

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
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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
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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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Adjourn

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

2 8:39 a.m.

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

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

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

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

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

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

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

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

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

7 CO-CHAIR HANRAHAN: Yes.

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

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

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

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

7 So, those are the themes.

8 CO-CHAIR HANRAHAN: Yes, thank you.

9 Thank you.

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

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

1 or certification programs to ensure quality.

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

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

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

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

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

1 are never submitted for whatever reason.

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

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

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

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

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

6 So, go ahead, Marcia.

7 DR. WILSON: Thank you, Nancy.

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

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

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

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

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

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

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

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

3 Kimberly? I'm sorry, Joan?

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

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

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

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

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

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

1 Remember that?

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

6 And one of the reasons why they were
7 going to be dropped is because there was no
8 stewarding moving forward for whatever reason.

9 And I can imagine those measures didn't have a
10 lot of validity given the concepts because it's
11 very hard to measure these kinds of concepts.

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

18 Go ahead, Clarke.

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

1 make that a CAHPS endorsed survey.

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

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

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

13 Okay, good. So we will move on.

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

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

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

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

8 And the staff preliminary analysis is
9 do not recommend because there is already Measure
10 0018 in the Family of Measures and it is blood
11 pressure control without -- so you're not with --
12 with the ESRD exclusion. So if you're at the
13 level of getting dialysis, you're excluded. And
14 it's also in federal programs.

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

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

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

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

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

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

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

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

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

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

22 And the last piece that I'd like to

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

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

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

19 Kimberly, thank you.

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

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

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

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

1 CO-CHAIR HANSEN: Go ahead, Gregg.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 measures that we have NQF endorsed that address
2 kidney disease.

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

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

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

19 DR. MUKHERJEE: So there is Measure
20 0729, Optimal Diabetes Care, and it's a composite
21 and it has statin use, blood pressure control, it
22 has various meds, A1C, tobacco use, aspirin,

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

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

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

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

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

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

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

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

1 this measure for something else as better
2 measures come along.

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

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

8 (Voting.)

9 Mady, if you could please submit your
10 vote.

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

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

19 MEMBER CHALK: I see.

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

22 MEMBER CHALK: Okay, I sent it,

1 assuming it's correct.

2 (Voting.)

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

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

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

21 CO-CHAIR HANSEN: Thanks, Kim.

22 Anybody else have any comments?

1 Okay, can we then proceed to a vote?

2 MS. AMIRAULT: Okay, so for Measure
3 2712, voting for the addition to the family of
4 measures, one being yes and two being no.

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

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

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

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

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

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

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

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

1 of medical home quality of care and monitoring.

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

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

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

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

22 MS. DAY: I'm actually on my way

1 there. This is Vanessa.

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

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

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

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

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

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

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

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

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

1 the medical and physical model.

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

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

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

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

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

3 So, the Starter Set currently includes
4 11 measures. They are fairly diverse and they
5 are generally made up of measures that are
6 longstanding, have -- you can actually see that
7 many of them have low numbers, low NQF numbers,
8 which means they came to NQF many years ago.

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

18 So I'll pause for questions.

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

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

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

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

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

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

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

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

1 Reconciliation -- excuse me, we removed that --
2 0646, Reconcile Medication List Received by
3 Discharged Patients, and 2456, Medication
4 Reconciliation Number of Unintentional Medication
5 Discrepancies Per Patient.

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

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

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

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

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

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

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

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

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

11 So, again, I agree with Michael.

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

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

1 we would proceed to the next measure.

2 Hearing none, we have two measures
3 that are companion measures. They're similar,
4 2091 and 2092, Persistent Indicators of Dementia
5 Without Diagnosis, Long-Stay and Short-Stay.

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

18 Can you use your mic?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 expense for family members to treat them.

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

9 Gwen?

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

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

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

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

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

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

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

22 CO-CHAIR HANRAHAN: Gregg?

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

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

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

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

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

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

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

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

3 MEMBER WARSHAW: Oh, okay.

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

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

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

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

22 MEMBER MONSON: Can I just make one

1 comment on the use of the measure?

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

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

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

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

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

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

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

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

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

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

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

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

1 could be a message.

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

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

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

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

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

1 family?

2 I'm going to rephrase the question.

3 Would anyone like to nominate either measure, the
4 short-stay or the long-stay, for removal from the
5 family?

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

8 MEMBER CHALK: No.

9 MS. ANDERSON: Thank you.

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

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

22 It is eligible and considered as

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 most is the high cost of post-acute care.

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

7 CO-CHAIR HANSEN: Okay, great.

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

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

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

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

1 and all the costs were three days before that
2 admission.

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

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

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

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

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

1 reconciliation with that.

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

7 CO-CHAIR HANSEN: Okay, thank you.

8 Tom?

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

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

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

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

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

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

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

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

20 CO-CHAIR HANSEN: Christine?

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

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

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

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

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

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

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

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

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

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

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

11 Alice?

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

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

22 So, you know, the Medicare piece is

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

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

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

8 CO-CHAIR HANSEN: Okay.

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

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

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

17 MS. ANDERSON: Okay, so thank you all.

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

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

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

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

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

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

19 Any questions? Yes.

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

1 means?

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

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

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

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

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

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

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

15 Further questions?

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

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

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

9 Further questions?

10 Okay, next slide?

11 So, the first group that we're going
12 to look at are the medication measures. So, we
13 have two medications current in the Starter Set,
14 0419, Documentation of Current Medications in the
15 Medical Record. This one was also voted high
16 priority by six members.

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

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

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

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

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

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

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

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

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

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

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

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

22 And, 0419 is in the hospital.

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

5 0419, was the other one?

6 MEMBER ZLOTNIK: Yes.

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

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

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

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

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

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

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

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

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

1 star set.

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

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

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

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

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

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

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

6 CO-CHAIR HANSEN: Gregg?

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

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

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

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

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

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

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

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

20 Those are my thoughts.

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

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

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

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

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

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

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

5 MS. ANDERSON: That is correct.

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

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

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

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

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

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

9 CO-CHAIR HANSEN: Kimberly?

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

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

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

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

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

5 So, we'll take the first one of adding
6 0097 to the Starter Set. Is that okay? So, that
7 is what we will vote on for the first one.

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

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

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

16 CO-CHAIR HANSEN: Thank you.

17 And then, your second recommendation?

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

22 CO-CHAIR HANSEN: Okay. Confirming

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

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

6 CO-CHAIR HANSEN: Removal of 0022.

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

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

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

14 MS. AMIRAULT: So, for Measure 0022,
15 for retention of the Starter Set, one for yes and
16 15 for no remove. So, based on the consensus,
17 this will be removed from the Starter Set.

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

1 MS. ANDERSON: Okay, thank you very
2 much.

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

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

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

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

1 beneficiaries and older adults and it is risk
2 adjusted.

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

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

9 0674 is the percent of residents'
10 experiences or more falls with major injury in
11 the long-stay. And the rationale for the six
12 votes for high priority was that it was an
13 important safety issue in dual beneficiaries and
14 other older adult populations, that falls with
15 injuries are a very important quality issue and
16 falls are a major cause of death in
17 institutionalization.

