NATIONAL QUALITY FORUM

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MEASURE APPLICATIONS PARTNERSHIP

DUAL ELIGIBLE BENEFICIARIES WORKGROUP

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WEDNESDAY

MARCH 29, 2017

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The Workgroup met at the National Quality Forum, 9th Floor Conference Room, 1030 15th Street, N.W., Washington, D.C., at 9:00 a.m., Jennie CO-CHAIR CHIN HANSEN and Michael Monson, Co-Chairs, presiding.

PRESENT:

JENNIE CHIN HANSEN, RN, MS, FAAN, Workgroup Co-Chair, Subject Matter Expert
MICHAEL MONSON, MPP, Substitute Workgroup Co-Chair, Centene Corporation
CHRISTINE AGUIAR LYNCH, MPH, Association for Community Affiliated Health Plans
JOE BAKER, JD, Medicare Rights Center*
RICHARD BRINGEWATT, SNP Alliance
GWENDOLEN BUHR, MD, MHS, Med, CMD, American Medical Directors Association
BEVERLY COURT, PhD, National Association of Medicaid Directors*
ALISON CUELLAR, PhD, Subject Matter Expert
WENDY FOX-GRAGE, MS, MPA, AARP Public Policy Institute
JOY HAMMEL, PhD, OTR/L, FAOTA, American Occupational Therapy Association
ALINE HOLMES, DNP, MSN, RN, New Jersey Hospital Association
K. CHARLIE LAKIN, PhD, Subject Matter Expert
THOMAS H. LUTZOW, PhD, MBA, iCare
STACEY LYTLE, MPH, CMS Medicare-Medicaid Coordination Office
D.E.B. POTTER, MS, Office of the Assistant Secretary for Planning and Evaluation
JENNIFER RAMONA, Homewatch CareGivers
KIMBERLY RASK, MD, PhD, Subject Matter Expert
E. CLARKE ROSS, DPA, Consortium for Citizens with Disabilities
JOAN LEVY ZLOTNIK, PhD, ACSW, National Association of Social Workers

*** present by teleconference**

NQF STAFF:

SHANTANU AGRAWAL, MD, MPhil, President and CEO

KATE BUCHANAN, MPH, Project Manager

ANN HAMMERSMITH, JD, General Counsel

MADISON JUNG, Project Analyst

TRACY LUSTIG, DPM, MPH, Senior Director

DEBJANI MUKHERJEE, MPH, Senior Director

ELISA MUNTHALI, MPH, Vice President, Quality Measurement

KIRSTEN REED, Project Manager

RACHEL ROILAND, MS, PhD, Senior Project Manager

MARCIA WILSON, PhD, MBA, Senior Vice President, Quality Measurement

ALSO PRESENT:

STUART GORDON, JD, Director, Policy and Healthcare Reform, NASMHPD

C O N T E N T S

C O N T E N T S (CONTINUED)

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

9:04 a.m.

MS. MUKHERJEE: Hello, everybody. Thanks for coming in, and welcome to the Measure Applications Partnership Dual Eligible Beneficiaries Workgroup In-Person Meeting that will happen over March 29th and 30th.

Just a quick few announcements. Please make sure you speak into the microphone, and when you speak, that the red button is -- you press the speak button and the red light is on. Once you are done, please turn it off because we only can have a couple of microphones on at a time.

If you would like to indicate that you would like to speak, please use your tent cards and raise it up.

With that, without further ado, I am going to turn it over to Ann Hammersmith to do DOIs as well as some introductions.

Thank you.

MS. HAMMERSMITH: Thanks, Debjani.

I am Ann Hammersmith and NQF's General Counsel.

As Debjani said, we are going to combine introductions with the DOIs because it is a little bit quicker.

So, you are a MAP committee. So, your DOI process is a little more complicated for purposes of full disclosure. We have organizational members who are subject matter experts. Your disclosures are different. And we also have representatives from the federal government. So, I am going to do this in pieces to try to make it a little bit easier, and we will see how we do.

Are there any federal government representatives here? Okay, two of you. Okay. If you could just introduce yourselves? You don't need to do disclosures.

MEMBER LYTLE: Stacey Lytle, and I am with the Medicare-Medicaid Coordination Office.

MEMBER POTTER: Hi. I'm D.E.B. Potter from the Office of the Assistant Secretary for

Planning and Evaluation, and I have been a member of this group from the beginning.

MS. HAMMERSMITH: Okay. Thank you.

So, next, we will move to the disclosures for the subject matter experts. Most members of this group are organizational members, but we do have subject matter experts. Subject matter experts sit as individuals, you are here because you are an expert. You don't represent your employer, any group you are associated with, anybody who may have nominated you for the Committee.

So, for subject matter experts only, we are interested in your disclosure of anything that you believe is relevant to your service on the Committee, in particular, research, grants, speaking engagements, consulting. So with that -- and I am going to call on the subject matter experts.

So I will start with our Chairs.

CO-CHAIR CHIN HANSEN: I'm Jennie Chin Hansen. I am the Co-Chair of this Committee. At

this point, I am a subject matter expert since I no longer am working with the original organization, the American Geriatric Society.

I have disclosed before that I am on a MAP of the NCQA on geriatric measures and, also, an advisor for measures with Econometrica. That is -- has received a CMS contract for PACE measures.

And finally, a newer development is I am connected to a relatively new startup that is helping commercial members right now choose physicians as well as be able to develop their cost co-share knowledge that they would have. But, ultimately, it will be with Medicare beneficiaries as well.

MS. HAMMERSMITH: Alison Cuellar?

(No response.)

Okay. Charlie Lakin?

MEMBER LAKIN: Hi. Charlie Lakin.

I think the only thing I would disclose is that I am a consultant in the Rehabilitation, Research, and Training Center on

Home and Community-Based Services Outcomes at the University of Minnesota, which we will hear a bit about tomorrow.

MS. HAMMERSMITH: Thank you.

Pamela Parker?

(No response.)

Is Pamela Parker -- oh, she is the one who is outside. Okay.

Kimberly Rask?

MEMBER RASK: Hi. I'm Kimberly Rask, and I am Chief Data Officer for Alliant, which is a company that has CMS contracts for the QIN-QIO work for Medicare in the Southeast, as well as ESRD networks in the Southeast, as well as Medicaid Quality Improvement and Utilization Review contracts for different states in the Southeast.

MS. HAMMERSMITH: Okay. Thank you.

Now we will move on to the organizational member disclosure, which is pretty simple. If you are an organizational member, you do represent the organization you are associated

with, and we expect you to bring that viewpoint to the table.

So, the disclosure is completely different for this group. The only thing that we are interested in is whether you have an interest of $10,000 or more in something that is relevant to the work of this Committee. So, for example -- I always use cardiologists, I don't know why -- let's say this was a cardiology committee. And let's say one of the measures in front of the committee had something to do with defibrillators and you have $100,000 in stock in the XYZ Defibrillator Company. We would be interested in you disclosing that.

So, does that help people understand this disclosure? Okay. So, we will start with Michael Monson.

CO-CHAIR MONSON: Hi. Michael Monson. I work with Centene Corporation, and I do not believe that I have any investments that reach the $10,000 mark.

MS. HAMMERSMITH: Okay. Thank you.

CO-CHAIR MONSON: Yes.

MS. HAMMERSMITH: Susan Reinhard?

MEMBER FOX-GRAGE: Hi. I am not Susan Reinhard. My name is Wendy Fox-Grage and I'm filling in for her because, unfortunately, she is ill. And we both work for the AARP Public Policy Institute. And I do not have $10,000 or more interest.

Thank you.

MS. HAMMERSMITH: Okay. Gwendolyn Buhr?

MEMBER BUHR: Hi. I'm Gwen Buhr, and I do not have anything to disclose.

MS. HAMMERSMITH: Thank you.

Joy Hammel?

MEMBER HAMMEL: Hi. I'm Joy Hammel. I'm here on behalf of the American Occupational Therapy Association, and I have nothing to disclose.

MS. HAMMERSMITH: Christine Lynch?

MEMBER AGUIAR LYNCH: Hi. I am Christine Aguiar Lynch with the Association for

Community Affiliated Plans, and I don't have anything to disclose.

MS. HAMMERSMITH: Okay. Clarke Ross?

MEMBER ROSS: Hi. I'm Clarke Ross. I work for the American Association on Health and Disability which is a member of the Consortium for Citizens with Disabilities, which is a D.C. coalition of 113 national disability groups. So, I am technically representing CCD at this meeting, and I have no disclosures.

MS. HAMMERSMITH: Thank you.

Jennifer Ramona?

MEMBER RAMONA: Hi. I'm Jennifer Ramona, Homewatch CareGivers, Homewatch International, Inc. I have nothing to disclose.

MS. HAMMERSMITH: Thomas Lutzow?

MEMBER LUTZOW: Yes, I am Tom Lutzow. I am with Independent Care Health Plan, and I have nothing to disclose.

MS. HAMMERSMITH: Okay. Is Joe Baker on the phone?

(No response.)

Is Beverly Court on the phone?

MEMBER COURT: Yes, Beverly Court, representing National Association of Medicaid Directors, and I have nothing to disclose.

MS. HAMMERSMITH: Thank you.

Joan Zlotnik?

MEMBER ZLOTNIK: I'm Joan Zlotnik. I am representing the National Association of Social Workers, and I have nothing to disclose.

MS. HAMMERSMITH: Okay. Aline Holmes?

MEMBER HOLMES: Hi. I'm Aline Holmes. I represent the New Jersey Hospital Association, and I have nothing to disclose.

MS. HAMMERSMITH: Okay. Richard Bringewatt?

MEMBER BRINGEWATT: Yes, Rich Bringewatt. I have nothing to disclose.

MS. HAMMERSMITH: Okay. Thank you.

Did I miss anybody here or on the phone?

(No response.)

Okay. Great. Thank you for those

disclosures.

Does anybody have any questions?

(No response.)

Okay. One more reminder before -- nothing to disclose? Okay.

Before I leave you, I want to remind you of one more thing. That is, if you think that the subject matter experts have a conflict of interest, we would ask you to speak up in real-time. You can bring it up in the Committee. You can bring it to your Co-Chairs. You can go to NQF staff. And we will do our best to resolve it.

Also, if you think someone is behaving with undue bias or they are just not listening to the other Committee members, we ask you to bring that to our attention as well.

Thank you.

MS. MUKHERJEE: Thank you, Ann.

This is Debjani again. I'm the Senior Director for the Duals Workgroup.

And now, I would like to turn it over

to Stacey Lytle from CMS for some welcoming remarks.

MEMBER LYTLE: Good morning, everyone. I shared my name, but I figured I would introduce myself a little bit further before remarks.

Again, it is Stacey Lytle, and I have been with the Medicare-Medicaid Coordination Office for six years now, so just about as long as we have been around, but not quite.

My work with quality and with this group is relatively new, as I moved through positions and acquired this work last summer. But I have -- looking around the room -- talked to many people in the room on the phone and other capacities, and done other work with them. So, it is good to put names with faces. And I wanted to share that because I know that it is sometimes odd when new people show up and you have no idea where they came from.

One of the things -- the reasons why that I am speaking first is because there has been information shared with some -- and we

haven't been able to get to everyone -- about the future of this Workgroup and how we will proceed after August.

As some people know, the Task Order for this work ends in August and, with that, we will be discontinuing the work of the Workgroup in its current form. And I wanted to start early by saying that and being able to thank the group for all of its work over the years.

I think that, having been in the Duals Office, I have been witness to a number of things that the Workgroup has done in terms of gap analyses and providing the family of measures. And those things have really been instrumental in guiding our work. And so, we are very appreciative for the work of this group.

We do sincerely apologize for how this information was shared. To be very transparent, we have been trying to share the information for a couple of weeks now and, with transitions and other things, we haven't been able to do it in the way we wanted to.

Speaking of transition, I know some people may be concerned about the fact that the new administration may have something to do with the shift. And I want to be clear that that is not necessarily what is happening here. As an office, we have been trying to figure out what our next best steps are, how we utilize our resources best. And we have noticed that there has been a lot of work that has come out of this Workgroup and we haven't had the resources to actually begin a lot of implementation. We have done some measure development and we have done some other things, but we really want to focus now on implementing a lot of the suggestions and recommendations that have been made.

And so, we can't speak about the full direction of quality and duals, but I did want to share that this is not a product of the administration change in shutting down the Workgroup. We hope to continue to work with each of you in whatever capacity possible. We will work with NQF and we will work with our

colleagues at CMS to see how we can continue to get input, because it has been so valuable over the years.

But I think that we just need to shift focus a little bit to make sure that we are able to implement a lot of the things that you all have recommended as being key to making sure that quality for duals is appropriately assessed. And I think D.E.B. knows well the work on socioeconomic status and its impact on quality. That has sort of re-energized us around the agency in a way, and we want to capitalize on that and make sure that we are involved in those discussions in whatever way possible.

And so, we are hoping that the shift in focus will help us move forward on a lot of the things that we've heard. So, I wanted to share that early, and we will have other opportunities to discuss what comes next throughout the day. But I do thank you for being kind and patient with me as I shared some not-so-good news with you.

MS. MUKHERJEE: Thank you, Stacey.

And what we will do is now turn it over to our Chairs and Shantanu for some opening remarks before we have any discussion.

CO-CHAIR MONSON: So, I know that was probably not the news that everyone wanted to get bright and early as we start our meeting. I mean, we are going to spend some of the day today, we've carved out some time -- actually, our first conversation after Shantanu makes his remarks is actually going to be an open conversation for us to have an opportunity to provide some final thoughts to CMS about where we think there are opportunities still. And especially as CMS is moving more towards measure development or working on socioeconomic status, this is a good opportunity for us to provide feedback.

We are going to have time again at the end of the day tomorrow. So, we have a couple of decent-sized chunks of time to do that.

We do have some work to do, though,

right, as we still have this Committee. And there are some measures that we need to do in terms of maintenance of the measure set and figuring out whether or not we are going to keep a couple of measures or add a couple of measures. That will be a big chunk of today and some part of tomorrow as well, as well as going through some new findings that I think everyone has seen already around behavioral health. And, Charlie, I'd reference the work from Minnesota.

I do want to -- you know, I think that all of our reactions are probably at various different stages of loss, the stages of grief probably. And so, I would just encourage everyone to channel their energy into as constructive a manner as possible because I think that while none of us want to see this Committee cease altogether, I think that the message is really more of a hiatus. I know that CMS and NQF are looking at other ways for us to continue some of this work, even without the formal contract. And this group still has a lot to offer and there

is an opportunity for us to provide some -- to continue to provide direction today.

All right. Shantanu?

DR. AGRAWAL: Thank you.

So, I have been CEO of NQF now for a couple of months. This is one of the more difficult conversations to have because I know of the tremendous work that you have done on the Committee to date. And I know that, for some who had not heard the news earlier, this is sudden. And even if you had, I think you probably are still sort of contemplating what it means and what can be done.

Let me just start by thanking our Chairs. This, again, has been really important work.

I also really want to take a moment to thank Stacey and CMS. Again, I know that their decision is not an easy one. I think it comes from the best place, and it is hard to be the messenger. But your support of this Committee can't be overstated. So, I think that is really

important.

NQF considers the work on dual eligibles to be a priority. We understand the specific issues of this population. We understand how vulnerable this population can be. So, I wanted to talk a little bit about from our standpoint what some next steps will be, just in light of the news, what we can do going forward.

First, you have my assurance that, even if this Committee were not to continue, that as we do other work -- so as we, for example, seek nominations for the MAP this year -- we will have an eye towards making sure we seat and bring on board members that are experts in the dual eligible population, so that that perspective can be preserved in MAP. That will be one of the many factors we try to balance as we seat a MAP committee or committees this year.

Second, there are other NQF committees that are clearly related to this area of work, so the work that we do on social disparities, on home- and community-based services. Again, as

those committees get seated, as new membership comes up, we are committed to making sure that we have the right experts at the table, so that the dual eligible perspective is also expressed.

A third thing I will mention as an opportunity. So, when I started this job, I think it became pretty clear in conversations with the leadership team here that all money is green, and that we don't necessarily have to rely on CMS dollars to seat these committees. That isn't a slight to CMS. It is just a reality.

And this work is a priority. So, I think my question for you all -- and it certainly can be part of the discussion or just for you to contemplate as we go forward -- is, should we seek funding from other sources to continue the work of the Committee? Now, if that were to happen, it would not be tied to MAP in the same way that it is today, but it would still afford the opportunity to continue on other areas of priority that the Committee can continue to advance on.

I have actually come to think that more of our committees should be funded from different sources than just CMS because it affords more flexibility and organizationally it is the right answer for us in many ways. This is an unexpected but sort of opportune time to apply that principle to this Committee. So, I encourage you to think about it. We will do the same. We will reach out to see if there are stakeholders interested who might be able to finance the Committee. You know, how it operates might change a little bit going forward, but I think it can at least continue to do the good work that it has done.

So, those are my comments. Let's look forward.

And let me just say, Michael's point is exactly right. You also have work to do now. So, let's not lose sight of that. I think continuing to make progress is really important for this population. I thank you for the hard work. Once we are on the other side of the

discussion, please stay focused on that work.

So, thank you.

CO-CHAIR MONSON: All right. So, let's open it up. At this point, this is our -- we have until 11:15, 11:00-ish, right, to have the conversation. I guess we are getting our slides up. Oh, there we are, Workgroup Discussion. Thanks.

So, Workgroup Discussion, right, was purposely amorphous because it is meant to be a Workgroup discussion. We have done a lot of work. You have just heard a lot of talking at you, right? So, let's step back and let's hear people's thoughts about any reactions to the news and, then, any thoughts about how people would like to see either the work of this Committee move forward or other suggestions.

So, yes, then, if you want to speak, tents up.

So, Clarke.

MEMBER ROSS: Thank you.

So, a couple of sensitive topics. If

you look at the National Quality Forum Board and you look at the MAP, it is largely a big-money, well-established interest. And the advantage of all the workgroups and task forces and committees has been a true commitment to multi-stakeholder in the broadest sense, consumers, families, non-medical professionals.

And so, my concern is the message. In December I sent around a Modern Healthcare article. Dr. Price's history as a Member of the House on the MACRA legislation was to diminish the role of the National Quality Forum, and the Senate didn't go along with that. He has been very clear for many, many years that medical specialty societies is where he thinks quality should be determined, and people like me should not be at the table. I am a father of a 28-year-old son with multiple disabilities, and other people around the table have non-clinical, non-medical/MD backgrounds.

So, the message I am trying to sort through in my mind -- which is sensitivity that I

know Quality Forum staff can't really upfront deal with -- but it is a diminishment of the consumer family, non-traditional, non-medical involvement, which has been outstanding, not just here, but in multiple committees, task forces, and workgroups of the National Quality Forum.

So, I just needed to get that off my chest. I had open heart surgery on January 30th. And so, my chest isn't fully healed, but I need to get that off my chest. And with whatever -- at least I have said it for the record, and however you are comfortable responding or not responding, fine.

But thank you.

CO-CHAIR MONSON: D.E.B.?

MEMBER POTTER: I just wanted to say that the nominations period for the MAP ends on April 6th, which is coming up soon. That's all.

MEMBER BRINGEWATT: Yes, I just had a couple of comments. First, I think it is important for all of us to just note appreciation for the work that the Dual Office does. We all

work in times where we have limited budgets and need to sort out how best to deal with those budgets and, you know -- so, I respect the decision, and we need to sort out how to deal with it within the context of kind of ongoing respect and support for the work that the Dual Office does.

Secondly is, I think there is no question there is still more work to be done as it relates to performance measurement for duals. I think we have gotten -- you know, we have a good start here, but we clearly haven't wrapped up ultimately what needs to be done. And so, it is important for us, I think, to figure out how to move forward with that.

As part of that, it seems to me like it is useful to think a little bit about what the advantages and benefits are of this particular group in the larger measurement development arena. There are two things that come to mind that may at least help me begin to think a little bit more about what comes next.

One is I think this is really the only measurement workgroup that has a consumer face. All of the other consumer workgroups have a provider face. You know, they are a plan, they are a hospital, they are a segment of the broader community. This Workgroup has a consumer face. I think it is critical that that kind of thinking continues in performance measurement.

And perhaps where another piece of that is, it seems to me like -- particularly if our interest is focusing on improving care for and performance measurement of care for high-risk populations -- that it is important for all of us to think about how do we move towards more of a population-based approach to performance management measurement as opposed to a measuring a particular performance by a particular profession or a particular provider at a particular point in time, is how do we rethink performance measurement for populations?

In some ways, duals is a population that you can get your hands around that has some

common characteristics. I was hoping, actually, as a next step in relation to that, that there are subsets of duals that also have a population characteristic to it that has a spillover effect to other performance measurement arenas, whether that is frail elders or adults with behavioral health problems or whether it is HIV/AIDS or other kinds of conditions.

But I think it is important for all of us to begin to shift our thinking a little bit in terms of what does it mean to do performance measurement at it relates to defined populations. And so, one of the regrets I have for not having this possibility of not having this group continue is it flips us back to an old framework of thinking where there still needs to be work done in each of the arenas of hospitals and nursing homes and post-acute care service providers. And that is ultimately where a lot of the application of our work is.

But there needs to be a driving force for addressing those issues. Without something

like this, I think it is possible that we could kind of spin back to an old kind of paradigm.

MEMBER ZLOTNIK: Like D.E.B., I have been part of this Workgroup from the beginning. And it has been interesting to see how it has evolved over time with a much stronger consumer perspective around the various populations of duals than it even started out with. It started out a little more medical then it has evolved over time.

I know that one of the big things we talked about -- I think at the last meeting and some of our rep calls -- has been, so we have identified all these gaps over the last five years and what is happening with them. So, I really want to thank CMS for an interest in actually trying to move forward on some of those pieces and to really think, like NQF, CMS also is very heavily medically-oriented.

And so, many of the gaps that have been identified really need to involve community providers. They need to involve consumers. They

need to involve providers who are not necessarily physicians or nurses or PAs. And the more that that can happen, kind of taking the experience of this Workgroup I think will be really important.

I think the idea of trying to sort of maintain or sustain this kind of Workgroup and input in other ways is really helpful, and really thinking about how the work on home- and community-based services or long-term care -- in particular are two that kind of come to my mind -- you know, really need to continue to have this kind of input and value.

I had the opportunity at one point to be the liaison to the Long-Term Care Group. That was such a different experience. Here there are not many chairs taken. But when I went to that group, the whole room was full of CMS staff and whole other pieces.

So, we have always been, I guess, kind of an outlier a little, but that is part of the value. And so, for NQF and for CMS and for other stakeholders, I ask the others to think about how

that work can kind of continue and grow and really deal with these measurement issues where we don't have measures for the things that perhaps are the most important because they are so muddy. And I think the kind of work we have done to bring in other people who are working in some of this area has been really important.

So, I look forward to going forward. And I know, sort of on behalf of the National Association of Social Workers -- and I'm not the only social worker sitting in the room, but everyone doesn't go out and identify themselves as that necessarily -- that we really want to stay involved.

CO-CHAIR CHIN HANSEN: Thanks.

This is Jennie speaking, and you can tell I am not fully 100 percent, but what I would like to do is comment as a member as well as an alternative thought, building on others.

I, too, have been a part of this from the get-go and really have seen the evolution and how important that has been as a partnership with

CMS. So, to your point, you know, the fact that we had to work with the original measures and really just tweak them from the side, just because they were almost the only measures we had, to moving to a kind of -- our agenda has proportionately started to shift to really think about the other NQF groups that are more population-focused. So, I just wanted to affirm that you know that this is where the work is and these are where the gaps are.

On my more personal hat, I am on the board of a foundation called the SCAN Foundation. We have actually financed work that is very consumer-focused. California, in particular, has had probably the only focus of the dual pilots in a way that we have actually done direct focus groups on the consumers themselves using AP-NORC methods. And now, that contract has been given to UCSF to do the final tranche of work. So, I think by the time we are done, we will have touched about 20,000 dual eligible responses there.

And going back to the consumer voice that several of you have brought, is the ability to make sure that as the duals work was being implemented by the health plans and by the local counties, the whole question is what impact has that had as an outcome on the beneficiary? And much to people's surprise, that after two-plus years of implementation, the beneficiaries have actually found that it has been effective in care coordination, getting appointments with their primary care, and self-reported reduced hospital utilization.

And so, our ability to perhaps take other information that has been very consumer-focused -- this is not asking the providers in all of this -- it later has been corroborated with the health plans that their -- the reduction for acute care is there.

So, I guess my only point in bringing this up is there are bodies of work going on, whether it is really state-specific -- some foundations are doing it. The ability to take

this and flip it a little bit more, you know, there is some momentum looking at socioeconomic factors or particular subgroups of duals.

But the ability to use other data, in addition to the quality science that we know -- I mean, there is a real method, but the method has been honed in on some more traditional ways to do things. And so, the whole consumer side of research is younger, and there are probably other ways to get valid information.

So, I think the ability to think of the next body of work incorporating other elements -- and I know Clarke has been very contributory to thinking about some of the tools that have been used in the disability community. So, it may -- I think our next body of work would have incorporated this a little bit more, because it is really hard -- going back to your comment, Joan -- when you go to some of these fixed programs, this is where the funds happen to go right now. And so, there is great interest. But we all sitting around this table have chosen to

be here because we know that quality is measured differently, but the tools are still evolving.

And so, I think having NQF have that ability -- along with CMS -- to try to get back to the truism of this -- just because the funding wasn't set up that way, we probably aren't getting true voices. And the ability to have a table that someday -- Joan, you know, you would have a team of people in the back interested in this.

But I think people -- you know, going back to worlds of public health -- know that clinical care is only 20 percent of health. And so, taking that back again as a concept of understanding total population health and some of the social underpinnings that NQF has taken on, how does that get incorporated in kind of the more enhanced and probably more accurate thinking that should be about quality, accountability, and outcomes?

So, it is like I think this group has worked so hard to work within the system that

exists and try to rattle the cage from the outside, but realizing that this may be a different construct entirely, which is part of what change is about. And it does take time for us to do that.

But there are probably means of doing that and people out in the trenches who are doing this right now, including consumer folks, but the health plans themselves are recognizing some of the socioeconomic elements. Some of the health systems are using their community benefit money differently that are more socially-based.

So, there is a lot of information out there. And so, I do agree, Shantanu, that perhaps thinking about funding in a slightly different way to get access to that, so that the reframing can occur, so that we can be parsimonious, we can be -- have valid measures, and a different kind of reliability when we do that.

But I think it is an exciting and genuine challenge, but the marketplace I think is

already beginning to respond to it. I think, for CMS, the ability to think about measurement in a way along in partnership with others, to think about reframing this, so that we use our resources in the best way and that people get the best results for it.

MEMBER LYTLE: I do appreciate that. As you were talking, I was thinking about being creative and, also, the fact that some of the things that I have heard and that we have discussed around hearing from consumers and hearing the person's perspective about the care that they receive has guided a lot of our work and our Financial Alignment Initiative.

You mentioned California. We do talk about the work that has gone on in California because it has been an important example for us. But we have also done work in other states where we have tried to figure out what do the people think is important and how do they see the care that they are receiving.

And so, I think, for us, the Financial

Alignment Initiative is a step in the direction of moving us forward when we think about the population of people that we serve. And so, we are rethinking how we look at quality, and we are focusing on how do we get to person-reported outcomes and how do we really assess quality of life. And I think that that discussion is not the same one that would have been happening years ago or that was happening years ago.

Of course, we are met with challenges because there are programs that assess quality in certain ways, and we have to work within certain frameworks. But it pushes us to be creative in our thinking, when we are doing measure development, think about what opportunities we have to work with other people in CMS or other entities in CMS that are already doing something, but can you push the envelope a little further to get some of the consumer voice heard?

And so, I think this conversation is just helping me to further understand and conceptualize how we can move forward as we think

about implementing -- I think even with our Financial Alignment Initiative, what can we do differently or what can we think about differently?

