NATIONAL QUALITY FORUM

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MEASURE APPLICATIONS PARTNERSHIP
DUAL ELIGIBLE BENEFICIARIES WORKGROUP

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WEDNESDAY
APRIL 20, 2016

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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 Chin Hansen and Nancy Hanrahan, Co-Chairs, presiding.

PRESENT:
JENNIE CHIN HANSEN, RN, MS, FAAN, Co-Chair
NANCY HANRAHAN, PhD, PN, FAAN, Co-Chair
CHRISTINE AGUIAR, Association for Community Affiliated Health Plans
GEORGE ANDREWS, MD, MBA, CPE, Humana, Inc.
ELIZA BANGIT, JD, U.S. Department of Health & Human Services
GWENDOLEN BUHR, MD, MHS, Med, CMD, AMDA - The Society for Post-Acute and long-Term Care Medicine
MADY CHALK, MSW, PhD, Treatment Research Institute*
JAMES DUNFORD, MD, City of San Diego EMS*
ALINE HOLMES, DNP, MSN, RN, New Jersey Hospital Association
K. CHARLIE LAKIN, PhD, National Institute on Disability and Rehabilitation Research
ALICE LIND, BSN, MPH, National Association of Medicaid Directors
THOMAS LUTZOW, PhD, MBA, iCare
MICHAEL MONSON, Centene Corporation
KIMBERLY RASK, MD, PhD, Alliant Health Solutions

E. CLARKE ROSS, DPA, Consortium for Citizens with Disabilities
GAIL STUART, PhD, RN, Medical University of South Carolina
GREGG WARSHAW, MD, American Geriatrics Society
JOAN LEVY ZLOTNIK, PhD, ACSW, National Association of Social Workers

NQF STAFF:
JANINE AMIRAULT, Project Analyst
ANDREW ANDERSON, MPH, Project Manager
MEGAN DUEVEL ANDERSON, Project Manager
DEBJANI MUKHERJEE, PhD, Senior Director
MARCIA WILSON, PhD, MBA, Senior Vice President, Quality Measurement

ALSO PRESENT:
VENESA DAY, Centers for Medicare & Medicaid Services
ROBYN GOLDEN, LCSW, Rush University Medical Center*

*** present by teleconference**

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8:39 a.m.

CO-CHAIR HANRAHAN: Good morning everyone. Hope everybody enjoyed their dinner last night. I certainly did.

We're going to start the day out with a recap of what happened yesterday and looking forward to the rest of the day, get everybody on board with where we're headed.

So, some of the themes from Day 1. CMS shared thoughts and brief reports about demonstrations that have been released. We talked about the emphasis on population health and a common core of measures that are needed to proceed. We need to look outside of traditional pipelines for innovative measures including interest and HCBS projects and how other countries are addressing quality measures in complex populations.

I think one area in particular that came forward was the HIPAA regulations and some of the limitations that we experience around --

or the barriers around that HIPAA and the communication and that other countries do this much differently than we do.

The importance of beneficiary perspectives from the beginning of measure development to measuring what matters. Easily said, but not easily done. A caution for unfunded responsibilities and mandates. Can you describe that? I can't remember who -- I think it was George that said something about unfunded responsibilities, or was it Tom? Do you remember that, Tom? Is it too early?

Well, I remember us talking about unfunded responsibilities and mandates and I think you were talking about really pulling in the economic side of the equation as we develop out these measures.

MEMBER LUTZOW: I think it's kind of easy to slip in a measure that creates an assumption of responsibility or an expectation that really goes beyond the funding that's available.

Sometimes you can stretch it and where it can be stretched, stretch it. But just be careful that you don't create an implied deliverable that goes beyond the scope of the funding. And sometimes I think there's an error created there.

CO-CHAIR HANRAHAN: Yes.

MEMBER LUTZOW: And, I mean, I think there is gains to be made by creating collaborative alliances, and efficiencies to be gained, that will allow CMS to reallocate funding to support some things that right now they're not sure they want to fund, telehealth is one of them but there may be others.

An example is they're very restrictive in terms of follow to home kinds of funding, you know, they require homebound status on the part of the member.

To really get to effectiveness on supporting transitions in care, CMS has got to loosen up a little bit, and they can't afford to. So can we generate savings through collaborative

programming, aligning, you know, all the resources, hospitals, physicians, nursing homes, hospice, home health agencies, creating efficiencies that will permit the reallocation of funding to support some of the things that they might not want to otherwise?

So, those are the themes.

CO-CHAIR HANRAHAN: Yes, thank you. Thank you.

So, the other thing we spoke about was the group in general supported continued evaluation of risk adjustment for SDS factors in the measurement endorsement process with a focus on poverty specifically.

We spoke about challenges or being challenged with maintaining a family of measures and balancing with an evolving science. And I think what we were referencing was really the evolving science of measurement, as I recall, and the importance of valid and reliable measures for the population or at the population level while recognizing the role of other tools, instruments,

or certification programs to ensure quality.

Anybody have any thoughts or additions in that summary? Go ahead, Clarke.

MEMBER ROSS: This concerns the observation of looking for innovative measures in other countries.

Charlie makes a point that I repeat over and over everywhere I go, we have hundreds of measures used by our states, state developmental disability systems, state mental health systems, just as a couple of examples, that are never submitted to the National Quality Forum for endorsement.

So, I'm not sure the utility of looking at what Denmark does when we have exciting, important things happening in our country, but states and those measure developers have not -- will not go through this process of the National Quality Forum endorsement process.

And, to me, that's a big strategic challenge for the National Quality Forum, is the existence of all these well-used measures that

are never submitted for whatever reason.

So, I'd just make that -- if we're writing a summary for the public, I would expand the other countries to this point about measures in our own country being used.

CO-CHAIR HANRAHAN: Yes, that's very good.

You know, Alice is going to be presenting to us about the Washington State measure development. I was early on a development of behavioral health measures, you know, 20 years ago and none of those have shown up here. And I know Mady has been involved in that development.

So we've all had a lot of experience. I think the point is, that I'm hearing, is that we want to have NQF here that grabs a process that needs to be added here is to review across the board all of these measures that are being developed, and maybe having the advantage of being a national, pick out those that may be utilized at the national level.

I think it's really good that they have a stewarding process for a measure. But that may be one of the barriers to moving this forward is that who's going to steward the measure if it goes forward?

So, go ahead, Marcia.

DR. WILSON: Thank you, Nancy.

I think it's a great point, Clarke. I would say, number one, not all measures need to come through the NQF process. And I don't think we've ever suggested that.

But we would welcome thoughts about how to learn more about those measures that are in use in the field that are deemed valuable that provide value in some way to some person. Now, to a provider, it might be because it's quality improvement, but I don't want to limit it to that.

And we would love to talk about, think about how we could engage that broad community and just as Nancy said, pick out some of those best measures and best may be defined different

ways, but those that have the greatest utility or value and allow that to share them with a broader audience.

Some of those I think probably should come through the NQF endorsement process. Not all of them should. But especially at the state level, NQF is very much thinking about how we can be a part of that, because especially we are a national perspective, but there is such critical work going on at the state level and we're really not engaged with that so thank you for bringing that up.

CO-CHAIR HANRAHAN: As I get to know more about the NQF resources, too, one of the things I know at the state level, they may not have, you know, the depth and breadth of resources for the science of measure that perhaps exists here so that it could be an augmentation. It could really help the states develop more validity.

In addition, the states are going to have the data that the validity testing can be

done on. So, it's really kind of a win-win situation. I appreciate you bringing that up.

Kimberly? I'm sorry, Joan?

MEMBER ZLOTNIK: I just kind of wanted to reinforce this conversation and I think it's an important question to ask Robyn Golden when she presents this afternoon, because what it costs to develop a measure, the issues of having the right knowledge and skills are big issues. And sort of the gaps, as you said, Nancy, in terms of behavioral health or disability and various psychosocial needs, I mean, these are the issues that, you know, the IOM report raised.

And there's no -- beyond what was great to hear yesterday from CMS, which is kind of a small work in progress, I will include some behavioral health measures, there's no great funding source for this and as there's more and more focus on outcome measures, it just raises a lot of issues about how we're going to actually get there unless CMS or foundations or someone really want to make those kinds of investments.

CO-CHAIR HANSEN: I think that this is actually great substance to carry on this afternoon when we talk about strategically some of the things that we would like to see this committee offer.

And so I think these are different points to amplify and using perhaps the leverage of NQF itself to help point the way for these areas that have often not been studied or integrated, you know, with the disability work and the whole need in behavioral health that has been oftentimes not elevated to great strength when there are pieces of work that have been done. But tying it together with a complex population that have functional psychosocial as well physiological issues that come together.

So, let's make sure that we put that kind of in our parking lot for discussion this afternoon about, you know, how do we use our work as a committee together to leverage what we know?

CO-CHAIR HANRAHAN: Yesterday we also spent quite a long time on the CAHPS measures.

Remember that?

And, really struggling with the idea that we are going to drop these measures where the concepts really rang true for what we believe is -- should be measured.

And one of the reasons why they were going to be dropped is because there was no stewarding moving forward for whatever reason. And I can imagine those measures didn't have a lot of validity given the concepts because it's very hard to measure these kinds of concepts.

But, perhaps, you know, another -- a shift in focus for NQF would be to pick up from our review that these measures are important and take on measures like this as a way of moving forward and using their expertise. So, let's put that in the parking lot too.

Go ahead, Clarke.

MEMBER ROSS: The CMS Medicaid Home and Community Based Experience Survey, which the Person and Family-Centered Committee would consider, a lot of us have high -- the plan is to

make that a CAHPS endorsed survey.

So a lot of us have high expectations, not seeing any of the content or the testing results, but that could fill a big void. It's person-centered. The questionnaire itself was grounded in a lot of practice around the country.

So I have hope that within a year this will be endorsed and it'll meet the expectations of consumers and families and community organizations.

CO-CHAIR HANRAHAN: Any other thoughts about yesterday that we missed in this summary?

Okay, good. So we will move on.

DR. MUKHERJEE: So now we'll quickly revisit two of the measures that were nominated yesterday for voting and discussion.

So the first one is NQF Number 1662, Angiotensin Converting Enzyme Inhibitor or Angiotensin Receptive Blocker Therapy, ACE and ARB. And the measure is for a percentage of patients under 18 years and older of a diagnoses of CKD not receiving dialysis of any form and

proteinuria who were prescribed ACE or ARB therapy within a 12-month period.

It's a process measure and collected by administrative claims, electronic clinical data, paper medical records, and the level of analysis is clinician, either a group practice or individual or a team of clinicians.

And the staff preliminary analysis is do not recommend because there is already Measure 0018 in the Family of Measures and it is blood pressure control without -- so you're not with -- with the ESRD exclusion. So if you're at the level of getting dialysis, you're excluded. And it's also in federal programs.

And I can pull up that measure and talk more about it if you want to hear more about the 0018. And 0018 is also in multiple federal programs already.

CO-CHAIR HANSEN: George, I think you were the person who brought it up yesterday, and I think what the staff have done was do some kind of drop as to what the family is.

MEMBER ANDREWS: Yes. The use of ACE inhibition therapy and ARB blocker therapy is so fundamentally critical to a number of conditions that I would say constitute the majority of cost in terms of care delivery.

They touched conditions, diseases that impact the majority of the population. I would say a significant proportion of our population has conditions of hypertension, diabetes, we know that, and heart disease.

So -- and from what we see, at least on the health plan side, is that there is still, despite the fact that there may be 0018 measure, there is still significant noncompliance in the provider community in terms of applying the recommendations or staying up with guidelines.

On the member side, again, if I were to look at it from the patient perspective, in this particular instance this measure applies to the ones who have a diagnosis of chronic kidney disease. These are individuals who already have already developed renal insufficiency, kidney

insufficiency and they have already demonstrated proteinuria. So if anything else, these are the people that absolutely definitely need to be on this medication.

So for me, even though in a way it may be another way of approaching treatment and control of various diseases from a different angle than what the blood pressure control does, it still highlights the significance of this type of therapy that, even though it's simple, and even though process-oriented, it is tied and very closely linked to outcomes.

And those outcomes are obviously improved quality of life, wellness, reduction of admissions from complications of progressive kidney disease and so forth and so on.

So, I feel very strongly that in the -- under the wellness -- health and wellness category or bucket, this certainly fits very well because it addresses not just disease control, but even prevention.

And the last piece that I'd like to

point out, and this ties to what Tom has been saying all along, and this is what I also believe and I agree with Tom, is that we need to be looking at measures that, whether I'm in an office, whether I'm in a hospital, whether I'm in a nursing home, whether I'm -- wherever I am, and that patient is moving from side of service to side of service that every single caregiver has the same incentive to support the same measure. That way, we're all exponentially improving the compliance with that measure.

And as you can see, the care setting essentially applies everywhere. So for all of those reasons, I like this one.

CO-CHAIR HANSEN: Thank you, George, that was really quite a contextual explanation. And so, does anybody else have some comments here?

Kimberly, thank you.

MEMBER RASK: I also -- I'm a little bit more ambivalent about adding it, but for a different reason.

I think over all the reasons that George mentioned, it really is different from the blood pressure control. It offers something special in terms of appropriate treatment that would be relevant to a significant portion of potential dual eligibles.

And so, I feel -- I like the fact that it's sort of on that appropriate treatment arm. It does offer something new. The only reason I have -- I'm not overwhelmingly enthusiastic is I tend to be a fan of having fewer measures rather than more. And so, my only limit is, you know, is weighing that, is this providing enough extra that I'm willing to add it?

I think, as I think about it, I think that it does and it moves us to a kind of measure that is kind of looking more and more for which is appropriate management and saying are people really putting people on the right evidence-based treatments that will improve their quality of life? And so, for that reason, I also would favor adding it.

CO-CHAIR HANSEN: Go ahead, Gregg.

MEMBER WARSHAW: So I agree with George and Kimberly's comments.

My problem with it is it's a little narrow. I'd like to see some conversation about the fact that it's just targeted at people that are diagnosed with chronic kidney disease.

I mean, I would say in my practice the number one indication is people who were diagnosed with diabetes and that is a problem in older adults. A lot of older adults do not receive base therapy when they have diabetes and they are a group that are at high risk of developing kidney disease. ACE inhibitors actually -- one of the goals is to prevent the kidney disease from occurring.

So I'm wondering if it's a little too narrow, this particular measure.

CO-CHAIR HANRAHAN: We actually don't have any kidney disease measures. So, it's -- this one actually is one of the few that addresses kidney disease. So, it is narrow

focused, but perhaps needed in the family for that reason.

MS. ANDERSON: I'll just add just briefly, we don't have any kidney disease measures in the family and that is rooted in the history that the workgroup has been presented with data while a large portion of end-stage renal disease patients are dual eligible because of the patchwork quilt, we recognize that the -- there's a very, very small sliver of dual beneficiaries that have kidney disease. So, it's which lens are you looking at it from?

So, there's a small portion, I think it's less than five percent, of dual beneficiaries that have any kidney -- have any renal disease and kidney disease. And there's large portion of people that have kidney disease that are dual beneficiaries.

So, while this is an interesting measure for many of the things that you've said, I think we can look at other kidney measures more comprehensively. There was a recent renal

project that was finished, and I'm just pulling up very quickly, we have on the order of 25 measures that recently went under review for maintenance of kidney care.

However, this is only one of then that was newly endorsed. So we may -- if you were interested, we may be able to find a more comprehensive kidney disease measure if you'd like to look at those 25 in total.

But because of your concerns about it being narrow, I'm bringing this up. But that's a lot of measures to look at that's not included in our agenda and on the schedule.

CO-CHAIR HANRAHAN: So can you summarize what the question is right now?

MS. ANDERSON: So the question -- it was proposed that the workgroup consider including 1662 in the family of measures.

And so, the question to the group is does anyone want to include this measure in the family? I can verbally list to you, but it would be hard for me to show you the other 25 or more

measures that we have NQF endorsed that address kidney disease.

MEMBER WARSHAW: I just -- I think that I understood that's appropriate for this morning, but I think the -- I was thinking more of measures that might have a broader description of the indications for use of ACE inhibitors and ARBs rather than disease-specific indications.

Because these are, I think, George made the case, these are critical medications in the use and we want to make sure that they're used properly in this population because they have a lot to offer this population.

But I would be more interested in a measure that showed -- had a broader description of when they'd be best used that included diabetes and maybe congestive heart failure and some other indications.

DR. MUKHERJEE: So there is Measure 0729, Optimal Diabetes Care, and it's a composite and it has statin use, blood pressure control, it has various meds, A1C, tobacco use, aspirin,

antiplatelet for ischemic disease, so there is one comprehensive for diabetes and that is 0729. And it is a composite that looks at all the aspects of diabetes care. But not specifically, no.

CO-CHAIR HANRAHAN: And it's also specific to a particular disease.

MEMBER ANDREWS: Yes, but even though diabetes is one of the more critical diseases that need to have this type of protection, you can have hypertension, obviously, that does lead to renal insufficiency.

And I had, in my early years of training, I had a young man of 45 years of age that he didn't pay attention to his hypertension and essentially, within a matter of six months, developed kidney failure and basically died very soon thereafter.

So, again, you don't have to have diabetes for these, you know, for the kidney to begin to function to deteriorate if you do not have the proper approach and treatments for it.

Again, and I -- and Alice pointed out to me another measure where ACE inhibition or ARB therapy is used for left ventricular dysfunction. And, again, yesterday, I think I did mention that these are medications that are -- is the foundation of heart failure treatment, diabetes prevention, hypertension and so forth and so on. Even in atrial fibrillation, ACE inhibition therapy stabilizes the atria and reduces the likelihood of developing atrial fibrillation.

So, there is a lot of advantages to this medication. So, for me, if I were to choose a measure that may be a duplicate, this would be one because I want every physician to be prescribing this medicine and getting their patients to buy into taking this medication because the benefits are so overwhelmingly defeating any possibility of any side effect.

And I should point out, again, we constantly review measures and we remove measures and we add new measures. There is nothing that says that at a later time we can't substitute

this measure for something else as better measures come along.

CO-CHAIR HANRAHAN: So let's call for a vote then.

MS. AMIRAULT: Okay, so voting for Measure 1662 for the addition to the family of measures, one being yes and two being no.

(Voting.)

Mady, if you could please submit your vote.

MEMBER CHALK: I don't know how to do it.

MS. ANDERSON: Hey, Mady. There is a chat box on the web streaming and we have you on the web streaming. So, to the left of the slides in the bottom left hand corner, there is a type here, and you can just say yes or no and that is a private vote.

MEMBER CHALK: I see.

CO-CHAIR HANRAHAN: So, there's still one missing here. Do you want us to do it again?

MEMBER CHALK: Okay, I sent it,

assuming it's correct.

(Voting.)

MS. AMIRAULT: Okay, so we have 13 yes and three no. And based on the 81 percent, it's consensus to add it to the family of measures.

DR. MUKHERJEE: The next measure is NQF 2712, Statin Use in Persons With Diabetes, and it is for the percentage of patients 40 to 75 years were dispensed a medication for diabetes that receive a statin medication. It's a process measure and it's a pharmacy care setting measure. There is an alternative measure right now in the family of measures, and it's 0729 and it's a diabetes care composite that does include statin use along with other therapies. And 0729 is also in federal programs.

MEMBER RASK: Yes, I was the one that had asked about this. If it's included in the composite diabetes care measure, I don't see a reason to add it separately.

CO-CHAIR HANSEN: Thanks, Kim.

Anybody else have any comments?

Okay, can we then proceed to a vote?

MS. AMIRAULT: Okay, so for Measure 2712, voting for the addition to the family of measures, one being yes and two being no.

Okay, so zero for yes and 16 for no. And based on the consensus, it will not be added.

CO-CHAIR HANSEN: Thanks, Kim, for the expeditious comment.

CO-CHAIR HANRAHAN: Okay, now we seek consensus to add three measures to address gap areas. 0679, Percent of High-Risk Residents With Pressure Ulcers, Long-Stay, 0678, Percent of Residents or Patients With Pressure Ulcers That Are New or Worsened, and then Functional Outcomes Assessment. I'm going to have Megan talk about these.

MS. ANDERSON: Yes, this is just a summary of the additions to the family yesterday.

Not a lot of contents to describe, but just to show you what we accomplished, and the next slide is the consensus to remove six measures that are no longer endorsed from the

family, including 0007 and CQI's Mental for CAHPS for Adult Questionnaire, the pressure ulcer measure which you saw the two replacements for from the hospital acquired, though there still remains a gap across care settings.

We also have 0554, Medication Reconciliation Post-Discharge, which is actually harmonized and included now in 0097, so we don't lose anything there. The 0692 and 1902 are both CAHPS measures that are no longer being maintained by the steward. So we're not maintaining them in the family, but these are topics that are highly valued by residents and critically important for the population but not reflected in the available measures. So we encourage further development in those areas.

And, we also have 1909, Medical Home System Survey which is not being maintained by the steward. And we are looking towards -- in this case, we're going to be looking towards other certification and accreditation types of the program to address medical -- these are a set

of medical home quality of care and monitoring.

That is the summary of the measures that were added and removed. One additional measure we just covered, and that's 1662 which will make it into the summary for the final summary of this meeting.

We will now move on to the next slide if there are no questions.

Okay. And just -- I'm going to remind Mady, please chime in anytime you feel when you have an open line. We'll be expecting Jim Dunford on the phone as well today, but it's quite early there. So we'll hear from him soon, I'm sure. And we also have several CMS colleagues on the phone. Please add thoughts and comments if you'd like to share them. We would be interested in them throughout the day.

Unfortunately, they're not able to be in the room with us today. So, Vanessa and Carolyn are on the phone and we appreciate their attendance.

MS. DAY: I'm actually on my way

there. This is Vanessa.

MS. ANDERSON: Oh, great. So you're on the phone in the car. Okay, well be safe and we'll see you soon.

All right, so we're going to talk about prioritizing the family of measures. And if you recall, we talked about the exercise that the workgroup completed a little bit yesterday and we used it to inform your decision making and started the discussion yesterday.

We wanted to be responsive to that and continue to update what we call the Starter Set of Measures. So, we're going to talk about the prioritization exercise a little bit more and the Starter Set of Measures in this next hour.

And so, we're kind of looking forward to doing that, and we'll review the votes, review the prioritized measures, and consider additions and removals to the family of measures during this agenda item.

Next slide. So briefly, you've seen these before. We had eight members respond. We

had six measures that were voted low priority. We actually removed two of those from the family already today. So we're going to talk more about four today.

And then we had some measures that were identified as high priority and we'll talk about those and how they might relate or compete with measures that are already in the Starter Set.

So we want to make sure that we also understand kind of the point of the Starter Set. Next slide.

Again, themes from the summary -- excuse me, the prioritization exercise, is really that there's kind of a mismatch between the population needs and the available measures in the family. And so you'll see that the Starter Set is a little bit more representative of that based on your past work, and that there's a significant impact on the population from behavioral health and mental health issues while there's many measures that are focused more on

the medical and physical model.

We heard from workgroup members that there's a real need to have any screening or an assessment followed up by treatment, but back to some of -- related to Tom's point that screening shouldn't be done in absence of resources to treat. And so the obligation without resources is a constant theme here. Next slide.

We also talked already this morning in the themes of yesterday about the lack of measures that represent the beneficiaries' perspective, that are meaningful measures, and there's general support from the exercise for measures of communication and care coordination.

And we've discussed briefly the National Quality Strategy priorities and how they are important in the measure selection criteria, but they -- not necessarily as a sound foundation and framework for organizing the family of measures.

And so we have -- also voices we've heard this morning also about the importance of

parsimony and that the -- adding measures just to the point of adding measures. Next slide.

So, the Starter Set currently includes 11 measures. They are fairly diverse and they are generally made up of measures that are longstanding, have -- you can actually see that many of them have low numbers, low NQF numbers, which means they came to NQF many years ago.

And so they have been longstanding. They're in use across federal programs, well aligned. There's lots of experience with them. And generally, there's a strong need that they still need to be in use. These measures have not been put on reserve status. There's still room for improvement and there's still need to continue to work on these quality issues. Next slide.

So I'll pause for questions.

CO-CHAIR HANSEN: Just a notation, I think the clue that these measures have been used for a long time are the -- especially the 00 numbers and earlier, I wonder if it would be a

hassle in the future to just put a date as to when they really first came into use. It just, you know, just gives us an anchor in terms of date stamping them.

MS. ANDERSON: All right. So, now we're going to talk about measures that were voted for low priority. And these measures -- next slide -- have -- were voted by three or four individuals as low priority in the family. And while that is informative, it does not make them automatic suggestions for removal from the family.

So we'd like you to consider these and whether or not they continue to be a priority and warrant maintaining in the family. We removed some measures yesterday related to endorsement status change and so this is a different -- slightly different question. These measures are still endorsed, but they are no longer in the family -- or excuse me, that they were voted as lower priority and are up for the workgroup discussion. Okay, next slide.

So the first measure is 0176, Improvement in Management of Oral Medications. This was an outcome measure for home health. It's also in current use in the Home Health Quality Reporting. It was voted as high priority with four votes and low priority with three votes. So it's pretty split.

And so we have a focus on medications and that we've talked about before and the importance of that in the population. But, it's also a question of whether or not it addresses the high priority area.

So, we have several other measures that address medication management in the family and I will tell them to you.

They include 0022, which is Use of High-Risk Medications in the Elderly, 0097, Medication Reconciliation Post-Discharge, 0105, Antidepressant Medication Management, 0419, Documentation of Current Medications in the Medical Record, 0553, Care for Older Adults Medication Review, 0554, Medication

Reconciliation -- excuse me, we removed that -- 0646, Reconcile Medication List Received by Discharged Patients, and 2456, Medication Reconciliation Number of Unintentional Medication Discrepancies Per Patient.

So the question to the workgroup is if you'd like to discuss removing this measure from the family, 0176, Improvement in Medication Management of Oral Medications?

MEMBER MONSON: So, as you went through that list, I didn't hear any of those measures which was talking about compliance or improvement of the actual utilization of the medication as opposed to -- it sounded like a lot of reconciliations.

MS. ANDERSON: There are no other measures of improvement of medication management.

MEMBER MONSON: I'm sorry, say it again?

MS. ANDERSON: There are no other measures of improvement of medication management that are endorsed or in the family.

MEMBER MONSON: I mean, then I would rise in favor of this measure. I do feel like that, for this population, you know, one of the things that home health, you know, this is a home health measurement. One of the things that home health can be very good at is the teaching and the coaching that happens post -- during the episode that then lasts post the episode.

And the ability of ensuring that people understand the medications they're supposed to take and be able to improve the access to that medication, you know, as we were talking about medications earlier in a very specific case, you know, it's no good if the member doesn't take it or the patient doesn't take the medication. So, I think this is a pretty critical measure.

MEMBER ANDREWS: Yes, I would agree with Michael. All of those other measures don't address the understanding, the appropriate taking of medications by the patient in the home setting.

And I think that home health plays a major role there in terms of supporting this population, and recognizing the fact that there is a lot of over-the-counter that, intentionally or unintentionally, the patients do bring into the home. I think this puts more of a burden -- I shouldn't call it a burden, more of a responsibility on the home health caregiver to ensure that they oversee all the medications, not just the prescription medications.

So, again, I agree with Michael.

CO-CHAIR HANRAHAN: I'd just like to agree with that. I mean, this is a critical issue for the dual eligible population. They often are taking more than 10 to 20 medications a day. It is complicated. So to not have something of this nature in the measure set doesn't make sense to me.

MS. ANDERSON: If anyone would like to nominate this measure for removal from the family, we can do that and then we can go to a vote. Otherwise, if there's no cause for vote,

we would proceed to the next measure.

Hearing none, we have two measures that are companion measures. They're similar, 2091 and 2092, Persistent Indicators of Dementia Without Diagnosis, Long-Stay and Short-Stay.

On the slide 142, you see the long-stay measure. This is a nursing home measure for individuals 65 and older with persistent indicators of dementia and no diagnosis of dementia. It was voted as high priority by one individual because of the importance of dementia in the population, and it was voted low -- and, excuse me, also because of the impact on the individual in the family. It was voted low priority by three individuals because of the question of how the diagnosis would affect treatment and in the spirit of parsimony.

Can you use your mic?

MEMBER ZLOTNIK: It just seems like there's exactly the same reasons that one said it was a low priority as the one -- but, it is a high priority.

MS. ANDERSON: So, would anyone like to talk about the dementia measures, dementia long-stay?

MEMBER WARSHAW: Well, I think, for this measure and the short-stay one that comes next, it's really a sign of quality in the facility if they've identified people in the facility accurately that have dementia that would affect the way they might approach the patient and the patient's family planning for the future, how they would assess changes in cognition.

It seems unfortunate if there's a lot of people in a facility that probably are displaying some symptoms of dementia but nobody's actually documented in the chart that they have this problem. So, these seem pretty basic to me, that you would want to identify people like this in a facility and be aware of it.

I mean, the flip side of this would be kind of an attitude that it doesn't make any difference, these people are in a nursing home and they're all confused and we don't really care

why, which doesn't seem like a very good approach to care for this population. So I would support keeping this in the family.

MEMBER BUHR: I think a counter argument is I don't think people are using this measure. So, I'm not sure it's adding anything of value. I don't know if you guys know anything about that.

I think recently it was an AMDA measure and we were asked for data from the NQF to support the measure and keep it going or endorsed, I guess. And we didn't have any data. So -- and we couldn't find any clinicians who were using the measure. So, would that mean that it was going to be not endorsed later?

MS. ANDERSON: I also don't have any measure use data related to this measure. I would also say that the other measure of dementia care that we have is 2111, Antipsychotic Use in Persons With Dementia.

MEMBER STUART: I'm just going to say, I think a lot of the interventions are

behavioral. And in that sense, it's the behavior that you're assessing. I don't know that the diagnosis of dementia is actually -- especially in long-term care facilities, is going to change anything other than behavioral interventions.

CO-CHAIR HANRAHAN: It seems to me that the measure forces attention to cognitive decline which is, you know, it's across the board.

I'm, you know, most of -- this is directed toward nursing homes, skilled facility that they use the MDS. MDS measures cognitive status. So, maybe this measure is redundant in a sense.

The other thing I think that's missing from this measure, and I can understand why because this is Medicare-driven, is a lot of the problems are in the assisted living environments.

They are now advertising for memory care units, but they have no idea what the status of that individual's cognitive status is and they're treating them, and they're driving huge

expense for family members to treat them.

And they advertise that they have this skill, the memory unit, but they don't have the skill level in order to take care of people. So, I would advocate for, you know, adding in assisted living to this measure and I'm not sure how that's going to fit with what Medicare wants to do.

Gwen?

MEMBER BUHR: Well, you can't really add assisted living because they don't use the MDS, so -- and the measure is based on MDS data.

So -- but the point of the measure is that the nurses or the MDS coordinator does the MDS and the sense was that people don't pay attention to the MDS results.

