Refocusing Value-Based Care Management Beyond Cost Reduction and Toward Patient Centeredness

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Abstract

IMPORTANCE Care management programs are increasingly being utilized by health systems as a new foundational strategy to advance value-based care. These programs offer the promise of improving patient outcomes while decreasing health care utilization and costs. However, as these programs proliferate in number and specialization, the field of care management is increasingly at risk of fragmentation, inefficiency, and failure to meet the core needs of the patient.

OBSERVATIONS This review of the current state of care management identifies several key challenges for the field, including an unclear value proposition, a focus on system- vs patient-centered outcomes, increased specialization by private and public entrants that produces care fragmentation, and lack of coordination among health and social service entities. A framework is proposed for reorienting care management to truly address the needs of patients through acknowledging the dynamic nature of patient care needs, providing a continuum of need-targeted programming, coordinating care among all involved entities and staff, and performing regular evaluations of outcomes that include patient-centered and health equity measures. Guidance on how this framework can be implemented within a health system and an outline of recommendations is provided for how policymakers may incentivize the development of high value and more equitable care management programs.

CONCLUSIONS AND RELEVANCE With increased focus on care management as a cornerstone of value-based care, value-based health leaders and policymakers can improve the effectiveness and value of care management programs, reduce patient financial burden for care management services, and promote stakeholder coordination.

Importance

Modern value-based care (VBC) seeks to improve clinical outcomes while decreasing costs, and care management has become a foundational tool to advance VBC strategy. Not to be confused with managed care, a term referring to payer strategies to control costs via physician networks and utilization management,1 care management refers to the practice of supporting selected patients via multidisciplinary teams to improve health-related outcomes.2 Care management began in the 1980s as health plans sought to contain costs for patients with complex and high-risk conditions.3 As health systems and Accountable Care Organizations (ACOs) entered the VBC arena and assumed risk for patient outcomes, they followed payers in implementing care management, largely focusing on decreasing costs to improve value.3

Given that the top 5% of patients incurring the highest costs account for half of all US health care spending,4 focusing on patients deemed high-risk (ie, outliers) suggests an efficient way to control costs. However, beyond addressing utilization and cost, care management can improve...
health outcomes by optimizing clinical care and addressing the relevant social determinants of health for a given patient.

Most modern-day care management programs fulfill several of 3 primary functions: disease management (condition-specific or social determinant-specific), navigation, and utilization management or cost control.5 Policymakers have promoted this multidimensional approach to care management via novel innovation incentive programs, including several US Centers for Medicare & Medicaid Services (CMS) Innovation Center (CMMI) models and state Medicaid alternative payment models (APMs).

**Observations**

Despite the growing emphasis on care management, the field of care management is increasingly at risk of not meeting patient needs. Therefore, the true meaning of value in VBC is being undermined by several factors.

**Lacking a Patient-Centered Definition**

A unified, patient-centered definition of the value of care management is lacking. Despite the seemingly straightforward value proposition of improving outcomes and reducing cost, the definition of success for care management programs varies. Studies evaluating care management show mixed results, partly because of varied rigor of study designs, metrics, and emphasis on utilization and cost. For example, a meta-analysis reviewing 36 evaluations of high-risk care management found no significant differences in common metrics, eg, utilization, cost, or mortality; however, self-reported health status and patient satisfaction improved. Another example, the high-profile randomized clinical trial of the Camden Coalition’s “hot spotting” program for “super utilizer” patients, showed no decrease in readmission rates.7 These results generated substantial discussion regarding the usefulness of care management. However, a focus primarily on readmissions ignores other meaningful outcomes, including non-inpatient utilization and mitigation of upstream social determinants of health, eg, the study noted a significant rise in participants receiving food assistance. It also suggested a need for a longer evaluation period because many care programs may require at least 1 year to achieve benefits.