We have been doing a lot of work lately on how do we hear from consumers about their experiences with their home- and community-based services within the demonstrations? We are trying to get to that, and it is important for us to hear that not from all of the providers and the case managers, but from the people. And so, it reinforces that goal of ours to hear those voices.

CO-CHAIR MONSON: MMCO just released a series of reports like on Friday or Monday that are focus groups of consumers --

MEMBER LYTLE: Yes.

CO-CHAIR MONSON: -- who are in the demonstration. I want to encourage everyone to read it. It is actually quite fascinating.

MEMBER LYTLE: There are three of them.

CO-CHAIR MONSON: There are some promising things about the demonstrations there, but certainly areas for improvement as well. But it was, I think, a real marker that CMS is taking seriously, a real person-centered approach in going to the consumer directly to get that information, instead of filtering out through health plans and the provider.

MEMBER LYTLE: Yes.

CO-CHAIR MONSON: Tom? Oh, sorry.

MEMBER LYTLE: Yes, we are excited about those, too.

(Laughter.)

CO-CHAIR MONSON: Tom?

MEMBER LUTZOW: I share some of the same concerns that have been expressed. You know, I am left with a feeling that there is a lot of work that is not now going to be done, not that this group has the burden to solve all the world's problems.

But here is the danger: if we don't get the metrics right for the duals population,

the resources available to that population are going to leave. Because if the measures are set up for the average population, we are going to see those resources migrate toward the average population, and the duals population is very difficult to fit into the average measures.

So, the danger is, what is important? And I know it is a complex problem. You have multiple segments of the duals, the IDD group, the physically-disabled group, the frail elderly group. And they all have their own characteristics. So, it is a complicated issue.

But, if we don't get measures that are important to this group, tailored to this group, we are going to see resources leave this group. And so, we are in no way done on this. If we don't get it right, these folks are going to find themselves without support.

So, you know, in Wisconsin we have a family care program, long-term services and supports, managed care that it wants to go to a pay-for-performance kind of a program. And in

talking to the leadership at the State, they are at a loss pretty much to find peer-validated measures.

Certainly, there is the National Core Indicators set. But, truly, getting at what is important, and certainly medically-important, the danger is setting up measures that cause a migration of Medicare and Medicaid dollars into social services. I mean, there is a barrier there that shouldn't be crossed.

But, at the same time, you know, you are looking at a population, 80 percent of our admissions are through the emergency room, not through the PCP. The PCP is the last to know. Now that is quite a distinctive characteristic for the duals group.

The no-show rate for the duals group is excessively high, maybe 50 percent. That is a waste of resources because providers are sitting around waiting for people to show up for their appointments.

So, to some extent, how do we get at

those kinds of problems through an incentive performance structure? You know, is this about controlling diabetes? Yes, but it is also about engagement and achieving those kinds of outcomes. Where do we see a reflection of that in our measurement set?

So, going back to the first point, if we don't get it right, we are going to see resources leave the innercity and go toward populations that are easier to work with.

CO-CHAIR MONSON: Go ahead, Christine.

MEMBER AGUIAR LYNCH: Yes, I want to just pick up on Tom's point. I do agree with it. I do.

I also want to give credit to the Duals Office and to CMS in general for all of your work. I am glad to hear that you guys are focusing on filling in the measurement gaps and, also, focusing on the issue of social determinants of health and the Star Ratings Program. That is the biggest issue for our plans.

I think the ASPE Report highlighted it so perfectly, just so beautifully, such a rigorous methodology. I think we are talking about that report later today.

And so, I encourage CMS to pick up on that and to really start looking for solutions, I mean to the Star Rating Program, in particular, but, then, also just across, across the five-years' payment, across measurement development.

To Tom's point, I think gaps measurement is a priority, you know, addressing social risk factors and the quality measurement systems, the payment systems we have currently. And then, also, just trying to look at the other measures, just to make sure that we are actually accurately capturing quality for the dual eligibles, which according to my member plans, we just are not yet doing. So, I would say that is my feedback for CMS.

For this group, it has been really interesting to hear you all, especially those of you have been on since the beginning, talk about

sort of the value and evolution of the group. It strikes me that the real benefit of it is in this focusing on the consumer and really thinking outside of the box.

And to Rich's point, taking it next. Okay. So, not where is quality measurement now, but where should it be going? And highlighting things that nobody else is talking about, to Jennie's point: where the plans are going; what are people really doing with social determinants of health?

I think there is a role for that. I think that work can and should live on. I don't have in mind, unfortunately, which funders you all should be reaching out to, but I would hope that that type of work can continue.

To Clarke's point, I think, of course, the tension there is, then, you know, depending on who you are funding, sort of like there is the new sort of mission and vision of the duals that are the MAP, or whatever it is going to be called in the future, and then, who your funders are.

Are they the right match? Are they going to push this in a direction where it is really going against the original purpose of it?

But I would encourage to seek those resources out and to try to see a way for it to continue, even if it is not in its current form.

CO-CHAIR MONSON: So, I will just take my Chair hat off and now add as a member: I would echo many of the comments that others have made around consumer-centrism. But I think there is a really important point that Tom raised that I think is important to flesh out, especially as things go forward, which is that there is like a crosstab that we have to think about with measures for the duals.

So, there is the heterogeneity of the population. Just because you are dual, there are so many different versions of duals, because people are people and there are very different types of people who have very different issues. And so, the issues that different subpopulations face cannot be ignored.

At the same time that there are different issues that all duals face, right, and that are not captured in the current measure sets. One of the things that this Committee has attempted to do over time is to speak out about we can't just use the measure sets that we have already have, the MDS data, the OASIS data, the hospital data. Because those data, they don't actually capture the kind of issues that an LTSS might face, a beneficiary, or that an individual with severe substance abuse or mental health issues is facing. And so, I think we do need to think about this from a crosstab of measures.

The other thing that I would add would be that I would strongly encourage CMS to be thinking about -- well, this is true for all the demonstrations as well as all LTSS programs, fee-for-service, or managed care. And I have said this before, but I will say it again, which is we do capture all this information on comprehensive assessments.

We spend a lot of time and energy and

money to capture what is really happening with people. And then, when it works really well, we use that to create person-centered care plans. And I think we all know that there is a long way to go to get that correct.

But there is a lot of robust data there, and it isn't standardized yet, but there is a lot of it that is very similar across the states. And so, that is a real rich data source for us to think about as a measurement set, and maybe as we think about funding sources, we think about ways to tap into this as a new place for information. And then, ultimately, even trying to figure out if there is a way to capture data right off those person-centered care plans, because that would really give us a sense of incentive.

MEMBER LYTLE: Can I speak to that for just a second? It is funny you said that. We have been thinking about in our office how we capture information from what we hear from the plans that isn't necessarily standardized.

And one of the things, we like to hear some of the success stories. And we have been thinking about, how do we synthesize that information and how do we make it usable for other plans, and what do we learn from it? So, I think that that is definitely something we need to go back and think about in terms of all of the rich data that we collect.

And we are using it, of course, to serve people, but are there other things that we can learn from it that help move the population, the quality of care for the population forward? So, I appreciate that.

I didn't get to talk a little earlier about some of the measure development, but I wanted to speak to what to Tom mentioned. We have been working on some measures, and I think you heard about some of them last year, hospitalizations for ambulatory care, sensitive conditions, and a composite measure of some of the patient-reported access to care, things that are being collected by the Financial Alignment

Initiative plans.

And we have been moving forward on those. So, that kind of work is still happening. And I think what you said about getting the measure right is very important to us. Testing has been done, and we think it looks hopeful. We are in the risk-adjustment phase with those.

Just Friday or this week -- my days are running together -- just this week, we released for public comment the Healthy Days and the Community Measure, which doesn't necessarily ask people per se, but tries to get to what healthy looks like.

And so, we are trying to think about how does measurement happen differently than it has been. And then, once we have these measures, where do we place them? The fortunate thing is that we do have a Financial Alignment Initiative where we can collect information on new measures without upsetting the apple cart and all the other plans and, then, push them forward.

But I think that those types of

opportunities for us are important. And we will still have that measure development contract for at least another year. So, we hope to identify things that get to what Tom was saying about making sure that we are measuring the right thing for the population we serve, rather than just looking at hospital data and saying, okay, the duals look different, but, really, how do we get to what people in our target population need? So, I thank you for that. I wanted to share that because I didn't earlier.

CO-CHAIR MONSON: Do we have any Committee members on the phone who want to chime-in?

MEMBER BAKER: This is Joe Baker. I did join on the phone just now, but nothing to say. Thanks.

CO-CHAIR MONSON: Joe, we need you to do your quick disclosure of interests. Do you have any conflicts of interest that you need to disclose?

MEMBER BAKER: No, I don't. I don't.

CO-CHAIR MONSON: Okay. Other comments? Oh, sorry, go ahead. I didn't see you. Sorry.

MEMBER HAMMEL: I'm going to take a couple of hats here. I am here on behalf of the OT Association, but I also am a member of the disability rights community and have done a lot of participatory action research with them as well.

There are a couple of groups here that I am really worried about or issues I am worried about as this leaves. That is that group of people under dual eligibles that are transitioning between lots of things. They are transitioning between settings, between groups. They are dealing with multiple aging times, long-term disability times, chronic conditions. And they are trying to transition into the community now, too, as a civil rights issue, right, an Olmstead issue, which is above and beyond any kind of service delivery, but sets squarely in what CMS has been doing over the years in trying

to change those systems to be receptive to civil rights, too, and not just the medical-only end of it, right?

So, that is the group, you know, the group that ends up fitting in and out of, say, a nursing home, maybe an emergency room, maybe some homelessness. Then, they are trying to come back into, all of a sudden, having to figure out, are they even eligible for Medicaid, Medicare? What would it be? Every state is different, you know, in how they do that.

So, these consumer-directed assessments we have been talking about I think are incredibly important, but also these social determinants of health kinds of issues. So, when I hear Healthy Days, I worry that that means days without disability and people with disabilities are going to get penalized for that, versus saying healthy supports with it. You know, like what are they? If they get personal attendance, if they get assistive technology or affordable housing or vouchers or waivers, whichever, does

that make a difference on Healthy Days in the community, right?

And that healthy is considered very broadly versus what I have seen in the past with this group, which is they get penalized. They are the group that is often called the frail, the vulnerable, the marginalized. And they are not the same, right?

So, that is the group that I really worry about here if this doesn't happen. And after decades of trying to get Olmstead and long-term support changes that come via policy of CMS, I really worry if those could get stripped and not there anymore. You know, like if there are things that could happen there, too.

So, I think there really is a reason for continuing the group and under funding mechanisms or other things that would allow us to do some of that research and continue to select assessments and measures that fit the transitioning group, the group that doesn't fit anywhere else, and that is flitting, literally

flitting, between which system do I even belong to and how do I get in there.

MEMBER LYTLE: So, I want to say that I think that those are definitely the issues with the measure that we are interested in. Because how we define "healthy" differs for different populations.

With that, I encourage you to please comment as it relates to that. Because since it is in its early form and we are just at the public comment phase, those are the kinds of things that we need to make sure that we have documented.

DR. AGRAWAL: Yes, thank you.

I just wanted to circle back to where Clarke started the conversation, and I think a few folks have echoed-in. So, I think you are absolutely right that the consumer or patient voice at NQF is extremely important to us. It is also a little bit, as I look at sort of health care overall, it is a little unique that we do have this very multi-stakeholder approach. We

are highly committed to that.

The fact that you have called attention to some of our Board membership, I have been sort of thinking about your comment since you made it. I will continue to think about it because I think that is an important comment. And we will see what we can do about that.

I also do think you have called out a really important thread about sort of what MACRA has sort of stated about NQF and how much it prioritizes as a piece of legislation or the sort of people behind it, a multi-stakeholder approach. You know, I share your concern. I think it is a real concern.

I have sort of two answers. Or, really, I want to make you aware of one dynamic and, then, kind of a longer-term answer. So, the dynamic is -- and it is important for everybody to be aware, if you are not -- NQF, as an entity, is authorized by Congress every few years. This is one of those years, right? Our funding runs out at the end of the federal fiscal year.

And so, yes, in this context of MACRA and some, I think, skepticism both on the Hill and in the Department about the role of multi-stakeholder organizations, or perhaps NQF in particular, we will have to make our argument about continued government funding to continue the committee work that we have, to continue the MAP work that we have.

So, any assistance you want to provide to advocate on the Hill we would welcome. You will hear more about this, I think, in the coming weeks, in case you are interested in doing that. But I think this will be sort of an uphill walk in order to really get there.

The longer-term answer, something that we have been talking a lot about internally, is how we move away from being as predominantly government-funded as we are today without losing track of the mission. So, I take everybody's point about, if funding comes from different places, will we be able to prioritize/focus on the areas of greatest need or concern, especially

in the view of the committees that we are convening?

I think that is a real concern. We do actually have some funding models for other areas of work that are very multi-stakeholder in their funding approach, that actually allow this organization and its committees to pursue the highest-priority areas without that being sort of altered or in some way affected by the funding approach.

So, I think we can do it. There are models even within NQF that demonstrate that we can do it. And I think the longer-term vision of this place, certainly that I have and that we need to deliver on in some period of time, is not being so highly government-reliant, so that we can continue to drive our mission and these reauthorizations, hopefully, will not stop, but they will be bumps in the road, instead of the major speed bumps that they are today.

So, Clarke, I think you are hitting on the right topics and I appreciate the input.

MEMBER ROSS: As a representative of a home- and community-based provider, and the consumer end, non-medical, I appreciate everybody's contributions to the importance of it and the measures that come that are outside of just medical- or condition-based.

I think what has been expressed in terms of the gaps that are there is real and significant, and we have a long way to go. And I hope that the work can continue, and maybe look at some of the for-profit providers in the space of personal support services for data and for information about what we can measure, and understand what really is improving the lives of people in their homes, and not get too focused on whether or not we currently have the evidence behind it.

You can have evidence-based tools, but whether or not it has been already ferreted out, but there are tools and opportunities and a great wealth of data among the providers out there that I think we could tap into, if we saw it as not a

-- well, they are not yet providing government, you know, they are not receiving CMS payments, whether it be through Medicare or Medicaid. But our population is often those that are quickly becoming the dual eligible. They might be currently only on Medicare and, then, they are going into Medicaid dual eligible status. And how can we even look at the information we have on that to help reduce the number of dual eligibles that we have?

MEMBER LUTZOW: Yes, I just want to make a comment on MACRA. MACRA leaves out the duals. In its measures it ignores the duals. You are going to see the effect of MACRA is going to be a focus on primary care on a non-duals population. So, from a lobbying standpoint, from an advocacy standpoint, MACRA needs to be attacked for its measurement set.

CO-CHAIR MONSON: And I would just add to that, when you look at MACRA, MACRA is medically focused. It ignores everything else we have just had a whole conversation about, and

with these populations, in particular, are going to be critical. So, there is a deficit. And so, there is a real risk if we don't continue to work with these populations about other types of measures, and that it just goes back to this medical model, which ignores the real issues and the real challenges.

And as you think about states with less money on their Medicaid programs and how they think about this, we need to have tools and data that they can use to make better decisions about how to allocate their limited resources, so that they don't get siphoned off to other areas.

Charlie, you look like you want to say something.

MEMBER LAKIN: Some years ago, I had the privilege of working here in Washington. As Director of the National Institute on Disability and Rehabilitation Research, I had another function, which was to chair what was called the Interagency Committee on Disability Research, which brought representatives from a lot of

federal agencies together, with the goal that we would coordinate what we did.

And I felt an abject failure when I left with regard to that. People would show up. We would have great discussions. We would all commit to what we were doing and, then, we would all go back to our own silos and act autonomously about the same issues that we had discussed and said we needed to coordinate.

I have always been struck with how many efforts that are going on in Washington at the same time, so many measure-development activities, so many evaluations of measures, so much investment in measures, but with little sense that there is something scandalously inefficient about all of this.

I just stay amazed at how poorly we make all of this fit together. We communicate at times, but we integrate never. And it is almost to me like, if we talk about a National Quality Forum, what we really need one on is the agencies. Somehow we have got to get agencies

together to talk about a unified effort to define, measure and expect quality.

In the same way, I think about within the Department of Health and Human Services. CMS is out developing its own measure for home- and community-based services quality. In ACL there is investment in promoting the National Core Indicators and expanding it to measurements for persons who are aged and disabled.

And I just don't know how we are ever going to get anywhere unless we can get away from this autonomous behavior of all of these different agencies, frankly, including us, if we want to consider ourselves an agency.

So, I don't know the answer to that, but, you know, I was on this NQF committee on home- and community-based services. We didn't really get too much into measures. We really got into kind of what measures should measure, I guess.

But that activity was followed up by a NIDRR-funded Rehabilitation Research and

Training Center, a five-year commitment to really take what the NQF committee outlined and to develop a program of research and development around that. Someone is going to talk about that tomorrow.

But, yet, it seems to me that somehow, by beginning to work together, agencies could make us more efficient, more effective and better use forums like this and hopefully forums amongst themselves to really address quality both in a substantive way, but also in an efficient and integrative way. Because we are just going to keep talking in our own silos forever and really get nowhere because CMS is going to develop some measures and everyone will be compelled to use them. And we are not going to really do anything but say we like them or we don't like them.

I think that is an unfortunate use of this resource, but really of federal resources, too, which we all know are going to become scarcer and scarcer.

MEMBER BRINGEWATT: Yes, the question

that comes to mind for me in all this discussion -- and I think it's a really good discussion -- is -- maybe it is too simplistic -- but what is the dual lens, and what is most important, if we look at the world through the dual lens, what is most important for us in thinking about performance measurement to address?

You know, the bottom line is duals require the same services that non-duals require. And so, what is it that is unique about duals that becomes the responsibility of this particular group in addressing performance measurement?

It seems to me like there are two primary ones that keep coming up in the discussion here. One relates to social determinants of health. You know, the defining characteristic for duals is that there is a lack of income, but it is not simply a lack of income that requires somebody else to help finance their care. But it brings with it a culture of poverty that is with this.

And so, I think any time we look at performance measurement, it is important for us to look through that social-determinants lens to see how any of these measures either work or don't work and whether there is something more that needs to be done.

And that is part of why I have been really excited about that agenda moving onto the dual agenda, onto our agenda. It really is pretty core to who duals are.

Secondly is just an ocean of systems-ness. Duals are in the midst of an environment where they have to deal with things coming at them from Medicare and Medicaid. They have to deal with things coming at them from a medical and a non-medical perspective. They have to deal with things coming at them from multiple provider involvement in serving them.

And so, it is all about trying to help connect the dots from the different players that are involved. Now there may be others, but it seems to me like those are two issues that are

perhaps most unique to duals and maybe helps us focus. You know, where do we focus next? What should be our priority so that we can actually get something done? You know, so that it isn't simply talk, that we move beyond talk to doing something.

In some ways, these kinds of decisions force all of us to kind of rethink what it is that we do, what is most important that we do. If we can kind of take that challenge, it seems to me like we are going to be better going forward than we were before we were faced with this decision today.

CO-CHAIR CHIN HANSEN: Two things. One is to pick up the MACRA comment, and the other one is picking up Rich and others, that you just brought up, what is it that we measure, and what you brought up, Stacey, the latest work on what is a good day or a healthy day.

That begs the question of defining a third element. You had system-ness and socioeconomic status of elements. But there is a

component that the disability world has always emphasized, and that is function. And so, the ability to elevate function in a way that, depending on whatever group, you know, so it is not what is a healthy day; what is a functional day.

And I think there is actually momentum that comes from the World Health Organization. Their theme this past year on chronicity was all about function. And so, that could be a more universal umbrella, but defined perhaps differently, depending -- you know, for somebody who is dealing with behavioral health, somebody who is dealing with transition. Because that is an element of quality of life, and function could be defined differently for somebody who is in a more palliative state as compared to somebody is hoping to transition to another environment.

So, I wonder if there is some science underneath that, because there is certainly on a global level some work going on thinking about function as a much more dominant variable than

being the dependent variable.

But, back to MACRA, I think the point that has been brought up by everybody is real important. Before I left my role at the American Geriatric Society, I was on the board of the physician group called the Council of Medical Specialty Societies, representing 750,000 physicians.

And one of the themes -- and I think it is somewhat represented in Dr. Price's thinking about quality measurement via registries. And physician registries is a very big thing of most physician groups.

Unfortunately, the irony of it, even though it is good and it includes consumers, but it is based on everybody's own specialty. If you are a cardiologist, you have one; if you are a neurologist, you have one.

Nobody was easily thinking about people who might have multiple conditions. And then, how do your measures affect somebody who is on the receiving end?

So, I was one of the lone voices, as you can imagine, raising that quite a bit. Didn't get any solid traction. But it is a danger with the whole movement toward MACRA and thinking about quality measurement.

So, it is an area of push that has to get flipped to understand this. I think I have raised this with our duals staff before, whether or not there is some investment in the journey mapping of people who are duals, transition duals, younger disabled, behavioral health, substance abuse, to be able to kind of track their journey backward and show how the unsystem-ness affects people.

But, somehow, the story has to be more powerfully spoken about and conveyed because, otherwise, it is about structures. And what happens is that is where the silos come in. But, if we flip it to really talk about the journey map of people who are in situations and where they might go and what happens to them, it gives a different feeling of the fact that we are

oftentimes inadvertently the cause of their discoordination.

And so, I don't know whether there are resources at CMS to kind of look at it that way. Because what happens, it comes from the data that comes down, rather than thinking about what that experience of being the dual-eligible in different categories tends to be and where the barriers just come up rather quickly, once you start looking at what that experience is.

So, it is one of the areas where I think that, then, we can get back to the concept of function, which is, then, a much more universal one, and thinking about how do you develop measurement and improvement based on function.

So, the higher-functioning anybody can be at any point, frankly, the better their living is. And then, secondly, it, frankly, costs a lot less.

MEMBER COURT: This is Bev Court from the National Association of Medicaid Directors.

And one concern I have, again, the despair with NQF potentially not being linked with CMS, for example, the recent evaluations at CMS just put out, used a metric looking at serious and persistent mental illness. Actually, CMS is holding that measure to be proprietary and won't share it with the states; that that measure, that kind of outside evaluation is using.

And so, my message to Stacey, hi, Stacey. We talk a lot. But, really, I am concerned about, if this is an approach that CMS is going towards proprietary measures where they won't share the technical specifications, I am very concerned about that. And I think other Medicaid agencies will be very concerned about that also.

MEMBER LYTLE: Hi, Bev. I know we have talked about that measure some, and I don't think that we want to say that that is the direction we are moving in.

Since this is a direct question, I

want to answer, we can certainly talk more about that specific measure and how we arrived there and what we might be able to do. But I am pretty confident that we don't want to move in the direction where the measures that we develop or use are proprietary.

MEMBER PARKER: Okay. I was really interested in Charlie's overview because he said just exactly what I am sitting here thinking about. Having been involved in this at a state level for a long time, and a little bit now from looking at health plans, and from a consumer standpoint, as a caregiver myself -- I am having a medical issue today; sorry, I have to jump in and out.

The problem is just the whole thing doesn't make sense, and because all the agencies are doing just what Charlie said. No one in their right mind -- you know, experts, people like myself who have been in this for years and years and years can't follow all the pieces, you know, all the measures, all the specs, all the

changes, all the adjustments that have to be made to them. There is hardly anybody that can do that.

And so, you have providers, states, plans, consumer groups, advocacy groups, everyone. It is impossible to have a really good sense of the big picture of what is going on at any one time.

And the measure developers and the agencies I don't see necessarily working together in the same tracks. I mean, they are kind of on their own and, then, the agencies decide to pick up on some of them or don't.

My concern is that what we really need is somebody to bang heads together and make decisions and simplify and synthesize. I don't see that. If CMS is going to give up some of the role around this population, where everything comes together in a big crunch, everything is magnified and, you know, exponentially more complicated with the duals population.

So, if that is not going to happen,

being sponsored by the feds, I don't see it happening in the private sector. So, if this movement, you know, if all this work goes into a private sector, I don't see there being any clout in that effort. It might be a great, gallant effort and maybe great insights will come from it, but I just don't see it, then, having the oomph.

And so, I may be echoing what Bev just said about, you know, without the connection to the agencies, how do you actually make it happen and make anything come of it?

So, you know, I am disappointed that you would be having to disband this group. I don't know if this is the right group to do it. I mean, I almost think, you know, HHS or somebody has to have an overarching strategy that goes across all the provider groups and takes all these things into consideration.

And certainly, there has been a huge amount of learning through all these groups. That needs to be synthesized. But nobody can

make sense of this system right now, and there are too many layers and at too many different levels. And they are likely to be exacerbated by what you are saying about MACRA, and going backwards perhaps on some of the things that we think are the most important for the most chronically ill and most costly population.

So, just begging for -- I don't know who in the sky it would be -- but somebody to bring it together and make it make sense.

CO-CHAIR MONSON: I think an important point of clarification, Pam -- and I thank you for that.

And, Stacey, correct me. I don't want to put words in your mouth. But my understanding wasn't that CMS is walking away from the duals population and measure sets. I think this group is going on a hiatus to actually put more resources into actually doing measure development and then at some point, there would be a need to have some endorsement. Is that an accurate statement, Stacey?

MEMBER LYTLE: I think so. I think that we have been thinking about it in terms of let's figure out how to move forward and how to coordinate with some of the various entities that exist around our agency.

I mean, there are some efforts that currently exist. We have affinity groups, and I think D.E.B. is on some of those that are happening across agencies and how do we look at issues from the various agencies.

But, then, we also want to make sure that, as measures are being developed in other places within CMS and around, that we are able to engage and we are able to make sure that they don't ignore the population of people that are duals.

And so, I don't think we are saying that we are stepping back from the importance of it, but we want to get to where we do have a system that people can navigate easily and that we can understand. Because I am kind of like you, Pam, you know, we have all been doing it a

long time, but if we have to actually use the services, it is still just as confusing because of how our systems are set up.

So, I think we want to get out of that world and this is why we are taking this sort of pause or hiatus. And, you know, we can't speak to the future indefinitely, for a number of reasons, but, for right now, that is what our focus needs to be.

CO-CHAIR MONSON: Yes, Christine?

MEMBER AGUIAR LYNCH: So, I have a suggestion for the NQF staff. I think it may be worth thinking about whether or not the audience has to change. Because, right now, I think it has been CMS and it has been a very top-down approach.

But I think there may be some value in looking at it from more of a bottom-up approach as well. You could have, let's say this could break up into a couple of smaller initiatives, a couple of smaller work groups, and work with someone, like health plans, for example, or

providers, for example.

I have yet to hear consensus amongst at least the member plans I work with about which are the measures that you actually do have the data to report, that actually are, you feel, somewhat accurate, if not completely accurate. How would you like to change them? I haven't seen that, what could be done.

And I think if you get that consensus, then that could sort of start to even push pressure -- I don't want to put pressure on CMS per se, but I think it actually might be really helpful to you guys to put a little pressure on CMS. So, just a suggestion, maybe to think about multiple initiatives moving forward.

MEMBER POTTER: I appreciate everyone's conversations, and I am sitting here taking it all in. I thought I would just share my personal perspective, as someone who is in the Department but doesn't work for CMS.

Everyone seems to think of CMS as this single agent. From my point of view, I see,

well, there's the Medicaid people and there's the Medicare people and there's the people in the duals office and the people in this office. And wait a minute, don't you know that this group over here is doing this? And part of my job is to send those emails that say, you really need to talk to this person. I think you are trying to do the same thing.

CMS is a huge organization. So, I would just like to share that perspective, that, well, top-down, because some things are top-down, but there is a lot that goes like this and there is a lot that goes lower down also.

And so, part of the job of people who aren't in CMS is to help CMS see the connections within its agency and how oh, well, what you're doing in this Medicaid program really aligns with what you're doing in this alternative payment model demonstration. And why aren't you doing it and measuring it the same way?

So, I just thought I would throw that out there.

MEMBER COURT: This is Bev Court from NAMD.

We are painfully aware of that. Thank you for bringing that up and validating that. Thanks.