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

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

1 Set from the family.

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

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

11 CO-CHAIR HANSEN: So --

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

15 CO-CHAIR HANSEN: Aline?

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

21 CO-CHAIR HANSEN: And, Gregg?

22 MEMBER WARSHAW: So, just clarify the

1 settings in which 202 and 674 are applicable.

2 They seem to be discrete.

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

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

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

13 And, the second one is 0674 is the
14 question?

15 0674 is percent of residents
16 experience one or more major falls with injury.
17 That is also an outcome measure that is not risk
18 adjusted. It is for settings of care in nursing
19 home and it is for the facility level of
20 analysis.

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

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

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

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

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

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

1 It's used in 11 state demonstrations.

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

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

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

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

17 CO-CHAIR HANSEN: Joan, in the
18 meantime?

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

22 And, counting is one thing and having

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

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

11 So, I think you kind of need both.

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

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

22 MS. ANDERSON: Yes, among post-acute

1 care settings.

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

5 MS. ANDERSON: Thank you very much.

6 CO-CHAIR HANSEN: So, yes.

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

10 CO-CHAIR HANSEN: Gregg?

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

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

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

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

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

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

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

11 MEMBER WARSHAW: Yes.

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

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

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

21 I see a taker here. Okay, Kim?

22 MEMBER RASK: You know, I like the

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

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

13 Is there one that we would want to
14 highlight?

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

18 MEMBER CHALK: This is Mady.

19 CO-CHAIR HANSEN: Yes?

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

1 addition to the issue of falls.

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

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

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

10 MEMBER CHALK: Okay, got it.

11 CO-CHAIR HANSEN: All right.

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

15 MEMBER ANDREWS: Well, I would agree
16 with what's already said. That I think that the
17 0101 does a great job in representing this
18 particular area in the Starter Set.

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

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

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

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

9 CO-CHAIR HANSEN: Okay.

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

12 CO-CHAIR HANSEN: Okay, all right.

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

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

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

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

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

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

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

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

22 It is used in three demonstrations but

1 not used in any other federal programs.

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

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

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

22 And, those are the three measures of

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

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

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

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

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

19 MEMBER ANDREWS: I would favor adding
20 0648. I think the timely transmission of
21 information is critical to that seamless
22 continuity of care.

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

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

7 CO-CHAIR HANSEN: This is a stepping
8 out, again, for a moment. This is a factual
9 information point that's probably relative to
10 0647.

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

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

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

1 the three items would be probably included.

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

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

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

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

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

16 MS. ANDERSON: Yes.

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

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

22 MEMBER WARSHAW: Excuse me, can you on

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

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

5 CO-CHAIR HANSEN: Thank you, Gwen.

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

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

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

19 CO-CHAIR HANSEN: So, Gregg?

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

1 question that gets to understanding.

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

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

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

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

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

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

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

1 take just --

2 MEMBER WARSHAW: One at the time.

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

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

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

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

13 Just one second to vote for the next.

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

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

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

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

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

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

13 And, we have one measure of
14 readmissions in the Starter Set currently. It is
15 1768, Plan All-Cause Readmissions. It was voted
16 for, best I remember, is high priority because
17 it's aligned with federal programs, encourages
18 system approach to disease management and
19 promotes care planning.

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

1 Facility 30-Day All-Cause Readmission measure.

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

9 I will also pull up the
10 specifications.

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

20 2510 is an outcome measure that is in
21 nursing home facilities and it is a CMMI priority
22 measure for monitoring and evaluation.

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

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

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

10 1768 is risk adjusted.

11 MEMBER MONSON: Thank you.

12 CO-CHAIR HANSEN: Okay. Yes, Aline?

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

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

22 MEMBER AGUIAR: Yes, I agree. I

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

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

8 CO-CHAIR HANSEN: Okay. Tom?

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

12 CO-CHAIR HANSEN: Checking.

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

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

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

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

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

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

9 All right, George?

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

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

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

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

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

8 CO-CHAIR HANSEN: Go ahead.

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

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

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

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

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

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

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

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

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

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

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

11 CO-CHAIR HANSEN: Okay, thank you.

12 One more comment, Tom?

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

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

1 It was a question back to the sponsors
2 of both.

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

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

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

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

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

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

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

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

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

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

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

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

3 MEMBER LUTZOW: Okay.

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

7 Mady, any final comments?

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

10 CO-CHAIR HANSEN: Okay.

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

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

17 CO-CHAIR HANSEN: Okay.

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

21 They each received seven votes for
22 high priority.

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

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

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

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

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

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

4 One vote for low priority because of
5 parsimony.

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

9 MEMBER DUNFORD: Good morning.

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

12 Aline? Okay.

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

16 CO-CHAIR HANSEN: Okay, Gwen?

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

19 MEMBER BUHR: I have a question and a
20 comment.

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

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

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

9 And some guidelines say that should be
10 150/90 for people over 65.

11 So, it would be in conflict with
12 guidelines.

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

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

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

22 DR. MUKHERJEE: They are, too, waiting

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

5 CO-CHAIR HANSEN: George?

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

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

16 CO-CHAIR HANSEN: Any other comment or
17 question?

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

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

1 MS. AMIRAULT: Okay, so for Measure
2 0018, voting on the addition to the Starter Set,
3 one being yes and two being no.

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

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

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

12 CO-CHAIR HANSEN: Okay, yes.

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

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

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

21 MEMBER DUNFORD: Yes, I agree.

22 MS. ANDERSON: Okay.

1 MEMBER DUNFORD: Yes, that's my vote.

2 MS. ANDERSON: Thank you.

3 MEMBER DUNFORD: No, I'm in favor.

4 Thank you.

5 MS. AMIRAULT: Thank you.

6 CO-CHAIR HANSEN: That's clear.

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

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

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

15 CO-CHAIR HANSEN: Okay, thank you.

16 Yes, comments for 0326, Advanced Care
17 Plan?

18 Michael?

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

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

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

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

12 CO-CHAIR HANSEN: Thank you.

13 Tom?

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

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

1 an ethnic class that's not appreciated.

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

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

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

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

21 CO-CHAIR HANSEN: Thank you.

22 Yes, Clarke?

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

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

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

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

16 CO-CHAIR HANSEN: Thank you.

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

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

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

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

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

22 But, at least make sure that everyone

1 knows that this is a right that they have.

2 MS. ANDERSON: And, medication --

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

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

13 So, just to share the other dynamic.

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

22 It is specified for ambulatory care

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

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

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

12 MEMBER MONSON: I think we should add
13 it.

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

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

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

22 The reason I mention it is there are

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

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

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

17 MEMBER DUNFORD: Thank you.

18 CO-CHAIR HANSEN: All right.

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

21 Oh, excuse me, sorry.

22 MEMBER ZLOTNIK: Just a point of I was

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

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

8 MEMBER ZLOTNIK: We sort of said that
9 before.

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

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

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

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

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

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

3 CO-CHAIR HANSEN: Okay, thank you.

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

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

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

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

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

1 disorder or related condition.

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

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

7 CO-CHAIR HANSEN: Any comments on this
8 one?

9 Clarke?

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

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

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

22 CO-CHAIR HANSEN: Any other input

1 comment?

2 Jim or Mady?

3 MEMBER CHALK: Yes, I have a question.

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

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

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

14 MEMBER BUHR: Mady, excuse me if I get
15 this wrong, but it says a 60-day -- greater than
16 60-day supply for cholinesterase inhibitor or an
17 NMDA receptor antagonist.

