

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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FRIDAY
APRIL 4, 2014

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The Care Coordination Committee met at
the National Quality Forum, 9th Floor
Conference Room, 1030 15th Street NW,
Washington, D.C., at 9:00 a.m., Mark
Redding, Chair, presiding.

PRESENT:

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Project, Chair
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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
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ILENE STEIN, JD, Service Employees
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NQF STAFF:

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LAURA IBRAGIMOVA, Project Analyst
WUNMI ISIJOLA, Project Manager
SARAH LASH, Senior Director
WENDY PRINS, Senior Director
ZEHRA SHAHAB, Project Analyst

ALSO PRESENT:

MAUREEN DAILEY, DNSc, RN, CWOCN, American
Nurses Association

ERIN GRACE, MHA, Agency for Healthcare
Research and Quality *

KATE GOODRICH, MD, MHS, Center for Clinical
Standards and Quality *

ELLEN MAKAR, RN, MSN, Office of the National
Coordinator

KORYN RUBIN, American Medical Association

JULIA SKAPIK, MD, MPH, Office of the Chief
Medical Officer

* Present via teleconference

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

2 (9:00 a.m.)

3 DR. REDDING: Good morning,
4 everyone. I hope everybody got some sleep for
5 another exciting day today.

6 We just wanted to spend a couple
7 minutes, and again, everything that's being
8 presented to you obviously has flexibility.
9 We're just trying to slowly bring it down to
10 a common framework.

11 This domains and process example
12 is very much that way. It doesn't capture
13 everything. I think you've gotten a handout
14 that does a better job of that, that Sarah's
15 going to go over with us.

16 In this example, I was going to
17 ask you to think of a community. And we could
18 have a long discussion as to what that is, but
19 think of a community. And then think of an at
20 risk individual or a not at risk individual in
21 that community slowly working through a system
22 of care.

1 And so what we tried to capture
2 with this is at least some of the ideas that
3 came up in our discussion yesterday. So you
4 have this at risk or not at risk person who
5 lives in a community.

6 And in that community there is --
7 and I kind of like the term, orchestration --
8 but that includes communication, linkages,
9 relationships and a focus on efficiency and
10 accountability.

11 It's a system for all people. So
12 even if you're not at risk, and then you
13 suddenly become at risk, hopefully this system
14 is going to identify you. There is intensive
15 care coordination for individuals.

16 And again, I think we had some
17 great discussion over definitions, and I am
18 not convinced we have that completely figured
19 out. But I think at the moment we're using
20 the term care coordination for both systems
21 and individuals.

22 And that could change. But to

1 keep the theme going, there is care
2 coordination based on risk and other factors
3 that is intensive if I'm an at risk
4 individual.

5 The care coordination includes a
6 comprehensive assessment, so I'll be evaluated
7 for health, social behavioral health, even
8 employment and adult education.

9 It's not just boxes to check.
10 It's not a big pile of paperwork that shows up
11 for a managed care office that has no meaning.
12 It is one plan of care that is developed, not
13 six. And the patient is involved and has
14 ownership and engagement in this plan of care.

15 The comprehensive assessment that
16 determines these goals in plan of care is
17 repeated multiple times to reassess what their
18 needs are and what their plan of care should
19 be.

20 The care coordination team that's
21 taking care of this at risk individual is
22 designed and based on goals and needs. It's

1 not just a standard six or eight person
2 package for everyone. It has working
3 relationships with defined goals, and I should
4 have put a football team here, but with
5 defined goals and shared accountability.

6 The individual is a key part of
7 that team. Goal setting, again, is completed
8 with the patient as part of the decision
9 making team and responsibility is specific to
10 team members.

11 And it is prioritized with a
12 balance between the patient's priorities and
13 critical outcomes that are being considered by
14 appropriate staff to balance that. Next slide
15 please. Yes?

16 DR. EISENBERG: I'm sorry, I
17 assume that the care coordination team is the
18 care team.

19 DR. REDDING: Yes, that's correct.
20 And thank you for that clarification. Next
21 slide please.

22 And then finally, goal attainment

1 is measured at, and I think this is another
2 longer conversation, but what gets measured at
3 the system level, what gets measured at the
4 individual level. There's a lot of crossover
5 there.

6 Safety is considered. And then
7 availability of services is evaluated,
8 monitored. There may be too many services in
9 the community or there may not be enough
10 services in the community. Quality of service
11 is evaluated. The patient has a way to
12 communicate how it is working for them as part
13 of their experience of care.

14 Please feel free, as part of the
15 meeting or in any other way, to respond to
16 this. I think it will come out, this sketch
17 will come out much more clearly in the
18 overview document.

19 So I want next just to review the
20 agenda and go over what we're supposed to
21 accomplish today. And I don't quite have it
22 memorized, but you're doing fine. We'll take

1 a technical moment here.

2 So at 9:15, we've got Health IT's
3 Role in Supporting a Paradigm Shift. And that
4 will be pretty exciting conversation with Kate
5 Goodrich.

6 At 11:45, we'll have public
7 comment, lunch at 11:50, 12:30 a Final Measure
8 Gap Prioritization Exercise, at 1:30 a round
9 robin discussion of Themes and Recommendations
10 and at 2:15 a final opportunity for public
11 comment, wrap-up at 2:30 so we can run to
12 those airplanes.

13 We will, before we close, go
14 around to each individual in the room for your
15 final thoughts and comments. And so please be
16 prepared for that. Thank you. And Sarah?

17 MS. LASH: Great. Good morning,
18 everyone. You have, at your place, an updated
19 document showing the domains and sub-domains
20 of measurement based on yesterday's
21 conversation. And I'll just sort of highlight
22 some of the major changes that we made based

1 on what we heard from you.

2 First is we've re-titled the first
3 column to be a joint creation of the person-
4 centered plan of care, because of the
5 discussion that multiple people need to be
6 involved in this creation, including the care
7 recipient and their family.

8 Under comprehensive assessment,
9 we've added sub-domains to or modified some of
10 the existing related to, at the bottom,
11 estimating risk level and customizing the care
12 coordination approach appropriately and then
13 this idea of continuous, holistic monitoring
14 that the assessment is ongoing.

15 Under goal setting, bullets now
16 saying that we will prioritize appropriate and
17 guideline driven interventions to improve
18 health outcomes. And the plan of care will be
19 updated regularly.

20 Going to the center column, re-
21 titled the first domain area, so instead of
22 availability of services it's about the

1 quality of those community services.

2 And then we've merged what used to
3 be the relationships and the communications
4 domains into something more around linkages or
5 synchronization. Because the point of having
6 relationships was to facilitate the
7 communication. So there is a sub-domain about
8 bidirectional communication to make that
9 connection happen.

10 Under experience, we rearranged
11 and condensed here to reflect that everyone is
12 a part of the care team, the care recipient,
13 the family, primary care providers and the
14 community service providers. And we're most
15 interested in their experience of care
16 coordination, not their general satisfaction
17 with outcomes.

18 Going down, we had intended to
19 make an update, and we will, to retitle goal
20 attainment to progression towards goals. So
21 you don't have to fully satisfy the goals to
22 be moving in the right direction.

1 And sub-domains there, looking for
2 maximized health and functional status rather
3 than necessarily improved, that patient safety
4 is ensured, and we would also look for
5 outcomes related to an increased level of care
6 recipient or family activation. Finally,
7 under efficiency, a new sub-domain for
8 reducing the total cost of care.

9 I also want to note that HIT is
10 probably present in every domain, and we'll be
11 capturing that as something very foundational
12 to achieving measurements throughout the care
13 coordination system and just generally
14 emphasizing over and over that the care plan
15 is shared, it's longitudinal, it's fluid and
16 it's person-centered.

17 So with that, I promised that we
18 would go back to the care coordination
19 definition. I want to avoid wordsmithing this
20 morning in the interest of time.

21 So I think that for now our
22 suggested edit is that we would replace the

1 word organization with integration. But that
 2 probably encapsulates most of our current
 3 thinking when taken together with the domains,
 4 sub-domains and other explanatory language
 5 with the conceptual framework. Richard?

6 DR. BIRKEL: Just a point. I
 7 mean, one of the things that I see in this
 8 that changed from what we did yesterday is the
 9 improved health outcomes. We now have
 10 activation, safety, functional status. That
 11 likely is going to have to change.

12 MS. LASH: Okay. So it's
 13 additional outcomes that we're interested in,
 14 getting the health --

15 (Off microphone discussion)

16 DR. BIRKEL: It's to achieve
 17 person-centered goals, as documented in the
 18 care plan. But the point is that improved
 19 health outcomes won't capture the discussion.

20 MS. LASH: It's too narrow? Okay.
 21 Gerri?

22 DR. LAMB: I'm not sure where it

1 sits, but something about the whole idea of it
2 being mutual and joint, something about co-
3 construction, so that it's not just, you know,
4 and again not wordsmithing, but it's not just
5 deliberate. There's a mutual process going
6 on. I think that's a core theme from
7 yesterday.

8 MS. LASH: Thank you. Fred?
9 Microphone? Thank you.

10 DR. RACHMAN: So I like this a
11 lot. I wondered did you consider keeping the
12 old concept, you know, maybe even like putting
13 the word design or something in there,
14 organization or design, something like that?

15 Because it's not only integration,
16 there was something about how it's organized
17 and how it's designed that maybe we don't want
18 to lose.

19 MS. LASH: Okay.

20 DR. RACHMAN: And then just a
21 question, we talked yesterday in efficiency
22 about cost from the patient standpoint and

1 resources from the patient. I personally
2 would love to see that sort of called out.

3 MS. LASH: All right. We'll do
4 some further refinement and send this back
5 around. Woody, did you have something?

6 (Off microphone discussion)

7 MS. LASH: Okay. All right. I
8 think with that you're probably ready to hear
9 from Sam and then start this morning's
10 presentation.

11 MS. MEKLIR: Good morning. Just a
12 quick minute. I just want to, again, thank
13 Susan and Mark, the co-chairs, and Don and
14 Gerri for sharing all of your expertise and
15 really helping us build off of all the years
16 that you and your colleagues have invested on
17 this topic, and then Sarah and Lauralei and
18 the folks here at NQF.

19 And I just want to reassure you
20 that I've already gotten a lot of emails from
21 folks. And there'll be a whole lot of follow-
22 up across the department with people that are

1 tracking this and interested.

2 And you don't hear us talk a lot,
3 because this really isn't about us talking,
4 it's really about you talking and informing
5 us.

6 So I just wanted, again, to thank
7 you for that. And we will have some more HHS
8 voices today. But again, I just want to thank
9 the colleagues who have been contacting me and
10 listening in and for all of their
11 contributions as well.

12 So just quickly, you don't have a
13 working assignment over lunch today, so I just
14 want to ask that you do for a minute.

15 A critical part of this report
16 will be the recommendations to HHS. And we're
17 going to kind of debrief at the end of the day
18 and go around. And you'll be able to kind of
19 provide your final comments, thoughts.

20 I'd really encourage you to think
21 about, before you break off for lunch, just on
22 your own, take a minute, sit down, jot down

1 your short term recommendations to HHS, your
2 longer term recommendations.

3 There's no like time period for
4 short term/long term. I think it's kind of
5 balancing the practical with the aspirational.
6 But, you know, you can kind of think of these
7 as some of them could be low hanging fruit,
8 very specific targeted recommendations for a
9 specific program.

10 I know, Russ, you had some
11 thoughts on things that, you know, Meaningful
12 Use Stage 3. You had some thoughts on, gee,
13 it could be great if we had a FACA on the care
14 team. And those are very specific
15 recommendations.

16 So I just want to encourage you.
17 You can be broad, you can be specific, you can
18 be targeted. But really just kind of think
19 short term/long term and get that down.

20 And then, when we go around, that
21 will really help Sarah when she has to kind of
22 synthesize all this and write that

1 recommendation part of this report. Because
2 it really is a critical piece, since, you
3 know, we're not voting on explicit measures,
4 per se. So again, I just encourage you to do
5 that.

6 And then I just want to thank Russ
7 and Fred for leading us through a rich HIT
8 discussion this morning. We packed a lot in.
9 I'm sure it's a challenge for both of you to
10 just spend, you know, you're probably used to
11 spending a whole lot time on these topics so
12 very much looking forward to it. I know I
13 will learn a lot and thank you. That's it.
14 So thanks.

15 DR. REDDING: So I want to
16 introduce Kate Goodrich and also mention that
17 Russell, Russ, will also be following that
18 with another complimentary presentation. It's
19 and exciting morning.

20 And with Kate, Kate Goodrich is
21 the Director of Quality Measurement in the
22 Health Assessment Group Center for Clinical

1 Standards and Quality at CMS. And, Kate, I'd
2 like to turn it over to you. Where is she?
3 Oh, you're on the phone.

4 DR. GOODRICH: Kate is on the
5 phone.

6 DR. REDDING: That's great.

7 DR. GOODRICH: Can you hear me?

8 DR. REDDING: We can hear you
9 well.

10 DR. GOODRICH: Okay, great. Thank
11 you. And I apologize for not being able to be
12 there in person today. But I am very happy to
13 be able to sort of give you all the context
14 under which this work is happening.

15 This work, like all the work that
16 the National Quality Forum does, is really
17 part of our ongoing partnership with NQF, and
18 by extension all of you, to advance our shared
19 work in what is truly a critically important
20 area and an area in which I think we really
21 feel we need guidance from multiple
22 stakeholders to help us figure out how to do

1 this right.

2 So I'm going to be talking just
3 for a few minutes, starting off talking about
4 our recently released CMS Quality Strategy.
5 And then I'm going to focus a little more on
6 the third goal of our quality strategy which
7 is to promote effective communication and care
8 coordination.

9 And then I'm going to touch on our
10 ongoing efforts on measure development for
11 care coordination. I'll touch a little bit on
12 the Health IT aspect of that.

13 So I want to start off by talking
14 a little bit about the relationship between
15 the National Quality Strategy and the CMS
16 Quality Strategy.

17 You know, the National Quality
18 Strategy really afforded for us to finally
19 sort of have a framework for measure
20 development. The quality strategy, of course,
21 is about all things quality, quality
22 improvement, but it really gave us a very nice

1 framework for measure development.

2 And the National Quality Strategy,
3 a large group of us here at CMS across the
4 entire organization, not just within the
5 Center for Clinical Standards and Quality, we
6 sort of organized to put together a CMS
7 Quality Strategy that really builds off of the
8 framework of the National Quality Strategy.

9 So the CMS Quality Strategy has
10 six goals which really map to the six
11 priorities of the National Quality Strategy,
12 of which communication and care coordination
13 is one.

14 And we have defined very clear
15 objectives underneath each goal, as well as
16 sort of drilling down even further specific
17 initiatives, and then drilling down further
18 than that very, very specific activities that
19 we either are or will be undertaking at CMS.

20 We also see the CMS Quality
21 Strategy though not just as a strategy for
22 what we internally here at CMS need to be

1 doing but what our hopes and expectations are
2 for front line providers to be doing to
3 promote the six goals of the CMS and National
4 Quality Strategy. Because they really are
5 essentially the same.

6 So the goals for the CMS Quality
7 Strategy include improvement, making care
8 safer, improving patient and family
9 engagement, promotion of effective
10 communication and care coordination, effective
11 clinical care and prevention, affordable care
12 and population health. So those should all be
13 very, very familiar to you.

14 So I want to drill down a little
15 bit into the third goal, which is promotion of
16 effective communication and care coordination.
17 Oh, I'm sorry. And before I do that actually,
18 there is one other thing I want to highlight
19 that we did with the quality strategy.

20 As we were developing it, one of
21 the things that we realized, there were
22 certain topics that kept coming up that we

1 couldn't really figure out where they fit, but
2 we knew they were so important.

3 And we ended up deciding that
4 these would really be our foundational
5 principles, because they really cut across all
6 of the different goals of the quality
7 strategy.

8 So those include elimination of
9 health disparities, strengthening of
10 infrastructure and data systems, and this is
11 not only strengthening of CMS' own internal
12 data systems, but really to strengthen the
13 Health IT infrastructure across the country
14 enabling local innovations.

15 Because we do understand that all
16 healthcare truly is local. And while CMS can
17 certainly help create the environment and set
18 the context for improvement, that true
19 improvement really happens at the local level.

20 And we should be using our various
21 levers to incentivize innovation at the local
22 level to improve and then finally fostering

1 learning organizations.

2 Those of you who have been paying
3 attention to our QIO work, as well as the work
4 that comes out of the Innovation Center around
5 quality improvement, have seen that one of the
6 elements of all of those efforts is the
7 development of learning and diffusion networks
8 or learning and action networks so that all
9 teach and all learn, that's really been sort
10 of our mantra for that.

11 So drilling down into the third
12 goal, which is effective communication and
13 care coordination, we had a number of
14 objectives under that goal. And so we have
15 four. And I'll just read them out to you.

16 They include reducing admissions
17 and re-admissions, because we see excessive
18 re-admissions and admissions as, at least in
19 part, a reflection of poor care coordination.
20 Of course, those relate to safety and other
21 domains as well. But certainly we think that
22 they are a reflection of care coordination.

1 Embedding best practices to manage
2 transitions to all practice settings is our
3 second objective, enabling effective
4 healthcare system navigation and then finally
5 promotion of electronic exchange of
6 information.

7 So we think that developing the
8 right kinds of measures will help us to meet
9 these objectives, help the Nation to meet
10 these objectives, understanding that quality
11 measurement is by no means the only lever to
12 meet those objectives. But it certainly is an
13 important one which again is why we're all
14 here today.

15 And so we think that we do need
16 help in thinking through what the best
17 concepts are for care coordination, for
18 quality measure development.

19 And we started doing some of that
20 thinking a while ago through a task force we
21 have here at CMS that some of you may be
22 familiar with called the Quality Measure Task

1 Force.

2 And since we were using the
3 National Quality Strategy as our framework for
4 measure development to help us better organize
5 our thinking and to organize how we prioritize
6 measure development, we undertook an effort to
7 identify sub-domains of each of the domains of
8 the National Quality Strategy.

9 And I know that's some of the work
10 that you all have been doing yesterday and
11 continued today. So what we sort of came up
12 with is by no means set in stone. And we
13 anticipate learning from the work that you all
14 are doing to help further evolve our thinking
15 around care coordination measure development.

16 So we thought about care
17 coordination measure sub-domains. And we
18 thought of three, we developed three sub-
19 domains.

20 First would be person and family
21 activation, so these are measures of patient
22 activation and behaviors of individuals and

1 their families that lead to them obtaining the
2 greatest benefit possible from the health and
3 community services available to them, so
4 shared decision making type measures, care
5 giver engagement. Patient trust and health
6 literacy sort of fall under that sub-domain.

7 We also thought about care
8 coordination measures as being sort of
9 infrastructure and processes for care
10 coordination, so use of electronic health
11 records, personal health records, HIEs, case
12 management services, that sort of thing.

13 So those types of measures can
14 sometimes be structural in type but can also
15 be measures that reflect social and community
16 resources and support and care coordination
17 service availability and access.

18 And then finally, we thought of
19 care coordination in terms of the impact of
20 care coordination, good or bad care
21 coordination. So these would be measures and
22 outcomes that primarily reflect successful

1 care coordination.

2 And of course, we've always put
3 our re-admission measures into this bucket,
4 also avoidable admissions for ambulatory care
5 sensitive conditions or from post-acute care
6 facilities, ED visits. Service duplication,
7 for example, might fall under that category.

8 So this sort of reflects our
9 initial thinking over the last, you know, year
10 or two about care coordination, but it
11 definitely is an area that needs further
12 development and to have, I think, more detail
13 around it to help us understand what the next
14 phase of care coordination measure development
15 should be for us.

16 So in terms of measures that
17 directly address care coordination that we
18 have now, they are ones that you are probably
19 very familiar with.

20 A lot of them do tend to be sort
21 of check box type measures, because I think
22 that's just where we have been with measure

1 development in this area. So for example,
2 some of the medication reconciliation measures
3 are really check box measures.

4 One measure that our partners at
5 the Office of the National Coordinator have
6 been developing, and we've obviously been
7 collaborating very closely with them on this,
8 is a measure called Closing the Referral Loop.

9 And this is a measure that
10 continues to be an evolution. We are using it
11 for Stage 2 of Meaningful Use. But it is a
12 measure that we are continuing to evolve so
13 that it can really leverage the capabilities
14 of truly interoperable EHRs.

15 And, you know, currently it really
16 is more in sort of a check box type form. But
17 we wanted to get it out there, but recognizing
18 that for it really to be a meaningful measure,
19 an actionable measure, that it needs to be
20 advanced as the technology and
21 interoperability advances.

22 So our future plans for measure

1 development and program use, many of you know
2 that we have really be focusing our measure
3 development in terms of the data type. We are
4 really focused on eMeasures.

5 We still think that there is a
6 role for claims based measures, particularly
7 the measure outcomes of care where outcomes
8 really can't, there's not a data source for
9 outcomes other than claims. But we certainly
10 do want to evolve to mostly electronic
11 measures over time.

12 We also are exploring the
13 feasibility of what we are calling hybrid
14 measures which are a hybrid of claims and
15 electronic health record data elements,
16 particularly to be used for risk adjustment
17 for measures.

18 So that's very exciting. We are
19 in the process of testing that concept
20 currently. But there's nothing out there in
21 use yet.

22 But our goal over time for all of

1 our programs is really to use electronic
2 measures, survey-based measures like the CAHPS
3 family of measures, claims-based measures
4 where appropriate and certainly, for the
5 hospital and post-acute care setting, the NHSN
6 measures as well.

7 But those are generally the data
8 sources that we prefer for our programs and
9 really, I think, are transitioning to for most
10 of our programs.

11 So I do think that our future
12 development for electronic measures in the
13 care coordination area is going to be greatly
14 informed by the work that you all do. And we
15 will be following along, and looking at your
16 report and probably reaching out to people
17 with great interest over the coming weeks.

18 We are at a point right now in our
19 measure development cycle where we anticipate
20 starting a lot of new measure development in
21 2015. So this timing could not be better for
22 us.

1 And again, I think we not only
2 would welcome your input and expertise on
3 specific concepts, in addition to a framework
4 for care coordination measures, but also to
5 help us think about ways through the
6 Meaningful Use program that we could leverage
7 these sort of functional measures within that
8 program to better enable care coordination and
9 smoothing care transitions and so forth.

10 So not necessarily just in the
11 quality measure realm, although I think that
12 is, you know, what we're mostly interested in,
13 but really to also help us think about how we
14 can design or develop policies to enable more
15 seamless care transitions and care
16 coordination through use of electronic health
17 records.

18 And this is obviously work that
19 the HIT policy committee is also doing. But
20 we would welcome any input that you all would
21 have in that realm as well. And so I will
22 stop there and see if you all have any

1 questions for me.

2 DR. REDDING: Kate, thank you very
3 much. Are there any questions? Don?

4 DR. CASEY: Kate, Don Casey, co-
5 chair with Gerri Lamb of the measures steering
6 committee that's just wrapping up. Thank you
7 for the overview.

8 And I think it's, in my mind, very
9 congruent with our discussions. And we've
10 obviously tried to reflect on the work that
11 you're doing at CMS in terms of being sure
12 we're lined up together at a point in time.

13 I do think, having been at this
14 for a while, that sometimes I get a little bit
15 concerned about some of the terms we use. And
16 I wanted to ask you sort of two levels of
17 questions.

18 First, you know, with respect to
19 using terms like health IT, some people think
20 that encompasses a whole lot more than it
21 actually is. I view it, really, pretty much,
22 no offense to anyone in the health IT

1 industry, as electronic tools, hardware,
2 software, that helps enable better
3 communication, better more rapid achievement
4 of transactions, as I'll call them, et cetera,
5 et cetera.

6 But I don't view, for example, the
7 data management side of things as much in the
8 IT realm, i.e. having data standards, having
9 database design that is more functionally
10 correct. I mean, you could argue that point,
11 but I think that I struggle a little bit with
12 that.

13 And then the third part is what we
14 do with the data. And I don't think that has
15 anything to do with IT. I think it really is
16 ultimately creating enough information for
17 really smart people who are more, and I hate
18 this word, analytical, to actually get data
19 that they can actually do something with.

20 So I'm just trying to call out the
21 need for us to maybe look at some of these
22 terms we're using and be a little more second

1 decade, 21st century about them. Because I
2 think that sometimes we just get wrapped up in
3 these things, like it's all under IT. So
4 that's my pet peeve.

5 The second is if you could give us
6 sort of a back of the envelope on the
7 framework for evaluating this plan and sort of
8 a time line in terms of what would success
9 look like, for example, in the next two years
10 if we were to take this and move it from where
11 it is.

12 DR. REDDING: Thank you, Don.

13 DR. GOODRICH: Thank you, Don. So
14 on your first point, quickly, I would agree
15 with you. We do. And I certainly don't see
16 health IT as an all encompassing term.

17 And I think it does make sense to
18 sort of separate out the tools from the
19 analytic capacity. I think the tools enable
20 the analytic capacity. But you're right, I
21 think they are separate things.

22 Now, when you say evaluate this

1 plan, I just want to be sure I understand what
2 you're asking. What do you mean by this plan?
3 Do you mean the report that's coming out of
4 this committee or something different? I just
5 want to be sure I understand.

6 DR. CASEY: I was speaking
7 specifically of what you just presented in
8 terms of what you're going to be doing over
9 the next few months. And maybe two years is
10 not a correct time frame.

11 I'm just trying to get at, knowing
12 that you're gathering more information,
13 getting input obviously from ths group in
14 terms of how do you envision the puck moving,
15 for example, in a time frame. I just made up
16 the two years. But I just want to get a sense
17 of how rapidly we want to move on this and
18 evaluate the impact too.

19 DR. GOODRICH: Yes. Well, I think
20 in terms of both measurement and even at a
21 higher altitude, the care coordination sort of
22 objective or goal of the CMS Quality Strategy

1 and the National Quality Strategy, you know,
2 I think we have generally been of the mindset
3 that, for right or wrong, that we would really
4 like to see this work accelerated so that we
5 can, you know, get to improvement faster but
6 in a leaner kind of fashion.

7 So many of you know that we have
8 been bringing, over the last year and a half
9 or so, lean thinking and lean processing to
10 our work here within my group.

11 And so we started to think about
12 things like this in terms of what is our ideal
13 state, whenever you achieve that, the ideal
14 state without necessarily a time line attached
15 to it?

16 And then what is our next future
17 state? In our next future state, we do try to
18 attach a time line to it if we can, typically
19 thinking in terms of, depending on the scope
20 of it, in terms of a year versus six months or
21 whatever.

22 And so I think, for our ideal

1 state we want, as I think, and you all can
2 tell me if this is right or wrong, that for
3 quality measurement in this realm and in other
4 realms to essentially be a part of the natural
5 work flow and something that providers,
6 whoever they may be, hospitals, clinicians,
7 whatever, to not even be something that they
8 have to think about.

9 It would be just something that is
10 part of the natural work flow, that is enabled
11 by technology and that there is, you know,
12 seamless communication across providers, and
13 not just across providers but with patients
14 and their care givers across the continuum,
15 and not to be thinking about care so much
16 within the silos that it exists now but
17 thinking really the broader system level of
18 care.

19 And I think this is what has been
20 articulated, you know. Again, I know that's
21 very high altitude, but that's what's been
22 articulated by a number of folks who have

1 working in this space for a long time. And I
2 think it's really no different for us.

3 I think, you know, we have a long
4 way, and a lot of steps and some really smart
5 thinking that needs to happen to get there.
6 And we think that Stage 3 of Meaningful Use
7 will be a next important step to really get
8 there. But it's not going to be, you know,
9 it's not going to be the ultimate step. It's
10 not going to be our ideal state yet.

11 So I think we are hoping for Stage
12 3 -- and we sort of think about it in terms of
13 the stages just because there is a time line
14 attached to that, so that makes it a little
15 bit easier to think about -- that we hope to
16 be able to get to a place where we have more
17 interoperability and that we have measures
18 that are developed really in a de novo
19 fashion.

20 And that's what we've been doing
21 lately, is really working just on de novo
22 measures with the input of electronic health

1 record vendors, from patients and from
2 providers, in order to enable getting towards
3 that ideal state of having it be just part of
4 the natural work flow and not something that
5 people have to take 27 extra steps to extract
6 the data from the EHR to put together the
7 quality measure, whatever it might be.

8 And so I think that is maybe a
9 little bit aspirational, but I think it's
10 actually doable. But that involves a lot of
11 work from you guys, from us and ONC to make
12 sure that we do have the right standards in
13 place, that we are doing this in a
14 collaborative fashion with the people who are
15 actually doing the work.

16 So that's probably a higher
17 altitude than you wanted, but generally we
18 think that we can at least take a pretty major
19 step to getting to that ideal state over the
20 next two to three years.

21 DR. REDDING: Thank you. That's a
22 very reassuring goal. I've got another

1 question from Sharon.

2 MS. MCCAULEY: Good morning, Kate,
3 Sharon McCauley from the Academy of Nutrition
4 and Dietetics. And I was wondering if you
5 could just glean out a little bit more about
6 the program that you mentioned about all teach
7 and all learn and how you see that panning out
8 working with all the community providers.

9 DR. GOODRICH: So that, in and of
10 itself, is not a particular program. But it
11 is, those are tasks that we have embedded into
12 a lot of the improvement work that is going on
13 in the agency.

14 So this is not directly in my
15 realm of work, but our partners here at CMS,
16 through the quality improvement group and the
17 Center for Medicare and Medicaid Innovation,
18 through their improvement activities, so for
19 example the Partnership for Patients, you're
20 probably familiar with the Million Hearts.

21 But also a lot of the, in fact all
22 of the payment models that are out there

1 through the Innovation Center have a component
2 embedded within them for what I'll call
3 learning and action networks which is
4 basically the development of networks for
5 those basically who are already high
6 performers in a particular area.

7 So let's just take Partnership for
8 Patients, for example, for experts in reducing
9 of re-admissions, and reducing of hospital
10 acquired conditions and hospitals who have
11 achieved very low rates of HACs or of re-
12 admissions, to be able to spread that
13 knowledge for what works to other
14 organizations, other hospitals, that maybe
15 have had a harder time, have struggled more
16 with reducing their re-admissions and sort of
17 developing a real and a virtual community.

18 And it's not one single community,
19 it's multiple communities, for providers to be
20 able to learn from one another for what works.
21 So that is also something that is built in, as
22 I said, not only for something like

1 Partnership for Patients which is a true
2 improvement project.

3 And actually, NQF has done a lot
4 of work with us to convene the National
5 Priorities Partnership and other providers as
6 sort of part of that learning network.

7 They've been very instrumental in
8 helping us to do that. And so that is the kind
9 of thing that we're embedding into all of our
10 improvement work, certainly for the 11th
11 statement of work for the QIOs that's going to
12 be coming up later in the year.

13 That is a major part of that
14 statement of work, is to embed those types of
15 activities into all the QIO work. And the
16 same, again, goes for the Innovation Center
17 work.

18 MS. MCCAULEY: Okay, thank you
19 very much. That's a good way for us to
20 springboard off best practices --

21 DR. GOODRICH: Yes.

22 MS. MCCAULEY: -- into care

1 coordination, into this group. Thank you.

2 DR. GOODRICH: Great.

3 DR. REDDING: And Gerri Lamb?

4 DR. LAMB: Hi, Kate. This is
5 Gerri Lamb. I've co-chaired the three
6 measurement committees at NQF on care
7 coordination with Don Casey.

8 And I was wondering if you could
9 talk a little bit about any priorities in
10 moving from the big picture that you're
11 describing to the next two to three years.

12 You know, a reflection on where
13 we've been when I look at the three sub-
14 domains that you identified, we've done some
15 work on outcomes. Most of the measures we've
16 reviewed are structural, some outcomes.

17 But as we've talked about
18 yesterday, there's not as much in patient
19 family activation, certainly not in the kinds
20 of processes that you were talking about, like
21 closing the loop.

22 Any ideas about where the

1 priorities are going to be for measure
2 development over the next two to three years?

3 DR. GOODRICH: Yes. I couldn't
4 agree with you more. I think that where we do
5 have our measures for care coordination are in
6 the two domains or sub-domains that you
7 identified.

8 So when you started off your
9 question, I immediately went to the person and
10 family activation side. And I think one of
11 the reasons we don't have measures, or very
12 many anyway or very robust ones in that area,
13 is because they're harder to do.

14 So I think that that is an area
15 that I would love to have more input from you
16 all and advice on very specifically what would
17 be important measure concepts in that area.

18 Because I do think that the
19 patient perspective or the care giver
20 perspective on care coordination is critical.
21 I'd like to think about how we embed that into
22 our measures.

1 One of the things that has become
2 a priority for us in our day-to-day work is
3 ensuring that the patient voice is a part of
4 our measure development in a very specific and
5 very important way.

