

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 LYTTLE, 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

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

2 9:04 a.m.

3 MS. MUKHERJEE: Hello, everybody.

4 Thanks for coming in, and welcome to the Measure
5 Applications Partnership Dual Eligible
6 Beneficiaries Workgroup In-Person Meeting that
7 will happen over March 29th and 30th.

8 Just a quick few announcements.

9 Please make sure you speak into the microphone,
10 and when you speak, that the red button is -- you
11 press the speak button and the red light is on.
12 Once you are done, please turn it off because we
13 only can have a couple of microphones on at a
14 time.

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

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

21 Thank you.

22 MS. HAMMERSMITH: Thanks, Debjani.

1 I am Ann Hammersmith and NQF's General
2 Counsel.

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

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

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

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

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

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

3 MS. HAMMERSMITH: Okay. Thank you.

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

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

20 So I will start with our Chairs.

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

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

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

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

16 MS. HAMMERSMITH: Alison Cuellar?

17 (No response.)

18 Okay. Charlie Lakin?

19 MEMBER LAKIN: Hi. Charlie Lakin.

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

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

4 MS. HAMMERSMITH: Thank you.

5 Pamela Parker?

6 (No response.)

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

9 Kimberly Rask?

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

18 MS. HAMMERSMITH: Okay. Thank you.

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

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

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

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

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

22 MS. HAMMERSMITH: Okay. Thank you.

1 CO-CHAIR MONSON: Yes.

2 MS. HAMMERSMITH: Susan Reinhard?

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

9 Thank you.

10 MS. HAMMERSMITH: Okay. Gwendolyn
11 Buhr?

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

14 MS. HAMMERSMITH: Thank you.

15 Joy Hammel?

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

20 MS. HAMMERSMITH: Christine Lynch?

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

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

3 MS. HAMMERSMITH: Okay. Clarke Ross?

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

11 MS. HAMMERSMITH: Thank you.

12 Jennifer Ramona?

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

16 MS. HAMMERSMITH: Thomas Lutzow?

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

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

22 (No response.)

1 Is Beverly Court on the phone?

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

5 MS. HAMMERSMITH: Thank you.

6 Joan Zlotnik?

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

10 MS. HAMMERSMITH: Okay. Aline Holmes?

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

14 MS. HAMMERSMITH: Okay. Richard
15 Bringewatt?

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

18 MS. HAMMERSMITH: Okay. Thank you.
19 Did I miss anybody here or on the
20 phone?

21 (No response.)

22 Okay. Great. Thank you for those

1 disclosures.

2 Does anybody have any questions?

3 (No response.)

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

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

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

18 Thank you.

19 MS. MUKHERJEE: Thank you, Ann.

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

22 And now, I would like to turn it over

1 to Stacey Lytle from CMS for some welcoming
2 remarks.

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

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

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

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

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

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

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

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

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

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

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

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

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

1 MS. MUKHERJEE: Thank you, Stacey.

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

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

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

22 We do have some work to do, though,

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

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

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

3 All right. Shantanu?

4 DR. AGRAWAL: Thank you.

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

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

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

1 important.

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

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

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

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

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

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

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

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

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

1 discussion, please stay focused on that work.

2 So, thank you.

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

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

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

20 So, Clarke.

21 MEMBER ROSS: Thank you.

22 So, a couple of sensitive topics. If

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

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

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

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

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

14 But thank you.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

15 CO-CHAIR CHIN HANSEN: Thanks.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22 And so, I think, for us, the Financial

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

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

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

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

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

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

17 MEMBER LYTTLE: Yes.

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

21 MEMBER LYTTLE: There are three of
22 them.

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

9 MEMBER LYTTLE: Yes.

10 CO-CHAIR MONSON: Tom? Oh, sorry.

11 MEMBER LYTTLE: Yes, we are excited
12 about those, too.

13 (Laughter.)

14 CO-CHAIR MONSON: Tom?

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

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

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

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

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

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

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

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

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

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

22 So, to some extent, how do we get at

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

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

11 CO-CHAIR MONSON: Go ahead, Christine.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22 We spend a lot of time and energy and

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

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

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

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

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

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

1 Initiative plans.

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

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

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

22 But I think that those types of

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

14 DR. AGRAWAL: Yes, thank you.

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

1 are highly committed to that.

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

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

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

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

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

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

1 in the view of the committees that we are
2 convening?

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

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

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

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

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

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

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

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

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

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

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

14 Charlie, you look like you want to say
15 something.

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

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

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

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

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

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

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

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

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

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

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

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

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

22 MEMBER BRINGEWATT: Yes, the question

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 being the dependent variable.

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

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

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

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

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

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

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

1 oftentimes inadvertently the cause of their
2 discoordination.

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

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

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

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

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

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

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

22 Since this is a direct question, I

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

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

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

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

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

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

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

22 So, if that is not going to happen,

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

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

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

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

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

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

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

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

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

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

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

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

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

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

10 CO-CHAIR MONSON: Yes, Christine?

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

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

1 providers, for example.

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

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

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

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

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

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

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

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

1 MEMBER COURT: This is Bev Court from
2 NAMD.

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

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

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

16 MEMBER LYTTLE: I will be here
17 tomorrow.

18 CO-CHAIR MONSON: Fantastic.

19 MEMBER LYTTLE: I'm looking forward to
20 it.

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

1 (Laughter.)

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

6 Does anybody on the phone have any
7 last comments?

8 (No response.)

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

11 (Whereupon, the above-entitled matter
12 went off the record at 10:29 a.m. and resumed at
13 10:46 a.m.)

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

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

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

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

11 Rachel, take it away.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6 The current family of measures contain
7 74 measures that are all NQF-endorsed for the
8 most part. We'll be going over those that have
9 lost endorsement later on today. But as it
10 stands, the family has 74 measures.

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

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

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

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

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

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

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

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

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

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

1 family since they have lost endorsement.

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

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

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

22 Again, this one focuses on factors to

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

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

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

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

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

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

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

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

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

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

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

15 MEMBER CUELLAR: These are currently
16 in the family.

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

1 you off a little bit.

2 MEMBER CUELLAR: Okay.

3 DR. ROILAND: But this is the current
4 family.

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

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

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

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

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

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

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

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

22 DR. ROILAND: I know one for sure

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 true.

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

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

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

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

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

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

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

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

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

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

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

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

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

22 The other thing that I've been sort of

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

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

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

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

1 12 months as part of that plan?

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

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

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

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

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

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

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

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

1 meaningful way that's not excessively expensive.

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

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

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

22 DR. ROILAND: Yes. What we can do is

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

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

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

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

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

1 because you said two.

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

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

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

11 MEMBER CUELLAR: None.

12 CO-CHAIR MONSON: Excellent. Thank
13 you.

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

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

1 right.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22 DR. ROILAND: No. It's a good

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

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

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

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

18 DR. ROILAND: No.

19 MEMBER PARKER: Okay.

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

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

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

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

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

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

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

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

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

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

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

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

17 And it really doesn't work as a hybrid
18 measure similar to the -- so that's 0418. I mean
19 that's been a very poor-performing measure. The
20 0421, similarly, it doesn't lend itself well to
21 hybrid measure either. It's kind of failing on
22 both sides.

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

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

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

22 So it might be worth having a

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

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

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

1 get to it.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

7 CO-CHAIR MONSON: Alison.

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

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

1 particularly what meaningful use ask them to --

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

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

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

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

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

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

22 That leads me to going back to what

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

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

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

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

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

22 That's our current activity. I don't

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

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

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

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

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

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

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

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

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

9 But it's commonly used. It's in over
10 30 states. And it's soon going to hopefully in
11 the next few years be in 50 states.

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

22 I know it's a big structural issue.

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

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

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

22 But because the states are in an

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

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

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

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

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

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

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

1 about it.

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

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

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

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

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

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

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

22 MS. MUNTHALI: This is Elisa again.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 and K, but also to test if your clickers are
2 working well. So what I'll do is I'll read out.
3 The polling is open. You guys will click option
4 1 or 2. Then after that, we will see the
5 results.

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

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

13 (Voting.)

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

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

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

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

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

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

12 MEMBER BAKER: That would be great.
13 Thank you.

14 DR. ROILAND: Okay. Just a second.

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

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

22 MEMBER COURT: Will do.

1 MS. BUCHANAN: Thank you.

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

8 The next measure we have up is Measure
9 0682: Percent of Residents or Patients Assessed
10 and Appropriately Given the Pneumococcal Vaccine
11 in short-term stay for removal from the family of
12 measures. Option 1 is yes. Option 2 is no.
13 Voting is now open.

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

17 MEMBER BAKER: Yes, I did. Thank you.

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

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

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

8 DR. ROILAND: Yes.

9 MS. JUNG: Do we want to go back?

10 Apologies about that. For measure
11 0557 we have 100 percent yes with 17 votes for
12 the removal from the family of measures.

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

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

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

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

5 There we go. Thank you. We have 16
6 votes for yes with 94 percent; 1 vote for no with
7 6 percent. And the measure 0682 will be removed
8 from the family of measures.

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

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

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

1 considered for removal.

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

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

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

17 (Whereupon, the above-entitled matter
18 went off the record at 12:02 p.m. and resumed at
19 12:35 p.m.)

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

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

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

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

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

22 We reviewed those projects that had

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

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

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

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

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

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

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

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

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

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

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

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

22 With that, that's just a very quick

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

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

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

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

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

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

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

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

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

22 MEMBER COURT: Because again while it

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

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

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

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

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

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

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

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

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

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

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

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

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

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

9 MEMBER POTTER: Thank you for that
10 clarification. Thanks.

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

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

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

22 MEMBER COURT: Right. The question

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22 MEMBER RASK: I think the point is

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

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

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

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

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

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

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

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

9 MEMBER LYTTLE: Thanks, Bev. Duly
10 noted.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 CO-CHAIR MONSON: Jen.

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

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

9 MEMBER BRINGEWATT: Most are dual
10 eligible, yes.

11 MEMBER RAMONA: Okay.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 or are we endorsing at that state population-
2 level?

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

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

20 Did that bring some clarity?

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

1 comments, I think you want to vote.

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

6 MS. MUKHERJEE: So they're about
7 213,000 Medicaid enrollees with HIV. Out of that
8 29 percent are dually eligible.

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

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

19 MS. JUNG: Great. The voting for
20 Measure 3086: Population Level HIV Viral Load
21 Suppression is now open. Option 1, yes. Option
22 2, no. And this is for addition to the family of

1 measures.

2 (Voting.)

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

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

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

1 nursing facility regardless of payer source.

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

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

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

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

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

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

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

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

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

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

12 CO-CHAIR MONSON: That I know.

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

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

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

22 CO-CHAIR MONSON: Christine.

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

6 CO-CHAIR MONSON: Or NFs.

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

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

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

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

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

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

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

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

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

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

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

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

10 MEMBER PARKER: Michael, can I?

11 CO-CHAIR MONSON: Yes.

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

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

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

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

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

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

21 CO-CHAIR MONSON: Anybody on the
22 phone?

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

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

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

14 MS. JUNG: Okay. Voting for measure
15 2858, Discharge to Community is now open. Option
16 one yes. Option two no.

17 (Voting)

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

22 DR. ROILAND: All right. Thank you,

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

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

10 The first of these measures is measure
11 2614: CoreQ or Short Stay Discharge Measure. The
12 description of this measure is that the measure
13 calculates the percentage of individuals
14 discharged in the six month time period from a
15 skilled nursing facility, within 100 days of
16 admission, who are satisfied. This patient
17 reported outcome measure is based on the CoreQ
18 Short Stay Discharge questionnaire that utilizes
19 four items.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 Now four and five I count as satisfied.

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

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

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

14 DR. ROILAND: You can go either.

15 MEMBER FOX-GRAGE: Okay.

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

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

1 to ---

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

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

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

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

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

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

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

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

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

22 The other problem that occurs in some

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

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

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

22 DR. ROILAND: I'll do just a really

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

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

14 DR. ROILAND: Yes.

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

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

1 recommending this facility to your friends and
2 family how would you rate it overall. And the
3 ratings are one poor, two average, three is good,
4 four is very good and five is excellent.

5 Question two is overall how would you rate the
6 staff. Three is how would you rate the care
7 you've received. And four is how would you rate
8 how well your discharge needs were met.

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

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

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

22 DR. ROILAND: You're free to go.

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

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

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

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

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

7 (Voting.)

8 All 18 responses are in. The results
9 are 11 for yes with 61 percent, seven for no with
10 39 percent. With that 61 percent, it does pass
11 the majority criteria and measure 2614 is voted
12 into addition for the family of measures.

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

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

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

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

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

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

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

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

8 CO-CHAIR MONSON: Joan.

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

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

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

22 MEMBER HAMMEL: Do they say who asks

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 residents. So that's what I know.

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

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

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

1 setting.

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

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

17 CO-CHAIR MONSON: Clarke.

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

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

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

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

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

5 CO-CHAIR MONSON: Joan, Gwen and Joy.

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

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

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

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

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

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

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

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

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

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

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

22 And then when it comes up for its one

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

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

11 CO-CHAIR MONSON: Joy first and then
12 we'll go to --

13 MEMBER HAMMEL: Just lost my train of
14 thought. I'm going to take a few. Go ahead.

15 MEMBER RAMONA: Okay, if that wasn't
16 confusing, this is Jen. I was going to say much
17 of what Gwen was saying with regard to, it is
18 very valuable to be asking these questions. Yet
19 how valuable are they if they don't give a lot of
20 content.

