



**Donald Casey, MD, MPH, MBA, FACP, FAHA (Co-Chair)**

*Principal, IPO4Health*

Dr. Donald E. Casey, Jr. joined NYU Langone Medical Center in August 2012 where he served as Vice President of Network Integration and Chief Medical Officer (CMO) of the NYUPN Clinically Integrated Network and was the Clinical Professor of Medicine in the Department of Population Health at the NYU School of Medicine. A Fellow of the American College of Physicians (ACP) and the American Heart Association (AHA), Dr. Casey has participated in developing and implementing numerous clinical practice guidelines and quality performance measures through the ACP, the AHA, the American College of Cardiology, the Agency for Healthcare Research and Quality, the National Quality Forum (NQF), The Joint Commission and the Centers for Medicare and Medicaid Services, among others. He has served as an advisor, consultant and participant on many national initiatives, including Chair of the NQF Care Coordination Steering Committee from 2006 to 2012. Dr. Casey has published more than 75 peer-reviewed journal articles and book chapters, including his most recent invited commentary on September 23, 2013 in JAMA Internal Medicine, titled: Commentary, Why Don't Physicians (and Patients) Consistently Follow Clinical Practice Guidelines?

**Gerri Lamb, PhD, RN, FAAN (Co-Chair)**

*Associate Professor, Arizona State University*

Gerri Lamb, PhD, RN, FAAN co-chaired both of the NQF Steering Committees on Care Coordination and is a nationally recognized expert in care coordination. She currently serves as subject matter expert on care coordination for the MAP Subcommittee on post-acute and long-term care. She is well known for her leadership and research on care coordination, case management, and transitional care. She has presented numerous papers and published extensively on the process and outcomes of care coordination in acute care, long-term care and community settings.

**Dana Alexander, RN, MSN, MBA**

*VP Integrated Care Delivery, Caradigm*

Dana Alexander, RN, MSN, MBA, is VP of Integrated Care Delivery at Caradigm. In her previous role as VP and Chief Nursing Officer at GE Healthcare she advocated to achieve high performance and accountable healthcare. She is engaged with break-through initiatives to support new models of care across care settings to include engaging patients as partners in their care. Building bridges and leveraging professional connections to impact policy, improve quality outcomes and patient safety are key strategies for change that Ms. Alexander employs. She has consistently contributed to nursing and healthcare through leadership as an Advanced Practice Nurse, CNO, & CEO roles.

**Richard Antonelli, MD, MS**

*Medical Director for Integrated Care, Boston Children's Hospital, Harvard Medical School*

Dr. Richard Antonelli is Medical Director of Integrated Care and Physician Relations and Outreach for Boston Children's Hospital and is on the faculty of the Harvard Medical School Department of Pediatrics. He has served on numerous national and state-level committees to further the evolution of care coordination functions to enable systems to become high performing delivery models and has published widely on this topic. Dr. Antonelli has previously served on the NQF Care Coordination Steering Committee and has served as an individual subject

matter expert on child health for the Measures Application Partnership. Throughout his career, Dr. Antonelli's work has focused on providing comprehensive, family-centered care for children, especially those with special health care needs.

**R. Colby Bearch, MA-SF, MA-M, BA, RN, CDONA**

*Vice President Quality & Outcomes Management, The Coordinating Center*

Mr. Bearch has worked in healthcare administration and quality for 14 years. Mr. Bearch is passionate about quality management and is an innovative and strategic leader in this arena. His approaches to quality are not only culminated by his experiences, but also supported in his extensive academic background. As previously and in his current position as VP of Quality and Outcomes Management, Mr. Bearch has focused his passions for patient centered care to lead the organization to deliver high quality outcomes, implement challenging strategic designs and enhance the lives of those served by the organization.

**Jeremy Boal, MD, BSc**

*Executive Vice President and Chief Medical Officer, The Mount Sinai Health System*

Dr. Jeremy Boal, a board certified internist and geriatrician, is Executive Vice President and Chief Medical Officer of the Mount Sinai Health System. Prior to that, he held the position of Chief Medical Officer of the North Shore LIJ Health System. Dr. Boal has spent the majority of his clinical and academic career at Mount Sinai where he has focused on improving care for patients with advanced and life threatening illnesses. Dr. Boal received his undergraduate degree from McGill University and his medical degree from the Medical College of Wisconsin.

