NATIONAL QUALITY FORUM

+ + + + +

HEALTH WORKFORCE COMMITTEE

+ + + + +

TUESDAY
APRIL 15, 2014

+ + + + +

The Steering Committee met at the National Quality Forum, 9th Floor Conference Room, 1030 15th Street, N.W., Washington, D.C., at 9:30 a.m., Melissa Geddes and Ann Lefebvre, Co-Chairs, presiding.

PRESENT:
MELISSA GERDES, MD (Co-chair), Methodist Health System
ANN LEFEBVRE, MSW, CPHQ (Co-chair), University of North Carolina at Chapel Hill
GIRMA ALEMU, Office of Planning, Analysis, and Evaluation, HRSA
EVALINE ALESSANDRINI, MD, MSCE , Cincinnati Children's Hospital Medical Center
HOWARD BERLINER, ScD, Service Employees International Union (SEIU)
BARBARA BRANDT, PhD, University of Minnesota
AMY KHAN, MD, MPH, Saint Mary's Health Plan
CHRISTINE KOVNER, PhD, RN, FAAN, New York University, College of Nursing
PETER LEE, MD, MPH, FACOEM, General Electric
GAIL MacINNES, MSW, Public Health Institute (PHI)
TAMI MARK, PhD, MBA, Truven Health Analytics
JEAN MOORE, BSN, MSN, State University of New York at Albany School of Public Health
ROBERT MOSER, MD, Kansas Department of Health and Environment*

SUNITA MUTHA, MD, University of California San Francisco
ROBERT PHILLIPS, MD, MSPH, American Board of Family Medicine
WILLIAM PILKINGTON, PhD, Cabarrus Health Alliance, Kannapolis, NC
JON SCHOMMER, PhD, University of Minnesota*
JOHN SNYDER, MD, MS, MPH, FACP, Health Resources and Services Administration
JULIE SOCHALSKI, PhD, RN, University of Pennsylvania, School of Nursing
CHARLES VONGUNTEN, MD, PhD, Ohio Health Kobacker House
GREGG WARSHAW, MD, AGSF, University of Cincinnati College of Medicine
GEORGE ZANGARO, PhD, RN, Health Resources and Services Administration
ANDREW ZINKEL, MD, FACEP, HealthPartners

NQF STAFF:

KAREN ADAMS, PhD, Vice President, Strategic Partnerships
LAURA IBRAGIMOVA, MPH, Project Analyst
ALLISON LUDWIG, MHA, Senior Project Manager, Strategic Partnerships
WENDY PRINS, Senior Director, Strategic Partnerships

ALSO PRESENT:

CILLE KENNEDY, Office of the Assistant Secretary for Planning and Evaluation, HHS
ANN PAGE, Office of the Assistant Secretary for Planning and Evaluation, HHS
EDWARD SALSBERG, MPH, George Washington University

* present by teleconference

A-G-E-N-D-A

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

9:04 a.m.

MS. FRANKLIN: Hi, everyone, and welcome to the Priority- Setting for Healthcare Performance Measurement: Addressing Performance Measure Gaps in Priority Areas.

This is the Health Workforce Committee Meeting and my name is Angela Franklin. I'm senior director for the project.

And I have with me our co-chairs, Melissa Gerdes and Ann Lefebvre. And with that I will turn it over to them.

MS. LEFEBVRE: Great, thank you. Good morning, everyone. It's nice to be here in person and put faces with names.

I think the first thing that we're going to do is go over our objectives for our time together.

So, our first objective is to really build and share an understanding of

environmental drivers of workforce measurement activities.

We also want to refine domains and sub-domains of measurements for the deployment of healthcare workforce developing potential measurement concepts in key areas.

And then we want to prioritize opportunities for healthcare workforce measurement to inform the Department of Health and Human Services.

MS. FRANKLIN: So today's agenda is highlighted before you. And as you can see we're at the 9 o'clock hour where we'll have a review and welcome to everyone.

And before we go much further we'd like to go around the table and just have the committee members introduce themselves and just give their titles. And then we will launch into the rest of the meeting. So we'll start with the committee chairs.

DR. GERDES: Sure, good morning.

This is Melissa Gerdes. I'm co-chair with Ann. Welcome, everyone.

I practice about 40 percent time as a family physician and am an administrator for Methodist Health System in Dallas, my 60 to 160 percent of the time. I've been doing that for about three years.

We run an ACO participating in Medicare Shared Savings Program. We were one of four team ACOs to actually qualify for interim Shared Savings, so very proud of that.

In addition, I'm active in the American Academy of Family Physicians and chair the Commission on Quality and Practice.

MS. LEFEBVRE: And I'm Ann Lefebvre. And I'm an associate director of the North Carolina AHEC program. And our AHEC program is a very large statewide program.

And in that I'm directly responsible for the direct community-based practice piece where I have 40 coaches that go

out into 1,140 community-based practices across the state to work with them both as the regional extension center, to help them meet Meaningful Use, to help them improve clinical quality outcomes in disease-specific categories and to transform their practices into becoming patient-centered medical homes.

In addition to that I'm on the Department of Family Medicine at UNC-Chapel Hill where I help in their fellowship programs for developing residency directors specific to quality improvement.

MS. LUDWIG: Hi, I'm Allison Ludwig. I'm staff here at NQF.

MS. PRINS: Good morning, everyone, I'm Wendy Prins, also staff at NQF.

MR. ALEMU: My name is Girma Alemu and I'm from HRSA. I am the assigned subject matter lead for this project and I work very closely with the NQF team.

DR. KHAN: Good morning, I'm Amy

Khan. I'm the chief medical officer at St. Mary's Health Plans in Reno, Nevada.

I've got a background in primary care, internal medicine as well as preventive medicine. I'm very passionate about patient-centered care and the development of a new model of care that features better care, integration and care coordination. So, pleased to be here.

MS. MARK: I'm Tami Mark from Truven Health Analytics and I'm also a visiting scholar at Brandeis University at Truven Health.

I'm the vice president of the Division of Behavioral Health and Quality Research. I'm trained as a health economist.

DR. MUTHA: Good morning, I'm Sunita Mutha. I'm from the University of California - San Francisco and director of the Center for the Health Profession and professor of clinical medicine. I'm trained as a general

internist and delighted to be here today.

MR. BERLINER: Hi, I'm Howard Berliner. I'm the director of health policy for the Service Employees International Union. We represent over 1 million healthcare workers in 38 states across the country.

MR. PILKINGTON: Hello, I'm William Pilkington. I'm the public health officer and chief executive officer at the Cabarrus Health Alliance in North Carolina.

MS. PAGE: I'm Ann Page. I'm a guest here today and I'm with the Department of Health and Human Services.

DR. SNYDER: My name is John Snyder. I'm a senior medical officer at HRSA, a practicing internist and a former North Carolina AHEC program director.

MR. ZANGARO: George Zangaro from Health and Human Services, HRSA.

MS. MOORE: Jean Moore. I'm the director of the Center for Health Workforce

Studies which is based at the State University of New York at Albany School of Public Health.

MS. KOVNER: Chris Kovner, a public health nurse and professor of nursing at New York University. I run a 10-year panel survey of new nurses. We're in our about eighth year and that's funded by the Robert Wood Johnson Foundation.

DR. ZINKEL: Drew Zinkel. I practice halftime as medical director of quality for Health Partners Health Plan. And then halftime I practice as emergency physician at a level 1 trauma center. And I'm representing the American College of Emergency Physicians here today.

DR. WARSHAW: I'm Gregg Warshaw. I'm a family physician/geriatrician. I direct the geriatric medicine program at the University of Cincinnati. And I've been very active with the American Geriatric Society.

MS. MACINNES: Good morning, my

name is Gail MacInnes and I'm a national policy analyst with the Paraprofessional Healthcare Institute which focuses on the direct care workforce, home health aides, personal care assistants and certified nursing assistants in nursing homes.

MS. KENNEDY: Hi, I'm Cille Kennedy. Like Ann I am also from the Office of the Assistant Secretary for Planning and Evaluation but my role is to work with Girma and NQF, oversee the project that's identifying five different areas of gaps analysis and this is one of them.

MS. ADAMS: Good morning, I'm Karen Adams. I'm vice president, strategic partnerships, at NQF.

Please allow me to really thank you for all the hard work I know that you've already done to lead up to this meeting and all the preparation.

I'd also like to acknowledge the

leadership of our co-chairs Melissa and Ann, and our team. I know that Angela, Allison, Wendy and Laura have been working hard to support you. And we've been really learning a lot and enjoying that so we want to thank you for that.

MS. SOCHALSKI: Hi, Julie Sochalski, late and wet but nonetheless glad to be here. Thank you for this wonderful weather.

From the University of Pennsylvania School of Nursing and glad to be aboard.

MS. LEFEBVRE: I think we have a few committee members on the line. If you're there can you please introduce yourselves?

MR. SCHOMMER: Good morning, this is John Schommer. I'm a professor at the University of Minnesota College of Pharmacy and I serve as one of the investigators for the National Pharmacist Workforce Survey.

DR. MOSER: Yes, this is Bob Moser. I'm the AASHTO Region 7 director and currently

serve as Secretary and state health officer for the Kansas Department of Health and Environment.

My background is family medicine. I practiced 22 years in a frontier area of Kansas.

MS. LUDWIG: All right, now before we dig into the content I just want to do a few housekeeping announcements.

And thank you already for using the microphones. We're allowed to have three on at a time or else, you know, all breaks loose.

So, we'll also use our -- I'm sure in similar fashion to other meetings that you've been a part of your tent cards as a means to be ready to make a comment.

And let me look at my list here, I have a few other things. If you're on the phone please mute your line when you're not speaking so we don't get too much background noise in the room.

Restrooms are through the front door that you came through and around the corner to the right. We'll be having a self-paid dinner tonight. If you're interested in joining please let myself, Laura, or Angela know.

And travel expenses can be submitted to us or our meetings team following the two days.

Am I missing anything, NQF team? Okay.

DR. GERDES: Okay, thank you. At this time I wanted to welcome Ann Page from the Office of the Assistant Secretary for Planning and Evaluation, HHS, and Girma Alemu, Office of Planning, Analysis and Evaluation for HRSA to do our opening remarks. Ann?

MS. PAGE: Sure. I want to thank the group for its work to date and also for the opportunity to have the HHS Interagency Workgroup on the Healthcare Workforce open this

meeting which is a really important meeting.

You've had members from that group as part of your committee all along so I know it's been well represented but I want to sort of take this time to underscore some of the discussions that one of the workgroups had had, one of the groups that was thinking a lot about assessment and metrics.

And so I know that we gave some early input into the process that you have here. And I just want to underscore some of the themes that that group talked about. And they seem especially relevant to the discussion that you're going to have today and tomorrow. So, I want to share those with you.

The group recognized that there are lots of agencies that collect measures of the healthcare workforce. And so we actually did a little digging on our own to try to just identify within the Department what measurement looked like.

And no surprise, it found a lot of what you found, that there's a lot of attention to structural measures, how many people are there and where are they in the distribution.

Not so much information on process measures, how they are deployed and not so much information on the results of those kinds of deployments.

And the other thing that we grappled with first was the work that you all have had to grapple with which was what did we actually mean when we said we wanted to measure the workforce.

As you all have grappled with, the workforce underpins the entire healthcare system so what distinguishes a workforce measure from just a measure of healthcare delivery. And that was something that we struggled with.

We did develop some guidelines for our own work. And I know again we've shared a

lot of that with you but I just wanted to underscore them again today. Sort of four points that the group spent a lot of time thinking about.

The first is that we really wanted to develop a person-centered needs-based approach to our work as opposed to a provider-focused supply-based approach to our work. And so what did we mean by that.

We spent some time articulating what is it that people need that the healthcare providers will deliver. And so that was sort of a lot of our organizing principles.

And so we thought, and I'm just going to run through a real quick list of what are those person-centered needs. People need the knowledge they need to keep themselves healthy, information on nutrition and exercise and risk factors and when to seek care. People do need primary care and oral health care, but people also need the knowledge and skills to be

activated consumers in their care.

They need help to navigate the healthcare system. They need help to coordinate the care they receive. They need knowledge and skills to manage their chronic illness. They need assistance with activities of daily living when they're disabled.

Education and assistance with life skills if they have developmental disability. They do indeed need specialty medical services including speech, physical and occupational therapy. And indeed, they need person-centered care as defined by the Institute of Medicine.

So when we thought about, well, what measures are we looking for those are the types of measures that we were looking for.

And they're hard to come by. But a good example of one that does exist and hopefully there will be more of these is that the Medicare current beneficiaries survey

includes this question: "My doctor explains things to me in terms that I can easily understand." Does that happen usually, sometimes, always, never.

And so here is a measure of is the workforce -- and explicitly mentions a type of worker within the workforce, a physician, and it asks is that worker giving you what you need to do these person-centered things.

The second thing that we talked a lot about was paying attention to structure, process and outcome. And we know that outcomes are the holy grail.

But I'll admit to a bias in old Donabedian approach that although Donabedian says that structure is a real blunt instrument for assessing quality he also says that good structure, that is, a sufficiency of resources and proper system design, is probably the most important means of protecting and promoting quality of care.

So we don't want to just set aside, or give less importance to, or just say that's old school, we're doing new school, we're doing outcomes. That both structure/process/outcome are all important.

And the way we conceptualize structural measures is sort of looking at the number of workers by type, permissible activities and scope of practice laws, skill mix of teams, worker retention, composition of primary care practices, education and training.

By process measures we meant how that workforce is deployed. For example, measures of staffing ratios caseload, types of workers delivering specific care, use of team- based care, use of health information technology. Workplace conditions that promote workforce safety and other workplace infrastructure supports.

We also felt that, and this is not

a typical NQF metric, but that at times we are going to need qualitative descriptions of how the workforce is deployed. There are so many different models and there's a lot of research the Center for Medicare and Medicaid Innovation is testing. A lot of those models you all are involved in those models.

And it's hard to assess things without having almost a text -- a narrative description of what does this deployment of the workforce look like in this situation. So it's something that our group thought about. It may be a precursor to a metric, but it's information that we need to assess the healthcare workforce.

And with respect to outcome measures we had looked at access, are people able to get access to a provider when they need it. Do they actually receive the service when they need it. Again, do they receive those things that we talked about in terms of a

person- centered needs-based approach. Do they receive the knowledge they need to keep themselves healthy? Do they have the knowledge and skills to be activated consumers?

In addition to worker satisfaction and experience of care. In addition to patient experiences of care what are worker experiences of satisfaction of care.

And then of course the costs of delivering the healthcare that people need.

The third theme that we talked a lot about was acknowledging all components of the healthcare workforce. And I know that this group obviously knows that the workforce is very diverse. We were just talking about new types, new labels of different kinds of workers.

We also wanted to pay attention to just two buckets of workers which are the paid and the unpaid workers. Acknowledging that there is a large unpaid workforce. These can

be peer counselors. These can be informal supports, people who deliver care based on a prior personal relationship.

And they deliver a large volume of healthcare in this country. And to not acknowledge that risks some displacement of the informal supports which with its attendant costs. And perhaps in some instances not better quality of care because oftentimes informal supports and peer supports have unique knowledge that other types of workers can't possess.

And then lastly to -- we tried to sort of wrap all of this up with respect to the workforce and think, well gee, what are we really looking at, what do we want to really focus on. And I see these themes in the framework here which is workforce capacity, how effective it is and then workforce efficiency.

And so after our committee identified what it was looking for we tried to

find those. And I know this probably will resonate with this group here but we found that workforce measures are difficult to locate.

We found that measures that were proffered up as workforce measures when we looked at them we didn't necessarily think they were workforce measures. By that we meant that there was no particular worker type in the measure specification.

So it was difficult to attribute this as a workforce measure as opposed to an organizational measure, or a healthcare delivery system measure. So we were really looking for measures that actually had specific reference to a portion or a type of healthcare workforce.

And some of them just did not logically point to it being a workforce measure.

So, all of this is to say that the work of this committee is really, really

important to come up with a framework that can help unify a lot of different efforts that are underway to understand the healthcare workforce.

When our small group in the Department talked to the Center for Medicare and Medicaid Innovation they were thrilled that there was a group of people that were trying to come up with concepts to help them understand the workforce. Julie, I know you had those conversations too.

So there's -- I just want to let folks know. I think you already know this because of HRSA's efforts and Cille's efforts, but there is a ready audience for the work of this group.

And it's really important to be able to understand the investments that are being made. The President's budget has a $14 billion appropriation for workforce development.

And if we are going to develop

policy in a meaningful way we need to understand this concept of the workforce and how it is deployed and how we can gauge its effectiveness and its efficiency. And so I want to thank you and say yay, you know, go to it and thank you very, very much.

MS. SOCHALSKI: I just had a couple of questions.

And so, given that the framework that you opened with which is person-centered needs-based, and given the charge to the health workforce which was directed to spheres of work, not sort of writ large. So it is prevention, intercoordination. So and I'm assuming that -- or certainly our challenge is to look within there.

Because the way one might articulate some of these could look different depending on what you're doing. I mean, care coordination seems to sweep in lots of stuff but I think that's what our challenge is.

My second sort of comment or thought is that as you're going through the various examples of what you had, you're right, they are -- they are hard to find.

And I think the other challenge that we face is those measures which are more proximal to what we are trying to do, whether they're structure, process, or outcome, and those that are somewhat more distal.

So, when I look at in mentioning skill mix and scope of practice, all of those, those are things that direct individuals. The challenge is to what degree is that a measure of workforce that's needed for person-centered, needs-based.

And so those are the lenses which I think are appropriate ones that you started with which I think are good ones for us to be -- to have ever present as we're thinking about these.

And we may be looking at some things

that are distal because we don't have them, ones that are proximal.

MS. PAGE: Absolutely. I mean, I think you're right. I don't think it's going out on a limb to say that measurement is not where we want it to be.

MS. SOCHALSKI: And that's part of why this is needed.

MS. PAGE: Exactly. And I think it makes the framework really important, too, to help direct and focus future work.

MS. SOCHALSKI: Okay, thank you.

MR. ALEMU: First of all, welcome and thank you for your commitment and contribution to this timely and important project.

As I said earlier I am from HRSA and assigned HHS subject matter lead for this project.

My role is to coordinate input from HHS internal team which is organized for this

specific project and work closely with NQF team.

I would like to take this opportunity to thank Cille Kennedy who is the government task lead for the project, Colette Burke from CMS who manages multiple HHS/NQF projects including this one, and Jane Hammond from CMS who is the COR. COR is contracting officer's representative.

We have colleagues here with us today who have provided input starting from the project's inception. We have Ann Page from ASPE. She was very crucial for this project.

We have Shanita Williams and Lakisha Smith from HRSA that have provided excellent input through this project.

The National Quality Strategy has two parts in its document, broad aims and priorities that have been informed by extensive consultation with the stakeholders.

Many stakeholders have important

roles to play in promoting high-quality care, but the role of the health workforce is one of the most decisive elements for its success.

Within the context of achieving the aims and priorities that are outlined in the strategy this specific project focuses on the development, capacity and deployment of health workforce specifically related to prevention and care coordination.

As discussed during the committee's web meeting successful efforts to improve prevention and care coordination rely on deploying well-trained, diverse, culturally competent, team-based, incentivized health workforce supported by policies, equipped with infrastructure such as health information technology and evidence-based interventions through strong partnerships between local health providers, public health professionals, communities, patients and individuals.

This project will look -- NQF has

invested a lot of time and effort to prepare the draft conceptual framework with input from the HHS team, the NQF advisory group and from this committee as a whole.

As your expert guidance and any additional input the refined conceptual framework will be a very important part of the work that determines the content of the final product.

This project will look into existing measures related to the subject area, identify measure gaps and make recommendations for prioritizing measure gaps that can be acted upon.

Just to highlight, I want really to highlight this one. This project is intended to give the final product concrete and actionable recommendations focusing on high-leverage and high-impact measurement areas.

Again, we are delighted to have you

here today and look forward to your contributions to make this project a success.

I will stop here by expressing my special thanks to the NQF team, to Angela, to Allison, to Wendy, to Karen, to Laura and to Sophia who is not here today. So, thanks to all of you and we look forward to a very productive discussion.

DR. GERDES: Thank you. Are there any questions for Mr. Alemu? Thank you, I think that's very helpful in setting our frame for our work the next two days.

I did just want to mention to everyone that we will take a break formally about 10:45. Feel free, there's food and coffee and drinks in the back here for everyone and restrooms are through the doors, past the elevators to the right. I'm not sure we mentioned that before.

Next, we're going to take a look at reviewing our project progress to date. As you

know we've had a web meeting and done a homework exercise as well. And Angela Franklin and Allison Ludwig from NQF are going to take us through our next slides to summarize our work to date.

MS. FRANKLIN: Great. Thank you, Melissa. This is Angela Franklin.

And I just want to pause for a second just to do a check on our phone to see if there are any additional committee members that may have joined that haven't previously announced themselves. And we're specifically looking for Evaline Alessandrini, Christine Kovner, or Peter Lee.

MS. KOVNER: I'm here.

MS. FRANKLIN: Oh, I'm sorry, so sorry. Peter Lee? All right.

So with that I wanted to give everyone an overview of our project to date. As you all recall we met by web back in January to discuss initial concepts about the

framework. And thanks to your good work and input we came up with the following framework definitions.

As you can see here we came up with a definition of healthcare workforce including all people engaged in actions whose primary intent is to enhance health. And we also wanted to include clinical and non-clinical as well as the LTSS workforce.

And we also came up with a definition of "care coordination" that is aligned with our care coordination project.

And we also wanted to include the experience of care coordination from the community and volunteer workforce perspectives per input from the committee.

And we wanted to identify primary care and we adopted the IOM definition, the provision of integrated accessible healthcare services by clinicians accountable for addressing a large majority of personal

healthcare needs, developing a sustained partnership with parents and practicing in the context of family and community.

And our initial work on the draft framework was also informed by the AHRQ Clinical Community Relationships Measures Atlas and Roadmap. And we don't have a slide for that but we wanted to make sure that everyone knew it was the AHRQ roadmap, the IOM Health Professions Education Bridge to Quality Report, the NQF Multiple Chronic Conditions Framework also went into developing our framework as well as input from our initial advisors, HHS and our HRSA colleagues.

So, before I move on I just wanted to go around or open the floor to folks to see if these definitions still are what we agree on as a group.

MS. SOCHALSKI: I think that in part from Ann's remarks and looking at this generally and specifically where you have care

coordination and the experience of care the definition of "health" by the WHO, there's been a number of international efforts to take a look at that since that's, what, like a 1945 effort.

And the extension of that is around the individual's capacity for health and their capacity to maintain their health. And if we think about that, not just a complete absence which of course we want.

But that speaks to the experience with care and it broadens the definition of who we're thinking about and what's the activity of health that we're looking to support from the workforce. So I just add that sort of as a modifier to that.

MS. FRANKLIN: Great, that's a great modification. Any comments around that? Okay. Moving on. Great comment.

So with that that brings us to our conceptual framework that you'll see before you.

So we wanted to develop the framework in the envisioning the workforce deployment through the lens of assessing the community's needs in terms of prevention and care coordination which will be at the bottom of the framework when you see it, the inputs and outputs for immediate and long-term outcomes that we expect to see.

And we captured these from the literature and frameworks that we reviewed. That was on the previous slide.

And then the domains which we'll walk through on later slides were frequently discussed in both the literature, from our expert advisors and also on framework devices that we reviewed.

And to Ann's comments earlier we also did try to keep the model person- centered also in keeping with the IOM's Health Professionals Education Bridges to Quality Report.

So here's the draft framework in full. We'll deconstruct it on the following slides just to tease out the various elements.

And also as I work through it I'd urge the committee to consider how it might be edited if we agree with the framework as it is.

I also ask that people ask questions as they feel for clarification or to make points about the framework.

So we took a broad approach to drafting it hoping to try and encompass measurement across the life span. And we also wanted to measure or try and capture measurement opportunities beyond the clinical setting. So trying to get at that community and unpaid and informal workforce as well to the extent we can with measurement.

While the framework primarily focuses on paid professionals we agreed that we did want to get at that community and volunteer workforce.

We also agreed that -- you can see over on the far right of the framework that we wanted to ground it in the National Quality Strategy goals. And that is to improve on and achieve better care, healthy families and communities and affordable care. And these should be the ultimate outcomes of any of the measures that we come up with -- measure concepts we come up with today.

And this ultimate outcome on the right side of your screen is expected to be achieved through the operation of the inputs that you'll see in the white boxes. The intermediate outcomes in the middle.

And although the workforce is critical to achieving all six aims we just teased out these three aims. Specific, working with communities to promote the wide use of best practices in living and promoting healthy and effective communication and coordination of care.

So, these priorities on the right side of the framework are going to be our North Star as we work through our concepts development today.

Over on the far left in the little yellow box we're well aware that there are influencing factors that are going to impact the measures that we come up with. So we kind of put them over on the lefthand side. Keep in mind as the committee is going through we're aware of them. And if there's any other influencing factors you think should be added let us know.

And we also include in the framework additional necessary components for measure construction. As you're thinking through concepts today we want you to think about who the expected accountable entities will be. That is, who we expect to measure with the measures. And the expected levels of analysis.

So, for example, are these measures at the local/state/federal level. And those are considerations to think about.

We do have the potential for some significant overlaps with some other projects. And Wendy Prins will talk to us about that later.

So, just quickly as, again, as I said we want to ensure as we think about the opportunities for measurement that we're considering these within the context of influencing factors including policy constraints such as regulations, fiscal realities and changing payment models.

We also identified as influencing factors diverse needs of various communities, current and future workforce trends. For example, an aging workforce or a workforce in need of retraining.

We also thought about population demographics including social and cultural

factors, and also the issue of data sources that are needed to inform measure development and inform evidence-based measurement. We also want to consider as I said before accountable entities.

So, here's our inputs side broken out. And again, guided by early input from our advisors we included training and development, infrastructure recruitment and retention, and assessment of community and workforce needs in these buckets.

And we wanted to include in the training bucket interprofessional and collaborative practice which is intended to allow workers to deliver care in the new models of care that we're all talking about today. ACOs, patient-centered medical homes, dental homes and other coordinated systems of care.

And these models, these new models will require different disciplines to work together to achieve the outcomes that we're

aiming for.

The committee might also want to consider recommending a set of core competencies and training. In reviewing the homework we got a lot of comments about core competency training. So that will be included in our concepts development work today.

Again, we also included faculty training in training and development.

For infrastructure we're expected -- in this bucket we included supports for clinicians and organizations. Measurement in this area might address how organizations and practitioners leverage healthcare information technology such as the use of EHRs, telemedicine, telehealth to deliver care. Also, scope of practice policies is in this bucket.

Any structural enhancements that are intended to improve care at the organizational level. And any participation

of course in the new models of care such as participation in an ACO or a patient-centered medical home.

The recruitment and retention box is including hiring practices or other retention strategies, any strategies -- yes, Chris. Yes, yes, please, I'm sorry. Go ahead.