CO-CHAIR MONSON: Well, this has been a very robust conversation. We have opportunity again tomorrow at the end of the day. So, I would actually encourage people, throughout the course of the work today, and then tomorrow, if you have other final thoughts or suggestions for CMS, that will be a great opportunity to see them again.

I think, Stacey, will you be here still tomorrow?

MEMBER LYTLE: I will be here tomorrow.

CO-CHAIR MONSON: Fantastic.

MEMBER LYTLE: I'm looking forward to it.

CO-CHAIR MONSON: We would get you the information anyway, if you weren't going to be.

(Laughter.)

So, unless anybody has anything else they want to say right now, and I will make sure the people on the phone -- I think we are going to take a 15-minute break.

Does anybody on the phone have any last comments?

(No response.)

Okay. So, why don't we resume at 10:45 Eastern?

(Whereupon, the above-entitled matter went off the record at 10:29 a.m. and resumed at 10:46 a.m.)

CO-CHAIR MONSON: All right. I think we're going to get back to work. We are now moving on to our slides which we see often which is Maintaining the Family of Measures. Rachel is going to go through the family of measures.

I actually would encourage everyone especially in light of our minute hiatus to think about the family and the structure of the family to see if there is any last guidance we would

give around that. I know we may not all pay as much attention to this part as we normally would. But I would encourage --

That's not a reflection of the work at all. It's just that we hear it often. Sometimes when you hear it all the time you don't pay as much attention. So I would encourage everyone to really pay attention to this and with that lens that this is our last opportunity for now to make an adjustment to this.

Rachel, take it away.

DR. ROILAND: All right. Thank you, Michael. Hello again everyone. My name is Rachel Roiland. And I'm a Senior Project Manager here at NQF. And I'll be leading us through the next section of our agenda which as Michael said is putting our family of measures through the maintenance process.

But before I do that, I just want to make a few other housekeeping announcements that we weren't able to make this morning. For folks on the phone and folks in the room, we do have

public comment periods set aside throughout the day. They're marked in the agenda. For the public and other members who might want to comment on the discussions and proceedings, we do have time coming up for that.

And also for our folks on the phone, if you do want to make a comment, please feel free to jump in when you can. It might make things a little bit easier if you do use the raise of the hand function within the webinar platform. It just helps us. It's easier for us to realize that you want to say something. If you're able to do that, please feel free to do so.

With that, those are the only other housekeeping announcements. Sorry. To bring your attention back to the family of measures, as was mentioned earlier this morning, the work in front of us today is sort of twofold. Tomorrow we will be having a lot of discussion around broad measurement issues with respect to the dual-eligible population.

But today our focus really is on the family. What we're going to be doing is talking about the family as a whole right now. I'll be giving you a quick update on the current state of the family. A lot of the information will be the information that you heard during the February webinar where we did an overview of the current state of the family, but we wanted to do it again today at a higher level just to set the conversation for the discussion and the voting that will be happening this afternoon.

So I'll be doing a quick overview. And then we'll have a discussion right before going to lunch just talking about your thoughts on the family as it stands and how it could be improved moving forward.

Just to take us right to the very beginning of the work group and how the family came about, the duals work group, as you all know, is part of the overall Measure Applications Partnership or MAP structure here at NQF. And the purpose of MAP is to provide HHS with input

during the pre-rulemaking process where they select performance measures for various federal programs.

The MAP also engages in a variety of different feedback loops with HHS regarding the implementation of current program measure sets. And this is a really important focus because there is a lot of emphasis on looking at the measure sets as a whole for various programs. We're trying to take the same perspective, too, with the family of measures and realizing that individual measures, it's important to consider them in terms of are they appropriate for the duals population. But in addition, we should also consider the family as a whole and evaluate where it's strong and where it has some gaps.

Also within the MAP, the purpose behind all of this work is to really promote optimal care delivery. We want to find measures that align across various programs, settings, levels of analysis and populations. And really another focus when looking at the program measure

sets is to focus on how we can reduce data-collection burden. We don't want to just keep adding more and more measures. We want to make sure that we're adding measures that are meaningful to consumers and also don't place too much burden on consumers as well as providers.

The duals work group as we all know has a twofold charge. The first charge is really related to what we'll be talking about tomorrow. Those are to consider and make recommendations around a range of measurement issues relevant to the dual-eligible population. A lot of those discussions in the past have focused on how quality measurement can identify and address the various complex medical and social needs that are often found in the dual-eligible population or subgroups within that population. And the second fold of the charge is really to again maintain this family of measures.

With respect to the broader quality measurement issues with the dual-eligible population, this group in the past has talked

about a variety of different issues. A few are listed up here on the slide now. Issues around quality of life, measuring quality of life in various models that have been found to have a positive impact on the quality of life for consumers. The group has also discussed ways that we can advance person- and family-centered care through measurement, particularly through the lens of examining health disparities. And then last year you all had a really robust discussion around addressing connections across health care and community supports and services. It's the recognition that health care is only 20 percent of or visits to the clinics or other settings are only 20 percent of health and the health care we receive. So how do we expand the lens of quality measurement to include those providers and experiences outside of traditional health care settings?

For our current family of measures, just an overview of what the family of measures is for those of you listening in from the public

or those of you who are new to the work group, it's really a set of measures that are identified as the best available to address quality issues across the continuum of care for the dual-eligible beneficiary population.

The current family of measures contain 74 measures that are all NQF-endorsed for the most part. We'll be going over those that have lost endorsement later on today. But as it stands, the family has 74 measures.

And a subset of those measures are included in what we call the starter set. And there are 17 measures in the current starter set. Those are measures that are considered as currently specified most ready for implementation within programs that may have served the dual-eligible beneficiary population. And they're considered the most appropriate to start with or to be considered in the starter set because their measure focus is either cross-setting in that it addresses multiple conditions, populations or settings or the measure is focused on a specific

condition that's highly prevalent or considered of high importance in the dual-eligible beneficiary population or a particular subgroup within the dual-eligible population.

And the family is really intended to be a resource for those in the field. We want it to be a place where folks can go, be a first stop to try to find quality measures that may be appropriate for the program or services they're trying to implement. We've recognized that 74 measures is a lot of measures. So it's not meant that all those measures would be implemented in a given program. But it's really meant to be a repository for selection of the measures that would be appropriate for a given program.

And just given changes in quality measurement science, changes in needs or the dual-eligible population, we do consider it best practice to periodically update the family of measures. That's what we'll be doing today.

What we do is we consider changes to measures if there's been any. And we identify

new measures that may be appropriate to add to the family to address any current gaps that may exist within the family and also to just take into consideration MAP's pre-rulemaking programs specific recommendations and whether or not those recommendations lead us to think there are additions to the family that would be appropriate.

Our strategies for maintaining the family of measures, we try to consider a lot of different variables when looking at the family of measures as a whole. The first two bullet points really highlight the three major factors that we would like you all to consider and that we've considered when looking at the family of measures and proposing measures for addition. Those three things are, first, the measure selection criteria which are used by the other MAP work groups to assess the program measure sets as a whole. And then we also ask you to consider this work group's previously identified high-leverage opportunities for measurement as well as priority

gap areas. I'll go over those in just a moment.

But we really want those second two, the high-leverage opportunities and the gap areas. We really thought about those when trying to propose measures to add to the family whether or not we had any newly NQF-endorsed measures that might address those two areas. And then the measure selection criteria we'll present that to you as well. And we just wanted folks to use that to consider again the family as a whole and whether or not it's addressing the needs of the dual-eligible population. And, if not, where do the current gaps exist?

The next bullet points really just talk about the concrete steps that we as the staff have taken to go through the process of updating the family. We found measures within the family that are no longer NQF-endorsed. We'll be presenting those to you later. We'll have a discussion around whether or not there are alternatives available and whether or not we want to consider removing those measures from the

family since they have lost endorsement.

We have also identified newly endorsed measures that we believe may address an opportunity area or gap area. And then maintaining the starter set was actually an activity you all engaged in last year. So we won't be doing that specifically this year given that there weren't any major changes to the measures included in the starter set, the official major changes.

And the last two bullets just circle back to the issues highlighted in the previous slide of really wanting to make sure that when we're considering changes to the family that we discuss and address measurement burden related to the additional measures we might add as well as think about how our family aligns with other programs discussed by other MAP work groups.

This slide is a little tiny. I apologize if it's difficult to read. But this again is just the MAP measure selection criteria.

Again, this one focuses on factors to

consider when looking at the family as a whole: various things to consider are whether or not our family is adequately addressing the National Quality Strategy's three aims; whether or not the program measure set is responsive to -- this says specific program goals and requirements, but for us that's the dual-eligible population -- whether or not we have an appropriate mix of measure types. It also includes does the measure set enable measurement of person- and family-centered care and services, one of our past topics of discussion; as well as does the measure set currently include considerations for health care disparities and cultural competency; and, finally, does the program measure set promote parsimony and alignment.

Again, these are meant to be guideposts to considering the family as a whole and whether or not the family is hitting the mark on these criteria.

One of the other factors we ask you to consider are the previously identified prior

opportunities for measurement for the dual-eligible population. And these areas have been identified by the group in prior reports and prior activities as being important areas to measure and high-opportunity areas to measure for the dual-eligible population.

Those include again quality of life, care coordination, screening and assessment, mental health and substance abuse, structural measures to really determine whether or not the services are in place or the processes are in place to deliver appropriate services as well as burden reduction related to data collection and reporting, again, is an important area to consider when looking at areas where we'd want to add measures.

Previously identified priority gap areas -- and based on our conversation this morning, we've done a really good job identifying gap areas. So we're really hoping to take these into consideration when looking at measures to add to the family. I won't go through this list

up here, but just some highlights: shared decision-making; systems to coordinate acute long-term services and nonmedical community resources. I think that gets at the issue of systemness that came up before. Also there are measures around beneficiaries' sense of control, autonomy and self-determination. I know I helped staff the HCBS project last year and that was a huge topic of conversation in really needing more measures around that area.

HCBS is listed up there as a gap area as well. Hopefully, the presentations tomorrow will give us some hope that that gap is being addressed a little bit as we move forward. And also another gap area is affordable and cost-effective care. Our family only has a few measures related to cost. I think this is another major gap area that we're focused on.

I kind of preempted myself from giving you a lead on the affordable care measures. But this is a breakdown of the current family and how they're categorized into the National Quality

Strategy priorities areas. Again, this was reviewed during the February webinar.

But just to give an overview again, we do have a lot of measures that are categorized in the effective communication and care coordination areas. But we're really looking for more measures and would like to add more measures related to affordable care as well as prevention and treatment of leading causes of mortality. It just gives you a breakdown as we move through the discussion later on today to consider whether any of the measures that we proposed for inclusion hit on these areas where we're really wanting more measures in our family.

MEMBER CUELLAR: These are currently in the family.

DR. ROILAND: Yes, this is a current breakdown of the measures of the current family. And there are some measures -- I believe this one totals more than 74 -- some members may be classified as hitting more than one strategy. So if you're trying to do the math, that may throw

you off a little bit.

MEMBER CUELLAR: Okay.

DR. ROILAND: But this is the current family.

This is just another breakdown of the current family by measure type. And so we have a lot of process measures which I think is a symptom of just the evolution of quality measurements. Process measures seem to have been the first proliferation of quality measurement development. Now we're really trying to focus on outcome measures, particularly patient-reported or person-reported outcome measures.

CO-CHAIR MONSON: Rachel, just back on the other slide. Where would qualify of life measures fall into Joe's buckets? I know this is the overall framework. But do they sit in here at all or are they just lost?

DR. ROILAND: I'm sorry. Go ahead.

MS. MUKHERJEE: They could be going in health and well-being or quality of life will probably be health and well-being from a very

practical perspective. But they could technically go into person- and family-centered care because you're getting to the person's quality of life.

DR. ROILAND: And just to clarify, when measures are submitted, the developer can tag it for a specific quality strategy. So there's room for interpretation there as to where it could be put. It's not a hard and fast rule as to where one would be categorized.

And again this slide is the current family of measures broken down by measure type. Like I said, a dominance of process measures, but we're trying to move towards more outcome measures particularly person-centered outcome measures.

CO-CHAIR CHIN HANSEN: Just a question from the last slide and this one. There are two relative to affordable care and the next slide, there's cost resource use was one. Do you recall what that specific measure is?

DR. ROILAND: I know one for sure

because I just reviewed it in cost and resource use. One of them I know for sure is 2158 which is Medicare spending per beneficiary at the hospital level. I apologize. I can't remember off the top of my head the other one. But I can definitely find it for you.

CO-CHAIR CHIN HANSEN: So that really is at the institution level.

DR. ROILAND: Yes. I know they're working on one at the provider level. But that's not ready for rollout yet because they're wanting to use that in one of the upcoming federal programs.

All right. And then this slide just shows those 17 measures that are included in our current starter set. Again, these measures are meant to be deemed those most ready to be immediately implemented and of high relevance or of higher relevance, I should say, to the dual-eligible beneficiary population because they're either cross-cutting or hit on a specific condition that's of particular importance in this

population. We wanted to make sure that you had that up there just for a refresher.

And there also should be a handout of the slides at each of your seats as well as we sent the Excel document with the family and the starter set in the meeting invite a few weeks ago, as well. If you wanted to pull that up on your computers you could certainly do that, as well.

And so what we'll be doing now, not right now, but after lunch is going through the actual maintenance of the family of measures and going through discussion and voting. And what we'll be doing is we'll be looking at measures that are currently in the family which is what we're doing now.

Then this afternoon we'll be looking at measures in the family that are no longer endorsed that we think should be removed from the family because, once a measure loses endorsement, it does not go through maintenance process by the developer. So we can't be assured of its

continued scientific acceptability, feasibility and just overall applicability to the dual population.

We'll also be going through the measures that have been newly endorsed since the last time this group met and suggesting measures that we believe would be appropriate for inclusion in the family either because they address a priority area or a gap area that we think we can try to fill with one of our newly endorsed measures.

How the afternoon will go is we'll review those measures and we'll actually be voting. That's what these lovely blue clickers are for. And for this group, we have a 60 percent threshold for reaching consensus which for us is I believe 13. I'll have to check my math after lunch to see who is still in the room.

But we do have quorums. We're going to vote. And it will be a simple up or down vote as to whether or not the measure should be added or not added or removed from the family.

And just for those who are on the phone, I'll go over this again this afternoon. But you'll be able to vote as well via the chatbox in the webinar platform.

With that, that was a very quick overview. But I hope it was helpful. I will turn it over to Michael now just to help us lead a discussion of the family and get us started with that work.

CO-CHAIR MONSON: All right. Thoughts that people have on the family. Are there things that we want to rework? Are there areas that we think are missing? Again, this is our kind of last step here.

MEMBER BRINGEWATT: Yes, I had a comment on the slide relating to characteristics of the measures and the family relative to National Quality Strategy, the one prior to that. My first instinct is to think if there's only two in one category and there's 24 in another, we need more in that two or more where there's only seven. And I don't know that that's necessarily

true.

I think in some ways this may reflect serving the dual population and what measures are most important in serving the dual population as opposed to whether we have enough of them or not. And then there's just also the quality of the measures within those sets that I think we have to look at as to whether they're the right measures.

CO-CHAIR MONSON: Do you want to respond to that directly?

MEMBER POTTER: A follow-on is do you have a version of this for the 17 core measures?

DR. ROILAND: Unfortunately, D.E.B., we don't have that broken down. But that would be a good idea to report. Thank you.

MEMBER ROSS: I just wanted to remind us all that Monday a week ago the National Quality Forum MAP submitted its final report to CMS and they identified six, quote, high value, unquote, measure areas. And from the consumer perspective, one of the high of the six is

patient-reported outcomes. And a second area of the six are patient experience, quality of life, coordination -- there are four or five things all under one thing.

But the patient experience and the patient-reported outcomes are two of the six MAP high-value recommendations to CMS. So that's the lens that I'm going to be looking at is every time I can reinforce what National Quality Forum already recommended to CMS through the MAP in those areas. That's a lens that's high-priority for me.

MEMBER AGUIAR LYNCH: I have a question. Are there any measures specifically about addressing social determinants of health in these, or are those just presumed in some of the other measures?

DR. ROILAND: We don't have any measures in the family currently that directly look at that. There may be some that have specific risk adjustment strategies that might incorporate some of those. But I apologize. I

don't know directly off the top of my head.

But I think also that issue is part of the -- was the inspiration behind the homework assignment that we had talking about social risk factors, just because we recognized that a lot of the measures don't adequately capture those issues.

MEMBER LUTZOW: Just a couple of observations. You know when you look at the MACRA measures or the PQRS measures I believe which are going to be retired depending upon the specialty I can pick and choose what I want to measure.

And don't we have a similar situation based on our population segments within the duals group that we should be picking and choosing what's appropriate specific to the population. Would that be a better model than trying to have a cover set that covers everything? That's just a question. We're handling this differently than other groups are handling the measurement task.

The other thing that I've been sort of

left with observing the 5-Star Program, for instance, there's a measure on completing a plan. And to some extent, it's too shallow a measure. There may be a need for corollary measures attached to it.

For instance -- and I understand the danger of doing this -- if somebody requires a plan who is diagnosed with mental illness as a condition, to get to the blend of medical and social services, shouldn't the measure be have I attached that member to a community resource to address that condition outside of the health care plan. Now I'm measuring whether I reached across from the medical to the social effectively.

And I've actually attached that member to a community resource and I have evidence of that. So I've dealt with the issue.

Another corollary would be is there something in the plan that effectively has addressed a social condition or social determinant of health. Can I point to it? Can I point to the achievement of that within the last

12 months as part of that plan?

And now again I've bridged, I've created a bridge between the integration of medical and social. Isn't that what we have to do with duals?

Again, I understand this is dangerous, and it has to be tested because it can be gamed and all of those things. But isn't that the direction we need to go? If we're serious about coordinating medical and social and bridging that gap, the measures have to allow us to go there.

And maybe we should allow the users of these measures to pick and choose in the same way that -- well, the MACRA set, the specialist can pick and choose what's appropriate. Do we need to pick and choose what's appropriate to the population segment that we do?

MEMBER ROSS: I also wanted to reinforce the point that Jennie made this morning about -- and maybe a few others made it -- on the co-occurring dynamic. I have National Core Indicators which historically has been the

quality measurement system for people with intellectual disability and DD and now has been expanded as Charlie has said.

But consistently between 31 and 36 percent of people with intellectual disabilities served in the state DD system have a co-occurring mental illness. So we have a population co-occurring mental illness and substance use disorder. We have people with co-occurring disabilities. We have people with co-occurring disability and chronic illness.

This is the hardest -- I would argue -- the hardest-to-serve population. Systems each try to pass the buck off. The state mental health system does not have comparable data on the percent of people with ID, DD or served in a state mental health system.

So another lens, and this is sort of a big gap analysis, a big need are the dual population with co-occurring illnesses and disabilities and how we build them into the system and track them and report them in some

meaningful way that's not excessively expensive.

CO-CHAIR MONSON: I had a process question which is I know tomorrow we're going to look at the -- sorry. I know tomorrow we're going to look at the experience of care survey and the new CAHPS survey. And we're vote on that. Will we have an opportunity then to consider that to the starter set?

DR. ROILAND: We have not put on the schedule any additions or changes to the starter set just because the update happened last year. But I guess I would defer to Debjani if she thinks that would be appropriate.

MS. MUKHERJEE: We can make a decision that ad hoc we're going to add those two to the starter set. We can do that without having to relook at it. We can do an ad hoc and sort of relook and just add those two without having to look at every other measure in the starter set. We can do that one-off if the group decides to do so.

DR. ROILAND: Yes. What we can do is

after we hear the presentation and have a discussion we can take a vote on whether or not we want to add it to the family and then take a second vote.

CO-CHAIR MONSON: Comments from anyone on the phone? Clarke, do you have something else?

MEMBER RAMONA: Just because it was asked, I did quickly look at the starter set and what the composition was with regards to the key characteristics. One was affordable care. Two were person- and family-centered care. Seven were effective communication and care coordination. Two, health and well-being. Two, prevention and treatment of leading causes of mortality. And three for patient safety.

CO-CHAIR MONSON: Okay. Thanks, Rachel, unless you have anything else on this topic. Yes. Sorry.

MEMBER CUELLAR: Just following about that significant proportion of defining health and well-being relative to those two factors,

because you said two.

MEMBER RAMONA: Two were health and well-being. The largest portion was under effective communication and care coordination with seven.

MEMBER CUELLAR: That's out of whack in other words when we look at the core set.

CO-CHAIR MONSON: Colleen. Alison, we need your disclosure of any conflict of interests.

MEMBER CUELLAR: None.

CO-CHAIR MONSON: Excellent. Thank you.

I think we're done with this section. I think we're running ahead. So I would suggest we just keep going and then we can pause for lunch.

DR. ROILAND: Yes, we're currently scheduled to have lunch at 12:30, but hopefully that will be delivered a little bit earlier so we can have that earlier. If you're all okay with it, we can keep going and push on through. All

right.

The first set of measures we'll be considering are measures that are currently within the family that have had changes in endorsement. And if you do have the Excel document that we sent along, these measures can be found in the second tab on that Excel document called, I believe it's labelled Endorsement Removed.

There are currently ten measures listed within that tab. Four of those ten have officially had their endorsement removed for various reasons that I'll go over in just a minute.

The other six measures have not officially had their endorsement removed. They're going through review or various stages of review. So we won't be voting on those explicitly right now. But we just wanted to keep you aware that those six measures are currently under review as well. Apologies if there was any confusion around that.

But the first two of those four measures that have had their endorsement removed are related to pneumonia vaccine. The first is measure 0043 Pneumococcal Vaccination Status for Older Adults. For this measure, the developer did not resubmit the measure for maintenance review. So given that the developer chose not to resubmit it, it lost its endorsement.

The other measure is 0682, Percent of Residents or Patients Assessed and Properly Given the Pneumococcal Vaccine. This is for short-stay residents in skills nursing facilities. And again the developer did submit a request to NQF, an intent not to submit. So again because the developer will not maintain this measure, the endorsement will be removed for these two measures.

CO-CHAIR MONSON: Do we have any other pneumococcal vaccination measures?

DR. ROILAND: Within our repository we currently do not have. I apologize. I was going to get to that after the full review. But we do

not currently have any proposed alternatives for these two. I believe 0043 is at the health plan level, and 0682 is for skilled nursing facilities, as I said. So we unfortunately do not have any to propose in place of these two.

CO-CHAIR MONSON: I would just say I find this curious. This seems weird. This is for older adults and pneumococcal vaccination is a critical health indicator. The MDS I think collects it in the facilities. I think it's a HEDIS measure. I'm confused as to how it's just disappearing altogether.

DR. ROILAND: The various reasons for a developer to not resubmit a measure for NQF endorsement, there's a variety of reasons for that. So I don't know each developer's reasons for not resubmitting. Elisa, do you want to weigh in there?

MS. MUNTHALI: Yes. I'm Elisa Munthali, Vice President for Quality Measurement. The reason the developer did not resubmit is because they didn't have the resources to

continue to maintain the measure. That is the reason they submitted it to NQF.

CO-CHAIR CHIN HANSEN: What's the usual source of the funding for, say, this developer to have gotten funds to do this?

MS. MUNTHALI: We don't know what their usual source is, but it sounded like they didn't have the staff resources to continue testing and maintaining the measure through our maintenance process. Every three years, the measure should come back so that we can attest it's still evidence-based, the testing is still valid. And it sounded like they didn't have the resources to continue that.

MEMBER PARKER: Is there another measure that captures this somewhere? I mean, didn't we just say that there is something in HEDIS? So why is that not submitted? Why isn't something like that not get into the family of measures or something? I may be ignorant because this is my first meeting.

DR. ROILAND: No. It's a good

question. I believe there is one measure, but it's strictly to inpatient that we have in our repository. And so given the focus of the work group has been on community settings or non-hospital settings, we thought perhaps that was not appropriate for inclusion here.

MEMBER PARKER: But isn't there a measure somewhere that's being used that's for not inpatient, not for just skilled, but for general vaccinations. Isn't there, I mean, for this pneumococcal somewhere?

DR. ROILAND: There is one. Within our NQF repository, we did not find one that we thought would be appropriate for replacing these two, an NQF-endorsed measure.

MEMBER PARKER: But that doesn't mean there isn't one out there.

DR. ROILAND: No.

MEMBER PARKER: Okay.

MEMBER BUHR: Another issue is that there recently has been a recommendation to give two pneumococcal vaccines. If you read this

measure, it's not quite right because the people are supposed to have both pneumococcal and Prevnar 13 vaccines.

So the measure would need to be updated. If the developer is not going to update it, it wouldn't be a proper measure I don't think.

CO-CHAIR CHIN HANSEN: Who is making that recommendation, the two-step? I know that actually I belong to Kaiser as the health plan and I've gotten the two-step from them. So where is the source that a system like Kaiser is adhering to?

MEMBER BUHR: I guess the CDC or the Immunization Advisory whatever they're called. They have initials.

CO-CHAIR MONSON: I guess the question, Rachel, then is what are the implications if we vote not to remove the measures and they're not maintained.

DR. ROILAND: The implication then is that we have a non NQF-endorsed measure in the

family, meaning we can't assure the scientific acceptability in the measure, the assurance that the measure is based on strong evidence, based on recommendations from guidelines. That's the consequence, and I guess the work group would need to discuss what they think about that.

MEMBER AGUIAR LYNCH: In situations such as this where I think we all think this is an incredibly important measure and otherwise would not have it removed, is there some way to indicate it's not endorsed for the specific reason. But it's not that we don't endorse it in principle. Is there somewhere to a parking lot -- - not a parking lot, that's not the right word -- but someplace to put this measure where we say this is really important, but don't have the right actual measure now because the developer can't update it?

DR. ROILAND: We can definitely note that in the report. I think this could also be highlighted under one of our gap areas or our opportunities for measurement which is screening

and prevention. We could definitely highlight it as a sub-area underneath that as a way to acknowledge this. The work group believes this is a very important issue and unfortunately, just given things out of our control, these measures could not be maintained and then therefore could not be in the family. There's an option there to call it out. Yes, there's an option there.

MEMBER COURT: This is Beverly Court. And I know there are a number of reasons behind a number of these measures that are proposed for removal. And I do support them. For example, the screening for clinical depression and follow-up, the coding used gives you somewhere in the neighborhood of 1.6 percent when you're using claims-based.

And it really doesn't work as a hybrid measure similar to the -- so that's 0418. I mean that's been a very poor-performing measure. The 0421, similarly, it doesn't lend itself well to hybrid measure either. It's kind of failing on both sides.

So there are reasons behind why these are being dropped by their steward. And I would not hold on with NQF endorsement of measures that not even the measure steward is holding out as the latest and greatest.

MEMBER RASK: Yes, and I would echo that. I think in terms of particularly for the pneumococcal vaccination measure we may say it's important to have a measure of pneumococcal vaccination. However, this no longer meets the clinical guidelines or the evidence-based recommendation of what someone needs to receive in order to be appropriately vaccinated. Given that, I don't think we want that in our measures.

MEMBER POTTER: I know that CMS is in the process of taking measures that are inpatient-based measures as well as outpatient-based measures and doing development work for them, especially testing them in an eMeasure environment to roll them out, subsequently, as outpatient measures.

So it might be worth having a

conversation with people in CCSQ to see if they have a pneumococcal measure that's in the development stage for outpatient or if they've done additional testing on their current inpatient measure for application to outpatient. For example, do they not have an pneumococcal measure in Medicare Advantage? I think that's worth following up.

Another place to follow up would be a search of the National Quality Measures Clearinghouse to see if there's another potential measure there for outpatient.

CO-CHAIR CHIN HANSEN: I think all these points are extremely important and have great validity if this is not accurate. But going back to a more person-centered way to think about it if we think this is important, and perhaps it comes from CDC and maybe there are other places, it does point to the kind of confusion of what's important when we're looking at this. Maybe it's because we are looking at it in a silo of our own, but there are other ways to

get to it.

