NATIONAL QUALITY FORUM

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HEALTH WORKFORCE COMMITTEE

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WEDNESDAY
APRIL 16, 2014

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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
HOWARD BERLINER, ScD, Service Employees International Union (SEIU)
AMY KHAN, MD, MPH, Saint Mary=s Health Plan
CHRISTINE KOVNER, PhD, RN, FAAN, New York University, College of Nursing
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
SUNITA MUTHA, MD, University of California San Francisco
WILLIAM PILKINGTON, PhD, Cabarrus Health Alliance, Kannapolis, NC

JON SCHOMMER, PhD, University of Minnesota*

JULIE SOCHALSKI, PhD, RN, University of Pennsylvania, School of Nursing
GREGG WARSHAW, MD, AGSF, University of Cincinnati College of Medicine
ANDREW ZINKEL, MD, FACEP, HealthPartners

NQF STAFF:

CHRISTINE CASSEL, MD, President and CEO
ANGELA J. FRANKLIN, Senior Director, Performance Measurement
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

* present by teleconference

C-O-N-T-E-N-T-S

C-O-N-T-E-N-T-S (CONTINUED)

Teams that Are Performing Well on National Measure Sets

C-O-N-T-E-N-T-S (CONTINUED)

C-O-N-T-E-N-T-S (CONTINUED)

Health?

C-O-N-T-E-N-T-S (CONTINUED)

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

9:01 a.m.

CO-CHAIR GERDES: Good morning. Welcome back to our NQF Workforce meeting.

We're going to go ahead and get started and, hopefully, some more individuals will trickle in as we go.

Again, we have got food in the back for breakfast. So, feel free to get yourself food today.

May I ask who's on the phone, please?

MEMBER SCHOMMER: This is Jon Schommer from Minnesota.

CO-CHAIR GERDES: Good morning.

MEMBER SCHOMMER: Good morning.

CO-CHAIR GERDES: Anyone else?

(No response.)

Okay. This morning first on our agenda -- I wonder if she's here.

DR. CASSEL: I am.

CO-CHAIR GERDES: Oh, you're on the phone. I'm sorry. Okay.

(Laughter.)

That's great to know.

DR. CASSEL: Good morning.

CO-CHAIR GERDES: Okay. Dr. Christine Cassel, CEO of NQF, is going to provide some opening remarks to our Committee today.

DR. CASSEL: Well, thank you, and I want to thank everyone on the Committee for the contributions that you have made. I understand that you had a really interesting and productive day already. What I wanted to do is sort of put this in context, and I imagine around some of the things that you already have been thinking about.

This is the first, I think -- Allison and Angela can correct me if I'm wrong -- time that NQF has really gathered a group like this to look broadly at the issue

of the healthcare workforce in the context of quality of care and performance measurement. It builds on that 2003 Institute of Medicine report that was a member of the committee that took part in that, which laid out, actually, in a surprisingly directly relevant way any of the skills that we think the workforce needs in this new era.

But just to say what those are, we always are going to be faced with the challenge of keeping up with new science. And that couldn't be more true in the decades ahead, looking at issues of personalized medicine and more specific sources of both genetic information and, also, population-based information, but also the context of how health professionals access data and what kinds of information they have to work from, and what kinds of new skills they need to know to make sense of that kind of information and evaluate it critically.

They also, of course, need to know quality science and how to use data to actually drive improvement, to understand where there are gaps and to drive improvement, and there are probably others as well.

But what this suggests is that much of the work that the National Quality Forum has done over its first 15 years has been focused on evaluating performance of different aspects of the healthcare system that rely on health professionals. So, they are part of producing those results, but also individual performance, in particular, physicians. But here we are now working in a context where these new payment models and new ways of delivering care are consciously much more reliant on teams and on understanding systems and group interactions.

And so, probably the No. 1 methodologic challenge in that work is this question of attribution. Who is responsible

for any particular outcome for any particular patient?

So, these are really big and important issues, and they affect how we think about the workforce going forward, as well as how we think about who we are training for that workforce and what the levers are to be able to develop the right kinds of training and, also, the right kinds of mixes of disciplines for the population that we need to serve.

Along those lines, let me just say a couple of other things and, then, I would be happy to take comments from people. As I looked at the list of your group, it is clear to me that we have a number of people who are new to NQF or relatively new to NQF. And so, we particularly welcome that and welcome your fresh perspective and eyes on both our specific project in front of us, but also our process.

And we hope that those of you who belong to organizations who are not members of

NQF will consider joining and, in particular, to become part of our newly-named National Quality Partners. This is a group that is drawn from the broad range of members of every stakeholder group in healthcare that worked together in a collaborative way to advance quality of care, and a way that uniquely only multistakeholder groups can do.

And so, we have the representational organizations, healthcare delivery organizations, healthcare professional organizations, consumer groups, but also the government, both state and federal, and regulatory private sector organizations, such as NCQA and The Joint Commission and the medical certifying boards, and AAMC.

So, we are really looking at everyone's role in this process of advancing quality and would love for you to learn more about the National Quality Partners from our

NQF staff during the breaks, or I'm happy to get together on a phone call or in Washington. And you can get my email address from one of the NQF staff.

So, let me just end with that comment and see if there are any questions. And just, once again, thank you for your contribution.

CO-CHAIR GERDES: Thank you, Dr. Cassel.

Are there any comments or questions?

(No response.)

Thank you.

Next, I am just going to kind of briefly go through our agenda for today. We will be continuing our work from our breakout groups yesterday. You will see on the wall in front of you the purple sheets with the blue tape. That will help us prioritize our measures as we go through this morning.

First, we are going to kind of round up our priorities and our top recommendations. We will take some time for public comments. Have a break again about 10:45.

We will do our gap prioritization exercise on the wall upfront there at 11:00. Lunch at 12:30.

And then, we will have a discussion this afternoon about future directions for NQF as it relates to workforce and kind of a wishlist of new measures to be developed.

And then, we will be done at 2:00 today.

CO-CHAIR LEFEBVRE: I think we are going to jump right into the exercise this morning.

So, as Melissa was talking about, we have placed up on the wall the same -- there we go. So, if you picture the purple material up on the wall as being the same diagram as you have here on the slides in front of you, in this

quadrant what the NQF staff has done is they have taken all of the measure concepts that we developed in our groups yesterday and put them on the white pieces of paper. And then, they took their first stab at putting them in what they took a shot at, appropriate quadrants.

And so, I think for our activity this morning, we need to discuss about, you know, are these the appropriate quadrants. I think this has been done with the expectation that everything up there might change.

And so, the top right quadrant is high impact, that the measure will have a high impact and it's highly feasible. The top left quadrant is that it will have a high impact, but perhaps may not be feasible. And then, the lower quadrants are that it would have, on the left it is a low impact, perhaps not feasible, and on the right lower is a low impact but highly feasible. So, this quadrant has been set up.

Now are we talking, do we want us to

walk around? How do we want to do this?

So, I am Vanna White this morning.

(Laughter.)

So, should I just read through them, and then, we take a vote? Are they well enough that I can reach them?

(Laughter.)

Any suggestions on where you would like to start or just kind of jump in?

You can help move things? Okay. Spin the letters around. Okay.

So, I guess we'll just jump in and start.

So, this one is under the subdomain of infrastructure. The measurement concept is that integrated personnel -- this is hard because I wasn't in this group -- so, integrated personnel, HIE personnel, management of systems, it says.

MS. FRANKLIN: Right, and I was in this group. This one was about making sure

that there was personnel within a system or a hospital or a facility that is able to ensure that HIE was connected and integrated. So, it is one piece.

The second piece would be whether the HIE was actually integrated, and the first step was having the personnel onboard.

CO-CHAIR LEFEBVRE: Okay. So, I think what we are thinking so far is that this might be a low-impact measure, but highly feasible to get.

MS. FRANKLIN: Right now, we have it in the high impact, low feasibility. It might be difficult to get these people.

MEMBER MacINNES: Not knowing a lot about that, it sounds to me more like a highly feasible, low impact.

CO-CHAIR LEFEBVRE: Melissa?

CO-CHAIR GERDES: I was almost concerned that it would be low feasibility and high impact. Yes, well, it would move down to

low -- oh, I'm sorry. Yes, you do have it in the right place there.

MS. FRANKLIN: This is low/low. This is low on both.

CO-CHAIR GERDES: Yes. That's low impact. Okay. So, you do have it in the right place there.

Because I think, as we discussed yesterday, we thought it was important to have individuals with skill sets to do the data mining and run the IT platforms that we would need for new models of care. And we would have difficulty finding individuals currently trained with that skill set. And we have no measurements today to measure who has them, where they are getting them from, or their effectiveness. So, that kind of goes to low feasibility, because those would all need to be developed.

MS. KOVNER: It seems to me that is it the kind of structure measure that would be

so easy to game, that I'm just not sure i8t would have much of an impact. Because everybody is going to say, "Of course I have somebody like that." And then, are we going to say, "Well, you need one of those people for every 200 beds?" Do they all need to have master's degrees in blah-blah?

CO-CHAIR LEFEBVRE: What if we say, "Well, you said on this that you have this personnel; therefore, where's your data?" There's no excuse to not get me your data if you, in fact, are on the Health Information Exchange and have said you have qualified personnel to help you with that.

MS. KOVNER: I think that's a good idea.

CO-CHAIR LEFEBVRE: And I don't know; I'm just saying some measures lead to other things.

MEMBER KHAN: One thought might be to modify this measure to assess -- I think this

would be feasible -- to assess the community or local HIE and ask how many healthcare systems are currently engaged in using the HIE. And maybe there are a couple of parameters that might be listed. And use that as the source. There's not that many, you know, per state. I think there may be a reasonable amount of data that you could get from that.

CO-CHAIR LEFEBVRE: Number of health systems on the HIE. I think that is a great point. I know in our State it was just legislatively mandated that health systems use the HIE.

MS. PRINS: Don't we have the complementary measure concept that the group discussed yesterday, where we have the system and, then, we also have the -- so, I am wondering if this one can be sort of combined with -- it sounds like a blending.

MS. FRANKLIN: Yes. Yes, we have one right next to it, which is true, meaningful

use of HIE. So, we kind of had them sort of --

MS. PRINS: So, do those two sort of start to go together?

MS. FRANKLIN: -- connected, but we were trying to tease out each one.

MS. PRINS: Are they?

CO-CHAIR LEFEBVRE: Go ahead.

MEMBER PILKINGTON: In some ways I think we are getting to where our group was trying to get to yesterday. We are not necessarily concerned with the number of health systems on the HIE. We are concerned with the number of HIEs using the HIE.

Because what's happening in this country is we are developing independent HIEs instead of state HIEs. It makes no sense to have an HIE if it's all a one-system HIE, unless you have one system that dominates the country.

Because the whole purpose of an HIE is to exchange information. So that, if I'm in the hospital here in D.C. tonight, my system in

North Carolina has the ability to pull my record instantly and see what is going on with me.

CO-CHAIR LEFEBVRE: So, I think this actually would get -- so, number of health systems on the HIE would get at what you're talking about. So, if Carolinas and Novant both have to be on there, then you would be able to get data from both of them if you connected to the HIE.

So, do we agree? If we put these together, which that is what I think is true, meaningful use of an HIE, is what you're getting at, too, is that it is truly exchanging health information and not just improving communications within a system.

So, if we put these two together, do we feel that we have them placed appropriately with high impact, low feasibility? I actually think this is highly feasible.

From my experience, you can contact

my HIE tomorrow and get a list of all the contracted entities that they are working with.

MEMBER KHAN: Just a comment, though. I think that meaningful use, as I understand it, is slightly different in that --

CO-CHAIR LEFEBVRE: I think this means the meaningful use of Health Information Exchange.

MEMBER KHAN: Okay.

CO-CHAIR LEFEBVRE: I think they played on the words there.

MEMBER KHAN: Oh, okay.

CO-CHAIR LEFEBVRE: I don't think it's the technical Meaningful Use.

MEMBER KHAN: Okay, because that still, to me, would be a reasonable measure, and you could get that, I think, through CMS, just who is meeting the Meaningful Use criteria.

CO-CHAIR LEFEBVRE: Because you have to be on a Health Information Exchange to meet Meaningful Use --

MEMBER KHAN: Right.

CO-CHAIR LEFEBVRE: -- in stage two.

MEMBER KHAN: Right. But there are other components of it.

CO-CHAIR LEFEBVRE: But Meaningful Use -- and keep in mind, I'm one of the largest reps in the country -- Meaningful Use is a really low bar for this.

MEMBER KHAN: But my understanding is around some of the requirements for the second stage is that there is a certain proportion of your patient panel that you need to be reaching through an electronic platform, and that that would be yet another way to sort of demonstrate --

CO-CHAIR LEFEBVRE: There is a patient portal piece. It is 5 percent.

MEMBER KHAN: Right. So, that's what I'm saying; it's a slightly different net, if you will, in terms of what data you could get.

They almost would complement each other. You could get data from the HIE system, whether it be a local, state, or multistate system. And then, you could also get the Meaningful Use out of station components by providers in your state, because I think there's other value in that.

CO-CHAIR LEFEBVRE: You can. I mean, we can give you lots of data. I can give you anybody in my State who has met Meaningful Use, either through Medicaid or Medicare. So, I can get you the data. I'm just saying that I'm not sure that it gets at meaningfully using Health Information Exchange. Just because you met stage two of Meaningful Use does not mean you're making meaningful use of exchanging that information. But it gets us somewhere. I mean, I agree I think it's a step, and the data sources are very feasible.

So, do we want to keep this in low feasibility or do we want to move this to -- do

we feel that this is high impact, I guess is the first?

Okay. Do we feel that it is -- understanding that now we're talking about getting the data from the HIEs and we can get it from the Meaningful Use programs as well, do we, then, want to move that to high feasibility?

You're right, this is high impact, low feasibility. Right, this is high impact, low feasibility. I was thinking -- so, are we thinking we should move that to highly feasible?

If we have data sources, to me, that's I think feasible, is data sources. Okay?

Maybe we should go over there next and see if we can't -- do you want to start on one over there or do you want to keep going?

Okay. The next one is under the subdomain of clinical community and

cross-disciplinary relationships. And the measure concept is practice to community resources.

So, I don't know if there is anybody in this group who wants to expand on that, but it's my understanding that it's like a count of does this practice use community resources. Was there, from the group, was there an idea of data source on that? Or does anybody in the larger group have an idea of data source on that?

CO-CHAIR GERDES: Yes. So, that was a measure of individual practices, awareness and use of community-based resources that are outside their enterprise. And the data source was the NCQA PCMH application, because that's one of the elements in the application, to keep a list of top five resources, one being mental health or substance abuse, and a monthly log of referrals made.

So, I think NCQA has that. Will

they publish and release it? I don't know.

CO-CHAIR LEFEBVRE: And practices have to have applied for PCMH recognition.

MS. PRINS: Yes, that seems pretty feasible, then, if there's already a standard out there. It is, I guess, a willingness to --

CO-CHAIR LEFEBVRE: It is privately-owned data.

MS. PRINS: Yes.

CO-CHAIR LEFEBVRE: So, that is an NQF call as to whether that is --

CO-CHAIR GERDES: And it would be a nice subset of practices, too.

CO-CHAIR LEFEBVRE: Right.

CO-CHAIR GERDES: Certainly, not all practices are even applying for that recognition.

CO-CHAIR LEFEBVRE: Right. So, I think it is going to be on a subset of practices. And if we think about it, it is going to be on the subset of practices that probably already

feels that they're fairly highly performing. Otherwise, they wouldn't have applied.

MS. PRINS: Yes, I guess the question for me is whether this could be turned into something that was more broadly applicable outside of -- I mean, is this an idea of something that would be good to have all practices doing to some extent, that would, then, sort of foster those increased connections between private practices and communities?

CO-CHAIR GERDES: If you are going to measure workforce, and particularly look at, you know, community, maybe even volunteer-type workforce, I would think that would be a way to get at measuring that. I don't know how easy it will be to get that.

MEMBER KHAN: I just had a question. If there were any sort of consistent or standard community resources in which we do or can get data on, or have reporting, so we

could look at it from that end, you know, the opposite side --

CO-CHAIR LEFEBVRE: There are some. There are some. So, again, talking about real community resources, so like mental health services and things like that, you know, it depends on the type of thing, but referral to psychiatry is not. But Quit Line is one. I know we use Quit Line in our State. I can go to Quit Line and get a list of providers that they have received a referral from in the last 12 months.

And so, that's just one that I can think of. I don't know if there are others. I mean, it would be nice if we had like national contracts with Weight Watchers, or whatever it is, but we don't currently.

MEMBER MARK: Is this one related? We also talked about connections with social services. Was that a separate one or is that one related to that? Because you also

mentioned Medicaid ACOs, surveys of consumers about their perceptions, connections with social services.

MS. FRANKLIN: We do have up here a separate measure, access to services for social issues. That is the one maybe --

MEMBER MARK: Okay. It's related in that it is the other side of the coin.

CO-CHAIR LEFEBVRE: But I guess maybe the question, we probably can finish this one up and, then, we will move to that one next since it is closely related.

So, the question is, this one might be appropriately placed. Do we feel that this is a high impact, the practices being connected to community resources? Do we agree that that is high impact? Okay. Okay.

And then, what about feasibility? Do we agree that it might be low feasibility, meaning that it doesn't have a straight data source? Does anyone feel we should move it to

high feasibility? Okay. So, we'll leave it where it is. Any objections?