MS. KOVNER: I don't understand inputs to bridge to community. It seems to me that the influencing factors influence directly all of the inputs.

And I'm not sure what it means to have these inputs affect community and volunteer workforce. Because I would see that I guess in the top where you have team-based -- and I guess instead of focus on professional/paraprofessional I would say and community and volunteer workforce.

Because I don't -- this arrow, if you think about it as a causal model, you have

these factors on the left influencing bridge to community, but not in any way affecting the inputs.

And I think what we mean is that these influencing factors influence the inputs and possibly directly impact the longer-term objectives.

MS. FRANKLIN: That's an excellent point. I mean, we had trouble with that arrow.

When we first constructed it we were thinking that the opportunities for measurement were mostly in those white boxes and to the extent we could face them towards the yellow box, community and volunteer workforce, that would be ideal. So that's why we kind of had it outside of the model.

But what I'm hearing is you're saying it should just be included as part of the overall picture.

MS. KOVNER: I think so, or there needs to be some explanation to inputs to

bridging the community, what that means.

But I'd be very interested in what other people think about this.

MS. FRANKLIN: So are there thoughts as to -- if we just integrate it into the whole thing, that box goes into the whole framework and we're thinking about this as we go through each of these measures then that could be the way, just absorb it into the framework and include it in the title at the top.

But are there other thoughts about how to handle that? Gail?

MS. MACINNES: I guess I'm of two minds. One that, you know, particularly family caregivers are such a huge chunk of the delivery system for long-term services and supports that it seems like a huge gap to not be including them as a -- or incorporating them fully.

However, we really don't have the

representation here from the -- I mean, that I can see of family caregiver perspectives. And I kind of struggle to think of really measuring a family member on their performance. I mean --

MS. FRANKLIN: That was our issue. We can't really measure them in any kind of way. And it would be more how the workforce incorporates them, say, into plans and in planning and caregiving along the continuum. But, it could be an element of everything we discussed. Julie?

MS. SOCHALSKI: So, following on Chris's comment, if we are thinking about this in terms of a logic model if you will then you do want these things well connected.

So, having a clear definition or thinking about what it means to be an input to bridge to community, that may or may not be necessary if in fact these are factors that really influence inputs.

And as our discussion goes forward we may see that they also influence other factors directly and not just through their influence on the inputs.

And, Gail, to your point I agree. When you look at the percent of long-term services and supports that are provided outside of paid workers. Important to think about that.

I would say that there are ways to measure that input. And so not performance of the individual, but to what degree are we including those individuals as members of the team and the communication between teams. And we don't have good measures of that.

But that's composition of the team. And we should see a better outcome as a result of that. So, I think making sure that they're integral to that. And what are the influencing factors there as well. So I think there are elements of how different people are both

engaged in and if we're really person-centered then we should have the family at the center and looking at how we're using those workers.

So I would think there are ways. I think we have to think more creatively.

We have such a lockstep now structural way of thinking about workforce. And we have excellent measures, they're just still so far from what it is that we're trying to really capture here. So I think, yes, we do have our work cut out for us.

MS. LEFEBVRE: I just wanted to add I agree, so I take my co-chair hat off and my committee member.

But I think looking at the family and the patient themselves as I guess part of the workforce I think we need to look at what are the supports that the workforce is giving them.

So you know, when they're discharged from the hospital, when they're

leaving the physician office, those types of things, what are the supports that that family member has in their performance level, agreeing that we can't measure their individual performance level. But I do think we can measure the support that they're given.

MS. MACINNES: Well, I just wanted also to agree with you and agree with Julie's point about measuring based on -- to which they're included or the communication takes place.

MS. MARK: Just a general question about the framework. What's the vision for the end user? Who -- I'm having trouble evaluating it without some context about who we vision the user being and how we envision the measures being used.

MS. FRANKLIN: So we envision -- the users of the framework?

MS. MARK: No, the users of the measures.

MS. FRANKLIN: The users of the measures.

MS. MARK: It just seems like that has to be part of the framework.

MS. FRANKLIN: We'll have a speaker speak to that a little bit later. But potential uses could be inclusion in federal programs, for example, measuring entities, used to -- there might be someone better around the table to talk about how they might be used.

But basically used in both public and private plans to measure the deployment of the workforce in terms of whether they're addressing these buckets that we've identified on the framework.

DR. GERDES: I believe we have a speaker at 10:10 who's here, Mr. Salsberg, specifically to address potential uses.

MS. FRANKLIN: Other questions about the framework before I move on? So that's a very rich discussion. Like I said, we

do have to think outside of the box and try and be creative about it, especially that community and volunteer workforce piece.

And so that brings us to our intermediate outcomes piece. And here we're trying to include experience. As you heard earlier both from the practitioners' experience as well as the person and family experience of care.

And then also the community volunteer experience. And that's where we kind of were drawing in that community link in the box and intermediate outcomes.

For clinical, community and cross-disciplinary relationships in that category we're hoping to measure staff knowledge of the community resources, use of team-based plans of care which we now know will include our unpaid workforce.

Care coordination with financial education and social services for active and

ready clinicians. And communities are one of the expected intermediate outcomes.

Regarding capacity and productivity we were looking for measures here of workforce effectiveness and efficiency, how the workforce would be geographically distributed and how we might improve that. And again, having proactive and ready clinicians.

Regarding workforce diversity and retention we included under this category minority representation in the workforce, cultural competency training. Increased cultural competency training is expected from the training in the inputs box. And increased worker retention.

Any questions about this particular segment? Yes.

MR. BERLINER: Where would you include things like conditions of work and salary, wages, things like that in this model?

MS. FRANKLIN: So conditions, we

wanted to include in the experience box, but salary might be included in workforce diversity and retention pieces of the framework. Does that make sense to folks around the table?

And again, as we mentioned before, our longer-term outcome or our North Star is the improvements articulated by the NQF, those three broad aims focused on better care, healthy people and communities, and affordable care.

And this is a way, just keeping these in mind is a way to ensure that our measure concepts project here remains focused and the committee is able to produce some clear priorities for the field going forward.

So, let's see. And again, this is the full framework. And I wondered if there were any additional questions that I didn't touch on as I was walking through.

With that, that brings us to our environmental scan of measures.

MS. LUDWIG: Okay. So, in conjunction with the development of the framework we've also -- staff here has done a scan of approximately 6,000 measures.

And with that we found 215 measures. But I would also point to Ann and Julie's early comments that some of these are very generously mapped to workforce.

Though we did do some overly generous mapping to the domains that you've just previously seen. And you can hear the number of measures mapped to those domains and where the frequency lies.

So many of those are mapped to training and development and are less so to the assessment of the community and workforce needs.

So, you may be wondering where we got these measures. And these are some of the sources that we used in conducting the environmental scan.

So we look to the NQF portfolio here. The CMS measures under consideration is a list that CMS gives us, gives MAP, the Measure Applications Partnership here, so we looked there. The HHS inventory, the measures, the Clinical and Community Relationship Measure Atlas, the National Measures Clearinghouse, the Health Indicators Warehouse, and a consultant survey that we've done previously for previous work at NQF.

And I know we've asked you on our web meeting if there were any other sources to consider but we're always looking for additional sources that we can kind of keep in our environmental scan.

So if you think of those later feel free to email the team here. We're happy to look more into that and work with you on that.

So, as I mentioned there's actually gap areas across the board. When we're really thinking about the deployment specifically for

prevention and care coordination.

But we do have some NQF-endorsed measures in the first bucket there. But there's certainly broad gap areas in the clinical and community and cross-disciplinary relationships, recruitment and retention and the assessment of community and workforce needs.

Here is just a list. I mean, I know it's hard to read but you have that in your PowerPoint, of some of the NQF-endorsed measures.

So we do have the skill mix measure, the nursing hours per patient day measure, but not too many when you think of the broadness of the NQF portfolio.

And that's -- we're going to have to stop there. And I actually have -- we're having a little difficulty with our slides so I'm going to read out the -- let's see here. Apologies.

So, the web meeting themes. We had obviously the web meeting on January 28 in which we provided this conceptual framework and the preliminary environmental scan.

And we had a discussion around the domains and the potential sub-domains within that. So we as a committee discussed the concrete and highly actionable measure recommendations. So, similar to this discussion that we've been having. And we're focusing on high-leverage and high-impact measurement areas with an eye toward the future workforce.

So, specifically as we've already discussed the utilization of family caregivers as part of the health workforce, the utilization of information technology as a tool to improve care coordination and assurance of preventive services, measure on actual health information exchange where individuals are able to collect information, health

workforce's readiness to assist individuals in meeting their personal health goals as part of a long-term outcome, and the health workforce competencies that will lead to improved patient's experience and ultimately leading to reduced cost.

So I'll give you guys a minute to have that soak in. And I'm actually going to pull it up so that we can visualize it. So apologies for this little malfunction.

Okay, so thanks for being patient while we swapped that out. So, as I just read this slide to you and if you have any further thoughts about the conclusions of the web meeting, the environmental scan or the draft conceptual framework we'd like to just confirm these elements and carry on with the next.

So, by lack of comment I think that this is confirmed with the thinking of the group in January and we can move onto our next section.

MS. LEFEBVRE: Okay, thank you. So our next section is really going to be talking about a number of different related projects that are happening here at NQF. And Wendy Prins is here. Well, I'm going to have to do a little song and dance for a minute.

(Laughter)

MS. LEFEBVRE: But there's a number of related priorities going on here at NQF. I understand this is their fourth group convening I think in almost a month. And that's intentionally staged. And so I think Wendy's going to talk with us this morning about how these programs work together in a conjoined effort with NQF. So, Wendy's a director here at NQF.

MS. PRINS: So, I have a couple of slides for you all this morning but just really wanted to make you aware of the other projects that are going on in this area.

Cille mentioned earlier that this

particular project is part of a much bigger project. It's five parts around identifying and prioritizing measure gaps.

And I know we've been over this before with you on your web meeting but we know that you are all out there wearing multiple hats and so it's helpful to kind of revisit it and let you know the progress that's been made and sort of how it ties into the work that you all are doing here today.

So, you've heard and Angela mentioned this in her slides with the framework the National Quality Strategy is sort of our beacon with the Triple Aim of better care, healthy people and affordable care.

And your group is really focused in on those aspects of prevention and treatment and effective communication and care coordination, but recognizing that when we're talking about the workforce we really need a workforce that is going to be able to help us

achieve this. And I think that elements that have already come up around person- and family- centered care are important to think about. Affordability obviously being one of the pieces of the Triple Aim.

Also very important in thinking about how to have the most efficient workforce. And I think a lot of that gets at some scope of practice things. And who are the people who really ideally should be doing certain pieces of the work to really get us to where we're trying to go.

So these are the five areas that we're working on this year. Adult immunizations, Alzheimer's disease and related dementias. That one is phased a little bit later to take advantage of the work of the other groups.

We had a care coordination meeting last week which is very closely connected to this work and I'll talk a little bit more about

that, health workforce, and then person- centered care and outcomes.

So, this meeting is the fourth of four with the exception of Alzheimer's disease. So we've been going full steam for the past several weeks getting all of this good work done and thinking about how it all relates to one another.

So, I'm going to talk really quickly about adult immunizations because I think it ties in certainly to the prevention piece.

So this group met and talked about what are the important measurement areas for adult immunizations, recognizing that I think -- I think, what did I say, there were maybe around 90 measures of adult immunizations but they were all sort of around flu and pneumo.

So we don't have measures for some of these other areas like zoster or HPV and Tdap. So, they've made some recommendations and that group is going to be, or the staff will

be sort of compiling that over the coming weeks getting ready for the reports, all of which -- the draft reports will be due, or will be out for public comment sometime in June.

Some of the interesting things that they talked about with this group were the importance of composite measures. So, not just having a lot of individual measures but how do you roll those in.

And also how they might recommend rolling them into sort of broader prevention measures. So, with other preventive services do the appropriate adult immunizations get rolled in.

And one of the things that they talked about too which might have implications here is what are the measures that they need at a provider level which can help with improvement efforts. But then also what are measures that are more at a population level so they can see how we're doing on a national basis

with addressing this area.

So, the next project that I'm going to talk about a little bit is Alzheimer's disease and related dementias. And it's not a coincidence that we have people with a geriatric background here on this committee, particularly given that -- given the aging population.

So how are we going to be able to take care of the number of patients that may end up having some type of dementia or other serious illness. And the workforce obviously plays a big role in that.

So, this project is really focused on identifying areas for performance measurement across the trajectory of a disease. So we've used our episode of care framework if you all are familiar with that which looks at what types of measures you would need for a population at risk, what types of measures you would need as they enter into an episode of

care. And in this case we're thinking about it as they start to show signs of cognitive impairments, what would those measures be.

And then as the patient progresses and as their families' needs progress and become more substantive what types of measures would you need. And then all the way progressing to sort of more of the palliative care and then on into end of life and also bereavement areas.

So, an interesting project here given the nature of the illness. So we've talked about episodes of care for things like acute MI, things that are very sort of confined to you have an event, you go into the system, you need to transition through that system and then you reenter the population. But in this case the patient is going to get progressively worse. So what are the measurement needs and implications there.

And then also really importantly in

what you all raised earlier is what are the implications for the family and caregiver here.

So, for this project we do have a number of people with that perspective. And so as we move forward with this work we may want to circle back with them and sort of whatever recommendations you come up with maybe do a litmus test with them and sort of make sure that we're capturing things.

And it may very well be that it's the family and the caregiver's experience of the workforce that is what we can measure in terms of how the workforce is doing. Not necessarily the performance of the workforce but are they being given the supports and the resources that they need to be able to take care of their loved ones.

So, this is our care coordination project which they had such a lovely diagram I had to bring it in for you all today. And I think it really speaks to some of the work that

you're going to be doing here today. So I think this framework might help sort of conceptualize where the measurement opportunities are and where you would best be able to measure.

But this group is focused on also the aspects of prevention and community health. So that intersection between primary care, and a patient's more social work community needs, and how do you get at measurement that's really going to drive improvement there.

So, less focus on hospital to home and more about the intersection of clinics and clinicians with the community resources. And how do you begin to identify measures that will help us to improve in that area.

And then also the measurement opportunities between clinicians and care recipients and their families, between care recipients and their families and the community, and then of course that sweet spot in the middle where if we could figure out how

to measure the effectiveness and the ability of our system and communities and families to all work together to improve health I think we'd have the silver bullet.

But my guess is we're going to be probably focusing or identifying measures more in the overlap between two of the areas. But if we could find some things in the center there that would be wonderful.

So, as I mentioned this group met last week and these are the things that they centered on as their important areas for measurement.

So they, similar to you, did a prioritization exercise and had a lot of really rich discussions about measurement. And this is evolving. So, I'll preface that with this is what we went into with. This is sort of what's come out. But the team is really taking a lot of the discussions and will be refining this.

But they really, really wanted to emphasize the importance of a comprehensive assessment. So, not an assessment that just focuses on what your current diagnosis is the day you walk in the door and that's what we're going to treat and send you on your way.

So, what are their current supports and assets, what is their functional status, what social needs do they have, do they have behavioral health needs, really wrapping all of these things up into something that addresses the entire needs of the person. And how do you capture that in a way that is meaningful.

And one of the things that they discussed is -- you see at the very last bullet is the continuous holistic monitoring. So, it's not just that you have a comprehensive plan but that it's continually revisited and revised as needed based on the patient and the family's needs.

Shared accountability was a huge

piece for this group. And again I think it has big implications for the workforce is how do you establish a shared accountability for patients and where does that locus of control live. Who has ultimate responsibility.

And they got into discussions around the care team and just, you know, the challenges of being able to measure who's on the team, how do you define who's accountable, et cetera.

Then the next area -- so they had created basically three domains and then did their prioritization. But the next piece that they talked about was the utilization of the health neighborhood and executing the plan of care and the importance of linkages between the clinical care system and particularly the community, but also of course what are the patient's needs basically driving that.

And so how do you identify what community services a patient needs, how do you

connect them. And then how do you communicate between them and coordinate which is a big issues that we have now is everyone having sort of a piece of the pie but not really knowing what the other person is doing.

And then finally, progression towards goals. So, we really want this to be goal- driven, focused on achieving outcomes and making sure that the services that someone receives are congruent with that person's particular goals and preferences.

So if their desire is to maximize a certain part of their life that their goals and their medical care and their community resources are organized in such a way that it will help them to achieve those.

Let me -- I can stop here for a moment before, or I can finish up. Okay, sure.

MS. MACINNES: I wondered, in that slide you spoke of community providers. Does that include direct care workers? Was there

discussion of them?

MS. PRINS: There wasn't a discussion about them particularly but I think that's certainly something that this group will probably grapple with.

It was really focusing more on I think a bigger picture of probably holding the providers accountable. But I think within certain clinical aspects it would be at more of an individual level. But we haven't really talked specifically about how to measure at the direct care workforce level. So, if you have thoughts on that I'm sure that would be.

I would mention too that, I don't know if we've gone through the time-line, but I mentioned that our reports will go out for public comment over the summer. And I would really encourage -- we've been encouraging all of these committees because of the interrelatedness to take a look at those and to offer any suggestions that you might have as to

where different pieces might fit in. So.

Did you have something in particular in mind?

MS. MACINNES: Well, I just was trying to understand where they fit in, whether the group was thinking of them as in the clinician group or the community resources.

I honestly am having difficulty kind of understanding the discussion even. It's pretty conceptual to me.

MS. PRINS: It is.

MS. MACINNES: I almost feel like I would love it, and I don't think this is probably a possibility, to have a whole separate meeting where we talk about the direct care workforce and how we're going to measure that. Because I feel like it's easily lost.

When we talk about, you know, workforce measures honestly we're just still at the very basics of measuring how many there are, what their wages are, the extent, you know,

retention. And that data doesn't even exist yet. So, when I provided feedback prior to the meeting it was that kind of feedback.

But I feel like there's real experts on quality measurement. It would be so helpful to have their suggestions on what could be measured.

But one last thing. I know that there was a project at CMS or at HHS, the National Balancing Indicators Project. And I believe it may still be ongoing. I was looking for information online. But they I know had some workforce measures. So they might be a good project to connect with.

MS. PRINS: Yes, I think there's -- when we talk about shared accountability I think a lot of times we're talking about at a practice level or in these new models of care, at an ACO level or at a health system level. And you know, and this is a really good question because where the

direct care workforce comes in is, you know, is it being utilized or are they being trained to operate at their fullest potential which could potentially be something that you could take from this and glean where is the field headed, and where are their priorities, and how do you then integrate that back into your work.

But certainly it would be interesting to talk about that a little bit in more detail. Because I do think it sounds like sort of a separate project even.

MS. MOORE: I think sort of a big fly in the ointment here that relates to Gail's issues is the whole -- the fact that health professions regulation occurs at a state level and what direct care workers, medical assistants, pharmacists, et cetera are allowed to do varies by state.

So a lot of these conceptually make an awful lot of sense except when you hit a state level the rules are different. So what you

think you might be looking for may not be there. And recognizing how challenging that variation is in trying to sort this out I think is really important.

DR. KHAN: I really appreciate the content in the patient-centered plan of care and the issues around the neighborhood which is going to support that plan of care.

What I feel is perhaps lacking or maybe is going to be addressed somewhere else is the sort of how the communication occurs.

And I think for many of us, most of us across the country we don't have an integrated system of care. And I'm just marveling at all the components here. And it's very exciting.

But let's face it, if we don't -- you know, we're sort of in the rotary phone, you know, mode of communication right now. And so how do we get beyond that and where might we see some of that discussion.

So I think it's essential, wherever you are in that care continuum, providing that care, this communication is the key component. Thank you.

MS. LEFEBVRE: I'm going to build off the discussion about I think the health profession's scope of practice coming in at the state level is a really important piece.

But I also think my experience is as you look at these large healthcare systems and these new models of care and ACOs there's a lot to be said for standardization. I think that it's really needed. But I also think that in a lot of these cases we're -- through different types of health information technology and others we're forcing people to the bottom of their license with different permissions in the EHR, not being allowed to go here and do this.

And some of it's out of necessity and standardizing first and then improving. But I think in addition to the state level I

think we have, at least I'm seeing now some very interesting, I don't know whether you want to call them regional-level or local-level changes in the way that we can do things because of the way that the new models of care are rolling out.

MS. PRINS: Let me finish up here. I know we're a little behind. So, the last two things that I want to just talk about really quickly are our work around person-centered care.

So, there's a lot of work going on at NQF right now. I think we have four separate projects sort of related to this topic. We have a gaps project which is what you see in front of you here. And this is evolving also after their meeting two weeks ago.

But their working definition of person-centered care was that the planning, delivery and evaluation of care across settings would be approached in a way that's anchored by

and respectful of and responsive to an individual's preferences, needs and values. So, really having that person-directed or influenced care plan.

And then the core concepts that this group was working from were very much focused on sort of thinking about the entire person and again what their preferences and goals are. But also a lot of elements around just respecting the person and the person's time, and what they're going through, communication, how do you communicate with patients and their families to make sure that they're well equipped. So I think this has implications for this work too in terms of how -- what the interaction is like between the workforce and patients and their families at all levels.

So I think from my -- I'm a physical therapist and I know from my perspective a lot of the times in the hospitals the patients really knew the housekeepers a lot better than

they knew the nurses.

You know, and there are certain professions that have more time and get into more of the details and build trust and can really get at some of the social issues that you can't necessarily do in a five-minute interaction. So I think all of those things have big implications for how the workforce is trained and deployed.

The other thing that we're doing right now is the Measure Applications Partnership which is responsible for making recommendations for the selection of measures for public reporting and payment.

We're developing through them a family of measures. And I know there's a lot of lingo that's NQF-specific that we're throwing at you today and we can certainly talk about -- talk with you more about that.

But this group is -- so the MAP has put together several what we've called families

of measures which are essentially meant to align measures across various settings and programs. And what those groups do is also build sort of a framework to think about measurement and then they look to existing measures but also gaps in measures to build out that framework.

And so the things that they are focusing on are really making sure that there are measures that get at the experience of care, that get at quality of life, that get at the burden of illness in terms of symptoms and treatment burden, the extent to which shared decision- making is conducted and the extent to which patients are able to navigate and self-manage. So that is a project that's ongoing and will be wrapping up in early July.

So a lot of work in this area as I mentioned but I think big implications because without a workforce that is able to help people be able to navigate and self-manage, when it

comes to this and assessing patients and how they feel about this we're likely to not get very far if we don't have the workforce that's capable of delivering this type of care.

So, I'll stop there and see if there are any other questions. I really appreciate the opportunity to bring this work to you in sort of realtime.

So again, in sort of summary what these groups, the gaps groups have done is they've been trying to identify measure concepts.

So those domains and sub-domains that I presented to you on a slide, they actually did a lot of work during their meetings to sort of say here are the measure concepts that we should try to get at.

So I think what I presented was conceptual, but as you're going to do later today and tomorrow we're really trying to get more at -- starting to get at that

numerator/denominator and what would that actually start to look like for measure development purposes.

So, you know, you have to start sort of broad but then our goal really has been and HHS has really encouraged us to try to get at that numerator/denominator level. We don't have to get necessarily to all the specifications that would go into measure development because that would obviously be up to the measure developers, but we're really trying to get good guidance on sort of an investment strategy for measure development. Questions?

You have your work cut out for you because of course in all of these other conversations when we talk about the workforce we say well the workforce group will handle that. Don't you worry about it. That's right, they'll do it.

DR. GERDES: Thank you, I think

that's very helpful to hear from what the other groups are doing so we can have some synergy.

Next we will be hearing from Edward Salsberg who's visiting us from George Washington University to talk to us about environmental context and measurement uses which we had a question on earlier. Thank you.

MR. SALSBERG: Thank you. Good to see all of you. First time I've seen many of you since I've changed positions. It's nice to be able to be here today and talk about this issue.

I was generally familiar with the project six months, eight months ago when I was at HRSA but I have not followed it closely the last few weeks. I did look very closely at the materials that were recently developed.

And I really come at this from a different perspective which is just from workforce planning and workforce data, the need for workforce intelligence to inform

decision-making, what information, what data, what metrics would be valuable to those who have to make decisions.

My simple way of looking at things, and I must admit when I hear you talk about having looked at 6,000 different metrics it feels that my way of looking at things is really very simple. But hopefully this is helpful.

So, when we think about workforce planning and we sometimes don't use the term "planning." Sometimes we use the term "intelligence" or "information" to really guide decision-making. The ultimate goal is really to have an adequate supply and distribution of well prepared and skilled health workers to assure access to high-quality, efficient and effective care.

That hits lots of the buzzwords but I think it really gets at what are we trying to do here.

The prevention and care

coordination to high-need populations is a subset of that, clearly an extremely important subset. I don't think you can do prevention or care coordination if you don't have any workers, or if you don't have well qualified workers, or well prepared workers.

So when you dissect that these are what I think the key components are that policymakers and those concerned with healthcare redesign are most concerned about.

I will tell you I added at the bottom equity and that is also diversity. It does fit in terms of high-quality care and culturally competent care, but I think that there are important issues of equity in terms of access to health careers that really should not be overlooked.

Again, I recognize that the goal here is looking at quality of care and metrics around quality and prevention. But I think we are well served to also find a way to make sure

that we look at equity and diversity of the health workforce.

Each one of these -- obviously there's another way of perhaps looking at the domains or the sub-domains of what we are concerned about.

When I think about health workforce decision-making who makes the decisions that impact on the health workforce. This is sort of the list. And I probably could add others. But let me talk for a few moments what I think are important to each of these key constituency groups.

First, federal and state policymakers. Clearly we're not just talking about the health sector, we are talking about the education and training sector. We're talking about the licensure boards.

I sometimes think we make a mistake in our health discussions and health policy discussions including our health workforce

discussions of only talking to our friends in the health community and not realizing the education community makes enormous decisions that impact on the supply and distribution.

And when I was at the national center at HRSA I always felt that the people among our constituents that needed data and information were those community colleges and training programs across the country.

And what they needed to know is like, well, what do you need. Do you need more physical therapy assistants? Do you need more -- do you need care coordinators? Who are the care coordinators? What are the skill sets? Those are the types of questions that our education community would ask.

The Labor Department are clearly critical. They invest hundreds of millions of dollars in training. The beauty of this is that they want to train people where there are jobs. So, if we do a good job on the health side

in saying this is what we need there are some resources, albeit limited.

And Jean Moore mentioned state licensure boards play a critical role. What information do they need, what data do they need? They need some hard research that tells them when it's appropriate for a particular type of health professional or health worker to carry out a task.

So, if you're a licensure board in New York and you want to know should home health aides be allowed to administer medications where do you get that information? Should NPs be allowed to prescribe and should there be limits on the prescription authority. So, those sort of information that are really critical to the state policymakers.

We saw universities, colleges and training programs were really critical because again they're the ones that influence not only the supply but the supply, the distribution and

the skill sets that people come in with when they're working. And so they need information about what are the skill sets.