6 So one of the things that we've
7 done is require that patients are part, that
8 our measure developers, our contractors,
9 actually have patients involved in the measure
10 development.

11 We're thinking about the best ways
12 to do that, but we think it's really
13 important. And so I think for something like
14 this that that would be absolutely critical.
15 I think it's critical for all measures, but
16 it's particularly critical here.

17 And so I think that's an area of
18 measure development that needs growth, that
19 needs study. But that, I think, is where we
20 would really value your input specifically.

21 I think the outcomes of care
22 coordination are easier to do. We've done a

1 lot of it. It's not that we don't think that
2 that continues to be important, and we need to
3 continue to have measures in that area. But
4 I think the person and family activation and
5 how you can think about embedding that within
6 EHRs or PHRs would be very, very welcome
7 input.

8 DR. REDDING: Thank you. I think
9 the closing the loop measures progress. And
10 we won't give you the details now, but there
11 was definitely some work that would fit in
12 that area.

13 And two other closing questions,
14 some of the thought that has come through this
15 meeting and has been out there is that care
16 coordination is done in a team, and then the
17 team's constructed on the patient's needs.
18 And then their needs are considered beyond
19 medical, so social, behavioral health and
20 others.

21 And sometimes the care
22 coordination team, based on a medical

1 provider's capacity and based on the community
2 resources, it may not be centered in a
3 physician's office.

4 Most of that work might come out
5 of a behavioral health center. It might come
6 out of a social service program. Obviously
7 the information should be very well connected
8 to the primary care provider and the primary
9 care provider a part of the team.

10 I just wanted to check in with you
11 on that concept as, I think, a lot of states
12 are focusing it all to physician offices,
13 which some of us have an environment that
14 would support that and some of us are very
15 medically oriented.

16 DR. GOODRICH: Yes. I think
17 that's right. I mean, you know, one of the
18 challenges, I think, that we face is that our
19 measurement programs, you know, they're all
20 authorized by Congress through one law or
21 another, are rather siloed programs in the way
22 that they are stood up.

1 So they're authorized by setting
2 of care. And so that makes it more
3 challenging to think about how we enact
4 policies and measures that can actually
5 improve health of a population, understanding
6 that health of a population is not just
7 dependent upon medical care. It's also
8 dependent upon the things that you are talking
9 about.

10 So, you know, we sort of struggle
11 with this a lot, is how do we actually,
12 through not just our measurement programs but
13 our improvement programs as well, try to get
14 at that aspect of health.

15 And again, very difficult to do
16 under sort of your traditional Medicare fee-
17 for-service measurement program construct.

18 So one of the things that we have
19 thought about -- and I'd love to hear, you
20 know, have you all weigh in on this if you
21 have time and would like to -- is through, for
22 example, our clinician level programs like

1 PQRS, and value modifier and that sort of
2 thing, thinking about how we can have measures
3 of a community's health.

4 And I say that just very broadly,
5 so population health level measures which may
6 embed measures related to community supports
7 and environmental determinants and so forth.

8 How can we measure a community's
9 health and have part of a physician or group
10 practice's performance score be about the
11 health of that community that they're in.
12 Because I think it's hard to argue that
13 physicians and other clinicians don't have
14 some contribution to the health of their
15 community.

16 So if you think about it in terms
17 of, like just to get a little bit more
18 concrete, to let you know sort of how we're
19 thinking about this -- and by the way, we're
20 not sure how to do it, so again, this is where
21 your help would be wonderful -- if you had a
22 total performance score for, let's say, a

1 physician or a physician group that, you know,
2 I'm just throwing out numbers here, but 40
3 percent of that score is at the individual
4 clinician level, and another 40 percent of
5 that score is the group practice score on
6 quality measures.

7 And in the last, you know,
8 somewhere between, let's say, 15 and 20
9 percent of their total performance score is a
10 score of the health of the community that they
11 serve.

12 So that is one way that we're
13 thinking about, you know, trying to
14 incorporate some of the concepts that you're
15 talking about. But, you know, I'd love to
16 have feedback from you all on how that sounds.

17 DR. REDDING: Gerri Lamb?

18 DR. LAMB: Kate, just to follow
19 that up, I find it really interesting in terms
20 of program authorization kind of driving the
21 models. And it's really interesting to think
22 about what new models might be to match the

1 dialogues we've been having here.

2 I'm very aware that, you know, as
3 Mark was saying and in your language, it was
4 more the primary care physician kind of
5 practice where we have a lot of evolving
6 practices with a lot of community
7 practitioners, including the huge growth in
8 community lay workers, and how they really get
9 involved in those models and how these
10 programs will address their role in the
11 healthcare system.

12 So I really appreciate the
13 invitation to think about those models,
14 because what I hear and what I see out in
15 practice aren't necessarily matching right
16 now.

17 DR. GOODRICH: Yes. That makes
18 sense.

19 DR. REDDING: And just a quick
20 sketch of a little bit of the detail we got
21 into yesterday is the patient gets a
22 comprehensive assessment.

1 Their needs are identified. Then
2 let's say their primary needs are housing,
3 behavioral health and adult education, for
4 example. They need a primary care doctor.

5 Those are all social needs, but I
6 think this recent JAMA article, or many of
7 them are social needs, this JAMA article's
8 saying ten percent of a person's health is
9 related to healthcare.

10 I think it gives us all a wake up
11 call that we need to have a community system
12 of care that can pay attention to those needs
13 first, before they land in an ambulance with
14 some health related outcome that comes from
15 that. Your points are very well taken. We're
16 really excited you're thinking about that.

17 One final question is we've got
18 some pediatricians and child focus people in
19 the group. And there was a call for a way to
20 identify risk factors in infants and children
21 well before, potentially years before they
22 land in the back of an ambulance and intervene

1 on those risk factors, such as obesity
2 prevention, evidence-based parenting, improve
3 educational outcomes which are connected to
4 economic outcomes, which are connected to
5 health, and other key factors where we have
6 evidence-based interventions that can address
7 identified early upstream risk factors.

8 You don't have to go into detail
9 in this, and we appreciate your dialogue.

10 DR. GOODRICH: I apologize. Was
11 there a question in there? I'm sorry.

12 DR. REDDING: Is there, we hear
13 you, we hear the focus on reduced admissions
14 --

15 DR. GOODRICH: Yes.

16 DR. REDDING: -- and reduced
17 hospitalization. The way to have the biggest
18 impact on this may be to go a little further
19 upstream.

20 DR. GOODRICH: Yes.

21 DR. REDDING: So if you had a
22 couple of words to say about that. And then

1 I think that's our final question and thank
2 you.

3 DR. GOODRICH: Sure, yes. So it's
4 interesting you say that. We actually, from
5 a measurement construct and, you know, in the
6 Medicare program it's obviously not something
7 we have spent a lot of time focusing on
8 traditionally.

9 However, I will say that one of
10 the really exciting things about being here is
11 that I get to work with my Medicaid colleagues
12 and my marketplace colleagues on a regular
13 basis so that we can really sort of get away
14 from thinking just in these sort of
15 Medicare/Medicaid, you know, and somewhere in
16 the middle now, the marketplace silos of
17 measurement, but really think about how we are
18 measuring care sort of across the life span
19 for all of the work that we're doing.

20 So it is something that, even
21 within the Medicare programs, we are starting
22 to think about. We actually do have some

1 measures that are within the PQRS program,
2 believe it or not, that get at some of those
3 types of concepts of identifying risk factors
4 early, early in life.

5 And many of those are ones that
6 our Medicaid colleagues have helped us to
7 promote having in there. So I do think that
8 there is starting to be a different way of
9 thinking about how we measure populations and
10 not just thinking about it in such a, you
11 know, sort of insurance, if you will, silo as
12 we have traditionally done.

13 So those conversations are
14 actually starting to happen, I think in part
15 because we have leadership here that, you
16 know, cares about that, and sees that as a
17 priority and that part of our responsibility
18 is really not just for traditional Medicare
19 beneficiaries but for the population as a
20 whole.

21 And, you know, a number of our
22 programs are actually all payer programs, even

1 though they're authorized under a statute for
2 CMS, for the Medicare programs.

3 We also have authority to collect
4 all payer data which is, you know, partly why
5 we've really started to think about it more
6 broadly and not just the 65 and older
7 population who already have all of these
8 chronic diseases and maybe haven't always
9 gotten the best preventive care throughout
10 their life and identification of risk factors.

11 So I love that you're thinking
12 that way. I think we are starting to think
13 that way as well. So we'd welcome anything in
14 your report that sort of advances that for us
15 going forward.

16 DR. REDDING: Tremendous. Well,
17 the transformation that's in progress is, it's
18 wonderful to get to be part of it. And thank
19 you so much for joining us today.

20 Is Erin Grace also on the phone
21 from HRQ?

22 MS. GRACE: Hi. Yes, I am. And I

1 have been listening with great interest
2 yesterday and again this morning. And, Kate,
3 I appreciate the enlightenment I've received
4 today from your presentation as well.

5 And I know we're maybe a little
6 bit behind schedule, so I won't take up too
7 much of your time. But AHRQ is, as many of
8 you probably know, AHRQ's mission is to
9 provide the evidence to make healthcare safer,
10 and higher quality, more accessible, equitable
11 and affordable.

12 So our role is to create the
13 evidence and then work with HHS and other
14 partners to make sure that that evidence is
15 understood and used.

16 And so in the health IT realm, we
17 have done some work in the past, more
18 generally in how do you develop and then use
19 electronic measurements from electronic health
20 records, et cetera.

21 I'll just point folks for
22 interest, if you have interest later on, to

1 look at the AHRQ health IT website which is
2 healthit.ahrq.gov. And some of the more
3 recent projects or older projects that we did
4 is we funded about 15 grants a number of years
5 ago to look at enabling quality measurement
6 through health information technology.

7 And those projects looked at, we
8 have a summary report of those projects
9 looking at that you must have best practice to
10 implement electronic quality measurement.

11 We've also, more recently, through
12 the National Quality Strategy, have developed
13 a couple of reports, in part gathering
14 information from out in the field on what's
15 needed to enable quality measurement,
16 electronic quality measurement.

17 And then most recently, picking up
18 on some of the comments that Kate made,
19 looking forward to Meaningful Use Stage 3,
20 AHRQ has funded some grants and contracts to
21 do some sort of rapid turnaround testing of
22 some of the proposed Meaningful Use Stage 3

1 rules and criteria to sort of get a real world
2 look at how those criteria sort of play out in
3 the practice and in the hospital setting.

4 So those grants were awarded last
5 fall and they're rapid turnarounds. So I
6 think that we're supposed to be getting early
7 results out from those grants this fall.

8 And then, of course, my colleague,
9 Jan Geneviro, she may be on the phone or she
10 may be there in the room, you know, has done
11 a lot of the work with our primary care team
12 here at AHRQ and the coordination of care
13 measure work that's already begun to be looked
14 at. And so that's about all I have to add,
15 unless anyone has questions about any of that.

16 DR. REDDING: Thank you, Erin.
17 Any additional questions? Don Casey?

18 DR. CASEY: Hi, Erin, Don Casey.
19 My comments to Kate regarding these terms,
20 health IT, is kind of, in my mind, a garbage
21 term, forgive me.

22 And I think we need to get clearer

1 on the intersection of the hardware and
2 software with standardized data that's
3 structured correctly, that requires database
4 scientists to think clearly about the back end
5 of these systems which, you know, for the most
6 part in my experience don't really exist.

7 It's lovely to expect that the
8 vendors are partially interested in this but,
9 you know, without getting into my own personal
10 experience in too much detail, I've found that
11 to be pretty lacking. And it usually ends up
12 on the backs of those that buy the stuff off
13 the shelf and try to put it into place.

14 And then the third part which is
15 not at all, in my opinion, anything to do with
16 IT, and that is what we do with the
17 information, how we apply more rigorous and
18 advanced sort of data science models rather
19 than, you know, multiple regression models
20 looking at, for example, patterns of care
21 through, let's say, advanced Markov blanket
22 models and things like that that are used in

1 more sophisticated analytic worlds like
2 looking at the human genome.

3 I think the scientific part of
4 this is so far ahead of what's actually used
5 by our researchers. And I think we need to
6 take advantage of that brainiac world to help
7 us sort of merge these three things together.

8 MS. GRACE: I think that's a great
9 point. And the health IT portfolio at AHRQ
10 has been engaged in, over the past year, a
11 horizon scamming exercise where we've been
12 sort of looking at, you know, what's coming
13 down the pike in the next five to ten years so
14 we can begin to ask the questions today that
15 are going to be relevant in the next five to
16 ten years.

17 And what you mentioned about the
18 data science, and the methods and so on was a
19 recurrent theme through most of the sessions
20 that we had sort of looking down the pike.

21 So I think that's something that
22 AHRQ is definitely considering in terms of our

1 future investments in health information
2 technology research.

3 DR. REDDING: Erin, thank you so
4 much. And thank you for joining us today.
5 Are there any others from HHS on the phone
6 that would like to join the conversation?
7 We'd love to hear from you. Oh, yes?

8 (Off microphone discussion)

9 DR. REDDING: Okay, yes. You
10 know, thank you.

11 (Off microphone discussion)

12 DR. SKAPIK: And I'm Julia Skapik.
13 I'm in the Office of the Chief Medical
14 Officer, also at ONC.

15 MS. LASH: Ladies, the red light
16 means the mic's on. So I don't think anyone
17 heard you introduce yourself on the phone. So
18 can you do that again? Thanks.

19 MS. MAKAR: I'm Ellen Makar. I'm
20 a registered nurse. I work in the Office of
21 the National Coordinator, specifically in the
22 Office of Consumer eHealth.

1 DR. SKAPIK: And I'm Julia Skapik,
2 I'm an internist. And I work in the Office of
3 the Chief Medical Officer, also at ONC.

4 So we threw some slides together.
5 And I think it was really fantastic that we
6 heard from Kate and I want to call her Ellen,
7 because I'm sitting next to you.

8 MS. GRACE: Erin.

9 (Simultaneous speaking)

10 DR. SKAPIK: And I want to thank
11 Kate for all of the work that she's been doing
12 to help coordinate this work across HHS.

13 And, Kate, if you're still on the
14 phone and seeing these slides, you will notice
15 a lot of references to lean. And I think that
16 continuing lean is going to do a lot to
17 improve care coordination and healthcare
18 quality.

19 Also a thank you to AHRQ, they've
20 been supporting a lot of the quality measure
21 stuff including some of the testing through
22 the USHC website which I encourage everyone to

1 look at it. It is very fantastic and user
2 friendly.

3 So today, we're going to talk
4 about care coordination from the ONC
5 perspective. And here's -- I can't go
6 forward, next slide?

7 So this is Ellen and my's titles,
8 so we can move on. This, I think, is a
9 required plug from the ONC Office of
10 Communication, so I left it in. Go ahead, one
11 more.

12 Okay, so these are some principles
13 that ONC considers critical for coordinated
14 care, seamless transition of data through all
15 care settings and providers.

16 And I heard this morning the
17 comments that it's unclear to some people
18 whether care coordination includes both. I
19 would say, from ONC's perspective it certainly
20 does.

21 The patient's preferences and
22 goals are central. I know that everyone here

1 certainly agrees with that. And, Ellen, if
2 you have anything you want to add --

3 MS. MAKAR: I'll jump in.

4 DR. SKAPIK: -- jump in.

5 MS. MAKAR: Okay.

6 DR. SKAPIK: So one of the things
7 I considered to be part of the ideal state,
8 certainly we've struggled to get even to
9 coordination within healthcare, but I think
10 there are a lot of opportunities outside of
11 healthcare settings to do what I would
12 consider to be part of care coordination.

13 And then finally, one of the
14 things I think actually the quality measures
15 are presenting the opportunity for is that
16 every care provider and every member of the
17 team starts to develop a shared sense of
18 responsibility for making the highest level of
19 care quality come to the patient at every
20 setting.

21 So imagine how wonderful it could
22 be if you, as a primary care doc, see that the

1 INR check has been missed on your patient on
2 Coumadin and you're able to flag the
3 dermatologist to get the patient to go and get
4 their level done.

5 So I think that that's one of the
6 things that we're looking, is not that we heap
7 all of the responsibility for care
8 coordination on one provider, such as the
9 primary care physician, but that everyone
10 starts to develop that sense that, yes,
11 they're accountable. And, yes, they're going
12 to take action when it's necessary.

13 Next slide. So while there're a
14 lot of struggles here today in care
15 coordination, I'd just like to give everyone
16 a little perspective on where we come from in
17 terms of care coordination.

18 I know that we're not where we
19 need to be now, but I think we could argue
20 that we're doing better than we were. And I
21 think we know that we can do much better than
22 we are.

1 So next slide. And this is just a
2 quick overview. So you know that there are,
3 in Stage 1 and Stage 2, two major pieces of
4 the objectives, talk about care coordination
5 and transmitting information electronically
6 across patient care settings.

7 So next slide. And here I sort of
8 drilled down. I actually heard in the
9 afternoon, one of the break-outs yesterday,
10 someone referenced this list.

11 I think that while this list
12 exists, one of the things we need to recognize
13 is that this data, even if it's there, may not
14 be very useable or meaningful to providers.

15 In some cases actually having too
16 much information is harmful to providing care,
17 because, if you can't filter down to the
18 information you need, you end up putting a lot
19 of time and energy into what's really low
20 value to you and the patient.

21 Specifically, some of these pieces
22 such as the care plan fields tend to be really

1 inconsistently applied across different
2 implementations.

3 And I would argue that any
4 provider has the right to complain about how
5 difficult it is to know where this information
6 is found in different locations and different
7 EHR programs.

8 So this is part of the current
9 state of care coordination. And I know direct
10 was mentioned a number of times yesterday as
11 well.

12 You know, there are multiple
13 direct protocols. But direct is probably one
14 of the successes over ONC using the S&I
15 framework creating standardized methods of
16 creating and storing data and then
17 transferring it with a number of layers of
18 security and checks for data quality.

19 And I think this is just a
20 shoving-off point in terms of where we can go,
21 what we can do with standards.

22 In response to some of the

1 comments about health IT, I would argue that
2 standards and terminology are critically
3 important pieces of health IT and how we
4 provide care.

5 And probably it's been a
6 disservice to the care community that there
7 hasn't been enough participation of people who
8 have clinical and patient perspective on how
9 we structure data. Because if the fundamental
10 data structure and the fundamental data
11 transfer is flawed, then everything we build
12 upon that is going to have similar flaws.

13 So this is more of the current
14 state, Meaningful Use Stage 2 quality
15 measures that touch on care coordination.
16 Measure 26, on the top here, is a perfect
17 example of how we need standards to support
18 what we want to do in terms of quality care
19 and care coordination.

20 So this measure contains a number
21 of requirements for what exists in a home
22 management plan for asthma, so a list of the

1 medications, a list of the control strategy,
2 a list of the rescue strategy, the contact
3 information and the appointment plans. And
4 that was all written down nicely into a chart
5 abstracted measure.

6 What we found when we tried to
7 electronically implement this -- and I'll say
8 that one of our very smartest developers put
9 in several hundred hours trying to put this
10 into the electronic specification standards
11 as we currently have them -- and in the end
12 basically all of that information's got to be
13 pulled out the spec.

14 And the spec basically says check
15 and make sure you have all this stuff in a
16 document. So that's not, obviously, how we
17 envision this to operate.

18 And it's an example of how we
19 really need to push hard to think about the
20 way that we structure this information and to
21 make all of the layers of standards that are
22 necessary support the level of detail that we

1 need so that we can make this a reality.

2 CMS 50, Kate mentioned closing the
3 referral loop. In Stage 2 the referral loop
4 is more of a half-moon, because we only
5 require the first part of this transaction
6 between the referring provider and the
7 specialist.

8 And Stage 3, you're going to see
9 on the next slide, we intend to close that.
10 I mentioned CMS 68 was just asking people to
11 perform a complete medication list which is
12 an implied reconciliation of medications.

13 I know that this is also a source
14 of frustration for people. And we frequently
15 still don't end up with a really accurate
16 list of medications when we get through what
17 we have here in Stage 2. But I'll touch on
18 that for the future state.

19 Next slide? So these are four of
20 the measures that refer to coordinated care
21 in Stage 3. I can't promise that any of
22 these measures will make it to Stage 3,

1 although I think that they will. They're
2 proposed right now, and they're under
3 development.

4 So closing the referral loop, you
5 see the first two actually refer back to
6 Kate's comments on exchange of referrals and
7 referral information.

8 So these two measures together
9 would close that loop so that it requires
10 electronic transmission of the information
11 for the referral and then receipt of that
12 information electronically back to the
13 referring physician.

14 You also see that there are two
15 measures below looking at patients who have
16 asthma or chest pain and show up to the
17 emergency room.

18 In my personal experience, I found
19 I'm very unlikely to receive that information
20 from the care setting the patient was seen.
21 And often it happens because the patient
22 says, oh, yes, like five weeks ago I went to

1 the ER for chest pain.

2 So this measure would look to try
3 and create a loop where information comes
4 directly to the primary care physician so
5 that they can be aware of this and take
6 action to try and follow-up with the patient
7 in a really timely fashion and not at the
8 next scheduled visit when they happen to hear
9 that this care was provided.

10 So next slide. So here I just
11 want to talk about what we envision the
12 future state of care coordination to be.
13 It's not just quality measures, and it's not
14 just continuing to work on secure standards
15 for data transfer.

16 I think that everyone has noted
17 that the patient-centered plan of care is
18 critical. And patient-centered plan of care
19 involves the patient making decisions about
20 what the goals are, the patient clearly
21 defining their preferences, their preferences
22 being incorporated into that plan of care and

1 then the patient being able to see and
2 interact with their plan of care.

3 They say, oh, I remember the
4 doctor said something about my cholesterol.
5 The patient should be able to go and look at
6 that information, to even ask questions about
7 it. That would be in our ideal world.

8 Clinical decision support should
9 be able to look at patient preferences and
10 use that information to provide the physician
11 with only the sort of interventions that are
12 appropriate based on the patients goals and
13 needs.

14 Integrating all specialists and
15 providers, that's probably the near or future
16 state as opposed to integrating things like
17 behavioral health and occupational health.

18 I know this continues to be a
19 challenge. There have been some interesting
20 proposals, for example, for a measure that
21 would look at patients who work in high
22 levels of radiation exposure occupations to

1 provide the information that comes from their
2 occupational health monitoring directly back
3 to the physician so that they could, say,
4 alter their plan of screening for various
5 oncologic problems.

6 Home and remote health
7 opportunities, inside of healthcare a lot of
8 people are doing this work without our
9 participation sometimes. And I think we
10 should take this opportunity to engage the
11 people who are out there doing app
12 development, and out there doing Google
13 monitoring and try and bring that data into
14 helping the patient.

15 Next slide? So some of the pilot
16 work that we are proposing currently under
17 patient-centered care funding would be
18 educational settings.

19 So for pediatricians, I think the
20 world of what you can understand about your
21 pediatric patient is so limited compared to
22 what the school setting sees. And I think a

1 rich exchange of data would really allow
2 pediatricians and the educational providers
3 to really offer a lot more to the patient and
4 to their family.

5 So one of the proposed examples we
6 have is working with kids who have conditions
7 like ADHD or behavioral problems and trying
8 to help the psychiatrist or the primary care
9 pediatrician get information from the teacher
10 but also to transmit, potentially with
11 permission from the parents, information
12 about what the goals of care are to them so
13 they could actually participate in that plan
14 as well.

15 Insurers and payers are
16 increasingly contacting patients outside of
17 the care setting. I think if we're going to
18 talk about patient preferences, we know some
19 patients prefer to use non-traditional
20 medical settings or alternative medical
21 settings.

22 If we chose to cut them out of our

1 care coordination, then we're kind of cutting
2 out the patient and potentially missing
3 opportunities for us to make the care
4 settings richer rather than sort of
5 stratified.

6 And then, of course, Federal and
7 state agencies could increasingly participate
8 with providers to do things like allow the
9 provider to put in a referral for food
10 assistance or to bring information from FEMA
11 about disaster relief back into the medical
12 record.

13 One more slide, okay. More data
14 integration from outside healthcare settings,
15 I think I touched on this a lot. I'd like to
16 point out nutrition, and fitness and wellness
17 settings.

18 Someone had mentioned just a
19 little bit ago how we're so focused on
20 treatment of disease rather than the
21 provision, and prevention and optimizing the
22 health and wellness of the patient. So we

1 could really bring that to the patient and
2 let them be empowered by it and also let them
3 demonstrate to their provider what they're
4 doing to improve their health.

5 And, of course, personal care
6 providers and family participation care
7 givers infrequently get to have any
8 interaction with the care plan directly. And
9 we'd like to see that happen. Okay, so the
10 vision of, oh --

11 MS. MAKAR: There's only a couple
12 of things that I would add to this. And one
13 of those would be patient reported outcome
14 measures.

15 So looking from patients, what
16 they're, and caregivers, what those outcome
17 measures were, not just patient generated
18 health data. But that's certainly a part to
19 inform the learning healthcare system.

20 And two other issues, one is data
21 segmentation. So that whole area of thinking
22 about what portion of the data that, as a

1 preference, patients do not want to share,
2 along with looking at the provenance of the
3 data so that the timing is correct.

4 When you're looking at the data
5 and the order of things, especially when
6 things are changing, that you are able to see
7 which one comes first. And when I think
8 about that, I especially think about advance
9 directives as an example of that.

10 And I had one other, oh, the last
11 thing I wanted to mention is, as a RN, I
12 dealt with a lot of patients whose medical
13 issues stemmed from problems with dental
14 care. So very often we talk about medical
15 care, but we don't talk about dental care.
16 And so I would just kind of throw that in as
17 a global thing for everyone to always think
18 about.

19 DR. REDDING: Excellent.

20 DR. SKAPIK: We have one more
21 slide. So I think Ellen covered some of it
22 there. So this is, ONC's vision for care

1 coordination, a clearly defined, dynamic,
2 longitudinal care plan developed as part of
3 shared decision making.

4 I could envision a day where
5 instead of you writing the assessment, and
6 plan and every little note that you write,
7 that that information goes into the overall
8 care plan and enriches it at every step.

9 Highly usable care coordination
10 tools, a lot of the health IT tools we have
11 now are questionably usable. That's
12 definitely something that ONC wants to help
13 push forward.

14 Data management, wouldn't it be
15 fantastic if you didn't have to do the med
16 rec yourself in the computer, but the
17 computer would help you support machine
18 learning to suggest where they see
19 discrepancies and ask you to select which is
20 the correct one.

21 We just mentioned data
22 segmentation, and that's some of the work

1 that ONC has already been pushing forward,
2 automated push and pull of data to and from
3 the providers so that you don't have to ask
4 for information. It comes to you without you
5 needing to take any additional steps.

6 And then finally, the common well
7 defined data elements that are exchangeable
8 so that we have a high level of competence in
9 our data quality and can build those
10 analytics on top of it. So now we're done.

11 MS. MAKAR: Well, I have one more
12 thing to add, consumer mediated exchange
13 which some folks have also referred to as
14 consumer information exchange, but patients
15 being their HIE of one in the cases where
16 they have to do that. And that would be also
17 known as Blue Button.

18 DR. REDDING: Very good. Thank
19 you so much. Anything else, anything else to
20 add? That's fantastic. We've got some
21 questions. The cards are going up. So
22 Michael?

1 (Off microphone discussion)

2 DR. PARCHMAN: Okay, there we go,
3 good. Hi. This is Michael Parchman. This is
4 really great. And I really admire the work
5 you guys have done. It's been really cutting
6 edge thinking over the last few years. And
7 you've really pushed the envelope in helping
8 us think this through.

9 One of the things that I wanted to
10 ask you about though is what we're finding
11 when it comes to the use of health IT to
12 coordinate care, is that it's not the IT that
13 becomes the problem usually. Usually it's
14 around how the people who use the IT use the
15 IT.

16 So in implementing an EMR, for
17 example, it's the work flow and how you
18 redesign the work flow for people who are
19 sometimes threatened by the fact that you're
20 asking them to take on different roles and
21 tasks than what they're used to or who don't
22 understand how to do their work anymore,

1 their daily work, and helping them rethink
2 that and redesign their work, especially
3 around getting information into and
4 information out of the system.

5 And then how do you get people to
6 talk to each other about how they do this?
7 And I wonder if ONC is tackling, in terms of
8 the care coordination, the relational aspect
9 of what goes on between people, not between
10 electrons, and where you see that in terms of
11 division of care coordination?

12 DR. SKAPIK: So I think it's a
13 real shame that some of what happened with
14 the implementation of health IT was an
15 assumption that the tool is, in itself, a
16 means to an end.

17 The tool is only as good as the
18 way that it's designed and implemented. And
19 I think there was an assumption that tools
20 would have been designed to be implemented in
21 an easy way that would require no lift on the
22 side of healthcare providers. And that's

1 just absolutely not true, obviously.

2 I think that the real solution to
3 this is the people who do the care actually
4 coming together and having to redesign the
5 way that the tool works into the work flow
6 and into the care settings.

7 And I like that Kate, again,
8 brought up our lean work, because a major
9 principle of lean is that the only people who
10 can improve the process are the people who do
11 the actual work.

12 And I myself had the pleasure of
13 going to Denver Health and looking at some of
14 their lean work. And it's actually the
15 nurses and the docs that help to develop the
16 work flows. And that determines how the work
17 gets implemented and done.

18 So having a vendor give you a very
19 expensive product is not necessarily going to
20 help you more than having your care team sit
21 down for a few days and decide, well, this is
22 causing us a lot of pain. Instead of

1 complaining about it, let's decide what's
2 going to reduce our pain, make our work
3 better and make our care safer.

4 And I think that that's actually
5 part of ONC's vision, is that we give people
6 the tools, and the time and the will to
7 actually take that time out to learn about
8 how to make the process work right for them.

9 DR. PARCHMAN: Is that explicitly
10 listed here in terms of your vision? Or
11 where is that in ONC's vision?

12 DR. SKAPIK: You know, I didn't
13 actually get that onto the slide. We
14 actually have been working on some proposals
15 to use the HHS Innovation lab and to work
16 into the next cycles of measure development,
17 work flow, mapping, prior to the actual
18 creation of the electronic spec, so that the
19 specification anticipates the actions that it
20 looks for in the health record occur in the
21 order and in the way in which they actually
22 occur in the setting of care. And that, full

1 disclosure, that was not done for the
2 measures that exist.

3 DR. PARCHMAN: Yes. I think,
4 personally, it would help for the vision to
5 be very explicit about giving teams time and
6 space to have these sense making
7 conversations around work flow and how to use
8 the IT and for that to be very explicit
9 language in bullets that encourage people to
10 do that. Because otherwise we're going to
11 continue down this road of just assuming that
12 the health IT implementation will be, you
13 know, automatic.

14 DR. REDDING: Thank you. Rita?

15 DR. MANGIONE-SMITH: I'm Rita
16 Mangione-Smith from the Seattle Children's
17 Research Institute.

18 So I have been involved in an
19 effort, the CHIPRA grants efforts, in
20 developing care coordination measures for
21 children with complex medical needs. So
22 although they're children, their medical

1 issues are much more similar to elderly
2 adults because they kind of have a lot of
3 stuff going on.

4 So a lot of what you've talked
5 about here is very relevant to that
6 population of children that are the really
7 high risk group of kids who need really good
8 care coordination and care plans.

9 Something that struck me when you
10 said you had somebody hundreds of hours
11 trying to figure out how to spec out, like
12 how would we actually have a really useful
13 electronic version of a care plan that's
14 accessible by everybody and has all the
15 elements that we all believe the care plan
16 should have, really struck me.

17 Because as we've gone in and tried
18 to implement our measures, very similar to
19 what you had written in text there about care
20 plans manually abstracting, even in paper
21 charts or even people going into their own
22 Epic charts, nothing like that exists, right,

1 which is, I think, partly what you were
2 trying to address with that effort.

3 And it strikes me that one of the
4 problems is our current work flow as
5 pediatricians, it may also be true of adult
6 providers. That's we don't create care
7 plans. I mean, that's actually a new push,
8 right, to do that.

9 So as I'm trying to think of what
10 Michael was just saying about we really need
11 to think about the work flow, and talk
12 together and make the electronic, you know,
13 tools fit the work flow, that work flow, at
14 least in my world, doesn't currently exist.

15 It should, and I think there's a
16 big National push to get us to do this for
17 complex patients who need care plans. But I
18 think some of the disconnect and why people
19 are finding it so difficult is it's not even
20 something that's part of our routine, you
21 know.

22 And I think that's why all of the

1 information that we say should be there, when
2 our nurse abstracters go in and go through
3 the charts they find it, but it's like all
4 over the place. It's not in one nice
5 coordinated --

6 MS. MAKAR: Are you referring to
7 in-patient or out-patient?

8 DR. MANGIONE-SMITH: Out-patient.

9 MS. MAKAR: Okay.

10 DR. SKAPIK: Yes. And so that's a
11 little bit why I was trying to talk about how
12 we need to come together and decide what the
13 best way to do this is.