We all need some caffeine, I think.

So, the next one, the same thing, under clinical community and cross-disciplinary relationships, is the one that says access -- the measure concept is access to services for social issues, which we were just talking about.

I don't know the data sources on that. I think that might be a challenge, such an important thing. Data sources?

MEMBER MacINNES: Well, I just had a question. When we are talking about impact and feasibility, we are talking -- so, like, for example, on the HIE, are we saying we think that it is high impact if a practice is using HIE or are we saying like the particular measure is high impact?

CO-CHAIR LEFEBVRE: I guess the way that I'm understanding it, which I'm not sure

matters, I think the way that I look at that, so for the HIE one, it was that there's integrated personnel and HIE personnel. And we are looking at the number of health systems that are connected to the HIE.

So, I think the impact of that is making sure that the health systems are at least connected to the HIEs, so that the systems then become available. Is that kind of what you're asking?

MEMBER MacINNES: Yes. So, going back to the community resource thing, I do think it is powerful for medical practices to be using community resources, but I'm not as sure that it would be high impact to have them keep a list of the top five.

CO-CHAIR LEFEBVRE: You keep a list of the top five practices using community resources? Is that what you're saying?

MEMBER MacINNES: The top five resources, I thought it was --

CO-CHAIR LEFEBVRE: Okay.

MEMBER MacINNES: -- that that was under discussion. So, I think that the concept is potentially high impact. I'm not sure that that measure is.

MS. PRINS: And I think that that is what we need. We need sort of what does the group feel like the concepts that are high impact. And then, obviously, there would be research --

CO-CHAIR LEFEBVRE: But the measure might --

MS. PRINS: -- and the measure developers would need to do testing and all this type of stuff. So, that particular measure, maybe it does get at what you want; maybe it doesn't. But I think, particularly to become a performance measure that was NQF-endorsed, it would go through the measure development and testing process.

But if you think the concept is

valuable, then I think -- and Girma is over her nodding, saying for care coordination, this is big when you are thinking about the psychosocial issues.

CO-CHAIR LEFEBVRE: I think for reduction in chronic disease it probably has one of the largest impacts, but it is so varied among communities.

So, do we feel that these two are correct in their placement of high impact, low feasibility?

Okay, I'm moving on. Capacity and productivity. The measure concept is performance on national measure set, such as the ACO measurement set or others, as compared to the team mix, meaning provider mix and workforce credentials. It goes under the subdomain of workforce effectiveness and efficiency. So, we have that as high impact, low feasibility.

MEMBER MacINNES: Could you repeat

that?

CO-CHAIR LEFEBVRE: Sure. Performance on national measure set as compared to team mix. So, the national measure set, for example, could be the ACO 33 measure set, and team mix could be either simply provider mix, such as MDs and DOs along with advanced practice providers or a full workforce credential, such as social workers, nurses, clinicians, those types of things.

CO-CHAIR GERDES: I think we did talk about yesterday trying to encourage federally- and state-funded programs to include and/or require reporting on workforce, that that might be a smart idea because we have identified that as an important issue that needs to be measured and studied, and for future policy decisionmaking and a lot of reasons.

So, I think that is what that is getting at, is perhaps making a measure, so, you know, like the ACOs or the

Affordable-Care-Act-sponsored pilots can put those metrics into their quality metrics when they are collecting. Is that correct?

CO-CHAIR LEFEBVRE: I think that is what we are getting at.

CO-CHAIR GERDES: Yes.

CO-CHAIR LEFEBVRE: So, that is one way to do it. So, if you are going to share savings with Medicare, then you are going to report your team mix to Medicare.

MEMBER MARK: We also had a discussion in our group about that the team will vary depending on the condition that you have, and that it may be more important or equally as important to capture the patient's perspective on whether they are getting coordinated care and communication across all of the providers that they are touching, that they are all on the same page, rather than focusing on the inputs.

CO-CHAIR LEFEBVRE: Right.

MS. KOVNER: I was in that group.

I think that I would put it more to the left. So, I think it will have very high impact, but I think it is even less feasible -- well, not that far.

(Laughter.)

But what does everybody else think? I just think it is less feasible than the --

MS. PRINS: So, I have a clarifying question then. I think we had two things. One was we don't really know what the team mix is that we need. So, it would be really hard to establish a performance measure around that until we kind of know more about it.

And to your point, depending on what type of a patient you are or what type of patient population, you may need a different mix. But it seems to me that this one is more about, as part of the reporting programs and so that we can learn more about what programs work and what mix of staff they have, that that would be a reporting requirement. So, you could start to

understand.

CO-CHAIR LEFEBVRE: For our group, because it was under the subdomain of workforce effectiveness, we thought including performance on the national performance indicators. And so, not just that you are in the top quartile in diabetes care, but you're in the top quartile of diabetes care and here's your team mix for diabetes care.

MEMBER MARK: I mean, this is where it gets a little confusing for me because, yes, when I think about NQF measures, I think about them as having a judgment. You know, like the more of, the better you do on this measure.

And this one sounds like we are not really asking for a judgment. We just want to collect data. So, I think we just need --

CO-CHAIR LEFEBVRE: I think this is more like in the process category.

MEMBER MARK: Well, it is not even in the process. Even in the process measures,

most of them have some kind of judgment. Like the more you do your diabetes testing, the better. The more immunizations, the better.

I think, with this one, what I am hearing is we are not saying the more team looks like this, the better.

CO-CHAIR LEFEBVRE: Right.

MEMBER MARK: We are just saying it would be nice to get data on what --

CO-CHAIR LEFEBVRE: Right.

MEMBER MARK: -- the team looks like.

CO-CHAIR LEFEBVRE: It is information gathering, so we can move to a judgment.

MEMBER MARK: So, it is important that we transmit that when we transmit this recommendation, that it is not a recommendation with a --

CO-CHAIR LEFEBVRE: It is almost to gather baseline.

MEMBER MARK: Yes.

MS. PRINS: Yes. It is kind of the foundational element to get us to the next -- it is almost a stepping stone.

MEMBER MARK: But you need this data to understand maybe how to improve care and what's working and what's not. But we are not going to make a judgment call because you don't have a PT or an OT or --

CO-CHAIR LEFEBVRE: Right. Well, and that's where we got -- because, really, this is an efficiency, an effectiveness and efficiency measure. And what we were saying was, well, we need to be careful with that efficiency component, because if I'm a CEO of a very large ACO, I may want to look at what is the cheapest team mix I can have. I don't mean to make them all bad guys.

But you don't want to look at what just simply is the most efficient. You want to look at what is the most effective. And we

don't know that yet.

So, okay, moving on. Okay, so, under infrastructure, the measure concept is patient ability to use after-visit data electronic calling.

I am not sure, what is data electronic calling?

MEMBER MARK: What is the last word you're saying?

CO-CHAIR LEFEBVRE: Calling.

MEMBER MARK: We mean like data portals. So, you could find out after you went in --

CO-CHAIR LEFEBVRE: Okay, not calling, but patient portals?

MEMBER MARK: Yes.

CO-CHAIR LEFEBVRE: Right? I just want to make sure. So, patient ability to use after-visit data access or something? Okay. Portal access.

So, I don't know. Would the

group -- so, this is a Meaningful Use measure. I mean, I know that there is also some of this in NCQA. But anything that is reported to the federal government is easier to get. So, portal use is a Meaningful Use measure. So, that is something you could obtain. Having one and using one are two different things, but you've got to start somewhere.

MS. KOVNER: So, with that said, are you suggesting that it is much more feasible than where it is?

CO-CHAIR LEFEBVRE: I guess I'm putting it out there and asking what do you all think of feasibility on it.

CO-CHAIR GERDES: I think it is pretty feasible. I am just questioning impacts. I don't know if anybody can talk from that group, what they thought the impact would be of measuring percent of patients, because it is percent of patients using a portal, is the Meaningful Use measure, correct?

CO-CHAIR LEFEBVRE: It is. And so, in stage two, it is a very low --

CO-CHAIR GERDES: Right.

CO-CHAIR LEFEBVRE: So, 5 percent of your patients have to use your portal for Meaningful Use. And by use, it means they logged on once, even if it was sitting in your lobby.

I mean, I think that it does get at access, I think.

MEMBER ZINKEL: I think this one is a little bit more feasible. There are groups that are doing this already. There are groups that you can log on and look at your medical record from home. So, I think it's out there; it's being done. I think this is one that would be a little bit more feasible.

CO-CHAIR LEFEBVRE: So, you think that it is higher in feasibility. What about impact?

MS. KOVNER: I am not sure how much

impact. It seems like you would need to know more what they're doing, what they're looking at. Did looking at that change their behavior in some way?

CO-CHAIR LEFEBVRE: Right.

MS. KOVNER: So, I don't know how much impact it is.

CO-CHAIR LEFEBVRE: Some of the challenge, in my mind, is that portal structure is not standardized. And so, I don't know; do you all use a portal in your clinic? Can they make appointments or can they see their lab data? What can they see in the portal?

MEMBER PILKINGTON: Yes, they can do all those things in the portal.

CO-CHAIR LEFEBVRE: Yes. So, it all depends on how your practice sets up your portal, which a lot of times is what is the investment financially you have made into your portal.

MS. KOVNER: So, my physician, the

group practice has portals. And it just seems to me there is a huge difference between using it to make an appointment and using it to remind you what your lab values are and what are the things that, when you last visited the practitioner, the practitioner said this is what you should work on.

So, I guess that is why I am not sure about the impact.

CO-CHAIR LEFEBVRE: Yes. And then, some practices will put a link to up-to-date and those types of things in there, and then, they will encourage their patients to only go here for online education rather than just Googling. Again, it is not standardized.

MS. KOVNER: What is also not clear from research, I would say, what type of use of a patient portal impacts patients' health. And until we know that certain kinds of use is related to patient health, I am not sure I would want to make it a measure.

CO-CHAIR LEFEBVRE: Yes, and I think a lot of places will call it access. And I'm not convinced that it is access, either.

MEMBER KHAN: You know, I agree that it may be certainly variable, how it is implemented, because you are right on; I don't think there's a standard. However, I guess the question is, is it useful from informing us around workforce training and workforce needs, to find out who has already sort of started down that path?

Because I do think this is maybe developmental. I mean, maybe start with you can look at your lab, and I love the idea that there is a care plan, that eventually it could be more personalized.

But I guess if the data source is available, it might be helpful to know, do only 10 percent of the practices have this or is it more like 90 percent? But I feel like this is where care is going in terms of having more

electronic access.

CO-CHAIR LEFEBVRE: Right.

MEMBER KHAN: And so, the impact in terms of changing behavior I agree may not be so, you know, robust. However, perhaps it does inform us around what kind of infrastructure folks are investing in, whether it might be training or workforce needs, but I don't know. I just put that out.

MEMBER MARK: Is there a way to categorize it as need to understand more about the impact or do we have to pick high or low?

MS. FRANKLIN: No, we can certainly qualify this measure. And it could be that it is just another one of those measures where we are gathering baseline data, so we can better understand the issues and lead us to real measurement in the area. We could categorize it that way.

But, at this point, it sounds like the measure may be or the concept is lower

impact.

CO-CHAIR LEFEBVRE: So, anyone who meets stage two of Meaningful Use has to have a portal? Like they can't meet stage two without a portal? But, then, you are going to have a whole bunch of practices out there that aren't eligible for Meaningful Use. They may have fabulous patient portals, but they are not eligible for Meaningful Use. So, I think there is some data.

MS. PRINS: This one, to me, just isn't connecting. How does it connect to the workforce? I know we are talking infrastructure, but what is it about the workforce that this connects to?

CO-CHAIR LEFEBVRE: I think it is because people tend to put patient portals in an access category. And again, I'm not sure that it translates really into access into the practice. It might translate into access to your patient record, but access to the practice

or care, I'm not sure it does.

MS. KOVNER: But if you broadly interpret workforce as including patients and their families, then it does relate to workforce. I just think using it doesn't tell you very much.

MEMBER KHAN: You know, I know yesterday in our group we talked about the content that may be pushed to a patient by the clinician or physician or support staff, what have you, and that there was a certain amount of training involved for the physician to appropriately phrase -- or, you know, writing a note to a patient is a very different thing than what you might say in an office, and that that was identified as a potential need in terms of how you communicate in written form. And we've got a whole generation that are texting and soundbites, and how does that translate? It still may be difficult to measure; I don't know.

CO-CHAIR LEFEBVRE: So, like for my thought, like portal access for nursing home patients might be, I would find that more useful, so that I could check on my mom today, but it doesn't exist. But that would be great.

MS. FRANKLIN: Or lower feasibility. I think I heard low impact, high feasibility if we want to just pull the Meaningful Use data.

CO-CHAIR LEFEBVRE: So, this one looks like it is intentionally straddling the line.

MS. FRANKLIN: Yes.

CO-CHAIR LEFEBVRE: Okay. So, this, again, is infrastructure, and it is looking at telehealth. And I think it says behavioral health, geography, decisionmaking tools.

Anyone from the infrastructure group want to expand on that? Is it just like the use of telehealth maybe?

MEMBER MARK: Yes, it was the use of telehealth to reach underresourced communities. So, it could be rural or it could be urban communities with difficulties with transportation.

CO-CHAIR LEFEBVRE: But it may be underserved with subspecialty care or something like that?

MEMBER MARK: Yes.

CO-CHAIR LEFEBVRE: So, can you tell me -- Amy, I'm looking at you -- there is not a special code for -- is there a CPT for telehealth?

MEMBER KHAN: So, there is a different code.

CO-CHAIR LEFEBVRE: Okay.

MEMBER KHAN: And it is usually by minutes, how many minutes you had in terms of the interaction.

CO-CHAIR LEFEBVRE: Okay.

MEMBER KHAN: I'm just struggling

with how, unless you were able to get to, again, CMS, Medicare/Medicaid billing, I don't know where you would get, how you would find it, how you would know.

CO-CHAIR LEFEBVRE: I guess that would be my first question. Are they billing it appropriately? Because we are only as good as the data we're putting in there. If it is being coded appropriately going in, and it's recognized by public payment, then we should have some data on it. And especially if we are looking at underserved communities benefitting from telehealth, then that would be the public payment programs, just kind of thinking outloud.

CO-CHAIR GERDES: Is Medicare paying for the CPT codes today?

MEMBER KHAN: Yes.

CO-CHAIR GERDES: Okay.

MEMBER KHAN: So, there are certain requirements that qualify for telemedicine in

the CMS guidance. And it is, to a certain extent, restricted to rural areas and federally-qualified clinics. But, absolutely, they have a payment pathway.

MEMBER BERLINER: I understand what the measure is. I'm not sure what the meaning of the measure would be in any community. If there was a lot of telehealth, is that good or bad? Or if there was little, is that good or bad?

CO-CHAIR LEFEBVRE: Right.

MEMBER BERLINER: And I don't see how, I mean, what the baseline would be for like -- how do you know it's a needy community or a disadvantaged community that is using it versus just, you know, I mean, using it for the sake of getting extra billings?

CO-CHAIR LEFEBVRE: Right. So, let me just play devil's advocate a little bit here and say, what if I looked at all the HPSA areas in the state and said, "How many of those

have at least one telehealth code coming in?" Meaning that they are using telehealth to make up for their HPSA, their shortage areas. Does that get at more of --

MEMBER BERLINER: Except if you don't know anything about the community itself except that there is a professional --

CO-CHAIR LEFEBVRE: Shortage.

MEMBER BERLINER: -- shortage. So, maybe it is a community that doesn't need it, I mean that's healthy, right?

CO-CHAIR LEFEBVRE: Yes. See, I don't know if --

MEMBER BERLINER: And that is the part that I'm confused about.

CO-CHAIR LEFEBVRE: Yes, and I don't know. This is how I'm thinking. It is under infrastructure. And so, I think what it is talking about is, is there adequate infrastructure to support better access? And I think telehealth would be one measurement of

that. Does the infrastructure exist to support better access to healthcare? And if there is telehealth being used in the area, then that is one piece of infrastructure that does exist to support it. Am I stretching it? I don't know.

MS. KOVNER: That sounds like it's a yes or no, which I think meets some of your concern, Howard.

CO-CHAIR LEFEBVRE: Yes, I think that's all we can get to right now.

MS. KOVNER: Yes or no?

CO-CHAIR LEFEBVRE: Now whether it's good telehealth, I mean, I think that all goes in the same bucket of healthcare. You know, we are not sure whether that is improving health or not.

MEMBER MacINNES: You might have already touched on this, but would you link it to particular areas that are underserved? This isn't my independent idea.

CO-CHAIR LEFEBVRE: Right. So, I think maybe targeting specific -- well, it does have geography in here, which I am guessing the group meant by maybe some HPSA health professional shortage areas and those types of things.

So, you know, yes, I think that it can be done. I don't think we are saying that every practice should be doing telehealth. But I think what we are saying is, to have a supportive infrastructure and looking at workforce issues, telehealth is one means to overcome shortage areas.

MEMBER MacINNES: And maybe, yes, linking it to the shortage areas and even distance to an accessible provider.

CO-CHAIR LEFEBVRE: Yes. So, like in North Carolina we just put it out on one of our barrier islands. And that is because it is only accessible by ferry. So, now they can telehealth out there.

Melissa?