**Juan Emilio Carrillo, MD, MPH**

*VP, Community Health, New York-Presbyterian, Associate Professor, Weill Cornell Medical College*

Dr. J. Emilio Carrillo is VP of Community Health at New York-Presbyterian and Associate Professor of Clinical Public Health and Medicine at Weill Cornell Medical College. He graduated from Columbia College, received his M.D. and M.P.H. from Harvard, and was on the faculties of Harvard Medical and Public Health schools for ten years. He served the RWJF as Senior-Fellow in Residence and Distinguished Scholar in the Network for Multicultural Research on Health-Healthcare. His research and collaborations at Harvard laid the foundation for Patient Based Cross-Cultural Healthcare. Dr. Carrillo's work has helped to define the fields of Cultural Competence and Cross-Cultural Communication.

**Shari Erickson, MPH**

*Vice President, Governmental & Regulatory Affairs, American College of Physicians*

Shari M. Erickson is Vice President of Governmental and Regulatory Affairs with ACP. She directs and collaborates on the development of ACP policies and advocacy strategies to influence delivery system and payment reforms, such as ACOs, PCMHs, and the PCMH-neighborhood. Ms. Erickson also Co-Chairs the Patient-Centered Primary Care Collaborative's Center for Advocacy & Public Policy. Prior to ACP, she was a Senior Program Director with NQF and a Program Officer at the Institute of Medicine where she worked on multiple health care quality studies, including the landmark report, "Crossing the Quality Chasm: A New Health System for the 21st Century."

**Pamela Foster, LCSW, MBA, ACM**

*Coordinator, Care Coordination Program, Mayo Clinic Health System*

Pamela Foster is a Licensed Clinical Social Worker with extensive experience in healthcare coordination and quality measure development at both a clinical and administrative level. Currently, Pamela is the Coordinator of the Care Coordination Program at the Mayo Clinic Health System. Pamela has managed care coordination issues in multiple clinical settings including acute care, skilled nursing, and home health care where many best practices in care coordination have been developed. She has developed multiple initiatives to prevent

readmissions and has worked diligently to understand the cause of readmissions. Pamela has spent the majority of her career in the acute care setting working with geriatric and medically complex populations.

**Barbara Gage, PhD, MPA**

*Fellow, Brookings Institute*

I have directed PAC research for CMS or for Congress for the last 20 years. As Director of Post-Acute Research at RTI, I have lead numerous technical expert panels, national studies of PAC populations, claims-based case-mix analysis, care coordination studies, and outcome analyses associated with services following hospital discharge. I have led teams to develop quality measures for CMS, and worked closely with the policymakers and PAC industries over the years. I have given hundreds of presentations at research conferences, association meetings, and written extensively on these topics.

**Dawn Hohl, RN, BSN, MS, PhD**

*Director of Customer Service, Johns Hopkins Home Care Group*

Dawn Hohl has been serving as the Director of Customer Service for Johns Hopkins Home Care Group for the past ten years. As a member of the executive team, oversees care coordination and discharge planning functions for Hopkins hospitals and affiliates for all home-based services. Included in responsibilities are patient satisfaction data reporting, lead customer service initiatives and liaison on service and safety initiatives with Johns including readmission preventions. Previous work experience includes Director of Community Relations and Contracting at VNA of Maryland and Senior Vice-President, Patient Care Services, Home Care/Hospice Administrator, Bon Secours Baltimore, and a staff nurse at Johns Hopkins Hospital. Dawn was an Examiner for the Malcolm Baldrige National Quality Award for three years, and Associate Faculty at the College of Notre Dame of Maryland and University of Maryland.

**Marcia James, MS, MBA, CPC**

*Vice President, Accountable Care, Mercy Health Systems*

With over 27 years of experience in healthcare leadership and management from both the payer and provider sides, Marcia has been a key strategic and operational leader involved with development of accountable care organizations and population health capabilities including patient centered medical home. Additionally, she is a subject matter expert on Meaningful Use and is currently serving on a WEDI workgroup on payment models. Currently, she is the Vice President, Accountable Care for Mercy Health System of Southeastern Pennsylvania where she is responsible for development of the framework and activity surrounding accountable care and population health capabilities.

**Emma Kopleff, MPH**

*Senior Policy Advisor, National Partnership for Women and Families*

Emma Kopleff, MPH, is Senior Policy Advisor for the Consumer-Purchaser Alliance. Within this role she advocates on behalf of consumers for the use of meaningful performance measures to drive health care quality improvement and affordability. Emma's experience includes performance measurement evaluation and engagement in quality improvement initiatives across settings (e.g., hospital, ambulatory, nursing home, etc.), and populations (e.g., children, mothers, Medicare, patients with multiple chronic conditions). Prior to her work in DC, Emma was working in her hometown of Cleveland, Ohio, supporting the implementation of NCQA's Diabetes Recognition Program across Ohio's largest primary care physician group.

