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:

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

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

NQF STAFF:

LAURALEI DORIAN, Project Manager
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

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

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

(9:00 a.m.)

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

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

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

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

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

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

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

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

And that could change. But to

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

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

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

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

The care coordination team that's taking care of this at risk individual is designed and based on goals and needs. It's not just a standard six or eight person package for everyone. It has working relationships with defined goals, and I should have put a football team here, but with defined goals and shared accountability.

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

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

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

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

And then finally, goal attainment

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

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

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

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

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

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

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

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

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

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

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

Going to the center column, re-titled the first domain area, so instead of availability of services it's about the quality of those community services.

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

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

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

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

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

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

So I think that for now our suggested edit is that we would replace the word organization with integration. But that probably encapsulates most of our current thinking when taken together with the domains, sub-domains and other explanatory language with the conceptual framework. Richard?

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

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

(Off microphone discussion)

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

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

DR. LAMB: I'm not sure where it

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

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

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

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

MS. LASH: Okay.

DR. RACHMAN: And then just a question, we talked yesterday in efficiency about cost from the patient standpoint and resources from the patient. I personally would love to see that sort of called out.

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

(Off microphone discussion)

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

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

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

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

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

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

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

I'd really encourage you to think about, before you break off for lunch, just on your own, take a minute, sit down, jot down your short term recommendations to HHS, your longer term recommendations.

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

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

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

And then, when we go around, that will really help Sarah when she has to kind of synthesize all this and write that recommendation part of this report. Because it really is a critical piece, since, you know, we're not voting on explicit measures, per se. So again, I just encourage you to do that.

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

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

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

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

DR. GOODRICH: Kate is on the phone.

DR. REDDING: That's great.

DR. GOODRICH: Can you hear me?

DR. REDDING: We can hear you well.

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

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

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

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

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

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

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

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

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

We also see the CMS Quality Strategy though not just as a strategy for what we internally here at CMS need to be doing but what our hopes and expectations are for front line providers to be doing to promote the six goals of the CMS and National Quality Strategy. Because they really are essentially the same.

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

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

As we were developing it, one of the things that we realized, there were certain topics that kept coming up that we couldn't really figure out where they fit, but we knew they were so important.

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

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

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

And we should be using our various levers to incentivize innovation at the local level to improve and then finally fostering learning organizations.

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

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

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

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

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

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

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

Force.

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

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

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

First would be person and family activation, so these are measures of patient activation and behaviors of individuals and their families that lead to them obtaining the greatest benefit possible from the health and community services available to them, so shared decision making type measures, care giver engagement. Patient trust and health literacy sort of fall under that sub-domain.

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

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

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

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

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

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

A lot of them do tend to be sort of check box type measures, because I think that's just where we have been with measure development in this area. So for example, some of the medication reconciliation measures are really check box measures.

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

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

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

So our future plans for measure

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

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

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

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

But our goal over time for all of

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

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

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

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

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

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

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

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

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

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

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

First, you know, with respect to using terms like health IT, some people think that encompasses a whole lot more than it actually is. I view it, really, pretty much, no offense to anyone in the health IT industry, as electronic tools, hardware, software, that helps enable better communication, better more rapid achievement of transactions, as I'll call them, et cetera, et cetera.

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

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

So I'm just trying to call out the need for us to maybe look at some of these terms we're using and be a little more second decade, 21st century about them. Because I think that sometimes we just get wrapped up in these things, like it's all under IT. So that's my pet peeve.

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

DR. REDDING: Thank you, Don.

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

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

Now, when you say evaluate this

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

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

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

DR. GOODRICH: Yes. Well, I think in terms of both measurement and even at a higher altitude, the care coordination sort of objective or goal of the CMS Quality Strategy and the National Quality Strategy, you know, I think we have generally been of the mindset that, for right or wrong, that we would really like to see this work accelerated so that we can, you know, get to improvement faster but in a leaner kind of fashion.

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

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

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

And so I think, for our ideal

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

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

And I think this is what has been articulated, you know. Again, I know that's very high altitude, but that's what's been articulated by a number of folks who have working in this space for a long time. And I think it's really no different for us.

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

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

And that's what we've been doing lately, is really working just on de novo measures with the input of electronic health record vendors, from patients and from providers, in order to enable getting towards that ideal state of having it be just part of the natural work flow and not something that people have to take 27 extra steps to extract the data from the EHR to put together the quality measure, whatever it might be.

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

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

DR. REDDING: Thank you. That's a very reassuring goal. I've got another question from Sharon.

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

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

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

But also a lot of the, in fact all of the payment models that are out there through the Innovation Center have a component embedded within them for what I'll call learning and action networks which is basically the development of networks for those basically who are already high performers in a particular area.

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

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

Partnership for Patients which is a true improvement project.

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

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

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

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

DR. GOODRICH: Yes.

MS. MCCAULEY: -- into care

coordination, into this group. Thank you.

DR. GOODRICH: Great.

DR. REDDING: And Gerri Lamb?

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

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

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

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

Any ideas about where the

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

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

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

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

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

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

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

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

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

I think the outcomes of care coordination are easier to do. We've done a lot of it. It's not that we don't think that that continues to be important, and we need to continue to have measures in that area. But I think the person and family activation and how you can think about embedding that within EHRs or PHRs would be very, very welcome input.

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

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

And sometimes the care coordination team, based on a medical provider's capacity and based on the community resources, it may not be centered in a physician's office.

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

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

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

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

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

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

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

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

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

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

So if you think about it in terms of, like just to get a little bit more concrete, to let you know sort of how we're thinking about this -- and by the way, we're not sure how to do it, so again, this is where your help would be wonderful -- if you had a total performance score for, let's say, a physician or a physician group that, you know, I'm just throwing out numbers here, but 40 percent of that score is at the individual clinician level, and another 40 percent of that score is the group practice score on quality measures.

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

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

DR. REDDING: Gerri Lamb?

DR. LAMB: Kate, just to follow that up, I find it really interesting in terms of program authorization kind of driving the models. And it's really interesting to think about what new models might be to match the dialogues we've been having here.

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

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

DR. GOODRICH: Yes. That makes sense.

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

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

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

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

One final question is we've got some pediatricians and child focus people in the group. And there was a call for a way to identify risk factors in infants and children well before, potentially years before they land in the back of an ambulance and intervene on those risk factors, such as obesity prevention, evidence-based parenting, improve educational outcomes which are connected to economic outcomes, which are connected to health, and other key factors where we have evidence-based interventions that can address identified early upstream risk factors.

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

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

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

DR. GOODRICH: Yes.

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

DR. GOODRICH: Yes.

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

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

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

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

So it is something that, even within the Medicare programs, we are starting to think about. We actually do have some measures that are within the PQRS program, believe it or not, that get at some of those types of concepts of identifying risk factors early, early in life.

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

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

And, you know, a number of our programs are actually all payer programs, even though they're authorized under a statute for CMS, for the Medicare programs.

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

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

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

Is Erin Grace also on the phone from HRQ?

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

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

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

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

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

I'll just point folks for interest, if you have interest later on, to look at the AHRQ health IT website which is healthit.ahrq.gov. And some of the more recent projects or older projects that we did is we funded about 15 grants a number of years ago to look at enabling quality measurement through health information technology.

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

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

And then most recently, picking up on some of the comments that Kate made, looking forward to Meaningful Use Stage 3, AHRQ has funded some grants and contracts to do some sort of rapid turnaround testing of some of the proposed Meaningful Use Stage 3 rules and criteria to sort of get a real world look at how those criteria sort of play out in the practice and in the hospital setting.

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

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

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

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

And I think we need to get clearer

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

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

And then the third part which is not at all, in my opinion, anything to do with IT, and that is what we do with the information, how we apply more rigorous and advanced sort of data science models rather than, you know, multiple regression models looking at, for example, patterns of care through, let's say, advanced Markov blanket models and things like that that are used in more sophisticated analytic worlds like looking at the human genome.

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

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

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

So I think that's something that AHRQ is definitely considering in terms of our future investments in health information technology research.

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

(Off microphone discussion)

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

(Off microphone discussion)

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

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

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

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

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

MS. GRACE: Erin.

(Simultaneous speaking)

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

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

Also a thank you to AHRQ, they've been supporting a lot of the quality measure stuff including some of the testing through the USHC website which I encourage everyone to look at it. It is very fantastic and user friendly.

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

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

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

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

The patient's preferences and goals are central. I know that everyone here certainly agrees with that. And, Ellen, if you have anything you want to add --

MS. MAKAR: I'll jump in.

DR. SKAPIK: -- jump in.

MS. MAKAR: Okay.

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

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

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

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

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

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

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

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

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

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

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

Specifically, some of these pieces such as the care plan fields tend to be really inconsistently applied across different implementations.

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

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

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

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

In response to some of the

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

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

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

So this measure contains a number of requirements for what exists in a home management plan for asthma, so a list of the medications, a list of the control strategy, a list of the rescue strategy, the contact information and the appointment plans. And that was all written down nicely into a chart abstracted measure.

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

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

And it's an example of how we really need to push hard to think about the way that we structure this information and to make all of the layers of standards that are necessary support the level of detail that we need so that we can make this a reality.

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

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

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

Next slide? So these are four of the measures that refer to coordinated care in Stage 3. I can't promise that any of these measures will make it to Stage 3, although I think that they will. They're proposed right now, and they're under development.

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

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

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

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

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

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

I think that everyone has noted that the patient-centered plan of care is critical. And patient-centered plan of care involves the patient making decisions about what the goals are, the patient clearly defining their preferences, their preferences being incorporated into that plan of care and then the patient being able to see and interact with their plan of care.

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

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

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

I know this continues to be a challenge. There have been some interesting proposals, for example, for a measure that would look at patients who work in high levels of radiation exposure occupations to provide the information that comes from their occupational health monitoring directly back to the physician so that they could, say, alter their plan of screening for various oncologic problems.

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

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

So for pediatricians, I think the world of what you can understand about your pediatric patient is so limited compared to what the school setting sees. And I think a rich exchange of data would really allow pediatricians and the educational providers to really offer a lot more to the patient and to their family.

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

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

If we chose to cut them out of our

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

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

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

Someone had mentioned just a little bit ago how we're so focused on treatment of disease rather than the provision, and prevention and optimizing the health and wellness of the patient. So we could really bring that to the patient and let them be empowered by it and also let them demonstrate to their provider what they're doing to improve their health.

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

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

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

And two other issues, one is data segmentation. So that whole area of thinking about what portion of the data that, as a preference, patients do not want to share, along with looking at the provenance of the data so that the timing is correct.

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

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

DR. REDDING: Excellent.

DR. SKAPIK: We have one more slide. So I think Ellen covered some of it there. So this is, ONC's vision for care coordination, a clearly defined, dynamic, longitudinal care plan developed as part of shared decision making.

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

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

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

We just mentioned data segmentation, and that's some of the work that ONC has already been pushing forward, automated push and pull of data to and from the providers so that you don't have to ask for information. It comes to you without you needing to take any additional steps.

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

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

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

(Off microphone discussion)

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

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

So in implementing an EMR, for example, it's the work flow and how you redesign the work flow for people who are sometimes threatened by the fact that you're asking them to take on different roles and tasks than what they're used to or who don't understand how to do their work anymore, their daily work, and helping them rethink that and redesign their work, especially around getting information into and information out of the system.

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

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

The tool is only as good as the way that it's designed and implemented. And I think there was an assumption that tools would have been designed to be implemented in an easy way that would require no lift on the side of healthcare providers. And that's just absolutely not true, obviously.

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

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

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

So having a vendor give you a very expensive product is not necessarily going to help you more than having your care team sit down for a few days and decide, well, this is causing us a lot of pain. Instead of complaining about it, let's decide what's going to reduce our pain, make our work better and make our care safer.

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

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

DR. SKAPIK: You know, I didn't actually get that onto the slide. We actually have been working on some proposals to use the HHS Innovation lab and to work into the next cycles of measure development, work flow, mapping, prior to the actual creation of the electronic spec, so that the specification anticipates the actions that it looks for in the health record occur in the order and in the way in which they actually occur in the setting of care. And that, full disclosure, that was not done for the measures that exist.

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

DR. REDDING: Thank you. Rita?

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

So I have been involved in an effort, the CHIPRA grants efforts, in developing care coordination measures for children with complex medical needs. So although they're children, their medical issues are much more similar to elderly adults because they kind of have a lot of stuff going on.

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

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

Because as we've gone in and tried to implement our measures, very similar to what you had written in text there about care plans manually abstracting, even in paper charts or even people going into their own Epic charts, nothing like that exists, right, which is, I think, partly what you were trying to address with that effort.

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

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

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

And I think that's why all of the

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

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

DR. MANGIONE-SMITH: Out-patient.

MS. MAKAR: Okay.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

And perhaps clinicians who are in a 3-D world moving around, the training for them is not best to be sitting at a desk with a computer in front of them but in their true environment. And I think calling that out is important.

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

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

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

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

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

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

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

MS. MAKAR: Well, the first thing I'd say is never assume. Because I don't think that is truly there yet.

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

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

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

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

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

DR. REDDING: Thank you. And Linda?

(Off microphone discussion)

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

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

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

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

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

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

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

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

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

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

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

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

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

DR. SKAPIK: So I'll try to give two speed answers. In terms of lean, the Denver Health model is that lean internally trains their own experts. And the requirement is that their own experts continue to train others and that the work is internal.

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

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

And it's our goal to use the information that we've learned and also the information we're going to gather through this work flow testing and increasing kinds of field testing to re-write all of the content there so that every piece of data is naturally there and gets sucked into the measure. It should require almost never you taking an extra click.

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

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

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

But they do need training, and I think that there needs to be resources dedicated to training those types of workers to engage in the system.

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

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

DR. SKAPIK: Yes, so a major challenge that we faced was that we lacked the standards to implement all of this work in a short period of time. And so since standards were created and they had relatively limited testing, the goal is to try to make them relatively simple so that there wouldn't need to be a lot of extra work to determine how to make things more complex.

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

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

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

The last piece of that is we absolutely have to come to a decision on what the core data that's required for every system to have and how we define that data. Because you can exchange data all day. If you're exchanging apples and oranges and trying to call them both apples, then you're not getting high data quality and you won't understand what the information you're getting is.

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

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

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

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

(Off microphone comments)

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

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

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

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

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

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

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

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

DR. SKAPIK: Thank you.

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

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

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

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

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

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

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

And I was just thinking that when I was a teenager my family took like life savings and took this big trip to California from Philadelphia. And in those days we had to have a travel agent to coordinate getting airplane tickets and figuring out the cars and figuring out how the hotels would go and how we would coordinate certain tickets for certain events and everything.

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

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

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

If you look at E-Prescribing it's up in the 80 percents. So that's rapidly changing. So I really hope that as we contemplate these measures we're contemplating the rapidity with which the system is changing and we're not sort of facilitating.

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

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

And, you know, we very passionately believe, those of us that make this our focus and our life work, actually passionately believe that we need to be comprehensive and put it all together. That it's the siloing of the development of technology and the development of the stuff and the software and doing that in absence of understanding exactly how care is delivered and how we as consumers use it that has caused the challenges we have today.