The Camden authors stated “...we learned that all of us focused on health need to widen the aperture on our metrics for success,” a statement relevant for all designing and evaluating care management programs.7 The process of widening the aperture should include participant voices to create truly person-centered definitions for success, as complex care leaders and patient advocates have argued.8 Discussions with consumer stakeholders reveal differences between health system and patient perspectives on what value means, with some patients noting that they value interventions that empower achievement of personal health goals, even if these do not translate into financial value for health systems.9

**Risk of Increasing Fragmentation**

There is a risk of increasing fragmentation of care management across multiple health system players that is complicating patient care. With the growth of APMs and venture capital funding, numerous entrants have promoted care management as a key strategy to optimize performance. As payers, health systems, clinics, community-based health services organizations, and disrupter health care entrants increasingly rely on care management, from the patient perspective there are multiple captains steering their care journey. For example, 1 patient may have a care coordinator with a mental health community organization, a community health worker via their primary care practitioner (PCP), and an eldercare case manager through their Medicare Advantage plan. Additionally, electronic information system interoperability is rare among care management programs, exacerbating fragmentation. It is increasingly unclear how responsibility is delegated or whether parties are working together, which creates the potential for frustration among clinicians and confusion among...
patients. Additional and specific patient and staff perspectives on the challenges of fragmented care management are provided in Table 1.

Rise of Condition-Based Disease Management
A rise of stand-alone, condition-based disease management programming risks moving the focus away from patient-centeredness to health system-centeredness. Interest in condition-based disease management has increased in the past decade for conditions ranging from end-stage kidney disease to dementia. Although these approaches allow intensive and tailored support of patients with specialty-trained teams, without integration they may create new redundancies and care fragmentation for patients with multiple chronic conditions.

Discussion
A Patient-Centered Comprehensive Care Management Continuum
Given the context described, we propose reframing the value-based care management strategy in the US health system, away from its historic roots of cost and utilization management and toward a truly patient-centered model for a population-based care management continuum. This model would acknowledge the following 5 points:

1. Patients are multidimensional, and their care trajectories are not static or unidirectional
Patients’ risk for poor health outcomes can fluctuate, and their health conditions may evolve. Individuals may experience periods of exacerbation of health conditions and increased care utilization, as well as health improvements and reduced utilization.

2. Individuals should be offered a continuum of care management programming support matched to their specific needs
Expanding beyond stemming utilization of a narrow subset of complex patients, modern care management programs can also support less complex or “rising risk” patients. For someone with low social and medical complexity and focused needs, a targeted, low-touch, condition-specific program may be appropriate. If that same patient’s complexity subsequently increases (eg, a new severe behavioral health episode exacerbates other chronic conditions), they may benefit from graduation to programming provided by a multidisciplinary team well versed in holistic, complex care.

Table 1. Qualitative Examples of How Fragmented Care Coordination Affects Patients and Staff

<table>
<thead>
<tr>
<th>Experience theme</th>
<th>Example</th>
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<tbody>
<tr>
<td>Lack of understanding of care management and potential underutilization of services</td>
<td>“I am a bit unclear about the care coordinator’s role and what exactly she does. Not sure why I am eligible for this service.” Patient A&lt;sup&gt;a&lt;/sup&gt;</td>
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<td>“I’m not clear on what services are available and can be provided. [My care manager] may have explained in some form but that has not been clear.” Patient B&lt;sup&gt;a&lt;/sup&gt;</td>
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<tr>
<td>Confusion regarding how care managers and other care team members work with each other</td>
<td>“I have no idea if [my doctor] knows that I have one [a care manager].” Patient C&lt;sup&gt;a&lt;/sup&gt;</td>
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<td>“I have a whole list [of needs] - it’s overwhelming...[I] don’t know who I am supposed to be seeing [and am] running out of medicine.” Patient D&lt;sup&gt;a&lt;/sup&gt;</td>
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<td>Lack of understanding and trust by staff regarding outside care management services</td>
<td>“I receive care management plans faxed over from [name of health insurer] for my patients but I just recycle them. They aren’t helpful and I’m not sure what the utility of those are.” Primary care clinician E&lt;sup&gt;b&lt;/sup&gt;</td>
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<td></td>
<td>“I’ve never been contacted once directly by the care managers provided by [name of health insurer] and have never reached out to them as my patient already has a care manager provided by my own health system. I would rather coordinate with my own system’s staff than an outside party.” Primary care clinician F&lt;sup&gt;b&lt;/sup&gt;</td>
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<td>Challenges with communicating with outside care management services</td>
<td>“Often we are not aligned on the priority goals for a patient and have limited means of communication...no one closes the loop with me on whether or not the goal was accomplished.” Primary care clinician G&lt;sup&gt;b&lt;/sup&gt;</td>
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<td>Difficulties delegating tasks between care management teams negatively impacting patient care</td>
<td>“As the patient had been stabilized medically, our [clinic-based care management team] transferred her to a [community-based organization] to lead care coordination...However, we discovered later that the [community-based organization] charged with working on these issues...had not been in contact with the patient for several months. The patient...did not have transportation to medical appointments and no progress was made on locating in-home services.” Care manager H&lt;sup&gt;b&lt;/sup&gt;</td>
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<sup>a</sup> Examples from interviews with patients receiving care coordination via a community organization–provided care coordinator, as well as primary care within a separate health system.