**Jennifer Lail, MD**

*Assistant Vice-President of Chronic Care, Cincinnati Children's Medical Center*

Dr. Jennifer Lail joined the James Anderson Center for Health Systems Excellence at CCHMC in September 2012 as AVP for Chronic Care Systems. Currently, Dr. Lail is leading the Care Coordination and Outcomes Strategic Plan initiative at CCHMC to support outcome improvement for children with chronic conditions. As

well, she cares for patients in Cincinnati Children's Complex Care Clinic. For thirty-one years prior, she practiced clinical pediatrics at Chapel Hill Pediatrics and Adolescents, P.A. with a particular interest in the health care delivery for children with special health care needs (CSHCN). She served as affiliate faculty in the department of Pediatrics at both Duke and the University of North Carolina. Implementation of practice strategies that improve care for children and youth with chronic conditions has been her particular interest, including development of clinical registries, care coordination programs, family engagement, pre-visit care planning, improved communications with subspecialists and transition planning for CSHCN. Dr. Lail led her practice in Level 3 NCQA certification and re-certification at two office sites. She is a current member of the AAP Council on Children with Disabilities, the Medical Home Project Advisory Committee, Quality Improvement Innovation Network, and the Specialist-Medical Home Leadership Team and serves on the Medical Home Network Work Team of the Children's Hospital Association.

**Charlie Lakin, PhD, MA**

*Director, National Institute on Disability and Rehabilitation Research*

K. Charlie Lakin, Ph.D., is Director of National Institute on Disability and Rehabilitation Research, U.S. Department of Education. Mr. Lakin has more than 40 years of experience in services to individuals with disabilities as a teacher, researcher, consultant and community living advocate. Before coming to NIDRR in 2011, Mr. Lakin was Director of Research and Training Center on Community Living at the University of Minnesota. In his career Mr. Lakin has directed dozens of research and training projects and has authored or co-authored more than 300 publications based on that work. He has consulted frequently with state, federal and international agencies in matters of policy, research and evaluation. Among recognitions for his work are appointments by President Clinton and President Obama and service, leadership and humanitarian awards from several national organizations and the Minnesota's Outstanding Community Service Award.

**Brenda Leath, MHSA, PMP**

*Senior Director, Westat*

Brenda Leath, MHSA, PMP is a senior study director at Westat and co-executive director of the Center on Pathways Community Care Coordination for Westat's non-profit affiliate, the Rockville Institute. Throughout her profession she has consistently focused on quality improvement and reduction of health disparities among racial and ethnic minority population groups, persons with disabilities, and economically and socially disenfranchised populations. Ms. Leath is a graduate of the Georgetown and the George Washington Universities. She is the recipient of a presidential committee appointment, gubernatorial and mayoral citations, and a department award from the US Department of Health and Human Services.

**James Lee, MD**

*Director, Everett Clinic*

Dr. James Lee currently serves as the Medical Director for Hospital Kaizan (efficiency) between the Everett Clinic and Providence Regional Medical Center Everett. This kaizan is a 4 year lean process improvement event that won "People's Choice" award within Providence Health System. In addition, Dr. Lee is also a Facility Medical Director at the Everett Clinic, responsible for quality, safety and patient experience for 15,000 lives. Prior to his current roles, He was the Associate Medical Director for Care Coordination at the Everett Clinic and was involved with community initiatives including chronic illness management, hospital transition coach program, and expansion of outpatient palliative care program called Partners in Palliative Care. Between 2005-2008, Dr. Lee served as an Assistant Medical Director for CMS Physician Group Practice Demonstration Project. Dr. Lee is also a practicing physician in Interdisciplinary medicine.

**Russell Leftwich, MD**

*State of Tennessee, Office of eHealth Initiatives, Nashville, TN*

Dr. Leftwich is Chief Medical Informatics Officer for Tennessee Office of eHealth Initiatives and has served as lead in the Office of the National Coordinator (ONC) Standards & Interoperability Framework Transitions of

Care Initiative and is currently a lead in the ONC Longitudinal Coordination of Care Initiative, is a member of the National Quality Forum's (NQF) HIT Advisory Committee and served previously on the NQF Care Coordination Steering Committee. He currently serves on the ONC HIT Standards Committee Consumer Technology Workgroup, as HL7 Patient Care Workgroup Co-chair, and as Chair of the HL7 Health Professional Engagement Initiative.

