

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

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

2 9:02 a.m.

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

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

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

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

5 (Applause)

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

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

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

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

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

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

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

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

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

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

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

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

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

7 (Laughter)

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

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

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

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

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

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

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

1       and even employment.

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

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

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

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

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

22                      And we're focusing mainly on the

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

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

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

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

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

22 Then we will have a review by

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

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

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

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

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

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

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

16                    So you can eat, but you know,  
17    you're not going to eat only during that time.  
18    You will have an exercise, a very important  
19    exercise that coming back we will spend a good  
20    90 minutes with real activity building on the  
21    work that you've done individually but as a  
22    group really looking at elements of the impact

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

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

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

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

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

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

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

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

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

14 (Laughter)

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

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

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

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

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

12                 DR. REINHARD: Russ?

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

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

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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

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

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

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

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

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

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

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

10 DR. REINHARD: Great, thank you.

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

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

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

1       that to our academy to represent over the  
2       94,000 credentialed practitioners to make sure  
3       that they are qualified to do what they are  
4       assigned to do.

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

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

13              DR. REINHARD: Thank you.

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

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

1 services for safety net health centers.

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

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

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

20 Because as the rich funding of the  
21 330 funding came to that small community  
22 organization it started to lose its community

1       ties so this is very close to my heart.

2                   DR. REINHARD:   Wow, when was that?

3                   DR. RACHMAN:   Pardon?

4                   DR. REINHARD:   When was that  
5       grant?

6                   DR. RACHMAN:   Oh my God.

7                   (Laughter)

8                   DR. RACHMAN:   Thirty, almost  
9       thirty years ago.

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

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

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

22                  As you know, NCQA is in the

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

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

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

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

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

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

4 DR. REINHARD: Great, welcome.

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

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

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

21 DR. REINHARD: Thank you for being  
22 here.

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

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

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

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

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

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

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

7 DR. REINHARD: Great, thank you.

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

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

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

22 My research currently is focused

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

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

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

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

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

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

4 DR. REINHARD: You're welcome.

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

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

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

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

5 DR. REINHARD: Okay, great. Thank  
6 you.

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

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

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

19 DR. NG: I went to McKinley.

20 DR. SEHGAL: McKinley, good girl.

21 (Laughter)

22 DR. SEHGAL: My nightmare is that

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

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

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

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

1 tracking those things.

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

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

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

18 DR. REINHARD: You're wide awake.

19 DR. SEHGAL: Coffee.

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

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

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

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

16 DR. REINHARD: Thank you.  
17 Samantha?

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

22 I've been with the Department for

1 14 years, 15, I don't know. It's amazing  
2 because I'm still only 22, so I'm not sure how  
3 that happened.

4 (Laughter)

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

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

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

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

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

1     quality and quality measurement issues for  
2     vulnerable populations specifically.

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

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

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

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

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

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

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

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

14 MS. LASH: Thanks, Carolyn.

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

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

1       so welcome.

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

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

14                      DR. REINHARD: Thank you.

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

1 materials she can get them to you.

2 DR. REINHARD: And Wendy?

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

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

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

18 DR. REINHARD: Thank you.

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

1 she's also contributed to bringing us here  
2 today.

3 DR. REINHARD: Lauralei?

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

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

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

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

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

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

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

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

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

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

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

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

22 And a special thanks to Mark and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 broader health neighborhood.

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

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

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

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

1 in any sense.

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

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

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

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

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

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

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

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

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

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

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

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

1 on the details to help define key concepts and  
2 domains.

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

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

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

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

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

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

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

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

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

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

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

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

1 focus on primary care.

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

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

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

22 The practices go onto describe the

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22 The clinician might also know that

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22            MS. LASH: Sure, certainly. We

1 can certainly add that detail. Gerri?

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

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

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

16 MS. LASH: Great. Michael?

17 DR. PARCHMAN: I think --

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

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

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

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

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

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

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

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

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

22                  DR. MANGIONE-SMITH: Yes. I think

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

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

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

21 MS. LASH: Fred?

22 DR. RACHMAN: Yes. So, I guess

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

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

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

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

22 And I do think that the way to get

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4 MS. LASH: Russ?

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

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

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

4 MS. LASH: Richard?

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

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

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

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

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

12                 MS. LASH: Michael.

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

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

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

1 management person or a care coordinator.

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

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

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

18 DR. REINHARD: Thank you for  
19 raising that.

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

1       questioning the definition. Did somebody  
2       raise that? Yes.

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

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

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

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

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

1 suggest to improve this?

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

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

9 MS. LASH: Gerri?

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

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

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

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

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

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

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

22                So that we may be, you know, we

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

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

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

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

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

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

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

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

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

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

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

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

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

11 Don?

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

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

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

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

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

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

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

1 map in terms of what they do.

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

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

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

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

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

21 MS. LASH: Judy, go ahead.

22 DR. NG: Just, two quick things.

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

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

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

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

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

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

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

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

22                   MS. INGRAM: Thanks. You know,

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

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

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

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

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

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

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

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

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

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

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

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

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

13 Just, you heard this on the web  
14 meeting but to recap. We reviewed close to  
15 6,000 measures from various major databases  
16 like the Quality Measures Clearinghouse.

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

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

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

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

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

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

1 handshake.

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

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

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

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

1 resources and emphasize the role of social  
2 determinants.

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

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

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

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

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

1        meaningful measures.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 connect between the discussions here and  
2 measurement are absolutely critical.

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

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

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

22 So that as we're looking at, say

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22 I'm not sure that in thinking you

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

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

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

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

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

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

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

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

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

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

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

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

1 time-consuming to look at those connects.

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

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

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

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

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

1 technologies.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22             The feasibility thing is huge.

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

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

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

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

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

1 (Laughter)

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

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

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

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

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

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

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

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

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

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

1     you're last.

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

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

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

1 the core of the problem of our health system.

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

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

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

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

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

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

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

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

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

19 MS. LASH: Did you want to add?

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

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

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

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

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

20 MS. LASH: Rita has a burning  
21 comment.

22 DR. MANGIONE-SMITH: One follow-up

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

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

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

1 difference.

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

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

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

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

1 Thank you.

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

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

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

22 It is intended to be practical.

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

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

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

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

17 And we're in the first year of  
18 what we hope and expect to be a three-year  
19 project. The first draft of the guide was  
20 posted for member and public comment just  
21 yesterday and it will be available until April  
22 16.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22 Each element in the guide provides

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

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

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

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

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

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

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

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

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

1     you all as committee members understand as  
2     well.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 expect some really interesting conversations  
2 next week.

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

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

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

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

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

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

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

22 But Cille, do you want to offer

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

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

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

10                  (Laughter)

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

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

1 is similar.

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

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

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

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

1 very much.

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

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

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

18 (Laughter)

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

1     selection of measures for different programs  
2     for the federal government.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1       they received.

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

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

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

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

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

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

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

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

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

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

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

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

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

1 bring them into our scan as well.

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

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

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

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

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

22

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3 DR. CASEY: Thanks.

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

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

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

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

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

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

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

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

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

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

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

8 MS. LASH: Very good points.  
9 Vija?

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

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

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

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

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

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

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

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

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

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

15                    MS. LASH: Great, thanks.  
16    Michael?

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

20                    MS. LASH: Sure.

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

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

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

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

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

22 DR. PARCHMAN: So, right. So

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

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

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

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

1 can find.

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

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

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

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

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

1 opportunity.

2 DR. PARCHMAN: Okay.

3 MS. LASH: Don?

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

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

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

22 We need to think about the payment

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

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

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

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

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

1       structure.

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

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

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

22                  DR. REINHARD: No, no, just that

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

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

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

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

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

1 more levels than I had realized was possible.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22 On shared accountability we would

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

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

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

1 and community-based services population.

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

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

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

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

1       whether that coordination was effective.

2                   Goal attainment, very important.

3       Have unmet needs been met as a result of these  
4       activities for the services in alignment with  
5       the person's goals and preferences? Did they  
6       get what was in their plan?

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

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

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

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

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

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

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

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

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

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

22                DR. EISENBERG: My comment is that

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

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

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

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

22 DR. CASEY: Quickly. I think that

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

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

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

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

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

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

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

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

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

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

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

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

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

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

19                 DR. SEHGAL: Vee-yah.

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

22                 DR. SEHGAL: Just building on what

1 Richard just said.

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

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

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

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

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

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

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

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

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

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

1 decision is.

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

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

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

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

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

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

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

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

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

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

22                  MR. CUSANO: Yes, thank you. On

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

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

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

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

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

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

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

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

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

5 One thing just back to this  
6 discussion earlier about integration, that's  
7 a concept that maybe does not come through  
8 very clearly here. And just a couple of  
9 thoughts of where that could be.

10 You know, shared accountability,  
11 is that something that might be tweaked a  
12 little bit to have this idea of integration?

13 And then the continuous  
14 communication. Again, is that something that  
15 could be tweaked a little bit. Either one of  
16 those categories actually becoming integration  
17 or something that gets at that concept that,  
18 you know, this isn't a bunch of separate  
19 coordinated care plans, this is a single  
20 effort.

21 The other thing, just a little  
22 thing around the -- well, I mean not so

1 little, but in the goal-setting and in the  
2 assessment, this emerging emphasis on patient-  
3 reported outcomes. And our goals as providers  
4 may be very different or often very different  
5 from what a user would come up with.

6 I mean, you look at a lot of  
7 medication regimens, for example. Quality of  
8 life may actually deteriorate as someone is  
9 meeting our medical quality measures and  
10 somehow that should be contemplated. So,  
11 somehow calling that out specifically, that  
12 there's some attention to that.

13 And then the last thing, I like  
14 that idea of the financial. And I would pitch  
15 that we think about that on both sides. So,  
16 what is the impact on cost, both dollars and  
17 time on both sides.

18 Because sometimes I think our  
19 notion of coordinated care may actually be  
20 adding burdens unwittingly onto the person  
21 being coordinated.

22 DR. REDDING: Fred, just a

1 reiteration back to you for clarification.  
2 But on one level we've got measures of an  
3 individual and we're organized in that. On  
4 another level we've got measures on a system  
5 of care or a population of individuals and on  
6 from there. And all those are critical to  
7 care coordination.

8 And like Michael has talked about,  
9 the interfaces between those different areas.  
10 Thank you. Michael?

11 DR. PARCHMAN: Just a few points  
12 around the creation of the plan of care. I  
13 think in addition to thinking about evidence-  
14 based for outcomes which was mentioned earlier  
15 I think we also need to consider burden on the  
16 patient and on the caregiver in goal-setting.

17 And I know we say shared decision-  
18 making here, but I can tell you from having  
19 sat in a lot of exam rooms with a lot of  
20 patients who have very complex healthcare  
21 needs that oftentimes in developing a care  
22 plan the full implication of the amount of

1     burden on them that this care plan is going to  
2     create is not taken into consideration.

3                 And patients walk out with this  
4     after-visit summary that's spit out by our EMR  
5     that can go on and on and on and on for what  
6     they're being asked to do.

7                 So I think somehow in terms of the  
8     patient-centered care plan the burden needs to  
9     be considered.

10                Second, as a health services  
11     researcher and the health services research  
12     community, we make a real clear distinction  
13     between measuring patient satisfaction and  
14     measuring patient's experiences of care.

15                And so I know there's been some  
16     concern voiced in the room about measuring  
17     this. But we're getting a lot better now at  
18     coming up with ways to get patients to tell us  
19     about their experience of care instead of  
20     their satisfaction with care. And those are  
21     two very distinct domains. So I don't want to  
22     throw the baby out with the bath water here on

1 asking patients what they think about care  
2 coordination. Because we're getting really  
3 better at that.

4 And lastly, about the  
5 relationships. I agree with Rita, this  
6 awareness just doesn't do it for me. It's  
7 really about the linkage piece between the  
8 community agencies, the community resources,  
9 the providers between communities, and it's  
10 about things like frequency of communication,  
11 accuracy of communication, timeliness of  
12 communication, communication that is problem-  
13 solving communication about shared knowledge  
14 about what each other is capable of doing in  
15 terms of abilities and competencies.

16 And there are some measures to  
17 that out there. Survey measures mostly,  
18 still, surveys about the degree to which  
19 between me and you as a service provider our  
20 accuracy of communication, our timeliness, our  
21 problem-solving, our relationship in terms of  
22 shared goals and shared understanding about

1       what each other is capable of doing.

2                       And we're getting a little bit  
3       better at measuring that relational  
4       coordination piece.  So, I'd like us to flesh  
5       that out -- piece that a little bit better,  
6       perhaps in our workgroups.

7                       DR. REDDING:  Thank you, Michael.  
8       One point of clarification I think in terms of  
9       using the term "relationships."  There is good  
10      data to show a completely different kind of  
11      relationship, but the supportive relationship  
12      that the care coordinator actually has with  
13      their patient.

14                      And how it's a warm and fuzzy  
15      component but it actually has evidence behind  
16      it to make things go forward.

17                      But I think you're using the term  
18      "relationships" in terms of the other system  
19      providers that are working together for that  
20      care.  Very good, thank you.  David.

21                      One quick point, David, before you  
22      go on.  I just wanted to mention your point

1     about premature versus aspirational versus  
2     now. That seemed like an important -- it took  
3     me a little while to get it through my brain,  
4     but yes, that seems to tap into what Don was  
5     saying, so thank you.

6                     But, please.

7                     DR. EISENBERG: I'm glad you said  
8     thank you. I wasn't sure if I did something  
9     wrong.

10                    (Laughter)

11                    DR. EISENBERG: I echo the prior  
12     comments about having a financial measure of  
13     this.

14                    And I was interested, the idea of  
15     the financial consequences on the patient as  
16     well as -- or the person as opposed to the  
17     provider.

18                    On the other hand you could be  
19     creating excess care that comes at a cost not  
20     only in time but also in a copay or out-of-  
21     pocket expense. So I think that would be  
22     important.

1                   The other thing is that I don't  
2           see here is an appropriateness. That is, and  
3           I'm thinking about that either on an  
4           individual level or an organizational level or  
5           at a system level or a community level is the  
6           level of activity, is the level of effort  
7           appropriate to the needs of the group.

8                   So you know, are we -- is there a  
9           lot of effort being given to coordinate care  
10          for someone who is just happy being left to  
11          their own resources?

12                   DR. REDDING: Excellent comment.  
13          One quick builder on that is in Ohio as  
14          Medicaid managed care plans are paying for and  
15          paying higher for at-risk care coordination.

16                   The newest proposal is to have an  
17          actually separate individual go out and assess  
18          their risk, take the data and determine the  
19          appropriateness of care coordination and then  
20          hand it over to someone else so that it's more  
21          objective. Because I think what you're saying  
22          does go on since care coordination brings

1       financing and it's based on individual  
2       caseloads.   Excellent point.

3               DR. EISENBERG:   And just to add on  
4       that.   In the special needs plans, the  
5       Medicare, Medicaid, the dual eligibles,  
6       probably all of the special needs plans under  
7       CMS there's a requirement to do comprehensive  
8       evaluations and to have integrated care plans  
9       for everyone.

10              And sort of without I think an  
11       acknowledgment that there's -- that the level  
12       of effort, that the complexity of the plan  
13       should be different based upon the needs.   And  
14       that's never been explicitly said.

15              DR. REDDING:   It's also a question  
16       is when do they no longer intensive care  
17       coordination.   When is there a level of need  
18       to a point they could make it on their own?  
19       Very excellent.   Russ?

20              DR. LEFTWICH:   Don and Vija may  
21       have touched on this, but under comprehensive  
22       assessment it seems like we're missing capture

1 patient preferences and priorities, patient  
2 family preferences and priorities.

3 And secondly, probably next to  
4 assess health literacy would be assess  
5 technology adoption level. Because we're  
6 really creating a framework in Meaningful Use  
7 of electronic access to your information.

8 Somebody in a state that I may  
9 live in suggested that we should give the  
10 Medicaid enrollees a free app for their  
11 smartphone to access their claims data.  
12 Really? You know. So I would say that should  
13 be part of the assessment.

14 DR. REDDING: Excellent, thank  
15 you. And my 15-year-old son would say he'd  
16 like to see that assessment applied to me  
17 because he feels I'm so backwards, but thank  
18 you.

19 (Laughter)

20 DR. REDDING: Yes, Don.

21 DR. CASEY: So, three really quick  
22 follow-ups that might help.

1                   One is this I think someone  
2                   mentioned cost and utilization. Someone else  
3                   mentioned appropriateness.

4                   But I think that low-value versus  
5                   high-value moves us away on the cost and  
6                   utilization side from this perception that  
7                   that's an actuarial sort of evaluation as  
8                   opposed to assigning expectation of outcome to  
9                   the inputs.

10                  And you know, low-value or no  
11                  value versus high-value also encompasses  
12                  appropriateness because high value is doing  
13                  things that are appropriate and have an  
14                  impact. So, we ought to think about being  
15                  careful about how -- we're all trying to get  
16                  at the same thing about how we frame it.

17                  The second is, and again it's just  
18                  my pet peeve so I'll repeat it. I think the  
19                  phrase "evidence-based" is old and out of  
20                  date. Just because you've done a systematic  
21                  review doesn't mean you've crafted thoughtful  
22                  guideline statements in accordance with

1 evidence.

2                   So, the term that we're using in  
3 our ACCHA guidelines around heart failure and  
4 other cardiac care is not evidence-based but  
5 guideline-directed which implies that there's  
6 been a next level of evaluation of evidence  
7 which then turns it into specific statements  
8 about what has the highest impact.

9                   And then maybe on this linkage  
10 thing, I mean so Russ and I are linked, right?  
11 But, we're not necessarily on the same page  
12 about everything. So linkage is kind of again  
13 this connection or handoff.

14                   I sort of think of  
15 synchronization. And maybe it's timely  
16 synchronization of linkages, I don't know.  
17 But just trying to put that all into one  
18 knockout punch to say let's get it done and  
19 let's be sure everyone is on the same page.  
20 You know, linkage is still sort of a little  
21 wishy-washy to me.

22                   DR. REDDING: Don, just

1 clarification. Back to you but I've heard it  
2 said that if our outcomes report could be the  
3 same as our invoice sheet where the value of  
4 the impact is directly tied to that -- and I  
5 know we're not there yet and so they need to  
6 be succinct. But that would be -- that's  
7 consistent with what you're saying, I think.

8 DR. CASEY: Well, I think that  
9 just looking at cost and not thinking about  
10 what the consequences, positive and negative,  
11 are, just thinking about cost is where I fall,  
12 so.

13 There are underutilized services  
14 which could cost us more that will impact all  
15 this stuff in a positive way. So just trying  
16 to be thoughtful about it rather than  
17 actuarially.