So, you have all this data from the MDS, but if nobody looks at it and the clinicians don't look at it and see that the screening instrument of the BIMS, which is the cognitive instrument in MDS, is scoring low, but nobody's paying attention to that, then the clinicians and

the nurses treating the patient don't really know that they have a screening that is showing dementia.

So if you make them look at it because the measure is measuring whether you're doing something in response to a low score on the BIMS, that's the point of the measure.

Well, so that was my first point, that if nobody's using the measure -- and I think nobody's using the measure because in the nursing home, most people don't have electronic health records yet, and it's difficult, a lot of nursing home physicians aren't using any measures because it's difficult with paper charts and they just don't participate in PQRS or other things.

And so I think that's why it's not being used. I mean, maybe in the future once more nursing homes get electronic records and it's easier to measure anything, then they'll be using this measure, because it's a simple measure to use in the nursing home if you use measures.

CO-CHAIR HANRAHAN: Gregg?

MEMBER WARSHAW: Well, this is a good discussion and I think -- I mean, Gwen is representing MDA, and if MDA's not certain that this measure can really can even be maintained because it's not utilized enough, then that weakens the measure.

I'd still make the case that, for quality of care in nursing facilities, we should be accurately diagnosing the individuals that have Alzheimer's disease or other dementia.

It's true that we're treating behaviors but I mean there's always examples that we -- all of us who have worked in that clinical setting know that people have demonstrated symptoms of dementia that have not been recognized and when it's brought to our attention we may identify some other reason why they're behaving this way. They may just be very deaf and you give them some hearing aids and they perk up and seem pretty normal again.

So I mean you'd want -- in a team setting, the ideal would be that the MDS nurse

who completed this assessment and found the BIMS and then looked at the chart and saw that there was no diagnosis would come to the clinicians, the nurse practitioner or the physician of the facility and say, you should check this patient. They seem to be scoring low on this exam and there's no mention of dementia in their chart. What's -- why is the person confused at this point? That seems like good clinical care.

However, if this particular measure doesn't work, then I guess -- and I don't know what the process is. You tried to find out from NQF whether the measure is being used. Do you have data like that? Do you know what's being used?

MS. ANDERSON: We have -- we do, as an organization, track use in federal programs and use in other programs such as state that are readily available. We have efforts to collect more information about measure use across the board that informs what the CAP and measure applications partnership.

We also asked of measure stewards to submit measure use information --

MEMBER WARSHAW: Oh, okay.

MS. ANDERSON: -- during their annual maintenance and when measures come for maintenance on their three-year anniversary.

And so, we continue to do that and so I think that's what Gwen is responding to. So, I think, from their research and from our tracking, we have really no data to back up that this measure is being used significantly in any way.

CO-CHAIR HANRAHAN: I also know that, in order to get into a nursing home, to be admitted, and particularly the skilled nursing, you have to document the incapacity, and usually, it has to do with cognitive status. So isn't this kind of redundant?

Michael? That may change from state to state because it's more Medicaid-driven, the admission and the payment of the nursing home or the skilled nursing facility.

MEMBER MONSON: Can I just make one

comment on the use of the measure?

And again, I say this as a new member, isn't part of what we're doing identifying the measures that we think are valuable such that then CMS will use that to make policy that would potentially drive people to use the measure?

Is that -- isn't that part of what we're doing? If that is, then I'm not sure if what is being used or not right now -- because if we made it -- if we suddenly tied this thing to payment or put in the star scores for nursing homes, my guess is that they would start to use it.

DR. WILSON: No, I think that's a good point, Michael. And the other point I would make about the data is we do ask for data, we don't always get data. And that is not necessarily the fault of the measure stewards.

We would love to have complete data on every measure that's coming back through review for maintenance, but sometimes those data are not available, the measure steward doesn't have

access to it. There may need to be a data use agreement.

Sometimes the data are proprietary or, as you all know from your work, I'm sure the complete data set on this population is not always easy to get, even what's held sometimes at the state level or the sources of data can be spotty at best.

So we certainly ask for the data, but we're currently looking at different ways that we can get access to the data. So part of the problem, when we say the measure is not in use, sometimes that means we can't confirm that it's being used by data, but yet, when some of the measure stewards will bring their measures forward, they will say, it's being used for quality improvement processes but they can't get their hands on the data.

So I just want to caveat concerns about the data. It is quite problematic and we don't always have the data that we would like for a measure. Just wanted to make that comment.

CO-CHAIR HANSEN: I'm stepping out of my role as co-chair here.

Is the comment I think Michael made is directionally, you know, how are we looking at the measures? One is strictly for accountability and the other is pay-for-performance, but the other one is to kind of indicate to the field things that should be looked at, and I would categorize your comment falling in that area.

And at this point, since we know that the fastest growing population, generally speaking, is the 85 plus and anywhere from 40 to close to 50 percent will have some form of dementia. It seems like a population-based directionality.

And so, you know, my thinking -- you know, I think the rationale of the facts right now would allude to the fact that we withdraw it, but I could see if we were to go to the latter and third point, and that is directionality, it helps shape this for quality and to use MDS data, for example, rather than just collect it. That

could be a message.

CO-CHAIR HANRAHAN: I'm just curious why NQF considered -- wanted us to consider removal?

MS. ANDERSON: It is up for consideration because of the prioritization exercise results. It was three or four members who voted low priority that brought it for your consideration.

I would kind of emphasize that there's only one other measure of dementia care and it's antipsychotic use in individuals with dementia, and we don't have any other dementia measures that are endorsed and available for consideration as alternatives. We also have psychosocial needs as a primary -- one of our priority gap areas for the population, just to remind you of some of the back facts.

CO-CHAIR HANRAHAN: Shall we call a vote? Okay. All right.

MS. ANDERSON: Would anyone like to nominate this measure for removal from the

family?

I'm going to rephrase the question. Would anyone like to nominate either measure, the short-stay or the long-stay, for removal from the family?

Seeing none, Mady, do you have anything to add?

MEMBER CHALK: No.

MS. ANDERSON: Thank you.

And we'll move on to the last measure for consideration for removal from the family.

And this measure is 2158, Payment Standardized Medicare Spending Per Beneficiary. This is a cost measure that is important to assess value along with quality. It's the cost of services performed by hospitals and other healthcare providers during a hospitalization episode. An episode includes costs three days prior to hospital admission through 30 days post-discharge but does not include post-acute care, long-term care hospitals.

It is eligible and considered as

Medicare Parts A and B who are discharged from short-term acute hospitals. There's no risk adjustment for dual eligibility but that was explored during the development of the measure and the measure performance was not impacted.

So they considered -- they're continuing to consider other SES variables, and we heard yesterday about our SES ongoing work at NQF.

So, the aims of the measure are really to improve care coordination and addresses the National Quality Strategy of affordability.

Again, this is a split vote measure. We have three individuals voted it as high priority because it's the only available measure to understand the critical issue of cost and four measures that -- four individuals that voted it low priority, however, there was no rationale provided.

So, the staff analysis, because of that lack of rationale and because of the gap area that it addresses was to maintain the family

as the only measure of cost and affordable care. Would anyone like to discuss or nominate this measure for removal from the family?

MEMBER ANDREWS: I would recommend we remove this. For one, there is no risk adjustment for dual eligibility. You know, the cost and the intensity of care that would have to be provided to a dual eligible versus a typical Medicare beneficiary are vastly different. And the complexity of their conditions, diseases, et cetera, is greater.

Additionally, the cost of services is driven by other variables that, you know, physicians or -- that don't have much of control over contractually, et cetera.

So I think for me, you know, cost of care and a provision of cost effective care, a better measure that we have is the readmissions measure, et cetera. So I don't think this adds any value for what we're trying to do.

CO-CHAIR HANSEN: Alice, Kim and then also Aline.

MEMBER LIND: So, I actually did put a rationalization in for my -- weighting this one low priority.

It just doesn't ever tell the whole story to have Medicare spending for duals, and so I don't think any cost measure that doesn't have both Medicare and Medicaid spending in the measure makes sense for this.

MEMBER RASK: Okay, so I'll be the disagree one.

You know, this measure is used a lot. It's used for hospitals. It's used for physicians. It's harmonizing across more and more similar measures. It relates to all the bundling of payments. It relates to ACOs. To me, it's just as relevant to the dual eligible population as it is to every other person that's included on it.

It is not -- you know, it's always tough in looking at cost issues because we're about health, we're not about dollars. At the same time, I think we work in a system where

dollars matter, and having some kind of measure I think is a good thing.

And because it is comparable, it is being used across providers in a whole lot of areas. I think we would disadvantage dual eligibles to not -- to exclude them from that because it's implicitly going to be done anyway. And I think we could recommend things like it needs to be stratified, it needs to be estimated with Medicaid, there needs to be better coordination, I think we can make those kinds of advice for how this measure should be used or used properly in a dual eligible population, but I don't think we should say not use it at all.

MEMBER HOLMES: I'm confused because this one says it does not include post-acute care in this definition. But, in fact, the hospitals have just started receiving reports beginning in January and it does include -- from CMS perspective, they are including the sub-acute care afterwards which, at least for many of our hospitals, that's where they're getting hit the

most is the high cost of post-acute care.

So I'm wondering if there's a different definition that CMS is using in their release of their reports on Medicare spending per beneficiary because it very definitely does include post-acute care.

CO-CHAIR HANSEN: Okay, great.

So, I think you a response to that, Kim?

MEMBER RASK: Yes, I'm wondering if that bullet point refers to that it doesn't -- it's not triggered by a post-acute care episode and it's not triggered by a long-term care episode.

But my understanding of the measure also is that it includes all costs 30 days where ever those are incurred, which could be post-acute, it could be a long-term care hospital.

MS. ANDERSON: Yes, the measure is specified as that it is initiated when someone is admitted to the hospital with a three-day look back period to whatever setting of care they were

and all the costs were three days before that admission.

In addition to 30 days after that admission, that discharge.

And so, that care 30 days after that discharge is at any setting. All the costs of that care in any of the settings.

CO-CHAIR HANSEN: We have Michael and then Tom.

MEMBER MONSON: I agree with many of the comments that have been made, but someone said it yesterday that we shouldn't let the perfect be the enemy of the good, that there are issues with this measure but it is our only cost-effectiveness measure, which I actually think the bigger point is that we should have on our gap list, that we don't cost-effectiveness measures.

And, maybe that's not in our purview, but it's a little hard to think about how we make some of these judgments without having some measure of, you know, what is good quality care for the dollar? Or some way of having some

reconciliation with that.

So, I mean, for that reason, I think we should put that on our gap list and then I would also suggest that -- and I would also hold this in the family for now until we have a better measure.

CO-CHAIR HANSEN: Okay, thank you.

Tom?

MEMBER LUTZOW: Yes, my suggestion would be that I think this measure -- it's dated maybe. It's not in line with pay-for-value concepts that seem to be overtaking standardized payment averages per member.

Bundling is at risk of going by the wayside. I think it is just a bigger DRG strategy. And, it still is fee-for-service in concept. It seeks to transfer risk but it remains a fee-for-service based concept.

And, isn't there a pay-for-value measure out there somewhere that is more modern in terms of its approach to this?

MS. ANDERSON: No, we don't have any

other more up to date measure. This is a fairly new measure that took a significant amount of time to develop from what we heard from the developers for the review two years ago.

And, there are some relative resource use measures that are particularly condition specific and I think it's more related to bundled payments such as total knee replacement.

And, just from the staff side, I'll respond to Alice briefly that, the work group previously provided input to the developer steward that Medicaid costs should be considered.

As a response, George, there is no risk adjustment for dual eligibility. However, they did do a study on that when they developed the measure. They looked at the data to question whether or not there was a cause for risk adjustment for dual beneficiaries. But that it is also stratifiable by dual beneficiaries.

CO-CHAIR HANSEN: Christine?

MEMBER AGUIAR: Sure. So, I would say while I agree that this measure is definitely not

perfect and there is more work to be done in this area, particularly around how do we capture value, I see that as sort of perhaps the next phase of where the measure development is going.

But, in my current life as an advocate and my former life at MedPac, this is the kind of measure that captures attention really well, particularly with Congress and also with CMS and is the type of analyses that we really use to get attention, to draw attention to the fact that there is a problem here.

So, I would not want us to lose it for that reason.

CO-CHAIR HANSEN: Would anybody like to nominate withdrawal of this particular item?

MEMBER ANDREWS: I still have concerns. I mean I agree with what Christine just said. I think it's important to keep it out on the forefront. Cost is important.

But, I'm also concerned about information that they're not being as accurate in capturing the true cost of care. And, having

that information being utilized, whether it be by CMS or others, to formulate what that cost should be.

CO-CHAIR HANSEN: So, George, are you nominating this for withdrawal?

MEMBER ANDREWS: I guess that will be the easiest way to proceed here, so I would nominate this for removal and see what happens.

CO-CHAIR HANSEN: More comments before we have a vote?

Alice?

MEMBER LIND: So, I was just scrambling to find the study. I knew that the Washington Health Alliance had put out a study of the difference between payment for different hospital admits across the State of Washington.

And they report the difference between what was paid by Medicare and what was billed by the hospital and it's a difference of like $15,000.00, $20,000.00 on a stoke admit that the total admit is only $20,000.00 to $40,000.00.

So, you know, the Medicare piece is

just little. It's just, you know, it's such a sliver of the story.

CO-CHAIR HANSEN: Mady, do you have any comments?

MEMBER CHALK: No, other than it seems to me since it's the only measure we've got, we may need to stick with it for now.

CO-CHAIR HANSEN: Okay.

MS. AMIRAULT: Okay, voting for Measure 2158 on the removal from the family of measures, one being yes remove and two being no.

Mady, if you could just send your vote in the chat box. Thank you.

Okay, four yes and 12 no. And, based on the 75 percent, this will remain in the family of measures.

MS. ANDERSON: Okay, so thank you all.

We'll be moving on to measures that were voted high priority in the family of measures.

And, there were nine additional measures to consider for inclusion in the Starter

Set because they were voted as high priority by six or seven individuals that responded to the prioritization exercise.

As a reminder, we have 11 measures in the Starter Set currently. And, if you would like to see that list, you have it in front of you in your materials you received yesterday a handy dandy sheet that you may have been using throughout.

And, the current Starter Set of measures starts on page two and continues to page three. And, it is 11 measures, note that the last measure of that list, 1909, has been removed from the family, so it's also removed from the Starter Set.

So, in addition to those 11 measures, there are nine additional measures to consider for addition to the Starter Set.

Any questions? Yes.

MEMBER ZLOTNIK: Could you just re-explain, even though I've been here at all these meetings, just re-explain what the Starter Set

means?

MS. ANDERSON: So the family of measures is a long pick list from which individuals who might be looking to develop or start a measurement program, they can look at and say these are the best available measures for dual beneficiary populations and sub-populations.

The Starter Set is the start here. This is the before you pass Go, look at these measures. If you have a limited amount of resources and everyone has a limited amount of resources, if you really need to start with something and you need to know where to start first. This is where you start first.

These are the best available measures that address the population needs. They are generally the foundation of from what the work group would like people to start from when they look at quality of care.

They are also generalizably measures that have been in use for a long time, are well validated. There's lots of measure use

experience that indicates that they do support quality improvement in the field. And, they are also well aligned across other programs and generally in use.

So, they would be less burdensome to collect. And so, the Starter Set is 11 measures that really boil to the top.

It was a very difficult process, if you all remember, we understand it's really difficult to prioritize measures and I can imagine when you're selecting measures from a list of 76, it would be nice to have maybe even a more focused place to go to get started. And, from my past experience, I can agree.

Further questions?

MEMBER RASK: Again, also just being new, with the existing Starter Set, are they broken out by the different priority areas so that they're like -- someone can see -- so that we can see we've got three in this area, none in the other, something that that might encourage us to want to add?

MS. ANDERSON: I don't have that graphical depiction which would be a good thing we can include in the report for sure.

But, what we do have is, as we go through the measures that were nominated as high priority, I do list the measures that are already in the Starter Set that compete with them that address the similar topic areas.

Further questions?

Okay, next slide?

So, the first group that we're going to look at are the medication measures. So, we have two medications current in the Starter Set, 0419, Documentation of Current Medications in the Medical Record. This one was also voted high priority by six members.

And, 0022, Use of High-Risk Medications in the Elderly was also voted a high priority by four measures.

While we understand the importance of and continuing to elevate measures that are working well, we want to make sure that we're not

simply adding to the Starter Set so that it becomes, itself, overwhelming.

So, the next high level bullet is to consider substitution for measures that received seven high priority votes.

So, there are two measures that received seven high priority votes that all address medication use and those are 0553, Careful Older Adults Medication Review which received seven priority votes because the population is a high risk for polypharmacy and related adverse events, it's important for effective treatment.

And, the in home review would be a more effective in a persons living in the community.

It is also noted as a narrow target population by the individual that voted low priority.

The next measure is 0097, Medication Reconciliation Post-Discharge. This measure was voted high priority with seven votes because this

is important for effective treatment. The population is at high risk for polypharmacy and medication barriers. And, it must be used timely in transitions of care.

So, I would put it to the group if they would like to discuss addition or replacement of any of the measures that were also voted high priority into the Starter Set from those that are already addressed, medication management and any nominations to call for a vote.

MEMBER ZLOTNIK: So, if I'm reading this correctly and understanding this, the two high priority measures on the bottom are kind of dealing in different settings.

So, 0553 is about medication review that would kind of happen in the home where there's risk that people had the medicines they got when they were in hospital and the medicines they had beforehand and they all get mushed together.

And, 0419 is in the hospital.

MS. ANDERSON: 0553 has specifications for care settings of the ambulatory care and inpatient rehabilitation facilities, long-term care acute hospitals and nursing home care.

0419, was the other one?

MEMBER ZLOTNIK: Yes.

MS. ANDERSON: 0419 is specified for ambulatory care settings.

MEMBER ZLOTNIK: So, 0553 is actually broader because it has more settings, right? It's only specific to older adults which 0022 is only specific to older adults but it's only high risk medications. So, in a way, 0553 could replace 0022 because it's looking at medications broadly rather than high risk because probably any medication is really a risk.

MEMBER ANDREWS: The high risk is usually a whole slew of medications that the physicians are not supposed to prescribe and that list keeps changing all the time.

Additionally, the issue with the high risk medication measure is that there are

medications that physicians don't feel that are high risk, they just need to be used cautiously in terms of with other medications.

And, they have a place because a lot of times, patients do benefit from use of those medications. And, a lot of times, they have to be substituted with a brand medication because the generic is in the list of high risk so it creates some issues for patients compliance.

So, the other point that I want to make, I'm sorry if I'm taking somebody else's turn, is that the medication review, for me, is also more important than documentation in the medical record.

Yes, it is important to have documentation in the medical record, but if I'm going to do a medication review, it's going to be documented.

MEMBER LUTZOW: I have a similar bent on this. I understand from the call letter now that CMS is moving high risk medication to a display, their display page, and off of the five

star set.

And, I'm in agreement with that because similar to what George has said, I think the perception out there is the Beers list is maybe being misinterpreted, misused.

And there's something else that has bothered me all along and that is this measure comes in direct conflict with a CAHPS measure that asks the member, are you getting all the medications you need?

And so, this is a potential conflict with that measure. A high score on high risk medication control could result and does result in some instances in a low score on the CAHPS survey.

And, that seems to be an inherent flaw when you have two measures in conflict -- potential conflict with each other.

So, here again, we hear from doctors that some of these medications listed as high risk, in their opinion, are not. They work with, you know, they work well, they're effective and

should not be disparaged, they need to be used cautiously but without penalty.

So, it's something that has always caused confusion and maybe doesn't deserve to be in the Starter Set.

CO-CHAIR HANSEN: Gregg?

MEMBER WARSHAW: This all gets a little confusing with all the different types of measures. But, it seems to me that 0419 which is currently in the Starter Set applies to all ages and indicates that there is some place where the medications are documented.

Which it is agreed, a review is going to lead to a documentation. But, somewhere in the record, there needs to be a complete list of medications that everybody can see.

And, the electronic health record that is improving, but it's still a challenge, because different people enter stuff in the record.

And, as a primary care physician, I'm frequently having to reconcile many other physicians' lists of medications in the record

and trying to clean it up to one list that seems to be accurate based on what the patient presents to me in the office.

So, I think that's an important one. I think it probably subsumes to 0553 which is the medication review of older adults because older adults are included in that 0419. So, I'm not sure we'd add anything by moving 0553 into the Starter Set.

I understand the high risk medication in the elderly in the Beers list and other similar lists are controversial. And, I do think medication reconciliation post-discharge is really important.

So, I can see replacing 0022 or 0097 in the Starter Set just as replacing something that we are little agree that that's really critical to get that hospital discharge medication list in order.

Those are my thoughts.

CO-CHAIR HANSEN: I'm stepping out of my chair role for a moment.

And, I think the whole aspect of the Beers list is I think both of you, both Tom and George have acknowledged, often times gets used rather dramatically and that was never the intent of putting that list out.

So, the question is, you know, Gregg, you're one of the leaders in NAGS and if you think that the issue of appropriate use would be then reflected in the other ones that you have cited to maintain, that that would handle that concern.

Since, on the flip side, there are many medications that are prescribed to older people that are not appropriate. And, people may think they're appropriate sometimes because people have been on it for a while.

So, this is a real clinical judgment more than anything else. But, it's tough when you get rated for quality, you know, and payment for this.

MEMBER WARSHAW: Well, I certainly support the high risk medication list and a

chance to have that in the family of measures. But we're not talking about taking it out of the family of measures, we're just talking about changing the Starter Set.

MS. ANDERSON: That is correct.

MEMBER WARSHAW: And so, if there was -- I mean, I think 0419 is fine. I don't think we need to add 0553. And, if there are concerns about the 0022, 0097 is a good one to put in the Starter Set so we could replace that if we want to do something or we can just leave it like it is.

But, I would not be in favor of taking the high risk medication out of the family, just changing where it lives.

MS. ANDERSON: I would add that we have measure use data on all of these. And that, all of them, 0419, 0022 and 0097 are used in most of the state demonstrations. So, they are well used for this population specifically in addition to other federal programs.

CO-CHAIR HANSEN: Okay. So, Gregg, is

the formal nomination of adding 0097? I just want to make sure I'm correct.

MEMBER WARSHAW: I don't think I'm going to make a motion. I'm not unhappy the way things are, but I'm open to somebody else if somebody is not happy with having the high risk medication in the Starter Set. I think we have an option if somebody wants to make that motion.

CO-CHAIR HANSEN: Kimberly?

MEMBER RASK: Yes, I'd like to make that motion in part on the grounds that I like the idea that if bringing 0097 up into the Starter list would be two measures that could be -- that reach across the dual eligible population.

And then, the high risk medications in the elderly is still part of the family of measures, but it says in our Starter measure we've got two non-age dependent measures as starting points for people to look at.

So, I would put a motion for moving -- flipping the two out, putting 0097 in the Starter

and taking 0022 out of the Starter, but keeping it in the family.

CO-CHAIR HANSEL: Okay. So, that made sense. We'll do one at a time.

So, we'll take the first one of adding 0097 to the Starter Set. Is that okay? So, that is what we will vote on for the first one.

Yes, the first one is adding 0097 to the Starter Set, that's an add on.

MS. AMIRAULT: Okay, voting for Measure 0097 for the addition of the Starter Set, one being yes and two being no.

Okay, 16 yes and zero no, so based on the 100 percent consensus this will be added to the Starter Set.

CO-CHAIR HANSEN: Thank you.

And then, your second recommendation?

MEMBER RASK: The second recommendation is to remove 0022 from the Starter Set, remaining in the family but not in the Starter Set.

CO-CHAIR HANSEN: Okay. Confirming

that we're voting on removing 0022 from the Starter Set.

MS. AMIRAULT: Okay, voting is open for Measure 0022 for the retention to the Starter Set. So, one --

CO-CHAIR HANSEN: Removal of 0022.

MS. AMIRAULT: Okay, so one will be to keep it in to the Starter Set and two will be to remove it from the Starter Set.

MS. ANDERSON: If you would like to remove from the Starter Set, it's number two.

Mady, if you can let us know maybe by saying removal or keep.

MS. AMIRAULT: So, for Measure 0022, for retention of the Starter Set, one for yes and 15 for no remove. So, based on the consensus, this will be removed from the Starter Set.

DR. WILSON: And, Janine, could I just confirm that if someone votes one the first time and then realized they voted the wrong way and they vote two, it captures that second vote, correct? Thank you.

MS. ANDERSON: Okay, thank you very much.

We're going to be moving on to the next topic of measures that were voted high priority for consider for addition to the Starter Set and those are falls measures.

Currently, we have one measure of falls in the Starter Set and that is 0101, Falls Screening Risk Assessment and Plan of Care to Prevent Future Falls.

This was voted high priority with seven votes and with the rationale being it's a priority patient safety issue in dual beneficiaries and older adults. The risk of falling increases after a fall and that falls are a measure of death and institutionalization.

And, there are two measures that were voted with six or seven high priority votes for consideration for addition to the Starter Set and those are 0202, Falls With Injury and was voted as high priority by six individuals because it's aligned with other programs, a priority for dual

beneficiaries and older adults and it is risk adjusted.

Excuse me, I will confirm if it is risk adjusted. The slide is not clear.

It was voted low priority by one individual because they were sure that minor falls should not be included in the measure, though it is.

0674 is the percent of residents' experiences or more falls with major injury in the long-stay. And the rationale for the six votes for high priority was that it was an important safety issue in dual beneficiaries and other older adult populations, that falls with injuries are a very important quality issue and falls are a major cause of death in institutionalization.

It was voted low priority by one individual because of parsimony.

And so, open it up for discussion about the substitution or addition of a falls measures into the family, I mean into the Starter

Set from the family.

MEMBER RASK: I like the idea of moving one of these into the Starter Set with the notion that it moves us from screening in a plan of care to a little bit more of an outcome measure in terms of how many falls are happening.

So, I think it compliments it and would give somebody who is interested in looking at the falls issue an opportunity to look at both prevention as well as monitoring.

CO-CHAIR HANSEN: So --

MEMBER STUART: I would just add, I agree with that because it's actually an outcome measure instead of just a process.

CO-CHAIR HANSEN: Aline?

MEMBER HOLMES: And, I agree with that, too, just because even if you have a plan of care to prevent falls, if your falls keep going up, you need to go back and look at your plan. So, I would agree with both.

CO-CHAIR HANSEN: And, Gregg?

MEMBER WARSHAW: So, just clarify the

settings in which 202 and 674 are applicable. They seem to be discrete.

MS. ANDERSON: 0202, falls with injury as an outcome measure, that is, in fact, risk adjusted.

It is in the care settings of hospital acute care facilities and inpatient rehabilitation facilities. And, it's at the level of the analysis of the team in the facility.

It is an AFRQ as using the measure and one state demonstration is using the measure.

And, the second one is 0674 is the question?

0674 is percent of residents experience one or more major falls with injury. That is also an outcome measure that is not risk adjusted. It is for settings of care in nursing home and it is for the facility level of analysis.

This measure is similar to some others we've talked about and is from MDS data. It is

used in Nursing Home Quality Initiative and Compare, also used in LTCH Quality Reporting programs and used in three demonstrations.

CO-CHAIR HANSEN: Would you also look up sites for 0101?

MS. ANDERSON: 0101 follows screening risk assessment and plan of care to prevent falls is a process measure that is not risk adjusted and is for ambulatory care settings, inpatient rehabilitation facilities and nursing home facilities.

It is also for a clinician, group practice, an individual level and it is collected from administrative claims and paper medical records or electronic clinical data.

It is well aligned in Medicaid Shared Savings Programs for ACOs, the Meaningful Use for Eligible Professionals, Physician Quality Reporting System, Physician Value-Based Payment Modifier as well as in the HEDIS Physician or Health Plan Measures and the Minnesota Integrated Care Coordination for Medicare and Medicaid.

It's used in 11 state demonstrations.

CO-CHAIR HANSEN: Okay, we have comments from Michael and then from Joan.

MEMBER MONSON: I just have a clarification question because when I looked at my sheet, on 0202, I didn't hear you say post-acute and nursing facility settings. But, on my sheet it says post-acute, but that was my work --

MS. ANDERSON: 0202 I have possible acute care and long-term care, inpatient rehabilitation facilities. I will confirm with our database.

MEMBER MONSON: Because would it include home health, too? That would be -- that was kind of, you know, I would have thought it would have been post-acute.

CO-CHAIR HANSEN: Joan, in the meantime?

MEMBER ZLOTNIK: Yes, I mean I think that's the question I was kind of asking, too. Are things in a different settings?

And, counting is one thing and having

a plan of care is another. So, they're both important. You want to know how often this happens, like if people are constantly falling out of their bed in the hospital, that's a problem.

But, also, if we're just counting and we're not thinking what should we do to remove the rug in someone's room so that they don't fall again and we don't have a plan of care, we're not leading also.

So, I think you kind of need both.

MS. ANDERSON: The 0202, falls with injury, is confirmed only specified for hospital acute care facilities and inpatient rehabilitation facilities. We have to see about the gremlins we got in your Excel sheet.

MEMBER RASK: I think it has post-acute and then there's a colon and then it says -- so that's what, yes, so I think that's how I interpreted it, they listed like that's only that cite.

MS. ANDERSON: Yes, among post-acute

care settings.

MEMBER RASK: As my mother, the English teacher, always said, grammar is very important.

MS. ANDERSON: Thank you very much.

CO-CHAIR HANSEN: So, yes.

MS. ANDERSON: Any other questions or nominations for a substitution or addition of high priority measures into the Starter Set?

CO-CHAIR HANSEN: Gregg?

MEMBER WARSHAW: Much more clear, but Joan, I think your point is well taken. The question is, 0101 seems to cover a broad range of settings and it addresses the screening and assessment part.

It seems like either one of the other measures will miss some settings, but injuries -- falls with injury are a critical thing to measure.

So, I don't know which one of those to pick. I guess it just depends on which settings we think are most important.

It sounds like the 0202 is more at the hospital level and the 674 is more at the long-term post-acute level.

MEMBER ZLOTNIK: You don't have to pick any.

MEMBER WARSHAW: No, we don't have to put either of them in the Starter Set or we could put both of them in the Starter Set.

MS. ANDERSON: But, they are retained in the family of measures.

MEMBER WARSHAW: Yes.

CO-CHAIR HANSEN: We'll entertain one direction or the other with any of these. Anybody want to make a nomination?

Gregg, is your tent still up? No, okay.

All right, so, if there's no nomination, they are still in the family of measures, but they would not be in the Starter Set.

I see a taker here. Okay, Kim?

MEMBER RASK: You know, I like the

idea of having an outcome measure related to falls in the Starter Set. I think it's a common condition and something that is important for dual eligibles.

What I would appreciate any other input if whether or not people feel that the appropriate motion is we need to cover all sites of care so, therefore, we want to both or is there one of those two that would be most relevant of the two knowing that they're both going to stay in the overall set so they're available for use.

Is there one that we would want to highlight?

CO-CHAIR HANSEN: Well, I think Kim is asking for some technical assistance here from the rest of you on either one.

MEMBER CHALK: This is Mady.