21 Also it does say on the form, on the
22 questionnaire that somebody else can fill it out.

1 But the exclusion is that if it was filled out by
2 somebody else it doesn't count.

3 That also gets to the point of
4 literacy and health literacy and even using words
5 like discharge on the previous question and here,
6 people really understanding what they're being
7 asked. And then particularly if the questions
8 are going to be asked in context of other
9 questions that the facility can add just to get
10 more information about their satisfaction. It
11 could also skew how the answers are being replied
12 to based on what other questions are framed
13 around it.

14 CO-CHAIR MONSON: Joy, Aline, Alison.

15 MEMBER HAMMEL: Okay, I remembered
16 mine. The survey --- the questions seem skewed.
17 They're talking about your satisfaction with the
18 SNF, but they're not asking the questions about
19 were you offered alternatives, did you get any --
20 you know, were you satisfied with the information
21 you got. Was it --- and what we're really trying
22 to get at is did they know about their rights to

1 leave this facility or get in the community if
2 they want to.

3 It just seems skewed without that part
4 of it that you're going to get a high
5 satisfaction rating of somebody who's in the
6 middle of an institution being asked when
7 everything is riding on it even if it is self-
8 report.

9 MEMBER HOLMES: So I probably know
10 more about this than I should. But the New
11 Jersey Hospital Association, a federally-
12 certified patient organization, we actually hold
13 the PSO contract for AHCA for their NCAL product.
14 So we've been working with them.

15 And I was on their site trying to
16 figure out where the testing came from and I
17 can't find any -- they don't mention who tested
18 it, they only have --- and I think they're still
19 very early with it because it doesn't come up on
20 their trend tracker which is where you can
21 download reports.

22 So I don't think that it has a lot of

1 work behind it either because we've been talking
2 to them a lot about some of their measures and
3 stuff. So I'm not very comfortable with how
4 they've developed this. My sense is that they've
5 not spent a lot of work on really testing it out
6 even in their organization, because it doesn't
7 even come up. They say you can download ten
8 reports, but it doesn't come up even as a
9 possible selection.

10 CO-CHAIR MONSON: Alison.

11 MEMBER CUELLAR: So if a hospital
12 sends one of these through the mail and gets a
13 response from a patient based on their experience
14 in the hospital, we're more comfortable with that
15 because the hospital staff aren't there while the
16 person is filling it out. That seems to be the
17 big difference.

18 And then I guess I'm less and less --
19 I was going to say if it's endorsed haven't they
20 thought through some of these issues? It sounds
21 like no. I realize we're not endorsing, but
22 we're asking some fairly standard validity and

1 reliability questions here. And it sounds like
2 we can't take endorsement as telling us anything
3 about validity and reliability.

4 DR. ROILAND: This is Rachel and I can
5 jump in on that. There is testing on validity
6 and reliability done on this measure. The
7 standing committee for Person- and Family-
8 Centered Care did find it acceptable.

9 I have the testing attachment pulled
10 up here and I won't read all 30 pages of it for
11 you. But they did do -- let me just make sure --
12 they tested the measure for reliability and
13 validity. The pilot CoreQ long-stay resident
14 questionnaire was examined using responses from
15 1700 residents from a national sample of nursing
16 facilities. They also did some testing of some
17 sociodemographic variables using the same sample.

18 The validity testing for the long-stay
19 resident questionnaire was examined using
20 responses from 100 residents from the Pittsburgh
21 area. Additional testing was done using
22 responses from 223 facilities that included

1 responses from 7,307 residents. So they've done
2 testing with decent sample sizes.

3 In terms of how it's administered,
4 they do have an appendix that's included in their
5 measure submission that talks about how these
6 three questions for this measure can be ---that
7 vendors that Debjani mentioned earlier can add
8 these three questions to their questionnaires
9 that they administer on behalf of various
10 facilities. And they also list in there that if
11 their vendor does not include these questions to
12 contact them and they can help them work with
13 their vendor to add them.

14 If they don't have a vendor, they
15 encourage them to contact Dr. Nick Castle who I
16 believe is a pretty prominent researcher in this
17 space to talk to him about how to incorporate
18 these measures into their work flow. So I don't
19 want --- it was tested and the committee that
20 reviewed it found the testing to be acceptable
21 and therefore recommended it for endorsement.

22 MS. JUNG: And also just looking at

1 the Person- and Family-Centered Care Report from
2 2015 and 2016, and I can read a brief summary of
3 the points that the staff had summarized from the
4 comments of the committee.

5 For comments in terms of this, this
6 new PRO-PM is very similar to number 2614 CoreQ
7 Short-Stay Discharge Measure and number 2616
8 CoreQ Long-Stay Family Measure. The committee
9 had questions about validity and whether staff
10 members were allowed to fill out surveys on
11 behalf of patients.

12 The developer responded that there is
13 no way to stop staff from doing so. But if staff
14 indicate that they had responded on behalf of a
15 patient that data will be excluded.

16 The committee agreed that the measure
17 is very similar to 2614 and did not require
18 additional discussion or voting. Ultimately, the
19 committee recommended this measure for
20 endorsement. And there's also a summary for 2616
21 which I would also be happy to read out once we
22 get to that point.

1 MEMBER PARKER: I don't know if I --
2 I don't want to speak exactly to the point here.
3 But I just wanted to make a more general
4 statement about the --- we can look for the
5 perfect way to collect this information from
6 individuals. And I once was part of a project
7 that was looking at that perfect way where they
8 had very highly trained people administering the
9 survey. It was done over the phone, but it was
10 with frail elders, not people in nursing homes.

11 But my point is going to be that it's
12 even more applicable to people in nursing homes.
13 And they were trained at how to follow up the
14 questions and all this. This was called a
15 Braceland study. I don't know if it's in print
16 anymore, but it was done east.

17 Anyway, we were able to listen to
18 recordings of many of the conversations that the
19 interviewers had with frail elderly. The scaling
20 was a bigger issue than anything else. And the
21 scaling was quite hilarious.

22 We would get the question about on a

1 scale of one to ten how did you like your doctor.
2 How did you feel your doctor did? And people
3 would say excellent.

4 And then they'd say, well if you want
5 to give that a number what number would you give
6 it?

7 My friend Mary gave hers a five, but
8 I would give her a nine because blah blah.

9 And these were people that were living
10 at home and fairly cognitively intact enough to
11 stay at home. But the scaling and the
12 administration were both so far off that it was
13 very, very hard to capture even though they had
14 done practically the perfect way of doing it. It
15 was very hard to capture anything.

16 So if we want to wait around for the
17 perfect scaling and the perfect administrative
18 approach we may have to wait a long time, is my
19 point. So I would hope that we wouldn't get too
20 hung up on that part of it.

21 CO-CHAIR MONSON: I'll just go down
22 the line starting with Charlie.

1 MEMBER LAKIN: I agree with Pam on
2 both items. This is stuff you need to ask and
3 scaling is a big problem.

4 With regard to the reliability, it's
5 a fact that skewed distributions are usually
6 associated with high reliability. This sort of
7 begs another question for me and that is does
8 this discriminate between organizations? Does
9 every organization report 95 percent performance
10 on the upper end of the scale? And I suspect it
11 probably does.

12 In a sense, given its use, what is its
13 use? And I don't have the data to look at, but I
14 would wonder whether this is really very useful
15 because I would guess the distributions are very
16 heavily toward the very high end of the scale.

17 CO-CHAIR MONSON: Clarke, why don't
18 you go?

19 MEMBER ROSS: So I'd like to try to
20 tie Gwen and Pam and Joy's comments and
21 Charlie's, too. Almost all the measures I've
22 supported since 2012 are inadequate, incomplete,

1 restricted, limited, narrow, developed by a
2 provider group and a developer and have the
3 weaknesses like Charlie and Joy have identified.

4 Yet I go back to Gwen's point. In the
5 absence of a vacuum and nothing, is this
6 particular measure a helpful first step? Now
7 this gets into the burden issue. So I'm
8 responsible for some of the burden because I
9 generally support these things.

10 But if there's no measure in an area
11 and it's targeted to individual recipients, then
12 I tend to support it even though it's not a very
13 good measure and in the aggregate, it adds to
14 burden. So we each have to go through that. Is
15 this meaningful enough in the absence of nothing
16 to put up with with all the limitations that Joy
17 and Charlie have identified?

18 CO-CHAIR MONSON: Right down the line.

19 MEMBER AGUIAR LYNCH: I have a
20 question for the NQF staff. So I hear what -- a
21 lot of people are clearly uncomfortable with this
22 measure. I hear what you guys are saying that

1 this is the best that we've got right now, so we
2 should go ahead and try to plug the gap.

3 But my question is if a better -- if
4 we do that and a better measure comes online,
5 part of it seems like when you guys bring these
6 measures to us for consideration part of the
7 assessment is whether or not there already is a
8 measure that addresses the same issue. In that
9 analysis, do either the NQF staff or do we go
10 back and relitigate the original measure that's
11 already existing there?

12 So for example, if like two years from
13 now or three years from now presuming this group
14 is still here and a new, better measure came.
15 Would we be evaluating it with respect to this
16 measure two years of testing in order to be able
17 to know which one is better? Do we vote one in,
18 vote one out?

19 MS. MUKHERJEE: Sure. It happens a
20 couple of ways. One way is if a new measure came
21 through the endorsement process that's better
22 there would be a related and competing analysis

1 that NQF staff would have done. When that was
2 endorsed, when we are looking through our
3 measures, we would see that and then we would
4 present that to the group as an option to swap
5 this out and not necessarily saying that this
6 would go off.

7 And then the other one is that
8 potentially this loses endorsement because after
9 it's been in the field the measure developer
10 decides not to support it. The measure steward
11 no longer does all the maintenance. That will go
12 away and that's when we would also look for other
13 measures.

14 Honestly, the field of especially
15 surveys and patient-reported outcome measures is
16 very much in development and growing. So we hope
17 that in the next two, three years there would be
18 a lot more, better measures for us to consider
19 than where we are right now.

20 MEMBER CUELLAR: I share many of the
21 qualms around this measure and I would love it if
22 somebody tested the smiley faces and the frownies

1 instead of the numbers, lots of people in the
2 state of decline have trouble with numbers.

3 Yet at the same time, I don't find
4 that I'm raising a duals-specific issue as I
5 ponder these things. These are general issues
6 for anybody who stayed in this kind of facility
7 where quality is being measured.

8 And if you were to ask me, well we
9 have a menu of measures, is this a duals-relevant
10 one, I would say yes. Duals spend time
11 disproportionately in facilities like this. So
12 I'm not hearing myself raise a duals-specific
13 concern. It's a concern, but if --- this measure
14 is highly relevant to a duals population.

15 CO-CHAIR MONSON: Gwen.

16 MEMBER BUHR: So I was thinking that a
17 lot of facilities and especially corporate
18 facilities and whatever, they're already doing
19 some sort of surveying. At least, the one where
20 I work does a Holleran or whatever that company
21 was. Holleran or, I can't remember. It was on
22 your list.

1 They use that company and they do a
2 survey. And I heard somebody say that they could
3 just add these questions to that existing survey.
4 So it doesn't seem like a huge burden, it's three
5 questions.

6 And it does give words. So it's not
7 just on a scale of one to five. It has words.
8 So I think that's valuable that it says poor,
9 good, very good. I think that's also
10 encouraging.

11 DR. ROILAND: So this is a
12 distribution of scores that they provide in the
13 measure submission. I'm having a little trouble
14 interpreting it. Madison, can you make it a
15 little bit bigger?

16 On the lefthand side, it says number
17 of facilities with measures score. And then at
18 the bottom it says percent measure score. It's
19 not giving us the distribution of one to five.
20 Do they have that farther up? These are by
21 items. I don't know if that's helpful for you
22 all.

1 CO-CHAIR MONSON: I had a question.
2 Debjani and I had a sidebar, but I think this is
3 important for the group. I think, D.E.B., you
4 mentioned this, too, that there's no CAHPS
5 measures for nursing facilities right now. But
6 Debjani seemed to indicate that there's another
7 measure.

8 So I think it's important because if
9 there's another measure out there, or it's in
10 development. So there is nothing besides this
11 right now.

12 MS. MUKHERJEE: Nothing.

13 MEMBER POTTER: There used to be CAHPS
14 measures for long-stay, short-stay and family.
15 And they had endorsement at one time. But I
16 think the last time they came through maintenance
17 AHRQ made a decision to no longer support the
18 measure. So they no longer have endorsement.

19 MEMBER CUELLAR: Was the issue any of
20 the kinds of things we're talking about?

21 MS. MUKHERJEE: They pulled them
22 because they're developing new measures. So it's

1 not that there's a vacuum. At one point we will
2 have a new set.

3 MS. JUNG: And also that measure
4 endorses an instrument and we no longer endorse
5 instruments.

6 CO-CHAIR MONSON: I would just put my
7 two cents in which is I do think it's critical
8 for us to have the voice of the consumer. I am
9 leery of an industry-administered survey test
10 that seems to actually make everybody look really
11 good, especially for an industry that is
12 attempting to position itself against changing
13 tides of consumer sentiment.

14 It does give me pause. I wish there
15 was another survey. But if there is one coming,
16 from my perspective it might be worth waiting for
17 that one instead of using this one.

18 So we might have beaten this one to
19 death. But it was a very healthy conversation
20 and an important conversation. Anybody else on
21 the phone have any other comments before we move
22 to a vote?

1 (No audible response.)