CO-CHAIR GERDES: Yes, I think this metric, again, goes back to measuring the workforce. So, it is measuring using telehealth as defined by access to physicians or specialists when you don't have them in person. So, we discussed geography. We discussed behavioral health, you know, as another topic area just to measure kind of the Meaningful Use of telehealth. And we might be able to use the CPT codes, because they are somewhat restricted, to get at that, again, assuming they are measuring them properly.

But this is just like we talked about with scope of practice, with measuring, you know, PAs and nurse practitioners, and are they going into rural underserved areas in primary care or not? I think we kind of need to know that, where this telehealth, by that narrow definition, is actually being used today. Because we may find out it is just being

used at kiosks and downtown Washington, D.C., and Dallas, and not out in the rural areas.

CO-CHAIR LEFEBVRE: Right.

CO-CHAIR GERDES: And that would be good to know --

CO-CHAIR LEFEBVRE: Right.

CO-CHAIR GERDES: -- you know, if that is a workforce extender or not.

CO-CHAIR LEFEBVRE: I think that that is a great way to look at it because I think, if we are going to start to look at -- if we are only looking at workforce as number of persons in a given area, then we are missing this whole section that could be used. And so, I think it has to be in there along with some sort of computation of bodies, too.

Okay. So, now we have that all figured out. I need the impact and the feasibility.

MEMBER MARK: I mean, I think this is another one where we are at the beginning of

understanding.

CO-CHAIR LEFEBVRE: Uh-hum.

MEMBER MARK: So, we don't want to say low impact and, then, not encourage people to pursue it.

CO-CHAIR LEFEBVRE: Right.

MEMBER MARK: But we don't quite understand.

CO-CHAIR LEFEBVRE: Right. So, do we feel that it might have potential for high impact? I guess that would be a way to get around our insecurity with that.

Okay. So, I think it could have potential high impact. And feasibility, anything that can be claims-based I think is some of the best data sources we have. So, okay. So, I think we might try to move it over there. It is good that that quadrant is full.

So, this next one is under infrastructure again. Or let's skip to something different.

(Laughter.)

So, how about training and development? So, under the subdomain of training and development, the measure concept is training to improve access via health information technology.

Anybody want to help expand on that one before we talk about impact and feasibility?

I think, was that group two, training and development? Improving access, training to improve access via health information technology.

Anyone, like does that mean email visits? What does HIT mean there, do you think?

MEMBER LUDWIG: I was in group two. Is this the measure about the telehealth, too, and not maybe specifically health IT but telehealth, the access?

CO-CHAIR GERDES: And are you

talking about training staff, personnel, to help patients gain access?

MEMBER MacINNES: Yes, my recollection was a discussion about like a dermatologist being able to diagnose a skin condition via telehealth. So, that there would be access to trained practitioners using HIT.

MEMBER KHAN: And the technical training as well. I mean, I think one is the clinicians being able to use it, but --

CO-CHAIR LEFEBVRE: Okay. So, this is access to training?

MEMBER KHAN: Yes.

CO-CHAIR LEFEBVRE: Not patient access?

MEMBER KHAN: Right.

CO-CHAIR LEFEBVRE: Okay. So, that might be a good clarification there. Yes, so I would put "access to training of HIT". Okay, I think that is more of what we are looking

at.

MS. KOVNER: And who will be accountable for that?

CO-CHAIR LEFEBVRE: For the access to the training?

MS. KOVNER: I mean, somebody from the group from yesterday.

CO-CHAIR LEFEBVRE: Who is --

MS. KOVNER: Accountable?

CO-CHAIR LEFEBVRE: -- accountable to make sure that there's enough access to training programs?

MEMBER KHAN: Gregg might want to comment, but I think we talked about relative to schools, that there would be curriculum, faculty that were skilled and able to provide that sort of coursework.

MS. KOVNER: One is formal education? But formal education is distance learning or something?

MEMBER WARSHAW: I think all the

areas we talked related to training, skills that we thought were essential for the workforce to have. We have to think about the approaches to people that are still in their initial training period, they haven't started work yet, and then, people that already in the field.

CO-CHAIR LEFEBVRE: Right.

MEMBER WARSHAW: So, that's two approaches for each of these categories.

But, clearly, for the people that are still in their health profession school, we wanted to make sure they had access to training because they will be moving into working settings where this health information technology is available.

For people in the community who are already working, then I guess it is their employer or health system that's going to be responsible.

CO-CHAIR LEFEBVRE: Or

certification bodies.

MEMBER WARSHAW: What's that?

CO-CHAIR LEFEBVRE: Certifying bodies.

MEMBER WARSHAW: Yes, or certifying bodies. But we were really interested in two aspects. One, the fact that have the expertise, that they have been taught in some setting, the expertise to use the technology. And then, two, that there are people available, trained people available, faculty, teachers, to teach them how to do that.

MS. KOVNER: That sounds different than what I initially heard your group saying. So, that sounds like you're saying that we should be sure that everybody who graduates from a health professions or some kind of a program like that has the ability to access information about something by using some kind of an electronic device. That sounds different than asking the schools to be

accountable for making sure that students have the option of taking formal coursework in some electronic way.

CO-CHAIR LEFEBVRE: I think what I heard him say was that it is making sure that teaching curriculums -- it's a school; it could be a CNA course, those types of things -- are including health information technology in it, so that this student comes out trained for the current workforce which is technology-based.

MEMBER WARSHAW: Yes, that is correct. That's right. We weren't specifically thinking about distance learning or --

CO-CHAIR LEFEBVRE: Right.

MEMBER WARSHAW: -- ways that universities can use technology.

CO-CHAIR LEFEBVRE: But it is that we're training these people to work in a setting that is based with technology, not that they're coming out trained for healthcare 20 years ago.

MEMBER WARSHAW: Uh-hum.

MS. PRINS: So, this was one of the core competencies that was identified whenever it was that Chris Cassel mentioned the IOM work that we have been talking about, too. So, it just seems like, if we are going to talk about training and development, that there are some core competencies that you all are probably honing-in on, and this seems like one of them.

So, regardless of whether it is your formal training or certification or --

CO-CHAIR LEFEBVRE: Right. So, you don't have to take an informatics -- you don't have to professionally go into informatics to make sure that you have some HIT training.

MS. PRINS: Right, but at this point should this really be integrated into everyone's professional development?

CO-CHAIR LEFEBVRE: Yes, I think it should.

MS. PRINS: And it could also be an accreditation piece for the accrediting organizations.

CO-CHAIR LEFEBVRE: The schools.

MS. PRINS: Or for home health agencies.

CO-CHAIR LEFEBVRE: Right.

MS. PRINS: So, thinking about those two pieces to the accreditation and certification I think has huge implications here for not only this, but for the telehealth and things like that. So, we might want to think beyond --

MEMBER SOCHALSKI: And given that part of what we are looking at is care coordination, I think there's a lot of areas of technology. But if what we are looking at is what is our opportunity not only to extend access, but to better manage and better coordinate care, then I think that that is an important lens. I mean, that is the way they

are practicing. So, I mean, if we don't teach it, they're going to learn it when they get to the setting.

But I think what is important is to what degree is that HIT being used to support those things that are very important in care coordination, because there is certainly a lot we could be doing on the technology of health that extends it through some of the things that we have been looking at.

CO-CHAIR LEFEBVRE: So, some thoughts on data sources are, definitely, all schools are accredited. There are some pieces there. And then, I think you had some good thoughts, Wendy, about accrediting bodies of institutions. But, then, there is also this can become required in your certification, you know, your hours towards licensure as a nurse. Part of your maintenance of certification as a physician has to be -- you know, I mean, I think that it needs to start to infuse.

MS. PRINS: And if it becomes a known need, the suppliers will come around, because three years ago I couldn't find a single course on reducing readmissions. And now --

CO-CHAIR LEFEBVRE: Oh, yes.

MS. PRINS: -- everywhere I looked there are courses being offered on readmissions.

CO-CHAIR LEFEBVRE: Right, right.

MS. PRINS: So, it is because of the national attention to it.

CO-CHAIR LEFEBVRE: You know, I don't mean to be a public service announcement for AHECs, but I will tell you, I mean, this is what AHEC is supposed to do. And so, your State, AHEC, if hopefully you still have one, should see this as this is a need in health professions and that is what we do. And so, we should be building out courses and meetings and all kinds of stuff for it.

MS. PRINS: That's right.

CO-CHAIR LEFEBVRE: So, knowing that we have, and so those are all measurable data sources, impact and feasibility.

MS. KOVNER: I think that it is very measurable if you are talking in the formal education. I think it is less easily measured -- I mean, I suppose state licensing agencies could say this year, in addition to your infection course, you must take a three-hour blah-blah course.

CO-CHAIR LEFEBVRE: I can give you data on anyone in North Carolina who attended a training course on HIT. Give me a call; I can give you a number.

MS. KOVNER: Howard, I believe that would never go through New York. I mean, it is hard to imagine the State Health Department or Department of Ed all agreeing to make this.

MEMBER BERLINER: Well, all agreeing and, you know, I mean, just general provider resistance and getting the courses all

to be equally competent in what they are trying to do, and finding some way of measuring what they were doing and who stores the data and --

CO-CHAIR LEFEBVRE: Just to dumb this down a little bit, so I agree there's all those issues. But this is saying access to these training programs. This is not saying what these training programs are and what they do.

So, again, taking a workforce look at this, saying, does our workforce need to improve its access to training program for HIT, is the way I think we're looking at it here. Because I agree with all those issues about, well, what is a training program and is it certified and does it count, and those are all different pieces.

So, measuring the access to training for HIT, is that high or low impact?

MS. KOVNER: Don't you think -- I mean, I don't know this -- but I would suspect

there is already some course on the internet that does this. And so, doesn't everybody sort of already have access?

CO-CHAIR LEFEBVRE: With HITEC, we had a huge workforce rollout in this country that is still available online, whether that is promoted in industry or not --

MS. KOVNER: So, does that count as --

CO-CHAIR LEFEBVRE: At this point, because it is no longer federally funded, it is not measurable. It's open. It's open source. But it is not measurable. It could be, but it is not.

So, again, is this available? Yes. So, I think what we are saying is access to improvement, I mean, so that is what we want to look at, is impact versus feasibility.

MS. KOVNER: So, if it is already available, then it won't be helpful to measure whether people have access or not. So, what do

you learn from that? Yes, everybody has access.

MEMBER BERLINER: The issue isn't access; it's use.

MS. KOVNER: Yes, it is really use --

CO-CHAIR LEFEBVRE: Is that? Okay.

MS. KOVNER: -- or taking the course --

CO-CHAIR LEFEBVRE: Okay.

MS. KOVNER: -- not being access.

CO-CHAIR LEFEBVRE: Okay. So, change that to use. So, change that to use.

First of all, does everybody in group two agree with that? Because I think it was yours, and we don't want to hijack it.

But, if that's the case, then do we feel that that's -- is it a high impact?

MEMBER WARSHAW: Yes, it is a high impact because it is an essential skill that

people need to have to work in the modern healthcare system.

CO-CHAIR LEFEBVRE: Okay.

MEMBER WARSHAW: So, then, how we measure it is more complicated. I think we didn't get too far in that discussion, but if you look at gathering information from health education schools or from health systems, where a lot of this training will take place, that's probably feasible.

CO-CHAIR LEFEBVRE: Right. So, training, but retraining not so much --

MEMBER WARSHAW: When you start moving on to trying to have accreditation bodies require it or have state licensure requirements, that's much more complicated.

CO-CHAIR LEFEBVRE: Okay.

MEMBER WARSHAW: We don't have as much control over that.

CO-CHAIR LEFEBVRE: So, move it over here to high impact but low feasibility?

MS. KOVNER: That's what I think.

MEMBER WARSHAW: Okay.

CO-CHAIR LEFEBVRE: So, let me explain it. So, this afternoon we are all going to be able to vote. So, we are just getting these in the right places right now.

MEMBER WARSHAW: All right. All right. That's fine. That's fine.

CO-CHAIR LEFEBVRE: And then, this afternoon you're going to have stickies where you can vote on it.

MEMBER WARSHAW: That's fine.

CO-CHAIR LEFEBVRE: So, does that help? Okay.

And put it maybe over here towards the line. How's that?

Okay. So, infrastructure. The concept is patient access to primary care physician.

MS. KOVNER: First of all, I would like to say, could we possibly change that to

patient access to healthcare provider? Or primary? Because did the group mean primary care provider or did they mean --

CO-CHAIR LEFEBVRE: This is group one. Is that okay?

MS. KOVNER: So, could we change that to primary care provider?

CO-CHAIR LEFEBVRE: So, ideas on data source which goes with feasibility?

MS. KOVNER: Some of this can be done with, have a survey. Everything doesn't have to be existing. So, also, AHRQ has the MEPS data, the Medical Expenditure Survey. So, I think in there you might be able to find these data. But, if not, we could do a survey, get one of those polling places --

CO-CHAIR LEFEBVRE: I'm just asking, who would you --

MS. KOVNER: Just everybody.

CO-CHAIR LEFEBVRE: Patients?

MS. KOVNER: Everybody, a random

sample, the way they do the political polls. Those are fairly, they have a pretty narrow standard deviation, and they know how to do that. They can do that. They can do a survey like that of 1100 people.

CO-CHAIR LEFEBVRE: Do we feel that that is a measurement of access?

MS. KOVNER: You ask the people, "Do you have access?" or "What does that mean?" or "If you got sick, do you have somewhere where you can go besides the emergency room?" I mean, you would have to work on the questions.

CO-CHAIR LEFEBVRE: Right. Yes.

MEMBER SOCHALSKI: So, what you are saying is, looking at what we have in the way of existing data sources, probably federal because they would be national in scope, so National Health Interview Survey, MEPS, something like that.

MS. KOVNER: Yes.

MEMBER SOCHALSKI: That may -- I

don't know -- thinking specifically about what we are trying to do here, I am not sure exactly what is there, but it would certainly be a place to start.

MS. KOVNER: And if they don't have it, then --

CO-CHAIR LEFEBVRE: Again, just pushing back a little bit, what if you're uninsured? Just because there's a doctor in your community doesn't mean that they will see you.

MS. KOVNER: But you ask a question like, if you something or other, where would you go for care? And one of the choices -- would you go for care to some health professional and, if so, where would you go?

I mean, obviously, just having it in their community, but this is asking -- really, what we want to know is do people have the perception that they can get access to primary care. And we can define in some survey, if we

have to go to that, what that means and what is a good example.

So, measles might be a good example that doesn't require going to an emergency department.

CO-CHAIR LEFEBVRE: And I like the word "perception". I think that, if it was a survey, that is what you would be measuring, is their perception.

MS. KOVNER: But isn't that what we're interested in, is their perception? I mean, if they belong to, if they're fully insured and there's a healthcare provider two doors away, if they don't think that they can access primary care, that's what matters.

MEMBER KHAN: Yes, I certainly think that there may be opportunities to look at MEPS or other national surveys, as well as NCQA on the MCAHPS survey, the Member CAHPS survey, would be a way to look at it. And I think there is a question -- I can't exactly

remember the wording, but it is something to the effect, "Did you have access to your doctor when you needed it?", or something like that.

CO-CHAIR LEFEBVRE: Uh-hum, right.

MEMBER KHAN: But those might be worth looking at those surveys and see what might apply, maybe call a few of those responses just to look.

And certainly, you're right, that those that are uninsured and continue to be uninsured may not be reflected accurately.

CO-CHAIR LEFEBVRE: Right.

MEMBER KHAN: But perception might be the way to start.

CO-CHAIR LEFEBVRE: Yes, yes. So, I think that's good. And I agree with the CAHPS survey, but the challenge is, those CAHPS surveys are only issued to those patients who have come in.

MEMBER SOCHALSKI: So, you have got to do a survey that is of the public larger.

So, this will get you some perception, some measure, of people's ability --

CO-CHAIR LEFEBVRE: It gets at it.

MEMBER SOCHALSKI: -- they believe, to see a primary care physician or a primary care provider.

So, yes, to your point, is that what the -- will that answer that question? Is that a metric? Is that what we are saying is a metric for this?

CO-CHAIR LEFEBVRE: I guess that is getting to the feasibility piece.

Melissa?

CO-CHAIR GERDES: I was in this group, and we were talking about this from the patient-centered point of view. We wanted their opinion of the measurement of workforce, essentially, was what drove this.

So, we have in our health system -- and this is also part of the NCQA Medical Home application -- you can assign a PCP

to patients and measure in your EHR what percent of the time they visit that person. That is one way to look at it.

We, also, in our health system, we asked patients, over the last 12 months, what percent of the time were you able to get an appointment with the provider of your choice and, also, in the timeframe that you wanted? So, that is really patient-centered. I mean, we can say it needs to be two days or two weeks and it needs to be this doctor or that provider, but we really kind of flipped that and wanted to know, from the patient's perception, is the workforce adequate for what they want, you know, which is going to be very individualized.

CO-CHAIR LEFEBVRE: And I think Bill mentioned the issue when you were talking about, I think it was, you know, it is more important to the patient to be seen this Friday --

CO-CHAIR GERDES: Yes.

CO-CHAIR LEFEBVRE: -- because that is the only time they can get off work. Then, they may choose that over seeing their own physician.

CO-CHAIR GERDES: Yes, and that becomes important. And a lot of your membership societies are doing this work with patients and focus groups. You know, Gallup or any of these places we were talking about can do this with the consumers or we can ask for it to be tagged onto like the ACO population. They get a CAHPS survey that is 90 questions.

CO-CHAIR LEFEBVRE: Their continuity scores.