Tom, you brought up an earlier point about these measures. And I think it's Beverly on the phone that said sometimes these measures are only completed at 1.6 percent.

The interesting other way to think about why these things are less filled out is they're not seen as important by the providers themselves who don't tend to focus on this group. They again are focusing on averages and what's easiest to complete at all.

And here we may have different subgroups for which certain kinds of measures would weigh more strongly for that we would have. And this would be one example for older adults who might be more frail. This might be an especially important one that one methodological question is can you weight this a little bit more so that you get a little more credit for it.

But otherwise people will go toward the central tendency of the majority of measures that are able to be executed more easily. And we

don't do things as much for a smaller outlier groups.

So it's more of a comment and reflection on the fact that people reacted to this relative to pneumococcal vaccination. Truly, you do want it to be the most current evidence without a doubt. So this doesn't do this.

But then bottom line is, how do you begin to look at protecting any vulnerable, older person regardless of whether they happen to belong to Kaiser or not and have the best practice being encouraged there? It's more how do we gear people to the most appropriate measures to complete for certain groups of people rather than just giving a good general, technically correct set of 74.

MEMBER COURT: This is Bev Court. And I just want to clarify that what I'm talking about is that the data is not captured adequately either in claims or in medical records in the electronic medical records. I actually did a

medical record review. You find much more evidence that something happened. It's just that the collection methodology isn't up to speed yet.

So I don't think that dropping endorsement means that these important areas go away. It means that the state of the art of measurement hasn't caught up with anything that's worthwhile yet.

So does that mean that these have to take time to mature? Does it mean that alternative ways of capturing the information? Does it mean the actual coding sets and the value sets used?

I would take as very serious that endorsement removal means that there is something that's not working with these measures. I don't believe people are abandoning measures that are important. It's just that these particular measures as they're currently technically spec'd out have some problems.

And I am incredibly, painfully aware of these because some of these are used by CMS.

And I have to say back, this is a poorly spec'd measure. You can't tell what's going on. I can't tell what's going on. It's not reflective of reality. So you using this to, or any of us using it, to monitor our dual populations, this is time wasted.

CO-CHAIR MONSON: Alison.

MEMBER CUELLAR: I'm trying to follow up on what I heard Christine saying is this parking lot idea, which is there are things that are not currently being maintained. But it might be a relatively light lift to get to the more up-to-date conversations with CMS along the lines that D.E.B. was talking about. How far away are we from a better measure versus ones where we haven't started much work on the construct itself?

And I guess the issue with things in the EHR are in the wrong place. Well, they're going to be in the wrong place forever until somebody asks that they be placed in the correct place and monitored. EHRs respond to

particularly what meaningful use ask them to --

We had blood pressure in the wrong place for a long time. And it now more consistently appears in a place that we can find. So if we're asking the EHR or we're waiting for the day that the EHR puts this immunization in the place where we can find it, we may actually have to have the measure say it needs to be found. Programmer, place it where we can retrieve it.

I hear the argument. But on the other hand, these measures can serve another purpose which is to drive the EHR to produce something sensible.

MEMBER COURT: This is Beverly again. People hold NQF endorsement as pretty sacred. And I've seen examples where some measures haven't been tested enough that don't warrant that endorsement. So I'm gravely concerned when there is consideration of continuing endorsement for measures that aren't even being supported by their stewards at this moment in time.

I agree that it's good to have a parking lot of areas that are important but may not have an updated definition at this time.

MEMBER PARKER: I was going to say something similar to what Beverly just said about the data. My understanding is that you can have these kinds of immunizations across different provider offices and maybe even at the drug store or in another setting where they're doing it in a group. So there isn't one place to collect the data. That has always been a problem.

And then when you self-collect, when you self-report, you know CAHPS has had I think a pneumococcal question in it for a long time. I think that one is often used. But CAHPS captures such a teeny proportion of duals, depending on whether it's done in a health plan, where it's lumped in with all other products, or in a big Medicare-Medicaid plan where it might be lumped in with other people. So you don't capture everything in dual. So it's not very good.

That leads me to going back to what

Christine is trying to say. Do you only have measures -- and this is my ignorance about the process here, I think, with NQF. Do you only have measures that are brought to you and then maintained up for endorsement? Or do you ever go out and say, well, there's all these other measures out here like someone was just saying earlier -- D.E.B. was saying -- that there are these other places to look at measures? And should you have a track that goes a little farther and says, yes, you bring your measures here, but for new ones ---

But there are some out there that we want to reach out to and look at and say, these should be part of our family. Even though they weren't brought to us, they should be considered or in a parking lot place saying that there should be one on this, and here's the best one we can see out there or something. Maybe it isn't official. It isn't NQF-endorsed, but it's something that at least is a placeholder for where do we want to go so that someone is

bringing together the whole big picture in some of these areas. I don't know if that makes any sense.

DR. ROILAND: No, it makes total sense. And I'll take a stab at this, and then Elisa or Marcia or Debjani -- in terms of do we go out and look for measures, we do a lot of technical assistance with measure developers who have submitted to us in the past. Or when we meet folks through various avenues that may have measures they want to submit, we do offer technical assistance as well.

And I know also as part of our strategic plan, we've identified areas where we want measurement, and we really want to get into what we call measures that matter. So we're taking steps in that direction of trying to not just be a receiver but being more proactive and going out there and trying to work with folks who may develop measures in the areas that we have identified as gap areas or priority areas.

That's our current activity. I don't

know if there's anything else to add on that.

MS. MUNTHALI: No, I think you did a good job. We really recognize that the measures that we may get from the call for measures may not be the measures that we need. And so we're trying to reach out to the folks that are not typically around our tables that know about us, and trying to give earlier input in measures, perhaps even before they come to us.

With these pneumococcal measures, I know these measures very well. They're part of projects I've worked very closely with. There were about six or seven pneumococcal vaccine measures at different levels of analysis.

And what our committee was trying to do was get to a universal measure that could be applied at broad settings. There is this issue of measure burden. By the time it comes to us as a fully specified measure, it's really too late to give that input.

What we're trying to do is give earlier input in the measure development cycle or

process to developers to say, perhaps consider broader application. Perhaps consider these settings. So what we're realizing is the earlier we get to developers, the more technical assistance, the more we reach out to the folks with more an aggressive reach out and not just sitting here waiting for people to respond, the better we'll all be in the process.

MEMBER ROSS: This is a process question that's been discussed since I've been here in 2012. You have to have a steward, and you have to have a steward who applies. And this idea of some kind of recognition of widely used, commonly used, frequently used measures that have not sought endorsement would be really important.

Charlie and I have been a broken record on the National Core Indicators. Over 30 states use the National Core Indicators for people with intellectual and developmental disabilities under a five year grant from the Administration for Community Living. The goal is all 50 states.

The National Core Indicators people have decided not to seek endorsement because their instrument is a composite of interviews around multi-dimensions around beneficiaries. There's not one single measure that you could pull out. And they haven't been willing to go through the National Quality Forum process because of the way the process is structured.

But it's commonly used. It's in over 30 states. And it's soon going to hopefully in the next few years be in 50 states.

It would be really helpful for the National Quality Forum to have some parking lot of recognition that's not endorsed but are -- and I don't know what the threshold is. I know that's really difficult. But with the National Core Indicators, if 30 states are using it or if five state Medicaid programs are using the same measure but it's not endorsed, to me, that should be officially recognized in National Quality Forum website materials and list.

I know it's a big structural issue.

It's been discussed for a long time. But I just want to reinforce the value and need of having such a list with the National Quality Forum letterhead in some way.

MS. MUNTHALI: I think it's a great idea. I think it goes really in line with what Rachel was talking about, us beginning to prioritize and recognize that we don't have all of the measures that we need. And I think this could be something we do in conjunction with prioritizing the measure gaps and showing some promising measures out there that may not be NQF-endorsed. But they may be getting to where we need to get to.

CO-CHAIR CHIN HANSEN: I just would like to affirm that that's one of maybe our last comments as the group that it's important. There may be five or more states, Medicaid states, who are already using it. And if that's the case, that's already driving standards in the community without NQF formality.

But because the states are in an

urgent situation where they really require this as more bundling of payments, more capitation arrangements are occurring, it's going to happen anyway.

So it would be better to be in some awareness and alignment where possible. It may be that some of these results are starting to come out from the states that will be informing the next book of work that we'll take on.

It just seems like -- I can vouch for Clarke bringing this up from the very get-go. But now that it has hit 30 states, and in a matter of not too long it will be 50 states, it's an important player.

CO-CHAIR MONSON: And I would just add to that which is I think we have to look at the process. If we have measures that are widely used that are not making it through the endorsement process, then we might have a problem with the endorsement process. And I think especially -- and that may not be true for all the core medical measures, but as we continue to

talk about the need for community-based measures, individuals who are accessing LTSS services and the social determinants, all the stuff we talk about all the time. The groups that are making those measure may not be able to fit into the NQF endorsement process because the NQF endorsement process is so medically-oriented.

So I think it would be a mistake to not address that. And just calling them promising measures is a little -- it's not doing it justice. I think what would be dangerous honestly for NQF is the whole system could just pass NQF by. And then people are going to say that they're going to have their own measures. If NQF is not going to endorse it, so be it.

The states have to, on the Medicaid side, the final rule on managed care, they have to have an entire quality review system set up in place by July, which they're not going to meet. But there's a whole movement afoot that will absolutely impact duals but will impact everybody as well. I would just encourage you all to think

about it.

MS. MUNTHALI: I think that's a great point. I think as we're thinking about where we go with the duals, I see this being a role for the workgroup going forward helping us to think about how we may want to perhaps relook at our measure evaluation process.

Perhaps the criteria, maybe it is too medicalized. We went through this process with our Population Health and Well-Being Committee. They provided some guidance. They may want to look at it again -- that was about four years ago -- and see if they want to make some more structural changes to our criteria as it relates to population health and health and well-being.

We've been taking notes here thinking about scope and possibilities of continued engagement and interaction that can help us get to the measures that we need.

DR. ROILAND: And Bev, I know on the phone you have your hand raised. Did you want to say something?

MEMBER COURT: Yes. I just wanted to point out that a complicating factor is that in many areas that are deemed important by the states, there's a raft of proprietary measures developed by different entities. And that's avoidable ED. There must be -- goodness, who knows how many proprietary algorithms for that. One of the problems is what's open source algorithm.

I do think that review is necessary even for homegrown measures. We use homegrown measures in Washington State. But it is necessary I think to have external review of those. And I think what will be interesting to see is if some of these, for example, in a couple of months are going to be revisited and updated.

Just a question. When you got the feedback from the measure stewards, did they say that they were dropping them entirely or that they didn't have updated specifications at this time?

MS. MUNTHALI: This is Elisa again.

When we reached out to the steward, it was at the start of the most recent health and well-being endorsement project. That was in 2016. And at the time, they said they were no longer maintaining NQF endorsement. That doesn't mean that they're no longer maintaining the measure. But they're no longer maintaining NQF endorsement. As a result, we withdrew endorsement.

DR. ROILAND: All right. Are there any other comments?

We do have two other measures that have lost endorsement, and I'll go over those now. Then we'll vote on each afterwards. Does that work for everybody?

All right. The other two measures that have lost endorsement are 0558: Post Discharge Continuing Plan of Care Transmitted to Next Level of Care Provided Upon Discharge. This measure was withdrawn from the developer during its review process, as well as Measure 0057: Post Discharge Continuing Care Plan Created. That was

also withdrawn from the developer. Withdrawn means that the measure was perhaps going under review, but at some point because of either competing priorities or a lack of resources, the developer or the steward was not able to continue through with the review process and have the endorsement of the measure maintained.

For these measures, we currently have four other measures within the family related to transitions. So we did not propose any other measures to replace these two measures just given we already do have four measures related to transitions of care that we thought would be appropriate, and given our look towards data collection burden. And wanting to make the family of measures as parsimonious as possible, we did not propose replacement measures for these two measures either.

That's a total of four measures that have lost endorsement. If anyone wants to have any discussion about these two measures, we can certainly have that now.

MEMBER RAMONA: In reading in the detail, these are specific to psychiatric. Is that accurate? And do we feel like the other four are still capturing the unique properties with the psychiatric population or issues?

DR. ROILAND: My understanding of them is that they're not specific to psychiatric institutions. It would result in a gap in that specific area. Because of those four measures and in our search of the repository, we didn't find any specific follow-up measures for the psychiatric population that we thought would be appropriate for inclusion in the family.

MEMBER POTTER: The Joint Commission measures were originally developed for the psychiatric inpatient population. And when they resubmitted them the last time to the NQF for endorsement, they expanded the population of interest to be all inpatient.

The Inpatient Quality Reporting program at CMS originally included these measures in that quality reporting program. But they

subsequently substituted two additional transition measures and took these two out.

And after these two were removed from the Medicare Inpatient Quality Reporting Program, I think that's why the Joint Commission didn't go forward. They were replaced by these other transition to care measures, which I don't remember. I think one of them is 0645 or something like that. And it was a better measure. It included more elements as part of the requirements for the transition.

DR. ROILAND: All right. If there are no other comments, we can move onto the voting portion of our discussion. For that, we're going to have Madison actually lead us through voting. But just for a reminder for our folks on the phone, please submit your votes through the chatbox function of the webinar platform.

MS. JUNG: Great. Thank you, Rachel. Just to start off as a quick kind of test question both to see if you guys are attending dinner tonight, 5:45 p.m. at P.J. Clarke's, 16th

and K, but also to test if your clickers are working well. So what I'll do is I'll read out. The polling is open. You guys will click option 1 or 2. Then after that, we will see the results.

And did Tom step out? So if either Rich or Joe you wouldn't mind clicking one of the options just so we can ensure that all clickers are working. Thank you.

So now voting for if you're planning to attend dinner is now open. Option 1 is yes. Option 2 is no. It should light up.

(Voting.)

Okay. Great. We all have 18 votes in. Voting is now closed. We have 6 for yes with 33 percent; 12 for no with 67 percent. Voting is now closed for that. Thank you for that.

Moving on to voting of the actual measures. So voting for Measure 0043 is now open for the removal from the family of measures. Option 1, yes. Option 2, no.

MEMBER COURT: Sorry. This is Bev Court on the phone. It's not coming up on our system. So I'll just email you my votes for the measures. Or I'll just send in a comment.

DR. ROILAND: Thank you, Bev. That works great. And Joe, are you still on the line?

MEMBER BAKER: I am. And I'll have to do the same since I'm not online.

DR. ROILAND: Okay. Do you have -- Do you want me to send you an email quickly so you have the address or?

MEMBER BAKER: That would be great. Thank you.

DR. ROILAND: Okay. Just a second.

MS. JUNG: Currently, we're just waiting for the online votes for Measure 0043: Pneumococcal Vaccination Status for Older Adults.

MS. BUCHANAN: Bev, this is Kate Buchanan from NQF. Would you mind just typing yes or no into the chat functions so we can capture it?

MEMBER COURT: Will do.

MS. BUCHANAN: Thank you.

MS. JUNG: Okay. I think we've all votes. We will have a total of 17 votes with this since Tom has stepped out. We have 14 votes for yes, with 82 percent; 3 votes for no with 18 percent. And with that, the measure will be removed from the family of measures.

The next measure we have up is Measure 0682: Percent of Residents or Patients Assessed and Appropriately Given the Pneumococcal Vaccine in short-term stay for removal from the family of measures. Option 1 is yes. Option 2 is no. Voting is now open.

DR. ROILAND: Hi, Joe. If you could just email your vote, I would appreciate it. Thank you. Oh, there you are. Thanks.

MEMBER BAKER: Yes, I did. Thank you.

MS. JUNG: Voting is now closed. We have 100 percent for yes for removal from the family of measures with 16 votes. With that, the measure will be removed from the family of measures.

Next up for voting for removal is Measure 0557. That is HBIPS-6 Post Discharge Continuing Care Plan Created. Option 1, yes. Option 2, no. Voting is now open.

Voting is now closed. We have 100 percent -- did we only have 16 votes for that last one?

DR. ROILAND: Yes.

MS. JUNG: Do we want to go back?

Apologies about that. For measure 0557 we have 100 percent yes with 17 votes for the removal from the family of measures.

And apologies, but could we just please go back and revote on the previous measure. We seem to be missing one vote that did not register. In a moment, I'll just reopen voting. Thank you.

CO-CHAIR CHIN HANSEN: It wouldn't be a meeting if the voting didn't go a little bit astray.

MS. JUNG: Let's try this again. For Measure 0682 for removal from family of measures,

and that is Percent of Residents or Patients Assessed and Appropriately Given the Pneumococcal Vaccine (Short-Stay). Option 1, yes. Option 2, no.

There we go. Thank you. We have 16 votes for yes with 94 percent; 1 vote for no with 6 percent. And the measure 0682 will be removed from the family of measures.

And for the final one voting for removal we have Measure 0558: HBIPS-7 Post Discharge Continuing Care Plan Transmitted to the Next Level of Care Provider Upon Discharge. Option 1, yes. Option 2, no.

And we're missing one more vote. If everyone could just press the button one more time. Yes please. Got it. Great. Thank you very much.

We have all the votes. Voting is now closed for Measure 0558. We have 100 percent for yes with 18 votes. This measure is removed from the family of measures. With that, that concludes the voting on the measures to be

considered for removal.

DR. ROILAND: All right. Thank you, Madison. So we've gone through the not fun part of removing the measures from the family. I know that's not always people's favorite part. Those are all the measures we're going to vote on today for removal from the family.

Now we're going to break for lunch. I think they're just setting up. So we'll have a half an hour lunch and reconvene around 12:30 p.m. Then at that point we'll discuss a number of measures that we are considering for addition to the family of measures.

Thank you all. For those of you on the webinar platform, we'll be back around 12:30 p.m. Thank you.

(Whereupon, the above-entitled matter went off the record at 12:02 p.m. and resumed at 12:35 p.m.)

DR. ROILAND: Hello again, everyone. I hope you enjoyed the lunch. For the rest of the afternoon, we're really going to focus on

talking about measures to add to the family of measures as well as hear from one of our other NQF colleagues to talk about the behavioral health project specifically and talk about the measures from our family that they reviewed within that project.

That will happen after we go through our voting procedure today. We just wanted to make sure you all hear from that group. That's what you have to look forward to.

DR. ROILAND: But to start us off, I'll just give you a quick overview of how we actually identify these measures that we're proposing for addition to the family of measures.

Since you all met last April, there have been several consensus development process projects that have been going on at NQF. And consensus development process or CDP projects are the projects wherein we do a formal review and evaluation of measures and have our standing committees review the measure for endorsement.

We reviewed those projects that had

happened since last year, April 2016. And we identified the measures within those projects that were newly endorsed for the first time. There may be some maintenance measures in some of those projects. But we really wanted to focus on newly endorsed measures that we thought would be relevant to the dual eligible population.

To help us make that determination, we used three major factors that I highlighted earlier in the morning: whether or not the measure seemed to address a priority gap area or a measurement opportunity area; or taking the lens of the measure selection criteria, of whether it helped fill out our family of measures as a whole in terms of again addressing those gap areas or opportunities for measurement.

What we did is we then identified those measures and have compiled them here for you today. We'll go through each individually giving you a description of the measure as well as just some highlights of our preliminary analyses and rationale as to why we believe the

measure may be of benefit to add to the current family of measures.

We'll review the measure, discuss the measure, and then vote on the measure. That will be the pattern of the day.

The newly endorsed measures that we are proposing for consideration do fall into four different National Quality Strategy priority areas. One measure falls under the health and well-being category, one under effective communication and care coordination. Six fall under the person and family-centered care priority area. One of those measures is the HCBS measures that we'll be talking about tomorrow. I just want to give you a heads-up on that.

I apologize. They address three priority areas. The last bullet point highlights that we unfortunately didn't find areas in the affordability, prevention, and treatment of leading causes of mortality or patient safety areas for this round of consideration. So we're really focused on the areas of health and well-

being, effective communication and care coordination, and for the most part, person and family-centered care.

That leads us right to our first measure that we're proposing for inclusion in the family of measures. This is Measure 3086: Population Level HIV Viral Load Suppression. And listed on the slide currently on display is the description of the measure which is the percentage of persons over the age of 13 with a diagnosed HIV infection. I won't read through the numerator and denominator just for the sake of time. But we do have those listed on the slide up for you as well.

The next slide we give our initial rationale as to why we're proposing this measure be included in the family. And that is the staff, when we reviewed the family and then reviewed the newly endorsed measures, we noted that the family currently has one HIV-relevant measure. It's process Measure 2079: HIV Medical Visit Frequency.

And we thought 3086 would be a good addition to the family because it's an intermediate clinical outcome measure that we thought would be a good compliment to the process measure we have in the family. And also, it specified for a wide age range. We do try to look for measure that have a wide age range for the family given that the duals population can span many ages. And also we thought this measure would be, as I said before, a compliment to the process measure we have. And also it would address a condition that can be frequently encountered in the dual population.

That is our very quick overview of measure 3086. I do also want to highlight that the third tab on the Excel document that we sent you with the meeting materials has the detailed specifications for each of these measures if you wanted to go and dig in there. Oh, it's the fourth tab. I'm sorry. Thank you. Appreciate it.

With that, that's just a very quick

overview for this measure. And I'll open it up for discussion.

CO-CHAIR MONSON: Comments? Questions? Rich, go ahead.

MEMBER BRINGEWATT: Yes. This just reminds me of a comment that's consistently made by one of our members from AIDS Healthcare Foundation where she can get perfect scores on all the other HEDIS measures. But if she doesn't deal with viral loads, she doesn't adequately care for the population that is the target for the program. So this is a very important measure in addressing this particular problem.

MEMBER COURT: This is Bev Court. I assume this is a BRFSS measure since it comes from CDC. And I don't believe they have a distinction for dual eligibles in that. So while I applaud the measure, I don't know how it would be applicable to duals as a target group.

DR. ROILAND: Hi Bev. This is Rachel. I'm sorry, Rich. Did you want to respond to that?

MEMBER BRINGEWATT: Just a point of clarification in terms of the chronic condition special needs plan that's focused on duals. The vast majority of current enrollment are duals.

DR. ROILAND: And Bev, this is Rachel. Just a point of clarification on the process that we go through for identifying these measures. They don't need to be specifically specified for duals. It's just is the measure applicable for duals, and can it be used in that population? It doesn't need to be specific only to that population. Does the clear up your question?

MEMBER COURT: No. The question was, in the specifications, it's not an eMeasure. So it must be a survey-based measure. And I'm assuming it's through the BRFSS survey that Centers for Disease Control and Prevention proposes. Is that correct?

DR. ROILAND: I'm just checking on the specs here for you really quickly. Just one second.

MEMBER COURT: Because again while it

may be a great measure, if the collection vehicle is BRFSS, then I don't see how one could apply that to a dual population specifically.

MEMBER RASK: This is Kim. I think the way it's specified, it's specified to be done in a population or regional or a state level. If the question is if someone wanted to use this measure to apply to their dual eligible population to characterize quality of care, they could use these specifications to do so.

MEMBER COURT: So this would only be collectible on a either hybrid measure methodology or some sort of survey. I guess part of -- sometimes the NQF endorsement doesn't go or the specs don't go far enough in terms of how the information is being collected. I just point that out as a challenge with this measure.

CO-CHAIR MONSON: Silence is the staff looking through the spec, everybody on the phone.

MS. MUNTHALI: So what's on our QPS, our Quality Positioning System, the database, the library of measures doesn't include the entire

specs. But if you look, Rachel, on the infectious disease project, it was just looked at two weeks ago. The entire specs are there. We can get more details.

DR. ROILAND: Okay. Are you okay with waiting while I pull that up really quickly? Is everyone okay with that?

CO-CHAIR MONSON: Did you want to share something?

MEMBER POTTER: I just had a process question. So we're going to go through each of the measures individually, and then at the end, you're going to do the voting? Or are you going to do the voting --

MS. MUKHERJEE: One by one. We're going to discuss the measure.

MEMBER POTTER: One by one. But in the past, haven't we then had the exercise of, well, this is too many measures, and which are the most important ones? I'm just asking for --

MS. MUKHERJEE: Yes, last year we did that because we were changing the starter set as

well. So we did for the big group, and then we looked at those smaller groups.

But this year because we're losing four measures which were the four we took off this morning, and there are just six new ones to consider, we're not looking at the larger set. Even if we add 50 percent or even all of them, we're still just adding a couple more than --

MEMBER POTTER: Thank you for that clarification. Thanks.

MS. MUKHERJEE: Yes, it's not a problem.

DR. ROILAND: For those of you on the webinar platform or dialing in, what we have pulled up right now in and will be screensharing soon is the measure worksheet that gives us more detailed information about the data source for this measure.

MS. MUKHERJEE: It's the National HIV Surveillance System and one of the data sources. Beverly, was that your question?

MEMBER COURT: Right. The question

is, will that data source have an accurate identification of who's dual, and who is not dual? And I don't believe it does. So while one can get as population-based stuff regardless of payer source or regardless of eligibility -- that would be of general interest to see what's happening with the population or region -- I don't see how it can be applied to duals and be a duals measure limited to duals.

MEMBER POTTER: Are we confusing the data set that was used for measure testing from the actual potential data or population that could be used with the measure?

MS. MUKHERJEE: Yes. Beverly, what we're saying is we're adding this to the family of measures if it was voted to be added as yes as a possible measure, not that it was developed to be a dual-specific measure.

MEMBER POTTER: But I think the issue that's being raised on the telephone is the measure uses the BRFSS survey. And therefore, that may not be appropriate. But the flip side

of it is it could be tested in BRFSS but then applied to a duals plan.

The denominator is still the population that has HIV. The denominator is not all people who took the BRFSS. So one was a testing population, and the other is the measure.

MEMBER LUTZOW: Yes, just a question. I noticed this measure is not subject to risk adjustment. And we had a group working on the impact of SDS measures and so on. Has this measure been reviewed by that group? And did they come to the conclusion that there's no SDS influence on outcomes here?

MS. MUNTHALI: So the SDS work across NQF is reviewed within each topical area. So even though we have a disparities group, they are overseeing the SDS trial. But each topic area, health and well-being, cardiovascular, is looking at the measures that come in front of them to see whether or not there's a conceptual relationship for SDS. And if one is shown, then to verify if there's empirical testing.

This developer did not include it because they didn't really see a conceptual relationship. And they felt that they'd be able to -- I can't remember what the exact rationale was. If you go down to validity and go down to risk adjustment, it should have the rationale there. And it's 2B. Sorry. I don't have my glasses.

MEMBER COURT: For example, the specifications don't include a continuous enrollment criteria for example. Just taking interesting measures and applying them when they haven't been developed for the managed care environment or fee-for-service environment can be problematic.

CO-CHAIR MONSON: Perhaps, Bev, you can share with us a little more of that concern so that everyone can understand where the translation issue is so that we're all up to speed with you.

MEMBER COURT: Okay. So let's say for example that someone thought this would be a

great measure for a capitated dual plan. And there was no criteria that a person had to be enrolled for a certain amount of time in that plan like virtually all the HEDIS measures have some sort of continuous enrollment criteria. One would even have to know that this person has HIV.

For example, if a person in question had been enrolled with the plan for one month, likely that capitated plan would have no idea whether the person has HIV or not. And because they haven't paid for any services for that person, they don't necessarily get a list of past Medicare data to say, oh, by the way, these folks were -- there's no registry that comes with that person when they're first enrolled.

Even identifying who has HIV, one assumes that you have a certain amount of time in a capitated environment for the evidence to come up that the patient has HIV. There is some sort of diagnosis, some sort of treatment.

Again, taking these measures that were developed for a BRFSS survey environment and then

applying them to, say, a capitated managed care organization, it doesn't translate directly. There would need to be more specs that were developed particularly for applying it in that environment.

MEMBER BRINGEWATT: Maybe I'm confused here, but it seems to me like we have a number of measures that focus on a particular condition or illness and treatment of a particular illness where somebody might be enrolled in a plan that doesn't have the illness. At some point during the year, they have the illness. Then there are measures that look at the treatment of that person.