So when you talk about some of the quality patient-centered factors that you're concerned about you have to get that message to community colleges and universities to change their curriculum in some way.

It's hard to say what's the metric here. They need that information. And I don't know what the metric is. I know they need information that would say you want practitioners who have this skill set.

Credentialing bodies and professional associations play an incredibly important role. They're obviously outside the public domain. They're private. They are for the most part committed to providing and assuring high-quality care. They too need information.

I think we're in a new stage that's

being led by medicine. Many of you know medicine for most specialties have now moved for certification of maintenance of competence requiring ongoing clinical assessment of skills at least every 10 years.

This is in fact I think a truly major development in our country. It's something that other professions are going to have to seriously grapple with in that it's more than just taking some continuing professional education classes and saying well, you are now well qualified, or you continue to be well qualified.

So, thinking about what are -- and in this case again it may not be a metric, but it is organizations who are very interested in data and getting that information. So if you want workers with a different set of skills we need to be clear and be able to advise the credentialing bodies and professional associations about that.

Employers and providers I think are particularly interested in the numbers and will there be enough workers. They're the ones who are paying for the workers. And so they actually know if there's a shortage, when they have to pay more to get nurses or if they can in fact not pay more to get nurses. They have a good sense of what the marketplace is.

When they're trying to figure out whether they can expand access to services they need to know will there be an adequate supply of workers to do that. So again, I think they're interested in the supply, the distribution and the skill set of the workers that come in.

Insurers are interested again in my mind in supply and distribution and adequacy of training and knowing who they should be paying for what services.

They are sometimes caught in between the advocates who say we should pay more

for this practitioner doing this set of services and there's not necessarily consensus in the field. But again, they're interested in supply, demand and who's competent.

And health workers and potential health workers. People, you know, this is truly an open marketplace here in America and people will go into a profession where they feel are reasonable opportunities and reasonable pay. So it's important to keep the pay in mind. But they want to know will there be jobs.

The marketplace is incredibly sensitive to the job market. Potential people thinking of health careers are extremely sensitive to the job market.

And so when we think about our desire to have more primary care practitioners we can measure how many primary care practitioners there are. But understanding why people are or are not going into primary care is critical. And that requires better

data and better metrics.

As I've been saying I think these are some of the key questions that I've dealt with in the centers that I've run. You know, do we need more now and will we need more in the future, occupation skill.

And I want to make sure I really get to emphasize the last point. The mix of workers, what mix of workers yields the best results at a reasonable cost.

It's really important to keep in mind that we think in silos on the professions because that's the way we train them. But the reality is that different practitioners can provide the same set or similar sets of services. And so there is not one mathematical solution to assuring an adequate supply of well prepared practitioners. There are many solutions.

We don't have the sophistication yet to really understand how to measure the

cost-benefit of alternative workers. We're getting there a little.

And so we can say well, you know, if you have a team and you have a physician and three nurse practitioners or two PAs and this many medical assistants can they deliver the same set of services. We're truly just getting there.

And we don't have good measures of outcomes. So we may be able to say that the team that's composed this way can serve so many patients and a team composed that way can serve so many patients. The issue of what's the difference on the cost and the quality I think -- well, we probably can measure cost. The quality outcomes are going to be extremely challenging.

But again, the key point I want to make here is that there isn't a right answer. And so some of the goals that you articulated that the other groups are looking at, such as

you want comprehensive patient-centered care for Alzheimer's patients, there are a lot of ways to do that. There are a lot of workers who could do that. There are a lot of mixes that can do that. There's not going to be one way. So you've got to think about your measurements on the supply side, how you're going to link that to your measurements on the outcomes side which may be different.

I just want to close two more slides. Medicine is an interesting example. You know, Medicine has been around longer and more established. They have an incredible array of data. Not everything you want but compared to some of our other workforce, our paraprofessionals, our direct care workers this is night and day.

So they start with data on applicants to medical school. They know their sociodemographic background. They know their performance as undergraduates. They get data

on medical school performance. They survey them when they graduate. They do certification exams. They know what training programs they had. They have information from a variety of sources like the MMS to find out where are they practicing, what are they doing.

We have CMS and private payer insurance data. AAMC and others and are working on a new data commons. Tremendous potential for research.

And I'm not saying we have the right metrics yet, but I just think it's really worth thinking about what has Medicine done in terms of pulling data together. And is there any way to get there for some of the other professions. You know, can we do it for the physical therapists. Can we do it for the medical assistants. What do we do with the data we have. What metrics have they developed and are there models that we should be thinking about for other professions.

Finally, some comments and opportunities. I wanted to -- some of you may know Bob Phillips isn't here, couldn't make it today, but Bob was one of the members of the Negotiated Rulemaking Committee which I was as well.

We spent a lot of time. We spent 18 months, 36 days of in-person meetings to try and develop metrics that measure the adequacy of access to primary care and the adequacy of the supply of primary care practitioners in a community.

It was not easy. So your task is not easy if you want to come up with several indicators.

The recommendations of the Negotiated Rulemaking Committee I think are valuable. They were submitted to the Secretary of Health and Human Services on October 31, 2011. Because they were developing a composite.

Because the reality of measuring the adequacy of primary care practitioners is not -- cannot be done by merely counting the primary care practitioners. You can slice and dice them 100 ways or more, but unless you compare supply with demand you're not measuring the gaps, potential gaps in services.

So, to me we need to think about those composite measures that have both supply and demand or supply and need together.

And clearly we're aware of it. One thousand people who are young and healthy will have very different needs and 1,000 people who are old and have chronic illnesses. So again the challenge here is you're not going to find a single measure. We may over the years when asked how many primary care practitioners do we need in our community, and I can give them here's what GMENAC said 30 years ago. I can say this is the average in the nation. But the reality is it doesn't tell us very much about

whether that community has an adequate supply. So, it's something again to look at.

I think the metrics on teams, this is a supply side. We just don't have good metrics how to explain and describe the "teaminess." I was going to do teaminess but I couldn't figure out how do I spell "teaminess."

We are aggressively promoting teams. We really believe in collaborative practice. But I haven't seen anything that tells me here's A model and B, C, D, E, F, G. It's just teams and they all look different.

I think distribution is an incredibly challenging problem. And this gets to the geographical unit of analysis.

National indicators are of limited value on the supply or even on the average quality, average supply is meaningless to a nation of this size and scope. So it's a real challenge.

Because I can tell you if the nation were to need a million physicians but they were not where they were needed to be. And then the assumption on national figures is that if you have a high supply in New York and a low supply in Mississippi that somehow it's going to move there.

Or if you have, you know, again, the average quality doesn't tell you if we have some really great quality and some terrible quality. So that analytical unit is really critical to your thinking.

My usual pitch is the need to invest more for real research in this area, particularly those linking inputs and outputs.

And whether you're an ACO or a group practice or a state legislator and you say I love the idea of collaborative practice, I love the idea of teams. Now, what's the structure of the teams and what difference does it make. And does it make any difference if I have one

physician with four NPs and PAs or I limit it to two NPs and PAs and maybe I use MAs instead. So you know, we really need research to guide decision-making.

One of the examples I use, and I should note we have great opportunities here in America. One of the examples I used is the expansion of scope of practice of psychologists to include prescriptive privileges which was in New Mexico and I believe Louisiana now. Okay, great.

Is this a good idea? Is this a bad idea? Okay, we've got two states doing it. Can someone go out and evaluate it and try and do a real evaluation so we know if it works?

Should home health aides be allowed to administer medications? I mean, where's the science, where's the research that should be guiding communities. So, urgent need in my mind for a greater investment in research in this area.

And then just a final thought. The importance on building on existing data.

You know, the federal government invests an incredible amount of money to collect data. And we're really just beginning to tap into that in terms of health workforce.

Some of you know we've been promoting or I've been promoting at HRSA the new SOC revision which is the Standard Occupational Classification which is used for all federal reporting around occupations is being revised for 2018. That begins this year.

If you want to measure the difference, you know, home health aides, is it a clear definition, is a community health worker a clear definition. Do I need some other definitions in order that the federal government collect better data? It's used in the, again, for the Labor Department as well as the Census Bureau.

And then final thought, just one

particular interest. The Census Bureau and the American Community Survey, their advisory committee considering a proposal to -- in the American Community Survey to include information on credentialing and licensure. You know, they ask your most recent occupation. They don't ask if you're licensed or credentialed.

So, for workforce tracking, you know, to know someone was trained and certified and licensed as a nurse but they're now a teacher, or they're now doing something else, you lose it if you don't collect that information. So, it's a small piece but again it's around building on the workforce data that is now collected.

Similarly, the National Ambulatory Medical Care Survey last year went into about 17,000 physician offices. We're investing tens of millions of dollars to get information about what's going on in that physician

practice, in that group practice. Can we build on it, or is there some easy way to build additional workforce questions that will serve us to build better metrics.

I think you all have a challenge ahead. There are real difficulties.

I don't know how you develop metrics without good data sources to begin with and high-quality data.

So first, maybe it's a simultaneous action of, one, building metrics from what is there now and then two, identifying where new data would support better metrics.

So, I'll stop there and I hope that helps your deliberations.

DR. GERDES: Are there any comments or questions for Mr. Salsberg?

MR. SALSBERG: I know you all agree with me.

(Laughter)

MS. SOCHALSKI: So, I think the

challenge that we face is in looking forward and as the dynamic of how we do care is changing some of the metrics that we've had in the past won't serve us as well any longer.

So when you have something like a Project Echo that can traverse distances and provide a skill, the location of a person in that isolated rural county does not become as important any longer. Because what you need is that expertise and we can do it through our telemedicine and other capacities. So, it changes incredibly what we need and how we measure those things.

So that's where I think some of the structural measures we've used in the past may only serve as indicators.

But perhaps what we're going to have to think about is how do we capture the dynamic. So if we want to see what's going on and what works, if we're staying focused on the outcome and we want it to be person-centered.

You know, when you were going through your data resources that we could be using to amass information maybe some of those are going to be in places where they are doing things differently. And what suggestions can we use for ways to collect that.

So you have $1 billion that was put out in the Healthcare Innovation Awards Round 1. Every single one of those has a workforce component in it. So there may be innovative things that are going on.

And it's not going to be some giant data source that's out there in a collected form. We may have to collect some on-the-ground things that will give us some measures.

You mentioned the training centers and these accrediting bodies. Accrediting bodies are collecting a tremendous amount of information about skill sets and what they're being trained in.

Knowing that is going to be very important in putting together sort of those right-sized, right-skilled teams. But it's the classic, you know, flying the plane as we're building it. And so it's suspending some of that ambiguity as we try to move forward.

And maybe part of what we'll do is chart those places where we know where we're going and chart those metrics that will help guide us as to where we need to go so you can tell the community college what to do. Because it's hard to do that right now.

MS. LEFEBVRE: Thank you very much. That was really interesting.

I think, being from North Carolina which in some counties is at or below Mississippi I think this whole supply and demand piece is so important.

Because I work in some very small, rural practices that every patient through the door is hypertensive. Every patient through

the door has diabetes.

And so that's very different than a primary care practice in Aspen, Colorado who treats multiple comorbid conditions for several patients instead of every patient.

And the demographic of that is really no longer age-based. It used to be that demographic was Medicare. That's no longer the case in a lot of especially eastern North Carolina. And I think that's not unique around the country. But certainly in some places in this country it's not like that as much as it is in others.

So I think that supply and demand and to use these measures to get back to the policymakers within our state to how do we really influence health in communities, and what influence of that health of communities has on not just the payment of our healthcare system but the whole needed workforce.

MR. BERLINER: You know, I think

one of the real problems with collection of data is that we can collect data, you know, sometimes we do it better than in others. Very easy in workforce to get data on supply. I mean, all the things that it has up there are really supply things. It's demand that's really problematic and I think is most critical to discussing, to creating useful metrics for any kind of measurement.

Ed brought up the GMENAC study which if people don't remember in 1980 projected that there would be a surplus of almost 200,000 physicians by the year 2000.

In the mid-nineties at the peak of managed care in this country when physician use was actually even substantially lower than when GMENAC did their studies we suddenly turned around and said no, there's a shortage of physicians, a substantial shortage. We have to start producing more doctors. So, what exactly happened there?

We don't know what the demand for home care workers is. If it was easier to get home care workers, if it wasn't almost imperative on family and friends to provide care then pay home care workers would be doing a lot more work.

And I think the same thing is true for most of the things that we're looking at here. If we don't really understand demand better, I mean, it's really hard to come up with metrics that have a substantial meaning.

MS. MARK: I'm struggling a little bit with sort of the undercurrent of some of the discussion that seems to imply that there's somebody determining the supply of providers. Unlike lawyers or accountants or brokers or investment bankers, you know, when people want more of them and the salaries go up, people go and get those jobs.

So it might be helpful for me just to understand a little bit more about what we

think the constraints are on supply and why we need to provide data to whoever those are who are constraining supply and not just have, you know, work as in other markets.

If it's credentialing bodies that will not allow enough primary care providers to be produced unless they see these numbers maybe that's something that we could just sort of be more explicit about.

Because the other point that I didn't hear is what are we giving consumers. It's all about these decision-makers who are determining the supply and we need to give them information.

And as you pointed out, it's incredibly hard. That's why in most markets we don't determine the supply because who knows what the demand is going to be. See what the demand is and then the supply responds.

So I'm just having a fundamental in my economist hat problem with the discussion.

MR. SALSBERG: I would say that the supply is very market-driven, maybe a little slow to respond. And it's market-driven not only on today's market but on the prevailing sort of wisdom.

So what we're seeing is that in a whole series of health professions the number of graduates has now doubled or is doubling. Those are NPs, PAs, pharmacists, NCPTs too.

And so that is not really reflective so much of a government policy but the decisions by hundreds of colleges and universities that say I hear there are going to be great opportunity for PAs and so we've doubled and then redoubled the number of PA programs. So that's not been constrained by government policy.

I'm actually beginning to worry that we're over-producing health workers. I know this repeats history but because we have not developed good data and good metrics and we

haven't done as adequate a job in projecting we're going to continue to do this cyclical up too many and then too few. Because the market -- all educational institutions are responding to the same market indicators.

Anyway, I'd love to talk to the health economists about it.

DR. KHAN: Great, thank you. I love having an economist here at the meeting. I think it's terrific. I think your question is spot on around supply.

I would just say from a demand point of view I think we tend to confuse needed care with just general care, and what gets paid and what doesn't get paid.

And when it comes to health we spend so much of our time, energy, resources on treatment and don't talk a lot about true determinants of health, whether they be lifestyle, genetic, environment, all those things we know will make a huge difference in

the true need or demand if you will.

And I just again think the market we're talking about in terms of the healthcare economy isn't like anything else. And we have permitted that in a lot of ways.

And as someone who works on the payer side of this equation I see it every day. And to re-engage the healthcare workforce in a broad way I think is critical. But we also have to look at the systems and the payer sources for those particular workers.

MR. SALSBERG: I think that's a really excellent point. I think we really do tend to think the health workforce of the doctors and nurses. And it really, particularly when you're talking about prevention then you're really talking about the social services and the human services workforce which sometimes the people in the health field don't think it part of their workforce. But in terms of again prevention

and care coordination definitely are.

DR. GERDES: Well, thank you for the presentation and the great discussion afterwards. Are you going to stick around for a little bit if anyone wants to talk with Mr. Salsberg?

We are going to go ahead and take our break for about 10 minutes. We're a little bit behind. If everyone will come back about 11:05 I think that will be reasonable and we can go with the rest of our agenda. Thank you.

(Whereupon, the foregoing matter went off the record at 10:56 a.m. and went back on the record at 11:11 a.m.)

DR. GERDES: We're going to call the meeting back to order and we're going to go into our NQF endorsement criteria.

Karen Pace who is senior director of NQF is on the phone and is going to lead us through this next section. Karen?

DR. PACE: All right, thank you.

Good morning, everyone. And I'll just move onto the first slide. Or the next slide, whoever's moving them.

MS. FRANKLIN: Can you see we have healthcare performance measurement slide up?

DR. PACE: Yes. I'm sorry. It's just a little delayed on my computer. Thank you.

So, just -- I'm going to go through a little bit about type of measures and then a little bit about NQF criteria in terms of how we evaluate measures for potential endorsement as national standards.

So, measures are really used for quantifying the performance of different aspects of the healthcare system. The goal is to improve the quality of healthcare received by patients and ultimately health.

So, although NQF is focused on endorsing performance measures, measures are pretty much a means to an end, not the ending

in itself. So it really is to use them for the purposes of identifying where things need to improve and measuring improvement.

So, there's multiple types of performance measures. The ones that we're most used to are quality. We have outcome which can include patient-reported outcome. Sometimes use of services, maybe use of the cost sheet for outcome or cost. We have intermediate clinical outcome, process, structure.

And then resource use and cost, efficiency and composites. So there's a variety of focus and construction of performance measures. Next slide.

So, I'm going to just talk about this in a little more detail. What we mean by a health outcome is basically health status of the patient or change in health status resulting from healthcare.

And health outcomes could be

desirable or adverse. An adverse health outcome would be, for example, mortality or some complication.

And in some cases resource use may be considered a proxy for a health state. So for example, a hospitalization may represent a deterioration in health status.

Patient-reported outcomes include the domains of health-related quality of life or functional status, symptom and symptom burden, experience with care and health-related behaviors.

And the key thing is that patient-reported outcomes are reported by the patient without any kind of filtering through a healthcare provider or anyone else.

Intermediate clinical outcomes generally signify a change in physiologic state that leads to a longer-term health outcome.

So, an example here might be blood pressure or a particular lab value such as

hemoglobin A1c in patients with diabetes. Next slide.

And then we have process measures that are focused on healthcare-related activity performed for, on behalf of or by a patient.

And then structures which are -- you can think of as features in healthcare organizations or clinicians that are related to the capacity to provide high-quality healthcare. So, structures may be organizational policies and procedures, systems, experience of staff, et cetera. Next slide.

NQF endorses performance measures based on evaluation of the measure. There's the standard set of criteria that we'll talk about in a minute. To ensure that it's suitable for use in accountability applications such as public reporting, pay-for-performance, in addition to

performance improvement.

So, basically our performance measures that NQF endorses are useful to identify areas for performance improvement but are also used and intended to be used in accountability applications. Next slide.

So, we have five major criterion which I'm going to run through here. And we look at them in a particular order. And I'll show a little bit about the reasons for this. I think some of this was in your background materials.

But our first major criterion is about evidence, performance gap and priority. And we refer to it as importance to measure and report.

This is a must-pass criterion, meaning that -- we look at this first because if there's not evidence to say that everyone should do it, if there's no data demonstrating that there's a gap in performance or that it's

a high-priority area then the other criteria are really less meaningful. So, we really want to look at this one first.

The next major criterion is about reliability and validity of the performance measure as it's specified. And we refer to this as scientific acceptability of the measure property.

It's also a must-pass criterion. And we look at this second. And the reason that it's a must-pass is if a measure is really not considered to be reliable and valid then we have risk of misclassification and improper interpretation. And it doesn't really matter how easy it is to collect the information if it's not going to give us a reliable and valid performance score.

The next major criterion is feasibility. And the objective is to create as low a burden as possible, or try to minimize the burden.

This is not a must-pass criterion and sometimes this will be improved over time if a really good measure that has some burden to it gets implemented.

The fourth area is usability and use. And we really intend for measures that are endorsed by NQF to be implemented for use in accountability applications.

And if there's really no plan to use it in that way then NQF endorsement is probably not necessary. If it's only going to be used in an internal quality improvement process then it may not be worthwhile to bring through the NQF process. In fact, that's one of the conditions of bringing a measure to NQF is that it would be used for both improvement and accountability.

And then the last major criterion is about related and competing measures, and the need to select the best measure, or multiple measures trying to do the same thing, or if

there are related measures to have some consistency and alignment to create as low a burden as possible. Next slide.

So, I know that you'll be talking about performance measure concepts. And basically when you're talking about a concept you're going to be identifying what structure, process, or outcome you think should be measured, what patients or personnel should be included in the performance measure. You'll probably have some discussions about the data source and whose performance is actually being measured. Is there a hospital, an ACA, a health plan, et cetera. Next slide.

So, when you're looking at measure concepts the NQF criterion that's most relevant at that stage before you actually have a specified and tested measure is to look at importance to measure and report. And so I'm going to dig down a little bit more into the sub-criteria within importance to measure and

report.

And the first one is evidence to support the measure focus, or to have a rationale for outcome.

So, if it's a process, structure, or intermediate clinical outcome there really should be empirical evidence of the relationship to the desirable health outcome to really support it being endorsed as a national standard.

For outcomes including patient-reported outcomes we ask that there be a rationale, that that outcome is influenced by at least one healthcare structure, process, intervention, or service. So, there definitely should be a connection but we're not asking for the same kind of systematic review of the evidence when we're dealing with outcomes.

The second sub-criterion is that there's a performance gap. And this also

includes -- the performance gap could be across the measure entity such as the hospitals, or the nursing home.

But it also could be across patients and populations. It could be that the performance gap is disparities, that minorities may have a low achieving of an outcome, or receive a process with less frequency. So, we look at both of those under performance gap.

And then high priority. For example, for PROs we want to see information that it's valuable and meaningful to patients and consumers. For other measures that it's related to national priority or a high-volume, high-resource use area of care. Or that there's important consequences of poor quality.

And then there's a sub-criterion about composite performance measures which probably won't be too relevant to some of your

work today.

I think the one key thing to point out about importance to measure and report is that it is about evaluating a measure and the supporting information that's submitted against the sub-criteria.

There are lots of things that are important to do in practice but they don't necessarily all need to be codified into a national standard performance measure. So, we really do try to focus on meeting these sub-criteria.

Because as you all are aware there are limited resources for data collection, public reporting, et cetera, and we really want to focus that whole effort for data collection, performance measurement and the endorsement process for those things that meet these criteria. Next slide.

So, I just wanted to talk again a little bit about structure, process and

outcome. And NQF does have a hierarchical preference for measures of outcomes, first. And certainly those that are linked to evidence-based processes and structures.

Certainly outcomes of substantially importance with plausible process-structure relationships.

Then intermediate outcomes. And then process and structures that are most closely linked to desired outcomes.

And I think -- the reason for this stated preference is, again, outcomes are the things that patients are seeking healthcare for and providers are interested in achieving outcomes. And so they really are the heart of what patients are seeking and healthcare is trying to achieve.

And outcomes also are more integrated. They are reflective of a lot of process and structure. So, from that stance they are also parsimonious.

There are certainly some evidence-based structures and processes and intermediate outcomes that are useful for performance measurement in improvement and accountability. And we like to see those that are most closely linked to the desired outcomes. And we'll go to the next slide to illustrate a little bit more.

Because sometimes we'll talk about things that are distal or proximal to the desired outcome. So, I want to just run through an example with you. So as you're thinking about things that you might want to put forward for potential measure concepts how some of this might apply.

So, this is about structure, process and outcome. And I'm really going to just focus on the process and how there are often multiple process steps within a particular area. And that we're really most interested in what's most close to the outcome.

So, a lot of process has involved an assessment, then identifying a potential problem or diagnosis, to choosing a plan or intervention and then ultimately providing the intervention.

And it's the actually providing the intervention that is known to be effective in achieving the particular outcome that is most closely linked or most proximal to the outcome.

So, I'll give you an example. So, if we're talking about administering a flu vaccination. We know that flu vaccination is an effective process or intervention in preventing flu and preventing some of the effects of flu, hospitalization, morbidity, lost days of work, et cetera.

But you don't just give a vaccination. You assess someone's immunization status. You identify that they need the immunization and that there's no contraindication. You choose the

intervention. What product is received, for example, depends on age. And then you actually provide the vaccination.

So, you could measure is immunization status addressed. Was the correct -- what was the process for choosing the right intervention. Was it discussed with the patient, et cetera.

But the intervention where the evidence really resides and is most proximal to the outcome is actually providing the vaccination. So, this is just to say that if you're going to think about a process measure, think about the actual intervention or activity that's most closely linked to the desired outcome. Next slide.

I think that might be the last one. Oh okay, this is the last one.

So, some key questions to consider for a national standard performance measure, especially in relationship to measure concept

is what are the desired outcomes. You know, can they be measured. Are they influenced by at least one process or structure.

For structures or processes, is there evidence that indicates that it rises to the level that all specified entities should implement in their systems.

You know, endorsing a performance measure puts in motion people implementing structures and processes to make sure that whatever is being measured is done. And so we really do want to focus on those things where the evidence is such that you could confidently say yes, this is something that really should be done by all hospitals, or all nursing homes for these types of patients.

Is there a performance gap? Again, we really want to focus on things where there is a need. So, if -- there could be a very important evidence-based area that if everyone is doing it already again we probably need to

devote resources to an area where there is a performance gap and need for improvement.

And then is the outcome, process, or structure directly related to achieving a national priority.

So, I will stop there and see what questions that's raised in your minds and try to address those for you. And thanks for the opportunity.

DR. GERDES: Thank you, Karen. Are there any questions or comments? Okay, seeing none we'll move onto our next area for discussion which is considerations for performance measurement.

We have a list of questions for the group to consider. And this does flow from the presentations we've had this morning. But the answers to this, and I think listening to each other's comments on these questions will help us frame up our work as we get into all our small groups and actually discuss the domains and

sub-domains of the measures in a little bit here. Ann?

MS. LEFEBVRE: Great. So, we have a couple of slides' worth of questions that we want to really use as stimulus for the group discussion.

And so starting out with our first one, really looking at structure, process and outcome measures like Karen was just talking about, including patient-reported outcomes. So to me that means experience and things like that. How can measures of the workforce promote improvements in deployment?

MS. MACINNES: So, one thought I had related to the use or deployment of home care workers, or their interaction with the team would be measuring the extent to which either the family caregiver, the patient, or the direct care worker noticed and communicated kind of early warning signs of a more -- or a worsening of condition.

And I think measuring the extent to which that happens could tell us, you know, help us evaluate the communication that's going on. As well as kind of the skill level of the worker.

MS. LEFEBVRE: So really kind of using -- it seems to me that that would be good. Because they have somewhat of a baseline knowledge of this person. If they're in there working in their home and they know them they would have a baseline knowledge. So, unlike maybe a care manager who would see them, you know, that might be the next step is care management, that they would know them a little bit. But I think, to me that's a key piece of using home health.

MS. MACINNES: Yes. So yes, definitely that's our perspective. As well as the family caregiver is engaged with the patient presumably in a similar way. Or if the patient themselves is educated on what the early warning signs is.

MS. SOCHALSKI: About the question. So, you're asking for workforce measures that would promote improvements in deployment. So, what are you deploying that I'm trying to improve? Deploying workers? Deploying skills? Not certain what the deployment is.

So, I like the framing of that, measure the workforce to promote this, because that's one way to think about how we're going about this on the structure and process, outcome. But why is improvement a deployment? Or what was meant by that and thinking about that? So, what are we trying to deploy?