2 All right. Madison.

3 MS. JUNG: Okay. Measure 2615, CoreQ
4 Long-Stay Resident measure is now open for
5 voting. Option one yes. Option two no.

6 DR. ROILAND: Did someone step out?

7 MS. JUNG: Oh, snuck out. With that,
8 17 votes. The voting is now closed. We have
9 seven votes for yes with 41 percent and 10 votes
10 for no with 59 percent. It does not -- okay, so
11 the measure will not be added to the family of
12 measures.

13 CO-CHAIR MONSON: Okay. Jen, do you
14 have a comment? You're standing between us and a
15 break. Just be aware of that.

16 MEMBER RAMONA: I'll try to make it
17 quick. It seems that the questions that we're
18 asked that maybe changed the results would have
19 applied to the short-stay. So from a process
20 standpoint, is there --

21 MS. MUKHERJEE: The workgroup can
22 request for a revote depending on the discussion

1 and just give a rationale when you're requesting
2 that as well.

3 MEMBER RAMONA: After the break.

4 CO-CHAIR MONSON: When we return.

5 MEMBER RAMONA: Okay. For me they're
6 not --

7 CO-CHAIR MONSON: We will be reopening
8 the vote, or will we?

9 MEMBER RAMONA: Because they're not
10 there. They're not under control at the nursing
11 home.

12 CO-CHAIR MONSON: Okay. Fifteen
13 minutes. That would be 2:25 p.m. Eastern.

14 (Whereupon, the above-entitled matter
15 went off the record at 2:09 p.m. and resumed at
16 2:25 p.m.)

17 CO-CHAIR MONSON: Everyone back. Break
18 is over. Where we last left our heroes --- no,
19 so seriously I think --- so did --- Jen, you had
20 the floor. Did you want to --- I don't know if
21 you need to make a motion or just a request to --
22 - do you want to make your request that you made

1 before the break?

2 (No audible response.)

3 CO-CHAIR MONSON: Mic, mic, mic.

4 MEMBER RAMONA: I would request a
5 revote on the Short-Stay measure ---

6 MS. JUNG: 2-6-1-4?

7 MEMBER RAMONA: Yes, 2614.

8 CO-CHAIR MONSON: Do we need to vote
9 on a revote, or do we --- can we just take a
10 revote?

11 (No audible response.)

12 CO-CHAIR MONSON: Is there an objection
13 to a revote on the Short-Stay measure? There's
14 an objection. Would you like to hit your
15 microphone and explain your objection?

16 MEMBER RASK: Say the --- my reasons
17 for voting differently had to do with the
18 population long-stay versus short-stay. It
19 didn't have to do with the other issues.

20 CO-CHAIR MONSON: Do --- but do you
21 object to having a revote?

22 MEMBER RASK: Oh, I'm sorry.

1 CO-CHAIR MONSON: So, yes let's ---
2 let's --- so anyone object to opening up the
3 discussion again and then revoting on whichever
4 the --- the short-stay version of CoreQ?

5 (No audible response.)

6 CO-CHAIR MONSON: Okay, hearing no
7 objections, we're back on that topic again. So
8 now, Kimberly would you like to explain your ---
9 why you would --- yes, go ahead. No? You
10 didn't. All right. Does anyone else want to
11 make a comment about --- yes?

12 MEMBER PARKER: Well I just don't ---
13 I don't think the two things are exactly the same
14 and I just don't want to go over the whole
15 conversation again. That's all.

16 CO-CHAIR MONSON: Yes, Charlie?

17 MEMBER LAKIN: I would just say the
18 contexts are quite different in the two. One
19 being you're a --- you're an inmate. The other
20 you're --- you've been liberated and you have a
21 little bit more independence in observation I
22 think, in the latter.

1 CO-CHAIR MONSON: That is an excellent
2 comment. Okay, anybody on the phone want to make
3 a comment about Short-Stay CoreQ 2614?

4 (No audible response.)

5 CO-CHAIR MONSON: All right, Madison,
6 we're revoting then.

7 MS. JUNG: Okay, the voting for
8 Measure 2614, CoreQ: Short-Stay Discharge Measure
9 is now open. Option one, yes. Option two, no.
10 And the --- the sensor is over here by
11 me, so ---

12 Okay, we have a total of 17 votes.
13 The results are ten for yes with 59 percent,
14 seven for no with 41 percent. And with a 59
15 percent it does not meet the threshold, so this
16 will not be added to the family of measures.

17 MS. MUKHERJEE: And just to clear up
18 any confusion, the --- we will need a rationale,
19 so the rationale is --- does anybody want to
20 summarize? There was a lot of discussion. Jen,
21 do you want to summarize the rationale for the
22 revote and sort of --- oh --- Gwen?

1 MEMBER BUHR: Did we have 18 votes
2 last time?

3 CO-CHAIR MONSON: I think we did.

4 MEMBER BUHR: Because it seems like we
5 need to include Tom if we included him the first
6 time. I don't --- I think we should wait till he
7 comes back for this revote, personally. I don't
8 think it's valid.

9 CO-CHAIR MONSON: I think that's fair.

10 MS. JUNG: Okay, would we like to
11 table this for now and move on to the next one?

12 CO-CHAIR MONSON: Let's do that.

13 MS. JUNG: Okay.

14 DR. ROILAND: All right, so I think
15 that's back to me then. So our --- we do have
16 one more CoreQ measure to go over and that is NQF
17 2616: CoreQ: Long-Stay Family Measure. And the
18 description for this measure is that the measure
19 calculates the percentage of family or designated
20 responsible party for long-stay residents, i.e.
21 residents living in the facility for 100 days or
22 more who are satisfied.

1 This is a consumer-reported outcome
2 measure that is again based on the CoreQ Long-
3 Stay Family Questionnaire that has three items.
4 I'll read you those three items now. The first
5 question is in recommending the facility to your
6 friends and family, how would you rate it
7 overall? Response options are one, poor; two,
8 average; three, good; four, very good; or five,
9 excellent.

10 The second question is overall, how
11 would you rate the staff? The same response
12 options. And the third question is how would you
13 rate the care your family member received?
14 Again, the same response options. The numerator
15 and denominator are listed on the slides as well
16 as the exclusions.

17 For the staff the preliminary analysis
18 rationale is similar to the other CoreQ measures.
19 We thought it addressed several measurement ---
20 priority measurement and gap areas. Again it's a
21 --- a patient- or consumer-reported outcome
22 measure and had a --- did not have limits on age

1 or disease.

2 MEMBER AGUIAR LYNCH: Didn't we vote
3 on this one already?

4 MS. JUNG: You voted on the Long-Stay
5 Person-Reported ---

6 MEMBER AGUIAR LYNCH: Oh, this family
7 measure.

8 MS. JUNG: Yes.

9 MEMBER AGUIAR LYNCH: Got it.

10 CO-CHAIR MONSON: Jen, do you have
11 your tent up, or is that a residual? Aline?

12 MEMBER HOLMES: Under one of the
13 slides it says --- the preliminary analysis says
14 it's a patient-reported outcome measure, is ---
15 it's a family-reported, not a patient-reported --
16 -

17 MS. JUNG: Yes, I apologize. That's
18 a typo.

19 MEMBER HOLMES: Okay. Just wanted to
20 clarify that.

21 MS. JUNG: It should be a consumer-
22 reported outcome measure.

1 MEMBER HAMMEL: I have the same
2 concerns as the last one in terms of the scale
3 and --- and same issues with bias, and families
4 could be --- if they're in a long-term care ---
5 easily be persuaded as well to say yes to
6 something.

7 MEMBER BUHR: I think --- I think
8 families have very little place to give their
9 feedback. And again, I just think we have to
10 start somewhere. And especially when things
11 aren't going well. And they can put in complaint
12 surveys, and they can call the ombudsman and they
13 can do all these things, but they're very
14 reluctant to do a lot of things because they're
15 afraid of retaliation.

16 So some sort of anonymous survey seems
17 like a safe way for the family to be able to give
18 their feedback and for the facilities to be
19 compared one to another, rather than relying on
20 the family to do things that are more visible to
21 the facility. So I --- I think it's a good ---
22 good thing.

1 CO-CHAIR MONSON: Pam and then Rich.

2 MEMBER PARKER: Well, I --- I just
3 think the things you just reeled off are --- are
4 things that would invalidate almost any, you
5 know, questions that you could ask of people in -
6 -- in nursing homes. It would be --- if you
7 can't ask the families, you can't ask them
8 because we don't approve of any of the
9 methodologies, or we think they're going to be
10 too influenced and biased to be able to say
11 anything, it pretty much knocks out the whole ---
12 anything we could ever do.

13 So I --- I can't --- I can't go
14 endorse, you know, that approach. I think we
15 have to look for something that is usable within
16 a reasonable context. And then I think this is
17 about as good as we're going to find.

18 MEMBER BRINGEWATT: Two quick
19 comments. One is I think this is good as it
20 gets. You have to be careful of, you know, the -
21 -- being the enemy of the good here. The other
22 comment is I think we shouldn't underestimate the

1 power of just asking the questions. Just the
2 mere fact that somebody is walking in the room,
3 giving you a survey.

4 The staff know that there's a survey
5 being distributed. And you know that in itself I
6 think has power. And part of what we're trying
7 to do is, you know, increase the power of the
8 beneficiary. And I don't know that it's harmful,
9 you know, and I think that on balance there's
10 more good than bad that can come out of this.

11 MEMBER LAKIN: I won't ask to see the
12 distribution again. But I think there's a --- a
13 question to be raised about a survey where 86
14 percent of the people participating rate --- rate
15 services between --- 86 percent rate them from
16 good to excellent. I mean is there --- is there
17 a validity to that?

18 And I think in part it's how they've
19 set up the survey. I think people tend to look
20 at Likert scales and --- and even if there's ---
21 average to them is in the middle. And if you ---
22 if you scale average down to two, and people mark

1 them --- mark average as the middle, you've
2 already --- you've already said it's good. And -
3 -- but I --- I just, again, wonder what is the
4 point if it doesn't --- other than, I think, the
5 good point that Rich makes. What is the point if
6 everybody is at the high end? It just --- only
7 in Minnesota are --- are all the kids above
8 average.

9 MEMBER BUHR: Well maybe we could see
10 the distribution, because I think families are
11 generally less satisfied than the patients. I
12 don't know, that's my experience.

13 DR. ROILAND: We're pulling that up
14 for you right now. It'll be the distribution for
15 each of the items. Yes. Eight actually, sorry.

16 So this is from the testing attachment
17 from the measure submission, and the column on
18 the far --- my right side shows you the response
19 percentage for each --- response option for each
20 item.

21 CO-CHAIR MONSON: Aline, did you ---
22 or --- did you want to go and then Jen?

1 MEMBER HOLMES: Do we have a breakdown
2 of what percentage of these residents that they
3 used the survey on the testing were dual
4 eligibles? Because it looks like the
5 investigator who did it was working for Manna
6 Care which is a for-profit long-term care. And I
7 don't know how many --- they don't take a lot of
8 Medicaid patients, and so I would be interested
9 to see --- for its applicability in the dual-
10 eligible population, this is really tested on
11 that --- you know, did they include a large
12 number of those long-stay residents who were
13 Medicaid? Because I don't know that they have
14 that many of them.

15 DR. ROILAND: So, I'm looking at the
16 testing attachment right now, looking at their
17 data --- their sample for the testing. It
18 doesn't give me any descriptions. The
19 demographics for the respondents --- it's just
20 gender, year of birth, highest level of education
21 and race. So they don't have dual status on
22 here.

1 MEMBER RAMONA: Just a point of
2 clarification, so the third question is how would
3 you rate the care you received? Not your loved
4 one? Not your family member?

5 DR. ROILAND: I'm suspecting that's a
6 typo in their submission, since the first ---
7 second question.

8 MS. JUNG: Yes, so it seems that the
9 --- for this questionnaire, the question slightly
10 differs. So the first two questions are the
11 same. Question one, in recommending this
12 facility to your friends and family, how would
13 you rate it overall? Question two, overall, how
14 would you rate the staff? And question three is
15 changed to how would you rate the care your
16 family member received?

17 DR. ROILAND: So I'm not sure why it
18 says that there. It's a typo. I'm not sure.

19 CO-CHAIR MONSON: Questions on --- for
20 folks on the phone?

21 (No audible response.)

22 CO-CHAIR MONSON: All right, then I

1 think, Madison, we are ready to vote.

2 MS. JUNG: Voting for Measure 2616:
3 CoreQ Long-Stay Family Questionnaire is now open.
4 Option one, yes; option two, no.

5 Okay, the voting is now closed with 18
6 votes. The --- give it a second.

7 No, that's not it. Oh, technical
8 difficulties. Just give me one second and I will
9 reset it.

10 Okay, let's try that again. Voting
11 for 2616: CoreQ Long-Stay Family Measure now
12 open. Option one, yes; option two, no.

13 Oh, something is not working. Do ---
14 would we like to move to a hand vote while we try
15 and sort this out?

16 (No audible response.)

17 CO-CHAIR MONSON: Are people
18 comfortable with a hand vote?

19 PARTICIPANT: Sure.

20 PARTICIPANT: Yes.

21 (Laughter.)

22 CO-CHAIR MONSON: Okay. All in favor

1 of this measure, voting yes.

2 And opposed. So what's this now?

3 MS. JUNG: With nine votes, that would
4 not meet the 60 percent --- nine --- nine votes
5 for yes, that would mean that it would not meet
6 the 60 percent threshold. So therefore it would
7 not be added to the family of measures.