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

20 MEMBER CHALK: That's dementia.

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

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

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

6 MS. ANDERSON: Okay, just on --

7 MEMBER CHALK: So, I'm asking --

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

11 MEMBER CHALK: Okay.

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

14 MEMBER CHALK: No.

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

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

20 CO-CHAIR HANSEN: Okay.

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

1 CO-CHAIR HANSEN: To include it, yes.

2 Okay, so, this is the final vote.

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

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

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

11 So, Megan, logistics?

12 MS. ANDERSON: A break only five
13 minutes.

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

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

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

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

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

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

9 MS. ANDERSON: Starting exactly at
10 quarter after.

11 (Whereupon, the above-entitled matter
12 went off the record at 11:07 a.m. and resumed at
13 11:15 a.m.)

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

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

20 Welcome, Drew.

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

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

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

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

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

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

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

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

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

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

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

1 spending on LTSS.

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

4 Okay. Yes. I think this will work
5 better.

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

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

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

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

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

1 quality measurement initiatives.

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

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

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

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

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

1 together.

2 Next slide. So before I get into the
3 details, I just wanted to give you an overview of
4 where we are. So I didn't mention -- of course,
5 this is a two-year project that's funded by HHS.
6 And we started in late -- oh, actually in early
7 2015. And the Committee attempted to create a
8 conceptual framework for measurement first and
9 then an operational definition for HCBS. And
10 I'll go into those.

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

18 The Committee met on March 30th and
19 31st and they began the discussion of gaps,
20 reviewing the findings of this environmental scan
21 and they've begun to craft recommendations which
22 we will be synthesizing and putting together over

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

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

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

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

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

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

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

22 Next slide. Right. And some of these

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

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

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

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

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

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

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

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

22 And then we also looked at all the

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

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

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

1 recommendations and where things are going.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

8 (Pause.)

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

11 CO-CHAIR HANRAHAN: Thank you.

12 So thoughts?

13 MEMBER ROSS: Eliza and Charlie are on
14 the Committee?

15 MR. ANDERSON: Right.

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

20 CO-CHAIR HANRAHAN: Thank you.

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

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

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

11 So, Charlie, if you have any thoughts?

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

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

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

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

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

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

6 CO-CHAIR HANRAHAN: Thank you. Go
7 ahead.

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

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

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

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

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

1 measure?

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

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

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

1 improvement?

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

4 MR. ANDERSON: Right.

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

10 MR. ANDERSON: Yes.

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

13 MR. ANDERSON: Yes.

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

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

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

18 (Simultaneous speaking.)

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

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

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

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

1 that work.

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

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

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

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

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

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

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

13 MR. ANDERSON: Right.

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

20 MR. ANDERSON: Yes.

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

1 that, I think.

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

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

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

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

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

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

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

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

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

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

1 extended conversation in the Committee itself.

2 So to me it's a great resource for all of

3 National Quality Forum.

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

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

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

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

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

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

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

12 MEMBER LAKIN: (No audible response.)

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

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

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

1 Gail, do you want to say anything
2 more?

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

15 CO-CHAIR HANRAHAN: Go ahead, Tom.

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

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

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

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

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

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

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

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

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

5 Sorry. Did somebody speak?

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

8 CO-CHAIR HANRAHAN: Thank you.

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

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

22 So I'm just starting out with a quick

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

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

1 the AHRQ Clinical-Community Relationship Measure
2 Atlas.

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

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

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

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

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

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

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

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

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

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

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

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

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

1 quality of care.

2 DR. MUKHERJEE: Next slide, please.

3 Oh, no, no, no. This slide. Sorry.

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

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

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

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

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

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

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

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

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

1 patient-level data sharing.

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

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

1 presented.

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

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

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

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

22 Governance and operations. Leverage

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

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

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

22 So some of the caveats provided is the

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

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

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

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

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

18 So are there thoughts? And, Debjani,
19 if there's a particular area that you wanted that
20 the Committee might comment on.

21 DR. MUKHERJEE: I think probably one
22 thing that would be helpful is to say what does

1 community integration mean for this population
2 and what are some key aspects? Because a lot of
3 this was domains that are important and domains
4 that were repeated throughout different studies
5 but that necessarily might not translate to sort
6 of the collective thinking of the workgroup and
7 just their experience.

8 MEMBER ROSS: I had two frustrations
9 to share. First of all, the Commonwealth Fund
10 does excellent work, and I'm looking at the PRIDE
11 report, but they obviously never read any of the
12 reports of this workgroup from 2013, '14 and '15
13 when we developed high-priority measure gaps.
14 And I'm really disappointed that a Commonwealth-
15 funded that you're reporting on -- the measure
16 gaps do not mention individuals, goal-directed
17 shared decision making, beneficiary sense of
18 control, autonomy, self-determination. And it's
19 a reflection on what are we doing here? We've
20 issued these reports and here's this report that
21 you're citing and they've ignored the person
22 dynamics of this workgroup for three years. So

1 I'm disappointed about that.

2 And I guess I'm also disappointed that
3 you would say, well, what is integration when we
4 just had Drew and Charlie -- where integration is
5 a major element of the Home and Community Based
6 Service Committee, its definition. So I'm
7 frustrated that it seems like we're -- the people
8 are ignoring, we're ignoring the home and
9 community based service work and you're reporting
10 on a Commonwealth report that ignored our work.

11 And then the question is why are we
12 sitting here for two days around the table if
13 we're -- there's disconnects, so many
14 disconnects.

15 DR. MUKHERJEE: So is it coordination
16 of integration of community efforts as one of the
17 recommendations?

18 CO-CHAIR HANSEN: Well, why don't we
19 keep talking and then we'll pull out a few
20 things. I have some thoughts on that, but I
21 don't want to interject just yet.

22 So Joan and then after that Tom.

1 MEMBER ZLOTNIK: That was an
2 incredible amount of information to present.
3 Really important information. And one of the
4 things that -- a few things struck me in that
5 kind of 15-minute intense overview of millions of
6 millions of dollars worth of efforts that have
7 gone on is the difference between a planned
8 organized kind of managed effort to implement an
9 integrated health and social service system as
10 some communities have with the sort of difference
11 of the reality of kind of one person at a time
12 needs for care coordination. And they're
13 different. And I think we need to make that
14 clear.

15 The other thing that struck me in that
16 there was a table that had a list and it talked
17 about what things had measures. And my next
18 question in my head was are any of those NQF-
19 endorsed measures in terms of something that's
20 been a theme of our conversation here that there
21 are a lot of measures that are being used by this
22 expensive and a whole other set of strategies to

1 be in an NQF-endorsed measure?

2 And I guess the other thing that was
3 striking me is; and maybe this kind of comes out
4 of more of like a medical bent, providers and
5 hospitals and social service agencies and
6 individuals with needs are all part of the
7 community. So like we might just think a little
8 differently when we're thinking about community
9 integration, because many of these examples I
10 think we're looking at how do we provide a more
11 integrated service delivery system. They're
12 system issues. They're not really there's the
13 hospital and there's -- even though that's the
14 way it comes out. So that's a little -- my
15 thinking. But this is something that is many
16 days worth of conversation that was synthesized
17 in 20 minutes.