CO-CHAIR HANSEN: Yes?

MEMBER CHALK: If I were choosing, I would choose 0101 specifically because it includes a plan of care and risk assessments in

addition to the issue of falls.

CO-CHAIR HANSEN: Okay. And, Mady, that is currently in there so there's no worry about that leaving.

The question now is whether or not we add one of the two that are offered, 0202, Falls With Injury and 0674 with long-term stays here.

So, its settings, the other ones covered different settings.

MEMBER CHALK: Okay, got it.

CO-CHAIR HANSEN: All right.

Did anybody want to do this? So, Kim, if there's no TA here for you -- oh see the George card.

MEMBER ANDREWS: Well, I would agree with what's already said. That I think that the 0101 does a great job in representing this particular area in the Starter Set.

And also, more importantly, it does have a care plan as to how to prevent.

The others are basically just a statistic of so many falls, there were so many

with injury. And, we know that if there is a fall the likelihood of injury is going to be there whether it's 30 percent or 40 percent.

The key is to prevent it. And, I do feel that the first one that addresses all the elements that need to be in place to prevent it and also to prepare for it, then I don't think we necessarily need to have anything else added.

CO-CHAIR HANSEN: Okay.

MEMBER RASK: I don't have anything to nominate.

CO-CHAIR HANSEN: Okay, all right.

Thank you. I think we can move on. Again, very good discussion. Thank you and appreciate it.

MS. ANDERSON: And so, the next topics to consider for the Starter Set are care transitions and we have three measures of care transitions to discuss.

One measure is currently in the Starter Set. It is 0228, the three item care transition measure.

And, I'm going to learn from previous experience here and tell you in advance, this is a patient reported outcome measure and it is at the hospital acute care level of analysis.

And, it is also in use in inpatient quality reporting programs.

And, the second measure to consider for addition to the family or substitution that received six high priority votes is 0647, Transition Record With Specified Elements Received at Discharge by Patients.

And, this was voted as high priority because it's important for patient and caregivers to understand discharge plan. It's effective care and is important for care coordination and discharge planning.

And so, that measure is a process measure that is specified for a facility level but also integrated delivery systems at the ambulatory care level and inpatient rehabilitation facility level and nursing homes.

It is used in three demonstrations but

not used in any other federal programs.

We also have a third measure to consider and it is 0648, the Family Transition of Transition Record and it was voted with six votes for high priority because it is important for effective care continuity, coordination transitions, especially for individuals with complex illness and beneficiaries using long-term supports and services and it streamlines measures.

This is a process measure that is specified for, again, ambulatory care centers, ambulatory surgery centers, excuse me, hospital acute care, inpatient rehabilitation facilities and skilled nursing facilities and is the facility level and integrated delivery system level of analysis.

And, this measure is used in 11 state demonstrations and it is also a priority measure for evaluation monitoring and is in the CMS core set for adults.

And, those are the three measures of

care transition in the Starter Set, excuse me, in the family of measures.

And, the question and discussion for the work group is whether or we'd add any of the two additional measures voted as high priority to the Starter Set or replace 0028 with these measures.

MEMBER STUART: So, I think these two measures should be added to the Starter Set for the behavioral health population, these are two critical points.

When you see complications in care they either have not received elements at discharge or their follow up care doesn't receive things.

So, for 40 percent of the population that's behavioral health related, these are important measures.

MEMBER ANDREWS: I would favor adding 0648. I think the timely transmission of information is critical to that seamless continuity of care.

If that doesn't happen, there is more of a likelihood of decompensation, readmission and other complication to ensue.

So, I'd really like that to be in the Starter Set because, again, it's a very important element to be part of good quality.

CO-CHAIR HANSEN: This is a stepping out, again, for a moment. This is a factual information point that's probably relative to 0647.

Across the country, there is a state by state act called the CARE Act. And, the CARE Act is about letting family members know what the transition plan is.

So, without our quality measure, there is some grounding swell that's state legislatures are actually doing this and they're doing this in combination with the American Hospital Association. So, there is actually a consumer level movement for this quality.

And so, just a comment is, well, not replaces in the care transition because that's

the three items would be probably included.

So, I just wanted to let the committee as a whole know that that is actually happening on the state by state level.

So, I heard the recommendation from George as well as an offering by Dale. Would you like to make a specific recommendation? I think Dale -- oh, excuse me, Gregg?

MEMBER WARSHAW: Well, I agree with Dale and partly with George.

I mean, I think they both should be in the Starter Set. So, I'll make a recommendation that they both be moved into the Starter Set.

CO-CHAIR HANSEN: Okay. Should we do it one by one?

MS. ANDERSON: Yes.

CO-CHAIR HANSEN: Okay. So, the question is, this would be three measures or do we replace the care transition which is, frankly, you know, widely used.

So, all right, well, let's take --

MEMBER WARSHAW: Excuse me, can you on

the 0228 tell us briefly what the three item pieces are?

MEMBER BUHR: I have it right here, I looked it up if you want me to read it.

CO-CHAIR HANSEN: Thank you, Gwen.

MEMBER BUHR: Okay. It's a questionnaire given to the patient and the questions are, during this hospital stay, staff took my preferences and those in my family or caregiver into account in deciding what my healthcare needs would be when I left.

Question two, when I left the hospital, I had a good understanding of the things I was responsible for in managing my health.

And, number three, when I left the hospital, I clearly understood the purpose for taking each of my medications.

CO-CHAIR HANSEN: So, Gregg?

MEMBER WARSHAW: Yes, I think that they all three work together really well. I think the first one really is a patient-centered

question that gets to understanding.

The 647 means that there was some document given to the patient or family member that they can take to the next setting which has the key information on it and they can use for their own resources, which I see families using a lot.

And then, the third one is, and George mentioned this, the actual provider, the provider transfer of information thing.

The only problem, if they give them 24 hour -- it's too long. If somebody is sick and discharged from the hospital, a day is a long time.

But, that's the best we've got, so I'll give it 24 hours.

CO-CHAIR HANSEN: Okay. Well, Gregg, I assume you'll offer 0647 as one to add on the Starter Set?

MEMBER WARSHAW: So, I think I'd like to add 0647 and 0648 to the Starter Set.

CO-CHAIR HANSEN: Okay. So, we'll

take just --

MEMBER WARSHAW: One at the time.

CO-CHAIR HANSEN: -- just for voting purposes, voting -- yes, okay.

So, we are voting to add to the Starter Set 0647.

MS. AMIRAULT: Okay, voting for Measure 0647 for the addition to the Starter Set is now open, one being yes and two being no.

Okay, 15 for yes and one for no. So, based on the consensus, this will be added to the Starter Set.

Just one second to vote for the next.

CO-CHAIR HANSEN: Okay. So, the next thing as she's booting up, we are voting on adding 0648 to the Starter Set.

MS. AMIRAULT: Okay, for Measure 0648 for the addition to the Starter Set, one being yes and two being no.

Fifteen for yes and one for no. So, based on the consensus, this will be added to the Starter Set as well.

CO-CHAIR HANSEN: Okay. We have a number of items to do. Originally, our break was scheduled for quarter to and so, our suggestion is to move with the rest of the measures because after our break, we'll have an internal NQF person doing a presentation before our external speaker comes.

Okay, so we'll just break a little bit late. But, we're going to continue to try to finish through.

MS. ANDERSON: Okay, so the next topic to discuss is readmissions.

And, we have one measure of readmissions in the Starter Set currently. It is 1768, Plan All-Cause Readmissions. It was voted for, best I remember, is high priority because it's aligned with federal programs, encourages system approach to disease management and promotes care planning.

There was also one measure that received six or seven high priority votes, we will say six, and it is 2510, Skilled Nursing

Facility 30-Day All-Cause Readmission measure.

This measure was voted as a high priority because it is a global measure of care planning and implementation, encourages system approach to disease management and readmissions lead to deterioration and it addresses frequent transitions in care and instability, addresses priority area for the benefit of the population.

I will also pull up the specifications.

1768 is a process measure and this measure is specified for health plans and integrated delivery system. It is used across the different federal programs including the Medicaid adult core set, CMS home health measure set, the health insurance exchange quality rating system, Medicare Part C and D star ratings and other state-based programs including 11 demonstrations.

2510 is an outcome measure that is in nursing home facilities and it is a CMMI priority measure for monitoring and evaluation.

It's the hospital inpatient quality reporting program. That doesn't make sense.

MEMBER MONSON: Is it a clarifying question? So, on 1768, this is the same star measure that we already have that's already risk adjusted versus a different one?

MS. ANDERSON: It is a star measure that we already have in the Starter Set in the family of measures.

1768 is risk adjusted.

MEMBER MONSON: Thank you.

CO-CHAIR HANSEN: Okay. Yes, Aline?

MEMBER HOLMES: I would really encourage moving 2510 into the Starter Set. I think that as we move forward, we're seeing a lot of readmissions from nursing homes, especially around staff and the inability to care for patients as they have infections or even minor stuff and they bounce them back to the hospital.

So, I think this is really important as far as resource utilization and cost.

MEMBER AGUIAR: Yes, I agree. I

think, you know, it's important to have the -- whereas we try to move towards population health and delivery system reform, it's important for the providers and the plans to have the same signals.

And so, I think moving this in would really accomplish that.

CO-CHAIR HANSEN: Okay. Tom?

MEMBER LUTZOW: Do we have anything in the family for home health agencies for this same measure?

CO-CHAIR HANSEN: Checking.

MS. ANDERSON: We have emergency department use without hospitalization, hospital readmission during the first 30 days of home health.

These measures with the 25, that start with the 2500s, those are new measures that were voted into the family last year. So, these are relatively newly developed and endorsed measures.

The emergency department without hospital readmission during the first 30 days of

home health is a risk adjusted home health measure and it's also a CMMI priority measure and for inpatient quality reporting and hospital value-based purchasing.

And, that is the only measure for home health that I have in the family.

CO-CHAIR HANSEN: Okay. Any other -- Aline? Okay, thank you.

All right, George?

MEMBER ANDREWS: Yes, I would agree that this is an important measure to consider moving into the Starter Set because it ties to how well this SNF care is or was but, it also, the part that makes me uncomfortable, it also ties a lot in terms of what happens post-discharge from the SNF facility that is the home care.

So, it, to me, it reflects more of what the home care level of quality is rather than the SNF in itself.

For the SNF, to me, I would be more interested in a measure that looks at acute to

SNF and percent of patients kind of back from SNF back to acute that would reflect the care delivered in the SNF.

And so, even though I'd like to have something on the SNF, somehow, this measure, for me, doesn't reflect the way it is, the accountability where it belongs.

CO-CHAIR HANSEN: Go ahead.

MEMBER WARSHAW: Yes, I think that's a good comment, George. I like 1768 because it's a system focused measure. This is a system problem.

In communities where the hospitals have taken recidivism penalty seriously, they already have this information on the skilled nursing facilities. They have identified which facilities in their community do a good job and which ones don't.

That's a responsibility, I think, of the hospital to figure that out in their community. They have the resources to do that. And, it's a responsibility of the facilities in

the community who want to do post-acute care to provide that information to the hospitals so that there's some reasonable expectation of quality care.

The finances have driven this kind of conversation which is really good. This is a system issue. The same thing would apply with home health.

I think the community has to take responsibility and the hospital is their leaders in the community. And, I like 1768, I think it's a really good measure.

I think picking out the nursing facility one is useful, but not as valuable as the global view and I think that's where we're heading is, more of a community-wide global responsibility.

There are a lot of times when the reason that there's a readmission from a skilled nursing facility occurs is because the discharge planning at the hospital level was poor. Information was not sent correctly, maybe the

patient wasn't stable when they were sent to the nursing facility.

In really effective systems, if it's a complicated patient, the hospital sends teams to the nursing home to help manage the patients so that the nursing home has a chance of keeping the patient out of the hospital.

These are things that are happening in communities. I don't think 2510 captures any of that.

CO-CHAIR HANSEN: Okay, thank you.

One more comment, Tom?

MEMBER LUTZOW: My only concern with both of these measures is back to the sponsor is whether both measures are protected against gaming if the patient is put in for observation and then readmitted for observation, that doesn't count toward the penalty.

And, I'm just wondering if those decisions on medical necessity are really protected and tight enough or whether this measure is, you know, lose enough to be managed.

It was a question back to the sponsors of both.

MS. ANDERSON: There is no information about the timing of admissions and ED visit for plan all-cause readmission.

While there are other measures of ED use, so the ED visit is for home health.

CO-CHAIR HANRAHAN: So, the way I would advocate for the 2510 to be added to the Starter because I think these two measures do distinctly different things.

The first measure focuses on readmissions to the hospital. The second measure focuses on readmission to the SNF or the skilled nursing facility.

And so, if I'm going to study readmissions, I would have a category that would be for skilled nursing facilities readmitting to hospitals.

So, I think they do distinctly two different things and I think they're both really needed.

CO-CHAIR HANSEN: Okay, we're going to entertain a vote of hearing from members suggesting the addition of 2510. So, may we do that?

MEMBER HOLMES: That was my confusion on that interpretation, so is 2510 patient gets discharged from the nursing facility, go to the community and comes back? That's counting those readmissions?

Or, is it the patients in the hospitals goes to skilled nursing facility and goes back to the hospital?

MS. ANDERSON: 2510 is skilled nursing facility 30-day all-cause readmission measure. This measure estimates the risk standardized rate of all-cause unplanned hospital readmissions for patients who have been admitted to skilled nursing facilities within 30 days of discharge from their prior proximal hospitalization.

The prior proximal hospitalization is defined as an admission to an IPPS, CAH, critical access hospital and/or a psychiatric hospital.

The measure is based on 12 months of SNF admission data.

MEMBER LUTZOW: Okay.

CO-CHAIR HANSEN: All right, that's clarified. It seems to be a request for addition. Can we do a vote?

Mady, any final comments?

MEMBER CHALK: No, I don't have any final comments.

CO-CHAIR HANSEN: Okay.

MS. AMIRAULT: So, for Measure 2510, on the addition to the Starter Set, one being yes and two being no.

Okay, 12 for yes and five for no. And, based on the 71 percent consensus, this will be added to the Starter Set.

CO-CHAIR HANSEN: Okay.

MS. ANDERSON: So, the next slide has three measures which then fit in a nice, clean category. So, we'll consider them one by one.

They each received seven votes for high priority.

So, we'll take the measure is 0018, Controlling High Blood Pressure.

This is an outcome measure. It is NQF endorsed. The percent of patients 18 to 85 years old who have had a diagnosis of hypertension and who's blood pressure was adequately controlled during the measurement year.

And, it is not risk adjusted. It is at the health plan integrated delivery system level of analysis. However, it is at the ambulatory setting of care.

It is well aligned along federal programs, including the Medicaid adult core set, health quality rating system, Medicare Assured Savings Program for ACOs, hospital value-based purchasing, PQRS, among others.

It was voted high priority because it's on a standard care that's important for physical health conditions and that can lead to other issues and the measure should be maintained with current guidelines, I'm trying to interpret that comment, but maintains current guidelines.

I think there have been some updates to blood pressure guidelines recently, so I think that's what that means.

One vote for low priority because of parsimony.

I also want to acknowledge that Jim has joined us on the phone and on the web, so thank you, Jim.

MEMBER DUNFORD: Good morning.

CO-CHAIR HANSEN: Okay, we'll start with each one of these.

Aline? Okay.

MS. ANDERSON: So, any discussion about adding 0018, Controlling High Blood Pressure to the family of measures?

CO-CHAIR HANSEN: Okay, Gwen?

MS. ANDERSON: Excuse me, to the Starter Set.

MEMBER BUHR: I have a question and a comment.

Do we have other blood pressure measures that are in the Starter Set already?

MS. ANDERSON: We don't have other blood pressure measures in the Starter Set. We have some in the family, but this one was voted high priority.

MEMBER BUHR: And, a comment I have is that, the measure says it's for people 18 to 85 and that you should make the blood pressure less than 140/90.

And some guidelines say that should be 150/90 for people over 65.

So, it would be in conflict with guidelines.

MS. ANDERSON: And, I think that is one of the concerns and I've heard feedback to a developer that the measure needs to be maintained with the current guidelines.

And so, we would expect that when it comes back for NQF endorsement at annual maintenance.

MEMBER BUHR: And, what is it going to do that?

DR. MUKHERJEE: They are, too, waiting

for the guideline to get completed. So, the guideline to the update to be done and then the measure developer will pick it up and then we'll get it.

CO-CHAIR HANSEN: George?

MEMBER ANDREWS: I would recommend that the controlling high blood pressure be part. I think hypertension is so prevalent that whether you're dealing with 150, whether you're dealing with 140, it's better to be controlled even at those ranges than not be controlled at all.

So, having it in the Starter Set is, again, one of the foundational measures of medical care delivery that, for me, it has to be in the Starter Set.

CO-CHAIR HANSEN: Any other comment or question?

So, there is a recommendation then to add 0018, Controlling High Blood Pressure to the Starter Set.

So, I think we're ready for a vote for, yes, 0018.

MS. AMIRAULT: Okay, so for Measure 0018, voting on the addition to the Starter Set, one being yes and two being no.

Jim, if you could just submit your vote into the chat box.

CO-CHAIR HANSEN: And, I'm queuing up people for 0326, the Advanced Care Plan after we summarize the vote.

MS. ANDERSON: Jim, can you submit your vote in the chat please of let us know if you're abstaining?

CO-CHAIR HANSEN: Okay, yes.

Well, if Jim comes back on to vote, we'll add it on. Perhaps we can still tally it at this point to see what we have.

MEMBER DUNFORD: I'm so sorry. I had to step away for one second.

MS. ANDERSON: So, Jim, the vote is to include 0018, Controlling High Blood Pressure into the Starter Set of --

MEMBER DUNFORD: Yes, I agree.

MS. ANDERSON: Okay.

MEMBER DUNFORD: Yes, that's my vote.

MS. ANDERSON: Thank you.

MEMBER DUNFORD: No, I'm in favor. Thank you.

MS. AMIRAULT: Thank you.

CO-CHAIR HANSEN: That's clear.

MS. ANDERSON: So, we're going to move on to 03 -- we're going to read the results first.

MS. AMIRAULT: So, for 0018 for the addition to the Starter Set, 14 for yes and 3 for no.

So, based on the consensus, this will be added.

CO-CHAIR HANSEN: Okay, thank you.

Yes, comments for 0326, Advanced Care Plan?

Michael?

MS. ANDERSON: Do you want to go over it? No?

MEMBER MONSON: So, this is a really critical measure for everybody, actually, beyond

just this population. But, for this population, for individuals, they have the ability to understand what they want their end of life needs to look like so they can be doing that in an appropriate way and be able to have the care that is most appropriate for them.

I think if we're going to be person-centered, which we all want to, you know, we all stated we want to be, this is a very person-centered thing to be doing to have an Advanced Care Plan and it doesn't happen enough.

CO-CHAIR HANSEN: Thank you.

Tom?

MEMBER LUTZOW: Yes, I think there's, not to diminish the value of this -- it's important to be cautious here because advanced care planning is culturally sensitive. There is evidence that inner city populations view this plan as differently than others.

There's evidence that those that don't trust the healthcare system to fight for the prolonging of life, especially if you belong to

an ethnic class that's not appreciated.

There's evidence that that ethnic class doesn't believe the system's going to fight for their life.

There's evidence that where there's disability, especially cognitive disability, those plans aren't trusted by the courts or even enforced by the courts.

So, all of those things considered, there's evidence that high cost cases tend to have Advanced Care Plans and low cost cases tend not to for obvious reasons that if I have a condition that, you know, is high cost already and suggest that end of life is near, I may be more interested in having a plan than a relatively healthy individual that doesn't appreciate the need for it.

So, I'm just saying, not that this isn't important and shouldn't be recommended, there are disparities associated with this.

CO-CHAIR HANSEN: Thank you.

Yes, Clarke?

MEMBER ROSS: Tom mentioned people with disabilities. There are rights oriented, organizations and folks in the disability field who disagree with this.

But, there are also a mainstream of disability organizations and families who say we should have the right to make the same decision that everybody else makes.

So, I'm just reporting that there is a division within the disability movement on what advanced care planning really means and the issues that Tom identified.

And so, I'll just leave it at that. One can find on the web either side with the term disability next to it.

CO-CHAIR HANSEN: Thank you.

MEMBER MONSON: Can I just make one point of clarification?

The measure, as I understand the measure, isn't that there has to be an Advanced Care Plan, it has to be that there was a documented discussion of an Advanced Care Plan.

And, much like self-direction, which is not for everybody in the disability community or any community, the reality is that this should be an option that is presented to everybody so they have the option to choose it and they can choose it or they cannot choose it.

But, too many people aren't even getting that choice and that are getting substantial care that they don't really want and they're not in a position to make those decisions because they -- and, if they get to a point where they are cognitively impaired and their decisions aren't listened to and people don't know what to do at that juncture.

So, this is about giving people the option to make that choice. And, if they so choose that it's not appropriate for them because it's culturally not what they want to do or it's not something they believe in, they have the option to say no, I'm not interested in an Advanced Care Plan.

But, at least make sure that everyone

knows that this is a right that they have.

MS. ANDERSON: And, medication --

MEMBER ROSS: So, Michael, I personally agree with exactly what you've said and I'll probably vote for it.

But, there are disability rights people would say we're in a coercive environment and I live in a group home with six people and the administrator's telling me I have to make a decision and I have to tell all the staff my decision. And that is a coercive dynamic when the power differential is not equal.

So, just to share the other dynamic.

MS. ANDERSON: The measure description is the percent of patients aged 65 and older who have an Advanced Care Plan or surrogate decision maker documented in the medical record or documentation in the medical record that the Advanced Care Plan was discussed but the patient did not wish or was not able to name a surrogate decision maker to provide an Advanced Care Plan.

It is specified for ambulatory care

settings, home health, hospice, hospital acute care settings, post-acute long-term care inpatient rehabilitation facilities as well as the nursing home facilities.

It is not a risk adjusted measure and it is in use in the PQRS and the value modifier program for physicians as well as two state demonstrations.

CO-CHAIR HANSEN: Okay, so again, confirming our backdrop, is the -- do you then request, Michael, to have this be voted on?

MEMBER MONSON: I think we should add it.

CO-CHAIR HANSEN: Okay. So, any final comments from either Jim or Mady?

MEMBER DUNFORD: I have a question. This is Jim.

Does anyone know whether a physician order for life sustaining treatment, the POLST document, is sufficient? Does that qualify as an Advanced Care Plan?

The reason I mention it is there are

multiple states now that are moving to electronic registries for POLST and have chosen that document over a tradition Advanced Care Plan as an easier document to be able to retrieve via registries that can be quickly moved to the appropriate clinician whether it's a paramedic pushed electronically to their electronic health record or to an emergency physician.

MS. ANDERSON: That information was not specified in the measure information as currently. But, it is a recommendation that could be made to the steward as they continue to maintain the measure.

The measure is specified for data collection via administrative claims as well as electronic clinical data.

MEMBER DUNFORD: Thank you.

CO-CHAIR HANSEN: All right.

Any more -- I think we're ready to vote.

Oh, excuse me, sorry.

MEMBER ZLOTNIK: Just a point of I was

just like looking at it and said it was for persons 65 and older. And, I think part of the conversation is -- we could make a recommendation that it be for everyone, which is what it says in the far column over on the right.

CO-CHAIR HANSEN: Right. Thank you for noticing.

MEMBER ZLOTNIK: We sort of said that before.

CO-CHAIR HANSEN: Because, yes, currently it does say for 65 and older.

All right, so with some of these addenda, I would entertain that -- to ask for the vote.

MS. AMIRAULT: So, for Measure 0326 for the addition to the Starter Set, one being yes and two being no.

CO-CHAIR HANSEN: As we wait with bated breath, we have one more final measure to consider before our break.

MS. AMIRAULT: Okay, and 15 for yes and 2 for no.

So, based on the consensus, 0326 will be added to the Starter Set.

CO-CHAIR HANSEN: Okay, thank you.

MS. ANDERSON: The next and last measure to consider for addition to the Starter Set is 2111, Antipsychotic Use in Persons With Dementia.

We have previously discussed the importance of dementia in this population earlier today.

The measure was voted by seven measures as high priority because it's important to prevent overuse of medications in at-risk population and prevent harm, addresses quality of life and supports the individual in the lowest level of appropriate care.

It's voted a low priority by two individuals and I have no rationale on record.

The measure is the percentage of individuals 65 years of age and older with dementia who are receiving an antipsychotic medication without evidence of a psychotic

disorder or related condition.

It is specified for health level of analysis and the data is administrative claims collected from pharmacy and other sources.

It is also included in a state-based integrated coordinated care map.

CO-CHAIR HANSEN: Any comments on this one?

Clarke?

MEMBER ROSS: Just to report that the disability rights organizations and activists strongly support this. They think not only dementia but other -- anybody with behavior that's out of some norm that the nursing home or a facility has established gets over medicated.

And, we have GAO and Inspector General studies showing that.

So, I'm just reporting that the disability rights segment of the disability movement, this is a high priority from a rights perspective for them.

CO-CHAIR HANSEN: Any other input

comment?

Jim or Mady?

MEMBER CHALK: Yes, I have a question.

It says antipsychotic use, but then in the rationale it just says this is only for antipsychotic medications, nothing else, right?

CO-CHAIR HANSEN: I'm sorry, could you say that again?

MEMBER CHALK: Is this measure simply antipsychotic medication? Prevent overuse of medications in at-risk populations is what it says. I even say antipsychotic use, so it's only about that?

MEMBER BUHR: Mady, excuse me if I get this wrong, but it says a 60-day -- greater than 60-day supply for cholinesterase inhibitor or an NMDA receptor antagonist.

That's just how they're defining dementia, so they're setting --

MEMBER CHALK: That's dementia.

MEMBER BUHR: And, people with dementia or who have had those medicines that are

typically used to treat dementia, that's who they're defining dementia. But, the measure is measuring antipsychotic use, that's what I understand.

MEMBER CHALK: Yes, that's what I see.

MS. ANDERSON: Okay, just on --

MEMBER CHALK: So, I'm asking --

MS. ANDERSON: -- 30-day supply of any antipsychotic medication does not specify medications.

MEMBER CHALK: Okay.

CO-CHAIR HANSEN: Okay. All right, any other clarifications?

MEMBER CHALK: No.

CO-CHAIR HANSEN: So, Clarke, you would like to see this voted on?

MEMBER ROSS: Oh behalf of the disability rights component of the disability movement, yes.

CO-CHAIR HANSEN: Okay.

MS. ANDERSON: Nomination to be included in the Starter Set?

CO-CHAIR HANSEN: To include it, yes.

Okay, so, this is the final vote.

MS. AMIRAULT: For Measure 2111 for the addition to the Starter Set, one being yes and two being no.

Okay, 17 yes and zero no. So, based on the 100 percent consensus, this will be added to the Starter Set.

CO-CHAIR HANSEN: Wow, what a way to end. So, okay.

So, Megan, logistics?

MS. ANDERSON: A break only five minutes.

CO-CHAIR HANSEN: Right. Five minutes? Oh, she's being generous. Can we say ten minutes?

MS. ANDERSON: Just to give everyone a matter of perspective, we have a home and community-based project update from our colleagues and they're from NQF, that's going on at 10:45, excuse me, and public comments scheduled at 11:30 on that discussion.

And then, this afternoon, we'll talk more about community integration.

So, Andrew's been so kind as to be patient with us.

Five to ten minutes and we'll come back and hear from our colleagues from NQF.

CO-CHAIR HANSEN: Yes, we'll start exactly at quarter after.

MS. ANDERSON: Starting exactly at quarter after.

(Whereupon, the above-entitled matter went off the record at 11:07 a.m. and resumed at 11:15 a.m.)

MS. ANDERSON: So we are about to get started with our HCBS presentation this morning.

And we have Drew Anderson from our HCBS team presenting, and he will present on and provide us with an update on the Home and Community Based Services project.

Welcome, Drew.

MR. ANDERSON: Thanks. All right. So good morning, everyone. Thanks for having me to

come and speak with you today. My name is Drew and I'm a project manager here at NQF. I just wanted to spend some time to give you an update on where we are with the Home and Community Based Services Project.

Next slide. So here are updates -- sorry, objectives for today's session. First, I'm going to just talk about some of the major drivers of HCBS quality measurement and then I'll do a project overview for those of you who haven't been able to follow the project as closely over the last year-and-a-half. And then I'll summarize the findings of our first and second interim report. We've had therefore and reports for this project. Sorry, I'm chipping in and out. And so we've completed two of them so far. And then I'll talk about our next steps.

Next slide. So the project staff on this is comprised of five NQF staff members. I'm one of two project managers.

Next slide. It's also being led by our HHS Advisory Group, which is a cross-agency

effort around this project. We have representation from CMS, ACL, ASPE, SAMHSA.

Next slide. Okay. So I'm just going to jump right in. Why is it important to measure the quality of home and community based services? So these services, as we know, are very critical to promoting independence, wellness and self-determination for people with long-term care needs. And then we also know that they are -- people prefer to live in their home and communities with their family and friends rather than in an institutional setting. And some examples of these services include personal care, supported employment, Meals on Wheels, family caregiver supports.

And we've begun to see more and more of a shift from institutional care to HCBS over the years through states. So recent data from CMS has shown that over half of Medicaid's long-term care expenditures are now comprised of HCBS, and we see that the trend is continuing. We're seeing a divergence between institutional care

and -- or monies spent on institutional care versus HCBS.

And beyond Medicaid, even though it is a major payer, there are other federal agencies that fund HCBS, as well as a significant private payer market. And it's also worth mentioning that beyond the payment these services are also provided by family members and friends and informal supports, or natural supports.

Next slide. So some of the drivers of HCBS quality measurement. So we've seen a growing demand for LTSS in general and that we anticipate that demand to continue to grow over the next 20 years as our population ages. And then we see this shift from quantity to value in addition to this whole idea of value-based care. We want to focus on the value that we're getting for the care that's provided. And then we want to continue to see care being more person-centered and coordinated, and HCBS is one of those ways of achieving that goal. And as I mentioned, there's a re-balancing of public

spending on LTSS.

Am I chipping in and out? It kind of sounds like it. No? Okay.

Okay. Yes. I think this will work better.

And then we're also seeing a push for more standardization in quality measurement across care settings, not just in HCBS, but in healthcare. So it definitely translates to this space. And then there are also DHS' quality principles here that we put -- HCBS will allow us to achieve better care, smarter spending and healthier people.

Next slide. So just to quickly go over some of the policies, guidance, legislation and regulations. This project really focused on making sure that we're building on previous efforts, and it's really a culmination of all of these activities that have led to prioritizing this effort. So we know of like things like the National Quality Strategy where a lot of measurement initiatives have been built off of.

We have more recently the IMPACT Act. We have Secretary Sebelius' guidance on person-centered planning.

And more really critical is like the ADA where we've seen since the 1970s the independent living movement, and that's really a culmination of several legislations prior to that that really has shifted our perspective on how we view how people participate in the community. It's more if people aren't participating, there's a systems problem or we're looking at it from a societal perspective rather than not being able to participate because of capability or the desire to participate.