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

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

And that is because we within our walls have many, many, many of the services that typically a stand-alone practice would be coordinating. Not only preventive medical care, primary care, chronic disease care, hospital care, coordination of specialty care, but we often will have behavioral health services, dental, nutrition, case management, education.

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

I will also just say as background, we were one of the early AHRQ demonstration projects for incorporation of clinical quality measures and clinical decision support related to those measures into the EMR. And I'm also really thrilled that we're one of the sites that are doing these early rapid feedbacks on Meaningful Use.

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

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

And one of the big points is to move from one to two that data capture to sharing, many of you made that point, means you have to really understand something about data and its use, how it should be captured and how it's going to be used.

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

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

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

So here are just some real-world examples in an EMR of what clinical decision support looks like. And it ranges from a passive decision support, which is really just a template.

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

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

This is another example of

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

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

Again this template is the same. You're prompted to be paying attention to these things in the visit today, but you're also being given information of what the previous response to the patient was so you can relate, see whether it was ever addressed, if it was, where there's an issue.

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

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

We're seeing historically what the status of the patient is with regard to that recommendation, and there's an opportunity right there in a very efficient way in the work flow to address it. And there is a clinical, there's some kind of visual cue to prompt and draw attention to where there's a deficiency.

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

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

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

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

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

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

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

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

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

We could drill down into sites or providers. We could change the time period we were looking at. We could change the graphs and the views. And because it's real time, it can be used to print out a report for this morning in one particular measurement of patients coming in that day, what are they due for?

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

Now here's a really fun thing. This is a CMS innovations project that we're doing with University of Chicago. University of Chicago for years has been employing college students to walk the streets of the community and catalog in meticulous detail what community assets are there.

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

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

What this represents is, we have taken an atlas that they developed of those assets and linked it to the EMR. And what happens in real time is a patient's problem list related to a care plan hits this database and then generates back to the provider in real time a list of assets within the community that are nearby that patient's recorded address of where they can go for food, for vegetables. You'll see entitlement services in here relevant to care coordination. This is happening today as we speak.

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

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

How many of those that have your

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

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

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

It's actually optimized where we're not going to be counting how many minutes a provider spends with a patient. Or we're not going to be deciding whether we will pay for housing or something else.

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

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

So some of our colleagues in the social service realm and the behavioral health realm actually are even more resistant to that kind of Excel model of reporting information, because it's kind of a birthright to be more sort of narrative and more editorial.

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

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

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

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

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

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

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

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

So it reflects, actually, what the public is saying and what ONC is saying. There's an evolution that we're in of the ownership of data from practitioner to then the health care institution viewed they owned it, and then we've been through this period where the payors felt they were the owners of the data, and now we're moving into this accountable care entity which is scary that many people are sort of mixing up and equating with managed care.

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

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

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

Then we have this health information exchange infrastructure which will take a subset of that data and make it available across system-wide. And then we have the patient's view of data.

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

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

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

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

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

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

And then a second area are the patient reported outcomes. We touched on them, but I also want to highlight that this is also a set of standards based tools that exist and could be utilized and are patient focused, and begin to reflect goals that are more, perhaps more reflective of the patient than the goals that we think about in the medical realm, like did they get their hemoglobin A1c.

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

So the last thing I want to show you is this other project that we did with the CDC, and if there were more time I'd go into more detail. But do you see that little red alert in the corner?

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

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

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

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

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

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

So for example, the blood pressure cuff on the top right corner that costs roughly $100 and is FDA approved, why will we chase after patients to get their blood pressure taken in an exam room or go somewhere, when for that much money they could be continuously monitoring it at home?

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

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

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

DR. REDDING: Fred, thank you.

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

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

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

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

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

And think of this as sort of like

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

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

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

It's a virtual space of wikis and webexes and phone calls managed by contractors with ONC. But most of the work is really done by committed volunteers from industry and health and health care organizations and academia-government-professional societies.

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

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

And in some cases standards don't exist, and in some cases more than one standard exists that might be used. So the next stage of these processes is to harmonize the existing standards in a way that they can be used, implemented and specified as the standards to be used.

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

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

If there are negative comments

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

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

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

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

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

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

I was also a co-lead of a sub-workgroup called the Care Plan Sub-workgroup. And after the first few calls of that workgroup there was a lot of concern that what was being referred to as care coordination was really just a fragment, if you will, of care coordination. That it wasn't really about a whole patient care coordination, it was about those transitions of care as if that was all there was to care coordination for an individual.

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

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

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

What that is is a document markup standard, a way of coding information in a document that is both human readable and machine readable. It is, in part, structured data that Fred referred to earlier, but it is also, unlike the vision of some people or a concept that some people have it does not exclude having a narrative in those documents or even multimedia and other types of information in the documents. But it does specify a way to identify and maintain the integrity of those electronic document files as they are exchanged.

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

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

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

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

The one that everyone has heard about and throws around the acronym for, as if we all had the same understanding of what it is, is a CCD or a continuity of care document. In that consolidated CDA standard there are actually eight other document types, all of which are specified as part of the standard for Meaningful Use Stage 2, which does not actually mention any of the document types, just this consolidated clinical document architecture standard.

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

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

As far as HL7 is concerned you could not include one of those things and it would still be a CCD or a CDA document, but as far as Meaningful Use is concerned you have to include certain things that aren't really specified by HL7.

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

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

If it's the allergy section Lego that creates interoperability from the get-go allowing this information to be exchanged between systems. And as is the point of today's presentation, allowing this information to be the basis of quality measures, where those specified section templates and the information they contain could be the basis of some quality measure.

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

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

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

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

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

So that initiative has been driven largely by the long term post-acute care community to develop standards around care transfers in that community and longitudinal care planning that is meant to be patient centered and comprehensive care planning based on a blueprint that is a comprehensive care plan.

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

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

Not what they get, not what the sender of the data assumes they need, but they created an elaborate survey and distributed to 46 different organizations, 11 different types of organizations. And well over 1,000 individuals completed that survey and then they tabulated the results and came up with several different datasets and an overarching dataset of data that would be needed for these transfers.

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

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

And it may be counterintuitive that the request for that test or procedure is actually more data, but that's because it really needs to include the historical information and essential information about the patient and the reason for that test or procedure.

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

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

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

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

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

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

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

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

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

So 150 more data elements, some of which are those data elements that Fred referred to in the nursing plan of care in the hospital are lost, as Fred alluded when the patient leaves the hospital. But they are in fact the same data that those respondents to the survey said they needed when they received the patient, particularly in the long term, post-acute care care settings.

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

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

And that was the reason for this

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

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

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

The functional status is actually specified as one of the requirements in Meaningful Use Stage 2, but as it's turning out there's not a very good way to include it in the existing clinical summaries that are generated from EHRs that will be facilitated by the development of these new templates.

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

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

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

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

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

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

And then there are overarching goals that usually come only from the patient or the family, like I want to dance at my daughter's wedding is not either a computable or definable goal in terms of standards, but may be the most important goal to the individual who's the subject of a care plan.

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

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

So this standard that's being

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

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

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

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

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

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

So the next step of course is to create interventions and link them to goals and to members of the care team to allow assessment in the future of progress towards goals and results of those interventions.

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

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

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

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

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

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

DR. LEFTWICH: Okay.

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

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

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

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

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

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

And you hear people complain about

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

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

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

But what, I guess, is important in

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

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

So it may look funny to you if you look at those diagrams, but the anticipated requirement of the future is that we will have to collect those individual reports from different organizations and then match them up. And it would absolutely be necessary that they be produced according to the same standard so that they can be combined, if you will, into a population level quality report across organizations.

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

The other use of the CDA standard that is new and little known is that in December HL7 published a standard, an implementation guide that's referred to as electronic questionnaire and response that is an implementation guide, a framework for producing an electronic questionnaire and responses that are a CDA document that could then be consumed by an EHR that can consume CDA documents.

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

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

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

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

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

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

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

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

DR. MANGIONE-SMITH: Yes, so we at Seattle Children's, we've been collecting health related quality of life data on inpatients at admission and then for four weeks after admission, and the large majority of those are done, all the surveys are done electronically, many self administered on computer and some by interview with the interviewer inputting.

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

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

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

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

This new standard will enable

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

DR. MANGIONE-SMITH: That is so cool.

DR. REDDING: Gerri?

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

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

DR. LEFTWICH: Well, it's at the printer, if you will, and it hasn't come back from the printer yet. But yes. I mean, this is, in Wayne Gretzky's word, you know, we're skating to where the puck's going to be.

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

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

One other, let me mention one other thing that I think is very important that speaks to a lot of the concerns about the broad care team members who don't have EHRs, and that is, that same impact project in Boston has created a software tool called SEE, S-E-E, which stands for Surrogate EHR Environment that is about to be piloted in Boston and that I've organized some acute care hospital and some long term facilities in Chattanooga to pilot as well.

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

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

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

So those CDA documents can be sent

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

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

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

DR. LEFTWICH: Exactly. Absolutely. Once this pilot, you know, skating to where the puck's going to be, but once these pilots have sort of gotten the glitches out of the software --

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

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

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

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

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

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

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

I also think that, you know, having been through this now several times with clinically integrated networks that have EMRs and HIEs in place and have patient reported outcomes on tablets and offices that, you know, what's missing many times is that there isn't enough look at the encounter data that payers have.

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

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

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

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

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

So, you know, I think that there's

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

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

It makes no sense to reconcile medication lists or problem lists. There should be one source of truth for those types of things and it should be the patient's record somewhere and their care plan should sit there as well. And then maybe at that point we can afford to have care plans for people who aren't all that complicated.

DR. CASEY: And be free too.

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

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

DR. REDDING: Yes.

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

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

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

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

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

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

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

DR. LEFTWICH: Yes, we haven't had

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

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

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

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

DR. REDDING: Thank you. Amazingly, patient-centered. That's wonderful. So we need to also, before breaking for lunch, ask if there is anyone on the line or any public comment. And Lauralei?

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

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

And there are no public questions.

DR. REDDING: Thank you.

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

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

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

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

DR. LEFTWICH: Well, I think registries will have to be based on the same interoperability standards that the records will be based on. HL7 is about to publish, may have already published a standard for cancer registry entries.

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

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

DR. RACHMAN: Yes, I'd just respond also that registry is, so EMRs were not really designed out of the box to do population level work like registries. They're transactional databases.

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

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

DR. REDDING: Thank you.

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

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

(Whereupon, the foregoing matter went off the record at 12:16 p.m. and went back on the record at 12:48 p.m.)

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

(12:48 p.m.)

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

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

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

This is again to provide guidance to HHS about where they should direct their measure development resources. And those resources are available, but they are finite. And so we're not saying that anything on our list of domains and sub-domains is not important. But if you were going to run into a burning building to save care coordination, who would you pick? Which domains are we going to elevate from this group.

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

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

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

DR. LAMB: The new ones.

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

MS. DORIAN: Okay, so everybody should have a voting device. We're hoping this will work today. We have a backup plan if not. We usually use this in the measure of valuation process where there's only one response, but.

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

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

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

MS. LASH: So the way we'll

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

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

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

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

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

MS. DORIAN: That's correct,

right. Correct.

DR. ROCA: Okay.

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

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

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

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

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

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

MS. INGRAM: Okay.

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

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

MS. DORIAN: Great.

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

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

So do think about impact. Do think about feasibility. Do think about everything we learned this morning about the state of data and where we're trying to be you know, heading with new capabilities. And you know, your own perspective and expertise as well.

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

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

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

DR. LEFTWICH: Is that --

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

DR. LEFTWICH: Great.

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

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

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

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

MS. LASH: Responses.

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

MS. LASH: Did anyone not feel

confident that they participated in the vote? No truly, we want to capture the data.

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

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

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

MR. CUSANO: Yes, my only question

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

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

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

DR. MANGIONE-SMITH: Yes. So I was going through the same through process. And I noticed then under comprehensive assessment, it says capture preferences and goals. So I felt like under comprehensive assessment, you're getting to that goal setting piece.

MS. LASH: Michael?

DR. PARCHMAN: I just want to make a brief plug for efficiency. Because as I was reflecting on our small group meeting yesterday around the far right column in our little table, the outcomes, and thinking what's possible to measure. And thinking about examples of when I've thought to myself, gosh, we did a bad job coordinating care here.

The major reasons I came up with were always around duplicative services, areas where something was provided to the patient that shouldn't have been provided to the patient that actually was contraindicated because someone didn't know about something that was pre-existing in the patient. Or -- and you know I appreciate helping patients obtain their goals, but I think there's a purpose behind why we try to coordinate care.

And a lot of it has to do with efficiency in preventing harm and improving outcomes. And if we don't start prioritizing measures in that area, I think we're missing the goal of what we're trying to do as providers in coordinating care.

MS. LASH: Vija, did you want to respond to that?

DR. SEHGAL: I just absolutely want to echo what Michael just said. I think of all of the goals, efficiency is probably the one that is the least nebulous in my mind. And the one that's easiest to measure. And the one that has the easiest you know, it's the most quantify able.

It's also the one that you know, we're actively involved in a number of shared savings programs and these are exactly the measures that we are actively measuring, reporting and being reimbursed on. So I think --

MS. LASH: Okay. Gerri?

DR. LAMB: And what you just said was the reason that I didn't vote for it. Is I was going for the ones that I thought were going to be more difficult to more forward. I figured efficiency and experience are going to happen, because they must.

But the others are the ones that we haven't seen. So I was going to for the ones that we've really emphasized and need to move forward.

MS. LASH: So difference in strategy. Fred?

DR. RACHMAN: Okay, so we're making a pitch for the underdogs here. And I remembered the microphone, I just want credit for that.

I'm a little disappointed about experience you all. Because I'm -- I think we could improve those other domains and actually not improve the experience at all.

I'm just thoughtful about people that have 14 care coordinators going and visiting their house. Or they get referred to a service that is so far away, but that it's difficult for them to get to it, or it's not --

And I also am worried about burden that gets placed on primary care providers, where it gets sort of dumped on them. Or on community health center staff, or whatever. And we're not going to capture, we're not going to be able to track and capture what that impact is on both sides. And especially since we don't really know what works well. Or what the ultimate impact of it is.

This is sort of a way -- it's like kind of a net for us to be monitoring. Like what does it actually now feel like to be in the system. So I'm a little disappointed that that scored so low.

MS. LASH: Richard?

DR. BIRKEL: Just to also make a plug for efficiency. I assume, I mean my reason is simple Gerri. It is -- we won't get anyone to pay for care coordination unless it reduces costs. And so we've got to measure it. And we've got to pay for it.

That's my view.

MS. LASH: David?

DR. ACKMAN: Ditto. The -- you know, the -- right now payers are, I mean they're very few codes that really capture care coordination. And most people don't pay for them. I think unless you demonstrate in a very compelling way that this works, and not -- it either saves money, or at least is better outcomes.

I don't -- I think you're going to end up being able to show that it's doing all the things you wanted it to do, but the people who are ultimately going to pay for it will want to know a little bit more.

MS. LASH: Okay. Ilene?

