Questions/Topics to Guide Subject Matter Expert Panel Discussions

Subject Matter Expert Panel Discussion: To assist in grounding the panel discussion, the PTAC Chair will briefly reference the Agency for Healthcare Research and Quality (AHRQ) definition of care coordination and the list of common functions associated with care coordination that are included in the environmental scan (see Attachment). After the Chair introduces the session, the discussion will begin by panelists introducing themselves. The Chair will then ask the questions associated with each topic below sequentially. Unless otherwise specified, the Chair will invite two to three SMEs to provide their particular expertise and perspectives for each topic. Other SME panelists will also have an opportunity to provide their perspectives on a given topic, time-permitting. Some panelists may have expertise to share in more than one area. Panelists will also have an opportunity to respond to follow-up questions from PTAC Committee members.

NOTE: In the interest of ensuring balance across different perspectives and questions, the Chair will encourage all panelists to keep each response to a few minutes.

I. **The role and aims of care coordination in the context of value-based care and alternative payment models (APMs) and physician-focused payment models (PFPMs):** *(All of the panelists will be asked to respond.)*

From your own experience, perspective, and expertise, please tell us what you see as the role and the objectives of care coordination in the context of value-based care.

Are specific functions or activities of care coordination most important for improving quality and reducing costs in APMs or PFPMs?

- *Do these functions or activities vary based on context – such as care coordination for population-wide health management; care coordination for specific populations, such as those with chronic diseases or vulnerable populations (including clinical episodes of care); or care coordination related to an acute event?*
- *Which activities are more important for specific populations versus specific clinical settings or situations?*
- *Which activities are useful across many populations?*
- *Do these functions vary based on specialty, practice size, setting, geographic area, or discipline?*

II. **Optimizing care delivery through care coordination in APMs and PFPMs (e.g., population health, care setting, technology, workforce):** *(Two or three of the panelists will be asked to respond.)*

The public health emergency related to COVID-19 brought unique challenges to coordinating patient care with the immediate disruption of regular delivery of services and quick expansion of telehealth.

- *Can you speak to the evolution of care coordination, especially as it relates to any lessons learned over the last year and a half?*
- *Are there any specific lessons connected to equity?*

III. Opportunities and best practices: *(Two or three of the panelists will be asked to respond.)*

Next, we'd like your input on opportunities that you see for implementing and evaluating care coordination activities broadly.

What do you see as facilitators, or best practices, for the effective adoption of care coordination in APMs and PFPMs? Why?

- *Are there specific care delivery models that have proven most effective for adopting care coordination?*
- *In your experience, what are the best or most promising approaches for using payment mechanisms to incentivize effective care coordination? Why?*

In order to support the expansion of effective care coordination across the United States, it is important to accurately measure performance, quality, and effectiveness of care coordination.

- *In your area of expertise, what existing measures best assess the effectiveness of care coordination?*
- *What are the limitations of existing measures?*
- *Do new performance or quality indicators need to be developed to evaluate care coordination?*

As we think about ways to improve care delivered to all individuals, ensuring health equity is a priority.

- *Where do you see opportunities to design and implement care coordination activities that address health equity challenges in APMs and PFPMs (e.g., ensuring equitable access to care coordination and using care coordination to focus on areas of existing health care disparities)?*

IV. Major challenges or unanswered questions: *(Two or three of the panelists will be asked to respond.)*

- *What are the major challenges or unanswered questions that you believe need to be addressed before the health care system can better incorporate care coordination into APMs and PFPMs?*

V. Conclusion: *(All of the panelists will be asked to respond.)*

- *Are there any additional critical insights you would like to share with regard to care coordination and APMs, PFPMs, the relationship between them, and their potential for optimizing outcomes for patients and transforming value-based care?*

Questions/Topics to Guide Subject Matter Expert Panel

Attachment: Care Coordination Definition and Related Functional Domains Being Used by PTAC

PTAC is using the Agency for Health Care Research and Quality's (AHRQ's) working definition of the term care coordination as a guide for focusing the discussion during the June 2021 Public Meeting:

> *"Care coordination involves deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care. This means that the patient's needs and preferences are known ahead of time and communicated at the right time to the right people, and that this information is used to provide safe, appropriate, and effective care to the patient."*

Within the broader context of care coordination, PTAC considers the following AHRQ functional domains to be particularly important for optimizing care coordination in the context of APMs and PFPMs:

- Establishing accountability or negotiating responsibility
- Communication among participants in patient care
- Facilitating transitions and coordinating care across settings
- Assessing patient needs and goals
- Developing a care plan
- Monitoring and follow-up
- Supporting self-management goals
- Linking to community resources
- Aligning resources with patient and population needs

While strategies for optimizing some functions could also involve structural changes (such as financial management and planning across operational units), PTAC is particularly focused on strategies for improving clinical coordination in the context of value-based transformation.