So as I'm hearing what's being said here, I'm hearing the same problem applies to a lot of different conditions. My assumption on the endorsement here is that these are measures that are understood to be important for measuring quality care for people who are dually eligible and also might be important for people who are not dually eligible but have a particular

relationship for duals and that it's not site-specific. These measures apply to a lot of different places.

MEMBER COURT: But the technical specifications have not been developed that make it applicable to specific sites. We have so many, I mean, innumerable examples of where it was developed for one methodology of data collection and totally nonsensical when applied in a different setting.

MEMBER BRINGEWATT: So are we suggesting that we would reject measures that haven't been tested in all the different settings?

MEMBER COURT: I think that there needs to be additional work that says, if you're going to apply this for dual populations, it has to have been actually applied and tested in that environment. It hasn't.

CO-CHAIR MONSON: Let's go to Kimberly and then Clarke.

MEMBER RASK: I think the point is

well-taken about really thinking about how these measures could be used. There are so many issues that come along in development, validating, and then the actual implementation of them. The reality is that we don't even have as many measures out there as we need. And those of us who use measures to measure quality in Medicaid programs or Medicare programs often are stuck with using the next best, not being able to wait for just what is exactly right.

When I look at this measure, I could use this measure tomorrow for our Medicaid programs that we help produce quality indicators for. It has enough specifications in terms of that the diagnosis has not to be during the measurement year, and the person has to still be alive.

I would take our data. I would look for folks that had a known diagnosis the year before, look for the viral load when we do our clinical chart review, and at least having a layout. I recognize that there's still unsolved

issues for every specific situation. But I feel that the NQF group that endorsed this gave it the good housekeeping seal of approval for reliability and validity.

Then me as someone who would be using a quality indicator and want to use it to be able to say something about how things are going in Georgia, and are there areas that we need to look at for problems, I feel that this would give me some guidance and a place to start. It doesn't answer every question I might have for implementing. But it gives me something to work with.

MS. MUKHERJEE: Beverly, I just wanted to say that most of the measures in the duals family were not tested specifically in the duals population. And all these measures, as Rachel mentioned before, are based on our measure selection criteria, the gap areas that this group has identified over the years, as well as potential new measures that have come through and addressed a major issue for the duals population.

In a way, if we look for duals testing, most of the family of measures would go away.

MEMBER COURT: This is as much a comment for CMS's ears as anything. It's just that you can't pick of these measures as stated and plop them into a requirement, for example, without more work on adjusting them for the environment that they're going to be used.

MEMBER LYTLE: Thanks, Bev. Duly noted.

MEMBER ROSS: The issue of payer use of a measure and whether it's mandatory, voluntary, recommended is a different issue than what we're asked to do. We're asked to promote the health and well-being of people who are dually eligible. So Rich asked the question and I want to support -- this is Clarke Ross -- I want to support Kimberly's observations.

Like Joan, I was two years on the Long-Term Care/Post-Acute Care Workgroup as a liaison where we were trying to have universal measures across setting. And one setting would

say, we haven't really developed that. So I want you to reject the entire measure, even though three other settings commonly used it.

CMS decides -- and over the next few years, will probably not decide -- what should be required of state Medicaid programs and dual demos and providers and everybody else. My test is, is this a gap area that will improve the health and welfare of people with a given condition who are dually eligible? And is it workable in the larger scheme of things?

The mandatory compliance thing by everybody, if everybody was doing something, we wouldn't have to have the whole National Quality Forum process. Everybody is doing great things.

But our task is, will this make incremental improvement to the health of individual people in a given area? And the mandatory or non-mandatory use by a payer is a whole different question.

I'm supportive of the thrust of the recommendation. I only get reluctant when we

have multiple measures in the same general area. Then, okay, that could be burdensome quickly.

But if this is a unique area of measurement, then this will target an important area of health and welfare of people who are dually eligible. That's my personal view.

CO-CHAIR MONSON: This is an important topic actually not just for this measure, but I think for all the measures. So I welcome other comments on this because I think this is a philosophical question about all these measures. We should just all make sure that we're in accordance. Yes, D.E.B.

MEMBER POTTER: My personal opinion here, the measure was tested and endorsed where the population of interest, the accountable entity, was a state or a population. That means the measure was tested to compare state A to state B. It was not tested to compare health plan A to health plan B in the same state, which I think is part of the issue that is being brought up on the telephone.

As a statistician, I would argue, we don't even know if you have enough numbers to make that legitimate comparison between plan A and plan B. This measure was endorsed as a state or population measure, not as a plan measure.

CO-CHAIR MONSON: So D.E.B., are you arguing then that if the measure is endorsed based on that type of venue, then we should not endorse it if we're going to use it for a different purpose?

MEMBER POTTER: Correct, because it wasn't tested for those other purposes. I mean when measures go through the endorsement process, it says what's the entity you're holding accountable, and your testing compares entity 1 to entity 2. So if it wasn't endorsed for that, there wasn't any testing in that.

And part of what we're trying to say is if you have NQF endorsement, you know there's science behind the measure. So there's science behind the measure at the population level comparing state A to state B.

CO-CHAIR MONSON: Jen.

MEMBER RAMONA: Rachel, you said this was a common occurrence among dual eligibles. Do we have a percentage?

And then, Rich, I just want to clarify that you said the converse of that for the AIDS population, most are dual eligible. Did I understand that statement right?

MEMBER BRINGEWATT: Most are dual eligible, yes.

MEMBER RAMONA: Okay.

DR. ROILAND: And, Jen, we're looking for that stat for you right now. Apologizes. Thanks.

MEMBER AGUIAR LYNCH: I have a question for NQF staff and then for CMS. I think we're having discussion about what does NQF endorsement actually mean. Does it mean we think this measure should be taken and can applied to any provider, payment, quality measurement system, or payment system. I'm not quite sure how the public perceives it versus how CMS

perceives it. That's one of my questions to CMS. Is CMS aware, when you see these measures, that they need to be properly tested in a health plan environment or tested with a particular provider site before actually going live?

MEMBER LYTLE: So the answer that I have is that it depends. I think that we do our best to ensure that the measure that we're using has been tested in the proper environment. But then there are some cases in which you may use a measure that may have not been tested in a certain environment with plans or other things. So I think both happen.

With respect to this particular measure, I guess my mind goes immediately to our Financial Alignment Initiative and the plans there. And if we go to use a measure similar to this that was not tested in the environment, I think it may still give us helpful information.

But I think as Bev mentioned, there are certain places in which we wouldn't want to just take the measure and use it because it

wouldn't capture what we're looking. So Bev is in Washington, where we really have a different type of demonstration happening. So we wouldn't automatically go to a fee-for-service state and say use this because it wouldn't capture necessarily what we're looking at. So we try to think about all of that.

MEMBER AGUIAR LYNCH: So my suggestion for NQF, and this may be something that's specific to the Duals MAP and not the other MAPs that are very provider-specific. So since the Duals MAP has changed, take this for what it is. But I think it might be helpful to actually have where you say the endorsed measure and then maybe a table or something that says it's been tested in this population. Or it hasn't been tested in the population, and we're not sure about its applicability to managed care or to certain provider, et cetera.

This way whoever is digesting the information is just clear up front that this is where it's been tested, and we know it's valid

for this situation. We're not sure; it's been tested for this.

MS. MUNTHALI: I would just add one point. We do say that the measure should be used for the level for which it's specified. And we don't have any control how CMS may use that. That is a tension we have not just for the duals population and measures that are applicable to duals but for all of our measures. We're in constant discussions with CMS, strategic discussions, about using the measures appropriately for how they were specified.

MEMBER PARKER: I assume that because this is a newly endorsed measure, someone in NQF on another committee or something has looked at this already. Is there any other information available from that process, because I'm assuming they would have had to specify somewhere where this could be used appropriately in reference to what you were just saying.

MS. MUNTHALI: So D.E.B. is very right. It has broad application at state and

population level. It's a population-level measure. Some have used population-level measures for health plan and Medicaid because they have a large enough sample size.

But it is a population-level measure. It wouldn't be one that we would use, let's say, for a clinician to assess clinician practice.

MEMBER PARKER: Well, in that case, it seems to me it's just like what Stacey said. It depends. And I think if somebody has looked at this measure and thinks that it could be applicable because it's relatively straightforward at the plan level, I don't know why it would have been necessarily tested there.

If plans are actually asking for this kind of a measure, they're saying this is what they need, I mean, isn't there some way to find out if there's a reason that it isn't applicable to a plan and couldn't be used at that level?

CO-CHAIR MONSON: But can we just step back and look at what we're being asked to endorse? Are we endorsing it at the plan-level

or are we endorsing at that state population-level?

DR. ROILAND: I just want to clarify language. We are as a work group not endorsing anything. We are selecting measures that have -- we are discussing and possibly selecting measures that have been endorsed, meaning they have been reviewed by others, by a standing committee of a multi-stakeholder group of experts, and they have deemed that this measure as specified, as tested, is worthy of NQF endorsement.

We're not talking about the measure being used at a different level of analysis. We're talking about whether this measure, as tested and specified and endorsed, is appropriate to include in our family of measures. And that family is a group of measures that we think may be applicable to the dual eligible population and used as specified in that population.

Did that bring some clarity?

CO-CHAIR MONSON: I think that's very helpful. Given that, if there are no more

comments, I think you want to vote.

DR. ROILAND: Well, I just want to respond to Jen's comment. We apologize. The most recent data we have is from 2007, and it's -- I'm sorry, Debjani. What was the number again?

MS. MUKHERJEE: So they're about 213,000 Medicaid enrollees with HIV. Out of that 29 percent are dually eligible.

DR. ROILAND: All right. If there are no discussion, are we ready to vote on the addition of this measure to the family of measures?

All right. So I will turn it over to Madison now who will walk us through the voting. And folks on the phone, we'll just use the same process as before. Submit your votes via email or chatbox, whatever works for you. And I'll turn it over to Madison.

MS. JUNG: Great. The voting for Measure 3086: Population Level HIV Viral Load Suppression is now open. Option 1, yes. Option 2, no. And this is for addition to the family of

measures.

(Voting.)

Great. All 18 votes are in. Voting is now closed. The results are 17 yes, with 94 percent, and 1 no, with six percent. The measure is now added to the family of measures.

DR. ROILAND: Thank you, Madison. We're going to move onto the next measure which is Measure 2858 which is Discharge to Community. This was reviewed by our Admissions and Readmissions Standing Committee.

This is a measure where -- I'm going to have to pull it up on my computer because my eyes are getting bad. I'll just read the measure description to you for this measure. What this measure does is it determines the percentage of all new admissions from a hospital who are discharged back to the community alive and remain out of a skilled nursing facility for the next 30 days. The measure referring to a rolling year of MDS entries is calculated each quarter. The measure includes all new admissions to a skilled

nursing facility regardless of payer source.

And the numerator statement and the denominator statement are listed in the slide set.

CO-CHAIR MONSON: I had a question about this measure.

DR. ROILAND: Sorry. Mike, you can go ahead while we switch.

CO-CHAIR MONSON: I had a question about this measure because it talks about admission to any SNF, and then after discharge from the SNF, who is collecting the information? That wasn't clear, and I couldn't find it in the spec either. How would SNF A know that person B was readmitted to SNF C? That's a lot of letters.

MEMBER BUHR: It's from the MDS data. And every time somebody is admitted to a SNF. An MDS is filled out. And the government gets that data. That's how it's known.

CO-CHAIR MONSON: So it is coming off the MDS?

MEMBER BUHR: I think that's what she said.

DR. ROILAND: The data source -- let me double check.

CO-CHAIR MONSON: And who is the reporting entity? In other words, if it has to come off the MDS and the reporting entity is -- it can't be the nursing facility. It has to be the state or CMS.

MEMBER BUHR: Yes, the nursing facility fills out the MDS.

CO-CHAIR MONSON: That I know.

MEMBER BUHR: Then it's transmitted to the --

CO-CHAIR MONSON: Who is collecting the metric, I guess? That was my question. Because whoever is collecting the metric has to have access to that data to be able to pull that information.

MEMBER POTTER: I think CMS calculates the measure from the MDS data.

CO-CHAIR MONSON: Christine.

MEMBER AGUIAR LYNCH: So I just have a couple of I don't want to say concerns about this measure, but there are a couple of things that just strike me as a bit odd. One is that it's just SNFs. Or it ignores IRFs or LTACs.

CO-CHAIR MONSON: Or NFs.

MEMBER AGUIAR LYNCH: Exactly. Or NFs. That would be something that I think if you're truly trying to get discharge community, I would include those other post-acute care providers as well.

The other thing is I think, it strikes me that it carries a bit of a value judgement. Obviously the discharge to community is the preferred, and we all agree with that. But there are people for whom it is a appropriate for them to actually go to a post-acute care setting. It's necessary for stabilization.

I worry that it doesn't seem like those people are excluded. I guess that's my question. Is there an exclusion for people for whom discharge to community would be unsafe?

MEMBER BUHR: It's talking about readmission. So it's not talking about the initial. What it's trying to measure is, once you have been to the SNF and have gotten your rehab and then you get discharged to the community, do you stay there? So it's trying to improve upon the discharge process and transition of care from the SNF to the community which traditionally hasn't been focused on at all.

And the SNFs have not been trying to do -- I mean maybe they've been trying to do a good job. But there's been no measurement of them or no incentives for them to do a good job transferring people after they've done their rehab and making sure they stay there. All the focus has been on the hospital and readmissions to the hospital and the hospital doing a good job with transitions, but not so much the SNFs.

MEMBER AGUIAR LYNCH: That is an important point of clarification. That's not clear to me though from the measure description the way it's written. So I don't know if it

needs to be revised. To me, I read it as it's from a hospital to home and avoiding the SNF stay to begin with.

MEMBER ROSS: In participating in this process since 2012, this is a generalization, but it appears that most of the measures we endorse are for limited populations in limited settings of limited age groups. So we would never endorse anything because the measure has only been designed and tested in a given setting.

If the concept is important, as a consumer representative, if the concept is important and will improve the overall health and wellness of individual people, even if it's limited to just one little setting or a big setting that could be applied to others, we generally support it as the best in class at the moment. So I wish it would include all of these other categories. I wish that for all of our measures --

When we get to the psychiatric measures, the measures are for one or two

diagnoses in one little age group in one little setting. And yet that's progress. That's my response to Christine's first point which is, yes, I wish measures included multiple settings and all kinds of conditions and all kinds of ages.

But they generally don't. They come to us in this package. And that's what we have to vote on.

MEMBER PARKER: Michael, can I?

CO-CHAIR MONSON: Yes.

MEMBER PARKER: Okay. But I would submit that this is not just a little thing. This is probably the biggest source of Medicaid eligibility that a state has is people staying or overstaying a SNF stay, ending up going back multiple times and then ending up on Medicaid. I think it is a really critical thing that you get the people out of there in a period of time. Both those measures seem to deal with that.

So I think it's a really good thing to measure because it really impacts so much of the

Medicaid eligibility as well. And those other settings aren't that big in the same regard.

MS. MUKHERJEE: I just want to quickly reiterate Clarke's point and also a point that Rachel made. We are not endorsing a measure. So we're not looking at measure mechanics and talking about where was it tested and the evidence, the reliability, the validity.

I think the main charge of this group is to look at a measure and see is it filling a gap within the duals population? Can it be a best in class if not the best or the most appropriate for the duals? Will it add to the family of measures? Is it addressing a gap area? Does it fill some of the criteria, the measure selection criteria and things like that?

I just want to keep that at the forefront because that's the voting process, the decision, the discussions. So we're not endorsing. Thank you.

CO-CHAIR MONSON: Anybody on the phone?

MEMBER COURT: This is Bev Court. We've done something similar and it's been valuable to look at this area.

MEMBER RAMONA: Just in case it hasn't been noted in the numerator and denominator statement, it is assuming that they've gone from an acute hospital to a SNF. And that the community is discharged to private home or apartment or care of assisted living in groups. So it does capture some of the other settings as well.

CO-CHAIR MONSON: All right. Let's vote.

MS. JUNG: Okay. Voting for measure 2858, Discharge to Community is now open. Option one yes. Option two no.

(Voting)

Okay. Voting is now closed. All 18 votes are in. We have 100 percent yes with 18 votes for addition to the family of measures for measure 2858.

DR. ROILAND: All right. Thank you,

Madison. Thank you, everyone. We're going to go to the next set of measures then. Sorry, we didn't quite reach these slides for the 2858.

The next set of measures we're going to be reviewing were reviewed by our Patient and Family-Centered Care Standing Committee and thus with the bulk. The remaining measures were reviewed by that standing committee last spring or early summer I believe.

The first of these measures is measure 2614: CoreQ or Short Stay Discharge Measure. The description of this measure is that the measure calculates the percentage of individuals discharged in the six month time period from a skilled nursing facility, within 100 days of admission, who are satisfied. This patient reported outcome measure is based on the CoreQ Short Stay Discharge questionnaire that utilizes four items.

We have the numerator listed here as well the denominator statement listed on the next slide, a long list of exclusions which I'm sure

may be a point of discussion. But even with these exclusions we thought the measure was important given it's a patient-reported outcome and we are looking to enhance our number of patient-reported outcomes in our portfolio. So that hits on the preliminary analysis from the staff.

We believe this measure addresses several priority measurement and gap areas including systems to coordinate acute care, LTSS and non-medical community services, screening and assessment, beneficiary sense of control, autonomy and self-determination.

As I said before, it's a patient-reported outcome measure. And it's also not age or condition specific. So we thought it was also widely applicable to the dual eligible population.

With that, I'll open the floor for discussion.

CO-CHAIR MONSON: Jen. I'll ask a question. There are a lot of exclusions that

don't seem to make a lot of sense. But I'm not sure almost any of these make any sense. Do we know --- understood that we're not endorsing a measure, but do we have any understanding about why they excluded all these individuals?

MEMBER COURT: I think for dead people it's pretty obvious.

DR. ROILAND: Sorry. What was that, Bev? I talked over you. I apologize.

MEMBER COURT: I'm sorry. I think some of these are for example if you can't get a hold of them, if they're dead, patients discharged on hospice. They're at end of life and you don't want to bother them at that point. I think there are real reasons behind these exclusions. I've seen that in survey work.

DR. ROILAND: Michael, I don't have specific reasons for each of the exclusions in the documentation. I have, I guess other specific ones or is it literally all of them that don't make sense?

CO-CHAIR MONSON: No, not all. But I

mean just because you're discharged to another facility it shouldn't exclude you. Just because you have a court appointed, legal guardian doesn't mean that we shouldn't be getting the feedback. Hospice I think is debatable whether or not. You could make it available to people in hospice and they could choose not to participate. The ones who --- AMA even more so to get their opinion on a customer satisfaction survey.

And then just because they're filled out by somebody else, especially if someone has visual impairment or maybe they're not accessible documents, I don't know why. I mean look, understood that maybe there's a response period or the potential of dementia. But the rest of those didn't seem to be reasonable exclusions.

DR. ROILAND: And this is Rachel again. I'm just reading through the report for this measure. And in the exclusion criteria they talked about where it's focused around the cognitive testing which I think there's rationale there as to why they needed to use cognitive

testing and use that as a way in the exclusion criteria. But the other ones there are not specific reasons given as to why those were excluded.

MEMBER FOX-GRAGE: I have a question about the numerator. It really is truly a question because I'm not familiar with this. So they have to have an average satisfaction score of equal to or more than three. So my question is, does the scale go up to five?

DR. ROILAND: I'll pull up the specs right now really quick.

MS. JUNG: Yes, if you check in -- this is the Person- And Family-Centered Care Report. And this is a final report and it should be on the NQF website if you would like to follow along. But it does go from a scale of one poor up to five excellent.

MEMBER FOX-GRAGE: Because in my experience with the one to five, if it's equal to three, three is kind of neutral. So that's not in my view satisfied. That's sort of middle.

Now four and five I count as satisfied.

That's my only little hang-up with this is that you're counting folks who give it a three as saying they're satisfied instead of sort of neutral. So I just question that.

DR. ROILAND: Yes. This is Rachel. It's a point of discussion for the group as to whether or not you think that. If that's how the measure is specified again, not to reiterate that again and again, is that acceptable to the group for our family of measures?

MEMBER FOX-GRAGE: So we can't say four or five. Make it a four.

DR. ROILAND: You can go either.

MEMBER FOX-GRAGE: Okay.

CO-CHAIR MONSON: We're going Charlie, Tom, Rich.

MEMBER LAKIN: Just sort of related to Wendy's comment, there's research that shows on Likert Scales the average response is about 70 percent in the direction of the most positive. So a three is really probably a two, if we were

to ---

I was just curious. In my general ignorance, I don't know this instrument. What are the four items that people are reporting satisfaction on? We didn't find it in the summary I don't think.

DR. ROILAND: We're pulling that up for you, Charlie. Just a second please. We'll pull up the specs.

MS. JUNG: The report doesn't indicate that, but we can pull that up. The reason that it is not indicated in the report is because the measure was --- it was most likely submitted as an attachment to the measure when it was evaluated for endorsement. We will try and pull that up now.

CO-CHAIR MONSON: All right. We're going to Tom.

MEMBER LUTZOW: Yes, these exclusions we could use some of these in CAHPS. I wonder if there isn't a bias when it comes to including people that require someone else to fill out the

questionnaire, whether the IDD population is infected by that exclusion.

And it's just interesting that cognitive impairment could be an exclusion in one case but not another.

MEMBER BRINGEWATT: Not sure what the question I have necessarily speaks for or against including this, but it's a question that comes up consistently among our members as it relates to self-report. There's a lot of support, broad support, for doing everything we can to get consumer input as it relates to quality and satisfaction.

Yet at the same time some questions -- and I don't know whether it's the case in this regard -- I know that in some cases the presence of dual status has discounted the answer because the assumption is that duals have a built-in bias that's more positive than non-duals. So that has been discounted in some measure. I don't know whether that's the case with this measure or not.

The other problem that occurs in some

locations is some places have a high degree of non-English speaking people where both culture and language are important to the answer and affect the answer and affect quality ratings. I don't know how that affects this specific measure. But I think it's important for us to take that into account.

So part of me says this is an important measure to look at. It has lots of benefits to it. At the same time, there's complications in the application process for plans that specialize in care of duals and that particularly specialize in care of duals that have -- it looks like cognitive impairment is addressed here.

But I don't know that --- whether the language issues, the cultural issues are fully assessed. So I don't know whether it's possible to support something and at the same time call for more exploration of its potential impact or use as it relates to certain subgroups of duals.

DR. ROILAND: I'll do just a really

quick response. We can say that -- and I believe we did this in the last year's report a little bit -- highlighting that we think the measure is a valuable addition to the Family, but would appreciate the work group's support/exploration on X, Y and Z issues. It would just be added, but we would add that little extra to it.

CO-CHAIR CHIN HANSEN: Well, I think that Rich's comments I would certainly concur with relative to looking at other populations. The other one is as you were looking for materials, Rachel, I noticed --- is the measurement developer AHCA?

DR. ROILAND: Yes.

CO-CHAIR CHIN HANSEN: And so the opportunity of this to make sure that it's not so tipped in possibly one direction given the fact that objectively what does a three stand for. So it just seems like it requires a little bit more objectivity perhaps to this.

MS. MUKHERJEE: So I have the questions for the CoreQ. So the first one is in

recommending this facility to your friends and family how would you rate it overall. And the ratings are one poor, two average, three is good, four is very good and five is excellent. Question two is overall how would you rate the staff. Three is how would you rate the care you've received. And four is how would you rate how well your discharge needs were met.

CO-CHAIR CHIN HANSEN: Well I was just going to ask more about the CoreQ and she just said it. But I don't think it's adjusted for duals in this case. I think that happens in CAHPS surveys. So I think there probably isn't a countervailing adjustment of positivity, that was taken away for duals. I would be surprised if it was at the nursing home levels. It sounds like a nursing home level set of measures.

DR. ROILAND: Bev, I believe you also had a comment. I'm sorry. You can say that now.

MEMBER COURT: Am I okay to go? I can't make eye contact. This is kind of hard.

DR. ROILAND: You're free to go.

MEMBER COURT: Just a comment just from a statistical standpoint. This measure was developed for facilities. And if you include three, four and five, if you include three, then you have a higher number just so that you can get -- so you don't have to scrap the entire measure because of small number size. So there's a statistical reason to include it, that three.

There's a reason for the exclusions of reported by someone other than the patient. Because we know from survey data that there can be big discrepancies between what the family member and what the patient will report. And so it's the stability of that measurement as well. So there are reasons for all the permutations behind those.

MEMBER RAMONA: From being with clients I think the fourth question is a challenge for them to know whether their discharge needs were met or not. And particularly there's a two month reporting window that after two months the responses are not valid

and sometimes it's not understood until after two months that their discharge needs were met or not.

MS. JUNG: Voting for measure 2614, CoreQ Short Stay Discharge Measure is now open. Option one yes. Option two no.

(Voting.)

All 18 responses are in. The results are 11 for yes with 61 percent, seven for no with 39 percent. With that 61 percent, it does pass the majority criteria and measure 2614 is voted into addition for the family of measures.

DR. ROILAND: All right. Thank you, Madison. So we'll go on to the next measure which is measure 2615, CoreQ Long-Stay Resident Measure.

This measure calculates the percentage of long-stay residents, those living in the facility for 100 days or more who are satisfied. This patient-reported outcome measure is based on the CoreQ Long-Stay Resident Questionnaire that is a three item questionnaire.

And just to preempt Charlie's question, those questions are pretty much the same that Debjani read. But I'll reiterate them.

In recommending this facility to your friends and family, how would you rate it overall? Response options are one poor, two average, three good, four very good and five excellent. The second question is overall how you rate the staff with the same response options. And the third question is how would you rate the care you received, again with the same response options.

We have the denominator again that list of exclusions listed on the slide above as well as in the Excel document we sent you earlier. For staff preliminary analysis, we thought this measure again similar to the previous measure addressed several priority measurement and gap areas. I won't reiterate those again.

But again, it's also a patient-reported outcome measure where we're interested

in adding more of those to the Family. And it also covers a wide age range and is not disease-specific, again emphasizing that crosscutting nature that we like our measures in our Family to have.

So with that, I'll turn it over to discussion.

CO-CHAIR MONSON: Joan.

MEMBER ZLOTNIK: Yes. Could you just read the questions again that is part of this?

DR. ROILAND: Oh sure. All right. The first question is in recommending this facility to your friends and family, how would you rate it overall. And the response options are one poor, two, average, three good, four very good or five excellent.

The second question is overall how you rate the staff with the same response options. And the third question is how would you rate the care you receive, again with the same response options.

MEMBER HAMMEL: Do they say who asks

this? I'm only saying it because again we know enough in nursing homes that people can be -- if it's the nursing home staff asking it, they can be under a lot of pressure to answer this in a certain way. Whereas, we've had enough research to show that if it's asked by an external body you might get a really different answer. Just concern.

DR. ROILAND: We'll look that up for you, Joy, really quickly and get back to you as soon as we find that.

CO-CHAIR MONSON: While we wait, Rich, go ahead.

MEMBER BRINGEWATT: Are there other surveys, questions like this that are currently being used that have been endorsed? I mean this seems like such a basic question about quality for --

CO-CHAIR MONSON: Let's hold. Let's let them research one thing at a time. I wonder if somebody has another comment that doesn't require the staff to research something. By all

means, let's go ahead. And then we'll come back and take both of these.

MEMBER AGUIAR LYNCH: I just have a question. So if we --- I understand these measures are endorsed and we're not now reendorsing them. But I think for some of them we're raised some really good considerations and concerns. And what happens to that? Is anything done with that information? Is it given back to the individuals that endorse, the committee that endorses it?

DR. ROILAND: I apologize, I'm trying to read and listen at the same time. So your question was related to how is feedback given to the standing committee? The major mechanism by which we do that right now is our maintenance process, sorry, our annual review as well as our maintenance process.

Measures are required to go through an annual update or review that doesn't strictly involve the standing committee. But they are up for maintenance review every three years as well.