14 It's just an idea that I have that
15 instead of us putting a plan in our notes
16 somehow we update a living plan that exists
17 in a unified place.

18 Obviously, this is something that
19 a lot of people who actually provide care
20 could come together to think about. What in
21 my work flow could I reuse to enable to
22 creation of the care plan.

1 Because us continuing to add
2 additional layers and requirements on top of
3 the work people are already doing is
4 naturally creating a real problem for
5 providers.

6 MS. MAKAR: What I would say is
7 this also speaks to the care team. And
8 nursing has fundamentally been a proponent of
9 care plans, always. So specifically we think
10 of that in the acute care setting, but also
11 home care and long-term care.

12 The difference, I think, that
13 we're talking about is going across those
14 settings with a care plan central to that
15 patient, so that that information isn't
16 siloed to this episode of care, narrowly
17 defined by in-patient, out-patient, rehab.

18 DR. MANGIONE-SMITH: I do think we
19 have a fair amount of work though to get the
20 primary care physician population to embrace
21 care planning. Because I don't think it's
22 something that we have been trained to do.

1 And I don't think it's something we do very
2 well.

3 DR. SKAPIK: Yes. And I'll say,
4 in regards to Kate's comments about lean,
5 we've had incredible success in the Federal
6 Government.

7 Because lean requires that you go
8 face-to-face and talk to and work things out
9 with someone directly. And you find that
10 actually that turns out to be a very
11 satisfying experience.

12 And I think that it would be the
13 exact same in care teams. You would find
14 that you share frustration about something,
15 and then you are empowered to improve that.
16 And that leads to better personal and
17 professional relationships and a lot better
18 coordination within and across the care team.

19 MS. MAKAR: Something that I'll
20 share with you that hits both of your points
21 is I just came off an implementation about a
22 year ago at a large academic medical center.

1 And one of the best things we did
2 was training in 3-D as a team, including
3 physicians, nurses, clerks and environmental
4 techs if that was appropriate, a whole care
5 team that would simulate through our sim lab
6 what the new system was going to look like so
7 that we could see where some of those hand-
8 offs were and those work flow issues had to
9 change.

10 But that was a huge, huge monetary
11 investment and also an investment in time.
12 But we had enough participation from really
13 high risk areas that were concerned, so blood
14 transfusions, pediatric emergencies, OR,
15 chemotherapy.

16 But I think that implementation
17 part, having folks really think about it's
18 not just the system that I'm purchasing, but
19 I need to invest in that training.

20 And perhaps clinicians who are in
21 a 3-D world moving around, the training for
22 them is not best to be sitting at a desk with

1 a computer in front of them but in their true
2 environment. And I think calling that out is
3 important.

4 DR. SKAPIK: And I'll say that I
5 don't think we need to invest any additional
6 resources to get this done. Because so many
7 people are not working at the maximum level
8 of their training and capacity.

9 So the time that I have ever spent
10 in my life faxing paperwork back and forth as
11 a resident, probably not high value.

12 And I think that what we can do is
13 look to see where people are doing things
14 that could be performed by someone else or
15 could be automated so that that person's time
16 is freed up for the things that are really
17 valuable, that maximizes their ability to
18 participate in the care team. And that goes
19 for every single person in the care team.

20 DR. REDDING: Excellent. Thank
21 you. And this conversation fits into a lot
22 of our discussion.

1 So this committee has sort of
2 developed a speed mode where we're running
3 out of time. But we want to get some final
4 comments. So if we could go to speed mode
5 and speed answers, if that's possible,
6 that'll help a lot. This is great. Richard?

7 DR. BIRKEL: Thank you, Mark.
8 Quickly, I want to push you out beyond the
9 primary care setting. And presuming that the
10 care plan is a tool for integrating all the
11 services available, both within the health
12 system and in the community, I assume the
13 care plan exists somewhere in the cloud and
14 that community agencies have access and can
15 input to that same shared plan.

16 I'd like you to talk a little bit
17 about whether that's consistent with what ONC
18 believes the future holds. And more
19 importantly, where do the resources for that
20 infrastructure development come from?

21 MS. MAKAR: Well, the first thing
22 I'd say is never assume. Because I don't

1 think that is truly there yet.

2 DR. SKAPIK: I think the trend in
3 the industry is moving towards the cloud
4 already. So I think that expectation is
5 probably reasonable.

6 And in terms of who owns it, I
7 think that probably we shouldn't jump to any
8 conclusions and think about what would be the
9 best model for where we store that
10 information, who owns it and who pays for it?

11 DR. BIRKEL: So it's not so much
12 who owns it. That is an important question.
13 But, you know, there's been lots of, ONC has
14 supported the development of IT within the
15 health community. But there's no parallel
16 development within the communities.

17 So the integration of those, the
18 communication between those sectors, can't
19 happen. And so it fundamentally limits a
20 possibility of a health neighborhood ever
21 being created. And so that's really, to my
22 mind, the most important.

1 Where is the capital investment
2 for community agencies to develop access, to
3 develop the capacity to access a cloud-based,
4 let's say, care plan? I mean, everything
5 we've been doing here assumes that they're
6 part of a care plan. They're part of a care
7 team. How would they interact with that care
8 plan?

9 DR. REDDING: Thank you. And
10 Linda?

11 (Off microphone discussion)

12 DR. LINDEKE: I really appreciate
13 your being here. I hope this is going to
14 work. It's Linda Lindeke. I'm a pediatric
15 nurse practitioner. I work with the sickest,
16 smallest of the Nation, that's children,
17 prematurely born children.

18 I've been on the same care team
19 for over 30 years. Our team has evolved.
20 We're very electronic. We're in Minnesota,
21 so we've got Meaningful Use, plus, plus, and
22 electronic most things.

1 And so what I will tell you, I
2 could say so many things, but I will tell you
3 a couple of things. The most interesting is
4 an out of date care plan.

5 The people who know it's out of
6 date are the parents, typically, almost
7 always. Even if they have low health
8 literacy, they'll ask questions.

9 And the problem now that I see, I
10 see four to six very complicated kids in an
11 afternoon. And I work in a clinic where
12 we're seeing 15 that afternoon.

13 So we do team work with
14 psychologists, occupational therapists,
15 neonatologists, lots of students and nurse
16 practitioners. And it takes immense
17 communication. I call it a ballet.

18 Lean teams could come in, and what
19 they'll do is look at us and do a work
20 around. And that is not going to deliver the
21 electronic measures we're talking about. So
22 there's many, many things.

1 And I think work force has to do a
2 great deal of self-scrutiny. We require all
3 our graduate nursing students to take a
4 course in informatics. So when you think
5 about work force, we've got to speak the same
6 language. Even yesterday, we were ending up
7 using new terms that we like better. But we
8 can't keep making up new terms for things.

9 One final thing of many I could
10 say, and that is that we have people working
11 at the top of their license, to the best of
12 our ability. So what that does is that we've
13 got LPNs spending a half hour with the family
14 to do Meaningful Use before we, as the team,
15 get to see the patient.

16 So all the boxes are checked, so
17 the reimbursement will come in at the right
18 level. And then we've got either a
19 frustrated or a worn out family from
20 clickings, and then we're trying to work in a
21 shared decision making capacity in a very
22 limited way, in an interprofessional model.

1 So we can't assume very much here,
2 except that it's incredibly hard, it's
3 incredibly expensive.

4 And I would just say, what do some
5 other countries do to make a simpler model
6 that goes across settings, that has a public
7 health focus and that does not have to work
8 with this, with all due respect, talking
9 about the quarterback being involved in all
10 of these things.

11 We have to do clinical decision
12 making all along the way and not go back to
13 the quarterback. And I say that with great
14 respect to all of the folks that have, you
15 know, that mentality just as part of our
16 socialization. I appreciate being able to
17 make a few comments, and I admire the work.

18 DR. SKAPIK: So I'll try to give
19 two speed answers. In terms of lean, the
20 Denver Health model is that lean internally
21 trains their own experts. And the
22 requirement is that their own experts

1 continue to train others and that the work is
2 internal.

3 It probably takes like seven years
4 to create a culture of lean in an
5 organization. Therefore, getting a
6 contractor to come in and tell you what to do
7 is not lean in my mind. And it's not what
8 we're doing at CMS and at ONC. We're sort of
9 following that internal culture change.

10 Two, in terms of the lift of
11 getting to Meaningful Use and getting the
12 measure information there, we do know how
13 really hard it is for a lot of people. And
14 we've seen really great implementations, and
15 we've seen really terrible ones.

16 And it's our goal to use the
17 information that we've learned and also the
18 information we're going to gather through
19 this work flow testing and increasing kinds
20 of field testing to re-write all of the
21 content there so that every piece of data is
22 naturally there and gets sucked into the

1 measure. It should require almost never you
2 taking an extra click.

3 DR. REDDING: Thank you. So I'm
4 going to ask if you can in one sentence to
5 ask your question, and answer the same,
6 because we've never had this many cards go
7 up. So it's a big compliment.

8 MS. STEIN: I might use two
9 sentences just because I have two comments.
10 One, I'm Ilene Stein from the Service
11 Employees International Union. We really
12 appreciated the fact that you put personal
13 care attendance as part of the care team.
14 They are often not discussed in this context.

15 And also your reference to
16 environmental workers and other front line
17 workers. They are also somebody, a sector
18 that is left off and out of this conversation
19 even though we have found that they play a
20 tremendous role.

21 But they do need training, and I
22 think that there needs to be resources

1 dedicated to training those types of workers
2 to engage in the system.

3 And then the second comment, and I
4 guess we're going to get to this in the
5 followup presentation, is just having been
6 through the ACA enrollment process with CMS
7 and working on it, if data cannot be
8 exchanged, if there's no interoperability
9 between systems the entire thing breaks down.

10 So my real question is about that,
11 is what are you doing to make sure that
12 systems can actually speak to each other?
13 Because if the data exchanges don't work,
14 then it doesn't matter what's actually in
15 each individual system.

16 DR. SKAPIK: Yes, so a major
17 challenge that we faced was that we lacked
18 the standards to implement all of this work
19 in a short period of time. And so since
20 standards were created and they had
21 relatively limited testing, the goal is to
22 try to make them relatively simple so that

1 there wouldn't need to be a lot of extra work
2 to determine how to make things more complex.

3 But actually what seemed to be
4 simple required that then you take real-world
5 constructs and write them into a hundred
6 lines of code where you're saying and, and,
7 and, instead of "if then."

8 So we are rewriting those
9 standards now. There's a project going on
10 which we refer to as Tacoma, where we're
11 trying to unite the standard for clinical
12 decision support, which is exactly a more
13 agile standard, with the standard for the
14 quality measures.

15 Quality measures are actually
16 going to be published in Meaningful Use Stage
17 3 in a new version of that format. And it's
18 going to hopefully make the data a lot
19 simpler and make data exchange better.

20 The last piece of that is we
21 absolutely have to come to a decision on what
22 the core data that's required for every

1 system to have and how we define that data.
2 Because you can exchange data all day. If
3 you're exchanging apples and oranges and
4 trying to call them both apples, then you're
5 not getting high data quality and you won't
6 understand what the information you're
7 getting is.

8 MS. MAKAR: I just want to add one
9 thing to that. We do have to remember that
10 as far as cultural change, we're having a
11 cultural change in the greater society in
12 which we live with patient empowerment and
13 patient engagement. And to add to that
14 patient and family, right?

15 And then on top of that we're
16 having technological leaps. We're having
17 real changes in the technology and our
18 ability to work some of these issues. And
19 then I think within the whole culture of how
20 care is delivered, I think we're seeing that
21 change.

22

1 The care team is a good example of
2 that. So those three spheres of change make
3 this extremely difficult work, but very
4 rewarding.

5 DR. REDDING: Thank you so much.
6 And then the final three, can you guys make
7 it extra quick and then we'll move on. We're
8 going to talk about health IT all morning so
9 we'll have other opportunities. But Fred?

10 (Off microphone comments)

11 DR. REDDING: Oh, yes. No, we're
12 going to come to you, absolutely. You're who
13 we're rushing for. So good. Woody?

14 DR. EISENBERG: Hi, I'm Woody
15 Eisenberg from the Pharmacy Quality Alliance.
16 I have a question that may just reflect my
17 own ignorance.

18 I'm surprised that during our
19 conversations but particularly during this
20 conversation, the word HIPAA has not come up.
21 Have all of those barriers been finessed in
22 way or another?

1 DR. SKAPIK: So I think to some
2 extent, actually, HIPAA isn't the hardest
3 problem, which is a fantastic thing to say.
4 But like the quality measures, implementation
5 of HIPAA can be more seamless and higher
6 fidelity.

7 And this data segmentation project
8 we've been working on try and cut the most
9 sensitive information into a different layer
10 of security, and a different layer of
11 technology protection is probably what the
12 future is for the next, you know, the next
13 major cycle.

14 MS. MAKAR: And part of a HIPAA
15 challenge is actually having patients
16 understand they have the right to their data
17 at some times. Sometimes patients are told
18 you can't have that information, and a big
19 effort has been underway to let patients know
20 that they can have access to their data.

21 DR. REDDING: Excellent. Thank
22 you. And Woody, you're done, and we are --

1 Julia and Ellen, I just want to particularly
 2 thank you for being here with us in person
 3 this morning. This was really a helpful
 4 discussion and exercise, and I'm sure we'll
 5 have more questions that we'll send through
 6 other ways to you. Thank you very much.

7 DR. SKAPIK: Thank you.

8 MS. MAKAR: We'll hang out for a
 9 little bit.

10 DR. REDDING: So we have got Fred
 11 Rachman here as part of our team, but also to
 12 present on what the exciting things that the
 13 Alliance of Chicago is doing. And Fred,
 14 please proceed.

15 DR. RACHMAN: Great. And just to
 16 be clear, I'll use some things that we're
 17 doing as examples.

18 But the hope is to kind of bring
 19 both current and future things that are on
 20 the horizon in terms of health and technology
 21 into our thinking. Because I know we've
 22 talked about being aspirational, and I think

1 I've been making the point that the measures
2 that we develop right now are really
3 critical, I think, in shaping how people are
4 going to be devoting their efforts. And so
5 I'm hoping that we'll contemplate a future
6 paradigm.

7 I'm going to just talk as like,
8 we've talked about a lot of these themes. I
9 want to change it all up, but I do want to
10 use some of the graphics and some of the
11 illustrations in here. So I hope I won't
12 make you all dizzy by jumping around in these
13 slides.

14 One thing it occurred to me that I
15 want to do to set the stage is, you know,
16 we've been talking about this difference
17 between a coordinated care system and care
18 coordination.

19 And I was just thinking that when
20 I was a teenager my family took like life
21 savings and took this big trip to California
22 from Philadelphia. And in those days we had

1 to have a travel agent to coordinate getting
2 airplane tickets and figuring out the cars
3 and figuring out how the hotels would go and
4 how we would coordinate certain tickets for
5 certain events and everything.

6 Last month I took a trip to India.
7 I had never been to India. I orchestrated
8 the entire trip on this phone, everything.
9 Every single aspect of that trip.

10 And so that's what I'd like us to
11 think about is it's amazing how little the
12 health system has changed since that
13 California trip in terms of how technology
14 has enabled the way we do things.

15 And that is changing. It's
16 changing extremely rapidly. I mean, you
17 heard from ONC. You look at the rapid
18 adoption. We now have more than 50 percent
19 of outpatient providers on EMRs.

20 If you look at E-Prescribing it's
21 up in the 80 percents. So that's rapidly
22 changing. So I really hope that as we

1 contemplate these measures we're
2 contemplating the rapidity with which the
3 system is changing and we're not sort of
4 facilitating.

5 We're not sort of building out a
6 set of measures for travel agents, when
7 really what we want to be doing is setting
8 out a set of measures that contemplate what's
9 going to be important to build the right
10 systems in this kind of methodology. So
11 that's the -- now you can go to sleep.

12 But I do want to sort of try to
13 make the point that this stuff is real and
14 that it's happening. I also just want to
15 express, you know, since I have this title,
16 Health Information Technology, I want to be
17 careful that I'm not viewed as something in a
18 garbage can.

19 And, you know, we very
20 passionately believe, those of us that make
21 this our focus and our life work, actually
22 passionately believe that we need to be

1 comprehensive and put it all together. That
2 it's the siloing of the development of
3 technology and the development of the stuff
4 and the software and doing that in absence of
5 understanding exactly how care is delivered
6 and how we as consumers use it that has
7 caused the challenges we have today.

8 So my big argument is it all has
9 to be integrated. We have to be thinking
10 about this together in one bucket. So with
11 that let me see if I can figure out the
12 technology. Maybe not. Where am I aiming by
13 the way? Oh good, okay.

14 I'm going to skip all the fluff in
15 this talk. I do want to say this just as a
16 grounding. For those of you not familiar
17 with -- sorry. Just for grounding, the world
18 I come from, community health centers, we
19 actually have an internal care coordination
20 challenge.

21 And that is because we within our
22 walls have many, many, many of the services

1 that typically a stand-alone practice would
2 be coordinating. Not only preventive medical
3 care, primary care, chronic disease care,
4 hospital care, coordination of specialty
5 care, but we often will have behavioral
6 health services, dental, nutrition, case
7 management, education.

8 And actually this journey for me
9 in health information technology began with
10 the sad realization that although all those
11 things were within our walls, they were very
12 siloed and very uncoordinated. And
13 therefore, one of the reasons we undertook
14 health information technology was to try to
15 help solve that problem.

16 I will also just say as
17 background, we were one of the early AHRQ
18 demonstration projects for incorporation of
19 clinical quality measures and clinical
20 decision support related to those measures
21 into the EMR. And I'm also really thrilled
22 that we're one of the sites that are doing

1 these early rapid feedbacks on Meaningful
2 Use.

3 So just some context for the
4 remarks. I'm going to skip this. Actually,
5 maybe this is fun. I was going to say, you
6 know, we're often accused when we think of
7 HIT as being the hammer and looking at every
8 problem as a nail, but I'd submit to you that
9 in the absence of a screwdriver, with enough
10 determination you can use a hammer to pound a
11 Phillips screw into a board. So I'm going to
12 skip this stuff and get to some meat.

13 So the reality of where we are in
14 Meaningful Use is we've gone very rapidly
15 from data capture and sharing, which in
16 reality, practical terms, means throwing an
17 EMR into practices. And now moving to using
18 advanced clinical processes.

19 And one of the big points is to
20 move from one to two that data capture to
21 sharing, many of you made that point, means
22 you have to really understand something about

1 data and its use, how it should be captured
2 and how it's going to be used.

3 And part of the challenge we're
4 facing in moving from Stage 1 to Stage 2 is
5 care has not been paid to how to utilize
6 these systems to capture data in standardized
7 ways. Sorry to make you dizzy.

8 All right, I want to spend some
9 time on clinical decision support which is
10 one of these advanced processes that we're
11 looking at. And clinical decision support is
12 really how we bring rich information, total
13 information to the point of decision making
14 in any care process to make sure we're doing,
15 you know, the right thing.

16 And I think if we think of that
17 capability more broadly than just medical,
18 you'll see as we go on that that has a lot of
19 implications for care coordination.

20 So here are just some real-world
21 examples in an EMR of what clinical decision
22 support looks like. And it ranges from a

1 passive decision support, which is really
2 just a template.

3 And I apologize if this is a
4 little eye chart, but if you -- is there a
5 pointer on here? No. If you look, if you
6 can strain your eyes a little bit and look on
7 the left, that second box up from the bottom,
8 Patient Learning and Communication Needs, as
9 an example. This is a template or an alert
10 to the team that they should collect that
11 information.

12 And furthermore, just so you see,
13 if you're live in a visit the white boxes is
14 what you can do today. The gray boxes are
15 historical. So not only are you prompted to
16 what things you should be paying attention to
17 more holistically, but you're also being
18 reminded of whether that has ever been
19 addressed in the past and what the previous
20 answer was. So in terms of prompting that
21 kind of longitudinal view, very powerful.

22 This is another example of

1 clinical decision support. Now this is
2 medical, but this is an order set. And for
3 the pediatricians in the room what this is,
4 if you look at the month, or excuse me, the
5 age of the child, it automatically, by
6 clicking that box it automatically delivers
7 to you and orders the recommended set of
8 orders for a child that age. So this kind of
9 decision support can be useful not only in a
10 medical domain, but any kind of domain.

11 And finally, in the assessment
12 realm, this is what the assessment fields
13 look like in an electronic health record.
14 And if you can see just as you scroll down
15 you would see many of the domains that we
16 talked about in care coordination.

17 Again this template is the same.
18 You're prompted to be paying attention to
19 these things in the visit today, but you're
20 also being given information of what the
21 previous response to the patient was so you
22 can relate, see whether it was ever

1 addressed, if it was, where there's an issue.

2 And it would be possible also to
3 create something within the system that would
4 flag particular areas in limited time that
5 you needed to pay attention to. So this is
6 real. This is in existence today.

7 Now what it's predicated on is, if
8 you'll notice these are very highly
9 structured fields. Let me keep going for
10 just a minute. All right, let's just take a
11 minute. This is the most kind of
12 sophisticated clinical decision support.
13 What you have here is again an eye chart, on
14 the left in black is a practice guideline.
15 It's some evidence based set of
16 recommendations.

17 We're seeing historically what the
18 status of the patient is with regard to that
19 recommendation, and there's an opportunity
20 right there in a very efficient way in the
21 work flow to address it. And there is a
22 clinical, there's some kind of visual cue to

1 prompt and draw attention to where there's a
2 deficiency.

3 All right, I'm going to skip ahead
4 for a minute. What a lot of this is
5 predicated on is this structured data entry.
6 And what I'd say to you is it's the
7 difference between Word and Excel.

8 So the way we've implemented many
9 electronic records today is like Word, so
10 over a paper chart that's a huge advantage.
11 Because now it's legible. It could be
12 templated. People think, you know, we're in
13 an electronic health record because it's, you
14 know, all printed and you can pull it up and
15 retrieve it.

16 But that is not getting us to
17 computational capability. Think of an Excel
18 spreadsheet now. In order for an Excel
19 spreadsheet to work you must enter data into
20 a particular place on that form in a
21 particular way. If you enter a word in the
22 number field it's not going to work.

1 So an EMR is the same way, and a
2 lot of the disappointment that we're seeing
3 is when people are not grasping the
4 importance or significance of this. And I'll
5 say that a lot of this has to do with change.

6 I had some slides in here on
7 change management. I'm not going to spend a
8 lot of time there. But many of our
9 clinicians deliberately shopped for EMRs that
10 would change their work flow as little as
11 possible. And that was a really critical
12 error. Because that in a Word document we
13 get to keep our old way of doing things and
14 we think it's great and we think this is a
15 wonderful EMR, when really we needed to
16 stretch.

17 We needed to change. We needed to
18 change the way we view data, capture it, to
19 be more in alignment with an Excel
20 spreadsheet. And I think we're just catching
21 up to this and we're just sort of having some
22 realization about this.

1 But I think for this committee to
2 be contemplating how we're going to bring
3 careful coordination or coordinated care into
4 the EMR age, we need to be contemplating
5 this. Now let me go back and show you some
6 fun stuff.

7 So first of all, that was our old
8 data. This is a new data warehouse that we
9 implemented. It's a very, very powerful tool
10 that extracts data from the EMR every 15
11 minutes. And then we can build measures off
12 of that in real time that allow in a very
13 dynamic way people to view the data.

14 So this is a data population level
15 that can be viewed for managing populations
16 to see where they are and how they're doing.
17 If this were a dynamic, if we were on the
18 Internet we could play with it.

19 We could drill down into sites or
20 providers. We could change the time period
21 we were looking at. We could change the
22 graphs and the views. And because it's real

1 time, it can be used to print out a report
2 for this morning in one particular
3 measurement of patients coming in that day,
4 what are they due for?

5 So you can see how that could be
6 very powerful in coordinating care,
7 particularly since that data warehouse is now
8 not the EMR. It's layered over the EMR. So
9 the potential is that that data warehouse
10 could be pulling data from multiple sources
11 including other databases, other state
12 programs, et cetera, so that the reporting
13 coming out could alert people that are coming
14 into the clinic that day or coming into the
15 housing program that day or coming anywhere
16 that day, services that are due anywhere in
17 the system.

18 Now here's a really fun thing.
19 This is a CMS innovations project that we're
20 doing with University of Chicago. University
21 of Chicago for years has been employing
22 college students to walk the streets of the

1 community and catalog in meticulous detail
2 what community assets are there.

3 And one of the most powerful
4 examples for me were if you did a Google
5 search for food in some of the south side
6 neighborhoods in Chicago, you would not find
7 anything but McDonald's. You'd be looking
8 for fresh food, you wouldn't find it.

9 When actually, in that
10 neighborhood the liquor store is where people
11 go to get their fresh fruits and vegetables
12 because they have maintained a department in
13 that liquor store knowing that there's a need
14 for that. You would never know this if you
15 didn't have people who knew the neighborhood
16 and worked around.

17 What this represents is, we have
18 taken an atlas that they developed of those
19 assets and linked it to the EMR. And what
20 happens in real time is a patient's problem
21 list related to a care plan hits this
22 database and then generates back to the

1 provider in real time a list of assets within
2 the community that are nearby that patient's
3 recorded address of where they can go for
4 food, for vegetables. You'll see entitlement
5 services in here relevant to care
6 coordination. This is happening today as we
7 speak.

8 I'm going to skip some of that
9 stuff. I want to make this point of where we
10 are and why I think it's so critical for this
11 committee to be thinking aspirationally. The
12 reality of where we are, and I know I was
13 supposed to respond to that article, and
14 forgive me.

15 But that article is a reflection
16 of what people are feeling. They're seeing
17 the limitations. How many of you carried one
18 of these phones? Any of you? How many of
19 you were around when these phones were out
20 there but didn't want any one part of it,
21 right?

22 How many of those that have your

1 hand up now, keep your hands up, how many of
2 you carry one of these? Okay, great. You
3 would never have this if some of us hadn't
4 carried this. It was the use of this over
5 time that led us to develop this.

6 And that's the plea is we have got
7 to exercise more and more. We've got to
8 pushing more and more on the use of this
9 clumsy brick, maybe it's even worse than that
10 right now. Maybe it's even those little
11 suitcase things. But unless we are pushing
12 it we will never, never move to this. And I
13 have every confidence that we will.

14 We'll just show a couple more.
15 These are the change slides, we'll skip
16 those. Just to vet where we are in
17 implementing technology, the technology we're
18 implementing is actually optimized for future
19 reimbursement systems.

20 It's actually optimized where
21 we're not going to be counting how many
22 minutes a provider spends with a patient. Or

1 we're not going to be deciding whether we
2 will pay for housing or something else.

3 The technology we're implementing
4 is optimized for really managing towards
5 outcomes and quality. However, we're asking
6 people to use it while they're still being
7 paid the old way. And so again, this is one
8 of the things I think we need to grapple
9 with.

10 Now in terms of standardization,
11 one of the issues that we're facing as we try
12 to extend all of this content to non-medical
13 and broader health concept is we're having
14 enough trouble in the medical realm where
15 data standards exist. When we go out to some
16 of these other fields it's even harder
17 because the data standards do not exist and
18 there are actually some barriers.

19 So some of our colleagues in the
20 social service realm and the behavioral
21 health realm actually are even more resistant
22 to that kind of Excel model of reporting

1 information, because it's kind of a
2 birthright to be more sort of narrative and
3 more editorial.

4 We're going to have to crack this.
5 We're going to have to recruit that group to
6 recognize that in order to play in the future
7 paradigm we have to figure out a way to
8 structure and capture some of that data.
9 Otherwise, we'll never be able to do, push
10 the envelope of some of these things you saw.

11 The second thing is we actually do
12 have some legislative and administrative
13 barriers. We're working our way through some
14 of the legislative barriers, for example,
15 around sharing of substance abuse or HIV
16 information, but the administrative barriers
17 are the ones that I think are the most shame.

18 And, you know, Richard, I think
19 you alluded to these. But we actually have
20 barriers on funding mechanisms that are
21 actually standing in the way of integrating
22 the information.

1 And I think that's something we
2 should contemplate. I wish there was some
3 way to have a quality measure for state
4 administrative bureaucracies around care
5 coordination.

6 So that by the way, maybe I will
7 show you that. So I just played with a
8 little bit, if you assume that during the
9 course of a year an individual would have
10 four visits to a primary care setting, and
11 that's pretty good, and of those four visits
12 they had like an hour of valuable time,
13 valuable time, not waiting time, this is
14 about how much time, that's the 0.046 percent
15 is what percent of that individual's life
16 that represents. So if we're thinking about
17 impacting health, obviously that's not where
18 it is. It's everywhere else.

19 So in the paper all due to the
20 paradigm, those of you as old as me remember
21 this shot. This is very much still, we laugh
22 at it, but this is very much still our view

1 of medical records.

2 We look out from our practice and
3 the institution and we've constructed, and
4 this is the way we have our detailed
5 knowledge and this is the way we construct
6 everything. And this is not a way that we
7 could ever coordinate things.

8 This is 2014. We have the
9 capability to be able to take, zoom out, view
10 the data from another perspective. And from
11 a point of view of care coordination, this is
12 the vision of information that we need to
13 promulgate and not that old one.

14 So it reflects, actually, what the
15 public is saying and what ONC is saying.
16 There's an evolution that we're in of the
17 ownership of data from practitioner to then
18 the health care institution viewed they owned
19 it, and then we've been through this period
20 where the payors felt they were the owners of
21 the data, and now we're moving into this
22 accountable care entity which is scary that

1 many people are sort of mixing up and
2 equating with managed care.

3 So it's still in some ways, the
4 payors are viewing. But there's a mounting,
5 mounting, mounting sentiment that this data
6 actually belongs to us as consumers. And
7 from a care coordination perspective that's,
8 I think, what we need to really embrace.

9 So if you remember the slide that
10 we looked at that was put together that I
11 thought was beautiful -- I'm almost done,
12 promise -- with this care recipients and
13 community resources in clinics and stuff, I
14 took that and mapped it against how the
15 information spheres work today.

16 And so we have the EHRS which is
17 the institutional based view of the record.
18 And you could actually blow that up. That
19 could be the record of any kind of service
20 provider.

21 Then we have this health
22 information exchange infrastructure which

1 will take a subset of that data and make it
2 available across system-wide. And then we
3 have the patient's view of data.

4 And more and more they're being
5 able to take information from both of those
6 places and have their own record that would
7 also contain some information that maybe the
8 provider community would not think was
9 important that they're contributing
10 themselves.

11 So there are all these spheres of
12 information. And care coordination from an
13 information perspective lies at the
14 intersection of all of these. That little
15 spot in the middle there. So just a couple
16 thoughts about structured data and where we
17 might be wanting to put some emphasis.

18 So first of all, the nursing world
19 is way ahead on this. So nursing, when we
20 talk about what the definition of a care plan
21 is, nurses have had a longitudinal care plan
22 for years, but it's been like this stealth

1 object.

2 It's like no one cares about this
3 thing. You know, when people go into the
4 hospital they get this beautiful nursing care
5 plan that crosses all of these domains and
6 looks at their family support and looks at
7 all of this stuff.

8 I don't think anyone ever reads
9 this. No one reads it. And furthermore,
10 what's even worse is when the hospital chart
11 gets closed the care plan gets closed.
12 What's even more beautiful about that care
13 plan is there are a set of data standards
14 that underpin it. There's a whole nursing
15 language that underpins it.

16 And so this is, under the covers,
17 may be something else that we could
18 contemplate thinking about is how that kind
19 of standardized data is used and reported.

20 And then a second area are the
21 patient reported outcomes. We touched on
22 them, but I also want to highlight that this

1 is also a set of standards based tools that
2 exist and could be utilized and are patient
3 focused, and begin to reflect goals that are
4 more, perhaps more reflective of the patient
5 than the goals that we think about in the
6 medical realm, like did they get their
7 hemoglobin A1c.

8 And these are web based tools, and
9 furthermore they've been enabled through a
10 computer adaptive testing to be very
11 practical to administrate. So you could have
12 a tool that has a thousand questions on it,
13 but what a computer adaptive testing mode
14 does is your answer to the first question is
15 going to already narrow down the next set of
16 questions. And very quickly, within eight or
17 ten questions, we'll get to the meat of
18 what's important to that patient.

19 So the last thing I want to show
20 you is this other project that we did with
21 the CDC, and if there were more time I'd go
22 into more detail. But do you see that little

1 red alert in the corner?

2 What's really significant about
3 this is, this is a public health alert. And
4 the way that alert was generated was that
5 observations from within the EMR went out and
6 hit a rules engine at the CDC, and the CDC
7 determined that a public health alert was
8 relevant to that patient.