18 DR. REDDING: Very good, thank  
19 you. Gerri?

20 DR. LAMB: I think this is a great  
21 start. Just a couple of things to build on  
22 others.

1 Under comprehensive assessment the  
2 things that this raises for me is one of  
3 balance among the measures which may be  
4 premature but just to say it, that this is  
5 ripe for composite. But I'd rather not see  
6 400 measures here and nothing anywhere else.

7 The other thing it raises for me  
8 in the discussion of patient engagement and  
9 whose goals is the taxonomy here which is  
10 whose language.

11 This is all provider language and  
12 all provider categories. Do consumers frame  
13 their health needs in the same language that  
14 we are? And I know that opens a can of worms  
15 but people who focused on patient engagement  
16 raised that.

17 And then the last one in that  
18 category is risk level. There's been a lot of  
19 work on thinking through not just risk  
20 adjustment but low-, moderate-, high-risk for  
21 what and we need to be more specific about  
22 risk for what and how do we titrate the rest

1 of this for that.

2 Under shared accountability, just  
3 to connect is we now have the National Center  
4 for Interprofessional Practice and Education  
5 and a huge focus on measurement. They just  
6 completed a review of all the team-based  
7 measures, team performance, team behaviors,  
8 team outcomes and that might be a place to  
9 look for that.

10 I too, the level of relationships  
11 is off for me. It's too low on the Bloom's  
12 Taxonomy. I think we need to up it to  
13 behavioral measures.

14 I'm not quite sure I have the same  
15 problem that Rita does. I'm not as concerned  
16 about whether you value it. Are you willing  
17 to use it and use it effectively?

18 And then I agree with the  
19 discussions about we need to move towards more  
20 integration. And I agree with Don, it's more  
21 the synchronicity is are you on the same page  
22 and can you move forward and how to capture

1       that.  That's it.

2                       DR. REDDING:  Thank you,  
3       excellent.  Wow.  Susan?

4                       DR. REINHARD:  I tend to think in  
5       terms of multiple chronic conditions so I'm  
6       just going to put that out there.  I just  
7       think everyone needs care coordination.  
8       Certainly those -- and I include preemies with  
9       this, not just older people, of course.

10                      And so to Judy's point, the  
11       improvement of health status, it really needs  
12       to be at least health and functional status.  
13       And we do assess function under that.  But it  
14       is about whether or not you can get through  
15       life and you can function day to day.

16                      And that, by the way, is being  
17       confirmed by the SCAN Foundation who's putting  
18       a lot of emphasis on this.

19                      And it also gets to the use of  
20       community resources.  That's what you're  
21       trying to do there is link them to resources  
22       to help them function better.

1                   And the second one is that there -  
2           - I'm trying to see whether this would be  
3           under goal-setting, or shared accountability,  
4           or continuous communication. But the care  
5           plan has -- it's not static. It has to keep  
6           changing.

7                   So we talk about continuous  
8           communication, but this care plan has to be a  
9           living, breathing document kind of thing  
10          guiding the care.

11                  DR. REDDING: Excellent. And it  
12          seems that that ties into the reevaluation of  
13          a person's risk and need and where they are,  
14          whether they've gotten worse, and then  
15          tracking their risk change over time,  
16          individual versus populations at risk.  
17          Excellent. Thank you.

18                  I want to check in with Sarah  
19          really quick with our time. Or can we go over  
20          a little bit?

21                  MS. LASH: Yes, let's keep going  
22          since we started the session a little late and

1 I think this is a really, really rich  
2 dialogue.

3 MS. INGRAM: This is Carolyn. If  
4 we have enough time I just have a couple of  
5 comments.

6 DR. REDDING: Please do, Carolyn.  
7 Thank you for speaking up.

8 MS. INGRAM: Okay, sure. So, on  
9 the right-hand column when you're going down  
10 and the bullets that are on there listing out  
11 primary care providers and community service  
12 providers. Maybe this comes when you do the  
13 definitions of how this is used but just to  
14 make sure that we include other than  
15 traditional primary care providers like  
16 community mental health centers sometimes  
17 serve as primary care entities. Sometimes in  
18 tribal communities there are tribal entities  
19 that serve as PCPS. So just to make sure  
20 we're sensitive to that.

21 And again, that can be captured  
22 maybe in the definition. I'm not saying it

1 has to all go on here.

2 And then I think some of the  
3 previous speakers talked about appropriate  
4 improved health status. And I just wanted to  
5 echo that I would agree with them on that.

6 A lot of our more vulnerable  
7 populations that we deal with may not always  
8 have improved health status. And maybe it's  
9 just appropriate to either maintain that  
10 health status or maintain some type of quality  
11 of life even while the health status is  
12 declining for our elders in the community.  
13 Thank you.

14 DR. REDDING: Excellent, thank  
15 you. Yes, I think to us medical providers the  
16 new JAMA article saying 10 percent of a  
17 person's health is related to healthcare was  
18 kind of a shock. So there are some other  
19 folks out there critical to communicate with.  
20 Richard?

21 DR. BIRKEL: Just one quick point  
22 and a question.

1                   The point I want to make is back -  
2                   - I'm trying to re-frame what I said earlier  
3                   maybe a little bit more specifically.

4                   But it seems to me that the  
5                   patient needs to be engaged in the creation of  
6                   the care team. In other words, who is at the  
7                   table, and particularly in regard to  
8                   community-based services. So, they may prefer  
9                   to work through their church to get certain  
10                  things done, or the YMCA, or the Alzheimer's  
11                  Association. That needs to be assessed up  
12                  front and those are the people who should be  
13                  at the table.

14                  My question goes to this issue. I  
15                  was really impressed with what Sarah showed  
16                  the person- and family-centered care group,  
17                  the MAP that they were using. And how does  
18                  our outcomes, achievement of outcomes, relate  
19                  to the outcomes that they're defining?

20                  For example, they had experience  
21                  of care, health-related quality of life which  
22                  we don't have. The burden of illness which

1       again isn't on here.

2                       I'm just wondering why wouldn't we  
3       want to adopt a shared outcomes template of  
4       some kind? Are we inventing a whole separate  
5       set of outcomes that isn't going to relate to  
6       what that group is doing? So that's a  
7       question really.

8                       DR. REDDING: Very good, thank  
9       you. Nancy.

10                      DR. GIUNTA: Hi, thank you. I  
11       find myself agreeing with so many comments.  
12       I really want to underscore the question of  
13       who owns the person-centered plan of care and  
14       who drives it.

15                      And I agree with Gerri where we  
16       need to make sure the listing of measures is  
17       not necessarily provider-focused in provider  
18       language.

19                      There is a bullet point for  
20       documenting care recipient's strengths and  
21       assets and supports, but really incorporating  
22       that into the plan of care is I think

1 important.

2 Also, the area of relationships.  
3 I will be in that workgroup too. So really  
4 looking at not only knowledge of community-  
5 based services but what are the facilitators  
6 and barriers to patients or clients accessing  
7 those services.

8 Particularly I'm thinking about  
9 funding streams and funding sources and what  
10 helps people be eligible for community-based  
11 services.

12 And someone mentioned the  
13 bidirectionality piece. I think it's really  
14 important to be aware that this is not  
15 unidirectional, this is not one-directional,  
16 but it's multidirectional between clients and  
17 providers and community services.

18 DR. REDDING: Thank you. And as  
19 somebody who's on the ground doing this work  
20 we're glad you're here with others. Thank  
21 you. Rita?

22 DR. MANGIONE-SMITH: Getting back

1 to you asked me to think about some other  
2 things to put in that relationship bucket.  
3 And this may be getting too specific. Feel  
4 free to reject. These are just -- I'm trying  
5 to resonate some of what I've heard around the  
6 room.

7 So, appropriate community services  
8 identified and contacted based on a needs  
9 assessment. Care recipient and family  
10 successfully engages with and utilizes  
11 community services. Shared understanding by  
12 providers, community services and care  
13 recipients of care coordination goals.

14 So to me that's more the kinds of  
15 relationships that I would want to see come  
16 from executing a care plan.

17 And I just have to say this  
18 because it's been bothering me. Under the  
19 comprehensive assessment there's nothing about  
20 the goals of the care recipient in there which  
21 seem like should really drive how that care  
22 plan gets constructed.

1 DR. REDDING: Absolutely. It  
2 ought to be driven by the plan of care. Thank  
3 you. Linda?

4 DR. LINDEKE: Really good thinking  
5 going on here today. It's very encouraging.

6 Continuous holistic monitoring has  
7 to be in here. I've been searching to see  
8 where there's a nuance of it.

9 And then the question is who does  
10 that monitoring. The level of workforce. So  
11 I was very interested in searching on who was  
12 on the workforce work of NQF.

13 And I always remember tuning into  
14 a webcast and they were demonstrating their  
15 good care coordination. And they said, well  
16 who did you hire. Well, the phlebotomist  
17 really knew what families needed because she's  
18 got a child with blah blah.

19 And I thought oh my gosh, that's  
20 fine. That's not the skill set I hope that  
21 this phlebotomist -- anyway, you can finish  
22 the thought.

1                   The other piece is a huge  
2           blossoming career of health coaches, health  
3           guides, health whatever they're calling them,  
4           navigators, whatever. What is their skill set  
5           for continuous holistic guideline-driven. But  
6           then I say whose guideline. So I like you're  
7           getting from evidence-based but then whose  
8           guideline? So, continuous holistic monitoring  
9           and then we can dig into that.

10                   DR. REDDING: I think your point  
11           is particularly poignant for programs, for  
12           example, who pay and expend a lot of their  
13           employees' time training them and then have  
14           other programs pull in right next door, give  
15           them a 2-hour training and say they're doing  
16           the same thing. It really taps into the  
17           economics. Thank you. Judy?

18                   MS. STEIN: I just wanted to say  
19           totally agree with the earlier comments about  
20           patients needing to be involved in determining  
21           the composition of their care team. It is  
22           something that's very personal.

1                   And I'm not sure if any of these  
2                   capture how you determine what the appropriate  
3                   composition of the care team is, and if the  
4                   right people are at the table. I guess the  
5                   hope is that in choosing the outcomes you  
6                   assume that -- if you have good outcomes you  
7                   assume the right people were at the table and  
8                   part of the team.

9                   But I think that I have two other  
10                  comments. One is we talked a little bit about  
11                  the definition of providers and we talked a  
12                  lot on the call about needing a good  
13                  definition of community service providers as  
14                  well. Because that is a pretty expansive  
15                  category of services.

16                 And then curious whether it  
17                 includes things like people who help with  
18                 activities of daily living. Those are  
19                 certainly services that are provided in the  
20                 community and community-based care and  
21                 essential especially for people with  
22                 complicated chronic diseases.

1                   And lastly, in addition to  
2           updating the care plan I think that you also  
3           need to update the actual care team. I mean  
4           as the individuals' conditions evolve new  
5           people might need to be brought into the care  
6           team. And I'm not sure how exactly to capture  
7           that as well.

8                   And some people might need to move  
9           off. But I think that underscores kind of the  
10          theme of flexibility in developing care plans  
11          over time, to meet the needs of patients.

12                  DR. REDDING: Excellent. So that  
13          we have time to feed you, so that you can do  
14          more of this this afternoon I'll just ask for  
15          a high-speed if that's okay report-out. And  
16          feel free to put your sign up. Sharon?

17                  MS. MCCAULEY: Yes. Just to  
18          reiterate a few of the ideas that have already  
19          percolated up.

20                  The big thing is that monitoring  
21          that evaluation, that reassessment, I think  
22          that's what you just hit on, that we have to

1 have the right providers at the right table.  
2 And I still question who that healthcare  
3 worker is, that health neighborhood who's  
4 really going to be manning or coordinating.

5 Like who's going to be the person  
6 who's going to start that assessment and  
7 continue that and make sure we keep bringing  
8 the right people at the table at the right  
9 time.

10 And the big thing is to make sure  
11 their standards are set for the knowledge.  
12 This is the first base. Then you get into  
13 that practice experience to make sure that  
14 that individual is really the person who can  
15 do that work. Are they going to be able to  
16 handle -- do they want to be there.

17 And then the last point I wanted  
18 to make is I highly agree with the priority-  
19 based applying that evidence. Because many  
20 times we have so many different areas here  
21 that have to be addressed.

22 How do you prioritize what comes

1 first, second and third? You cannot overwhelm  
2 the care recipient. And I think so many times  
3 we do. And they're not going to be able to  
4 hear us. So we really need to make sure based  
5 on evidence what's the highest priority number  
6 one, two, three of the goals that we've set in  
7 that shared decision-making can we hit and  
8 then again go back and reassess, re-monitor  
9 and then, you know, then the next group of  
10 care providers come in to help out.

11 DR. REDDING: Excellent, thank  
12 you. Michael.

13 DR. PARCHMAN: Just real quick.  
14 For those of you who are going to be in the  
15 creation of person-centered plan of care group  
16 this afternoon I'd challenge you to think  
17 about the burden on the primary care team of  
18 doing everything in that lefthand column on  
19 every patient who comes in the door from 8  
20 a.m. until 6 p.m.

21 DR. REDDING: Excellent. That's  
22 where you need that care coordinator.

1 DR. PARCHMAN: No, no. You need a  
2 way to risk-stratify your population and say  
3 who needs this and who doesn't.

4 DR. REDDING: Right.

5 DR. PARCHMAN: So how do you do  
6 that as a primary care organization.

7 Now, there are people that are  
8 developing ways of doing that and there's the  
9 famous Kaiser pyramid which many of you are  
10 familiar with about that top of the pyramid  
11 people who need what's in this lefthand  
12 column.

13 But that has got to be taken into  
14 account when we think about these issues in  
15 terms of developing measures. So enough said.

16 DR. REDDING: Excellent, thank  
17 you. David.

18 DR. ACKMAN: Also, in this first  
19 column I think is this always starting and is  
20 this always under the responsibility of the  
21 primary care team? Is it always coming out of  
22 the medical setting?

1                   Probably -- I mean, certainly not  
2                   when you're talking about chronically mentally  
3                   ill persons who are primarily connected  
4                   through the mental health system. And that  
5                   probably should be sort of recognized.

6                   DR. REDDING: Since there's others  
7                   out in the community who know the social  
8                   systems possibly better than the primary care  
9                   physician, but the physician needs to be able  
10                  to lean on somebody related to those aspects.  
11                  Very good. Don?

12                  DR. CASEY: Just quickly. I  
13                  appreciate this discussion and evaluation and  
14                  wonder if in the heading achievement and  
15                  outcomes, embedded in that is an implication  
16                  that the outcomes and performance measures  
17                  have been used to measure the outcomes  
18                  correctly.

19                  So, achievement, you know, you're  
20                  not describing a system of performance  
21                  measurement. And maybe that needs to be more  
22                  explicitly in this model. And maybe it's more

1 broadly writ evaluation which would include  
2 other things besides performance measurement.  
3 But getting at evaluation not just to the  
4 microsystem but also the community and then in  
5 aggregate at the macro level from an HHS  
6 standpoint seems to be an opportunity.

7 I think that right now we have  
8 lots of what I would call sort of loose  
9 innovation going on. So I don't want to  
10 discourage that, but the more we get  
11 standardized we have to be careful about not  
12 discouraging innovation.

13 We ultimately have to have  
14 generalizable and sustainable results and  
15 adoption in a knowledge-based system that  
16 promotes rapid dissemination independent of  
17 publication to get improvements more rapidly  
18 into place. Not that we don't want to be  
19 scientific about it.

20 So I'm just, I'm calling out  
21 whether evaluation, performance measurement  
22 methods ought to be either in a separate

1 column or embedded in here a little more  
2 discretely so that it's clear.

3 DR. REDDING: Seems like a very  
4 critical point. Just quick reiteration. We  
5 need measurement at the individual level and  
6 then we need it at a system level. And  
7 system-level particularly we don't have.

8 DR. CASEY: But evaluation too,  
9 you know, which includes performance  
10 measurement. So writ broadly.

11 DR. REDDING: Yes.

12 DR. CASEY: Program evaluation so  
13 to speak.

14 DR. REDDING: Gotcha. Thank you  
15 very much. Robert?

16 DR. ROCA: Very briefly. Having  
17 been a participant in creating plans of care  
18 and a witness to the creation of plans of care  
19 I know that it's often the case that the  
20 members of the team are not aware of what's in  
21 the plan of care.

22 (Laughter)

1 DR. ROCA: And I don't see any  
2 mention here of the extent to which the  
3 members of the team are -- and then that's the  
4 other one, do they use it.

5 I've seen many plans of care put  
6 on the shelf or created just for the sake of  
7 creating them. So it may be implied in all of  
8 this but some explicit mention of the extent  
9 to which members of the team know about the  
10 plan of care and the extent to which they use  
11 it I think would be important.

12 DR. REDDING: Thank you,  
13 excellent. Karen?

14 DR. GIUNTA: I also want to  
15 piggyback on Michael's comments about the  
16 primary care setting responsibility to collect  
17 all this information. It might not only be  
18 the primary care setting's responsibility.

19 If you look at access to  
20 information, that community-based services  
21 might already have that. And the role of  
22 community-based services in potentially

1     advocating for people, clients, patients, that  
2     could be used to inform information that you  
3     may need, that primary care settings may need  
4     for assessments.

5             DR. REDDING:   Similar to that term  
6     "integration" in our definition somewhere,  
7     yes.   Thank you.

8             Fantastic work.   Thank you very,  
9     very much.   Sarah, anything else before lunch?

10            MS. LASH:   We have two things to  
11    do before lunch.   The first is to pause for  
12    public comment.   The second is to actually  
13    preview the next part of the agenda so that  
14    you can do some individual work as you're  
15    eating.

16            So we'll do the public comment  
17    now.   Operator, if you would queue the phone  
18    participants and in the meantime we'll see if  
19    there's any in the room.

20            OPERATOR:   Okay.   To make a public  
21    comment please press \* and then the number 1  
22    on your telephone keypad.   No, no public

1        comments at this time.

2                    DR. DAILEY:    Hi, I'm Maureen  
3        Dailey from the American Nurses Association.  
4        And I know that you looked at ANA's framework  
5        for measuring nurses' contributions to care  
6        coordination.

7                    And we all use the IOM six aims of  
8        care for the domains.    Patient safety is  
9        missing here.    And it's my personal experience  
10       with my daughter with a missed diagnosis of a  
11       massive tumor in two academic medical centers.  
12       And luckily we were able to get the right  
13       care.    But it took a lot of care coordination  
14       to fill in the gaps of missed care.

15                   And also being dismissed.    So  
16       patient safety is important and I think that  
17       should be considered to be added.    Thank you.

18                   DR. REINHARD:    So, you may have  
19       noticed that you got a little handout here  
20       during our break.    And when we -- so while  
21       you're eating, as I said, this is not a free  
22       lunch.    You really do have to do work.    And

1 we're running behind, so together with that.

2 We're asking you to take these  
3 nine domains that we've been talking about  
4 that you have before you of course and take  
5 each one. You see these little stickies,  
6 right?