There's also the CMS HCBS Final Rule, which is more recent. This rule really defines what settings are considered home and community based. And then there are several other acts that have limited age discrimination and attempted to provide more services to children. And of course the Affordable Care Act over the last seven years that's really sparked a lot of

quality measurement initiatives.

And then there are a lot of these programs you all are probably familiar with. Money Follows the Person. I mentioned some of the Balancing Incentive stuff. There's also the -- managed care organizations are partnering with states to deliver services. Health Homes, more focused on care coordination. One of the big grants in this area right now is the Testing Experience and Functional Tools, which is the TEFT grant. We have actually right now the HCBS consumer survey. That's going through the endorsement process right in the Person-Centered and Family -- Person and Family-Centered Care Project. And then we also have work going on around Accountable Health Communities and more so connecting healthcare and HCBS.

Next slide. Okay. So that brings us to this project. Like I said, it's really a culmination of all the efforts that have led up to this point. We have attempted to provided upstream strategic guidance on the highest

priorities for measurement in home and community based services, so NQF has convened a panel of experts from a variety of different backgrounds. And this work is really building off of the -- like I said, the National Quality Strategy, the CMS Quality Strategy and the HHS Community Living Council.

Next slide. Oh, I also wanted to say that the work is encompassing all settings, all payers and all services. So it's very broad in scope. So we've taken on a challenge.

So this is the Quality -- the HCBS Quality Committee. Like I was saying, we have a lot of representation here, people from the HIT world. We have researchers. We have caregivers, people who are actually consumers of HCBS themselves. We have health plans. We try to get a very diverse mix of people here. And we've continued to hear -- we haven't -- it's rare that these types of minds have come together to talk about these issues. So we continue to get positive feedback on how this committee works

together.

Next slide. So before I get into the details, I just wanted to give you an overview of where we are. So I didn't mention -- of course, this is a two-year project that's funded by HHS. And we started in late -- oh, actually in early 2015. And the Committee attempted to create a conceptual framework for measurement first and then an operational definition for HCBS. And I'll go into those.

From there, through the Committee's guidance, our staff performed an environmental scan and synthesis of evidence to identify measures, measure concepts and instruments to help the Committee identify gaps in measurement and to get a sense of what the HCBS measurement landscape looks like.

The Committee met on March 30th and 31st and they began the discussion of gaps, reviewing the findings of this environmental scan and they've begun to craft recommendations which we will be synthesizing and putting together over

the next few months. And that will be presented in a third interim report on June 15th. And I'll give some more details after this.

Next slide. Okay. So I'll just first talk about the first interim report, which came out on July 15th of 2015.

Next slide. So this was a challenge, coming up with a definition that is inclusive of all settings, services and populations. We tried -- the Committee essentially went back and forth with how to come up with a definition that reflects what HCBS is, and then also making sure that they highlight what high-quality HCBS is. So I'm just going to read off this slide.

So the definition is, "HCBS refers to an array of services and supports that promote the independence, well-being, self-determination, and community inclusion of an individual of any age who has significant, long-term physical, cognitive, and/or behavioral health needs and that are delivered in the home or other integrated community setting."

So it's a mouthful, but it has a lot of the key elements that the Committee believes are what constitutes HCBS.

Next slide. So like I said, it wasn't enough to just say what it is, but the Committee really wanted to define what high-quality -- or the characteristics of high-quality HCBS. So I'm not going to read these, but some of the ideas of social connectedness and inclusion, making sure that the system is integrated with healthcare and social services. Of course that idea of a person-driven system or consumer-driven.

Next slide. Making sure that privacy and dignity and respect are included, making sure there's support for family caregivers and allowing -- and this more breach idea or conceptual idea of allowing the individuals to participate in the design and implementation evaluation of the system and not just having choice and control over the services that they receive.

Next slide. Right. And some of these

focusing on looking at the system, making sure there aren't disparities, trying to align with other measurement frameworks, making sure that the system fosters accountability through measurement and reporting of quality and outcomes, which is the ultimate goal here of measurement.

Next slide. Okay. So from those characteristics of high-quality HCBS the Committee distilled those into 11 priority domains. And some of these are the usual suspects of choice and control, community inclusion, caregiver support, but like I said there are some more focused on like equity, human and legal rights, and then this idea of consumer leadership and the system development. So really not that they just have choice, but that they're involved in providing upstream input into how those services or the system is designed to best meet their needs.

Oh, one back. Oh, and then we also have the Committee put together an illustration

of the what the mechanism of quality measurement in this space looks like. So really there's a Venn diagram there that shows a feedback loop ultimately leading to measurement, leading to quality measure improvement activities or quality improvement activities that leads to improved consumer outcomes. So they really wanted to focus on the consumer at the center of measurement.

Next slide. So from there we moved into the synthesis of evidence and environmental scan portion. We took the Committee's domains. And actually I didn't include the sub-domains, but there are sub-domains under each one of those domains, as well as descriptions for those domains and sub-domains, but we are still refining them for the third interim report.

Next slide. So as I said earlier, the objectives of the environmental scan and synthesis was really to identify measures, measure concepts and instruments and to get a sense of what's out there right now, what's the

current state of measurement? In this environmental scan the measures were captured in a compendium of measures, which is a really long Excel spreadsheet, but we tried to capture some key elements about each measure so that the Committee could make some high-level judgments about what kinds of measurement is happening and how much. And so this was really a tool to help the Committee identify gaps and to prioritize where measure development should happen.

Next slide. So this is our approach. Starting at the beginning of the project we collected over 200-plus sources to inform the creation of the operational definition, so that definition didn't just come out of nowhere. We had actually looked at all of the other existing definitions and we took some of the best pieces of the others and kind of Frankensteined them together into something that we thought was more -- or they thought was more reflective of what HCBS is and what it should be.

And then we also looked at all the

domains and sub-domains that were in the literature to inform and we did a crosswalk between what the Committee had come up with, their characteristics and then the existing domains and the definition and how -- in the literature and how those are described.

But for this step we extracted -- we first flagged all of the sources that had measures and then of course we extracted them from them and put them in the compendium, which you can see in the second interim report.

Another piece of the environmental scan was looking at the states. So we identified Minnesota, Oregon and Washington as having high-performing LTS system based on some of the score cards. And there are also states that have some of the highest spending on HCBS. So we decided to do more of a case study on these, or case studies on these states to see what kind of measurement activities, especially innovative ones that other states could learn from or that could somehow inform the Committee's

recommendations and where things are going.

In addition to looking at the state level, we also looked at international sources. So we selected England, Canada and Australia because they're also -- we identified them as having HCBS systems that are also high-performing, and actually we found that they're in a similar framework development area than -- as we are, but they're a little bit farther ahead. Some of these have single payer health systems, which makes things a little different.

Next slide. So here are the results of the environmental scan. So this is from looking through the literature, looking for existing compendiums and measure repositories. And so, this is just a summary slide. We found over 700 measures, measure concepts and instruments.

And so, what we mean by "measure concepts" are measures that we weren't able to find evidence of testing information, but we were -- for the measures that we flagged we were able

to find that information, although we didn't do any kind of extensive analysis of the quality of these measures. Like I said, this was just to get a sense of what types of measures are out there and what's happening in the field.

Oh, and I guess I also wanted to point out -- so we see a lot of measures in service delivery, system performance and effectiveness, but we don't see as many measures here in things like community inclusion and caregiver support, equity, and we found no measures in that domain of consumer leadership and system development.

Next slide. So as far as our state findings, we found a lot of great things actually happening in like Washington State where we're seeing measure sets being developed and used in HCBS contracts with state agencies. Oregon is using a consumer experience survey. Minnesota is disseminating the National Core Indictor Survey that focuses on aging and disabilities. I don't know if you all are familiar with NCI, but it's a very popular survey.

Next slide. And then just to briefly go over some of our international findings. England calls HCBS social care, so they have an adult social care outcomes framework. And it also -- well, I guess the major findings from these were that their domains of measurement were very similar to the domains of measurement that the Committee had flagged.

In Canada they have home health quality measures that focus on accessible care, effective, safe, person-centered.

Australia is developing a new national disability insurance scheme that focuses on those domains there like choice and control, health and well-being and these social, community and civic participation, all of these things that are also being included in the Committee's framework.

Next slide. Okay. So as far as next steps, I had alluded to our third interim report. Since the Committee met on March 30th and 31st we've been working with them in smaller groups, in workgroups to really refine the

recommendations, but we don't have a final list of recommendations yet because we're still pulling all of that information together. But those recommendations will be highlighted in the third interim report, which will be available on June 15th, like I said.

And following that of course we'll have our typical 30-day public comment period and the Committee will reconvene again in late July to discuss those public comments and work on finalizing the recommendations and these different components as far as the operational definition, the domains and sub-domains. And then we would like to have a list of example measures that fall under this category of domains that have existing measures that could potentially be put forward for NQF endorsement or more widespread use. The final report will be available on September 4th and we'll be working hard to disseminate that over the next year.

So, questions? I know that was a lot of information.

CO-CHAIR HANRAHAN: Well, thank you, Andrew. Because it's about the time, I'm going to turn to the operator and ask if there is any public comments.

OPERATOR: Okay. At this time if you'd like to make a comment, please press star, then the number one.

(Pause.)

OPERATOR: Okay. And at this time there are no public comments from the phone line.

CO-CHAIR HANRAHAN: Thank you.

So thoughts?

MEMBER ROSS: Eliza and Charlie are on the Committee?

MR. ANDERSON: Right.

MEMBER ROSS: I'd be interested in whatever impressions they want to either reinforce or something that maybe wasn't emphasized my Drew.

CO-CHAIR HANRAHAN: Thank you.

MEMBER BANGIT: Thank you, Drew, for the update. I thought that was really

comprehensive and I'm really interested to really just see the report. I know that's coming in a few weeks. But I know that you all are very busy in sort of synthesizing the comments that you received at the in-person meeting. And I mean, I would leave it at that. I mean, I know you guys have done a really tremendous job.

I'm actually the government task lead, so I would leave comments about the specific work to Charlie, who's actually a committee member.

So, Charlie, if you have any thoughts?

MEMBER LAKIN: Well, Drew, thanks. I think you went through it rapidly but well.

One of the things that's really different about this activity as opposed to most of the -- at least the other NQF subcommittees that I've been on is that it takes a more proactive approach than a reactive approach. Sort of starting from the beginning, what is it that matters? What is it that we need to measure? And I think that's allowed us to be somewhat pragmatic.

We look for things that are both used and useful. We look across disability. And kind of building on Tom's earlier point, we're really looking for common core elements that cut across disability, even though in some superficial way people are quite different at the core, at their human core they have aspirations for many of the same things.

So the other thing that Drew didn't mention that I think is important is that there are a couple other projects that kind of dovetail with what's happening in the NQF HCBS project that are really going to get into the evaluation of instrumentation that is well aligned with the areas that the HCBS Committee developed. And hopefully as part of that process we'll be able to sort of flesh out the framework, which is about where the HCBS project is going to end. It's going to offer a framework, and then the task begins of filling that out.

But it's been a really great group. Lots of different perspectives, a lot of energy

and a lot of enthusiasm for the idea that the federal government is committed to measuring things that are kind of hard to measure, but that are fundamentally important to people. So I'll just leave it at that.

CO-CHAIR HANRAHAN: Thank you. Go ahead.

MEMBER BANGIT: Thanks, Charlie, for that. And I just wanted to -- I know Charlie had spoken about future projects or existing projects now that could really benefit from this work, and I just wanted to follow through. I'd be remiss if I also didn't mention that ACL, where I work, had funded the National Institute of Disability, Independent Living and Rehabilitation Research, just NIDILRR, had provided a grant to the University of Minnesota to actually look at this work that NQF is doing on HCBS and would really benefit from that report to guide the work, quality measurement work that they're tasked to do in the next five years. So the work that we're doing here is really important and future

sort of direction that we'd like to take for quality measurement and HCBS.

CO-CHAIR HANRAHAN: So let's go with Michael and then Tom.

MEMBER MONSON: Well first of all, this is very exciting work and we've been -- I've been following it, our company has been following it very closely because measures in this category are disparate, far, few between. There's not a lot of consensus on them. So getting a good set of measures is so critical for us to run an effective system. So thank you for everything you're doing.

So anyway, just a couple comments and actually I had a question for Eliza, too. So I guess one thing is as you think about the framework that you're going to come up with at the end of this, is it going to -- because I've -- the domains are all there and you've kind of got some measures that you've looked at when you did your stand. Is it going to then kind of tie out to what you're trying to achieve with each

measure?

So I guess I would encourage you to think about the measures not just so they line up against the domains, but then it should be to drive certain types of activities in the world, right, to lead us to certain places. And so, that's the piece that has -- that's the disconnect I have. I haven't seen that piece connected yet. And so, maybe I've missed it, which is entirely possible. And so that would be one thing I guess I would ask.

And then I guess the question to Eliza would be so this work is going to finish and then, ACL, you're doing the work you just described. CMS is also doing the work that we heard about yesterday. So our CMS and ACL working hand-in-glove so that we end up with one set of measures as opposed to multiple sets of measures?

MR. ANDERSON: Oh, okay. So your question is whether or not these measures are going to be tied to certain activities of quality

improvement?

MEMBER MONSON: No. So the idea being that you measure something --

MR. ANDERSON: Right.

MEMBER MONSON: -- because you want to drive a certain outcome in the world, right? And you want to drive the system, providers, payers, other individuals, other allied interests that are involved --

MR. ANDERSON: Yes.

MEMBER MONSON: -- because you want to drive to a certain performance --

MR. ANDERSON: Yes.

MEMBER MONSON: -- that happens. And so, that's -- so my question is how have you guys been thinking about how you're going to put that together? I mean, we've had a conversation this morning about, well, we want to put this measure on here because we believe this is an important outcome and so we want to kind of drive the system in that direction. So it's that kind of thing.

MR. ANDERSON: Right. And I think -- so the measures that we're going to be including in the final report are really going to be just illustrative of the types of measurement that may already be happening or some best examples. But the key pieces are really going to be the sub-domains, these concepts that should be measured. And those are the concepts that they believe the -- which are in line with the characteristics. So it's really to point to doing these kinds of activities or setting a certain standard. But as far as like specific measures, the recommendations won't quite look like this measure should be used for this purpose, per se. I don't know if that answers your --

MEMBER MONSON: It will be that these domains are attempting to drive --

(Simultaneous speaking.)

MR. ANDERSON: Yes, right. Right. So the rationale -- so the Committee has been thinking about of course the rationale for how they want to drive quality improvement in this

area. So the way that these domains and sub-domains are described are trying to get at that. So it's very -- they have connected those ideas, I would say.

MEMBER BANGIT: And with regard to your second question about working with CMS, clearly have a very good relationship. We have created an HSS Advisory Team for this particular project. We have two folks from CMS who participate: Ellen Blackwell and Michael Smith. And we also have Lisa Patton from SAMHSA and we have D.E.B. Potter from ASPE from the secretary's office in ACL. So this is a five-member advisory group.

And we felt very strongly that this multi-stakeholder, multi-division, if you will, advisory group was really important. So that really sets the stage for sort of our future collaboration and work. Clearly, there's going to be a lot of work that's coming out of the NIDILRR ACL grants and we'll most certainly try to engage our other partners, including CMS in

that work.

MEMBER LUTZOW: Yes, my suggestion would be that sometimes as caregivers we forget that the member is also a caregiver. They care for themselves and they're present 24/7 to themselves. And one of the responsibilities we have as caregivers is to empower the member to be more self-caring, more effective as a self-caring resource. And this resource is worth trillions of dollars, if you look at the country. And so, how have we enabled the patient to be an effective caregiver of themselves is the question. We have some responsibility to motivate, to educate, certainly, to inform, to activate.

And my question of the domains that you're looking at is is that responsibility as caregivers to empower adequately addressed? Certainly the member needs to be central to the care planning assessment process, the care delivery process, but central to -- as a delivery resource, as a partner in the actual delivery of

care. And so, have we enabled engagement sufficiently and are we measuring that aspect of the process?

MR. ANDERSON: Yes, I think the Committee has had many conversations about this idea. They really actually want to make sure that the consumer is at the center of all of this and is really driving not only their choice of services and on how it's provided, but also that whole idea of designing the system. And behind all of these domains it's really about supporting independence and allowing people to take control of their own care. And so, whatever level that is for them, how can we get people to really just get the services that will allow them to stay in their home and community? So it's not -- it is really about empowering the individual to be independent and to make those choices. So I don't know. Does that answer your question?

MEMBER LUTZOW: Yes, I think I would go so far as -- we have to build into the system the expectation that the patient is activated as

a partner in the delivery process. We expect and have a right to expect the patient to self-manage. And now, to do any less than that is not to dignify the patient, I think.

I mean, I come from 25 years of working with folks with cerebral palsy and Down syndrome and so on and respect and dignity is a key piece of that, that they are independent contributing resources to their own lives and to the community. And so, to treat them as a victim where we have all the responsibility and they have none is to de-dignify their lives.

MR. ANDERSON: Right.

MEMBER LUTZOW: And now our role is to empower them, educate, encourage, support, but they are agents, not just patients. They are patients, but they're agents as well. And somehow we have to allow them to participate in their own care, and even insist on it.

MR. ANDERSON: Yes.

MEMBER LUTZOW: So I mean, I think as a caregiving community we sometimes lose sight of

that, I think.

MR. ANDERSON: Right. And one of the Committee's sub-domains is on of course the consumer's involvement in their care, but there is also an idea of dignity of risk that is within some of these sub-domains. So it really is not the provider being prescriptive about what and they should and shouldn't do, but them choosing those, whether or not they want to take risk or not and what level to which they want to take that risk.

So, yes, I think a lot of those ideas that you just presented are a part of the sub-domains. And you'll see that once we've pulled them all together. So thank you.

CO-CHAIR HANRAHAN: Venesa, did you want to say something?

MS. DAY: No, I was just going to add to Lisa's comment about the coordination between the HCBS work and what's happening at CMS. I think it is all very much so integrated. We have about what, two -- one new group and one older,

more standing group that works on HCBS issues and kind of brings in the expertise from the folks that we have working on ACL.

One of my staff people, Betsy -- or the Duals Office staff people, Betsy Ricksecker, sits on a panel for HCBS. And then we have a separate meeting where it's internal, but we include D.E.B. Potter, where we discuss and bring together those different avenues where everybody has tentacles and we just kind of bring in house and talk through what's happening, how the work overlaps and how we can build those sort of connections. So it is very much integrated.

CO-CHAIR HANSEN: Taking off my chair role, one of the things that is probably available that you have looked at is the SCAN Foundation has created some body of work around dignity-driven decision making as an actual tool. And so, the ability to think through the whole aspect of the involvement from the very get-go of people's degrees of values and what's important to them and what their goals are is something

that was done probably about three years ago and available online.

MEMBER ROSS: All of the National Quality Forum committees and workgroups, including the MAP and this one, use the same term, but many of us sitting around the table have a different definition and concept of what the term means. The Home and Community Based Services Committee has spent a lot of time defining not only important -- identifying important domains and sub-domains, but defining them. And even though I personally don't agree with each and every definition, it's the multi-stakeholder process that represents like every interest of importance in home and community based services.

So I would encourage us and every other committee to use the definitions when they're finalized by the Home and Community Based Services Committee rather than re-arguing or revisiting or reopening some of these important concepts because they have been topics of

extended conversation in the Committee itself. So to me it's a great resource for all of National Quality Forum.

CO-CHAIR HANRAHAN: Janine, can you go to 173 slide?

I just want to point something out that I noticed that -- this theme has been really -- has dominated our conversations.

It's in Andrew's area. No. I have 173. The table, yes. Environmental scan.

So this group did an environmental scan. If you noticed the environmental scan choice and control, there were 34 instruments that were identified in the environmental scan which really I think validates our greatest concern here that the shared decision making and control be an issue that gets addressed. In my experience these are very hard things to measure. So it's very interesting that that dominates in the instruments, on the instrument side.

So are there any thoughts or comments, Jim, or Mady, you want to make?

MEMBER DUNFORD: No, I think it's exciting and I'm just looking forward to this. And maybe my only question is just curious whether social media tools for obtaining those kind of novel measures are being entertained and whether there's anything interesting in Australia or any of the other -- England or any place in terms of being able to aggregate data in novel ways to measure these home-based measures.

MR. ANDERSON: Right. So did you want to say something, Charlie?

MEMBER LAKIN: (No audible response.)

MR. ANDERSON: Oh. No. Yes, so at the last in-person meeting the Committee did start talking about these more innovative approaches to measurement. One of the ones they had talked about is actual social media and doing like text analysis to see what people's needs are based on what they're saying. They also talked about point -- of like point of service feedback. So thinking of services like Uber or Lyft where you're able to kind of submit your feedback on

your experience immediately rather than having to wait. So finding ways to integrate those kind of approaches in the HCBS system moving forward. So those conversations have been happening.

CO-CHAIR HANRAHAN: You know, I just have one last comment, too, and I think Gail Stuart can maybe pitch in here. But the workforce issue is really big. It's a big, big issue around a workforce that is not educated to address a patient-centered environment. And we also are looking at expansion of the workforce into community providers, care navigators. And that expansion I think is needed. And that is going to move into then patients and families becoming more participatory in that workforce. And we're already looking at -- already paying for family members to take care of people in the home. So the whole workforce arm. I'd encourage us to really have some kind of focused area at NQF to look at how we can develop out incentives to make that workforce be more efficient and effective in this kind of new environment.

Gail, do you want to say anything more?

MEMBER STUART: Well, I think what we know is the specialty workforce will never be able to meet the needs. And so, we have to redefine what we mean by "workforce," and it does include the patient them self, as you were saying, families. But nurses who are not specialty nurses, but just they're everywhere. There's 4 million of them. Social workers. So I think we have to get our head around a very different concept of workforce. And then how we're going to educate them. I think these are critical issues.

CO-CHAIR HANRAHAN: Go ahead, Tom.

MEMBER LUTZOW: Yes, going back to the comment Jim just made on the phone, there is something that's not discussed a lot, and that is that right now all 9 million duals are eligible for a free Government cell phone, and many of them have free Government cell phones, and they're entitled to 250 free minutes per month.

If CMS were to get a hold of this, integrate with it, organize a communication strategy around it, there could be direct consumer feeds of information both ways, reminders outbound that you need your flu shot. Surveys inbound, how do you feel about your level of care and so on? We now have a program that I think is part of the federal food stamp program that could be used as part of the federal healthcare program if those two programs got together.

So just a thought. It's not an NQF issue. It may be an CMS issue. But who's working on it? Anybody? Maybe nobody. I don't know.

MEMBER LAKIN: Tom, there are some really interesting things happening with some of these outcome surveys in terms of using mobile devices to actually contact people about how they're feeling about some specific thing or three items at a time, not unloading a full-scale interview with them, but just select items at

different times. And those are being tested with people with fairly severe cognitive disabilities with response formats that are kind of icon-driven and with great success and great pleasure by the user. So I think there's enormous possibilities to be creative in this.

And it's so important because this whole area is driven by the individual receiving services as the data supplier. You just can't ask anyone else whether the person has enough control over his life, or whether the person likes the people who are providing direct support to them, or whether they fell able to make the decisions that are really important to them. So finding new ways, better ways, more effective ways of getting that from-the-heart information from people is really a challenge. But there are a lot of people who are really excited about meeting that challenge. So it's fun to watch.

CO-CHAIR HANRAHAN: Thank you. Are there any comments from anyone on the phone, public responses, operator?

OPERATOR: Once again, to make a comment please press star, one.

CO-CHAIR HANRAHAN: Well, thank you, Andrew.

Sorry. Did somebody speak?

OPERATOR: No, ma'am. I was going to let you know there's no comments.

CO-CHAIR HANRAHAN: Thank you.

Thank you, Andrew. It was a really great presentation.

So the next part of the afternoon will be around community integration for dual eligible beneficiaries. And just for logistics I will go through the setting of the framework and the background slides, and that should take us close to 12:30 and we can have some discussion. And then at 12:30 we'll break for lunch. And then we can come back and continue the discussion, because that is -- community integration is sort of the second bit topic for our meeting this year.

So I'm just starting out with a quick

background that the IOM Vital Signs report has come out, came out in 2015, and everybody's talking about it. The harmonization, parsimony, alignment were big themes at that, but they also listed engaged people as a critical domain, and which included individual and community engagement elements. So we just want to recognize the interrelatedness of these elements with health and well-being and as we go into our discussion today.

So to set the framework and the background, what we have done is look at certain publications and organizations to provide some background context setting. The Center for Health Care Strategies is one. We've also provided background on the National Quality Partners Population Health Framework. It's currently being updated, but we do have a snapshot of the current published one. Also looking at some State Integration of Health and Social Services. Another report from the Center for Health Care Strategies. And then finally,

the AHRQ Clinical-Community Relationship Measure Atlas.

So as always, we want to start with data. Integrated care programs have gained a lot of traction and have seen an increase in enrollment of the dually eligible Medicare/Medicaid beneficiaries population, however, quantitative data on the impact of these programs at present is unavailable or is not readily available and information available on the success of these programs comes mostly from health plans participating at the national effort, and it would be nice to start seeing some of the state data at some point.

So one of the efforts or programs that we focused on is the PRIDE, Promoting Integrated Care for Dual Eligibles. And PRIDE is a national effort funded by the Commonwealth Fund. It's a consortium of seven integrated healthcare organizations and the goal is to gather and examine information on program elements that have led to success, potential for existing measures

to accurately assess performance without adding new measures, and the potential for measures under development to accurately assess performance.

So the domains looked at by the PRIDE framework were leadership and organizational culture, infrastructure to scale up and stretch out while maintaining quality and value, financial and non-financial incentives and related mechanisms that align plan, provider and member interests, and coordinated care provided through comprehensive accessible networks and person/family-centered care planning.

So the goal of integration is to improve quality of care and life and reduce costs for this high-need, high-cost population. So what kind of benefits were included in these integrated care plans? Person-centered primary care, acute care, behavioral healthcare and long-term services and supports. And the main components of these programs included person-centered assessments, care plan and coordination.

So what this slide does is recaps the program attributes of successfully integrated care programs. And it started with person-centered accountable primary care, care management and coordination across all benefits and settings, comprehensive provider networks to meet the broad needs of the target population, data-sharing and communication across an individual's providers and caregivers, and financial alignment that blend Medicare and Medicaid funding.

And I just want to add at this point and say that some of these slides seem to be repeating themselves, but they are the themes that came through all the reports and all the information that were looked at to provide this context setting background information.

Performance measures for integrated care. So then it looked at performance measure aside and effective measures needed to capture performance in the following areas: Implementing needs assessments and patient-centered care

plans, engaging individuals in their care, addressing LTSS needs, and improving quality of life.

So then they did a look at the current landscape. What kind of measures are there and where are there gaps? So for implementing needs assessments and person-centered care there are existing measures, as well as measures under development.

Engaging individuals in their care. There are existing measures, but they're inadequate and do not address activities undertaken to engage individuals in their care, however, there are new measures in this area under development by NCQA.

Addressing LTSS needs. There are existing measures that provided limited data, as well as new measures that are under development.

Improving quality of care. Current measures are present, however, they're incapable of adequately capturing data on the quality of care. Sorry, quality of life. Sorry --- not

quality of care.

DR. MUKHERJEE: Next slide, please. Oh, no, no, no. This slide. Sorry.

So measure gap areas. As always in any literature, there were future directions and measure gap areas. And the three most commonly mentioned measure gap areas were care coordination, care management and quality of life.

So the framework started with individual-level data and then moved to a population health. And some of the things considered were maximizing community involvement and improving and sustaining quality.

And this slide the writing is very small. I realize that. And this is basically a snapshot of the National Quality Partners Population Health Framework. And it's a tool for frame shifting from individual to population health. And what it does is provide an action guide that lists each element that should be considered along with examples of things in that

element, as well as questions to consider that -- and provides links to helpful and relevant resources. And this is currently being updated.

So in the next couple of slides we'll provide state-level perspectives. And since we know that most of the innovation and work is happening at the state level -- and this is our first big frame shift from national to state-level efforts and program attributes.

So to do that I looked at a Commonwealth study that looked at state policy components and three components necessary for integration of health and social services at the state level. And they mentioned a coordination mechanism responsible for managing collaboration across services, and they called it "the "Integrator responsible for coordination and communication across state-level services. They looked at quality measurement and data-sharing tools to track outcomes and exchange information, and finally, payment and financing methods that support and reward effective service integration.

And what they did with that is provide a table. And I've adapted it and cut out some of the examples and other things to fit it in here. And what they looked at is the state, community and provider levels. And for each they talked about resources as far as coordinating mechanisms go, as well as data.

So for coordinating mechanisms at the state level they looked at Integrator agencies/entities along with interagency arrangements. At the community level they looked at health outcome trusts and accountable care communities. And at the provider level they looked at accountable care organizations and Medicaid health homes.

On the data side for quality measurement and data-sharing tools they looked at population health metrics, integrated claims database and analysis, integrated -- and for the community level they looked at integrated population health/quality report cards. And for provider they looked at e-referrals, integrated

patient-level data sharing.

And building on the state policy components they recommended framework implementation steps, and their recommendations were to establish goals based on current needs, circumstances and priorities; identify gaps and opportunities where needs are not being met and identify inefficiencies and reallocation of funds for increased return on investment; prioritize opportunities for integration based on community -- individual community strengths and resources, as well as balance long and short-term planning efforts; establish an implementation road map that highlights policy concerns and plan out both the long and short-term activities.

This is another state integration model, and what it does is create a framework with key domains to improve care for high-need, high-cost populations. And this was the CHCS work down for the Robert Wood Johnson Foundation. And what CHCS did was lay out key domains of the framework for the diagram that was just

presented.

And care model enhancements should evaluate the effectiveness of specific interventions, identify appropriate care management intensity.

Financial and accountability. Establish risk adjustment methodologies that includes social as well as medical complexities, refine approaches to managed care rate setting.

For the data and analytics, identify unique population subsets to tailor intervention approaches, increase access to real time integrated data systems.

They mentioned workforce development. Standardize tools and training specific to caring for high-need, high-cost populations and incorporation of new or different types of healthcare professional and non-traditional health workers. And here they did mention the HIPAA issue and using certain non-clinical health workers as -- HIPAA as being a hindrance to that.

Governance and operations. Leverage

governance to promote reinvestment in community capacity as well as develop management capacity to support operational excellence.

And finally policy and advocacy, to address key policy barriers and ensure that the voice of consumers is represented.

So what do we have as a resource for current performance measurement? So one of the resources found is the AHRQ Clinical-Community Relationship Measure Atlas. And it is designed to provide users with a measurement framework and lists existing measures for clinical-community relationship. It is intended to facilitate research, quality improvement projects and other interventions investigating clinical-community relationships that have been formed for the purposes of improving the delivery of clinical preventive services. And it is also intended to be used by researchers studying clinical-community relationships as well as evaluators of these relationships.