9 And it came back in real time as
10 the provider is doing the physical exam to
11 alert them, you should be watchful that this
12 patient who has GI symptoms might have a
13 foodborne illness because there's a foodborne
14 illness alert in your area.

15 What could this kind of
16 functionality do for care coordination? An
17 alert for, hey, this patient just became
18 homeless, when you're doing your checkup
19 today be aware that they need to have this.
20 Or hey, this person coming in for housing
21 just had an abnormal result that needs
22 followup. Please have them see their

1 provider.

2 Again, the point is, this kind of
3 functionality would have us not have to be
4 cleaning up the mess continuously. If we
5 push to embed this kind of functionality in
6 the way we deliver our services on a daily
7 basis, we have coordinated care. We won't
8 need care coordination.

9 And so then this is just the
10 technology that makes that possible. It is
11 this info button technology that allows you
12 to take observations within an EMR and go out
13 and hit some kind of external database.

14 So the last thing I just want to
15 show you is the other thing that's happening.
16 While we're pontificating in this room, our
17 consumers are going out and doing these
18 things.

19 So for example, the blood pressure
20 cuff on the top right corner that costs
21 roughly \$100 and is FDA approved, why will we
22 chase after patients to get their blood

1 pressure taken in an exam room or go
2 somewhere, when for that much money they
3 could be continuously monitoring it at home?

4 You know, similarly I could go
5 through all of these other devices here. But
6 something else that we need to be
7 contemplating is how are we holding ourselves
8 as accountable to use this kind of
9 technology?

10 Or I wouldn't even say use. It's
11 a bless-welcome, this kind of technology that
12 our patients and consumers are using. I
13 guarantee you it has economic implications,
14 which is part of the reason our large
15 institutions are not embracing it, right, if
16 they're not going to get paid when a consumer
17 takes their blood pressure or does a home
18 sleep study ten times.

19 So just some provocative thought
20 and I hope we have time for discussion left.
21 Yes, that's it.

22 DR. REDDING: Fred, thank you.

1 That was wonderful. I think it's given us a
2 lot to think about, and I'm going to ask if
3 folks could delay too many questions at the
4 moment just so we can catch up.

5 And we'll skip a slide, but
6 thankfully Fred's part of our team so we can
7 line up, I've got questions myself too.

8 So the next exciting presentation
9 is from Russell Leftwich, State of Tennessee
10 Office of eHealth Initiatives, and he also
11 has some pretty cool stuff to show us and
12 talk about. And following Russell, then we
13 are very close to lunch time.

14 DR. LEFTWICH: Lunch was a little
15 early on the schedule anyway. So thanks, and
16 my presentation is in two sections, really.

17 And I'm going to add about four
18 slides worth of information that I don't have
19 slides for at the end of the first section,
20 and if I need to take away we'll take away
21 from the second section.

22 And think of this as sort of like

1 one of those IMAX movies where the camera is
2 in a helicopter flying over some natural
3 wonder and we're going to pass over stuff
4 fairly quickly.

5 But unlike those movies, we will
6 have a chance to look back at the end and
7 then hopefully have a chance for a few
8 questions. And I'll pause for short
9 questions about the content at the end of the
10 first section, but then if we can hold the
11 discussion until after it's all over, and
12 Mark and Sarah can assess where we are in the
13 schedule.

14 So I wanted to talk first just a
15 little about the process that has evolved
16 over the last three years and I've been
17 involved with in the S&I framework, the ONC's
18 Standards & Interoperability framework, which
19 if you don't know is an open government
20 platform.

21 It's a virtual space of wikis and
22 webexes and phone calls managed by

1 contractors with ONC. But most of the work
2 is really done by committed volunteers from
3 industry and health and health care
4 organizations and academia-government-
5 professional societies.

6 And it works by someone, usually
7 ONC, posing a problem and a purpose for an
8 initiative. There are now something over 20
9 initiatives, 12 or 14 of them are still
10 active.

11 The group convenes and creates a
12 charter and a mission statement, and then
13 there's a use case developed around the
14 problem that's been posed, a model,
15 information model developed around that use
16 case, and then a standards analysis to say
17 what standards, interoperability standards do
18 exist that would enable this use case.

19 And in some cases standards don't
20 exist, and in some cases more than one
21 standard exists that might be used. So the
22 next stage of these processes is to harmonize

1 the existing standards in a way that they can
2 be used, implemented and specified as the
3 standards to be used.

4 And in more and more cases we're
5 identifying standards gaps where standards
6 really don't exist. And what has happened is
7 that over the past three years more and more
8 of the initiatives have become a
9 collaboration primarily with Health Level 7,
10 HL7, the standards development organization,
11 to work together to actually update standards
12 that exist, to fill those standards gaps, or
13 to in some cases, really, draft new
14 standards.

15 Then to work through the HL7
16 process, which is a international standards
17 development organization specified process of
18 consensus development of standards that the
19 standards are balloted in the end by the
20 members of HL7 that are interested in signing
21 up for a ballot.

22 If there are negative comments

1 about the ballots, those negative comments
2 all have to be resolved before the standard
3 can be published. And sometimes that's a
4 process that takes several months to work
5 through, so that the end product is some
6 modification of what was initially balloted
7 in most cases.

8 And then the process has become
9 that between HL7 and the S&I framework,
10 organizations that have been involved in the
11 development of standards actually work to
12 pilot those new standards, and when new
13 standards are published they're referred to
14 as DSTUs, draft standards for testing use.

15 And as part of that standards
16 development process, at the end of two years
17 the users of those draft standards get to
18 comment and refine what has been developed
19 before it's published as a normative
20 standard.

21 So early on, about three years
22 ago, I was co-lead in the Transitions of Care

1 Initiative which was really anticipating
2 Meaningful Use Stage 2 and the focus on
3 health information exchange, the verb, not
4 the Health Information Exchange networks, but
5 the process.

6 And specifically it was around
7 specialist closed-loop referrals and hospital
8 discharges as transitions of care, and to
9 model the clinical information that was
10 needed for those transitions and pick the
11 best at standards and then do a standards gap
12 analysis.

13 I was also a co-lead of a sub-
14 workgroup called the Care Plan Sub-workgroup.
15 And after the first few calls of that
16 workgroup there was a lot of concern that
17 what was being referred to as care
18 coordination was really just a fragment, if
19 you will, of care coordination. That it
20 wasn't really about a whole patient care
21 coordination, it was about those transitions
22 of care as if that was all there was to care

1 coordination for an individual.

2 That led to myself and two other
3 individuals writing a paper that I think you
4 got a copy of a week or two ago about the
5 concept of comprehensive care coordination,
6 if you will, and a blueprint for that that
7 would be a comprehensive care plan.

8 Our intent was to convene some
9 sort of forum for the concept of
10 comprehensive care coordination within the
11 S&I framework because that concept of
12 transitions of care left out many members of
13 the care team and really didn't enable what
14 we would have discussed here the past day and
15 a half as care coordination.

16 So the HL7 standard that is the
17 basis of information exchange that has been
18 specified in Meaningful Use is referred to as
19 a clinical document architecture.

20 What that is is a document markup
21 standard, a way of coding information in a
22 document that is both human readable and

1 machine readable. It is, in part, structured
2 data that Fred referred to earlier, but it is
3 also, unlike the vision of some people or a
4 concept that some people have it does not
5 exclude having a narrative in those documents
6 or even multimedia and other types of
7 information in the documents. But it does
8 specify a way to identify and maintain the
9 integrity of those electronic document files
10 as they are exchanged.

11 There are really only two absolute
12 requirements for those documents. One is
13 that it include the name of the patient, or
14 in HL7 language, the record target, so you
15 can't have a document that's not about
16 someone.

17 And the second requirement is that
18 there has to be a human readable form of that
19 document there. Other than that everything
20 else is an extension of that. And it really
21 allows a great deal of flexibility as to the
22 information that's included in these

1 documents.

2 But based on that CDA standard,
3 there are specific document templates that
4 are created for a purpose and have
5 specifications around them that HL7 refers to
6 as constraining the standard to specify
7 certain vocabularies that have to be used,
8 certain information that has to be included
9 in a particular document template.

10 And what was developed for Stage 2
11 of Meaningful Use and published in July of
12 2012 by HL7 is referred to as consolidated
13 clinical document architecture, sort of an
14 obscure name for this standard that is really
15 an implementation guide for a set of document
16 templates.

17 The one that everyone has heard
18 about and throws around the acronym for, as
19 if we all had the same understanding of what
20 it is, is a CCD or a continuity of care
21 document. In that consolidated CDA standard
22 there are actually eight other document

1 types, all of which are specified as part of
2 the standard for Meaningful Use Stage 2,
3 which does not actually mention any of the
4 document types, just this consolidated
5 clinical document architecture standard.

6 The version that was published in
7 July 2012 is what must be used for Meaningful
8 Use. So there are eight other document types
9 besides the CCD. There's a discharge
10 summary, a consultation note, a progress
11 note. And the only one that can't be used in
12 Meaningful Use is the unstructured document.

13 So what Meaningful Use requires is
14 something beyond what is actually in any one
15 of those specific documents. In the
16 transition of care, Meaningful Use says you
17 have to include in the clinical summary, you
18 have to include a medication list. You have
19 to include a problem list. You have to
20 include demographics.

21 As far as HL7 is concerned you
22 could not include one of those things and it

1 would still be a CCD or a CDA document, but
2 as far as Meaningful Use is concerned you
3 have to include certain things that aren't
4 really specified by HL7.

5 So all of those documents are
6 constructed of section templates. And think
7 of these as information Legos. In this
8 version of consolidated clinical document
9 architecture there are actually 71 of those
10 section templates.

11 Section templates like allergies,
12 medication lists, advance directives, chief
13 complaints, some of them briefer than other
14 sections. Social history, family history.
15 But those Legos are used to assemble all of
16 the different document types, and the Lego
17 that's in two different documents is
18 identical.

19 If it's the allergy section Lego
20 that creates interoperability from the get-go
21 allowing this information to be exchanged
22 between systems. And as is the point of

1 today's presentation, allowing this
2 information to be the basis of quality
3 measures, where those specified section
4 templates and the information they contain
5 could be the basis of some quality measure.

6 The current HL7 activity is to
7 produce a 2013 update of the consolidated CDA
8 standard that has recently concluded the
9 reconciliation process of the ballot which
10 had over 1,000 comments, or comments that had
11 to be reconciled.

12 So it would be expected that that
13 2013 update will probably be published about
14 May of this year as new updated standard.
15 And the intent was that that would be
16 available to be used for Meaningful Use Stage
17 3.

18 And I'll in a moment get to some
19 of the specifications that are part of the
20 update that are for the most part
21 specifically around care coordination and
22 care planning.

1 So that paper that we wrote two
2 and a half years ago intending to prompt ONC
3 to create an initiative that was more broad
4 and really was about patient centered care
5 coordination led to, in part, to the
6 development of the Longitudinal Coordination
7 of Care Initiative in the S&I framework.

8 And Michael will be heartened to
9 know that the first two calls were spent
10 fully determining whether we were going to
11 call it longitudinal coordination of care or
12 longitudinal care coordination. It has since
13 been reviewed to as LCC which could stand for
14 either one. So I'm not sure that was time
15 well spent.

16 So that initiative has been driven
17 largely by the long term post-acute care
18 community to develop standards around care
19 transfers in that community and longitudinal
20 care planning that is meant to be patient
21 centered and comprehensive care planning
22 based on a blueprint that is a comprehensive

1 care plan.

2 Another linked activity that has
3 helped to drive this LCC initiative is an
4 ONC/CMS challenge grant from about two and a
5 half years ago that's called the Improving
6 Massachusetts Post-Acute Care Transfers
7 Project. And I'll get to how that has
8 contributed to the development of the data
9 standards that are really the basis for a
10 longitudinal care plan.

11 One thing that that impact project
12 did that's been very important to the
13 advancement of these data standards and the
14 development of particularly the 2013 update
15 of the consolidated CDA, is they did a survey
16 of the data that the receivers of patients,
17 individuals in this community, the receivers,
18 the data that the receivers need.

19 Not what they get, not what the
20 sender of the data assumes they need, but
21 they created an elaborate survey and
22 distributed to 46 different organizations, 11

1 different types of organizations. And well
2 over 1,000 individuals completed that survey
3 and then they tabulated the results and came
4 up with several different datasets and an
5 overarching dataset of data that would be
6 needed for these transfers.

7 And that effort was driven by
8 Terry O'Malley who is the director of non-
9 acute care for Harvard partners and is
10 actually a current member of the Care
11 Coordination Measures Committee, and Dr.
12 Larry Garber who's the CMIO at Reliant health
13 care in Boston.

14 So what was found, what was
15 developed from this survey result was five
16 different transition datasets. And starting
17 with the smallest one, which the others sort
18 of subsume as part of their data, is a test
19 or procedure report, the smallest.

20 And it may be counterintuitive
21 that the request for that test or procedure
22 is actually more data, but that's because it

1 really needs to include the historical
2 information and essential information about
3 the patient and the reason for that test or
4 procedure.

5 The next largest dataset that this
6 effort defined was a shared care encounter
7 summary which would include the office visit
8 summary that Meaningful Use requires be sent
9 to the patient to their PHR. Also the
10 summary that a consultant would send to a PCP
11 or that the PCP would send to a consultant
12 when they referred a patient, or the summary
13 that the emergency department would send back
14 to the PCP or to the long term care facility
15 where the patient had been referred from.

16 The next dataset would be a
17 consultation request clinical summary. Once
18 again you need to send more data than you get
19 back. It's kind of counterintuitive, but the
20 consultant needs to know some things about
21 the patient and that therefore is actually a
22 larger collection of data.

1 And then larger yet than that is a
2 transfer of care summary that the information
3 that is needed if an individual is
4 transferred from one setting of care to
5 another where the responsibility for their
6 care is going to assumed in a new setting.

7 So a hospital discharge to skilled
8 nursing or to home health or even back to the
9 primary care physician would include this
10 larger dataset, particularly if the patient
11 is a person with multiple chronic problems
12 and more complex care plan, if you will, than
13 an average individual.

14 This dataset logically would also
15 be what you would send if a patient
16 transferred from one PCP to another.

17 And then overlapping with those
18 datasets would be the care plan. There's
19 some data that really isn't necessary in the
20 care plan, like the hospital course or all of
21 the historical lab results, but a certain
22 portion of this data like medications and

1 problems and such overlap with what would be
2 in a care plan.

3 But then there are things in the
4 care plan that aren't really usually part of
5 the clinical summaries for an individual,
6 like the care team and the interventions that
7 are proposed that the preferences of the
8 individual and their goals, the things that
9 are the essence of a care plan.

10 So when this large dataset was
11 defined and those subsets of that dataset,
12 there was a comparison to the existing
13 consolidated CDA data elements to determine
14 where the gaps were.

15 As it turns out there are really
16 only 175 data elements in a CCD, in that
17 defined continuity of care document. In the
18 impact data elements for a basic transition
19 of care there are actually 325 data elements.

20 So 150 more data elements, some
21 of which are those data elements that Fred
22 referred to in the nursing plan of care in

1 the hospital are lost, as Fred alluded when
2 the patient leaves the hospital. But they
3 are in fact the same data that those
4 respondents to the survey said they needed
5 when they received the patient, particularly
6 in the long term, post-acute care care
7 settings.

8 Then that yet larger set of data
9 that's needed when a patient actually
10 transfers to another setting of care, there
11 are actually 483 data elements defined that
12 include those care planning elements and,
13 really, the comprehensive dataset, if you
14 will, that is required for longitudinal care
15 planning.

16 Now it would be possible to
17 shoehorn those data elements into a CCD, at
18 least many of them, but in fact then you
19 still have 20 percent of data elements that
20 don't have a place to go in the existing CDA
21 documents.

22 And that was the reason for this

1 2013 CDA, consolidated CDA update, to include
2 these new document types that would be
3 specifically to serve these use cases of a
4 longitudinal care plan and of a care
5 transfer.

6 So I will not subject you to any
7 of the HL7 UML diagrams that are used to
8 construct the CDA implementation guides, but
9 I have a more visual and hopefully digestible
10 version of what is included in that
11 longitudinal care plan template that is being
12 balloted in HL7.

13 So it starts with a patient's
14 status assessment, and some of the missing
15 data elements, if you will, were around
16 functional status of the patient and
17 cognitive status.

18 The functional status is actually
19 specified as one of the requirements in
20 Meaningful Use Stage 2, but as it's turning
21 out there's not a very good way to include it
22 in the existing clinical summaries that are

1 generated from EHRs that will be facilitated
2 by the development of these new templates.

3 There are also, as you would
4 expect, physical findings about the patient
5 and then environmental factors, like as was
6 mentioned earlier, radiation exposure for
7 some individuals, those sorts of
8 environmental factors that currently aren't
9 really captured in typical clinical
10 summaries.

11 Then the other element of the care
12 plan is of course the patient's problem list,
13 or in the discussions around the development
14 of these documents we really refer to them as
15 health concerns because it goes beyond what
16 we would usually refer to as problems.

17 And it includes things like
18 wellness goals and barriers to care, all the
19 way from language barriers to socioeconomic
20 barriers, cultural barriers, then injuries
21 that occur, illnesses, incidental illnesses
22 along the way.

1 And risk and concerns that come
2 from many sources, from family history, from
3 genomics, from treatment, from interventions
4 of other conditions, of course generate
5 certain risk and concerns. Risk factors like
6 age and gender and environmental exposures.

7 From all this as we know in care
8 planning goals are created, and this entire
9 process was done with the concept that goals
10 would be created collaboratively with the
11 patient and family involved.

12 There are really three kinds of
13 goals that are part of a care plan. There
14 are computable goals that can be measured,
15 like keeping the hemoglobin A1c below a
16 certain level. There are behavioral goals
17 that can be documented but not measured in
18 the same way as those computable goals, like
19 smoking cessation or exercise programs.

20 And then there are overarching
21 goals that usually come only from the patient
22 or the family, like I want to dance at my

1 daughter's wedding is not either a computable
2 or definable goal in terms of standards, but
3 may be the most important goal to the
4 individual who's the subject of a care plan.

5 What the HL7/CDA template enables
6 with respect to these goals and health
7 concerns is that there can be lines drawn, if
8 you will, between a health concern and which
9 members of the care team are associated with
10 that health concern, presumably the patient
11 always is.

12 But the lines can be drawn with
13 which other members of the care team are
14 associated, which becomes very important in
15 terms of quality metrics as well as
16 communication between members of the care
17 team and what their role is on the care team.
18 The podiatrist doesn't probably need a copy
19 of the latest cardiology evaluation, but may
20 want to have information about diabetes
21 control.

22 So this standard that's being

1 developed and will soon be published does
2 enable associating the care team members and
3 multiple care team members with the health
4 concerns, with the goals, and with the
5 interventions that are associated with those
6 goals.

7 It also enables capturing
8 agreement with those goals or health concerns
9 in a way that it can reflect whether the
10 patient has acknowledged or agreed to certain
11 goals.

12 And there are certainly goals that
13 aren't shared by everyone on the health team,
14 and in care planning it's very important to
15 be able to capture that. That certain family
16 members disagree about a goal or an
17 intervention or a preference.

18 We also capture it with respect to
19 the providers, although we don't usually
20 refer to it as preferences. We refer to them
21 as recommendations if it comes from a
22 provider as opposed to a preference.

1 But in any case, the standards
2 allow connections between all of these data
3 elements and the members of the care team who
4 may be associated with them, which not to say
5 it's an easy task, but in measuring quality
6 of care plans and what contributes to good
7 outcomes versus bad outcomes that's all going
8 to be essential going forward.

9 Likewise, the standard allows us
10 to capture the preferences of patients and
11 their cultural factors in their social
12 history that may be care barriers, or as we
13 refer to the larger group of barriers and
14 risk factors and preferences and priorities
15 as care plan decision modifiers, all in one
16 category that will influence and would be
17 involved when there is decision support
18 around care planning would be data elements
19 that would feed into that.

20 So the next step of course is to
21 create interventions and link them to goals
22 and to members of the care team to allow

1 assessment in the future of progress towards
2 goals and results of those interventions.

3 And all of that comes together to
4 be a care plan that the essence of which is
5 those health concerns and the goals
6 associated with them, the interventions to
7 achieve those goals and the assessments to
8 track where we are with respect to the
9 progress towards the goals.

10 So that leads to the need to
11 define the care team in terms of sharing the
12 care plan and sharing the decision making
13 about the care plan and sharing the results
14 of those assessments about progress towards
15 goals.

16 And as I indicated, it's really
17 important to be able to distinguish which
18 care team members are associated with which
19 of those data elements so that we don't
20 produce information overload and bog down the
21 process of care planning or care coordination
22 by information fatigue, to coin a term

1 analogous to alert fatigue.

2 So the 2013 consolidated CDA
3 update includes an update of existing section
4 templates that had been found to be
5 insufficient, if you will. The addition of
6 diet and nutrition information to the
7 consolidated CDA summaries, and if you knew
8 me about three years ago you know that I was
9 on an almost constant rant about nutrition
10 not being included in CCDs. What's wrong
11 with this picture if we've got obesity and
12 diabetes and heart disease, yet we don't
13 capture nutrition in our clinical summaries.

14 So that's been fixed. I've calmed
15 down a little bit. Now I'm on a rant about
16 the care teams. So I didn't stay quiet for
17 long.

18 MS. LASH: And Russ, you've got
19 about ten minutes, if you could --

20 DR. LEFTWICH: Okay.

21 MS. LASH: -- hustle. People have
22 the slides, so if we want to --

1 DR. LEFTWICH: The addition of a
2 patient generated data header to enable
3 patient generated data submission, because
4 in the HL7 world these CDA documents
5 previously had to be generated by an EHR
6 system. They couldn't come from anywhere
7 else. That will be fixed with the 2013
8 update so that those documents can be
9 generated by patients.

10 An update of the consult note
11 template, and the addition of three new
12 document templates, and these are very
13 important to care planning and care
14 coordination. One is a referral note that's
15 the document that would be sent by the
16 referring provider to the consultant.

17 A transfer summary that includes
18 this very large dataset that has been
19 identified as what's needed when a patient in
20 particularly in the long term post-acute
21 care, or in those pediatric populations of
22 special needs children, the data that's

1 needed in those transfers of care.

2 And a care plan that includes all
3 those data elements I've mentioned including
4 the guidance for digital signatures. Because
5 this was really, the use case for this was
6 the CMS 485 form, which is the home health
7 plan of care and requires in its current
8 specification a wet signature by the
9 provider. There is an agreement that this
10 digital signature may be allowable in the
11 future.

12 So for that look back at where we
13 are and how interoperability around care
14 coordination has advanced and the
15 interoperable exchange of information, the
16 status in 2010, and going back to when the
17 CCD was first created in 2006, was that there
18 were at least three or four different
19 implementation guides for that CCD document
20 which meant that they truly weren't
21 interoperable.

22 And you hear people complain about

1 this now because you can't exchange those
2 older versions of CCDs. They were different
3 implementation guides.

4 So what the consolidated CDA
5 update in 2012 did was construct one
6 implementation guide for a CCD so that going
7 forward that should be a truly interoperable
8 document. It also included new document
9 templates, and then the 2013 update will
10 extend that to new document templates that
11 are particularly important to care planning
12 and care coordination.

13 The second part of the
14 presentation I will not present to you, but
15 it was to be about QRDA or Quality Reporting
16 Document Architecture. QRDA you'll notice
17 rhymes with CDA and it is based on those same
18 CDA Legos to be used in quality reporting.
19 The slides are there and you may be able to
20 make some sense out of them in just looking
21 at the slides you received.

22 But what, I guess, is important in

1 terms of care coordination measurement to
2 understand about that is that the population
3 reporting is actually based on individual
4 reporting.

5 And what you'll see maybe to your
6 surprise in that QRDA standard is that the
7 type 1 standard is actually about a quality
8 report about an individual. If we're going
9 to do quality reporting across organizations
10 in terms of care coordination, ultimately,
11 and this wouldn't be the low-hanging fruit
12 necessarily, there will be a need to produce
13 a quality report about an individual from
14 different organizations and then match those
15 individual quality reports up to produce a
16 quality report about an individual, and then
17 combine all those individuals into a
18 population level quality report across
19 different organizations.

20 So it may look funny to you if you
21 look at those diagrams, but the anticipated
22 requirement of the future is that we will

1 have to collect those individual reports from
2 different organizations and then match them
3 up. And it would absolutely be necessary
4 that they be produced according to the same
5 standard so that they can be combined, if you
6 will, into a population level quality report
7 across organizations.

8 The other couple of things I was
9 going to mention was the Blue Button standard
10 that was mentioned, which is now Blue Button
11 Plus which was another initiative of the S&I
12 framework, means that patients can download
13 and transmit from their own record or
14 information a CDA document that aligns with
15 those CDA documents that are produced by EHR
16 systems.

17 The other use of the CDA standard
18 that is new and little known is that in
19 December HL7 published a standard, an
20 implementation guide that's referred to as
21 electronic questionnaire and response that is
22 an implementation guide, a framework for

1 producing an electronic questionnaire and
2 responses that are a CDA document that could
3 then be consumed by an EHR that can consume
4 CDA documents.

5 What this would enable, will
6 enable, is that patient reported outcomes,
7 the questionnaire for that or for any other
8 survey of information from an individual, the
9 questionnaire could be a web service that the
10 patient fills out on a computer at home or a
11 tablet in a waiting room.

12 The questionnaire is really being
13 completed on a server in a cloud somewhere,
14 but the response is then returned to the EHR,
15 or to a quality reporting organization for
16 that matter, as a CDA document that can be
17 interoperably consumed. And I think that is,
18 you know, has great potential for our use in
19 quality measure for care coordination.

20 DR. REDDING: Just make any
21 closing comments, and then we want to make
22 sure you've got about four or five minutes

1 for questions too.

2 DR. LEFTWICH: Right. No, let's
3 go ahead and take some questions, and maybe I
4 can get any other thoughts in in my answers.

5 DR. REDDING: Thank you. And Russ
6 will be with us too, so you can add
7 additional questions. But Rita?

8 DR. MANGIONE-SMITH: So really
9 exciting and I'm glad you kind of brought the
10 slides to life. Because I looked at them
11 ahead of time and I was having a hard time
12 sort of absorbing it all, but that made it
13 really very clear.

14 How far away are we from that last
15 bit you were talking about do you think, with
16 the patient reported outcomes?

17 DR. LEFTWICH: We are in a vendor
18 implementing the standard away from it.

19 DR. MANGIONE-SMITH: Yes, so we at
20 Seattle Children's, we've been collecting
21 health related quality of life data on
22 inpatients at admission and then for four

1 weeks after admission, and the large majority
2 of those are done, all the surveys are done
3 electronically, many self administered on
4 computer and some by interview with the
5 interviewer inputting.

6 DR. LEFTWICH: So electronic
7 surveys are not new, but producing the
8 results in a form that is --

9 DR. MANGIONE-SMITH: But being
10 able to get those results into the record
11 would be revolutionary.

12 DR. LEFTWICH: Using a standard --
13 so I worked with some pediatricians in
14 Nashville a couple of years ago who wanted to
15 get their developmental surveys into their
16 EHR.

17 Well, it meant they were going to
18 have to pay for a proprietary conversion of
19 that questionnaire to be input into their
20 particular EHR and then that was all that
21 they would have.

22 This new standard will enable

1 having a web service, as I said, that
2 produces the result in a standard that can be
3 consumed by any EHR or any electronic system.

4 DR. MANGIONE-SMITH: That is so
5 cool.

6 DR. REDDING: Gerri?

7 DR. LAMB: Russ, I have a question
8 about the longitudinal care plan, and just
9 kind of struggling with what we talked about
10 yesterday and what's already done, because a
11 lot of the discussion in the groups I was in
12 yesterday was about those connections between
13 goals and team members and interventions.

14 And in this diagram it looks like
15 the standards are there for that. Is that a
16 correct perception? Is a lot of what we were
17 struggling towards measurement is already
18 standardized?

19 DR. LEFTWICH: Well, it's at the
20 printer, if you will, and it hasn't come back
21 from the printer yet. But yes. I mean, this
22 is, in Wayne Gretzky's word, you know, we're

1 skating to where the puck's going to be.

2 These standards haven't been
3 tested or piloted yet except that they are
4 not truly new standards. They are new
5 adaptations of existing standards. But it's
6 not going to be without some effort that they
7 do get implemented and that systems do get
8 updated.

9 The 2013 consolidated CDA update
10 is part of the 2015 certification criteria
11 that are published as an NPRM right now to be
12 included in that voluntary certification for
13 EHR. So they would become a part of that.

14 One other, let me mention one
15 other thing that I think is very important
16 that speaks to a lot of the concerns about
17 the broad care team members who don't have
18 EHRs, and that is, that same impact project
19 in Boston has created a software tool called
20 SEE, S-E-E, which stands for Surrogate EHR
21 Environment that is about to be piloted in
22 Boston and that I've organized some acute

1 care hospital and some long term facilities
2 in Chattanooga to pilot as well.

3 And what that software tool is is
4 an editor for that CDA document. So that
5 somebody that doesn't have an EHR can receive
6 a CDA document like a CCD from a hospital
7 that does have a certified EHR, they can open
8 that document up and they can update it.

9 And the editor is compliant with
10 the HL7 requirements that when somebody
11 changes something there's an audit trail that
12 shows who changed it, who created it. Once
13 you open the CCD it's no longer the same CCD.
14 It's now a new CCD.

15 That editor is actually integrated
16 with a Direct inbox, mail inbox. Somebody
17 mentioned Direct earlier. I hope everybody
18 is familiar with it. It's an email type
19 secure transport mechanism that's a
20 requirement of Meaningful Use Stage 2 for the
21 EHRs.

22 So those CDA documents can be sent

1 by a Direct message as an attachment, opened
2 up in this editor by home health, by long
3 term care, by behavioral health.

4 Behavioral health isn't involved
5 in these pilots, but ultimately anybody who
6 doesn't have an EHR could use this software
7 tool to edit those CDA documents then publish
8 them as a new CCD and send them to -- so part
9 of the Chattanooga pilot that I'm
10 constructing is that the long term care, when
11 they send a patient to the emergency
12 department will be able to send a current CCD
13 with the patient that includes current
14 information and why the patient's being sent
15 to the emergency room.

16 DR. REDDING: Awesome. And then
17 that might allow us to integrate social
18 agencies too. Wonderful.

19 DR. LEFTWICH: Exactly.
20 Absolutely. Once this pilot, you know,
21 skating to where the puck's going to be, but
22 once these pilots have sort of gotten the

1 glitches out of the software --

2 DR. REDDING: Great. Don? And
3 then we'll close for lunch.

4 DR. CASEY: Yes. So Russ, this is
5 really outstanding and, quite frankly,
6 overwhelming in terms of the amount of time
7 and effort, you know, folks like you have put
8 into this.

9 But it clearly is creating the
10 first stage of, you know, coming to a set of
11 national standards. And I sort of envision
12 this as really the data element side of
13 things, and it appears to me like it makes
14 sense to sort of do a kitchen sink approach.

15 I want to get to a comment about
16 impact and cost, but I also think that the
17 next sort of level of this is, what does the
18 actual system begin to look like as far as
19 database science, structure and function?
20 You know, what becomes the parsimony out of
21 the kitchen sink? What's pushing versus
22 pull?

1 You know, what's the efficiency of
2 the machine that holds all this stuff?
3 What's the utility of it? And, you know,
4 obviously we're dealing with a one to many
5 type of world in terms of the complexity of
6 information that needs to be made available.

7 And then below that is sort of
8 back to my favorite term, the data science
9 part of this, which is that the design of the
10 data elements and the data structure then
11 enables a much more facile approach to the
12 analytical side of this. And I'm talking at
13 a high level around using techniques such as
14 Bayesian estimation for both prediction and
15 causation with a very high level of
16 precision.

17 So I'm trying to sort of envision
18 that this system is one system as opposed to
19 silos. And so that's one sort of, not
20 question, but just sort of idea.

21 I also think that, you know,
22 having been through this now several times

1 with clinically integrated networks that have
2 EMRs and HIEs in place and have patient
3 reported outcomes on tablets and offices
4 that, you know, what's missing many times is
5 that there isn't enough look at the encounter
6 data that payers have.

7 And so intersecting the claims
8 part of this, knowing that ultimately this
9 will converge, looking at prescription
10 histories, looking at adherence patterns,
11 getting lab data directly into the EMR, not
12 so much from what comes back but through the
13 laboratory vendors, and even the imaging
14 reports which sometimes sit in different
15 spots, with perhaps maybe more structured
16 data.

17 You know, I'm thinking of cardiac
18 imaging have a move towards really clear sort
19 of measurement data elements in them that are
20 pretty complex that can inform decision
21 making. So obviously that intersection, you
22 know, is something that is hopeful.