7 So you take each one and you  
8 consider that domain in two ways. The first  
9 is the extent to which it would be feasible to  
10 develop measures for that particular domain.  
11 So think about that first.

12 And then think about the impact it  
13 would have if we could develop those measures.  
14 So there's two ways of looking at this and you  
15 will individually use this sheet for your  
16 worksheet.

17 When we come back we'll have a  
18 discussion and I think Lauralei or others will  
19 be listening to us. And we will see if we can  
20 achieve consensus as a group on where these  
21 domains fit.

22 Obviously the high-impact, high-

1 feasibility is the sweet spot. You see it's  
2 in red. It would be great to get to there.  
3 We have some over there, but we know that  
4 they're not all going to be there.

5 But before we did that, if that's  
6 okay with you, Sarah, I just wanted to turn to  
7 Don and Gerri for a moment. They're going to  
8 have an opportunity to talk with members of  
9 their committee after we come back from lunch.

10 But in conversation beforehand it  
11 seemed like some of the thinking of that  
12 committee might influence some of your  
13 thinking for the individual work you're doing  
14 in terms of feasibility and impact, the  
15 tradeoffs.

16 Either one of you want to say  
17 anything? Just a few words to guide us.

18 DR. CASEY: Well, we know for a  
19 fact again that the group is highly  
20 emotionally charged and committed to these  
21 discussions. And so we promised the committee  
22 that we would include them.

1                   But I think that relative to the  
2                   comments we made before the current measures  
3                   that come across are for the most part highly  
4                   feasible, but they're only measuring a small  
5                   amount.

6                   And I think it was maybe Nancy and  
7                   Rita who pointed out that as you get messier  
8                   feasibility is going to fall apart. And maybe  
9                   the part of this is sort of the ease of use of  
10                  how the measures themselves let alone how the  
11                  system works needs to really be thought  
12                  through.

13                  And without question I think that  
14                  impact is again at a very focused level. So,  
15                  I think we have to come up with an efficient  
16                  way to help measure developers specify what  
17                  outcomes would be the most important to  
18                  evaluate.

19                  As you get into outcome  
20                  measurement it's extremely expensive and  
21                  challenging to do that right. So that raises  
22                  a question about whether, you know, how far we

1 want to push the research agenda given our  
2 current environment.

3           So, in the meantime I do think  
4 that there are things that systems can do a  
5 lot better on. And I think we heard lots of  
6 examples from our committee members about  
7 these examples of how we could do a much more  
8 robust and efficient way at the delivery point  
9 of evaluating without feeling like we're in a  
10 study.

11           So, you know, I just think we have  
12 to think through how that data gets compiled  
13 and brought together.

14           DR. LAMB: I think we've covered a  
15 lot of the concerns of our committee.

16           One thing I would add to it is as  
17 we look at putting these different domains on  
18 the diagram is to remember what I think  
19 several people here said is that they are not  
20 separate from each other.

21           And I think the challenge here is  
22 that many of these things may be what we're

1     dealing with right now in terms of the state  
2     of the art may be -- or a lower-impact, high-  
3     feasibility, and what we're dealing with is  
4     necessary but not sufficient.

5                 So that it's going to really be I  
6     think the combination of things that we have  
7     to look at is where's the bang for the buck  
8     and what's going to really make this worth the  
9     time and effort to collect these data.

10                DR. CASEY:  Could I just?  I just  
11     got the announcement for today's Economist so  
12     this article says, "Is college worth it?  Too  
13     many degrees are a waste of money.  Return on  
14     higher education would be much better if  
15     college were cheaper."  So maybe there are  
16     lessons learned in other sectors -- I'm being  
17     serious -- about how we might approach some  
18     thinking here.

19                DR. REINHARD:  I'm thinking of the  
20     number of years of college education that  
21     occurred in this room alone, it's amazing.

22                Are there any questions about the

1 task head of us? Because when we return we're  
2 going to turn back to Don and Gerri and  
3 members of your committee who are I think  
4 going to join us on the phone. But I just  
5 wanted to have a teaser I guess of what you  
6 were thinking so you could apply that. Yes.

7 DR. GIUNTA: I know I'm sitting  
8 between you and lunch. But when we say impact  
9 is the ultimate goal, could you just give a  
10 one-sentence kind of description of what  
11 exactly we all mean by impact?

12 And if I'm the only person with  
13 that question -- then okay, okay.

14 DR. LAMB: I'm thinking about  
15 impact in terms of the review criteria for  
16 measurement which is does it lead to the  
17 outcomes. And what is the nature of the  
18 relationship between that activity and the  
19 achievement of the outcomes that we have in  
20 the right-hand column.

21 So is -- somebody that I work with  
22 frequently says is the juice worth the

1 squeeze. This is exactly that which is is the  
2 effort going to get us where we want to be.

3 DR. MANGIONE-SMITH: How do you  
4 apply that to the outcome domains that are on  
5 here?

6 DR. LAMB: Again, going back to  
7 the review criteria it's related to not only  
8 impact but importance which is do we have data  
9 that support the structure-process-outcome  
10 link both, you know, and I think we've talked  
11 about one of the algorithm is that narrative  
12 support is not considered evidence in the  
13 review criteria.

14 But we have a lot of narrative in  
15 care coordination and case management. So,  
16 how do we build the support that if we do this  
17 it's going to lead to the goal that we want.

18 DR. CASEY: Yes, and I would  
19 completely agree with Gerri.

20 What I'd say is that you've asked  
21 a key question and I think that's a journey,  
22 not a destination.

1                   And part of the problem is, and I  
2                   think Sarah pointed it out, endpoints in a lot  
3                   of things that are out there as far as impact  
4                   don't fit with each other. So we haven't sort  
5                   of tried to set the agenda about what impact  
6                   statements can be congruent through future  
7                   work. And so I think we have to get through  
8                   that. I hope that makes sense. I'm not --  
9                   there isn't a clear answer about exactly what  
10                  impact, but we have to really think through  
11                  it.

12                  And I think this "Achievement of  
13                  Outcomes" column is trying to get us to that  
14                  point. But until we have consistency we're  
15                  not going to be able to combine information.

16                  DR. REINHARD: So, I'm going to  
17                  give you two examples how I would think of it.  
18                  And if anyone wants to push back they could.

19                  In the long-term care arena the  
20                  measurement of which CMS started a long time  
21                  ago. I can't even tell you who developed  
22                  these measures but it had to do with

1 restraints, physical restraints. Took years  
2 and a lot of data. People had to measure  
3 this, dah dah dah.

4 It has been so improved. The use  
5 of physical restraints in nursing homes has  
6 declined so much that we're not even including  
7 the measure in our long-term care scorecard  
8 that's coming out in June.

9 Instead we're replacing it with  
10 antipsychotic medication use. And we're  
11 hoping that the impact of it is really  
12 amazing.

13 In your field, Linda, I'm trying  
14 to think. Is it elective deliveries? It has  
15 to do with newborns. And that measure which  
16 I believe this group had something to do with  
17 that, the National Quality Forum, it's amazing  
18 what has happened with that. If you could  
19 just address that for a second, do you mind?

20 DR. LINDEKE: Well, the elective  
21 deliveries at late term which would have been  
22 37 weeks-plus. And there's evidence and I

1 think the public is starting to listen to that  
2 and measurement, the quality of the outcome of  
3 the child. Some very physiologic measures.  
4 And they're paying attention, finally.

5 DR. REINHARD: I sit on the  
6 Leapfrog board of directors. I mean, this has  
7 been enormous. This is something that  
8 business has taken on as that measure.

9 So again, you've got to collect  
10 data, what was the feasibility of that. But  
11 the impact of it in a relatively short period  
12 of time has meant saved lives of babies and  
13 amazing drops in costs.

14 So those are just two examples  
15 that I would think of in terms of how hard is  
16 it to get to this measure or measure sets, and  
17 what impact would it have. And can you weigh  
18 that. Is that fair, Sarah? Is there anything  
19 else you want to add? Go ahead.

20 MS. PRINS: Can I -- I would love  
21 to add a little bit to this conversation  
22 because I think it's great that pretty much

1 every meeting that I go to now this EED  
2 example comes up.

3 And we were involved in sort of  
4 thinking about that because it's an endorsed  
5 measure. And when you think about the  
6 implications on the Triple-Aim, so cost,  
7 safety and health and outcomes of the baby.  
8 So there was evidence that it was being  
9 overused, that the cost to insurers was huge  
10 and that there were bad things that happened  
11 or that could happen to the baby.

12 So it was that sweet spot and it  
13 was, you know, it was just really we had a lot  
14 of people sort of working on it. And then it  
15 really, you know, everyone sort of came around  
16 it and it just exploded. And the results were  
17 amazing.

18 So, those types of things I think  
19 may be not as easy to find for this type of  
20 stuff, but where you feel like there may be  
21 those things that could really catapult us I  
22 think would be really important to highlight.

1 DR. REINHARD: Okay, Mark, and  
2 then we really want to eat.

3 DR. REDDING: One strategy, I  
4 think it just reiterates what you said. But  
5 obviously there's a huge amount of detail that  
6 could fall under each of these. And so if you  
7 have, and I'm asking this of you, Susan and  
8 Sarah.

9 If you have a sense that in those  
10 sub-units that would be there that there would  
11 be quite a few of them that would make this  
12 general item more feasible it may help you  
13 think through this scale. Because obviously  
14 there are big, broad brush strokes which is  
15 what we have to work with to begin. Does that  
16 make sense?

17 DR. REINHARD: All right, thank  
18 you. Enjoy your lunch.

19 (Whereupon, the foregoing matter  
20 went off the record at 12:54 p.m. and went  
21 back on the record at 1:23 p.m.)

22 DR. REINHARD: Okay, if you could

1 return to your seats. What we're going to do  
2 is Don and Gerri before they ate lunch kindly  
3 jumped in at my request to talk about what  
4 their committee has been doing to help inform  
5 your individual work and then our group work.

6 But we think there are members of  
7 your committee perhaps online. And so I just  
8 want to find out if they are and if you'd like  
9 to invite them for further comments.

10 DR. CASEY: They might be, I can't  
11 remember. Angela, do you remember if we cued  
12 any of the committee members as to what time  
13 to call in? Do you remember?

14 Okay, so anyone on the webinar  
15 from the steering committee who wants to make  
16 a comment identify yourself and let her rip.

17 DR. REINHARD: We heard a beep.

18 MS. LEATH: That may have been  
19 measure just un-muting my phone. This is  
20 Brenda Leath.

21 DR. REINHARD: Okay.

22 DR. CASEY: Are they on listen-

1       only?  They're open lines?  Okay, good.

2                   DR. REINHARD:  Okay.  Yes?

3                   MS. SCHULTZ:  This is Ellen  
4       Schultz, a member of this other committee.  
5       I'd like to thank all of you for the  
6       opportunity to speak up and also just to  
7       listen and enjoy this really rich discussion.

8                   I have something I kind of want to  
9       put out there to maybe provoke some thinking.  
10      Looking at this framework and thinking from a  
11      measure developer viewpoint what would be  
12      high-impact and what would be feasibility.

13                  And one idea I had thinking  
14      especially how do we get to outcomes is  
15      thinking, you know, looking under this goal  
16      attainment box.

17                  Instead of thinking of specific  
18      kinds of goals, even broad ones such as  
19      reducing unmet needs, or improving health  
20      status, or maintaining health status, what  
21      about just thinking, you know, did the patient  
22      achieve a goal.  And keeping it really broad

1 to really be anchored in this person-centered  
2 care framework.

3 Now, I know that's a daunting  
4 prospect in terms of feasibility. But just  
5 for the purposes of discussion I kind of want  
6 to put that out there, that instead of trying  
7 to think about what goals people should have  
8 or what we think they might want, what if we  
9 could just look at did they achieve a goal?

10 And how would that really spur  
11 this process of assessment and shared  
12 decision-making and setting goals, and spur  
13 the process of helping supporting people in  
14 being able to achieve those goals.

15 DR. REINHARD: Can you identify  
16 yourself again and where you're from?

17 MS. SCHULTZ: This is Ellen  
18 Schultz. I'm a researcher at Stanford  
19 University and I'm a member of the Care  
20 Coordination Steering Committee.

21 DR. REINHARD: Great, thank you.  
22 You know, that statement made me think of

1 something Don said earlier where one of your  
2 patients had a goal. I don't know what her  
3 quality of life goal was but it was different  
4 than perhaps a physician might think of it.  
5 And she I guess attained her goal.

6 DR. CASEY: Well, I think it was a  
7 combination of me trying to be a physician  
8 without telling her what to do and letting her  
9 know my perspective. And then ultimately, you  
10 know, letting her follow her wishes. Being  
11 available to her at every step in case she had  
12 other information or changed her mind.

13 DR. REINHARD: Okay, all right.  
14 So then are we ready, Sarah, to move onto the  
15 exercise?

16 So, the goal here is that we're  
17 going to take one domain at a time and start  
18 with sort of a show of hands initially on,  
19 first, feasibility and then impact. And see  
20 if there's any consensus around each of these  
21 domains and where they fit on a quadrant.

22 This is in part preparation for

1 the next stage which will get us more into  
2 potential measure concepts.

3 So we are fine on time. We  
4 actually thought it would be an hour worth of  
5 this discussion. I think we're just fine. We  
6 don't mean to cut anyone short, but it will  
7 take away from the next section of the agenda.  
8 But I think an hour is a pretty substantial  
9 amount of time to have this conversation.

10 So, efficiency. I think that was  
11 the first one, was it? I lost track of where  
12 they were. No, which was the first one?  
13 Comprehensive assessment. Thank you.

14 So, feasibility. High, low?  
15 Anyone want to start? Well, just say whether  
16 you think it's high or low, feasibility.  
17 Okay, so we have one saying quite feasible.

18 Okay. Anyone disagree? No, not  
19 impact, feasibility. High feasibility?  
20 Everyone agree? Show of hands? Okay, good.

21 How about impact? Fred, it  
22 sounded like you had a thought about that.

1 I'm just guessing. Put your mike on, please,  
2 so we can hear you.

3 DR. RACHMAN: I'm really bad at  
4 this. I'm not coordinated.

5 It seems to me that it's almost a  
6 starting point. Because unless we're sure  
7 that we have defined all the domains and we're  
8 sure that we're able to use that as a lens to  
9 which we're judging how well everything is  
10 coordinated how are we going to measure it.  
11 So it seems like it's high impact to me.

12 DR. REINHARD: High impact.  
13 Anyone else agree? Rita?

14 DR. MANGIONE-SMITH: Actually, I'm  
15 in the bucket of low-impact.

16 And the only reason I say that,  
17 again, is our experience with this field test  
18 we just did where in the medical record we  
19 could many times find an assessment like this  
20 for a kid with complex medical needs.

21 And then we surveyed the parents  
22 of those same children. And only about half

1 of the time would they even endorse that they  
2 knew that they had a care plan.

3 So, I guess I'm a little hung up  
4 on how we measure this. So if it's measured  
5 based on what's documented and not really  
6 paying attention to do all the players  
7 actually know it exists and use it and update  
8 it then I think it's pretty low-impact.

9 DR. REINHARD: Okay. Don't forget  
10 to put up your -- and Gerri, I know you have  
11 a thought about this because you already gave  
12 us a clue early on.

13 DR. LAMB: I think this is one  
14 that for me falls smack in the necessary but  
15 not sufficient which means we need to do it.

16 I'm not sure that I would put it  
17 as high as some of the discussion in terms of  
18 feasibility because I think, Rita, you were  
19 speaking to this is depending on where you  
20 sit, what discipline, how you work with  
21 consumers, patients, you may define these  
22 categories differently.

1                   I don't think there's tremendous  
2                   agreement across disciplines on what we mean  
3                   by some of these things. So I pushed  
4                   feasibility to moderate.

5                   And I also pushed impact. It's  
6                   important but lacking everything else it's not  
7                   where I'd hang my hat.

8                   DR. REINHARD: Where did you put  
9                   it?

10                  DR. LAMB: Moderate, moderate.

11                  DR. REINHARD: Moderate, moderate.  
12                  I'll go right down then. Russ?

13                  DR. LEFTWICH: So, I agree with  
14                  Gerri. I think it's necessary but not  
15                  sufficient. And if it's necessary I think  
16                  it's high-impact. I think it's absolutely at  
17                  the highest impact.

18                  DR. REINHARD: So that's  
19                  interesting because I keep -- I think I'm  
20                  hearing a little bit like of course, like  
21                  you've got to have this, right. But does that  
22                  make it high-impact which gets back to your

1 original question, Nancy, about well, what is  
2 impact. Right? Yes.

3 DR. LEFTWICH: Somebody said  
4 earlier that we don't know what works. We  
5 know what doesn't work. And if there is no  
6 communication.

7 DR. REINHARD: Yes, okay. You  
8 have high feasibility, high impact?

9 DR. LEFTWICH: I had feasibility  
10 not quite up at the top, but impact, yes, up  
11 at the top.

12 DR. REINHARD: Interesting. Okay,  
13 well, keep going. Dave, then just keep going  
14 down the row. Could you put on your mike?

15 DR. ACKMAN: So you're saying we  
16 know that it does work. Is that?

17 DR. LEFTWICH: We know that care  
18 coordination can't work without it.

19 DR. REINHARD: It gets back to  
20 Gerri's necessary but not sufficient.

21 DR. LEFTWICH: If it's missing  
22 nothing else or --

1 DR. REINHARD: Okay.

2 DR. LEFTWICH: -- spontaneous care  
3 coordination.

4 DR. REINHARD: Okay, go ahead.

5 DR. EISENBERG: I think it's  
6 entirely dependent on if we're able to  
7 prioritize who gets this comprehensive  
8 assessment or not.

9 As David and Michael and others  
10 said earlier if we're going to have a  
11 comprehensive assessment of everyone it will  
12 be very high burden and very low impact and  
13 incredibly expensive.

14 So I would urge that we think  
15 about that as we're doing this exercise.

16 DR. REINHARD: Can I ask that  
17 question, Sarah? Because maybe I missed it  
18 early on in our discussions. Are we saying  
19 this care coordination work we're doing is for  
20 high-risk populations wherever they are,  
21 whether they're older adults or fragile babies  
22 or whatever. We're talking about risk.

1 MS. LASH: I think no one has made  
2 the explicit decision that we're targeting  
3 high-risk, but if you think about the  
4 populations that benefit most from care  
5 coordination interventions those come to mind.

6 There is a sub-domain about sort  
7 of tiering risk and matching people with the  
8 appropriate level of supports within this  
9 comprehensive assessment domain.

10 DR. REINHARD: Okay. Well, we'll  
11 keep going down. So, Michael and then Fred.

12 DR. PARCHMAN: I personally will  
13 probably find the next hour extraordinary  
14 painful.

15 (Laughter)

16 DR. REINHARD: Will find it what?  
17 An excellent --

18 DR. PARCHMAN: Extraordinary  
19 painful. Because we're doing such the  
20 traditional academic let's just break  
21 everything down into its individual pieces,  
22 reductionism, and that just is so counter to

1       care coordination in terms of what it actually  
2       is. It's just orthogonal.