So some of the caveats provided is the

idea of measuring clinical-community relationships is new and that measurement domains within this Atlas may evolve, and probably will evolve over time. Some of these domains lack measures, or the measures that do exist require additional evidence to establish their effectiveness in evaluating clinical-community relationships. And the Atlas is being established in part to investigate potential measures for evaluating clinical-community relationships.

And with that frame setting background we have some questions such as what is the most relevant framework/model for the duals population? What domains are high priority for this population? And what should be the next level of strategic discussion for this group to further this conversation this afternoon as well as in the future?

CO-CHAIR HANSEN: Thank you, Debjani. The ability to pull all this together in many ways -- there's a density to this because of the

methodological kind of explanation. So we would really welcome some interaction by members of the Committee who are thinking about this whole concept of community integration and providers.

Implicit in that, I think, some of the different programs that have started already include like the Hospital Care Transition Program that have brought together community organizations and hospital systems. And that I understand is obviously one of the ACA programs, but it's had some bits a little jagged components because you have two different cultures of a community-based provider for home and community based program services. And then you have an institutional provider, whether it's a nursing facility, a post-acute facility, and especially a hospital.

So are there thoughts? And, Debjani, if there's a particular area that you wanted that the Committee might comment on.

DR. MUKHERJEE: I think probably one thing that would be helpful is to say what does

community integration mean for this population and what are some key aspects? Because a lot of this was domains that are important and domains that were repeated throughout different studies but that necessarily might not translate to sort of the collective thinking of the workgroup and just their experience.

MEMBER ROSS: I had two frustrations to share. First of all, the Commonwealth Fund does excellent work, and I'm looking at the PRIDE report, but they obviously never read any of the reports of this workgroup from 2013, '14 and '15 when we developed high-priority measure gaps. And I'm really disappointed that a Commonwealth-funded that you're reporting on -- the measure gaps do not mention individuals, goal-directed shared decision making, beneficiary sense of control, autonomy, self-determination. And it's a reflection on what are we doing here? We've issued these reports and here's this report that you're citing and they've ignored the person dynamics of this workgroup for three years. So

I'm disappointed about that.

And I guess I'm also disappointed that you would say, well, what is integration when we just had Drew and Charlie -- where integration is a major element of the Home and Community Based Service Committee, its definition. So I'm frustrated that it seems like we're -- the people are ignoring, we're ignoring the home and community based service work and you're reporting on a Commonwealth report that ignored our work.

And then the question is why are we sitting here for two days around the table if we're -- there's disconnects, so many disconnects.

DR. MUKHERJEE: So is it coordination of integration of community efforts as one of the recommendations?

CO-CHAIR HANSEN: Well, why don't we keep talking and then we'll pull out a few things. I have some thoughts on that, but I don't want to interject just yet.

So Joan and then after that Tom.

MEMBER ZLOTNIK: That was an incredible amount of information to present. Really important information. And one of the things that -- a few things struck me in that kind of 15-minute intense overview of millions of millions of dollars worth of efforts that have gone on is the difference between a planned organized kind of managed effort to implement an integrated health and social service system as some communities have with the sort of difference of the reality of kind of one person at a time needs for care coordination. And they're different. And I think we need to make that clear.

The other thing that struck me in that there was a table that had a list and it talked about what things had measures. And my next question in my head was are any of those NQF-endorsed measures in terms of something that's been a theme of our conversation here that there are a lot of measures that are being used by this expensive and a whole other set of strategies to

be in an NQF-endorsed measure?

And I guess the other thing that was striking me is; and maybe this kind of comes out of more of like a medical bent, providers and hospitals and social service agencies and individuals with needs are all part of the community. So like we might just think a little differently when we're thinking about community integration, because many of these examples I think we're looking at how do we provide a more integrated service delivery system. They're system issues. They're not really there's the hospital and there's -- even though that's the way it comes out. So that's a little -- my thinking. But this is something that is many days worth of conversation that was synthesized in 20 minutes.

MEMBER LUTZOW: You know, this issue of integration, we don't have it of course and we need to evaluate it. I want to give you examples. And this doesn't really rise to the level of conceptual generalization yet, even in

own my mind.

The idea of capturing for the purpose of integrating medical and social services around an individual, it is -- it amazes me. I don't know if you knew this; I didn't know this, all of the American Lung Association offices sponsor a Better Breathers Club. It's called Better Breathers Club. And the purpose of the Better Breathers Club is to bring together people that have asthma and COPD and other lung-related kinds of disabilities and educate them about their condition and how they can self-manage.

This was a new discovery to me. I didn't know there were Better Breathers Clubs. We weren't integrated with Better Breathers Clubs. We didn't send our patients/members to those clubs, pay for their transportation. That was a new thing.

That's just one example of these resources out there that are not brought to bear on chronic disease management by health plans and health providers. So somehow in -- talk about

unfunded responsibilities. This is an example of where we can extend responsibility that probably is funded, and yet we're not moving the system in that direction.

Another example. It amazes me that day care programs that serve the elderly in our community, Wisconsin, don't have access to medical information. And yet it's at those day care programs where meds are dispensed. And so, when there's a change in the medication regimen, they don't know because they're not wired into any system.

We have this firewall between medical and social services when social services can be brought to bear, whether it's day care, CBRFs, RCACs -- brought to bear as a resource in executing medication compliance. They're the ones who dispense the medication. And yet there's this firewall that exists for HIPAA reasons or God knows what which just doesn't tap the resource. That has to be broken down. So we have to change our laws or something to

accommodate an integrate those resources in the care delivery process. They have a place at the table, and it's a legitimate place.

Apart from just the absence of information integration we have basic opioid abuse where unless we track where these folks are getting these medications, they'll go to any number of pharmacies and tap them all for the same meds. And I mean, it's fundamental that we have to even within the medical community integrate information and share it more quickly and rapidly. But there, too, there's again a firewall between the medical environment and the social environment.

So the barriers to integration are huge. They're huge. And we are not going to wrap ourselves around the correct management of complex conditions, chronic conditions unless we do a better job of this.

MEMBER LIND: So I have to tell you one of my favorite Dilbert cartoons is where the guy writes a 200-page report and then he hands it

to his boss and he turns it into a 3-page executive summary who turns it into a set of bullet points for a PowerPoint slide who turns it into the executive CEO with the comment "Nice tie." It's like to goes from 200 pages to nice tie and he says, "Good job."

So that's how I feel about this Commonwealth report. It's like a ton of work. And iCare was one of the organizations that participated in the PRIDE project and out of every project -- I mean; you probably have had this experience, you try to summarize what bits you can glean from it. And one of the bits was to say the PRIDE project has only been going on for a year-and-a-half. We have to produce something that ties all this ton of work that's been going on to can we actually start measuring it and reporting it now?

So I actually helped write that report, and it does reference NQF's work and points to some of the things you were talking about. I mean, that's like a 7-page issue brief

with 30 references in order to pull in Truven's work and pull in the home and community based services client survey work and the NCI work and then say here's what we know about what they've been able to accomplish in PRIDE and here's where the gaps are.

And so, I don't think the slides capture all of that, but neither does the seven-page brief because it's a -- I mean, a ton of work went into that PRIDE group. I don't know if you participated in any of the meetings, but rich, rich discussion about what should we be doing to improve quality of care but to try to summarize it. I think there's still another paper to come out of that. But it was not easy, I'll have to say, in my own defense.

CO-CHAIR HANSEN: Thank you, Alice.

Gail?

MEMBER STUART: So I recognize the tremendous amount of work, but I'm struck by a couple of things. One is it doesn't address at all the social determinants of health. It

continues to go down a medical model road. And we are never going to get out of the rut we are in unless we really look at a public health model. And I just think what has not been addressed is enormous in terms of this report, whether it's economic, food farms. I mean, it's just incredible what we're not looking at.

And then the second thing is my observation that we may not be able to get out of the medical model, but this is going to happen based on technology. Because as we all have smartphones and tele-health and all this technology, that's going to be the transforming element to how we provide care, where we provide care. And I think that's on the horizon. But I really feel like we need to in this discussion at least talk about more of a public health perspective.

MEMBER DUNFORD: Jennie, this is Jim.

CO-CHAIR HANSEN: (No audible response.)

MEMBER DUNFORD: Can you guys hear me

all right?

CO-CHAIR HANSEN: I hope you can hear me now. I didn't have my microphone on.

MEMBER DUNFORD: Oh, okay. I just wanted to make a comment. I agree with the last comment about technologic solutions to this.

I participated last year in Washington at Health Information Technology Policy Committee where I testified on a -- it was called the Advanced Health Models and Meaningful use Workgroup. And there were -- this is part of the Office of the National Coordinator for Health Information Technology where seven model programs in the country that were beginning to merge social and health data were discussed.

And all the barriers are very real, but I would hope that we're looking at the technology side of the Government for some of these solutions. Because there really are some very exciting projects that are underway that actually begin to bridge social data and begin to wrap around patients, sometimes entire states,

sometimes local communities that are taking social information and bringing these into very sophisticated information centers and beginning to aggregate it and then bring it all the way down to the individual patient level.

So one of the silos that we have to avoid is failing to understand what's going on over there in the health information technology world where there's a tremendous amount of interest. I'm sure everybody knows the Institute of Medicine has said that the social determinants of health must be incorporated into the health record of the future. But those are basic social metrics. And there are other ones that communities themselves are beginning to identify.

Here in San Diego we've created a Social Information Exchange that actually shares across housing providers, Meals on Wheels, and regardless of whatever database you use; if you're HMIS, for example, the housing providers will use that, you can all share information across. But the obstacle is that the Health

Information Exchange here in San Diego doesn't want to touch it because of the HIPAA rules.

So getting back to the barriers, for whatever reason healthcare association's information technology is extremely loathe to move toward trusting the trust network that's necessary in order to be able to take advantage of this wealth of information that exists on vulnerable individuals. Thanks.

CO-CHAIR HANSEN: Thank you very much, Jim.

We have two more speakers before we summarize some of this.

Charlie?

MEMBER LAKIN: Well, I was just going to say that I find terminology really frustrating here. Over 30 years ago I helped start an institute at the University of Minnesota called the Institute on Community Integration. And what we meant by that, and what we still mean by that, is that people are in and of and actively participating in their community. and that's why

we did what we did. And now I come and hear -- and somehow community integration, which has been widely used in this disability field, to mean people's lives is now somehow akin to service coordination or something. I can't quite figure out what's meant by it.

And I feel the same thing with person-centered. I see it used to mean that you assess somebody and then based on the assessment you do something that's sort of relevant to their needs, where in the disability field person-centered means I drive my experiences.

And we just have these different terminologies. And I don't know if that is confusing to others as much as it is to me, but I honestly don't know what people are talking about so often when they use terms that I've used for 35 years. So, yes, it's confusing to me how the language is different as you talk about different topics.

CO-CHAIR HANSEN: Thanks for that point, Charlie.

Okay. Christine, and I see Michael, who has the final comment.

MEMBER AGUIAR: Sure. So I think that community integration is an area where NQF can lead by signaling, right, so signaling this is where the expectation is for you to go. But then you get into a chicken and egg situation. And you also don't want to penalize ACOs or plans or providers who are trying to do this and want to do this, but they're not financially responsible for those services, and there's a lack of them in the credibility. I mean, I think it's important to keep in mind the barriers when constructing the measures. So it's this balance between incentives and which direction do you want to move towards, but then also what are the real challenges and barriers?

So this is something that we deal with all the time talking about with our plans. We talk to them about food as medicine. Many of them were involved in private collaborative and many of them are working on this. But again, so

I think it's an important area and important for signaling what are expectations are, but it has to be done in a way that recognizes that many of these services are provided by the state and there's just real limitations to them.

I'd mention again the privacy restrictions. And again, it keeps coming up here. I would make it important to note that we do -- in our advocacy around this issue we are clear that it's 42 CFR Part 2 and not HIPAA. That's the restricting regulation, because it is -- those that are concerned about having the 42 CFR Part 2 exemption are fearful that we're trying to eliminate HIPAA. And that's actually not what the concern is.

CO-CHAIR HANSEN: Thank you.

MEMBER MONSON: So I know I'm probably standing between us and lunch, but the one thing I will just add to this conversation, to build on what Charlie was saying and a couple others have said, is that I think what we're -- the reason we're talking about community integration is

because we have fragmentation in the system, and that fragmentation in the system is partially because of the Medicare and the Medicaid benefit structure. It's because some things are social, some things are medical.

And so we've been talking about these issues as -- from a vantage point I think -- and many people are coming from different vantage points in that system. And if we really want to talk about integration and how we do this correctly, we should start with the consumer and work our way outward. And what is it that the consumer needs? And then were are the breakdowns in the system and how do we think about measures that might stitch that together to overcome those breakdowns in the system?

CO-CHAIR HANSEN: Well, thank you, Michael. That's actually I think a perfect summary and a way to get back to some of the language we keep talking about, because right now we're talking about some of the structures, the processes, the lack of system-ness that we have.

So if we flipped it and go back to what -- Clarke and Charlie always bring up is starting with the person. And what would be a great outcome for a person regardless -- not so much regardless, but in view of different kind of life issues that they're having? How can they maintain their best well-being under the circumstances?

So one of the things that I think about for us with this Committee; and we can perhaps talk about it this afternoon when we're talking about strategy, is is there a way that we can convey an infographic in a way that speaks to what happens to many of the dual eligibles and show kind of almost a graphic area of if things were aligned and they got to a point of highest best functioning and quality of living, what would that look like? And then let's map out some of these things that show where they break down.

But the uber issue of the barrier of privacy, the handoff of information to assure that, that's a major policy and statutory

consideration. So maybe this is one of the areas that it really speaks to what is the role that NQF can play, that as we move with this and work with CMS and have ACL as a part of this if we were to achieve the highest best outcome with the least necessary use of extra cost and people functioned, how could that look?

And how does the rest of our stuff fit into this, the evidence-based kinds of things that we have, the things that we will need to develop? What is the ultimate outcome, not just an ultimate -- not just an outcome measurement, but what is the ultimate outcome that we're looking at for the different populations of the duals who comprise our charge?

So, but thank you for each of you bringing this and thank you, Debjani, for trying to distill this. And here we have some -- a primary author of the study. And I think we all feel this jaggedness and the fact that we want -- I think we're aligned that we want the best for this with the parsimony of resources that are

needed, but with the highest value.

So let's perhaps table some of this discussion that we can bring onto the 3:30 strategy discussion that we may have.

And as we end, I just wanted to make sure that those of you who have worked with Megan have a chance to hear from her as she moves into a different stage.

MS. ANDERSON: Thanks. I have two things. I'll make sure that we communicate with our External Affairs Office that you heard from yesterday morning about this challenge and discuss with them the role that NQF has or could have in some of these concerns about the role of and the barriers to the advancement and effectiveness of quality measurement because of privacy rules. And so, we can talk about NQF's role and how that works.

My announcement is, I guess, a little strange. And I'm just pleased to share with you and wanted to thank you all for your time over the last four years. I will be moving on this

summer. I'll be going to Johns Hopkins University to start on a masters of science in the nursing program, and I'll be there for almost two years. I'm looking forward to coming back to the area and keeping in touch with all of you. And thank you all for your inspiration and mentorship over the years. I really appreciate it. Can't begin to describe how much I've learned.

CO-CHAIR HANSEN: Can we give her a hand for her --

(Applause.)

CO-CHAIR HANSEN: Do we have a speaker coming?

MS. ANDERSON: We have a speaker starting at 1:00, so we'll reconvene at 1:00.

Sorry. Go ahead.

MS. GOLDEN: Hi. It's Robyn. Should I come back at 1:00?

CO-CHAIR HANSEN: Hey, Robyn. How are you?

MS. GOLDEN: Hi, Jennie. How are you?

CO-CHAIR HANSEN: I'm good. Yes, well, please give us probably at --

MS. GOLDEN: Yes.

CO-CHAIR HANSEN: -- the latest 1:05 we'll get going.

MS. GOLDEN: No problem.

CO-CHAIR HANSEN: Okay. Thank you very much.

MS. GOLDEN: Thank you.

(Whereupon, the above-entitled matter went off the record at 12:42 p.m. and resumed at 1:00 p.m.)

CO-CHAIR HANSEN: As some of you continue to finish your lunch, I will go ahead and have a chance to do an introduction of the next speaker.

The rest of the afternoon really brings together some of the conceptual things we have talked about in a much more granular with our two speakers, Robyn Golden, who I will introduce in a moment, as well as our own Alice Lind who will give us a sense of how a state is

handling the whole financial alignment.

After the presentation from Alice, this moves to the afternoon session that I have been alluding to relative to having some time together about the strategic direction of this particular Workgroup, given the fact that we have heard all of this, we have gone through measurement recommendations and all, just what is our role? We have been having hints of conversations of that that I would like to have a chance to pull together.

So, also, let me just turn this over for a moment to my Co-Chair Nancy.

CO-CHAIR HANRAHAN: I am going to be leaving at 3:00. I have to catch a plane. But I wanted to thank you all. So, I will just slip out in the middle of everything, look forward to seeing you again.

CO-CHAIR HANSEN: Thanks so much, Nancy.

Okay. So, I have the delight and pleasure of introducing, as some of you have kind

of picked up, I have known Robyn for a long time. Robyn Golden serves as the Director of Population Health and Aging at Rush University Medical Center in Chicago, where she holds multiple academic appointments at Rush in preventive medicine, geriatric medicine, nursing, psychiatry, and health systems management, as well as the College of Nursing.

She is responsible for developing and overseeing health promotion and disease prevention, mental health, care coordination, and transitional care services for older adults, their family caregivers, and people with chronic conditions.

She is the PI for the HRSA-funded Geriatric Workforce Enhancement Program, and we will bring up some of the workforce components people have mentioned, as well as the Commonwealth Fund Primary Care Redesign Project.

For over 25 years now, Robyn has been actively involved in service provision, program development, education, research, public policy,

public policy that, in particular, aims at developing innovative initiatives and system integration in order to improve the health and well-being of older adults and their family.

She was honored to be a John Heinz Senate Fellow back in 2003 and 2004 in the office of Senator Hillary Rodham Clinton back in D.C.

Robyn is also the past Chair of the American Society on Aging and currently co-chairs the National Coalition on Care Coordination. She is a Fellow of the Gerontological Society of America and she holds a master's degree from the School of Social Service Administration at the University of Chicago.

So, Robyn, we look forward to your discussion of field examples relative to care coordination. One of the things that has been discussed here is the use of terminology and how many people have actually been doing the care, like yourself, for decades, but there is terminology. So, I think knowing who you are and knowing your manner of presenting, I think you

will help us kind of unpack this and make this much more tangible for us to hear.

So, we turn this over to you and welcome you to our Committee.

MS. GOLDEN: Thank you, Jennie.

Can you hear me okay?

CO-CHAIR HANSEN: We can hear you well. Thank you.

MS. GOLDEN: Okay. Great.

So, I am so sorry I am not there in person, because I did listen in a little yesterday morning to kick it off and, then, the last hour. And I have to say the complexity of what you are dealing with is quite impressive, and I give you a lot of credit.

For those of you in the audience I know -- thank you, Joan Zlotnik, for having me invited today -- and for those of you who I do not, I want to say hello to the people I know and the people I don't, but I don't have a list of who is there. So, maybe when you ask questions later, you will say your name.

I cannot advance the slides, correct?

DR. MUKHERJEE: That's correct. But if you say "Next," Janine will.

MS. GOLDEN: Next, Janine.

So, just to start off, I know you have been talking about social determinants. So, I am just reinforcing the importance of that. I feel like we who have been trying to raise the social determinant flag for years finally, you know, we are having some traction, and it is exciting.

For good, bad, or indifferent, the new innovations FOA that came out of the Innovation Center at CMS is very much trying to bridge some of what we have been talking about, the notion of the hospital in the community in its new FOA. We will see how that works. It is a tough one, but it is exciting at least that I think more and more people are addressing it.

You can see in this next slide -- I think Jennie referred to this yesterday -- it is a critical factor when you look at that 60 percent that is influencing the non-medical

adherence to care. The issues related to care are expensive when we are not quite addressing those as we should.

I just came -- this is the advantage of being here, I guess -- I just came from a two-hour meeting about health risk assessment. We tried to come up with one across our Rush system, inpatient and outpatient, and trying to look at it as payer-agnostic, as we call it. But how I had to raise the flag in that meeting about social determinants. Yet again, trying to make sure they are part of that health risk assessment was still a little bit of an uphill battle for that gang in the room. It was a very interdisciplinary group, et cetera.

But I think there is still this push toward the medical model when we are looking at risk and health outcomes. I told them I was going off to do this talk and maybe they should tune in. No, I'm kidding. I will give it to them later.

(Laughter.)

But, if we turn to the next page, I think it reinforces that this is really our blindspot in healthcare. We know that psychosocial issues really have an impact on health outcomes and cost. Yet, that person- and family-center coordinated care with links to the community are rare in most care models. Mental health is often forgotten.

And there is that difference in worlds, as you talked about, different language in the hospital than the community. For me, I have lived in both worlds. So, it is useful that I consider myself, and I only hire people who consider themselves, kind of bilingual and bicultural in that way, that they know the medical as well as the social-service-community-based world.

So, there is this whole system of community-based services out there which we often ignore or, as you said earlier, we assume that they are there. In some states they are devolving as we speak, mine being one of them

where we still don't have a state budget a year later.

I think someone mentioned the psychosocial aspect of the social determinant report from IOM, but there was another one in 2012 that talked to the past, to continuously learning healthcare in America, recommended community links, assessing those psychosocial issues, delivering services in the community, and communicating these issues with the medical team.

So, if we look at the next slide, it basically does take that team, and that team needs to incorporate lots of different people from multi-sectors. This study that was done in 2011 is very interesting because people often, particularly older adults and dually-eligible people, they consult primary care most comfortably. When social issues lead to physical symptoms, that primary care may be the best haven in which people hear about those social issues.

However, in the survey done in 2011, there was a survey of 1,000 primary care

physicians, and that they did not have the time, basically -- and I think that has probably even gotten tightened, as some of the physicians in the room would agree -- or sufficient staff to address these social needs, such as access to nutritious food, transportation assistance, adequate housing, even though they knew that those were important issues to address as medical conditions. And that was a direct quote from the report.

Four in five reported that they did not feel confident in their capacity to meet their patients' social needs, which they believe impeded in the care, and that they weren't aware of social services or community services around them, four out of five.

Eighty-five percent of the primary care docs surveyed believe that these unmet social needs really did make a difference, but they were always so concerned, too, about opening a Pandora's box if they did raise some of these.

And then, I thought this was

interesting: that one out of seven, if they could write a prescription for social determinant issues, their prescriptions, one out of seven would be for social determinant issues.

So, that is kind of what brings me to, if we can look to the next slide, the whole notion of care coordination. When we look at care coordination, we have to look at it from the person- and family-centered, as you have been talking about, based on assessment of individual preferences and strengths and their needs, and focus on all of the aspects we have been talking about, medical, social, behavioral, and to integrate those health and social services. And then, it is not always on the physician.

And that is what I want to talk about today, is some programs we have developed on the ground that kind of enhance healthcare and the experience for the patient and probably make a difference in terms of overall tripling kinds of things.

If we go to the next slide, a lot of

what we based our work on was listening to our patients, the voices of Rush patients. They talked about, we have talked to thousands of people, and many of the themes were the barriers that were getting in the way to getting to appointments. You know, people automatically assume that patients sometimes don't come because they are resistant or reluctant. And then, you hear stories about grandma who is raising five grandchildren because her daughter just went into prison, and there is much more going on than we just think a non-adherent patient. That is not what is happening. They are real-life barriers that get in the way.

And sometimes patients are afraid to say the wrong things. They feel overwhelmed about who to call. All of those kinds of voices for us made us, if we could go to the next page, kind of look at things more broadly.

I was brought to Rush almost 12 years ago. It has been a great experience because, basically, they wanted me to come and enhance

what was a strong geriatric program and to provide not only community-based services, but enhancements within the medical center to better connect to the community.

And that is what we have done, kind of that wraparound in a very traditional hospital, sometimes a hospital that, as we say, Medicare built. So, we are still very much in a fee-for-service environment here, although crossing over on that trend to value-based and alternative payment mechanisms as well.

So, we are a hospital that is 664 beds on the west side of Chicago. We have primary and specialty care, and we have been ranked fairly high in geriatrics over the years.

If we can go to the next slide, part of what we established was our Health in Aging Department.

Can you push to the next one? It might be animated. I don't know if you can get to that. There we go.

So, we have our transitional care area

that started, basically, because we heard from discharge planners loud and clear that they never knew what happened to people after they went home. So, we did some pilots and recognized that this was a big area. And this was even before 30-day re-admission reduction became a big thing.

And we talked to other transitional care programs out there, as in Mary Naylor, Eric Coleman, and really started raising this. Because in our pilot we saw that social determinants were part of the reason that people were being re-admitted and not a lot was being addressed in that area.

Then, I move over to the next box, which I am going to get into more detail with, the outpatient social work. So, we were really focused on people going home and making sure they get home in a safety net kind of way, but we also wanted to make sure we were wrapping social determiner, non-medical issues around primary care to try to prevent people getting hospitalized in the first place. So, we

developed social workers. We have social workers wrapping around primary care.

And then, most recently, in the last two years, our last box, we have gone into what is a Medicaid ACO. That has been a really interesting experience for us, to be a in RIF, cost-savings kind of world, thinking about care coordination and connection to community.

So, if we can go to the next one, I will dig a little deeper in our transitional care model, which is called the bridge model of transitional care. It has been replicated in about 65 sites across the country.

The bridge model helps patients transition safely from an inpatient hospital visit back to the community through intensive care coordination/care management, integration of psychotherapeutic techniques, motivational interviewing, you name it.

As you see, the person is in the middle. We call our social workers bridge care coordinators, and they address not only overall

health issues, but they very much do a bio/psychosocial assessment to try to understand what is going on.

What we find is that the systems that people are sent to very often upon discharge are not responding, and it may be that the home health agency doesn't come out because they didn't get the right paperwork, or you name it. It is amazing what happens, and there is no fingerpointing involved. There is just a way that we try to make sure that the patient and caregiver are going home safely.

We both have bridge models set up across the country where the hospital is coming out to the community, the social workers starting at the bedside, and then, following them into the communities, sometimes telephonically, sometimes in person.

But, equally, and even more so, we have community-based agencies who have been trained in the bridge model who go into hospitals and provide this role as well. And they truly --

excuse the term -- are the bridge and they make sure they understand both where the hospital pressure is coming from as well as the community, and try to make those connections.

So, if we could go to the next slide, you just get a sense of all of what is going on here. When our model works well, it works very well. When there are little hiccups, we get all those people on the phone together and, believe it or not, have a 10-minute care coordination call that has been shown to make an unbelievable difference, even with our super-utilizers. Those people who come to the hospital a lot that you don't think you can make a difference with, it has made a difference with those folks because we finally get the primary care doc on the phone with the hospital docs, with the aging network, with the home health agency, with anyone who is involved, to make sure everybody is on the same page. The one flaw of our model is that we don't necessarily get the patients and the family on that call, which is something we are really

thinking about.

Just to the next slide, I want to show you that there will be a JAGS, there is a study that will be printed in the Journal of the American Geriatric Society that talks about our strengths, bridge strengths: that we have repeated assessments, person-specific tailored interviews, that we are well-suited to address the transitional care needs of adults with complex medical, behavioral, and social needs.

All along, this is a social-work-based model, and no one has said social workers are better at doing this. We have just said social workers can do this transitional care work, too. We are part of the team, and we can be part of this and make a difference.

If you go to the next slide, you will see we have made a difference in reductions in re-admissions overall. We have done a randomized controlled trial and, then, we have done this other compared trial. We would like to test it even more, but we have been viewed as an

evidence-based intervention by many different sources over time, and we are excited about that. It is a very replicable model.

So, let me go to the next piece, our AIMS model, which is the Ambulatory Integration of the Medical and Social, a mouthful, AIMS. Again, it is using master's-level social workers who are based out of an ambulatory setting. They wrap around medical care by addressing these non-medical needs that are making a difference in people's lives.

We started this when we went for NCQA certification many years ago and really helped our practices meet that certification because of the care coordination aspect and the connection to team. So, it took a while. It was a bit of a culture change, but I think we have gotten to the point where many of the providers and the practices know that they can't live without us.

Basically, the demand is greater than our supply most of the time in terms of our social workers to intervene. So, it is a good

thing. It is an exciting thing. And we are trying to focus on targeting complexity, so we know who to hone-in on, who we make the biggest difference on.

If we look at the next piece, you will see this is kind of the progression of what we do in the AIMS model. Again, this has been replicated in other sites around the country. We engage the patient and the caregiver. We try to develop a care plan involving the interdisciplinary team. We provide telephonic and in-person case management, when able. We focus on goals. We try to narrow the goals, so they are possible, smart goals.

And then, we care, as needed, in an ongoing way based on whether or not people have been able to self-manage. Patient empowerment is a big part of this as well as resource linkage.

So, if we can go on, let me just show you some of the impact of this. This was a pilot study and we did show a difference in admissions. Thirty-day re-admissions and ED visits were down

as a result of AIMS participants in a six-month period. So, it was pretty amazing that that touch -- and sometimes it is a very light touch -- has made a difference in that way.

It is so interesting that the Commonwealth Fund, based on a health affairs article we wrote a few years ago, if we can go to the next page, on social determinants and non-medical issues approached us and have funded us to study this model in a more rigorous manner. So, we have been recognized by AHRQ as an innovation model as well as been funded a lot by the Weinberg Foundation to expand this model to other sites in Illinois and Maryland.

So, we are excited, very excited, to see the results of the Commonwealth Fund study, which will be ending in April 2017, where we are very much looking at the impact on patient's health service utilization, outcome satisfaction with healthcare service delivery, including community-based organizations, and identify the core aspects essential to the success of the

model.

Just our last, if I go to the next slide, our last area has been really more in this managed care ACO world around Medicaid. This is really the Medicaid expansion stuff. As busy as this slide looks, it is a metaphor for the complexity of what we have gotten ourselves into here.

But it is a challenge and an exciting one. We are part of a group that is covering the southeast side as well as the west side of Chicago, and in partnership with two other hospital systems as well as nine federally-qualified health centers. We are connected via a real-time portal. So, if someone shows up in an emergency room in another hospital, I will be signaled as the care manager.

And our care management team consists of -- you can go to the next page -- consists of a patient navigator, a care manager who is a social worker, and an RN. These triads -- so, this is different here -- these triads do

different things, but, basically, they manage a panel of patients who have been labeled as more high-risk, based on a health risk assessment.

What we are trying to do is help people live differently and better, not just drive down their health utilization and improve their health outcomes, but very much looking at them holistically and recognizing, again, food is medicine; the shelter is medicine, all the social determinant factors.

As you can see, the type of issues we are dealing with has a lot to do with 34 percent have transportation problems, difficulty paying for medications, some mental health issues, high mental health issues, a lot around substance abuse. And many, 40 percent, need help getting food, clothing, or housing.