1 But, you know, the real question
2 that I think about all the time is with all
3 this effort going when are we going to know
4 about the impact of outcomes? I'm not asking
5 you to answer that question, but I do think
6 that we have to sort of filter everything
7 that's happening now through the lens of if
8 and when and how all of this effort will
9 impact on outcomes and cost, right?

10 And I'm not just talking about
11 cost of care. I'm talking about the fixed
12 costs of even maintaining this type of
13 activity.

14 And then the last part on the
15 QRDAs is important because, you know, for
16 example, mammography in New York City is
17 often done, probably, 20 percent of the time
18 by physicians who are out of network who
19 don't submit claims. So trying to get HEDIS
20 data and reconcile that with reality that is
21 not just EMR based is a nightmare.

22 So, you know, I think that there's

1 a lot of other work to do, but I do
2 congratulate you and everyone in the world
3 who's been working on this as the first step.
4 But I'm trying to be a bit aspirational here.

5 DR. LEFTWICH: Well, you know, I
6 think maybe the ultimate answer to that is
7 this same answer to Richard's questions that,
8 you know, ultimately, my view of the future
9 is that ten years from now, maybe sooner,
10 individuals will have a record that's their
11 record. The same as that progression to the
12 patient owns the record, but individuals will
13 have a record that's their record outside of
14 any system in the cloud or whatever buzz word
15 we have for it in the future, their record is
16 there.

17 It makes no sense to reconcile
18 medication lists or problem lists. There
19 should be one source of truth for those types
20 of things and it should be the patient's
21 record somewhere and their care plan should
22 sit there as well. And then maybe at that

1 point we can afford to have care plans for
2 people who aren't all that complicated.

3 DR. CASEY: And be free too.

4 DR. LEFTWICH: Well, and be
5 affordable at least. We don't eliminate the
6 need for interoperability, but we do cut down
7 on the need for storing the same data in a
8 lot of different places.

9 One of the S&I initiatives was
10 called Query Health which was about creating
11 distributed queries, so that in terms of
12 analytics instead of having to have data
13 warehouses, it was called sending the
14 question to the data. You literally send the
15 query to the EHR and get back a de-identified
16 population level response that can be used to
17 do the analytics without having to move all
18 of the data on a whole --

19 DR. REDDING: Yes.

20 DR. LEFTWICH: -- community around
21 to do analytics that you really want on a
22 small population on a small set of data

1 elements.

2 DR. REDDING: Well, Russ, thank
3 you for so -- oh, okay. Well, if it's quick,
4 Fred, please do.

5 DR. RACHMAN: It's hopeless, you
6 all.

7 DR. REDDING: If you could make it
8 quick that would be much appreciated.

9 DR. RACHMAN: Hopeless, hopeless.
10 Yes, thanks. It takes a village. It takes a
11 village, you all.

12 Just, you know, this thing keeps
13 coming up about the patient, you know,
14 centric record. And the HIE option that has
15 never really been used is the medical record
16 banking approach where the patient is the
17 vector and it just gets plugged in each time
18 they move around.

19 Do you have a sense of what it is
20 that stands in the, because we're standing up
21 these HIEs that are struggling with --

22 DR. LEFTWICH: Yes, we haven't had

1 the interoperability to do it previously, but
2 I think we're getting there with the
3 consolidated CDA standard that --

4 DR. RACHMAN: Well, I just think
5 of all the money and effort that's being
6 spent on pursuing other options and what that
7 would do if the full-court press was on that
8 approach and what you think the hope of that
9 is.

10 DR. LEFTWICH: I think that HIES
11 will look very different from what we thought
12 they were going to look like, and will be
13 more based on accessing the information
14 that's in those patient-owned records rather
15 than sending data to a repository, which for
16 one thing is more expensive to do because you
17 have to maintain that.

18 The consent and privacy issues are
19 much greater and have never really been
20 solved in most places, whereas if it's
21 patient-owned data in their own record then
22 they can consent or not consent based on each

1 use of their data.

2 DR. REDDING: Thank you.

3 Amazingly, patient-centered. That's
4 wonderful. So we need to also, before
5 breaking for lunch, ask if there is anyone on
6 the line or any public comment. And
7 Lauralei?

8 MS. DORIAN: Kathy, could you
9 please open up the lines for public comment?

10 OPERATOR: Certainly. If you
11 would like to ask a question, please press
12 star 1 on your telephone keypad. Again if
13 you would like to ask a question, please
14 press star 1 on your telephone keypad.

15 And there are no public questions.

16 DR. REDDING: Thank you.

17 MS. RUBIN: Hi. Koryn Rubin from
18 the American Medical Association. Thank you
19 for providing the opportunity to comment, and
20 that presentation right now was wonderful.
21 If it's possible also to get the slides for
22 participants.

1 One omitted thing that I didn't
2 see in the discussion is how to coordinate
3 information that's captured in registries
4 into care coordination and shared decision
5 making. Because a lot of the clinical
6 registries that physicians are participating
7 in have a shared decision making element and
8 there's a lot of rich data that can be
9 captured there and moved to that piece where
10 the EHR and the physician engagement is more
11 seamless.

12 So I think that's something that
13 needs to be discussed and addressed in your
14 recommendations or framework.

15 DR. REDDING: I think both Russ
16 and Fred had concepts based on that, if you'd
17 like to answer.

18 DR. LEFTWICH: Well, I think
19 registries will have to be based on the same
20 interoperability standards that the records
21 will be based on. HL7 is about to publish,
22 may have already published a standard for

1 cancer registry entries.

2 And I think it will take, you
3 know, standards for registries to allow that
4 exchange between EHRs, PHRs and other systems
5 and the registries to really be effective and
6 to contribute to shared decision making.

7 DR. SKAPIK: And if I could make a
8 followup comment on that, Julia Skapik from
9 ONC. While the Tacoma project that I
10 mentioned, the standards harmonization work
11 between clinical decision support and
12 clinical quality measurement is a first step,
13 the intention is to take the standards
14 harmonization work all the way through all
15 the potential use cases and to do the same
16 thing as we develop a core set of common data
17 elements. So that all the standards and all
18 the data elements would be reusable for any
19 purpose that we needed.

20 DR. RACHMAN: Yes, I'd just
21 respond also that registry is, so EMRs were
22 not really designed out of the box to do

1 population level work like registries.

2 They're transactional databases.

3 And so we have used registry or
4 registry-like functions, population
5 management software, things to overcome that.
6 And I think where we're moving is something
7 where we'll have a more elegant way to bridge
8 that gap between the transactional databases
9 in EMRs and population level functions.

10 And, you know, I think that the
11 need for registries hopefully is going to
12 fade. We actually have never used a registry
13 at the Alliance. We have used the
14 combination of the EMR with the right kind of
15 data storage and analytics to use just the
16 EMR itself as a registry.

17 DR. REDDING: Thank you.

18 MS. DORIAN: And I just wanted to
19 note that for those of you who are on the
20 phone or members of the public today, we will
21 be posting those extra slides to the NQF
22 website following the meeting.

1 MS. LASH: And we'll take 30
2 minutes for lunch, so if you could plan to
3 return at quarter til.

4 (Whereupon, the foregoing matter
5 went off the record at 12:16 p.m. and went
6 back on the record at 12:48 p.m.)
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1 A-F-T-E-R-N-O-O-N S-E-S-S-I-O-N

2 (12:48 p.m.)

3 DR. REDDING: So if we could come
4 back together again. It's been an exciting
5 discussing this morning. And we've got a
6 little bit more for you this afternoon.

7 We've got a Final Measure Gap
8 Prioritization Exercise. And I am turning it
9 over to Sarah.

10 MS. LASH: All right. Thanks
11 everyone for the continued participation.
12 And I'll apologize in advance of the session
13 for anyone in the room who prefers to think
14 in nice shades of gray and that everything is
15 unified. Because we're going to try to get
16 more black and white on a clear consensus for
17 priorities for measure development.

18 This is again to provide guidance
19 to HHS about where they should direct their
20 measure development resources. And those
21 resources are available, but they are finite.
22 And so we're not saying that anything on our

1 list of domains and sub-domains is not
2 important. But if you were going to run into
3 a burning building to save care coordination,
4 who would you pick? Which domains are we
5 going to elevate from this group.

6 So I'll have Lauralei tell you how
7 you're going to be using the clicker device
8 you have at your seat to do electronic
9 voting. And if you don't have a device,
10 please raise your hand and one of our team
11 members can get you one.

12 DR. LAMB: If we're using the
13 domains that are on Page 61, are we using
14 those, or are we using the new ones?

15 MS. LASH: We are going to be
16 using the new ones.

17 DR. LAMB: The new ones.

18 MS. LASH: And there will be
19 slides that will take you through that.
20 Today's a green heading handout.

21 MS. DORIAN: Okay, so everybody
22 should have a voting device. We're hoping

1 this will work today. We have a backup plan
2 if not. We usually use this in the measure
3 of valuation process where there's only one
4 response, but.

5 So we're going -- first you're
6 going to choose your top four of the nine
7 major, of the now eight major domains. And
8 to do that, you see they're all numbered.

9 So you're going to, not yet, but
10 when I start the timer, you'll have 60
11 seconds. You're going to hit, say you choose
12 1, 2, 3 and 4. You'll hit 1, 2, 3, 4 and
13 then the send button. And if you try to aim
14 it over here where the receiver device is.

15 So they don't have to be in any
16 order, just your top four. And you just hit
17 6, 2, 3, 1, whatever it happens to be. And
18 then send. And you should see a green light
19 when you're doing that. So if you don't, let
20 us know, it probably means you don't have
21 batteries, so we can replace it.

22 MS. LASH: So the way we'll

1 conduct this exercise, we'll vote on the
2 domains first and we'll look at our
3 distribution. And we'll have some
4 opportunity to discuss in the group if you're
5 all comfortable with how that prioritization
6 fell out.

7 And then we'll go to sub-domain
8 prioritization. But only within the top four
9 or so, whatever the natural cut point is of
10 the prioritized domains. We don't need to
11 keep you here all afternoon voting.

12 And we think that will be enough
13 potential opportunities for measurement.
14 Probably more than enough. And we'll have a
15 lot of good detail to support that voting
16 results as well.

17 So, any questions about what we're
18 about to do? Yes.

19 DR. ROCA: Did I understand you to
20 say we put in all four before we hit send.
21 We don't hit send after each one.

22 MS. DORIAN: That's correct,

1 right. Correct.

2 DR. ROCA: Okay.

3 MS. DORIAN: And then we move on
4 to the next four or so sub-domains, you'll
5 just be choosing one selection. So you'll
6 hit the one and then send. The order doesn't
7 matter on this first one.

8 And if you change your mind, it'll
9 just capture the last four that you enter.
10 Or on the subsequent ones, the last one that
11 you enter.

12 DR. REDDING: If we vote and then
13 we have a lot of good discussion and we
14 substantially change our minds, can we vote
15 again before it becomes official?

16 MS. DORIAN: Yes. And Caroline,
17 you're on the phone, right?

18 MS. INGRAM: I am. And I was just
19 corresponding with Lauralei that I could
20 email my votes I think to her. And then she
21 could maybe, she could put them in there.
22 I'm not sure if that would work or not.

1 MS. DORIAN: Perfect. Yes, this
2 is Lauralei. Yes, just email them to me and
3 we'll add them to the list.

4 MS. INGRAM: Okay.

5 MS. LASH: We'll do out best to
6 redo the list.

7 MS. INGRAM: All right, so before
8 we're through I'll just shoot an email to
9 here.

10 MS. DORIAN: Great.

11 DR. ACKMAN: Not to confuse
12 things, but is the basis for our vote impact,
13 or is it --

14 MS. LASH: Thanks for that
15 opportunity. I meant to say that when I
16 began. Let's think of this as the sum total
17 of all the discussion we've had in this room.
18 Your prior knowledge of measurement. Really
19 everything should be accumulating in the
20 prioritization.

21 So do think about impact. Do
22 think about feasibility. Do think about

1 everything we learned this morning about the
2 state of data and where we're trying to be
3 you know, heading with new capabilities. And
4 you know, your own perspective and expertise
5 as well.

6 So we'll give you a moment to
7 really think through this before we start the
8 timer and the voting process. Because I know
9 some of you probably want to be very
10 thoughtful about this. Russ?

11 DR. LEFTWICH: There was an
12 editorial suggestion by a couple of us
13 yesterday that goal attainment be modified to
14 progress towards goal.

15 MS. LASH: Yes we'll cap -- we can
16 capture that.

17 DR. LEFTWICH: Is that --

18 MS. DORIAN: That's actually
19 already been changed in the slides. It might
20 be later on, but we'll cap -- it's been
21 changed in certain places, but it will be
22 changed in all the places.

1 DR. LEFTWICH: Great.

2 MS. LASH: Thank you for
3 clarifying that for everyone. Are we ready
4 to get started?

5 MS. DORIAN: Folks feeling ready
6 to vote? So remember to point over here.
7 You can start when you see the clock. It
8 will say 60 and then you'll have 60 seconds.
9 And go.

10 (Whereupon, the foregoing went off
11 the record at 12:55 p.m. and went
12 back on the record at 12:56 p.m.)

13 MS. DORIAN: We have 12. All
14 right, we should have 17 --

15 MS. LASH: Responses.

16 MS. DORIAN: At the end, so.
17 Okay, has everybody. Remember to hit send at
18 the end of it. 15, we're almost there.
19 Maybe if everybody could hit send again just
20 to make sure it's -- so I think, let me just
21 --

22 MS. LASH: Did anyone not feel

1 confident that they participated in the vote?

2 No truly, we want to capture the data.

3 MS. DORIAN: We had 16 of 17 and
4 then I have Caroline's. It won't capture it
5 now. Did you want to either -- are you
6 comfortable saying it out loud, your top
7 four, or write it to us? Thank you, great.

8 So we had nine for comprehensive
9 assessment. We have eight for goal setting.
10 Ten for shared -- actually 11, sorry for
11 shared accountability. Two for availability
12 of services. 12 for linkages and
13 synchronization. Sorry, that's 13 for
14 linkages and synchronization. 7 for
15 experience. 10 for goal attainment. And 8
16 for efficiency.

17 MS. LASH: All right so that means
18 our top are linkages and synchronization,
19 shared accountability, progression towards
20 goals and then comprehensive assessment. Any
21 discussion about the results? David?

22 MR. CUSANO: Yes, my only question

1 is if attainment, or moving towards attaining
2 goals is one of our tops, then I'm trying to
3 figure out the interplay between that and
4 goal setting if we don't know what the goals
5 are. Is there an issue with moving towards
6 goal attainment without have the goal set.

7 And could we include -- I'm just
8 trying to think about if there's a way to
9 capture that in another domain.

10 MS. LASH: Right. So this is
11 about you know, what measures we need to
12 create. Not to say that processes might be
13 existing that wouldn't be measured. But
14 Rita, do you want to respond to that?

15 DR. MANGIONE-SMITH: Yes. So I
16 was going through the same through process.
17 And I noticed then under comprehensive
18 assessment, it says capture preferences and
19 goals. So I felt like under comprehensive
20 assessment, you're getting to that goal
21 setting piece.

22 MS. LASH: Michael?

1 DR. PARCHMAN: I just want to make
2 a brief plug for efficiency. Because as I
3 was reflecting on our small group meeting
4 yesterday around the far right column in our
5 little table, the outcomes, and thinking
6 what's possible to measure. And thinking
7 about examples of when I've thought to
8 myself, gosh, we did a bad job coordinating
9 care here.

10 The major reasons I came up with
11 were always around duplicative services,
12 areas where something was provided to the
13 patient that shouldn't have been provided to
14 the patient that actually was contraindicated
15 because someone didn't know about something
16 that was pre-existing in the patient. Or --
17 and you know I appreciate helping patients
18 obtain their goals, but I think there's a
19 purpose behind why we try to coordinate care.

20 And a lot of it has to do with
21 efficiency in preventing harm and improving
22 outcomes. And if we don't start prioritizing

1 measures in that area, I think we're missing
2 the goal of what we're trying to do as
3 providers in coordinating care.

4 MS. LASH: Vija, did you want to
5 respond to that?

6 DR. SEHGAL: I just absolutely
7 want to echo what Michael just said. I think
8 of all of the goals, efficiency is probably
9 the one that is the least nebulous in my
10 mind. And the one that's easiest to measure.
11 And the one that has the easiest you know,
12 it's the most quantify able.

13 It's also the one that you know,
14 we're actively involved in a number of shared
15 savings programs and these are exactly the
16 measures that we are actively measuring,
17 reporting and being reimbursed on. So I
18 think --

19 MS. LASH: Okay. Gerri?

20 DR. LAMB: And what you just said
21 was the reason that I didn't vote for it. Is
22 I was going for the ones that I thought were

1 going to be more difficult to move forward.
2 I figured efficiency and experience are going
3 to happen, because they must.

4 But the others are the ones that
5 we haven't seen. So I was going to for the
6 ones that we've really emphasized and need to
7 move forward.

8 MS. LASH: So difference in
9 strategy. Fred?

10 DR. RACHMAN: Okay, so we're
11 making a pitch for the underdogs here. And I
12 remembered the microphone, I just want credit
13 for that.

14 I'm a little disappointed about
15 experience you all. Because I'm -- I think
16 we could improve those other domains and
17 actually not improve the experience at all.

18 I'm just thoughtful about people
19 that have 14 care coordinators going and
20 visiting their house. Or they get referred
21 to a service that is so far away, but that
22 it's difficult for them to get to it, or it's

1 not --

2 And I also am worried about burden
3 that gets placed on primary care providers,
4 where it gets sort of dumped on them. Or on
5 community health center staff, or whatever.
6 And we're not going to capture, we're not
7 going to be able to track and capture what
8 that impact is on both sides. And especially
9 since we don't really know what works well.
10 Or what the ultimate impact of it is.

11 This is sort of a way -- it's like
12 kind of a net for us to be monitoring. Like
13 what does it actually now feel like to be in
14 the system. So I'm a little disappointed
15 that that scored so low.

16 MS. LASH: Richard?

17 DR. BIRKEL: Just to also make a
18 plug for efficiency. I assume, I mean my
19 reason is simple Gerri. It is -- we won't
20 get anyone to pay for care coordination
21 unless it reduces costs. And so we've got to
22 measure it. And we've got to pay for it.

1 That's my view.

2 MS. LASH: David?

3 DR. ACKMAN: Ditto. The -- you
4 know, the -- right now payers are, I mean
5 they're very few codes that really capture
6 care coordination. And most people don't pay
7 for them. I think unless you demonstrate in
8 a very compelling way that this works, and
9 not -- it either saves money, or at least is
10 better outcomes.

11 I don't -- I think you're going to
12 end up being able to show that it's doing all
13 the things you wanted it to do, but the
14 people who are ultimately going to pay for it
15 will want to know a little bit more.

16 MS. LASH: Okay. Ilene?

17 MS. STEIN: Just jumping back to
18 the point about goal setting and progression
19 towards goals. There's just -- the update
20 plan of care regularly as in goal setting,
21 and I think it's true that comprehensive
22 assessment, some of the sub-domains kind of

1 capture what's in goal setting. But the
2 update plan --

3 MS. LASH: Could you just speak up
4 a little, sorry.

5 MS. STEIN: Oh, sorry. The update
6 plan of care plan regularly I think needs to
7 be reflected in the comprehensive assessment
8 in order to make it link appropriately toward
9 progression goals.

10 MS. LASH: Okay. Robert?

11 DR. ROCA: I just wanted to put in
12 a pitch for experience. You know I think
13 that in the end, the patients, I mean the
14 providers to some extent, but the patients
15 are the ones who are probably the best judges
16 of whether the coordination took place or
17 not. Because the burden often falls on them
18 or their families to accomplish that when
19 it's not happening.

20 So I'm disappointed it scored so
21 poorly.

22 MS. LASH: Um-hum. David?

1 MR. CUSANO: Yes. On the
2 experience piece I struggled between
3 experience and goal attainment. And my
4 thought was that you know goal -- experience
5 may be computed maybe indirectly through goal
6 attainment. Because you know, if individuals
7 need to have a positive experience in order
8 to achieve their goals, so I'm wondering if
9 maybe that's -- maybe that gets a little bit
10 at the experience piece.

11 And then just on the efficiency
12 point, I agree, I think it's important to
13 measure. Having been on the other side on
14 the payer side, and drafting some of the
15 shared savings programs, and considering
16 quality measures, I think this is a
17 relatively new concept. And I think it's
18 going to evolve. And I think we need to
19 measure it so that the outcomes that we're
20 looking at, you know we continue to capture
21 what the appropriate outcomes are. What the
22 appropriate allocations are, you know, so

1 that we continue to have innovation that's
2 based around quality.

3 MS. LASH: Russ?

4 DR. LEFTWICH: I guess I would
5 make the argument for efficiency that was
6 made for goal setting. And I don't think it
7 should be one of the categories because I
8 think it will follow with the ones that we
9 do have as the top four.

10 MS. LASH: Don?

11 DR. CASEY: Yes. I would agree
12 with that. I think there's enough good --
13 well good being not excellent, methodology
14 out there around episodes of care that are
15 used in standardized assessments of cost of
16 care. But I view efficiency much broader.
17 And I hope it's not being an apples to apples
18 cost equals efficiency. Because I think
19 there's a lot more in efficiency such as
20 appropriate use that needs to be captured.

21 But I still think that if we're
22 just talking about the cost of care product

1 efficiency, I think there's enough good
2 ability now to measure that.

3 MS. LASH: Judy?

4 DR. NG: Another plug for
5 efficiency. I see it as because as an
6 outcomes measure, it can reflect a lot of
7 other things that are further upstream
8 including processes and some of these other
9 domains.

10 DR. BIRKEL: Could you just repeat
11 that, Lisa. Are you saying no or yes, I
12 couldn't tell.

13 DR. NG: Yes, a plug for
14 efficiency.

15 DR. BIRKEL: Could I ask though,
16 because I feel like Russ and Don and Gerri,
17 you all endorsed efficiency, but said you
18 know what, it's low hanging fruit. It's
19 already going to be done.

20 So is that a gimme? I mean
21 basically we got that one and we shouldn't
22 put it in a priority for HHS because it's

1 already being taken care of? Is that what
2 I'm hearing?

3 DR. CASEY: Well I think my
4 approach is having now been three cycles,
5 four cycles of this, and been on four
6 technical expert panels for CMS on cost of
7 care for a variety of conditions. I think we
8 have enough critical mass to say that that
9 maybe isn't as important. I'm not saying
10 it's -- I'm not trying to devalue it. I'm
11 just trying to say in these other domains, we
12 don't have really anything, right.

13 MS. LASH: Nancy?

14 DR. GIUNTA: I just wanted to
15 share my thoughts on the efficiency piece. I
16 came to this thinking we're trying to
17 identify big gaps in where we have measures.
18 So for me that's -- I agree, I think measures
19 of efficiency are being captured. Maybe not
20 process oriented efficiency.

21 And also the measure of experience
22 may be -- may be combined with some of the

1 others. David mentioned -- which one did you
2 mention? Goal attainment? Yes. I was
3 thinking maybe experience could be within the
4 linkages synchronization area where
5 stakeholders could share their perceptions on
6 how linkages took place.

7 MS. LASH: Vija?

8 DR. SEHGAL: Yes. So I wasn't one
9 of the two who voted for quality or
10 availability of services. However as an
11 after thought, and really I wouldn't be doing
12 my job, my real job a service if I didn't put
13 a plug in for it.

14 One of the biggest problems with
15 the under-served communities is access to
16 care. Access to specialists. Access to
17 anything quite honestly. And it's -- you
18 know, and yet we deal with some of the
19 sickest most complex patients. And the
20 primary care physicians and the primary care
21 teams really struggle to coordinate their
22 care by themselves without being able to

1 access specialists and whatnot.

2 So I think access to care, it's a
3 huge, huge disparity right now.

4 MS. LASH: Fred and Don, did you
5 want to add on something you said earlier, or
6 are you finished? Your card's still up. You
7 Tim? Finished. Okay, Russ?

8 DR. LEFTWICH: So access to
9 services, availability is important. It's a
10 disparity, but I don't see how it's a measure
11 of care coordination.

12 MS. LASH: Okay. I am going to
13 probably assume that everyone wants to re-
14 vote based on the discussion?

15 DR. REDDING: Could -- just based
16 on Russ's comment. What came up yesterday, -
17 - and because this is a good -- it's a good
18 questions. Is that it's -- and maybe this is
19 what you say yesterday Russ, it -- someone,
20 it might have been you, said that it is at
21 least -- it goes along with the same, our you
22 know, discussion about whether there's too

1 many services, not enough, or poor quality.

2 It's at least a very critical data
3 element within -- especially, I say where --
4 especially where if we're seeing care
5 coordination, which I think has been some of
6 the definitional challenge with folks. If
7 we're seeing care coordination as including
8 individuals as well as systems of care, that
9 that's all under the umbrella of the term
10 care coordination, which I think we could
11 have a rich discussion about.

12 But if it is, which it seems to be
13 at the moment, then you need at least at that
14 system level, it seems like you need that
15 data element. And that it's critical. But
16 I'm ask -- you guys know better than I do.

17 Or could I add one other point?
18 I'll give you another point on that.

19 In our care coordination work, we
20 track pathways that look at whether or not
21 people connection to prenatal care. And so
22 we realized it was taking a really long time,

1 it was insurance based.

2 And so within the pathway, it has
3 -- when they are able to get insurance, or
4 when the client's able to get insurance, what
5 we found out in this little rural Ohio
6 county, we have urban counties too. But the
7 rural Ohio county was that people couldn't
8 get prenatal care in a timely way because
9 they couldn't get insurance.

10 And the reason why they couldn't
11 get insurance even though they were pregnant
12 and qualified, is because none of the doctors
13 in that community would see a patient unless
14 they had insurance. So -- and so they
15 couldn't go anywhere to get a pregnancy test
16 that would qualify to Medicaid that they
17 needed the insurance.

18 So it wasn't until the data was
19 evaluated at a system level where we had a
20 couple of hundred of these stacked up that
21 somebody then made a policy decision. And
22 actually it was just a phone call to the

1 Public Health Department who agreed to
2 qualify them as being pregnant on a -- you
3 know, on a pregnancy test.

4 So this data of -- especially data
5 that shows where there's not a service, can
6 be transformative.

7 MS. LASH: Last comment from
8 Michael.

9 DR. PARCHMAN: I was just going to
10 respond to that. That for me is still
11 working on the improving access issue. Once
12 you have access to the service, then you
13 begin working on the coordination piece. But
14 that's just my mental bother.

15 MS. LASH: Ilene?

16 MS. STEIN: Sorry. So is it
17 possible based on the four that end up
18 getting the most votes, that we could shift
19 around some of the sub-domains to make sure
20 that the --

21 MS. LASH: Potentially, yes.

22 MS. STEIN: Okay.

1 MS. LASH: Yes. All right, so
2 think again about what you'd like to
3 prioritize as domains and we'll take a second
4 vote.

5 MS. DORIAN: Okay, if everybody is
6 -- actually before you start, can everybody
7 push their button and see if a green light
8 appears. Any button. I haven't started it
9 yet, so it doesn't --

10 Okay. It hasn't started, so
11 nothing's captured. Okay. And remember to
12 point over here and hit enter after you enter
13 your four choices. Point this way Don.

14 (Whereupon, the foregoing went off
15 the record at 1:15 p.m. and went
16 back on the record at 1:16 p.m.)

17 MS. DORIAN: Is everybody -- okay.
18 Yea, we've got it. No I actually have all of
19 them at this point. It's just getting that.
20 And Carolyn, we were voting on all of the
21 eight major domains again.

22 So if you could just email me to

1 let me know if you have the same choices, or
2 you wanted to change your choice based on the
3 discussion.

4 MS. INGRAM: Okay, thanks.

5 MS. DORIAN: Just to give Carolyn
6 a second. Well we'll add Carolyn's in when
7 she emails them to us.

8 But for now we have 12
9 comprehensive assessment. 3 for goal
10 setting. 9 for shared accountability. Zero
11 for availability of services. 13 for
12 linkages. 6 for experience. 13 for progress
13 towards goal attainment. And 6 for
14 efficiency.

15 MS. LASH: So we have a further
16 divide between our top three and the fourth
17 choice. Would people like to prioritize sub-
18 domains for comprehensive assessment, linkage
19 and synchronization and progression towards
20 goals only? Or would you also like to
21 prioritize a sub-domain in shared
22 accountability? The latter?

1 We could re-vote with a show of
2 hands or you could say that you're
3 comfortable with this result. But it's up to
4 you. Yes, and thanks for being quantitative.

5 DR. CASEY: I was wondering if a
6 zero on availability of services is correct,
7 but.

8 DR. REDDING: I think I had it on
9 there. Oh, you know what? I -- it's I was
10 advocating for it on part of it being -- it
11 wasn't measured, but it wasn't in my top
12 five.

13 MS. DORIAN: The other -- I mean,
14 there's a possibility that if somebody didn't
15 push the fourth button hard enough, it
16 captured three.

17 DR. CASEY: Could I just make a
18 suggestion, we do the first three and then we
19 can figure out what to do with the rest. And
20 I just wanted to make a point here Sarah,
21 just as a marker.

22 Maybe on the availability of

1 service, maybe, it's less important to
2 measure it. But more important to provide a
3 framework for assessing it. If that makes
4 sense. In other words maybe it isn't a
5 performance measure as much as it is a
6 checklist of available services.

7 So it might then not make it
8 appear that it's not important. But just
9 that we think maybe there's a different way
10 to get at it then performance measurements.
11 So it's just a thought.

12 MS. McCAULEY: And I agree with
13 you John, that that's how I started looking
14 at it. That the quality of services now is
15 in that linkages and synchronization. And
16 the other point was I agree just to do the
17 top three. Because that shared
18 accountability only has two sub-domains.
19 Right?

20 MS. LASH: Excellent point.

21 MS. McCAULEY: Yes. So I mean we
22 could do that, but --

1 MS. LASH: Okay.

2 MS. McCAULEY: They're both to me
3 equally as important.

4 MS. LASH: All right. But let's
5 move on to prioritizing sub-domains within
6 comprehensive assessment. Sure, sorry, yes.

7 DR. MANGIONE-SMITH: Yes. Just to
8 -- if you don't have people accountable for
9 the pieces of the comprehensive care plan,
10 it's not going to get executed. It's going
11 to sit as a document on a shelf. And that --
12 I mean a lot of us voted for that. I will
13 out myself. I not only voted for it.

14 And I mean that really is rooted
15 in having done a lot of focus group work with
16 parents with complex kids who you know,
17 literally say oh, yes, I've got the document.
18 We don't use it, but I've got it.

19 You know, because like all these
20 things are laid out, but it doesn't say who's
21 -- you know, who's the quarter back, right?
22 Sorry.

1 DR. CASEY: So Rita, -- Rita,
2 maybe the -- but maybe Rita, potentially out
3 of the measures that we create, that then
4 becomes the framework for assured
5 accountability. I'm just saying. Maybe it's
6 not so much an individual domain of
7 measurement. But it's the result of us doing
8 it. I'm just speculating.

9 DR. BIRKEL: The one I thought
10 where there was some overlap was linkages,
11 that first domain, shared understanding of
12 care coordination goals, blah, blah, blah. I
13 thought that overlapped to some degree with
14 shared accountability.

15 Do you see that not?

16 MS. McCAULEY: No I -- I a -- now
17 I've changed my mind back to what Rita said.
18 Because that is specifically the plan of
19 care. There's two sub-domains is about that
20 care plan. Whereas I understand what you're
21 saying, but is that shared understanding, but
22 not really implementing and being accountable

1 for that plan of care. And making sure that
2 it's done.

3 MS. LASH: Fred?

4 DR. RACHMAN: So, I wonder if --
5 can we go back to the -- so just to, let me
6 go back to the sub-domains. Oops. So I
7 wonder if we did ten Rita, if that helps?

8 DR. MANGIONE-SMITH: I don't know
9 what that has to do with, I'm sorry.

10 DR. RACHMAN: I'm sorry?

11 DR. MANGIONE-SMITH: I really
12 don't --

13 DR. RACHMAN: No, could there be
14 something around that, that said you know,
15 because if it's just sitting there, if
16 there's not any changes to it, or any
17 updating to it or any -- you know then it's
18 not going to -- you know, it wouldn't need a
19 measure that we could design for that.

20 And I'm also wondering if it's
21 also that holistic monitoring, if we could be
22 creative and shoehorn some kind of experience

1 thing in there. I mean I don't know, but you
2 know, maybe that's where we should aim.

3 Because I don't see how we would
4 prioritize the rest. Because in
5 comprehensive, is it -- to me one through
6 nine are the elements of a comprehensive risk
7 assessment.