<sup>b</sup> Examples from interviews with primary care clinicians and care managers with patients enrolled in care management programs outside of the health system in which the staff member practices.
(3) Responsible patient-centered care management requires all offering care management services to integrate and coordinate efforts to determine their role on the "continuum" available to an individual.

Care managers and program leaders should use a partner-focused approach to coordinate care management to reduce fragmentation in patients' care experiences. Designated care team leaders can serve the function of facilitating collaboration among involved parties, while also delegating responsibilities. For example, a health system–based care leader could help a patient maximally leverage resources available to them via their insurance plan and/or community-based care coordination organizations. As opposed to asking patients to self-navigate all supports available, the leader could directly delegate specific care responsibilities to other involved parties (eg, asking a community-based mental health organization to connect the patient to an affiliated therapist). Successfully executing this approach requires timely and meaningful communication among all parties. In addition to improving data interoperability, programs should provide effective methods of communication with each other. For instance, a payer-based care management program could provide PCPs with multiple options for interaction (eg, telephone calls vs facsimile updates to care plans) to ensure ongoing alignment for each mutual patient.

(4) Patient-centeredness includes a commitment to rigorous regular evaluation of broad program effectiveness.

Care management program evaluations should be designed in advance and be routinely conducted to assess metrics beyond utilization and cost, including patient experience and health equity (discussed further in point 5). Both short- and long-term measures should be included because the short-term increases in utilization may be offset by other longer-term benefits. Agile approaches to evaluation should also be considered (eg, short cycles of testing) to enable adaptive design that is responsive to interim findings.

(5) Patient-centered care management also means redefining value from a person-centered and health equity–based perspective.

Value should be defined not only from a system perspective (eg, targeting high-spend outliers to address cost) but from patient perspectives (eg, individuals self-identify what value means to them). Focusing on patient-centered values may result in programs not generating a utilization-based return on investment in the short term. Programs relying on patient buy-in may also take 1 year or more to generate sustainable return on investment because time is needed to build relationships and facilitate behavioral change. Additionally, targeted efforts to explicitly address disparities may actually increase system costs but provide high value from a health equity standpoint. For example, programs for vulnerable populations with historically poor access to care may increase short-term expenditures as patients newly access needed services, receive new diagnoses, and undergo clinical testing. Approaching program design from the patient perspective can strengthen VBC programs by broadening definitions of success with more holistic and equitable definitions of value.

The Right Program for the Right Patient: Learnings From an ACO

We draw from our experience at Mass General Brigham, a large northeastern health system serving more than 1.7 million patients yearly and participating in multiple risk-based ACO arrangements (commercial, Medicare, and Medicaid). In the past decade of its VBC journey, our system has used care management as a core component of its population health strategy and developed a suite of care management programs to serve patients on a multidimensional continuum (Figure 1 and Table 2).

Our care management philosophy is to find the right program for the right patient in a particular moment in time. First, we provide multiple ways for patients to access care management. Outpatients can voice needs to their clinicians, who can refer them for care management. Others are identified proactively via risk-based algorithms or utilization-specific environments (eg, via
emergency department [ED]-situated navigators or dialysis center care managers). After patients are identified as having care management needs, they are assessed along 3 dimensions: (1) level of medical and/or social complexity, (2) anticipated length of care management needs, and (3) the best site for care (eg, community-based services for unhoused patients or home-based services for palliative care). Based on this assessment, they are matched to a candidate program, offered enrollment, and, once engaged, given the opportunity to mutually develop a care plan that incorporates their goals and preferences. Engaged patients are periodically assessed for graduation back to primary care or a step-up or step-down to different programs on the continuum.