So, you can see the nature of the population very similar to what you are talking about and how complex it is, but what we are doing is really trying to use this triad notion and figure out who in the triad is best to

coordinate the team efforts and when we need everybody and when we don't, because we are trying to be as effective and efficient as possible.

You can see on the next slide we are making a difference in terms of total cost-of-care reductions, ACA, you know, the whole re-admissions have been reduced, utilization, and patient engagement, a higher patient engagement compared to a non-orchestrated group of comparable Medicaid folks who aren't part of the medical home network.

So, let me just conclude with the next slide, kind of finishing up. And then, we can have some questions and answers.

What do we think it takes? We think it takes prevention and wellness strategies, innovative models, really thinking out of the box or replicating what is there, attention to multiple chronic conditions. I am constantly pushed and pressured to look at one disease at a time, and we fight that. We challenge that

because we know it is about multiple chronic conditions.

We need the collaborative team-based care with seasoned clinicians across disciplines that have respect for one another. And we need those community engagements and partnerships in a formalized way where community agencies are not just feeling dumped on, but part of the important process and benefitting from the lack of capital that they receive, the lack of investment in our society as compared to some other international folks who invest in social services in a different way.

There has to be data-sharing between health systems and the CBO. We had a situation last week with a patient who has been in our emergency room or the hospital next door's emergency room, the University of Illinois, 70 -- seven zero -- times since January 1st. We finally recognized it, which is scary in and of itself that it took that long.

But we started talking through our

mechanism with University of Illinois, Chicago, next door. And then, we found out there was a community based agency, and this gentleman was coming to our ED to get his anti-psychotic medications. Well, we found out, after talking to this community agency, that they actually supply those medications. We thought he was homeless and they were housing him.

So, all these disconnects about what the reality was were very intense. We set up a meeting with the CBO of a community-based organization, and they cancelled that day because they were fearful of talking to us because of HIPAA violations. So, in that case, how do we get through that in terms of teams of CBOs?

If we could go to the next slide, I wanted to bring it just to how will we measure this. I know you know this better than I, but I think how do we make sure we measure what matters to clients, patients, and families and the customization of our service plans to priorities. It is not just plug-and-chug with gold, and the

care plans cannot just be cut and pasted. How do we think about comfort? How do we think about the need for independence or interdependence, financial controls?

These things are not largely captured by measures. They certainly would make a difference in the value of healthcare systems when they are addressed in partnership with the community.

And then, the next slide is just, again, measuring what matters. You know this, again, as well as I. And how do we align these services and how do we make sure people have confidence in the care system and that they understand that the care system cuts across the silos? And how do we look at measuring efficiency and waste and dosage and targeting and all those kinds of things?

So, to end on my last slide, it is just kind of a little vision for all of us. In a time of major changes to the healthcare delivery and payment systems, connecting clinical work to

community partners and resources brings a sense of renewal and hope to the challenges ahead. Going beyond our clinical walls to solve complex problems is a prescription for success.

So, on that note, I turn it back to you. Hopefully, we can have a bit of a discussion.

CO-CHAIR HANSEN: Thank you. Thank you, Robyn, for really this extensive array of work that you and your colleagues are doing at Rush.

So, we will start with some questions here. Tom? Tom Lutzow is a physician.

MEMBER LUTZOW: Yes, Robyn, I happen to be from Milwaukee just north of you.

MS. GOLDEN: Oh, hi. How are you?

MEMBER LUTZOW: Good, good.

I have been using an image of Chicago, whether fair or not, for a long time and it derives from an article that I saw -- and I just Googled it; it still exists -- that shows that healthcare workers, home healthcare workers, as

they go to those high-rises are accompanied by armed guards.

MS. GOLDEN: Uh-hum, uh-hum.

MEMBER LUTZOW: And I am wondering if that is true or not. It was pictured in the paper, and I have always kept that because, all along when socioeconomic conditions were dismissed as relevant to the healthcare system, I always thought of those healthcare workers going into those apartments with armed guards and wondering, first of all, the fee schedule, did the reimbursement cover those armed guards?

(Laughter.)

That was one thing.

MS. GOLDEN: Doubtful.

MEMBER LUTZOW: Yes. How do you miss the implications of that when it comes to SES determinants of health and the effectiveness of healthcare based on poverty and other social conditions, and so on?

MS. GOLDEN: No, it is a great question, and it is hard to miss the degree of

violence we have in Chicago that you hear on the news all the time as well. So, that adds that factor, too.

You know, as someone who did home visits for 25 years and never went in with an armed guard, just learned to go in in the morning, that it was safer than later in the day, and learned those kinds of tricks of the trade and to be smart and to watch what I was doing, and I went into some not-such-great areas. But I do think there are programs that -- unfortunately, we are a very segregated city. So, we make assumptions about where the tougher areas are, I don't know if good, bad, or indifferent as a result. It is hard not to think some of it is racial profiling.

But the result is that I am sure a lot of places do go in as duos. So, they are not going in alone per se. I know a lot of our community health workers that come out of our federally-qualified health centers go in pairs until they get to know the situation, and those

kinds of things happen.

They probably do become friendly with some of the guards that are associated with some of our housing facilities that are in areas that are a little tougher than others. That aside, I am sure it does happen, but I don't think it deters people from trying to at least go out there. I don't know hear that much as the reason an agency won't take on a case, for example.

MEMBER LUTZOW: I was going to follow up by saying I think there is an area that may deserve -- it is the no-show rate. I am sure you have a high --

MS. GOLDEN: Uh-hum, absolutely. Absolutely.

MEMBER LUTZOW: Think about the impact of the no-show rate. First of all, the cost to the system, the providers have staff at the ready. They are being paid, and nobody is there to receive the service. The individual who should be receiving primary care misses it and maybe even misses a test and misses other things.

And so, it has implications in that regard, too.

How do we solve for that?

MS. GOLDEN: Yes.

MEMBER LUTZOW: Is that a measurable area?

MS. GOLDEN: Yes. It is a very measurable area. We actually were just gathering our no-show rate to make a case during budget time to pay for transportation for people. Absolutely, vouchers, you know, cab fare if needed, developing a relationship with Uber possibly or Lyft, being very creative.

Because what we hear and why so many people use the emergency room so often as their primary care site is because they can call 911 because they don't have the cab or the car fare or the bus far to get to the hospital for a primary care visit.

When you discover these things, you do have to wonder. So, the no-show rate is something we do focus on. And all of our work, post-hospital, in-between visits, is trying to

get people back to their medical home the next time and avoiding any barriers.

I mean, we have social workers going down the street and pushing people in a wheelchair to get them to their visits because they know what a difference it will make. And that is part of the plan that they came up with in their coordinating calls that they have with the other providers.

So, we kind of do some magical things to get people to those visits. But once you figure out that the barriers are fixable, it really does make a difference, and it helps the providers to recognize, again, it is not just a patient who is not compliant with your recommendations, but there is something really going on. So, you build the empathy by the provider hearing what is going on from a community-based person, from a direct-care worker.

I mean, I once heard one of our geriatricians say the best care coordination

system would be for the direct-care worker to know what I am thinking and for me to know what the direct-care worker who is spending 20 hours a week in that older person's home or anyone's home what they are thinking and seeing.

CO-CHAIR HANSEN: Thank you, Robyn.

Is there any other question directly here? Gregg? Okay, yes? Oh, okay, Jim, why don't you just go ahead? And then, we will have Gregg Warshaw.

MEMBER DUNFORD: Okay. Thanks.

This is just terrific. This is the area that I have spent the last 15 years in. When you talked about the idea of an individual who is has had 70 visits for anti-psychotics to the emergency room without anybody actually knowing about it until recently --

MS. GOLDEN: Isn't that amazing?

MEMBER DUNFORD: Well, it's not to me.

MS. GOLDEN: Yes.

MEMBER DUNFORD: As the City of San Diego Medical Director, one of the things that we

have that a lot of communities don't have, and we get back to the concept of the systemness of things and measuring, is that there are data sources that could have identified that person, but are not tapped into.

And by that, I mean the emergency medical services that are serving, let's say, Chicago or in my case San Diego, we know that patient probably went to the emergency room by ambulance over half the time. When any one hospital looks at their problems from an emergency department, they are failing to probably realize that that psychotic man probably went to the three or four other emergency departments, and the system is not surveilling and looking for those people.

And so, on a population level, one of the key things that I continue to emphasize is the idea of using kind of untapped data. That would include emergency medical services data to identify your most expensive needy people.

This requires the collective impact

model in order to really approach these kinds of people. It is something that we also at AHRQ are certified on. The notion that you can actually see those individuals that are collectively impacting everybody, because they don't just cost the hospitals, they cost Chicago police, fire, EMS --

MS. GOLDEN: Yes.

MEMBER DUNFORD: -- incredible amounts of money. And so, we lack systems that attempt to assist all the other people that are suffering. And I am literally talking about enormous burnout rates now in firefighters and police officers because of the lack of ability to address these kinds of societal issues, and the need to have some sort of orchestrated governance approach that also helps to reward programs when they try to help.

The best social workers probably in Chicago, and I know in San Diego, the best street social workers in my community are the police department's homeless outreach team. And so, the

notion of going into communities to take care of your most complex people inherently requires some physical risk at times. I mean, the most expensive 100 people in my community are in jail about a third of the time.

So, looking at these novel community partnerships and, also, creating models around them with hospitals that are willing to kind of partner, those are really atypical partnerships when hospitals want to partner with police offices and sheriffs and those kinds of folks, but it is actually really essential to be able to get to the solutions to some of these most complicated people.

But congratulations. This is terrific.

MS. GOLDEN: Yes, absolutely. I mean, you know, if we had a global budget, I think we could each other's feet to the fire a little more in our world. That would help. But I absolutely agree with you, more of a public health perspective. You know, I kind of look at the

Camden Coalition as coming close to some of what you are talking about, too.

MEMBER DUNFORD: Very much so, yes, and I work closely with Jeff Brenner, exactly, on this project.

MS. GOLDEN: Yes, absolutely. Absolutely.

CO-CHAIR HANSEN: All right. Okay. Gregg? Dr. Gregg Warshaw.

MEMBER WARSHAW: Hi, Robyn.

MS. GOLDEN: Hi, Gregg.

MEMBER WARSHAW: This is Gregg Warshaw. Howdy.

MS. GOLDEN: Hi, Gregg. How are you doing, Gregg?

MEMBER WARSHAW: I'm great, and I appreciate your presentation. I have a comment, then a question.

As you know, I'm just totally dependent on my social workers supporters.

MS. GOLDEN: Uh-hum, you are.

MEMBER WARSHAW: And we have embedded

social workers in our offices. One of them is just going to deliver a baby, and we are all having withdrawal. All we have been wanting to know is what her backup plans are. We don't want to show up there one day without social work support.

The question I had is in our system -- I am now in Chapel Hill at the University of North Carolina.

MS. GOLDEN: I know. I know. You left Ohio.

MEMBER WARSHAW: In our system we are doing really a good job with social-work-led care transition. Where I am seeing problems, being relatively new there, is with the patients that are discharged to SNFs. We are doing much better with the people who are discharged home.

And I wondered in your bridge program how you have succeeded with the SNFs. I find that there is not continuity of medical care and nursing care in the SNFs, and the social work communication with the SNFs is not as effective

as with the community-based patients.

MS. GOLDEN: I am so glad you raised that because that was a missing component in my presentation. But we have this intensive followup with not only SNFs, Gregg, but we have problems with home health, too, sometimes. But we have weekly phone calls with home health, wherever our patients go, and most of the SNFs where our patients go, to talk about who was discharged that week, how they are doing, what is the plan. Very much our bridge care coordinators are part of those calls and part of those connections to see what the next step will be, because there is that disconnect, we know.

We try; we make a difference, I think. The SNF re-admission rates have gone down as a result. But, you know, part of the toughest things with SNFs is we finally get something going with a team there, and the teams change very often in these facilities.

We try not to push people to certain facilities in any way possible because they need

to have choice, but it is sometimes hard not to have preferred providers because we know some places are providing better care and attentive to this care, and being discharged way too soon very often, too.

So, we are on it. We are trying, Gregg. We have made a difference in terms of re-admission and I hope overall well-being, just by constant communication.

MEMBER WARSHAW: Thanks.

CO-CHAIR HANSEN: Okay. Robyn, I actually have a question relative to the issue of privacy, communication, HIPAA being one cluster.

MS. GOLDEN: Yes.

CO-CHAIR HANSEN: What kind of measures are you using for the study that you are doing for the Commonwealth Fund?

And the other last item is I noticed that your social workers may have kind of advanced training on this. Have you talked about a different combination of workforce, since I know that it is a very small number, frankly, of

people who are going into social work are necessarily focusing on complexity and aging.

MS. GOLDEN: Right. Well, let me take the first question first, Jennie. We have a whole battery. We have research assistants wrapping around the social workers, doing a whole battery of tests, anything from the patient activation measure to the SF-12, Social Function 12, to depression scores. And then, we are very deep into with our QIO knowing what the re-admission rates, the healthcare utilization data as well. We are also looking at caregiver reaction and function and just, also, things like A1c measures, just A1c; I don't think we are looking at cholesterol. So, a fair amount of measures both on the clinical side, the healthcare utilization side, and then, social determinant aspect.

On the other question -- it is so interesting you mention this -- we very much view this, because we have a lot of students that come here to train and a lot of people who are

interested in these models, and we do a lot of speaking on them. We have stuck to MSWs because we believe they are the best ones to do this kind of work. But we also want to look at social workers with community health workers and, also, try to figure out kind of who should do what, like I mentioned. Should the nurse be the lead, should the navigator, the CHW be the lead? Should the social worker be the lead?

But we also are trying to incorporate this kind of thinking in the future training with the Council on Social Work Education and have very much tried to look at these evidence-based approaches, because there is evidence to all of these now, as part of healthcare. As hard as it sometimes is for social workers who believe, like all of us, that maybe more of what they do is an art rather than a science, trying to apply that science throughout their training and after their training, kind of in a retraining way, particularly with thinking about the Affordable Care Act, has been a real mission of ours.

And we are doing that a lot. We will be doing that through our Geriatric Workforce Enhancement Program as well, kind of pushing these models forward.

CO-CHAIR HANSEN: Great. And how about the issue of sharing information for this coordination?

MS. GOLDEN: Oh, it's bad, yes. Well, I feel as if, you know, short of getting permission from the patient themselves that we can talk to other places that were involved, you know, I have a feeling community-based agents is like this one example that I used. I feel like their interpretation is a fairly strict one. And how do we come to some understanding?

So, we are applying for that innovation grant that I mentioned, and we are all signing MOUs that will allow us to look like we are entities very much working together. Hopefully, we will be able to share and communicate a little better than what we have been able to do going forward.

So, it is a tough one, but so much of it is different agencies' interpretations of it or different hospitals' interpretation of it. I know a lot of work being done at a fairly high level, and I think it was mentioned maybe yesterday, as to what is HIPAA and who has created it and what does that mean in terms of care everywhere.

CO-CHAIR HANSEN: Thank you.

I notice we have a couple of more tent cards up. I just want to double-check.

Gregg, do you have yours up again? Okay.

Aline? And then, Nancy.

MEMBER HOLMES: Hi. I'm Aline Holmes, but I work at the New Jersey Hospital Association. We have partnered a lot with Jeff Brenner and the Camden Coalition.

MS. GOLDEN: Oh, great.

MEMBER HOLMES: And just something that might be of interest. About a year ago, we started in our HEN project, which we are one of

the CMS 17 HENs, around re-admissions, and we were looking at south Jersey, specifically in the Camden area. So, we ended up hiring about 20 ex-military honorably-discharged veterans to be partnered with nurses and social workers in the community down there, and they were from those communities. Many of them were bilingual. Actually, of the 20 we hired, four had PhDs. So, they are very well-educated, but they are very much into that service mode and really wanting to help their communities because that is part of being in the military culture.

They have been very successful as far as most-hard-to-access parts of Camden, which is, arguably, the poorest city in the country and, again, an area that has a high violence and homicide rate. And we have been looking at those data, too.

But, just as a thought, they are very eager to serve. It has been a dream. Once they get on something, they will not let go. I mean, trying to find a house for somebody who is in a

homeless shelter who is a veteran, they will work unbelievably to get that done. So, we have been very successful.

MS. GOLDEN: What a great idea on so many levels. Thank you.

MEMBER HOLMES: You're welcome.

CO-CHAIR HANRAHAN: So, Robyn, I worked with Phyllis Solomon at Penn, and we did a pilot study for people with serious mental illness using a transitional care model. We first went into the psychiatric hospital to transition and found that the privacy acts were so obstructionistic --

MS. GOLDEN: Oh, unbelievable.

CO-CHAIR HANRAHAN: -- for us going in working with people. There are 13 hospitals in Philadelphia, and we could get into the medical hospitals and communicate with the medical people, but we could not communicate with anybody on the behavioral health side. And each of these hospitals had their own privacy paperwork that you had to deal with. So, it was really

obstructionistic.

The thing that we found out, though, is that we really believe that a team that transitions outside of the hospital that could be embedded in the hospital and transition outside of the hospital was a key to transition in care for these very -- and most of them are dual-eligibles or at least represent some of the more complex care people that we work with.

And we found that a social worker, and not just a registered nurse, but an advanced practice nurse who could go out into the communities post-hospital and actually work with the medications, because it was very difficult to access the physicians that were working directly with patients they are office-bound; whereas, as these nurses could go out and they had a direct line in for communicating.

We didn't have them initiate medication, but we had them alter the medication if it seems appropriate, and often it did because they would get into the homes and all the pill

bottles from every possible provider you can imagine were all over the place. It was a mess. And so, having an advanced practitioner I think for this very highly-needy population is very important.

The other part that we did is we added in a peer support because engagement is a primary problem. The peer support actually was a big help for us getting into the homes and really making sure that we were meeting the individuals' needs as they perceived them versus our needs as a provider, which is often commonly what happens.

So, we did find that the psychiatric hospital transition just was too difficult, but we moved into the medical surgical environment, and we started to pick up people in the emergency room.

MS. GOLDEN: Uh-hum.

CO-CHAIR HANRAHAN: And often, we would divert admissions --

MS. GOLDEN: Absolutely.

CO-CHAIR HANRAHAN: -- by engaging

this team. But those that got into the hospitals, as you all know, that are providers, these medical surgical environments are rapid turnover and they don't have the specialty expertise to deal with somebody with schizophrenia or bipolar disorder or behavioral symptoms. So, we would be in the settings and they would depend on us. And then, we would transition the person out of the hospital.

MS. GOLDEN: Yes, it was the way you resolved the HIPAA issue. That was great. It was continuity of care and continuity of communication.

CO-CHAIR HANRAHAN: Yes.

MS. GOLDEN: It is perfect.

CO-CHAIR HANRAHAN: Yes.

MS. GOLDEN: Great work. Thank you.

I mean, we have involved APNs and pharmacists because, quite frankly, the medication reconciliation cannot happen telephonically for sure.

CO-CHAIR HANSEN: Okay. Well, thank

you so much for your time and your preparation of your remarks, Robyn. I think it has been a great exchange to kind of think about ultimately these issues of linkages and different opportunities that many of you have expressed of how we can begin to work through it.

Our job collectively is to figure out how do you measure accountability, quality, and help shape the direction for this. But one major overarching thing that we have been talking a lot about that you just conversed on is this whole issue of being able to communicate and coordinate, given the kind of barriers that are interpreted not only by HIPAA, but, Christine, what was the CF --

MEMBER AGUIAR: It's 42 CFR Part 2.

CO-CHAIR HANSEN: So, things like that.

MS. GOLDEN: Yes.

MEMBER DUNFORD: Jennie?

CO-CHAIR HANSEN: Yes? Sure, Jim.

MEMBER DUNFORD: Hi, this is Jim. May

I just add one last thing just for everybody to keep on the horizon?

There is also another group of healthcare providers that is loosely called the community paramedic that is growing very rapidly in the United States. These are specially-trained paramedics that can fulfill a lot of the roles that you were describing that veterans are fulfilling, but they come with a much deeper knowledge and medical background, and they are connected and they are 24/7/365 in communities.

The Office of the National Coordinator has taken a real interest in this, and the State of California recently received the first grant, a demonstration grant, which is going to be happening here in southern California, to build a bidirectional information exchange between hospitals and HIEs, Regional Health Information Exchanges, and EMS.

The entire EMS system of the United States is rapidly moving to wireless cloud-based systems. In fact, they are being mandated to do

so.

In my own community, 125,000 times a year paramedics are in people's homes. They are there and they have the opportunity to capture things that nobody ever would know about until they have the opportunity to push at two hospitals. And so, there is a strong interest in Regional Health Information Exchanges beginning to share data with their EMS systems, and you already see this in Indianapolis and other kinds of pilot programs that are capturing these data and informing.

For example, primary care physicians in Indianapolis noticed 25 percent of the time 911 calls went without transport, but the physicians had no ideas that their patients with epilepsy or diabetes or repeated fall victims were actually having these incidents occur. And it wouldn't be until the patient suffered a serious injury, broke their hip, that they actually knew that the fire department had been out there 15 times already to put the person back

to bed.

So, there again is this other really unique opportunity for people to begin to look at these new national EMS information systems that are being built that are already in home and have never really been tapped into until just the last couple of years.

Thanks.

CO-CHAIR HANSEN: Oh, that is fantastic new information. And it goes back to this whole area of technology being a new area that this group talked about.

So, one final comment. Aline?

MEMBER HOLMES: Hi, Jim. It is Aline Homes again.

I just wanted to say, I mean, we have a couple of areas in our State that have done that, but the vast majority of pre-hospitals, transportation to hospitals in New Jersey, because we are a home rule state, is by voluntary first aid squads. And so, we have little or no control over them.

We have tried to engage the paramedics, and some of the cities and the hospitals have been able to do that, but that was our issue upfront.

But I forgot to mention we do train our veterans on -- they are all Certified Application Counselors. They all go through the Camden Coalition's Health Coach Model, which is an Americorps-based program, and they all went through training by the Mental Health Association on mental health first aid.

CO-CHAIR HANSEN: Thank you, Aline.

All right. Robyn, thank you again for your comments.

MS. GOLDEN: Thank you all.

CO-CHAIR HANSEN: Okay.

MS. GOLDEN: The best of luck. Thank you. I would love to hear the results soon.

CO-CHAIR HANSEN: Okay. Just a few years.

(Laughter.)

MS. GOLDEN: Take care. Bye-bye.

CO-CHAIR HANSEN: Take care. Bye-bye.

CO-CHAIR HANRAHAN: So, we are going to move on to listen as Alice Lind talks about the Washington Health Authority Financial Alignment Demonstration. And I am going to turn this to Debjani to introduce Alice.

DR. MUKHERJEE: I'm sure you all have worked with Alice longer than I have. So, I guess she needs no introduction.

Our former Chair, Alice Lind.

MEMBER LIND: Yes. So, when I started, actually, when I was the former Chair at the beginning of the MAP, I was working for the Center for Health Care Strategies. That was my "five-year" two-year sabbatical. It was on a two-year leave of absence that stretched out from the Washington State Medicaid Agency.

And now I'm back. Right after I got back to Washington, the first demonstration of the managed fee for service for dual-eligibles program was implemented. So, I got back in 2013, and right around the same time we started

enrolling clients.

So, it has been kind of a whirlwind, I have to say, but it has been different being on this side of the measurement experience. That is what I will be mainly talking about today, not so much the program, but I will start off just by introducing the program a little bit.

So, the next slide. Who has slides? Hi. The next slide.

(Laughter.)

So, the Managed Fee-for-Service Demonstration, if you recall, when the demo opportunity was put out by CMS, they allowed states to either put in proposals for managed care demonstrations or managed fee-for-service demonstrations. Washington and Colorado were the only two states that put in for managed fee-for-service.

And so, when the question came up on our webinar a few months ago about what is happening on the managed fee-for-service side, that is why I volunteered to just share a little

bit about it.

The way that we set about this was -- and this was when I was still at the Center for Health Care Strategies -- is we provided some technical assistance through CMS, Duals Office, two states who were interested in putting together demos. Washington went around the State, met with clients, providers, advocates to say, you know, in your role helping people who are on both Medicare and Medicaid or in your role as a family member supporting people who have both Medicare and Medicaid, or as a dual yourself, what could we do to help improve the system and put kind of the building blocks together from that?

And then, the legislature left it up to counties to decide if they would want to participate in more of a fee-for-service demonstration or a managed care demo. And the only two that stepped up to be managed care demos were King County and Snohomish County, which are actually two of the more populace counties. King

is certainly the most populace county in the State where Seattle is, and Snohomish right north of it. They volunteered to be capitated demos, and we worked on that project for another year after the managed fee-for-service demo went into place.

By virtue of we just couldn't make the cost equation work out for the health plans to participate, that one fizzled, and the managed fee-for-service demonstration, they are still going strong. I say "strong," but you will hear a couple of caveats to that, as we proceed.

In every county except King and Snohomish, we are assigning to Health Homes now. We started off with half the counties and, then, three months later brought up the other half of the counties, just for kind of ease of implementation.

So, the next slide, Health Homes were put out as an opportunity by CMS through the ACA. There is a little section called Section 2703 that allowed states to pay for Health Home

services, and states could have done this in all kinds of variety of ways. But any state who created this Health Home opportunity through their state plan amendment would get 90 percent federal match. So, there was a big incentive for states to put together a Health Home Program.

So, we combined this Health Home opportunity with the duals opportunity to convince the legislature that we could make the math work. Otherwise, it might have been kind of hard for us to sell and remained kind of hard to sell through the life of the program, up until just a few months ago.

You know, every state did this a little bit differently. Some states kind of certified Health Homes through like providers. Like they would say to primary care medical home groups, "We'll designate you as a Health Home," and just funnel money through them.

The way that we did it was to build a network of care coordination organizations, and we contract with kind of lead organizations.

Some of them are managed care organizations to serve the folks who are not duals, but, then, in the community we contract mainly through community-based organizations that were formed out of coalitions of AAAs or other kinds of CBOs. They sort of in a couple of places sprung up just to serve this population of duals. And then, they, in turn, the Health Home leads provide care coordination through contracts with CCOs or themselves directly, if it is a AAA or a mental health agency.

The kinds of things that are allowed to bill under Health Home Model are care transition assistance, care coordination, comprehensive care management, assistance to persons and their families for referrals, and health promotion.

We put another kind of layer onto that because of our experience in having run chronic care management programs in the past, where we also require this Health Action Plan. All of the care coordinators have to use the same Health

Action Plan. They all have to do a certain set of screenings and, then, create a person-centered care plan that is very much based on what the person wants to do themselves to help manage their own chronic disease. And a hallmark of it is how we integrate Medicare and Medicaid data and make those datasets available to the care coordinators.

Of the folks who qualify for the program, we target the folks who are one-and-a-half times the average risk of the Medicaid population to be enrolled, and that is about 40 percent of our duals and 20 percent of non-dual population. Out of that group, they become the eligible Health Home population.

So, at the end of the day, about a third of the clients we enroll are duals and about two-thirds not. Most of the folks who are not duals are enrolled through managed care plans. Most of the folks who are duals are enrolled through community-based organizations.

Because we have integrated data across

all the systems of care in the State, we know that the overlap for service needs is about what is shown here on this slide. Most of the folks who are enrolled are eligible for some kind of long-term care service, and a high proportion have serious mental illness, and there are smaller overlaps with people who have alcohol and drug abuse or a substance use disorder or are involved in the developmental disabilities system.

Over time we have gradually gotten almost all the eligibles enrolled into the Health Home Program. Then, go to the next slide. A smaller proportion are the folks who are actually engaged.

So, this is a completely voluntary program for clients. And so, as one of the Health Home folks represented to me the other day, it is like you are training these care coordinators to be vacuum cleaner sales people. They have to go like cold call these clients. They have no idea that they have been enrolled in

the program. We send them letters, but most people don't open the mail from the Medicaid agency.

So, we send them a letter and say, "Congratulations. You have a Health Home Coordinator now," but they don't read the mail. The next thing they know somebody is either calling them or knocking on their door and saying, "Hi. I would like you to participate in this wonderful thing." And they are like, "Who are you?", if they even pick up the phone.

So, they have to have a real cheerleader kind of aspect to their work of, you know, why we think that this can help you. The engagement rate of 15 percent is much lower than we were hoping for, and the community-based folks who work with the duals, I think the peak that they had gotten to towards fall of last year was 40 percent. So, we were very pleased with the community-based folks.

On the managed care side, they had a lot of different tools in the toolbox. So, they

can engage people through a chronic care management program; they can engage people through the physicians or nurse practitioners. And if they hit 15 percent on this one particular program, they feel like they are doing good. So, I don't know if we will get much above that 15-percent engagement.

So, next slide.

The successes that I am going to outline next about where we have gotten to with measurement, this is our Research and Data Analysis folks. They call this a rising tide floats all boats because the things that we have been instilling in terms of having linkages in the community between the folks who go out there in person and deliver the Health Home service and the medical system and their other providers has, we think, produced the kind of communication that needs to be in place regardless of whether folks are in Health Home or not.

It has really reinforced the need for good emergency department communication. So now,

all the health plans have real-time emergency department notification when somebody comes in the door of an ED.

And then, just having the access to the integrated data has been really helpful, too, so that they can actually see, when a care coordinator gets engaged with a client, they can pull up this system that shows all the prescriptions that they have had and, then, the gaps, all the times they have been intervened in the ED, and then, the gaps of where they haven't been seen for months at a time. And so, having just the data in their hands has been really valuable, too. Again, it helps whether the client is engaged or not engaged.

This is the system that supports that data integration. The guy who started it was not a big fan of the theory that data shouldn't be shared across the Department of Social and Health Services. He had been told no several times when he said, "Could I link this and this?", "Could I link this and this?"

And then, one night -- you know, this is a guy who is retired, and he told me this at his retirement party -- one night he just like went in the basement of DSHS and plugged all the computers together. That was like the first model many, many years ago of having an integrated database.

And now, of course, it is all above board and all the data use agreements are in place. They have gone from beyond just the data systems that support the services that are paid for by state Medicaid and juvenile rehab, voc rehab, et cetera. Now it is also tied to the corrections database, the Washington State Patrol database, the Department of Health for birth and death records, et cetera. So, it is really quite a rich source of information for care coordinators to use.

The name of it is PRISM. This is just a list of all the kinds of data sources, and the data is refreshed on a weekly basis. Because we got into the duals demonstration, we also now

have Medicare data, and that is quite an amazing feat. It took a long time to get the data use agreements in place. And now that they are in place, having the data there available for people to use has been quite wonderful.

So now, I am going to turn from the kind of underpinnings of what we are doing to the evaluation side. So, we have multiple layers of Health Home evaluation in place. Because the Health Home Program is not just a duals demonstration, it is also authorized by Medicaid under that 2703 rule, we have different ways that the program is evaluated.

So, the first one is that CMS has contracted out for an independent evaluation of all the Health Home Programs for different cost savings measures and quality measures that are reported on by the state. The next layer in is the dual-eligible demo demonstration. That evaluation is being done by a different contractor, based on measures collected by CMS and, then, augmented by other data that we

supply.