8 CO-CHAIR MONSON: Yes, Clarke, go
9 ahead.

10 MEMBER ROSS: If people are
11 comfortable with this, I'd like our report to
12 show that we're generally very supportive of the
13 intent behind these questions, but the concern
14 was the validity of the responses given how it's
15 administered. I don't want to convey to the
16 public, and so I was just reading the report,
17 that we as a group are not committed to the
18 intent of these questions.

19 CO-CHAIR MONSON: Yes, I think that's
20 a great point. We should definitely do that.
21 Because I --- I don't think there's a person in
22 here who objects to that concept. I think that -

1 -- I'll speak as one who voted no --- it's more
2 the --- the validity you're talking about. That
3 we don't have a poor measure out there that
4 obfuscates as opposed to having a good enough
5 measure that allows us to have directional
6 intent.

7 Okay, since Tom is back in the room,
8 we're going to go back. Tom, what you missed
9 before was that we are revoting on the CoreQ:
10 Short-Stay Resident measure. Jen had asked us to
11 revote.

12 I think Jen, you had asked us to
13 revote in light of the conversation that we had
14 around the Long-Stay measure and many similar
15 issues. It was a similar instrument that you
16 wanted us to revote. Does that satisfy that?
17 Thank you. All right. So, do we want to try the
18 machine again? Or do you want to do the hand
19 vote?

20 MS. JUNG: I think the machine might
21 work.

22 CO-CHAIR MONSON: Okay.

1 (Laughter.)

2 MS. JUNG: I am semi-confident in
3 that. Okay, so the vote --- oh.

4 CO-CHAIR MONSON: Oh, yes. Tom,
5 sorry.

6 MEMBER LUTZOW: Yes, these two
7 measures -- 2615, 2216 --- seemed like brother
8 and sister. One directed at the resident, the
9 other directed at family members. Are they both
10 given at the same time?

11 CO-CHAIR MONSON: Are they both what
12 at the same time?

13 MEMBER LUTZOW: Administered at the
14 same time.

15 CO-CHAIR MONSON: -- that we know, but
16 ---

17 MEMBER LUTZOW: One to the family ---
18 one to the resident, one to the family.

19 CO-CHAIR MONSON: So just --- but
20 we're voting on 2614 now.

21 MEMBER LUTZOW: I understand. I'm
22 asking a question as to whether there's a

1 relationship between 2616 and 2615.

2 DR. ROILAND: We're looking it up now.

3 MEMBER LUTZOW: 2615 is long-stay and
4 2616 is long-stay. They're both long-stay. Yes,
5 I'm not talking about 14. I'm taking about 15
6 and 16. 16 failed --- or, 15 failed also? Okay.

7 CO-CHAIR MONSON: Fifteen's failed,
8 sixteen's failed. We're now voting on 14, which
9 originally passed and now, in light of ---

10 MEMBER LUTZOW: I see. Okay.

11 CO-CHAIR MONSON: Fifteen and 16 we're
12 revoting on 14.

13 MEMBER LUTZOW: Okay, got it.

14 CO-CHAIR MONSON: Okay. Do you still
15 need the answer, or are you ready to --- thank
16 you.

17 MS. JUNG: Okay, voting for Measure
18 2614: CoreQ: Short-Stay Discharge Measure is now
19 open. Option one, yes; option two, no.

20 (Voting.)

21 MS. JUNG: Okay. Okay, we might need
22 to move to a hand vote while this --- we reset

1 the whole presentation.

2 CO-CHAIR MONSON: Okay, so we're going
3 to hand vote again. So all who are voting yes on
4 2614, please raise your hands.

5 I'm counting nine.

6 Let's just --- keep those --- let's do
7 that again. Just to make sure we get the count
8 correct.

9 Ten out of --- ten out of 18. So
10 that's 60 percent?

11 MS. BUCHANAN: It's still not --- it's
12 59.

13 CO-CHAIR MONSON: It's 59? It's ten
14 divided by 18. Yes, it's 55. So 2614 looks like
15 it --- it's ten votes for yes, and we need 11.
16 With 18 voters, we need 11 to pass. So it does
17 not pass. But I think we should add the same ---
18 I think for all these, 14, 15 and 16, we should
19 add Clarke's comments about general support for
20 the concept, just concern about this particular
21 vehicle.

22 DR. ROILAND: All right.

1 CO-CHAIR MONSON: Next.

2 DR. ROILAND: We've got a few other
3 measures to get through, so we'll just keep on
4 trucking. Excuse me while I roll through this.
5 All right, the next few measures we have to
6 consider are related to function. And these
7 again are from the Person and Family-Centered
8 Care Standing Committee who reviewed these
9 measures.

10 And the first measure we have up for
11 consideration is measure 2775: Functional Change:
12 Change in Motor Score for Skilled Nursing
13 Facilities. And the measure description is the
14 change in rasch derived values of motor function
15 from admission to discharge among adult short-
16 term rehabilitation skilled nursing facility
17 patients aged 18 years and older who were
18 discharged alive.

19 The time frame for the measure is 12
20 months. And the measure includes the following
21 12 items: feeding, grooming, dressing upper body,
22 dressing lower body, toileting, bowel,

1 expression, memory, transfer
2 bed/chair/wheelchair, transfer toilet, locomotion
3 and stairs. And we have the numerator and
4 denominator available on the slides as well. And
5 the staff's preliminary analysis, sort of
6 rationale for including this measure in the
7 family of measures, is that it again addresses
8 several priority measurement and gap areas.

9 And we also, in the current family we
10 only have one function-related measure. That's
11 2624, a process measure focused on the
12 documentation of the assessment of function in
13 the care plan created around that. So I believe
14 that Measure 2775, which is an outcome measure
15 would be of benefit to add to the family of
16 measures. And with that summary, I'll open it up
17 for discussion.

18 MEMBER PARKER: How is adult short-
19 term rehab skilled nursing facility --- is that
20 anybody who's in there? And the reason I'm
21 asking is because it seems to me this is going to
22 be entirely relative to patient mix. And the

1 patient that are truly there for post-acute care
2 for a typical rehab thing like a hip surgery or
3 knee surgery or something, versus those who are
4 in decline or have a big problem and are probably
5 --- cancer or something where they're going to
6 die. But they're in the nursing home post-acute
7 because that's where the hospital has to put them
8 until somebody can figure out what else to do.
9 And they need to just die there.

10 So it's going to --- and so in small,
11 rural facilities and things like that, there's
12 only facility. And they're going to have
13 everybody. And in metro areas they're going to
14 have fancy ones that are just going to have those
15 sorted out people, rehab people, and they're
16 going to look wonderful because they're getting
17 everybody with a knee replacement. And they're
18 going to get them right out of there.

19 So I --- and the other ones are going
20 to be relegated to their few days of Medicare
21 stay in a short-stay facility and then be on
22 Medicaid or whatever. So I don't see how this

1 can be fairly done. And I don't understand how
2 it would be utilized.

3 MS. MUKHERJEE: It is risk-adjusted.

4 MEMBER PARKER: In what way?

5 MS. MUKHERJEE: So stratification by
6 risk category subgroup, and the adjusted
7 procedure is an indirect standardization
8 procedure: observed facility average over
9 expected facility average.

10 MEMBER PARKER: Okay.

11 MS. MUKHERJEE: So the numerator is
12 the facility's average motor functional change
13 score the denominator is meant to reflect the
14 expected motor functional change score at the
15 facility. If the facility has the same direction
16 of SNF-CMGs, impairment, functional status at
17 admission, and age at admission.

18 MEMBER PARKER: It's a complicated
19 one. Is that related to the facility case mix
20 represented?

21 MS. MUKHERJEE: It doesn't say. I'm
22 reading directly out of the report from the

1 committee.

2 MEMBER PARKER: It says CMG.

3 CO-CHAIR MONSON: Do we have any
4 understanding of that --- how they're coming up
5 with that expected component? Because that seems
6 to be a pretty critical piece of this. They're
7 basically --- they're forecasting what they would
8 have expected someone who looks like this to have
9 done.

10 DR. ROILAND: Debjani, I found the
11 section in the testing attachment for this
12 measure. And it says to calculate the facility's
13 adjusted expected change in rasch derived values,
14 we used indirect standardization which weights
15 national SNF-CMG specific values by facility-
16 specific SNF-CMG proportions.

17 CMG adjustment derives the expected
18 value based on the case mix and severity mix of
19 each facility, the skilled nursing facilities
20 case mix groups, classification system groups,
21 similarly impaired patients based on functional
22 status at admission or patient severity.

1 Patients with the same SNF-CMG are expected to
2 have similar resource utilization needs and
3 similar outcomes. Does that answer your
4 question?

5 MEMBER ROSS: So there are long-term
6 care advocates and facility representatives on
7 the Person and Family-Centered Care Committee,
8 which has endorsed this. The question is, do we
9 as a work group interested in people who are
10 dually-eligible aspire to an improved functional
11 change in a nursing facility and another National
12 Qualify Forum Committee with multi-stakeholder
13 balance endorse this measure? So with that, I'm
14 going to vote to endorse it because of that.

15 MEMBER COURT: This is Bev Court. My
16 experience with the weighting algorithm is that
17 it --- they use a --- the expected value is based
18 on Medicare, and it's not necessarily related to
19 duals. So again, without knowing the intricacies
20 of the expected estimation technique, I'm not
21 sold that this would be directly applicable to
22 duals. And apparently --- and I believe there's

1 no documentation of its application to this
2 population?

3 DR. ROILAND: Hi Bev, this is Rachel,
4 and there isn't any specific testing for duals
5 within their submission.

6 MEMBER HOLMES: I'm on the FIM
7 website, and so it's --- the system's been around
8 since 1994, and it says it's an outcome
9 management program for skilled nursing, sub-
10 acutes, long-term care, Veteran's Administration
11 programs, international rehab hospitals, and
12 other related venues of care. And there is
13 documentation with it. But I remember when I
14 worked in long-term care having to do this. So
15 it has been around for a long time and has been
16 used a lot.

17 MEMBER RAMONA: Quick question. Is
18 this the FIM? The Functional Independence
19 Measure? Because they're not saying that.

20 DR. ROILAND: So this measure uses the
21 FIM. It says, and is similar to ---

22 MEMBER RAMONA: Okay.

1 DR. ROILAND: Yes, it uses the FIM.
2 And the Committee also talked about whether this
3 was too similar to the care tool as well as other
4 data collected by the minimum data set. But the
5 data explained that this measure includes self-
6 care items of both cognitive and physical
7 function, while the care measure or other
8 measures of self care only cover physical
9 function. Excuse me.

10 And they also noted that the data
11 shows a change over time when using the FIM-based
12 measures, but the change is not shown for reports
13 using the MDS, which led the developer to
14 conclude that they're measuring different
15 functional domains using this measure.

16 CO-CHAIR MONSON: Aline, did you have
17 another comment?

18 Well I would just say that I think
19 that if we could have a score --- if this works,
20 right, we can actually see a functional score
21 that allows people to show improvement in a
22 nursing facility. I mean that's a very positive

1 development.

2 And then gives us more opportunities
3 to then have conversations with those individuals
4 about moving back to the community if that's
5 where they want to be. And takes away some of
6 that noise about whether or not they have the
7 functional capability to do that. So I would
8 also endorse this measure. Any more comments
9 before we vote? Do you want to try it one more
10 time?

11 MEMBER COURT: This is Bev. I just --
12 - we're looking at two measure that are very
13 related. One looking at that change in skilled
14 nursing facilities, and one looking at it in
15 long-term, acute care facilities. I think you're
16 --- the type of people in long-term, acute care
17 is quite different than skilled nursing, so just
18 a point of clarification.

19 DR. ROILAND: Right, and everyone ---
20 just so --- this measure is for the skilled
21 nursing facilities. The next measure will be the
22 long-term care, acute facilities. So just right

1 now we're focused on the SNFs.

2 MS. JUNG: All right. Voting for
3 Measure 2775: Functional Change: Change in Motor
4 Score for Skilled Nursing Facilities is now open
5 for addition to Family of Measures. Option one,
6 yes; option two, no.

7 (Voting.)

8 Okay, voting is now closed. The
9 results are --- the results are not pulling up
10 again. Apologies about that everyone.

11 CO-CHAIR MONSON: All right, so let's
12 do it by hand again. All who are voting yes on
13 2775.

14 MS. BUCHANAN: The result is 18, so
15 100 percent voted yes.

16 DR. ROILAND: All right, so we'll ---
17 with that we'll move on to the last measure. It
18 is Measure 2776. Again, a measure reviewed by
19 the Person and Family-Centered Care Standing
20 Committee --- oh, sorry you guys. Getting a
21 little --- need more coffee.

22 So this measure is Functional Change:

1 Change in Motor Score in Long-Term Acute Care
2 Facilities. The description of this measure it's
3 a change in rasch derived values of motor
4 function from admission to discharge among adult
5 long-term acute care facility patients aged 18
6 years and older who are discharged alive. And
7 the time frame for the measure is 12 months.

8 The measure includes the following
9 twelve items, which are the same for this measure
10 as for the 2776, and they are feeding, grooming,
11 dressing upper body, dressing lower body,
12 toileting, bowel, expression, memory, transfer
13 bed/chair/wheelchair, transfer toilet, locomotion
14 and stairs. And again, the numerator and
15 denominator are provided on the slides.