MS. FRANKLIN: We were thinking about deployment of the workforce, of workers. But to the extent we can look at it differently. Because as you said, there's deployment of skills.

MS. SOCHALSKI: You're deploying to get to what end? So, is it to bring care to

people? So, is it underserved areas? An inadequate distribution of skill, not a person, a skill, a component of work that doesn't get somewhere. And so it's not just, you know, geographic deployment. There's lots of ways of thinking about. And so that's what I'm trying to kind of grapple with.

MS. LEFEBVRE: I like that, I think it's a good point. That there's a difference between a bodied worker versus a skill that they're delivering. It doesn't necessarily have to be physically onsite but the skill can still be delivered.

MS. SOCHALSKI: That's right. So, if you do -- in rural areas, do you do telepsychiatry because you'll never have, you know, enough mental health providers in an area. But you can do telepsychiatry.

But you have to bring that skill. And that takes some amount of resources. And so there are workforce components to that.

I mean, you'd certainly want to have enough -- but working in teams. How do they work with that community.

MS. LEFEBVRE: An infrastructure. Interesting.

DR. ZINKEL: I think some measures of access to care I think are key for that. If you look at how many days, you know, if I want to see a primary care provider how many days does it take before I can actually see that provider. I think it's more of an issue in some of the specialty care areas as well. But I think those are important things to look at as far as deployment.

MS. LEFEBVRE: So, like a time to third available measurement piece?

I wonder, too, can I add onto that that not just within the physician practice but how much home health is available. I mean, there's all these other components of healthcare and we don't measure access in

those. So, it's not just a matter of getting in, but services received as well.

DR. ZINKEL: To the telemedicine point, it doesn't necessarily have to be going to a physical visit, but a face-to-face or even a televisit.

MS. LEFEBVRE: Right. But if you're waiting three weeks for a video conference it's still waiting three weeks.

Well, let's move on but I think we can come back as the conversation goes. But this one was an interesting one to me of what measures are important to stakeholders. And that might be you yourselves here as stakeholders, but it could be consumers. And certainly there's a whole breadth of stakeholders out there.

MS. MACINNES: I love to participate.

(Laughter)

MS. MACINNES: So, in Ed's

presentation, in his list of the stakeholders this was kind of not specifically said, but the one that is discussed so often are the payers.

And I know that a couple of the bullet points were payers, like the insurance companies and the policymakers. But I think what's important to them and to people on the Hill a lot is the extent to which costs are held down.

MS. LEFEBVRE: So, costs and measures of costs certainly in the costs themselves, but maybe also in efficiencies. So what they get for those costs.

MS. MARK: Julie and I were having a conversation about the importance of being able to tell whether your providers are going to be in your plan.

MS. LEFEBVRE: Can you speak up?

MS. MARK: As a consumer we were discussing the importance of being able to tell if your provider, your physician or other

clinician was going to be in your plan.

MS. SOCHALSKI: Their network status. So whether they're going to be your physician still.

DR. MUTHA: I'm struggling a little bit because I feel like we're in between paradigms. We have this paradigm of individual clinicians and what we can count easily versus what we're trying to move to.

And so the issue with I think trying to figure out time to next available appointment, those things are measurable. There's some validity which is great which really helps some of the things we talked about.

But the issue is really around communication. Do you get what you need when you want it. And for most people it involves some type of communication, whether it's in-person or through telemedicine or something else.

So, I'm struggling a little bit

because it's so easy to count bodies and individuals and services in that way. But if we're talking about a team that we don't even know what the right composition, that we just know it needs to be a team-based, we don't know how to count teams. But we know how to count the outcome of what teams can produce a little bit better at least.

So that's -- and I think that links to some of these things, like what's important to stakeholders. How do they promote improvements. I think somewhere in there has to be something around what communication looks like and what that end result is which I think is what stakeholders really and patients, and that's patient-centered.

DR. GERDES: I think so too. When I look at stakeholders, to me the most important stakeholder is the consumer, is the patient. I mean, that's why we're here, right?

So I think what would also be

important to them is managing complexity. I see a lot of patients do their first access to healthcare outside of the traditional healthcare system because it's too complicated to gain access.

So in measuring workforce I think we need to take into context pharmacists, alternative medicine providers, your neighbor, the internets. Because that's where people are accessing their healthcare because those are the easy buttons relative to what we've built as a healthcare system.

So I think as we're looking at workforce we need to keep that in mind to include those community providers of health, but also not build something that's so onerous that it makes it more complex and therefore not accessible.

DR. KHAN: I think just building on that, convenience in terms of accessibility and timeliness I think are key. Being very

person-focused.

As well as the assurance that it's of value. And again, value not only having a quality component but one that's cost-effective as well.

You know, I do think we need to change our thinking as Sunita mentioned around -- kind of away from this, all the currency is a one-to-one visit somehow to a number of ways in which you can get care. Different players if you will, but also different modalities.

I believe that's the most exciting piece about what the future may hold is leveraging some of the technology that brings care to the individual as opposed to the individual having to go to care.

MS. LEFEBVRE: I would also say that I think -- so this is me adding my comment -- but I think one of the stakeholders I think that's key in this is the employer. And

not the healthcare employer, but the purchaser of healthcare. And the largest purchaser of healthcare in this country is the government.

And I think that then the employers that's purchasing the health plan and understanding what they're doing.

And I think it gets at is my physician in my network and those types of things. Well, who delivers the care. If it's a team-delivered care, who delivers it and what type of supply, you know, what type of supply do I need to purchase to meet the demand of my employees and their families. So I think that's a key stakeholder.

DR. MUTHA: I'm just adding a little bit of granularity to the earlier comment.

I think that one way to do this is to look at timeliness of communication. So I'm thinking of we increasingly use portals through the electronic health record as a way for people

to have access to information.

And if we're focusing on prevention that is a very specific place. That's what people do. They turn to those kinds of resources that we might want to think about.

And it doesn't matter necessarily who is on the other end providing that out of a team member. But it's the timeliness of that response to a request could be another way to look at this.

MS. LEFEBVRE: And with technology it makes it measurable.

DR. MUTHA: And I'm intentionally not wanting to go to the other extreme because I think there is a value to measuring who is delivering the care. But I'm challenged mentally trying to think about how do we bridge those two things that we're trying to do which is the stuff that needs to be in-person and to really count the workforce that's contributing to it with the new models that we're trying to

use. And how are they helping us respond to patients' needs.

MS. MACINNES: So, I think picking up on your point about consumers being important. I think, you know, thinking of myself as a consumer what's important to me to be measured is does the person know what they're talking about. You know, the competence of the worker and whether I can trust them.

MS. LEFEBVRE: Trust in their knowledge and competence.

Well and then the last one for this slide is how can measures promote improvements in care delivery by the workforce. I think we've touched on that some in our discussions. I don't think these things are exclusive. I think access is care delivery. Are there other comments and input you want to have on how the measures can promote improvements in care delivery?

To me I think the measurement of a

team, it keeps coming back to that of, you know, if you get a call back from the front desk giving you an appointment, is that a response really to your entry into the portal, or you know, or did you get a call from someone on the team who's competent and knowledgeable and can answer a question. Those are two different pieces of care delivery.

DR. ZINKEL: I know this is a pretty indirect measure, but if you're talking about employers as a purchaser of health insurance what's most important to them is having healthy workers at work. And so days lost from work due to health conditions could be an indirect measure of some of those things as well.

MS. MACINNES: Just thinking in terms of the direct care workforce. I think the way that these measures could improve the care that's delivered is just giving information to policymakers about the workforce so that they can make policy

decisions about bolstering the workforce if that's needed.

MS. SOCHALSKI: Is this where some of the material that we had on competencies, is that something that fits in here? So is that -- if what we're looking at is trying to improve the care.

There's work that needs to be done, a workforce that is responsible for that. So the workforce measures are what you're looking at. So is this part of it?

So, when you talked about teams. So is it team practice, team competency? What are the kinds of things that are required? What requisite skills and practices would tell us something, that if these were present you're more likely to have better care delivery.

So it's not just you trained and got licensed or whatever. In those models of care what are the kinds of things that we have some evidence or could build an evidence base that

yields better care.

MS. LEFEBVRE: Right, right. So improved from what it was with some of these measurements of workforce.

MS. SOCHALSKI: Because the skill and the competency, that is not necessarily part of one component of the workforce. That's shared. So different workers could master the skill, and in fact might master it in different ways.

And if what we need are, I guess Ed was saying, lots of different ways that one might go about different mixes that put that -- it's -- the focus is what things need to occur. So the teamness is some of that.

And that may occur for very important reasons differently in different areas. You don't have access to those workers there. People can in fact bond and work differently there.

This might also be a place where to

what degree is that. Not only that the team is functioning well, but are they functioning in a person-centered way. So, what person- centered skills. That's very different delivery. I mean, we think patient-centered is bring the patient to us. That's still not patient-centered. Yes.

MS. LEFEBVRE: I agree with you. The way that I look at this is there are members of the team who have a real clinical understanding of this patient.

And then there's -- as a social worker I was the one saying, you know, I think we should switch Ed's dialysis to the 1 p.m. shift because here's what he's doing in the morning.

And I think that's different than his clinical components. And I think those two things work together to deliver this person's care carefully.

There was someone on the phone?

DR. GERDES: Did someone just join us on the phone?

MS. MOORE: So, it's hard for me to think about this without thinking about patients or the population being served, looking at them first. And trying to understand what are the most pressing needs.

So, I know in New York a lot of times when we do research that's meant to inform health workforce planning we look at things like ambulatory care-sensitive hospital discharges, or ambulatory care-sensitive ER visits.

Or things that shouldn't be happening and trying to understand what we need to do, or what improvements need to be made in the system in order to better understand that.

I mean, your point about every patient who comes in is hypertensive. I mean, there are some parts of New York where the majority of patients either have diabetes or

are at risk for. And building a system that understands that need and is responsive is extremely important.

So, it's really hard for me to -- I feel it's important to somehow look at patient needs in order to figure out what those measures are. And to look, in fact, for improvements in some of these outcomes by restructuring or re-deploying workforce in different ways.

MS. LEFEBVRE: So, I think in some ways, I think what I hear you saying is what we have needs to be dynamic enough so that you're measuring something that really measures the community that then helps you deploy a workforce to meet the needs of that community.

MS. PRINS: Can I make a comment too? I think this conversation is really important in terms of thinking about sort of the individual interactions versus sort of the bigger picture. And Julie, I think you brought that up, and Sunita, also.

Because some of the work, and I'll just read you a little bit of some of the work of our care coordination group. Because I think you're coming up with similar sort of what I would call measure concepts that kind of at the experience of a patient.

And so some of the things that they came up with, for example, was the number of care recipients who feel their care team communicates with one another and works together to achieve patients' goals. And the denominator would be sort of the total number of care recipients.

And I hear similar things in terms of this is the outcome that we want. And whether the workforce sort of metrics that can complement that and help us get there.

And I think the point about really understanding, like this to me is at a patient to provider, or patient to team. But what are the bigger needs to help us get the right

workforce into places.

And I think this is such a critical question. Because the supply as we've talked about can be market-driven, but how do you deploy it and get that right geographical distribution if you don't know what your population's needs are.

And so maybe it's some of this population-based thinking that we could hone in on.

MS. LEFEBVRE: So, to measure the demand or the need of the constituents, really, of the health.

MS. PRINS: Yes, or the community, or you know. And how does this tie in maybe to some of the work that's going on in non-profits around the community health needs assessment and what are the workforce components that once you identify what your community's health needs are do you actually even have the workforce within your community to help you achieve them.

MS. SOCHALSKI: I definitely think there are some atypical places that we may want to go as our data resources to inform us.

So, you've got those. You know, the community health improvement plans. The community health needs assessment. You have all of those that were built in as part of the ACA. Everybody's out there doing them.

And they are collecting -- and there are very specific directions on how to do that.

So our challenge is looking at that because that's giving us our endpoint and integrating workforce in a much more dynamic way which we have not done to date.

So, what's a good first step in trying to get there? What metrics might tell us not so much the direct link, but that we're on the path maybe to getting to that place? Because there's a reason we haven't done it. It's hard. We haven't figured it out yet.

And so maybe part of it is if we have

a better idea of where we're wanting to get, what are those mileposts in between and where are we going. So if that's what care coordination is looking at, learning how many feel that their providers are talking with one another, broadening the definition then of providers.

So, what workforce metrics would say that they are? How would we measure the effectiveness of that communication, that inclusion, those changes in how care is being delivered? And did they get that in their training? Or is that something that goes on in certain places?

So I think there are some antecedent workforce measures that would get us there. But that's a very different set than what's available in sort of the conventional data set that we think about.

MR. SALSBERG: I have a hard time sometimes in the discussion because we're

talking about outcome variables at the community level which makes it very difficult to tie it back to what's the workforce metric.

So I end up coming back to sort of the input side and saying that while there's no guarantee that it will lead to the outputs. The question of -- particularly in prevention and care coordination is do the practitioners get the education and training around prevention. Are they tested on it for certification? Are they tested on it for recertification? That might give you some comfort that at least they're coming in with a knowledge of what a good, preventive -- and I leave it to the individual profession to say what knowledge and skill base would you want each of them to have. But again you can test the inputs and the education and training, and the competence.

Around being prepared for care coordination, the question of, again, I think

looking at certification and recertification, of whether the individual has had the training of working in teams. And I don't -- it seems we have a hard time defining what "teaminess" is it's hard to know how to measure adequate competency.

You can certainly ask a practitioner when they're being certified did you actually have any experience in your education and training working with other practitioners. But it's an area where we could look further to see if there is a way to adequately measure preparation to work in teams. And then look at is there some way to test individuals.

I mean, you put it in a certifying or recertifying exam, people pay attention to it. So again, if we can think of how to test for preparation. Again, doesn't guarantee outcomes but I think would be -- could be helpful.

DR. ZINKEL: On top of that one of the things I think you can look at and we see from a health plan perspective is in rural communities how many people have either been certified and allowed it to lapse, or are not certified at all and never were. And I think that could be a proxy for some of the competence issues that we've talked about already.

MR. BERLINER: You know, I think everyone wants teams to work for a whole variety of reasons, some of which, maybe many of which have to do with just workforce needs.

But I think the research is tending to show that teams work for certain populations at certain times and not for everyone. And therefore it's not clear what the measurement would be around teaminess or whatever the right word is. What is it and what the comparisons would be.

And I think that's just -- I think that probably extends to many of the measures

we could look at. But I think it's a particular one in terms of this.

MS. LEFEBVRE: So again, making sure that they're flexible enough to meet the community need. So we're really measuring the need in the community and then -- I mean, I know as AHEC we fly physicians into rural areas. So if there's a pediatric pulmonologist that's needed we fly them in and they do a Tuesday clinic. We fly them every Tuesday out to that rural part of the state.

Well, to think that they can provide that care adequately is wrong. Those clinicians that we fly, I love talking to them because they get this team-centered care. Because they fly in -- that community is there. They really have to understand the team. They rely on that team to bring them all of this information. And so maybe it is, it goes back to that community-based measures.

MS. SOCHALSKI: You know, I'm

thinking back, and John, I can't remember if you were also -- Ed, I think you might have been part of the meeting that it gets to that.

ASPE had brought together a group of people that were these sort of like model primary care groups, model primary care teams. And what they did was talk a lot about the metrics of examples of it working.

And there were some really striking things. But I think you're right, Howard. You know, it's like in some places.

But we can also push forward on what makes for that if we in fact believe that these are things that can lead to better care and it's the kind of care that patients and families want. So it's not a luxury to say to do it. This is what you would do.

But they had examples of things that happened and how they practiced together that actually probably are a little more process.

And so the thing would be, okay, so

how did you get there. What were the things you needed to do.

And you might also need a robust set of other kinds of technology. And technology could be knowledge. But they got it. And some of them were in inner-city areas with very complex patients. And some of them were AHEC-type rural areas where they get it. It's like you know, you see that there so how do we get them to get there.

I think some of what you were saying, Ed, I think sort of resonates. The metrics of that, but to get to something that is truly need-based, is market-responsive. But that's what people want. So how do we tee ourselves up to do that.

Which in some places it is going to be reinventing of who's doing what. And thinking very differently about the family and the direct care worker that's there. And the direct care worker may be the family. In many

instances.

MS. LEFEBVRE: I think it comes back to that trust in the competency.

MS. SOCHALSKI: Yes. But you're right, they get it. And so it is -- and it was very instructive listening to these examples of what they had. Because it did look at that functioning as a team. But understanding what skills and what brings those together to yield a much better outcome.

MS. PRINS: So, I was just having a little bit of deja-vu from when I was in physical therapy school and we were in UNC in the Department of Allied Health. And we had courses in interdisciplinary care.

And they put us in with -- so it was PT, OT and speech, and then it was the med techs and I think dietitians, and I think maybe radiology.

And from the student's perspective we sat there and go well, where are the nurses

and the physicians because those are the people that we interact with and need to really -- so, you know, it was just, it was the allied health, but it didn't get at the broader need to really function as a team.

And then when you got out in practice you realized just how divided those schools of thought were. And I don't know if, you know, that was awhile ago so I won't date myself.

MS. LEFEBVRE: I think we're all still working on it. Those of us who are in medical education, we all still work on it.

But I will tell you I still quiz our residents on what is the difference between OT and PT. And many of them struggle with that. And so I think it's how do you make an appropriate referral if you don't know what your team members are doing and those sorts of things. But I think it's something that everybody continues to struggle with.

MS. PRINS: When we talk about efficiency it has huge implications. When you have an entire cadre of interns and residents writing PT, OT and speech on every patient who then gets an evaluation.

So, the patients that need things, and I'm going back to acute care which is not really the focus of this, but they're getting a lot of care which is then pulling that workforce away from other patients that really could use the more intensive services.

MS. LEFEBVRE: Okay, so I think we'll move onto the next set of questions.

DR. GERDES: Yes, and actually you all have done some great anticipation. I think we've had pretty good discussion around these questions.

These next questions are about level of analysis. So at what level do we think the analysis and the measures should come from what would be most useful and what are most

likely to have the greatest chance of promoting improvements at the different levels.

What I've heard from the group is that probably one of the most beneficial places to do the analysis is at the local community because of variance and differences in workforce deployment there.

But to be reminded and pay attention that the education, funding and training decision-making is done at a different level, and not necessarily the community. So that those analyses do need to be fed back or made in conjunction with other levels. I hope that's a fair summary statement but I wanted to open the floor to any other discussion on level of analysis.

MS. KOVNER: I can't answer that question. The answer I think is it depends what the question is. And so to speculate which is the best without knowing what the question is I think will not get us very far.

Does that totally shut off all conversation? People can disagree with that.

(Laughter)

DR. GERDES: So it depends. Anyone else on levels of analyses?

MS. MACINNES: I would just note that oftentimes the level of analysis, the level at which the analysis is done is different than the level at which the data is collected. Maybe that's obvious.

MS. MARK: I would add the health plan level.

MR. SALSBERG: And I would agree with Chris, the point that so much depends on the question.

So if the sort of question's about the national policies around physician education, you may need national indicators.

But if you're down at the community saying can we get care then you need data from -- for that community.

DR. KHAN: So it seems to me there are some challenges related to the question in terms of what level of analysis, but also we're trying to compare different forms of delivery across a continuum or in some cases in the same region, in the same local area. So a closed system versus a not-closed system versus rural versus urban.

And the care team is going to look very different. I think in the future we're going to also see virtual teams where literally you don't know the other folks. The member hopefully knows or the patient knows, but the team members may not be known to the provider. So I think it does sort of pose an interesting problem in terms of our analysis.

And I kind of agree, Gail, with your comment that in some ways there are going to be different sort of measures or different metrics or even units. Then we've got to somehow adjust those so that you can compare.

MS. LEFEBVRE: I think one piece, and now I might be bleeding into our next discussion about data sources, but there's a whole host of healthcare that's both performed by but really subsidized by government contracts, whether that's grants and other subsidized fundings. So FQHCs and you know, different pieces that are all subsidized.

And I'm not sure we ask workforce questions when, well, I know we don't. So I work on huge government contracts. I'm a regional extension center. I work with the CDC, all of these.

Other than when the stimulus law came out and I worked under ARRA funding nobody asked me about the workforce that I was employing with their money.

And so I think that there's some opportunity. I might be getting too much into data sources, but I think there's at some level of analysis we could be asking more questions

and analyzing what we're putting out there with the grants and contracts and things like that that we have to start with some low-hanging fruit.

So yes, I think I might have just broke the lid on this one. So, I think looking at data sources, what are some of the pros and cons of various data sources. Knowing that I don't think we're sitting on a single pot of gold with a data source.

So, we'll just open that up. I think pros and cons. And then short-term considerations versus long-term considerations might come after the pros and cons discussion.

MS. KOVNER: I think there's a lot of literature out there that does the pros and cons of different kinds of data. Joanne Spetz wrote an article about a year ago in Nursing Economics where she went through a whole bunch of stuff on demand.

One thing I think is important is as we're looking at the data, for the data talking about jobs or the data talking about human beings. Because that gets very confusing. Sometimes if you look at BLS data compared to, say, the National Sample Survey data.

So, sort of the same answer I had to the last question. Depends what the question is.

MS. LEFEBVRE: Well, and I think it does, there's no question.

I also think the community piece comes into this because there are certain jobs. So, again my background is social work and prior to social work I was a speech pathologist so I have a pretty rounded background I think.

And then I work in rural communities and sometimes in rural communities you jump in and you do what's needed because there isn't the workforce there. So I think maybe that adds another layer of who's doing the needed work.

Because as a social worker in this community I did this. And in another community that I was in a large hospital system I didn't have to do that anymore. There was someone else who did that.

So, I think those are important things to look at. You know, it doesn't always go with credential. It doesn't always go. You know, I mean we have to understand what the need is and how are we filling that need.

Because in healthcare it's rare that a need can go unmet. It has to be met somehow. It's a need in health.

MR. SALSBERG: Once again I sort of agree, I do agree with Chris.

So many -- there are the 101 different questions that one would want to answer with different data sources.

At HRSA we put together a guidebook on federal data sources that could be used. And I think there were about 19. And there are

some that are very clearly workforce, the AMA Masterfile, or -- you know, clearly data around workforce.

There are others that are more subtle which get to the community need issue which you can tap into.

Anyway, I just find the question so broad that it's hard to respond. I mean, clearly there are issues of concern. Some of the data sources, they're not 100 percent, or maybe they're sample surveys and you don't know the denominator well. We have a lot of gaps in the available data.

One of the projects we promoted at HRSA was a minimum data set. And I can tell you working with PTs or social workers and others, you know, we have good data on physicians. We don't have good data on so many of the professions to even know where they are. So that's one of the shortcomings and obviously an area for future work.

Anyway, I tend to look towards what are the big data sources that we might tap into already. But I don't want that to preclude being focused on what do we need, what are the big gaps in our data.

MS. LEFEBVRE: It seems to me too, Ed, and you would know more about this, but so in North Carolina it's my understanding that we have some --

MR. SALSBERG: You have the best data.

MS. LEFEBVRE: But I will tell you that we struggle to continue to fund that at certain levels. And it's not always the fancy, sexy stuff that likes to be funded, you know, to gather data on these things. And we're continually having to kind of petition to either continue to fund what we currently have, or to increase that to do additional studies and things like that. So I think workforce data is something that needs to be better understood in

order to be funded.

MS. SOCHALSKI: It seems that what you have is, you know, there's always going to be competing demands, but there's -- you can never have enough data. I mean, have you ever been in a room where one of the solutions isn't more data? You know. So we chase a lot of it but I think -- and in that process we are trying to figure out what we actually do need. So we get it wrong a few times, but we do get it right.

But if we haven't done what we're asking ourselves in this task force to do and that is to align important metrics, identify a set and align important metrics of workforce that have important implications for delivering high-quality equitable care then it is hard to make the case.

You know, so why am I collecting all of this information that feeds a bunch of studies that might tell us about supply in a contorted market but isn't really aligned with

where some of the earlier slides you had on structure and process, some of the things that you were presenting.

So that's our challenge I think is the metric. It is, Chris, it's going to depend on the question. But I think our challenge then is to say which are the ones that help us. You know, if I were sitting in a planning seat and wanted to know where I was going to allocate dollars, how I was going to do that. If we come up with metrics that align better to that it's easier. Never easy, easier to defend. But also would be getting people to collect the right thing.

So I think about on primary care training, one of the things you want to know is, you know, so if you put money in it did they work in primary care and how long. You know, we don't collect that. We collect a whole lot of other stuff, but we don't collect that one piece of information. What does it take to do that.

So, to your point I think that's really, at least would make not only things defensible but I think we would be able to use it. And I think it has ripples for educators and for the regulators and for ACOs and people who are trying to change the AHRQ and how they're delivering care.

MS. LEFEBVRE: I agree and I would add to that the piece of retraining too. I think that's another whole component in this that we haven't really touched on is retraining the current workforce.

So, with the advent of technology, with the enormous amount of health data that's now available. It's my job to get providers up on health information exchange.

You go into a solo provider's office that's a physician and his wife or her husband running this practice and serving this county, and now all of a sudden we connect them up and they have hoards of information.

Trying to get their front desk person to understand they need a nine-point match before they can really consider this patient's information, you know, I mean it's -- we're talking a whole different skill set.

And so I think it's not just future workforce, but it's current workforce and what are the retraining needs we have because healthcare is changing.

MS. SOCHALSKI: Because we look at changing curricula but that's the tip of the iceberg. The part that's submerged? Oy vey. You know, we've got a lot.

MS. LEFEBVRE: Yes. The big part is they're already out there working and I think Erin Fraher discusses it as 18 million people currently in the workforce that need either continual training or retraining to meet the needs of what we have. That's a huge piece and a data source that we don't necessarily follow.

DR. KHAN: So, one of the things that I think you mentioned and -- so, thinking about it relative to the public payers, Medicare, Medicaid and other programs feels like there is an opportunity since it's a relatively controlled source I guess.

I mean, I'm thinking about it from the perspective of if there was a requirement, say, to not only have reportable measures around quality which we all know in most programs, the Stars programs, what have you.

If there was also a requirement to report on how services are provided or relative to -- is there a care manager in their office. Is it an embedded care manager? Do you use an EMR? Do you participate in the certainly HIE? Do you have some kind of transition of care component and what that is?

I'm sort of thinking about many of us in the healthcare payer side and the insurance side have looked at products where

there's in their own network.

And at least in our system I know we made a very deliberate effort in selecting who was going to be in that narrow network by asking about 20 questions around their relationship with behavioral health, with some of the other key partners in community care delivery. And that had a bearing on whether or not they were selected.

Obviously we did also look at performance in terms of total cost of care and quality measures, et cetera. But it does feel like at least starting there if there were some standard set of questions that were assessed and reported on at least we could look at what seems to be most cost-effective in terms of outcome and quality care. But I think it's some way to at least start to frame it.