MS. STEIN: Just jumping back to the point about goal setting and progression towards goals. There's just -- the update plan of care regularly as in goal setting, and I think it's true that comprehensive assessment, some of the sub-domains kind of capture what's in goal setting. But the update plan --

MS. LASH: Could you just speak up a little, sorry.

MS. STEIN: Oh, sorry. The update plan of care plan regularly I think needs to be reflected in the comprehensive assessment in order to make it link appropriately toward progression goals.

MS. LASH: Okay. Robert?

DR. ROCA: I just wanted to put in a pitch for experience. You know I think that in the end, the patients, I mean the providers to some extent, but the patients are the ones who are probably the best judges of whether the coordination took place or not. Because the burden often falls on them or their families to accomplish that when it's not happening.

So I'm disappointed it scored so poorly.

MS. LASH: Um-hum. David?

MR. CUSANO: Yes. On the experience piece I struggled between experience and goal attainment. And my thought was that you know goal -- experience may be computed maybe indirectly through goal attainment. Because you know, if individuals need to have a positive experience in order to achieve their goals, so I'm wondering if maybe that's -- maybe that gets a little bit at the experience piece.

And then just on the efficiency point, I agree, I think it's important to measure. Having been on the other side on the payer side, and drafting some of the shared savings programs, and considering quality measures, I think this is a relatively new concept. And I think it's going to evolve. And I think we need to measure it so that the outcomes that we're looking at, you know we continue to capture what the appropriate outcomes are. What the appropriate allocations are, you know, so that we continue to have innovation that's based around quality.

MS. LASH: Russ?

DR. LEFTWICH: I guess I would make the argument for efficiency that was made for goal setting. And I don't think it should be one of the categories because I think it will follow withe the ones that we do have as the top four.

MS. LASH: Don?

DR. CASEY: Yes. I would agree with that. I think there's enough good -- well good being not excellent, methodology out there around episodes of care that are used in standardized assessments of cost of care. But I view efficiency much broader. And I hope it's not being an apples to apples cost equals efficiency. Because I think there's a lot more in efficiency such as appropriate use that needs to be captured.

But I still think that if we're just talking about the cost of care product efficiency, I think there's enough good ability now to measure that.

MS. LASH: Judy?

DR. NG: Another plug for efficiency. I see it as because as an outcomes measure, it can reflect a lot of other things that are further upstream including processes and some of these other domains.

DR. BIRKEL: Could you just repeat that, Lisa. Are you saying no or yes, I couldn't tell.

DR. NG: Yes, a plug for efficiency.

DR. BIRKEL: Could I ask though, because I feel like Russ and Don and Gerri, you all endorsed efficiency, but said you know what, it's low hanging fruit. It's already going to be done.

So is that a gimme? I mean basically we got that one and we shouldn't put it in a priority for HHS because it's already being taken care of? Is that what I'm hearing?

DR. CASEY: Well I think my approach is having now been three cycles, four cycles of this, and been on four technical expert panels for CMS on cost of care for a variety of conditions. I think we have enough critical mass to say that that maybe isn't as important. I'm not saying it's -- I'm not trying to devalue it. I'm just trying to say in these other domains, we don't have really anything, right.

MS. LASH: Nancy?

DR. GIUNTA: I just wanted to share my thoughts on the efficiency piece. I came to this thinking we're trying to identify big gaps in where we have measures. So for me that's -- I agree, I think measures of efficiency are being captured. Maybe not process oriented efficiency.

And also the measure of experience may be -- may be combined with some of the others. David mentioned -- which one did you mention? Goal attainment? Yes. I was thinking maybe experience could be within the linkages synchronization area where stakeholders could share their perceptions on how linkages took place.

MS. LASH: Vija?

DR. SEHGAL: Yes. So I wasn't one of the two who voted for quality or availability of services. However as an after thought, and really I wouldn't be doing my job, my real job a service if I didn't put a plug in for it.

One of the biggest problems with the under-served communities is access to care. Access to specialists. Access to anything quite honestly. And it's -- you know, and yet we deal with some of the sickest most complex patients. And the primary care physicians and the primary care teams really struggle to coordinate their care by themselves without being able to access specialists and whatnot.

So I think access to care, it's a huge, huge disparity right now.

MS. LASH: Fred and Don, did you want to add on something you said earlier, or are you finished? Your card's still up. You Tim? Finished. Okay, Russ?

DR. LEFTWICH: So access to services, availability is important. It's a disparity, but I don't see how it's a measure of care coordination.

MS. LASH: Okay. I am going to probably assume that everyone wants to re-vote based on the discussion?

DR. REDDING: Could -- just based on Russ's comment. What came up yesterday, -- and because this is a good -- it's a good questions. Is that it's -- and maybe this is what you say yesterday Russ, it -- someone, it might have been you, said that it is at least -- it goes along with the same, our you know, discussion about whether there's too many services, not enough, or poor quality.

It's at least a very critical data element within -- especially, I say where -- especially where if we're seeing care coordination, which I think has been some of the definitional challenge with folks. If we're seeing care coordination as including individuals as well as systems of care, that that's all under the umbrella of the term care coordination, which I think we could have a rich discussion about.

But if it is, which it seems to be at the moment, then you need at least at that system level, it seems like you need that data element. And that it's critical. But I'm ask -- you guys know better than I do.

Or could I add one other point? I'll give you another point on that.

In our care coordination work, we track pathways that look at whether or not people connection to prenatal care. And so we realized it was taking a really long time, it was insurance based.

And so within the pathway, it has -- when they are able to get insurance, or when the client's able to get insurance, what we found out in this little rural Ohio county, we have urban counties too. But the rural Ohio county was that people couldn't get prenatal care in a timely way because they couldn't get insurance.

And the reason why they couldn't get insurance even though they were pregnant and qualified, is because none of the doctors in that community would see a patient unless they had insurance. So -- and so they couldn't go anywhere to get a pregnancy test that would qualify to Medicaid that they needed the insurance.

So it wasn't until the data was evaluated at a system level where we had a couple of hundred of these stacked up that somebody then made a policy decision. And actually it was just a phone call to the

Public Health Department who agreed to qualify them as being pregnant on a -- you know, on a pregnancy test.

So this data of -- especially data that shows where there's not a service, can be transformative.

MS. LASH: Last comment from Michael.

DR. PARCHMAN: I was just going to respond to that. That for me is still working on the improving access issue. Once you have access to the service, then you begin working on the coordination piece. But that's just my mental bother.

MS. LASH: Ilene?

MS. STEIN: Sorry. So is it possible based on the four that end up getting the most votes, that we could shift around some of the sub-domains to make sure that the --

MS. LASH: Potentially, yes.

MS. STEIN: Okay.

MS. LASH: Yes. All right, so think again about what you'd like to prioritize as domains and we'll take a second vote.

MS. DORIAN: Okay, if everybody is -- actually before you start, can everybody push their button and see if a green light appears. Any button. I haven't started it yet, so it doesn't --

Okay. It hasn't started, so nothing's captured. Okay. And remember to point over here and hit enter after you enter your four choices. Point this way Don.

(Whereupon, the foregoing went off the record at 1:15 p.m. and went back on the record at 1:16 p.m.)

MS. DORIAN: Is everybody -- okay. Yea, we've got it. No I actually have all of them at this point. It's just getting that. And Carolyn, we were voting on all of the eight major domains again.

So if you could just email me to

let me know if you have the same choices, or you wanted to change your choice based on the discussion.

MS. INGRAM: Okay, thanks.

MS. DORIAN: Just to give Carolyn a second. Well we'll add Carolyn's in when she emails them to us.

But for now we have 12 comprehensive assessment. 3 for goal setting. 9 for shared accountability. Zero for availability of services. 13 for linkages. 6 for experience. 13 for progress towards goal attainment. And 6 for efficiency.

MS. LASH: So we have a further divide between our top three and the fourth choice. Would people like to prioritize sub-domains for comprehensive assessment, linkage and synchronization and progression towards goals only? Or would you also like to prioritize a sub-domain in shared accountability? The latter?

We could re-vote with a show of hands or you could say that you're comfortable with this result. But it's up to you. Yes, and thanks for being quantitative.

DR. CASEY: I was wondering if a zero on availability of services is correct, but.

DR. REDDING: I think I had it on there. Oh, you know what? I -- it's I was advocating for it on part of it being -- it wasn't measured, but it wasn't in my top five.

MS. DORIAN: The other -- I mean, there's a possibility that if somebody didn't push the fourth button hard enough, it captured three.

DR. CASEY: Could I just make a suggestion, we do the first three and then we can figure out what to do with the rest. And I just wanted to make a point here Sarah, just as a marker.

Maybe on the availability of

service, maybe, it's less important to measure it. But more important to provide a framework for assessing it. If that makes sense. In other words maybe it isn't a performance measure as much as it is a checklist of available services.

So it might then not make it appear that it's not important. But just that we think maybe there's a different way to get at it then performance measurements. So it's just a thought.

MS. McCAULEY: And I agree with you John, that that's how I started looking at it. That the quality of services now is in that linkages and synchronization. And the other point was I agree just to do the top three. Because that shared accountability only has two sub-domains. Right?

MS. LASH: Excellent point.

MS. McCAULEY: Yes. So I mean we could do that, but --

MS. LASH: Okay.

MS. McCAULEY: They're both to me equally as important.

MS. LASH: All right. But let's move on to prioritizing sub-domains within comprehensive assessment. Sure, sorry, yes.

DR. MANGIONE-SMITH: Yes. Just to -- if you don't have people accountable for the pieces of the comprehensive care plan, it's not going to get executed. It's going to sit as a document on a shelf. And that -- I mean a lot of us voted for that. I will out myself. I not only voted for it.

And I mean that really is rooted in having done a lot of focus group work with parents with complex kids who you know, literally say oh, yes, I've got the document. We don't use it, but I've got it.

You know, because like all these things are laid out, but it doesn't say who's -- you know, who's the quarter back, right? Sorry.

DR. CASEY: So Rita, -- Rita, maybe the -- but maybe Rita, potentially out of the measures that we create, that then becomes the framework for assured accountability. I'm just saying. Maybe it's not so much an individual domain of measurement. But it's the result of us doing it. I'm just speculating.

DR. BIRKEL: The one I thought where there was some overlap was linkages, that first domain, shared understanding of care coordination goals, blah, blah, blah. I thought that overlapped to some degree with shared accountability.

Do you see that not?

MS. McCAULEY: No I -- I a -- now I've changed my mind back to what Rita said. Because that is specifically the plan of care. There's two sub-domains is about that care plan. Whereas I understand what you're saying, but is that shared understanding, but not really implementing and being accountable for that plan of care. And making sure that it's done.

MS. LASH: Fred?

DR. RACHMAN: So, I wonder if -- can we go back to the -- so just to, let me go back to the sub-domains. Oops. So I wonder if we did ten Rita, if that helps?

DR. MANGIONE-SMITH: I don't know what that has to do with, I'm sorry.

DR. RACHMAN: I'm sorry?

DR. MANGIONE-SMITH: I really don't --

DR. RACHMAN: No, could there be something around that, that said you know, because if it's just sitting there, if there's not any changes to it, or any updating to it or any -- you know then it's not going to -- you know, it wouldn't need a measure that we could design for that.

And I'm also wondering if it's also that holistic monitoring, if we could be creative and shoehorn some kind of experience thing in there. I mean I don't know, but you know, maybe that's where we should aim.

Because I don't see how we would prioritize the rest. Because in comprehensive, is it -- to me one through nine are the elements of a comprehensive risk assessment.

So like if we choose one or two, we're like, I don't know.

MS. McCAULEY: Except I think what Ilene had said earlier was the update plan of care regularly would be moved up to comprehensive assessment. Is you move -- you're requesting to move that from goal setting up. So then -- but it still doesn't have that accountability.

MS. STEIN: Yes. And I guess maybe that would be incorporated into continuous holistic monitoring. I feel like the staff is about to kill me for what I'm going to say. But I guess if I had known that we were going to choose one sub-domain, I would have worded the sub-domains differently. So that they were more -- like they encompassed more than they currently do.

But I would change -- I would also, as Fred said, pick ten. But maybe like modify it a bit so that it captures something more than what it currently captures. But I do feel like that's the most on of all of them.

DR. PARCHMAN: I'm confused about the conversation. Isn't it one of the top four? Accountability, right? We're only going to do three? I didn't understand it we had limited it to three. I mean if --

MS. LASH: Well we --

DR. PARCHMAN: So are we choosing four or are we choosing three?

MS. McCAULEY: No, no, no. We're not talking about the sub-domains. We're going back -- go back to the domains.

DR. PARCHMAN: I'm going back to the domains we've chosen to --

MS. McCAULEY: We had four, but we're saying that we're just going to do the top three and then that left shared accountability out.

DR. PARCHMAN: I didn't understand that we'd agreed to the top three. Is that a vote we took? Or what's the process here? What's our process here as a group?

MS. LASH: Let's do a show of hands on who would like to prioritize the top three, raise your hands. Versus the top four. Okay, so we'll communicate that all four of those domains are prioritized.

And now we'll vote on sub-domains within. And Rita has a questions, sure.

DR. MANGIONE-SMITH: I'm really worried about the comprehensive assessment thing, just being able to pick one. I mean there are 17 of us and there are 10. You know, how are you going to get a majority in any of them, because they're all important.

Yes, you're only allowed to pick

one sub-domain.

MS. LASH: A measure development priority.

DR. BIRKEL: Yes --

DR. MANGIONE-SMITH: Since there's so many, could we chose more for that one?

MS. LASH: Do you want two?

DR. RACHMAN: Could I try again? I mean my suggestion with this one looking at it, again is that really one through nine are the elements of a comprehensive assessment.

So there really are two areas for measure here. One is measure that a comprehensive assessment doing all those domains is done. And the second is that it's continuously updated and used.

And that -- I think that's it. I mean I don't think we, personally -- pick. I say that's what we should put out.

MS. LASH: So are you meant to change the sub-domains entirely to talk about all elements including A through F, or whatever number of elements there are. And then the second part was that it would be continuously used and updated?

David?

DR. ACKMAN: Yes, the problem with that is that you need -- presumably if you're trying to measure it, if you're missing one element, you're -- you miss on that measure. What?

DR. MANGIONE-SMITH: Not necessarily.

DR. ACKMAN: Well that's -- no, but that's what he's saying. That one through nine are -- that is if the -- what you described was you have to be 100 percent complaint or complete on this, or you do not get credit for it.

DR. MANGIONE-SMITH: But you -- you can -- I'm talking out of turn, I know. You can structure a measure for personal credit. So if you have a laundry list of things like this that you're looking for content wise in a particular document or care plan, we do this all the time when we develop measures. We say you know, you get you know, if there's five things, you get 20 percent for each one of those, right.

So you take the mean of the things that are there to get the score. So you don't -- you can make it all or nothing, that's pretty stringent. That's pretty uncommon in quality measurement.

MS. LASH: Richard, did you want to add something?

DR. BIRKEL: I would agree. I mean I think the comprehensive assessment is one through nine, there's probably a couple missing. But it's good enough. And then the monitoring may be where we just really don't have measures. I would say that that's a gap. Continuous monitor.

But anyway, that's my opinion.