8 So like if we choose one or two,
9 we're like, I don't know.

10 MS. McCAULEY: Except I think what
11 Ilene had said earlier was the update plan of
12 care regularly would be moved up to
13 comprehensive assessment. Is you move --
14 you're requesting to move that from goal
15 setting up. So then -- but it still doesn't
16 have that accountability.

17 MS. STEIN: Yes. And I guess
18 maybe that would be incorporated into
19 continuous holistic monitoring. I feel like
20 the staff is about to kill me for what I'm
21 going to say. But I guess if I had known
22 that we were going to choose one sub-domain,

1 I would have worded the sub-domains
2 differently. So that they were more -- like
3 they encompassed more than they currently do.

4 But I would change -- I would
5 also, as Fred said, pick ten. But maybe like
6 modify it a bit so that it captures something
7 more than what it currently captures. But I
8 do feel like that's the most on of all of
9 them.

10 DR. PARCHMAN: I'm confused about
11 the conversation. Isn't it one of the top
12 four? Accountability, right? We're only
13 going to do three? I didn't understand it we
14 had limited it to three. I mean if --

15 MS. LASH: Well we --

16 DR. PARCHMAN: So are we choosing
17 four or are we choosing three?

18 MS. McCAULEY: No, no, no. We're
19 not talking about the sub-domains. We're
20 going back -- go back to the domains.

21 DR. PARCHMAN: I'm going back to
22 the domains we've chosen to --

1 MS. McCAULEY: We had four, but
2 we're saying that we're just going to do the
3 top three and then that left shared
4 accountability out.

5 DR. PARCHMAN: I didn't understand
6 that we'd agreed to the top three. Is that a
7 vote we took? Or what's the process here?
8 What's our process here as a group?

9 MS. LASH: Let's do a show of
10 hands on who would like to prioritize the top
11 three, raise your hands. Versus the top
12 four. Okay, so we'll communicate that all
13 four of those domains are prioritized.

14 And now we'll vote on sub-domains
15 within. And Rita has a questions, sure.

16 DR. MANGIONE-SMITH: I'm really
17 worried about the comprehensive assessment
18 thing, just being able to pick one. I mean
19 there are 17 of us and there are 10. You
20 know, how are you going to get a majority in
21 any of them, because they're all important.

22 Yes, you're only allowed to pick

1 one sub-domain.

2 MS. LASH: A measure development
3 priority.

4 DR. BIRKEL: Yes --

5 DR. MANGIONE-SMITH: Since there's
6 so many, could we chose more for that one?

7 MS. LASH: Do you want two?

8 DR. RACHMAN: Could I try again?
9 I mean my suggestion with this one looking at
10 it, again is that really one through nine are
11 the elements of a comprehensive assessment.

12 So there really are two areas for
13 measure here. One is measure that a
14 comprehensive assessment doing all those
15 domains is done. And the second is that it's
16 continuously updated and used.

17 And that -- I think that's it. I
18 mean I don't think we, personally -- pick. I
19 say that's what we should put out.

20 MS. LASH: So are you meant to
21 change the sub-domains entirely to talk about
22 all elements including A through F, or

1 whatever number of elements there are. And
2 then the second part was that it would be
3 continuously used and updated?

4 David?

5 DR. ACKMAN: Yes, the problem with
6 that is that you need -- presumably if you're
7 trying to measure it, if you're missing one
8 element, you're -- you miss on that measure.
9 What?

10 DR. MANGIONE-SMITH: Not
11 necessarily.

12 DR. ACKMAN: Well that's -- no,
13 but that's what he's saying. That one
14 through nine are -- that is if the -- what
15 you described was you have to be 100 percent
16 complaint or complete on this, or you do not
17 get credit for it.

18 DR. MANGIONE-SMITH: But you --
19 you can -- I'm talking out of turn, I know.
20 You can structure a measure for personal
21 credit. So if you have a laundry list of
22 things like this that you're looking for

1 content wise in a particular document or care
2 plan, we do this all the time when we develop
3 measures. We say you know, you get you know,
4 if there's five things, you get 20 percent
5 for each one of those, right.

6 So you take the mean of the things
7 that are there to get the score. So you
8 don't -- you can make it all or nothing,
9 that's pretty stringent. That's pretty
10 uncommon in quality measurement.

11 MS. LASH: Richard, did you want
12 to add something?

13 DR. BIRKEL: I would agree. I
14 mean I think the comprehensive assessment is
15 one through nine, there's probably a couple
16 missing. But it's good enough. And then the
17 monitoring may be where we just really don't
18 have measures. I would say that that's a
19 gap. Continuous monitor.

20 But anyway, that's my opinion.

21 DR. REDDING: The only part of it
22 I would just nudge on would be to keep the

1 mention of risk in there. We have a lot of
2 evidence that people most at risk don't
3 connect to care. And I don't -- maybe
4 there's another way like we did with the
5 other -- maybe there's another way to do
6 that. Maybe our outcome measurement folks
7 know.

8 But there's got to be a better
9 focus. We need to be making sure the most at
10 risk people get the services they need. And
11 right now they're not. And part of it's due
12 to a measure.

13 I think the other thing that's
14 been shown is that our services generally run
15 from people who are most at risk. Whether
16 it's primary care or even care coordination,
17 because they're so complex, it take so much
18 more time. It may not be of our culture.

19 So somewhere, and maybe you guys
20 would know how to do it, risk needs to be
21 focused. Thank you.

22 DR. LEFTWICH: Albert Einstein

1 said you don't understand something until you
2 can explain it to your grandmother. And I
3 could not explain continuous holistic
4 monitoring to my grandmother. I have no idea
5 what that means.

6 MS. LASH: We might be re-framing
7 that as the assessment is repeated on an
8 ongoing basis and reflected in the plan of
9 care. Is that what was intended by whoever
10 suggested we added that yesterday? Okay.

11 DR. CASEY: So I think the intent
12 of this exercise is not to feel like we're
13 locking ourselves in to anything. And I
14 think that you know, maybe the question is,
15 if we were forced to prioritize on these,
16 what would that look like? And if the answer
17 based upon what people use in the clickers,
18 the first go around, covers it all, maybe
19 we're done by saying that's it.

20 I'm just -- I think what we're
21 just trying to do is get directionality and
22 not feel like you know, if we get zero votes

1 on one, that it's not important anymore. I
2 think you're just trying to sort of do this
3 so maybe if people just punched in two and
4 we see what we got, and not view this as like
5 --

6 MS. LASH: Yes, more of a straw
7 poll.

8 DR. CASEY: The ballot box.
9 Right. Just to see where things are and let
10 it fly.

11 MS. LASH: Okay. Yes, this has
12 been a rich discussion and it's showing that
13 you know, we need to re-frame the potential
14 draft of the domains and sub-domains as we're
15 going to communicate their priority. So it
16 seems like there will be -- need to be some
17 written email follow up with the group after
18 the meeting.

19 So I'll suggest that after we get
20 a comment from Fred, we vote for two of these
21 existing sub-domains. And we'll take into
22 account the results as we edit the content of

1 this domain.

2 DR. BIRKEL: Just a comment, are
3 we going to have trouble with number 10
4 because that's two digits?

5 MS. LASH: Let's assume that it
6 has to do with the reassessment on an ongoing
7 basis to inform.

8 DR. BIRKEL: Punching it into our
9 little clicker.

10 MS. LASH: Oh, oh, sorry.

11 MS. DORIAN: Zero, yes zero.

12 DR. BIRKEL: Just use zero, good.

13 MS. LASH: Fred did you want to
14 add something?

15 DR. RACHMAN: Well now I have two
16 questions. So the first question was, I do
17 think we should clarify a little bit what
18 we're voting on for 10. And so I think the
19 continuous you covered.

20 And I wonder if I'm making a leap
21 in my interpretation of holistic. But what I
22 thought that meant was that multiple sort of

1 service provider types are contributing. So
2 it's not just a medical monitoring, but it's
3 a -- is that what everyone else thought of by
4 holistic? Okay, so at least we know what
5 we're voting on.

6 So now I have a second question
7 Sarah, because I thought we maybe suggested
8 that one through nine are not separable. And
9 also Mark, nine I think covers your point
10 about tying it to some notion of risk.

11 So I personally will have trouble
12 like pulling four out versus six, or
13 something. I don't know if others will have
14 that same problem.

15 So I don't know how to vote in
16 that. If we're choosing two from this, I
17 would have a lot of trouble.

18 MS. LASH: Linda?

19 DR. LINDEKE: As somebody who
20 corrects -- as someone who corrects student
21 grammar a lot, this list could be -- this
22 list, I'm saying as someone who corrects

1 student grammar, this could be so simplified
2 by having one verb, the verb is assess.
3 Documentation is assumed and then having the
4 sub-points.

5 And then change number 10 to a
6 second verb, assuming that all those other
7 things are under the verb assess. And then
8 the second is monitor continuously and
9 holistically. And then you have a very small
10 measure with sub-points.

11 MS. INGRAM: I really like that
12 suggestion.

13 MS. LASH: So we'll -- I'm not
14 sure if I'm in charge, or Mark is, or Sam is.
15 So should we just dispatch with the vote?

16 DR. RACHMAN: You would have a
17 great system with what Linda said. I think
18 if we --

19 MS. LASH: We can't unfortunately
20 redo it.

21 MS. McCAULEY: So I -- if I could
22 just like paraphrase what Linda said. So

1 Linda you're saying, number one, document
2 care recipients current supports and assets
3 stays. Then --

4 DR. LINDEKE: I'm just saying put
5 assess as the up front of the verb for this
6 entire one to nine.

7 MS. McCAULEY: Entire thing, all
8 the way down to ten.

9 DR. LINDEKE: All the way down.

10 MS. McCAULEY: Okay.

11 DR. LINDEKE: And then your second
12 verb could be monitor with continuous and
13 holistic.

14 MS. McCAULEY: Well then that's
15 just two.

16 DR. CASEY: So -- so can I just --
17 just so we understand again the process.
18 This -- these documents, I think the input is
19 good, but trying to wordsmith it right now,
20 give qualitative input. But this is going to
21 go out for public comment.

22 The word smithing is going to

1 happen. Ten iterations are going to be 500
2 times as many people looking at this. And I
3 think we just have to sort of capture the
4 points about what you made about the verb.
5 And we can modify them anyway we want.

6 But this is really a first round
7 as opposed to an end game, so.

8 DR. REDDING: Vija?

9 DR. SEHGAL: I just want to second
10 what Mark said. Actually I have no trouble,
11 I have a hard time lumping them. I have an
12 easier time separating them because I
13 actually see some significant gaps in some of
14 these measures. Especially the risk one like
15 you said. And I'm going to add social in.

16 So I mean I've just disclosed how
17 I'm going to vote. But I actually think that
18 there are severe gaps. And when we do have
19 care analysis, we don't adequately address
20 each one of these measures. And if we're
21 trying to identify what the gaps are, that's
22 all we're trying to identify right now, so.

1 DR. REDDING: I wonder, is it
2 possible, and would it be meaningful to you
3 if we broke out, it looks like either three
4 or four categories there. And then left the
5 one under assess with some sub-categories.

6 So for example, if we had under
7 assess, like Linda said, and I know we can't
8 retype the slide. But if under assessment
9 was all the different things we're assessing,
10 2, 3, 4, 5, 6. And another sub-heading under
11 assess was that it's continuous, but we leave
12 that -- the assess, that puts it in one
13 bucket.

14 And then you've got capture
15 preferences and goals is a second bucket.
16 Risk is a third bucket and we've got -- and
17 then -- yes, we're done, we've got three
18 buckets.

19 Would -- is that doable Gerri?

20 DR. LAMB: Because I would support
21 would be able to suggest is if we want
22 specificity, if we start lumping, it's going

1 to be really hard to interpret it.

2 So if we vote for where we think
3 there are gaps that need to be addressed as a
4 priority, then at least we know where we're
5 at. If we start lumping, we won't know.

6 DR. REDDING: and my question,
7 just to clarify because you guys know, but in
8 this case there would be sub-lumps. So there
9 would be a large lump and little lumps. So
10 we wouldn't be -- we wouldn't take it off,
11 but maybe that makes it to -- we're not
12 allowed to go that far. But I understand.

13 They do fit into a -- I think what
14 Fred's been pointing us at, is they do sort
15 of fit into a category. And yet this sub-
16 categories are critical.

17 Rita?

18 DR. MANGIONE-SMITH: I'm going to
19 make one more pitch for us to allow the list
20 to act as a whole. And here's my reasoning.
21 When we did our field test of the survey
22 measures we developed, we asked about do you

1 have a care plan? And then we asked a series
2 of things. Does this care plan include you
3 know, assessment of your child's function,
4 assessment of your social needs.
5 Operationalized so that parents could
6 understand what we were asking, right.

7 And what we saw in the scoring of
8 that measure, was that there were some of
9 these, everybody had medication, you know.
10 That was on everybody's you know, allergies
11 was on everybody's, how to contact their
12 primary care provider was on everybody's.
13 But some of these other ones were not.

14 So you would think why don't I
15 think we should just do it all separately and
16 prioritize the ones that you know, we
17 identified, or I know are more likely to be
18 lacking. None of them were, other than
19 medications, were great.

20 And so I just feel like collecting
21 the information on the full assessment, the
22 comprehensive assessment, can kind of drive

1 improvement because we can see where all of
2 the deficits are. And if we see that
3 medications is not a big deficit, we don't
4 need you know, that's not where our
5 improvement needs to be. It kind of directs
6 us that we really need to do better at
7 accessing risk and assessing engagement in
8 this instance.

9 DR. REDDING: So as a re -- just
10 to -- as a -- to check in with what you just
11 said. This is a group of measures that
12 should not be taken apart. It should hold
13 its own as a whole. And I don't know if that
14 -- in other words if you took out one
15 component, it would significantly weaken the
16 whole domain.

17 DR. MANGIONE-SMITH: I think the
18 measure would be less informative.

19 DR. REDDING: Okay.

20 DR. MANGIONE-SMITH: Because you
21 know, it assumes, oh, we're already doing
22 that check. We don't have to ask, or we

1 don't have to look.

2 DR. REDDING: Okay. Excellent.

3 DR. MANGIONE-SMITH: And my
4 concern is, even on medications, even though
5 it was 88 percent, 12 percent of the time it
6 still wasn't there. You know what I'm
7 saying? And the only way you know that is
8 when you construct the measure, you require
9 that each one of those things is looked for.

10 DR. REDDING: That seems like an
11 excellent point. Don?

12 DR. CASEY: So I just want to
13 point out here that what you're talking about
14 in NQF lingo is a composite measure, right?
15 And I would suggest that an important part of
16 the composite measure is to assess the sub-
17 domains in terms of importance, validity,
18 reliability and usability. Those are the
19 four categories.

20 And I'm just looking at the
21 difference between assessing behavioral
22 health needs and health literacy. Now the

1 two are related, but I could imagine going to
2 Dr. Roca and spending three hours on number
3 4. And you know someone taking my medication
4 management needs you know, in about 15
5 minutes.

6 So all I'm saying is I think these
7 things fit together as a composite. And I
8 think if we said conceptually we believe this
9 is a composite measure, we still should help
10 prioritize where we think the biggest
11 opportunities are.

12 DR. BIRKEL: Could I -- can I make
13 a friendly amendment then to both. So to go
14 with the three, but then within the composite
15 measure, vote for the one or two that are the
16 highest priority for development. But to do
17 both things in sequence. The three element
18 approach which you suggested Mark.

19 DR. REDDING: Okay.

20 DR. BIRKEL: And then within the
21 first element, which of those in the
22 composite assessment is the weakest.

1 DR. REDDING: Oh, okay. Yes, does
2 that make sense to you Don?

3 DR. CASEY: I view that as one
4 possibility.

5 DR. BIRKEL: Well, no. The three
6 is the assess -- the comprehensive
7 assessment, the risk level assessment and the
8 monitoring.

9 DR. REDDING: So he's got -- he's
10 making -- he's taking -- he's making three
11 measures. One of them has a composite
12 because it has -- the other ones fall out
13 within a group. So one of them would be a
14 composite into --

15 DR. CASEY: At this point that's
16 going to be up to the panel development I
17 guess.

18 DR. REDDING: Okay. One -- this
19 may be inappropriate. But one other thing
20 that seems to be missing and would hate to
21 have this go forward is we do not have assess
22 health needs. And I know we're trying to

1 focus on the other needs. But it's not on
2 the list with -- if it's not inappropriate,
3 could I -- could we request to add that sub-
4 domain? Just as part of the laundry list
5 under the other ones? Okay.

6 And so -- so would there be a show
7 -- how do you recommend Sarah, should we have
8 a show of hands, or -- so I think we've -- I
9 think we have two things on the table. I'm
10 trying to make sure we could maybe put them
11 both together.

12 I think that -- I think that what
13 Don and Russ and Gerri are saying is, I think
14 we could put this on the table. They will --
15 others will create the right groups. And
16 they still want to know of this full set,
17 which ones are priority. Am I saying that
18 right?

19 MS. LASH: Where to start.

20 DR. REDDING: Yes, where to start.
21 And even though we know there's lumps and
22 sub-lumps, they want to know even in the sub-

1 lump category, what there is. So whole new
2 terminology we're developing.

3 No, but anyway, so is that okay
4 with everybody, show of hands? That we just
5 vote on the three most, or -- is it two or
6 three? Two most important of this list.

7 DR. LINDEKE: How do you do a
8 double digit entry for number ten?

9 DR. REDDING: Zero.

10 DR. LINDEKE: That's a zero, thank
11 you.

12 DR. REDDING: It is zero, yes.

13 DR. LINDEKE: I was just wondering
14 that, thank you.

15 MS. McCAULEY: I just wanted to
16 follow up. So with the health needs,
17 describe what that means. Assess health
18 needs. Would that be the nutrition?

19 DR. REDDING: It could be
20 nutrition, it could be --

21 MS. McCAULEY: Physical?

22 DR. REDDING: Primary care

1 physician, it could be -- do you have up
2 chronic illness. I think there's a long list
3 to that one.

4 MS. McCAULEY: That's what I'm
5 saying. So that's where I was thinking --

6 DR. REDDING: Yes.

7 MS. McCAULEY: Because we don't
8 have a -- because we've got specifics.

9 DR. REDDING: Yes, so as you vote,
10 oh, you know what? We're going to have to
11 have a show of hands if health needs is one
12 of your top two.

13 Fred, did you have something, I'm
14 sorry?

15 DR. RACHMAN: Well, maybe I just
16 need to be a dissenting vote you all. But I
17 am very troubled by prioritizing behavioral
18 health needs over social needs. Over health
19 -- I'm very troubled by this process.

20 I'm very fundamentally troubled.
21 And I think the whole point here about care
22 coordination is that we're not going to

1 segment and bucket these. And you've lost
2 me. Well you've lost me on this one.

3 And I -- you know, the other thing
4 is, one of the other values of this, is this
5 is going to be potentially a -- something
6 that's going to drive how people begin to
7 structure their information systems and how
8 they collect things. And how they you know,
9 prioritize data, et cetera.

10 So I'm -- I just have to say I'm
11 very troubled. And I personally, I cannot
12 vote one versus the other in those
13 categories.

14 DR. REDDING: Fred, if you have a
15 recommendation, I think our ears are open. I
16 think one of the things that I may be talk --
17 walking away from the discussion with is that
18 we don't have to be responsible for
19 categories. And there are so few measure out
20 there now across a -- you know, across a huge
21 list that's tough for any of us to
22 prioritize.

1 Which one of -- I think the
2 question is which one of these is in a state
3 of readiness as a pilot within a need for a
4 huge expansive measures? But if you have any
5 suggestions, it's open.

6 DR. RACHMAN: And the suggestion
7 was, if we're saying that we're not ready to
8 have a measure that -- because look at the
9 title of this. It's comprehensive
10 assessment. What this group is saying is
11 that if we can't handle a measure around a
12 comprehensive assessment, scrap it. But
13 don't like, pick assess medication management
14 need, because that is not comprehensive
15 assessment. It defeats the whole purpose of
16 what I came here to talk about.

17 I just can't tell you how
18 passionate I feel about this.

19 DR. REDDING: So could -- well
20 could -- so one -- so there might be two
21 options there. One might be to scrap it and
22 to move on. The other one might be and I'm

1 asking the measurement folks, is to go ahead
2 and vote, but to request very much that what
3 Fred -- that this vote is qualified by the
4 fact that it's a much bigger issue than those
5 two little items.

6 And if you think that it might get
7 -- the misinterpretation that Fred's stating
8 might be real, then maybe we should scrap it.
9 And we're asking. We need your guidance.
10 Gerri or Don or Russ?

11 DR. MANGIONE-SMITH: Well, Fred
12 I'm totally with you. I mean I very clearly
13 hear your concern. And I think the challenge
14 right now is it sounds like the word voting
15 means we're locking our selves into something
16 we don't want to you know, that is going to
17 be publicly displayed. And is going to set
18 the state for the wrong mind set.

19 I don't -- I view this as more of
20 an exercise -- a thought experiment. Maybe
21 it's the wrong thought experiment, but you
22 know, which of these are going to be harder?

1 Not that they're -- that one is more
2 important than the other, but which might you
3 know, be more of a challenge? And I'm not a
4 measure developer. I'm just one that has
5 dealt a lot with consensus development around
6 things like composite measures.

7 So I don't think, maybe voting is
8 the wrong word. I don't know. I think we're
9 just trying to get the temperature of the
10 room on some of the specific areas and see
11 what we get. And not worry that this is
12 going to be in the New York Times tomorrow.

13 DR. REDDING: Fred please?

14 DR. RACHMAN: Just one last
15 question.

16 DR. REDDING: Sure.

17 DR. RACHMAN: I still don't
18 understand why the suggestion of bundling
19 these together as one measure with a percent
20 for each one, why we can't do that? And I
21 just want to tell you that I showed you a
22 screen in our EMR, we're essentially doing

1 almost all these measures.

2 The only one that I think you
3 know, I'm not sure that we're doing very
4 accurately right now is health literacy. But
5 that's a small leap.

6 And it would be possible to -- so
7 I know that it's possible to do this you all.
8 So I -- again, I just -- I don't know why we
9 are scrapping that idea of saying erase 1
10 through 8 and call it comprehensive
11 assessment with bullets. Why we can't do
12 that.

13 DR. CASEY: Were you here when we
14 talked about composites?

15 DR. RACHMAN: Yes.

16 DR. REDDING: Yes, I think we can
17 if we call 1 through 8 one composite lump
18 with sub-lumps.

19 Yes, Sharon?

20 MS. McCAULEY: So would health
21 needs be in that?

22 DR. REDDING: It would.

1 MS. McCAULEY: 1 through 8, well 1
2 through 9.

3 DR. REDDING: Yes.

4 MS. McCAULEY: So we can't do
5 that, but we'll have to -- okay.

6 DR. REDDING: Well we could do it.
7 I think we could accomplish it. We've got
8 strategies to still accomplish the vote.
9 Because it would all go under one. You would
10 just be voting on the assessment.

11 MS. McCAULEY: Right.

12 DR. REDDING: Michael?

13 DR. PARCHMAN: I've heard over and
14 over again now that 2 through 6 are
15 considered to be a single construct, this
16 assessment construct. But I've also heard
17 that also looking at supports and assets is
18 different then assessing needs, which is what
19 2 through 6 seems to be.

20 So one way to do this is to talk
21 about there being really five sub-domains,
22 which is optimizing supports and asset. The

1 assessment function, which is 2 through 6.
2 Looking at their level of activation.
3 Capturing their goals and preferences. And
4 then customizing the coordination approach.

5 That would give you really one,
6 two, three, four, five sub-domains. And I've
7 heard that several times suggested around the
8 room this afternoon. Maybe I've
9 misunderstood the conversation. But it seems
10 like to me we need to come to closure at this
11 point. And I think Sarah and Mark were
12 looking to your help to help us, force us to
13 come to some closure on this.

14 DR. LEFTWICH: So I have to say
15 that from a data capture standpoint, grouping
16 2 through 6 is -- doesn't make -- makes it
17 very difficult. And it might cause measure
18 developers to say no. Not even going to try.

19 Whereas at least some of those as
20 individual measures, would be captured in the
21 course of care. In the course of care
22 planning maybe I should say. Like capturing

1 preferences and goals.

2 DR. REDDING: So one of the ways
3 that I think it might clarify is, I think
4 we're stuck on this one because there's -- we
5 can't get them all into one -- we need the
6 ability to make another sub-category.

7 And even though we weren't
8 supposed to go that far, the issues are too
9 critical. So instead of say clumping them
10 all into one measure, it's a family of
11 measure -- or a group of measures like Don
12 was saying.

13 So let's -- let me ask, if we
14 could have a proposition for a for group
15 number, and we'll just go through this
16 exercise and if it's successful, great. If
17 not, what goes in group one, we'll just call
18 it group one of a grouping of these.

19 Is it function social needs, and
20 again, this isn't separating it out as a
21 measure, it's separating it out as a group of
22 specific measures. I think it's function,

1 social needs, behavioral health, medication
2 management, health literacy and health. Is
3 that correct?

4 And Michael does that fit with
5 what you're saying? Okay, so that would be
6 group one would be under -- and it would all
7 be under assess.

8 And then we've got group number
9 two would be measure, care, recipient
10 activation. Is that correct Michael? Okay.

11 DR. BIRKEL: Just a comment, I
12 mean is there a strong relation between
13 number one and number -- I'm sorry, between
14 number one and number seven?

15 DR. REDDING: Yes. So --

16 DR. PARCHMAN: What was --

17 DR. REDDING: Yes, thank you, yes.
18 So two is activation, well to simplify it.
19 Three is preferences. Yes. And four is
20 risk. And five --

21 As long as we say assess
22 continuously, I think fitting with what Fred

1 talked about earlier where everyone is
2 beneath the umbrella of the system, couldn't
3 we just say assess continuously. And that
4 would allow us to collapse continuous
5 holistic monitoring with assess.

6 In other words, we're going to --
7 I don't mean to make it -- but we are going
8 to have a continuous approach to assessing
9 these issues. So from the time the baby
10 shows up we're going to be assessing it. And
11 there will be a first one, but it just comes
12 along with it.

13 So that would give us -- so that
14 would give us preferences -- yes, so that
15 would give us four. And realizing that one
16 is very much, and they probably all represent
17 families of measures, but one represents
18 families of measures.

19 And then we -- could we vote for
20 the top two in those four? And would that be
21 helpful to the folks trying to figure out
22 measures? No? You need something more

1 specific?

2 DR. CASEY: I guess. So let me be
3 clear. We're chairing the consensus
4 development on submitted measures. So I
5 don't want to continue to posit myself as the
6 expert in this. I really don't. I don't
7 think Gerri does either.

8 So we're just trying to bring our
9 experience of measure development, consensus
10 development into play here in terms of this.
11 But at this point, I'm comfortable with the
12 direction this is going in. I --

13 DR. REDDING: To vote with these -
14 - one of these four, would be at least
15 helpful?

16 DR. CASEY: At this point we're
17 going around in circles. So I'm just hoping
18 we can --

19 DR. REDDING: Come to closure?

20 DR. CASEY: Do something.

21 DR. REDDING: Okay. Okay. So is
22 there an electronic way to vote one through

1 four if we know what it is? Then do you want
2 to do show of hands? Okay.

3 MS. LASH: I think we've still got
4 some people still in the room.

5 DR. REDDING: Oh yes. Sorry.
6 Quick questions, Fred?

7 DR. RACHMAN: Russ' remark made me
8 want to ask this question. Are we -- is the
9 lens -- one of the lenses we should be using
10 whether these are ready for prime time for e-
11 specification? Because that -- that would
12 change a lot.

13 Or are we saying that you know,
14 we're putting these measures out there you
15 know, as an aspirational set of measures.
16 And both we want measure developers to be
17 thinking about it, but we also want the field
18 to be thinking about how potentially they
19 could -- we could figure out how to collect
20 them electronically?

21 DR. REDDING: Great question. I
22 do think part of the difficulty is around

1 specificity. And so you know, do you need
2 large groups, little groups, or actually
3 specific measures to go out and measure? I
4 think that's where we've had the biggest
5 challenges in group, in whether or not to
6 group things or not.

7 I think in some cases what you've
8 got here in terms of priorities, are some are
9 more specific than others obviously. And
10 that probably makes it a little bit confusing
11 in the comparison. Is that what you're
12 thinking Don? In part?

13 DR. CASEY: Not really.

14 DR. REDDING: Okay. So I think
15 any of the categories one through four could
16 break out into multiple specific e-ready
17 measures. Rita or -- oh, yes, Rita please go
18 ahead.

19 DR. MANGIONE-SMITH: So just a
20 couple. One thing I'd like to understand
21 better. So my assumption about what we've
22 been doing here the last day and a half is to

1 come up with priority areas for measure
2 development for HHS.

3 So although it won't go to the New
4 York Times, what we decide here will
5 influence how funding goes for measure
6 development. Am I correct about that
7 assumption? Okay.

8 So I think you know, it's not
9 trivial, a trivial exercise that we're going
10 through. And I think that's why many of us
11 are having a lot of angst about this.

12 I can honestly tell you,
13 psychometrically, those things under assess
14 will not go together when people -- when you
15 score them they will not flow as a domain. I
16 can promise you that. They are radically
17 different from each other. And just because
18 one's in place, there's no correlation that
19 another will be in place.

20 So I think what people think about
21 survey composites, that's not exactly how I
22 would think about this. I would think about

1 this as a multi part measure of a
2 comprehensive assessment.

3 And I think what I'm struggling
4 with is, as a quality measure developer, if
5 HHS came looking for people to develop
6 measures around a comprehensive assessment,
7 that would then get operationalized by the
8 developer.

9 And if we want to give some
10 suggestions about what we think that should
11 include, I think that's reasonable. But I
12 don't really feel like these are sub-domains.

13 And I think where in other areas
14 what we've identified really feel like sub-
15 domains, these don't. And I think it's just
16 this long list of all of our wishes you know,
17 that these all end up on the comprehensive
18 plan you know.

19 So I'm having a hard time with
20 breaking them into any kind of groups to be
21 honest with you.

22 DR. REDDING: So give -- help us

1 with -- you know, obviously there's, if we
2 went down the chain of measures, you know we
3 have health and then we go to behavioral
4 health. Help us with the terminology here to
5 straighten that out.

6 I think what we've got is four
7 different areas that measures could be
8 developed in. One of them being this
9 assessment or continuous assessment.

10 I also sense that people don't
11 want, and in fact self included, that we want
12 to make sure if we have assessment there,
13 that those other items are very clearly in
14 there in that group. Otherwise people won't
15 assess social needs and other things.

16 So do you have terminology we
17 could use that would clarify it?

18 DR. MANGIONE-SMITH: I mean to me,
19 as a measure developer, I would look at this
20 as you know, is there a comprehensive
21 assessment available for the patient? Right.
22 So that would be --

1 DR. REDDING: Number one.

2 DR. MANGIONE-SMITH: Measure
3 number one. I'd get all of eligible patients
4 and numerators, do they have an assessment in
5 place.

6 Measure number two would be does
7 the assessment include the following
8 elements.

9 DR. REDDING: Yes, that's great.

10 DR. MANGIONE-SMITH: Ding, ding,
11 ding, ding, ding, ding, ding.

12 DR. REDDING: That's great, that's
13 great.

14 DR. MANGIONE-SMITH: And I will
15 give you partial credit for every single one
16 of those that you hit.

17 DR. REDDING: Yes, that's great.

18 DR. MANGIONE-SMITH: And but
19 that's a measure. One measure. It's not
20 four measures. That's one measure.

21 DR. REDDING: I understand. Okay.

22 DR. MANGIONE-SMITH: I do think

1 that I would have a third measure that would
2 say is there documentation or evidence that
3 the comprehensive assessment was reassessed
4 and updated on a regular basis?

5 DR. REDDING: Okay.

6 DR. MANGIONE-SMITH: You know, so
7 I kind of see three potential measures. Do
8 you have the plan? Does it have the right
9 elements? Do you reassess it and update it
10 on a regular basis?

11 DR. REDDING: Okay. And that is
12 what we would need to cover this assessment,
13 what we have as a group right now. We need
14 three separate measures.

15 And then as a totally separate
16 category moving down the list would be the
17 activation, the preferences and risk?

18 DR. MANGIONE-SMITH: No, I would
19 include that as an element of the
20 comprehensive assessment.

21 DR. REDDING: Aahh, okay.

22 DR. MANGIONE-SMITH: I mean to me

1 one through nine are all part of a
2 comprehensive assessment.

3 DR. REDDING: Okay. That sounds
4 good. So let's see, let me go to Nancy real
5 quick.

6 DR. MANGIONE-SMITH: Don't go
7 crazy, I think you could assess them each
8 individually, right. You know, then you
9 would get a score for each of them.