16 And then the staff rationale is
17 similar to that for 2775 in that it addresses
18 several priority gap areas. And also given the
19 current family had only one measure related to
20 functional status, we thought this would be a
21 positive addition to the family along with 2775.
22 Sorry, that is a typo. It should say 2776 down

1 there. And with that, I'll open up the floor for
2 discussion.

3 MEMBER COURT: Just a point of
4 clarification. In the spread sheet, you say that
5 it's from discharge at the facility level for
6 short-term rehab patients. But I thought you
7 were talking about long-term acute care
8 facilities. Is that correct? That would be
9 column --- what column is that? Numerator
10 statement.

11 DR. ROILAND: Hi Bev, this is Rachel.
12 You're right, we do have it as being discharge at
13 the facility for short-term rehabilitation
14 patients. Let me just double check that we have
15 the numerator correct. Was that -- that is
16 correct? Okay. Okay.

17 Sorry, no, that is the correct
18 statement. So it is for discharge. So the
19 numerator is the average change in the rasch ---
20 the numerator, excuse me, is the average change
21 in rasch derived motor functional score from
22 admission to discharge at the facility level for

1 short-term rehabilitation patients. I'm not sure
2 if that ---

3 No, I'm reading the numerator
4 statement for 2776. So let me just double check
5 in our QPS system if ---

6 CO-CHAIR MONSON: Gwen, go ahead.

7 MEMBER BUHR: Well I think and ---
8 it's an LTAC, which is --- people can go there
9 for rehab as well as they can go to the skilled
10 nursing facility. So it's just a different side
11 of rehab.

12 CO-CHAIR CHIN HANSEN: So that's how
13 it's practically used. It could be used for
14 short-term rehab as well. Because I know that
15 the intent wasn't meant to be that initially.
16 But so --- the functional use is then for
17 potential short-term rehab.

18 MEMBER BUHR: Yes.

19 CO-CHAIR MONSON: Pam ---

20 MEMBER PARKER: I'm confused now about
21 what facilities we're talking about. Are we ---
22 sorry. Are we talking about in-patient acute,

1 long --- when you go after hospitalization? Or
2 are you talking about long-term care hospitals?
3 Because generally, there's been a difference in
4 those. And the long-term care hospitals are
5 where you send your heavy-duty vent cases and
6 that kind of stuff.

7 And yes, they're probably going to be
8 there much longer than they would be in the acute
9 --- in-patient acute rehab, which is usually
10 limited to about six weeks or something. So I
11 don't get what we're actually --- what the
12 facility base is here.

13 MEMBER BUHR: Well, I think even in
14 those long-term, like, vent places, the goal is
15 still to get them better.

16 MEMBER PARKER: Sure.

17 MEMBER BUHR: Right? So they may have
18 a different trajectory --- obviously, they're
19 having a different trajectory, but they're still
20 trying to get off the vent, improve, have a
21 discharge plan, get better.

22 MEMBER PARKER: Sure, but it sounds

1 like we're trying to carve out a group, the
2 short-term rehab patients, out of that group. So
3 that's what I don't get. Because that reference
4 to the short-term rehab patients, we --- out of
5 either group, I'm not sure then who are we
6 talking about about the short-term rehab group?

7 MS. MUKHERJEE: So the committee said
8 --- the committee agreed that many of the issues
9 discussed in this one were similar to the one we
10 discussed before. And the main difference
11 between two --- these measures being that this
12 one is LTAC instead of SNF.

13 MEMBER PARKER: And who are they
14 including in LTACs?

15 Because this is over 12 months, isn't
16 it? Yes, both of them are over 12 months. So --
17 -

18 DR. ROILAND: So just on a ---

19 MEMBER PARKER: I'm having problems
20 with the 12 months and the short-term rehab.

21 DR. ROILAND: I don't have a specific
22 answer for that question yet. But just an

1 additional point of discussion that came up with
2 the committee. It says that the developer noted
3 that the same drastic level of functional
4 improvement is not expected to be seen in LTACs,
5 but a slight improvement can be possible. The
6 measure can be used to identify patients who are
7 starting to decline and need readmission to acute
8 or intensive care.

9 And patients at the lowest level,
10 complete dependents, are also captured with this
11 measure. In addition, the developer said that
12 LTACs had not traditionally measured function,
13 and they believe that asking questions about
14 function can improve the quality of care by
15 reminding providers of the importance of mobility
16 and overall function.

17 So they acknowledge that this measure
18 has not been used widely. And the committee did
19 question that, but they thought it would be good
20 to start measuring that, measuring function in
21 this setting.

22 CO-CHAIR MONSON: Clarke?

1 MEMBER ROSS: So I'd like to reinforce
2 the importance of this measure. The state of the
3 field is that each facility type organizes and
4 has their own measurement and performance system.
5 And we're aspiring to remove those barriers over
6 time.

7 But why wouldn't we want, as the
8 advocate for the dually-eligible population, to
9 see a positive functional change for everybody
10 who goes into a facility? And no matter how
11 severely disabled they are, with the right
12 interventions over time, we can see improvement.

13 And why would we want to go on record
14 not agreeing with the Person and Family-Centered
15 National Quality Forum Committee that already
16 endorsed this. The implied message is we don't
17 think everybody can improve, and so we're not
18 going to endorse the measure. That's the way I
19 would read it.

20 MEMBER PARKER: I think it's just, do
21 we even know who it applies to? I mean, I don't
22 know who it applies to now. But ---

1 CO-CHAIR CHIN HANSEN: I agree. I
2 think Pam was just saying --- it's not the fact
3 that the improvement isn't there. There's just
4 some technicalities, too, of who it applies to.
5 And I think the funding is significantly
6 different between LTACs and regular facilities.
7 The reason I pay attention to that, or am aware,
8 when I was on MedPAC, that was real --- kind of
9 deeply looked at.

10 And the payment system with the LTAC
11 program is quite significantly higher than
12 regular rehab. So it's just other noise, not the
13 principle of what --- of course we would want to
14 see improvement. But it just is the use of a
15 designated provider with certain criteria for
16 eligibility.

17 The idea of using a system like that
18 --- and LTACs are not that available throughout
19 the country. It's really band of them on the
20 coast and in the South. So it's not a standard
21 facility that's available all over. So it's more
22 for me, kind of, almost a structural issue. Not

1 the principle of what you said. And it sounds
2 like other committee actually asked some similar
3 questions.

4 MEMBER RAMONA: I'm sure there's an
5 expert in here. Can a LTAC designate somebody as
6 a short-term rehab patient versus not? Because
7 is it really just then saying anyone that
8 discharges, since the measure description is
9 about somebody from a long-term --- or, yes, from
10 a LTAC that discharges alive? So if you can't
11 designate somebody as short-term or not, does
12 that become a moot question?

13 CO-CHAIR CHIN HANSEN: There are other
14 experts here, but I think there's a threshold of
15 clinical criteria and function criteria in order
16 to even get admitted to an LTAC. So if there ---
17 that's the reason I think I asked Gwen if they're
18 now using it, with question mark for short-term
19 rehab stays. That's actually not the formal
20 intent of those programs.

21 MS. MUKHERJEE: I don't know if this
22 is going to help, but for the LTAC, they have

1 primary medical reasons for the LTAC stay for
2 this measure, such as stroke, joint replacement,
3 brain injury. So they --- among others, so they
4 --- I don't know if that helps determine what
5 kind.

6 MEMBER BUHR: And the measure does say
7 for short-term rehab patients. So I don't know
8 if they can somehow designate that. I don't
9 know.

10 DR. ROILAND: Yes, and looking in the
11 measure submission, there's a section called the
12 Calculation Algorithm and Measure Logic, and
13 within that, they don't have a specific step that
14 helps them identify rehab patients specifically.
15 It just says identify all patients during
16 assessment time frame.

17 Exclude any patients who died at the
18 LTAC. Exclude any patients who are less than 18
19 at the time of admissions at LTAC. Calculate the
20 motor change score. Go through the process of
21 deriving the rasch score and then calculating the
22 ratio for the facility. So it doesn't

1 specifically say how they identify short-term
2 rehab patients.

3 MEMBER AGUIAR LYNCH: It may just be
4 that --- that the short-term rehab is misnomer
5 for when it's used in the LTAC. I think that's
6 what it is. Because if it's brain and spinal,
7 those are --- to your point Jenny, those are
8 populations that are appropriate for the LTAC.
9 The joint replacement I think should not be seen
10 in the LTAC. But it sounds like, from the
11 specifications, that it's actually not asking
12 them to identify short-term rehab but to pull
13 from specific disease categories or conditions.

14 CO-CHAIR MONSON: For what it's worth,
15 if you think about it, what it sounds like is
16 that --- so there seems to be some ambiguity
17 about which populations we're talking about. But
18 whether it's --- let's assume it's --- if it's
19 one direction where it's all, everybody who's
20 actually in an LTAC, then this seems like a
21 reasonable measure.

22 Right? Because it's capturing ---

1 there should be --- there's potential for
2 functional improvement. There shouldn't be --- I
3 mean, we shouldn't assume that people in an LTAC
4 can't have functional improvement. And then if
5 for some strange reason there is some short-term
6 rehab happening there, if we improve the short-
7 term rehab for a nursing facility, it would seem
8 like we should improve short-term rehab for an
9 LTAC, too.

10 So from my perspective, it feels like
11 it's a no-lose to vote yes on this one.

12 MEMBER COURT: I think that there's
13 going to be definitional challenges to this. And
14 I think it's going to be small gains.

15 CO-CHAIR MONSON: Small --- say that
16 last part again, Bev?

17 MEMBER COURT: I think that there's
18 going to be --- so I think there's some validity
19 issues here. I think there's stability issues,
20 especially with that population. I don't --- to
21 me it's different than the short stay in a
22 skilled nursing facility.

1 I mean, the point of that setup is to
2 advance the client. And I don't think, given all
3 the types of conditions, that this is going to be
4 a very sensitive measure. And I think it can
5 easily get misinterpreted. I'm not a fan.

6 MEMBER ROSS: So the chair --- one of
7 the co-chairs of the Consortium for Citizens with
8 Disabilities Task Force on Health is a member of
9 this committee. United Spinal Association is an
10 active CCD member, and the Christopher and Dana
11 Reeve Foundation -- paralysis foundation -- is an
12 active member of CCD. They're very supportive of
13 this.

14 As the consumer, goal when you get
15 admitted should be functional improvement, and no
16 matter how severely disabled you are, with the
17 right supports, you can improve functionally.
18 Facilities are represented on this committee. I
19 just really don't see us sending the message that
20 we can't support another endorsement of another
21 committee that functional improvement should be a
22 goal, regardless of the severity of your

1 paralysis or spinal cord injury which these two
2 major consumer groups demonstrate to us every day
3 with all of their consumers.

4 So again, two cents worth, but I think
5 this is a grave mistake if we send the message
6 that we think there's some technical challenge,
7 and we can't send the message of supporting this.

8 MEMBER RAMONA: I'll second that, but
9 also say that it may be since it's also adjusted
10 for expectation, that it's maintenance, not just
11 improvement. And so that you're not going to see
12 a decline in functionality, and I think that's as
13 important as well.

14 CO-CHAIR MONSON: What we might want
15 to do, regardless of how we end up with the vote,
16 I think there's certainly something to add in the
17 report about confusion about which population is
18 targeted here and that the measure doesn't seem
19 to be entirely clear. Right?

20 So whether we vote to approve it or
21 not, that --- I think that the tenor of this
22 conversation should be captured in our report.

1 DR. ROILAND: Noted.

2 CO-CHAIR MONSON: Any other comments?

3 Do you want to just do a hand vote?

4 MS. JUNG: It's your preference.

5 CO-CHAIR MONSON: What ---

6 MS. JUNG: I mean, it --- we can try.

7 I believe in it.

8 CO-CHAIR MONSON: Okay, we're going to
9 try it one more time.

10 (Laughter.)

11 MS. JUNG: I'm holding out. All
12 right.

13 CO-CHAIR MONSON: No pressure.

14 MS. JUNG: Yes. This is --- little
15 train that could. For Measure 2776: Functional
16 Change: Change in Motor Score in Long-Term Acute
17 Care Facilities. Option one, yes; option two,
18 no.

19 One more. Okay. Success. And also
20 that --- so 94 percent vote for yes. That
21 concludes that this Measure 2776 will be included
22 in the family of measures. Seventeen votes for

1 yes; one vote for no.

2 DR. ROILAND: All right, and now we'll
3 --- I just have a few more slides, and then we'll
4 move to public comment. So we are done with
5 voting for new measures to add to the family.
6 We've just gone through this process of whether
7 or not these newly-endorsed measures should be
8 included in the family.

9 We'll give you a summary slide
10 tomorrow morning, too, that gives you an overview
11 of all of our decisions for these measures. So
12 congratulations; you're done with that section of
13 the meeting. We did also just want to give you a
14 quick update that there are some measures in our
15 family that are currently undergoing the review
16 process.

17 There haven't been any final decisions
18 made on these measures, but we did want to make
19 sure we kept you informed about the sort of
20 status of these measures. We currently have six
21 consensus development or CDP projects reviewing
22 measures within our family. Their final status

1 will be decided during --

2 MEMBER ZLOTNIK: Rachel, could you
3 just slow down a little?

4 (Laughter.)

5 DR. ROILAND: Oh, sure. Sorry. Not
6 the first time I've heard that, so I --- the
7 final status of these measures will be decided
8 during our CSAC meeting in July. But we'll ---
9 the staff up here will continue to communicate
10 any changes in endorsement to these measures to
11 you all over the course of the summer. Those
12 measures that are currently undergoing review,
13 there's one that the Patient Safety Standing
14 Committee has --- is currently reviewing.