DR. REDDING: The only part of it I would just nudge on would be to keep the mention of risk in there. We have a lot of evidence that people most at risk don't connect to care. And I don't -- maybe there's another way like we did with the other -- maybe there's another way to do that. Maybe our outcome measurement folks know.

But there's got to be a better focus. We need to be making sure the most at risk people get the services they need. And right now they're not. And part of it's due to a measure.

I think the other thing that's been shown is that our services generally run from people who are most at risk. Wether it's primary care or even care coordination, because they're so complex, it take so much more time. It may not be of our culture.

So somewhere, and maybe you guys would know how to do it, risk needs to be focused. Thank you.

DR. LEFTWICH: Albert Einstein

said you don't understand something until you can explain it to your grandmother. And I could not explain continuous holistic monitoring to my grandmother. I have no idea what that means.

MS. LASH: We might be re-framing that as the assessment is repeated on an ongoing basis and reflected in the plan of care. Is that what was intended by whoever suggested we added that yesterday? Okay.

DR. CASEY: So I think the intent of this exercise is not to feel like we're locking ourselves in to anything. And I think that you know, maybe the question is, if we were forced to prioritize on these, what would that look like? And if the answer based upon what people use in the clickers, the first go around, covers it all, maybe we're done by saying that's it.

I'm just -- I think what we're just trying to do is get directionality and not feel like you know, if we get zero votes on one, that it's not important anymore. I think you're just trying to sort of do this so maybe if people just punched in two and we see what we got, and not view this as like --

MS. LASH: Yes, more of a straw poll.

DR. CASEY: The ballot box. Right. Just to see where things are and let it fly.

MS. LASH: Okay. Yes, this has been a rich discussion and it's showing that you know, we need to re-frame the potential draft of the domains and sub-domains as we're going to communicate their priority. So it seems like there will be -- need to be some written email follow up with the group after the meeting.

So I'll suggest that after we get a comment from Fred, we vote for two of these existing sub-domains. And we'll take into account the results as we edit the content of this domain.

DR. BIRKEL: Just a comment, are we going to have trouble with number 10 because that's two digits?

MS. LASH: Let's assume that it has to do with the reassessment on an ongoing basis to inform.

DR. BIRKEL: Punching it into our little clicker.

MS. LASH: Oh, oh, sorry.

MS. DORIAN: Zero, yes zero.

DR. BIRKEL: Just use zero, good.

MS. LASH: Fred did you want to add something?

DR. RACHMAN: Well now I have two questions. So the first question was, I do think we should clarify a little bit what we're voting on for 10. And so I think the continuous you covered.

And I wonder if I'm making a leap in my interpretation of holistic. But what I thought that meant was that multiple sort of service provider types are contributing. So it's not just a medical monitoring, but it's a -- is that what everyone else thought of by holistic? Okay, so at least we know what we're voting on.

So now I have a second question Sarah, because I thought we maybe suggested that one through nine are not separable. And also Mark, nine I think covers your point about tying it to some notion of risk.

So I personally will have trouble like pulling four out versus six, or something. I don't know if others will have that same problem.

So I don't know how to vote in that. If we're choosing two from this, I would have a lot of trouble.

MS. LASH: Linda?

DR. LINDEKE: As somebody who corrects -- as someone who corrects student grammar a lot, this list could be -- this list, I'm saying as someone who corrects student grammar, this could be so simplified by having one verb, the verb is assess. Documentation is assumed and then having the sub-points.

And then change number 10 to a second verb, assuming that all those other things are under the verb assess. And then the second is monitor continuously and holistically. And then you have a very small measure with sub-points.

MS. INGRAM: I really like that suggestion.

MS. LASH: So we'll -- I'm not sure if I'm in charge, or Mark is, or Sam is. So should we just dispatch with the vote?

DR. RACHMAN: You would have a great system with what Linda said. I think if we --

MS. LASH: We can't unfortunately redo it.

MS. McCAULEY: So I -- if I could just like paraphrase what Linda said. So

Linda you're saying, number one, document care recipients current supports and assets stays. Then --

DR. LINDEKE: I'm just saying put assess as the up front of the verb for this entire one to nine.

MS. McCAULEY: Entire thing, all the way down to ten.

DR. LINDEKE: All the way down.

MS. McCAULEY: Okay.

DR. LINDEKE: And then your second verb could be monitor with continuous and holistic.

MS. McCAULEY: Well then that's just two.

DR. CASEY: So -- so can I just -- just so we understand again the process. This -- these documents, I think the input is good, but trying to wordsmith it right now, give qualitative input. But this is going to go out for public comment.

The word smithing is going to

happen. Ten iterations are going to be 500 times as many people looking at this. And I think we just have to sort of capture the points about what you made about the verb. And we can modify them anyway we want.

But this is really a first round as opposed to an end game, so.

DR. REDDING: Vija?

DR. SEHGAL: I just want to second what Mark said. Actually I have no trouble, I have a hard time lumping them. I have an easier time separating them because I actually see some significant gaps in some of these measures. Especially the risk one like you said. And I'm going to add social in.

So I mean I've just disclosed how I'm going to vote. But I actually think that there are severe gaps. And when we do have care analysis, we don't adequately address each one of these measures. And if we're trying to identify what the gaps are, that's all we're trying to identify right now, so.

DR. REDDING: I wonder, is it possible, and would it be meaningful to you if we broke out, it looks like either three or four categories there. And then left the one under assess with some sub-categories.

So for example, if we had under assess, like Linda said, and I know we can't retype the slide. But if under assessment was all the different things we're assessing, 2, 3, 4, 5, 6. And another sub-heading under assess was that it's continuous, but we leave that -- the assess, that puts it in one bucket.

And then you've got capture preferences and goals is a second bucket. Risk is a third bucket and we've got -- and then -- yes, we're done, we've got three buckets.

Would -- is that doable Gerri?

DR. LAMB: Because I would support would be able to suggest is if we want specificity, if we start lumping, it's going to be really hard to interpret it.

So if we vote for where we think there are gaps that need to be addressed as a priority, then at least we know where we're at. If we start lumping, we won't know.

DR. REDDING: and my question, just to clarify because you guys know, but in this case there would be sub-lumps. So there would be a large lump and little lumps. So we wouldn't be -- we wouldn't take it off, but maybe that makes it to -- we're not allowed to go that far. But I understand.

They do fit into a -- I think what Fred's been pointing us at, is they do sort of fit into a category. And yet this sub-categories are critical.

Rita?

DR. MANGIONE-SMITH: I'm going to make one more pitch for us to allow the list to act as a whole. And here's my reasoning. When we did our field test of the survey measures we developed, we asked about do you have a care plan? And then we asked a series of things. Does this care plan include you know, assessment of your child's function, assessment of your social needs. Operationalized so that parents could understand what we were asking, right.

And what we saw in the scoring of that measure, was that there were some of these, everybody had medication, you know. That was on everybody's you know, allergies was on everybody's, how to contact their primary care provider was on everybody's. But some of these other ones were not.

So you would think why don't I think we should just do it all separately and prioritize the ones that you know, we identified, or I know are more likely to be lacking. None of them were, other than medications, were great.

And so I just feel like collecting the information on the full assessment, the comprehensive assessment, can kind of drive improvement because we can see where all of the deficits are. And if we see that medications is not a big deficit, we don't need you know, that's not where our improvement needs to be. It kind of directs us that we really need to do better at accessing risk and assessing engagement in this instance.

DR. REDDING: So as a re -- just to -- as a -- to check in with what you just said. This is a group of measures that should not be taken apart. It should hold its own as a whole. And I don't know if that -- in other words if you took out one component, it would significantly weaken the whole domain.

DR. MANGIONE-SMITH: I think the measure would be less informative.

DR. REDDING: Okay.

DR. MANGIONE-SMITH: Because you know, it assumes, oh, we're already doing that check. We don't have to ask, or we don't have to look.

DR. REDDING: Okay. Excellent.

DR. MANGIONE-SMITH: And my concern is, even on medications, even though it was 88 percent, 12 percent of the time it still wasn't there. You know what I'm saying? And the only way you know that is when you construct the measure, you require that each one of those things is looked for.

DR. REDDING: That seems like an excellent point. Don?

DR. CASEY: So I just want to point out here that what you're talking about in NQF lingo is a composite measure, right? And I would suggest that an important part of the composite measure is to assess the sub-domains in terms of importance, validity, reliability and usability. Those are the four categories.

And I'm just looking at the difference between assessing behavioral health needs and health literacy. Now the two are related, but I could imagine going to Dr. Roca and spending three hours on number 4. And you know someone taking my medication management needs you know, in about 15 minutes.

So all I'm saying is I think these things fit together as a composite. And I think if we said conceptually we believe this is a composite measure, we still should help prioritize where we think the biggest opportunities are.

DR. BIRKEL: Could I -- can I make a friendly amendment then to both. So to go with the three, but then within the composite measure, vote for the one or two that are the highest priority for development. But to do both things in sequence. The three element approach which you suggested Mark.

DR. REDDING: Okay.

DR. BIRKEL: And then within the first element, which of those in the composite assessment is the weakest.

DR. REDDING: Oh, okay. Yes, does that make sense to you Don?

DR. CASEY: I view that as one possibility.

DR. BIRKEL: Well, no. The three is the assess -- the comprehensive assessment, the risk level assessment and the monitoring.

DR. REDDING: So he's got -- he's making -- he's taking -- he's making three measures. One of them has a composite because it has -- the other ones fall out within a group. So one of them would be a composite into --

DR. CASEY: At this point that's going to be up to the panel development I guess.

DR. REDDING: Okay. One -- this may be inappropriate. But one other thing that seems to be missing and would hate to have this go forward is we do not have assess health needs. And I know we're trying to focus on the other needs. But it's not on the list with -- if it's not inappropriate, could I -- could we request to add that sub-domain? Just as part of the laundry list under the other ones? Okay.

And so -- so would there be a show -- how do you recommend Sarah, should we have a show of hands, or -- so I think we've -- I think we have two things on the table. I'm trying to make sure we could maybe put them both together.

I think that -- I think that what Don and Russ and Gerri are saying is, I think we could put this on the table. They will -- others will create the right groups. And they still want to know of this full set, which ones are priority. Am I saying that right?

MS. LASH: Where to start.

DR. REDDING: Yes, where to start. And even though we know there's lumps and sub-lumps, they want to know even in the sublump category, what there is. So whole new terminology we're developing.

No, but anyway, so is that okay with everybody, show of hands? That we just vote on the three most, or -- is it two or three? Two most important of this list.

DR. LINDEKE: How do you do a double digit entry for number ten?

DR. REDDING: Zero.

DR. LINDEKE: That's a zero, thank you.

DR. REDDING: It is zero, yes.

DR. LINDEKE: I was just wondering that, thank you.

MS. McCAULEY: I just wanted to follow up. So with the health needs, describe what that means. Assess health needs. Would that be the nutrition?

DR. REDDING: It could be nutrition, it could be --

MS. McCAULEY: Physical?

DR. REDDING: Primary care

physician, it could be -- do you have up chronic illness. I think there's a long list to that one.

MS. McCAULEY: That's what I'm saying. So that's where I was thinking --

DR. REDDING: Yes.

MS. McCAULEY: Because we don't have a -- because we've got specifics.

DR. REDDING: Yes, so as you vote, oh, you know what? We're going to have to have a show of hands if health needs is one of your top two.

Fred, did you have something, I'm sorry?

DR. RACHMAN: Well, maybe I just need to be a dissenting vote you all. But I am very troubled by prioritizing behavioral health needs over social needs. Over health -- I'm very troubled by this process.

I'm very fundamentally troubled. And I think the whole point here about care coordination is that we're not going to segment and bucket these. And you've lost me. Well you've lost me on this one.

And I -- you know, the other thing is, one of the other values of this, is this is going to be potentially a -- something that's going to drive how people begin to structure their information systems and how they collect things. And how they you know, prioritize data, et cetera.

So I'm -- I just have to say I'm very troubled. And I personally, I cannot vote one versus the other in those categories.

DR. REDDING: Fred, if you have a recommendation, I think our ears are open. I think one of the things that I may be talk -- walking away from the discussion with is that we don't have to be responsible for categories. And there are so few measure out there now across a -- you know, across a huge list that's tough for any of us to prioritize.

Which one of -- I think the question is which one of these is in a state of readiness as a pilot within a need for a huge expansive measures? But if you have any suggestions, it's open.

DR. RACHMAN: And the suggestion was, if we're saying that we're not ready to have a measure that -- because look at the title of this. It's comprehensive assessment. What this group is saying is that if we can't handle a measure around a comprehensive assessment, scrap it. But don't like, pick assess medication management need, because that is not comprehensive assessment. It defeats the whole purpose of what I came here to talk about.

I just can't tell you how passionate I feel about this.

DR. REDDING: So could -- well could -- so one -- so there might be two options there. One might be to scrap it and to move on. The other one might be and I'm asking the measurement folks, is to go ahead and vote, but to request very much that what Fred -- that this vote is qualified by the fact that it's a much bigger issue than those two little items.

And if you think that it might get -- the misinterpretation that Fred's stating might be real, then maybe we should scrap it. And we're asking. We need your guidance. Gerri or Don or Russ?

DR. MANGIONE-SMITH: Well, Fred I'm totally with you. I mean I very clearly hear your concern. And I think the challenge right now is it sounds like the word voting means we're locking our selves into something we don't want to you know, that is going to be publicly displayed. And is going to set the state for the wrong mind set.

I don't -- I view this as more of an exercise -- a thought experiment. Maybe it's the wrong thought experiment, but you know, which of these are going to be harder?

Not that they're -- that one is more important than the other, but which might you know, be more of a challenge? And I'm not a measure developer. I'm just one that has dealt a lot with consensus development around things like composite measures.

So I don't think, maybe voting is the wrong word. I don't know. I think we're just trying to get the temperature of the room on some of the specific areas and see what we get. And not worry that this is going to be in the New York Times tomorrow.

DR. REDDING: Fred please?

DR. RACHMAN: Just one last question.

DR. REDDING: Sure.

DR. RACHMAN: I still don't understand why the suggestion of bundling these together as one measure with a percent for each one, why we can't do that? And I just want to tell you that I showed you a screen in our EMR, we're essentially doing almost all these measures.

The only one that I think you know, I'm not sure that we're doing very accurately right now is health literacy. But that's a small leap.

And it would be possible to -- so I know that it's possible to do this you all. So I -- again, I just -- I don't know why we are scrapping that idea of saying erase 1 through 8 and call it comprehensive assessment with bullets. Why we can't do that.

DR. CASEY: Were you here when we talked about composites?

DR. RACHMAN: Yes.

DR. REDDING: Yes, I think we can if we call 1 through 8 one composite lump with sub-lumps.

Yes, Sharon?

MS. McCAULEY: So would health needs be in that?

DR. REDDING: It would.

MS. McCAULEY: 1 through 8, well 1 through 9.

DR. REDDING: Yes.

MS. McCAULEY: So we can't do that, but we'll have to -- okay.

DR. REDDING: Well we could do it. I think we could accomplish it. We've got strategies to still accomplish the vote. Because it would all go under one. You would just be voting on the assessment.