CO-CHAIR GERDES: Yes. So, I think there are some very feasible data sources out there. I would rely on NQF to pursue where they are. But you could put a number, a percentage or a number of times. So, it would be a true metric. But, again, that is the patient's perception of adequacy of workforce.

CO-CHAIR LEFEBVRE: Right. You might be able to pull that out of billing claims some, too.

MEMBER SCHOMMER: Comment from the phone?

CO-CHAIR LEFEBVRE: Yes.

MEMBER SCHOMMER: Hi. This is Jon Schommer.

I just wanted to make a comment about the patient perspective. I really appreciate this conversation. I wanted to iterate again that sometimes when we collect data from our patients at traditional care sites, we are not capturing all of the patients and all their perceptions. Many people go to non-licensed health facilities. It might be a community center or a church or it might be a complementary or alternative medication location that is not licensed. And also, more and more primary care is being provided at places like pharmacies, which are very

conveniently accessible, but might not be thought of as primary care centers.

So, I just wanted to add that the patient's perspective in the broad sense outside of our traditional places of practice I think is very important.

CO-CHAIR LEFEBVRE: Right. So, they might consider access much higher because they can go to those other places that you, a their provider, may not consider.

MEMBER SCHOMMER: Right.

CO-CHAIR LEFEBVRE: So, that is an interesting point.

Howard?

MEMBER BERLINER: I guess it is a question based on the way Melissa phrased it about adequacy of workforce. But if I can't get to see my particular doctor when I want to or, with respect to Chris, my nurse practitioner when I want to, what does that say about the adequacy of the workforce as opposed

to that individual practitioner?

So, the phrasing of it is just --

CO-CHAIR LEFEBVRE: I think in facilities we are getting at panel size, then, of what is the appropriate size panel for the practitioner to be able to truly manage them in a medical home.

CO-CHAIR GERDES: Yes, and we really restricted this to the primary care setting for this particular metric. We did have a discussion on asking consumers their ability to get their needs met. You know, in the social services domain, for instance, we were thinking about that.

The other thing I will just share with the group that we did in our primary care practices is we asked our patients, "Think about the last time you went to the emergency room or you took a family member to the emergency room, and why did you do that? And what would we need to have done different at our

primary care site to get you to come here?" And we just have them free-text, you know.

And sometimes they went because they had appendicitis. Well, that is where they should be. But sometimes it was, you know, "We had barriers in scheduling and that to get in," when it was really an ambulatory-sensitive condition.

So, these measures would be, I think, designed to look at, do we have a problem that we need to pursue or is the perception and the access really better out there than we think it is, or there are subgroups where it's a problem? You know, just to reaffirm that.

CO-CHAIR LEFEBVRE: So, let me bring us to impact and feasibility. Are we comfortable that this is a high-impact measure for workforce?

Julie?

MEMBER SOCHALSKI: As an infrastructure question --

CO-CHAIR LEFEBVRE: Right.

MEMBER SOCHALSKI: -- this is on being able to access a primary care provider. And the metrics that we have been talking about are the patient-focused ones. Do we have in other places some measure of the -- I don't know if this would be infrastructure, but we had some discussion yesterday about people going into and staying in primary care. I mean, so it is the adequacy side of the workforce. And I don't know if that is captured in here. Is that captured somewhere else? So, not just the numbers of people, but, you know, are they staying in primary care? And that might be a wholly separate dimension. It is just when you are talking about adequacy --

CO-CHAIR LEFEBVRE: Yes, that might be more retention.

MS. FRANKLIN: Was that a potential measure concept? Is that a suggested measure concept, Julie?

MEMBER SOCHALSKI: On a separate topic.

MS. FRANKLIN: On a separate topic? Okay.

CO-CHAIR LEFEBVRE: So, is this high impact? Okay. Is it highly feasible?

MEMBER SOCHALSKI: If it is in existing data sources, then it is very feasible. If you have to go -- I mean, you may, in fact, want to do that in some of the practices if you really wanted to get a little more granular and understand something more than some general question.

But I'm not deeply enough versed in all of the federal data sources that are asking that of patients at large, individuals at large. But, if it is, then it is very feasible.

MS. KOVNER: You know, even if it is not an existing data source, I think it is data that is pretty easy to get from a survey.

CO-CHAIR LEFEBVRE: Okay. So, we

will leave it as high impact, highly feasible?

MS. KOVNER: So, I think that it is high impact, high feasibility.

CO-CHAIR LEFEBVRE: Okay. All right.

Let's move to this one, capacity and productivity. The measure concept is the ratio of healthcare workforce discipline-specific workers to the general population. And this is under a subdomain of geographical distribution of workforce.

MS. KOVNER: That was our group. I think we said that it also could be of a specific population. So, it was some ratio of provider-to-population, but it might not be the general population. If you are looking at pediatricians, you might want to only look at children under a certain age.

CO-CHAIR LEFEBVRE: Okay.

Yes?

MEMBER MacINNES: So, I like this

one from a direct-care-workforce perspective if it included direct-care workers.

CO-CHAIR LEFEBVRE: Sure. I mean, I think that's what we were trying to say with discipline-specific, meaning it could be any of them.

MEMBER MacINNES: So, with the long-term care population.

CO-CHAIR LEFEBVRE: Uh-hum. Okay.

So, do we feel that that measurement is getting to that ratio? And again, it sounds like this might be baseline because I'm not sure it is available. Is that high impact? I mean, it seems like that would be a high impact for a workforce group.

And then, what about feasibility?

MS. KOVNER: It is feasible, depending on how you measure those subpopulations.

CO-CHAIR LEFEBVRE: Okay.

MS. KOVNER: So, the more general it is, the more feasible. And the more specific, the less feasible.

CO-CHAIR LEFEBVRE: Okay.

Gail?

MEMBER MacINNES: Howard, if you could jump in, too?

I feel like we have data from the Department of Labor generally about the occupation, number of people in the occupation. But I know it is really tough to get providers to submit data on their workers.

CO-CHAIR LEFEBVRE: Yes. I think that our group talked a lot yesterday about what is available in Census data, getting at some of these things, because it really gives us a much better breakdown of what you are actually working in and those sorts of things. So, I think that was definitely considered as a data source, was Census data. And that, too, would be directly related to the population in that

Census.

So, are we comfortable with it as high impact, highly feasible?

Howard, you look like you're -- okay.

(Laughter.)

Okay. So, then, in training and development, the measure concept is core competency in care for older adults. And I am assuming this is across all disciplines.

MEMBER WARSHAW: Yes. This was just the idea of using an established set of basic competencies and, then, surveying health professional schools to see if they had --

CO-CHAIR LEFEBVRE: See if they had it in their curriculum?

MEMBER WARSHAW: Yes.

CO-CHAIR LEFEBVRE: Okay.

MEMBER WARSHAW: It was just a core skill that we thought the workforce needed for the future.

CO-CHAIR LEFEBVRE: Okay.

MEMBER WARSHAW: And since there is this relatively-recent collaboration between about 10 disciplines to develop these, it seemed like an easy one to look around to.

CO-CHAIR LEFEBVRE: Okay. Do we all feel that that is high impact?

And feasibility?

CO-CHAIR GERDES: It sounds like it's feasible.

CO-CHAIR LEFEBVRE: Okay. Good.

In recruitment and retention, the measure concept is amount of standard deviation from ideal in workforce retention and recruitment by discipline. The subdomain is needs-based recruitment and retraining.

So, this is the one -- I'll try to explain this. Chris, you can jump in.

So, this is the one where we were trying to get at, you know, what is the amount of retention in workforce. So, if you wanted

to look at primary care, you could look at any part of healthcare.

And so, basically, we were saying that, if you take what is the ideal and, then, if you have a standard deviation above that, then you may have more workforce than you need. And if you have a standard deviation below that, then you have less.

And so, we were thinking specifically with training programs, if in a field of study we find that we are at least a standard deviation above what is needed, then it is the responsibility of the training programs in the schools to start to decrease admissions, so that we don't become, you know, submerged in one aspect of healthcare and another aspect is depleted.

And we thought that this also could be used in retraining, meaning that if we have a surplus of this profession but they could be retrained into an area where we have a deficit,

so it is this matter of understanding what is needed, and then, seeing the standard deviations, either positive or negative, from there.

MEMBER BERLINER: So, the first issue is the word "ideal".

CO-CHAIR LEFEBVRE: Uh-hum.

MEMBER BERLINER: Right? I mean, since we have no way of knowing what an ideal number of people would be in any occupation.

The second thing is, you know, some people believe that the market adjusts for over- or undersupply. I guess we see with most schools that that doesn't work very quickly.

CO-CHAIR LEFEBVRE: Uh-hum.

MEMBER BERLINER: But, I mean, I think there's just a lot of belief out there that, you know, I mean schools, particularly less on the professional side, more on the vocational and occupational side --

CO-CHAIR LEFEBVRE: Right.

MEMBER BERLINER: -- I mean do react.

CO-CHAIR LEFEBVRE: So, if you have a 26-year-old living at home right now, you understand how this works?

(Laughter.)

MEMBER BERLINER: And, you know, yes, go to law school.

(Laughter.)

You're staying with me anyway. What's the difference, right?

CO-CHAIR LEFEBVRE: So, yes, I agree. I think that the difficulty is in what is the ideal and, then, how do you get standard deviations from this.

I think our group -- and help me here -- but I think our group was talking about, if some of these other measures are measuring what is the penetration of access to providers -- and so, this is based off of the concept that we would have some of these other

measures already coming in, so that we know the distribution of primary care providers in a geographic region. And then, we would have a measurement of access. And if we have those things, then can we look at do we have standard deviations and can we get training and retraining programs to respond more quickly because we have that information?

MS. KOVNER: I think the flaw in that logic is that is assuming that the mean is what it should be. So, if you are saying, on average, in the U.S. we have -- I don't know -- 100 nurses per 100,000 population, we don't know, I think what Howard was also saying, we don't know whether that is good or bad.

CO-CHAIR LEFEBVRE: Uh-hum.

MS. KOVNER: And we were saying, well, that's the mean. So, if you are below that, we are going to assume you are not adequately meeting the needs. But we don't know whether -- given that argument, 20 years

ago we would have been producing more physicians and not even thinking about nurse practitioners being able to do that. But the world changes. And so, these means may be off.

CO-CHAIR LEFEBVRE: Julie?

MEMBER SOCHALSKI: Whatever base we are using in standard deviations, did your group talk about what workers we are talking about? Because we do collect -- I mean, information is more available certainly on some than others. So, I didn't know if that was a part of it.

And also, given the focus of what we are looking at, which is not just at the workforce at large, but workforce in particular areas, in prevention and care coordination. Are there other workers that we are not collecting that information on now that we would want that are a critical part of prevention, that are parts of care coordination, those sorts of things? So, do we

need to be cognizant of that?

I mean, I think it is legitimate to have the discussion about what is the ideal because we don't know.

CO-CHAIR LEFEBVRE: Yes, and I think --

MEMBER SOCHALSKI: And there is overlap. So, do you look --

CO-CHAIR LEFEBVRE: Well, and it differs depending on the section of healthcare. So, you know, long-term care versus pediatrics. I think you could also look at it, if these are community health workers, you know, how many community health workers do you need to support a community? I have no idea.

MEMBER SOCHALSKI: Right, and so, that's why I think it is knowing what it is --

CO-CHAIR LEFEBVRE: Right.

MEMBER SOCHALSKI: -- that will create the challenges.

CO-CHAIR LEFEBVRE: But I would

call this -- I don't know if my group is comfortable with it, but I almost think this is like a secondary measure. You know what I mean? You have to have other measurement first in order for this to come into play. But I do think that it is something that is worth keeping on the radar because we have to start doing this, and I don't feel like we have our hands around it.

MEMBER SOCHALSKI: Well, I think you had the point yesterday. It was, sometimes by doing this, you then get the data collected --

CO-CHAIR LEFEBVRE: Right.

MEMBER SOCHALSKI: -- as a result, because it is on the radar.

CO-CHAIR LEFEBVRE: Right.

MS. KOVNER: Another way to get at what the ideal is it can be an expert panel like this. I mean, it doesn't necessarily have to -- you don't necessarily have to use the mean

of what is currently going on.

But Julie and I will decide the nurse ones.

(Laughter.)

And somebody else can do family practice.

CO-CHAIR LEFEBVRE: Tami, go ahead.

MEMBER MARK: Yes, I will do the child psychiatrists and the social workers.

(Laughter.)

But, I mean, just to illustrate an example where this does work but, as you said, you need a combination of data, we know that we have low supply of child psychiatrists. We know from surveys of patients that they can't get access when they need it. So, that combination of data suggests that we are not producing enough -- yes, as an economist, as I mentioned yesterday, I would like to say that the market is relatively efficient in that it

will produce more child psychiatrists. But we have these, you know, we have these barriers. It is not like bartenders where, if you need more, we will produce more.

CO-CHAIR LEFEBVRE: Right.

MEMBER MARK: So, by producing this combination of information, we have a lever to --

CO-CHAIR LEFEBVRE: Right.

MEMBER MARK: -- pursue the boards and the institutions to meet the demand.

MEMBER BERLINER: I mean, one of the difficulties of this is that, if you think of a place like Manhattan in New York City which overall is by most standards incredibly over-doctored, yet there are parts of New York City which are HPSAs and things of that. So, what is the unit?

But, beyond that, the numbers range from something like one physician to every 17,000 people in Harlem to one physician to

every 60 people on the Upper East Side. But, if you went to the Upper East Side and you surveyed people, they would not say there's an oversupply of doctors, right? And that is part of the problem.

CO-CHAIR LEFEBVRE: Their perception of what they need.

MEMBER BERLINER: Or their perception of what is.

CO-CHAIR LEFEBVRE: Yes.

MEMBER BERLINER: I mean, it's just different, and I expect my doctor to be available to see me whenever, you know.

There was a guy who did some work in the seventies where he said, "Well, supposing we made the national supply of doctors equal to what it is in a very wealthy community." He picked Scarsdale, New York, a wealthy suburb in Westchester. I mean, the supply of docs you would need increases by hundreds of thousands.

CO-CHAIR LEFEBVRE: Right.

MEMBER BERLINER: But it doesn't mean that the supply in Scarsdale is -- maybe it's still not enough.

CO-CHAIR LEFEBVRE: Appropriate, right.

MEMBER BERLINER: And that's the problem; we don't have any kind of an adequate -- when you talk about specific professions or occupations where we know that we could use more workers.

But do we have nurse practitioners because nurse practitioners provide a particular service or have nurse practitioners grown because it is so difficult to produce more physicians? And other things being equal and if the barriers weren't there, we just would have produced more physicians when we decided there was a shortage of physicians.

CO-CHAIR LEFEBVRE: Yes. No, and I think that that's true. You can take that all out to -- so, why do we have a burgeoning

field of community health workers? Well, that's because the healthcare system as it is is not meeting some need that this new profession is now supposed to meet.

MEMBER BERLINER: But especially with community health workers, I mean, no one -- and maybe not no one -- but, I mean, almost no one can define what a community health worker is or does. And it is a group that ranges from people with very low education, very low skills, through kind of Texas promotores --

CO-CHAIR LEFEBVRE: Sure.

MEMBER BERLINER: -- to, you know, nurse practitioners and MSWs who work in very specific kinds of areas. I mean, and they all call themselves community health workers.

CO-CHAIR LEFEBVRE: Right, right.

MEMBER BERLINER: I mean, that's problematic.

CO-CHAIR LEFEBVRE: That's a

challenge, yes. Yes. I agree.

So, what about this? So, what do we do with this? Do we take it off? This is kind of our group; we can do whatever we want. Do you want to put it in a parking lot? Do we want to tuck it away for after we get some better measurement in workforce? Is it something we look at there?

MEMBER KOVNER: I kind of think we should keep it, recognizing that it is only going to work for certain occupations.

CO-CHAIR LEFEBVRE: So, I think what I am hearing you say is that, ideally, it's high impact, but it's low feasibility. I mean how to make this work without existing datasets and understanding of what people need is pretty hard.

MEMBER BERLINER: But if we keep it there, is it a way of calling for more data collection or different data collection or more thought about what kinds of data to collect in

that area?

CO-CHAIR LEFEBVRE: Right.

MEMBER BERLINER: I mean, if that is the case, then I think we should promote it.

MEMBER SOCHALSKI: And does it also support geographic distribution? So, if the point is to look at that, and so I don't know Scarsdale is the measure that I use, but if Scarsdale looks real different from the South Bronx, then at least you have a starting point. You know, maybe you will norm somewhere.

And I think that's why I was asking about these other workers. Real challenges in defining the dataset. I think we have to because they are meeting a very important need in the system that the current health occupations are not meeting. And so, maybe some of this would push it.

But, if we could do this for better distribution, because what we are looking at, it is sort of the flip of the perceptions. If

people can't get access to something, we are looking at what workforce metrics do we want to have available to tell us that we are meeting their need. And does this help us?

And so, it does help; it could be helping on distribution. Then, that way, I think it could have high impact. Otherwise, I'm questioning them.

MEMBER MARK: We aren't going to be able to produce a supply with this information. We are just putting the information out. I mean, then the people, you know, the --

CO-CHAIR LEFEBVRE: Well, the policy can be built on it. So, one of the reasons the RAI program is different in North Carolina is that they looked at the geographic distribution of physicians around medical schools, around medical centers, you know, academic medical centers. And then, they looked at rural populations.