Questions/Topics to Guide Previous Submitters Panel Discussions

Questions for Previous Submitters Panel: To assist in grounding the panel discussion, the PTAC Vice Chair will briefly reference the Agency for Healthcare Research and Quality (AHRQ) definition of care coordination and the list of common functions associated with care coordination that are included in the environmental scan (see Attachment). *After brief introductions, the Vice Chair will ask the questions associated with each topic below sequentially. Unless otherwise specified, the Vice Chair will invite two to three panelists to respond for each topic. Other panelists will also have an opportunity to provide their perspectives on a given topic, time-permitting. Panelists will also have an opportunity to respond to follow-up questions from PTAC members.*

NOTE: In the interest of ensuring balance across different perspectives and questions, the Vice Chair will encourage all panelists to keep each response to a few minutes.

I. **Please provide a brief description of how care coordination was incorporated into your proposed physician-focused payment model (PFPM).** *(All of the previous submitters will be asked to respond.)*

II. **The role and aims of care coordination in the context of value-based care and alternative payment models (APMs) and PFPMs:** *(Two or three of the previous submitters will be asked to respond.)*

What specific functions or activities of care coordination are most important for improving quality and reducing costs in APMs and PFPMs?

- *Do these functions or activities vary based on context – such as care coordination for population-wide health management; care coordination for specific populations, such as those with chronic diseases or vulnerable populations (including clinical episodes of care); or care coordination related to an acute event?*
- *Which activities are more important for specific populations versus specific clinical settings or situations?*
- *Which activities are useful across many populations?*
- *Do these functions vary based on specialty, practice size, setting, geographic area, or discipline?*

III. **Optimizing care delivery through care coordination in APMs and PFPMs (e.g., population health, care setting, technology, workforce):** *(Two or three of the previous submitters will be asked to respond.)*

The public health emergency related to COVID-19 brought unique challenges to coordinating patient care with the immediate disruption of regular delivery of services and quick expansion in the use of telehealth. Can you speak to the evolution of care coordination, especially as it relates to any lessons learned over the last year and a half?

- *Have you had any recent experiences, related to the public health emergency or more broadly, that may inform or extend your ideas on care coordination and its relevance to APMs and PFPMs?*
- *Are there any specific lessons connected to equity?*

Questions/Topics to Guide Previous Submitters Panel

IV. Opportunities and best practices: *(Two or three of the previous submitters will be asked to respond.)*

Next we'd like to get your input on opportunities that you see for developing and evaluating care coordination activities broadly.

What do you see as facilitators, or best practices, for the effective adoption of care coordination in APMs and PFPMs? Why?

- *What specific care delivery models have been most effective for effectively adopting care coordination? Why?*

In your experience, what are the best or most promising approaches for using payment mechanisms to incentivize effective care coordination? Why?

In order to support the expansion of effective care coordination across the United States, it is important to accurately measure performance, quality, and effectiveness of care coordination.

- *In your proposed PFPM's area of focus, what existing measures best assess the effectiveness of care coordination in improving quality and reducing costs?*
- *What are the limitations of existing measures?*
- *Do new performance or quality indicators need to be developed to evaluate care coordination?*

As we think about ways to improve care delivered to all individuals, ensuring health equity is a priority.

- *Where do you see opportunities for designing and implementing care coordination activities that address health equity challenges in APMs and PFPMs (e.g., ensuring equitable access to care coordination and using care coordination to focus on areas of existing health care disparities)?*

V. Major challenges or unanswered questions: *(Two or three of the previous submitters will be asked to respond.)*

What are the major challenges or unanswered questions that you believe need to be addressed before the health care system can better incorporate care coordination into APMs and PFPMs?

VI. Conclusion: *(All of the previous submitters will be asked to respond.)*

Are there any additional critical insights you would like to share with regard to care coordination and APMS and PFPMs, the relationship between them, and their potential for optimizing outcomes for patients and transforming value-based care?

Questions/Topics to Guide Previous Submitters Panel

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