18 MEMBER LUTZOW: You know, this issue
19 of integration, we don't have it of course and we
20 need to evaluate it. I want to give you
21 examples. And this doesn't really rise to the
22 level of conceptual generalization yet, even in

1 own my mind.

2 The idea of capturing for the purpose
3 of integrating medical and social services around
4 an individual, it is -- it amazes me. I don't
5 know if you knew this; I didn't know this, all of
6 the American Lung Association offices sponsor a
7 Better Breathers Club. It's called Better
8 Breathers Club. And the purpose of the Better
9 Breathers Club is to bring together people that
10 have asthma and COPD and other lung-related kinds
11 of disabilities and educate them about their
12 condition and how they can self-manage.

13 This was a new discovery to me. I
14 didn't know there were Better Breathers Clubs.
15 We weren't integrated with Better Breathers
16 Clubs. We didn't send our patients/members to
17 those clubs, pay for their transportation. That
18 was a new thing.

19 That's just one example of these
20 resources out there that are not brought to bear
21 on chronic disease management by health plans and
22 health providers. So somehow in -- talk about

1 unfunded responsibilities. This is an example of
2 where we can extend responsibility that probably
3 is funded, and yet we're not moving the system in
4 that direction.

5 Another example. It amazes me that
6 day care programs that serve the elderly in our
7 community, Wisconsin, don't have access to
8 medical information. And yet it's at those day
9 care programs where meds are dispensed. And so,
10 when there's a change in the medication regimen,
11 they don't know because they're not wired into
12 any system.

13 We have this firewall between medical
14 and social services when social services can be
15 brought to bear, whether it's day care, CBRFs,
16 RCACs -- brought to bear as a resource in
17 executing medication compliance. They're the
18 ones who dispense the medication. And yet
19 there's this firewall that exists for HIPAA
20 reasons or God knows what which just doesn't tap
21 the resource. That has to be broken down. So we
22 have to change our laws or something to

1 accommodate an integrate those resources in the
2 care delivery process. They have a place at the
3 table, and it's a legitimate place.

4 Apart from just the absence of
5 information integration we have basic opioid
6 abuse where unless we track where these folks are
7 getting these medications, they'll go to any
8 number of pharmacies and tap them all for the
9 same meds. And I mean, it's fundamental that we
10 have to even within the medical community
11 integrate information and share it more quickly
12 and rapidly. But there, too, there's again a
13 firewall between the medical environment and the
14 social environment.

15 So the barriers to integration are
16 huge. They're huge. And we are not going to
17 wrap ourselves around the correct management of
18 complex conditions, chronic conditions unless we
19 do a better job of this.

20 MEMBER LIND: So I have to tell you
21 one of my favorite Dilbert cartoons is where the
22 guy writes a 200-page report and then he hands it

1 to his boss and he turns it into a 3-page
2 executive summary who turns it into a set of
3 bullet points for a PowerPoint slide who turns it
4 into the executive CEO with the comment "Nice
5 tie." It's like to goes from 200 pages to nice
6 tie and he says, "Good job."

7 So that's how I feel about this
8 Commonwealth report. It's like a ton of work.
9 And iCare was one of the organizations that
10 participated in the PRIDE project and out of
11 every project -- I mean; you probably have had
12 this experience, you try to summarize what bits
13 you can glean from it. And one of the bits was
14 to say the PRIDE project has only been going on
15 for a year-and-a-half. We have to produce
16 something that ties all this ton of work that's
17 been going on to can we actually start measuring
18 it and reporting it now?

19 So I actually helped write that
20 report, and it does reference NQF's work and
21 points to some of the things you were talking
22 about. I mean, that's like a 7-page issue brief

1 with 30 references in order to pull in Truven's
2 work and pull in the home and community based
3 services client survey work and the NCI work and
4 then say here's what we know about what they've
5 been able to accomplish in PRIDE and here's where
6 the gaps are.

7 And so, I don't think the slides
8 capture all of that, but neither does the seven-
9 page brief because it's a -- I mean, a ton of
10 work went into that PRIDE group. I don't know if
11 you participated in any of the meetings, but
12 rich, rich discussion about what should we be
13 doing to improve quality of care but to try to
14 summarize it. I think there's still another
15 paper to come out of that. But it was not easy,
16 I'll have to say, in my own defense.

17 CO-CHAIR HANSEN: Thank you, Alice.

18 Gail?

19 MEMBER STUART: So I recognize the
20 tremendous amount of work, but I'm struck by a
21 couple of things. One is it doesn't address at
22 all the social determinants of health. It

1 continues to go down a medical model road. And
2 we are never going to get out of the rut we are
3 in unless we really look at a public health
4 model. And I just think what has not been
5 addressed is enormous in terms of this report,
6 whether it's economic, food farms. I mean, it's
7 just incredible what we're not looking at.

8 And then the second thing is my
9 observation that we may not be able to get out of
10 the medical model, but this is going to happen
11 based on technology. Because as we all have
12 smartphones and tele-health and all this
13 technology, that's going to be the transforming
14 element to how we provide care, where we provide
15 care. And I think that's on the horizon. But I
16 really feel like we need to in this discussion at
17 least talk about more of a public health
18 perspective.

19 MEMBER DUNFORD: Jennie, this is Jim.

20 CO-CHAIR HANSEN: (No audible
21 response.)

22 MEMBER DUNFORD: Can you guys hear me

1 all right?

2 CO-CHAIR HANSEN: I hope you can hear
3 me now. I didn't have my microphone on.

4 MEMBER DUNFORD: Oh, okay. I just
5 wanted to make a comment. I agree with the last
6 comment about technologic solutions to this.

7 I participated last year in Washington
8 at Health Information Technology Policy Committee
9 where I testified on a -- it was called the
10 Advanced Health Models and Meaningful use
11 Workgroup. And there were -- this is part of the
12 Office of the National Coordinator for Health
13 Information Technology where seven model programs
14 in the country that were beginning to merge
15 social and health data were discussed.

16 And all the barriers are very real,
17 but I would hope that we're looking at the
18 technology side of the Government for some of
19 these solutions. Because there really are some
20 very exciting projects that are underway that
21 actually begin to bridge social data and begin to
22 wrap around patients, sometimes entire states,

1 sometimes local communities that are taking
2 social information and bringing these into very
3 sophisticated information centers and beginning
4 to aggregate it and then bring it all the way
5 down to the individual patient level.

6 So one of the silos that we have to
7 avoid is failing to understand what's going on
8 over there in the health information technology
9 world where there's a tremendous amount of
10 interest. I'm sure everybody knows the Institute
11 of Medicine has said that the social determinants
12 of health must be incorporated into the health
13 record of the future. But those are basic social
14 metrics. And there are other ones that
15 communities themselves are beginning to identify.

16 Here in San Diego we've created a
17 Social Information Exchange that actually shares
18 across housing providers, Meals on Wheels, and
19 regardless of whatever database you use; if
20 you're HMIS, for example, the housing providers
21 will use that, you can all share information
22 across. But the obstacle is that the Health

1 Information Exchange here in San Diego doesn't
2 want to touch it because of the HIPAA rules.

3 So getting back to the barriers, for
4 whatever reason healthcare association's
5 information technology is extremely loathe to
6 move toward trusting the trust network that's
7 necessary in order to be able to take advantage
8 of this wealth of information that exists on
9 vulnerable individuals. Thanks.