3                   And so I would agree with people,  
4       this by itself is low-impact. Right? But if  
5       you were to bundle it as your review found  
6       it's probably essential as a part of the  
7       bundle.

8                   DR. REINHARD: Do we have an  
9       essential component?

10                  DR. PARCHMAN: I don't know that  
11       I'm going to find this exercise very helpful,  
12       to be honest with you.

13                  DR. REINHARD: Okay. But Fred,  
14       you were next.

15                  DR. RACHMAN: So, that question  
16       that came up for whom, high-risk, low-risk,  
17       was something I've actually been struggling  
18       with through the day so far. And I wonder if  
19       we could maybe answer that question.

20                  I could say the way I came to this  
21       thinking that it is everyone. And again, back  
22       to that bucket of care coordination versus

1 coordinated care.

2 And I think our health system  
3 needs coordinated care. And I'm a  
4 pediatrician. And I sit through all these  
5 meetings where we talk about that top whatever  
6 percent that's responsible for 90 percent of  
7 our cost and everything.

8 I see those people walk through my  
9 exam room as healthy babies. What happens  
10 between then and there? And if we really want  
11 to bend the curve that's the way we need to be  
12 thinking.

13 Because otherwise it's like  
14 managed care. We're going to keep skimming  
15 the top off but they're going to be replaced  
16 by the next wave and we're never going to  
17 really achieve any bend in the curve.

18 So I make the assumption that  
19 we're talking about everyone. And when we  
20 talk about care coordination, like care  
21 coordinators, clearly we can't afford to  
22 assign a care coordinator to every person in

1 the country. That's completely unaffordable.  
2 So, I think that's where that disconnect  
3 occurs. Because that is high-risk people.

4 And I guess I'm hoping that if  
5 everyone is on board with thinking more  
6 broadly we need some measures that are helping  
7 us track how the system evolves to be more  
8 efficient and effective at taking care of  
9 everybody.

10 DR. REINHARD: This is a pretty  
11 fundamental question. I think we're going to  
12 have to pause because it will affect every  
13 issue. You raised it early this morning to  
14 begin with. I wrote it down that that was an  
15 important thing.

16 So are we talking care  
17 coordination for everyone? Sarah, shall we  
18 start there? Is there any -- it's up to us?  
19 Okay. Go ahead, Mark.

20 DR. REDDING: You mentioned if  
21 risk screening is done appropriately and if  
22 everyone has some form of risk screening,

1     whether it's by geo-coding or other  
2     strategies, then that baby that is going to  
3     start out healthy and end up in significant  
4     trouble would have critical risk factors that  
5     might be related to environment or parenting.  
6     I'm so glad there's so many pediatricians  
7     here.

8                 But if you risk-score that baby  
9     you certainly aren't going to find as many  
10    risk items as you would 30 years later. But  
11    there -- so for example, in Mansfield there  
12    are neighborhoods where 50 percent of the  
13    little boys go to prison.

14                And there's other neighborhoods  
15    where 80 to 90 percent of them finish college.  
16    So there are ways to look at currently healthy  
17    folks that have risk factors. It's not  
18    perfect.

19                I agree that there should be  
20    something related to the whole population, but  
21    I know for the contracts related to care  
22    coordination both in Ohio and nationally most

1 of the payers want some form of risk focus.

2 DR. RACHMAN: So just, again, you  
3 keep going to care coordination. I think  
4 you're absolutely right for that.

5 DR. REDDING: Coordinating care.

6 DR. RACHMAN: I'm really trying --  
7 coordinated care.

8 DR. REDDING: I understand.

9 DR. RACHMAN: So how is it that we  
10 have systems in place? Because risk is  
11 dynamic and risk is continuous. How is it  
12 that we have systems in place where there is  
13 such a coordination amongst entitlements or  
14 things aimed at social determinants that we're  
15 catching people? So that's what I'm aiming  
16 at.

17 And so I think there are two  
18 separate things. One are measures of how the  
19 system is set up to be holistic, to be  
20 comprehensive, to be coordinated.

21 The other is how we deal with  
22 people that require intensive kinds of

1 services to manage. And there's not an --

2 DR. REDDING: Perfect.

3 DR. RACHMAN: -- here at all. And  
4 I'm just pleading with the group that we  
5 figure out a way to hold both because I think  
6 this exercise will look different for the two  
7 buckets.

8 DR. REINHARD: I agree with that.  
9 So Fred, I just want to be clear. It sounded  
10 to me you were saying coordinated care is the  
11 system level. Is that what you're saying?  
12 And that care coordination is more individual  
13 level.

14 DR. RACHMAN: I think we drift  
15 very quickly to that. And I'd submit to you  
16 it's very much a payer-based view of the  
17 world.

18 DR. REINHARD: Right.

19 DR. RACHMAN: And if we're trying  
20 to be aspirational I think, you know, we want  
21 to be thinking a little bit more preventive,  
22 a little bit more, you know.

1 DR. REINHARD: Yes, I tend to  
2 think of care coordination as the -- we need  
3 care coordination because we don't have  
4 integrated care. You know what I mean? It's  
5 like the solution we keep going to because of  
6 the fragmentation. And you're right to be  
7 thinking.

8 Gerri, I know you've been  
9 wiggling.

10 DR. LAMB: I wanted just to give  
11 kind of a historical perspective on that  
12 debate. Because it's something that in the  
13 first care coordination measurement group, and  
14 I think, Russ, you were on it as well. We  
15 kept debating should we split out case  
16 management, the more intense versions,  
17 transitional care.

18 And we made the decision to keep  
19 it fully integrated in care coordination for  
20 much the same reason that we're talking about  
21 here is to keep a broader, holistic view of  
22 care coordination.

1                   And also the assumption that all  
2 patients, all individuals need coordinated  
3 care. And that it's a question of intensity  
4 and scope when you start risk-stratifying  
5 which has been around for 50 years.

6                   So, that's actually one of my  
7 favorite parts of our report was our  
8 justification for really leaving them  
9 integrated.

10                  DR. REINHARD: Which report?

11                  DR. LAMB: Care Coordination 1.  
12 It was -- what year was that? Is that the  
13 2006?

14                  DR. REINHARD: Okay. So we should  
15 read that again. Yes, go ahead, Richard.

16                  DR. BIRKEL: I'm wondering if a  
17 more fruitful approach to this exercise might  
18 be for each person to nominate two of their  
19 favorite domains for that high-impact, high-  
20 feasibility. Because if we go domain by  
21 domain we will have this debate at every  
22 single measure.

1 DR. REINHARD: Well, I think Fred  
2 might argue that we have to have this  
3 discussion anyway.

4 DR. RACHMAN: I agree it's been  
5 fruitful. But if we have it for the next  
6 measure as well I don't think we'll get  
7 through it.

8 DR. REINHARD: But can we think  
9 system and individual as we're talking about  
10 it? Or is that not fruitful? Gerri? Is that  
11 not fruitful?

12 I just want to hear what you said  
13 just now, that in 2006 you did this  
14 foundational work that we should be paying  
15 attention to. And what was the conclusion?

16 DR. LAMB: I think the conclusion  
17 was related to do we segment out according to  
18 risk stratification the care coordination and  
19 case management. And are we only talking  
20 about high-risk individuals. And that  
21 decision was not to segment them out.

22 I think the one that Richard's

1     raising is a different issue related to are we  
2     going to keep getting into this discussion of  
3     do we think about this as an effective bundle.

4             Because within that bundle, within  
5     that bundle -- and I think, Rita, that's what  
6     you were talking about is some of the  
7     difficulty with measurement is, you know, I  
8     know I'm going to sit here and say if I look  
9     at something within the context of all the  
10    domains then I'm going to place it.

11            But my thinking is never out of  
12    the context of the total. So it's, you know,  
13    I'm going to pretty much be a broken record in  
14    there because I do think of it as a bundle.

15            DR. REINHARD: But Gerri, I just  
16    want to be also clear. Is it both individual  
17    and system? I understand it was all, light  
18    touch to very focused, sustained care  
19    coordination, but did you think of the  
20    integrated care system and individual care  
21    coordination?

22            DR. LAMB: I'm going to need some

1 help remembering here. I think we reviewed --  
2 we looked at both individual- and system-level  
3 measures. And it wasn't one or the other. It  
4 just became an issue related to feasibility  
5 and what level. But I think we came to the  
6 conclusion you have to have both. Because of  
7 the accountability issues.

8 DR. REINHARD: Okay. So Fred,  
9 what do you think about this? Put on your  
10 mike, please.

11 DR. RACHMAN: I'm somewhere in the  
12 sub-educable --

13 (Laughter)

14 DR. RACHMAN: I am really happy to  
15 hear that. I would bet that and I'm hoping  
16 that we can do that. And I do think it makes  
17 it challenging to do this exercise because we  
18 might rate certain ones of these things one  
19 way through one lens and one way through  
20 another lens and how would we balance them.

21 DR. REINHARD: Well, I think we  
22 could do both. Sarah, right? Couldn't we do

1     both?  Make a note that it's -- she's trying  
2     to eat, the poor thing.  So as you're chewing  
3     I'm just going to say what I think is being  
4     stated and then you can -- I know people have  
5     things up.  I'm just trying to get to is there  
6     any stages of this that we do want to think  
7     globally or broadly, that everybody needs some  
8     degree of care coordination sometime in their  
9     life depending on what's going on.

10                   And then there's this system  
11     versus -- not versus but system and individual  
12     level, family, there's probably all kinds of  
13     things in between, right?

14                   And that I think what Fred is  
15     encouraging us to do is to articulate when  
16     we're saying it's at the individual level,  
17     when it's at the system level.  And I heard  
18     Gerri say you talked about measures at both  
19     levels anyway and that we need to do that.

20                   So can we do that, Sarah?

21                   MS. LASH:  I think you can.  Maybe  
22     I want to take a step back and re-frame the

1 goal of what we're trying to get through  
2 torturing you with an exercise like this and  
3 that is an identification of the measure  
4 domains that are at the extremes. So what is  
5 both high-impact and high-feasibility.

6 As fertile ground let's go there  
7 first. Not to say that everything isn't a  
8 priority to someone for something, but if  
9 there are domains that we think are both low-  
10 impact and low-feasibility that would I think  
11 influence the prioritization of those relative  
12 to the others.

13 So, I liked the suggestion that we  
14 might want to just think about what goes in  
15 the upper right quadrant and why. And  
16 incorporate both system- and individual-level  
17 thinking there.

18 DR. REINHARD: Sounds good. Rita,  
19 I think you had yours up.

20 DR. MANGIONE-SMITH: Okay, so not  
21 I'm going to be the real measurement geek  
22 here.

1                   I think what we're struggling with  
2                   right now are what's the denominator. What's  
3                   the denominator of any given quality measure  
4                   that might come out of --

5                   DR. REINHARD: Which we will get  
6                   to. There's a whole section on that.

7                   DR. MANGIONE-SMITH: Well, but  
8                   it's really important because there's  
9                   cognitive dissonance for me. If I'm thinking  
10                  about some of these areas of domains of  
11                  measurement and I think children with complex  
12                  medical needs. Oh yes, that's high-impact for  
13                  them. A kid who's healthy? Not such high  
14                  impact for them.

15                 Making sure a child gets an  
16                 immunization every time they come to a sick  
17                 visit when they're behind. High-impact for  
18                 the complex kid? Absolutely. How about for  
19                 the low-complex or the normal kid, the healthy  
20                 kid? Absolutely. You know, so it's just  
21                 that's the problem about not sort of knowing  
22                 what we're talking about as we go through this

1 exercise. Because it changes my judgment  
2 depending on who my denominator population is.

3 And I think that denominator, that  
4 risk can be either medical risk or social  
5 risk. And whoever said it's dynamic and  
6 changes all through your life is absolutely  
7 right. So I think at any given point where we  
8 measure we have to figure out who's the at-  
9 risk population where we really think this  
10 measure matters.

11 DR. REINHARD: Okay. Anyone else?  
12 David? Could you put on your mike, please?  
13 Thank you.

14 DR. ACKMAN: Two thoughts. One is  
15 I hear this not so much as the distinction  
16 between individual and system, rather as sort  
17 of a program or an activity versus system.

18 So you know, on one hand you're  
19 sort of measuring the activities and that we  
20 are calling or putting into this group of  
21 services that we're calling care coordination.  
22 The other is sort of how the system is

1 functioning, whatever is in the mix.

2 I think your point, Rita, is a  
3 good one, particularly about the risk. I  
4 mean, the way we assign risk now is medical  
5 risk. It's cost -- it's prediction of future  
6 cost, prediction of future utilization.

7 That may not be really what is  
8 most impacted by some of these things. I mean  
9 I think about the nurse-family partnership.  
10 That's all about social risk. It has impact  
11 on medical spend but it's mostly about social  
12 risk.

13 DR. REINHARD: Good point. All  
14 right, can we -- is there another -- Judy, is  
15 that you up?

16 DR. NG: I just wanted to make  
17 another plug from the measure developer end of  
18 it to look at it in terms of denominator.  
19 Because someone who's healthy who's never had  
20 an encounter with the health system, what  
21 their care coordination is going to look like  
22 might be invisible and will be very different.

1           The other thing also is that if --  
2   when you think about measurement, this goes  
3   back to the individual versus larger system.  
4   Also when you think about measurement you  
5   don't want to just measure only when a person  
6   is sick, you want to capture them somehow when  
7   they look healthy, maybe medically, but they  
8   might have other risk factors. So just  
9   another plug to think about that way too.

10           DR. REINHARD: Okay, go ahead.

11           DR. REDDING: When AHRQ pulled  
12   folks together this was also a point of major  
13   struggle. And they had care coordination  
14   programs from across the country.

15           And it really came down very  
16   clearly to what David said is although the two  
17   are part of one whole it's a different  
18   conversation if you're talking about the  
19   individual versus the system. The measures  
20   are going to be different. But they're both  
21   critical and interrelated.

22           And they ran into the same thing

1     and they ended up doing just what you're  
2     advising is to -- if you could put a little  
3     preface on the comment, are you talking about  
4     here or here, it suddenly makes it easier.

5                 DR. REINHARD: Well, you know  
6     what? To just move us along I'm going to try  
7     something. David, is yours still up? Okay.

8                 And that's to turn to Gerri. I'm  
9     sorry to put you on the spot but you have this  
10    history and you've been bringing a lot of that  
11    wisdom, and Don. Just that you happen to say  
12    it first I guess.

13                And that is which domain would you  
14    put in high-impact, high-feasibility? Just to  
15    get us started. Do you have any in that  
16    space?

17                DR. LAMB: I have efficiency.

18                DR. REINHARD: Efficiency. All  
19    right, so let's talk about that for a moment.  
20    Anyone agree? Oh, lots. Okay, David and then  
21    Ilene. David, can you say more about why you  
22    think it is?

1 DR. ACKMAN: I think it's been  
2 done on a large scale. People pay attention.  
3 It's -- my experience, the reference I'm  
4 making is to the health home program in New  
5 York State which they assigned I think  
6 hundreds of thousands of people to health  
7 homes. And there was a measure of -- I mean,  
8 it was really a cost-avoidance measure, an  
9 efficiency measure of reducing  
10 hospitalizations and I think overall spend.  
11 So, it's been done.

12 DR. REINHARD: I'll admit I had it  
13 in high-impact. I wasn't sure if it was  
14 feasible. So those who are more in the  
15 measurement area, then that's good news to me  
16 if that could be over there.

17 DR. ACKMAN: I haven't been part  
18 of it and I think there's a lot of discussion  
19 about whether it's because of the whole risk  
20 adjustment thing and accountability. So I  
21 remember those issues. I sort of walked away  
22 from it so I don't know how it resolved.

1 DR. REINHARD: Okay. Michael?

2 DR. PARCHMAN: I would agree. And  
3 I think it gets back to that comment I made  
4 earlier about who is the end user of the  
5 measurement. Who are the stakeholders that  
6 are most likely to use these measurements.

7 And it's probably going to be the  
8 health plans, the payers, the governmental  
9 groups that are looking across organizations,  
10 and across providers, and across clinics, and  
11 across clinics and hospitals, and across  
12 clinics and community resources. Because  
13 they're the ones who want this measure. And  
14 communities, and community groups, right? So  
15 I would say yes.

16 DR. REINHARD: You know, getting  
17 back to the system and individual, however you  
18 want to look at it, I do think the more  
19 integrated the system the less you'd need a  
20 care coordinator to make sure you don't get  
21 duplicative tasks and what have you.

22 Again, if the system -- you

1 brought that out earlier, Fred, with your  
2 example on immunizations. If you had the  
3 information because the system was integrated  
4 you would know I don't have to give the  
5 immunization rather than fear that you're  
6 going to get dinged because you didn't do it.  
7 So.

8                   Anyone disagree with putting --  
9 I'm just trying to move us along. Anyone  
10 disagree with the high-impact high-  
11 feasibility? Yes, okay. Vija.

12                   DR. SEHGAL: Yes, I absolutely  
13 agree that it is extremely -- has incredibly  
14 high impact. But especially again this is  
15 where we go back to my world. It's very --  
16 feasibility is not there. Yes, so I put it as  
17 high-impact and low-feasibility. Low  
18 feasibility because it's difficult to  
19 implement. And I'm thinking feasibility in  
20 terms of implementation.

21                   So until you have -- I mean, if  
22 everything, if it was a perfect world and we

1     had those interfaces built up and we had that  
2     health information exchange then absolutely we  
3     would have a very efficient system which would  
4     yield high impact. But right now there's so  
5     much discordance.

6                     DR. REINHARD: So you're  
7     questioning how feasible. David?

8                     MR. CUSANO: I would actually  
9     agree with that. So, in thinking about the  
10    feasibility piece a lot of the successes we've  
11    seen, particularly coming from the industry  
12    side is the concept of the medical home which  
13    is really clinically focused.

14                    And we're talking about care  
15    coordination. We're expanding the resources  
16    to include community resources and other  
17    resources that might not be integrated into  
18    the medical delivery model. And so I think  
19    when you're thinking about the feasibility you  
20    have to consider the new resources that we're  
21    trying to bring to the table and how that --  
22    how those efficiencies will be measured from

1 a feasibility perspective. And being  
2 inclusive of the holistic set of resources  
3 that we're looking to include.

4 DR. REINHARD: Okay. Could I  
5 suggest -- go ahead. That you think it's less  
6 feasible than we thought? Okay.

7 So, should we put it in the  
8 middle? Sarah?

9 MS. LASH: Sure.

10 DR. REINHARD: You're okay with  
11 that? You said if we weren't sure you could  
12 put it on the line. I think so, I think  
13 there's a -- yes, just a little bit. We're  
14 not saying it's totally low. If something  
15 gets high we'll sort of put it in that zone.  
16 Okay.