And again the measures are brought back to the same standing committee with updated testing. We put greater emphasis on the performance data that the developer provides as well as any issues around feasibility and use and usability. Those are our main feedback loop options with these measures.

But given this is a newly endorsed measure, it's just starting its journey on that loop. In three years, we'll have the big maintenance review. And in one year we'll have the annual update.

MS. MUKHERJEE: So I have some of the research, the customer satisfaction vendor uses and administers the CoreQ. They're aligned by Brighton Consulting Group. There's like a whole bunch of them, about ten. They're the ones that administer the questionnaire for the facilities.

MEMBER HAMMEL: But as paid by the facilities or are they a part of the facilities like they're affiliated with it? Or are they an external group?

MS. MUKHERJEE: It doesn't say. It just says Align, Bivarus, Inc., Brighton Consulting Group, Healthcare Academy, ReadyQ, Holieran, inQ Experience Surveys, Lighthouse Care Updates, Market Research Answers (CareSat), National Research Corporation (My InnerView), Pinnacle, Providigm/abaqis, Sensight Surveys, Service Trac. And it says that association is working with the vendors to add CoreQ questions to the questionnaires and/or to administer it. And these are vendors of the survey.

And I'm reading right off of the AHCA website, American Health Care Association.

MEMBER POTTER: Surveys like My InnnerView, they are vendors that go out and administer the survey at the nursing home. But they're not interviewer-administered surveys. So they drop the survey off either in rooms or hand them to people or whatever.

The CAHPS nursing home survey is no longer endorsed. It was an interview-administered survey for both short- and long-stay

residents. So that's what I know.

CO-CHAIR MONSON: Rich, what was your question again? What was your question? We put you on hold while we were answering the first question, which is now answered.

MEMBER BRINGEWATT: This seems like such an important question to ask that I was wondering whether there were other questions like that that have been endorsed or whether this really is filling in a gap. Part of the question is reporting burden. If there is already something endorsed that essentially accomplishes the same thing and it's better or not, that's the only reason I'm raising it.

DR. ROILAND: In each measure submission, there's a related and competing section where we ask the developer and the staff also to go through the NQF measure repository to try to identify measures that are either related, so they have the same measure focus, or competing where they have the same measure focus as well as they're specified for the same population and

setting.

For these measure submissions, the only other measure that's identified as related and competing is the measure we just talked about. But again it's related given that it's specified for short-stay residents whereas this one is specified for long-stay residents. So through that mechanism we can determine that there aren't similar measures beyond these two.

MS. MUKHERJEE: And if you go to some of the websites like I'm looking at the Align website, they can actually create some custom surveys for you for these settings. They're not endorsed. They're not competing or related. They're just a vendor out there who will create a customized survey to meet your needs.

CO-CHAIR MONSON: Clarke.

MEMBER ROSS: I wanted to reply to Joy and follow up that discussion. A lot of this is philosophic purity on who does the interviewing and how pure and legitimate the interview is. So in the mental health field, we have two states,

Massachusetts and Maryland, and we have parts of two other states, Pennsylvania and Wisconsin, that use consumer-trained interviewers with mental --- a history of mental illness to interview people currently experiencing mental illness. So that's sort of like the gold standard of purity. But that's two states and two partial states. And then we have all kinds of gradations of whether you're an employee of a state agency or whether you're an employee of a university or whether you are independent.

This issue was discussed --- the National Quality Forum had a patient-reported outcome committee like 2012 to 2014 and discussed some of the advantages and disadvantages of that. So many of us believe the gold standard is trained peers interviewing peers. But that's the gold standard, that doesn't really exist.

The question is, is the interviewer informed and trained and can do this in a standardized way. But this is a very important issue to the consumer and family movement. It's

who does the interviewing. And it's just an important issue partially addressed in a previous National Quality Forum report and could always use more addressing and more testing.

CO-CHAIR MONSON: Joan, Gwen and Joy.

MEMBER ZLOTNIK: I thought that D.E.B. said that it's actually just a survey and not interviewer-reported.

MEMBER POTTER: Yes, there's a bunch of surveys out there that attempt to measure experience and satisfaction that aren't interviewer-administered. They are self-administered. And most of these are self-administered. They don't even have an interviewer.

So there's the peer experts which might be the gold standard. Then I'd argue for at least trained systematic interviewers. And then there is no interviewers. So it could be self-reported.

Most of the CAHPS health plan surveys or the hospital surveys are self-reported. So

the person fills out the questionnaire or answers on the telephone and there's no intermediary in there.

MEMBER ZLOTNIK: My concern is that this is very much --- while we want to know about quality this is pretty much the same thing that Fitzgerald Subaru asks me when I get my car serviced. And often there's a nuance to it that yes, I like the staff and yes I got what I needed, but not exactly. And there's no opportunity to really tell the truth.

And I go back to my mother who spent six years in a long-term care facility in Maryland and think she wasn't in a position to answer it. But even if I answered it, would it really get at something that's meaningful? Particularly when the industry is putting this out and the industry has not been particularly resident-friendly in many ways, particularly the for-profit nursing homes, I don't think this gets us very far. I don't even know what kind of return rate they would actually get on people

filling it out because many of the people in the facilities may not have the facility to fill it out.

So it just raises concerns to me that it's not -- it's trying to measure quality, but it's not a quality way to do it.

MEMBER BUHR: I was going to make a similar point about that it's just somebody filling out a survey. And a lot of the long-term, long-stay residents aren't able to fill out a survey. It says that they could have somebody -- if they could say what they thought, somebody else could fill in the blanks. It says that on there.

So I agree that it's not the best kind of measure of quality. But we've been in the habit. Like your point, there isn't another survey. And we've been in the habit of not asking people. We don't have that many patient-reported outcome measures so, maybe this one is better than nothing.

And then when it comes up for its one

year maintenance and three year whatever, we can look at the data and say --- or whoever can look at the data and realize that they're not getting very much return on their survey or how can they make it better. But I feel like we have to start somewhere with asking the actual people if they like things because we're not currently doing that.

MEMBER RAMONA: Gwen said much of what I was going to say. I'm sorry.

CO-CHAIR MONSON: Joy first and then we'll go to --

MEMBER HAMMEL: Just lost my train of thought. I'm going to take a few. Go ahead.

MEMBER RAMONA: Okay, if that wasn't confusing, this is Jen. I was going to say much of what Gwen was saying with regard to, it is very valuable to be asking these questions. Yet how valuable are they if they don't give a lot of content.

Also it does say on the form, on the questionnaire that somebody else can fill it out.

But the exclusion is that if it was filled out by somebody else it doesn't count.

That also gets to the point of literacy and health literacy and even using words like discharge on the previous question and here, people really understanding what they're being asked. And then particularly if the questions are going to be asked in context of other questions that the facility can add just to get more information about their satisfaction. It could also skew how the answers are being replied to based on what other questions are framed around it.

CO-CHAIR MONSON: Joy, Aline, Alison.

MEMBER HAMMEL: Okay, I remembered mine. The survey --- the questions seem skewed. They're talking about your satisfaction with the SNF, but they're not asking the questions about were you offered alternatives, did you get any -- you know, were you satisfied with the information you got. Was it --- and what we're really trying to get at is did they know about their rights to

leave this facility or get in the community if they want to.

It just seems skewed without that part of it that you're going to get a high satisfaction rating of somebody who's in the middle of an institution being asked when everything is riding on it even if it is self-report.

MEMBER HOLMES: So I probably know more about this than I should. But the New Jersey Hospital Association, a federally-certified patient organization, we actually hold the PSO contract for AHCA for their NCAL product. So we've been working with them.

And I was on their site trying to figure out where the testing came from and I can't find any -- they don't mention who tested it, they only have --- and I think they're still very early with it because it doesn't come up on their trend tracker which is where you can download reports.

So I don't think that it has a lot of

work behind it either because we've been talking to them a lot about some of their measures and stuff. So I'm not very comfortable with how they've developed this. My sense is that they've not spent a lot of work on really testing it out even in their organization, because it doesn't even come up. They say you can download ten reports, but it doesn't come up even as a possible selection.

CO-CHAIR MONSON: Alison.

MEMBER CUELLAR: So if a hospital sends one of these through the mail and gets a response from a patient based on their experience in the hospital, we're more comfortable with that because the hospital staff aren't there while the person is filling it out. That seems to be the big difference.

And then I guess I'm less and less -- I was going to say if it's endorsed haven't they thought through some of these issues? It sounds like no. I realize we're not endorsing, but we're asking some fairly standard validity and

reliability questions here. And it sounds like we can't take endorsement as telling us anything about validity and reliability.

DR. ROILAND: This is Rachel and I can jump in on that. There is testing on validity and reliability done on this measure. The standing committee for Person- and Family-Centered Care did find it acceptable.

I have the testing attachment pulled up here and I won't read all 30 pages of it for you. But they did do -- let me just make sure -- they tested the measure for reliability and validity. The pilot CoreQ long-stay resident questionnaire was examined using responses from 1700 residents from a national sample of nursing facilities. They also did some testing of some sociodemographic variables using the same sample.

The validity testing for the long-stay resident questionnaire was examined using responses from 100 residents from the Pittsburgh area. Additional testing was done using responses from 223 facilities that included

responses from 7,307 residents. So they've done testing with decent sample sizes.

In terms of how it's administered, they do have an appendix that's included in their measure submission that talks about how these three questions for this measure can be ---that vendors that Debjani mentioned earlier can add these three questions to their questionnaires that they administer on behalf of various facilities. And they also list in there that if their vendor does not include these questions to contact them and they can help them work with their vendor to add them.

If they don't have a vendor, they encourage them to contact Dr. Nick Castle who I believe is a pretty prominent researcher in this space to talk to him about how to incorporate these measures into their work flow. So I don't want --- it was tested and the committee that reviewed it found the testing to be acceptable and therefore recommended it for endorsement.

MS. JUNG: And also just looking at

the Person- and Family-Centered Care Report from 2015 and 2016, and I can read a brief summary of the points that the staff had summarized from the comments of the committee.

For comments in terms of this, this new PRO-PM is very similar to number 2614 CoreQ Short-Stay Discharge Measure and number 2616 CoreQ Long-Stay Family Measure. The committee had questions about validity and whether staff members were allowed to fill out surveys on behalf of patients.

The developer responded that there is no way to stop staff from doing so. But if staff indicate that they had responded on behalf of a patient that data will be excluded.

The committee agreed that the measure is very similar to 2614 and did not require additional discussion or voting. Ultimately, the committee recommended this measure for endorsement. And there's also a summary for 2616 which I would also be happy to read out once we get to that point.

MEMBER PARKER: I don't know if I -- I don't want to speak exactly to the point here. But I just wanted to make a more general statement about the --- we can look for the perfect way to collect this information from individuals. And I once was part of a project that was looking at that perfect way where they had very highly trained people administering the survey. It was done over the phone, but it was with frail elders, not people in nursing homes.

But my point is going to be that it's even more applicable to people in nursing homes. And they were trained at how to follow up the questions and all this. This was called a Braceland study. I don't know if it's in print anymore, but it was done east.

Anyway, we were able to listen to recordings of many of the conversations that the interviewers had with frail elderly. The scaling was a bigger issue than anything else. And the scaling was quite hilarious.

We would get the question about on a

scale of one to ten how did you like your doctor. How did you feel your doctor did? And people would say excellent.

And then they'd say, well if you want to give that a number what number would you give it?

My friend Mary gave hers a five, but I would give her a nine because blah blah.

And these were people that were living at home and fairly cognitively intact enough to stay at home. But the scaling and the administration were both so far off that it was very, very hard to capture even though they had done practically the perfect way of doing it. It was very hard to capture anything.

So if we want to wait around for the perfect scaling and the perfect administrative approach we may have to wait a long time, is my point. So I would hope that we wouldn't get too hung up on that part of it.

CO-CHAIR MONSON: I'll just go down the line starting with Charlie.

MEMBER LAKIN: I agree with Pam on both items. This is stuff you need to ask and scaling is a big problem.

With regard to the reliability, it's a fact that skewed distributions are usually associated with high reliability. This sort of begs another question for me and that is does this discriminate between organizations? Does every organization report 95 percent performance on the upper end of the scale? And I suspect it probably does.

In a sense, given its use, what is its use? And I don't have the data to look at, but I would wonder whether this is really very useful because I would guess the distributions are very heavily toward the very high end of the scale.

CO-CHAIR MONSON: Clarke, why don't you go?

MEMBER ROSS: So I'd like to try to tie Gwen and Pam and Joy's comments and Charlie's, too. Almost all the measures I've supported since 2012 are inadequate, incomplete,

restricted, limited, narrow, developed by a provider group and a developer and have the weaknesses like Charlie and Joy have identified.

Yet I go back to Gwen's point. In the absence of a vacuum and nothing, is this particular measure a helpful first step? Now this gets into the burden issue. So I'm responsible for some of the burden because I generally support these things.

But if there's no measure in an area and it's targeted to individual recipients, then I tend to support it even though it's not a very good measure and in the aggregate, it adds to burden. So we each have to go through that. Is this meaningful enough in the absence of nothing to put up with with all the limitations that Joy and Charlie have identified?

CO-CHAIR MONSON: Right down the line.

MEMBER AGUIAR LYNCH: I have a question for the NQF staff. So I hear what -- a lot of people are clearly uncomfortable with this measure. I hear what you guys are saying that

this is the best that we've got right now, so we should go ahead and try to plug the gap.

But my question is if a better -- if we do that and a better measure comes online, part of it seems like when you guys bring these measures to us for consideration part of the assessment is whether or not there already is a measure that addresses the same issue. In that analysis, do either the NQF staff or do we go back and relitigate the original measure that's already existing there?

So for example, if like two years from now or three years from now presuming this group is still here and a new, better measure came. Would we be evaluating it with respect to this measure two years of testing in order to be able to know which one is better? Do we vote one in, vote one out?

MS. MUKHERJEE: Sure. It happens a couple of ways. One way is if a new measure came through the endorsement process that's better there would be a related and competing analysis

that NQF staff would have done. When that was endorsed, when we are looking through our measures, we would see that and then we would present that to the group as an option to swap this out and not necessarily saying that this would go off.

And then the other one is that potentially this loses endorsement because after it's been in the field the measure developer decides not to support it. The measure steward no longer does all the maintenance. That will go away and that's when we would also look for other measures.

Honestly, the field of especially surveys and patient-reported outcome measures is very much in development and growing. So we hope that in the next two, three years there would be a lot more, better measures for us to consider than where we are right now.

MEMBER CUELLAR: I share many of the qualms around this measure and I would love it if somebody tested the smiley faces and the frownies

instead of the numbers, lots of people in the state of decline have trouble with numbers.

Yet at the same time, I don't find that I'm raising a duals-specific issue as I ponder these things. These are general issues for anybody who stayed in this kind of facility where quality is being measured.

And if you were to ask me, well we have a menu of measures, is this a duals-relevant one, I would say yes. Duals spend time disproportionately in facilities like this. So I'm not hearing myself raise a duals-specific concern. It's a concern, but if --- this measure is highly relevant to a duals population.

CO-CHAIR MONSON: Gwen.

MEMBER BUHR: So I was thinking that a lot of facilities and especially corporate facilities and whatever, they're already doing some sort of surveying. At least, the one where I work does a Holleran or whatever that company was. Holleran or, I can't remember. It was on your list.

They use that company and they do a survey. And I heard somebody say that they could just add these questions to that existing survey. So it doesn't seem like a huge burden, it's three questions.

And it does give words. So it's not just on a scale of one to five. It has words. So I think that's valuable that it says poor, good, very good. I think that's also encouraging.

DR. ROILAND: So this is a distribution of scores that they provide in the measure submission. I'm having a little trouble interpreting it. Madison, can you make it a little bit bigger?

On the lefthand side, it says number of facilities with measures score. And then at the bottom it says percent measure score. It's not giving us the distribution of one to five. Do they have that farther up? These are by items. I don't know if that's helpful for you all.

CO-CHAIR MONSON: I had a question. Debjani and I had a sidebar, but I think this is important for the group. I think, D.E.B., you mentioned this, too, that there's no CAHPS measures for nursing facilities right now. But Debjani seemed to indicate that there's another measure.

So I think it's important because if there's another measure out there, or it's in development. So there is nothing besides this right now.

MS. MUKHERJEE: Nothing.

MEMBER POTTER: There used to be CAHPS measures for long-stay, short-stay and family. And they had endorsement at one time. But I think the last time they came through maintenance AHRQ made a decision to no longer support the measure. So they no longer have endorsement.

MEMBER CUELLAR: Was the issue any of the kinds of things we're talking about?

MS. MUKHERJEE: They pulled them because they're developing new measures. So it's

not that there's a vacuum. At one point we will have a new set.

MS. JUNG: And also that measure endorses an instrument and we no longer endorse instruments.

CO-CHAIR MONSON: I would just put my two cents in which is I do think it's critical for us to have the voice of the consumer. I am leery of an industry-administered survey test that seems to actually make everybody look really good, especially for an industry that is attempting to position itself against changing tides of consumer sentiment.

It does give me pause. I wish there was another survey. But if there is one coming, from my perspective it might be worth waiting for that one instead of using this one.

So we might have beaten this one to death. But it was a very healthy conversation and an important conversation. Anybody else on the phone have any other comments before we move to a vote?

(No audible response.)

All right. Madison.

MS. JUNG: Okay. Measure 2615, CoreQ Long-Stay Resident measure is now open for voting. Option one yes. Option two no.

DR. ROILAND: Did someone step out?

MS. JUNG: Oh, snuck out. With that, 17 votes. The voting is now closed. We have seven votes for yes with 41 percent and 10 votes for no with 59 percent. It does not -- okay, so the measure will not be added to the family of measures.

CO-CHAIR MONSON: Okay. Jen, do you have a comment? You're standing between us and a break. Just be aware of that.

MEMBER RAMONA: I'll try to make it quick. It seems that the questions that we're asked that maybe changed the results would have applied to the short-stay. So from a process standpoint, is there --

MS. MUKHERJEE: The workgroup can request for a revote depending on the discussion

and just give a rationale when you're requesting that as well.

MEMBER RAMONA: After the break.

CO-CHAIR MONSON: When we return.

MEMBER RAMONA: Okay. For me they're not --

CO-CHAIR MONSON: We will be reopening the vote, or will we?

MEMBER RAMONA: Because they're not there. They're not under control at the nursing home.

CO-CHAIR MONSON: Okay. Fifteen minutes. That would be 2:25 p.m. Eastern.

(Whereupon, the above-entitled matter went off the record at 2:09 p.m. and resumed at 2:25 p.m.)

CO-CHAIR MONSON: Everyone back. Break is over. Where we last left our heroes --- no, so seriously I think --- so did --- Jen, you had the floor. Did you want to --- I don't know if you need to make a motion or just a request to --- do you want to make your request that you made

before the break?

(No audible response.)

CO-CHAIR MONSON: Mic, mic, mic.

MEMBER RAMONA: I would request a revote on the Short-Stay measure ---

MS. JUNG: 2-6-1-4?

MEMBER RAMONA: Yes, 2614.

CO-CHAIR MONSON: Do we need to vote on a revote, or do we --- can we just take a revote?

(No audible response.)

CO-CHAIR MONSON: Is there an objection to a revote on the Short-Stay measure? There's an objection. Would you like to hit your microphone and explain your objection?

MEMBER RASK: Say the --- my reasons for voting differently had to do with the population long-stay versus short-stay. It didn't have to do with the other issues.

CO-CHAIR MONSON: Do --- but do you object to having a revote?

MEMBER RASK: Oh, I'm sorry.

CO-CHAIR MONSON: So, yes let's --- let's --- so anyone object to opening up the discussion again and then revoting on whichever the --- the short-stay version of CoreQ?

(No audible response.)

CO-CHAIR MONSON: Okay, hearing no objections, we're back on that topic again. So now, Kimberly would you like to explain your --- why you would --- yes, go ahead. No? You didn't. All right. Does anyone else want to make a comment about --- yes?

MEMBER PARKER: Well I just don't --- I don't think the two things are exactly the same and I just don't want to go over the whole conversation again. That's all.

CO-CHAIR MONSON: Yes, Charlie?

MEMBER LAKIN: I would just say the contexts are quite different in the two. One being you're a --- you're an inmate. The other you're --- you've been liberated and you have a little bit more independence in observation I think, in the latter.

CO-CHAIR MONSON: That is an excellent comment. Okay, anybody on the phone want to make a comment about Short-Stay CoreQ 2614?

(No audible response.)

CO-CHAIR MONSON: All right, Madison, we're revoting then.

MS. JUNG: Okay, the voting for Measure 2614, CoreQ: Short-Stay Discharge Measure is now open. Option one, yes. Option two, no.

And the --- the sensor is over here by me, so ---

Okay, we have a total of 17 votes. The results are ten for yes with 59 percent, seven for no with 41 percent. And with a 59 percent it does not meet the threshold, so this will not be added to the family of measures.

MS. MUKHERJEE: And just to clear up any confusion, the --- we will need a rationale, so the rationale is --- does anybody want to summarize? There was a lot of discussion. Jen, do you want to summarize the rationale for the revote and sort of --- oh --- Gwen?

MEMBER BUHR: Did we have 18 votes last time?

CO-CHAIR MONSON: I think we did.

MEMBER BUHR: Because it seems like we need to include Tom if we included him the first time. I don't --- I think we should wait till he comes back for this revote, personally. I don't think it's valid.

CO-CHAIR MONSON: I think that's fair.

MS. JUNG: Okay, would we like to table this for now and move on to the next one?

CO-CHAIR MONSON: Let's do that.

MS. JUNG: Okay.

DR. ROILAND: All right, so I think that's back to me then. So our --- we do have one more CoreQ measure to go over and that is NQF 2616: CoreQ: Long-Stay Family Measure. And the description for this measure is that the measure calculates the percentage of family or designated responsible party for long-stay residents, i.e. residents living in the facility for 100 days or more who are satisfied.

This is a consumer-reported outcome measure that is again based on the CoreQ Long-Stay Family Questionnaire that has three items. I'll read you those three items now. The first question is in recommending the facility to your friends and family, how would you rate it overall? Response options are one, poor; two, average; three, good; four, very good; or five, excellent.

The second question is overall, how would you rate the staff? The same response options. And the third question is how would you rate the care your family member received? Again, the same response options. The numerator and denominator are listed on the slides as well as the exclusions.

For the staff the preliminary analysis rationale is similar to the other CoreQ measures. We thought it addressed several measurement --- priority measurement and gap areas. Again it's a --- a patient- or consumer-reported outcome measure and had a --- did not have limits on age

or disease.

MEMBER AGUIAR LYNCH: Didn't we vote on this one already?

MS. JUNG: You voted on the Long-Stay Person-Reported ---

MEMBER AGUIAR LYNCH: Oh, this family measure.

MS. JUNG: Yes.

MEMBER AGUIAR LYNCH: Got it.

CO-CHAIR MONSON: Jen, do you have your tent up, or is that a residual? Aline?

MEMBER HOLMES: Under one of the slides it says --- the preliminary analysis says it's a patient-reported outcome measure, is --- it's a family-reported, not a patient-reported ---

MS. JUNG: Yes, I apologize. That's a typo.

MEMBER HOLMES: Okay. Just wanted to clarify that.

MS. JUNG: It should be a consumer-reported outcome measure.

MEMBER HAMMEL: I have the same concerns as the last one in terms of the scale and --- and same issues with bias, and families could be --- if they're in a long-term care --- easily be persuaded as well to say yes to something.

MEMBER BUHR: I think --- I think families have very little place to give their feedback. And again, I just think we have to start somewhere. And especially when things aren't going well. And they can put in complaint surveys, and they can call the ombudsman and they can do all these things, but they're very reluctant to do a lot of things because they're afraid of retaliation.

So some sort of anonymous survey seems like a safe way for the family to be able to give their feedback and for the facilities to be compared one to another, rather than relying on the family to do things that are more visible to the facility. So I --- I think it's a good --- good thing.

CO-CHAIR MONSON: Pam and then Rich.

MEMBER PARKER: Well, I --- I just think the things you just reeled off are --- are things that would invalidate almost any, you know, questions that you could ask of people in --- in nursing homes. It would be --- if you can't ask the families, you can't ask them because we don't approve of any of the methodologies, or we think they're going to be too influenced and biased to be able to say anything, it pretty much knocks out the whole --- anything we could ever do.

So I --- I can't --- I can't go endorse, you know, that approach. I think we have to look for something that is usable within a reasonable context. And then I think this is about as good as we're going to find.

MEMBER BRINGEWATT: Two quick comments. One is I think this is good as it gets. You have to be careful of, you know, the --- being the enemy of the good here. The other comment is I think we shouldn't underestimate the

power of just asking the questions. Just the mere fact that somebody is walking in the room, giving you a survey.

The staff know that there's a survey being distributed. And you know that in itself I think has power. And part of what we're trying to do is, you know, increase the power of the beneficiary. And I don't know that it's harmful, you know, and I think that on balance there's more good than bad that can come out of this.

MEMBER LAKIN: I won't ask to see the distribution again. But I think there's a --- a question to be raised about a survey where 86 percent of the people participating rate --- rate services between --- 86 percent rate them from good to excellent. I mean is there --- is there a validity to that?

And I think in part it's how they've set up the survey. I think people tend to look at Likert scales and --- and even if there's --- average to them is in the middle. And if you --- if you scale average down to two, and people mark

them --- mark average as the middle, you've already --- you've already said it's good. And --- but I --- I just, again, wonder what is the point if it doesn't --- other than, I think, the good point that Rich makes. What is the point if everybody is at the high end? It just --- only in Minnesota are --- are all the kids above average.

MEMBER BUHR: Well maybe we could see the distribution, because I think families are generally less satisfied than the patients. I don't know, that's my experience.

DR. ROILAND: We're pulling that up for you right now. It'll be the distribution for each of the items. Yes. Eight actually, sorry.

So this is from the testing attachment from the measure submission, and the column on the far --- my right side shows you the response percentage for each --- response option for each item.

CO-CHAIR MONSON: Aline, did you --- or --- did you want to go and then Jen?

MEMBER HOLMES: Do we have a breakdown of what percentage of these residents that they used the survey on the testing were dual eligibles? Because it looks like the investigator who did it was working for Manna Care which is a for-profit long-term care. And I don't know how many --- they don't take a lot of Medicaid patients, and so I would be interested to see --- for its applicability in the dual-eligible population, this is really tested on that --- you know, did they include a large number of those long-stay residents who were Medicaid? Because I don't know that they have that many of them.

DR. ROILAND: So, I'm looking at the testing attachment right now, looking at their data --- their sample for the testing. It doesn't give me any descriptions. The demographics for the respondents --- it's just gender, year of birth, highest level of education and race. So they don't have dual status on here.

MEMBER RAMONA: Just a point of clarification, so the third question is how would you rate the care you received? Not your loved one? Not your family member?

DR. ROILAND: I'm suspecting that's a typo in their submission, since the first --- second question.

MS. JUNG: Yes, so it seems that the --- for this questionnaire, the question slightly differs. So the first two questions are the same. Question one, in recommending this facility to your friends and family, how would you rate it overall? Question two, overall, how would you rate the staff? And question three is changed to how would you rate the care your family member received?

DR. ROILAND: So I'm not sure why it says that there. It's a typo. I'm not sure.

CO-CHAIR MONSON: Questions on --- for folks on the phone?

(No audible response.)

CO-CHAIR MONSON: All right, then I

think, Madison, we are ready to vote.

MS. JUNG: Voting for Measure 2616: CoreQ Long-Stay Family Questionnaire is now open. Option one, yes; option two, no.

Okay, the voting is now closed with 18 votes. The --- give it a second.

No, that's not it. Oh, technical difficulties. Just give me one second and I will reset it.

Okay, let's try that again. Voting for 2616: CoreQ Long-Stay Family Measure now open. Option one, yes; option two, no.

Oh, something is not working. Do --- would we like to move to a hand vote while we try and sort this out?