15 It's Measure 0022: Use of High-Risk
16 Medications in the Elderly. The Care
17 Coordination Standing Committee at the end of
18 February just recently reviewed a number of our
19 measures including 0326: Advanced Care Plan,
20 0646: Reconciled Medication List Received from
21 Discharge Patients, 0647: Transition Record with
22 Specific Elements Received by Discharge Patients,

1 0648: Timely Transmission of Transition Record,
2 and 0649: the Transition Record with Specified
3 Elements Received by Discharge Patients.

4 And just a heads up that the Care
5 Coordination Team will be releasing their draft
6 technical report for public comment. If it's not
7 already up, it will be up in the next few weeks.
8 And so if you are so inclined, you can certainly
9 make a public comment as a member of the public.

10 Additional standing committees
11 reviewing other measures in our family: we have
12 the Health and Well-Being Standing Committee
13 having reviewed 0032: Cervical Cancer Screening,
14 0659: Influenza Immunization. The Infectious
15 Disease Standing Committee is reviewing 2079: HIV
16 Medical Visit Frequency. The Cost and Resource
17 Use Group just reviewed Measure 2158: the
18 Medicare Spending Per Beneficiary Measure.

19 And the Behavioral Health Group, who
20 you'll be hearing from one of their staff people
21 in a little bit, they have reviewed three of our
22 measures: 0008: the Experience of Care and Health

1 Outcomes or ECHO Survey was reviewed to a certain
2 degree by that standing committee, and they had
3 an interesting discussion around the status of
4 that measure. And Kirsten will give us an update
5 on that when she comes up in a few minutes. And
6 they're also reviewing 0027: Medical Assistance
7 for Smoking and Tobacco Use Cessation, as well as
8 Measure 0576: Follow Up After Hospitalization for
9 Mental Illness.

10 So I just want to reiterate that these
11 measures are currently going under review. We
12 don't have any final decision on their
13 recommendations for endorsement. But we'll
14 certainly keep you updated on all of that as they
15 move through the CDP process and make --- and the
16 final decisions are made on these various
17 measures.

18 So with that I will actually turn it
19 over to our co-chairs to ask the Operator to open
20 it up for public comment.

21 CO-CHAIR MONSON: Operator, will you
22 please open up the line for public comment?

1 OPERATOR: Yes, sir.

2 CO-CHAIR MONSON: And I think, those
3 who are on the web chat, if you just want to ---
4 you can chat in a question too, and the staff can
5 see it, and we'll --

6 OPERATOR: Okay. And at this time, if
7 you would like to make a public comment, please
8 press star then the number one.

9 And there are no public comments from
10 the phone line.

11 DR. ROILAND: All right, it looks like
12 there's no public comments in the room. We're a
13 little bit ahead of schedule now, so we'll check
14 in with our presenter. I asked her to come
15 early, and then it looked like the conversation
16 was going on longer. So we'll try to get her up
17 here soon. So you all have a break for about the
18 next ten minutes until we get the next presenter
19 up here.

20 (Whereupon, the above-entitled matter
21 went off the record at 3:21 p.m. and resumed at
22 3:31 p.m.)

1 DR. ROILAND: All right, everyone, if
2 we want to take a seat. We'll hear from our last
3 presenter for the day. So I'm actually going to
4 turn over the presentation to my colleague,
5 Kirsten Reed, who is a project manager here at
6 the National Quality Forum and helps staff the
7 Behavioral Health CDP Project that met in
8 February. Right? Am I ---

9 MS. REED: Yes.

10 DR. ROILAND: Okay, I just wanted to
11 make sure. And so she's just going to give us an
12 update on the project and just be available for
13 any questions you all might have about measures
14 that they reviewed related to our family of
15 measures. So Kirsten, over to you.

16 MS. REED: Thanks, hi everyone. As
17 Rachel mentioned, my name is Kirsten Reed, and I
18 am the project manager for the Behavioral Health
19 Project. So I'm going to briefly just kind of go
20 over the portfolio as a whole.

21 We currently have about 50 endorsed
22 measures within this area, and they focus on a

1 number of topic areas including alcohol and
2 substance use, tobacco use, ADHD, depression and
3 schizophrenia. This is kind of a different look
4 at our portfolio. You can see that it kind of
5 encompasses a number of different areas such as
6 physical health, general behavioral health,
7 alcohol and other drug disorders, tobacco use,
8 and depression. And as you can see by this
9 breakdown, no one topic area is more focused on
10 than others within the portfolio, but gaps really
11 do still remain.

12 And this is just another look at the
13 portfolio. Different break down. You have care
14 coordination here, medication use, the
15 continuation of medications, adherence, and so
16 on. So as we were trying to kind of figure out
17 ways to portray our portfolio of measures, we
18 decided that depicting is as a care trajectory
19 was the most appropriate way in doing so.

20 So each of the measures in our
21 portfolio fit into this care trajectory and
22 address populations at risk, which we're

1 referring to as phase 1. Evaluation and initial
2 diagnosis as phase 2, and Follow-up Care, which
3 is phase 3. It's also important to note that
4 about 15 percent of these measures span between
5 phases 1 and 2, and about 3 percent span between
6 phases 2 and 3.

7 MEMBER ZLOTNIK: Are these adult
8 measures?

9 MS. REED: I'm sorry?

10 MEMBER ZLOTNIK: Are these exclusively
11 adult measures?

12 MS. REED: No, they are everything.

13 MEMBER ZLOTNIK: Okay.

14 MS. REED: So this is similar to the
15 previous slide, but shows what percentage of
16 measures in our portfolio fall into each of the
17 phases. And while we recognize that those
18 suffering from mental illness can and do recover
19 when provided with timely and coordinated care,
20 we know that it's extremely important to have
21 measures that span across the full, kind of,
22 continuum of care. And as you can see by this, a

1 number of our measures are really siloed. We
2 don't really --- kind of cross all the different
3 areas.

4 So our Behavioral Health Standing
5 Committee reconvened in October of last year to
6 begin looking at a couple of measures. So we
7 reviewed seven new measures and six maintenance
8 measures. And they focused on things such as
9 tobacco use, alcohol and substance abuse, ADHD,
10 depression, medication continuation, and follow
11 up after hospitalization for a mental illness.

12 So the standing committee, as Rachel
13 said, were brought together at the end of
14 February. And of those we had seven measures
15 that were recommended, four that were not
16 recommended, and one was deferred. So
17 specifically, I was asked to speak about three
18 measures that were recently reviewed by the
19 Behavioral Health Committee that pertain to your
20 work here on this committee.

21 The first of which is the ECHO Survey,
22 which as you can see by the measure number, is

1 one of our oldest measure. This patient-reported
2 outcome measure was originally endorsed in 2007
3 and assesses patient experiences with behavioral
4 health services in areas such as getting
5 treatment quickly, communication with clinicians,
6 and information about treatment options.

7 Shortly before the in-person meeting,
8 the NQF, in agreement with our committee co-
9 chairs, decided to defer consideration of
10 endorsement for this measure because there was
11 not yet enough data for the committee to
12 consider. So the developer explained that they
13 do not currently have data on performance scores
14 and use, but they do know that there has been an
15 uptick in using this instrument.

16 They also noted that there are several
17 large studies currently under way, and they are
18 in the process of performing new field testing.
19 So the committee agreed that the measures that
20 capture patient experience are extremely
21 important, especially as this one --- this is one
22 of the few patient experience measures for

1 behavioral health. And preferred to give
2 feedback to developer during the in-person
3 meeting about kind of the things that they were
4 looking for, rather than risking them bringing it
5 to the committee to look at it and then have the
6 potential of not passing.

7 So the developer is now working to
8 update their submission, and we expect to review
9 this measure during its annual review. But as of
10 now, it is still currently endorsed.

11 So the next measure is Medical
12 Assistance with Smoking and Tobacco Use
13 Cessation. This is a health plan-level process
14 measure initially endorsed in 2009 and most
15 recently endorsed in 2012. It's a long-standing
16 measure that uses patient-reported data from the
17 CAHPS Survey to assess if patients have received
18 assistance from a doctor or a health care
19 provider to stop smoking and tobacco use.

20 The committee agreed that based on the
21 performance data provided by the developer, a gap
22 in care continues to exist for advising patients

1 to quit smoking, discussing cessation
2 medications, and discussing cessation strategies.
3 The committee did express concern around ensuring
4 that the questions in the measure are clearly
5 defined and that patients are able to
6 differentiate between each of the questions.
7 Overall, the committee recognized how high
8 tobacco use is within the mental illness
9 population and how useful this measure is and
10 voted for its continued endorsement.

11 And then, finally, the Follow-Up after
12 Hospitalization for Mental Illness. This is a
13 health plan-level process measure originally
14 endorsed in 2009 and then most recently endorsed
15 in 2012. And this assesses whether health plan
16 members who are hospitalized for a mental illness
17 received a timely follow-up visit.

18 The developer here provided several
19 new clinical guidelines supporting follow-up
20 after hospitalization and cited evidence that
21 timely follow-up reduces suicide attempts and
22 readmissions and improves functioning. The

1 committee expressed concern that coordinating
2 follow-up care in a system that is fragmented
3 could put hospitals in a challenging position,
4 but again realizes this is an important measure.

5 They did have a number of suggestions
6 for the developer to maybe consider in the
7 future, such as the use of telehealth to count
8 for a follow-up visit, to consider expanding the
9 definition of mental health practitioner, and to
10 add hospitalizations for drug and alcohol
11 disorders. So again, for this one, the committee
12 agreed to continue its endorsement.

13 MEMBER POTTER: Can you say the last
14 sentence again?

15 MS. REED: The committee agreed to
16 continue the endorsement for this. So it is still
17 --- or still considered endorsed. And that is my
18 update. Are there any questions?

19 MEMBER LAKIN: I was sort of struck
20 with how few mentions there were of anything that
21 we might call outcomes. Things like employment,
22 relationships, independent living, those sorts of

1 things. Is that not considered an important part
2 of ---

3 MS. REED: So it definitely is, and as
4 the committee met recently, they all brought up
5 that exact same point and recognized they really
6 needed to start moving towards outcome measures,
7 because there really are not many in the
8 portfolio. So that was listed as one of the
9 gaps.

10 CO-CHAIR MONSON: Joan?

11 MEMBER ZLOTNIK: Two questions. One,
12 when you talked about the mental health measure,
13 you talked about considering expanding the
14 definition of mental health practitioner. Could
15 you tell me what the definition of mental health
16 practitioner is that's being used?

17 DR. LUSTIG: Hi, I'm Tracy Lustig. I
18 work with Kirsten on the project. I don't know
19 if I have it in front of me, but really just what
20 it had to do with was, within the specifications
21 of the measure, they had only certain types of
22 providers listed. And the committee suggested

1 expanding that.

2 There was a lot of discussion in the
3 meeting as well about whether a mental health
4 provider should be someone who has specific
5 expertise, but also recognizing there are a lot
6 of primary care providers that are providing
7 follow-up for a lot of these hospitalizations.
8 So that's what that had to do with. I'll look to
9 see if I have the specific definition in front of
10 me.

11 MEMBER POTTER: Yes, it includes
12 psychiatrists and psychologists and those types
13 of people, but if you're an internist or a family
14 practitioner, you're not considered, quote, a
15 mental health provider.

16 MEMBER ZLOTNIK: Now, I had another
17 question too. But I can't quite remember what it
18 is now. I'll have to think about it.

19 MEMBER ROSS: I had several questions
20 on the ECHO. So you have a statistic that five
21 percent of the existing portfolio is experience
22 of care. Is that the ECHO? Or what is the other

1 experience of care that --- what constitutes the
2 five percent?

3 MS. REED: There are a couple other
4 ones. We can send those around, but there are a
5 couple of other CAHPS surveys for follow-up for
6 people who received mental health treatment.

7 MEMBER POTTER: There's a hospital-
8 based experience of care one for ---

9 MEMBER ROSS: I was about to say ---

10 MEMBER POTTER: Psychiatric --- yes.

11 MEMBER ROSS: -- operates, the
12 National Research Institute I thought reports on
13 a hospital-based experience of care. So that's
14 what that would be.

15 MS. REED: Yes.

16 MEMBER ROSS: So who's the steward for
17 --- for the ECHO?

18 MS. REED: CMS. AHRQ, well, AHRQ is
19 now run it --- oh, yes, you're right. It's AHRQ.
20 Sorry. And there's a guy from Yale who's now the
21 developer for the measure.

22 MEMBER POTTER: And their developer is

1 the CAHPS --- the developer is the CAHPS
2 Consortium.

3 MEMBER ROSS: And D.E.B. could
4 probably answer this better than you can. Why
5 has this not been used in the mental health
6 field? Why don't the state mental health
7 agencies use it and require it by the over 2,000
8 community mental health centers?

9 MEMBER POTTER: I can't really speak
10 directly to that. With respect to the community
11 mental health centers, the federal government has
12 real mixed accountability when it comes to
13 community mental health centers. It's not like a
14 CMS program that they have direct ---

15 MEMBER ROSS: Well there's the SAMHSA
16 Mental Health Block Grant that finances every
17 state ---

18 MEMBER POTTER: That's all through the
19 block grant mechanism.

20 MEMBER ROSS: -- mental health agency
21 and ---

22 MEMBER POTTER: SO it's a block grant

1 as opposed to a quality reporting program.