10 CO-CHAIR HANSEN: Thank you very much,
11 Jim.

12 We have two more speakers before we
13 summarize some of this.

14 Charlie?

15 MEMBER LAKIN: Well, I was just going
16 to say that I find terminology really frustrating
17 here. Over 30 years ago I helped start an
18 institute at the University of Minnesota called
19 the Institute on Community Integration. And what
20 we meant by that, and what we still mean by that,
21 is that people are in and of and actively
22 participating in their community. and that's why

1 we did what we did. And now I come and hear --
2 and somehow community integration, which has been
3 widely used in this disability field, to mean
4 people's lives is now somehow akin to service
5 coordination or something. I can't quite figure
6 out what's meant by it.

7 And I feel the same thing with person-
8 centered. I see it used to mean that you assess
9 somebody and then based on the assessment you do
10 something that's sort of relevant to their needs,
11 where in the disability field person-centered
12 means I drive my experiences.

13 And we just have these different
14 terminologies. And I don't know if that is
15 confusing to others as much as it is to me, but I
16 honestly don't know what people are talking about
17 so often when they use terms that I've used for
18 35 years. So, yes, it's confusing to me how the
19 language is different as you talk about different
20 topics.

21 CO-CHAIR HANSEN: Thanks for that
22 point, Charlie.

1 Okay. Christine, and I see Michael,
2 who has the final comment.

3 MEMBER AGUIAR: Sure. So I think that
4 community integration is an area where NQF can
5 lead by signaling, right, so signaling this is
6 where the expectation is for you to go. But then
7 you get into a chicken and egg situation. And
8 you also don't want to penalize ACOs or plans or
9 providers who are trying to do this and want to
10 do this, but they're not financially responsible
11 for those services, and there's a lack of them in
12 the credibility. I mean, I think it's important
13 to keep in mind the barriers when constructing
14 the measures. So it's this balance between
15 incentives and which direction do you want to
16 move towards, but then also what are the real
17 challenges and barriers?

18 So this is something that we deal with
19 all the time talking about with our plans. We
20 talk to them about food as medicine. Many of
21 them were involved in private collaborative and
22 many of them are working on this. But again, so

1 I think it's an important area and important for
2 signaling what are expectations are, but it has
3 to be done in a way that recognizes that many of
4 these services are provided by the state and
5 there's just real limitations to them.

6 I'd mention again the privacy
7 restrictions. And again, it keeps coming up
8 here. I would make it important to note that we
9 do -- in our advocacy around this issue we are
10 clear that it's 42 CFR Part 2 and not HIPAA.
11 That's the restricting regulation, because it is
12 -- those that are concerned about having the 42
13 CFR Part 2 exemption are fearful that we're
14 trying to eliminate HIPAA. And that's actually
15 not what the concern is.

16 CO-CHAIR HANSEN: Thank you.

17 MEMBER MONSON: So I know I'm probably
18 standing between us and lunch, but the one thing
19 I will just add to this conversation, to build on
20 what Charlie was saying and a couple others have
21 said, is that I think what we're -- the reason
22 we're talking about community integration is

1 because we have fragmentation in the system, and
2 that fragmentation in the system is partially
3 because of the Medicare and the Medicaid benefit
4 structure. It's because some things are social,
5 some things are medical.

6 And so we've been talking about these
7 issues as -- from a vantage point I think -- and
8 many people are coming from different vantage
9 points in that system. And if we really want to
10 talk about integration and how we do this
11 correctly, we should start with the consumer and
12 work our way outward. And what is it that the
13 consumer needs? And then there are the breakdowns
14 in the system and how do we think about measures
15 that might stitch that together to overcome those
16 breakdowns in the system?

17 CO-CHAIR HANSEN: Well, thank you,
18 Michael. That's actually I think a perfect
19 summary and a way to get back to some of the
20 language we keep talking about, because right now
21 we're talking about some of the structures, the
22 processes, the lack of system-ness that we have.

1 So if we flipped it and go back to what -- Clarke
2 and Charlie always bring up is starting with the
3 person. And what would be a great outcome for a
4 person regardless -- not so much regardless, but
5 in view of different kind of life issues that
6 they're having? How can they maintain their best
7 well-being under the circumstances?

8 So one of the things that I think
9 about for us with this Committee; and we can
10 perhaps talk about it this afternoon when we're
11 talking about strategy, is is there a way that we
12 can convey an infographic in a way that speaks to
13 what happens to many of the dual eligibles and
14 show kind of almost a graphic area of if things
15 were aligned and they got to a point of highest
16 best functioning and quality of living, what
17 would that look like? And then let's map out
18 some of these things that show where they break
19 down.

20 But the uber issue of the barrier of
21 privacy, the handoff of information to assure
22 that, that's a major policy and statutory

1 consideration. So maybe this is one of the areas
2 that it really speaks to what is the role that
3 NQF can play, that as we move with this and work
4 with CMS and have ACL as a part of this if we
5 were to achieve the highest best outcome with the
6 least necessary use of extra cost and people
7 functioned, how could that look?

8 And how does the rest of our stuff fit
9 into this, the evidence-based kinds of things
10 that we have, the things that we will need to
11 develop? What is the ultimate outcome, not just
12 an ultimate -- not just an outcome measurement,
13 but what is the ultimate outcome that we're
14 looking at for the different populations of the
15 duals who comprise our charge?

16 So, but thank you for each of you
17 bringing this and thank you, Debjani, for trying
18 to distill this. And here we have some -- a
19 primary author of the study. And I think we all
20 feel this jaggedness and the fact that we want --
21 I think we're aligned that we want the best for
22 this with the parsimony of resources that are

1 needed, but with the highest value.

2 So let's perhaps table some of this
3 discussion that we can bring onto the 3:30
4 strategy discussion that we may have.

5 And as we end, I just wanted to make
6 sure that those of you who have worked with Megan
7 have a chance to hear from her as she moves into
8 a different stage.

9 MS. ANDERSON: Thanks. I have two
10 things. I'll make sure that we communicate with
11 our External Affairs Office that you heard from
12 yesterday morning about this challenge and
13 discuss with them the role that NQF has or could
14 have in some of these concerns about the role of
15 and the barriers to the advancement and
16 effectiveness of quality measurement because of
17 privacy rules. And so, we can talk about NQF's
18 role and how that works.

19 My announcement is, I guess, a little
20 strange. And I'm just pleased to share with you
21 and wanted to thank you all for your time over
22 the last four years. I will be moving on this

1 summer. I'll be going to Johns Hopkins
2 University to start on a masters of science in
3 the nursing program, and I'll be there for almost
4 two years. I'm looking forward to coming back to
5 the area and keeping in touch with all of you.
6 And thank you all for your inspiration and
7 mentorship over the years. I really appreciate
8 it. Can't begin to describe how much I've
9 learned.

10 CO-CHAIR HANSEN: Can we give her a
11 hand for her --

12 (Applause.)