(No audible response.)

CO-CHAIR MONSON: Are people comfortable with a hand vote?

PARTICIPANT: Sure.

PARTICIPANT: Yes.

(Laughter.)

CO-CHAIR MONSON: Okay. All in favor

of this measure, voting yes.

And opposed. So what's this now?

MS. JUNG: With nine votes, that would not meet the 60 percent --- nine --- nine votes for yes, that would mean that it would not meet the 60 percent threshold. So therefore it would not be added to the family of measures.

CO-CHAIR MONSON: Yes, Clarke, go ahead.

MEMBER ROSS: If people are comfortable with this, I'd like our report to show that we're generally very supportive of the intent behind these questions, but the concern was the validity of the responses given how it's administered. I don't want to convey to the public, and so I was just reading the report, that we as a group are not committed to the intent of these questions.

CO-CHAIR MONSON: Yes, I think that's a great point. We should definitely do that. Because I --- I don't think there's a person in here who objects to that concept. I think that -

-- I'll speak as one who voted no --- it's more the --- the validity you're talking about. That we don't have a poor measure out there that obfuscates as opposed to having a good enough measure that allows us to have directional intent.

Okay, since Tom is back in the room, we're going to go back. Tom, what you missed before was that we are revoting on the CoreQ: Short-Stay Resident measure. Jen had asked us to revote.

I think Jen, you had asked us to revote in light of the conversation that we had around the Long-Stay measure and many similar issues. It was a similar instrument that you wanted us to revote. Does that satisfy that? Thank you. All right. So, do we want to try the machine again? Or do you want to do the hand vote?

MS. JUNG: I think the machine might work.

CO-CHAIR MONSON: Okay.

(Laughter.)

MS. JUNG: I am semi-confident in that. Okay, so the vote --- oh.

CO-CHAIR MONSON: Oh, yes. Tom, sorry.

MEMBER LUTZOW: Yes, these two measures -- 2615, 2216 --- seemed like brother and sister. One directed at the resident, the other directed at family members. Are they both given at the same time?

CO-CHAIR MONSON: Are they both what at the same time?

MEMBER LUTZOW: Administered at the same time.

CO-CHAIR MONSON: -- that we know, but ---

MEMBER LUTZOW: One to the family --- one to the resident, one to the family.

CO-CHAIR MONSON: So just --- but we're voting on 2614 now.

MEMBER LUTZOW: I understand. I'm asking a question as to whether there's a

relationship between 2616 and 2615.

DR. ROILAND: We're looking it up now.

MEMBER LUTZOW: 2615 is long-stay and 2616 is long-stay. They're both long-stay. Yes, I'm not talking about 14. I'm taking about 15 and 16. 16 failed --- or, 15 failed also? Okay.

CO-CHAIR MONSON: Fifteen's failed, sixteen's failed. We're now voting on 14, which originally passed and now, in light of ---

MEMBER LUTZOW: I see. Okay.

CO-CHAIR MONSON: Fifteen and 16 we're revoting on 14.

MEMBER LUTZOW: Okay, got it.

CO-CHAIR MONSON: Okay. Do you still need the answer, or are you ready to --- thank you.

MS. JUNG: Okay, voting for Measure 2614: CoreQ: Short-Stay Discharge Measure is now open. Option one, yes; option two, no.

(Voting.)

MS. JUNG: Okay. Okay, we might need to move to a hand vote while this --- we reset

the whole presentation.

CO-CHAIR MONSON: Okay, so we're going to hand vote again. So all who are voting yes on 2614, please raise your hands.

I'm counting nine.

Let's just --- keep those --- let's do that again. Just to make sure we get the count correct.

Ten out of --- ten out of 18. So that's 60 percent?

MS. BUCHANAN: It's still not --- it's 59.

CO-CHAIR MONSON: It's 59? It's ten divided by 18. Yes, it's 55. So 2614 looks like it --- it's ten votes for yes, and we need 11. With 18 voters, we need 11 to pass. So it does not pass. But I think we should add the same --- I think for all these, 14, 15 and 16, we should add Clarke's comments about general support for the concept, just concern about this particular vehicle.

DR. ROILAND: All right.

CO-CHAIR MONSON: Next.

DR. ROILAND: We've got a few other measures to get through, so we'll just keep on trucking. Excuse me while I roll through this. All right, the next few measures we have to consider are related to function. And these again are from the Person and Family-Centered Care Standing Committee who reviewed these measures.

And the first measure we have up for consideration is measure 2775: Functional Change: Change in Motor Score for Skilled Nursing Facilities. And the measure description is the change in rasch derived values of motor function from admission to discharge among adult short-term rehabilitation skilled nursing facility patients aged 18 years and older who were discharged alive.

The time frame for the measure is 12 months. And the measure includes the following 12 items: feeding, grooming, dressing upper body, dressing lower body, toileting, bowel,

expression, memory, transfer bed/chair/wheelchair, transfer toilet, locomotion and stairs. And we have the numerator and denominator available on the slides as well. And the staff's preliminary analysis, sort of rationale for including this measure in the family of measures, is that it again addresses several priority measurement and gap areas.

And we also, in the current family we only have one function-related measure. That's 2624, a process measure focused on the documentation of the assessment of function in the care plan created around that. So I believe that Measure 2775, which is an outcome measure would be of benefit to add to the family of measures. And with that summary, I'll open it up for discussion.

MEMBER PARKER: How is adult short-term rehab skilled nursing facility --- is that anybody who's in there? And the reason I'm asking is because it seems to me this is going to be entirely relative to patient mix. And the

patient that are truly there for post-acute care for a typical rehab thing like a hip surgery or knee surgery or something, versus those who are in decline or have a big problem and are probably --- cancer or something where they're going to die. But they're in the nursing home post-acute because that's where the hospital has to put them until somebody can figure out what else to do. And they need to just die there.

So it's going to --- and so in small, rural facilities and things like that, there's only facility. And they're going to have everybody. And in metro areas they're going to have fancy ones that are just going to have those sorted out people, rehab people, and they're going to look wonderful because they're getting everybody with a knee replacement. And they're going to get them right out of there.

So I --- and the other ones are going to be relegated to their few days of Medicare stay in a short-stay facility and then be on Medicaid or whatever. So I don't see how this

can be fairly done. And I don't understand how it would be utilized.

MS. MUKHERJEE: It is risk-adjusted.

MEMBER PARKER: In what way?

MS. MUKHERJEE: So stratification by risk category subgroup, and the adjusted procedure is an indirect standardization procedure: observed facility average over expected facility average.

MEMBER PARKER: Okay.

MS. MUKHERJEE: So the numerator is the facility's average motor functional change score the denominator is meant to reflect the expected motor functional change score at the facility. If the facility has the same direction of SNF-CMGs, impairment, functional status at admission, and age at admission.

MEMBER PARKER: It's a complicated one. Is that related to the facility case mix represented?

MS. MUKHERJEE: It doesn't say. I'm reading directly out of the report from the

committee.

MEMBER PARKER: It says CMG.

CO-CHAIR MONSON: Do we have any understanding of that --- how they're coming up with that expected component? Because that seems to be a pretty critical piece of this. They're basically --- they're forecasting what they would have expected someone who looks like this to have done.

DR. ROILAND: Debjani, I found the section in the testing attachment for this measure. And it says to calculate the facility's adjusted expected change in rasch derived values, we used indirect standardization which weights national SNF-CMG specific values by facility-specific SNF-CMG proportions.

CMG adjustment derives the expected value based on the case mix and severity mix of each facility, the skilled nursing facilities case mix groups, classification system groups, similarly impaired patients based on functional status at admission or patient severity.

Patients with the same SNF-CMG are expected to have similar resource utilization needs and similar outcomes. Does that answer your question?

MEMBER ROSS: So there are long-term care advocates and facility representatives on the Person and Family-Centered Care Committee, which has endorsed this. The question is, do we as a work group interested in people who are dually-eligible aspire to an improved functional change in a nursing facility and another National Qualify Forum Committee with multi-stakeholder balance endorse this measure? So with that, I'm going to vote to endorse it because of that.

MEMBER COURT: This is Bev Court. My experience with the weighting algorithm is that it --- they use a --- the expected value is based on Medicare, and it's not necessarily related to duals. So again, without knowing the intricacies of the expected estimation technique, I'm not sold that this would be directly applicable to duals. And apparently --- and I believe there's

no documentation of its application to this population?

DR. ROILAND: Hi Bev, this is Rachel, and there isn't any specific testing for duals within their submission.

MEMBER HOLMES: I'm on the FIM website, and so it's --- the system's been around since 1994, and it says it's an outcome management program for skilled nursing, sub-acutes, long-term care, Veteran's Administration programs, international rehab hospitals, and other related venues of care. And there is documentation with it. But I remember when I worked in long-term care having to do this. So it has been around for a long time and has been used a lot.

MEMBER RAMONA: Quick question. Is this the FIM? The Functional Independence Measure? Because they're not saying that.

DR. ROILAND: So this measure uses the FIM. It says, and is similar to ---

MEMBER RAMONA: Okay.

DR. ROILAND: Yes, it uses the FIM. And the Committee also talked about whether this was too similar to the care tool as well as other data collected by the minimum data set. But the data explained that this measure includes self-care items of both cognitive and physical function, while the care measure or other measures of self care only cover physical function. Excuse me.

And they also noted that the data shows a change over time when using the FIM-based measures, but the change is not shown for reports using the MDS, which led the developer to conclude that they're measuring different functional domains using this measure.

CO-CHAIR MONSON: Aline, did you have another comment?

Well I would just say that I think that if we could have a score --- if this works, right, we can actually see a functional score that allows people to show improvement in a nursing facility. I mean that's a very positive

development.

And then gives us more opportunities to then have conversations with those individuals about moving back to the community if that's where they want to be. And takes away some of that noise about whether or not they have the functional capability to do that. So I would also endorse this measure. Any more comments before we vote? Do you want to try it one more time?

MEMBER COURT: This is Bev. I just -- - we're looking at two measure that are very related. One looking at that change in skilled nursing facilities, and one looking at it in long-term, acute care facilities. I think you're --- the type of people in long-term, acute care is quite different than skilled nursing, so just a point of clarification.

DR. ROILAND: Right, and everyone --- just so --- this measure is for the skilled nursing facilities. The next measure will be the long-term care, acute facilities. So just right

now we're focused on the SNFs.

MS. JUNG: All right. Voting for Measure 2775: Functional Change: Change in Motor Score for Skilled Nursing Facilities is now open for addition to Family of Measures. Option one, yes; option two, no.

(Voting.)

Okay, voting is now closed. The results are --- the results are not pulling up again. Apologies about that everyone.

CO-CHAIR MONSON: All right, so let's do it by hand again. All who are voting yes on 2775.

MS. BUCHANAN: The result is 18, so 100 percent voted yes.

DR. ROILAND: All right, so we'll --- with that we'll move on to the last measure. It is Measure 2776. Again, a measure reviewed by the Person and Family-Centered Care Standing Committee --- oh, sorry you guys. Getting a little --- need more coffee.

So this measure is Functional Change:

Change in Motor Score in Long-Term Acute Care Facilities. The description of this measure it's a change in rasch derived values of motor function from admission to discharge among adult long-term acute care facility patients aged 18 years and older who are discharged alive. And the time frame for the measure is 12 months.

The measure includes the following twelve items, which are the same for this measure as for the 2776, and they are feeding, grooming, dressing upper body, dressing lower body, toileting, bowel, expression, memory, transfer bed/chair/wheelchair, transfer toilet, locomotion and stairs. And again, the numerator and denominator are provided on the slides.

And then the staff rationale is similar to that for 2775 in that it addresses several priority gap areas. And also given the current family had only one measure related to functional status, we thought this would be a positive addition to the family along with 2775. Sorry, that is a typo. It should say 2776 down

there. And with that, I'll open up the floor for discussion.

MEMBER COURT: Just a point of clarification. In the spread sheet, you say that it's from discharge at the facility level for short-term rehab patients. But I thought you were talking about long-term acute care facilities. Is that correct? That would be column --- what column is that? Numerator statement.

DR. ROILAND: Hi Bev, this is Rachel. You're right, we do have it as being discharge at the facility for short-term rehabilitation patients. Let me just double check that we have the numerator correct. Was that -- that is correct? Okay. Okay.

Sorry, no, that is the correct statement. So it is for discharge. So the numerator is the average change in the rasch --- the numerator, excuse me, is the average change in rasch derived motor functional score from admission to discharge at the facility level for

short-term rehabilitation patients. I'm not sure if that ---

No, I'm reading the numerator statement for 2776. So let me just double check in our QPS system if ---

CO-CHAIR MONSON: Gwen, go ahead.

MEMBER BUHR: Well I think and --- it's an LTAC, which is --- people can go there for rehab as well as they can go to the skilled nursing facility. So it's just a different side of rehab.

CO-CHAIR CHIN HANSEN: So that's how it's practically used. It could be used for short-term rehab as well. Because I know that the intent wasn't meant to be that initially. But so --- the functional use is then for potential short-term rehab.

MEMBER BUHR: Yes.

CO-CHAIR MONSON: Pam ---

MEMBER PARKER: I'm confused now about what facilities we're talking about. Are we --- sorry. Are we talking about in-patient acute,

long --- when you go after hospitalization? Or are you talking about long-term care hospitals? Because generally, there's been a difference in those. And the long-term care hospitals are where you send your heavy-duty vent cases and that kind of stuff.

And yes, they're probably going to be there much longer than they would be in the acute --- in-patient acute rehab, which is usually limited to about six weeks or something. So I don't get what we're actually --- what the facility base is here.

MEMBER BUHR: Well, I think even in those long-term, like, vent places, the goal is still to get them better.

MEMBER PARKER: Sure.

MEMBER BUHR: Right? So they may have a different trajectory --- obviously, they're having a different trajectory, but they're still trying to get off the vent, improve, have a discharge plan, get better.

MEMBER PARKER: Sure, but it sounds

like we're trying to carve out a group, the short-term rehab patients, out of that group. So that's what I don't get. Because that reference to the short-term rehab patients, we --- out of either group, I'm not sure then who are we talking about about the short-term rehab group?

MS. MUKHERJEE: So the committee said --- the committee agreed that many of the issues discussed in this one were similar to the one we discussed before. And the main difference between two --- these measures being that this one is LTAC instead of SNF.

MEMBER PARKER: And who are they including in LTACs?

Because this is over 12 months, isn't it? Yes, both of them are over 12 months. So ---

DR. ROILAND: So just on a ---

MEMBER PARKER: I'm having problems with the 12 months and the short-term rehab.

DR. ROILAND: I don't have a specific answer for that question yet. But just an

additional point of discussion that came up with the committee. It says that the developer noted that the same drastic level of functional improvement is not expected to be seen in LTACs, but a slight improvement can be possible. The measure can be used to identify patients who are starting to decline and need readmission to acute or intensive care.

And patients at the lowest level, complete dependents, are also captured with this measure. In addition, the developer said that LTACs had not traditionally measured function, and they believe that asking questions about function can improve the quality of care by reminding providers of the importance of mobility and overall function.

So they acknowledge that this measure has not been used widely. And the committee did question that, but they thought it would be good to start measuring that, measuring function in this setting.

CO-CHAIR MONSON: Clarke?

MEMBER ROSS: So I'd like to reinforce the importance of this measure. The state of the field is that each facility type organizes and has their own measurement and performance system. And we're aspiring to remove those barriers over time.

But why wouldn't we want, as the advocate for the dually-eligible population, to see a positive functional change for everybody who goes into a facility? And no matter how severely disabled they are, with the right interventions over time, we can see improvement.

And why would we want to go on record not agreeing with the Person and Family-Centered National Quality Forum Committee that already endorsed this. The implied message is we don't think everybody can improve, and so we're not going to endorse the measure. That's the way I would read it.

MEMBER PARKER: I think it's just, do we even know who it applies to? I mean, I don't know who it applies to now. But ---

CO-CHAIR CHIN HANSEN: I agree. I think Pam was just saying --- it's not the fact that the improvement isn't there. There's just some technicalities, too, of who it applies to. And I think the funding is significantly different between LTACs and regular facilities. The reason I pay attention to that, or am aware, when I was on MedPAC, that was real --- kind of deeply looked at.

And the payment system with the LTAC program is quite significantly higher than regular rehab. So it's just other noise, not the principle of what --- of course we would want to see improvement. But it just is the use of a designated provider with certain criteria for eligibility.

The idea of using a system like that --- and LTACs are not that available throughout the country. It's really band of them on the coast and in the South. So it's not a standard facility that's available all over. So it's more for me, kind of, almost a structural issue. Not

the principle of what you said. And it sounds like other committee actually asked some similar questions.

MEMBER RAMONA: I'm sure there's an expert in here. Can a LTAC designate somebody as a short-term rehab patient versus not? Because is it really just then saying anyone that discharges, since the measure description is about somebody from a long-term --- or, yes, from a LTAC that discharges alive? So if you can't designate somebody as short-term or not, does that become a moot question?

CO-CHAIR CHIN HANSEN: There are other experts here, but I think there's a threshold of clinical criteria and function criteria in order to even get admitted to an LTAC. So if there --- that's the reason I think I asked Gwen if they're now using it, with question mark for short-term rehab stays. That's actually not the formal intent of those programs.

MS. MUKHERJEE: I don't know if this is going to help, but for the LTAC, they have

primary medical reasons for the LTAC stay for this measure, such as stroke, joint replacement, brain injury. So they --- among others, so they --- I don't know if that helps determine what kind.

MEMBER BUHR: And the measure does say for short-term rehab patients. So I don't know if they can somehow designate that. I don't know.

DR. ROILAND: Yes, and looking in the measure submission, there's a section called the Calculation Algorithm and Measure Logic, and within that, they don't have a specific step that helps them identify rehab patients specifically. It just says identify all patients during assessment time frame.

Exclude any patients who died at the LTAC. Exclude any patients who are less than 18 at the time of admissions at LTAC. Calculate the motor change score. Go through the process of deriving the rasch score and then calculating the ratio for the facility. So it doesn't

specifically say how they identify short-term rehab patients.

MEMBER AGUIAR LYNCH: It may just be that --- that the short-term rehab is misnomer for when it's used in the LTAC. I think that's what it is. Because if it's brain and spinal, those are --- to your point Jenny, those are populations that are appropriate for the LTAC. The joint replacement I think should not be seen in the LTAC. But it sounds like, from the specifications, that it's actually not asking them to identify short-term rehab but to pull from specific disease categories or conditions.

CO-CHAIR MONSON: For what it's worth, if you think about it, what it sounds like is that --- so there seems to be some ambiguity about which populations we're talking about. But whether it's --- let's assume it's --- if it's one direction where it's all, everybody who's actually in an LTAC, then this seems like a reasonable measure.

Right? Because it's capturing ---

there should be --- there's potential for functional improvement. There shouldn't be --- I mean, we shouldn't assume that people in an LTAC can't have functional improvement. And then if for some strange reason there is some short-term rehab happening there, if we improve the short-term rehab for a nursing facility, it would seem like we should improve short-term rehab for an LTAC, too.

So from my perspective, it feels like it's a no-lose to vote yes on this one.

MEMBER COURT: I think that there's going to be definitional challenges to this. And I think it's going to be small gains.

CO-CHAIR MONSON: Small --- say that last part again, Bev?

MEMBER COURT: I think that there's going to be --- so I think there's some validity issues here. I think there's stability issues, especially with that population. I don't --- to me it's different than the short stay in a skilled nursing facility.

I mean, the point of that setup is to advance the client. And I don't think, given all the types of conditions, that this is going to be a very sensitive measure. And I think it can easily get misinterpreted. I'm not a fan.

MEMBER ROSS: So the chair --- one of the co-chairs of the Consortium for Citizens with Disabilities Task Force on Health is a member of this committee. United Spinal Association is an active CCD member, and the Christopher and Dana Reeve Foundation -- paralysis foundation -- is an active member of CCD. They're very supportive of this.

As the consumer, goal when you get admitted should be functional improvement, and no matter how severely disabled you are, with the right supports, you can improve functionally. Facilities are represented on this committee. I just really don't see us sending the message that we can't support another endorsement of another committee that functional improvement should be a goal, regardless of the severity of your

paralysis or spinal cord injury which these two major consumer groups demonstrate to us every day with all of their consumers.

So again, two cents worth, but I think this is a grave mistake if we send the message that we think there's some technical challenge, and we can't send the message of supporting this.

MEMBER RAMONA: I'll second that, but also say that it may be since it's also adjusted for expectation, that it's maintenance, not just improvement. And so that you're not going to see a decline in functionality, and I think that's as important as well.

CO-CHAIR MONSON: What we might want to do, regardless of how we end up with the vote, I think there's certainly something to add in the report about confusion about which population is targeted here and that the measure doesn't seem to be entirely clear. Right?

So whether we vote to approve it or not, that --- I think that the tenor of this conversation should be captured in our report.

DR. ROILAND: Noted.

CO-CHAIR MONSON: Any other comments?

Do you want to just do a hand vote?

MS. JUNG: It's your preference.

CO-CHAIR MONSON: What ---

MS. JUNG: I mean, it --- we can try. I believe in it.

CO-CHAIR MONSON: Okay, we're going to try it one more time.

(Laughter.)

MS. JUNG: I'm holding out. All right.

CO-CHAIR MONSON: No pressure.

MS. JUNG: Yes. This is --- little train that could. For Measure 2776: Functional Change: Change in Motor Score in Long-Term Acute Care Facilities. Option one, yes; option two, no.

One more. Okay. Success. And also that --- so 94 percent vote for yes. That concludes that this Measure 2776 will be included in the family of measures. Seventeen votes for

yes; one vote for no.

DR. ROILAND: All right, and now we'll --- I just have a few more slides, and then we'll move to public comment. So we are done with voting for new measures to add to the family. We've just gone through this process of whether or not these newly-endorsed measures should be included in the family.

We'll give you a summary slide tomorrow morning, too, that gives you an overview of all of our decisions for these measures. So congratulations; you're done with that section of the meeting. We did also just want to give you a quick update that there are some measures in our family that are currently undergoing the review process.

There haven't been any final decisions made on these measures, but we did want to make sure we kept you informed about the sort of status of these measures. We currently have six consensus development or CDP projects reviewing measures within our family. Their final status

will be decided during --

MEMBER ZLOTNIK: Rachel, could you just slow down a little?

(Laughter.)

DR. ROILAND: Oh, sure. Sorry. Not the first time I've heard that, so I --- the final status of these measures will be decided during our CSAC meeting in July. But we'll --- the staff up here will continue to communicate any changes in endorsement to these measures to you all over the course of the summer. Those measures that are currently undergoing review, there's one that the Patient Safety Standing Committee has --- is currently reviewing.

It's Measure 0022: Use of High-Risk Medications in the Elderly. The Care Coordination Standing Committee at the end of February just recently reviewed a number of our measures including 0326: Advanced Care Plan, 0646: Reconciled Medication List Received from Discharge Patients, 0647: Transition Record with Specific Elements Received by Discharge Patients,

0648: Timely Transmission of Transition Record, and 0649: the Transition Record with Specified Elements Received by Discharge Patients.

And just a heads up that the Care Coordination Team will be releasing their draft technical report for public comment. If it's not already up, it will be up in the next few weeks. And so if you are so inclined, you can certainly make a public comment as a member of the public.

Additional standing committees reviewing other measures in our family: we have the Health and Well-Being Standing Committee having reviewed 0032: Cervical Cancer Screening, 0659: Influenza Immunization. The Infectious Disease Standing Committee is reviewing 2079: HIV Medical Visit Frequency. The Cost and Resource Use Group just reviewed Measure 2158: the Medicare Spending Per Beneficiary Measure.

And the Behavioral Health Group, who you'll be hearing from one of their staff people in a little bit, they have reviewed three of our measures: 0008: the Experience of Care and Health

Outcomes or ECHO Survey was reviewed to a certain degree by that standing committee, and they had an interesting discussion around the status of that measure. And Kirsten will give us an update on that when she comes up in a few minutes. And they're also reviewing 0027: Medical Assistance for Smoking and Tobacco Use Cessation, as well as Measure 0576: Follow Up After Hospitalization for Mental Illness.

So I just want to reiterate that these measures are currently going under review. We don't have any final decision on their recommendations for endorsement. But we'll certainly keep you updated on all of that as they move through the CDP process and make --- and the final decisions are made on these various measures.

So with that I will actually turn it over to our co-chairs to ask the Operator to open it up for public comment.

CO-CHAIR MONSON: Operator, will you please open up the line for public comment?

OPERATOR: Yes, sir.

CO-CHAIR MONSON: And I think, those who are on the web chat, if you just want to --- you can chat in a question too, and the staff can see it, and we'll --

OPERATOR: Okay. And at this time, if you would like to make a public comment, please press star then the number one.

And there are no public comments from the phone line.

DR. ROILAND: All right, it looks like there's no public comments in the room. We're a little bit ahead of schedule now, so we'll check in with our presenter. I asked her to come early, and then it looked like the conversation was going on longer. So we'll try to get her up here soon. So you all have a break for about the next ten minutes until we get the next presenter up here.

(Whereupon, the above-entitled matter went off the record at 3:21 p.m. and resumed at 3:31 p.m.)

DR. ROILAND: All right, everyone, if we want to take a seat. We'll hear from our last presenter for the day. So I'm actually going to turn over the presentation to my colleague, Kirsten Reed, who is a project manager here at the National Quality Forum and helps staff the Behavioral Health CDP Project that met in February. Right? Am I ---

MS. REED: Yes.

DR. ROILAND: Okay, I just wanted to make sure. And so she's just going to give us an update on the project and just be available for any questions you all might have about measures that they reviewed related to our family of measures. So Kirsten, over to you.

MS. REED: Thanks, hi everyone. As Rachel mentioned, my name is Kirsten Reed, and I am the project manager for the Behavioral Health Project. So I'm going to briefly just kind of go over the portfolio as a whole.

We currently have about 50 endorsed measures within this area, and they focus on a

number of topic areas including alcohol and substance use, tobacco use, ADHD, depression and schizophrenia. This is kind of a different look at our portfolio. You can see that it kind of encompasses a number of different areas such as physical health, general behavioral health, alcohol and other drug disorders, tobacco use, and depression. And as you can see by this breakdown, no one topic area is more focused on than others within the portfolio, but gaps really do still remain.

And this is just another look at the portfolio. Different break down. You have care coordination here, medication use, the continuation of medications, adherence, and so on. So as we were trying to kind of figure out ways to portray our portfolio of measures, we decided that depicting is as a care trajectory was the most appropriate way in doing so.

So each of the measures in our portfolio fit into this care trajectory and address populations at risk, which we're

referring to as phase 1. Evaluation and initial diagnosis as phase 2, and Follow-up Care, which is phase 3. It's also important to note that about 15 percent of these measures span between phases 1 and 2, and about 3 percent span between phases 2 and 3.

MEMBER ZLOTNIK: Are these adult measures?

MS. REED: I'm sorry?

MEMBER ZLOTNIK: Are these exclusively adult measures?

MS. REED: No, they are everything.

MEMBER ZLOTNIK: Okay.

MS. REED: So this is similar to the previous slide, but shows what percentage of measures in our portfolio fall into each of the phases. And while we recognize that those suffering from mental illness can and do recover when provided with timely and coordinated care, we know that it's extremely important to have measures that span across the full, kind of, continuum of care. And as you can see by this, a

number of our measures are really siloed. We don't really --- kind of cross all the different areas.

So our Behavioral Health Standing Committee reconvened in October of last year to begin looking at a couple of measures. So we reviewed seven new measures and six maintenance measures. And they focused on things such as tobacco use, alcohol and substance abuse, ADHD, depression, medication continuation, and follow up after hospitalization for a mental illness.

So the standing committee, as Rachel said, were brought together at the end of February. And of those we had seven measures that were recommended, four that were not recommended, and one was deferred. So specifically, I was asked to speak about three measures that were recently reviewed by the Behavioral Health Committee that pertain to your work here on this committee.