MS. McCAULEY: Right.

DR. REDDING: Michael?

DR. PARCHMAN: I've heard over and over again now that 2 through 6 are considered to be a single construct, this assessment construct. But I've also heard that also looking at supports and assets is different then assessing needs, which is what 2 through 6 seems to be.

So one way to do this is to talk about there being really five sub-domains, which is optimenting supports and asset. The assessment function, which is 2 through 6. Looking at their level of activation. Capturing their goals and preferences. And then customizing the coordination approach.

That would give you really one, two, three, four, five sub-domains. And I've heard that several times suggested around the room this afternoon. Maybe I've misunderstood the conversation. But it seems like to me we need to come to closure at this point. And I think Sarah and Mark were looking to your help to help us, force us to come to some closure on this.

DR. LEFTWICH: So I have to say that from a data capture standpoint, grouping 2 through 6 is -- doesn't make -- makes it very difficult. And it might cause measure developers to say no. Not even going to try.

Whereas at least some of those as individual measures, would be captured in the course of care. In the course of care planning maybe I should say. Like capturing preferences and goals.

DR. REDDING: So one of the ways that I think it might clarify is, I think we're stuck on this one because there's -- we can't get them all into one -- we need the ability to make another sub-category.

And even though we weren't supposed to go that far, the issues are too critical. So instead of say clumping them all into one measure, it's a family of measure -- or a group of measures like Don was saying.

So let's -- let me ask, if we could have a proposition for a for group number, and we'll just go through this exercise and if it's successful, great. If not, what goes in group one, we'll just call it group one of a grouping of these.

Is it function social needs, and again, this isn't separating it out as a measure, it's separating it out as a group of specific measures. I think it's function, social needs, behavioral health, medication management, health literacy and health. Is that correct?

And Michael does that fit with what you're saying? Okay, so that would be group one would be under -- and it would all be under assess.

And then we've got group number two would be measure, care, recipient activation. Is that correct Michael? Okay.

DR. BIRKEL: Just a comment, I mean is there a strong relation between number one and number -- I'm sorry, between number one and number seven?

DR. REDDING: Yes. So --

DR. PARCHMAN: What was --

DR. REDDING: Yes, thank you, yes. So two is activation, well to simplify it. Three is preferences. Yes. And four is risk. And five --

As long as we say assess continuously, I think fitting with what Fred talked about earlier where everyone is beneath the umbrella of the system, couldn't we just say assess continuously. And that would allow us to collapse continuous holistic monitoring with assess.

In other words, we're going to -- I don't mean to make it -- but we are going to have a continuous approach to assessing these issues. So from the time the baby shows up we're going to be assessing it. And there will be a first one, but it just comes along with it.

So that would give us -- so that would give us preferences -- yes, so that would give us four. And realizing that one is very much, and they probably all represent families of measures, but one represents families of measures.

And then we -- could we vote for the top two in those four? And would that be helpful to the folks trying to figure out measures? No? You need something more specific?

DR. CASEY: I guess. So let me be clear. We're chairing the consensus development on submitted measures. So I don't want to continue to posit myself as the expert in this. I really don't. I don't think Gerri does either.

So we're just trying to bring our experience of measure development, consensus development into play here in terms of this. But at this point, I'm comfortable with the direction this is going in. I --

DR. REDDING: To vote with these -- one of these four, would be at least helpful?

DR. CASEY: At this point we're going around in circles. So I'm just hoping we can --

DR. REDDING: Come to closure?

DR. CASEY: Do something.

DR. REDDING: Okay. Okay. So is there an electronic way to vote one through four if we know what it is? Then do you want to do show of hands? Okay.

MS. LASH: I think we've still got some people still in the room.

DR. REDDING: Oh yes. Sorry. Quick questions, Fred?

DR. RACHMAN: Russ' remark made me want to ask this question. Are we -- is the lens -- one of the lenses we should be using whether these are ready for prime time for e-specification? Because that -- that would change a lot.

Or are we saying that you know, we're putting these measures out there you know, as an aspirational set of measures. And both we want measure developers to be thinking about it, but we also want the field to be thinking about how potentially they could -- we could figure out how to collect them electronically?

DR. REDDING: Great question. I do think part of the difficulty is around specificity. And so you know, do you need large groups, little groups, or actually specific measures to go out and measure? I think that's where we've had the biggest challenges in group, in whether or not to group things or not.

I think in some cases what you've got here in terms of priorities, are some are more specific than others obviously. And that probably makes it a little bit confusing in the comparison. Is that what you're thinking Don? In part?

DR. CASEY: Not really.

DR. REDDING: Okay. So I think any of the categories one through four could break out into multiple specific e-ready measures. Rita or -- oh, yes, Rita please go ahead.

DR. MANGIONE-SMITH: So just a couple. One thing I'd like to understand better. So my assumption about what we've been doing here the last day and a half is to come up with priority areas for measure development for HHS.

So although it won't go to the New York Times, what we decide here will influence how funding goes for measure development. Am I correct about that assumption? Okay.

So I think you know, it's not trivial, a trivial exercise that we're going through. And I think that's why many of us are having a lot of angst about this.

I can honestly tell you, psychometrically, those things under assess will not go together when people -- when you score them they will not flow as a domain. I can promise you that. They are radically different from each other. And just because one's in place, there's no correlation that another will be in place.

So I think what people think about survey composites, that's not exactly how I would think about this. I would think about this as a multi part measure of a comprehensive assessment.

And I think what I'm struggling with is, as a quality measure developer, if HHS came looking for people to develop measures around a comprehensive assessment, that would then get operationalized by the developer.

And if we want to give some suggestions about what we think that should include, I think that's reasonable. But I don't really feel like these are sub-domains.

And I think where in other areas what we've identified really feel like sub-domains, these don't. And I think it's just this long list of all of our wishes you know, that these all end up on the comprehensive plan you know.

So I'm having a hard time with breaking them into any kind of groups to be honest with you.

DR. REDDING: So give -- help us

with -- you know, obviously there's, if we went down the chain of measures, you know we have health and then we go to behavioral health. Help us with the terminology here to straighten that out.

I think what we've got is four different areas that measures could be developed in. One of them being this assessment or continuous assessment.

I also sense that people don't want, and in fact self included, that we want to make sure if we have assessment there, that those other items are very clearly in there in that group. Otherwise people won't assess social needs and other things.

So do you have terminology we could use that would clarify it?

DR. MANGIONE-SMITH: I mean to me, as a measure developer, I would look at this as you know, is there a comprehensive assessment available for the patient? Right. So that would be --

DR. REDDING: Number one.

DR. MANGIONE-SMITH: Measure number one. I'd get all of eligible patients and numerators, do they have an assessment in place.

Measure number two would be does the assessment include the following elements.

DR. REDDING: Yes, that's great.

DR. MANGIONE-SMITH: Ding, ding, ding, ding, ding, ding, ding.

DR. REDDING: That's great, that's great.

DR. MANGIONE-SMITH: And I will give you partial credit for every single one of those that you hit.

DR. REDDING: Yes, that's great.

DR. MANGIONE-SMITH: And but that's a measure. One measure. It's not four measures. That's one measure.

DR. REDDING: I understand. Okay.

DR. MANGIONE-SMITH: I do think

that I would have a third measure that would say is there documentation or evidence that the comprehensive assessment was reassessed and updated on a regular basis?

DR. REDDING: Okay.

DR. MANGIONE-SMITH: You know, so I kind of see three potential measures. Do you have the plan? Does it have the right elements? Do you reassess it and update it on a regular basis?

DR. REDDING: Okay. And that is what we would need to cover this assessment, what we have as a group right now. We need three separate measures.

And then as a totally separate category moving down the list would be the activation, the preferences and risk?

DR. MANGIONE-SMITH: No, I would include that as an element of the comprehensive assessment.

DR. REDDING: Aahh, okay.

DR. MANGIONE-SMITH: I mean to me

one through nine are all part of a comprehensive assessment.

DR. REDDING: Okay. That sounds good. So let's see, let me go to Nancy real quick.

DR. MANGIONE-SMITH: Don't go crazy, I think you could assess them each individually, right. You know, then you would get a score for each of them.

DR. LEFTWICH: I agree with what you're saying. But I have to reiterate that where are you going to get the data for this measure? It's not there.

DR. MANGIONE-SMITH: We're not there yet. This is aspirational, right?

DR. LEFTWICH: Well this is more than aspirational. I mean some of the data is there. Assess function.

DR. MANGIONE-SMITH: Fred seemed to say that they've got everything but health literacy on their, you know, so I don't know.

DR. REDDING: So Nancy, please.

DR. GIUNTA: I think my comment might be not be valid anymore. But just -- I want to make sure we're not eliminating current supports and assets, that's all.

DR. REDDING: Okay. Excellent. No, I don't think we are. Sharon?

MS. McCAULEY: So I'm just making sure I follow. So when you have all your assessment -- because to me, like nutrition, physical activity, that's a part of function. It could be a part of social needs, behavioral, it's affecting everything. So it's not called out.

So I know everyone wants their pieces. So if you just said health, if you just said you know, assess health, would all of those, isn't that all a part of health? No? I don't know.

DR. REDDING: Thank you. No, that's helpful. David?

DR. ACKMAN: The question, where's the data going to come from? Plans at least are measured on this. That is they're -- you know, the special needs plans are required to do a comprehensive assessment and update it every year.

It's self report, audit able, but that's at least on a plan level, I mean they don't hand the attestation is that the instrument you're using, which you've submitted to HRSA or to CMS and they've approved, contains all the elements. So at least at that -- for our plan, --

DR. LEFTWICH: There's data, okay.

DR. ACKMAN: Whether if you're measuring, if it's a different entity, that may be more problematic.

DR. REDDING: Okay, thank you. Russ?

DR. LEFTWICH: I'm talking about electronic data capture and not self attestation about something even if it's audit able. In the end, another -- I can't imagine after this discussion that we publish a vote on anything.

DR. REDDING: Yes.

DR. LEFTWICH: No, really.

DR. REDDING: Well I think that -- so I think the plan would be -- but it's been a very rich discussion. I think a couple -- I think we should -- it seems like we should scrap everything except for comprehensive assessment. Except we're not scraping -- I don't think we are scrapping that we think under comprehensive assessment, these items and including health assessment, are absolutely critical.

And kind of like Fred and others have said, it's pretty touch to weight one over the other. So we've got -- so if we could send back as our report, and I'm looking around the room, that we feel comprehensive assessment is important.

And that we feel that if you're going to do it, it's got to have this whole laundry basket of stuff. And if you want us to prioritize, we tried and it's very difficult to do.

But this is essentially our beginning definition of what a comprehensive assessment is. And we don't think it should be done in parts. And could we have a show of hands for that kind of concept? Wonderful.

I think we've got one more question, Fred I hope? Okay, good. So Fred -- so good. All right. What's next Sarah? Good work.

MS. LASH: All right, given the complexity of the last discussion, I'm a little hesitant to try to have voting on the additional sub-domains. But maybe we could go through them briefly and systematically just to discuss whether you think they're an accurate reflection of the types of concepts you'd like to see within those domains.

So that as a whole they are standing together well. And we can maybe confirm that with you and follow up. But this discussion has been very helpful I think in reshaping this domain in particular.

I think the other ones might be a little bit more straight forward. And then we can progress with the meeting so that we can end closer to on time.

So yes, I guess that brings us to shared accountability where we had two sub-domains of our plan of care documenting who was a part of the care team, including everyone that's been discussed and all sorts of community providers. And that the plan of care is assigning responsibilities to that care team for how they're contributing to the care recipient's goals.

Any suggested changes? I'll take it as a no. Wonderful. Consensus. Maybe not, Russ?

DR. LEFTWICH: Oh, the -- didn't want to change anything, just maybe the concept that the care team members accept their responsibility.

MS. LASH: Yes, they need to be aware of it and accept it, yes.

DR. LEFTWICH: Yes, not just --

MS. LASH: Just being --

DR. LEFTWICH: Assigned it. But it is accepted. Because I think that's very important. I mean reality and practice is patients say that's my primary care doctor. And she says no I'm not.

MS. LASH: Right, okay. Don?

DR. CASEY: I would just say I think that these are necessary but not sufficient. I sort of look at the title and don't see shared accountability in those two items in the sense that you know, everyone's sort of doing their part, but feeling like they did theirs so they're done.

So somehow or another if that -- if it's implied that your accountability is to each other, and again, how you measure that I don't know. But in other words, if here was let's say a composite measure like we just did, that everyone I that group would be accountable for the same composite measure as an example.

So I'm just trying to get at I don't think there's enough emphasis on the fact that this has got to be one unit of accountability as opposed to islands in the sea, so.

MS. LASH: Michael?

DR. PARCHMAN: This actually might be also the area where we can start thinking about the 47 care coordinators in the community and the six different care coordinators per individual in terms of thinking about now only who's responsible, but clearly defining who's responsible for what in terms of the accountability.

DR. REDDING: That's excellent Michael. So I want -- so what if we added, right now if we use our system and individual concepts, we've got some more individually focused approach on this. But we also need a system level focus on accountability. Or at least to leave the door open for that. Which would look at -- an example of which would be to examine duplication of service.

Any comments of that? And how would that be worded, shared accountability and systems of care including for example, the prevention of unnecessary duplication?

DR. PARCHMAN: I might use language like agreement among the care team for a response. Agreement among -- across the care team about responsibilities. So it's not just the sign of responsibilities, but there's an exception that there's some agreement among the care team for who's responsible for what.

DR. REDDING: So I think we're measuring duplication of service and we've got a research project on it. So it has everything that you know, the 15 care coordinators, one can be from the health department, one from a not for profit, one from children's services. You know what I'm saying.

And so they all need to be in a care team and that's -- so maybe so by care team I think you're -- are you implying across a community of -- an organized community of care, or do you mean within more of a specific system like a hospital or? Okay. Okay.

So a care team at both the community and individual level. That's great. Yes, that's great. No, I think that's wonderful. What's really neat about that to me is that we need teams around the patient in a community at the state and federal level. And right now we're a bunch of silos all driving the patient crazy. So yes, that's awesome. Okay.

So a team -- so a -- could we say a team approach, or an approach to accountability that is at the individual and system level? How would -- does Don or anybody else have idea how to word that? Rita?

MS. LASH: I'll suggest that we maybe think about the wording later and move on in the interest of time.

DR. REDDING: Okay great. You've got it. That would be great. Thank you Sarah.

MS. LASH: I know we have a lot more opportunity we want to hear from others. And let's quickly go to linkages and synchronization. Any burning comments? It's a construct validity here.

DR. CASEY: The only thing I'll say here is that this is you know, group one and group three fit nicely in terms of what the people that we're discussing in group two are accountable for. So you know I think these things sort of tie together and I think that hence the synchronization fits in with our discussion on the previous slide, so.

DR. BIRKEL: The only question I had really is number five. What does it mean to be the initial linkage. Why did we use that term? The initial linkage? I'm just not sure.

MS. LASH: Actually, I think that's something that we edited out. So if you look at your sheet, there's only five sub-domains that I apologize didn't get translated to this slide.