2 MEMBER ROSS: So AHRQ's never really
3 promoted the ECHO within the mental health ---
4 public mental health system?

5 MEMBER POTTER: I can't speak to
6 promoting or not promoting. It's been sitting on
7 the AHRQ website for years. So I do know that
8 some people say well why do I need a separate
9 measure for behavioral health if the CAHPS Health
10 Plan Measure, which I really need to do, has
11 questions about specialty care and access and
12 things like that.

13 So some of it is that there's other
14 CAHPS surveys, like the health plan surveys and
15 the CAHPS Medicaid survey. Some of that. But I
16 can't speak more to that.

17 MS. REED: So I think it is being
18 used. I think that they are not receiving the
19 data that they need on who's actually using it,
20 which is one of the issues that was brought up.
21 So a number of the committee members did kind of
22 recommend various people and places to go to so

1 they can start kind of getting that data and
2 showing the effects of it.

3 MEMBER POTTER: And Clarke, there ---
4 there is an experience with care survey that
5 SAMHSA uses for the block grants. I forget what
6 the name of it is. So ---

7 CO-CHAIR MONSON: Tom?

8 MEMBER LUTZOW: Yes, this idea of
9 telehealth. I'm wondering if you could expand on
10 that. I mean, it's hopeful as a strategy, but do
11 we have evidence that it works? I can see where
12 even in the case of police, first-responders the
13 telehealth capability would be an immediate
14 professionalization of an encounter, perhaps.
15 But how did that get there from an evidence-based
16 point of view?

17 MS. REED: So it's actually just a
18 recommendation from the committee since the field
19 is trying to move in that direction. So they
20 were just asking the developer to kind of explore
21 that option. If it could be kind of somehow put
22 into the measure, if it could be reported on,

1 things like that.

2 DR. LUSTIG: And just to follow up,
3 for that particular measure also, there were a
4 number of follow-up visits that were required
5 within about a nine-month period, and one of the
6 suggestions the committee had was to consider
7 whether at least one of those visits could be a
8 telehealth measure.

9 The other thing I wanted to add for
10 those that aren't aware, we actually currently
11 have a framework project here at NQF looking at
12 telehealth specifically for how we begin to think
13 about evaluating the quality of care as provided
14 by telehealth, either in comparison to other
15 modalities, or even if the alternative is no care
16 at all. But that project is currently underway.

17 CO-CHAIR CHIN HANSEN: Actually I just
18 want to --- I have a different question, but to
19 pick up on that. So much of the broader world is
20 developing these apps, whether it's for a
21 physician, or in the area of social, mental
22 health, behavioral health. Is there linkage from

1 the kind of analysis that you're doing here at
2 NQF to what the marketplace is doing?

3 DR. LUSTIG: So the way that we're
4 approaching the telehealth framework is to try in
5 some ways to not be specific to the modalities
6 that exist now, because we don't want it to
7 become dated as soon as it gets out, but really
8 just think about telehealth as a concept in
9 general, a remote service. But definitely
10 considering apps and every other type of thing we
11 can think of at this time, as well as trying to
12 create a framework that really is just thinking
13 more about the dimensions of quality and how we
14 could apply anything that comes along to that.

15 CO-CHAIR CHIN HANSEN: Sure. No, I'm
16 just glad --- I agree. It's not like one
17 particular app or company. But it just seems
18 that has been a social response that has just
19 been that much more prevalent. And especially
20 with behavioral health but isolation issues. I
21 don't know if that comes under your umbrella.

22 DR. LUSTIG: So right now one of the

1 domains definitely that we're looking at is
2 patient experience, and it has to do with, when
3 you say patient experience, many things are meant
4 by that. Anything from, hey, I don't have to
5 spend two hours driving in my car to go to the
6 doctor, to I can immediately talk to someone when
7 I need it, which could be also part of that
8 social isolation.

9 CO-CHAIR MONSON: Joan and then
10 Clarke.

11 MEMBER ZLOTNIK: I remembered what my
12 other question was. In terms of the measures
13 that you had reviewed and included, discharge
14 from hospital, but many people with behavioral
15 health issues are never hospitalized. And so are
16 there measures that are being used, related to
17 service delivery outcomes, that are not covering
18 people who are hospitalized? And my other
19 question is, do people with Alzheimer's and
20 dementia come under behavioral health here or
21 elsewhere? Because that's another issue.

22 DR. LUSTIG: Yes, I don't remember

1 anything specific in the behavioral health
2 portfolio related to dementias or other cognitive
3 disorders, unless it had to do with someone who
4 had as substance use disorder and that sort of
5 thing. It's the other types of mental illness
6 are primary. In terms of outcomes, I'm actually
7 trying to think of any that would fit what you're
8 looking for. We really don't have a whole ---
9 I'm trying to remember any with --- we certainly
10 didn't look at any outcome measures.

11 MEMBER ZLOTNIK: Since it's basically
12 a community-based service delivery system block
13 granted to states.

14 DR. LUSTIG: Well, and that's what we
15 found in our sort of just very cursory overview
16 of the portfolio as a whole, a lot of the
17 measures that are --- you saw there was a
18 preponderance of measures in that later stage,
19 which was follow-up care, which sort of surprised
20 our committee.

21 But those were really things like,
22 once a medication is prescribed, did you get a

1 follow-up visit with that provider within 30
2 days? Within whatever? So it's a lot of follow-
3 up to that immediate sort of care. But as we
4 talked about, the committee was really interested
5 in, okay great, they stay on their medication for
6 30 days. But what's the ultimate outcome? And
7 that's what they really would like to see
8 measures going toward.

9 MEMBER ROSS: I have a question on if
10 any of these measures address co-occurring mental
11 illness other disorders. The National Core
12 Indicators, which is the quality system for
13 people with intellectual and developmental
14 disabilities used for over 20 years in half the
15 states, starts with the prevalence of co-
16 occurring disorders, including the prevalence of
17 co-occurring developmental disabilities and
18 mental illness, which is --- averages between 31
19 and 36 percent.

20 Are there measures that address mental
21 illness and substance abuse disorder, mental
22 illness and intellectual disability, mental

1 illness and dementia?

2 MS. REED: There really wasn't, and we
3 did have a woman on the committee who's in the
4 substance use field. And she was really pushing
5 for that, that they shouldn't be separate
6 measures. We should be screening for all of
7 those things at the same time.

8 There's also a huge push now for the
9 integration of behavioral health and physical
10 health, so we are seeing measures kind of looking
11 at that. And so, you know, screening for
12 depression as well as diabetes. And that is ---
13 so we are seeing a push for that, but not quite
14 yet for integrating substance use and behavioral
15 health.

16 DR. LUSTIG: And when Kirsten showed
17 you the diagrams earlier, and you saw that it
18 said about a quarter of the measures were
19 physical health, it was actually what you were
20 saying. It was for people who have
21 schizophrenia, have they had their HbA1c tested?
22 Have they had their blood pressure tested?

1 So that's how we define physical
2 health, was that for individuals with
3 schizophrenia or depression or others that are at
4 risk for diabetes/high blood pressure, what ---
5 yes, what we didn't see is what you were talking
6 about. I don't recall any where it's talking
7 about comorbid mental illnesses or developmental
8 disability.

9 MEMBER POTTER: I just wanted to
10 follow up on Joan's question. There is a similar
11 measure of follow up after treat and release at
12 the ER if people have mental health or people who
13 have substance abuse. And then there's also a
14 few measures around depression where the outcome
15 is measured with -- change in depression in
16 measured with the PHQ. So it's true outcome.

17 CO-CHAIR CHIN HANSEN: My question is
18 broader, and it goes back to Charlie's initial
19 question about what outcomes would be. And it
20 just seems that, especially in the area of
21 behavioral health, there would be some work that
22 would have been done long ago about having people

1 functioning in the community and all of that.

2 Is there any other group or body of
3 work that you can point us to that looks at the
4 employability of somebody of employment age and
5 function from a behavioral health a little bit
6 differently from the way we've approached it?

7 DR. LUSTIG: One of the things we were
8 really grateful for is we added a new member to
9 the committee from NAMI, the National Alliance
10 for Mental Illness. And he's really bringing us
11 that perspective of the things that matter to
12 that population.

13 And we actually met with him earlier
14 today to talk --- he wanted to learn more about
15 measured development, but he was really
16 interested in things like that. Caring about,
17 can I function? Can I keep at my job? Those
18 sorts of things. And so I'm hoping that he'll
19 bring that perspective to our committee. But we
20 can reach out to him and see if he has
21 suggestions.

22 CO-CHAIR CHIN HANSEN: I think this

1 framing is what we talked about very -- earlier
2 in the day, of just thinking about this beyond
3 the process in the clinical. Of really,
4 ultimately, is the person able to function in
5 society better because of our processes and our
6 structures?

7 So it just is one of those areas in
8 general it seems that this is kind of like the
9 2.0 of quality is what matters, and do people
10 function and live their lives better? And that
11 would tie together some of the things that we've
12 focused on. But it's part of, hopefully, kind of
13 the framing work that NQF is looking at. Because
14 it is ultimately, the functional result --- I say
15 functional, but whatever better term could be ---
16 is people living their lives as productively as
17 possible.

18 DR. LUSTIG: And Jennie, I know I
19 don't have to tell you these types of things, but
20 there is some other work at NQF. It's not
21 related specifically behavioral health, but on
22 the National Quality Partners side, we just did

1 some work related to advanced illness care.

2 And really talked about what are
3 patient preferences, as we called them. And
4 health or physical health was just one small
5 portion of it. There was do I feel financially
6 secure? What are my relationships with my
7 family? Do I feel like I have sense of purpose
8 in life? All those things, and I think those
9 could apply broadly. And so we are thinking
10 about those things.

11 MEMBER ROSS: There are two states,
12 Maryland and Massachusetts, and parts of two
13 other states, Pennsylvania and Wisconsin, that
14 use independent, community-based, peer-operated
15 organizations as the quality assurance mechanism
16 where teams of trained peers interview client
17 peers in the system.

18 Have you been studying those
19 experiences in those four states? And the NAMI
20 rep, who I know well, would not bring that to
21 your attention. But a member of the National
22 Quality Forum Home and Community-Based Service

1 Committee, Dr. Jonathan Delman from
2 Massachusetts, he founded the Massachusetts
3 consumer --- can't remember the exact name ---
4 monitoring project. But there is some published
5 support. There is, of course, two states and
6 some counties in two other states who financially
7 support peer-to-peer quality monitoring. So ---

8 MS. REED: I wasn't aware of that, so
9 I'll definitely look into that. Thank you.

10 MEMBER RAMONA: Has there been any
11 discussion around assessment or evaluation of
12 their support structure? Informal or formal,
13 care givers, family support, what it looks like?
14 How that impacts their outcomes? Anything in
15 that space?

16 DR. LUSTIG: Certainly not in this
17 past meeting. The most I can think about it was
18 related to the ECHO measure where there was
19 discussion about, since it's a patient survey,
20 who can fill out the survey for the patient?
21 Which, as you would know, could raise all sorts
22 of issues about who's filling it out and what

1 they say occurred.

2 But we really haven't gotten into
3 those issues about the larger support systems.

4 MEMBER RAMONA: Because it could,
5 obviously, with the behavioral health segment,
6 their own structure is often stressed itself. So
7 if there's not also an evaluation of how they're
8 doing in terms of being able to have respite,
9 being able to have even a sense of community
10 around the issue is pretty significant to the
11 success of the individual.

12 DR. LUSTIG: The closest I can just
13 think of that came up was we had a measure about
14 follow-up for ADHD medication. And they were
15 actually showing that the people that were more
16 compliant, that had had all follow-up visits that
17 were required, actually had higher ED usage than
18 people that didn't have regular follow-up.

19 And the theory was that parents that
20 are vigilant are going to bring their kid in at
21 the first sign of any issue. Versus people that
22 aren't as compliant and don't make all their

1 follow-up visits and aren't going to rush to the
2 ED. It was just sort of an interesting thing in
3 that it sort of came out the opposite of what you
4 might think would happen.

5 That the whole supposition was if you
6 have more follow-up, you won't go to the ED
7 because you won't have the emergency visits. But
8 that was sort of the only sort of family
9 structure issue I can think of that came up
10 specifically.

11 MEMBER PARKER: This maybe goes off in
12 a little bit different direction, but I wanted to
13 get it in here somewhere. When you're talking
14 about the outcomes, the ECHO, and put it on kind
15 of a burner, I guess, for a while. Is there any
16 talk about the hierarchy of all these different
17 survey --- experience surveys? Like, I'm
18 thinking that, you know, a people on Medicaid are
19 going to get one. There's the Medicaid CAHPS.
20 There's the Medicare CAHPS if you're in health
21 plan. There's also then a Part D CAHPS for
22 those, or a similar thing.

1 There's clinic-based, hospital-based,
2 then surveys. There's home-community based
3 surveys, state versions. Or they are not CAHPS
4 directly, but they're experience of care surveys.
5 The clinic --- then there's also this ECHO
6 evidently, which I hadn't been aware of before,
7 and probably something in substance abuse.

8 And I could see the poor mental health
9 patient getting all of these at some point. And
10 maybe within quick succession. And I think this
11 isn't true of just the mental health people, but
12 it's certainly a big burden for them. And then
13 it could be true of others as well.

14 So I'm just wondering, who's
15 coordinating the decision making? Maybe D.E.B.
16 knows this, of which one gets priority or what
17 the coordination of all these are in the field.
18 What the --- just the priority and hierarchy of
19 this is.