The first of which is the ECHO Survey, which as you can see by the measure number, is

one of our oldest measure. This patient-reported outcome measure was originally endorsed in 2007 and assesses patient experiences with behavioral health services in areas such as getting treatment quickly, communication with clinicians, and information about treatment options.

Shortly before the in-person meeting, the NQF, in agreement with our committee co-chairs, decided to defer consideration of endorsement for this measure because there was not yet enough data for the committee to consider. So the developer explained that they do not currently have data on performance scores and use, but they do know that there has been an uptick in using this instrument.

They also noted that there are several large studies currently under way, and they are in the process of performing new field testing. So the committee agreed that the measures that capture patient experience are extremely important, especially as this one --- this is one of the few patient experience measures for

behavioral health. And preferred to give feedback to developer during the in-person meeting about kind of the things that they were looking for, rather than risking them bringing it to the committee to look at it and then have the potential of not passing.

So the developer is now working to update their submission, and we expect to review this measure during its annual review. But as of now, it is still currently endorsed.

So the next measure is Medical Assistance with Smoking and Tobacco Use Cessation. This is a health plan-level process measure initially endorsed in 2009 and most recently endorsed in 2012. It's a long-standing measure that uses patient-reported data from the CAHPS Survey to assess if patients have received assistance from a doctor or a health care provider to stop smoking and tobacco use.

The committee agreed that based on the performance data provided by the developer, a gap in care continues to exist for advising patients

to quit smoking, discussing cessation medications, and discussing cessation strategies. The committee did express concern around ensuring that the questions in the measure are clearly defined and that patients are able to differentiate between each of the questions. Overall, the committee recognized how high tobacco use is within the mental illness population and how useful this measure is and voted for its continued endorsement.

And then, finally, the Follow-Up after Hospitalization for Mental Illness. This is a health plan-level process measure originally endorsed in 2009 and then most recently endorsed in 2012. And this assesses whether health plan members who are hospitalized for a mental illness received a timely follow-up visit.

The developer here provided several new clinical guidelines supporting follow-up after hospitalization and cited evidence that timely follow-up reduces suicide attempts and readmissions and improves functioning. The

committee expressed concern that coordinating follow-up care in a system that is fragmented could put hospitals in a challenging position, but again realizes this is an important measure.

They did have a number of suggestions for the developer to maybe consider in the future, such as the use of telehealth to count for a follow-up visit, to consider expanding the definition of mental health practitioner, and to add hospitalizations for drug and alcohol disorders. So again, for this one, the committee agreed to continue its endorsement.

MEMBER POTTER: Can you say the last sentence again?

MS. REED: The committee agreed to continue the endorsement for this. So it is still --- or still considered endorsed. And that is my update. Are there any questions?

MEMBER LAKIN: I was sort of struck with how few mentions there were of anything that we might call outcomes. Things like employment, relationships, independent living, those sorts of

things. Is that not considered an important part of ---

MS. REED: So it definitely is, and as the committee met recently, they all brought up that exact same point and recognized they really needed to start moving towards outcome measures, because there really are not many in the portfolio. So that was listed as one of the gaps.

CO-CHAIR MONSON: Joan?

MEMBER ZLOTNIK: Two questions. One, when you talked about the mental health measure, you talked about considering expanding the definition of mental health practitioner. Could you tell me what the definition of mental health practitioner is that's being used?

DR. LUSTIG: Hi, I'm Tracy Lustig. I work with Kirsten on the project. I don't know if I have it in front of me, but really just what it had to do with was, within the specifications of the measure, they had only certain types of providers listed. And the committee suggested

expanding that.

There was a lot of discussion in the meeting as well about whether a mental health provider should be someone who has specific expertise, but also recognizing there are a lot of primary care providers that are providing follow-up for a lot of these hospitalizations. So that's what that had to do with. I'll look to see if I have the specific definition in front of me.

MEMBER POTTER: Yes, it includes psychiatrists and psychologists and those types of people, but if you're an internist or a family practitioner, you're not considered, quote, a mental health provider.

MEMBER ZLOTNIK: Now, I had another question too. But I can't quite remember what it is now. I'll have to think about it.

MEMBER ROSS: I had several questions on the ECHO. So you have a statistic that five percent of the existing portfolio is experience of care. Is that the ECHO? Or what is the other

experience of care that --- what constitutes the five percent?

MS. REED: There are a couple other ones. We can send those around, but there are a couple of other CAHPS surveys for follow-up for people who received mental health treatment.

MEMBER POTTER: There's a hospital-based experience of care one for ---

MEMBER ROSS: I was about to say ---

MEMBER POTTER: Psychiatric --- yes.

MEMBER ROSS: -- operates, the National Research Institute I thought reports on a hospital-based experience of care. So that's what that would be.

MS. REED: Yes.

MEMBER ROSS: So who's the steward for --- for the ECHO?

MS. REED: CMS. AHRQ, well, AHRQ is now run it --- oh, yes, you're right. It's AHRQ. Sorry. And there's a guy from Yale who's now the developer for the measure.

MEMBER POTTER: And their developer is

the CAHPS --- the developer is the CAHPS Consortium.

MEMBER ROSS: And D.E.B. could probably answer this better than you can. Why has this not been used in the mental health field? Why don't the state mental health agencies use it and require it by the over 2,000 community mental health centers?

MEMBER POTTER: I can't really speak directly to that. With respect to the community mental health centers, the federal government has real mixed accountability when it comes to community mental health centers. It's not like a CMS program that they have direct ---

MEMBER ROSS: Well there's the SAMHSA Mental Health Block Grant that finances every state ---

MEMBER POTTER: That's all through the block grant mechanism.

MEMBER ROSS: -- mental health agency and ---

MEMBER POTTER: SO it's a block grant

as opposed to a quality reporting program.

MEMBER ROSS: So AHRQ's never really promoted the ECHO within the mental health --- public mental health system?

MEMBER POTTER: I can't speak to promoting or not promoting. It's been sitting on the AHRQ website for years. So I do know that some people say well why do I need a separate measure for behavioral health if the CAHPS Health Plan Measure, which I really need to do, has questions about specialty care and access and things like that.

So some of it is that there's other CAHPS surveys, like the health plan surveys and the CAHPS Medicaid survey. Some of that. But I can't speak more to that.

MS. REED: So I think it is being used. I think that they are not receiving the data that they need on who's actually using it, which is one of the issues that was brought up. So a number of the committee members did kind of recommend various people and places to go to so

they can start kind of getting that data and showing the effects of it.

MEMBER POTTER: And Clarke, there --- there is an experience with care survey that SAMHSA uses for the block grants. I forget what the name of it is. So ---

CO-CHAIR MONSON: Tom?

MEMBER LUTZOW: Yes, this idea of telehealth. I'm wondering if you could expand on that. I mean, it's hopeful as a strategy, but do we have evidence that it works? I can see where even in the case of police, first-responders the telehealth capability would be an immediate professionalization of an encounter, perhaps. But how did that get there from an evidence-based point of view?

MS. REED: So it's actually just a recommendation from the committee since the field is trying to move in that direction. So they were just asking the developer to kind of explore that option. If it could be kind of somehow put into the measure, if it could be reported on,

things like that.

DR. LUSTIG: And just to follow up, for that particular measure also, there were a number of follow-up visits that were required within about a nine-month period, and one of the suggestions the committee had was to consider whether at least one of those visits could be a telehealth measure.

The other thing I wanted to add for those that aren't aware, we actually currently have a framework project here at NQF looking at telehealth specifically for how we begin to think about evaluating the quality of care as provided by telehealth, either in comparison to other modalities, or even if the alternative is no care at all. But that project is currently underway.

CO-CHAIR CHIN HANSEN: Actually I just want to --- I have a different question, but to pick up on that. So much of the broader world is developing these apps, whether it's for a physician, or in the area of social, mental health, behavioral health. Is there linkage from

the kind of analysis that you're doing here at NQF to what the marketplace is doing?

DR. LUSTIG: So the way that we're approaching the telehealth framework is to try in some ways to not be specific to the modalities that exist now, because we don't want it to become dated as soon as it gets out, but really just think about telehealth as a concept in general, a remote service. But definitely considering apps and every other type of thing we can think of at this time, as well as trying to create a framework that really is just thinking more about the dimensions of quality and how we could apply anything that comes along to that.

CO-CHAIR CHIN HANSEN: Sure. No, I'm just glad --- I agree. It's not like one particular app or company. But it just seems that has been a social response that has just been that much more prevalent. And especially with behavioral health but isolation issues. I don't know if that comes under your umbrella.

DR. LUSTIG: So right now one of the

domains definitely that we're looking at is patient experience, and it has to do with, when you say patient experience, many things are meant by that. Anything from, hey, I don't have to spend two hours driving in my car to go to the doctor, to I can immediately talk to someone when I need it, which could be also part of that social isolation.

CO-CHAIR MONSON: Joan and then Clarke.

MEMBER ZLOTNIK: I remembered what my other question was. In terms of the measures that you had reviewed and included, discharge from hospital, but many people with behavioral health issues are never hospitalized. And so are there measures that are being used, related to service delivery outcomes, that are not covering people who are hospitalized? And my other question is, do people with Alzheimer's and dementia come under behavioral health here or elsewhere? Because that's another issue.

DR. LUSTIG: Yes, I don't remember

anything specific in the behavioral health portfolio related to dementias or other cognitive disorders, unless it had to do with someone who had as substance use disorder and that sort of thing. It's the other types of mental illness are primary. In terms of outcomes, I'm actually trying to think of any that would fit what you're looking for. We really don't have a whole --- I'm trying to remember any with --- we certainly didn't look at any outcome measures.

MEMBER ZLOTNIK: Since it's basically a community-based service delivery system block granted to states.

DR. LUSTIG: Well, and that's what we found in our sort of just very cursory overview of the portfolio as a whole, a lot of the measures that are --- you saw there was a preponderance of measures in that later stage, which was follow-up care, which sort of surprised our committee.

But those were really things like, once a medication is prescribed, did you get a

follow-up visit with that provider within 30 days? Within whatever? So it's a lot of follow-up to that immediate sort of care. But as we talked about, the committee was really interested in, okay great, they stay on their medication for 30 days. But what's the ultimate outcome? And that's what they really would like to see measures going toward.

MEMBER ROSS: I have a question on if any of these measures address co-occurring mental illness other disorders. The National Core Indicators, which is the quality system for people with intellectual and developmental disabilities used for over 20 years in half the states, starts with the prevalence of co-occurring disorders, including the prevalence of co-occurring developmental disabilities and mental illness, which is --- averages between 31 and 36 percent.

Are there measures that address mental illness and substance abuse disorder, mental illness and intellectual disability, mental

illness and dementia?

MS. REED: There really wasn't, and we did have a woman on the committee who's in the substance use field. And she was really pushing for that, that they shouldn't be separate measures. We should be screening for all of those things at the same time.

There's also a huge push now for the integration of behavioral health and physical health, so we are seeing measures kind of looking at that. And so, you know, screening for depression as well as diabetes. And that is --- so we are seeing a push for that, but not quite yet for integrating substance use and behavioral health.

DR. LUSTIG: And when Kirsten showed you the diagrams earlier, and you saw that it said about a quarter of the measures were physical health, it was actually what you were saying. It was for people who have schizophrenia, have they had their HbA1c tested? Have they had their blood pressure tested?

So that's how we define physical health, was that for individuals with schizophrenia or depression or others that are at risk for diabetes/high blood pressure, what --- yes, what we didn't see is what you were talking about. I don't recall any where it's talking about comorbid mental illnesses or developmental disability.

MEMBER POTTER: I just wanted to follow up on Joan's question. There is a similar measure of follow up after treat and release at the ER if people have mental health or people who have substance abuse. And then there's also a few measures around depression where the outcome is measured with -- change in depression in measured with the PHQ. So it's true outcome.

CO-CHAIR CHIN HANSEN: My question is broader, and it goes back to Charlie's initial question about what outcomes would be. And it just seems that, especially in the area of behavioral health, there would be some work that would have been done long ago about having people

functioning in the community and all of that.

Is there any other group or body of work that you can point us to that looks at the employability of somebody of employment age and function from a behavioral health a little bit differently from the way we've approached it?

DR. LUSTIG: One of the things we were really grateful for is we added a new member to the committee from NAMI, the National Alliance for Mental Illness. And he's really bringing us that perspective of the things that matter to that population.

And we actually met with him earlier today to talk --- he wanted to learn more about measured development, but he was really interested in things like that. Caring about, can I function? Can I keep at my job? Those sorts of things. And so I'm hoping that he'll bring that perspective to our committee. But we can reach out to him and see if he has suggestions.

CO-CHAIR CHIN HANSEN: I think this

framing is what we talked about very -- earlier in the day, of just thinking about this beyond the process in the clinical. Of really, ultimately, is the person able to function in society better because of our processes and our structures?

So it just is one of those areas in general it seems that this is kind of like the 2.0 of quality is what matters, and do people function and live their lives better? And that would tie together some of the things that we've focused on. But it's part of, hopefully, kind of the framing work that NQF is looking at. Because it is ultimately, the functional result --- I say functional, but whatever better term could be --- is people living their lives as productively as possible.

DR. LUSTIG: And Jennie, I know I don't have to tell you these types of things, but there is some other work at NQF. It's not related specifically behavioral health, but on the National Quality Partners side, we just did

some work related to advanced illness care.

And really talked about what are patient preferences, as we called them. And health or physical health was just one small portion of it. There was do I feel financially secure? What are my relationships with my family? Do I feel like I have sense of purpose in life? All those things, and I think those could apply broadly. And so we are thinking about those things.

MEMBER ROSS: There are two states, Maryland and Massachusetts, and parts of two other states, Pennsylvania and Wisconsin, that use independent, community-based, peer-operated organizations as the quality assurance mechanism where teams of trained peers interview client peers in the system.

Have you been studying those experiences in those four states? And the NAMI rep, who I know well, would not bring that to your attention. But a member of the National Quality Forum Home and Community-Based Service

Committee, Dr. Jonathan Delman from Massachusetts, he founded the Massachusetts consumer --- can't remember the exact name --- monitoring project. But there is some published support. There is, of course, two states and some counties in two other states who financially support peer-to-peer quality monitoring. So ---

MS. REED: I wasn't aware of that, so I'll definitely look into that. Thank you.

MEMBER RAMONA: Has there been any discussion around assessment or evaluation of their support structure? Informal or formal, care givers, family support, what it looks like? How that impacts their outcomes? Anything in that space?

DR. LUSTIG: Certainly not in this past meeting. The most I can think about it was related to the ECHO measure where there was discussion about, since it's a patient survey, who can fill out the survey for the patient? Which, as you would know, could raise all sorts of issues about who's filling it out and what

they say occurred.

But we really haven't gotten into those issues about the larger support systems.

MEMBER RAMONA: Because it could, obviously, with the behavioral health segment, their own structure is often stressed itself. So if there's not also an evaluation of how they're doing in terms of being able to have respite, being able to have even a sense of community around the issue is pretty significant to the success of the individual.

DR. LUSTIG: The closest I can just think of that came up was we had a measure about follow-up for ADHD medication. And they were actually showing that the people that were more compliant, that had had all follow-up visits that were required, actually had higher ED usage than people that didn't have regular follow-up.

And the theory was that parents that are vigilant are going to bring their kid in at the first sign of any issue. Versus people that aren't as compliant and don't make all their

follow-up visits and aren't going to rush to the ED. It was just sort of an interesting thing in that it sort of came out the opposite of what you might think would happen.

That the whole supposition was if you have more follow-up, you won't go to the ED because you won't have the emergency visits. But that was sort of the only sort of family structure issue I can think of that came up specifically.

MEMBER PARKER: This maybe goes off in a little bit different direction, but I wanted to get it in here somewhere. When you're talking about the outcomes, the ECHO, and put it on kind of a burner, I guess, for a while. Is there any talk about the hierarchy of all these different survey --- experience surveys? Like, I'm thinking that, you know, a people on Medicaid are going to get one. There's the Medicaid CAHPS. There's the Medicare CAHPS if you're in health plan. There's also then a Part D CAHPS for those, or a similar thing.

There's clinic-based, hospital-based, then surveys. There's home-community based surveys, state versions. Or they are not CAHPS directly, but they're experience of care surveys. The clinic --- then there's also this ECHO evidently, which I hadn't been aware of before, and probably something in substance abuse.

And I could see the poor mental health patient getting all of these at some point. And maybe within quick succession. And I think this isn't true of just the mental health people, but it's certainly a big burden for them. And then it could be true of others as well.

So I'm just wondering, who's coordinating the decision making? Maybe D.E.B. knows this, of which one gets priority or what the coordination of all these are in the field. What the --- just the priority and hierarchy of this is.

In Minnesota, we tried to integrate the Medicare and the Medicaid CAHPS for an unintegrated program that we had that covers

about 30,000-40,000 people. Actually covers more than that, now that I think of it. And that was difficult. But we did send out one survey. And that's what we're doing. At least combine the Medicare and Medicaid. But that doesn't count all the other things that we're talking about.

And then there was the nursing home one for a while. So it just seems like somebody needs to take hold of that.

DR. LUSTIG: I think that goes beyond what the little mental health --- or behavioral health committee can do. But I mean I ---

MEMBER PARKER: Sure, but did they discuss --- I mean, do other people discuss this in these committees?

DR. LUSTIG: Well, that didn't come up in our discussion. This particular survey is a --- it's sort of modeled after CAHPS. And that's some of the work I think the developer is in the middle of right now, is they're actually revamping the survey, and I think it may become part of the CAHPS survey. But certainly, measure

burden and reducing the number of measures is something that we all are talking about here all the time.

Yes, yes. A burden for everyone.

MEMBER POTTER: I think for the duals behavioral health population, there's another issue there we haven't talked about at all. And that is the carve out of the behavioral health organizations within the Medicaid programs. And the health plans that have -- that are in states with the carve out, they're not responsible for the behavioral health, and the carve out plans aren't responsible for the healthcare. And they don't necessarily share data across.

And so I think that's a serious problem for the behavioral healthcare population that's on Medicaid, which limits the data infrastructure that's available to support anything. So, for example I know HEDIS just closed its give us comments on the next round of HEDIS measures. And there were measures in there that one of the things they were considering is,

well, should we only make it applicable to the health plans that are in charge of behavioral health care?

And if it's a health plan that doesn't have behavioral healthcare, then they won't have to be in charge of it. Well in that situation, then, everything in the state's not going to get measured. Because the health plan that doesn't have behavioral health isn't going to measure. And the behavioral health carve out doesn't have access to the healthcare part and the pharmacy part. So they're not going to be responsible. So I just throw that out there as something for us all think about.

DR. LUSTIG: And I can just tell you that the Behavioral Health Committee shared those exact frustrations in talking about measures going forward. And while there are things we want to measure, that's what gets in the way often is being able to have access to the data you need on both sides.

MEMBER ROSS: I'd just like to build

on D.E.B.'s observations. So the state mental health authority is largely a siloed, single agency focused on whoever they define as mentally ill. A separate authority in most states is the substance use disorder authority -- alcohol, drug abuse, traditionally.

And substance use disorder folks want nothing to do with the mental health folks, even though like 60 percent of the population is a co-occurring population. So there are these --- and then in managed care is follow the same principle, carve-out industry and other industry. And those are system realities, and it undermines quality and quality measurement, but I don't know what --- how the National Quality Forum in considering measures can deal with any of this, other than through the physical health integration as a prototype model to try to bridge some of these other silo gaps.

But the silos are --- I represented the State Mental Health Directors for a decade, and I, as the first executive director of the

American Managed Behavioral Healthcare Association, represented the carve out. And everybody is just really comfortable with their siloed approach.

When I was at NASMHPD, we aggressively lobbied not to have people with dementia under the authority, because there were too many people, severe, persistent, traditional mental illness, and we couldn't serve them. So the silo thing is just fact of life, and you should just acknowledge it going into any behavioral health report that the system is highly siloed and fragmented and go from there. And there are very few mental health interests who really are advocates of integration. There are handful. But traditional mental health groups are happy doing their silo thing, so good luck.

(Laughter.)

MEMBER LYTLE: I just wanted to piggyback on that because we have a couple of financial alignment initiatives in states that do carve out the mental health portion of the

benefit, and the whole goal is to integrate. Our desire and our hope and our earnest prayer is that we can learn something from the integrated care demonstrations that will teach us how to make the silos work even though they still exist.

For instance, in Michigan, we would not have had a demonstration had we not carved out the mental health portion of it, because people wanted the model that existed to remain. And so, just to kind of echo that sentiment, I think they are beyond quality just in the provision of care. In how we look at integration, we have to think about the fact that some of that is a reality for us.

CO-CHAIR MONSON: Just to build on all of that, I do think that there's an opportunity, then, because these carve-outs are a real problem. I mean they lead to --- it is not starting with the person and figuring out how to do what's best for that person.

And while it's very difficult to figure out the measures, I mean it's worth

considering that we should measure how bad some of these outcomes really are because of the --- the disaggregation, the fragmentation of the system. So it's worthwhile to think about, as you build those measures, to --- even though it's not perfect, right?

And you've got --- people say well I can't be responsible for that. I can't be responsible for that. And I'm sure people in my company who would say that. It is a way for us to start to highlight the fact that separate silos are really problematic, and build a case to overcome some of these objections that happen, and build the case to do integration. Whether it be on a provider-led integration or a plan-led integration.

MS. BUCHANAN: Thank you all very much. Shawn, if you wouldn't mind opening up the lines for public comment.

OPERATOR: At this time, if you would like to make a comment, please press star then a number one.

MS. JUNG: Furthermore, if you would like to make any comments in the chat box, staff will read them aloud.

CO-CHAIR MONSON: Stuart?

MR. GORDON: So ---

DR. ROILAND: And, Operator, I'm sorry, I just want to confirm, did you get any comments on the line?

OPERATOR: No, ma'am. There are no comments.

DR. ROILAND: Okay, thank you so much.

MR. GORDON: One of the measures that SAMHSA stands to support on the block grant, the consumer survey is a mental health statistical improvement program consumer survey. There's three versions of it. There's an adult version, a family version, parent version, and an adolescent version.

The measures that they look for on that survey are general satisfaction, quality and appropriateness, access to services, participation in treatment planning, social

connectedness, improved functioning, and positive outcomes. Again, that's a consumer-centered survey. And then there's some variation in that in terms of looking for information on cultural sensitivity, social connectedness, and patient involvement in treatment planning.

So those are the types of items that SAMHSA has been looking for. They've also been pretty heavily involved in urging greater integration. There have been a number of pilot programs, and I think you all know about the Section 223, Excellence in Mental Health Act, where we're now putting primary care in community mental health centers. That passed a couple years ago. It's a two-year pilot, not nearly long enough to actually get a good feel, but ---

So there's greater emphasis there. There's also greater emphasis in the states to the extent that the majority of states now have a behavioral health agency rather than a substance use agency or a mental health agency. Now that doesn't necessarily get rid of the silos because

very often you have separate divisions still between substance use and mental health all under an umbrella agency.

The only other thing I wanted to say was to sort of second what Pam said. Couple of years ago, before she left to go back to New Mexico, Pam Hyde offered up 23 new measures to be added to the block grant program. And actually, it might have been for the discretionary programs. But she shared it with the folks, the mental health agency directors. They were almost unanimous in talking about burden and talking about how difficult it would be to train the providers to report back the data that would have to be reported to SAMHSA.

The other problem was there was no coordination at all with what was being required under the Medicaid program, which all these providers currently operate under. So has improved that to some degree. They've come up with some new measures. They're working with the providers. They're working with the mental

health agencies and substance use agencies. But I can't emphasize enough how important Pam's comment was. Thank you.

MEMBER LAKIN: Stuart, could you share the Pam Hyde 23 proposed measures with the National Quality staff? Thanks.

MEMBER POTTER: If you go to the SAMHSA website, and you look up the 223 demonstration, eventually you can find their requirements, and there's a whole technical appendix on the quality measures that are required as part of that. Some of those measures are measures that are reported by the certified community mental health center. And some of them are measures that are reported by the state.

There was a huge effort by the Department, SAMHSA, CMS, Medicaid and ASPE, to coordinate the measures and to align wherever possible. So you'll see a lot of overlap with the 23 measures that were on Pam Hyde's list. And measures that are on the Medicaid core list and then measures for behavioral health that have

been around for --- for a while in terms --- like, in NQF 0004: Initiation and Engagement for Substance Abuse. So I'll just mention that.

MS. BUCHANAN: And are there any questions on the line?

Okay. I will turn it over to Rachel.

DR. ROILAND: All right. And actually, Madison, could you advance the slide? They don't have the picture. Thank you.

All right everyone, so we've done a lot of work today. Congratulations, and thank you so much for staying focused for as long as you did. I know that's really hard. I hope we gave you enough sugar. So we do have a few next steps, and I'll actually turn it over to our co-chairs to see if they have any closing remarks for the day?

CO-CHAIR CHIN HANSEN: I just actually have a point of information that is relevant for the behavioral health piece. Most of you may know that I was connected to the original program of All-inclusive Care to the Elderly, the PACE

program which integrates Medicare and Medicaid.

That original legislation was passed in 1997 so it's almost --- it's actually 20 years. In 2015, in November, the original legislation was opened up, and the intent was two particular populations. One was the physically disabled and then the second one was behavioral health. And so I don't think that's it's gone -- gotten really legs yet. But it just was opened for that.

So there may be some opportunity in the future of some movement along that line. So we don't know, but it is the one program that right now does combine the funding in a way that has a full capitation approach to it.

So I can imagine they're going --- they would have tremendous need to risk adjust for, you know, given the population and all, because even when I used to run the program for frail older -- elderly individuals, when we had major psychiatric, psychosocial issues for individuals, the cost factor was three-fold. And

some of that has kind of borne out with people with dementia as well.

So at the same time, so this is more the funding mechanism, structural mechanism. But ultimately the ability to have quality measures, to be a part of that broad program. And again I thank you all for bearing with me as I've kind of gone through my coughing jags here for the day. And really just want to thank Michael for the fantastic leadership that he has played today. And the staff, of course, for all the prep work that we've done. Thank you.

CO-CHAIR MONSON: Thank you, Jennie, I appreciate that. And thank you everybody, I know it's a little hard when we're kind of --- we got the news we got this morning. But everyone was really engaged today. I thought we had an extraordinarily productive set of conversations, which really just demonstrates the passion that everyone in this room has for these individuals. And so I thank you for that.

And I'm also supposed to tell you that

if you're going to dinner, dinner is at 5:45 at P.J. Clarke's which is somewhere nearby. And it is pay-as-you-go. And then we're starting at 9:00 again tomorrow, right?

MS. BUCHANAN: Yes, so we have breakfast at 8:30 again, and then starting the day off at 9:00. And I believe people are staying at the Capital Hilton? Is that accurate?

MS. JUNG: The Hyatt.

MS. BUCHANAN: Oh, the Hyatt. Never mind, I was going to say it's caddy-corner to the Hyatt. So P.J. Clarke's, if you come out of building, turn right and then turn right on K. It's on the corner of 16th and K, so it's a block-and-a-half away.

MS. JUNG: And the address is 1600 K.

CO-CHAIR CHIN HANSEN: It's right next to Starbucks.

(Laughter.)

MS. BUCHANAN: But we do have a question because we are ending a little bit early. Is there interest in us moving up dinner

reservation time? Or is it just fine as 5:45? Sounds like it's fine as 5:45.

And so the only other announcement I have is that we'll be compiling the results of the voting today and review those tomorrow morning. Other than that I think we've --- I think we've got it all set. So thank you all very much. Thank you everyone joining on the phone.

(Whereupon, the above-entitled matter went off the record at 4:18 p.m.)

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C E R T I F I C A T E

This is to certify that the foregoing transcript

In the matter of: Measure Applications Partnership
Dual Eligible Beneficiaries Workshop

Before: NQF

Date: 03-29-17

Place: Washington, DC

was duly recorded and accurately transcribed under my direction; further, that said transcript is a true and accurate record of the proceedings.

Neal R. Gross

Court Reporter