17 Any other nominations for a high-  
18 impact high-feasibility? Any other? Yes, go  
19 ahead, Robert.

20 DR. ROCA: Well, I for better or  
21 for worse put experience in there. It seems  
22 like it's important. I think it has

1       potentially high impact.

2                       I think asking people about, you  
3       know, whatever the complexities of measurement  
4       may be compared to many other things, asking  
5       people what their experience of how well  
6       organized things were doesn't seem all that  
7       difficult compared to some of the other things  
8       that we might be trying to measure here. So  
9       I would venture putting it in that category.

10                   DR. REINHARD: Okay. Anyone  
11       agree? Oh, I'm seeing a lot. Experience  
12       would be high-impact, high-feasibility.

13                   DR. ROCA: That's what I was  
14       proposing.

15                   DR. REINHARD: That's what he's  
16       nominating.

17                   DR. ROCA: That's what I'm  
18       nominating, yes.

19                   DR. REINHARD: How many agree?  
20       Okay, who disagrees. Okay. So here's another  
21       one.

22                   Okay, so let's start with

1 feasibility to separate what you agree and  
2 disagree with. How about feasibility? Who  
3 thinks it's high-feasibility? Okay. Low-  
4 feasibility? Okay, so Rita, I think you --  
5 let me call on you.

6 DR. MANGIONE-SMITH: Yes. Just,  
7 I'm a very, I'm a proponent of survey measures  
8 so I don't want to come across as somebody who  
9 doesn't think -- and that's how we get at  
10 experience, right, is to survey people.

11 I'm a firm believer in the CAHPS  
12 measures and like I said before, most of our  
13 care coordination measures that we developed  
14 were survey-based measures.

15 My -- but my skepticism about  
16 feasibility comes from my experience as a  
17 survey researcher and working with the CAHPS  
18 group at RAND. Response rates are really low.  
19 And you traditionally get very biased samples  
20 of people who will actually respond to those  
21 surveys when they're mailed to them.

22 We had tons of problems with

1 response when we field-tested our survey. So,  
2 while I think you get very rich information  
3 that can really be impactful and drive quality  
4 improvement I'm very -- I'm much more  
5 skeptical about broad feasibility.

6 DR. REINHARD: So would you say  
7 high-impact low-feasibility?

8 DR. MANGIONE-SMITH: Right, that's  
9 where I have it.

10 DR. REINHARD: You put it over  
11 there.

12 DR. MANGIONE-SMITH: Yes.

13 DR. REINHARD: And you did too.  
14 Okay. Go ahead, Don.

15 DR. CASEY: Having, again, chaired  
16 the technical expert panel with Chuck Darby on  
17 this back eight years ago I just believe that  
18 the patient experience measures, especially  
19 those related to care coordination which I  
20 think there are only three and I think the  
21 CTM-3 from Colorado, Eric Coleman is I think  
22 the only other experienced measurement set

1       that's endorsed and is focused on the  
2       perception of care coordination.

3               But they're just, they're way too  
4       transactional for me. And that's why I think  
5       they're lower impact. I just had them -- I  
6       think they're feasible because you can at  
7       least implement if you're doing large-scale  
8       sample size estimates of organizations, but at  
9       the patient level, you're right, the feedback  
10      becomes less meaningful. Everyone seems to  
11      focus on the comment box as being where they  
12      get the biggest bang for their buck.

13             DR. REINHARD: So it sounds like  
14      Don and Rita would put it in the middle again,  
15      but for different reasons. Oh you put it  
16      squarely, squarely in the -- okay, you might  
17      put it more on the middle?

18             DR. CASEY: I'd put it lower down  
19      below the line and closer to the middle.

20             DR. REINHARD: Okay. Anyone else?  
21      Yes, Fred?

22             DR. RACHMAN: Well, just, you

1 know, a question. If there -- if we couldn't  
2 figure out a way to make it feasible with  
3 different methodologies. This is a question  
4 to you. And whether there's any way to  
5 adjust. You know, there's things that you can  
6 do to adjust the responses or weight them or  
7 whatever before we put it -- before we throw  
8 it out.

9 Just one more on the problem side.  
10 I'm concerned about subjectivity. And many of  
11 our patients are very tolerant by comparison  
12 to a lot of dysfunction. And I'm worried that  
13 they're not going to, you know, we're not  
14 going to capture.

15 You know, I actually take care of  
16 a pretty diverse population and I'll tell you,  
17 affluent patients or more-resource patients  
18 will tolerate a whole lot less than many.

19 DR. REINHARD: So it sounds -- I  
20 don't know, Don. It sounds like we do think  
21 experience is important. I mean, if you don't  
22 know how this is working for patients,

1 families, or the providers, the care team,  
2 that's a pretty serious thing.

3 I don't know how we'll change  
4 anything if we don't know what people are  
5 thinking about it.

6 I think whether it's satisfaction  
7 versus something more meaningful, meaty is a  
8 big issue, a measurement issue. But that we  
9 need it. Maybe it's this necessary component  
10 but we seem to have to have it.

11 DR. CASEY: No, I'm speaking  
12 specifically to the paradigm of experience.  
13 And also on the provider side of it there's  
14 very little margin to make on whether you can  
15 actually act in a sustainable way to improve  
16 against benchmarks.

17 So, you know, this notion of  
18 having a consistent way to take the data and  
19 actually do something different is still all  
20 over the map.

21 DR. REINHARD: So, it sounds like,  
22 Don, you've been consistent throughout the day

1 on this. We've challenged the whole notion of  
2 experience, how it is conceptualized and  
3 measured at this point.

4 But would you offer that it could  
5 be conceptualized and measured differently?

6 DR. CASEY: Yes, and then it would  
7 be higher impact if it was focused much more  
8 discretely on defining things in terms of what  
9 someone I think alluded to as patient-reported  
10 outcomes or quality of life or things like  
11 that which are --

12 DR. REINHARD: I don't think we're  
13 confined to current measures, are we? No.

14 DR. CASEY: Well, then it becomes  
15 lower feasibility because we have to develop  
16 the measure.

17 DR. REINHARD: Well, there you go.  
18 So that puts us back in higher impact but at  
19 least heading towards lower feasibility.

20 Anyone else on this topic? Yes,  
21 Fred.

22 DR. RACHMAN: Just to connect.

1 Part of what we're struggling is like we don't  
2 know precisely what it is, but we sort of do  
3 know what it isn't. And this experience  
4 measure is really, like you could get at that.  
5 When you get providers and patients to tell  
6 you, you know, it isn't.

7 And so I just wonder if we  
8 couldn't put some creative thought to this and  
9 figure out some way to measure. Because I  
10 then it just seems like it would be

11 DR. REINHARD: I think that's the  
12 next part, right? That will be the next  
13 exercise.

14 DR. RACHMAN: -- there would be  
15 the ultimate common denominator. And actually  
16 when you think about it it would bridge all  
17 the populations. Because you would be asking  
18 people who are low users or, you know, are at  
19 the preventive end. And you would also be  
20 asking users who are at the more acute end.  
21 So I would love us to try to keep that  
22 somehow.

1 DR. REINHARD: Yes. So, let's  
2 keep it -- is everyone comfortable with at  
3 least now keeping it here and then in the  
4 measure development or concept stage we can  
5 talk more about it?

6 Any other -- I see nods so I'm  
7 just going to keep moving. Any other  
8 recommendation for the high-impact, low --  
9 high-feasibility?

10 DR. MANGIONE-SMITH: One quick  
11 response to something Fred said earlier. I  
12 was kind of -- when you said could we maybe do  
13 this somehow in the future and I think  
14 absolutely yes.

15 I think with the way being able to  
16 respond to surveys electronically is really  
17 taking off. I think that's going to make it  
18 much more feasible to do this kind of  
19 measurement. But we're not quite there yet.  
20 We're still using mail and phone.

21 DR. REINHARD: Well, that's  
22 encouraging. Thank you. I think -- did

1       someone have a recommendation? Russ?

2                   DR. LEFTWICH: Goal-setting.

3                   DR. REINHARD: Goal-setting.

4       Okay. For high-impact, high-feasibility. How  
5       many believe that? Okay. Who does not agree  
6       with that? I think that's -- okay, Gerri?

7                   DR. LAMB: I would agree with high  
8       impact. I'm not as optimistic about  
9       feasibility just because there's such  
10      diversity about what we mean by goal-setting.

11                  DR. REINHARD: So that falls in  
12      like what do we mean by experience, what do we  
13      mean by goal. So we keep getting to this  
14      fundamental.

15                  Did someone else before I go to  
16      Fred? No? Fred. Is that from the last time?

17                  DR. RACHMAN: It feels like I'm  
18      talking too much but at least I'm getting  
19      practice in using the microphone.

20                  (Laughter)

21                  DR. REINHARD: You're really doing  
22      well.

1 DR. RACHMAN: I'm worried that  
2 this one, its feasibility is also its  
3 downfall. Because it's going to be very easy  
4 to check the box, put the goal in, okay, we're  
5 done.

6 And then, you know, the problem is  
7 is that really translated into anything that's  
8 really getting at care coordination. And  
9 maybe it's back to that bundled thing or  
10 whatever, but I'm really worried about if  
11 we're going to select a few I would put this  
12 low in terms of impact.

13 I think we're probably doing  
14 really well on that right now. All these  
15 patients that are in medical homes. I mean  
16 you go to the charts, there's all these  
17 beautiful goals and care plans. But it's not  
18 doing it.

19 DR. REINHARD: Ilene?

20 MS. STEIN: Just on the idea that  
21 something is low-feasibility because no  
22 measures exist. It strikes me that there are

1       very few measures that exist on any of it.

2                   DR. REINHARD:  I can't hear you  
3       too well.  Can you move forward a little bit?

4                   MS. STEIN:  Oh, sorry.  So we keep  
5       on going back to the fact that there's no  
6       measures that exist and that makes it low-  
7       feasibility.

8                   DR. REINHARD:  Well, this is to  
9       develop them.

10                  MS. STEIN:  Right, right.  So, but  
11       that's my point is like there are actually  
12       very few measures developed in any of these  
13       areas.  That doesn't necessarily make it low  
14       feasibility.  So are we discussing the ability  
15       to develop measures?

16                  DR. REINHARD:  It's whether we  
17       think it's even possible.

18                  MS. STEIN:  Oh, to develop  
19       measures.

20                  DR. REINHARD:  Is it possible to  
21       get there.  Knowing there's work to be done.

22                  MS. STEIN:  So, something could be

1 high-feasibility even though it has no  
2 measures --

3 DR. REINHARD: That's right.

4 MS. STEIN: -- it's just a matter  
5 of --

6 DR. REINHARD: Is that right?  
7 Yes.

8 MS. STEIN: -- the idea that you  
9 can --

10 DR. REINHARD: Right.

11 MS. STEIN: -- the ease of  
12 developing those measures and capturing --

13 DR. REINHARD: I mean, there may  
14 be some that we think it's impossible. We  
15 just can't -- or like this, what Fred was  
16 saying is well, it's feasible, but what --  
17 it's so feasible. I think that's really  
18 interesting.

19 And who's checking the box  
20 attained the goal? Is it the nurse or doctors  
21 or somebody who's doing it? Is the person  
22 saying I attained my goal? How does that

1 work?

2 That's a very important -- because  
3 it could get misdirected. It could be the  
4 first thing we do and it could be really a  
5 problem.

6 There's a whole bunch over here.  
7 Russ, we'll just go down the island.

8 DR. LEFTWICH: So, I'm being  
9 aspirational and thinking that the care  
10 coordination will be done with the soon-to-be-  
11 published standards around the care plan that  
12 capture whether the patient either proposed  
13 that goal or acknowledged that goal, accepted  
14 that goal.

15 DR. REINHARD: Okay. Are you on  
16 goal-setting or goal attainment?

17 DR. LEFTWICH: I'm on goal-  
18 setting.

19 DR. REINHARD: Setting, okay.  
20 Sorry.

21 DR. LEFTWICH: And I have a  
22 different feeling about goal attainment. But

1 I'm on goal-setting.

2 DR. REINHARD: You're on goal-  
3 setting. Okay.

4 DR. LEFTWICH: Yes. And the  
5 patient did either propose that goal, set that  
6 goal, or endorse that goal.

7 DR. REINHARD: So you're saying  
8 that you are thinking it's possible to get to  
9 some kind of measurement system, that it's  
10 trustworthy --

11 DR. LEFTWICH: Right.

12 DR. REINHARD: -- to know that the  
13 patient or the person actually set that goal.

14 DR. LEFTWICH: Right. And not  
15 just the provider organization said yes, we  
16 set goals. No, not that. The goal is there  
17 and it was --

18 DR. REINHARD: Fred, he's trusting  
19 more than you are that we could get there.  
20 He's trusting more than you are that -- he's  
21 aspirational.

22 DR. RACHMAN: I'm still worried

1     about this thing about patients and what  
2     happens in the power dynamic with the provider  
3     and they say here's your goals and they'll say  
4     yes. And you ask them did you set the goal  
5     and they'll say yes. I don't know that we're  
6     really going to get at it.

7                     DR. REINHARD: Kind of rote.

8     Okay, did I get David?

9                     DR. ACKMAN: Yes, the question  
10    who's checking the box. Often no one needs to  
11    check the box, it just gets spit out through  
12    a care plan's software. So the input comes  
13    in, you haven't gotten the colonoscopy so the  
14    goal is -- and so I think for some things it  
15    works. You know, the input says you're  
16    missing something, so get it. Or, the input  
17    says don't have an educational gap. And so it  
18    says that's a goal. So in some ways that's  
19    very --

20                    DR. REINHARD: So you're skeptical  
21    too.

22                    DR. ACKMAN: That's very feasible.

1 And for some things it's absolutely  
2 appropriate and it's the right thing to do.  
3 But to get to the more difficult things.

4 Either you don't know whether --  
5 what the significance of the checked box, you  
6 don't really know how much thought is in. I  
7 think for the hard stuff it's probably not  
8 that good.

9 DR. REINHARD: Okay. Linda?

10 DR. LINDEKE: High-impact, low-  
11 feasibility with the example of children's  
12 dental caries. We would all agree with the  
13 impact. The measurement should be able to  
14 look in there and see if they've got them or  
15 not. And the feasibility of getting that  
16 basic care for every kid is just miserable in  
17 this country.

18 DR. REINHARD: Goal-setting.

19 DR. LINDEKE: Goal-setting to have  
20 -- the parents would agree the child doesn't  
21 want a toothache. We know it has health and  
22 behavior implications.

1                   Feasibility in this system, this  
2                   country makes me put it in the lower category.

3                   DR. REINHARD: Robert?

4                   DR. ROCA: Well, I think there are  
5                   all of the problems that people have  
6                   identified about gaming these kinds of  
7                   measures and so forth.

8                   But I honestly don't see how we  
9                   can have anything called a person-centered  
10                  plan of care without asking the patient what  
11                  the goals of care would be. So I think  
12                  acknowledging all of the complexities and  
13                  pitfalls here, I think it has to be there.

14                  And I think compared to many of  
15                  the other things we're looking at it is  
16                  relatively feasible.

17                  DR. REINHARD: Okay. Vija? Is it  
18                  Vija or Vie-ah?

19                  DR. SEHGAL: It's Vee-ya.

20                  DR. REINHARD: I said it right.

21                  DR. SEHGAL: And actually he just  
22                  echoed what I was going to say.

1                   You know, I actually really agree  
2                   with Fred's skepticism. And it's very  
3                   difficult to for any of us who have aspired or  
4                   attained PCMH certification, accreditation,  
5                   recognition, you know, we have to go through  
6                   the process of having our patients set their  
7                   goals. And it's very easy to check a box.

8                   That being said -- so I am  
9                   skeptical and I appreciate the skepticism.  
10                  That being said, I think it's something --  
11                  without setting a goal we will not be able to  
12                  do anything else. So it's absolutely whether  
13                  -- I mean I think it's our jobs as providers,  
14                  as care coordinators, as people working with  
15                  the clients we need to make sure that they buy  
16                  into the goals that they're setting.

17                  There may be some difficulty in  
18                  doing so but it's still relatively compared to  
19                  everything else feasible and we will never  
20                  achieve those goals attained if we don't set  
21                  them in the first place.

22                  DR. REINHARD: Well, Richard, and

1       then I know, Russ, you're dying to jump in  
2       there.

3                   DR. BIRKEL: On the community side  
4       we often set goals very differently. Not you  
5       need the colonoscopy, but patients might set  
6       a goal, a participant will set a goal that  
7       they want to attend their daughter's wedding  
8       in the fall, or they want to be able to walk  
9       down to the mailbox and get their mail on a  
10      regular basis. So we're really talking about  
11      a very different sort of set of goals.

12                  And I agree with what Russ said.  
13      If you can get to that place where you're  
14      actually setting a patient-centered goal that  
15      makes -- and the PCMH defines that goal as  
16      meaningful to the patient. I can't believe a  
17      colonoscopy is meaningful in that way, to be  
18      honest.

19                  (Laughter)

20                  DR. BIRKEL: But, if the goal is  
21      that I want to live a cancer-free life,  
22      whatever, in order to be around for my

1     grandchildren which is the way a patient would  
2     honestly frame that, then the physician is in  
3     a position to say well, of course, then we  
4     need to do some preventive screening.

5             Now, getting to that, that process  
6     is what's so challenging. So anyway, I do  
7     think that the goal-setting is both high-  
8     impact. Not so sure about the feasibility.

9             DR. REINHARD: So it sounds -- at  
10    minimum feasibility is in the middle. It  
11    might even be tilting further over. But I'm  
12    hearing generally high-impact, yes? So it's  
13    the feasibility question. Russ?

14            DR. LEFTWICH: So, I'm one of the  
15    world's great skeptics, actually. You have no  
16    idea.

17            DR. REINHARD: That's good to  
18    know, Russ.

19            DR. LEFTWICH: But I am making the  
20    assumption that this is a shared care plan and  
21    that it's going to use the standards that I've  
22    worked very hard on developing in the past

1 couple of years that do include three kinds of  
2 goals and one of them is overarching goals  
3 that are -- that solely belong to the patient.

4 And I think we can measure whether  
5 that's there in a care plan or not.

6 DR. REINHARD: Okay. David, we're  
7 going to give you one last shot.

8 DR. LEFTWICH: I think we will be  
9 able to, yes. Not now, but soon.

10 DR. REINHARD: Okay. Can everyone  
11 live with where we put it? Okay, we're good.

12 Let me try the other way. How  
13 about low-feasibility, low-impact? Any in  
14 that quadrant? Yes. Relationships. Okay.  
15 Anyone agree? Okay, David did. Okay, I'm  
16 seeing heads.