And then, the third one, Part 2B, is the shared savings calculation. That comes with its own separate performance measures that we report also to CMS.

So, the Health Home's evaluation that is being conducted by the external CMS contractor is only focused on the enrolled population. Again, if you remember that slide that showed only the little 15 percent of folks, they do not look at the big, big population of eligible people, but just the folks who have been enrolled. They look at cost savings that we report and they look at quality measures that we report. We have been back and forth in negotiation about those measures and what they need and when it will go. That is due at the end of this month.

The tricky thing about that is that the Health Home measures were basically shared with us as draft measures. Some of them overlap with the duals demo measures, but not entirely.

Some of them are just a little bit one-off for technical specifications from the duals demonstration measures.

They were not given final technical specs until last August. So, we were running the program for two whole years before the Health Home folks who do the oversight of that program, not Venesa and her colleagues, but in a whole different part of CMS, the Health Homes folks gave us the technical specs two years after the program had been up and running, which meant that we couldn't kind of track along the way to see are we doing well or poorly. How are we going to look in comparison? Is there a benchmark? Can we share anything with the Health Homes folks about how they are doing or not doing? And so, that has been quite the challenge.

Another expectation from CMS is that the Health Homes themselves would be able to submit this reports, kind of like the managed care plans are expected to submit HEDIS reports. But our Health Home providers are community-based

folks. They don't have claims data. They don't have access to physician-level data. So, it is not like they can actually create a measure of like how well is the blood pressure controlled and stuff like that.

So, what we are thinking of doing is our creating the measures, sending them to the Health Homes, and having the Health Homes send them back to us, as ludicrous as that is, but that is the only way we can figure out to meet the requirements of the program.

This is a handful of the kinds of measures that are required for the Health Home project. The plan, all-cause re-admission in patient utilization, ED visits, ambulatory care sensitive hospital admissions, and care transitions. The care transitions that we were just talking about today, that is the survey measure; we don't have access to those hospital cap surveys or the care transition surveys. So, that is not possible for us to do.

On the prevention side, adult body

mass index and, then, controlling high blood pressure also would require us to have access to either EMR data or actual patient records. And so, that is also not possible for us to do.

And there is a set of behavioral health measures. The screening for clinical depression would be a great one because we have embedded in our Health Action Plan all of the care coordinators do screen for clinical depression using the PHQ-9, but that is not literally how that measure is written up in the specs. You have to have a clinician do it and document it in the clinical record, for example, in a physician's office. So, that doesn't work for us, either.

Follow-up for hospitalization for mental illness is something that we can do just using claims data, and initiation and engagement of alcohol or other drug dependence treatment is one that we follow for all of our populations. And then, nursing facility utilization, we already have some results on that.

So, that was part one, one layer of the evaluation. Now on the dual-eligible CMS evaluation, there is, as I said, a couple of different ways that we are evaluating. The external way that Research Triangle Institute is doing for CMS focuses on the whole eligible population. So, it doesn't really take into account the fact that only 15 percent participate. It focuses on all of those targeted for the intervention. They report on many of the same measures, but, again, some are similar and some are different from the ways that they are done by the Health Home evaluator.

And then, finally, we have shared savings performance measures. These are used to determine whether or not we will get shared savings from this demonstration. Now again, we could not have possibly offered this service. You know, 1995 was the first time that we started working on disease management for clients. This program that came live in 2013 was the first program since I have worked for Medicaid that we

have ever offered a service like this for dual-eligibles.

The reason that we were able to do it was because of the promise of shared savings. Otherwise, it is like the Medicaid program invests tons of money into something that is going to save money from Medicare. There is not a return on investment. If you are a state where you are always trying to balance the budget, then it is really difficult to make the case.

So, thanks to this program and the promise of shared savings, we were able to sell the program to the legislature. It is a very complicated way that shared savings are evaluated. There is a pre- and post-design. CMS's contractor picked out comparison states. None of the comparison states could be demo states themselves. So, that rules out, you know, how many, 15 maybe, Venesa?

And then, besides having to meet a certain minimal savings threshold, then any savings above that threshold would be divided

50/50 between Medicare and the state. And we have to meet certain performance measures in order to achieve that.

So, year one, we had a set of performance measures that we reported in July of 2015 and, year two, those are due in 2016. For the year two and following years, we will be looking at benchmarks that CMS is choosing and we will measure against those benchmarks.

So, here are the year one measures. We are feeling pretty happy about these. The plan, all-cause re-admission rate is a hair below the 18-percent benchmark from CMS. ED visits, also a hair below; ambulatory care; sensitive hospital admissions, significantly below, and the care transitions just started being measured in year two.

There is a set of these process measures that we chose, Health Action Plans being completed within 90 days; training for care coordinators, and the change in the patient activation level. Those are the measures that we

knew that we would have access to electronic data coming in. So, those are the ones that we had picked.

We also have a handful in other areas of prevention, behavioral health, and long-term care. Again, some of these have not been benchmarked yet. We know that followup after hospitalization for mental illness is one where we are doing very well, 78 percent in the intervention group versus 60 percent without. And in the long-term care side, we are just following the percentage of people who receive care in the community versus institution.

So, back up to two slides ago about the savings, the thing that we found out in the savings is that there was a new report that came out from RTI in January of 2016 that points to a savings, because of being able to hit these measures, of $21 million. So, back to the theory of the rising tide lifts all boats, this is the only explanation that makes sense to us as to how we could have a 15-percent engagement rate and

$21 million in savings. We are just going to say thank you very much. It is being measured against a trend, and we are going to hope for the best.

There is a second step that still needs to happen because that was based on seven months of data claims runout, and CMS still needs to evaluate was spending higher on the Medicaid side. And if it was, then that gets taken out of that savings. But the $21 million savings, if we get $10 million back out of that, or even a little bit less, it is certainly enough to continue the program. And based on that, the legislature has agreed to continue and actually even expand into the last two counties.

So, this is just to highlight again the differences in some of the measures across Health Home and the duals program, just so you see how very much important it is to have endorsed measures. This is part of the course for the duals program. Anything we can do to convince the Health Home people to embrace the

same measures as the duals demo would certainly be a help to those of us using Health Homes to run programs for duals.

There are substantially different definitions for these asterisked measures. The plan, all-cause re-admission rate, the Health Home version is an unweighted measure versus the one that the duals demos use, which is the weighted measure. Ambulatory care sensitive hospital admission uses two different composites. So, Health Home uses a composite of nine and the duals demo uses a composite of twelve different rates of admits.

On the ER side, it is completely different definitions. The HEDIS measure is the Health Home measure and, then, the duals demos use the NYU Emergency Department definition, which kind of follows a little algorithm and makes a lot of sense to clinicians, too.

Screening for clinical depression and the followup plan, one allows EHR data to be used; the other one you have to use chart data.

The care transition record has two different numerators, depending on if it is a Health Home or the duals demo. And then, initiation of alcohol or other drug dependency treatment, on the one side it is initiation and engagement, and on the other side it is just the initiation.

So, you can just kind of see the frustration when you are out there living in the state and you have multiple evaluators and all from the same agency, and no blame at all on the Duals Office, who has worked so tirelessly with us to try to make sense of all this. But, you know, everybody like the Home Health Program people in their little bubble see things in their own unique way, and it is not always possible to bring all of those different interests together. So, just another kind of underlying reason that it is kind of difficult to manage all these different datasets.

I talked about this yesterday, and I promised not to talk about it again. So, you can just skip through these little data. These are

just, among other sets of measures that we are accountable for, we also have these that came out of our legislature. So, you can skip past this one and that one.

Here is the actual state evaluation. So, besides all the other evaluations, we want to see ourselves how we are doing. So, we have done this pre-/post-evaluation from before to after the Health Home Program started for duals.

Here is the increase in the patient activation score, which is the way that we track whether people are engaged in their own healthcare; percentage of high-risk duals receiving home- and community-based services, another statistically-significant increase from 58 to 64 percent.

The number of emergency room visits that were deemed non-emergent based on that NYU algorithm dropped almost 10 percent, and ambulatory care sensitive hospital admissions also has decreased. And that is another statistically-significant result.

Here is a kind of nice RTI finding of how the hospital admission rate decreased. And so, it is good to have that external validation of that one measure. And then, the next one is about the impact on skilled nursing facility admits.

And so, again, we do our measures ourselves, but it is very nice to have validation from RTI that we can go back to the legislature and say, "We are not cooking the books really. We are showing an impact on these high-priority measures."

So, I think that is it, right? Is that my last? Oh, no.

The other thing that RTI did for us was they released a focus group study. We have, of course, you know, probably hundreds of these kinds of stories. But, again, it was really nice for RTI to be out there doing focus groups, and this is the one from one client who said, "I was shut up in my house for years. My windows were drawn. I didn't have company. My house was

horrible. I'm completely off my psych medications, and I was on a lot of them for many years."

And then, since she got involved with the Home Health Program, she says, "I go outside. I interact with my neighbors. I go to church. My cholesterol is down to normal." So, those kinds of stories, of course, make the Health Home care coordinators and all of us know that the program is doing good for people in a way that they, themselves, find valuable. So, that is kind of the bottom line for us.

Thanks.

CO-CHAIR HANRAHAN: Go ahead, Tom.

MEMBER LUTZOW: Yes. Thank you.

You know by now that activation and engagement have to be, in our view, a key piece of the managed care formula. It is interesting, the PAM tool has gone a long way toward figuring out how to do that.

How did you implement that tool? I mean, it requires patient education. It requires

a lot of work in the home, it seems, maybe not. But how was that intervention delivered?

MEMBER LIND: So, in my mind, the biggest downside of the patient activation measure is it is a proprietary tool. So, we pay a license fee for it and train the Health Home care coordinators how to use it.

So, they deliver it in person in the home and collect that score. And then, it is delivered both to the folks who own the PAMs, which is a company called Insignia. So, they report it to Insignia and, then, they also report it to us in the Health Action Plan. So, we get an electronic version of it whenever they go out and do the assessment, and they reassess it every six months.

And I agree. I mean, I think it is a really useful tool. We had a conversation with NCQA about it last week, about whether it is a useful enough thing that we can help sell it. I mean, its real drawback is the proprietary nature, and they collect a lot of data that they

don't share back with us, you know. So, that is also kind of bothersome. I mean, I love the tool, but we need to have a publicly-accessible version of something like that.

CO-CHAIR HANRAHAN: Thank you, Alice. That was terrific.

Kim, do you want to ask a question?

MEMBER RASK: A question: when you were talking about all the different measures and the conflict with the different definitions, just out of curiosity, were they all NQF-endorsed measures? As those measures came up, what input do you think -- were people talking about whether or not they should be using NQF-endorsed? Was that even on the table?

MEMBER LIND: Well, I think part of the problem is we were the only managed fee-for-service demo when the measures were first on the table on the Health Home side. And on the Health Home side, there were 20 states, 22 states, that were rolling out Health Homes. And so, we were just like one little voice in that sea of people

in the Health Home Project saying, "Could we please synchronize these measures?"

But which of them were endorsed I couldn't swear to. I think probably some of them were alternative measures that are also endorsed, but I couldn't swear to which ones.

CO-CHAIR HANRAHAN: Venesa?

MS. DAY: Oh, I don't think I was next, but I will go.

In terms of like how the measures end up being not as aligned as we would want them to be, because we worked a lot to try to get measures that worked across all the programs, but the duals program isn't a Health Homes Program. So, it is not the base. When we started out, we had about eight, nine states maybe. Washington and a couple of other states selected Health Homes. Another state that is still in, Colorado, chose to use another platform that it has. It is called RCCOs, and it is kind of like a PCCM model.

So, what happened is we are measuring

at the demonstration level, at our program level. The Health Homes are measuring at the Health Home level, which would probably be ideal for everybody. Like in my fantasy quality measuring world, everybody would do it at the population level. But, then, when you are doing a program when you are trying to calculate the savings, then, that doesn't help out a state like Washington when they are trying to demonstrate that they can save for this particular population.

So, a lot of shenagling goes into what comes out of all of his. When we started, we started with the starter set that we got from this group back in 2012. And so, we from there said, okay, what makes sense? Who is collecting what across our programs and inside of CMS? Were the states collecting? What is it possible for states to collect? And then, what is our MAP telling us that it is important for states to collect?

So, two measures, I think maybe three

measures that we ultimately selected are those measures that the MAP told us are important, but just right now they are kind of proving impossible for states to collect for different reasons, like Colorado just kind of isn't there. They don't have the same data sophistication as Washington does. But, then, the other side of that is it takes a lot of resources to be able to collect. I mean, I feel like I am telling people who already know.

And we are very flexible about it. Like we start with the NQF-endorsed measures. But, by the time we make them right for our program, they are a long way away from what the original measure is, and so forth.

But it is not exact science at all. I mean, I don't feel like we ever come out in a good space for everybody on these.

CO-CHAIR HANRAHAN: Joan?

MEMBER ZLOTNIK: I was struck by some parallels to some of the things that you presented that Robyn had presented, like similar

use of evidence-based interventions, like motivational interviewing and things like that.

So, I guess one of the questions I had was related to the workforce and how the workforce, because you are dealing across multiple populations in what you are doing, what strategies were used to make sure that the workforce who were helping that woman who had been shut in her house for years, or whatever, go to church and get out, and things like that?

MEMBER LIND: So, the lead care coordinator has to either be a nurse or a social worker, but most of the teams also use a community health worker or a health navigator or a peer, depending on the individual. And so, they deploy different members of the team for different purposes.

Like that woman was saying how she was a hoarder, there is a lot of that kind of intervention that has to happen. Sometimes it is just like a working with the landlord to make sure that the heat works in the apartment or

working with the family to help get some of the garbage out of the house, or whatever.

Sometimes it is some really normal day-to-day kinds of things and having just a community health worker help kind of get a bunch of volunteer friends together to do that kind of stuff is enough. And then, you can start working on the health goals a couple of months later, when the person feels good about it.

So, yes, they usually use a team, and it is really there is a nursing shortage in Washington. I don't know how widespread it is in the country, but in Washington the nursing shortage has really hit them hard lately for trying to recruit.

MEMBER ROSS: I noticed the percent of high-risk duals receiving home- and community-based LTSS services is one of the duals measures. And we learned before lunch that the Home- and Community-Based Service Committee is going to be examining Washington as one of its three states.

So, how does their examination of

home- and community-based service measures fit into what you presented today?

MEMBER LIND: My hunch is probably not, but I could be wrong. But the Health Home, it is kind of funny, the folks who are administering the Health Home Program, half of the staff work for the long-term care administration part of DSHS and half of us work for the Medicaid medical side. We actually work for a completely different agency.

And so, that little staff had been part of the long-term services and support, and they got moved to behavioral health. And now, it is back in its little home again in the long-term services and support world. But they are very closely aligned and now they report to the same boss.

So, it could start getting linked up more. I mean, I know when I was on the outside of Washington for those few years, when we did an evaluation of Washington State and we said, "We want to come in and do a site visit," there were

like 12 people around the table. So, I wouldn't be surprised if NQF goes out to do a site visit or even gets somebody on the phone to do an inventory, that they would bring the Home Health people into the call and they would certainly involve a person who manages the people who manage the program. So, it wouldn't be unheard of that the knowledge gets transmitted across, but it doesn't seem like a one-to-one, if you know what I mean.

CO-CHAIR HANRAHAN: So, Tom, go ahead.

MEMBER LUTZOW: This comment focuses on PRISM. I have a question to ask about PRISM. Sometimes I get the feeling in our discussions that the healthcare system is now being asked to solve for poverty, and when we are successful at that, we are going to be asked to solve for world peace. In other words, the scope is increasing.

But, when you make the point that you have got 15 percent engagement and save $20 million, it sort of speaks to this issue that a small incremental change, if well-targeted, has

tremendous impact. I mean, millions of dollars worth of impact.

Part of the secret is having a predictive modeling tool that gets you into that space where you can make a difference. Some of those costs, some of the costs for our patients' end-of-life care, there is not a lot you can do, palliative care kinds of things, but you can't really change the course of events. Those costs are going to be incurred.

Below that is a set of people where interventions do make a difference if you get there in the right time. And so, is that tool PRISM a sweet-spot tool? I mean, prediction is such an art. The number of false-positives, false-negatives is huge, but where is PRISM on that ability to get you in that space where you can make -- yes?

MEMBER LIND: Well, you know, when we first started using it, I think what the statisticians in that group said is they thought it could predict about 40 percent of the future

cost. And so, that means that you are missing a lot and you are overguessing a lot.

The folks that were overpredicting I think are the ones who don't get engaged, and the ones who were underpredicting come through in different ways. So, we have this other referral pathway where a physician or a social worker or an ER person could say, "Gosh, I don't know why this person is not in the Health Home Program. It seems like they could really benefit from it." They fill out a clinical eligibility tool and send it in, and then, first, it hits a staff person who goes into the data and says, "Oh, yes, it looks like the claims just haven't caught up yet. So, let's go ahead and put them in."

And if that is not true, she brings it to me and says, what do you think? Does this person look like they would benefit? And so, there is that other referral pathway.

But, yes, I am sure it's getting there, but it's certainly not an exact science. I think I have probably said this in this group

before, that Aetna's care management folks said to me once that they thought one of the best predictors of future utilization was stable housing in the past 12 months, and that if you just added that one question to a health risk assessment, that you could pick up a huge proportion of the people who are going to be high-cost, high-needs people in the next year.

CO-CHAIR HANRAHAN: Christine?

MEMBER AGUIAR: So, I think the $21 million in savings and the 15-percent engagement, that is a huge finding. What worries me a little bit is I hope that the state is not expecting that to be achieved every year. I mean, I think at some point you are going to sort of level off. You can attack the low-hanging fruit and you could right-size care and achieve savings.

So, it strikes me as -- and then you have this great example from the focus group. That really captures a lot of the beauty of these programs.

I guess I have a two-part question.

One is, do you think that experience and that improvement in quality of care is being currently captured by any of the measures you are asked to report either to the state or to CMS? And then, do you think that if you start to see a decline in the savings that the state will still be committed to the program?

MEMBER LIND: So, we do participate in the client survey. I think the first client survey is going to come out in the next few weeks, right? So, because we're a demo state, we will have client survey results. Hopefully, that will help answer that first question.

But, no, we almost lost the program because, by the end of the second year of the program, when we knew the 90-percent match was going away, the legislature said, we just can't keep floating this program on the hope that savings will be achieved. They actually wrote into last year's budget that the program would end in December, two months, three months ago December.

And so, we had a little bit of a downturn in engagement as a result because the staff started looking for other jobs, and whatever. There is just not as much push, push, push. It is hard to get the vacuum cleaner sales people out there, you know, to knock on doors.

And so, no, if we don't keep on having at least some level of savings, and all they are asking for at this point is for us to break even, if we don't have enough savings to break even, the legislature would probably kill the program again, which would be very sad.

CO-CHAIR HANRAHAN: Joan?

MEMBER ZLOTNIK: Yes, I just wanted to kind of follow up on your comment about housing. I actually have a conference call now that I am not taking because I wanted to be part of this discussion. So, I was glancing through the slides and it said, Transitions of Care for PCORI-Funded Project.

And one of the critical issues, they have a follow-up protocol they are creating, and

one of the critical issues they have encountered has been related to people with unstable housing. So, it's just kind of a funny reinforcement for the kinds of things that we're not capturing in all of the more sort of medically-oriented protocols.

CO-CHAIR HANRAHAN: I have a question for you, Alice. I am thinking nuts and bolts here. Who were the key figures in pulling this off? What were the professional groups and non-professional employees that really made this work?

MEMBER LIND: Well, I mean, there is certainly like different layers. I would say that it couldn't have happened without the particular leaders in the Medicaid agency and DSHS. So, we were lucky enough to have -- I mean, the person who sweet talked me into coming back, MaryAnne Lindeblad, who is a nurse, a master's, an NPA nurse, and then, Jane Beyer, who was the head of DSHS at the time or the DSHS section that was in charge of long-term care and

mental health at the time, those two women by themselves I think probably sold it to the legislature. Without them, I don't think it could have happened.

But, then, in the community it was a lot the AAAs. I know that the Health Home community leads, at least one of them said the other day that they lost $250,000 in the first six months of the program, and it took all of two years for them to start making money on the program, to start paying back.

So, the fact that the AAAs and the county boards that kind of support -- the community-based boards that support those AAAs, they had to also support the program enough to say, we're convinced that this is the right thing to do and we are willing for you to take a loss to get it off the ground.

Because, you know, even with the 90-percent match, it's like we are not paying enough to try to engage the 85 percent of people who say no. You know what I mean? When you have a 15-

percent engagement rate, it means that you are doing a tremendous amount of work that's not being funded.

New York has done it a little differently. New York kind of prepays for a few months to try to get people engaged, and I guess we could have employed that model if we had done the math a little differently.

CO-CHAIR HANRAHAN: What about the analytics? Because, clearly, you had to have some really experienced people that could program and do the analytics.

MEMBER LIND: Yes. So, the PRISM system lives in the Research and Data Analysis Division of DSHS, and there is a genius guy there, David Mancuso. The only reason that he lives in Washington and works for DSHS is because he loves living in Washington. You know, he would have been snapped up by a million different people by now, but he lives on the water in the nice little part of Thurston County.

So, yes, we're really lucky to have

that, too, like the infrastructure that connects all the data and, then, a really genius guy with a really good team of analytic people to support us.

CO-CHAIR HANRAHAN: How about anybody on the phone? Do you have questions?

Operator, is there anybody that would like to contribute from the public?

OPERATOR: At this time, if you would like to make a comment, please press *, then the number 1.

(No response.)

And there are no public comments at this time.

MEMBER DUNFORD: Hi. This is Jim one last time.

I think this is my last meeting on the committee. When I first met the current presenter a number of years ago, I was just struck with how powerful she was. Alice, just congratulations on how far you continue to carry the ball here. It is really impressive. So,

once again, seeing you no longer as chair of our committee, but still as Honorary Chair, congratulations.

MEMBER LIND: Thanks. I hope to keep connected to you somehow, Jim.

CO-CHAIR HANRAHAN: Yes, I, too, want to ditto that. It was a fabulous example of where we could go and what we need to do. So, congratulations. Thank you for doing that.

CO-CHAIR HANSEN: Do folks want to take a 10-minute break? Okay. Why don't we do that and come back at 3:00?

Thank you, Alice, for a great presentation.

MS. ANDERSON: And for those of you on the phone, we are going to take a 10-minute break and come back at three o'clock.

(Whereupon, the above-entitled matter went off the record at 2:51 p.m. and resumed at 3:01 p.m.)

CO-CHAIR HANSEN: Hi, everybody. I know that people have travel plans and all. And

so, it was asked whether or not we are really going to go until five o'clock. The answer is no. So, I think that what we would like to do is get started here. Let's set a goal of leaving by 4:00, okay, in terms of our moving ahead?

So, I am sorry that I have lost our Co-Chair. Actually, Nancy and I met for the very first time yesterday. So, we have only been on the phone together.

But one of the things that we would like to do is we have this opportunity to refresh the committee. And so, as it turns out, when I asked you all how many of you were new for this particular in-person meeting, there were four of you.

So, this last period is really kind of summing-up what strategically some of the issues that we heard that both are on the parking lot as well as things that you all have felt strongly about. Is it time to kind of say, you know, what is it that our group, in particular, after these two days, really can think about in terms of

moving ahead?

But, since we also have four new people, I have actually asked each of them to make a little bit of a comment about what brought them to really choose to work on this MAP. Some of you have had experiences in other MAPs. But what were you hoping for by being a part of this MAP group, in particular? And what were you hoping to achieve by your participation broadly? And then, how does that tie into the experience that you've actually had with the content that we have covered over the past day-and-a-half?

We hope to kind of listen, then, to the whole group together, given the kinds of themes that we will touch base on, a couple of notes I have taken, but things that we put on the parking lot, and see if we can weave together for ourselves and for the staff to really think about what should our biggest focus be, and are there some low-hanging fruit that we need to do? Are there some other areas we should design for even our phone meetings that we could bring people in

on?

So, this is meant to be this last particular session here. We'll have the operator later on offer the opportunity for any public comment. And then, we'll have a chance to close the meeting. Janine will give us some logistical instructions. And now that Debjani is going to be one of our key staff people, she will have a chance to have a couple of comments.

So, that is what I would like to do for the next 55 minutes. Why don't I just kind of start down the line and go this way? So, Kim, I think you were one of our four newer people.

MEMBER RASK: I didn't know I was down the line. I was looking further.

(Laughter.)

Thank you.

Why I was interested in joining this group is I have spent a lot of my career originally on the research side looking at quality improvement, outcomes of measurement. And as I moved to trying to work now more

practically with organizations that are trying to measure quality, I have a real interest in being able to measure quality for our more complex members, beneficiaries, which dual-eligibles truly fit.

I'm optimistic enough or naive enough to still believe that there really can be good quality measurement and that it's tricky and there are a lot of different things we need to be able to put into account, but that, ultimately, if we really want to improve health and we really want to improve health outcomes, we have to be able to evaluate and measure what we do as providers, as caregivers, as health plans, as organizations that monitor quality. So, I think that made this piece very interesting or made me very interested in wanting to be a part of it.

Also, now that I work with the State Medicaid Plan, I am kind of a consumer of NQF measures. And I can't tell you how many times, when people come to me and say, we're going to monitor this and monitor that, I say, have you

looked to see is there a measure?"

And they Google it. So, everybody googles. Well, I found this, Joe's measure, and you are going to do this. I am like, no, I want you to look at the NQF. Is there an endorsed measure that gets at what we are trying to do?

When I do that, quite often, people will go and look at the many measures that are there, and they can't kind of get through to find what they're looking for, what it relates. It takes a somewhat sophisticated evaluator, not an evaluator but a person to kind of go through all the stuff and find out where the match is.

After having gone through yesterday and today, I have a better understanding of why and just how complicated this is. But part of what I would love to see for this workgroup, also, in addition to having a family of measures that we highlight as being appropriate for the dual-eligible community, to also slice and dice them a little bit maybe, so that someone can do like a quick search.

I'm looking for measures that would be applicable to the dual-eligible community that are only admin because all I have got is claims data. Or I'm looking for measures that are patient-reported. We are going to be doing a survey, and I want to add some questions to it. Or I'm looking for things that relate to dual-eligibles, but I'm a hospital. So, I want to know where the hospital-specific measures are. Something like that, in addition to the domain, that kind of would let people point to make it more bite-sized piece of what you are looking for.

And then, the other benefit I think to doing that is it would help us as a group to say, Uh-oh, here we are. Do you realize we don't have a single home health measure that is patient-reported or we don't have a single home health measure that is admin, or something like that, that it would help us identify gaps that we can, then, put out there in a more digestible form for other people who use this information.

CO-CHAIR HANSEN: Thank you. I think your background as well as pragmatic ways to help navigate and really find an easier human-centered design to kind of glom onto something that gets you going more quickly. Great. Thank you. Thank you.

Michael?

MEMBER MONSON: So, it's kind of an old axiom that what gets measured gets done, but it's totally true. It's overused, but it's totally true.

And so, from a reason of to join, you know, I think when you think about how you are going to make changes in the system that are going to help improve the system and help people lead better lives, if you don't get the measures right, you are not going to get anywhere. I think as we move more and more into a pay-for-performance world, it is like measures on steroids. And what it also means is that, if you pick the wrong measures, you will incent the wrong behaviors, and you will move down the wrong

path. So, that would be probably the main reason that I personally was interested in joining and we, as a company, are interested in being involved as well.

And I would say that, from a strategic viewpoint of where we would want to go next, I would be really interested, especially as the HCBS measures work comes out, broadening that to actually all of LTSS because there will be applicable measures from HCBS that will cross over. I think there are some measures that may not, that won't be on there, that we will need to think about how we add those.

But, importantly is matching those with the other measures we already have, because those measures will largely reflect the Medicaid measures, if you think about it from just the system perspective.

CO-CHAIR HANSEN: Right.

MEMBER MONSON: And they'll represent, you know, they are a different set of measures. And I think the interactivity between the medical

and the social measures -- in fact, if I look at the set we have today, it is largely a set of medical measures, by the by, not that those medical measures aren't indicative of quality of life, as we all know. But I think mapping that along with the social measures that are going to come out of the HCBS work and, then, coming up with the pairings that make sense, it actually allows us to potentially think about what a revised starter set could even look like, because you would actually have the full picture.

It would be that, if you are going to start measuring Measure A on the medical side, then you also want to be measuring Z, Y, and X on the social side, and vice versa. So, kind of thinking about how the interactivity between them would be very interesting.

CO-CHAIR HANSEN: Yes. Thank you. Thank you, Michael.

Let's see. Thanks. Eliza?

MEMBER BANGIT: Hi. So, why am I here? Primarily, it is driven by my involvement

to the NQF HCBS Quality Gaps Task Order.

And we talked heavily today and yesterday about integration and care coordination. I see my role really as sort of like that liaison; talk about workgroup coordination.

So, I would like to be able to not only take things to this workgroup that we learn from the HCBS Committee and provide you all with updates, but I would certainly like to be able to also create that bridge to the HCBS Committee about the work that we all are doing here.

And what else would I like to achieve? I am really learning from all of you. I am very new to this area. So, I have learned tremendously the last couple of days, and I am sure I would learn a whole lot more in the following months and years to come. So, I am really thrilled about that and I look forward to that.

My last observation really was that -- and this came out of one of the discussions, the

HCBS Committee in-person meeting, and that was a few of our members indicated that there really should be, that there is an important -- it's really important to have an infrastructure in place and to be able to make the infrastructure and the systems that we have work better. And that's why we have process measures.

But I am thrilled and glad to hear a few of the conversations and the discussions here the last couple of days that really emphasize and underscore the need for outcome measures. So, that, to me, I thought was one of the great sort of outcomes in my participation the last couple of days.

CO-CHAIR HANSEN: Great. Thanks so much.

MEMBER HOLMES: And I want to thank you, also, for all I have learned. I come out of mostly the acute care hospital wing and that's where I have practiced for years. But, obviously, the hospitals across the country have been inundated with metrics and measures. And it

was really to be here to have a better understanding of how that comes about and how those measures are developed and tested and implemented. I think is just a wonderful experience and, also, something that I can take back to my colleagues.

We have a group of all the quality people from all the state hospital associations. So, that will be information that will be very helpful for them as they move forward, because this is certainly a big-time measurement.

I am also the Co-Director of the Robert-Wood-Johnson-Foundation-funded New Jersey Nursing Initiative, and with the Executive Dean at Rutgers University. What we have been trying to look at is how do we identify the competencies of the nursing staff of the future, given where healthcare is going, and how do we bring together academia and practice together in our state to really look at those competencies, identify them? And how do we change or pilot different concepts in the curriculum to achieve those?

So, this will be very helpful because, when I go back to a lot of the faculty, they really don't have an understanding of how these kinds of measures are developed and how to use them. So, we've been giving them practice exercises, but I think it's been very advantageous for us.