Our system’s care management continuum provides varying intensity of care. For example, in our ED navigator program, an ED-based community health workers provide brief episode-based interventions and address social determinants of health needs for patients presenting with low-acuity concerns in the ED. In contrast, the Integrated Care Management Program (iCMP), our system’s longest-running care management program, provides longitudinal care management for months to years for patients with complex conditions via primary care practice-embedded staff. The most complex 1% of patients in our system are escalated to the iCMP PLUS program, an intensive version of iCMP that partners with an external nonprofit to provide services in home- and community-based settings. We have also developed programs for specific complex medical situations associated with both increased utilization and patient-level needs (eg, end-stage kidney disease, end-of-life care).

One care management continuum trajectory could be as follows (Figure 2): a Medicaid-insured patient without a PCP presents to the ED and meets an ED-based navigator, who refers them to housing services and connects them to a PCP. After presenting to primary care, the patient’s unstable housing and mental health conditions preclude effective engagement in an office-based model. Recognizing unmet needs, the clinician refers them to the high-intensity iCMP PLUS program for health visits in the shelter where the patient is staying and to provide wraparound community-based services. Program leaders review the referral and, if the patient meets the criteria for PLUS, transfer them to the program. After the patient obtains a residence and stabilizes medically, they will undergo a care management case review, and may step down to the less intensive iCMP program.

Implementing this continuum at a system level required (1) explicit leadership commitments to funding care management; (2) embedding staff in clinics and practices to improve coordination (as opposed to investing only in remote centralized resources); (3) educating many staff role groups about available programming to improve buy-in and referrals; and (4) evaluating effectiveness and sustainability.
Specifically, most programs in this continuum have demonstrated statistically significant effects on clinical outcomes and/or utilization (Table 2). Taking a comprehensive approach to evaluations, we evaluate cost and utilization but also assess broader measures, eg, connections to primary care and the staff-patient experience. Understanding that care management success cannot be defined by a narrow set of measures has been critical to cultivating a wide range of care management programming with dual value for patients and our health system.

Finally, in an example of cross-sector collaboration, our care management continuum now includes an external payer-sponsored community-based option, Community Partners. Created in 2018 by the Massachusetts’ Medicaid state agency (MassHealth) as part of a CMS Section 1115 demonstration waiver proposal, this program incentivizes ACOs to partner with community-based organizations called Community Partners. Community Partners provide Medicaid patients with care coordinators to address behavioral health and long-term support service needs. During 5 years of working with 26 Community Partners, we have learned that truly integrated care management between internal and external parties requires standardized coordination workflows, overcoming information sharing barriers, and assessing the quality of care provided by outside organizations.