17 Okay, who disagrees? Oh, lots.  
18 Okay. I'm going to start with Ilene and head  
19 over.

20 MS. STEIN: I mean, having, again,  
21 worked on the community service side I don't  
22 think providers have any clue what exists in

1 the community or how to connect to them.

2 No offense to any of the providers  
3 sitting around this table who probably have  
4 greater experience with care coordination and  
5 community services than most people within the  
6 community.

7 But having had to act as a care  
8 coordinator for clients with Medicare it's  
9 pretty apparent once you go through that  
10 process that there is a huge disconnect.

11 DR. REINHARD: Okay, but let me  
12 just -- I just want to make sure I'm clear on  
13 this. We're not talking about what is now.

14 We're talking about if -- can we  
15 measure and is it important. If you could  
16 measure this --

17 MS. STEIN: Right.

18 DR. REINHARD: -- and you could  
19 find out they know nothing, this group knows  
20 a little, this one knows a lot, would that  
21 have an impact on quality of life, on  
22 functioning, on meeting one's goals. So it's

1 not what's current.

2 MS. STEIN: Right, but currently  
3 it does. I mean, that's the whole point is  
4 that --

5 DR. REINHARD: Yes, right. Well,  
6 we know it sucks now.

7 MS. STEIN: Yes, that it doesn't  
8 exist and if you don't measure it --

9 DR. REINHARD: I agree with you.

10 MS. STEIN: -- and you don't  
11 create incentives for people to create those  
12 relationships then they won't exist.

13 DR. REINHARD: Right. Okay.  
14 Anyone else over here? Okay. Let me start in  
15 the middle here.

16 DR. EISENBERG: I think it's high-  
17 impact and it could be high-feasibility.

18 I think without relationships  
19 there is no coordination. You can define it  
20 in different ways but I think it's --  
21 relationships are at the very heart of  
22 coordination. So I think it's very high.

1 DR. REINHARD: Okay, okay.

2 Michael and then Russ and then Don.

3 DR. EISENBERG: And in terms of  
4 feasibility I think there are transactional  
5 ways to measure it.

6 DR. REINHARD: Transactional  
7 rates?

8 DR. EISENBERG: That may not be  
9 ideal. Numbers of referrals, numbers of  
10 feedback from the referrals, that sort of  
11 thing. Which gets at --

12 DR. REINHARD: Gets you started.

13 DR. EISENBERG: -- at the  
14 relationships actually working.

15 DR. REINHARD: Okay, good.  
16 Michael?

17 DR. PARCHMAN: I agree. I think  
18 it's high-impact for sure and definitely  
19 potentially highly feasible at a transactional  
20 level.

21 By gathering both secondary  
22 existing data sources, looking at secondary

1 existing data sources as well as talking to  
2 people who are involved in the care.

3 And I think it's easier sometimes  
4 to get better responses from them than it is  
5 from patients on this.

6 DR. REINHARD: This seems to be  
7 falling in the category of goal-setting, for  
8 example. You know, if we're not getting there  
9 then what are we talking about? If people are  
10 not talking to each other, there's no  
11 exchange, then there's no linking, there's  
12 nothing.

13 So in that vein it seems critical.  
14 I don't know, I guess high-impact. Does  
15 anyone disagree with that? Because who  
16 nominated -- okay, go ahead, Russ.

17 DR. LEFTWICH: I think it's high-  
18 importance, but that's different from high-  
19 impact. Because I don't think you can change.  
20 If it's going to be high-impact, you're going  
21 to have to be able to change it.

22 And I don't think you can change

1       it because I think a lot of times it's limited  
2       by what relationships could exist. If you  
3       don't have that service in your community.

4                 DR. REINHARD: Okay, Michael. I'm  
5       going to let you because you're no-no'ing. Go  
6       ahead.

7                 DR. PARCHMAN: Well, I see a lot  
8       of no-nos.

9                 DR. REINHARD: I know but you said  
10      it out loud. We're going to go there and then  
11      we'll get some more.

12                DR. PARCHMAN: I'm representing  
13      the no, no, nos.

14                This is about building  
15      relationships. And yes, it is possible. This  
16      is a social networking phenomenon. And we do  
17      social networking all the time in our  
18      communities as a provider, as a family  
19      physician.

20                I'm always networking with people  
21      and building new relationships, trying to find  
22      out who's out there in the community. Oh, I

1 can no longer refer to them because they're no  
2 longer in business. Oh, I can refer to them  
3 because oh yes -- oh, that's a new resource.  
4 Okay, good. I didn't know about that. Let's  
5 figure that out.

6 But I spent a lot of time tracking  
7 community resources in the late-night hours  
8 after my clinic was closed because I couldn't  
9 figure out who was out there all the time.

10 But it is a matter of social  
11 networking and it is a relational process that  
12 you can develop.

13 DR. REINHARD: Don and then Linda.

14 DR. CASEY: Yes, I would echo  
15 that. I want to be careful we don't come  
16 across as seeming to make pejorative  
17 statements about the current state of nature  
18 with respect to, for example, this.

19 You know, as an example a friend  
20 of mine is in the White House as we speak all  
21 the way from Wichita, a physician advocating  
22 for harmonization of the Ryan White support

1 with the Affordable Care Act.

2 So, there's a perfect example of  
3 where providers wouldn't be able to do their  
4 business if they weren't emotionally and  
5 intellectually attached to community-based  
6 services. So, I'll just say that for the  
7 record.

8 But I think people were getting at  
9 my comment, but in the context of the roles  
10 and relationships of the people that are in  
11 the relationships, if those aren't clear then  
12 it's going to be lower impact and it gets back  
13 to I think what I'm hearing is being sure that  
14 these things are clearly defined in the  
15 context of everything else we've got going.

16 So that's why I ranked it a little  
17 lower.

18 DR. REINHARD: So you have to know  
19 what to measure, is that what you're saying,  
20 Don?

21 DR. CASEY: Well, I just, I think  
22 that measuring where roles and

1 responsibilities aren't clear in the  
2 relationships will lower the impact. I still  
3 think it's feasible to focus on. So it's  
4 maybe a nuance but I'm saying we've got to  
5 clearly define what the future state of the  
6 relationships would be in terms of clarity  
7 about who's doing what to who when.

8 DR. REINHARD: So are you in the  
9 middle of each?

10 DR. CASEY: No, I'm actually --  
11 I'm actually on a higher feasibility.

12 DR. REINHARD: Higher feasibility,  
13 lower impact.

14 DR. CASEY: Yes. But I'm sort of  
15 a little bit below the line on low-impact.

16 DR. REINHARD: Okay. Linda?

17 DR. LINDEKE: I think some out-of-  
18 the-box thinking may develop. And I saw a  
19 poster about a study of dialing 211 and the  
20 impact that that had. We could measure who  
21 calls. And this was on actually doing  
22 screening using a standardized tool during

1       that call. It was acceptable to the people  
2       who called. They were in a teachable moment.

3               When we limit our measurement to  
4       what's in an electronic health record we are  
5       I think limiting the possibility to really  
6       show impact at a population and an individual  
7       basis.

8               And this was a relationship. That  
9       was in this study, that in that call at at  
10      teachable moment when they wanted help there  
11      was something powerful that could happen.

12              DR. REINHARD: Judy?

13              DR. NG: Just wanted to give an  
14      example of where the feasibility actually  
15      works for building relationships.

16              We just did a study of best  
17      practices where we looked at plans that did  
18      very well in a childhood immunization measure.  
19      Very high performance rates. We went and  
20      talked to providers, leadership in those  
21      plans, in-the-ground trench workers.

22              And a lot of it was about getting

1 to people whose children were not necessarily  
2 getting immunizations. A lot of them were on  
3 Medicaid, very low resource.

4 And what they all said to us was  
5 these people are not facing medical crises,  
6 they're facing social crises. Unless you can  
7 get them to the social resources they need and  
8 you know what they are they're not even going  
9 to come in for the care their child needs for  
10 immunizations.

11 So they built their resources up  
12 that way knowing they needed to achieve a  
13 particular measure. So it was feasible.

14 DR. REINHARD: Okay. I'm thinking  
15 -- okay, Mark. And then I'm going to suggest  
16 something. We'll move on.

17 DR. REDDING: So, if feasibility  
18 can be impacted in our thinking by some --  
19 they may be oddball current examples, but  
20 oddball current examples that are out there.

21 What's interesting about  
22 relationships is that -- and again, so I don't

1 drive some people crazy I'm in a subset of the  
2 subsets of community-based care coordinator  
3 going out.

4 But if that care coordinator has  
5 strong relationships with the patient then  
6 they -- and then if there's a system in place,  
7 going back to Fred's comment to work as a  
8 sieve to find the people who are at risk and  
9 continuously look for them, get them to  
10 someone who can have a good relationship,  
11 that's the person that can do a comprehensive  
12 assessment that includes the patient's  
13 perspective, set goals and achieve goals.

14 And there are existing programs  
15 using a pay-for-performance model so it isn't  
16 just little checkoff boxes. You actually --  
17 the managed care plan only pays if they are  
18 confirmed to connect to medical care,  
19 confirmed to connect to mental health.

20 But it's an oddball example. It's  
21 one of the reasons why I put those four things  
22 together.

1 DR. REINHARD: Carolyn, do you  
2 have any comments?

3 MS. INGRAM: Yes, this is of  
4 course harder to follow from being afar. And  
5 so I think you guys have moved onto some of  
6 the ones that I was looking at.

7 So I was thinking comprehensive  
8 assessment would have high-feasibility, high-  
9 impact. Goal-setting was the other one that  
10 I was putting into those two buckets.

11 DR. REINHARD: Okay, let's turn to  
12 assessment in a moment because I was --

13 MS. INGRAM: Okay, yes.

14 DR. REINHARD: So just hang in  
15 there for a second. I just want to finish  
16 with relationships.

17 MS. INGRAM: Okay.

18 DR. REINHARD: So, I'm hearing at  
19 least on the edge of impact how many think  
20 it's high-impact? High-impact? I'm talking  
21 about relationships, high-impact. Okay. Low-  
22 impact? Okay. So, we're going to put it on

1 high-impact. Can you live with that? Okay.

2 How about feasibility? High  
3 feasibility? Low feasibility? So that's sort  
4 of in the middle. So I think it's up higher  
5 on the impact and in the middle of  
6 feasibility. Okay.

7 So, Carolyn, can you speak to  
8 community assessment then? Or a comprehensive  
9 assessment? You were suggesting high-impact,  
10 high-feasibility.

11 MS. INGRAM: Yes, I'll just throw  
12 that out as a starting point. And the reason  
13 is I think by the list that we've been  
14 provided covering those different key areas I  
15 think and somewhat from personal experience as  
16 well it is, in terms of overseeing healthcare  
17 plans and that type of thing.

18 I think the feasibility of doing  
19 that and putting that into the plan of care is  
20 not hard to get done and measure.

21 I think the impact of that once  
22 it's in place may be, you know, I'll throw it

1 out as saying it's high-impact. I think it's  
2 harder to pull off, the delivery, after you've  
3 put those things into the plan of care.

4 But I think it's easier to at  
5 least measure that there's a high feasibility  
6 of getting it in there, easy to get to  
7 measurement, and I'll say maybe medium impact  
8 or something.

9 DR. REINHARD: All right. I'm  
10 just going to say something about this and  
11 then ask. I would have -- I put it there  
12 also. And I understand what you're saying,  
13 Gerri, about necessary but not sufficient.

14 But it seems if you could, and it  
15 depends on what's in the assessment, of  
16 course. But just asking some of these  
17 questions is unbelievable. People are not  
18 asked some of these things. So, again, it  
19 depends on what's in the comprehensive.

20 Like, family caregivers are never  
21 asked how they're doing. That's an example.  
22 Just asking them has an enormous consequence

1       for them.

2                       So, I was pitching for that but  
3       again it depends on what "it" is. Similar to  
4       experience and goal-setting what it exactly is  
5       and then how you measure it. It seemed like  
6       it was pretty feasible, but again, I'm not a  
7       measurement expert.

8                       So, anyone want to disagree with  
9       Carolyn and I? On feasibility. Let's take  
10      feasibility first. Anyone think this is low-  
11      feasibility? Okay, how about impact, low-  
12      impact? Oh, did you, David? Okay.

13                      MR. CUSANO: Yes, on the  
14      feasibility front, again, it's just thinking  
15      about the broad continuum of individuals that  
16      would be providing services in the coordinated  
17      care model.

18                      So you know, this assessment, you  
19      know, I wonder how feasible it would be to  
20      implement and say if someone started it  
21      through their church looking for services or  
22      through a more community-based organization

1       that might not have the training or skill set  
2       to do this level of assessment. So I worry  
3       about the feasibility depending on where the  
4       point of entry is into the coordinated care  
5       framework.

6                   DR. REINHARD: Okay. The  
7       feasibility of doing it, or of measuring it?

8                   MR. CUSANO: The feasibility of  
9       measuring, of both, actually I would say.

10                  DR. REINHARD: Okay. But it  
11       sounds like most think it's feasible. Okay.  
12       How about impact? High-impact. Carolyn and  
13       I thought high-impact. We might be alone.  
14       There's a couple of us.

15                  Okay, Carolyn, I think there's  
16       like maybe six -- one, two, three, four, five,  
17       six. Oh, I got it, six people. Seven.

18                  How about low-impact? Okay. So  
19       there's moderate, okay moderate impact? Okay.  
20       I'm thinking this is falling in the moderate  
21       impact, high feasibility. Does that sound  
22       right? Yes? Okay.

1 MS. INGRAM: I'm good with that.

2 DR. REINHARD: Okay. Any other  
3 nominations? We're getting there and we have  
4 a little time left. Yes, Don.

5 DR. CASEY: I have availability of  
6 services.

7 DR. REINHARD: Okay, and where did  
8 you put it?

9 DR. CASEY: High and high.

10 DR. REINHARD: High and high?  
11 Okay.

12 DR. CASEY: Yes. Because I think  
13 that, you know, the way I perceive this is to  
14 facilitate access. And I think that while  
15 some people might not know about it I think  
16 there's a lot out there. It's not  
17 coordinated, it could be coordinated better.

18 But you know, I can think of 10  
19 examples of where when I looked I found a lot  
20 more than was there.

21 So, all I'm saying is that while  
22 it's not perfect and it could vary by

1 community, you know, in New York City it's  
2 going to look a lot different than it is in  
3 let's say Mansfield, Ohio. We would hope.  
4 But that's neither here nor there.

5 The point of this is that I just  
6 sort of feel like this is a no-brainer to just  
7 work on.

8 DR. REINHARD: I just want to --  
9 this is only community services? Because it  
10 says adequacy of community services. Are we  
11 focusing only on community services?

12 MS. LASH: I guess that might  
13 assume that the primary care network is  
14 adequate. We could re-frame.

15 But I think we would want to  
16 include things like behavioral health,  
17 specialty type care, in addition to non-  
18 medical community services.

19 DR. REINHARD: And we also think  
20 of adequacy of primary care?

21 MS. LASH: Let's do that.

22 DR. REINHARD: Yes, okay.

1 DR. CASEY: Well, I mean if you  
2 think of what hospitals are accountable for,  
3 especially if they're not-for-profit it's  
4 community benefit. So, you know, to that  
5 extent this should be easy to grab onto.

6 DR. REINHARD: Okay. So how many  
7 agree with high-high for availability of  
8 services? Okay. Who disagrees on either end?

9 Okay, Fred, and then I'm going to  
10 come to Vija. Fred? Can you say why? Is it  
11 feasibility, or impact, or both?

12 DR. RACHMAN: I think it's  
13 probably more feasibility. Because I don't  
14 think we're very good at -- I mean, I know  
15 we're good at a provider saying they know what  
16 the availability is. But how do we judge the  
17 quality or the --

18 DR. REINHARD: This is who does  
19 this.

20 DR. RACHMAN: Yes, right. So how  
21 would you measure whether what you're getting  
22 there is accurate?

1                   And then there's also an impact  
2                   question which is -- and it gets back to  
3                   something, somebody said this earlier on like  
4                   are we contributing to the identification of  
5                   gaps and the filling of gaps in this process.

6                   And I'm worried that if you're  
7                   going to judge people based on how well  
8                   they're saying all these things are available,  
9                   you know, what are people going to do to pass  
10                  the test.

11                 DR. REINHARD: Is this about  
12                 providers passing a test?

13                 DR. RACHMAN: Yes, anyone. Like  
14                 considering we put a measure up there. You're  
15                 going to be judged on whether you are  
16                 providing availability for all of these  
17                 services. People are going to play to that  
18                 test, right? And how are you going to judge.  
19                 So it's both a feasibility and an impact for  
20                 me.

21                 DR. REINHARD: I guess I was  
22                 thinking system level. So this gets us back

1 to the individual and system. Are the  
2 services there.

3 DR. CASEY: Well, it is under the  
4 health neighborhood.

5 DR. REINHARD: Yes. I wasn't  
6 thinking individual would be, but it is an  
7 important question. Vija? Oh, you put it  
8 down? Robert?

9 DR. ROCA: Well, my concern was  
10 sort of a level of measurement, who's being  
11 measured kind of question. So maybe that's --  
12 because certainly the services that might be  
13 critical to somebody's well-being and wellness  
14 in the broader sense of the term may not be  
15 health services. There may be all kinds of  
16 other services that health systems normally  
17 don't dabble in or have any control over.

18 So I guess if you're looking at  
19 communities in the broadest sense maybe this  
20 is a very important and meaningful measure.  
21 But I'm not sure it's a meaningful measure at  
22 least for health systems.

1 DR. REINHARD: Sarah, do you want  
2 to say anything about this, whether this was  
3 providers being measured?

4 MS. LASH: Personally I would  
5 agree that it seems to operationalize better  
6 at a community level, yes.

7 DR. REINHARD: Okay.

8 MS. LASH: Because we had talked  
9 about the linkage to whether community health  
10 needs assessments could be informed by sort of  
11 these needs identified in care plans and then  
12 sort of elevated up to local decision-makers  
13 who would be more in control of influencing  
14 the total availability of different types of  
15 services in their communities.

16 DR. REINHARD: So who's held  
17 accountable is the question. This is an  
18 accountability --

19 MS. LASH: Yes, I think it's --  
20 the accountability makes more sense to me at  
21 a community level. But I'm definitely open to  
22 others' opinions.

1 DR. REINHARD: Okay. Vija?

2 DR. SEHGAL: Again, from the  
3 community health center perspective it's very  
4 easy -- a lot of people now are jumping on the  
5 bandwagon saying that they have all these  
6 services available. And yet the impact that  
7 these services provide may be questionable at  
8 this point in time.

9 The actual -- so in that case I  
10 actually put it kind of on the low-impact area  
11 right now, the jury's still out kind of thing.