10 DR. LEFTWICH: I agree with what
11 you're saying. But I have to reiterate that
12 where are you going to get the data for this
13 measure? It's not there.

14 DR. MANGIONE-SMITH: We're not
15 there yet. This is aspirational, right?

16 DR. LEFTWICH: Well this is more
17 than aspirational. I mean some of the data
18 is there. Assess function.

19 DR. MANGIONE-SMITH: Fred seemed
20 to say that they've got everything but health
21 literacy on their, you know, so I don't know.

22 DR. REDDING: So Nancy, please.

1 DR. GIUNTA: I think my comment
2 might be not be valid anymore. But just -- I
3 want to make sure we're not eliminating
4 current supports and assets, that's all.

5 DR. REDDING: Okay. Excellent.
6 No, I don't think we are. Sharon?

7 MS. McCAULEY: So I'm just making
8 sure I follow. So when you have all your
9 assessment -- because to me, like nutrition,
10 physical activity, that's a part of function.
11 It could be a part of social needs,
12 behavioral, it's affecting everything. So
13 it's not called out.

14 So I know everyone wants their
15 pieces. So if you just said health, if you
16 just said you know, assess health, would all
17 of those, isn't that all a part of health?
18 No? I don't know.

19 DR. REDDING: Thank you. No,
20 that's helpful. David?

21 DR. ACKMAN: The question, where's
22 the data going to come from? Plans at least

1 are measured on this. That is they're -- you
2 know, the special needs plans are required to
3 do a comprehensive assessment and update it
4 every year.

5 It's self report, audit able, but
6 that's at least on a plan level, I mean they
7 don't hand the attestation is that the
8 instrument you're using, which you've
9 submitted to HRSA or to CMS and they've
10 approved, contains all the elements. So at
11 least at that -- for our plan, --

12 DR. LEFTWICH: There's data, okay.

13 DR. ACKMAN: Whether if you're
14 measuring, if it's a different entity, that
15 may be more problematic.

16 DR. REDDING: Okay, thank you.

17 Russ?

18 DR. LEFTWICH: I'm talking about
19 electronic data capture and not self
20 attestation about something even if it's
21 audit able. In the end, another -- I can't
22 imagine after this discussion that we publish

1 a vote on anything.

2 DR. REDDING: Yes.

3 DR. LEFTWICH: No, really.

4 DR. REDDING: Well I think that --
 5 so I think the plan would be -- but it's been
 6 a very rich discussion. I think a couple --
 7 I think we should -- it seems like we should
 8 scrap everything except for comprehensive
 9 assessment. Except we're not scraping -- I
 10 don't think we are scrapping that we think
 11 under comprehensive assessment, these items
 12 and including health assessment, are
 13 absolutely critical.

14 And kind of like Fred and others
 15 have said, it's pretty touch to weight one
 16 over the other. So we've got -- so if we
 17 could send back as our report, and I'm
 18 looking around the room, that we feel
 19 comprehensive assessment is important.

20 And that we feel that if you're
 21 going to do it, it's got to have this whole
 22 laundry basket of stuff. And if you want us

1 to prioritize, we tried and it's very
2 difficult to do.

3 But this is essentially our
4 beginning definition of what a comprehensive
5 assessment is. And we don't think it should
6 be done in parts. And could we have a show
7 of hands for that kind of concept?
8 Wonderful.

9 I think we've got one more
10 question, Fred I hope? Okay, good. So Fred
11 -- so good. All right. What's next Sarah?
12 Good work.

13 MS. LASH: All right, given the
14 complexity of the last discussion, I'm a
15 little hesitant to try to have voting on the
16 additional sub-domains. But maybe we could
17 go through them briefly and systematically
18 just to discuss whether you think they're an
19 accurate reflection of the types of concepts
20 you'd like to see within those domains.

21 So that as a whole they are
22 standing together well. And we can maybe

1 confirm that with you and follow up. But
2 this discussion has been very helpful I think
3 in reshaping this domain in particular.

4 I think the other ones might be a
5 little bit more straight forward. And then
6 we can progress with the meeting so that we
7 can end closer to on time.

8 So yes, I guess that brings us to
9 shared accountability where we had two sub-
10 domains of our plan of care documenting who
11 was a part of the care team, including
12 everyone that's been discussed and all sorts
13 of community providers. And that the plan of
14 care is assigning responsibilities to that
15 care team for how they're contributing to the
16 care recipient's goals.

17 Any suggested changes? I'll take
18 it as a no. Wonderful. Consensus. Maybe
19 not, Russ?

20 DR. LEFTWICH: Oh, the -- didn't
21 want to change anything, just maybe the
22 concept that the care team members accept

1 their responsibility.

2 MS. LASH: Yes, they need to be
3 aware of it and accept it, yes.

4 DR. LEFTWICH: Yes, not just --

5 MS. LASH: Just being --

6 DR. LEFTWICH: Assigned it. But
7 it is accepted. Because I think that's very
8 important. I mean reality and practice is
9 patients say that's my primary care doctor.
10 And she says no I'm not.

11 MS. LASH: Right, okay. Don?

12 DR. CASEY: I would just say I
13 think that these are necessary but not
14 sufficient. I sort of look at the title and
15 don't see shared accountability in those two
16 items in the sense that you know, everyone's
17 sort of doing their part, but feeling like
18 they did theirs so they're done.

19 So somehow or another if that --
20 if it's implied that your accountability is
21 to each other, and again, how you measure
22 that I don't know. But in other words, if

1 here was let's say a composite measure like
2 we just did, that everyone I that group would
3 be accountable for the same composite measure
4 as an example.

5 So I'm just trying to get at I
6 don't think there's enough emphasis on the
7 fact that this has got to be one unit of
8 accountability as opposed to islands in the
9 sea, so.

10 MS. LASH: Michael?

11 DR. PARCHMAN: This actually might
12 be also the area where we can start thinking
13 about the 47 care coordinators in the
14 community and the six different care
15 coordinators per individual in terms of
16 thinking about now only who's responsible,
17 but clearly defining who's responsible for
18 what in terms of the accountability.

19 DR. REDDING: That's excellent
20 Michael. So I want -- so what if we added,
21 right now if we use our system and individual
22 concepts, we've got some more individually

1 focused approach on this. But we also need a
2 system level focus on accountability. Or at
3 least to leave the door open for that. Which
4 would look at -- an example of which would be
5 to examine duplication of service.

6 Any comments of that? And how
7 would that be worded, shared accountability
8 and systems of care including for example,
9 the prevention of unnecessary duplication?

10 DR. PARCHMAN: I might use
11 language like agreement among the care team
12 for a response. Agreement among -- across
13 the care team about responsibilities. So
14 it's not just the sign of responsibilities,
15 but there's an exception that there's some
16 agreement among the care team for who's
17 responsible for what.

18 DR. REDDING: So I think we're
19 measuring duplication of service and we've
20 got a research project on it. So it has
21 everything that you know, the 15 care
22 coordinators, one can be from the health

1 department, one from a not for profit, one
2 from children's services. You know what I'm
3 saying.

4 And so they all need to be in a
5 care team and that's -- so maybe so by care
6 team I think you're -- are you implying
7 across a community of -- an organized
8 community of care, or do you mean within more
9 of a specific system like a hospital or?
10 Okay. Okay.

11 So a care team at both the
12 community and individual level. That's
13 great. Yes, that's great. No, I think
14 that's wonderful. What's really neat about
15 that to me is that we need teams around the
16 patient in a community at the state and
17 federal level. And right now we're a bunch
18 of silos all driving the patient crazy. So
19 yes, that's awesome. Okay.

20 So a team -- so a -- could we say
21 a team approach, or an approach to
22 accountability that is at the individual and

1 system level? How would -- does Don or
2 anybody else have idea how to word that?
3 Rita?

4 MS. LASH: I'll suggest that we
5 maybe think about the wording later and move
6 on in the interest of time.

7 DR. REDDING: Okay great. You've
8 got it. That would be great. Thank you
9 Sarah.

10 MS. LASH: I know we have a lot
11 more opportunity we want to hear from others.
12 And let's quickly go to linkages and
13 synchronization. Any burning comments? It's
14 a construct validity here.

15 DR. CASEY: The only thing I'll
16 say here is that this is you know, group one
17 and group three fit nicely in terms of what
18 the people that we're discussing in group two
19 are accountable for. So you know I think
20 these things sort of tie together and I think
21 that hence the synchronization fits in with
22 our discussion on the previous slide, so.

1 DR. BIRKEL: The only question I
2 had really is number five. What does it mean
3 to be the initial linkage. Why did we use
4 that term? The initial linkage? I'm just
5 not sure.

6 MS. LASH: Actually, I think
7 that's something that we edited out. So if
8 you look at your sheet, there's only five
9 sub-domains that I apologize didn't get
10 translated to this slide.

11 DR. BIRKEL: Got it. So the ones
12 that are in our --

13 MS. LASH: This initial linkage
14 and the follow up are I think intended to be
15 part of the bi-directional communication and
16 not just of results but of ongoing
17 communication to facilitate coordination.

18 DR. BIRKEL: The ones on the paper
19 are better, right?

20 MS. LASH: Yes. We were
21 scrambling this morning. I apologize. Fred
22 go ahead.

1 DR. RACHMAN: Inspirational. How
2 would people feel about in that first bullet,
3 having it say shared documentation rather
4 than understanding? I'm looking at the
5 revised version. It says shared
6 understanding by a clinical provider
7 community crossing care recipients with care
8 coordination goals.

9 DR. PARCHMAN: I think
10 documentation is a long way from
11 understanding. A shared understanding. I
12 mean you can document the heck out of the
13 medical records, but if there isn't a shared
14 understanding, then the documentation doesn't
15 serve any purpose.

16 MS. LASH: What would be the
17 rationale for this suggestion? The change
18 you're suggesting?

19 DR. RACHMAN: So if we want
20 everybody marching from the same page, there
21 should be some place where that set of goals
22 is visible and used and shared. It seems

1 it's consistent with ONC direction, you know
2 that there is a single way that this gets
3 reported.

4 And you know, understanding how
5 you would like -- I don't know how you
6 operationalize understanding, whereas we
7 could operationalize the fact that anyone
8 would produce the same care plan where ever
9 they are, the same poles I mean.

10 DR. BIRKEL: The only thing I
11 might suggest is why wouldn't' that one, the
12 shared documentation be part of shared
13 accountability, the one we just got off of.
14 I like it there almost better. And then
15 going to Michael's point about understanding
16 being really part of the linkage
17 synchronization piece.

18 But the shared documentation, I
19 agree of a single plan might be better under
20 shared accountability. We don't have that
21 there. That there's one care plan.

22 DR. LEFTWICH: I would suggest

1 that it be harmonization of goals among all
2 of the team. I mean reality is that multiple
3 plans of care exist for many individuals out
4 there that may have different goals. And so
5 from where we are now, I think the realistic
6 step is harmonization of those goals.

7 DR. PARCHMAN: Is that the same as
8 shared agreement, and the share a common
9 thing is that --

10 DR. LEFTWICH: I think it's
11 probably analogous to shared agreement, but
12 harmonization may be more the process that's
13 needed to get there.

14 MS. LASH: Those that can be
15 consolidated would be, but others which are
16 more in one provider's prevue could remain
17 somewhat independent?

18 DR. LEFTWICH: Right.

19 MS. LASH: Okay. I think we can
20 reflect that. Michael did you have something
21 else you wanted to say before we move on?

22 DR. PARCHMAN: Well I was just

1 going to say that documentation may form the
2 basis of the first step towards shared
3 understanding. So if we're thinking about
4 operationalizing shared understanding, that
5 might be a direction that we can go toward
6 measurement.

7 But I don't think I would put it
8 in here as the sub-domain. I think
9 understanding is a more aspirational goal
10 then documentation.

11 MS. LASH: All right, let's move
12 on to progression towards goals. And again
13 this document will continue to be updated.
14 It's currently called goal attainment.

15 DR. CASEY: I sort of think maybe
16 if it was health and functional status as
17 opposed to health slash --

18 MS. LASH: Okay.

19 DR. CASEY: Functional status it
20 might help measure developers because --

21 MS. LASH: It's not one or the
22 other, it's both.

1 DR. CASEY: Well it's both, but
2 it's not the slash -- I think it's just and,
3 yes. With an H.

4 MS. LASH: Okay. Woody?

5 DR. EISENBERG: Given that this
6 is dynamic, I have to ask my measure
7 developing colleagues, is reduction of unmet
8 needs appropriate? Because new needs will
9 develop during the course of time. So if
10 we're developing a measure that's going to
11 look at the number of needs out there, and
12 maybe it's increased, but everything else has
13 been done just wonderfully.

14 So is there a better way for us to
15 measure that the needs expressed at say the
16 initial interview for example, have been met?

17 MS. LASH: Any suggestions about
18 how we would?

19 DR. MANGIONE-SMITH: I mean, I
20 think if I was trying to operationalize
21 reduction of unmet needs, obviously that's a
22 measure that would have to be done multiple

1 times, right. It could never be a cross-
2 sectional measure.

3 There would have to be an
4 assessment at one time point of you know,
5 what are you needs. And then at the next
6 time point, how many of those needs have been
7 met, in you know, X number of months.

8 It would be a very complex and
9 difficult measure to implement. But it --
10 that's probably how I would implement it.

11 MS. LASH: Great. It's very
12 aspirational. Ilene?

13 MS. STEIN: So in an earlier
14 discussion we were talking about maybe
15 incorporating elements of a patient
16 experience or -- into progression towards
17 goals. And I think that actually makes
18 sense, because a goal should be improve the
19 patient experience.

20 MS. LASH: Fred, did you have
21 something to add?

22 DR. RACHMAN: Could you just

1 repeat what you said.

2 MS. STEIN: So you were there when
3 we were talking about like the larger
4 domains. There was a comment that patient
5 experience in some ways to be rolled into
6 progression towards goals. And it does seem
7 like that would be a place to put it.
8 Because one of the goals should be
9 improvement in patient experience.

10 DR. RACHMAN: Thanks, because that
11 was going to be my comment.

12 MS. LASH: Russ?

13 DR. LEFTWICH: So wording to
14 incorporate Woody's thought would be
15 resolution of unmet needs.

16 MS. LASH: Not account of the
17 reduction, but as needs are identified they
18 are met. Okay. Do you want to repeat that
19 for Lauralei so that she can make that
20 change. It was -- you had a specific word.

21 DR. LEFTWICH: Resolution of unmet
22 needs.

1 MS. LASH: Thank you. David?

2 DR. ACKMAN: How do we think
3 insuring patient safety will be measured? I
4 mean you -- if it's identified as a need, you
5 know for all risk, medication risk, then it
6 sort of fit under that. But beyond that, how
7 do we think about patient's -- measure this
8 insuring patient safety?

9 DR. MANGIONE-SMITH: I would say
10 that that would, the only way I can think of
11 to operationalize that construct would
12 basically be no safety events, you know over
13 a given course of time with a patient. And
14 that assumes that you have a monitoring
15 system in place that's looking for adverse
16 events that's actually queryable and all of
17 that.

18 MS. LASH: I think it might be
19 fair that receiving safe healthcare is an
20 implicit goal of all patients, not an
21 explicit one. Maybe that's in the plan of
22 care.

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Russ?

DR. LEFTWICH: I guess I would say in terms of care planning, that if goals -- the goals that are risk of a harm event fall, whatever medication, if that's a goal, then there should be an intervention associated with it. That you could measure.

You've got a goal that's a reduce -- to reduce of it, patient safety risk. There should be an intervention.

DR. MANGIONE-SMITH: But reduced risk is different from insured.

DR. LEFTWICH: Or maybe insured is too strong a word.

DR. MANGIONE-SMITH: Yes, so I think I like your wording better. You know, reduce patient risk, because that does imply an intervention to reduce risk. You know whether that's med reconciliation or you know, a way to reduce falls, or whatever. I mean I like that actually better than insure.

MS. LASH: Nancy and then Vija.

1 DR. GIUNTA: I'd be really
2 cautious with this construct because when
3 we're talking about adults with disabilities
4 or older adults, or we're balancing
5 independence with safety, and is it up to us
6 to determine what's safe?

7 DR. SEHGAL: I'm actually having a
8 bit of a hard time with the whole unmet needs
9 issue. I mean when I look at progression
10 towards goals, I think of outcome measures.
11 I think of you know, if we're focusing on
12 improving someone's diabetes for example.

13 I look at lowering their
14 hemoglobin A1Cs. If I'm looking at fall
15 prevention, I'm -- well maybe not fall
16 prevention. But in terms of if I'm looking
17 at cardiovascular disease, I'm looking at
18 lowering blood pressure.

19 If I'm looking at medication
20 reconciliation or medication adherence, I'm
21 looking at -- and I don't see any of those
22 sorts of outcome measures in here.

1 I don't know if this is the right
2 spot for that, but those are discrete
3 measurable goals as opposed to these which
4 are a little fluid for me. I'm not.

5 DR. REDDING: Maybe I could jump
6 in there. It's a little bit like our
7 discussion before I think from an outcome
8 point of view. For example, what makes a
9 person have a health baby, the data showing
10 that it may have a lot more to do with a
11 whole bunch of social service issues like
12 housing, food, clothing, domestic, you know
13 all those kinds of things. So that it's sort
14 of like a category thing.

15 We want those bigger picture
16 health outcomes to appear. But if we don't
17 keep the details in mind of how you get
18 there. So I think that's where like the
19 comprehensive assessment determining things
20 like housing, food, clothing and all those
21 other things, and making sure we do due
22 diligence on each one, then can result in a

1 sort of the next category of outcome like a
2 healthy baby or a lowered blood pressure or
3 better hemoglobin A1C.

4 I don't know if that answers the
5 question. But I think your request is in
6 there. These are just -- we're just in the
7 weeds with some of the details.

8 DR. SEHGAL: Yes. No, and I don't
9 want the details in there. I'm just again,
10 what is an unmet need for example? Can I --
11 I'm having a just, that's --

12 DR. LEFTWICH: So if we did a
13 comprehensive risk -- one, this construct may
14 help, but if we did a comprehensive risk
15 assessment like social health, behavioral
16 health, then everything that was identified
17 as a problem, everything from lack of a
18 family doctor to no housing, to educational
19 support would be -- and interestingly it's
20 both a need and in some risk strategies, it's
21 a risk factor that needs to be mitigated or
22 addressed.

1 Anyway, good question though.

2 MS. LASH: All right, Judy, David
3 then maybe to Fred. I'd like to wrap up so
4 that we can get to our round robin and then
5 close the meeting.

6 Judy?

7 DR. NG: And I didn't think about
8 this until Vija you mentioned it, but this
9 idea of the unmet needs and coupled with what
10 you just said Mark. Is we also have these
11 other two bullets about maximizing health and
12 function and reducing patient safety. And if
13 you think about it holistically, they are
14 kind of interlinked.

15 So even if you're struggling with
16 the -- even if we end up struggling a bit
17 with this unmet needs concept, I think
18 thinking about it under the umbrella of
19 trying to maximize patient safety, whether
20 through reduction of risk factors, or
21 maximizing health function, or reducing
22 patient safety in terms of reducing fall

1 risk, et cetera. I think it would hit the
2 mark if for example the unmet needs piece
3 ends up being too iffy for us and maybe the
4 public to grasp.

5 MR. CUSANO: Yes, just on the
6 unmet needs. I know we're trying to be
7 aspirational, but just trying to be
8 practical. In terms of the concept of
9 resolution of unmet needs, I'm just wondering
10 if that may be too aspirational in the sense
11 that if it's food and clothing and housing,
12 maybe it's we need to address unmet needs.
13 But that -- you're actually going to resolve
14 them in every case from a measurement
15 perspective may -- may be a bit challenging.

16 DR. REDDING: So it's a good
17 point. But I think that there's a -- there
18 are odd ball examples, but there are programs
19 serving patients by the thousands that
20 actually are documenting initial food support
21 and ongoing food support. And they are
22 putting that together under the sort of the

1 larger categories they have.

2 So I think you're right. They're
3 very aspirational, but there's some examples
4 out there. Good, good question.

5 MS. LASH: Okay, Don?

6 DR. CASEY: This is just two
7 seconds, but I think Vija point. I sort of
8 let it go past maximized health and
9 functional status. But outcome seems like a
10 word that ought to be in there. Outcome is a
11 word that should be in there somewhere.

12 MS. LASH: Great. We'll capture
13 that. Now I think we're ready to go around
14 and hear you know, parting thoughts from all
15 members of the group. What's really
16 resonated with you from this discussion. You
17 heard Sam ask this morning for short and long
18 term actions for HHS to consider.

19 And I'll also suggest that anyone
20 who has a pressing need to leave for the
21 airport in the next half hour, might want to
22 indicate with their tent card. And we'll

1 call on you first before we get to others in
2 the room.

3 We've got a slide where we're
4 going to offer some ops. Any travelers?
5 Nancy? Sure.

6 Why don't you go ahead Nancy if
7 you're ready.

8 DR. GIUNTA: I was hoping to hear
9 from other people first, but that's okay.
10 Just -- I'm just so impressed with the
11 thoughtfulness that everyone has come here
12 with, and the passion and the ability to
13 describe jargon. Because I feel like I came
14 as a novice, and I still am.

15 Some of the goals that I think for
16 recommendations for DHHS are related to silos
17 and different funding streams and different
18 communication streams. Talking to each
19 other, I think breaking down those silos
20 between let's say, the aging services network
21 and the children and family services network
22 I think is really important. And obviously

1 the medical funding stream.

2 I think we did a lot of work. And
3 that's it.

4 MS. LASH: Thanks. And was it
5 David? You also signaled you were going to?
6 Okay.

7 Ilene can we put you on the spot?
8 Maybe come around this way.

9 MS. STEIN: So I -- this is
10 complicated. The -- I think what's really
11 interesting for me is because I'm also kind
12 of a novice in some ways, is especially in
13 the consumer community.

14 Everybody throws around patient
15 centered, and all these terms. And nobody
16 really has a sense of what they actually
17 mean. And it's interesting to see that these
18 can be made concrete in real ways.

19 I think the other thing is, there
20 are large gaps. And I feel like it's
21 difficult for HHS then any kind of government
22 body states, to be flexible in the fact that

1 they are going to have to try some measures
2 and then remove them when they don't work.
3 Or they're not capturing the right things.

4 Often time, and I think we saw
5 this with SGR probably, we institute
6 policies, and when they don't work, we just
7 build on top of them to fix them. And I
8 think it's really important in this that
9 they're willing to try. Because we just
10 don't have enough yet. And quickly remove,
11 if necessary and change. So.

12 MS. LASH: Sure, Nancy?

13 DR. GIUNTA: I forgot to add one
14 thing. Is that okay?

15 MS. LASH: Of course.

16 DR. GIUNTA: And also I encourage
17 you to make visible, or think about the role
18 of social work in this network of services,
19 or in this priorities -- in the priorities
20 that you're putting together.

21 I don't know how many other
22 committees have social work representation on

1 them. But I definitely encourage you to make
2 visible the role of social workers in
3 potentially being connectors to these
4 different silos. Thank you.

5 MS. LASH: Thanks for adding that.
6 Judy you ready?

7 DR. NG: I'm going to divide up
8 what I have to say in short mid and long term
9 thoughts if that's okay.

10 In the short term, coming from
11 more one end of the measure development
12 world, I know we all talk about being patient
13 centered. I think this idea of thinking of
14 patients in risk tiers is very important.

15 We talked about the need to have
16 coordination measures for everyone, versus
17 some sub-groups of people. And I think
18 that's really key when you get down to nitty
19 gritty of developing a measure.

20 Partly you think about people who
21 don't need a lot of care coordination for
22 them. Good care coordination, making sure

1 the annual check up was even done, might be
2 invisible to them. And that's the very
3 different measure for someone who's a little
4 sicker and needs different care coordination.

5 We talked about using everyone to
6 a level might save waste. What I'm getting
7 to it might save waste in the process and
8 workflow for providers to not have to measure
9 everyone and everything that is not
10 necessary.

11 So that gets through caring.
12 That's the short term. Mid term and this
13 goes to the theme I think I heard some people
14 talking about in terms of the evidence base.

15 And we seem to have good evidence
16 for some things, not so great on other
17 things. And I know NQF and many other
18 entities require evidence at a certain level.

19 We're in care coordination in a
20 place where we're not necessarily quite there
21 completely. We might be there in some
22 aspects, not in some aspects. So I think

1 thinking about things iteratively, I can't
2 even speak, it's Friday -- might be helpful.
3 Living, breathing measures to reflect the
4 state of evidence, not just evidence as we
5 want. Ultimately we want to build towards
6 that.

7 So can we have a place where we
8 are funding people to build the evidence we
9 need? We all talk about we want this measure
10 to look like this. Ultimately this is what
11 we want to measure. Can we look then
12 backwards upstream?

13 People who would do well on
14 something like this once it's implemented.
15 What are they doing to do so well? What are
16 the best practices? And can we learn from
17 that?

18 We don't always have to go to
19 another country to learn. We can learn from
20 our own best practices where people who are
21 performing well on maybe some of these
22 foundational things. Good EMRs, good you

1 know, basic care teams in place, et cetera.

2 And so that's more the mid term.

3 The long term I think, I'm going to draw from
4 a completely different academic discipline.
5 Economics because I live with one.

6 Is, where are the incentives to
7 get all this done? We have to think about
8 what incentivizes people. Obviously we think
9 about money. But if you get back to the
10 patient center thing for instance, just one
11 odd ball example I know, you think about goal
12 obtained on the patient scale.

13 We had a project where all the
14 patients that our goal was to stay in their
15 home and independently. But what they didn't
16 realize was they thought certain things they
17 reported their doctor would impede that goal.
18 Like reporting that they had urinary
19 incontinence.

20 So I know that part of that is
21 patient education. But that -- for that
22 patient that incentive was to stay at home.

1 And because of that, that impacted their
2 thinking and how they reported out the care
3 they needed.

4 So I just encourage us to think
5 about it. I know people didn't like the word
6 holistic, but from every single angle
7 possible. Especially from the patient's
8 angle.

9 MR. CUSANO: Well thank you. This
10 has been a great learning experience for me.
11 I think what resonated me with -- resonates
12 with me most is the concept of linkage and
13 synchronization.

14 I mean, I really think in order
15 for care coordination to work you need
16 engagement by you know, the patient, their
17 family, their care givers and then the
18 providers and resources in the community. So
19 I think I'm very excited about that linkage
20 and synchronization domain. I think that's
21 crucial.

22 I think, so short term really

1 focusing on that I think is really critical.
2 And then more a longer term, sticking with
3 that is you know, how do you use, I think
4 both Fred and Russ and the presenters from
5 HSS discussed today, using the IT resources
6 we have to make that more efficient. A more
7 patient centered experience you know.

8 Where we have hopefully down the
9 road, you know the patient with their care
10 plan. And in a way that's accessible to the
11 -- so the patient can take that to each
12 person. Each person that's within their care
13 plan that's delivering care to them. And
14 they're actually the holder of that.

15 I think we need to think about you
16 know, moving towards that level of
17 efficiency. So those are my thoughts.

18 DR. LINDEKE: What to say. I
19 think even the youngest people in the room
20 are amazed in the time of their career how
21 much has changed. And for some of us who are
22 more in the older people in the room, we're

1 exceptionally amazed at how much has changed.

2 I've had the experience of going
3 to central Asia. Kyrgyzstan, Kazakhstan.
4 Other places. And I predict that these
5 countries, these people, these very brilliant
6 people all over the world will leap past many
7 of the complexities that -- and the outcomes
8 that will be looked at in -- will be things
9 like cost, the life expectancy, the survival
10 of infants.

11 So you know, Winston Churchill
12 said Americans, what was it, you might know
13 the quote. They do the right thing after
14 they've tried everything else first. With
15 care coordination, we're trying a great deal.

16 People are sicker. They live
17 longer. We've added layers of complexity. I
18 think we will do the right thing. It may
19 take, and I predict, if I live long enough, a
20 different payment structure. Because so much
21 of what we do is not pay for performance,
22 it's pay for recording.

1 And so being here today and
2 yesterday was a great privilege to me. I
3 operate from something my friend says
4 elegantly, and I'll try to end with a quote.
5 She says, there are deeds that will never be
6 done unless you do them. And there are words
7 that will never be spoken unless you speak
8 them.

9 I commend you all in your work.
10 And hope we continue to make things better in
11 this country.

12 DR. MANGIONE-SMITH: So first of
13 all thank you for allowing me to be part of
14 this group and this process. It's been
15 really enriching and wonderful to hear from
16 all the different perspectives around the
17 table.

18 And I will put out an apology that
19 I'm so passionate about this particular topic
20 area. And I apologize if I might have
21 overstepped a few times.

22 So short term recommendations. I

1 struck me this morning as I was listening to
2 the presentation from the people from CMS,
3 that within CMS, I hope that there's
4 harmonization across what's going on with the
5 Medicare group and the Medicaid group.

6 We've spent the last three years
7 working on care coordination measures through
8 the CHIPRA efforts. And I really think a
9 tremendous amount could be learned on the
10 adult side from what we've been doing on the
11 child health side of things.

12 So anyway, we talk about that bi-
13 directional communication. I hope that's
14 going on there and that they're being
15 coordinated in their efforts around this very
16 important topic.

17 I have to echo what David said
18 about linkage and synchronization measures.
19 If I had to put my eggs in one basket, that's
20 -- I think that's the key to good care
21 coordination. It's the communication across
22 community sectors and healthcare sector and

1 all the different sectors that touch point
2 care recipient's lives, whether they're
3 children or adults.

4 And insight I'd like to kind of
5 share with HHS is this is a very, very
6 difficult space in which to develop measures.
7 I think that's why your committee hasn't seen
8 many good measures. I think it's why we have
9 just been sweating the last three years
10 trying to come up with operational realizable
11 measures that are not going to be too
12 expensive to implement. That actually are
13 not such low hanging fruit that nobody's
14 really going to care what they are. Right?

15 So very difficult. I would
16 encourage them to think about -- I know
17 there's a big focus on e-measurement. I
18 think it is the way it should be in the
19 future.

20 Some of these measures may need to
21 be trialed using more traditional
22 methodologies. Whether it be manual

1 abstraction of charts. Whether it be survey
2 data collection. I think some of them can be
3 trialed that way, and that may inform then
4 how do we then how do we then take the ones
5 that really show promise and try to move
6 forward with e-measured development.

7 Long term, I really hope
8 nationally there's a standardization movement
9 in EHRs. It feels like and sounds like from
10 what Russ was saying, and what Fred was
11 saying, that there is a movement towards
12 that. And that's exciting to me.

13 As somebody who works with
14 children, and dealing with Medicaid rather
15 than Medicare, there are 50 different data
16 sets. And trying to get a national litmus on
17 anything for children is really, really
18 tough. Because there just is not good
19 harmonization across Medicaid agencies and
20 the way they collect data.

21 So then the other last cautionary,
22 I would put out there is unintended

1 consequences. We have a comprehensive case
2 management clinic at Seattle Children's for
3 complex kids. And that clinic is being
4 followed with metrics to make sure that
5 they're giving high quality care, but they're
6 doing it efficiently.

7 And I know that there's a big
8 focus on value and I think that that's
9 appropriate. But I think it's also important
10 to embrace the idea that these are really
11 sick kids and there are really sick adults.
12 And care coordination for those really high
13 risk people is expensive. And doing it well
14 is really expensive.

15 So I just want to put a cautionary
16 out there that if people are so focused on
17 reducing costs, our ability to reach this
18 goal, this aspirational goal of highly -- of
19 a coordinated healthcare system is going to
20 be really tough.

21 I'll share one last quick antidote
22 that kind of shows this. That clinic had a

1 call to one of the case management people who
2 was on call, by a family whose child had been
3 seen in the emergency department earlier in
4 the day. Had been set home. Was seen for
5 abdominal pain and was said it's a virus,
6 it's okay. Just symptomatic care at home.

7 Called up the case manager because
8 the child was writhing in pain. And the case
9 manager called the physician who's in charge
10 of the clinic, who said you know, oh, just
11 give him XYZ, he'll be okay. Okay. But she
12 kept him out of the ED, right. Which is one
13 of the metrics that they're followed on. And
14 unfortunately that child went on to have a
15 stroke at home.

16 So I mean it's just -- and that's
17 a story that we've been telling at Seattle
18 Children's a lot because there's such a
19 fixation on reduced readmissions, and reduced
20 ED return visits. That it's starting to
21 effect people's clinical decision making.
22 And I think that's dangerous.

1 So unintended consequences, I just
2 think we have to be careful.

3 DR. ROCA: Well, let me, as
4 other's have, thank you all for the
5 opportunity to be here. It's been very
6 illuminating.

7 I'm a relative novice in this
8 area. Although I've certainly been, as I
9 said when I first introduced myself, kind of
10 a consumer in this area for some time working
11 in systems where we've been responding to
12 requirements to report measures.