### Table 2. Description and Outcomes of Mass General Brigham Care Management Programs

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<thead>
<tr>
<th>Program and description</th>
<th>Length</th>
<th>Outcomes</th>
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<tbody>
<tr>
<td>Emergency Department Navigator Program</td>
<td>Episode-based (1-7 d)</td>
<td>Study: matched retrospective cohort study of 30-d post-ED visit outcomes, predominately Medicaid patients. Outcomes: 52% significant increase in odds of primary care follow-up (all-comers); 32% significant decrease in odds of a second ED visit among patients with infrequent recent ED use</td>
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<td>Frequent utilization pilot: extension of standard program for patients with high ED use. Longer follow-up to address underlying drivers of ED visits and to connect patients to more longitudinal resources (eg, intensive care management or primary care)</td>
<td>1-6 mo</td>
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<tr>
<td>Integrated Care Management Program (ICMP) adult</td>
<td>Longer-term program, mo-y</td>
<td>Study: cohort study with staggered-entry control group; only Medicare patients studied. Outcomes: overall $101 savings/PMPM; 8% lower rate of hospitalization; stepwise decline in PMPM cost as time in ICMP increased (eg, −$210 with 7-12 mo vs −$654 with 25 mo)</td>
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<tr>
<td>Uses multidisciplinary teams led by primary care practice-embedded care managers (registered nurses, social workers, community health workers) to provide comprehensive care management for complex high-risk, high-cost chronically ill adult patients</td>
<td>Longer-term program, mo-y</td>
<td>Study: quasi-stepped-wedge design pre- and post-enrollment, difference-in-differences; patients insured by mix of payers. Outcomes: $749 savings/member/mo; 29% significant decrease in ED use, 82% decrease in inpatient use</td>
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<td>End-Stage Kidney Disease program</td>
<td>Mo-y</td>
<td>Study: descriptive study examining ESRD metrics compared with national averages. Outcomes: More transplant referrals (59% vs 20%; higher transplant rates (11% vs 3%) vs ESKD patients nationally</td>
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<td>Care management nurses support ESRD patients with complex needs with face-to-face visits in dialysis units to address ED and hospital utilization, and to facilitate access to kidney transplantation</td>
<td>Mo-y</td>
<td>Study: randomized study (PLUS vs standard ICMP); patients insured by mix of payers. Outcomes: TME reduction $1827 PMPM (P = .08); 66% decrease in rate of ED observation stays (P = .01)</td>
</tr>
<tr>
<td>Delivered through a contract with an external nonprofit, this program targets the highest-complexity patients in our system and delivers care via nurse practitioners in home and community settings</td>
<td>Mo-y</td>
<td></td>
</tr>
<tr>
<td>Home-based palliative care</td>
<td>Mo-y (usually &lt;2 y)</td>
<td>Study: difference-in-differences trend at end of life compared with propensity matched cohort; patients insured by a mix of payers. Outcomes: TME reduction of $8106 PMPM at end of life, no significant utilization difference/higher rate of hospice care (67% vs 40% in control group)</td>
</tr>
<tr>
<td>Provides palliative care services at home to patients with an estimated life expectancy of 1-2 y with advanced complex illness</td>
<td>Mo-y</td>
<td>Study: retrospective matched cohort of Medicaid ACO patients. Outcomes: no significant influence on ED utilization or hospital readmissions in the early years of the program</td>
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Abbreviations: ACO, Accountable Care Organization; CMS, US Centers for Medicare & Medicaid Services; ED, emergency department; PMPM, per member per month; TME, total medical expenditure.

* Unpublished internal data.
Policy and Care Delivery Recommendations

Policymakers and funders of value-focused APMs can incentivize health system players to move toward patient-centered care management that serves patients across a continuum and aligns stakeholders.

Leverage Federal and State Alternative Payment Model and Commercial Payer ACO Designs

Care management is currently required in many of the CMS Innovation Models. Beyond simply mandating this as a general function, future APM iterations can promote more comprehensive approaches to care management by defining program offering tiers, tying payments in a graduated manner to intensity and spectrum of services provided, and incentivizing collaboration with other existing care management entities in participants’ local health environments. As an example of state-level incentivization of more effective care management, Massachusetts piloted from 2018 to 2022 a state-wide expansion of access to community-based care management via a CMS Section 1115 waiver as described previously, ie, the Community Partners program.

The APMs can also encourage care management program development for vulnerable populations. Dual eligible beneficiaries who are younger than age 65 (eligible for Medicare and Medicaid, often with disabilities) may require complex care, with more than 40% requiring long-term care management.

Figure 2. Sample Patient Trajectory Through the Care Management Program Spectrum

Illustration of a patient’s possible trajectory through the care management program spectrum based on changing complexity and specific needs at a moment in time. ED refers to emergency department and PCP to primary care practitioner.
services and support while experiencing increased social barriers to navigating care. For instance, launched in 2022, California’s CalAIM initiative sought to improve care integration for dual eligibles and offered a new state-wide Medicaid benefit to support community-based enhanced care management for populations in vulnerable situations (eg, patients experiencing homelessness). California also created an Incentive Payment Program for managed care plans to invest in developing care management-related community organizational infrastructure.