**Lorna Lynn, MD**

*Director, Practice Assessment Development and Evaluation, American Board of Internal Medicine*

Lorna Lynn has spent the past 14 years at the American Board of Internal Medicine developing Practice Improvement Modules (PIMs) and other assessment tools to evaluate clinical practice performance. These tools have been used by thousands of practicing physicians and by many residency and fellowship programs. Prior to joining the staff at ABIM, Dr. Lynn was Assistant Professor in the Division of General Internal Medicine at the University of Pennsylvania, where she received a Robert Wood Johnson Foundation Generalist Physician Faculty Scholar Award and several teaching awards. Her recent work has focused on care coordination and teamwork.

**Jean Malouin, MD, MPH**

*Medical Director, Michigan Primary Care Transformations Project*

Dr. Jean Malouin has been a faculty member in the Department of Family Medicine at the University of Michigan since 1994 and currently holds the position of Associate Medical Director for the Faculty Group Practice. She serves as Medical Director for the Michigan Primary Care Transformation Project, a state-wide Michigan multi-payer pilot involving almost 400 PCMH-designated practices. In 2012, she began working as a Medical Director with Blue Cross Blue Shield of Michigan, leading development of a Care Management Resource Center for Physician Organizations. To date, over 350 care managers have been trained and are working in PCMH practices state-wide.

**Karen Michael, RN, MSN, MBA**

*Vice President, Corporate Medical Management, AmeriHealth Caritas Family of Companies*

Karen Michael is the vice president of corporate medical management for the AmeriHealth Caritas Family of Companies. She is responsible for medical management leadership and strategic vision for all AmeriHealth Caritas health plans and ancillary businesses. She has over 25 years of experience in the healthcare field, including 15 years in managed care and 10 years focusing on needs of vulnerable populations. Her nursing background includes critical care, homehealth and hospice. She earned her undergraduate degree from Trenton State College and holds a MBA from Eastern University and a MS in nursing science from Widener University.

**Terrance O'Malley, MD**

*Medical Director, Non-Acute Care Services, Partners Healthcare System*

Terrance O'Malley, MD is an internist/geriatrician who specializes in the care of nursing home patients. As Medical Director of Non-Acute Care Services for Partners Healthcare, Dr. O'Malley focuses on improving transitions of care and the exchange of clinical information during transitions. He is co-principal investigator of IMPACT (Improving Massachusetts Post-Acute Care Transitions), a project assessing the impact on healthcare utilization of electronically exchanging clinical data among acute and non-acute care sites during care transitions. He also co-chairs the Long Term and Post Acute Care Sub-workgroup within the Standards and Interoperability Framework for the Office of the National Coordinator for Health Information Technology. He graduated from Amherst College and Cornell University Medical College, and trained in Primary Care Medicine at the Massachusetts General Hospital. He is on the teaching faculty at MGH and Harvard Medical School where he provides clinical care and supervises medical students, residents and geriatric fellows.

**Ellen Schultz, MS**

*Project Coordinator, Stanford School of Medicine Center for Primary Care and Outcomes Research*

Ellen Schultz is a health services researcher at Stanford University focusing on quality measurement and care coordination. She managed the team that created and updated the Care Coordination Measures Atlas. She has reviewed the care coordination literature extensively while leading projects to assess the potential for EHR-based care coordination measurement, to evaluate care coordination measures suitable for accountability purposes, and to explore the care coordination evidence base. She is consulting on development of a new measure of coordination and has developed quality indicators for the home- and community-based services population, ambulatory care, and community health.

**Beth Ann Swan, PhD, CRNP, FAAN**

*Dean and Professor, Jefferson School of Nursing, Thomas Jefferson University*

Dr. Beth Ann Swan is Dean and Professor at the Jefferson School of Nursing Thomas Jefferson University in Philadelphia, Pennsylvania. Dr. Swan is past president of the American Academy of Ambulatory Care Nursing and a 2007-2010 Robert Wood Johnson Executive Nurse Fellow. In addition, she served as a 2005-2008 Member of the Review/Steering Committee of the National Quality Forum (NQF) for Standardizing Ambulatory Care Performance Measures. Dr. Swan has published and presented nationally and internationally on topics related to ambulatory care, and care coordination and transition management. She is co-editing the text, Core Curriculum for Care Coordination and Transition Management. Dr. Swan is the author of the November 2012 Health Affairs' Narrative Matters Feature, A Nurse Learns Firsthand That You May Fend for Yourself after a Hospital Stay.

*Please Note: NQF acknowledges that there are several gaps in the Standing Committee and is actively trying to fill these gaps. Should you identify any gaps, please offer insight and/or suggestions on persons to fill them.*