And then, lastly, I have personal experience. I have two siblings who have been dual-eligibles because of intellectual and disease-related disabilities. And so, I really do understand well the difficult path that it is, and we have to make it better because it is an impossible trip to navigate for our citizens and our residents.

So, thank you very much for this.

CO-CHAIR HANSEN: Thank you. Offline I will talk to you about a couple of nursing resources for the school as well. Thank you.

Christine?

MEMBER AGUIAR: Thank you.

So, I wanted to be on the MAP because

working with our member plans around quality measurement and stars, and how they can improve, is one of the things that we do. I did not know to expect, and I was very nervous because I am not a measurement expert, and so I thank you all for your expertise. I really appreciated that. That was very helpful for me when we were thinking through voting, particularly around the clinical decisions.

In terms of the strategic direction, you know, I think that NQF is really well-poised. I understand you have the bread and butter that you have to do, you know, nominating which measures and having the family of measures. But I think the group is also really well-poised to be thinking about the future and where we want population health and care delivery and Medicare and Medicaid and social services and value-based care, and all of that, going.

And quality measurement, it is a very strong signal, more so as it keeps getting picked up in the payment systems. And that's going to

be happening even more, not just in the big Medicare and Medicaid payment systems, but in the value-based contracting, that we are going to see plans and ECOs doing.

And so, I think it would be interesting if -- you know, I understand that there are measures that don't exist and there are gaps and things like that, but I think there is also an opportunity for NQF to put information out there about the importance of person-centered care, the importance of care delivery across all these systems and the gaps in that.

In a way to say that we would love to measure it, but we can't because of all these limitations, but here's where we think this field should be going, I think that would be very helpful.

CO-CHAIR HANSEN: Uh-hum. Thank you.

Thank you for those of you who are joining us for this first meeting in person. And for my seasoned colleagues here, you know, a number of you have made some consistent points

that this committee should do. But I would love to kind of have a chance to give people the opportunity to say something directly now, as we are doing some share. And that would be also, if the two of you are still online in your respective places, we would love to hear from you as well.

So, let me just open it to see who is willing to kind of say, strategically, let's reemphasize some points that you have made before that we can kind of do in this summation right now.

Clarke?

MEMBER ROSS: So, I'm a father of a 25-year-old son with autism and co-occurring disabilities, and he has trouble letting things go.

And he must have inherited it from me because I'm still frustrated with our discussion of community integration right before lunch, when we ignored the prior committee presentation on home- and community-based services. The larger

issue is that there are multiple -- I think there are like 35 committees and workgroups of the National Quality Forum, and half a dozen of them are directly related to this population.

We all operate in silos, and it is easy as an outsider to see the silos. But all the work that is done by one committee that does not get translated -- you know, we had the 15-minute or 20-minute presentation by Drew, which was a good overview. But they've grappled for two face-to-face meetings with community integration. And yet, our discussion pretended like that reference base wasn't there.

So, how do we integrate the Person- and Family-Centered Committee focus on Medicaid home- and community-based experience survey, and how will we integrate the Home- and Community-Based Services Committee? And you mentioned population health. There is the framework for population health.

And the MAP is not going to do this. I mean, you look at the MAP, and Bernie Sanders

would say that's the establishment. I mean, they are the big money, big powerful players, hospitals, for-profit nursing homes, physician groups.

And so, how do we meaningfully integrate between the silos, so that we are learning? I mean, I really don't want to have another debate here from scratch on community integration when the Home- and Community-Based Services Committee has defined that. So, okay, let's start with that, and we might want to refine it, change it, edit it.

So, that is my frustration and strategic challenge, is there's all this exciting, really important stuff happening in all these silos. And how do we meaningfully integrate it into not only our work, but how do we integrate our work into these other National Quality Forum committees?

So, thank you for listening.

CO-CHAIR HANSEN: Sure. Thanks, Clarke. I think that was part of the attempt,

and I have some calls in between any of our phone calls with my staff colleagues here. And the home- and community-based discussion, as well as the population health, as well as the patient- and family-centered, you know, how do we connect that together?

So, I think you saw the home- and community-based piece here, but there may be some important need to kind of think about how our Venn diagram comes together for some of these areas that are relatively new for NQF. They have not been the traditional.

You know, we are using the metaphor of lifting this boulder, of a different way in framing, and the conversation I had with Venesa before she left, and she is also trying to do this from her CMS side as well. So, there is a way that that may be part of our strategic discussion of how we try to do that.

And ideally, it's the time when we have what I call face time, because the kind of interactions we can do is just a lot easier when

these things are complex and there are nuances, there are people's reactions that you don't hear on the phone. So, I'm not saying we are going to wait until next year, but I think that we take next year's in-person meeting in a way that we really think together how do we use the preciousness of time that we have face-to-face, and how much kind of prep work we will do in advance personally and come ready to roll up our sleeves and make a pie.

So, thank you. Thank you very much for that.

Other people who want to make -- Tom?

MEMBER LUTZOW: Yes, I got here because I stopped in one day to complain to the National Quality Forum.

(Laughter.)

This is maybe three years ago when SES was being ignored and people were saying it didn't make a difference in health outcomes, and so on. And so, I actually made an appointment here and complained to the NQF that they weren't

sensitive enough to the impact of SES and it wasn't reflective in their measurements, and so on.

And I get an email a couple of days later inviting me to sit on the MAP. So, I mean, it just goes to show that.

But here I do have some concerns. I have a sense that the measures that are promoted by MAP are more successfully adopted in the managed care environment than the fee-for-service environment. And I am wondering if we should be concerned about that. In other words, are we working on a paradigm that doesn't fit well with the fee-for-service environment and that we need to consider the needs of that environment to measure itself? So, it's just a question. I think the adoption of NQF measures in the managed care environment is just easier and maybe more difficult. Why is that? Just a question.

I would also suggest that the NQF not ignore the social service environment, even though it is not CMS-funded directly. It is

indirectly in some cases through the Medicaid program. And I want to say that, even if it isn't funded by CMS directly or indirectly, NQF has a bully pulpit that can influence how privately-funded services are delivered.

For instance, where it says setting, a nursing home facility integrated plan, there is never social service setting daycare program. Those kinds of settings are not mentioned. And yet, don't we want to call them to be responsible partners in the effective delivery of healthcare?

So, I had mentioned before daycare programs, typically, very commonly dispense medications. That's where those meds are dispensed. They have a responsibility, then, for adherence, it seems to me. And there should be a standard of performance around that.

All of them, all of those social service providers have a deep impact on no-shows. They arrange for transportation. They should be responsible to make sure that their group home members and CBRF patients, and so on, get to see

primary care when those appointments are scheduled. They're responsible for that.

So, is that something that NQF needs to look at as part of the integration process? Setting the standard, is that within the scope, outside the scope? And what impact if NQF decided, no, it is inside the scope, and even though those services are privately-funded, we want to have a say into how they are measured and what their responsibilities are. Just a question.

CO-CHAIR HANSEN: Uh-hum.

MEMBER LUTZOW: I think there is something that sticks in my head and I think it should stick in all of our heads. It was a report, I believe this was the summer of 2014 where MedPAC came out and said, on this matter of measures, CMS has lost its way. That was the quote, lost its way.

And they didn't have in mind 50 measures or 600 measures or 900 measures. They had in mind 11 measures. Are we measuring so

many things that we are really aiding and abetting the lack of focus and the lack of real impact? Just a question.

It would be interesting to bring NQF here -- excuse me -- MedPAC here and ask them, what did you mean by -- I mean, talk about parsimony in the extreme, 11 measures compared to what we have now, not just NQF measures, but all the other sponsored measures.

What would Deming say about that? Is that anyway to run a company? Do we have to take another look at what our purpose is in focusing energy, effort, impact, and intervention? I don't think we're done with this story. I think we're going to hear about it more. Maybe not this generation, but the next generation is going to have the question raised, are you really making deep impact on the efficient use of healthcare dollars? So, that consideration needs to be thought through, I think.

CO-CHAIR HANSEN: Well, I think it's been great. We have had Marcia sitting with us

these two days. Again, it was really something nice to realize the commitment you have, as well as the fact that, in view of your last point, Tom, the fact that the NQF Board is looking precisely at what's it all about.

And so, perhaps whatever you would like to share, Marcia?

DR. WILSON: Yes, I would just like to make a brief comment. So many of your comments resonate with us here at NQF. And I will tell you that last summer our Board of Directors charged us with developing a strategic plan in response to a lot of similar comments that we have got.

You know, if you look at our database of 600 measures, if that were a library, you would say, yahoo, more books to check out. The problem is it doesn't function like a library. Somebody else is telling you what books to check out, and they are all slightly different.

We heard the variation from -- you know, Alice so eloquently talked about it in

Washington State, the incredible variation in all the measures that have to be reported and all the different programs. There are many reasons for that. We won't solve that today.

But I just want you to know that, as part of that strategic planning, we have been looking at very much these same issues, which is, one, how do you define those parsimonious clusters of measures that are going to be most meaningful in which situation? We talk a lot about measures that matter. Matter to whom?

I can tell you, from sitting through the HCBS Committee versus half a dozen other committees here, there are very different perspectives on which measures matter for what purpose. And I think that's what we need to be clear about, is to whom do these measures matter and for what purpose are they going to be used. So, we are looking at that.

And there was another comment someone else made, and I am just lapsing on it. I'm sorry.

But I want you to know the Board just approved the strategic plan this past month, and a lot of these issues are going to come up. And it is also what I hear you saying, which reinforces what we have been talking, is NQF using their position to have a voice, to have an opinion, to say, from all the experts that we bring around the table, from what we have learned from workgroups like this one and all the others, here's what we're hearing, and thinking about how we can use our influence, if you will, to help move some of these things along.

Because, for us, a lot of this is out of our purview. We don't develop measures, but we sit here and identify gaps. So, what can we do about that? What can we, as NQF, and you all, as a workgroup or other committees, do about helping -- kind of being a forcing function to help people move in that direction?

So, I will pause there. It was actually longer than I meant to take.

But, Charlie, do you have a specific

comment?

MEMBER LAKIN: Well, maybe it was sort of what you just said. But my reaction to my experience here has been that NQF just needs to be a lot more proactive. It can't do what needs to be done in a reactive mode. There are too many gaps to fill. There are too many things out there that are pretty good, but they are narrowly-defined. If it's a good measure in a rehab facility, is it a good measure that we can extend to other populations? There is so much out there that is being used that has so much promise and so much being done.

There aren't incentives for people to bring it to NQF. It's not going to add three more states to the 30 states that are using it right now. So, what can NQF do to go out and get those things?

I think, too, there needs to be some clarity in what we are talking about with regard to measures and composites and instruments. People are confused by that, and it is a

disincentive for them to even think about whether this is a place for them to send their work.

And then, the other thing is I think we settle for far too little in some of the areas that we have created families around. I sat in on the Care Coordination Subcommittee. You know, in the last analysis, the measures within that family are pretty much about timely transfer of medical records. That is not care coordination. That is timely transfer of medical records. There is so much more to it.

And there is so much out there that is being done to see whether people's service brokers or case managers, or whatever, are providing them the kind of support they need. But, again, I don't know that it's going to get here without somebody pulling it in. I would love to have somebody just sit down and think about the future of NQF, if it's going to attract more of what we need.

DR. WILSON: We agree, completely agree, and especially on the reactive versus the

proactive. What we are looking at through the Strategic Plan is, where is it appropriate for us to be proactive? What is the best use of our expertise?

And I would agree with you, historically, I have known NQF for a long time; I have not worked here very long, and I always thought they were a very reactive organization. Measures were brought forward and the organization would look at them.

I can tell you that mindset is definitely changing. Culture is going to have to change with it, which will be, as you all know, more challenging. That is an understatement.

But I agree with you 100 percent. And that is, as bits and pieces of this strategic plan are rolled out, I think you will see that very evident.

I would also charge you with telling us the ways -- and we have already heard some of this; I have taken some notes -- the ways in which we can be proactive. How can we be most

helpful on pushing on those levers?

Someone mentioned it before. It costs a boatload of money to develop a measure. This is not a cheap enterprise. So, how can we help bring this to the attention of the people with the money, that have the money to fund the measures? How can we work with people like the government? I mean, the government right now, sections of the government have some money for measure development. We should be telling them measures that we think are very important that should be developed.

But we would welcome suggestions from you of how we can be more proactive and help move things forward. So, thank you for bringing that up, Charlie.

CO-CHAIR HANSEN: Okay. We have Christine as well as Joan. Perhaps one of the things we'll do is we'll kind of summarize the particular mark here, with your representing essentially part of the leadership of NQF itself, and for us as a committee on certain things.

Again, I think I hear the recurrence coming up.

So, Christine?

MEMBER AGUIAR: Just to respond to the question that you posed, when I was saying my comments earlier that I think NQF is really well-positioned to drive policy and all the actors to work together, I think of it almost as I guess three things.

One thing is, do you know how CBO -- CBO scores the legislation. That is what they do. But every now and then they come up with a policy options document. And that is CBO going outside of their bread and butter and thinking about what policy should look like. And that is not always associated with a cost, but they don't usually score that.

So, I think something akin to that. You know, what we do here is what we do every day and, then, here is sort of where the field should go, using quality measures as incentives.

The other thing, another opportunity, I think, for NQF is, again, as I said before, you

have the payers. You have Medicare and Medicaid and commercial payers that are looking at quality for monitoring; also, quality for payment incentives. But, then, you also have this push towards value-based payments, so for individual providers and health plans and ACOs.

And so, I think, actually, it would be really helpful if NQF could say, of the measures that we already have endorsed, they are not trying to develop new measures -- you know, health plans, the Medicare Advantage plans, plans that take duals, plans for different populations -- here is some you may want to use in your value-based contracting. That, actually, I think would be incredibly helpful.

I know our plans are organically developing that. But to have NQF's bless, if you will, some measures for the use of value-based purchasing I think would be very helpful.

CO-CHAIR HANSEN: Well, it seems like your comment ties to Kim's comment as well. The way to help facilitate the best use of

identifying because for most places you don't have the specialists who are in measure development to realize, you know, a boatload of money goes into this one thing. But, then, how do we use it? How do we test it? How do we have reliability to these issues?

Having NQF perhaps evaluate this there and use the CBO -- that's a fantastic thing. And many of you may not know that Christine was a MedPAC staff for many years, and her special focus was dual-eligibles.

You know, we've got to use ourselves amongst us for the kind of talent, experience, and, frankly, the passion that you have in a way to leverage this much more.

So, I think the proactiveness and making things easier and useful. I think the comment about are there 11 measures, you know, in some way can they be aligned? After we hear your presentation, Alice, to see just the time you spend to kind of make it copacetic between these things, is there a way that NQF can help take a

lead?

When you see excellent providers who are struggling, is there a way to use them as your positive deviant example to see is there a different way to do this, to expedite that? You know, hearing from you to the state, you know, the state probably would pay attention, knowing that the phone call is from NQF.

DR. WILSON: And I would just mention CMS has given us funding to do a project which is underway on measure variation. It is this exact issue, looking at when NQF endorses a measure, it goes out into the field and there is just immediately 25 permutations, and then, it keeps growing exponentially, it seems like. And we end up with a situation where you have the same measure. There is a slightly different denominator. Okay, now I've got to collect it two different ways.

So, this committee is looking at the causes of variation and when is that a bad thing, because, then, you can't compare. The measures

are too different. And when is variation actually a good thing?

So, that's underway right now. They just, I think held their -- yes, one of the first reports is out. It's just going out for commenting, but that is an ongoing one. I think that is one contribution that NQF can make, is we have an expertise in what we would call measurement science, these cross-cutting issues like variation or attribution. And that, I think, is one place where we can make a contribution.

CO-CHAIR HANSEN: Joan?

MEMBER ZLOTNIK: I guess one of the things -- this is a great conversation, and I think many of the suggestions people have are really helpful. There are a few things that are going through my mind.

One of them, you know, I keep thinking about money follows the person. And it is sort of like money follows the activity, and they get very segmented because of that.

Part of it is thinking about collaborations. There is a lot going on, for instance, at the Patient-Centered Outcome Research Institute related to different things related to patient and family member engagement. Are there things that could be learned or are there ways that collaborations with PCORI could help promote the use of measures, or vice versa, help inform where there are gaps in measures? Because there's a lot of the same conversations going on in different places.

Another thing that comes to my mind is how does a committee get constituted. So, you went and complained to NQF and you got on the committee. For this particular committee, NQF came to NISW and said, we're having this committee on dual-eligibles. We think social work should be there. But, on care coordination, it's a totally medical care coordination conversation. So, it's very different. It's not a stakeholder.

I think there are also issues about

language. There are some of the same acronyms. You know, people talk about PRIDE. Well, there is a child welfare training program called PRIDE, you know, or different things.

So, making sure because it is such a diverse audience of people just even sitting in the room and on the phone, to make sure that we're talking in a language that we all understand because we're coming from different places.

I think this has been, actually, a really helpful meeting because it has been this combination of people kind of focused on population and quality of life and sort of professional issues with people who are actually using measures and really thinking about it. I think that's been incredibly useful.

But really thinking about what gets constituted, how much people who are sort of members and sort of buying into NQF control things versus how to have a broader view of this. Just like in healthcare people are thinking,

well, we need to be more engaged with the social service sector, the conversations that are going on in the social service sector are about how we need to have a more population health approach to eliminating child fatalities from child abuse or child welfare issues, or things like that.

So, there are some of these commonalities. NQF itself is not going to solve all those issues, but the places where there can be synergy I think are really important.

And then, the other piece really kind of goes back to some of the workforce issues. Some of the things we've heard in some of these presentations really has to do with what the quality and capacity and knowledge is. You just talked an effort going on in New Jersey. There are similar efforts going on in social work. But how do those workforce issues really play?

Rhonda Robinson Beale used to be on the committee. She would bring that up, you know, kind of from the beginning. So now, it's four years later. Where does that fit into NQF's

thinking overall?

CO-CHAIR HANSEN: Thank you.

Michael?

MEMBER MONSON: One of the things I think in the proactive vein that we could be thinking about doing is, you know, dual-eligibles, we say that word. There are 9 million people that are dual-eligibles, and they are very different. I mean, obviously, everyone is different, but there are also very different substrata and subpopulations.

A set of measures that may be applicable to individuals with intellectual and developmental disabilities may not be the same set of measures that are appropriate to measure for individuals with substance abuse or frail elders or individuals under 65 with disabilities.

So, I think that there's an opportunity for us to say, maybe again to think about, if we already have our starter set, right, maybe there is a starter set for the different types of populations. And obviously, there is

danger around that. I acknowledge that. I acknowledge that, as you put people into groups, that not everyone fits into that group.

However, we have the same danger on the flip. It is that we haven't recognized anyone's differences right now. So, we have to figure out how to balance that out.

But I think that there would be great benefit to thinking about how do we account for what would be the right set of measures for a certain population and maybe even in certain use cases, right? Because, right now, the measures are very focused around setting as opposed to people.

CO-CHAIR HANSEN: Uh-hum.

Yes, Marcia?

DR. WILSON: We just last week held our population health meeting, and it was the final in-person meeting of that project. I think Debjani showed you the action guide that came out of that.

But we were talking about next steps

where we could build on what that committee did. That was kind of where we went, Michael, was we called it like either a pyramid or a cascade of measures because, you know, Tom, I think you were talking about the core set of measures. You know, you want to get to that parsimonious core set of measures.

And I think at a certain level that's a very attractive idea. But, then, when you come down into different areas of care, then the measures need to be supplemented or in some way more detailed.

And now, Michael, you've just brought up a really important point. It was, even within duals, when you have all the different populations -- and, Charlie, we saw this play out in Home- and Community-Based Services. So many times, at some point at some level, you want to have a very specific set of measures that works for your people, you know, the group for which you are responsible. And we talked about at this population health meeting, is there a way to

think about those measures that they could roll up and roll down, where at the higher level you are going to have a more aggregate, maybe more a national or population-level picture, but, then, you would have subsets of measures?

I used to work in another project and we said all the time, national problems, local solutions. So, there would be some of these higher-level measures by which we, as a nation or in a larger group, could have a sense of how we are doing. But, for groups on the ground, there needs to be a different set of measures. But can we think about the ways in which those measures might be aggregated and, then, disaggregated? And maybe there is a national measure that is a composite. There are several components. And you are working in this particular area, which actually goes up to that aggregate.

So, just a conversation we had just literally last week in population health.

CO-CHAIR HANSEN: Okay. Clarke?

MEMBER ROSS: Yes, Michael's point

made me think maybe the staff should put together a two-pager on what the workgroup and committees have done previously. Because this is my fourth year here. We have focused on four major subpopulations. So, the focus on persons with multiple chronic conditions was the fourth of four. So, we went through this discussion in 2012 and 2013, and they may not have been the right four groups, but the committee at the time said these are four major cohorts. And we have meetings dedicated to one of the cohorts and, then, the next one.

So, there is an archive, and there are all these reports submitted to CMS that address three of the four cohorts. And you don't know that. So, what meaning does it have in 2016 that this work has been done and is it still relevant? And you can't just say, read this 250-page report. You have to say, here's a page-and-a-half summary.

And so, that's something for all the committees. It's more staff work, but I think it

is important.

MS. ANDERSON: Yes. Do you have any further questions on that? Would you like me to further describe the resources available? No? Okay.

CO-CHAIR HANSEN: No. It is just that -- and it was funny -- right now, she wrote me a note. She is going to send you the report from 2014 relative to this.

But the idea of having a very tight executive summary of a couple of pages would be really helpful, so that people can look at this.

The other comment -- before I say, let me ask our colleagues on the phone. Jim and Mady, if you are there, would you like to ask or add anything?

MEMBER CHALK: Yes, this is Mady. I'm here; I have been here all day on the phone.

I wanted to echo a lot of what Clarke said and what some other people have talked about. That has to do with there are two issues.

One is integrating across the

different committees that have been set up by NQF, Home- and Community-Based, Health Home. What Alice was talking about, in effect, I thought, is how much the linkages, when you talk about local solutions, in every state, the linkages across all of these different types of measures for any particular population depend on what is happening in a particular state, who is in what agency, how are they working together, how are they not.

In addition to details about how measures get implemented, I would be very interested in seeing what the committee that is talking about variation and measure implementation comes up with. Because, on the one hand, of course, we want accountability from the different sites, settings, and in relation to the populations we are talking about. We want accountability. On the other hand, we want to learn more about the barriers to implementation and what the variation is measuring.

I do think both frameworks from other

groups ought to be brought into the Dual-Eligibles group, whether it is Population Health or the HCBS. And I do think collaboration with PCORI or other groups that are doing accountability, a project on measurement, would be very useful. PCORI is focused in a particular way on patient-reported outcomes often, and that has been less the focus in our Committee, despite some of us talking about it a lot. So, I think we are at a point where we really need not the space so siloed.

And that is all I have to say.

CO-CHAIR HANSEN: Thank you, Mady. I think you are helping to corroborate some of the comments that were made, as you noted, and the whole sense of crossover here for alignment.

Jim, do you have anything to add, if you are on the call?

MEMBER DUNFORD: Hi, guys. I'm still here.

And thank you. Again, it has been my pleasure to kind of represent in some way the

voice of emergency medicine on the Committee for the last four years.

I spent 35 years in a public safety net emergency department here at the University of California, San Diego. For a long time, I thought I was the only guy seeing everything broken in the world kind of flowing at me. But that is really what you see when you are in an emergency department. All the issues that we are dealing with really flow through that final common pathway.

I think it is important to keep that in mind, that you can identify a lot of things early on that are happening in the emergency department. Even though they may begin out in the skilled nursing homes, or wherever, they finally come to the ED.

And one of the things that I would hope that you guys would do would be to continue to look at the evolving role of the emergency department and new measures of quality that are going to inevitably come. There is a very

significant and I think important move to move people who require admission to the hospital to home, where they would rather be. Particularly for seniors, this is going to save billions of dollars and make people happier.

And so, new measures of the safety and the effectiveness, and whether or not people get to have their wish to go home or not, are going to be important things in the future. And so, how you also get to the emergency department, increasingly, it is an ambulance. That is why I have felt that I wanted to bring the role of EMS to the attention of people who may not have really thought about emergency medical services before as an important part of the healthcare system. In fact, it is rapidly becoming so.

The third thing I think I just would continue to emphasize is data and the technology. Having been very involved in the development of our Beacon Health Information System here in San Diego, I am constantly reminded of what meaningful use means. And it is all about the

duals. If you really think, the definition of meaningful use of data is to improve safety, efficiency, to reduce disparity, engage patients, family, improve care coordination, population, public health. It is everything that we are talking about.

So, I think it is very important for NQF to be keeping one finger on the pulse at all times of the new technologies that are going to be gathering these data and incorporating them into health information, of looking at the new streams of data, and then, kind of leveraging those to be able to take advantage of this.

If you make the use of social data meaningful use, people are incentivized and tarnished if they don't use it. I think it is kind of an important thing to keep in mind in terms of how we actually really effect the things that we are hoping to accomplish, is to continue to kind of promote the meaningful use of the kinds of data that we think are important.

Anyway, thanks again for having me.

I have felt like 99 percent of the time I was a passive observer, but I sure learned a lot. And I would encourage you to invite other people from emergency medicine to come in, particularly young people. I just turned 66 the other day, so I don't know how meaningful I am anymore. But, honestly, there is a tremendous array of young people of all stripes and diversities who really want to get engaged in this process. I don't know; I think they are pretty much outside of it.

When I tried to explain to one of my sons, a 32-year-old guy who is health navigator here in San Diego working for 211 San Diego, which is the largest aggregator of social community-based organizations, nearly 6,000 -- he is the lead health navigator. It is difficult for him to really figure out how in the world would I ever get involved in the National Quality Forum, even though he is the No. 1 guy to try to point people to services in our community.

So, I think that there needs to be a way to kind of get a hold of this entire

generation of youthful people who are just striving so hard to be able to make things better, but they don't really know how to get engaged.

So, anyway, thanks again.

CO-CHAIR HANSEN: Thank you for your clarion voice and your fabulous examples that you provide.

I think there is one more comment before I close up.

MEMBER LUTZOW: Yes, I know I brought up this 11-measure thing. I think that is maybe so impossible.

(Laughter.)

What is possible, though, is a core set that can spread across estates, and I will use it in the French sense, spread across physician groups and hospitals and nursing homes. So, when there is a meeting, it is about how are we going to solve this. It is not just your problem; it is my problem, too. We are in the same boat here. We have to solve this together.

Right now, I think a lot of the quality programs that -- for instance, nursing homes, they have a staffing ratio domain. I think if a staffing ratio measure were brought to this group, it would be dismissed as, "What is this?" And I had nothing to do with the nursing home staffing ratio; neither does the hospital; neither does the physician.

I would like that nursing home to be responsible for diabetes. It is a condition that doesn't care what your disability is. It doesn't care how old you are. It attacks kidneys. It attacks the soft organs. It is a disease that crosses boundaries. I would like the nursing home industry to be as concerned about it as I am. And when I meet with a doctor, I want him to be as concerned about it as I am. I want him measured on it, so that we are in this conversation, how do we work together to deal with it?

That is the value that the Common Core would bring to the party. It would join the

party. And now, what we have is a little bit of a fractured system. Everybody is pursuing their own measures. They have their own set.

And this idea of could that core set be recommended as the basis for value-based contracting, I think that has got some potential. CMS is on this bandwagon that they want all contracts to be value-based. Well, yes, let's get to that high-impact set that can make a real difference in the quality of life and the cost of care. And diabetes is a huge cost-driver.

I think we have 11 people -- excuse me -- 100 people in our plan with diabetes as their primary condition, each attached to another comorbidity, that are driving about $8 million a year in cost. So, 100 people, it is huge, huge.

So, 11? You know, I don't know; maybe somebody else's lifetime, not mine. But the Common Core I think is possible.

CO-CHAIR HANSEN: Okay. Great.

I think that this has been a very rich discussion. For those of you who are new, I hope

this was useful. For those of us who have been around for a while and those of us leaving, the ability to have some thoughts, given the experience that you have had, having the leadership here of a senior executive of NQF sharing with us and spending the time, and the fact that we would love to leverage this organization. What is it that you can provide an opportunity like no other system can do? And using these elements that are about basics, but maybe this is a transformational time.

Issues of diabetes affecting the entire country, the ability to have voice and shaping this, which is actually moving. Is there a new way to begin to do this, so that when we spend time on measurement or accountability for performance and payment and for setting what the best health might be, is there a different way that we can do that together?

You all have expressed yourselves so well. I think Debjani as well as Megan have been keeping some notes. So, perhaps what we can do

is take a look at the summary of the meeting and we can put it back out, and maybe we can kind of organize it in a way that is focus for some of the rest of our meetings for this year, and, you know, rolling up to the future.

The final comment I have is what Jim was saying on the phone: how do we construct a strategic group? And he was saying be sure you get an ER-type person. But it is a thought that we have that perhaps would be guided by NQF as to what we are trying to achieve that lines up together.

So, it is good because we are glad you are here, Tom, that you do that. But, like any kind of leadership group, there should be a strategy behind it. Who needs to be on the bus for what period of time before we may need a different kind of team member? And so, some different thought about constructing committees and all would be there.

With that, I have broken my promise to you that we would be out of here by 4:00.

But I thank you for everybody's robust participation at this meeting.

I really thank the staff who worked so hard. I can't tell you how many times they have wrung their hands over different things and all.

So, Janine has joined in the past since October, is it?

And, Megan, any final comments to your audience here?

MS. ANDERSON: Thank you all so very much, again, for your input today and throughout the years. Please keep in touch, and I know that I will continue to use the experiences that I learned here. And I am looking forward to writing this report and getting your feedback.

And again, thank you to my colleagues and our Co-Chairs and NQF leadership for their guidance.

CO-CHAIR HANSEN: Thank you.

And, Debjani, you are going to be the person who is going to help carry us, continue --

DR. MUKHERJEE: Yes, it is a daunting

task.

It was very nice meeting all of you today, and I look forward to working with all of you in the future.

And I would like to thank Megan for all her work this year, and we will miss her, but she is moving on to bigger and better things. And we will always keep in touch. So, congratulations and a fond farewell and good luck.

CO-CHAIR HANSEN: Thank you.

And, Marcia, any last comments from you?

DR. WILSON: No, just your feedback is invaluable because, believe me, your voice is being heard at NQF. That is all I can say. So, thank you for your feedback.

You probably have my email address, but any other comments you want to make, shoot me an email. I welcome the input of this Committee.

CO-CHAIR HANSEN: Great. Thank you.

DR. WILSON: Thank you.

CO-CHAIR HANSEN: Safe travels, everybody. Okay. See you on the phone.

(Laughter.)

(Whereupon, at 4:03 p.m., the meeting was adjourned.)

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C E R T I F I C A T E

This is to certify that the foregoing transcript

In the matter of: Measure Applications Partnership
Dual Eligible Beneficiaries W/G

Before: NQF

Date: 04-20-16

Place: Washington, DC

was duly recorded and accurately transcribed under my direction; further, that said transcript is a true and accurate record of the proceedings.

Neal R. Gross

Court Reporter