13 A couple of kind -- a couple of
14 thoughts. I've been very impressed with the
15 focus on patient centeredness. One aspect
16 that I have not really heard discussed, even
17 in the context of the notion that the patient
18 owns the information, is how much control
19 does the patient have in these models of over
20 who gets the information? And who gets what
21 information exactly?

22 Certainly it, whenever medical

1 records, electronic records, these kinds of
2 issues are discussed in setting where mental
3 health providers are present. There's a lot
4 of concern about confidentiality. And there
5 are -- there are certain stigmatized
6 conditions -- stigmatizing conditions that
7 patients don't always want everybody to know,
8 including all of their health providers.

9 And one question I would have is,
10 do these measures contemplate that kind of,
11 or would they potentially contemplate that
12 kind of level of control on the part of the
13 patients? Or how much control were we really
14 envisioning the patients would have over this
15 information, if indeed they do own the
16 information?

17 In terms of the measures
18 themselves, this is kind of a meta idea, as
19 opposed to an idea that's focused on any
20 particular measure. I was very heartened to
21 hear the discussion of the impact of
22 measurement on, in terms of burden, on the

1 people who are doing the reporting. I think
2 there's certainly a sensitivity to that in
3 this group.

4 But the -- but in the world that I
5 inhabit, the -- there's a sense that we are
6 serving the medical record as much as we're
7 serving the patient.

8 And you know, when our patients
9 sort of give us a hard time for looking at
10 the computer screen as we're entering data,
11 or when I hear from my medical staff that
12 they're spending 30 percent more time than
13 they used to documenting. And that that's
14 taking away from the time they have to give
15 to patients, then I'm concerned about the
16 potential of unintended consequences that in
17 our effort to make things better, by
18 measuring things, we may in fact be
19 compromising care. And wearing down an
20 already sort of overburdened workforce.

21 So I guess one thing I would hope
22 is that it would be a -- one of the ground

1 rules in measure development would be showing
2 great sensitivity to this issue. And to the
3 -- great sensitivity to the importance to
4 work whatever kinds of requirements are put
5 into place by the measures into the existing
6 work flows.

7 Because as much as we may believe
8 the workflow should change. And as much as I
9 supposed we can force the work flows to
10 change by imposing some of these measures,
11 it's going to make things enormously more
12 difficult I think during the short term if we
13 don't -- if we're not really sensitive to
14 these kinds of considerations in our measure
15 development.

16 And that's it. Thanks.

17 MS. LASH: Let's go over to David
18 for --

19 DR. ACKMAN: Thank you very much.
20 Thank you for inviting me. I really enjoy
21 this. I think you really collected a group
22 of tremendous expertise and experience. And

1 really almost futuristic in their thinking of
2 where we're going with information and how we
3 use information in healthcare. So I think --
4 I really enjoyed this.

5 In terms of the bullets you have
6 here, I'm going to sort of skip on the first
7 one, and mostly skip on the second one. But
8 I do think that you know, some insights like
9 should go back in the report.

10 Two things occur to me. One is,
11 and I think this has already been said. The
12 evidence base for the effectiveness and the
13 cost savings of care coordination should be
14 emphasized where it is. And should also be
15 noted where it's lacking.

16 You know, we didn't talk about
17 that here. And I certainly am not an expert
18 on that. But I think that's important to
19 include in the report.

20 The other thing that occurred to
21 me was both you know, it sort of came out in
22 the measures we chose, and a lot of the

1 process discussion that we had, was the
2 importance of assessments in care plans. As
3 sort of the foundation for everything that
4 we're hoping to achieve through care
5 coordination.

6 And it's just my experience and I
7 think the experience of others in the room,
8 are that that practice, and the use of those
9 documents, is erratic. And so building a
10 system in which the foundation is not always
11 in place, maybe needs to be addressed.

12 And so maybe -- and really may
13 some vindicate a need for a substantial
14 change in how practitioners work. And you
15 know I think that's sort of what we get at
16 when we talk about team work in healthcare.
17 And that's sort of a -- it is a change.

18 And then the last thing is that in
19 all of this, what has occurred to me, is that
20 this is adding a tremendous amount of
21 responsibility, a new response -- in some
22 places, really new responsibility to -- into

1 the healthcare sector. And in particular I
2 think to primary care.

3 I think we've assumed in many
4 respects that care is always being given in
5 clinics. And we haven't really talked about
6 how this really works in small offices, small
7 groups.

8 So it adds that responsibility,
9 and it's going to add some costs. I don't
10 know what that is. And I appreciate what you
11 said about costs driving you know, the
12 overarching consideration and may be driving
13 bad care.

14 But I think that when we do add
15 responsibility and cost in an environment
16 where the imperative is to reduce costs, we
17 need to be able to prove that.

18 DR. SEHGAL: It's been a privilege
19 to be part of this team. It really has been.
20 And really an honor to meet all my colleagues
21 here. It's really been a fascinating
22 experience for me and I thank you.

1 In terms of what I found to be the
2 most important domain, I really think that I
3 will echo what everyone else said, linkage
4 and synchronization. Communication is
5 absolutely key to the goal of care
6 coordination is really to improve the patient
7 experience, the quality of care, and
8 ultimately decrease the cost. And I mean if
9 we're really going to focus on why we're all
10 here, it really is to cut healthcare costs,
11 which are you know, ballooning.

12 So in order to do so, we have to
13 have an efficient system. We need to avoid
14 the duplication of services. We need to
15 avoid redundancies. But ultimately focusing
16 on the quality of care.

17 I will continue echoing what I
18 came in here. What I -- the hat I wear, for
19 the hat I've worn for the last 20 years. And
20 that is really the importance of
21 incorporating social determinance of health.

22 Taking into consideration health

1 literacy, limited language proficiency and
2 other health disparities which really effect
3 the most vulnerable populations. The people
4 who are the sickest, the people who cannot
5 speak for themselves often times. We need to
6 absolutely take this into account.

7 And we also need to figure out a
8 way to risk adjust this. So that those of us
9 serving in community health centers and
10 working with these patients are paid
11 efficiently to be able to provide the
12 services we provide.

13 So if that was -- if I had one
14 dream for HHS, it would be to continue
15 focusing. And I'm glad they started already
16 doing some work on risk adjusting for social
17 determinants. Thank you so much.

18 DR. BIRKEL: Yes, same echo. It's
19 terrific to meet you all and to be part of
20 this group.

21 I think I'm going to start with
22 the last thing. If there was an insight in

1 my case that I would like to pass on and to
2 see, take it to HHS, it's the --it's my
3 revelation. For me a light bulb that really
4 care coordination is an evolving concept.

5 That it's really going to evolve
6 as technology improves. As system
7 integration improves. This is going to be a
8 very different set of activities in ten years
9 then it is now.

10 And that's important because I
11 think ultimately it can evolve to become a
12 team based, quality assurance process in
13 which we're really looking at, we're
14 reviewing, we're integrating, we're
15 evaluating the activities of all team
16 members, both individually and as a whole.
17 And we're doing that in a consistent, regular
18 matter.

19 So this idea that this is -- maybe
20 the old way we thought about care
21 coordination needs to change. And to push
22 that through measurement would be what I

1 think we would like to see. And we think
2 there's more potential for care management to
3 do more for systems for both quality and for
4 efficiency.

5 In terms of the two measures, I
6 agree linkages and synchronization, powerful
7 -- very powerful for creating the medical and
8 the health neighborhood. And in terms of
9 what I think is most powerful for producing
10 better health, I think it is the goal
11 progression, or goal attainment measures.

12 Those would have a powerful, I
13 think, impact on both health and really
14 changing practice.

15 MS. LASH: Before we go to the
16 other side of the table, I wanted to check in
17 with Carolyn if she's still on the phone so
18 that we don't leave you for last.

19 MS. INGRAM: I am still here.
20 Thank you for doing that. And I want to
21 thank everybody for participating and
22 especially thank the folks at NQF for

1 allowing me to participate from afar.

2 Because I know sometimes it wasn't
3 easy and I appreciate you all emailing me
4 back and forth and doing that coordinating.
5 This obviously is very hard work. And you
6 all that have been at it for such a long time
7 must be commended for that.

8 So I would say in the short term,
9 because a lot of states, I work with
10 obviously mostly state Medicaid agencies in
11 developing their programs. They're dying for
12 some of these consistent measures so that
13 they can implement their coordinated care
14 programs for people who are duly eligible.
15 So that they can better implement some of
16 their Medicaid managed care programs.

17 So in the short term, anything
18 that can be moved forward quickly that is
19 somewhat feasible, I would encourage HHS just
20 to go ahead and do that. Because the states
21 would like the consistency to be able to have
22 something to use out there. They don't have

1 a lot of resources to reinvent the wheel.

2 And then in the long term I would
3 then start to redo those measures. And re-
4 jigger them as necessary to focus more on
5 outcomes of health.

6 So I'll leave it there. Thank you
7 very much.

8 MS. LASH: Thank you Carolyn.
9 Fred, let's go down to you.

10 DR. RACHMAN: Just ditto. It's
11 just awesome to be included in this group. I
12 feel so humble and honored. And learned so
13 much from all of you and gained so many
14 insights.

15 So in terms of the first one, ones
16 that have the most -- measures that have the
17 most power. I think any of these measures
18 that are forcing a collaboration among --
19 crossing multiple domains of service
20 provision, any of the ones that are aiming or
21 forcing that to happen through their design
22 and to their collection.

1 And I had of course at the
2 midnight hour, this thought that I don't
3 think came up in the discussion is, could
4 there be measures that are aimed at payers,
5 administrators or you know, other funders
6 that are holding them accountable in their,
7 or measuring their policies, or the way they
8 administer or design programs. And how that
9 drives or does not drive coordination? And
10 that's a little teaser for something in my
11 last bucket.

12 In terms of the activities
13 associated. So I think document -- the
14 process of documenting contributing factors
15 and contributing services is going to be, and
16 the ability to -- and our ability to address
17 them, is going to be tremendously valuable in
18 beginning to develop more kinds of data and
19 evidence.

20 I think this is a really critical
21 time. And may be a little different from
22 other measure development efforts in that I

1 think these measures are going to be
2 important for people to design towards rather
3 than measure current activities so much.

4 So providing that the extent to
5 which these measures will provide that kind
6 of guidance or framework, I think will be --
7 will be very powerful. I think we talked
8 about a lot, recognizing consumer design
9 goals. I think this is really the -- this is
10 really the area where we could do that a lot.

11 And just to plug again that we
12 figure out somehow to shoehorn in experience
13 in there. And on both sides, the consumer
14 side and the provider side. Because I do
15 think we're in a really critical time in our
16 healthcare journey.

17 And then the last things is system
18 level account abilities. So wherever these
19 measures are driving, an accountability that
20 bridges beyond an individual institution or
21 provider. I think those activities are going
22 to be very powerful.

1 So the insights that I'd love to
2 share, I mean it's really the thing I've
3 been, I hope I haven't sounded too much like
4 a broken record. But this thing, this
5 addressing both.

6 Care coordination which is
7 definitely necessary, will always be
8 necessary for complex patients, is probably
9 more necessary today because of the
10 fragmentation of our system. But also an
11 evolutionary set of measures that are driving
12 the delivery system to be more proactively
13 coordinated so it's less necessary for us to
14 try to Band-Aid it.

15 And then the last one is calling
16 them and is the same problem as the teaser
17 from my first thing about measures aimed at
18 funders and bureaucracies. It's to call upon
19 our federal agencies that to really give a
20 new thought and maybe use this platform to be
21 thinking about how they are harmonizing their
22 investment, their funding priorities, their

1 measures. You know their policies and even
2 the way they're organizing infrastructure.

3 Because sitting out here, the way
4 we are funded and safety net organizations to
5 do our care. The way communities are funded
6 in terms of addressing all these social terms
7 are so fragmented. Some of the fragmentation
8 is trying to clean up, forgive me for being
9 cranky on a Friday afternoon, the mess that's
10 delivered because of the failure to
11 coordinate that at another level.

12 And Sam this is not aimed at you
13 at all. But I hope we could reflect back to
14 HRSA for example. Where do you look in HRSA
15 that there is some entity within HRSA that's
16 responsible for this? They're funding
17 homeless. They're funding nursing centers.
18 They're funding rural centers. They're
19 funding substance abuse. They're funding HIV
20 care. They're funding community health
21 centers.

22 Where do you look, where do you

1 find reflected in that infrastructure some
2 structure, some office, some person that's
3 responsible for that level of coordination
4 until you get to poor Dr. Wakefield, who how
5 could she be responsible to do that?

6 So that would be the last insight
7 that I hoped it wouldn't be too controversial
8 to suggest. Let alone HRSA against CDC, et
9 cetera, et cetera.

10 MS. LASH: Thanks. We're going to
11 come down her to Gerri since she's got to go.

12 DR. LAMB: Thank you. Thank you
13 for giving me the time. It's been an honor
14 to work with all of you.

15 Just a couple of closing thoughts.
16 I think you all know I came with both
17 practical and aspirational expectations.
18 Practical in co-chairing a committee that
19 we're not getting new measures for, and
20 really wanting to see new measures.

21 And aspirational, as a nurse I
22 feel as passionate, and Rita, don't ever

1 worry about overstepping. I think everybody
2 in the room is passionate about this. Is
3 that care coordination is the hallmark of a
4 caring healthcare system.

5 A couple of things. One is I'm
6 really delighted to see the collaboration and
7 the communication between the multiple
8 entities that are working on care
9 coordination. There's a lot going on in this
10 area. And it's really important to keep this
11 work connected.

12 Even in the committees that we all
13 sit on, you know, it gets frustrating not to
14 hear what's going on. And that people aren't
15 moving forward.

16 The things that I'm most excited
17 about in terms of the discussions are the
18 linkages and synchronization. I think
19 everybody else has spoken to that.

20 It gets us so much closer than
21 where we've been in terms of making
22 appointments or making referrals. It's

1 really beginning to get to the heart of
2 what's important.

3 And the other that I think has
4 been a surprise that I'm really also
5 resonating with, is the discussions about
6 shared accountability. We've been talking
7 about team work in healthcare for a very long
8 time. And this gives me hope we can actually
9 operationalize how each of our different
10 disciplines and the providers, as well as the
11 unlicensed personnel, contribute to outcomes.

12 And the timing is just so perfect
13 with a new national center in inter-
14 professional practice and education. And I
15 just see so many areas of synchrony.

16 So this has been great and I'm
17 going to run.

18 MS. LASH: Thank you Gerri.
19 Sharon. Let's go back down to you.

20 MS. McCAULEY: Again, thank you.
21 It's been an honor and thank you Sarah,
22 Lauralei and Laura. Great job. I know it's

1 a difficult to maneuver all the different
2 pieces and parts.

3 But thank you so much for asking
4 nutrition to be represented. And I have to
5 echo social work, sometimes you know we need
6 to be at the table. And I thank many of you
7 that have, like Russ, you know have spoken up
8 to get us where we need to be.

9 I guess for one of the areas of
10 measure development, not only the linkages
11 and synchronization, but I'm going to back to
12 the assessment and that plan of care.
13 Because we do have our nutrition care
14 process. And we are so embedded in those
15 different steps and all the different parts.

16 But I just want to make sure that
17 we do somehow, and it may not happen if when
18 we measure, that we do identify the correct
19 members, or the best members of that care
20 coordination team. Depending on the care
21 recipient's level of risk, to ensure that we
22 get the right community service and those

1 providers to give that service.

2 We may not all be in all those
3 different areas. We don't have you know, two
4 million registered dietician/nutritionists.
5 So you know, it's not -- we don't have one on
6 every corner.

7 So that's where a big reach out to
8 a goal for HHS is to you know, really make
9 sure that we do get that right practitioner.
10 And that we do need training and educating at
11 the community worker level.

12 And we are looking at that at our
13 association. Because we know how important
14 it is for practitioners of all areas of all
15 disciplines to be at that care coordination
16 level out in the community. And that health
17 is all local, therefore you know, we do have
18 to have the right individuals in those areas.

19 So in those neighborhoods, maybe
20 just try to include wellness and nutrition
21 coach programs, you know, that are you know,
22 are taught. And we're trying to look at that

1 for non-physician practitioners to make sure
2 that we really get those dedicated resources
3 to the area.

4 I think that's where we're going
5 to see that availability of services. I know
6 that was one of the measures we looked at.
7 But I want to make sure that that's known.

8 And to piggyback off on what Mark
9 had said about assess health. That that
10 assess health does include, and hopefully you
11 know, when we do the editing of that section,
12 that you kind of put an i.e., that is
13 nutrition, that is physical activity,
14 exercise, tobacco use, food sources.

15 You know we always talked about
16 the different medical history, clothing,
17 shelter, basic things like that. You know,
18 we do have those groups of practitioners
19 working in the community nutrition, which is
20 different than public health.

21 So I just again, some of the
22 insights. Just thanks for having us be at

1 the table with all of you. And I look
2 forward to working with you. Thank you.

3 MS. LASH: Michael -- sorry
4 Woody. Do you need to go or are you skipping
5 Michael?

6 DR. PARCHMAN: I will -- I told
7 him to go ahead.

8 MS. LASH: Oh, okay. Great.

9 DR. EISENBERG: Thank you. I too
10 am very pleased to have been included in this
11 group. I learned a lot. Thank you.

12 I'd like to just to emphasize
13 something that I think we all know, but there
14 wasn't a lot of discussion about it. There
15 seems to be an assumption that in many cases,
16 the healthcare teams are actually existing or
17 coming together. And from my experience,
18 that mostly isn't so.

19 So I would -- I think we should
20 emphasize that our work, our measure should
21 somehow further promote the coming together
22 of the care team. And similar to Sharon's

1 comments, I think that that's going to be
2 Especially important outside of just the
3 medical home, or whatever the medical model
4 will be.

5 Because getting out, whether it's
6 to social workers or to dieticians or to
7 pharmacists, which is the group that I
8 represent. Really is going to take an extra
9 effort.

10 And I would also, as a corollary
11 of that, think that we should encourage all
12 of these professionals to be working really
13 at the top of their license. Rita, I was
14 happy to hear that there were so many
15 medication measures out there.

16 But I'll bet you most of them are
17 not being implemented by the people that are
18 really experts in medication therapy, the
19 pharmacists. And I think it would be helpful
20 if our efforts could encourage that.

21 In terms of long term goals, I
22 would like to go to two areas that we didn't

1 talk to about at all. And probably Sarah
2 this should appear in the report. But
3 nonetheless, I think they're so important on
4 a foundational level, that I wanted to bring
5 them up.

6 One of them has to do with
7 clinical education. I have the opportunity
8 to work with medical students and with
9 pharmacy students. And I can tell you that
10 the only group, from an age perspective, the
11 only group that knows less than the older
12 doctors my age, and the older pharmacists my
13 age, are the students just coming out of
14 training.

15 It's appalling that the freshly
16 trained clinicians are not instep with the
17 things that we are discussing here. You do
18 much better if you talk to people that are
19 out ten years in practice.

20 They get it Because they have to
21 get it. They realize they've got another 30,
22 40 years in the profession. They've got to

1 make a living. This is -- times are
2 changing. The students know nothing.

3 So I don't know if HHS feels that
4 this is an area they need to step into or can
5 step into. But it's something that I think
6 is critical. And don't know if it's being
7 ignored, but it might be.

8 And then the last part, which is
9 even harder. Is promoting patient
10 accountability. And this is an area that we
11 as a society I think haven't really been
12 willing to step into.

13 Pretty much legislation has
14 purposely I think ignored the accountability
15 of the patient. And as a result, that's one
16 leg of the stool that's just gone. We've got
17 the payers in there. You've got the
18 providers isn't there. You don't have the
19 patients in there.

20 Again, I don't know if there's
21 anything that our efforts could do to address
22 this. But if there is, I think we should do

1 that. Thank you very much.

2 Thank you Michael.

3 DR. PARCHMAN: Sure. So I just
4 want to say thank you for inviting me and
5 allowing me to participate. This has been
6 fun.

7 I just want to leave on a hopeful
8 note. For the last year and a half, the
9 MacColl Center for Health Care Innovation has
10 been funded as the national program office by
11 the Robert Wood Johnson Foundation for a
12 project called LEAP. Learning from Effective
13 Ambulatory Practices.

14 We were charged with identifying
15 30 exemplar, high functioning, primary care
16 teams in practices across the U.S. And we
17 had the privilege of spending a week in each
18 of those sites this last year.

19 And I want to tell you, there are
20 some remarkable things going on in team work.
21 And in improving team work across the U.S.
22 right now. These teams are innovating,

1 they're improvising. They are figuring out
2 how to do the work that we're talking about
3 here yesterday and today.

4 And they're not limiting
5 themselves to their professional credentials
6 or their assigned roles. I love the
7 expression by one clinic leader-
8 administrator, who said, we have well defined
9 roles, but we have extraordinarily task
10 ambiguity built into our system.

11 He said and we don't hire for
12 professional degree. We hire for people
13 skills and intelligence. And then we figure
14 out how to make them fit into the system and
15 train them to do the work that we need them
16 to do to make sure that care is well
17 coordinated and patient centered. And we
18 build a culture of closing the loop in our
19 system in every aspect of care we deliver.

20 So there are some real fascinating
21 stories. There's some tools, resources. And
22 I feel like this is a shameless plug, and I

1 apologize for this. But the Robert Wood
2 Johnson Foundation would like us to do this.

3 We're going to begin the
4 discrimination phase of this project in
5 August and September of this year. And we're
6 going to have modules and curriculum and
7 resources and tools available for people on
8 how to do good care coordination for complex
9 chronically ill patients.

10 How to do -- to help people
11 operate at the top of their license. And
12 then how to achieve many of the functions
13 that we're talking about here yesterday and
14 today in terms of basic care coordination,
15 functions, comprehensive assessment. The
16 list just goes on and one.

17 The final thing I'll say is that
18 we've also been working with AHRQ on
19 developing an atlas of measures of team based
20 care. And we looked at our list of
21 identified measures that we accumulated over
22 the last year. And went back and compared

1 them to the measures that are in the AHRQ
2 atlas of care coordination. Well lots of
3 overlap between measures of team based care.
4 And measures of care coordination.

5 So I just want to encourage us to
6 think about care coordination as a team
7 sport. And any measures that we develop, any
8 tools that we develop around this, we have to
9 think about it at the level of people. And
10 people coordinating tasks and roles and
11 responsibilities at the team level.

12 So thank you for allowing me to be
13 here.

14 DR. LEFTWICH: So I too, it's been
15 a great experience to participate and meet
16 everyone. And get to tell some stories. And
17 always great to work with the NQF staff,
18 including the new members. And you all are
19 delightful and always effective. So I
20 appreciate that.

21 My theme would be patient --
22 creating the new paradigm of patient centered

1 care teams that the patient and family are
2 on. I do think that the cornerstone of that
3 concept is the care team roster with a
4 minimum data set that enables communication
5 between the care team members and for the
6 long run identifies the role of those members
7 with respect to that patient.

8 I would de-emphasize the system
9 level care coordination aspects in favor of a
10 patient centered care team that belongs to
11 the patient. As does the data.

12 And I think the areas that are
13 most ripe for measured development to improve
14 care are using that care team roster for
15 communication and accountability. Because it
16 really enables everyone on the team to accept
17 accountability including the patient and the
18 family.

19 And to start to view it as a team
20 effort that everyone is -- has a
21 responsibility for. And using the data, the
22 interoperable data that I've described as the

1 source for measures, because that data has to
2 flow to have effective care coordination on a
3 team.

4 So using it as the source of data
5 for measures is both efficient and sort of
6 unavoidable that that's where the important
7 data is. And that includes the community
8 based organizations and services and care
9 givers that are on that team.

10 And the activities that are most
11 important I think are that communication
12 amongst the team including harmonizing and
13 reconciling the data that's in those
14 different care settings. Particularly the
15 care plan, the goals and the interventions
16 that are associated with them.

17 And I think that's the most
18 effective way to improve outcomes for the
19 patients. And as far as insights that I
20 would emphasize, I'll claim the one that I
21 offered as my last comments.

22 And that is the availability, the

1 developing availability of software tools
2 that will enable non-EHR owners, non-eligible
3 providers, care team members, and that
4 includes the PHRs that the patients have,
5 that undoubtedly will soon develop the
6 ability to produce these documents as well.
7 And tools like the electronic questionnaire
8 and response.

9 I think that's the insight that I
10 would hope we can offer, that there is a way
11 to expand the technical, HIT interoperability
12 of that, the entire care team. And be able
13 to share information.

14 So thanks everyone for.

15 DR. CASEY: Well, thank you also.
16 I'm astounded with the amount of progress
17 we've made thanks to a lot of expertise and a
18 lot of insight.

19 Linda had a quote. I guess I
20 would quote a hero of mine who said, in a
21 concatenation of ten words, each two letters,
22 if it is to be, it is up to me. And I'll let

1 you look up who said that.

2 But the point of it is that what
3 we've done today is not an endpoint, but a
4 starting point. And I really believe that
5 each of us on the committee has more
6 responsibility to sort of go home and talk
7 this up. And really sort of get enthusiastic
8 people to be more engaged with NQF so we can
9 get more feedback.

10 As you know, this is the starting
11 point, not the end point. We have to create
12 a draft and then bring it out to the
13 membership and also the public and the
14 stakeholders for their input.

15 So trust me, this is -- you
16 haven't seen word smithing until you've seen
17 this process, so. So I actually look forward
18 to that because I think that's where we
19 really get further advancing in terms of what
20 it is we're going to do in the next few
21 years.

22 You know, I said at the beginning,

1 that the challenge of not getting new
2 measures was a chicken and egg question. And
3 I think I've decided I've landed on the
4 chicken. I think we've got the opportunity
5 here to really rethink this.

6 So I'm not going to try to repeat
7 what other people said Because I know I
8 agreed. But I believe that the feedback and
9 stakeholder process is going to be great.

10 I do want to echo Judy's comments
11 and Fred's points though about the further
12 guidance from -- I'll put them all together
13 in one room, HHS versus CMS and AHRQ, whoever
14 else about the investment.

15 And I like Fred's idea about sort
16 of creating a more dynamic view within these
17 agencies about this problem specifically
18 rather than the areas of focus. Because I
19 think it's a central challenge.

20 I also think that we -- and this
21 is more than a pet peeve. I really think we
22 need a brand new taxonomy for classifying

1 evidence now and in the future about impact.
2 And impact being whether we promote high
3 value activities. And we stop, or reduce low
4 value activities.

5 I think it's probably clear that a
6 lot of what we do isn't high value in this
7 arena. So relative to resources, we have to
8 be I think using some very different and
9 more standardized and modernized evaluation
10 methods then we're using now.

11 And you know, part of this is
12 because everything that gets submitted is
13 sort of usually all over the map in terms of
14 the evidence that's generated behind the
15 measures that are submitted. So it creates a
16 real problem.

17 And I just think again it's not
18 going to be perfect. It's never going to be
19 a one size fits all. But we've got to
20 support measure developers as well to not
21 just become better at this, but also create
22 the resources to help them do this.

1 You know relative to what I think
2 Mike said, I think Sarah, maybe one
3 opportunity here is to again, yet again, look
4 across the measure sets within NQF's library.
5 And start thinking about how we might begin
6 to cross link some of them.

7 Because I think Mike's point is
8 well taken, that I think there's an
9 opportunity at least to -- to at least
10 identify some of the measures that could
11 potentially be a starting point for this so
12 we don't appear like we're starting with a
13 blank slate.

14 I also think, and Lauralei knows
15 this is my sort of pet peeve about what we've
16 done in the past. I still think the
17 preferred practices are highly relevant. We
18 didn't spend a lot of time talking about them
19 here.

20 I think they obviously need to be
21 re-enhanced. But I do think that's another
22 sort of framework here that also helps. And

1 so maybe that hybrid could be useful.

2 And that's really it. I just, I
3 really am looking forward to the next few
4 weeks. Because there's going to be a lot of
5 activity.

6 And I want to thank Mark and Susan
7 for being excellent chairs for this. So,
8 thank you.

9 DR. REDDING: Thank you HHS and
10 Samantha for asking for our opinion on this.
11 It's wonderful. The concept of everybody
12 making decisions out up here and not --
13 anyway, thank you.

14 Thanks Sarah and Lauralei and
15 Laura and Wendy for coordinating what to me
16 was an amazing event. Just the whole process
17 of it was a lot to learn from.

18 And then this group. You know, we
19 haven't quite got -- this may not be
20 completely accurate, but I think almost every
21 health and social service funding stream, and
22 I would guess that every major health and

1 social service funding stream has a lot of
2 care coordination financing and strategy
3 within it.

4 Looking at housing just for a
5 moment, which is probably one of the most
6 traumatic things for someone with a health
7 issue to deal with, has a huge amount of
8 individually based care coordinators with
9 their own planning. And so Nancy's not here,
10 but we not only need social workers, we need
11 social service leadership and infrastructure,
12 if that's a big part -- if our goal is to
13 improve health, they need to hear Vija and
14 others. I hope I pronounced it right this
15 time, finally. Okay, good. So we need them
16 here to help us.

17 And then the really cool thing I
18 take away from this meeting is the sense of a
19 team working around the patient, like Michael
20 and many others have reiterated. And then
21 that going back to a team at a more local
22 system community level.

1 And then man, do we need our
2 states to work as a team. Because they're
3 all in their silos. And we need the federal
4 government is one challenge to also see that
5 need for, if we really want to focus on --
6 there's no way to focus on the patient
7 without being a team. And if the rest of
8 it's fragmented, it just comes down to the
9 patient.

10 And finally, in one of my hats
11 that I wear, there's a board member who is a
12 minister in a very disparate community. And
13 he sums it up by saying the least of these
14 are the least likely to connect to any health
15 or social intervention that's going to help
16 make things better.

17 The data show that -- and I leave
18 here like Michael said, much more hopeful
19 that that's possible. And so I can't believe
20 how you guys managed yourself with this huge
21 -- it may be one of the biggest concepts out
22 there. And brought your wisdom and guided us

1 to understand what you were trying to say.

2 It's very much appreciated. Thank
3 you.

4 (Applause)

5 MS. LASH: On behalf of the whole
6 staff at NQF, I'll add my sincere thanks to
7 our funders. To all of you for
8 participating. To my colleagues. And our
9 faithful members of the public on the phone
10 and web for hanging in with us. And of
11 course those that came to NQF today.

12 We just wanted to show one last
13 slide of next steps so you know what to look
14 forward to as this project continues. I
15 guess we could take a -- maybe before we do
16 that, pause for public comment. If we have
17 any on the phone.

18 Cathy would you cue our phone
19 participants please.

20 OPERATOR: If you would like to
21 make a comment, please press star 1 on your
22 telephone key pad. We have no comments or

1 questions.

2 MS. LASH: Thank you. Okay. No
3 one in the room. So our upcoming events, you
4 will probably get some type of written email
5 follow up from us in the coming weeks, just
6 to confirm our next version of the summary of
7 what we learned today and yesterday.

8 But in mid-June, we will have a
9 draft version of the report available for NQF
10 member and public commenting. While that is
11 available, we'll have a public facing webinar
12 to explain the highlights of the conclusions
13 of this report and how it fits with other
14 topic areas you heard Wendy discuss
15 yesterday. Just to sort of educate the
16 commenters about what we're looking for in
17 terms of feedback.

18 And then we'll have our final
19 report submitted in August to HHS and then
20 that will be publically available for
21 everyone to distribute and share.

22 And perhaps just thanks again for

1 the tremendous contributions. Sam?

2 MS. MEKLIR: For the timing for
3 the draft report, do they get a copy of the
4 draft before it's shared with webinar, or do
5 they get it when it's on the webinar?

6 MS. LASH: Well invite I think
7 maybe written comments back in the next few
8 weeks on something.

9 MS. MEKLIR: Okay.

10 MS. LASH: That's not in the full
11 report format.

12 MS. MEKLIR: Okay.

13 MS. LASH: But the real bones of
14 what we would hope to build on. And then you
15 would all be free to participate in the
16 commenting process if you wanted to add any
17 further thoughts at that point.

18 MS. MEKLIR: Okay. And so I just
19 would encourage all of you to use your
20 tentacles and invite your communities to
21 comment on the draft report. Because you see
22 all these public comments. And this

1 obviously such a topic that is so relevant
2 and timely to so many stakeholders.

3 And it would be nice to see kind
4 of more of them at the comment period and
5 providing comments. And you all really have
6 the reach and ability help make that happen.

7 So thank you for that.

8 (Whereupon, the above-entitled
9 matter was concluded at 3:28 p.m.)
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C E R T I F I C A T E

This is to certify that the foregoing transcript

In the matter of: Care Coordination Committee Meeting

Before: NQF

Date: 04-04-14

Place: Washington, DC

was duly recorded and accurately transcribed under
my direction; further, that said transcript is a
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