DR. BIRKEL: Got it. So the ones that are in our --

MS. LASH: This initial linkage and the follow up are I think intended to be part of the bi-directional communication and not just of results but of ongoing communication to facilitate coordination.

DR. BIRKEL: The ones on the paper are better, right?

MS. LASH: Yes. We were scrambling this morning. I apologize. Fred go ahead.

DR. RACHMAN: Inspirational. How would people feel about in that first bullet, having it say shared documentation rather than understanding? I'm looking at the revised version. It says shared understanding by a clinical provider community crossing care recipients with care coordination goals.

DR. PARCHMAN: I think documentation is a long way from understanding. A shared understanding. I mean you can document the heck out of the medical records, but if there isn't a shared understanding, then the documentation doesn't serve any purpose.

MS. LASH: What would be the rationale for this suggestion? The change you're suggesting?

DR. RACHMAN: So if we want everybody marching from the same page, there should be some place where that set of goals is visible and used and shared. It seems it's consistent with ONC direction, you know that there is a single way that this gets reported.

And you know, understanding how you would like -- I don't know how you operationalize understanding, whereas we could operationalize the fact that anyone would produce the same care plan where ever they are, the same poles I mean.

DR. BIRKEL: The only thing I might suggest is why wouldn't' that one, the shared documentation be part of shared accountability, the one we just got off of. I like it there almost better. And then going to Michael's point about understanding being really part of the linkage synchronization piece.

But the shared documentation, I agree of a single plan might be better under shared accountability. We don't have that there. That there's one care plan.

DR. LEFTWICH: I would suggest

that it be harmonization of goals among all of the team. I mean reality is that multiple plans of care exist for many individuals out there that may have different goals. And so from where we are now, I think the realistic step is harmonization of those goals.

DR. PARCHMAN: Is that the same as shared agreement, and the share a common thing is that --

DR. LEFTWICH: I think it's probably analogous to shared agreement, but harmonization may be more the process that's needed to get there.

MS. LASH: Those that can be consolidated would be, but others which are more in one provider's prevue could remain somewhat independent?

DR. LEFTWICH: Right.

MS. LASH: Okay. I think we can reflect that. Michael did you have something else you wanted to say before we move on?

DR. PARCHMAN: Well I was just

going to say that documentation may form the basis of the first step towards shared understanding. So if we're thinking about operationalizing shared understanding, that might be a direction that we can go toward measurement.

But I don't think I would put it in here as the sub-domain. I think understanding is a more aspirational goal then documentation.

MS. LASH: All right, let's move on to progression towards goals. And again this document will continue to be updated. It's currently called goal attainment.

DR. CASEY: I sort of think maybe if it was health and functional status as opposed to health slash --

MS. LASH: Okay.

DR. CASEY: Functional status it might help measure developers because --

MS. LASH: It's not one or the other, it's both.

DR. CASEY: Well it's both, but it's not the slash -- I think it's just and, yes. With an H.

MS. LASH: Okay. Woody?

DR. EISENBERG: Given that this is dynamic, I have to ask my measure developing colleagues, is reduction of unmet needs appropriate? Because new needs will develop during the course of time. So if we're developing a measure that's going to look at the number of needs out there, and maybe it's increased, but everything else has been done just wonderfully.

So is there a better way for us to measure that the needs expressed at say the initial interview for example, have been met?

MS. LASH: Any suggestions about how we would?

DR. MANGIONE-SMITH: I mean, I think if I was trying to operationalize reduction of unmet needs, obviously that's a measure that would have to be done multiple times, right. It could never be a cross-sectional measure.

There would have to be an assessment at one time point of you know, what are you needs. And then at the next time point, how many of those needs have been met, in you know, X number of months.

It would be a very complex and difficult measure to implement. But it -- that's probably how I would implement it.

MS. LASH: Great. It's very aspirational. Ilene?

MS. STEIN: So in an earlier discussion we were talking about maybe incorporating elements of a patient experience or -- into progression towards goals. And I think that actually makes sense, because a goal should be improve the patient experience.

MS. LASH: Fred, did you have something to add?

DR. RACHMAN: Could you just

repeat what you said.

MS. STEIN: So you were there when we were talking about like the larger domains. There was a comment that patient experience in some ways to be rolled into progression towards goals. And it does seem like that would be a place to put it. Because one of the goals should be improvement in patient experience.

DR. RACHMAN: Thanks, because that was going to be my comment.

MS. LASH: Russ?

DR. LEFTWICH: So wording to incorporate Woody's thought would be resolution of unmet needs.

MS. LASH: Not account of the reduction, but as needs are identified they are met. Okay. Do you want to repeat that for Lauralei so that she can make that change. It was -- you had a specific word.

DR. LEFTWICH: Resolution of unmet needs.

MS. LASH: Thank you. David?

DR. ACKMAN: How do we think insuring patient safety will be measured? I mean you -- if it's identified as a need, you know for all risk, medication risk, then it sort of fit under that. But beyond that, how do we think about patient's -- measure this insuring patient safety?

DR. MANGIONE-SMITH: I would say that that would, the only way I can think of to operationalize that construct would basically be no safety events, you know over a given course of time with a patient. And that assumes that you have a monitoring system in place that's looking for adverse events that's actually queryable and all of that.

MS. LASH: I think it might be fair that receiving safe healthcare is an implicit goal of all patients, not an explicit one. Maybe that's in the plan of care.

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.

DR. GIUNTA: I'd be really cautious with this construct because when we're talking about adults with disabilities or older adults, or we're balancing independence with safety, and is it up to us to determine what's safe?

DR. SEHGAL: I'm actually having a bit of a hard time with the whole unmet needs issue. I mean when I look at progression towards goals, I think of outcome measures. I think of you know, if we're focusing on improving someone's diabetes for example.

I look at lowering their hemoglobin A1Cs. If I'm looking at fall prevention, I'm -- well maybe not fall prevention. But in terms of if I'm looking at cardiovascular disease, I'm looking at lowering blood pressure.

If I'm looking at medication reconciliation or medication adherence, I'm looking at -- and I don't see any of those sorts of outcome measures in here.

I don't know if this is the right spot for that, but those are discrete measurable goals as opposed to these which are a little fluid for me. I'm not.

DR. REDDING: Maybe I could jump in there. It's a little bit like our discussion before I think from an outcome point of view. For example, what makes a person have a health baby, the data showing that it may have a lot more to do with a whole bunch of social service issues like housing, food, clothing, domestic, you know all those kinds of things. So that it's sort of like a category thing.

We want those bigger picture health outcomes to appear. But if we don't keep the details in mind of how you get there. So I think that's where like the comprehensive assessment determining things like housing, food, clothing and all those other things, and making sure we do due diligence on each one, then can result in a sort of the next category of outcome like a healthy baby or a lowered blood pressure or better hemoglobin A1C.

I don't know if that answers the question. But I think your request is in there. These are just -- we're just in the weeds with some of the details.

DR. SEHGAL: Yes. No, and I don't want the details in there. I'm just again, what is an unmet need for example? Can I -- I'm having a just, that's --

DR. LEFTWICH: So if we did a comprehensive risk -- one, this construct may help, but if we did a comprehensive risk assessment like social health, behavioral health, then everything that was identified as a problem, everything from lack of a family doctor to no housing, to educational support would be -- and interestingly it's both a need and in some risk strategies, it's a risk factor that needs to be mitigated or addressed.

Anyway, good question though.

MS. LASH: All right, Judy, David then maybe to Fred. I'd like to wrap up so that we can get to our round robin and then close the meeting.

Judy?

DR. NG: And I didn't think about this until Vija you mentioned it, but this idea of the unmet needs and coupled with what you just said Mark. Is we also have these other two bullets about maximizing health and function and reducing patient safety. And if you think about it holistically, they are kind of interlinked.

So even if you're struggling with the -- even if we end up struggling a bit with this unmet needs concept, I think thinking about it under the umbrella of trying to maximize patient safety, whether through reduction of risk factors, or maximizing health function, or reducing patient safety in terms of reducing fall risk, et cetera. I think it would hit the mark if for example the unmet needs piece ends up being too iffy for us and maybe the public to grasp.

MR. CUSANO: Yes, just on the unmet needs. I know we're trying to be aspirational, but just trying to be practical. In terms of the concept of resolution of unmet needs, I'm just wondering if that may be too aspirational in the sense that if it's food and clothing and housing, maybe it's we need to address unmet needs. But that -- you're actually going to resolve them in every case from a measurement perspective may -- may be a bit challenging.

DR. REDDING: So it's a good point. But I think that there's a -- there are odd ball examples, but there are programs serving patients by the thousands that actually are documenting initial food support and ongoing food support. And they are putting that together under the sort of the larger categories they have.

So I think you're right. They're very aspirational, but there's some examples out there. Good, good question.

MS. LASH: Okay, Don?

DR. CASEY: This is just two seconds, but I think Vija point. I sort of let it go past maximized health and functional status. But outcome seems like a word that ought to be in there. Outcome is a word that should be in there somewhere.

MS. LASH: Great. We'll capture that. Now I think we're ready to go around and hear you know, parting thoughts from all members of the group. What's really resonated with you from this discussion. You heard Sam ask this morning for short and long term actions for HHS to consider.

And I'll also suggest that anyone who has a pressing need to leave for the airport in the next half hour, might want to indicate with their tent card. And we'll call on you first before we get to others in the room.

We've got a slide where we're going to offer some ops. Any travelers? Nancy? Sure.

Why don't you go ahead Nancy if you're ready.

DR. GIUNTA: I was hoping to hear from other people first, but that's okay. Just -- I'm just so impressed with the thoughtfulness that everyone has come here with, and the passion and the ability to describe jargon. Because I feel like I came as a novice, and I still am.

Some of the goals that I think for recommendations for DHHS are related to silos and different funding streams and different communication streams. Talking to each other, I think breaking down those silos between let's say, the aging services network and the children and family services network I think is really important. And obviously the medical funding stream.

I think we did a lot of work. And that's it.

MS. LASH: Thanks. And was it David? You also signaled you were going to? Okay.

Ilene can we put you on the spot? Maybe come around this way.

MS. STEIN: So I -- this is complicated. The -- I think what's really interesting for me is because I'm also kind of a novice in some ways, is especially in the consumer community.

Everybody throws around patient centered, and all these terms. And nobody really has a sense of what they actually mean. And it's interesting to see that these can be made concrete in real ways.

I think the other thing is, there are large gaps. And I feel like it's difficult for HHS then any kind of government body states, to be flexible in the fact that they are going to have to try some measures and then remove them when they don't work. Or they're not capturing the right things.

Often time, and I think we saw this with SGR probably, we institute policies, and when they don't work, we just build on top of them to fix them. And I think it's really important in this that they're willing to try. Because we just don't have enough yet. And quickly remove, if necessary and change. So.

MS. LASH: Sure, Nancy?

DR. GIUNTA: I forgot to add one thing. Is that okay?

MS. LASH: Of course.

DR. GIUNTA: And also I encourage you to make visible, or think about the role of social work in this network of services, or in this priorities -- in the priorities that you're putting together.

I don't know how many other committees have social work representation on them. But I definitely encourage you to make visible the role of social workers in potentially being connectors to these different silos. Thank you.

MS. LASH: Thanks for adding that. Judy you ready?

DR. NG: I'm going to divide up what I have to say in short mid and long term thoughts if that's okay.

In the short term, coming from more one end of the measure development world, I know we all talk about being patient centered. I think this idea of thinking of patients in risk tiers is very important.

We talked about the need to have coordination measures for everyone, versus some sub-groups of people. And I think that's really key when you get down to nitty gritty of developing a measure.

Partly you think about people who don't need a lot of care coordination for them. Good care coordination, making sure the annual check up was even done, might be invisible to them. And that's the very different measure for someone who's a little sicker and needs different care coordination.

We talked about using everyone to a level might save waste. What I'm getting to it might save waste in the process and workflow for providers to not have to measure everyone and everything that is not necessary.

So that gets through caring. That's the short term. Mid term and this goes to the theme I think I heard some people talking about in terms of the evidence base.

And we seem to have good evidence for some things, not so great on other things. And I know NQF and many other entities require evidence at a certain level.

We're in care coordination in a place where we're not necessarily quite there completely. We might be there in some aspects, not in some aspects. So I think thinking about things iteratively, I can't even speak, it's Friday -- might be helpful. Living, breathing measures to reflect the state of evidence, not just evidence as we want. Ultimately we want to build towards that.

So can we have a place where we are funding people to build the evidence we need? We all talk about we want this measure to look like this. Ultimately this is what we want to measure. Can we look then backwards upstream?

People who would do well on something like this once it's implemented. What are they doing to do so well? What are the best practices? And can we learn from that?

We don't always have to go to another country to learn. We can learn from our own best practices where people who are performing well on maybe some of these foundational things. Good EMRs, good you know, basic care teams in place, et cetera.

And so that's more the mid term. The long term I think, I'm going to draw from a completely different academic discipline. Economics because I live with one.

Is, where are the incentives to get all this done? We have to think about what incentivizes people. Obviously we think about money. But if you get back to the patient center thing for instance, just one odd ball example I know, you think about goal obtained on the patient scale.

We had a project where all the patients that our goal was to stay in their home and independently. But what they didn't realize was they thought certain things they reported their doctor would impede that goal. Like reporting that they had urinary incontinence.

So I know that part of that is patient education. But that -- for that patient that incentive was to stay at home.

And because of that, that impacted their thinking and how they reported out the care they needed.

So I just encourage us to think about it. I know people didn't like the word holistic, but from every single angle possible. Especially from the patient's angle.

MR. CUSANO: Well thank you. This has been a great learning experience for me. I think what resonated me with -- resonates with me most is the concept of linkage and synchronization.

I mean, I really think in order for care coordination to work you need engagement by you know, the patient, their family, their care givers and then the providers and resources in the community. So I think I'm very excited about that linkage and synchronization domain. I think that's crucial.

I think, so short term really

focusing on that I think is really critical. And then more a longer term, sticking with that is you know, how do you use, I think both Fred and Russ and the presenters from HSS discussed today, using the IT resources we have to make that more efficient. A more patient centered experience you know.

Where we have hopefully down the road, you know the patient with their care plan. And in a way that's accessible to the -- so the patient can take that to each person. Each person that's within their care plan that's delivering care to them. And they're actually the holder of that.

I think we need to think about you know, moving towards that level of efficiency. So those are my thoughts.

DR. LINDEKE: What to say. I think even the youngest people in the room are amazed in the time of their career how much has changed. And for some of us who are more in the older people in the room, we're exceptionally amazed at how much has changed.

I've had the experience of going to central Asia. Kyrgyzstan, Kazakhstan. Other places. And I predict that these countries, these people, these very brilliant people all over the world will leap past many of the complexities that -- and the outcomes that will be looked at in -- will be things like cost, the life expectancy, the survival of infants.

So you know, Winston Churchill said Americans, what was it, you might know the quote. They do the right thing after they've tried everything else first. With care coordination, we're trying a great deal.

People are sicker. They live longer. We've added layers of complexity. I think we will do the right thing. It may take, and I predict, if I live long enough, a different payment structure. Because so much of what we do is not pay for performance, it's pay for recording.