12 In terms of feasibility of  
13 actually coordinating to access all these  
14 services, again from a community health center  
15 world it's very, very difficult. Even if you  
16 know they're out there it's very easy for a  
17 provider to say you need this, this and this.  
18 But you know, it's just like the case study we  
19 did in the very beginning. Unless you have  
20 someone really helping the patient, the client  
21 get to all these services it's very low  
22 feasibility to make it happen.

1 DR. REINHARD: All right. Can I  
2 just pause on a time check? What do you want  
3 to do?

4 MS. LASH: We don't have to  
5 finish.

6 DR. REINHARD: Should we just  
7 finish this one? I'll finish this one and  
8 then leave it at that? Okay. Yes.

9 DR. LEFTWICH: So I would say  
10 high-impact very strongly, but feasibility --  
11 the feasibility of measuring the existence of  
12 services is one thing but the availability,  
13 and even if it's a system measure it's  
14 availability for individuals.

15 So you may have a service that  
16 exists, but they don't have a new patient  
17 opening for nine months. And that's going to  
18 be very hard. Or they're not covered under  
19 this individual's --

20 DR. REINHARD: -- particular  
21 thing.

22 DR. LEFTWICH: So that is why I

1       said the feasibility I put as low. Because  
2       you just can't -- existence, yes.  
3       Availability. It would be hard to measure  
4       across. You know, you could pick one service  
5       and do it.

6                     DR. REINHARD: Okay, Michael?

7                     DR. PARCHMAN: I'm having a little  
8       cognitive dissonance with the concept and  
9       maybe you can help me connect the dots.

10                    I mean, I know that in order for  
11       the care coordination to occur the service has  
12       to be available. But if we're measuring --  
13       we're developing a measure that just measures  
14       availability of service how does that measure  
15       the degree to which care coordination is  
16       happening. So I'm not sure how it fits into  
17       the framework.

18                    DR. REINHARD: So you're thinking  
19       we don't need this domain? Is that what  
20       you're saying, Michael? You're wondering  
21       about the domain?

22                    DR. PARCHMAN: Yes, that's what

1     this conversation is making me think. I mean,  
2     it's a fundamental essential that the service  
3     has to be available for there to be care  
4     coordination. But if we're measuring just the  
5     availability of service aren't we measuring  
6     more access, not coordination?

7             DR. REINHARD: Well, that's a  
8     pretty fundamental question. That goes back  
9     to the earlier discussion should we take any  
10    of these off the table as domains. So Michael  
11    is now raising that issue. Go ahead, Sharon.

12            MS. MCCAULEY: So now you're  
13    making me think a little bit more. I was  
14    going to try to -- I had it at high-impact,  
15    high-feasibility. But now that you've  
16    mentioned that and I was listening to Russ  
17    availability of services, but look at the --  
18    saw the indicators underneath there. It's not  
19    really anything about available. It is  
20    adequacy, timeliness, reliability and  
21    accessibility. But exactly what Michael just  
22    said. You've got to have the service. If we

1 don't have the service we're not going to be  
2 able to even begin to measure it.

3 But I don't think that the  
4 availability of services is the right term.  
5 For those three descriptors that are  
6 underneath that.

7 DR. REINHARD: You could add to  
8 it. We could add availability? Yes, so we  
9 could. So if we added availability would you  
10 think it should be a domain? How many believe  
11 this should be a domain?

12 MS. MCCAULEY: I think it has to  
13 be a domain but -- you're saying have like a  
14 --

15 DR. REINHARD: You would like more  
16 underneath that, I understand.

17 MS. MCCAULEY: Right.

18 DR. REINHARD: Like availability.  
19 How many do not think this is a domain? As  
20 titled, how would you change it? Okay, okay.

21 MS. MCCAULEY: -- need to have an  
22 extra sub-domain about availability. I like

1     what's underneath there, I just don't like the  
2     name "availability of services" now that  
3     Michael brought that up.

4                     DR. REINHARD:   How about just  
5     services?

6                     MS. LASH:    Quality of services?  
7     Go ahead, Don.

8                     DR. CASEY:   I had access to  
9     available services.

10                    DR. REINHARD:  Access to available  
11    services.

12                    MS. MCCAULEY:  Yes.

13                    DR. REDDING:  My thing to throw  
14    out in this is it actually -- it's not  
15    impossible that this could be one of the most  
16    important domains for a data collection.

17                    If you do a comprehensive  
18    assessment and you connect the person to each  
19    of the risk factors or other things  
20    identified.  And again, I'm still down in the  
21    weeds.  In different communities you'll see  
22    different trends of what's not available.

1                   And if we do what Fred's got we've  
2                   got a system to measure not just individual  
3                   but hundreds of individuals together. It  
4                   empowers that system of care to say hey, we've  
5                   got 800 people in this community that cannot  
6                   connect to mental health services.

7                   So, actually, availability of  
8                   services is a measure at both the individual  
9                   and the system level could quite possibly be  
10                  the most important one. And according to  
11                  legislators in Ohio it's the one that they  
12                  don't know how to administer funding because  
13                  folks come forward for 180 million but they  
14                  can't document the need or the individuals.

15                 DR. REINHARD: So, I'm just going  
16                 to -- because we have to move on. I'm just  
17                 going to put my duals hat on for a moment.  
18                 Who else is in the duals workgroup? Is  
19                 everyone here? Yes, okay.

20                 So, if we don't -- if you are  
21                 talking about duals you're talking about  
22                 behavioral health, long-term care, you're

1     talking about a lot of different things a lot  
2     of which is not medical. It may not even be  
3     primary care. A lot of it is community-based  
4     services.

5                     And I would think the duals  
6     workgroup when talking about coordination  
7     would very much want to see something about  
8     services in there, whether we think it's high-  
9     impact, low-impact. But without it what are  
10    you coordinating? You're only coordinating  
11    within primary care. You're not care  
12    coordinating anywhere outside the health  
13    system.

14                    So, it seems pretty fundamental to  
15    the vision that we had from the beginning that  
16    there needs to be something about services  
17    more at a systems level it seems. Although  
18    the relationships gets to the interaction  
19    between providers and what they're doing with  
20    referrals and all that kind of stuff. But if  
21    there's nothing to refer to, or there's no  
22    availability or access to it it's sort of a

1     moot point which gets you to the community  
2     planning that the ACA has the hospitals do.  
3     I mean, there are levers to get to it. But if  
4     you don't have the data it's hard to advocate  
5     for anything.

6                 So, I can't speak to how feasible  
7     this is. Again, I'm not the measurement  
8     expert in this area. But I would speak to  
9     very high-impact.

10                So, what -- so my recommendation  
11     so we can move on is that anyone who has ideas  
12     for the name of this, if you could -- Sarah,  
13     can we give them to you? Okay.

14                And how many want to lead it as  
15     high-impact? Low-impact? Okay, so we move it  
16     a little bit away from the very highest  
17     impact. A little bit closer but not quite on  
18     the line. Okay.

19                And feasibility? High  
20     feasibility? I don't even know what to say  
21     about this. Low feasibility? Okay. So we've  
22     got to move it closer to low feasibility.

1       Into low feasibility. So should it be over  
2       there? Higher up but over the lower end?  
3       Lower? Move to the left. Move it to the  
4       left.

5                       Say high-impact but higher up.  
6       There you go. How do you like that? Okay.  
7       She wants it down. All right, you're right  
8       over there, you could just sneak it down,  
9       it'll be fine. We won't even know.

10                      So, I'm sorry we weren't able to  
11       complete it but you got a lot of input in the  
12       general thinking. So maybe you can direct us  
13       what we should do next, Sarah.

14                      MS. LASH: Sure.

15                      DR. REINHARD: We didn't do goal  
16       attainment.

17                      DR. CASEY: I think that was  
18       higher impact.

19                      DR. REINHARD: It was higher  
20       impact. But that's what that is, it's high --  
21       she just -- they want it higher. Of course  
22       Fred's going to move it down when we leave.

1       We're good?

2                   MS. LASH: We can think less about  
3       their relative placement and just look at the  
4       pattern which is that we have a lot of  
5       impactful measurement domains with varying  
6       levels of feasibility of measurement but a lot  
7       of challenges have been voiced in this  
8       discussion that were very important and will  
9       inform HHS.

10                  DR. CASEY: I don't think low-  
11       feasibility means impossible. I think it  
12       means --

13                  MS. LASH: Relatively --

14                  DR. REINHARD: Yes, that's right.  
15       Okay, any last words? I heard goal  
16       attainment. Is that a slam dunk? What would  
17       you say?

18                  DR. SEHGAL: I would put goal  
19       attainment in the high-impact, low-feasibility  
20       group.

21                  DR. REINHARD: Does everybody  
22       agree with that? Yes, okay. You only had one

1 down. We did pretty good.

2 All right, thank you for your  
3 attention and your help and we're going to  
4 move onto your break I think, Sarah?

5 MS. LASH: Yes, we'll take about a  
6 10-minute break instead of a 15 and then we'll  
7 reconvene and learn about the next activity.

8 DR. REINHARD: Okay, good.

9 DR. CASEY: Can I just make one  
10 comment about goal attainment? I think it's  
11 the progress towards the goal.

12 DR. REINHARD: That's interesting.

13 (Whereupon, the foregoing matter  
14 went off the record at 2:42 p.m. and went back  
15 on the record at 2:57 p.m.)

16 DR. REINHARD: I think we're ready  
17 to start if you could head back to your seats.

18 MS. DORIAN: I think, Cathy, if  
19 you could open the lines up to anyone who  
20 might want to make a comment. That includes  
21 members of HHS and I know the other Care  
22 Coordination Steering Committee, certain

1 members might be on the phone or members of  
2 the public.

3 OPERATOR: Okay, all the lines are  
4 open.

5 MS. DORIAN: Is there anybody on  
6 the line or even here who'd like to feed back  
7 on that last session or ask us any questions?  
8 Okay. Well, then I think we're good to wrap  
9 that last session up and move on.

10 Before we get started I'd just  
11 like to take a poll to see who would be  
12 interested. We have dinner reservations as I  
13 mentioned at 6:30 two blocks away. Great,  
14 we'll be there. Sarah and I will be there.  
15 We look forward to it.

16 Okay, so we've come to our next  
17 exercise. As many of you have already  
18 anticipated now that we've had this last  
19 brainstorming session although we didn't get  
20 through all of the concepts I think it was  
21 still really helpful to iron some of those  
22 major issues out, or to at least start

1 wrestling with them.

2                   So, now we'd like to talk about,  
3 we'd like to get a little bit more granular  
4 and start thinking about specific measure  
5 concepts that the group could potentially  
6 recommend.

7                   So to do this we have divided you  
8 into three small groups each of which has been  
9 assigned to one of the major domains that you  
10 see on the screen.

11                   So you'll be given -- each of  
12 these groups will go to a different room.  
13 I'll bring that up on the screen shortly. And  
14 either Sarah, myself or Laura will accompany  
15 you. And we'll give you sheets that look like  
16 this that essentially ask you to fill in by  
17 sub-domain. And we've updated this to reflect  
18 the comments that we had before when you fed  
19 back on the domains initially. So, to start  
20 really thinking about a denominator and a  
21 numerator statement and what potential data  
22 sources you might be drawing from.

1                   So, we ask that you consider what  
2                   you know about the evidence out there, what  
3                   it's pointing towards. And you might consider  
4                   other data sources and what information might  
5                   be pulled from them too for more impactful  
6                   measurement.

7                   So we do have an example at the  
8                   top. If you look at it -- you can't see it  
9                   now, I know -- but we say that the denominator  
10                  is all children ages 10 and up seen in the  
11                  primary care measurement year. And then the  
12                  numerator is the number of children age 10 and  
13                  up who screen positive for risk factors for  
14                  poor educational outcomes and for whom a  
15                  community referral is completed.

16                  So the denominator of course will  
17                  be the entire population that you're  
18                  interested in screening or measuring and the  
19                  numerator is what you want to know about that  
20                  denominator population.

21                  So, Sarah, did you want to add  
22                  anymore detail?

1 MS. LASH: I don't think so. We'd  
2 like you to try to, for one, measure a concept  
3 in each sub-domain. But don't restrict  
4 yourselves to picking system or individual or  
5 some of the other continuums that we've  
6 raised.

7 This is really a blank slate for  
8 you to try to operationalize the domain and  
9 sub-domain concepts for what might actually  
10 work.

11 And so we'll have these worksheets  
12 and staff facilitation to guide you. And  
13 we've got a few tricks in our back pocket if  
14 you get stuck. But we do want to encourage a  
15 lot of creativity here.

16 MS. DORIAN: So if you look at  
17 this slide these are the breakout sessions.  
18 The Group 1 will go with Laura and you're  
19 going to go to a meeting room that's down this  
20 way. Group 2 is going to stay here with  
21 Sarah. And the third group is going to come  
22 downstairs with me. And maybe if we could

1 just meet back there because you will need me  
2 to swipe you in when we get to the lower  
3 level.

4 Yes, Carolyn will be -- that's why  
5 we kept her -- oh wait -- yes, yes, Laura --  
6 yes, they've set that up. She's expecting  
7 that.

8 Are there any questions?

9 MS. LASH: As a preview for what  
10 we'd like to hear from you when you come back  
11 to share your progress, some of your strongest  
12 potential measure concepts, the types of  
13 measures your group thought might be most  
14 important, the domains where it was easy for  
15 you to come up with ideas, and then the data  
16 sources that you think you're looking at.

17 Is everyone caffeinated enough for  
18 this? Okay.

19 (Whereupon, the foregoing matter  
20 went off the record at 3:03 p.m. and went back  
21 on the record at 4:09 p.m.)

22 DR. REDDING: So let's call

1 everybody together. Everybody has got lots of  
2 energy, right? It's been amazing energy and  
3 thought today.

4 We're just going to start with --  
5 could the report-out individuals raise their  
6 hands? We've got Rita and where are the other  
7 two groups for the reporters. Three  
8 reporters? Okay.

9 So what about the third group?

10 MS. DORIAN: Any volunteers from  
11 the third group?

12 DR. REDDING: Or you can think  
13 about it for a minute. We'll start with your  
14 three reporters, Fred.

15 MR. CUSANO: So yes, we split up  
16 our work into -- we split up the domains. So  
17 we split up comprehensive assessment, goal-  
18 setting and shared accountability. So, we  
19 each worked separately on that.

20 So, Fred and I worked on the  
21 comprehensive assessment. And so our first  
22 approach was in defining comprehensive

1       assessment was to take the term "comprehensive  
2       assessment" and include in that assessment the  
3       measure sub-domains.

4               So, what would be included in a  
5       comprehensive assessment would be the measure  
6       sub-domains lead up to risk level and  
7       customized care. So that would be inclusive  
8       of the comprehensive assessment. That was our  
9       thought process there.

10              And in terms of the measurement  
11       for the numerator it would be anyone for whom  
12       an assessment is documented crossing domains.  
13       And the denominator would be anyone enrolled  
14       in the reporting entity.

15              So with that, I don't know if,  
16       Fred, if you had anything you wanted to add.

17              DR. REDDING: Very good. Okay,  
18       that's it?

19              MR. CUSANO: And then on the  
20       second measurement we looked at was the  
21       continuous holistic monitoring. And the  
22       numerator would be patients for whom a shared

1     care plan is in place. And the denominator  
2     would be that the care plan is visible and  
3     continuously updated by any service provider  
4     named in the care plan in the centralized  
5     database if possible.

6                     DR. REDDING: Excellent. Great.  
7     Any other reporters from your group?

8                     DR. SEHGAL: So Carolyn and I  
9     worked on goal-setting within the person-  
10    centered goals. And we had several examples.  
11    We found it best to talk about examples. And  
12    I think that really, now that I look at it  
13    they really do all tie together.

14                    So I'm going to use one example  
15    that we used which was patients at high risk  
16    for falling and the adverse consequences of  
17    falling. And so we placed that as our  
18    denominator in each of the different groups  
19    and then we focused on our data source was  
20    always the care plan which is noted within the  
21    EMR ideally with appropriate checkboxes on the  
22    care plan so that this data can be pulled out

1 of the EMR easily rather than having to do  
2 chart audits manually.

3 The numerator would be, for  
4 example, in person-centered communication  
5 would be communicating with the patients that  
6 are at high risk for falling and coming up  
7 with some goals. And this kind of went into  
8 the setting goals.

9 So, for example, a goal could be  
10 that the patient wanted to live at home. But  
11 if they wanted to be really specific we needed  
12 to focus on what would be -- what actions  
13 would need to be taken into place to make  
14 these goals realistic. For example, working  
15 with social service organizations to help them  
16 install non-slip bars and whatnot in their  
17 house and ramps and whatnot.

18 This would have to be a shared  
19 decision-making because by definition you  
20 can't really invade a person's home without  
21 their sharing the decision.

22 So, again, the whole purpose was

1 to get away from the cynical thinking that we  
2 were discussing most of this morning to really  
3 assume that the patients are involved in  
4 setting their own goals, assuming that when  
5 the checkbox is checked off within their care  
6 plan that the patient actually played a part  
7 in setting these goals.

8 And really, I think they all tied  
9 together in order to be effective, in order to  
10 move from the highly feasible to the high  
11 feasibility and high-impact box they need to  
12 actually be shared when being made.

13 DR. LAMB: Okay, Woody and I  
14 looked at shared accountability. And we  
15 decided to start at the level of the  
16 individual practitioner but thought it could  
17 also be at the practice level. And so for the  
18 shared accountability, taking into thinking  
19 that the patient family is part of that shared  
20 accountability. We had two different measures  
21 for the plan of care documents who was a part  
22 of the care team including community

1 providers.

2           The first one that the provider  
3 would do is in their caseload the percent of  
4 patients with a completed checklist of team  
5 members including, or a checklist of roles  
6 including we would create a list of who the  
7 roles might be.

8           The concern being is if it's -- if  
9 it's just who's involved we would have no way  
10 of knowing whether that was ever considered  
11 and whether the team list was complete. So we  
12 were envisioning a checklist that would go,  
13 you know, who's the PCP, the pharm, nurse,  
14 educator and so forth. If it's non-applicable  
15 that would be identified.

16           And then for the patient is the  
17 percent of patients who were asked who assists  
18 them in their healthcare or caring for  
19 themselves. And then we could figure, then we  
20 could picture a lot of different other  
21 questions related to how these people were  
22 invited to the team.

1                   We also looked at the plan of care  
2                   assigns responsibilities for meeting the care  
3                   recipient's goal. And we struggled a bit with  
4                   this one because the issue of feasibility.  
5                   There are a lot of people involved. If you  
6                   think about even the one that was just  
7                   suggested for falls or for diabetes education  
8                   there could be multiple interventions with a  
9                   variety of providers.