MS. LEFEBVRE: Yes, and I think I would take that even a step further and say a lot of those questions don't need to be asked.

The data is available. You just have to go to different data sources.

So, your state HIE knows who's on HIE. They also know what EHR system they're on. We need to work with different relationships on how you're going to gather that data and put that data in.

So again, I just think it's a matter of considering what data sources we have, understanding the pros and cons to them and the limitations of them.

But I think, and again, HIEs, I don't want to say all because there might be some that weren't, but they were federally subsidized. They received money from HITEC. And so that information should be used as a data set.

So I think, you know, looking at these data sources and how we use them, and posing these questions, not everything has to be asked in a new survey format, you know. I

mean, it's where do we get this data and how do we pull this together, trying to reduce the burden on physicians.

But I think looking at organizations. And again, I think so much of this is if you're going to take federal funding for any types of these programs I think this data should be used.

MS. MOORE: Ann, I want to build on your comment about the need for retraining the current workforce.

I think that a lot of this conversation has focused on supply and understanding how many are there, where are they. But I think it's really critical to also look at demand and to understand what the most pressing workforce needs are.

So a system that can capture good supply information but also understand demand for workers. And can inform efforts to retrain existing workers for the jobs that healthcare

providers are reporting that they need.

And the other piece to tie onto something Ed said was looking at the educational pipeline. Who are we producing and where are they going.

Again, I think building sort of a way to monitor these things is a way to really understand what's happening. We do that at a state level and you're right, getting the resources to do it, getting the cooperation of the different groups to make this happen is very challenging. But it also tells you a lot about what's happening and what's not happening.

MR. SALSBERG: So, some general thoughts.

First, you remind me of North Carolina. I mean, North Carolina does have probably the best state data on the supply side.

There are several sort of domains on the data sources. So, there's the practitioner data which you can get from the

licensure renewal.

There's also very important data from providers. Who are they employing. Where are there vacancies. It's something that's been used in nursing in the past to say this is what the needs are.

So, provider data which it's hard to drill down to that team concept, but what's the mix of the people that the providers are using.

There's patient data. And the question of are there surveys out there that can ask patients about -- that inform us about the workforce. I mean, you can ask general questions, did it take you a long time to get an appointment. That may or may not be -- that's any measure of the adequacy of supply. There may be other factors that influence that. Anyway, so there's the practitioners, there's the providers, the people who employ them, and then there are patients.

There's also, and fall someplace in between, claims data. Clearly there have been a lot more about Medicare patient access and service use because that claims database is available. And so that's another place to look.

And then I mentioned briefly but I'll come back to the work that we were doing on the minimum data set. I mean, the logic there, and again, you go to North Carolina and a handful of other states, is that there's a whole -- not every practitioner or caregiver is licensed, but many caregivers are licensed. They have to get re-licensed. That is an opportunity to get information. That basic census information then allows you to do sample surveys.

And so a pretty critical first step is to improve the census information which is usually best gotten through the licensure process. And we're working, there are a number

of national associations that are working at building that, whether it's the Federation of State Medical Boards, or the National Council of State Boards of Nursing, the PTs and others are trying to say can we build the basic core data.

And there is room to discuss what is in the core data. But if you set up a structure to collect the data then you can have that discussion about what else should be in there, or what can you collect periodically.

DR. GERDES: Thank you. I wanted to pause just a moment to see if we have any comments on the phone. We don't want to forget our folks on the phone.

MR. SCHOMMER: This is Jon Schommer. I have no comments. Thank you for asking.

DR. GERDES: Thank you. Okay.

DR. ZINKEL: One way to look at demand from a payer perspective might be to look

at when payments are made for in-network versus out-of-network benefits.

Typically when we do utilization review from the health plan perspective if there is no provider within a certain mile radius we'll approve those at in-network level for benefits because there's a shortage of providers and it's the right thing to do. And so that may be one data point, to look at demand from a payer perspective.

MS. LEFEBVRE: So, I think, I guess this kind of all bleeds in together. But we'll move on so that we get it in there before lunch.

But any discussion at all on the cost or burden of considerations of measurement? I think, you know, we'd be remiss in talking about any of this without talking about what it takes to send data, what it takes to gather this.

I know if you're a provider in the room I feel like you're feeling this crunch

pretty hard these days. So, I guess any thoughts at all about what are the costs and burden?

DR. GERDES: I can just speak from personal experience. Like I said, we are participating in the Medicare Shared Savings Program so annually we report on the CMS 33 quality metrics of which there is a subset that we have to collect.

And I really had kind of a tipping point moment on a CMS call coaching us about the GPRO portal and inputting all the data. One of the ACO callers asked for advice on how many man-hours to budget for collecting this data and transmitting it to CMS.

And the person who answered was an IT person, not a clinical front-line person of course. But the answer was 30 minutes.

I can tell you from our ACO which has 220 doctors, 30 on no EHR and the remaining 190 on 30 different EHRs, plus hospital system, we

had 14 full-time clinical and IT individuals with more than 300 man-hours and several thousand dollars over 8 weeks to collect this data. So there is a huge disconnect I think.

And this brings home to me how important this question is as we frame our metrics going forward. And the who, when, where and with what money is going to collect our workforce data.

MS. SOCHALSKI: So, I think your question, Ann, and your response made me think about. So, one of our key stakeholders in all of this is our payers. And the payer doesn't necessarily have to be an insurance plan. It's also, it's providers. It's individuals who are purchasing plans.

So, if you would look at the array of data that we're collecting right now. So you elected to participate in the Medicare Shared Savings Program for some set of reasons I have no doubt. But it did have a big

complement of data that had to be collected.

But there was a benefit to you for doing that. So you're participating and willing to invest in it. It may not be the most efficient of databases but we're willing to do that.

So, I guess I would look at providers and others, Ann, to say, you know, of the enormous amount of data what are we not getting that you really need to be able to more effectively meet that and hire the right people.

In our case we're looking at the workforce. What are the workforce elements. Do you understand enough about your product or what else would you need in order to be able to do it? Because I think that's kind of the missing variable.

MS. LEFEBVRE: It's the WIIFM, the what's in it for me. To increase data reporting so that we can get more data is not

necessarily on the radar screen of the provider that's laying hands on a patient today.

So I think understanding what that balance is of if we decide that this data is necessary and something that we need what does that get you in return. How does that see a return on your investment in providing this.

MS. SOCHALSKI: Right. So, the recent study that came out from the Institute of Medicine that you quoted from the Health Affairs paper, the one that said the 10 things that we ought to be doing to get to more effective care.

And what was underneath all of that, every single one of those, was being patient-centered. So, I mean these are a major stakeholder source saying this is the most important thing.

So, if we're looking at what is the workforce contributor to becoming more patient-centered. Is it the training? Is it

the retraining? Is it the teaminess? What are the things that we are doing on the workforce side to contribute to that outcome. And what metrics do we need in order to be able to tell us that.

So, if a stakeholder has already made that as an important statement about what needs to be done. And they have very good evidence of why it made a difference.

I mean, clearly shifted the AHRQ and particularly for some very high-cost patients. So, the cost burden of the data and the data collection could easily be offset by the more effective use of services and an ability to be able to predict what your cost profile is going to look like for the delivery of care if you have those pieces that are aligned to it.

MS. LEFEBVRE: Yes. I think there's a challenge in that is that being able to collect that patient-centeredness. Because I think we have a lot of practices who

have completed a very successful application in proving their patient-centeredness and not necessarily had a culture change in being patient-centered.

And I think -- so I think in the data collection if we're going to collect the data to make sure that there is actually -- that it's measuring what we're looking to get at versus a successful application.

MR. SALSBERG: There are a lot of efforts to collect data. One of the challenges that we run into is the public/private roles in data collection.

So, I've been impressed over the last several years that I personally have historically used the AMA Masterfile which is a not-for-profit but not free. So they do charge us for their data.

But then realize that there are a series of for-profit companies out there that do gather data, incredibly detailed data and

incredibly expensive data. And there seem to be a fair number of companies. So there is a market. Someone is willing to pay for data.

The problem is that we want it sort of for public use and not-for-profit uses. So we tend not to want to sell our data. And when I work with most professional groups they don't want to get into the business of selling their data. They're fine with it being used for research purposes.

So, I don't know what the right balance is. And if we wanted to go into business and sell data and -- the ones that amaze me were the data companies that can tell you the name of the receptionist to call and what time to call her if you want to sell her a drug. They didn't have very good information on education and training background, but they knew how to reach the physician or the purchaser.

So, trying to be creative about how

to respect the rights of the practitioners or the practices, but somehow find a way to make some money on this.

The other thought is just the importance of tapping into existing administrative processes, whether it's claims data or whether it's licensure renewal.

You know, if there are places where providers, practitioners, organizations go on a regular basis can we structure it to collect the data. I still think you do need to be sensitive to the time burden so you're not -- on a license renewal, you know, you can't have them spend 45 minutes on a questionnaire.

But again, I think there are ways to build on the existing data collection that we do need to look at.

MS. LEFEBVRE: I agree, and I think there's a lot to make sure that we understand about the data that we have too.

I will tell you, I've done a lot of

work in North Carolina and you still -- I defy you to tell me how many practices there are in North Carolina. You just can't. It doesn't exist.

I can tell you providers, I can tell you credentials, I can tell you a whole lot of things, but I cannot tell you how many physical locations there are for you to get care in North Carolina.

And that's because it's not tracked anywhere. You know, claims go to P.O. boxes, or they're bundled into different types of payments. And they're satellite clinics versus original clinics. They're just -- that data does not exist.

MR. SALSBERG: I thought for Medicare claims purposes that the practitioner had to have the exact location of the service. Now, I could be wrong.

MS. LEFEBVRE: They have to have the location of the service under the tax ID.

So it's under tax ID. It's not under the physical site of the location. And so there really isn't a way, at least to my knowledge. If someone has one please tell me because we have a lot of them. But there just is not a way to get practice site.

And so when you start to get at what is the needs of this community and how is healthcare and the health workforce meeting the needs in this community it's very difficult to get at. Because if we can't count the number of practices it's even harder to count the delivery of some of these other mechanisms. So, it's just interesting to know what we have.

I think we're just about -- is there any in summary? Go ahead.

MS. SOCHALSKI: So, your question is measuring the costs and burden. Of course, you want to be taking some of that into account.

I don't know if the subcommittee that met beforehand when you had the like 259

or something measures that came out of the 6,000 or something. And they had some loose affiliation, maybe had the word "work" in them or something. So they looked kind of like workforce. So they had a passing familiarity with what we might call a workforce measure.

So, did you like look through or vet or see what those do vis-a-vis the work this committee and sort of where are the gaps? Because the cost in all that is going to be around how big are the gaps.

And maybe one of the challenges that we have or the recommendations is we need to figure out what the cost is to try to do this. We might be all, you know, beating the drum for patient-centeredness but has anybody -- to belly up and really try to pay for this may not be the easiest thing because we're not even close to measuring it yet.

And so the cost and the burden would be substantial. The burden may not be, but the

cost could be substantial at least to get to the point where we have the measures now regularized enough so that people could easily collect those kind of things. So I didn't know how much that's even been looked at.

MS. LUDWIG: Yes, we didn't specifically look at the cost or the burden associated with the 250-some. We could certainly look at it but it would be more of a broad evaluation rather than something to quantify.

MS. SOCHALSKI: I mean, if it's like we're not even close now it tells me something that we've got -- there's going to be some expenditure to try to do this. Because if out of 6,000, and what, you know, a very small percentage could even raise their hand, and even those, they don't have it up very high. So, just knowing that, okay, so it's going to be burdensome.

MR. BERLINER: I was just going to

add to your point about the difference between some of the problems of administrative data.

In New York, fee-for-service Medicaid, I mean, providers can list 1 billing address and up to 20 practice addresses. And almost everyone just puts in the billing address or one practice address even though they may be practicing at multiple sites.

And so you get a very false sense of where people are located, how much time you're spending there based on the billings which have no relationship to where the practice is actually happening.

MS. LEFEBVRE: I actually -- I think that's very common across the country.

Okay, well thank you for that discussion. I think that that was very helpful. I heard lots of typing going on. And I think that that takes us into lunch.

DR. GERDES: We are eating in this room. Lunch is behind us. Go ahead.

MS. FRANKLIN: And I just was getting a program note. We also had a dinner set up for later on this evening. So, if folks who are still interested could let us know at lunchtime if they'd like to go out. We'll then make the reservation.

(Whereupon, the foregoing matter went off the record at 12:39 p.m. and went back on the record at 1:11 p.m.)

DR. GERDES: Okay, we're going to go ahead and reconvene the meeting at this point. If everyone could return to their seats please we're going to restart the meeting.

And our first item that we have this afternoon is opportunity for public comments. Cathy, if you'll open the line and invite the public audience to make comments? Those wanting to make a comment will press *1 to be added to the queue.

OPERATOR: At this time there are no public comments. There are no public

comments at this time.

DR. GERDES: Okay, there are no public comments on the phone. Anyone in the room? Any public comments?

All right, seeing none, Laura, did you have any via chat over the line? No? Okay.

Our next item then is to evaluate our draft domains and sub-domains for the health workforce measurement. And if you'll recall we did our homework over the last several weeks on a grid looking at domains and sub-domains and providing NQF feedback.

And we do have some results available for you today that Allison and Angela are going to review for us.

MS. LUDWIG: Thank you, Melissa. And thank you to the workgroup here for providing your input. We had a great response. We had 19 respondents.

And as you will recall we introduced

this exercise via email and we had asked you to select up to 15 sub-domains that were based off of the conceptual framework. And there was also an opportunity for adding additional sub-domains as needed.

Following that we did some staff work and we tallied your votes for each sub- domain and we grouped some of them together that were similar concepts that were added.

Again, we asked you to prioritize the sub-domains within the domains, so the eight key buckets there.

And what came out from the homework was that the highest priority domain was infrastructure. And then on like a sliding scale through training and development, capacity and productivity, clinical and community and cross-disciplinary relationships, and workforce diversity and retention.

There was actually a fairly clear

line here. And then with the three other domains kind of prioritized less highly.

Specifically for the sub-domain by ranking the top one was the common core competencies. This one received 15 votes with an average ranking of 2.6. So, the average ranking, of course 1 being the highest. And really the top five here were the ones that really came to the top. But I wanted to illustrate the top 15 as the group prioritized 15 measures. Fifteen concepts, pardon me.

These were more of what I'm calling the middle of the road sub-domains. So, received less votes and also middle of the road ranking. So like a seven or an eight. So, you can see some of these, where they're landing in terms of the sub-domains.

And I guess the question is here should any of these be prioritized a little bit higher. Is there an argument for doing so. We can come back to this in a discussion on the

homework altogether. So we'll do that.

And then finally these were the sub-domains that received one or fewer votes. There's asterisks along the left column that were added by you all. So, just to get a sense of where these folks may have prioritized these higher but they were just one off. So that's, they're not necessarily at the bottom but since they weren't pre-populated in the homework they might seem misleading at the bottom. So again, the question here is should any of these sub-domains be elevated.

Okay, I'll hand it over to Angela for more of a thematic qualitative review.

MS. FRANKLIN: Thanks, Allison, and thanks for your work in assessing all of the responses that came in. And thanks to the committee for sending those in.

And thematic clusters as you can see in front of you, clustered around infrastructure and training and development

which was the inputs side, from the input side of our framework. And also capacity and productivity, clinical and community and cross- disciplinary relationships, and diversity and retention. And those were within our buckets for intermediate outputs.

And so just to delve a little deeper into that. From your comments that we received which were very valuable we got in the infrastructure bucket the group was very interested in the use of health IT. Any enhancements to infrastructure that would enhance access. Participation in and measures related to the new models of care. Anything related to community connections and resources. That was identified as a key priority. Scope of practice, policies, was mentioned quite a bit as a very feasible place to start measurement. Staffing models as well as establishing core competencies and the rigors of training was identified as areas for

measurement.

In the training and development there was a lot of focus on certifications of course and retraining.

So, the thematic clusters, I'll break it down a little bit. Capacity and productivity. These are our intermediate outputs.

Suggestions focused around network adequacy, production of needed workforce specialties, understanding workers' experience of care, understanding geographical distributions.

In the area of clinical and community cross-disciplinary relationships there was a lot of focus on team-based plans of care. Interactions with public health, the workforce in the community and community resources.

There was also recognition of and community engagement to address social

determinants of health was raised as an issue.

For our diversity and retention bucket many members said address turnover in the workforce and really focus on retention planning.

A workforce that's representative of the community they're servicing was raised as an issue as well as reduction of areas of under-service.

There was also a lot of emphasis on a culturally competent workforce as an intermediate output.

So, just to go through some examples that were proffered as concepts from the homework. And these are just -- I couldn't put them all in here. There were a lot of good ones. These are just representative.

In the area of the sub-domain of use of health IT under our infrastructure bucket there's a concept, for example, adoption and use of a certified and qualified EHR. There's

an existing CMS measure.

And the accountable entity was identified as provider organizations both public and private. And data source is to be determined.

For scope of practice sub-domain there was a concept around assessment of practice agreements and standard operating procedure policies, and the degree to which workers can work to their full training levels.

And again, accountable entities were practice sites and the data source was identified as NCQA having data.

Flexibility and state licensing was another concept. And accountable entities would be state licensing authorities with the state licensing authorities also as the data source.

Over in the far right category you'll see suitability. And that refers to what each committee member felt the concepts

would be most relevant for.

And we talked about pushing these concepts out into the future. So as we get into our small groups think about the measures and concepts in the terms of whether they're good for accountability today or maybe we need benchmarking measures and improvement measures to get to accountability measures.

So, just real quickly, in the sub-domain of enhancements to improve access. There was a measurement suggestion around assessment of expanded hours and hiring and utilization of non-physicians for care delivery. Practice sites, again, the accountable entity with NCQA data being available.

In assessing new models of care it was suggested we look at certification levels and outcome benchmarks with individual clinicians and practices and systems as accountability entities. And the data source

certifying group data.

For the community resources we were asked to look at the presence of linkages between community resources and healthcare settings. And again, the accountable entities are practices and ACOs. And it would be a survey.

Staffing policies and models. Under that category we had a suggestion of assessing CNAs and RNs with direct care responsibilities with accountability at the level of the practices and ACOs.

Are there any comments about any of these concepts or the idea of suitability? Gail?

MS. MACINNES: On the staffing policies I would add there, or maybe just modify it to reflect home care. So home health aides and personal care attendants.

MS. FRANKLIN: Okay. Any other comments?

Okay, then moving onto the training and development bucket. We got some interesting concepts in the sub-domain of care and new delivery systems.

And the concept here was game training and experience, or readiness to practice in new models of care. This concept was considered suitable for benchmarking, improvement, or accountability.

In the area of common core competency sets the concept was the percentage of Council on Education for Public Health accredited schools of public health, academic programs, nursing schools integrating core competencies for public health professionals into their curricula.

And this was identified as suitable for benchmarking or improvement. Then there was also the idea of a competency assessment instrument survey. And the provider's mean score on the community resources scale. And

the data source, or the accountable entity would be a delivery system or community organizations.

For the continuing education sub-domain a suggestion was state requirements mandating continuing education. Of course, accountable entities would be individuals with state data as the data source. And this would be benchmarking.

Faculty development and training was a big -- a highly rated sub-domain. And the percentage of faculty accredited to teach new models of care was a potential concept with the individual faculty and schools and programs being accountable entities. Data sources of course from accrediting organizations. Any comments? Gail, go ahead.

MS. MACINNES: So, this isn't related to direct care workforce but on the faculty development and training.

I think another good measure would

be the percent of faculty that have geriatric training because there's such a lack of that. There are others who are more knowledgeable in that area.

But I think with the extent to which healthcare providers are going to have to be caring for older adults it's an important thing to look at.

MS. FRANKLIN: Great. Any other comments about this? Julie.

MS. SOCHALSKI: So, on the continuing education you have state requirements mandating continuing education which lots of states already do.

So, is part of what we're doing here or whomever offered it, or how you accreted that here, would that be particular areas? Would that be particular areas? So, not just -- so, to maintain my license I have to do 30 hours of continuing ed every 2 years.

And what you're seeing increasingly

across states is some of those hours are predetermined. So you have to do like a course in pain management. You know, whatever comes up. So, it's not just state requirements.

Would we think about, you know, for lack of teaminess or something. You know, so are there some things that we think are important on the workforce side and we would want to see that.

Of course, the regulatory environment notwithstanding. Of course they'll love the idea.

So, not just a requirement but certain kinds of requirements. And would they be specific to either some core competencies, or some select set of core competencies that we would like to see.

MS. FRANKLIN: That's exactly right. And this is something we'd want you to tease out in your workgroup discussion, what would those areas be that you'd want to have

focus in.

So, in the capacity and productivity piece we wanted to -- the group wanted to in the sub-domain of workforce effectiveness and efficiency assess network adequacy with the accountable entity being plans. Data source likely the plans. And suitable for benchmarking, improvement and accountability, that concept.

The percentage of total productive nursing hours by LPN, LVNs, both employer and contract workers with direct patient care responsibilities by hospital unit. And I think that's a specific measure that's already in existence. And the accountability of course is to delivery teams. And you get the data from the ANA management data. And we have it suitable for benchmarking.

With regard to geographical distribution, workforce distribution and measures of community need were highlighted.

And we weren't sure where we came down on the accountable entity but data sources, the HPSA and MUA and comparable data sources like that. There's a variety of public data sources that are listed for that. And that would be suitable for benchmarking.

Under the capacity sub-domain, the number of medical residents who completed primary care residencies. And this is a benchmarking measure with individuals being the accountability's entities, or the measured individuals. And the data sources would be regional survey.

Are there comments about the capacity and productivity piece? Yes.

MR. BERLINER: If I could a question about the workforce effectiveness and efficiency.

MS. FRANKLIN: Yes.

MR. BERLINER: I'm not sure I understand the number of total productive

nursing hours worked by LPNs or LVNs. I mean, what is that -- I mean, is that in relationship to total nursing? What's it supposed to measure I guess is the question.

MS. FRANKLIN: It's a good question.

DR. GERDES: Does anyone know? Do they want to contribute that measure? Provide more details on the specific measure. So Jean, did you have a comment?

MS. FRANKLIN: So, with regard to this one what I'm hearing is that there may be a different permutation of this measure. It doesn't make sense as it's currently constructed. Okay.

MS. MOORE: So, on capacity, number of medical residents who completed primary care residency. Unfortunately an increasing number of residents who complete primary care residency don't go into primary care and they go do other things. So it's not a matter of

completing it, it's a matter of completing it and then actually entering primary care practice.

And I would also make the case that if we don't start tracking NPs and PAs with regard to their participation in primary care we're going to be in big trouble. So I think that's an important piece of it as well. And again, it's not just what your specialty is, but what you're actually doing.

DR. ZINKEL: I would agree with that. I think we should be measuring all groups and where they're going.

And you might want to look at percentage of going into primary care versus all other specialties. Because I think we're seeing the percentage drop and that would be more helpful information.

DR. GERDES: I think we need to look at -- somebody had mentioned earlier over here retention in primary care. Because you see a

lot of primary care providers in their sixties, certainly fifties and before long I think it's going to be the forties who are going into administration, fellowship training, or leaving the profession, retiring altogether. So that's another multiplier on your workforce numbers.

MS. MACINNES: In terms of the feedback that you're looking for is this just a review of things that people suggested? Or is it --

MS. FRANKLIN: It's a review of what people suggested. And we just took some representative examples out.

And it's also to give food for thought when you go in your groups and start thinking about concepts.

MS. MACINNES: Okay.

DR. GERDES: I think it's helpful too to receive kind of add-ons and other considerations. We have a good group with

individuals from a wide variety of different backgrounds. Remember, when we go into the workgroups there's going to be five or six of you working on two or three domains.

So I think it is useful to hear comments from individuals that may not be in your workgroup as you go into that. So that's kind of the purpose as well.

MS. MACINNES: In that case I have a comment. On the capacity section I think there was some evidence collected from directors of the Money Follows the Person Programs, that that was a barrier to them being able to implement and get people out of institutions, the availability of direct care workers in one of the surveys done by Kaiser.

And so I think that that would be a good measure to measure the extent to which people -- you know, a lack of workers is -- so it's an access issue. I didn't make a complete sentence there but did you understand what I was

trying to say?

MS. LEFEBVRE: I guess I have one too. Under the same thought of we're going to break up and go into groups.

So, when looking at data sources, I don't know how key that is to doing this, but I think some of the data sources on here are reported because it's publicly reported and others are asked to report because you're trying to gain a recognition status. And I think that's a different type of data in my mind.

And so I just, I think that it's -- again, I don't want to say that it's not a reliable source, I think it's a very reliable source. But if we're looking to know how many practices are open extra hours, you know, what the practice is open versus what they completed on an application to get recognition so they could get a payment enhancement.

I just think it's important to know

that when there's a payment enhancement involved the data might be not the same as the UDS that's collected for FQHCs.

MS. FRANKLIN: No, Ann, that is an excellent point. And if -- when you get in your small groups if you could identify those issues around the various data sources. We would like you to identify data sources, but also any issues related to the data sources.

And then also if there's data sources I think we talked about earlier that need to be kind of developed. Because we are looking at this kind of in a futuristic kind of vein. Cille?

MS. KENNEDY: I realize it's not my place to make one of these comments, but I was just looking through these and most of them are focused on clinicians, clinical professions. So that the workforce here does not include some of the volunteers and the family caregivers if you will.

Some of these are receipts of things by patients and they show like cultural diversity or in the care coordination. And I don't want to say anything that gets tangled up now with the care coordination committee.

But I think if you're looking toward the future if there's any way that you can think of something that might be for the -- because nothing here just grabbed me as the long- term support service personnel, or the volunteers, or the family caregivers who are part of the teaminess.

MS. SOCHALSKI: The larger paraprofessional workforce and -- which is paid and non-professional. But that larger group that supports.

And not just in long-term services and support. We were talking about behavioral and mental health. You know, there's a huge group of people that are -- in which there is actually some evidence of effectiveness.

But sometimes even though we may think of it when we say the word "health professional" often is not really what's in that net.

MS. KENNEDY: But you may not be ready to have anything develop now because it may be too new an idea, but it's just worth at least a sentence or two.

MS. LEFEBVRE: I think we're largely moving that way. So like, if you look at the community health workers, a lot of states have already certified that profession. So there's already certification criteria out for community health workers. There's a lot of federal grant money being issued to develop community health worker programs and things like that. And yet we really don't have anything to measure that profession at all. So I think that's probably worth noting.

MS. MOORE: To build on your example, Ann. Community health workers. We

were actually involved in some research, and you're right, there are some states that are really trying to figure out how to move this forward.

But there's also been some pushback from community health workers themselves about efforts to standardize and concerns that you change kind of the grassroots nature of what they do. So there's actually some strife within the group about the issue of standardization.