And so being here today and yesterday was a great privilege to me. I operate from something my friend says elegantly, and I'll try to end with a quote. She says, there are deeds that will never be done unless you do them. And there are words that will never be spoken unless you speak them.

I commend you all in your work. And hope we continue to make things better in this country.

DR. MANGIONE-SMITH: So first of all thank you for allowing me to be part of this group and this process. It's been really enriching and wonderful to hear from all the different perspectives around the table.

And I will put out an apology that I'm so passionate about this particular topic area. And I apologize if I might have overstepped a few times.

So short term recommendations. I

struck me this morning as I was listening to the presentation from the people from CMS, that within CMS, I hope that there's harmonization across what's going on with the Medicare group and the Medicaid group.

We've spent the last three years working on care coordination measures through the CHIPRA efforts. And I really think a tremendous amount could be learned on the adult side form what we've been doing on the child health side of things.

So anyway, we talk about that bi-directional communication. I hope that's going on there and that they're being coordinated in their efforts around this very important topic.

I have to echo what David said about linkage and synchronization measures. If I had to put my eggs in one basket, that's -- I think that's the key to good care coordination. It's the communication across community sectors and healthcare sector and all the different sectors that touch point care recipient's lives, whether they're children or adults.

And insight I'd like to kind of share with HHS is this is a very, very difficult space in which to develop measures. I think that's why your committee hasn't seen many good measures. I think it's why we have just been sweating the last three years trying to come up with operational realizable measures that are not going to be too expensive to implement. That actually are not such low hanging fruit that nobody's really going to care what they are. Right?

So very difficult. I would encourage them to think about -- I know there's a big focus on e-measurement. I think it is the way it should be in the future.

Some of these measures may need to be trialed using more traditional methodologies. Whether it be manual abstraction of charts. Whether it be survey data collection. I think some of them can be trialed that way, and that may inform then how do we then how do we then take the ones that really show promise and try to move forward with e-measured development.

Long term, I really hope nationally there's a standardization movement in EHRs. It feels like and sounds like from what Russ was saying, and what Fred was saying, that there is a movement towards that. And that's exciting to me.

As somebody who works with children, and dealing with Medicaid rather than Medicare, there are 50 different data sets. And trying to get a national litmus on anything for children is really, really tough. Because there just is not good harmonization across Medicaid agencies and the way they collect data.

So then the other last cautionary, I would put out there is unintended consequences. We have a comprehensive case management clinic at Seattle Children's for complex kids. And that clinic is being followed with metrics to make sure that they're giving high quality care, but they're doing it efficiently.

And I know that there's a big focus on value and I think that that's appropriate. But I think it's also important to embrace the idea that these are really sick kids and there are really sick adults. And care coordination for those really high risk people is expensive. And doing it well is really expensive.

So I just want to put a cautionary out there that if people are so focused on reducing costs, our ability to reach this goal, this aspirational goal of highly -- of a coordinated healthcare system is going to be really tough.

I'll share one last quick antidote that kind of shows this. That clinic had a call to one of the case management people who was on call, by a family whose child had been seen in the emergency department earlier in the day. Had been set home. Was seen for abdominal pain and was said it's a virus, it's okay. Just symptomatic care at home.

Called up the case manager because the child was writhing in pain. And the case manager called the physician who's in charge of the clinic, who said you know, oh, just give him XYZ, he'll be okay. Okay. But she kept him out of the ED, right.   Which is one of the metrics that they're followed on. And unfortunately that child went on to have a stroke at home.

So I mean it's just -- and that's a story that we've been telling at Seattle Children's a lot because there's such a fixation on reduced readmissions, and reduced ED return visits. That it's starting to effect people's clinical decision making. And I think that's dangerous.

So unintended consequences, I just think we have to be careful.

DR. ROCA: Well, let me, as other's have, thank you all for the opportunity to be here. It's been very illuminating.

I'm a relative novice in this area. Although I've certainly been, as I said when I first introduced myself, kind of a consumer in this area for some time working in systems where we've been responding to requirements to report measures.

A couple of kind -- a couple of thoughts. I've been very impressed with the focus on patient centeredness. One aspect that I have not really heard discussed, even in the context of the notion that the patient owns the information, is how much control does the patient have in these models of over who gets the information? And who gets what information exactly?

Certainly it, whenever medical

records, electronic records, these kinds of issues are discussed in setting where mental health providers are present. There's a lot of concern about confidentiality. And there are -- there are certain stigmatized conditions -- stigmatizing conditions that patients don't always want everybody to know, including all of their health providers.

And one question I would have is, do these measures contemplate that kind of, or would they potentially contemplate that kind of level of control on the part of the patients? Or how much control ware we really envisioning the patients would have over this information, if indeed they do own the information?

In terms of the measures themselves, this is kind of a meta idea, as opposed to an idea that's focused on any particular measure. I was very heartened to hear the discussion of the impact of measurement on, in terms of burden, on the people who are doing the reporting. I think there's certainly a sensitivity to that in this group.

But the -- but in the world that I inhabit, the -- there's a sense that we are serving the medical record as much as we're serving the patient.

And you know, when our patients sort of give us a hard time for looking at the computer screen as we're entering data, or when I hear from my medical staff that they're spending 30 percent more time then they used to documenting. And that that's taking away from the time they have to give to patients, then I'm concerned about the potential of unintended consequences that in our effort to make things better, by measuring things, we may in fact be compromising care. And wearing down an already sort of overburdened workforce.

So I guess one thing I would hope is that it would be a -- one of the ground rules in measure development would be showing great sensitivity to this issue. And to the -- great sensitivity to the importance to work whatever kinds of requirements are put into place by the measures into the existing work flows.

Because as much as we may believe the workflow should change. And as much as I supposed we can force the work flows to change by imposing some of these measures, it's going to make things enormously more difficult I think during the short term if we don't -- if we're not really sensitive to these kinds of considerations in our measure development.

And that's it. Thanks.

MS. LASH: Let's go over to David for --

DR. ACKMAN: Thank you very much. Thank you for inviting me. I really enjoy this. I think you really collected a group of tremendous expertise and experience. And really almost futuristic in their thinking of where we're going with information and how we use information in healthcare. So I think -- I really enjoyed this.

In terms of the bullets you have here, I'm going to sort of skip on the first one, and mostly skip on the second one. But I do think that you know, some insights like should go back in the report.

Two things occur to me. One is, and I think this has already been said. The evidence base for the effectiveness and the cost savings of care coordination should be emphasized where it is. And should also be noted where it's lacking.

You know, we didn't talk about that here. And I certainly am not an expert on that. But I think that's important to include in the report.

The other thing that occurred to me was both you know, it sort of came out in the measures we chose, and a lot of the process discussion that we had, was the importance of assessments in care plans. As sort of the foundation for everything that we're hoping to achieve through care coordination.

And it's just my experience and I think the experience of others in the room, are that that practice, and the use of those documents, is erratic. And so building a system in which the foundation is not always in place, maybe needs to be addressed.

And so maybe -- and really may some vindicate a need for a substantial change in how practitioners work. And you know I think that's sort of what we get at when we talk about team work in healthcare. And that's sort of a -- it is a change.

And then the last thing is that in all of this, what has occurred to me, is that this is adding a tremendous amount of responsibility, a new response -- in some places, really new responsibility to -- into the healthcare sector. And in particular I think to primary care.

I think we've assumed in many respects that care is always being given in clinics. And we haven't really talked about how this really works in small offices, small groups.

So it adds that responsibility, and it's going to add some costs. I don't know what that is. And I appreciate what you said about costs driving you know, the overarching consideration and may be driving bad care.

But I think that when we do add responsibility and cost in an environment where the imperative is to reduce costs, we need to be able to prove that.

DR. SEHGAL: It's been a privilege to be part of this team. It really has been. And really an honor to meet all my colleagues here. It's really been a fascinating experience for me and I thank you.

In terms of what I found to be the most important domain, I really think that I will echo what everyone else said, linkage and synchronization. Communication is absolutely key to the goal of care coordination is really to improve the patient experience, the quality of care, and ultimately decrease the cost. And I mean if we're really going to focus on why we're all here, it really is to cut healthcare costs, which are you know, ballooning.

So in order to do so, we have to have an efficient system. We need to avoid the duplication of services. We need to avoid redundancies. But ultimately focusing on the quality of care.

I will continue echoing what I came in here. What I -- the hat I wear, for the hat I've worn for the last 20 years. And that is really the importance of incorporating social determinance of health.

Taking into consideration health

literacy, limited language proficiency and other health disparities which really effect the most vulnerable populations. The people who are the sickest, the people who cannot speak for themselfs often times. We need to absolutely take this into account.

And we also need to figure out a way to risk adjust this. So that those of us serving in community health centers and working with these patients are paid efficiently to be able to provide the services we provide.

So if that was -- if I had one dream for HHS, it would be to continue focusing. And I'm glad they started already doing some work on risk adjusting for social determinants. Thank you so much.

DR. BIRKEL: Yes, same echo. It's terrific to meet you all and to be part of this group.

I think I'm going to start with the last thing. If there was an insight in my case that I would like to pass on and to see, take it to HHS, it's the --it's my revelation. For me a light bulb that really care coordination is an evolving concept.

That it's really going to evolve as technology improves. As system integration improves. This is going to be a very different set of activities in ten years then it is now.

And that's important because I think ultimately it can evolve to become a team based, quality assurance process in which we're really looking at, we're reviewing, we're integrating, we're evaluating the activities of all team members, both individually and as a whole. And we're doing that in a consistent, regular matter.

So this idea that this is -- maybe the old way we thought about care coordination needs to change. And to push that through measurement would be what I think we would like to see. And we think there's more potential for care management to do more for systems for both quality and for efficiency.

In terms of the two measures, I agree linkages and synchronization, powerful -- very powerful for creating the medical and the health neighborhood. And in terms of what I think is most powerful for producing better health, I think it is the goal progression, or goal attainment measures.

Those would have a powerful, I think, impact on both health and really changing practice.

MS. LASH: Before we go to the other side of the table, I wanted to check in with Carolyn if she's still on the phone so that we don't leave you for last.

MS. INGRAM: I am still here. Thank you for doing that. And I want to thank everybody for participating and especially thank the folks at NQF for allowing me to participate from afar.

Because I know sometimes it wasn't easy and I appreciate you all emailing me back and forth and doing that coordinating. This obviously is very hard work. And you all that have been at it for such a long time must be commended for that.

So I would say in the short term, because a lot of states, I work with obviously mostly state Medicaid agencies in developing their programs. They're dying for some of these consistent measures so that they can implement their coordinated care programs for people who are duly eligible. So that they can better implement some of their Medicaid managed care programs.

So in the short term, anything that can be moved forward quickly that is somewhat feasible, I would encourage HHS just to go ahead and do that. Because the states would like the consistency to be able to have something to use out there. They don't have a lot of resources to reinvent the wheel.

And then in the long term I would then start to redo those measures. And re-jigger them as necessary to focus more on outcomes of health.

So I'll leave it there. Thank you very much.

MS. LASH: Thank you Carolyn. Fred, let's go down to you.

DR. RACHMAN: Just ditto. It's just awesome to be included in this group. I feel so humble and honored. And learned so much from all of you and gained so many insights.

So in terms of the first one, ones that have the most -- measures that have the most power. I think any of these measures that are forcing a collaboration among -- crossing multiple domains of service provision, any of the ones that are aiming or forcing that to happen through their design and to their collection.

And I had of course at the midnight hour, this thought that I don't think came up in the discussion is, could there be measures that are aimed at payers, administrators or you know, other funders that are holding them accountable in their, or measuring their policies, or the way they administer or design programs. And how that drives or does not drive coordination? And that's a little teaser for something in my last bucket.

In terms of the activities associated. So I think document -- the process of documenting contributing factors and contributing services is going to be, and the ability to -- and our ability to address them, is going to be tremendously valuable in beginning to develop more kinds of data and evidence.

I think this is a really critical time. And may be a little different from other measure development efforts in that I think these measures are going to be important for people to design towards rather than measure current activities so much.

So providing that the extent to which these measures will provide that kind of guidance or framework, I think will be -- will be very powerful. I think we talked about a lot, recognizing consumer design goals. I think this is really the -- this is really the area where we could do that a lot.

And just to plug again that we figure out somehow to shoehorn in experience in there. And on both sides, the consumer side and the provider side. Because I do think we're in a really critical time in our healthcare journey.

And then the last things is system level account abilities. So wherever these measures are driving, an accountability that bridges beyond an individual institution or provider. I think those activities are going to be very powerful.

So the insights that I'd love to share, I mean it's really the thing I've been, I hope I haven't sounded too much like a broken record. But this thing, this addressing both.

Care coordination which is definitely necessary, will always be necessary for complex patients, is probably more necessary today because of the fragmentation of our system. But also an evolutionary set of measures that are driving the delivery system to be more proactively coordinated so it's less necessary for us to try to Band-Aid it.

And then the last one is calling them and is the same problem as the teaser from my first thing about measures aimed at funders and bureaucracies. It's to call upon our federal agencies that to really give a new thought and maybe use this platform to be thinking about how they are harmonizing their investment, their funding priorities, their measures. You know their policies and even the way they're organizing infrastructure.

Because sitting out here, the way we are funded and safety net organizations to do our care. The way communities are funded in terms of addressing all these social terms are so fragmented. Some of the fragmentation is trying to clean up, forgive me for being cranky on a Friday afternoon, the mess that's delivered because of the failure to coordinate that at another level.

And Sam this is not aimed at you at all. But I hope we could reflect back to HRSA for example. Where do you look in HRSA that there is some entity within HRSA that's responsible for this? They're funding homeless. They're funding nursing centers. They're funding rural centers. They're funding substance abuse. They're funding HIV care. They're funding community health centers.

Where do you look, where do you

find reflected in that infrastructure some structure, some office, some person that's responsible for that level of coordination until you get to poor Dr. Wakefield, who how could she be responsible to do that?

So that would be the last insight that I hoped it wouldn't be too controversial to suggest. Let alone HRSA against CDC, et cetera, et cetera.

MS. LASH: Thanks. We're going to come down her to Gerri since she's got to go.

DR. LAMB: Thank you. Thank you for giving me the time. It's been an honor to work with all of you.

Just a couple of closing thoughts. I think you all know I came with both practical and aspirational expectations. Practical in co-chairing a committee that we're not getting new measures for, and really wanting to see new measures.

And aspirational, as a nurse I feel as passionate, and Rita, don't ever worry about overstepping. I think everybody in the room is passionate about this. Is that care coordination is the hallmark of a caring healthcare system.

A couple of things. One is I'm really delighted to see the collaboration and the communication between the multiple entities that are working on care coordination. There's a lot going on in this area. And it's really important to keep this work connected.

Even in the committees that we all sit on, you know, it gets frustrating not to hear what's going on. And that people aren't moving forward.

The things that I'm most excited about in terms of the discussions are the linkages and synchronization. I think everybody else has spoken to that.

It gets us so much closer than where we've been in terms of making appointments or making referrals. It's really beginning to get to the heart of what's important.

