed as well as other data from those clinical messages.

DR. REDDING: Excellent. So, in that discussion there was -- we needed to figure out what they needed and then we needed some kind of credible confirmation that they actually connected to that service or reached some outcome, and that the EHR has a variety of different strategies to help with that.

And I think also, Russ, you -- using your football player analogy we -- it was put in the context that it might actually be the front lineman who makes the referral.

DR. LEFTWICH: Right.

DR. REDDING: We would still -- that needed to have organized roles and responsibilities. But we would still be responsible to make sure that that lineman's referral actually did what it was supposed to do and that everybody on the football team knew their role and how they were going to

take care of the patient. And it was individualized, not 20 people on there if they didn't need to.

DR. LEFTWICH: Well, yes. In fact, well, in terms of the care team roster being complete and included in every patient's summary I think one measure we haven't been able to make that that would enable is do individuals who have 12 specialists on their care team actually have better outcomes than somebody who has three specialists.

Is there an optimum makeup of the care team. And we can't really tell that. But we could if that roster is part of the -- it would be high-feasibility and high-impact I would say.

DR. REDDING: I realize too if we're going to use your football thing I'm going to have to say linewomen because a lot of them are out there. But great.

DR. CASEY: Mark, could I just say something for group 3?

DR. REDDING: Oh yes, I'm sorry.

DR. CASEY: And that has more to do with our process than our output. I mean I thought we didn't get through all these. I wish we had more time. But what I experienced was a really good discussion amongst a lot of smart people from different perspectives to hone down.

I think we right off the bat kind of started getting -- we started behaving like measure developers and being really critical about it. And I think that was good. So I realize we wanted to be expedient.

But I don't know how to address this from your perspective, Sarah, but it seems like there's a lot more work here. And I don't know if you want this whole thing done or not but maybe we should try to do that at some point.

MS. LASH: I like the over-achieving impulse. All of the people in the room.

DR. CASEY: I'm speaking as an individual now.

DR. REDDING: And Don, we got -- it's all about these outcomes so we've got another couple of minutes if you want to please expand on that.

DR. CASEY: Well, all I'm saying is we didn't get a chance to discuss the rest of it. And I feel a little badly about that.

But I do think in fairness to the group, the group really did think hard about it. And we had some really good ideas. So I didn't want to say we ignored the rest. But there was benefit to have more time.

DR. REDDING: So, do I hear -- and to clarify, but do I hear a request that maybe somehow the group or someone once the level of detail we've defined here is settled down that we could make another run at further clarifying the ideas on the table?

DR. CASEY: I don't know if we want to sit in a room again like we did, but

I'm just putting a placeholder in the fact that we have some unfinished work. I don't know how we want to do that or not. Probably not this time around.

MS. LASH: We could always design like a follow-up activity after this meeting which we could complete electronically. Or -- we'd have to give it some thought about what mode might work the best.

I think there's a lot of ideas that we'll need to collect across the groups, to organize together with our now edited domains and sub-domains.

Just reflecting that back to you once more would probably have a lot of value in making sure that everything is accurate and everyone was in agreement. So, appreciate that, Don. We'll try to think of how best to complete this.

DR. CASEY: Okay.

DR. REDDING: And thank you. We're off to public comment, right? So is

there any public comment?

MS. DORIAN: Cathy, if you could open up the lines for public comment, please.

OPERATOR: And at this time if you would like to leave a comment or ask a question press * then the number 1 on your telephone keypad. And you do have a comment or a question from Yvonne Davis.

MS. DORIAN: Great. Go ahead.

MS. DAVIS: Yes, thank you very much. I think this process was really, really enlightening for me.

I wish I could have participated earlier in terms of like how the domains and sub-domains were created. But just jumping into this mid-process was very, very informative for me.

I guess in regards to this process the question I have is -- is this the formal process that NQF will be reconstructing as additional measures will be created? And I apologize that it's not directly related to

the sub-domains or domains that you were questioning. I was just curious about the process.

MS. LASH: So the overall goal of this meeting and this project is to make recommendations to HHS about where they might like to fund future measure development in the area of care coordination.

And so it's a model of gathering information and reflecting that, but it's -- in terms of an official NQF process there would still be other ways that development would be expected to take place. Does that answer the question?

MS. DAVIS: I guess so, yes. I'm just curious because I would think that some form of standardization would occur. Or maybe not, I don't know. It's something that I would think that it would be useful in regards to looking at other disciplines in regards to health. And so that's the only reason why I was asking the question.

MS. LASH: Okay. So the potential to explore other topics for measure development.

MS. DAVIS: Well, not only that but the process, using this same process. But yes, it's just something that I wanted to, you know, kind of grasp on my level in terms of like saying, okay, well, is this a process that has been successful in the past to make these types of recommendations.

MS. LASH: I guess we'll see if we're successful. And then we'll see if we can replicate it, if so.

MS. DAVIS: Got it. Okay. That's all, thank you.

OPERATOR: And there are no further public comment or questions at this time.

DR. REDDING: So, in closing, Sarah, I'd just like to know what you saw in terms of general themes today.

MS. LASH: All right. I did take

many notes throughout the day, but I'll just highlight maybe a few of them that I thought really changed the course of the conversation or were especially meaningful. And we look forward to hearing more from you.

I think there was good discussion about the dynamic nature of risk and needs for care coordination. And we need to be connecting relatively low-risk people with preventive services to stop them from experiencing any additional risks.

And those high-risk groups should be connected with trained coordinators that have relationships that can be leveraged to address their health more holistically. So, continuing to look at both individuals and families, practice and the community systems.

Also, some distinctions between coordinated care versus care coordination versus care management. We can continue to unpack that tomorrow.

I heard a lot about the electronic

plan of care as being very critical both as a reference for the team to use to achieve care coordination and also data to support measurement.

And as we are able to implement better methods for surveying care recipients and care teams it would be more feasible to think about experience as part of that plan of care process as well.

I think we want to guard against creating incentives that would lead our complex and evolving and dynamic health system to wasteful uses of resources instead of those where improvement can really be achieved.

And that the whole quadrant exercise this afternoon sort of showed that there was a general agreement in the group that if the domains are implemented well they would have an impact on care coordination and health outcomes. But the devil will be in the details of implementing them as well.

And really no doubt about it, this

type of measurement is going to be difficult. It might just be a question of how difficult. And finding some political will to come together around a few key areas that are deemed most feasible. I'll just stop there.

DR. REDDING: Thank you. And just in addition briefly it's an unbelievable task. It's such a poorly defined and fuzzy yet absolutely critical to the person getting care.

And it seems like we've got, it's almost like a meeting where we have individuals from completely different languages and cultures and perspectives, but all very knowledgeable from where they come from.

So part of our work today is to find a common language and a common ground and try to understand each other. I don't know how we could have made any more progress with that.

We just would encourage you if you

can stand it to talk about this even more amongst yourselves and encourage the communication. I think that speeds up the clarification and common ground process. Thank you.

(Whereupon, the foregoing matter went off the record at 4:42 p.m.)

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C E R T I F I C A T E

This is to certify that the foregoing transcript

In the matter of: Care Coordination Committee Meeting

Before: NQF

Date: 04-03-14

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