The APMs can also promote rigorous evaluation by delineating patient-centered outcomes as national standards for care management programs to measure. For example, the CMMI End Stage Renal Disease Treatment Choices Model randomizes one-third of the nation’s hospital referral regions’ dialysis facilities and managing clinicians to receive payment adjustments based on home dialysis and transplant rates. It also includes a novel health equity incentive based on improvements among dual-eligible and low-income subsidy beneficiaries. Other APMs may similarly incentivize both the measurement of patient-centered outcomes and the process implementation to achieve these goals.

These same principles may apply to commercial ACO contracts between health system and private entities (eg, payers). The ACO payment structures could enable health systems, particularly smaller ones, to obtain capital needed for costlier up-front investments to build care management programs. A study of 173 ACOs found that only 56% of private payer contracts provided up-front payments for care management, suggesting further contractual opportunities in this area.

Incentivize MA Plans to Improve Care Management
Medicare Advantage presents another opportunity for policymakers to incentivize health plans to improve care management-related integration and health system collaboration. To succeed in MA, plans have intensified risk coding, with subsequent faster rises in MA risk scores compared with similar members in traditional Medicare. These risk-coding efforts appear more likely to benefit plans than to translate into member value. As CMS refines MA plan payment and requirements to maximize value for patients, it could create specific incentives to improve the spectrum of care management available and to reward improved patient-centered coordination among payer-based services and health system and/or clinic-based teams. As a start, in its 2023 plan star ratings, CMS recently increased the weight of its patient experience measures from 2 to 4, including measures of care coordination. We advocate for further rewards for high-quality care management via purposeful design of measures (eg, structure measures for in-person care coordination supports vs simply telephonic coordination).

Minimize Financial Burden to Patients for Care Management Services via Billing Reform
Payer coverage of care management varies among Medicare, Medicaid, and commercial payers, with out-of-pocket costs varying as well. For instance, although Medicare now covers chronic care management as a billable service, patients without supplemental Medicare policies incur deductible and 20% coinsurance charges, which could pose barriers to patient engagement. Regardless of payer, adding regular charges for care management could dissuade patients in vulnerable situations—potentially those most likely to benefit from supports—from starting or continuing to participate in these programs. Eliminating cost-sharing requirements, proposed in 2021 by a bipartisan group of US Representatives, could help address inequities in care management access and alleviate barriers to an intervention with potential positive clinical and financial effectiveness.

Improve and Formalize Interstakeholder Coordination in Care Management
Beyond the public sector, the many entities that provide care management would benefit from working together in coalitions. In their “Blueprint for Complex Care,” the National Center for Complex Care and Social Needs, Center for Health Care Strategies, and Institute for Healthcare Improvement describe the complex care ecosystem of organizations involved in coordinating care for individuals with medical and social complexity. The Blueprint argues for the need for core competencies, formalized partnerships, data sharing, and learning collaboratives to improve collaboration among entities. Success also requires financing models and administrative support,
which can be created via collaborative arrangements. For instance, the Michigan Community Care program is supported by the Washtenaw Health Initiative, a collective of multiple organizations and funded by different hospital, government, and grant sources. Although governed centrally, the program provides care management via multiple organizations, assigning individuals to 1 "lead" organization that then coordinates care among all other relevant care management-related organizations to minimize redundancy and improve patient experiences. Similarly, payers, policymakers, and health systems may consider requiring care management programs to report whether their care managers have assumed roles of coordinating the coordinators or designated care management leads.

Finally, we believe that all stakeholders—health systems, payers, community-based organizations, newer market entrants—can commit to a collaborative patient-centered framework for care management. Regardless of the entity leading care management for patients, ensuring coordination across a continuum of programming will strengthen the health systems' abilities to deliver true value-based care by maximizing efficiency of resource investments and providing flexibility to tailor programs to patients' short-term and long-term needs.

**Conclusions**

Care management programs have been used to support patients considered to be at high risk and to control costs for specific patient populations. However, proliferation of program offerings by different health system players and increased program segmentation threaten to exacerbate the fragmentation of care delivery. To promote patient-centered care management, health systems can benefit from providing a patient-tailored continuum of care management offerings and better understanding the care management ecosystem available to patients via payers, community-based organizations, and other sources. Policymakers have a similar responsibility and opportunity to develop incentives to address worsening fragmentation in this field and to promote a more holistic, equitable, and patient-centered approach to care management aligned with value-based care.
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REFERENCES