And the other that I think has been a surprise that I'm really also resonating with, is the discussions about shared accountability. We've been talking about team work in healthcare for a very long time. And this gives me hope we an actually operationalize how each of our different disciplines and the providers, as well as the unlicensed personnel, contribute to outcomes.

And the timing is just so perfect with a new national center in inter-professional practice and education. And I just see so many areas of synchrony.

So this has been great and I'm going to run.

MS. LASH: Thank you Gerri. Sharon. Let's go back down to you.

MS. McCAULEY: Again, thank you. It's been an honor and thank you Sarah, Lauralei and Laura. Great job. I know it's a difficult to maneuver all the different pieces and parts.

But thank you so much for asking nutrition to be represented. And I have to echo social work, sometimes you know we need to be at the table. And I thank many of you that have, like Russ, you know have spoken up to get us where we need to be.

I guess for one of the areas of measure development, not only the linkages and synchronization, but I'm going to back to the assessment and that plan of care. Because we do have our nutrition care process. And we are so embedded in those different steps and all the different parts.

But I just want to make sure that we do somehow, and it may not happen if when we measure, that we do identify the correct members, or the best members of that care coordination team. Depending on the care recipient's level of risk, to ensure that we get the right community service and those providers to give that service.

We may not all be in all those different areas. We don't have you know, two million registered dietician/nutritionists. So you know, it's not -- we don't have one on every corner.

So that's where a big reach out to a goal for HHS is to you know, really make sure that we do get that right practitioner. And that we do need training and educating at the community worker level.

And we are looking at that at our association. Because we know how important it is for practitioners of all areas of all disciplines to be at that care coordination level out in the community. And that health is all local, therefore you know, we do have to have the right individuals in those areas.

So in those neighborhoods, maybe just try to include wellness and nutrition coach programs, you know, that are you know, are taught. And we're trying to look at that for non-physician practitioners to make sure that we really get those dedicated resources to the area.

I think that's where we're going to see that availability of services. I know that was one of the measures we looked at. But I want to make sure that that's known.

And to piggyback off on what Mark had said about assess health. That that assess health does include, and hopefully you know, when we do the editing of that section, that you kind of put an i.e., that is nutrition, that is physical activity, exercise, tobacco use, food sources.

You know we always talked about the different medical history, clothing, shelter, basic things like that. You know, we do have those groups of practitioners working in the community nutrition, which is different than public health.

So I just again, some of the insights. Just thanks for having us be at the table with all of you. And I look forward to working with you. Thank you.

MS. LASH: Michael -- sorry Woody. Do you need to go or are you skipping Michael?

DR. PARCHMAN: I will -- I told him to go ahead.

MS. LASH: Oh, okay. Great.

DR. EISENBERG: Thank you. I too am very pleased to have been included in this group. I learned a lot. Thank you.

I'd like to just to emphasize something that I think we all know, but there wasn't a lot of discussion about it. There seems to be an assumption that in many cases, the healthcare teams are actually existing or coming together. And from my experience, that mostly isn't so.

So I would -- I think we should emphasize that our work, our measure should somehow further promote the coming together of the care team. And similar to Sharon's comments, I think that that's going to be Especially important outside of just the medical home, or whatever the medical model will be.

Because getting out, whether it's to social workers or to dieticians or to pharmacists, which is the group that I represent. Really is going to take an extra effort.

And I would also, as a corollary of that, think that we should encourage all of these professionals to be working really at the top of their license. Rita, I was happy to hear that there were so many medication measures out there.

But I'll bet you most of them are not being implemented by the people that are really experts in medication therapy, the pharmacists. And I think it would be helpful if our efforts could encourage that.

In terms of long term goals, I would like to go to two areas that we didn't talk to about at all. And probably Sarah this should appear in the report. But nonetheless, I think they're so important on a foundational level, that I wanted to bring them up.

One of them has to do with clinical education. I have the opportunity to work with medical students and with pharmacy students. And I can tell you that the only group, from an age perspective, the only group that knows less than the older doctors my age, and the older pharmacists my age, are the students just coming out of training.

It's appalling that the freshly trained clinicians are not instep with the things that we are discussing here. You do much better if you talk to people that are out ten years in practice.

They get it Because they have to get it. They realize they've got another 30, 40 years in the profession. They've got to make a living. This is -- times are changing. The students know nothing.

So I don't know if HHS feels that this is an area they need to step into or can step into. But it's something that I think is critical. And don't know if it's being ignored, but it might be.

And then the last part, which is even harder. Is promoting patient accountability. And this is an area that we as a society I think haven't really been willing to step into.

Pretty much legislation has purposely I think ignored the accountability of the patient. And as a result, that's one leg of the stool that's just gone. We've got the payers in there. You've got the providers isn there. You don't have the patients in there.

Again, I don't know if there's anything that our efforts could do to address this. But if there is, I think we should do that. Thank you very much.

Thank you Michael.

DR. PARCHMAN: Sure. So I just want to say thank you for inviting me and allowing me to participate. This has been fun.

I just want to leave on a hopeful note. For the last year and a half, the MacColl Center for Heath Care Innovation has been funded as the national program office by the Robert Wood Johnson Foundation for a project called LEAP. Learning from Effective Ambulatory Practices.

We were charged with identifying 30 exemplar, high functioning, primary care teams in practices across the U.S. And we had the privilege of spending a week in each of those sites this last year.

And I want to tell you, there are some remarkable things going on in team work. And in improving team work across the U.S. right now. These teams are innovating, they're improvising. They are figuring out how to do the work that we're talking about here yesterday and today.

And they're not limiting themselves to their professional credentials or their assigned roles. I love the expression by one clinic leader-administrator, who said, we have well defined roles, but we have extraordinarily task ambiguity built into our system.

He said and we don't hire for professional degree. We hire for people skills and intelligence. And then we figure out how to make them fit into the system and train them to do the work that we need them to do to make sure that care is well coordinated and patient centered. And we build a culture of closing the loop in our system in every aspect of care we deliver.

So there are some real fascinating stories. There's some tools, resources. And I feel like this is a shameless plug, and I apologize for this. But the Robert Wood Johnson Foundation would like us to do this.

We're going to begin the discrimination phase of this project in August and September of this year. And we're going to have modules and curriculum and resources and tools available for people on how to do good care coordination for complex chronically ill patients.

How to do -- to help people operate at the top of their license. And then how to achieve many of the functions that we're talking about here yesterday and today in terms of basic care coordination, functions, comprehensive assessment. The list just goes on and one.

The final thing I'll say is that we've also been working with AHRQ on developing an atlas of measures of team based care. And we looked at our list of identified measures that we accumulated over the last year. And went back and compared them to the measures that are in the AHRQ atlas of care coordination. Well lots of overlap between measures of team based care. And measures of care coordination.

So I just want to encourage us to think about care coordination as a team sport. And any measures that we develop, any tools that we develop around this, we have to think about it at the level of people. And people coordinating tasks and roles and responsibilities at the team level.

So thank you for allowing me to be here.

DR. LEFTWICH: So I too, it's been a great experience to participate and meet everyone. And get to tell some stories. And always great to work with the NQF staff, including the new members. And you all are delightful and always effective. So I appreciate that.

My theme would be patient -- creating the new paradigm of patient centered care teams that the patient and family are on. I do think that the cornerstone of that concept is the care team rooster with a minimum data set that enables communication between the care team members and for the long run identifies the role of those members with respect to that patient.

I would de-emphasize the system level care coordination aspects in favor of a patient centered care team that belongs to the patient. As does the data.

And I think the areas that are most ripe for measured development to improve care are using that care team rooster for communication and accountability. Because it really enables everyone on the team to accept accountability including the patient and the family.

And to start to view it as a team effort that everyone is -- has a responsibility for. And using the data, the interoperable data that I've described as the source for measures, because that data has to flow to have effective care coordination on a team.

So using it as the source of data for measures is both efficient and sort of unavoidable that that's where the important data is. And that includes the community based organizations and services and care givers that are on that team.

And the activities that are most important I think are that communication amongst the team including harmonizing and reconciling the data that's in those different care settings. Particularly the care plan, the goals and the interventions that are associated with them.

And I think that's the most effective way to improve outcomes for the patients. And as far as insights that I would emphasize, I'll claim the one that I offered as my last comments.

And that is the availability, the

developing availability of software tools that will enable non-EHR owners, non-eligible providers, care team members, and that includes the PHRs that the patients have, that undoubtedly will soon develop the ability to produce these documents as well. And tools like the electronic questionnaire and response.

I think that's the insight that I would hope we can offer, that there is a way to expand the technical, HIT interoperability of that, the entire care team. And be able to share information.

So thanks everyone for.

DR. CASEY: Well, thank you also. I'm astounded with the amount of progress we've made thanks to a lot of expertise and a lot of insight.

Linda had a quote. I guess I would quote a hero of mine who said, in a concatenation of ten words, each two letters, if it is to be, it is up to me. And I'll let you look up who said that.

But the point of it is that what we've done today is not an endpoint, but a starting point. And I really believe that each of us on the committee has more responsibility to sort of go home and talk this up. And really sort of get enthusiastic people to be more engaged with NQF so we can get more feedback.

As you know, this is the starting point, not the end point. We have to create a draft and then bring it out to the membership and also the public and the stakeholders for their input.

So trust me, this is -- you haven't seen word smithing until you've seen this process, so. So I actually look forward to that because I think that's where we really get further advancing in terms of what it is we're going to do in the next few years.

You know, I said at the beginning,

that the challenge of not getting new measures was a chicken and egg question. And I think I've decided I've landed on the chicken. I think we've got the opportunity here to really rethink this.

So I'm not going to try to repeat what other people said Because I know I agreed. But I believe that the feedback and stakeholder process is going to be great.

I do want to echo Judy's comments and Fred's points though about the further guidance from -- I'll put them all together in one room, HHS versus CMS and AHRQ, whoever else about the investment.

And I like Fred's idea about sort of creating a more dynamic view within these agencies about this problem specifically rather than the areas of focus. Because I think it's a central challenge.

I also think that we -- and this is more than a pet peeve. I really think we need a brand new taxonomy for classifying evidence now and in the future about impact. And impact being whether we promote high value activities. And we stop, or reduce low value activities.

I think it's probably clear that a lot of what we do isn't high value in this arena. So relative to resources, we have to be I think using some very different and more standardized and modernized evaluation methods then we're using now.

And you know, part of this is because everything that gets submitted is sort of usually all over the map in terms of the evidence that's generated behind the measures that are submitted. So it creates a real problem.

And I just think again it's not going to be perfect. It's never going to be a one size fits all. But we've got to support measure developers as well to not just become better at this, but also create the resources to help them do this.

You know relative to what I think Mike said, I think Sarah, maybe one opportunity here is to again, yet again, look across the measure sets within NQF's library. And start thinking about how we might begin to cross link some of them.

Because I think Mike's point is well taken, that I think there's an opportunity at least to -- to at least identify some of the measures that could potentially be a starting point for this so we don't appear like we're starting with a blank slate.

I also think, and Lauralei knows this is my sort of pet peeve about what we've done in the past. I still think the preferred practices are highly relevant. We didn't spend a lot of time talking about them here.

I think they obviously need to be re-enhanced. But I do think that's another sort of framework here that also helps. And so maybe that hybrid could be useful.

And that's really it. I just, I really am looking forward to the next few weeks. Because there's going to be a lot of activity.

And I want to thank Mark and Susan for being excellent chairs for this. So, thank you.

DR. REDDING: Thank you HHS and Samantha for asking for our opinion on this. It's wonderful. The concept of everybody making decisions out up here and not -- anyway, thank you.

Thanks Sarah and Lauralei and Laura and Wendy for coordinating what to me was an amazing event. Just the whole process of it was a lot to learn from.

And then this group. You know, we haven't quite got -- this may not be completely accurate, but I think almost every health and social service funding stream, and I would guess that every major health and social service funding stream has a lot of care coordination financing and strategy within it.

Looking at housing just for a moment, which is probably one of the most traumatic things for someone with a health issue to deal with, has a huge amount of individually based care coordinators with their own planning. And so Nancy's not here, but we not only need social workers, we need social service leadership and infrastructure, if that's a big part -- if our goal is to improve health, they need to hear Vija and others. I hope I pronounced it right this time, finally. Okay, good. So we need them here to help us.

And then the really cool thing I take away from this meeting is the sense of a team working around the patient, like Michael and many others have reiterated. And then that going back to a team at a more local system community level.

And then man, do we need our states to work as a team. Because they're all in their silos. And we need the federal government is one challenge to also see that need for, if we really want to focus on -- there's no way to focus on the patient without being a team. And if the rest of it's fragmented, it just comes down to the patient.

And finally, in one of my hats that I wear, there's a board member who is a minister in a very disparate community. And he sums it up by saying the least of these are the least likely to connect to any health or social intervention that's going to help make things better.

The data show that -- and I leave here like Michael said, much more hopeful that that's possible. And so I can't believe how you guys managed yourself with this huge -- it may be one of the biggest concepts out there. And brought your wisdom and guided us to understand what you were trying to say.

It's very much appreciated. Thank you.

(Applause)

MS. LASH: On behalf of the whole staff at NQF, I'll add my sincere thanks to our funders. To all of you for participating. To my colleagues. And our faithful members of the public on the phone and web for hanging in with us. And of course those that came to NQF today.

We just wanted to show one last slide of next steps so you know what to look forward to as this project continues. I guess we could take a -- maybe before we do that, pause for public comment. If we have any on the phone.

Cathy would you cue our phone participants please.

OPERATOR: If you would like to make a comment, please press star 1 on your telephone key pad. We have no comments or questions.

MS. LASH: Thank you. Okay. No one in the room. So our upcoming events, you will probably get some type of written email follow up from us in the coming weeks, just to confirm our next version of the summary of what we learned today and yesterday.

But in mid-June, we will have a draft version of the report available for NQF member and public commenting. While that is available, we'll have a public facing webinar to explain the highlights of the conclusions of this report and how it fits with other topic areas you heard Wendy discuss yesterday. Just to sort of educate the commenters about what we're looking for in terms of feedback.

And then we'll have our final report submitted in August to HHS and then that will be publically available for everyone to distribute and share.

And perhaps just thanks again for

the tremendous contributions. Sam?

MS. MEKLIR: For the timing for the draft report, do they get a copy of the draft before it's shared with webinar, or do they get it when it's on the webinar?

MS. LASH: Well invite I think maybe written comments back in the next few weeks on something.

MS. MEKLIR: Okay.

MS. LASH: That's not in the full report format.

MS. MEKLIR: Okay.

MS. LASH: But the real bones of what we would hope to build on. And then you would all be free to participate in the commenting process if you wanted to add any further thoughts at that point.

MS. MEKLIR: Okay. And so I just would encourage all of you to use your tentacles and invite your communities to comment on the draft report. Because you see all these public comments. And this obviously such a topic that is so relevant and timely to so many stakeholders.

And it would be nice to see kind of more of them at the comment period and providing comments. And you all really have the reach and ability help make that happen.

So thank you for that.

(Whereupon, the above-entitled matter was concluded at 3:28 p.m.)

CERTIFICATE

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 true and accurate record of the proceedings.

Neal R Gross

Court Reporter