13 CO-CHAIR HANSEN: Do we have a speaker
14 coming?

15 MS. ANDERSON: We have a speaker
16 starting at 1:00, so we'll reconvene at 1:00.

17 Sorry. Go ahead.

18 MS. GOLDEN: Hi. It's Robyn. Should
19 I come back at 1:00?

20 CO-CHAIR HANSEN: Hey, Robyn. How are
21 you?

22 MS. GOLDEN: Hi, Jennie. How are you?

1 CO-CHAIR HANSEN: I'm good. Yes,
2 well, please give us probably at --

3 MS. GOLDEN: Yes.

4 CO-CHAIR HANSEN: -- the latest 1:05
5 we'll get going.

6 MS. GOLDEN: No problem.

7 CO-CHAIR HANSEN: Okay. Thank you
8 very much.

9 MS. GOLDEN: Thank you.

10 (Whereupon, the above-entitled matter
11 went off the record at 12:42 p.m. and resumed at
12 1:00 p.m.)

13 CO-CHAIR HANSEN: As some of you
14 continue to finish your lunch, I will go ahead
15 and have a chance to do an introduction of the
16 next speaker.

17 The rest of the afternoon really
18 brings together some of the conceptual things we
19 have talked about in a much more granular with
20 our two speakers, Robyn Golden, who I will
21 introduce in a moment, as well as our own Alice
22 Lind who will give us a sense of how a state is

1 handling the whole financial alignment.

2 After the presentation from Alice,
3 this moves to the afternoon session that I have
4 been alluding to relative to having some time
5 together about the strategic direction of this
6 particular Workgroup, given the fact that we have
7 heard all of this, we have gone through
8 measurement recommendations and all, just what is
9 our role? We have been having hints of
10 conversations of that that I would like to have a
11 chance to pull together.

12 So, also, let me just turn this over
13 for a moment to my Co-Chair Nancy.

14 CO-CHAIR HANRAHAN: I am going to be
15 leaving at 3:00. I have to catch a plane. But I
16 wanted to thank you all. So, I will just slip
17 out in the middle of everything, look forward to
18 seeing you again.

19 CO-CHAIR HANSEN: Thanks so much,
20 Nancy.

21 Okay. So, I have the delight and
22 pleasure of introducing, as some of you have kind

1 of picked up, I have known Robyn for a long time.
2 Robyn Golden serves as the Director of Population
3 Health and Aging at Rush University Medical
4 Center in Chicago, where she holds multiple
5 academic appointments at Rush in preventive
6 medicine, geriatric medicine, nursing,
7 psychiatry, and health systems management, as
8 well as the College of Nursing.

9 She is responsible for developing and
10 overseeing health promotion and disease
11 prevention, mental health, care coordination, and
12 transitional care services for older adults,
13 their family caregivers, and people with chronic
14 conditions.

15 She is the PI for the HRSA-funded
16 Geriatric Workforce Enhancement Program, and we
17 will bring up some of the workforce components
18 people have mentioned, as well as the
19 Commonwealth Fund Primary Care Redesign Project.

20 For over 25 years now, Robyn has been
21 actively involved in service provision, program
22 development, education, research, public policy,

1 public policy that, in particular, aims at
2 developing innovative initiatives and system
3 integration in order to improve the health and
4 well-being of older adults and their family.

5 She was honored to be a John Heinz
6 Senate Fellow back in 2003 and 2004 in the office
7 of Senator Hillary Rodham Clinton back in D.C.

8 Robyn is also the past Chair of the
9 American Society on Aging and currently co-chairs
10 the National Coalition on Care Coordination. She
11 is a Fellow of the Gerontological Society of
12 America and she holds a master's degree from the
13 School of Social Service Administration at the
14 University of Chicago.

15 So, Robyn, we look forward to your
16 discussion of field examples relative to care
17 coordination. One of the things that has been
18 discussed here is the use of terminology and how
19 many people have actually been doing the care,
20 like yourself, for decades, but there is
21 terminology. So, I think knowing who you are and
22 knowing your manner of presenting, I think you

1 will help us kind of unpack this and make this
2 much more tangible for us to hear.

3 So, we turn this over to you and
4 welcome you to our Committee.

5 MS. GOLDEN: Thank you, Jennie.

6 Can you hear me okay?

7 CO-CHAIR HANSEN: We can hear you
8 well. Thank you.

9 MS. GOLDEN: Okay. Great.

10 So, I am so sorry I am not there in
11 person, because I did listen in a little
12 yesterday morning to kick it off and, then, the
13 last hour. And I have to say the complexity of
14 what you are dealing with is quite impressive,
15 and I give you a lot of credit.

16 For those of you in the audience I
17 know -- thank you, Joan Zlotnik, for having me
18 invited today -- and for those of you who I do
19 not, I want to say hello to the people I know and
20 the people I don't, but I don't have a list of
21 who is there. So, maybe when you ask questions
22 later, you will say your name.

1 I cannot advance the slides, correct?

2 DR. MUKHERJEE: That's correct. But
3 if you say "Next," Janine will.

4 MS. GOLDEN: Next, Janine.

5 So, just to start off, I know you have
6 been talking about social determinants. So, I am
7 just reinforcing the importance of that. I feel
8 like we who have been trying to raise the social
9 determinant flag for years finally, you know, we
10 are having some traction, and it is exciting.

11 For good, bad, or indifferent, the new
12 innovations FOA that came out of the Innovation
13 Center at CMS is very much trying to bridge some
14 of what we have been talking about, the notion of
15 the hospital in the community in its new FOA. We
16 will see how that works. It is a tough one, but
17 it is exciting at least that I think more and
18 more people are addressing it.

19 You can see in this next slide -- I
20 think Jennie referred to this yesterday -- it is
21 a critical factor when you look at that 60
22 percent that is influencing the non-medical

1 adherence to care. The issues related to care
2 are expensive when we are not quite addressing
3 those as we should.

4 I just came -- this is the advantage
5 of being here, I guess -- I just came from a two-
6 hour meeting about health risk assessment. We
7 tried to come up with one across our Rush system,
8 inpatient and outpatient, and trying to look at
9 it as payer-agnostic, as we call it. But how I
10 had to raise the flag in that meeting about
11 social determinants. Yet again, trying to make
12 sure they are part of that health risk assessment
13 was still a little bit of an uphill battle for
14 that gang in the room. It was a very
15 interdisciplinary group, et cetera.

16 But I think there is still this push
17 toward the medical model when we are looking at
18 risk and health outcomes. I told them I was
19 going off to do this talk and maybe they should
20 tune in. No, I'm kidding. I will give it to
21 them later.

22 (Laughter.)

1 But, if we turn to the next page, I
2 think it reinforces that this is really our
3 blindspot in healthcare. We know that
4 psychosocial issues really have an impact on
5 health outcomes and cost. Yet, that person- and
6 family-center coordinated care with links to the
7 community are rare in most care models. Mental
8 health is often forgotten.

9 And there is that difference in
10 worlds, as you talked about, different language
11 in the hospital than the community. For me, I
12 have lived in both worlds. So, it is useful that
13 I consider myself, and I only hire people who
14 consider themselves, kind of bilingual and
15 bicultural in that way, that they know the
16 medical as well as the social-service-community-
17 based world.

18 So, there is this whole system of
19 community-based services out there which we often
20 ignore or, as you said earlier, we assume that
21 they are there. In some states they are
22 devolving as we speak, mine being one of them

1 where we still don't have a state budget a year
2 later.

3 I think someone mentioned the
4 psychosocial aspect of the social determinant
5 report from IOM, but there was another one in
6 2012 that talked to the past, to continuously
7 learning healthcare in America, recommended
8 community links, assessing those psychosocial
9 issues, delivering services in the community, and
10 communicating these issues with the medical team.