MS. LEFEBVRE: I would agree to that and I think in some of the forums that I've presented in including the National Governors Association earlier this year I think I might be one of the dissenting voices, honestly.

It's difficult to certify when we don't know yet what is the best community health worker. So I just -- without research it's tough for me to support a certification of a profession that we don't know the best way to

do it yet.

MS. MOORE: And I think in many ways they're still trying to sort out what are the most effective roles. And again, then of course there's that overlay of are there state requirements that we need to be paying attention to.

MS. LEFEBVRE: And payment models.

MS. MOORE: So it makes it a whole lot more -- yes, and how do we pay for it.

MS. FRANKLIN: Great. Any additional questions around capacity and productivity? This is all great information to take into our workgroups. Yes, Amy.

DR. KHAN: I am curious to know are there data available on the proportion of these practitioners, whether they be physicians or nurses practicing. And I'm thinking most specifically in the ambulatory care setting in groups versus in sort of onesies, twosies.

In other words do we have data to

suggest how our workforce is currently distributed relative to that ability to provide near-term or team care?

MS. LEFEBVRE: So data sets that I'm aware of, often group practices in -- so it's usually the federal government often uses less than 10 providers versus more than 10 providers to distinguish between a small practice and a large practice. So, 11 providers makes you a large practice. If you're in a 2-provider practice you think a 10-provider practice is pretty large.

So you know, but that's usually how -- so most of the federal contracts and grants that come out have a distinction of more than or less than, but I don't think that there's necessarily any data that I can think of that assigns number of physicians exactly per unit.

DR. KHAN: Thank you. I think beyond the number of doctors I was curious in

terms of do you have a team of care providers that aren't necessarily just rolling to that physician count. So, a physician that practices with, say, a nurse practitioner and a dietitian and a behavioral health practitioner in a unit.

MS. LEFEBVRE: The federal sets that I work on count providers, not physicians.

MS. FRANKLIN: Any additional questions? Okay.

So that moves us onto our clinical, community and cross-disciplinary relationships. The sub-domain of practitioner and staff knowledge of community resources.

The suggestions were around data-sharing between public health and healthcare with the community and practice sites being accountable entities suitable for all three purposes, benchmarking, improvement and accountability.

And then use of team-based care and that sub-domain. The multidisciplinary care plan measure concept. And then utilization of team members concept was raised around HIV, the percentage of pediatric patients whose multidisciplinary plan incorporates case management and nursing services with the accountable entity being the practice. And this would be suitable for improvement purposes.

The number for coordinating financial, educational and social services. The number or percent of patients referred to community health educators. That suggestion was to be the person -- I'm sorry, the entity to be measured was the practice. And this was for improvement purposes.

There was also a suggestion about community solution teams who use hot- spotting and other community analyses to identify the populations and geographies that need multiple

responses in order to improve care.

And that's an improvement measure as well with the community and practice being measured with multiple potential data sources.

Finally, for a proactive and ready clinician the concept was around functions and actions taken by organizations and clinicians to respond to patient and community needs with the practice being held accountable.

Questions? Yes, Chris.

MS. KOVNER: It wasn't clear to me whether the number or percent of patients referred to community health educators was good or bad. And so, if I were in a practice I might be unhappy that we were having to refer so many people because that meant that we hadn't been meeting the needs of the people that we should have been.

I don't know how we handle those going down the road. I just think it's hard to have a measure that most people can't agree on

whether it's positive or negative. Good or bad was the wrong word. Positive or negative. Health-promoting or not.

MS. FRANKLIN: Yes, and that would be very dependent on the construction of the measure and what evidence we have for what's the right percentages, right numbers.

MS. LEFEBVRE: But I think, Chris, if I understand what you're saying, you're saying that if this came out that we made a lot of referrals it would make us look deficient in the care that we're providing.

MS. KOVNER: Maybe. I mean, maybe not. Maybe we would want to make a lot of them because that would make sure that things got transferred.

I'm just saying that it's not clear with that particular measure if I were running a group practice whether I'd want to be high on that or low on that. And so I'd be unhappy if CMS was doing some reimbursement.

I mean, plus it's so easy to game that I'd probably like it if CMS was doing because then I could just make more money.

MS. LEFEBVRE: It probably puts it in very much similar to other referral measures. I think there's appropriate referrals and inappropriate referrals. I think it's the difficulty in measuring referrals.

MS. FRANKLIN: Any other questions about this particular theme? Okay.

So, our last theme that rose to the top in the intermediate outcomes category was workforce diversity and retention. And in the sub-domain of minority representation in the workforce.

The concept is race and ethnicity balances. And it's general. Accountable entities would be providers and the data source would be training or matriculation data or collected data.

It would be suitable for benchmarking, improvement and accountability. Again, we'd have to get into exact construction of this type of measure.

Under cultural competency the concept was percentage of individuals who report their care provider explained things so they could understand them. And this is the cultural competence implementation measure which is an organizational survey to assist healthcare organizations in identifying the degree to which they're providing culturally sensitive care.

And then there's also their adherence to 12 of the 45 NQF-endorsed cultural competency practices prioritized in the survey.

And this is useful for benchmarking, improvement and accountability. It's a patient survey data source measure. And recruitment and training organizations and

providers would be held accountable.

In the area of workforce retention assessment of workforce turnover was offered as a concept for improvement purposes. Accountable entities would be CNAs, HHAs and PCAs.

The data source would be the National Balancing Indicator Project and home health agencies and public authorities.

Questions?

MS. MACINNES: So, I think I made this suggestion. And I think I must have misunderstood. The accountable entity I think would be states maybe.

MS. FRANKLIN: So states to be measured.

MS. MACINNES: State Medicaid programs.

MS. FRANKLIN: Okay.

MS. MACINNES: Does that make sense? Well, the accountable entity is the

entity responsible for collecting the data. Right?

MS. FRANKLIN: That's being measured. That's the entity that's being measured.

MS. MACINNES: Oh, the entity that's being measured. Yes, okay, so that's -- then I guess that's correct.

MS. FRANKLIN: Then that's correct, okay. Howard?

MR. BERLINER: On the minority representation in the workforce. So that would be in the overall workforce, not on any geographic basis. Is that correct?

MS. FRANKLIN: That's correct.

MR. BERLINER: I'm not sure that's the best measure.

MS. FRANKLIN: So, if there's others that we can develop that get more at the issues that's what our exercise will be about this afternoon. Yes?

MS. KOVNER: I have a comment about retention. Workforce retention suggests that it's people being retained in the workforce and not leaving to go open a catering company. So I'm not sure whether that's what the person meant. So I think that would need to be clarified.

And if it's organizational turnover I think it needs to be clearer. Because there's some organizational turnover that's very good. And so I would want to know whether it was voluntary or involuntary turnover.

MS. MACINNES: So, having suggested that I think it does depend on the setting. In nursing homes I think you can measure -- the levels of turnover are so high that I think even accounting for good turnover, you know, people who -- they are so high that it should be brought down.

I think we have evidence that that's related to quality of care, having some

stability in your workforce.

In terms of home care what I was trying to get at there was more, you know, it's so important to individuals receiving care when they have a good relationship with the worker and that worker understands how they want to receive care for that relationship to continue.

And so the extent to which that person doesn't have kind of a rotating cycle of people coming through, and always having to like get to know a new person.

MS. KOVNER: Then I would call that organizational turnover, or unit turnover, or something like that. Because when you say workforce turnover I think there is -- and Jean, tell me what you think.

There's a sense that it's people leaving the workforce which is a totally different problem. When somebody -- a nurse leaves a hospital and goes, works at another hospital that's great for the community because

the new place is getting an experienced worker. And a lot of people would argue there's nothing wrong with that up to a certain level.

MS. MOORE: I'd have to agree with Chris. I think there's a lot of different pieces to this and you need to look at that.

At times when there's a really strong economy and you talk to home health agencies or nursing homes about their biggest issue they say things like I can't compete with Walmart because opportunities for entry-level workers are fabulous and in fact are a whole lot less stressful.

So I think that's the kind of turnover that we need to pay attention to. Are we giving people doable jobs with reasonable income, or are we in fact driving people out of the health workforce and into other places?

But I think the organizational turnover, I agree with Chris. I think there are some places that are poorly run. And one

of the outcomes of that is more turnover. And one would hope that it becomes a wake-up call to try to make some improvements.

MS. MACINNES: I just wanted to thank you for your comments and hope that maybe in our small groups we can have more discussion to really try to -- because I think that concept is an extremely important one for long-term services and supports. And if we could figure out together what is best measured that would be really helpful.

MR. BERLINER: But I mean, there's no reason why there couldn't be two measures. Those are two very separate things.

MS. FRANKLIN: Definitely. And when we get into our measure groups we'll want to be able to tease out, like, you're trying to get at stability of the workforce that's caring for patients, exactly what those concepts or set of concepts would be. So, we expect three to five to come out of each workgroup of

concepts.

Questions?

MS. LEFEBVRE: Just quickly. And I think it's building off what Howard was saying earlier in that in the race and ethnicity balances the accountable entity is the provider. But we really want the healthcare workforce.

I mean, it's more than just about what is the race and ethnicity of your provider. It's about your care team. Especially I'm thinking like home health workers and those types of things. But those are really important pieces.

DR. KHAN: So I do know that information is collected on NCQA surveys and that sort of thing. So those data are available.

And not only around ethnicity, cultural diversity but also language proficiency as well.

MS. FRANKLIN: Additional conversation about this? Yes.

DR. GERDES: Just one comment, backing up one slide to clinical, community and cross-disciplinary relationships. I just wanted to say again something that Ed Salsberg had said earlier this morning.

So, I live in the ACO world, so the data metrics around financial, educational and social in particular and some of the team-based care, that data is out there but it is owned by entities that don't want to freely give it up and don't even probably want to sell it today.

So as we're thinking about making these measurements and metrics a lot of them aren't made yet. So, the things we're talking about here, referral patterns and cross- disciplinary relationships, when they're presented by the big consulting agencies that pull us together and we get together in a think tank group and we kind of

share best practices for this new evolving world, they're all case study.

So there's no really aggregate result measures that I've seen reported out, even on the leading edge of who's doing this work here. Except maybe some in North Carolina. They're doing some.

So, the measures even as they do exist aren't quite to where we might want them to be and they're not for sale. So we'd be talking about reforming them which is a cost. So I just want to make sure we consider that as we're doing our work in our small groups this afternoon.

MS. FRANKLIN: Excellent point. So, any additional conversation before we go into kind of our overview of our work this afternoon? Okay. Yes, Girma.

MR. ALEMU: It was a great discussion. Very interesting points.

When we go now to different rooms I

think it's always good to remember the take-home part. Because that's really within that scope.

So, all this -- I mean workforce issues takes everything. I mean, it's difficult to separate into some cases.

But it's always good to think about, you know, those two issues and we formulate and we talk about concept areas.

MS. FRANKLIN: Great point.

MS. LUDWIG: Okay, so now our activity for the afternoon. We are going to break out into three groups to brainstorm more potential measure concepts for each of the measurement sub-domains.

We've already assigned you but please choose a lead amongst yourselves and try to brainstorm one concept for each of the sub-domains. More are welcome so please do your best there.

And we'll have worksheets. We have

some examples from our environmental scan and then of course the thematic clusters. And you'll have staff there to help record the activity.

So, on the worksheets you'll see that, you know, we're asking for concepts including the description, numerator, denominator and data source if you can.

And a good starting place again is the thematic clusters to brainstorm and maybe modify or select those. Jean, go ahead.

MS. MOORE: So, two questions. And maybe I'm putting the cart before the horse. But, should we be identifying the who, who ought to be collecting the data?

And the other thing, and again, I guess coming from the health workforce research world, should we be identifying funding sources. Because a lot of this stuff we're talking about requires resources to do.

Is that on the table, or are we doing

this sort of in a pure form without thinking about those realities? Because they will clearly impinge on how far this goes.

MS. LUDWIG: Yes. And part of the activity tomorrow is to think -- and I'll actually talk about this a little bit more right now, but the impact on the feasibility. So I think the feasibility certainly touches on potential funding streams and who is going to be able to do it and the burden related to that.

So, I think those are considerations. We don't have specific columns for that but if folks find that valuable we can certainly -- I can ask you to write that in.

Girma, do you think that would be helpful from a receiver of our recommendations? Okay.

So, here are the groups. And we have a few folks on the phone. So, staff will take care of calling you for those listening in.

And my group is actually -- McPherson Room is down one floor so I'll ask to meet over by the elevator bank. Laura, do you want to meet somewhere over here? And then you take the ninth floor. And Angela of course will be in this room.

And so, it's always good to know what you have to report out on before you start working I think. So, we're asking for the potential measure concepts, the type of the measure, your thoughts about the impact and the feasibility of measuring, and the concepts, the data sources. But any other important themes that you came up in your conversation that might not be related to a concept specifically but more along the lines of what we've been talking about today would be more than appreciated. So then we will come back.

I think we have plenty of time. And we've gained the benefit of being one of the last gap projects to go, so we've known that an

hour and 15 minutes might not be sufficient so we'll revisit and modify as needed. So, I'll put it back to this group.

I do want to take a quick break while folks gather their things and maybe, how much time do you think? Five minutes or so? And then we can -- so, I'll take the McPherson group over there, Laura, over in that corner, and then Angela, around here.

Is there any questions that I can help answer before we -- yes, bring your -- I think your PowerPoint if you have that printed out. And I will bring some worksheets, the environmental scan and if you have pens and other. If you want to bring your computers that's more than welcome too.

(Whereupon, the foregoing matter went off the record at 2:01 p.m. and went back on the record at 2:26 p.m.)

DR. GERDES: So, any thoughts on how we wanted to start on this? Any particular

domains or measures that anybody feels passionate about?

DR. MUTHA: Our focus is infrastructure, right?

DR. GERDES: We have two. We have infrastructure and we have clinical, community and cross-disciplinary relationships.

Now, I thought I heard this morning lots of talk around HIT and workforce turnover.

MR. PILKINGTON: HIT turnover is probably half of what it was five years ago.

DR. GERDES: What it was, yes. And I think the discussion on workforce turnover was more broad. It wasn't simply for HIT. Is that correct?

DR. MUTHA: That's correct, it's a broader perspective.

MR. BERLINER: Mostly about long-term care.

DR. GERDES: I think that's where some of the higher turnover rates tend to be in

medical care delivery, yes.

MR. BERLINER: Right.

DR. GERDES: So we start with what's first on the list then to make it easy, use of HIT including EHRs, telemedicine and telehealth.

I saw in one of our themes it was the implementation and what we would arguably call meaningful implementation of electronic health record systems.

There is a metric that's being used in the Medicare Shared Savings Program, I believe the pioneer ACOs too, on the percentage of primary care physicians who've installed a CCHIT or ONC-certified EHR. Which means that EHR has the capability of transmitting clinical quality data to the government, to CMS basically. PQRS, e-prescribing or the CMS 33 through GPRO.

And that is a metric, the percent of your primary care physicians in your ACO

structure that have done that. So I don't know if that's one we --

MR. PILKINGTON: Who have installed what? I didn't hear that.

DR. GERDES: CCHIT or ONC-certified electronic medical record system. And all that means, those are outside entities that certify the capability of the system to transmit clinical quality data to CMS in this case.

MR. BERLINER: Don't penalties start next year or the year after for primary care practices that don't have HIT?

DR. GERDES: They do and they're tiered to the number of physicians in your group which I believe is identified by the tax ID billing number. So, the penalties first go to groups of 100 or more physicians and then they will go to 100 or less. In 2015 I believe is when they start.

MR. BERLINER: But in theory then

there is a way of measuring this since they're going to do it.

DR. GERDES: Yes. And there is kind of a free pass. If you belong to Medicare Shared Savings Program you actually get a free pass for a few years because the ACO submits the clinical quality data on your behalf even if you don't have a certified EHR is the way I understand it.

MR. PILKINGTON: Trying to keep up with my notes. Who is the data source, ONC on this? Or who keeps up with this data?

DR. GERDES: The data source on this one, so it is self-reported through the GPRO portal which is CMS. So the data source is really covered beneficiaries and Medicare Shared Savings Program ACOs. But the collector and owner of the data if you will is CMS.

MS. FRANKLIN: So these are measures that are existing that we just talked

about, health IT. I just would throw out to the group whether there's other measures around use of health IT that might push the field forward a little bit more in terms of future workforce, what we might want to do with deployment in the future for prevention and care coordination.

MR. PILKINGTON: Do we want to look at the numbers that are Meaningful Use as one of those?

MS. FRANKLIN: That could be one, yes. Number of practices that -- do we have that already? It's not aimed at Meaningful Use but it's a Meaningful Use measure.

DR. GERDES: So, like the American Academy of Family Physicians collects on their primary care physician members, that's going to be practicing family physicians, the percent which attested to Meaningful Use year by year. So I imagine ACP does too for internists. I'm assuming that they collect that.

I don't know on the public

availability of that data, you know, if that's --

MR. PILKINGTON: I do know from our Beacon project that the numbers are very inaccurate. Inaccurate. What ONC says are the numbers of physicians who are meeting Meaningful Use and the actual number in any certainly are vastly different.

And they actually estimated it much lower. It's a much higher number. That's what we found.

DR. GERDES: Well, from ONC's perspective are they just going to look at sales of EHRs? Or are they looking at full implementation, you know, attestation attempts and attestation success. I mean, that's kind of four different things.

MR. PILKINGTON: They're looking at only attestation success.

DR. GERDES: Success, so the fourth one there. Okay.

MR. PILKINGTON: I don't know if we want to use as a measure or what we want to use as a measure.

MR. BERLINER: But you know, it seems likely that in most communities, I mean those, you know, medical homes, ACOs, hospital systems are going to have much greater chance of success with implementation than solo community providers.

And that may be where a lot of the disadvantaged population gets care. So there's got to be a way to find out how this spreads throughout the entire community, not just for the larger or more well resourced providers I think. But I don't know how you would actually do that.

The other thing I think that's important is Meaningful Use has -- it's a great term but I'm not sure it actually means anything. I'm on the board of a hospital which has meaningful use by the federal government

standards, but the EHR that's used in the hospital doesn't work in the emergency room. And they collect records by hand and enter it in manually because they can't -- the manufacturer doesn't support the ER. And the ER doctors want one thing. And I don't believe this is just this one particular hospital, I think this is something that's happening quite a bit.

And the other part of it is that the whole promise of EHR is the ability for community physicians to know what your whole medical record is. And you know, I don't see that happening, or I haven't heard that that's actually happening except in very special places yet. And that's really I think where we would actually see some real impact on the healthcare system from that.

DR. GERDES: Yes, I would almost say that's kind of a new metric and it would be meaningful use of HIEs essentially is what

you're talking about because that's that interconnectivity.

And so, you know, in Texas we have several large health systems who are kind of divide and conquer strategy, and they're building their own HIE and they're snapping up primary care practices.

We do have a federally funded health information exchange but very few entities are participating in it so it doesn't get to that community shared record at all. I mean, so now we have several HIEs on top of several EHRs, you know, so it's just more systems to get into.

But I would almost suggest that that's a new metric that I'm not aware of is defined is the percent of community-based physicians at the community level who are meaningfully using an HIE to share records for patient care.

Because you're right, the government Meaningful Use metrics, there are

some quality metrics that you pick to report on your outcomes. But the vast majority of them are operational, statistical collection processes is what they are. They're collecting age and gender and ethnicity and stuff that doesn't really have directly to do with direct patient care.

So that's why your ER doesn't want to mess with it because it's extra work and it's not impacting their ability to efficiently do what they think is their work.

MR. BERLINER: Also because the EHR wasn't designed for whatever reason to work in an ER. And the company has no interest in changing it. They don't see a market in it.

MS. FRANKLIN: I just captured something on the whiteboard and it's meaningful use of HIE. That's a concept. And the percentage of community-based providers.

MR. PILKINGTON: Are we concerned with the number using it, or are we more

concerned with the number that are using it and exchanging data that is of meaningful purpose?

DR. GERDES: For the meaningful purpose, number two.

I mean, we have -- our HIE has capability of transmitting a CCD, continuity of care document, right. And we were trying to teach our ACO physicians how to do that but we have no transmitter-receiver pairs. We have 220 doctors in the ACO and even within that structure we have no sender-receiver pairs to even pilot it. So, I think that's very important to define what is meaningful using this.

And I would go back to your definition, you know, with clinical data exchange. Which again I don't know though is a currently existing or validated measure.

MR. PILKINGTON: One of the basics for me is public health surveillance data most especially. That's one of the things I keep

looking for from an HIE that I'm not getting.

Basic laboratory reports, for example, from private labs that right now are taking weeks and sometimes longer to get to the relevant sources. Laboratory reports of public health-significant disease.

DR. MUTHA: Another consideration is that if we're thinking about this as being patient-centered I was just looking up the criteria to remind myself, but there's information in there about patient access to data which might be the one that is the most relevant.

So it basically says provide patients the ability to view online, download and transmit within four days. And then there's something about -- what else. And I think it's the after-visit summary, essentially.

DR. GERDES: What was that last piece?

DR. MUTHA: The after-visit summary.

DR. GERDES: And what criteria? What source?

DR. MUTHA: So these are stage 2 Meaningful Use core and menu measures from CMS. So it's number 7 on stage 2 and number 8.

DR. GERDES: Is there anything on there about transmitting a CCD or continuity of care document? I was thinking stage 2 had something about that. Okay, maybe I'm making that up.

DR. MUTHA: I'm looking really quickly. No, actually no. The only one that's similar to it is use clinically relevant information to identify patients who should receive reminders for preventive care. So is that maybe what you're thinking of? Yes. I don't see anything else in here.

Oh yes, there is. There's one on transitions of patients to other care settings

or providers. A summary record for each transition of care. Is that what you're thinking of? Okay.

DR. GERDES: Would that kind of metric kind of get to what you were talking about?

MR. BERLINER: I mean, I think that gets close. I mean I guess I have to think about exactly -- I think it obviously would be an improvement in care if people's records transferred with them to a different facility or a different level of the healthcare system.

DR. GERDES: We did a survey of female healthcare consumers and decision- makers in American homes. It was kind of a focus group survey. And the AFP did five or six years ago called What Women Want out of Healthcare.

And that metric is very non-patient centric. That's not what patients want. They don't want to be the conduit or the carrier of

their records between facilities. They really expect we should be able to do that electronically.

And they're not nearly as concerned about HIPAA as we are. Or maybe they should be. But I found that very interesting. They really think we should just already be doing that.

So I don't know if that necessitates a new type of metric, or if the metric is looking at that the records move with them regardless of who physically carries.

That one's existing. That's one of the CMS 33. That's the percent of your PCPs that have a CCHIT or ONC-certified EHR.

MS. FRANKLIN: My question is is that a gap or does the measure already exist.

DR. GERDES: I think we threw that out there as what is existing today that might get at that question. But it doesn't get at that question, it may need some improvement.

MS. FRANKLIN: So, the examples of

moving clinical data patients through public health surveillance data and lab reports, for example, is that a new piece though to the Meaningful Use measure I think? Public health surveillance data in particular. So it's a slight tweak system measure.

DR. GERDES: So, several of these measures are part of the NCQA patient- centered medical home application. But again, we get into that data issue of you're reporting to apply for points to get a recognition which is often key to payments. So we have to understand what that is.

But percent of records sent with transitions of care facility to facility is a metric in that application I can tell you.

Reporting of surveillance data to public health entities is in that application as well. So, I would think NCQA should be able to produce the percentage of its applicants who reported on those elements. I mean, I would

think they would be out there. Again, whether they will report or share or sell that, I don't know.

MS. FRANKLIN: So that could be another metric with NCQA as the data source.

MR. PILKINGTON: Is that different or part of number 2? I thought the NCQA data was part of number 2. Is that not --

DR. GERDES: Yes, I would -- those are the existing potential metrics that I'm aware of that could address number 2.

MR. PILKINGTON: Okay. And we know number 3, Medicare has that data for patients to use electronically with the big blue button so to speak. But we don't have that from the private side in most cases. Not universally at least.

MS. FRANKLIN: So, outside of the existing, any new concepts for health IT?

MS. MARK: What about electronic submission and approval of prior authorization

and step therapies? Prior authorization step therapy, of putting the whole catch-all of prior authorization.

Basically where you would need to get your health plan's permission before you had a medication paid for, or had a service paid for. Right now it's a very time-consuming, inefficient process that leads to large barriers in access to care.

It would sort of indirectly affect the, you know, reduce workforce needs like the number of admin people you'd have to have on the phone with the insurance company hour after hour.

And there is some movement in this direction but it would be nice as a consumer to know if I was signing up for a plan, you know, are you using the CVS/Caremark electronic prior authorization system, or am I going to have to wait five days to know whether my step 2 medication is going to be approved.

MS. FRANKLIN: So the accountable entity would be the plan?

MS. MARK: Yes. It would be measured at the plan level.

MS. FRANKLIN: And the data source would come from -- that's interesting that doesn't exist already. You'd think consumers would a lot of times think that this is happening already. Very interesting.

DR. GERDES: Consumers don't even know what prior authorization is.

MS. MARK: No, they showed up and they thought their doctor gave them medicine and that the pharmacy says oh no, I'm sorry, that was not approved. You need to go back and call your doctor. And then 30 percent of the time they never get the medicine because who has time for that.

MS. FRANKLIN: Other thoughts?

DR. GERDES: I think that's a good one because at a primary care practice that

process is a large time drain on workforce and mitigates ability of my MAs and staff to do other frankly more meaningful valued work for the patient. So I think that's an important one.

MS. FRANKLIN: Have we exhausted the health IT bucket?

MR. PILKINGTON: I was just sitting here wondering do we want to even touch the subject of integrated HIEs? Since as you said everybody is starting to do their own.

MS. FRANKLIN: Why not? Integrated HIEs.

MR. PILKINGTON: And the reason I bring that up, part of the problem in trying to in my area work with two major hospital systems on an HIE is that a good bit of the problem is not bringing the data together and working, it's the capability of personnel to do that. There are not competent HIE people who can pull it together.

So the hospital systems struggle with bringing those kinds of people onboard and they don't move forward with this and it's easier just to say we'll keep our data and we won't work with your data.

MS. FRANKLIN: So, am I hearing a little bit of maybe a structural measure around maybe having certain types of personnel that can do this kind of thing? Or simply having an integrated HIE?

MR. PILKINGTON: Both, probably. What we don't have are the highly skilled IT guys who understand networking and network systems enough to integrate the networks. And at the same time we don't have networks that are willing to make that investment. Because there's no reason to. There's nothing to be gained by making an investment.

DR. GERDES: Well, I think it's more that we don't know, we don't have any empiric research to show whether there is or is

not a benefit to building these today. So, there isn't a downside to not doing it and there's no clear ROI on clinical quality, cost, you know, whatever kind of metric you want to use. So it's hard so nobody does it.

MR. PILKINGTON: And you're right. The anecdotal data is plentiful there. I mean, physicians will tell you they'd much rather have that data at hand anytime when they're seeing a patient that's from another system right in front of them.