And so, the AHEC in North Carolina

owns and operates 11 primary care residency programs in rural communities, because where physicians train they typically stay. And so, in North Carolina this type of standard was used for policymaking and budget-driving, so that we could open rural-based residency programs.

MEMBER MARK: But let's say you open a residency program and it turned out that your projection of need was wrong, and they trained and they found, well, there's really no need there where projected. They just want to stay. You know, there is also the provider who is going to respond to where the need is.

CO-CHAIR LEFEBVRE: Right.

MEMBER MARK: So, it is not like -- it doesn't really worry about overstating it and supply this many in this rural area and you might get it wrong.

CO-CHAIR LEFEBVRE: Right.

MEMBER MARK: I mean, the provider will go where they get paid.

CO-CHAIR LEFEBVRE: Right. Yes. It doesn't change the market forces, absolutely.

MEMBER MARK: Yes.

CO-CHAIR LEFEBVRE: Yes.

MEMBER KOVNER: So, you have moved it way down there?

CO-CHAIR LEFEBVRE: I moved to high. Thank you. That's good. So, I moved it to high impact, low feasibility. Do you agree?

MEMBER KOVNER: Okay.

CO-CHAIR LEFEBVRE: Okay?

Do you want to keep going then and we'll take a break a little bit later?

Okay. So, training and development. I am just pulling them off, so that I know which one I'm on. Training and development, under the measure concept is evaluation of current faculty to teach care in new models and competencies. Reteaching.

Okay, so it is hours and reteachability. So, the measure concept is evaluation of current faculty to teach care in new models and competencies, looking specifically at hours and reteachability.

MEMBER WARSHAW: This is another one in the set that included sort of key skills that we wanted the workforce to be sure to leave their basic training with. And part of was, part of these discussions were around the content, ensuring that the content was being taught, but part of it was to be sure that there were faculty available to teach.

I think, for this particular one, we are most interested in documenting that in health profession schools learners had the opportunity to train in these new settings. So, we wanted to, through surveys of the health profession schools, find out whether students were exposed to professional settings, to Patient-Centered Medical Homes, to ACO models,

to settings that they are likely to be placed in when they leave school.

MEMBER SOCHALSKI: Yes, because that was key to developing those core competencies in their practice.

MEMBER WARSHAW: Yes.

MEMBER SOCHALSKI: Because they had to have exposure to this. So, it was making sure that they were getting these experiences. Definitely.

MEMBER WARSHAW: Right, that it was part of the training, and this applied to all health disciplines.

CO-CHAIR LEFEBVRE: So, am I thinking that your data source is certified schools?

MEMBER WARSHAW: Yes.

CO-CHAIR LEFEBVRE: Okay.

MEMBER WARSHAW: Yes, it would be some method of gathering this information from the accredited schools, and then, using as the

numerator the schools that were doing this and in the denominator the total number of schools.

MEMBER SOCHALSKI: Okay. Yes, and it would be like, with interprofessional, did you have any exposure or work in a team with a community health worker?

MEMBER WARSHAW: Right.

MEMBER SOCHALSKI: You know, that nurses are working with certified nursing assistants, those sorts of things.

If these are all component parts of it, and if we are going to have an integral workforce, they have to have these experiences.

CO-CHAIR LEFEBVRE: Okay. So, do we agree that this is high impact for the workforce?

What about feasibility? Do we agree that it is high feasibility?

Under assessment of community workforce needs, the measure concept is evaluate the composition of teams that are

performing well on national measure sets. The subdomain is team composition and function.

So, it is evaluating the composition of teams that are performing well on national measure sets. So, as a group, we decided that this was very similar to our other one. Oh, it has to do with the provider mix one.

I'm sorry, it's over here. Yes, this one.

So, they are very similar. Looking at the team mix and how they are performing on national measures.

Do we feel that this should probably go right along with the other one that we decided was high impact, low feasibility, again, in getting the discipline understanding what team mix is? Okay?

Under training and development, the measure concept is the hours of training, and in parentheses "clinical," in new delivery

systems. So, hours of clinical training in new delivery systems.

This sounds very similar to the ones that we just had. Oh, I think it was the one we just did. Oh, I think this was evaluation of faculty. So, one was evaluation of faculty to teach in new models, and now this one is the hours of training that are spent by the students. Okay.

So, is it understandable that that would go in high impact, high feasibility? Because if you are going to have well-trained faculty -- okay?

So, this is training and development, measure concept, hours of training in schools in new delivery systems. So, this one is based in the clinical training. And then, this is the other support staff throughout all disciplines in healthcare of hours of training in schools in new delivery systems.

It seems to me like those three go together.

MEMBER WARSHAW: I mean, there was a distinction made between training that would occur in the basic level of training that students would receive and, then, a lot of disciplines go on to some additional clinical experiences. And either one of those is probably a good place, then, to get those exposures to other sites of care, but we would have to probably identify a different survey group. You know, it would be probably surveying, in medicine it would be surveying like our residency training programs versus the medical schools.

CO-CHAIR LEFEBVRE: Right. Well, there's a lot of medical schools -- I know we have four medical schools; two of them I am on faculty on, and those two are both redoing their medical school curriculum right now to address some of these specific things about --

MEMBER WARSHAW: Right.

CO-CHAIR LEFEBVRE: -- you know, are they teaching how to improve on performance measures and those types of things?

MEMBER WARSHAW: Uh-hum. So, I think that's a moving, I mean, it is a measurable thing. So, we are going to see improvement.

CO-CHAIR LEFEBVRE: Right.

MEMBER WARSHAW: But I think the part that is really critical to these types of educational workforce measures is to really get a picture across all disciplines.

CO-CHAIR LEFEBVRE: Right.

MEMBER WARSHAW: We all have kind of our knowledge of what is going on in our own discipline. And then, we can get more sophisticated and start looking at how much of the training is going on in the disciplines working together.

CO-CHAIR LEFEBVRE: Yes. I love

some of that training in healthcare administration, too.

MEMBER WARSHAW: Yes. Yes.

CO-CHAIR LEFEBVRE: I think that it is a real deficit there.

MEMBER WARSHAW: Yes.

MEMBER KOVNER: I have been thinking about what new delivery systems means. And let's say we use this -- I guess I sort of think we are developing measures that will be good for "X" number of years. So, will there always be a need for -- let's just take academic programs -- to teach whatever the latest new idea is?

CO-CHAIR LEFEBVRE: In my opinion, yes, because I don't think we have achieved it yet. I don't think we're there with figuring out what the right model of care is yet.

MEMBER KOVNER: And we'll always be able to improve whatever it is.

CO-CHAIR LEFEBVRE: I think that is

what we should be teaching everyone who works in healthcare, is don't stop; it always needs improving.

So, this one is in recruitment and retention. The measure concept is the level of -- oh, okay.

Had I known I had to do this today, we would have done this differently yesterday.

(Laughter.)

So, this is the level of standard deviation from the ideal of forecasting at the state level. And this is where our group had to deal with workforce forecasting, which we discussed is an entire field of study in itself. And to our colleagues that have 30 to 40 years of investment in this field, we didn't feel it was right for us to develop their measure, but we did discuss that we felt that the accuracy of forecasting should be measured.

And so, I think this gets at -- and I think this one the ideal is a little bit

easier, meaning was the forecast correct; was the forecast right on? And if not, how far of a standard deviation away from correct was it?

And you continue to go back to the same meteorologist who gives you a poor weather forecast. I mean, I think that is really what we are talking about, is, do we continue to use the same workforce forecasting if it shows that it is not performing well? So, we made it more of an accuracy of forecasting.

What are people's thoughts on that? Are we clear? Is our group clear about what we are talking about?

CO-CHAIR GERDES: I think that might be an important measure if you look at it from the perspective that we don't really know how to measure workforce very well. That's why we are here today. So, that is kind of almost a referendum on how well or how poorly we are doing it.

However, if we don't know how to

measure workforce very well, what are we going to use for the middle, then, for the standard deviation?

CO-CHAIR LEFEBVRE: And what are we doing there?

CO-CHAIR GERDES: Yes. So, I kind of see it from both directions. So, feasibility is probably going to need a lot more work, you know, to get at that.

MEMBER KOVNER: But we do know how to do it in certain areas. And so, we can probably all agree that someone with A, B, and C characteristics would be defined as a physician. And therefore, we could make some prediction based on -- I mean BLS does it all the time.

It is more difficult to do it -- and Julie shakes her head because they are not always very accurate. We can't do that for community health workers because we don't know what they are.

CO-CHAIR LEFEBVRE: Tami?

MEMBER MARK: CMS for years has done projections of healthcare spending, and they got the same harsh -- you do all those projections, and we don't know if they are any good. So, the last year or so, they actually did go back and see how good their forecasting was, and it was useful. You learn things from them.

CO-CHAIR LEFEBVRE: Okay. Well, that's good to know.

MEMBER MARK: Yes.

MEMBER KOVNER: Was CMS doing demand or supply?

MEMBER MARK: Spending. Healthcare spending.

MEMBER KOVNER: But that could be demand?

MEMBER MARK: It is both, yes. Yes.

CO-CHAIR LEFEBVRE: Okay. So, we

do feel that this has a high impact. It is a high-impact measure, it sounds like. So, useful is good.

And so, then, judging from what Tami says, if CMS did this in other areas, it does sound like it is feasible. I don't know; it is way beyond my mental capacity to figure out how to do it. But I think that we agree that it is feasible by some really smart people figuring it out.

Okay. This merely has to do with my arm length; that's all.

(Laughter.)

So, this next one is workforce diversity and retention. The measure comes up as a community-level minority representation compared to the minority representation of the workforce, as represented in Census data.

And so, our group had lots of discussion about the fact that it should not be practice-by-practice, but it really has to be

the community as compared to the workforce in that community geared by Census data.

Any discussion on that? It seemed like a pretty -- it was our easy one. We got one easy one.

And so, impact, do we agree that that's high impact? It seems like it is pretty feasible when we are talking Census data. Okay.

This next one is workforce diversity and retention. This has to do with cultural competency. And it is the mean score on existing standardized tools for patient experience as it pertains to cultural competency.

And what we were talking about was the CAHPS tools and those types of things have great questions as to cultural competency versus you, as a provider, took a test to prove you are culturally competent. So, it is done on patient experience.

I told my group yesterday I would check, and nursing homes do not currently have standardized patient experience tools. So, in some parts of healthcare I think we are doing really well with this. Other parts of healthcare we're really not. I am guessing home health agencies don't have a standardized tool that they use for patient experience.

MEMBER MacINNES: Not that I know of.

CO-CHAIR LEFEBVRE: What's that?

MEMBER MacINNES: Now that I know of.

CO-CHAIR LEFEBVRE: Yes. So, I think this might be one case where it can drive the market. That is what happened with Press Ganey then moving to HCAHPS and those types of things. So, hopefully, that can make some changes there.

This is clinical community and cross-disciplinary relationships. The

measure concept is patient perception as compared to team-based care.

So, I don't know what group this is. Maybe two? Group one?

Patient perception --

CO-CHAIR GERDES: This I think was the one where we were grappling with what the definition of a team is. And your team is somewhat keyed to your current health situation, your family's health situation.

So, we were again trying to look at that from the patient perspective. Does the patient feel that they have a healthcare team that's functioning adequately with what they would expect out of a healthcare team? Because defining the team is going to be difficult to do.

And I gave a couple of examples from our health system. We went ahead and just asked our patients, "How satisfied are you with how your healthcare team is functioning as a

team, essentially?" And we gave them a five-point answer to feed back to us.

So, that might be a patient survey that kind of goes in tandem with some of these other patient-survey-type metrics we were talking about.

CO-CHAIR LEFEBVRE: Uh-hum. Okay.

CO-CHAIR GERDES: And again, looking at perception of adequacy of team-based care for the patients.

CO-CHAIR LEFEBVRE: Okay. I think that is perception of adequacy of team-based care.

CO-CHAIR GERDES: Yes, and that would help us capture who the workforce is really, you know, and the eye of the consumer.

MEMBER SOCHALSKI: The more that you talking, I think you're right; the patient experience is the voice that is missing. There has been a little too much gild on workforce.

And this is that opportunity to take a look at that and say okay. And so, you are not going to go all in one direction.

We really do need a healthy voice out of the experience and to be responsive. I mean, we know sort of clinically what needs to be trained. That's not what is not getting to people.

CO-CHAIR LEFEBVRE: Right.

MEMBER SOCHALSKI: What isn't getting to them is the behavior changes and the support to be able to stay healthy. And so, what has to fill-in around that? What is missing in our training? What is missing in our numbers? What is missing in our interactions?

CO-CHAIR LEFEBVRE: Right, and that can come out in those patient experience scores. And I think that the industry's response to those patient experience scores -- so, if your facility is supported by

a public payer, you know, Medicare can now insist that you collect this data. And so, that is how the CAHPS surveys came about.

I think it would be great to move this. And so, do we agree that that's high impact, high feasibility? The patient's perception? So, feasibility would have to be included in a patient experience. I don't believe that that is in CG-CAHPS right now.

CO-CHAIR GERDES: I don't think there is a specific question about team now.

CO-CHAIR LEFEBVRE: I don't think there is, either.

Yes, it was your experience, but it doesn't really talk about your team. So, does that make this high impact, low feasibility? I mean, I think it is feasible that it come out as a recommendation to be added to those surveys, but I just don't know. So, do we want to leave it as high feasibility? Okay. Good.

MEMBER KOVNER: I vote for moving

it down a little. I keep thinking about my mother who is 93. She has no idea who her team is and, in fact, really wishes she didn't have a team -- (laughter) -- because she doesn't like talking to the nurse practitioner. She only wants to talk to the doctor, the geriatrician.

And she really dislikes it when whoever is taking care of her puts her information in electronically and doesn't look her in the eye, the way people are supposed to.

CO-CHAIR LEFEBVRE: So, that is what we are getting at, is the patient's perception of that adequacy of their healthcare team. If her perception is poor, I think that that's fine. That is all the more reason why to collect that data. We think you having a well-rounded healthcare team is great, and your mother wants a doctor's cell phone number, period. And I think that that's her perception of her healthcare team. And I think that that is the information we need to collect.

MEMBER KOVNER: Oh, I was thinking more in terms of who is on the team. She would be clueless about that.

CO-CHAIR GERDES: I mean, this is your satisfaction with the team. So, if 50 percent of the survey population comes back and says, "We hate teams," what are we doing?

CO-CHAIR LEFEBVRE: Right. Then, why do we keep training people to work in teams, right?

CO-CHAIR GERDES: Right.

MEMBER SOCHALSKI: I am not sure that the lens is turned fully in the direction -- it is a little too much of our vision of what works, some of which is very effective. But if we are going to move it, you know, to make it a little clearer, it is to have that voice and to see what those were.

Maybe teams don't work because they are not really effective teams; they are not talking to one another. So, why is a skill in

HIT important? It is important so we can deliver more comprehensive care. You know it is not just knowing it for the heck of it. It is, do we use it? It has got to serve the end, you know, not become the end.

CO-CHAIR GERDES: We in this room, I mean, we know more about healthcare than the populace, obviously. And we do have to put on our safety hats, you know. I mean, a lot of times we are talking about life and death, making these decisions. So, I think the public relies on our expertise to advise them from a safety perspective. So, we do have to keep that in mind.

However, it is useful to get feedback of public perception, especially if we are asking for public funds to fund these things, because whether we like it or not, that is heavily shaped by public perceptions. So, I think we do need to know that.

CO-CHAIR LEFEBVRE: Well, and I

think that that is a great thing. Because, then, your response, your facility's response to the answers is up to you. So, if you get a 50 percent score on this, you could decide to shape your teams differently. You could decide to educate your patients about the importance of a healthcare team. I mean, there are different responses that you can make about why you feel these scores are low. That is why this is an improvement method.

So, workforce diversity and retention. The measure concept is retention as measured in discipline area, geographic location, organization, industry, and employment versus unemployment.

And so, I think what we were saying was that, in order to really get at retention, you need to look at it in different components. So, it is not just discipline. It is not just the geographic location. It is all of these different components built up, you know, a full

view of workforce retention. And each one of them I think would have different data sources.

MEMBER WARSHAW: I think that is right, and I think there's probably some disciplines that we want to pay particular attention to. So, when we have been talking about this, we have talked about the direct-care workforce and the value of continuity in settings, particularly in nursing homes, and high turnover is not a good quality measure in nursing homes. So, that is a special target.

Another one that we talked about was the primary care providers and people that start out on that career track and are they staying in that career track.

So, I think we would have to define sort of the measures based on each discipline and what our objectives are. Somebody even, I think, brought up yesterday that in some settings some turnover may be good --

CO-CHAIR LEFEBVRE: Right.

MEMBER WARSHAW: -- depending on if they are actually looking at the quality of the performance of people, and they are deciding that they need to change.

CO-CHAIR LEFEBVRE: Like in North Carolina, one of our deficit areas is general surgery.

MEMBER WARSHAW: Okay.

CO-CHAIR LEFEBVRE: I mean, we have a huge deficit in our rural areas. Our small hospitals stay open because of general surgery. And if we don't have enough general surgeons working in critical access hospitals, those communities lose their hospitals.

And so, I wouldn't say that surgery is an area that needs to look at workforce retention, but, absolutely, general surgery in rural communities absolutely does. So, I think that is kind of exactly the same thinking as why you can't just look at the discipline.