11 So, if we look at the next slide, it
12 basically does take that team, and that team
13 needs to incorporate lots of different people
14 from multi-sectors. This study that was done in
15 2011 is very interesting because people often,
16 particularly older adults and dually-eligible
17 people, they consult primary care most
18 comfortably. When social issues lead to physical
19 symptoms, that primary care may be the best haven
20 in which people hear about those social issues.

21 However, in the survey done in 2011,
22 there was a survey of 1,000 primary care

1 physicians, and that they did not have the time,
2 basically -- and I think that has probably even
3 gotten tightened, as some of the physicians in
4 the room would agree -- or sufficient staff to
5 address these social needs, such as access to
6 nutritious food, transportation assistance,
7 adequate housing, even though they knew that
8 those were important issues to address as medical
9 conditions. And that was a direct quote from the
10 report.

11 Four in five reported that they did
12 not feel confident in their capacity to meet
13 their patients' social needs, which they believe
14 impeded in the care, and that they weren't aware
15 of social services or community services around
16 them, four out of five.

17 Eighty-five percent of the primary
18 care docs surveyed believe that these unmet
19 social needs really did make a difference, but
20 they were always so concerned, too, about opening
21 a Pandora's box if they did raise some of these.

22 And then, I thought this was

1 interesting: that one out of seven, if they
2 could write a prescription for social determinant
3 issues, their prescriptions, one out of seven
4 would be for social determinant issues.

5 So, that is kind of what brings me to,
6 if we can look to the next slide, the whole
7 notion of care coordination. When we look at
8 care coordination, we have to look at it from the
9 person- and family-centered, as you have been
10 talking about, based on assessment of individual
11 preferences and strengths and their needs, and
12 focus on all of the aspects we have been talking
13 about, medical, social, behavioral, and to
14 integrate those health and social services. And
15 then, it is not always on the physician.

16 And that is what I want to talk about
17 today, is some programs we have developed on the
18 ground that kind of enhance healthcare and the
19 experience for the patient and probably make a
20 difference in terms of overall tripling kinds of
21 things.

22 If we go to the next slide, a lot of

1 what we based our work on was listening to our
2 patients, the voices of Rush patients. They
3 talked about, we have talked to thousands of
4 people, and many of the themes were the barriers
5 that were getting in the way to getting to
6 appointments. You know, people automatically
7 assume that patients sometimes don't come because
8 they are resistant or reluctant. And then, you
9 hear stories about grandma who is raising five
10 grandchildren because her daughter just went into
11 prison, and there is much more going on than we
12 just think a non-adherent patient. That is not
13 what is happening. They are real-life barriers
14 that get in the way.

15 And sometimes patients are afraid to
16 say the wrong things. They feel overwhelmed
17 about who to call. All of those kinds of voices
18 for us made us, if we could go to the next page,
19 kind of look at things more broadly.

20 I was brought to Rush almost 12 years
21 ago. It has been a great experience because,
22 basically, they wanted me to come and enhance

1 what was a strong geriatric program and to
2 provide not only community-based services, but
3 enhancements within the medical center to better
4 connect to the community.

5 And that is what we have done, kind of
6 that wraparound in a very traditional hospital,
7 sometimes a hospital that, as we say, Medicare
8 built. So, we are still very much in a fee-for-
9 service environment here, although crossing over
10 on that trend to value-based and alternative
11 payment mechanisms as well.

12 So, we are a hospital that is 664 beds
13 on the west side of Chicago. We have primary and
14 specialty care, and we have been ranked fairly
15 high in geriatrics over the years.

16 If we can go to the next slide, part
17 of what we established was our Health in Aging
18 Department.

19 Can you push to the next one? It
20 might be animated. I don't know if you can get
21 to that. There we go.

22 So, we have our transitional care area

1 that started, basically, because we heard from
2 discharge planners loud and clear that they never
3 knew what happened to people after they went
4 home. So, we did some pilots and recognized that
5 this was a big area. And this was even before
6 30-day re-admission reduction became a big thing.

7 And we talked to other transitional
8 care programs out there, as in Mary Naylor, Eric
9 Coleman, and really started raising this.
10 Because in our pilot we saw that social
11 determinants were part of the reason that people
12 were being re-admitted and not a lot was being
13 addressed in that area.

14 Then, I move over to the next box,
15 which I am going to get into more detail with,
16 the outpatient social work. So, we were really
17 focused on people going home and making sure they
18 get home in a safety net kind of way, but we also
19 wanted to make sure we were wrapping social
20 determiner, non-medical issues around primary
21 care to try to prevent people getting
22 hospitalized in the first place. So, we

1 developed social workers. We have social workers
2 wrapping around primary care.

3 And then, most recently, in the last
4 two years, our last box, we have gone into what
5 is a Medicaid ACO. That has been a really
6 interesting experience for us, to be a in RIF,
7 cost-savings kind of world, thinking about care
8 coordination and connection to community.

9 So, if we can go to the next one, I
10 will dig a little deeper in our transitional care
11 model, which is called the bridge model of
12 transitional care. It has been replicated in
13 about 65 sites across the country.

14 The bridge model helps patients
15 transition safely from an inpatient hospital
16 visit back to the community through intensive
17 care coordination/care management, integration of
18 psychotherapeutic techniques, motivational
19 interviewing, you name it.

20 As you see, the person is in the
21 middle. We call our social workers bridge care
22 coordinators, and they address not only overall

1 health issues, but they very much do a
2 bio/psychosocial assessment to try to understand
3 what is going on.

4 What we find is that the systems that
5 people are sent to very often upon discharge are
6 not responding, and it may be that the home
7 health agency doesn't come out because they
8 didn't get the right paperwork, or you name it.
9 It is amazing what happens, and there is no
10 fingerpointing involved. There is just a way
11 that we try to make sure that the patient and
12 caregiver are going home safely.

13 We both have bridge models set up
14 across the country where the hospital is coming
15 out to the community, the social workers starting
16 at the bedside, and then, following them into the
17 communities, sometimes telephonically, sometimes
18 in person.

19 But, equally, and even more so, we
20 have community-based agencies who have been
21 trained in the bridge model who go into hospitals
22 and provide this role as well. And they truly --

1 excuse the term -- are the bridge and they make
2 sure they understand both where the hospital
3 pressure is coming from as well as the community,
4 and try to make those connections.

5 So, if we could go to the next slide,
6 you just get a sense of all of what is going on
7 here. When our model works well, it works very
8 well. When there are little hiccups, we get all
9 those people on the phone together and, believe
10 it or not, have a 10-minute care coordination
11 call that has been shown to make an unbelievable
12 difference, even with our super-utilizers. Those
13 people who come to the hospital a lot that you
14 don't think you can make a difference with, it
15 has made a difference with those folks because we
16 finally get the primary care doc on the phone
17 with the hospital docs, with the aging network,
18 with the home health agency, with anyone who is
19 involved, to make sure everybody is on the same
20 page. The one flaw of our model is that we don't
21 necessarily get the patients and the family on
22 that call, which is something we are really

1 thinking about.