And I know -- I work in the public health side and our docs are always saying boy, it would have been nice to know they went through this hospital system for six months of care and then showed up to deliver a baby to us and we've never seen them before. They weigh 400 pounds. They've got all these other issues going on and there's no data on them. And it's all sitting in another system's information.

DR. GERDES: I agree, but none of

the physicians are funding that infrastructure build. That's, I mean, ROI and the argument for the funding agencies.

MS. FRANKLIN: Any other ideas around the HIT piece of things? Any around telemedicine?

MR. BERLINER: I was going to say what kind of measure could be used for telehealth or telemedicine?

MS. MARK: I mean, I was struggling with that because on one hand telehealth is increasingly important for access obviously for behavioral health care. But then there's so many unknowns.

I'm not an expert on it, but I think they're still trying to work out the kinks about licensing across states and how do you do it ethically and when do you have to be there in person. I don't know if it's prime-time for a measure yet. That's what I was wrestling with.

On one hand it's important for

access and on the other hand there's a lot of complexities that it seems like they're still working out.

MS. FRANKLIN: So we wanted to tease out some areas where maybe the measures aren't ready for prime-time but we feel like they might be important to start thinking about, or start trying to spec out.

So maybe telehealth we'll put a question mark by it specifically for behavioral health management?

DR. MUTHA: It might also be something that is geographically a priority but less so in urban areas. Because this access issue won't be -- for the rural, or when there's just very limited specialists, period.

MS. PRINS: Yes. And I would say given the time-line to develop measures, particularly for performance measures, that thinking about the future and where there's anecdotal evidence I guess, that maybe it's -- I

mean, I think there are some states that have been using telemedicine.

And then, you know, if you feel like it's got potential then throw it out there and the measure developers can figure out how to -- whether it's a state policy level or whether it's an accountability measure for health systems, or they can sort of take it to the next level or we can flesh it out a little bit more in the group discussion.

MS. MARK: I think we're talking about telehealth for underserved areas. Telehealth for underserved areas, or underresourced areas.

DR. GERDES: And by that you mean patient access to a physician and specialist essentially.

MS. MARK: Right.

DR. GERDES: Because when we talk about telehealth and telemedicine it's this huge umbrella term. And I think that's useful

to kind of narrow definitions.

MR. BERLINER: But there's another dimension to it. I mean, there's been discussion, for example, of giving home care workers expanded roles.

And one way to do that is through having someone take a picture of someone with their iPad and have it go to a doctor who will say, yes, bring them into the ER or no, do this. As a way of saving money, making things smoother and better and things like that.

So it's not just necessarily -- it could be -- it doesn't have to be remote areas. It could also be urban areas as well.

MS. FRANKLIN: So does underserved areas and populations capture that? Or it should be something more?

MS. PRINS: Well, that's almost more of a patient-centered approach to not having them travel, whether it's 20 minutes or whether it's 4 hours. If there's a way to get

that information to their provider or their physician it's an efficiency thing for the patients and for the system I think.

MS. FRANKLIN: It could be a really rich concept.

DR. MUTHA: Yes, another example of that one I think, Howard, is the people that have started to use iPads to do the home discharge transition where you can allow a connection to the community-based clinician while they're still hospitalized. And that's not limited by geography.

MS. FRANKLIN: Is that providers using say iPads? Okay. Providers using technology.

MR. PILKINGTON: It's not only providers. It's patients as well. We've done some great work with patients using iPads to bring information to the physician appointment.

And so instead of the physician

spending all the time sitting there reading all the things in the hall he or she walks in, looks at the iPad, says this is what's going on, we're good, move on. Using it very much in diabetes management.

MS. PRINS: It seems like the current measures that we have around this are very sort of check the box. Even the Meaningful Use measures that are just starting to get into this are still kind of do you have. And I feel like you guys are really starting to push into sort of optimal use that can really benefit patients and save them time as well.

MS. FRANKLIN: So I kind of have this a little bit under the communication piece.

Any other thoughts in this same vein, telehealth, telemedicine, remote care? Let's take a look at our concepts.

DR. GERDES: Do we want to stay on infrastructure? Or do we want to jump down to

clinical, community, cross-disciplinary to make sure we have some time for each? What does the group think?

MS. FRANKLIN: Before we leave -- my two cents. Before we leave infrastructure or anything anyone have thoughts about staffing policies or infrastructure measures around improving access?

We have several kinds of maybe check-the-box measures about staffing policies, but is there a way we can dig deeper in that? Or dig deeper into changes to the infrastructures to improve access by patients.

MR. BERLINER: How do you deal with measures that might be different state by state as with scope of practice? You can't have a single measure if each state has a different policy.

MS. FRANKLIN: That's the influencing factor issue. So, for a measure

like that where the policies are different I think we kind of would ignore the fact that -- we would want to be setting what we think is best regardless of what states have in practice right now.

Because we've been, again, looking towards the future. If we say as a group that the priority should be that staffing policies should look a certain way then that kind of leads the field in what needs to be changed to meet that metric.

MR. BERLINER: So, I'm just asking this question. So for example, a measure could be do nurse practitioners have the ability to prescribe independently. Even though many states don't allow that.

MS. FRANKLIN: Right, right. It still could be there. It's still something we'd recommend.

And to the extent, you know, we're not going to get into the weeds but if there's

evidence that proves that this is improving patient care we would present that as well. We're not getting to that level here I think.

DR. GERDES: One of our charges today is patient-centered and improving access. So, looking at it from that perspective I know in Texas we've been involved with a lot of time, money and angst over scope of practice kind of legal battles.

Now, this is happening in many states. And when I step back I think look at all that time and money and workforce we're spending battling over these different state laws and restrictions.

And for the most part we're kind of add-ons as we went. We haven't stepped back and done something smart for today really is what we're dealing with. And if we're trying to get at patient access and bringing workforce in a patient-centric fashion to patients we're kind of missing the boat with all of that.

And I think if we could have some workforce metrics that would go out and attempt to measure that, okay, what is the variability of laws across our states. How much time are we spending in legal battles? What were the outcomes? What's the variance in training programs and hours and licensure and certification requirements? Because that's what the battles tend to be over is just the differences place to place.

So, it may be useful to have workforce measures to collect that information to aid in streamlining these battles with the net results of having more individuals working to the top of their license and increasing access. I'm just kind of thinking of it that way.

Because I don't know as though any of those -- I think it's just your legal team goes out and tries to collect that whenever there's a case. I don't know if there's a

central warehouse of those metrics.

MS. FRANKLIN: How would we get the data? It's just survey or is it from the states?

DR. GERDES: I mean, you're going to have -- if you look at -- and I'm really talking about scheduled practice for nurse practitioners and physicians because that's what I've been involved with.

But there are scope battles in many other domains too. You know, optometry, optometrists, chiropractic. I mean, you name it, there's a bunch of different things like this going on.

So you probably ask their representative membership bodies I would think which there's going to be a little data bias there of course.

MS. PRINS: Yes, I almost wonder, Melissa, this sort of reminds me of what Drew was saying about when there isn't an in-network

provider available that they go ahead and approve an out-of-network because out of just fairness and equity. And I wonder if that isn't some type of metric.

Because you're right, if you -- I know as physical therapists we have battles with chiropractors all the time. There's always going to be this scope of practice and I don't know that that's a battle that we want to necessarily get into through this group. But how does the data help us to understand access issues that can then inform the scope of practice discussions in a meaningful way.

So, are -- especially with now all of these new enrollees under the Affordable Care Act is there a way to -- and people throw around there aren't going to be enough primary care physicians to see them. And so what does that mean. And how do you start to get a grasp on that. It really is more of an access question. But I think it speaks to the needs

side of the equation.

MS. FRANKLIN: So your concept, do you have a concept?

MS. PRINS: No.

(Laughter)

MS. PRINS: I was just sort of thinking about the flip side of it being more of a patient-centered measure as opposed to asking maybe the professional societies who are -- will be biased. Is there a way of assessing whether patients are getting access to primary care and does that then inform the scope of practice discussions. Maybe it's not just primary care.

MS. FRANKLIN: Like a survey, patient survey?

MS. MARK: What about -- I'll tie this into something -- addressing which is this issue of how do you address the network of your health plan when you're choosing it.

We've done a little work looking at

provider network regulations and it's all about distance to providers. It doesn't tell you anything about wait time.

So, just getting like how long did you have to wait to see a doctor, to see a specialist, to see a primary care doctor would be I think informative for consumers.

MR. BERLINER: But there's a question with that. And this actually comes up in Canada a lot where they have real waiting lists because -- which is is the issue can I get access to a doctor, or can I get access to you. And if you're the best heart surgeon around and I want to go to you to get my care, but you're busy for six months, you're booked up, doesn't mean that someone else couldn't see me tomorrow.

So what does that count as? I mean is there a six-month wait, or is there, you know? It's a very tough issue to actually measure because it has to be clear exactly what

it is you're measuring.

And those things about primary care capacity, I mean is it this particular facility or this particular doctor I want to use? Or is there someplace else that would be available if I really -- and of course then, how would I know about it. Is it convenient. I mean, all those other things come up. But it's just a very tough thing to actually really feel comfortable about.

MS. MARK: Yes, I think that's something that the measurers would have to wrestle with.

But I would argue that there's probably something to what consumers want, probably a reflection of quality in the case of Canada, that they can't get the special facility that they want. And it might be the same here. So I wouldn't discount it even if it's I couldn't get the doctor I wanted.

MR. BERLINER: So you're just

saying it's complicated.

MS. MARK: Yes, it's complicated. So that --

MR. BERLINER: People interpret it differently.

MS. MARK: Right, exactly.

DR. GERDES: And we have -- we run a medical home pilot with our employees because we're self-insured at Methodist. And so we made up some survey questions for pilot participants so we could find them out there.

And one of the ones we asked was what percent of the time over the last year did you receive an appointment with your primary care doctor in the time frame that you wanted, and what percent of the time over the last year did you receive an appointment with the provider that you wanted. You know, so those were just questions we asked to gauge expectation meeting.

And again, you're relying on the

patient's memory to go back a year and put a percent on that. But we kind of use that as a surrogate for getting at that.

MS. FRANKLIN: So, did I hear another like subset of the person? Okay. So time to received appointments.

MR. PILKINGTON: It's interesting though that if you really wanted, from a patient perspective if you really wanted the right data I don't only know when I can see that doctor, I want to know how good that doctor is.

For example, Mass General has come up with if you want an appointment with this doc, these are his numbers. If you want an appointment with this doc, these are his numbers, this is how long you wait.

So you can make your calculation. I can wait six months to see that cardiologist and this is his success rate, or I can see this cardiologist in two weeks and this is his success rate with the procedure I need.

And that's really what I want as a patient. I want to know which one of these doctors are going to do the best job on me. The accessibility is not as important to me as the acceptability.

DR. GERDES: I've seen some case studies too, and I don't know how they do this with the plans. I think it was in Colorado where they're doing -- using that consumer preference on time slot scheduling for radiology, for imaging. So, a CT facility will price a grid. If they look at where the highest demand is for CT of the brain, everybody wants to come Friday afternoon, so that's the highest price. And the lowest price is Monday morning. So then the consumer can pick based on price if they want to pay for that time period or not.

That would be interesting if we did that with providers based on outcomes rates. I'm sure that would be a much bigger discussion to have. But anyway, that's starting to kind

of happen with consumer preference.

MS. FRANKLIN: So, I have a potential concept of information provided to the patients regarding doctor quality, availability and price. Any other things? Any other concepts around access? Because we should move on probably because we have some really good nuggets to clinical, community and cross-disciplinary relationships.

DR. GERDES: Is that okay with everyone to move down to clinical, community and cross-disciplinary? Or did anyone have anything else on infrastructure?

MS. FRANKLIN: And you can see on your spreadsheet we had a handful of measure descriptions around community resources, that community assessment instrument. The degree to which Maternal and Child Health Bureau-supported programs facilitate provider screenings for health factors.

Clinician receipt of treatment plan

from service coordinator referral rate for intensive counseling from a community program. And effectiveness of communication between practice and community resource. Those are just ideas.

DR. GERDES: On our grid that we're filling out, practitioner and staff knowledge of community resources, there is an existing potential metric again in the NCQA patient-centered medical home application where practices must list their five top resources, one being mental health or substance abuse that are based in the community and not part of their own enterprise that they refer patients to. And then keep a log for a month every time they make that referral.

So I would think NCQA would be able to report out the percent of their applicants in the primary care world that have a top five list that they utilize and refer their patients to.

MS. FRANKLIN: This is under standards?

DR. GERDES: Yes, under standards. I believe it's standard 4A and B which is scary that I know that. I've been knee deep in the application.

MS. FRANKLIN: Did we have any additional thoughts around team-based care potential concepts?

MR. PILKINGTON: Is there any data on the percent of disciplines using team- based care?

MS. FRANKLIN: I doubt it. Anyone know?

MR. PILKINGTON: Anything in hospital systems on that kind of data?

MS. FRANKLIN: Not that I know of. But is that a concept and the data source just needs to be developed?

MR. PILKINGTON: Again, from a patient perspective it makes sense to me to know

that that X hospital system is using team-based care versus another hospital system for cancer, this particular cancer, this particular disease symptom.

MS. FRANKLIN: Okay.

DR. GERDES: I think you'd need a good kind of bounded definition of what team-based care is. Because I think if you asked any hospital in the country today they would all say yes, we use team. You know, because they have providers from different disciplines. So I think we'd need a pretty tight definition of that.

MS. FRANKLIN: So the issues would be definitional. Is there anything in the ACA about team-based? Or is it just around new models of care.

MR. PILKINGTON: I was also thinking it doesn't necessarily mean if you have a team-based care system that all the physicians are using it.

One of the things we learned in doing our Beacon project is we could set out all these things that we wanted to measure. And that we could then start asking all the physicians to do them.

For example, in diabetes, a foot exam. And we would find out that 80 percent of them, they just wouldn't do it. Weren't going to do it.

So the point we would like to I think emphasize in something like this is that if you have a team concept how many percentage of your physicians are using it. Is it an opt- out/opt-in thing?

DR. MUTHA: And Angela, maybe this gets at what you were talking about earlier about what's aspirational, like things that are for future.

One of them, and we said this earlier, is we actually don't know what the evidence base is for this, right? So it's been

more conceptual that we believe it makes sense. It's for structural reasons and access reasons. There's good reasons for it.

But there isn't the kind of evidence that we might ask for on composition of teams, ratios, all of those things.

MS. MARK: It's not related to patient-centered medical home, is it? This whole idea of team-based. I just keep thinking it sounds like patient-centered medical home.

DR. MUTHA: I don't know that it's formally in there. I think it makes sense as a way of making things more patient-centered around access and navigation through the system and things like that. But I don't know that it's actually in the language for PCMH.

MR. BERLINER: In the language for?

DR. MUTHA: For patient-centered medical home.

MS. FRANKLIN: The team-based element. You were asking if the team-based

elements within the PCMH, patient-centered medical home.

DR. MUTHA: Yes. Well, then I guess it gets back to what do we mean by team-based. Yes, I don't know.

MS. MARK: Yes, I mean "team" to me just sounds like you have more than one person working together and coordinating care which is basically care coordination. So maybe we should just move away from the term "team" and go back to what we've been calling it which is coordinating care.

MR. BERLINER: Coordinated care and a team-based approach. You can coordinate without a team.

Well, I could be in the hospital and discharge someone to a nursing home in a coordinated way. That doesn't mean we're a team. I assumed the team was more like the PCMH where you have a group of people, physicians, you know, dietitians, health educators,

community health workers, whatever that team consists of working together on a particular group of patients. So, I mean I think there is a distinction between those things.

That said, I mean there could be many different kinds of teams. And it could be a team of doctors. It could be like a team of pediatricians. What you might call a group in an older day.

MS. PRINS: It could be a team of teams where there are a lot of teams. I think I was at an IOM thing recently where we were talking about this and talking about team- based care and more specifically around patients and their roles as team members.

And we had a mother of a child with significant healthcare needs and she was talking about how she needs one team, but she's, you know, with all the things that she does she's got this team over here and this team over here. And what she really needs is just that

one team that's all coordinated.

And I think we're talking a lot about this but it's still I think probably worth throwing out there but recognizing that there's still a lot that we don't know. And how you get your hands around who the team is because the team can change.

MS. MARK: But the key thing is that all of her practitioners were patient-centered and communicating and coordinating, right? So it didn't matter that they were all called -- that's the essence of it, right? It's not --

MS. PRINS: Right. An ideal -- of course they weren't which was her point. But in an ideal world I think for her -- her desire was that it would all seem pretty seamless.

MS. MARK: So maybe rather than thinking about this as an input it's more the output. Does the patient perceive that the care is coordinated and the communication is

seamless and that all her practitioners know what's going on and are working together as a team.

Rather than, you know, they're all located together, they all have some kind of affiliation, they all wear the same uniform. It's more the perception of the patient that they're --

MS. PRINS: Yes, I think one of the challenges to me about this is that if the team, you know, team members come in and out. And so how do you build a measure around something that's evolving. And so, is it more of a, like you're saying, Tammy, is it the patient or the family's perspective on whether they are receiving care that's coordinated.

On the flip side it could be the team members' perception of whether they have access to all of the types of care providers that they would like to have involved in the patient's car which gets at of course capacity issues.

But then I think there are a whole lot of underlying issues about do we really -- does everyone really know, going back to the conversation before about do people know the difference between PT and OT is sort of those underlying things of do people really even know who they would want on the team.

Because you'd run the risk of saying well, I want everyone, and then of course you have a team the size of -- I can't think of a good analogy.

MS. FRANKLIN: So I had a thought bubble while you were talking. Patient perception of team-based care? Is that a measurement area concept?

MS. PRINS: It could be. I mean, there's a lot of work going on in this area now. And there is evidence out there that says patients prefer this type of care, and that their health, or they feel that their health is improved by this type of care. I just think

there's probably still more work to do.

MS. FRANKLIN: Still the same issues.

MS. PRINS: Yes, I think still some of the -- I think probably validity issues.

DR. GERDES: On that same survey I mentioned for our medical home pilot we have question number 4. For your first visit to your medical home primary care physician how satisfied are you with the way the medical home team functioned. So that's kind of how we got at it because we realized the team from the audience member which is the patient would have different meanings. So again, how close were we to meeting their expectations.

MR. BERLINER: How did people respond?

DR. GERDES: We have out of 218 respondents 67.4 percent very satisfied, 29.8 percent satisfied, a half a percent uncertain and 2.3 percent somewhat satisfied and zero not

satisfied. So we did a five-point scale for them.

This is a question we made up for --

MR. BERLINER: Did you have qualitative comments?

DR. GERDES: Yes, we had some free text. And I don't know if I have that on here. I don't have it on -- this is our most recent survey. I don't have it on this copy.

But I just know from previous ones they would say things like my nurse's name is Joyce. Joyce is an invaluable member of the team and they might write a little vignette about how she helped them with a prior auth or something at one point. So they would still usually kind of call out individuals.

The other thing they did comment on is the communication. So, if they were impressed by everybody kind of knowing them and not treating them as a number, that was another team thing that they would pull out.

MS. FRANKLIN: That's from the patients?

DR. GERDES: That's from the patient perspective, yes.

But we, again, we had to kind of make up some of these questions ourselves because we couldn't find them when we went and did a search for what we wanted to know. So this is good work we're doing here today.

MS. FRANKLIN: Anything else on community relationships? Coordination with financial, education, social services. I guess that comes under our first concept here. We talked about practice resources, contacts within the community and then also the number of referrals.

MS. MARK: Have we talked about the coordination with non-medical services?

MS. FRANKLIN: Non-medical, yes. Social aspects, social determinants, trying to get at that a little bit.

DR. MUTHA: This is a little simplistic but I think in some of the things that we're ascribing here, in a large system you would say that having the presence of a social worker or somebody who does those types of things would cover it. It's not going to apply to other settings --

MS. FRANKLIN: But in a large system.

DR. MUTHA: Within large systems or large groups you might have access to those resources.

MS. PRINS: And I guess one of my questions would be to dig a little deeper too is are there specific patient populations or instances in which you would definitely want to see that a social worker had been accessed. Whether it's the patients with multiple chronic conditions, whether it's someone with more than two admissions in a year. You know, I think there are a number of ways that a denominator

could be constructed.

So, part of it, I mean that's a structural measure. Whether there's access to the social worker or whether they're on staff. But in terms of a process, when are they engaged.

And for the purposes -- if we have this magical comprehensive assessment that we talked about, if a number of things are identified, whether they have social issues, or substance, or whatever, that that triggers this next piece.

MS. MARK: Thinking of a couple of populations, one would be children. You'd want to be communicating with the school system and potentially a bunch of other social services. And then homeless.

I'm sure the providers are going to love all of these measures. But being responsible for this.

MS. FRANKLIN: So, I have patient

populations that we might think about for this one was multiple chronic care. I have people with social issues, children, homeless.

MS. PRINS: Just some examples of how you might get to a more specific population.

DR. GERDES: I mean, I don't know if it's appropriate for this body to make suggestions to CMS and what they're surveying, but with the MSSP patients they're sending them the CHPS survey which I think has about 90-some questions on it I want to say. The Medicare Shared Savings, the ACO pilots out of the Affordable Care Act. So that's a captive group of, gosh, I don't know how many patients they're up to now, hundreds of thousands probably because there's 300 or so MSSPs.

I mean, that's a captive audience. And you're talking trying to get to a particular audience to encourage them to put some of these workforce assessment questions in there if we're being charged with assessing workforce.

Because I'd sure like to know from the patient's perspective if you have XYZ need were you able to or do you know how to access somebody to meet those needs. It doesn't matter to me if it's the doctor, the nurse, the social worker. I mean from the patient perspective it probably doesn't matter to them either, they just want their needs met.

MS. FRANKLIN: You said something?

DR. MUTHA: I just said we're fading.

MS. FRANKLIN: Oh okay.

(Laughter)

MS. FRANKLIN: All right. Is there anything that helps us get to the issue of supports at home? Would that be underneath the access to social worker?

MR. BERLINER: It gets us to the issue of? I didn't hear your question.

MS. FRANKLIN: Oh, I had a question about supports at home, something along those

lines. Is there any concepts or anything that we might think of in that regard? Throwing out an idea.

MS. PRINS: I think that kind of starts to get at it. Because what we're really talking about is regardless of whether it's school or home that the social needs are -- so we're thinking beyond just the medical needs. And who addresses those social needs, I think like we were saying, maybe in one place it's not necessarily a social worker, but someone else has that role. But regardless of who has that role that those needs are at least attempted to be, my grammar's not good. That we're at least attempting as a system to address those needs in one way or another.

MS. FRANKLIN: Any other thoughts and ideas as we wrap up? I think we're coming to the end of our time. About 10 minutes left.

So if there's no other thoughts I just wanted to run through what we've done so

far and see if we want to prioritize or star any of these concepts as our top concepts. Starting with our infrastructure piece.

The first health IT piece we had was the number of providers I believe reporting Meaningful Use attestation. They've done it. Any thoughts about that first one? Does it get a gold star?

DR. MUTHA: What's hard about this is what we've all said earlier which is what you can measure versus what's really meaningful. And if we're trying to get to the pieces that are around what is patient-centered and do patients care about this, I don't know.

MS. FRANKLIN: Okay. So, meaningful use of HIE, percentage of community- based providers. Using HIE for a meaningful purpose. And I think this is part, for example, clinical data exchange, public health surveillance data which I think was a new piece including lab reports. Patient records

that move with them which is part of Meaningful Use measures.

Do we feel like this is a priority in terms of what's important? I know we worry about feasibility later, but importance. Maybe a gold star?

DR. MUTHA: Would it -- I think my brain's in fog zone. Would it help if we maybe put those up and we just vote a little bit and just try to -- what do you think? Try to figure out.

MS. FRANKLIN: Sure, I mean raise of hands?

DR. MUTHA: Yes, however you want to do it. Dots.

MS. FRANKLIN: All right. So number 1, I don't think we wanted to include that one as a high priority.

Number 2, any show of hands for high priority for this one? Okay.

Patient ability to use after-visit

data electronically. Which is a Meaningful Use measure. And the data source could be Medicare. Is that a hand raised?

DR. MUTHA: Yes, that's mine.

MS. MARK: I didn't hear.

MS. FRANKLIN: So, we were trying to vote on whether patient ability to use after-visit data electronically like through a portal.

MS. MARK: Okay.

MS. FRANKLIN: Percentage of members reporting on elements of Meaningful Use.

DR. GERDES: I think that was just that you might be able to fold data or a data collecting agency, might be NCQA.

MS. FRANKLIN: Okay.

MS. PRINS: I have a clarifying question. For this first one since -- pardon me, I came in a couple of minutes late. But are you talking about HIT and people have access to

HIT? Or exchanges for these?

MS. FRANKLIN: We're talking really from this perspective systems, organizations having and using health IT. Number 3 was allowing patients the ability to use their patient portal.

MS. PRINS: Okay, so as an infrastructure I'm trying to think in terms of goals. Ideally we would like this entire workforce to be connected to something electronically. And so a measure of that could be whether community-based providers are actually using it for a meaningful purpose. So not necessarily as part of Meaningful Use but that they're --

MS. FRANKLIN: Sorry, repeat that?

MS. PRINS: I guess my question is whether our goal would be -- because we want a measure that's going to drive us towards a goal.

MS. FRANKLIN: Right.

MS. PRINS: Right. And what we're

moving towards is connectivity. So, we're moving towards a more connected workforce. And the infrastructure would be that they have access to HIT and that they're using it in a meaningful way. So it's kind of building off of Meaningful Use but thinking about the workforce more broadly as opposed to right now where it's just hospitals and clinicians.

MS. FRANKLIN: Okay, broadly.

DR. GERDES: I think we started with percent of physicians that are attesting to Meaningful Use successfully because that is a measure that is the most heavily financially resourced today. So we kind of looked at that being the best chance of collecting the reasonable number of physicians who are doing this.

And we heard from you that there's a lot of problems with data inaccuracy in that. But also realizing that the way Meaningful Use is structured today doesn't really translate to

improvement of patient by patient care necessarily. It's more of a process, data collecting for the population set of metrics.

So, we recognize that new metrics would need to have a more meaningful definition of using an HIE in that interconnectivity.

MS. FRANKLIN: So we have meaningful use of Meaningful Use.

DR. GERDES: Yes, exactly. A different audience. Meaningful to a different audience.

MS. FRANKLIN: We have to define which we try to tease out what we feel it really means a little bit. So I have this one captured.

Votes for electronic approval of prior authorization for a variety of services. For example, there are prescriptions, other things.

DR. GERDES: I think that one might be like an actual doable one. Is that what

you're -- yes. Low-hanging fruit? Yes.

MS. PRINS: And you were really talking about the implications for like efficiency for the staff and not wasting a lot of time, right?