You have to look at the geographic location. You also can look within organizations, you know. So, a federally-qualified health center and their needs serving an underserved community versus an ACO might be two different things.

Okay. So, impact?

MEMBER WARSHAW: I think for the types of things that we are talking about, the very specific challenges, these are high impact.

CO-CHAIR LEFEBVRE: Okay. And feasibility? I think there is a lot of data sources in here. It is just having the smarts to make them work together, I think.

MEMBER WARSHAW: Uh-hum.

CO-CHAIR LEFEBVRE: Julie?

MEMBER SOCHALSKI: I think that the feasibility goes up by doing the approach of what you're saying, which is to not take any one of those in isolation, but to think creatively

about how you use them. And so, the goal is to ensure we are able to meet patient and family needs. And it will change by area.

So, what do you need to know in order to be able to do that's the metrics. So, we are not going to say, you know, at this point in time, do we have enough general surgeons. What we want is a system that is dynamic enough or metrics that are dynamic enough to tell us we need to turn up the gas here or somewhere or we need to do something to meet a need.

And it could be regionally-specific. It could be discipline-specific. It could be need-specific. And that's where the creativity comes. So, how do we get psychiatry to areas where we are never going to be able to get psychiatrists to move? What do we do? How does that move that forward, some of which is workforce and some of which is workforce skill?

CO-CHAIR LEFEBVRE: Right.

MEMBER SOCHALSKI: But it is taking them into --

CO-CHAIR LEFEBVRE: But we have to know it first. So, we have to measure it. Okay.

Okay. Did we do this one? Okay. So, training and development. The measure concept is the use of the training in core competencies. So, the last one was access to, and this one is use of.

Does anyone in group two want to talk about this a little bit? I mean, I don't know how you measure this? Anybody have any good measurement ideas?

This is the one, the measure concept is the use of training in core competencies. I think we discussed earlier the access to training in core competencies, but this is getting at the use of.

MEMBER WARSHAW: Well, I mean, I think, once again, it was part of our series of

topics that we thought were really core skills. So, I guess this had to do with what was going on in practice.

I'm not quite sure how far we got on thinking about how we might measure something like that.

So, like if you are looking at skills related to interprofessional care, I mean, you can look at the training aspects of that. But, then, the question was --

CO-CHAIR LEFEBVRE: Did they do it?

MEMBER WARSHAW: -- is there activity going on? And we agreed that, although there are methods for looking at how teams function in actual clinical settings, that those are not going to be easy data for us to collect. It may be something that an individual health system might do as part of their quality improvement. But on a national scale it might be kind of hard to do.

So, I think it is important, but it

is probably low feasibility.

CO-CHAIR LEFEBVRE: So, maybe high impact, low feasibility?

MEMBER WARSHAW: Feasibility, yes.

CO-CHAIR LEFEBVRE: Does everyone agree with that? Okay.

In the area of experience, the measure concept is using existing CAHPS for member and patient experience, using CAHPS to address specific issues identified from survey. I think this is just getting at -- so, I am not sure. This might be group two again. I'm not sure who had the experience.

MEMBER KHAN: So, it is group two, and there are a number of questions, maybe three, that were addressed. Member experience and speak to, you know, did you get your needs met? Was your physician or provider able to help you --

CO-CHAIR LEFEBVRE: Explain it?

MEMBER KHAN: -- explain it, yes,

exactly. And it really is about comprehension or the accessibility of whatever is being offered to you, to the recipient. So, trying to be more patient-centric or person-focused in the assessment.

CO-CHAIR LEFEBVRE: Uh-hum.

MEMBER KHAN: And that was the intent of that.

CO-CHAIR LEFEBVRE: So, then, the idea is so many places are collecting this data, but nobody gathers it. So, is that what I'm understanding, is that saying that it's what we want to do is use this recommendation to push them a little further, so they have to submit their CAHPS data?

MEMBER KHAN: Yes.

CO-CHAIR LEFEBVRE: Okay.

MEMBER KHAN: So, this would be looking at their CAHPS results, uh-hum, specifically.

CO-CHAIR LEFEBVRE: Right.

MEMBER KHAN: And Julie and I were just talking, and this is really one source at least potentially --

CO-CHAIR LEFEBVRE: Right.

MEMBER KHAN: -- that we are not fully mining, I think, and taking advantage of.

But I think, more broadly, this morning as I have been thinking about the workforce, we have been a bit myopic in thinking about this being a healthcare professional, and thinking about, Gail, some of your comments from our group and yesterday in general. And, to me, there is a bigger educational, general educational potential need to say, whether it is primary or secondary education, what have you, what is being taught about health and health behaviors and navigation of the healthcare system?

CO-CHAIR LEFEBVRE: That's right.

MEMBER KHAN: I mean, it is sort of just really basic stuff.

CO-CHAIR LEFEBVRE: Right.

MEMBER KHAN: And I don't think the healthcare system is going to be able to explain all that and address all that gap in education.

CO-CHAIR LEFEBVRE: Right.

MEMBER KHAN: You know, this gets into a more public health sort of arena, but certainly general education to me seems like maybe there is something through the educational surveys that can assess whether or not this is even taught anymore.

CO-CHAIR LEFEBVRE: I think that is a great point. So, like on the CAHPS survey, if everybody comes out as being low in this certain area, is it the healthcare system, which it may be, or is it just that patients don't understand what they should expect from the healthcare system?

MEMBER SOCHALSKI: So, I think it is taking CAHPS, but you've got to do something with it.

CO-CHAIR LEFEBVRE: Right. Right.

MEMBER SOCHALSKI: So, the locus of that responsibility --

CO-CHAIR LEFEBVRE: Because everybody is bragging about the fact that they have CAHPS, but --

MEMBER SOCHALSKI: Right, yes. And I don't know how widespread it is. Like does everyone require it? Do you raise your hand and say, "I am going to do it."?

CO-CHAIR LEFEBVRE: Yes.

MEMBER SOCHALSKI: Because you would want it to also be tied to some of the other things that we said. So, how does that change curricula? How does that --

CO-CHAIR LEFEBVRE: Yes, it gives you a data source for a lot of the other measures, if we can get it so that it is mandated that they submit their CAHPS data.

Okay. So, that seems high impact,

and it seems like feasibility, because we have a lot of these, but we need home health agencies, long-term care facilities, all of those, to start recognizing patient experience.

MEMBER MARK: I did check. There is a CAHPS nursing home survey.

CO-CHAIR LEFEBVRE: There is?

MEMBER MARK: Yes.

CO-CHAIR LEFEBVRE: Great. So, I checked with my sister last night, who is a nursing home administrator, and she said that they do not do one, and she runs a very large nursing home. So, I think that's great to know that there is, but it is good to know that in the industry they don't do it.

MEMBER BERLINER: I thought it was part of the Star Rating.

CO-CHAIR LEFEBVRE: She said that her organization hires a private contractor to do patient surveys, yes, and they build the

surveys as to what they want to ask.

Anyway, under capacity and productivity, the measure concept is infant mortality rate in county or state as compared to workforce credentials or team mix. So, whatever you designate as wanting to know in the workforce as compared to the infant mortality rates.

And again, our group looked at this as, well, how can we look at general health, not just use of the healthcare system, but general health?

Any thoughts on that?

(No response.)

What about importance and feasibility? Or impact and feasibility?

MEMBER SOCHALSKI: Currently, these are data that are available or data that would have to become available?

CO-CHAIR LEFEBVRE: I believe they are available. I believe we already in this

country compare states' infant mortality rates.

MEMBER SOCHALSKI: Right.

CO-CHAIR LEFEBVRE: So, it is at least at the state level. I don't know; it probably can be drilled down?

MEMBER ZINKEL: Yes, they have it at the state level. I don't know if it gets down to zip code or county --

CO-CHAIR LEFEBVRE: Yes.

MEMBER ZINKEL: -- or anything like that.

CO-CHAIR LEFEBVRE: I don't know, but it certainly is collected. And then, I think you can compare that across your -- some of this data we already have. So, you have a ton of data as MD per state. So, compare licensing board to infant mortality rate data, and you get what we are talking about.

MEMBER KHAN: You know, I feel like there is some exploration, maybe looking at

this metric, potentially even looking at other national surveys like NHANES or BRFSS, and looking at that in terms of geographic variability. I think there are data in there that may actually be quite informative that relate to behaviors. And then, look at maybe, again, linking that with a certain aspect of what sort of access to care is available or what have you.

CO-CHAIR LEFEBVRE: Right. How is healthcare delivery supported in this region type of thing? And so, yes, what we were looking at, we used the infant mortality, but we were looking at was a general health score versus performance on a measure score.

So, impact? Do we feel that that is high or low impact?

MS. PRINS: I thought this was actually a really interesting way of looking at things, because I think we have Healthy People 2020 and we have a lot of sort of national-level

goals. But I don't think, you know, as far as the National Quality Strategy or we have the Triple Aim, better care, better health, lower cost, but we don't actually have an indicator or a metric.

CO-CHAIR LEFEBVRE: Yes.

MS. PRINS: So, this was actually intriguing to me because, while I think just looking at one would be kind of -- I wonder if it is a bigger or broader recommendation that this group could make. You might want to look to certain national-level indicators that could be looked at state-by-state or at a community level that are really, really important and that speak to sort of the integration of healthcare or community health. And so, maybe this is one that gets at a really important population, but --

MEMBER SOCHALSKI: Yes, that was one of the things I was thinking about that I was going to raise at the end, is the context

for this work that we are doing. So, we will vote and come up with metrics and all of this.

But I think there is a lot of context we don't want to lose that is going to be critical to capture because we are so underdeveloped in the way that we integrate even our thoughts about workforce vis-a-vis outcomes. I mean, it is still pretty clunky and pretty linear.

And so, is there in that broader context of what are we trying to do, even the discussion of patient engagement and all of that, I mean, that as a focus for what we are trying to do and how we are trying to shift I think would be very important to capture, to understand where we are going with this, and pushing some of the rest of this.

And so, that may be the next-generation discussion about that, but that is really where the discussion about workforce needs to go because it is about need

and skills-matching need, not people, skills-matching need. I mean, it is done by people, but what are the various ways we can do that?

MEMBER ZINKEL: And we just chose infant mortality as kind of one example, but you could use any quality metric out there and compare that to numbers in the workforce or skill --

MEMBER SOCHALSKI: But doing that, you know, that's not something that is conventionally done. We do these projection models, you know, over there in isolation.

CO-CHAIR LEFEBVRE: Yes, and one of the things we talked about is internationally we judge other countries according to these measures and what is the health of their population. And so, we were looking at, well, what is the health of our population and how does the supply of healthcare workers support that?

This is the last one, folks. Clinical and community and cross-disciplinary relationships. The measure concept was a facility's use of team-based care.

And we have had quite a bit of discussion about this. I think what I heard was team-based care, we all think it's great, but we don't really know what its impact is on health.

So, where do we see this in impact and feasibility? I mean, I think we all feel strongly that it is needed.

MEMBER SOCHALSKI: Would you read that again?

CO-CHAIR LEFEBVRE: A facility's use of team-based care.

CO-CHAIR GERDES: We had talked about -- I think, is that an infrastructure one? We had talked about in our group the difficulty in defining team. Because if you ask any hospital in the United States today, "Do you use

teams to provide care?", they are all going to say yes.

So, we looked at that. I almost would say that is kind of a lower priority, maybe in the lonely lower left square over here.

(Laughter.)

Simply because we wanted that to be an important concept in the future, we do think that needs to be measured, but we need a better definition of team and we need that consumer perspective of is this important, you know, in how we define team. And then, measure who is delivering that.

CO-CHAIR LEFEBVRE: Maybe if we can get it over here in some of the CAHPS surveys and those types of things, then being able to draw it out as to which facilities are high-performers and using team-based care and those types of things.

CO-CHAIR GERDES: Right.

MEMBER SOCHALSKI: So, if it was

more feasible to measure, so you improve definitions, would the impact be high or low? Because, right now, it is in low impact, low feasibility. I mean, I don't know. Yes, I am thinking out loud.

CO-CHAIR LEFEBVRE: It is currently in low impact, high feasibility. Or, no, it is in low/low. Sorry.

MEMBER SOCHALSKI: I was asking, if we got better -- do we think it is important enough and could have a high impact? Right now, we are just not there. So, it is not really feasible now. But, if it became something, it has an opportunity to have higher impact.

CO-CHAIR GERDES: Yes, but I look at it as kind of several years out, kind of future-direction-type thing.

CO-CHAIR LEFEBVRE: Yes, I agree, I don't think we know. I think that is the problem, is I don't think we know yet, but it

has potential.

Okay. I think that's all of them. So, thank you for your patience and your participation.

CO-CHAIR GERDES: Okay. At this point, I am going to hijack the agenda a little bit. I think here I will do a little agenda management, if that is okay.

Because we are a little behind -- our next exercise is actually to vote on these pages. So, we have a set of stickers that would indicate high, medium, and low priority for these pages up there. And our task is going to be to place the stickers on the concepts to indicate our assessment of priority.

And I think that word "priority" is purposely a broad word. So, you can fold into there financial feasibility, impact, importance, et cetera. But just your personal view.

I have counted up there. We have about 17 in our favorite square and about eight, I think, in the other ones. So, in looking at these, we are going to get a set of three stickers by color.

I would just kind of toss out there maybe everybody gets 10. Then, we would have 100 votes up there because there's about 10 of us here. Does that sound right to everybody?

MEMBER SOCHALSKI: So, we would place our 10 priorities out of all of them?

CO-CHAIR GERDES: Is that what you would like to do? Because we have opportunity for three different colors to be high, medium, and low priority.

Maybe we will do nine to make it easy, and we get three, three, and three. Does that kind of resonate with everyone? Is that the way the group would like to do it, to kind of force some prioritization?

Okay. So, we will do it that way.

MEMBER SOCHALSKI: Three high, three medium, three low.

CO-CHAIR GERDES: So, why don't we vote and take 30 minutes to do voting, mainly sticking them up there, and take a break? Reconvene about 11:45.

Will that give you time to kind of summarize? Does that work? So, pick up your stickers.

We have public comment now, yes.

MS. LUDWIG: I am going to hand out stickers, and we will do the traditional traffic signal. So, green is top priority, yellow is secondary priority, and third is bottom priority.

CO-CHAIR GERDES: Okay. So, is that going to be red?

MS. LUDWIG: So, green, yellow, and red.

CO-CHAIR GERDES: Green is go?

MS. LUDWIG: Green is go; second,

proceed with caution. Third is stop, but not really stop, but, yes, it is a lower priority, the lowest priority.

CO-CHAIR GERDES: Green, high priority; yellow, medium priority, and red, low priority. So, make sure you get three of each and put those up there, and take our break.

Right before we break, we do need to have opportunity for public comments.

So, Kathy, did you want to open the lines for public comment?

THE OPERATOR. At this time, if you would like to make a public comment, please press *, then the number 1.

There are no public comments at this time.

CO-CHAIR GERDES: Okay. Laura, do you have any comments on the chat line?

Okay. Any comments behind us here? Public comment?

(No response.)

No? And anyone on the phone?

(No response.)

Okay.

MEMBER ALEMU: I know it's late, but I just want to mention about team-based care. A lot of work is being done now, and it is premised on team-based care works.

And I recently had the group, I think professionals from different disciplines. And there was a discussion on this issue, team-based care, in the population on teams working together.

And I think it can be a high-impact area, but the feasibility, as you mentioned, you know, at this moment it may be a little bit difficult.

CO-CHAIR GERDES: Right.

MEMBER ALEMU: But the impact is very high. And really, the focus group, which was a symbol, there was opinion that this is something which should be moved forward.

And so, if you look at our teamwork, this is one of the items, important items. So, I think personally that it is a high-impact area with difficulty of getting some data on that one at this moment. So, I just recommend to move it to a high-impact area.

CO-CHAIR GERDES: All right. Thank you.

If we all put red, or green -- I'm sorry -- on that one, that would seem to prioritize it.

So, we will go ahead. I think we have one more comment. And then, we will go ahead, take our break, make sure the votes get done, and then, come back by 11:45.

MEMBER SOCHALSKI: And so, just for clarification, because I think it is good, our notion of priority is you are leaving the definition broad because, then, we also see what we are prioritizing.

CO-CHAIR GERDES: Right.

MEMBER SOCHALSKI: And so, when I look at team-based care, when I think about, I am thinking about it as a priority, why I would prioritize it. Does it work? You know, is the evidence solid that it works? And what does that mean by "working"?

So, it is the best way for people to understand what each other does and to change the mix of the workforce and do things more effectively. That is not an outcome. That is a patient -- I mean, there may also be one.

So, we are using different things, which I think is good in trying to move that forward. So, I just wanted to clarify that is like using in our heads what we think.

MEMBER PILKINGTON: Which color is which?

CO-CHAIR GERDES: Green is high priority; yellow is medium, and red is low. And nobody be funny and put blue up there. Okay?

(Laughter.)

(Whereupon, the foregoing matter went off the record at 11:20 a.m. and went back on the record at 11:57 a.m.)

CO-CHAIR GERDES: Angela is going to kind of summarize for us the dot project. Do you like the "dot project"? Yes, the dot project.

(Laughter.)

MS. FRANKLIN: Thanks, Melissa.

And thank you all for being so engaged in this process. We have got a lot of good concepts, and we had a lot of good participation in placing the dots. We really value this input.

So, this is going to be highly unscientific, as we are looking at the various quadrants that we have here. And it is clear we have a lot of measures in the high-impact, highly-feasible quadrant of our grid.