20 In Minnesota, we tried to integrate
21 the Medicare and the Medicaid CAHPS for an
22 unintegrated program that we had that covers

1 about 30,000-40,000 people. Actually covers more
2 than that, now that I think of it. And that was
3 difficult. But we did send out one survey. And
4 that's what we're doing. At least combine the
5 Medicare and Medicaid. But that doesn't count
6 all the other things that we're talking about.

7 And then there was the nursing home
8 one for a while. So it just seems like somebody
9 needs to take hold of that.

10 DR. LUSTIG: I think that goes beyond
11 what the little mental health --- or behavioral
12 health committee can do. But I mean I ---

13 MEMBER PARKER: Sure, but did they
14 discuss --- I mean, do other people discuss this
15 in these committees?

16 DR. LUSTIG: Well, that didn't come up
17 in our discussion. This particular survey is a -
18 -- it's sort of modeled after CAHPS. And that's
19 some of the work I think the developer is in the
20 middle of right now, is they're actually
21 revamping the survey, and I think it may become
22 part of the CAHPS survey. But certainly, measure

1 burden and reducing the number of measures is
2 something that we all are talking about here all
3 the time.

4 Yes, yes. A burden for everyone.

5 MEMBER POTTER: I think for the duals
6 behavioral health population, there's another
7 issue there we haven't talked about at all. And
8 that is the carve out of the behavioral health
9 organizations within the Medicaid programs. And
10 the health plans that have -- that are in states
11 with the carve out, they're not responsible for
12 the behavioral health, and the carve out plans
13 aren't responsible for the healthcare. And they
14 don't necessarily share data across.

15 And so I think that's a serious
16 problem for the behavioral healthcare population
17 that's on Medicaid, which limits the data
18 infrastructure that's available to support
19 anything. So, for example I know HEDIS just
20 closed its give us comments on the next round of
21 HEDIS measures. And there were measures in there
22 that one of the things they were considering is,

1 well, should we only make it applicable to the
2 health plans that are in charge of behavioral
3 health care?

4 And if it's a health plan that doesn't
5 have behavioral healthcare, then they won't have
6 to be in charge of it. Well in that situation,
7 then, everything in the state's not going to get
8 measured. Because the health plan that doesn't
9 have behavioral health isn't going to measure.
10 And the behavioral health carve out doesn't have
11 access to the healthcare part and the pharmacy
12 part. So they're not going to be responsible.
13 So I just throw that out there as something for
14 us all think about.

15 DR. LUSTIG: And I can just tell you
16 that the Behavioral Health Committee shared those
17 exact frustrations in talking about measures
18 going forward. And while there are things we
19 want to measure, that's what gets in the way
20 often is being able to have access to the data
21 you need on both sides.

22 MEMBER ROSS: I'd just like to build

1 on D.E.B.'s observations. So the state mental
2 health authority is largely a siloed, single
3 agency focused on whoever they define as mentally
4 ill. A separate authority in most states is the
5 substance use disorder authority -- alcohol, drug
6 abuse, traditionally.

7 And substance use disorder folks want
8 nothing to do with the mental health folks, even
9 though like 60 percent of the population is a co-
10 occurring population. So there are these --- and
11 then in managed care is follow the same
12 principle, carve-out industry and other industry.
13 And those are system realities, and it undermines
14 quality and quality measurement, but I don't know
15 what --- how the National Quality Forum in
16 considering measures can deal with any of this,
17 other than through the physical health
18 integration as a prototype model to try to bridge
19 some of these other silo gaps.

20 But the silos are --- I represented
21 the State Mental Health Directors for a decade,
22 and I, as the first executive director of the

1 American Managed Behavioral Healthcare
2 Association, represented the carve out. And
3 everybody is just really comfortable with their
4 siloed approach.

5 When I was at NASMHPD, we aggressively
6 lobbied not to have people with dementia under
7 the authority, because there were too many
8 people, severe, persistent, traditional mental
9 illness, and we couldn't serve them. So the silo
10 thing is just fact of life, and you should just
11 acknowledge it going into any behavioral health
12 report that the system is highly siloed and
13 fragmented and go from there. And there are very
14 few mental health interests who really are
15 advocates of integration. There are handful.
16 But traditional mental health groups are happy
17 doing their silo thing, so good luck.

18 (Laughter.)

19 MEMBER LYTTLE: I just wanted to
20 piggyback on that because we have a couple of
21 financial alignment initiatives in states that do
22 carve out the mental health portion of the

1 benefit, and the whole goal is to integrate. Our
2 desire and our hope and our earnest prayer is
3 that we can learn something from the integrated
4 care demonstrations that will teach us how to
5 make the silos work even though they still exist.

6 For instance, in Michigan, we would
7 not have had a demonstration had we not carved
8 out the mental health portion of it, because
9 people wanted the model that existed to remain.
10 And so, just to kind of echo that sentiment, I
11 think they are beyond quality just in the
12 provision of care. In how we look at
13 integration, we have to think about the fact that
14 some of that is a reality for us.

15 CO-CHAIR MONSON: Just to build on all
16 of that, I do think that there's an opportunity,
17 then, because these carve-outs are a real
18 problem. I mean they lead to --- it is not
19 starting with the person and figuring out how to
20 do what's best for that person.

21 And while it's very difficult to
22 figure out the measures, I mean it's worth

1 considering that we should measure how bad some
2 of these outcomes really are because of the ---
3 the disaggregation, the fragmentation of the
4 system. So it's worthwhile to think about, as
5 you build those measures, to --- even though it's
6 not perfect, right?

7 And you've got --- people say well I
8 can't be responsible for that. I can't be
9 responsible for that. And I'm sure people in my
10 company who would say that. It is a way for us
11 to start to highlight the fact that separate
12 silos are really problematic, and build a case to
13 overcome some of these objections that happen,
14 and build the case to do integration. Whether it
15 be on a provider-led integration or a plan-led
16 integration.

17 MS. BUCHANAN: Thank you all very
18 much. Shawn, if you wouldn't mind opening up the
19 lines for public comment.

20 OPERATOR: At this time, if you would
21 like to make a comment, please press star then a
22 number one.

1 MS. JUNG: Furthermore, if you would
2 like to make any comments in the chat box, staff
3 will read them aloud.

4 CO-CHAIR MONSON: Stuart?

5 MR. GORDON: So ---

6 DR. ROILAND: And, Operator, I'm
7 sorry, I just want to confirm, did you get any
8 comments on the line?

9 OPERATOR: No, ma'am. There are no
10 comments.

11 DR. ROILAND: Okay, thank you so much.

12 MR. GORDON: One of the measures that
13 SAMHSA stands to support on the block grant, the
14 consumer survey is a mental health statistical
15 improvement program consumer survey. There's
16 three versions of it. There's an adult version,
17 a family version, parent version, and an
18 adolescent version.

19 The measures that they look for on
20 that survey are general satisfaction, quality and
21 appropriateness, access to services,
22 participation in treatment planning, social

1 connectedness, improved functioning, and positive
2 outcomes. Again, that's a consumer-centered
3 survey. And then there's some variation in that
4 in terms of looking for information on cultural
5 sensitivity, social connectedness, and patient
6 involvement in treatment planning.

7 So those are the types of items that
8 SAMHSA has been looking for. They've also been
9 pretty heavily involved in urging greater
10 integration. There have been a number of pilot
11 programs, and I think you all know about the
12 Section 223, Excellence in Mental Health Act,
13 where we're now putting primary care in community
14 mental health centers. That passed a couple
15 years ago. It's a two-year pilot, not nearly
16 long enough to actually get a good feel, but ---

17 So there's greater emphasis there.
18 There's also greater emphasis in the states to
19 the extent that the majority of states now have a
20 behavioral health agency rather than a substance
21 use agency or a mental health agency. Now that
22 doesn't necessarily get rid of the silos because

1 very often you have separate divisions still
2 between substance use and mental health all under
3 an umbrella agency.

4 The only other thing I wanted to say
5 was to sort of second what Pam said. Couple of
6 years ago, before she left to go back to New
7 Mexico, Pam Hyde offered up 23 new measures to be
8 added to the block grant program. And actually,
9 it might have been for the discretionary
10 programs. But she shared it with the folks, the
11 mental health agency directors. They were almost
12 unanimous in talking about burden and talking
13 about how difficult it would be to train the
14 providers to report back the data that would have
15 to be reported to SAMHSA.

16 The other problem was there was no
17 coordination at all with what was being required
18 under the Medicaid program, which all these
19 providers currently operate under. So has
20 improved that to some degree. They've come up
21 with some new measures. They're working with the
22 providers. They're working with the mental

1 health agencies and substance use agencies. But
2 I can't emphasize enough how important Pam's
3 comment was. Thank you.

4 MEMBER LAKIN: Stuart, could you share
5 the Pam Hyde 23 proposed measures with the
6 National Quality staff? Thanks.

7 MEMBER POTTER: If you go to the SAMHSA
8 website, and you look up the 223 demonstration,
9 eventually you can find their requirements, and
10 there's a whole technical appendix on the quality
11 measures that are required as part of that. Some
12 of those measures are measures that are reported
13 by the certified community mental health center.
14 And some of them are measures that are reported
15 by the state.

16 There was a huge effort by the
17 Department, SAMHSA, CMS, Medicaid and ASPE, to
18 coordinate the measures and to align wherever
19 possible. So you'll see a lot of overlap with
20 the 23 measures that were on Pam Hyde's list.
21 And measures that are on the Medicaid core list
22 and then measures for behavioral health that have

1 been around for --- for a while in terms ---
2 like, in NQF 0004: Initiation and Engagement for
3 Substance Abuse. So I'll just mention that.

4 MS. BUCHANAN: And are there any
5 questions on the line?

6 Okay. I will turn it over to Rachel.

7 DR. ROILAND: All right. And
8 actually, Madison, could you advance the slide?
9 They don't have the picture. Thank you.

10 All right everyone, so we've done a
11 lot of work today. Congratulations, and thank
12 you so much for staying focused for as long as
13 you did. I know that's really hard. I hope we
14 gave you enough sugar. So we do have a few next
15 steps, and I'll actually turn it over to our co-
16 chairs to see if they have any closing remarks
17 for the day?

18 CO-CHAIR CHIN HANSEN: I just actually
19 have a point of information that is relevant for
20 the behavioral health piece. Most of you may
21 know that I was connected to the original program
22 of All-inclusive Care to the Elderly, the PACE

1 program which integrates Medicare and Medicaid.

2 That original legislation was passed
3 in 1997 so it's almost --- it's actually 20
4 years. In 2015, in November, the original
5 legislation was opened up, and the intent was two
6 particular populations. One was the physically
7 disabled and then the second one was behavioral
8 health. And so I don't think that's it's gone --
9 gotten really legs yet. But it just was opened
10 for that.

11 So there may be some opportunity in
12 the future of some movement along that line. So
13 we don't know, but it is the one program that
14 right now does combine the funding in a way that
15 has a full capitation approach to it.

16 So I can imagine they're going ---
17 they would have tremendous need to risk adjust
18 for, you know, given the population and all,
19 because even when I used to run the program for
20 frail older -- elderly individuals, when we had
21 major psychiatric, psychosocial issues for
22 individuals, the cost factor was three-fold. And

1 some of that has kind of borne out with people
2 with dementia as well.

3 So at the same time, so this is more
4 the funding mechanism, structural mechanism. But
5 ultimately the ability to have quality measures,
6 to be a part of that broad program. And again I
7 thank you all for bearing with me as I've kind of
8 gone through my coughing jags here for the day.
9 And really just want to thank Michael for the
10 fantastic leadership that he has played today.
11 And the staff, of course, for all the prep work
12 that we've done. Thank you.

13 CO-CHAIR MONSON: Thank you, Jennie,
14 I appreciate that. And thank you everybody, I
15 know it's a little hard when we're kind of --- we
16 got the news we got this morning. But everyone
17 was really engaged today. I thought we had an
18 extraordinarily productive set of conversations,
19 which really just demonstrates the passion that
20 everyone in this room has for these individuals.
21 And so I thank you for that.

22 And I'm also supposed to tell you that

1 if you're going to dinner, dinner is at 5:45 at
2 P.J. Clarke's which is somewhere nearby. And it
3 is pay-as-you-go. And then we're starting at
4 9:00 again tomorrow, right?

5 MS. BUCHANAN: Yes, so we have
6 breakfast at 8:30 again, and then starting the
7 day off at 9:00. And I believe people are
8 staying at the Capital Hilton? Is that accurate?

9 MS. JUNG: The Hyatt.

10 MS. BUCHANAN: Oh, the Hyatt. Never
11 mind, I was going to say it's caddy-corner to the
12 Hyatt. So P.J. Clarke's, if you come out of
13 building, turn right and then turn right on K.
14 It's on the corner of 16th and K, so it's a
15 block-and-a-half away.

16 MS. JUNG: And the address is 1600 K.

17 CO-CHAIR CHIN HANSEN: It's right next
18 to Starbucks.

19 (Laughter.)

20 MS. BUCHANAN: But we do have a
21 question because we are ending a little bit
22 early. Is there interest in us moving up dinner

1 reservation time? Or is it just fine as 5:45?

2 Sounds like it's fine as 5:45.

3 And so the only other announcement I
4 have is that we'll be compiling the results of
5 the voting today and review those tomorrow
6 morning. Other than that I think we've --- I
7 think we've got it all set. So thank you all
8 very much. Thank you everyone joining on the
9 phone.

10 (Whereupon, the above-entitled matter
11 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

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