DR. GERDES: And plans, and pharmacies, and you know, crisis management with an aggravated patient at the end of this whole process which I'm sure the plans have to do, the pharmacy and we have to do in offices. So, yes.

MS. FRANKLIN: And important from a patient perspective.

MS. PRINS: So can I ask are there examples right now of electronic approval of prior authorization? It's just not widespread.

MS. MARK: Yes. I mean I think Caremark is rolling it out. Some of it has to do with establishing regulations around it from CMS. And uniform electronic submission stuff.

But it's getting there but it's not -- it's still I would say 90 percent of prior approvals are still faxes, amazingly enough, or phone calls.

Which is -- because they save money. Because a lot of people end up not getting the medication and so it's actually a huge saver for the health plan, the employer, the payer. So, that's the incentive not to do it.

MS. PRINS: Maybe we should have a measure of the number of fax machines still in use.

(Laughter)

MS. PRINS: We would want a lower number would be better.

MS. FRANKLIN: Zero. Integrated HIEs. And we talked about having -- the idea of having HIT personnel resident that could ensure the integratedness of an HIE. And simply having an integrated HIE.

We did note there were issues with

the anecdotal, that this is an evidence base that's not as strong. And of course funding is a big factor. But it would have a high impact if it were in use. There's some definite feasibility problems.

MS. PRINS: Is this kind of a training and knowledge?

MS. FRANKLIN: No, it's more of the degree to which records talk to each other, records and systems are able to capture.

MR. PILKINGTON: Originally the concept was we would have one HIE per site, for example. But that didn't happen so each hospital system has been continuing to develop an HIE separately. And none of these HIEs will talk to each other very well.

MS. FRANKLIN: So, any hand raises for this one? Keeping in mind that, you know, we'll address feasibility issues later.

MS. MARK: What level would that be measured at?

MS. FRANKLIN: We had it at -- would it be system level? Would it be organizational?

MR. PILKINGTON: It would be at a system level.

MS. FRANKLIN: System level. All right. Telehealth for behavioral health management. And we don't have to limit it to behavioral health. It could be other conditions management.

But you had noted that geography can play a key part here and that telehealth for underserved areas and populations and specific patients might also be beneficial, appropriate.

And then we had a sub idea of this was providers and patients using technology such as iPads to make decisions and communicate.

Any hand raises for either of these concepts? Both of the concepts. That's a

good one. Hey, telehealth.

And for the access issue we had -- I thought this might be a benchmarking measure around assessing the variability of state laws resources the scope of practice for nurses, nurse practitioners, physicians, others. I should put dentists in there. And the data source would be the representative member bodies. Just to get a sense of where the field is or what the variability is.

MS. PRINS: That seems more like a project than a measure.

MS. FRANKLIN: More of a research project.

MS. PRINS: Because I think the answer is yes.

MS. FRANKLIN: We need research to do the item.

MS. PRINS: Yes.

MS. FRANKLIN: Okay. Next one was assessing patient access to primary care or a

specialist. And the data source would be a survey by the patients or plans. So, do I see hand raises for that? Okay.

And, oh, then there was some -- you saw the subsets. Percentage of time patients received appointments when wanted, information provided to patients regarding doctor quality, availability and price.

And then to community relationships. Practice resources and contacts within the community and number of referrals. That one's a hard one to read, sorry. That's a yes, okay.

Facility use of team-based care approaches. We said there's some definitional issues there and we'll have to develop a data source to make it really a measure.

And then a subset was if you have a team-based care model how many physicians are involved in it. And patient perception of teaminess. And patient satisfaction with the

team. Patient satisfaction with the team.

So, this is really a stretch one in terms of where we are with evidence and definitions. But do we still like this? Okay.

Last one, just in time. Access to social worker. And I put an asterisk for any other professionals that help with non-medical issues. Yes? Okay. Anyway, good work. Very good work, actually. This is more than we wanted.

(Whereupon, the foregoing matter went off the record at 3:50 p.m. and went back on the record at 4:03 p.m.)

MS. LEFEBVRE: So we're going to go through in order of the groups. And then it's my understanding we just want to hear what your group discussed. Would you like feedback on them or questions I guess maybe after each group?

MS. FRANKLIN: We could have a

quick Q&A after each group and we'll do more in the morning.

MS. LEFEBVRE: Okay. Okay, that sounds good. Okay, group 1. Who's the person reporting out for group 1?

MR. PILKINGTON: We started out with infrastructure and we looked first at the idea of Meaningful Use. That was our first concentration. And we looked at the number reporting Meaningful Use attestation. That wasn't one of our top ones, though. We prioritized them after we finished so that didn't get an orange or a gold star.

The second one we looked at was meaningful use of health information exchanges. In other words, the percent of community-based providers using HIEs for Meaningful Use purposes. Clinical data exchange would be one example. Public health surveillance data, lab reports. And patient records moving with them, mobile patient

records. So that was a high priority for us.

Also, the patient's ability to use after-visit data electronically and data sources -- one of the data sources would be Medicare records. Another data source would be NCQA.

And the percent of members reporting on elements of Meaningful Use. And that really goes back into this one.

So that was our -- we spent a lot of time talking about this for about 35 or 40 minutes. It took up a good deal of our time.

The next one was the electronic application of prior authorizations for a variety of services. We really wanted to move toward getting prior authorizations done electronically as opposed to faxes and such. That is, about 60 percent of them are done now using the Caremark example.

Feasibility is a big issue. Data sources would be the health plans.

Another one that got an orange star was the integrated HIEs. And that is the idea that every health system is now building its own separate HIE and we really wanted not to have that happen but it's happened anyway. So, how can we integrate these HIEs.

Part of the problem is the IT personnel in these hospital systems and their capability and ability to integrate these networks as a big complicating factor. And right now we only have a lot of anecdotal data on this so we don't have a lot of good data.

Another area was orange star of telehealth. We had it for behavioral health but it also works for all areas of health.

And this was primarily a result of geography. It could be urban geography as well as rural geography that fits into it.

Telehealth generally for underserved areas and underserved populations. And one of the -- to have providers and patients

using technology, iPads, et cetera to make decisions and communicate. So, using all the available technology that's out there.

Still sticking with the idea of infrastructure and technology we were looking at the variability of the laws regarding scope of practice. We didn't prioritize that one but that was one of the ones we talked about.

Another one that we did prioritize was access to patient records to primary care providers, specialists. And we're looking at data sources and surveys.

Ideas, percent of time that they received the appointments when wanted. We went back and forth about is it more important to get the appointment you want or the provider you want. So we talked a lot about that.

And information provided to patients regarding the doctor's quality and availability and price. Outcome rates. One of our participants even brought up the idea you

pay more if you want it done on a Friday afternoon as opposed to a Monday morning. So that was kind of an interesting approach.

Then we moved to our other area, the community relationship area. And the first one we prioritized there was practice resources and contacts within the community, looking at NCQA as the data source, the number of referrals.

In this idea we were trying to get providers to recognize the resources that a community has and how many times they're using. So you look at the number of patients referred, how often did they use the community resources to do that, and were they able to demonstrate that community resources were being utilized.

The second area that got an orange star was a facility that used team-based care approaches. There are some definitional issues, data source development issues.

We also looked at whether or not we

have models that we could look at with the number of physicians that are using team-based approaches. Is the evidence there that team- based approaches do more in terms of efficiency or less.

We talked about the patient perception of teaminess, or teamliness, or teamness, or whatever that word would be. And the validity and satisfaction with the team all weighed into that as well in terms of the specific elements of care that were available.

Finally, we talked about access not only to social work but allied healthcare services in the large systems. Patient populations for children, for homeless, those kinds of issues. Looked at data sources being ACO CAHPS survey including workforce metrics to get this kind of data and other professional ways of getting it.

So that's, as I said we spent a lot of time on infrastructure and not so much on

community resources but that was it. Yes.

DR. KHAN: I have a question related to the discussion around team-based care. And I think you had something on prior authorization moving from a fax to electronic processing.

I'm always struck with the fact that there seems to be so many players that are managing or at least overlooking the case, particularly the more costly the site. So, more case managers involved in the hospital setting, for example, or long-term acute care hospitals.

But they're not all talking to each other. You look at the group of the hospital case managers, you get the provider case managers, you might even get case managers coming from the clinical office, clinician's office. And whether we're talking about medical necessity or appropriateness, meeting criteria for admission, or continuity of care

related to discharge plannings and transitions of care, sites of service.

It feels to me like there's an opportunity to have sort of maybe some consolidation around the number of people that are looking at those various aspects, but also a platform in which everybody is sort of going to the same source. Did your group talk about that at all?

MR. PILKINGTON: We actually did. We talked about the proliferation of teams, that sometimes the patients do not know which team is their team. And how many teams they have to deal with.

And one of our participants talked about a survey they had done in their hospital system which interestingly enough showed that most patients were satisfied with the team concept. In fact, none of them were dissatisfied.

It's like 60 percent of them were

satisfied? Yes, very satisfied. So even though there seems to be a lot of confusion among the patients they like what they're getting. Maybe we think they're confused and they're really not.

MS. LEFEBVRE: I think there's a piece to that too as to what's included in the record. Because I think right now care management is typically not included in the patient's record.

And so right now there is no means for one care manager to see what another care manager did because it's held -- now in North Carolina I think we have a pretty substantial care management information system through our Medicaid program but it still is held outside of the patient record.

And so I think until we start getting that health information exchange to include notes from support mechanisms among these teams you're going to have that overlap

of services.

MR. PILKINGTON: Other questions? Thank you.

MS. LEFEBVRE: That was great. Thank you so much for doing that. Team 2.

DR. WARSHAW: We had the topic of training and development experience of care and we had our grid. And we started out talking about core competencies and how that fit into what we were trying to work on. And we came up with a variety of areas where we thought maybe the workforce was in need of more training either initially or further on in their careers around team care, care coordination, population health, chronic disease management, patient engagement. And that's -- we started to limit ourselves a little bit there. But we came up with those ideas.

And then we thought of some existing products that have been developed in the last few years that are sort of core curriculum, that

are interprofessional curriculum that can be applied to all health profession schools.

And so one example was the IPEC work on interprofessional training that was developed with the AAMC as kind of the coordinating body. But there were a lot of other health disciplines involved in the developing of those curriculum.

And we thought of the core competencies for graduates of the first level of health profession training in geriatrics, that the AGS helped develop through a partnership or a health in aging group. And there was maybe 10 health profession disciplines involved in that.

The advantages of these types of devices are they're pretty well done. And there was a consensus development process. And they apply to multiple disciplines. So, you don't have to look at each discipline and look for your own thing.

The disadvantage is because they were consensus documents they're fairly broad. But that also could be an advantage in terms of measuring because it gives people flexibility in how they implement them.

So we thought we could, for example, take things like this, like these documents, and you could actually through some process look at health profession schools through a survey process or through some existing surveys that they already do on their college to see if they are aware and have implemented any of these competencies, get some baseline data and see if over time they are implementing more of these competencies.

And if you looked at a few of these, whether it be interprofessional training or care of the older adult we'd eventually capture a lot of the areas we were concerned about. So, looking for existing documents that we could then survey and see if people are using. So

that was a good discussion.

And then we had more trouble thinking about how one would assess and measure activity in professionals that were already in practice. And we also talked about team care a bit.

One idea we had was looking at the actual availability of interprofessional care plans and their development, particularly for vulnerable people in health systems or in practices.

And I was thinking about in Ohio we have one of the demonstrations for integrated care that CMS is putting together where we're going to take 120,000 Ohio dual eligible patients and put them into managed care this year. This is happening in six or seven states right now.

Well, one of the early activities in that demonstration will be every single one of these clients will have a care plan put in

place, and the care plan will be assigned to a care manager.

And what's interesting to me about it, and one of the things we could measure, not just here in this demonstration but across health systems would be do the health team members, are they aware of the care plans. We were talking in the previous conversation about the lack of integration of the HIT systems.

In this particular demonstration I think it will be clear that every primary care provider will know the care plan. It's going to be delivered to them in some way for these vulnerable dual eligible patients. So it's a way that we might be able to get at what's happening in practice in terms of interprofessional activity, looking at care plan development. You could do that within a health system, an ACO, a demonstration project.

There's a lot of different settings where you could look at this, in the PCMH

practices. I mean, wherever you wanted to look care plan could be a proxy for interprofessional activity and practice.

Wouldn't say a lot about how effective it is necessarily, but at least say that somebody had thought about it.

We then got onto the idea of who's going to do the necessary training if we had higher expectations for health profession schools or for community-based practices or health systems.

And we talked about the need to ensure that the health profession schools are recruiting and supporting adequate number of faculty to do some of the training in these new areas, whether it be in chronic disease, or palliative care, or new models of care, or HIT, team care.

These areas that we think are probably underdeveloped in the educational and clinical system, we're not going to have the

training occur unless we have adequate faculty. So we talked about the need to document currently what the faculty availability is in the health profession schools to do this kind of teaching. Once again, that could be done through surveys that are already being done by the parent organizations of these colleges of nursing, or medicine, or podiatry, or pharmacy, or social work, or nursing.

And then we could sort of see where the gaps are and then build expectations for increasing the capabilities of the schools to do this kind of teaching. So that was an idea for how we might look at the faculty to try to help us in that area.

We talked a little bit about the -- just going back a step, we talked a little bit about training in new delivery systems, and talked about how we could also like we talked about some of those other content areas we think it's important that health profession students

somewhere in their training have exposure to new delivery systems, that they have some exposure either to an ACO or a PCMH or some type of integrated care model. Some community-based work.

It would be unfortunate if a student could graduate from a nursing college and never have been on a home visit and met a home health aide. Things like that are pretty essential to getting people predisposed to working in those kind of environments. And once again, that would be something we could ask of the colleges to see whether they're moving in that direction.

We talked a bit about what the role of accrediting bodies are in trying to move this along. And we agreed that that's an area that will probably happen over time. But that's one that's hard to intervene on. The accreditation bodies move at their own pace.

I was pleased to be able to tell the

group that medical schools now are expected to do interprofessional training as part of the accreditation requirements. Students in the last few years have had much more exposure in my medical school to what other health disciplines do. They work with the disciplines in their settings. That's a big change.

Nobody argued with me when I said that the limiting factor in health team work were the physicians. And so that's why I think medical schools, it's important that they took the step. Because if the physicians aren't on board then the team doesn't function too well. And we have a bad rep for team playing, for teamliness.

The last area we talked about a little bit was about recruitment and training and access which overlaps a bit with what the other group talked about.

The one thing that came up in our

group which I thought was important was that in terms of thinking about access to services in rural areas or urban areas, that we really need to -- in addition to doing body counts and head counts, is looking at access to services through technology. And that a lot of states are going to solve their access problems by having the ability to get consultations through telemedicine and other services.

So we really, when we look for measures which we didn't have time to think about that. But when we look for measures we really want to be looking at an individual county. If a person needs a service can they get it and in a timely manner, of some quality.

Even if there is no dermatologist in that county is there somebody somewhere, a dermatologist that is easily accessible to the primary care providers or the nurse practitioner in that county that can get that consult. So it's more than just where the

bodies are, it's now what they access.

Any members of my group want to elaborate? That's most of what I remember.

DR. KHAN: I think you did a great job summarizing the key points. And I think you referenced the business about member experience, patient experience and the use of CAHPS.

DR. WARSHAW: Yes, no, I didn't bring that up so I'm glad you reminded me about that. That was a really good idea.

One of the things that we were trying to think about was how we could measure client satisfaction with the healthcare team and the experience in the health system.

And we were reminded about the surveys that health systems do that are standardized and could be used as a proxy tool. Some of the questions within those surveys could be pulled out and we could get some baseline information and then just follow that

over time. Thanks. Thanks, Amy. Allison, is that what you remember we talked about?

MS. LUDWIG: Yes.

MS. LEFEBVRE: Okay, great. And team 3.

MS. KOVNER: Our focus was on capacity and productivity, recruitment and retention, and workforce diversity and retention.

And we first focused on geographical distribution of workforce. And we approached that in a very sort of simple, easy way which would be some ratio of health worker to population by defined geographic area. And our suggestion is to use Census data.

One of the limiting factors is for occupations such as physical therapy for which there are not a lot of physical therapists the geographic area that was the smallest that you could do would differ from ratios of nurses, for

example, to population.

Then our next area was workforce effectiveness and effectively. And we spent a lot of time on this. We had a lot of difficulty with this.

And we sort of decided to maybe just look at effectiveness, though it wasn't 100 percent clear that that's what we decided to do.

And I think what we came up with is okay. It was trying to understand what team mix is most highly correlated with high scores on some national measures like the 33 ACO measures. And so we were pretty happy with that.

The problem is how do you define or get the question of how the team is configured because there could be many, many permutations of that.

And so one approach we thought of was some kind of ratio of the different team members to each other. And that needs a little

bit more work.

We also thought that from a community or overall population focus that the simple measure of infant mortality might be a good one to look at, and then look at the health workers in that geographic area and see if there's any relationship. I think that's probably been done before.

But we were trying to look, to come up with a measure that was population- focused, not just accountable care organization focused, or health system focused.

And Drew was on my team and so he can add anything as we go along. Do you want to add anything so far?

DR. ZINKEL: That was pretty accurate.

MS. KOVNER: Then in capacity and productivity the number of available providers was the sub-domain. And we thought that was an easy one because we're going to just do it the

way we did capacity and productivity for geographical distribution. So we didn't spend much time on that.

Next under recruitment or retention was the area of workforce forecasting. And so we had some discussion about is the goal to do accurate workforce forecasting, or is the goal to just make sure that geographic areas or organizations do workforce forecasting whether it's accurate or not.

And we decided to look at workforce forecasting that was accurate. And Drew developed this great measure which is the standard deviation from perfect. So you want to talk about that more?

DR. ZINKEL: We talked about using state SOC data. I don't know if you can say anything more about that. But it gives you some kind of prediction of what the goal is to have of a certain number of providers for the state.

And so if you have that standpoint you can look at were they above or below that goal. And if they're below it, they should be recruiting more. If they're above it they should be hiring less. And looking at that kind of from a way to see if they're accurate at their forecasting.

MS. KOVNER: Next we were looking at need-based recruiting and retraining. We added retraining because we think that that might be an efficient way to do things.

Help me with this. We decided that we would use a similar measuring approach to this standard deviation from perfect.

DR. ZINKEL: And we could do that broken down by specific to a specialty type or to a certain type of provider.

MS. KOVNER: Okay. Then our next sub-domain was cultural competency. And we thought that there are already good measures of those and required by different

organizations -- is that right, Ann? Required by different organizations. Luckily we had Ann in our group who knew a lot.

MS. LEFEBVRE: I don't know about that. But getting back to the patient experience is measured in the CAHPS, whether it's HCAHPS or CG-CAHPS and those types of things. So, again, a level of patient experience regarding cultural competency within the surveys that are already developed.

MS. KOVNER: And we decided that that's an organizational-level data source but it's already collected and in fact might be information that some organizations would find useful. And we would measure that by the percentage of providers in the organization who scored excellent. So it would be sort of excellent, non-excellent and excellent is passing and non-excellent isn't. And we could do some kind of comparisons based -- or trending based on those percentages.

Then there was minority representation in the workforce. And we had a discussion that it's really not enough to know somebody's racial background or even Latino or not, that culture is much more complicated than that and we really needed to deal with that at some point.

So we talked about using Census data if we could. But I'm not sure now that I think about it as we're talking why Census would work.

I guess because we said -- I think I remember it now. Yes, go ahead, talk about it, John.

DR. SNYDER: Sure. Just because the Census actually collects occupational data for the SOC and other sort of ways that relate to workforce it would be a way of comparing sort of the diversity of a community and the diversity of the health workforce within that community.

So it's actually a matching of the

diversity of the two which is a little bit more accurate than just, say, checkboxes with race or ethnicity which is sort of historically how we do it.

MS. KOVNER: At least the Census form that I think I filled out the last time we had a Census had much more detailed breakdowns than just Asian or Black/African- American. It had Japanese, Filipino within that. So we think that's important.

And this would be a community-based measure, not an organizational-based measure.

We have a similar concern that we did with the ratios of workforce by population, that this will work pretty well with those occupations that have a lot of people in them like nursing, and not so well, there will be a lot of measurement error for those occupations like physical therapy or optometry.

The next area was workforce retention. We had a long discussion about what

that means. Is that in the field, in the organization, in healthcare.

And we think that this should be organizational-level data. But then there was an issue about does that really reflect the organization, or might it sometimes reflect what's going on in the communities, the rural areas. In fact, rural areas tend to have higher retention levels because there's no other place for people to work.

But what some might describe as undesirable urban areas, it may not be a reflection on the organization as much as it is a reflection on travel to get to that area.

And then we looked at under assessment of community and workforce needs team composition and function. We had these same issues around how do you measure team configuration. And so we took the simple approach which was to go back to what we had said under capacity and productivity and look at the

configurations that were most closely associated with good scores on, for example, the ACO measures.

Anything else, John?

DR. SNYDER: And with function, something like team steps where you're looking at coordination between different provider types.

MS. KOVNER: Thank you. Drew?

DR. ZINKEL: No.

MS. KOVNER: You want to add anything? Ann? We had a good time.

(Laughter)

MS. KOVNER: I mean we did, you know. We had a good time. But we were happy to end at 4 o'clock.

(Laughter)

DR. KHAN: I have a quick question for you because this workforce effectiveness versus efficiency I think is interesting and challenging. Certainly the Healthcare

Effectiveness Data Information center, HEDIS often will give some measure of, you know, certain types of clinical services, whether it be preventive or chronic care and may inform certain systems.

But relative to the efficiency, you know, I feel like that's an area that we still need to mine and figure out how to assess and measure.

And certainly with some of the transparency efforts and cost to transparency there may be some opportunity to look at that.

But one thing I'm struck with is in the occupational medicine field the entire sort of workforce is really geared around lost work days, functional work days, limitations and really define that pretty concretely when people come in for various types of illness or injury.

And I don't think basically generically our curative, chronic -- we don't

look at well, you're going to be out this much, or I have you on -- if you don't make that. And players probably, they let you know that you didn't make the mark.

And I think there may be some opportunity to look at other realms within the healthcare system, in particular occupational medicine where those efficiency and productivity measures might lend themselves to something that you can apply in this area.

But just a comment. I don't know if it came up. But it's a tough part.

MS. KOVNER: I guess I would see that more as effectiveness rather than efficiency. When we were talking about efficiency we were talking about historically that might be measured by the number of patients somebody encounters per day or time per encounter.

And we were worried with that kind of efficiency we may have quick visits with poor

outcomes. Where what you're talking about seems to be how effective the care was. I think it's a great idea.

DR. KHAN: Again, from a patient perspective. You know, there may be another way to look at it.

But I also would caution that I think what's happening in healthcare reform is that we have to get away from everything is defined as a visit and look at how there are a myriad of ways in which we touch the patient. It may be not a visit at all. So, the length of time, or how many visits in a day, or what have you may become less relevant in terms of a measure. It may be something to track.

But I think overall we're seeing that some people need a lot more time. You know, they maybe need to be seen more often. I think many of our folks that are medically fragile or have multiple conditions probably need to be seen maybe monthly. Whereas others

may never -- or not need to be seen at all, maybe for episodic care.

But I think efficiency around the healthcare component is really tough. And I just, I don't know what the answer is but certainly I think there is ways that we can continue to look at that.

MS. KOVNER: Well, that's why we decided not to tackle it. We thought -- we focused more on effectiveness. John?

DR. SNYDER: Exactly. And I think these are really great points.

And some of the concepts we were thinking about is from a visit standpoint what percent of the time is the patient sort of touched by each sort of worker. Some groups, I know GW is working on that with their workforce center.

But then to actually maybe perhaps tie it more to population health measures for the effectiveness component. That's where the

infant mortality idea came from, or percent children vaccinated.

And then to look sort of to the lowest cost or highest credentialed provider mix that actually gives you those sort of outcomes or percent working to the top scope of their education and training. But it is conceptually very difficult but I think speaks to that.

DR. WARSHAW: I think you covered what I wanted to say pretty much. It seems like connecting efficiency with workforce can also be looked at for a given population of people what kind of mix of workers do you need and how do you get that to be an economical mix.

We know there's a lot of variation in how that works within our current health system. I think going forward with new models of care we'll be able to identify high- functioning efficient systems and we'll be able to look at the mix of workers in that

system. And we'll say maybe that's a standard that other systems should be moving towards.

Because right now we have systems where the percent of workers in a particular discipline are much different than in other settings. And it's the way they organized the care. And some are much more expensive than others.

And since cost is a factor that we really have to be concerned about going forward. I don't think we want to lose the efficiency mix issue. So I'm glad you brought that up.

MS. LEFEBVRE: That's interesting. So that's really primarily what we talked about was, you know, not necessarily how many MDs do you need but who's providing good, solid, high-quality care and what is the makeup of their team, and what is that looked at. But never efficiency without quality. Never bad care faster. It's a good motto.

(Laughter)

MS. LEFEBVRE: Okay, well that was really interesting. Thank you, everyone, for reporting that out. I think that's kind of the meat of what we're doing here.

So I think right now we're going to take an opportunity for public comment. And so we will open the lines first.

MS. LUDWIG: Cathy, can you open the lines for public comment, please?

OPERATOR: At this time if you would like to make a comment please press * then the number 1 on your telephone keypad. Okay, at this time there are no public comments.

MS. LUDWIG: And in the room?

MS. DAILEY: Good afternoon, I'm Maureen Dailey, senior policy fellow from the American Nurses Association.

I'd just like to call out more clearly in the concepts patient safety as part of effectiveness. And Chris mentioned about

infant mortality.

But I think that we've learned in the hospital setting the importance of staffing and skill mix. And I qualify it that the ANA measure is all aspects of the direct care workforce in our staffing and skill mix measures.

But as far as patient safety we know that it takes adequate staffing and optimal staffing to achieve patient safety outcomes. And called out by the Partnership for Patients, reducing healthcare-acquired conditions and readmissions. Thank you.

MS. LEFEBVRE: Okay. So I think as we kind of get ready to adjourn and really kind of bring together what we did here today. It was very meaty. It was really a robust discussion all day long and greatly appreciated.

I think we have a lot to kind of compile and digest tonight and come back

tomorrow to further discuss it and really kind of pound out what we did today.

MS. FRANKLIN: Folks around the table, if you have your homework sheets, if you could pass them to me. Because we're going to be doing some compiling tonight and placing your measure concepts onto a grid for discussion tomorrow. So that will be very helpful.

DR. GERDES: Yes, tomorrow we'll have opportunity to prioritize the measures further and actually vote on what our priorities are on a grid. Which you can see on your slides if you care to look ahead at those.

Did you need to make an announcement about dinner as well?

MS. FRANKLIN: Yes, I'd just like to announce again if you're interested in going to dinner it's at 6:30 at Mio. And just let myself or Allison know. So far we have -- or Laura?

(Whereupon, the foregoing matter went off the record at 4:43 p.m.)