And it looks like our top concepts

came out as patient access to ambulatory care under the infrastructure piece. Under capacity and productivity, ratio of healthcare workforce discipline-specific workers to specific populations.

And this was one that was interesting because we noted it was also possibly a baseline measure. And so, we had our next highest appears to be the clinical community and cross-disciplinary relationships category, patient perception, team-based care. And this would include the perception of adequacy of team-based care, where we had five dots. So, that one was a highly-voted measure or concept.

Under workforce diversity and retention, we had four green dots for retention, as measured in disciplinary, geographic location, organization, industry, employment versus unemployment.

Also very highly rated under the

experience subdomain was using CAHPS for measure and patient experience? And that is using CAHPS to address specific issues identified from a survey with six greens dots.

We also had under capacity and productivity this measure concept of infant mortality rate -- I think we said by state because county would be difficult -- as compared to workforce credentials, team mix. And we were thinking of this as a proxy for general health, with four dots.

We also had some middle-of-the-road measures which we will capture in our report, but I wanted to go to measures that we felt at this time appear to be low priority.

So, starting with still in the high-feasibility, high-impact area --

CO-CHAIR LEFEBVRE: These are middle-of-the-road.

MS. FRANKLIN: Right.

CO-CHAIR LEFEBVRE: So, no dots?

MS. FRANKLIN: I think what we were saying --

CO-CHAIR LEFEBVRE: We'll stop at the no dots.

MS. FRANKLIN: -- was red wasn't that you didn't feel it was a priority.

CO-CHAIR LEFEBVRE: Right.

MS. FRANKLIN: Red was that you feel it was less of a priority than the green.

CO-CHAIR LEFEBVRE: At this time.

MS. FRANKLIN: But the ones with no dots at all would be of lowest priority.

CO-CHAIR LEFEBVRE: Correct. That is correct.

MS. FRANKLIN: So, interestingly enough --

CO-CHAIR LEFEBVRE: I think one way to do it, it might be total number of dots, no matter what the color. And then, of those with the highest number of dots, how many of them were green would give, you know --

MS. FRANKLIN: Give us the calculation of --

CO-CHAIR LEFEBVRE: -- maybe like a priority and urgency-type rating.

MS. FRANKLIN: Yes. Correct, although I can't do that at this moment in time.

(Laughter.)

CO-CHAIR LEFEBVRE: I think it might be just looking at the ones that had a lot of dots on them.

MS. FRANKLIN: Yes, yes. So, let's see, so I think we covered the ones with like a whole lot of dots on them, and did we talk about this one, clinical and community relationships, patient per section, team-based care? Not a whole lot of dots. I think we already talked about that one.

The experience of care seemed to have a whole lot of dots at eight for our previous topic here.

Training and development, we're at

five dots on that one.

And for hours of training in schools, new delivery systems, training and evaluation of current faculty to teach care in new models and competencies, very many dots at nine.

And training and development, that kind of falls into our middle-of-the-road in terms of hours of training, clinical and delivery, and new delivery systems.

But, again, this is how we unscientifically need to kind of evaluate the dots and the priorities that the Committee members have assigned here.

But suffice it to say we do have a number of these high-priority, high-impact dots and measure concepts that we will be capturing for the record and including in the report.

And as, Ann, you were saying, even where the one zero-dot area is training and

development, the measure concept, use of training to improve access via health IT, and that's in our high-impact quadrant, but low-feasibility quadrant. And so, we would probably put this in the report in a parking lot category to discuss the issues that are captured earlier in our conversation around this particular concept and concerns from the Committee.

Do we want to talk about the one dots?

CO-CHAIR LEFEBVRE: And there's some over there with four or five dots to your left there.

MS. FRANKLIN: Oh, yes, these.

So, this is over here in high impact, low feasibility. This one has five dots, and it is the measure concept evaluate the composition of teams that are performing well on national measure sets. The subdomain will be team composition function for this one. So,

it sounds like a lot of interest in seeing maybe this be a high-priority measure but with some issues with feasibility addressed.

Capacity and productivity, the concept is we have four dots for this concept, which is performance on national measure sets; for example, the ACO sets as compared to team mix, which would include provider mix and workforce credentials. And that is under the subdomain of workforce effectiveness and efficiency. So, four red dots on that one, again, which seems to indicate the Committee wants to elevate this measure as a high-impact measure, but, still, there are issues with data and evidence base.

Two dots, practice to community resources in the high-impact, low-feasibility area. Again, falls in the same category of high impact, issues with the evidence base and data.

And then, of course, let's see, one

red dot here. Amount of standard deviation from ideal workforce retention and recruitment by discipline. And I think we talked through many of the issues around this one.

And one little dot for training and development. Use of training and core competencies, and there was a note that this might be useful for QI only, and that will be reflected in the report.

Are there any reactions from the Committee on kind of what we have clustered high-impact concepts or high-feasibility concepts or, conversely, the concepts that are high impact, low feasibility? Any reactions?

We talked through a lot of the issues as we were doing this exercise.

Any general comments about the measure concepts that we have come up with?

MEMBER KOVNER: I said earlier, Melissa, that I'm sorry that I didn't bring up in my small group yesterday issues around

public health. Because I think all of these are very health-system-focused rather than public health.

And so, for example, major problems that we have in terms of health in this country are gunshot murders, suicide. I mean, suicide maybe could go here, but lung problems, heart and lung problems from air pollution, wearing seatbelts.

And we didn't talk at all about who are the health workers who make some of that happen. And so, are they environmental scientists who work at the Health Department or public health nurses? We didn't touch on that, and I'm sorry that we didn't.

MS. FRANKLIN: Any other comments?

MS. PRINS: Angela, I think as a next step, maybe when the group is at lunch, maybe we can, like you were saying, Ann, maybe do some counts and tiering and see. Because I think some of these cluster together, too, that

might be sort of combined.

I mean, I don't know how many are up there, 20 or so, 17, 18, but I think we can do some different organization as opposed to the feasibility and impact, now that there has been some dot voting. And then, we can sort of flesh that out a little bit more and bring it back to the group.

MS. FRANKLIN: Okay. Any more comments before we break for lunch? And I'm standing between lunch and everyone.

Ann or Melissa, did you have comments?

CO-CHAIR LEFEBVRE: No, I don't think so. I do think that kind of being able to visualize which had the most dots and which had the most green dots, you know, those types of things, the most red dots, you know, I mean, five versus five, there's a lot to say for five green dots.

So, I think somehow -- I don't mean

to put pressure on you all to get that done in a short period of time, but I think that that will help us kind of visualize. Because, then, I am interested in, do they cluster in some of the subdomains of workforce retention and patient experience? So, what subdomains received more dots and, then, more green dots I think would be interesting.

MEMBER KHAN: I am not sure how you would sort them other than just weight them with the dot. Green is three, and two, and one. And then, just kind of look at it that way. And I realize that one green dot is worth three, what, red dots, but whatever. But I do think that might be a way to at least start.

CO-CHAIR GERDES: I think they are kind of working on setting up lunch. We are technically supposed to go at 12:30. So, when they are ready, we can go. There is some food back there, I see. So, we can go to lunch and take a little bit extra lunch.

We will be back at one o'clock, then, for a round robin discussion of themes and future development of measures to go into our report to HHS. And we have some questions to TF. And then, we will also look forward to the ranking and subdomain mapping reports. Okay?

(Whereupon, the foregoing matter went off the record for lunch at 12:10 p.m. and went back on the record at 1:04 p.m.)

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

1:04 p.m.

CO-CHAIR GERDES: So, we have just one session left this afternoon. And then, we can go to our travel plans.

Angela is going to detail for us what she has done up on the purple sheet here as far as clustering our concepts into groups, based on our voting.

And then, we are going to have a discussion about themes and future development of measures that would go in our recommendations report to HHS. So, that is an opportunity, too, to bring up any ideas you feel in retrospect have been left out or any ideas you really feel are important for future direction.

MEMBER KOVNER: Would you go through the process of, once the report is written and we sort of all agree to it, just tell us what happens next.

CO-CHAIR GERDES: That is a wonderful question, and we just did a little round robin at this end of the table. We will do that at 1:50 with our wrapup because I have gotten that question a lot of times. So, thank you.

Yes, Angela?

MS. FRANKLIN: So, just real quick, and thanks to Wendy Prins for helping kind of organize our thoughts and voting here.

We organized them with not a lot of regard to our inputs and outputs buckets, but we, instead, organized them by category, such as access and experience of care, team-based care, health proxies, composition of the workforce and forecasting, as well as competencies and use of health IT/HIE technology, so infrastructure measures.

So, just to recap quickly, in the access and experience category, we had the measure concepts of using existing CAHPS for

numbers in patient experience. That received 22 votes by our weighted-vote count. And the measure concept of patient access to ambulatory care, which received seven votes by our weighted count of our top priorities.

And then, in terms of looking at teams and the team-based care, we landed as the highest priority in this particular topic area on patient perception, team-based care. So, the perception of the adequacy of team-based care was rated very highly, followed by a measure concept around evaluating the composition of teams performing well on national measure sets, followed by performance on national measure sets compared to the team mix, provider mix, and workforce credentials.

Access to services for social issues is the next concept.

Facility use of team-based care coming in at the end, as well as practice to community resources.

And we believe these last ones are not less important, but I think they fall short in terms of feasibility.

In the health proxy category, we had the excellent measure infant mortality rate in a state as compared to workforce credentials. And we agreed this was a general health proxy.

And we felt, also, that there could be several measures that could be unpacked from this concept. So, this was deemed as a very high priority in that area.

In the topic area of forecasting and composition of the workforce, retention as measured in disciplinary or geographic location, organization, industry, employment versus unemployment was the highest priority in this particular topic area, followed fairly closely by ratio of healthcare workers, specific discipline workers to specific populations. Again, that was a baseline measure, but highly important, deemed highly

important, of course, according to our vote.

Followed by community-level minority representation compared to minority representation of workforce, as represented in Census data. So, highly impactful and feasible.

Then, followed by mean score on existing standardized tools for patient experience as it pertains to cultural competency.

Level of standard deviation from ideal forecasting at the state levels, our next concept.

And then, the concept of amount of standard deviation from the ideal workforce retention and recruitment by discipline.

So, we also clustered our competencies in a group. And the highest-weighted competency was evaluation of current faculty to teach care and new models in terms of hours and reteachability, followed

closely by hours of training in schools and new delivery systems. So, we are thinking about medical schools, nursing schools, all disciplines.

Core competencies in care of older adults, followed by hours of training, clinical training, and new delivery systems, and use of training and core competencies falling into the QI category.

And highest ranked in the health IT kind of infrastructure bucket, use of telehealth -- I'm sorry -- telehealth in shortage areas, use for decisionmaking, and there's basically use of telehealth as a workforce extender. So, again, this is a great measure concept from which we think several measures could be probably developed.

Followed by true meaningful use of HIE. These are closely-related measures.

And then, the next measure concept would be integrated personnel, HIE personnel,

or the number of health systems on HIE, followed by e-approval for prior authorization, followed by patient ability to use after-visit data using portals of access.

And then, our lone measure concept that got no votes was use of training to improve access via health IT.

Any questions about that whirlwind tour of our voting? Any reactions?

(No response.)

Well, that was intentionally brief.

Melissa said we will go around and we would love to hear from you additional thoughts, any areas that we didn't kind of touch on in any of our discussions today and any thoughts you want to have us take away from today's and yesterday's discussions.

CO-CHAIR GERDES: I will open it up for any kind of burning platform issues, if anyone feels strongly about particular concept areas or, in addition, if they feel any concept

areas were left out and need to be elevated.

MEMBER MOORE: I apologize, I missed the morning. So, this could have already been discussed, and you'll just be catching me up.

But one thing I didn't see up there -- and I think I kind of understand why -- the scope-of-practice issues. I think it is challenging to even think about a metric. On the other hand, a lot of what we need to understand about the workforce could tie to that.

So, I guess I am just interested in, did it come up or was there any thought given to how one could deal with that issue?

CO-CHAIR GERDES: Does anyone have any comments on that?

CO-CHAIR LEFEBVRE: Well, it didn't come up, or at least not as I heard it specifically as scope of practice. I think it is a challenging area. I think a lot of times,

when you mention specifically the term "scope of practice," people tend to think of nursing. But I will tell you that I think it is discipline-wide.

My background is in social work. Talk about a diverse scope of practice. And like I said, I would have to change what I do according to what physician I worked with.

So, I think scope of practice, if we are going to have a discussion on it, I hope we can expand it to being of the healthcare workforce, yes.

MEMBER MOORE: Absolutely. I think there is a lot of attention paid to the scope-of-practice issues related to nurse practitioners. But I think it is also, you know, yesterday when Ed talked about home health agents being allowed to repackage medication, that is on the table in New York. And so, I think it is not just what people are allowed to do, but what falls under the

delegation authority.

CO-CHAIR GERDES: Thank you.

MEMBER ZINKEL: I think we had that conversation maybe as a side conversation, but, you know, the only way to really get a good idea of scope of practice is to go state-by-state, look at legislation, and document every discipline and what legislation has gone through to allow them to change their scope of practice. And without that analysis, you can't really create a measure that is going to work across the nation.

CO-CHAIR GERDES: We specifically talked about that in our work group and decided that was a research project and not a measure. So, we kind of tabled it for that reason.

CO-CHAIR LEFEBVRE: I think, too, in that discussion we have to talk about areas of need, too, because what you do in an area that has a very low healthcare workforce, you know, we can't make broad, sweeping goals about what

we are going to do with scope of practice and, then, say, "Well, that's all right. In this healthcare shortage area, those don't apply."

So, I think we have to be really careful about making sure that they are set to what we mean. And then, we all need to make sure that we are willing to change what our profession does according to what those decisions are.

So, like, I mean, in places where there are plenty of providers, there's differences than in this county where there is one provider. And if that provider happens to have different letters their name, they are willing to live there.

So, I mean, I think those are some of the things that have to come into consideration with scope of practice, is needs areas.

MEMBER KOVNER: But what worries me about that is to say, well, you know, for the

poor people in the urban city, it is okay if nurses, regular nurses, prescribe medicines, but in Manhattan, where there's plenty of physicians and nurse practitioners, it is not okay. I mean, that just sets up a two-class --

CO-CHAIR LEFEBVRE: Yes. No, I think that is what I was saying, is that I think we have to watch that and make sure that what we are saying can be done needs to be done across the board, and there needs to not be a difference in that because we do have some real needs areas. And we have to make sure that those are addressed.

MEMBER MOORE: But a lot of times scope expansions occur in response to a shortage. So, I think the whole concept of nurse practitioner came out of areas where there simply weren't sufficient physicians, and they built a model that expanded access in underserved communities.

So, you know, I think I wouldn't

preclude it, but I agree you don't want a two-tier system. But creating opportunities for regulatory flexibility where there is obvious need I think is the right thing to do. And then, from there, you say, should this be available more broadly?

CO-CHAIR LEFEBVRE: Thank you.

Yes, Howard?

MEMBER BERLINER: It is more of a question about NQF and its policies. I mean, NQF does work for CMS, and particularly for the Medicare program, which is a national program.

If you have different scopes of practice, essentially, you have CMS paying what is essentially a fixed rate, you know, for different kinds of inputs into that rate, right? I mean, in some places it may be a nurse doing something; in some places it may be a doctor; in some places it might be someone else.

To what extent can NQF say to CMS, "This is something we think you ought to pay us

to look into," or something like that? Just as both on the research side of it to find out what it actually is, but, then, also, to suggest to them that this might be something they might want to look at.

MS. FRANKLIN: So, to the extent that we can, we can make suggestions to CMS and we can include that into the suggestions we have to CMS as part of our process.

CO-CHAIR LEFEBVRE: Yes?

MEMBER WARSHAW: I think we talked about this briefly yesterday. In addition to looking at access and scope of practice, I am also interested in the efficiency side, which we sort of walked away from this a little bit. But I think it is going to be a bigger issue as time goes forward, as we try to learn how we are going to deliver good care at lower cost. That workforce mix and the types of services that we provide within any health system, we are probably going to be able to identify sort of

best practices for mix of professions, specialties within each profession, and then, types of professionals in the mix.

And I think that is something that we are not ready to do yet here, but I think it is something we don't want to leave out of the discussion of the scope of practice because I'm not picking a fight with anybody by using this as an example. But, I mean, a lot of times we put together preventive programs that are rather expensive to implement like colonoscopy every 10 years. And if we were serious about it as a national priority, we would probably identify a group of professionals who are not MDs who could do that very effectively and efficiently at a lot lower cost and maybe with better outcomes. But we just haven't put that into our mindset yet. But I hope that someday we will be thinking that way as we try to put together a more efficient healthcare system.

CO-CHAIR LEFEBVRE: All right.

Thank you.

Sunita?

MEMBER MUTHA: Two very different thoughts. One of them is I think there is in some cases an evidence base that is driving this, which is interesting. So, in California there has been a push to change the practice for emergency medicine, people that are out in the field. Because we know that the sooner you can get resuscitation started, the better the outcome. So, that is, I think, an example of evidence driving it, not just need, which is great.

And it does speak to the point I think that you made, Ann, about really trying to think about this broadly enough, so that it covers who we traditionally think of being affected now, that policies are affecting, as well as just what could come in the future.

The separate thought that I have is one of the issues that I have been struggling

with kind of all morning is that some of our indicators are ones where the lag time for the lever is really long because these are pipeline issues, right?