10                   And what's meaningful versus this  
11                   lengthy checklist of you got this one, I got  
12                   that one and the other person has that. So,  
13                   we started with percent of plans of care that  
14                   identifies a primary accountable person, but  
15                   we never could figure out -- we didn't get to  
16                   the place of how do we really figure out what  
17                   are the core interventions and who's  
18                   accountable for them so that we didn't have  
19                   this really humongous thing about, you know,  
20                   a list of 9,000 interventions and  
21                   accountability.

22                   Woody, anything else? Okay.

1 DR. REDDING: That fit into Russ's  
2 concept of having a football team, possibly a  
3 quarterback and figure out who was going to be  
4 quarterback. Is that?

5 DR. LAMB: Well, you know, that's  
6 somewhat of the elephant in the room is we  
7 really are looking at shared accountability.  
8 And if we have one quarterback and there's no  
9 dialogue about that, you know, is it really  
10 reflective of who the quarterback actually is.

11 DR. REDDING: If we could have  
12 Rita from utilization of the health  
13 neighborhood.

14 DR. MANGIONE-SMITH: Okay, so we  
15 had a lively discussion in our group. So we  
16 didn't split up so we might not have gotten  
17 quite as much done.

18 But the first thing we really  
19 struggled with was the label of availability  
20 of services. And we talked a bit about how  
21 that might be re-labeled as a domain, either  
22 availability of appropriate services,

1       availability of needed services.

2                       And once actually we found  
3       ourselves moving from that domain column to  
4       the sub-domain column we were able to kind of  
5       get our juices flowing and come up with some  
6       measure concepts or ideas.

7                       So, I'm going to just pick a  
8       couple of examples from the different domains.  
9       But before I do that, the other thing I should  
10      tell you we kind of globally decided to do  
11      among the domains was to collapse what is now  
12      relationships, linkages and synchronization  
13      with continuous communication. Because we  
14      really came to the conclusion that the whole  
15      reason you need these linkages and  
16      relationships was so that there would be good  
17      communication.

18                      And there was such a strong  
19      overlap in those two Venn diagram circles it  
20      seemed like they really were becoming one  
21      circle and so we collapsed them into one  
22      domain.

1                   So, within the availability of  
2                   services the sub-domain of adequacy of  
3                   community services to support self-management.  
4                   Wellness.

5                   One of the measurement ideas we  
6                   came up with denominator was, and I apologize,  
7                   I always think of denominators first because  
8                   that's just what quality measurement people  
9                   do. But overweight care recipients who wish  
10                  to lose weight would be the denominator.  
11                  Numerator is reportability to access a weight  
12                  loss program within their community. So that  
13                  was one idea we had. There's several more so  
14                  I won't tell you all of them.

15                  In the domain of relationships,  
16                  linkages, synchronization, one thing that our  
17                  group wanted to do was have one structural  
18                  measure. So that last one was obviously a  
19                  process measure. We would use survey data to  
20                  get at that last measure.

21                  This next one is a structural  
22                  measure and we would use EHR as the data

1 source. The denominator would be care  
2 recipients and families with a plan of care in  
3 place that lists all care team members. So  
4 that's what you need to get into the  
5 denominator, pretty specific.

6 Numerator is the care plan is  
7 accessible to all care team members including  
8 the family and all community service  
9 providers. So again, just really trying to  
10 have those successful connections and  
11 communication.

12 DR. EISENBERG: So, were the care  
13 team members the same for every patient?

14 DR. MANGIONE-SMITH: The care team  
15 members always have the patient themselves and  
16 their family or support system within their  
17 home, their caregivers. And then --

18 DR. EISENBERG: For example, if I  
19 -- the care team --

20 DR. MANGIONE-SMITH: No. So, it's  
21 individualized plan of care. Right. So as  
22 you structure that team and you structure that

1     care plan the people listed on that care plan  
2     are the people that that person needs, right?  
3     And those are all the people who need to have  
4     access to the plan for communication purposes.

5             And then the last one was again  
6     falling under that realm that we mushed  
7     together, the communication and relationships,  
8     follow-up protocol to ensure receipt of  
9     services.

10            So, our denominator there was care  
11     recipients with plans of care that include  
12     needed services documented. And the numerator  
13     is services obtained within two months of the  
14     identified need. So, and again we would say  
15     EHR for that particular measure.

16            So those were some of the ones we  
17     liked the best and felt like they might have  
18     some implications for Meaningful Use down the  
19     way and all of that.

20            I think I already talked about  
21     types of measures. We had some process, one  
22     structure. I don't think we found any of them

1 particularly easy. And I talked about the  
2 data sources. And the only other important  
3 thing was the fact that we decided to combine  
4 two of the domains.

5 DR. REDDING: And I think you  
6 mentioned that some of them you could see  
7 fitting in at an individual as well as a  
8 system coordination level.

9 DR. MANGIONE-SMITH: Right, you  
10 might measure at the individual level but they  
11 could be likely rolled up to the systems  
12 level.

13 DR. REDDING: Excellent. All  
14 right. And our outcomes team. Somebody has  
15 got to report out or we can't go to dinner.

16 DR. ACKMAN: So, we did not get  
17 that far down the list and I think we had a  
18 lot of sort of germs of ideas rather than  
19 fully formed ones. But I'll tell you what we  
20 thought.

21 In terms of -- the first one,  
22 experience, care recipients' experience. We

1     thought this was a survey, a care recipient  
2     survey.

3                 There was some discussion about  
4     whether the denominator would be everyone or  
5     whether it would be a subset of people who had  
6     had either encounters or contact with more  
7     than one caregiver.

8                 We talked about whether that would  
9     be encounter-based or whether there would be  
10    other ways to determine whether they had more  
11    than one.

12                But the thought was that the --  
13    the question or what we were trying to get at  
14    was that did people -- and then there was  
15    discussion about what the question was. Did  
16    people work together? Did you have a sense  
17    that people worked together? Did you have a  
18    sense that people communicated and that people  
19    knew more than -- that your problems and  
20    issues and needs were shared among different  
21    people.

22                I think that's -- when we talked

1 about empowerment we had even more difficulty  
2 with that because we weren't quite sure what  
3 that meant. We talked about -- there was a  
4 discussion as to whether this was some ability  
5 to solve problems on your own, maybe an  
6 ability to work with your providers. We  
7 weren't certain what that exactly was getting  
8 at.

9           The family experience, I think a  
10 good idea came up on that was a hassle, the  
11 hassle survey which is an existing tool about  
12 whether the family experienced hassles with  
13 getting certain things done. So that's  
14 something that we may want to look at.

15           Again, the denominator on that  
16 would be I think in the hassle survey was  
17 people with multiple complex chronic illnesses  
18 with I think substantial interaction with  
19 healthcare providers. Empowerment I think  
20 again we sort of skipped over that.

21           We had some difficulty with the  
22 care team's experience of coordination.

1 Michael, I think you had the best sort of  
2 ideas on that. Do you want to just share  
3 those?

4 DR. PARCHMAN: Yes. This was  
5 about focusing on the experiences of care  
6 providers and service agencies and being able  
7 to coordinate care between each other within  
8 the community and thinking about.

9 And there are some beginning  
10 scales out there in which people are  
11 establishing compacts between each other about  
12 what I agree to do, what you agree to do and  
13 then we'll score each other, we'll give each  
14 other report cards. There are communities in  
15 which this is going on as a way of thinking  
16 about ways to improve. But it's also a way of  
17 saying how well are we performing and working  
18 together around meeting patients' needs.

19 But it's all about my experience  
20 as a care provider in being able to meet the  
21 needs of my patient and working with other  
22 agencies or other groups.

1 DR. ACKMAN: And then the last one  
2 we touched on was goal attainment. And at the  
3 simplest level we could think about this as a  
4 series of HEDIS measures, that a need would be  
5 defined based upon the patient's age,  
6 condition. And you could identify what the  
7 expectation was in terms of care.

8 But then sort of going back at it  
9 again we sort of paid attention to the goal  
10 attainment and as documented in the  
11 assessment. And so I think we sort of came  
12 around to the idea that these would be goals  
13 that were documented either in assessment or  
14 in a care plan and that they would -- and that  
15 meeting goals would be an indication of a  
16 reduction in their unmet needs.

17 The denominator here either could  
18 be everyone with a care plan or an assessment,  
19 or it might be a subset of those who have  
20 complex needs.

21 And I think that's as far as we  
22 went down the list.

1 DR. REDDING: Very good. I think  
2 that's just the information that was being  
3 requested. That's awesome.

4 In terms of hassles, does that fit  
5 with a concept of barriers to connecting to  
6 care? Was it in the same context? Just for  
7 clarity. Could be anything from  
8 transportation to a rude appointment clerk.

9 DR. PARCHMAN: Or hassles getting  
10 refills three times a week because the end  
11 date expiration on the bottle expires for the  
12 16 medications they're on. So they're  
13 spending three days a week in the pharmacy  
14 getting refills.

15 DR. REDDING: Very good, thank  
16 you.

17 DR. LINDEKE: We touched on one  
18 other thing which was the goal attainment.  
19 Perhaps a better wording came up from before  
20 we broke which was progression towards goals.  
21 Maybe you said that and I --

22 DR. REDDING: Very good. So, with

1 Sarah's permission we're actually -- now we're  
2 finally doing better with time. If we could  
3 do one of those rapid things.

4 Could I check back in with each  
5 group. By hearing each other's presentations  
6 there may be just a few additional comments  
7 that each of the groups would like to say.

8 So if I could first check in with  
9 the person-centered plan of care group. Do  
10 you have any additional comments to make based  
11 on the discussion?

12 I know it's been a comprehensive  
13 discussion.

14 And what about Rita and your team,  
15 is there anyone else who'd like to say  
16 anything?

17 DR. LEFTWICH: We discussed the  
18 possibility that in the Meaningful Use  
19 promoted concept of electronic summaries  
20 coming back from a provider who a patient has  
21 been referred to, that piece of data that's  
22 generated in the course of care could be used

1 to document that a referral that was made was  
2 completed as well as other data from those  
3 clinical messages.

4 DR. REDDING: Excellent. So, in  
5 that discussion there was -- we needed to  
6 figure out what they needed and then we needed  
7 some kind of credible confirmation that they  
8 actually connected to that service or reached  
9 some outcome, and that the EHR has a variety  
10 of different strategies to help with that.

11 And I think also, Russ, you --  
12 using your football player analogy we -- it  
13 was put in the context that it might actually  
14 be the front lineman who makes the referral.

15 DR. LEFTWICH: Right.

16 DR. REDDING: We would still --  
17 that needed to have organized roles and  
18 responsibilities. But we would still be  
19 responsible to make sure that that lineman's  
20 referral actually did what it was supposed to  
21 do and that everybody on the football team  
22 knew their role and how they were going to

1 take care of the patient. And it was  
2 individualized, not 20 people on there if they  
3 didn't need to.

4 DR. LEFTWICH: Well, yes. In  
5 fact, well, in terms of the care team roster  
6 being complete and included in every patient's  
7 summary I think one measure we haven't been  
8 able to make that that would enable is do  
9 individuals who have 12 specialists on their  
10 care team actually have better outcomes than  
11 somebody who has three specialists.

12 Is there an optimum makeup of the  
13 care team. And we can't really tell that.  
14 But we could if that roster is part of the --  
15 it would be high-feasibility and high-impact  
16 I would say.

17 DR. REDDING: I realize too if  
18 we're going to use your football thing I'm  
19 going to have to say linewomen because a lot  
20 of them are out there. But great.

21 DR. CASEY: Mark, could I just say  
22 something for group 3?

1 DR. REDDING: Oh yes, I'm sorry.

2 DR. CASEY: And that has more to  
3 do with our process than our output. I mean  
4 I thought we didn't get through all these. I  
5 wish we had more time. But what I experienced  
6 was a really good discussion amongst a lot of  
7 smart people from different perspectives to  
8 hone down.

9 I think we right off the bat kind  
10 of started getting -- we started behaving like  
11 measure developers and being really critical  
12 about it. And I think that was good. So I  
13 realize we wanted to be expedient.

14 But I don't know how to address  
15 this from your perspective, Sarah, but it  
16 seems like there's a lot more work here. And  
17 I don't know if you want this whole thing done  
18 or not but maybe we should try to do that at  
19 some point.

20 MS. LASH: I like the over-  
21 achieving impulse. All of the people in the  
22 room.

1 DR. CASEY: I'm speaking as an  
2 individual now.

3 DR. REDDING: And Don, we got --  
4 it's all about these outcomes so we've got  
5 another couple of minutes if you want to  
6 please expand on that.

7 DR. CASEY: Well, all I'm saying  
8 is we didn't get a chance to discuss the rest  
9 of it. And I feel a little badly about that.  
10 But I do think in fairness to the  
11 group, the group really did think hard about  
12 it. And we had some really good ideas. So I  
13 didn't want to say we ignored the rest. But  
14 there was benefit to have more time.

15 DR. REDDING: So, do I hear -- and  
16 to clarify, but do I hear a request that maybe  
17 somehow the group or someone once the level of  
18 detail we've defined here is settled down that  
19 we could make another run at further  
20 clarifying the ideas on the table?

21 DR. CASEY: I don't know if we  
22 want to sit in a room again like we did, but

1 I'm just putting a placeholder in the fact  
2 that we have some unfinished work. I don't  
3 know how we want to do that or not. Probably  
4 not this time around.

5 MS. LASH: We could always design  
6 like a follow-up activity after this meeting  
7 which we could complete electronically. Or --  
8 we'd have to give it some thought about what  
9 mode might work the best.

10 I think there's a lot of ideas  
11 that we'll need to collect across the groups,  
12 to organize together with our now edited  
13 domains and sub-domains.

14 Just reflecting that back to you  
15 once more would probably have a lot of value  
16 in making sure that everything is accurate and  
17 everyone was in agreement. So, appreciate  
18 that, Don. We'll try to think of how best to  
19 complete this.

20 DR. CASEY: Okay.

21 DR. REDDING: And thank you.

22 We're off to public comment, right? So is

1       there any public comment?

2                   MS. DORIAN:  Cathy, if you could  
3       open up the lines for public comment, please.

4                   OPERATOR:  And at this time if you  
5       would like to leave a comment or ask a  
6       question press \* then the number 1 on your  
7       telephone keypad.  And you do have a comment  
8       or a question from Yvonne Davis.

9                   MS. DORIAN:  Great.  Go ahead.

10                  MS. DAVIS:  Yes, thank you very  
11       much.  I think this process was really, really  
12       enlightening for me.

13                  I wish I could have participated  
14       earlier in terms of like how the domains and  
15       sub-domains were created.  But just jumping  
16       into this mid-process was very, very  
17       informative for me.

18                  I guess in regards to this process  
19       the question I have is -- is this the formal  
20       process that NQF will be reconstructing as  
21       additional measures will be created?  And I  
22       apologize that it's not directly related to

1 the sub-domains or domains that you were  
2 questioning. I was just curious about the  
3 process.

4 MS. LASH: So the overall goal of  
5 this meeting and this project is to make  
6 recommendations to HHS about where they might  
7 like to fund future measure development in the  
8 area of care coordination.

9 And so it's a model of gathering  
10 information and reflecting that, but it's --  
11 in terms of an official NQF process there  
12 would still be other ways that development  
13 would be expected to take place. Does that  
14 answer the question?

15 MS. DAVIS: I guess so, yes. I'm  
16 just curious because I would think that some  
17 form of standardization would occur. Or maybe  
18 not, I don't know. It's something that I  
19 would think that it would be useful in regards  
20 to looking at other disciplines in regards to  
21 health. And so that's the only reason why I  
22 was asking the question.

1 MS. LASH: Okay. So the potential  
2 to explore other topics for measure  
3 development.

4 MS. DAVIS: Well, not only that  
5 but the process, using this same process. But  
6 yes, it's just something that I wanted to, you  
7 know, kind of grasp on my level in terms of  
8 like saying, okay, well, is this a process  
9 that has been successful in the past to make  
10 these types of recommendations.

11 MS. LASH: I guess we'll see if  
12 we're successful. And then we'll see if we  
13 can replicate it, if so.

14 MS. DAVIS: Got it. Okay. That's  
15 all, thank you.

16 OPERATOR: And there are no  
17 further public comment or questions at this  
18 time.

19 DR. REDDING: So, in closing,  
20 Sarah, I'd just like to know what you saw in  
21 terms of general themes today.

22 MS. LASH: All right. I did take

1 many notes throughout the day, but I'll just  
2 highlight maybe a few of them that I thought  
3 really changed the course of the conversation  
4 or were especially meaningful. And we look  
5 forward to hearing more from you.

6 I think there was good discussion  
7 about the dynamic nature of risk and needs for  
8 care coordination. And we need to be  
9 connecting relatively low-risk people with  
10 preventive services to stop them from  
11 experiencing any additional risks.

12 And those high-risk groups should  
13 be connected with trained coordinators that  
14 have relationships that can be leveraged to  
15 address their health more holistically. So,  
16 continuing to look at both individuals and  
17 families, practice and the community systems.

18 Also, some distinctions between  
19 coordinated care versus care coordination  
20 versus care management. We can continue to  
21 unpack that tomorrow.

22 I heard a lot about the electronic

1 plan of care as being very critical both as a  
2 reference for the team to use to achieve care  
3 coordination and also data to support  
4 measurement.

5 And as we are able to implement  
6 better methods for surveying care recipients  
7 and care teams it would be more feasible to  
8 think about experience as part of that plan of  
9 care process as well.

10 I think we want to guard against  
11 creating incentives that would lead our  
12 complex and evolving and dynamic health system  
13 to wasteful uses of resources instead of those  
14 where improvement can really be achieved.

15 And that the whole quadrant  
16 exercise this afternoon sort of showed that  
17 there was a general agreement in the group  
18 that if the domains are implemented well they  
19 would have an impact on care coordination and  
20 health outcomes. But the devil will be in the  
21 details of implementing them as well.

22 And really no doubt about it, this

1 type of measurement is going to be difficult.  
2 It might just be a question of how difficult.  
3 And finding some political will to come  
4 together around a few key areas that are  
5 deemed most feasible. I'll just stop there.

6 DR. REDDING: Thank you. And just  
7 in addition briefly it's an unbelievable task.  
8 It's such a poorly defined and fuzzy yet  
9 absolutely critical to the person getting  
10 care.

11 And it seems like we've got, it's  
12 almost like a meeting where we have  
13 individuals from completely different  
14 languages and cultures and perspectives, but  
15 all very knowledgeable from where they come  
16 from.

17 So part of our work today is to  
18 find a common language and a common ground and  
19 try to understand each other. I don't know  
20 how we could have made any more progress with  
21 that.

22 We just would encourage you if you

1       can stand it to talk about this even more  
2       amongst yourselves and encourage the  
3       communication. I think that speeds up the  
4       clarification and common ground process.  
5       Thank you.

6                       (Whereupon, the foregoing matter  
7       went off the record at 4:42 p.m.)

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In the matter of: Care Coordination Committee Meeting

Before: NQF

Date: 04-03-14

Place: Washington, DC

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