And so, the question that I have is -- maybe it is the one that you are going to get to at 1:50 -- which is around, how are these measures used over time? Because I think it is such an issue. In some cases we can turn the lever quickly and say there's a need; there's a gap; let's get the changes that we need. And in other cases we know the training time is just so long, and just wanting to think about what the consequences are of doing that and of highlighting the issue.

CO-CHAIR LEFEBVRE: I think that is a really good piece in what we are talking about. And I do think there is a difference between training and retraining. We talked about this some in our group yesterday.

If we have 18 million people in the

current workforce, then some of these perhaps aren't the pipeline; they are retraining.

And I think, for my, anyway, it comes down to that thought of, well, you know, where do we have health professions that are closely aligned with a needs gap that we could find faster pathways to retraining and move them into those areas?

So, one of the areas that I come across all the time is data management. And I have talked with some of you about this. I mean, so having small rural practices hooked up to the Health Information Exchange is a great thing until you actually go on there and try to find your patient's data.

And so, I mean, who in that practice is going to be retrained to really manage that data? We have had had to purchase extra licenses for Excel because EHR software packages don't come with Microsoft Office. So, we have to actually purchase extra licenses

for Excel to, then, install that in practices, so they can download data and have something to put it in, because they don't have this in their computer systems.

And so, I think those are just areas where there's skill sets -- I think I can train anyone to do this. It is not that it is hard, but it does have to be trained. It has to be retrained, and they have to understand what is good data management, what is HIPAA, what is security, what is all of these things.

And so, I think there is a pipeline aspect to this, but there is also some retraining components that I think could happen fairly quickly. And I think the market is going to make it happen quickly.

CO-CHAIR GERDES: Yes, I think that is a very nice segue -- thank you -- into our questions. NQF has about four questions that they kind of wanted answers to from us for guidance in writing our report to HHS.

And so, talking about the first question, which areas for measure deployment have the most power to transform the deployment workforce? And that is an excellent response, that probably retraining existing people is more powerful in the deployment of the workforce than pipeline issues and training new individuals coming into the workforce for the first time.

But any other comments on that about which areas are going to have the most power in workforce deployment?

MEMBER MacINNES: I think measures that get at the impact on patient quality of care. Just going back to what you were saying about the emergency medicine, you know, the fact that measures that give us evidence, that different deployment makes a difference.

CO-CHAIR GERDES: Any other thoughts on power to transform the deployment of the workforce?

CO-CHAIR LEFEBVRE: I would add that, I mean, some of that needs assessment. And so, some of these -- and I don't know where in the process that takes place, but you know what I mean?

So, there's a difference between "it would be great to have" and "it is an absolute need out in the field". And I think, you know, at some point there needs to be a measurement or a gap analysis of that.

MEMBER ZINKEL: I would agree with Gail's comments on quality, but I would maybe take it a little further and say measures that are meeting the Triple Aim, quality, cost, and with patient experience in mind, I think are going to be the keys.

MEMBER MacINNES: So, this is just another, it is an area in that it is emphasizing the direct-care workforce. Of the 18 million, you know, currently, 4 million, and in 2020 potentially 5 million will be direct-care

workers. So, I think that measures targeted to that workforce have huge implications, you know, and potential to shape the care that is delivered; and, also, just the demographics of the aging and more people who will be needing assistance.

CO-CHAIR GERDES: Thank you. And some of these answers are getting to Question No. 2. And I apologize, only a few of us can actually see the slides because they were up there yesterday and now they're not. So, if you want to refer -- oh, can you guys see them in the middle? Okay. It is kind of perpendicular to me, so I haven't seen those. Okay. Great.

So, the second question is: what activities and associated measurements will be most powerful in producing better health? And I think we are hearing that evidence-based, particularly as geared towards the Triple Aim, would probably get at that, not always, because

your performance on clinical quality metric and patient experience don't necessarily mean health, you know, depending on how you define health.

So, any comments on that question?

CO-CHAIR LEFEBVRE: I do think that some of the measures -- oh, I would have let you go first, Gail.

I am thinking that some of the measures we worked on were really about delivery of healthcare, which I think is just natural when you are talking about workforce, that you are really talking about delivery of healthcare. And I think that is very different than better health. And I think our healthcare system is built to be reactive. If we want it different, we need to build it differently.

So, I think we have a reactive healthcare system. And so, if we are looking at measurements in producing better health, I am not sure -- that is a whole different

workforce. I mean, I think there was some mention, Christine I think mentioned that that really does get at, you know, public health and more greenways and more access to fruits and vegetables, and, I mean, clean water. Those types of things I think are really impactful, but it is probably more of a workforce that is outside of the delivery system of a reactive healthcare system that we just didn't necessarily address with our work.

CO-CHAIR GERDES: Christine, did you want to say anything on that?

MEMBER KOVNER: I agree.

CO-CHAIR GERDES: Okay. All right.

Gail?

MEMBER MacINNES: I also totally agree. A great comment.

And what I was going to say is I think an activity, in general, that will really produce better healthcare and, hopefully,

better health is improved communication in every way. So, I think that is the activity that I would call out.

CO-CHAIR GERDES: I think, too, that a lot of our measures or concepts that we have prioritized focus-in on measuring consumer perception or patient perception. And I think that is powerful in two ways.

I think that gives us feedback if the healthcare services that we are delivering are delivering the right message, first of all. And, second of all, it gives a little bit of a halo effect. If we, as an industry, are measuring patient perception and their thoughts, that means we care about their thoughts and their experience. And sometimes that alone builds engagement, you know, just kind of broadcasting that we are interested in what the consumer thinks.

So, I think those activities that key back to patient perception are particularly

important in producing better health.

MEMBER BERLINER: I guess this is really more for the first one than the second one. But one of the things that seems clear is that we have lots of data and lots of measurements around professionals, and we much less so to almost none, even to the definitional level, for direct-care workers, for community health workers, and things like that. I mean occupations that we know are going to be growing rapidly, but we don't know anything about them.

I mean, one of the things Ed mentioned yesterday was, you know, the redesign or the updating of the Standard Industrial Codes, the Standard Occupational Codes. And maybe having CMS get closer to that process or having some involvement with that, since they paid for a lot of that stuff, you know, would be helpful in even formulating better numbers to allow us to get better measures and, therefore, do something.

CO-CHAIR GERDES: Our other questions are insights from this meeting that should be emphasized in the forthcoming report. And I think we have heard several insights. You know, a much broader definition of workforce than perhaps what we have considered in these two days. Public health definitely, scope of practice definitely.

Any other kind of insights trickle up after going through these two days?

Christine?

MEMBER KOVNER: I think that there was a lack of agreement or understanding of definitions of some things, like community health workers and team, and what is a good team. So, I think you need to consider that when drafting the report.

MEMBER ZINKEL: A couple of other things that came up -- sorry -- were just needing some baseline data to get answers to a lot of the questions that we have here. There

is a lot of data out there, but, then, there's a lot of gaps as well in baseline data. And so, if we don't have the baseline data, it is hard for us to create a measure to say what should it be. We don't even know what it is.

MEMBER MARK: I think there was a similar consensus that we better data, that data is useful, but it is very hard to estimate the correct supply, and that creating strict measures around what is the appropriate per-capita physician ratio may not be that useful. Even though the data is going to be useful really in context, it is not going to be very prescriptive in and of itself.

CO-CHAIR LEFEBVRE: I would word that as informative data versus improvement data. So, you are really looking for that data to inform.

MEMBER MARK: To inform when used with other information about access and outcomes, and understanding what are the

constraints on supply like licensing constraints. But it is not in itself an abstract measure that you can learn much from in isolation.

MEMBER WARSHAW: I agree with what has been said. I find this a difficult area to think about in terms of quality. So, I think that is one insight, that this is hard. I think it is hard for a lot of the reasons that people have mentioned.

I think, normally, we just think about, well, some profession says, "Well, we can't meet the demand. So, we need more of us." You know, that is always very self-serving. So, I think we want to get away from that because I think that is a kind of unreliable way of planning.

We do have a pretty pluralistic healthcare system with lots of different models being tested now. And that might be that way for a while, but I think we are going to start

seeing some best practices of how communities can be served efficiently and effectively. And we are going to have to start drawing on those best practices to come up with more national recommendations.

We are not quite ready for that yet, but I think that is going to be an opportunity. So, one of the insights is that we need to keep revisiting this as we learn more, and the experimenting is going on right now. Things we talk about, like scope of practice, could change, though workforce needs tremendously.

We haven't emphasized particular trends, secular trends, but we know aging is a secular trend we are going to have to deal with in the next 50 years. But we also have certain chronic disease problems that seem to be more difficult for us to control at the moment, and that is going to be a trend that we have to face up to.

And then, we have talked a little

bit about differences between urban and rural areas, and we may not have one solution for both urban and rural America.

So, I think it is a great effort that the group has tried to work at, but it has been hard.

CO-CHAIR GERDES: Thank you. I appreciate those comments.

Yes, Jean?

MEMBER MOORE: Yes, one other thing, I just want to build on something Gregg said. I do think that, for a long time, we asked ourselves how many doctors do we need, how many nurses do we need. And I think we need to change the question. I think we need to say, what do patients need and what are some of the ways that we can get them what they need? Which, then, supports opportunities for different workforce configurations, and that is where you find your best practices.

But I think you really have to

change what that first question is.

CO-CHAIR GERDES: Thank you.

Any comments on our last question? We talked some around this: the short- and long-term recommendations regarding this topic that HHS should consider. No. 1 is it's long-term and it is hard; keep revisiting, right?

And I think, just as I have gone through this process, putting some scope sights on what we are talking about, because even when we are talking about definitions, "workforce," you know, who and what are we talking? Reframe the question.

So, I think that we probably need to put some scope parameters maybe a little bit more tightly around the project as we go forward.

MEMBER MacINNES: I really liked linear comments from yesterday about, you know, the federal government being a future payer for

healthcare. And I think that would be one great recommendation, for them to start with the programs that they are already funding and have control over, and weave workforce measures into those.

I mean, because there are so many that have nothing, you know. And so, I think that is a really good starting place.

CO-CHAIR LEFEBVRE: I think it has already been said, but I think that the retraining versus the training is the short-term versus the long-term recommendations, to constantly keep an eye on that. I think that is what is going to allow us to be nimble going forward and not have to count on forecasting to be 100 percent accurate if we can really enhance our ability to retrain.

And I find that the workforce wants to be retrained when they don't feel useful. So, I think it is a good area.

CO-CHAIR GERDES: Any other

thoughts, final thoughts, for future direction?

(No response.)

Okay. I am going to go ahead, and, Kathy, will you open the lines for public comment now?

THE OPERATOR: At this time if you would like to make a comment, please press *, then the number 1.

There are no public comments at this time.

CO-CHAIR GERDES: Okay. And anyone in the room behind us here for comments?

(No response.)

Okay. Laura, did you have any comments in the chatroom?

MS. IBRAGIMOVA: No.

CO-CHAIR GERDES: Okay. Then, we want to move into our wrapup and next steps, and we are going to give NQF staff an opportunity to answer some of the questions that you have

all been asking about our work product from this meeting, our conceptual framework, and also where do we go from here.

So, Ann, do you want to start?

CO-CHAIR LEFEBVRE: Why don't we go to the process next? And then, we have some more concrete, what are the next steps for dates and those types of things.

CO-CHAIR GERDES: Sure.

CO-CHAIR LEFEBVRE: But perhaps we should go to more of the process?

MS. FRANKLIN: Sure, sure.

So, we got some questions, of course, about how we are going to write up today's work, what the next steps are for the final product that comes out of this group, and how the report might be used by HHS once it is delivered in August.

Keep in mind that we will be refining, writing and refining this report following this meeting. You will all have an

opportunity to review and provide comments on the Draft Report. So, we are continuing along on this iterative process.

So, from today's work, we plan to take all of your recommendations, and we have done some initial weighting already, but also organize the recommendations within our framework and provide a lot of discussion, rich discussion, that we have had over the past two days to provide context around each of the recommendations.

We do want to reemphasize that measures that fell lower in the prioritization exercise or measures that didn't get dots today will still be included in the report, and we will discuss issues around why they fell where they fell.

We also expect the HHS to use the report, when we do deliver it to them, to prioritize their work in terms of where to stimulate measure development, organize their

resources around the areas that we have elevated to the top of our priority list.

We also expect that this going to be useful to the field generally. Other private payers, other measure developers out there that want to look and stimulate measure development or do measure development on their own will receive guidance from this report.

And I think I wanted to say that we wanted to come out of this meeting with measure concepts, not fully-baked measures. We just wanted to provide guidance.

So, to the extent that we can provide them numerators and denominators, that's great, as suggestions, but we intend for us to come out with fully kind of specified or even numerator/denominator types of measures.

So, are there questions, though, that I haven't answered from the group?

Christine?

MEMBER KOVNER: So, there is no

other internal process here before it goes to HHS?

MS. FRANKLIN: Oh, we will still continue to do the drafting, and we will talk about upcoming activities and specifics on our timeline. There is a Draft Report that is going to go out for public comment after you all have looked at it and provided your comments.

And then, we will also be having a webinar to present our major findings at the end of June, and in August we will be refining the report once more and, then, presenting it to HHS.

MEMBER KOVNER: I guess what I meant, is there a committee somehow that makes some -- no? Okay.

MS. FRANKLIN: No. Sorry. No.

CO-CHAIR LEFEBVRE: These timeframes, like the June 30th webinar and those such things, is that all group summarized in one webinar or is that just specifically a

workforce --

MS. PRINS: It is actually a workforce care coordination and person- and family-centered care.

CO-CHAIR GERDES: Did you have comments?

MEMBER ALEMU: I just wanted to comment to the Committee that we had a great meeting with great participation and a productive one. So, thank you for that.

And there was a question now how we report these. And again, I will just mention this will be used by HHS to prioritize, you know, the measurement. They are looking at the areas. It will be used by public and private stakeholders, including policymakers, healthcare providers and systems, educational institutions, and measure developers. So, this will be a resource.

As we heard, our measure concepts are looking into many different areas. There

are some which are suited to or related to the teaching institutions, some with direct practices. There are some that need to be done by policymakers. And, yes, a lot of work to be done by different organizations and institutions.

And this will be a very good resource. This is really an area where not a lot has been done before, and it is challenging, but I think the group discussion provided us with very useful insight. And we will be working on this meeting's product and at the same time to refine; we will contact you to provide your input. Of course, there are issues which can be reviewed, refined by you, by the Committee members.

So, I think this was a very productive meeting, and thanks to all of you. And my special thanks to the Co-Chairs. I mean, they did a fantastic job, really.

(Applause.)

And, of course, the NQF, too. And thanks so much.

CO-CHAIR GERDES: Well, yes, and I wanted to thank everybody for participating. I know we are all busy and this is a lot of time out of your schedule.

The sun's out. We will be able to see some of D.C. maybe this afternoon, you all.

(Laughter.)

But I wanted to thank each and every one of you. I enjoyed meeting you, all smart, very interesting people.

I want to thank my Co-Chair Ann. I really enjoyed meeting you. She is a fascinating person, does a lot of cool things professionally and personally, if you didn't get a chance to talk to her.

And also, the NQF staff, you guys are very professional and very well-organized, and I appreciate being a Co-Chair of the meeting with you at the helm, definitely.

(Applause.)

I did want to open up to the group. Whenever I run a committee meeting, I like to have an opportunity at the end for feedback from the group as to how the meeting went, room, accommodations, timing, et cetera. So, I just kind of wanted to open that up for everybody because I think that may be useful to NQF staff. I am kind of springing that on you, but I always find that to be pretty helpful.

So, anybody have any comments?

MEMBER KOVNER: I found that the chairs were comfortable when you sat in them, but they were not very practical in terms of having a swivel seat. Because in a meeting like this you want people to look at each other. And so, if I needed to look at Howard, I had to go like that with my chair.

(Laughter.)

And Howard and I were talking about this. It seems like you have very nice

facilities. So, we didn't think it was like you were trying to save money by buying these chairs.

(Laughter.)

No, they don't swivel.

MEMBER MacINNES: I like the concept of doing the prioritizing and kind of visually being able to do that, but I wasn't able to see any of that. And so, if there is a different way to do that and maybe use the screens, you know, to do it electronically or something, it would be more helpful.

CO-CHAIR LEFEBVRE: I am going to bring that, because my husband is a software developer, and say, "We need a software program that can do this quickly on the fly."

(Laughter.)

So, we'll see.

MEMBER KHAN: Relative to the process, I really appreciated it. I think that it was super-helpful, as much as I didn't know

what way we were going yesterday morning especially, that we did have that sort of -- it kind of went wide first and, then, went back and focused. And I thought the process did work really well.

I also just appreciated the diversity in the room. It was really great. And thank you for that. I think it is rare that we have the opportunity to sort of have so many sort of blocks of professional perspectives, and I thought that made for a rich discussion. So, thank you.

CO-CHAIR LEFEBVRE: Okay. Well, I think we are close to adjournment.

Thank you so much. It was a real pleasure working with all of you. I have learned a lot in these last two days, and it has been really helpful.

So, thank you again for your time and effort to this. It is much appreciated. And I look forward to see where it leads in all

of these different organizations.

So, thank you. Travel safe.

CO-CHAIR GERDES: Thank you all.

(Applause.)

(Whereupon, at 1:48 p.m., the meeting was adjourned.)