2 Just to the next slide, I want to show
3 you that there will be a JAGS, there is a study
4 that will be printed in the Journal of the
5 American Geriatric Society that talks about our
6 strengths, bridge strengths: that we have
7 repeated assessments, person-specific tailored
8 interviews, that we are well-suited to address
9 the transitional care needs of adults with
10 complex medical, behavioral, and social needs.

11 All along, this is a social-work-based
12 model, and no one has said social workers are
13 better at doing this. We have just said social
14 workers can do this transitional care work, too.
15 We are part of the team, and we can be part of
16 this and make a difference.

17 If you go to the next slide, you will
18 see we have made a difference in reductions in
19 re-admissions overall. We have done a randomized
20 controlled trial and, then, we have done this
21 other compared trial. We would like to test it
22 even more, but we have been viewed as an

1 evidence-based intervention by many different
2 sources over time, and we are excited about that.
3 It is a very replicable model.

4 So, let me go to the next piece, our
5 AIMS model, which is the Ambulatory Integration
6 of the Medical and Social, a mouthful, AIMS.
7 Again, it is using master's-level social workers
8 who are based out of an ambulatory setting. They
9 wrap around medical care by addressing these non-
10 medical needs that are making a difference in
11 people's lives.

12 We started this when we went for NCQA
13 certification many years ago and really helped
14 our practices meet that certification because of
15 the care coordination aspect and the connection
16 to team. So, it took a while. It was a bit of a
17 culture change, but I think we have gotten to the
18 point where many of the providers and the
19 practices know that they can't live without us.

20 Basically, the demand is greater than
21 our supply most of the time in terms of our
22 social workers to intervene. So, it is a good

1 thing. It is an exciting thing. And we are
2 trying to focus on targeting complexity, so we
3 know who to hone-in on, who we make the biggest
4 difference on.

5 If we look at the next piece, you will
6 see this is kind of the progression of what we do
7 in the AIMS model. Again, this has been
8 replicated in other sites around the country. We
9 engage the patient and the caregiver. We try to
10 develop a care plan involving the
11 interdisciplinary team. We provide telephonic
12 and in-person case management, when able. We
13 focus on goals. We try to narrow the goals, so
14 they are possible, smart goals.

15 And then, we care, as needed, in an
16 ongoing way based on whether or not people have
17 been able to self-manage. Patient empowerment is
18 a big part of this as well as resource linkage.

19 So, if we can go on, let me just show
20 you some of the impact of this. This was a pilot
21 study and we did show a difference in admissions.
22 Thirty-day re-admissions and ED visits were down

1 as a result of AIMS participants in a six-month
2 period. So, it was pretty amazing that that
3 touch -- and sometimes it is a very light
4 touch -- has made a difference in that way.

5 It is so interesting that the
6 Commonwealth Fund, based on a health affairs
7 article we wrote a few years ago, if we can go to
8 the next page, on social determinants and non-
9 medical issues approached us and have funded us
10 to study this model in a more rigorous manner.
11 So, we have been recognized by AHRQ as an
12 innovation model as well as been funded a lot by
13 the Weinberg Foundation to expand this model to
14 other sites in Illinois and Maryland.

15 So, we are excited, very excited, to
16 see the results of the Commonwealth Fund study,
17 which will be ending in April 2017, where we are
18 very much looking at the impact on patient's
19 health service utilization, outcome satisfaction
20 with healthcare service delivery, including
21 community-based organizations, and identify the
22 core aspects essential to the success of the

1 model.

2 Just our last, if I go to the next
3 slide, our last area has been really more in this
4 managed care ACO world around Medicaid. This is
5 really the Medicaid expansion stuff. As busy as
6 this slide looks, it is a metaphor for the
7 complexity of what we have gotten ourselves into
8 here.

9 But it is a challenge and an exciting
10 one. We are part of a group that is covering the
11 southeast side as well as the west side of
12 Chicago, and in partnership with two other
13 hospital systems as well as nine federally-
14 qualified health centers. We are connected via a
15 real-time portal. So, if someone shows up in an
16 emergency room in another hospital, I will be
17 signaled as the care manager.

18 And our care management team consists
19 of -- you can go to the next page -- consists of
20 a patient navigator, a care manager who is a
21 social worker, and an RN. These triads -- so,
22 this is different here -- these triads do

1 different things, but, basically, they manage a
2 panel of patients who have been labeled as more
3 high-risk, based on a health risk assessment.

4 What we are trying to do is help
5 people live differently and better, not just
6 drive down their health utilization and improve
7 their health outcomes, but very much looking at
8 them holistically and recognizing, again, food is
9 medicine; the shelter is medicine, all the social
10 determinant factors.

11 As you can see, the type of issues we
12 are dealing with has a lot to do with 34 percent
13 have transportation problems, difficulty paying
14 for medications, some mental health issues, high
15 mental health issues, a lot around substance
16 abuse. And many, 40 percent, need help getting
17 food, clothing, or housing.

18 So, you can see the nature of the
19 population very similar to what you are talking
20 about and how complex it is, but what we are
21 doing is really trying to use this triad notion
22 and figure out who in the triad is best to

1 coordinate the team efforts and when we need
2 everybody and when we don't, because we are
3 trying to be as effective and efficient as
4 possible.

5 You can see on the next slide we are
6 making a difference in terms of total cost-
7 of-care reductions, ACA, you know, the whole re-
8 admissions have been reduced, utilization, and
9 patient engagement, a higher patient engagement
10 compared to a non-orchestrated group of
11 comparable Medicaid folks who aren't part of the
12 medical home network.

13 So, let me just conclude with the next
14 slide, kind of finishing up. And then, we can
15 have some questions and answers.

16 What do we think it takes? We think
17 it takes prevention and wellness strategies,
18 innovative models, really thinking out of the box
19 or replicating what is there, attention to
20 multiple chronic conditions. I am constantly
21 pushed and pressured to look at one disease at a
22 time, and we fight that. We challenge that

1 because we know it is about multiple chronic
2 conditions.

3 We need the collaborative team-based
4 care with seasoned clinicians across disciplines
5 that have respect for one another. And we need
6 those community engagements and partnerships in a
7 formalized way where community agencies are not
8 just feeling dumped on, but part of the important
9 process and benefitting from the lack of capital
10 that they receive, the lack of investment in our
11 society as compared to some other international
12 folks who invest in social services in a
13 different way.

14 There has to be data-sharing between
15 health systems and the CBO. We had a situation
16 last week with a patient who has been in our
17 emergency room or the hospital next door's
18 emergency room, the University of Illinois, 70 --
19 seven zero -- times since January 1st. We
20 finally recognized it, which is scary in and of
21 itself that it took that long.

22 But we started talking through our

1 mechanism with University of Illinois, Chicago,
2 next door. And then, we found out there was a
3 community based agency, and this gentleman was
4 coming to our ED to get his anti-psychotic
5 medications. Well, we found out, after talking
6 to this community agency, that they actually
7 supply those medications. We thought he was
8 homeless and they were housing him.

9 So, all these disconnects about what
10 the reality was were very intense. We set up a
11 meeting with the CBO of a community-based
12 organization, and they cancelled that day because
13 they were fearful of talking to us because of
14 HIPAA violations. So, in that case, how do we
15 get through that in terms of teams of CBOs?

16 If we could go to the next slide, I
17 wanted to bring it just to how will we measure
18 this. I know you know this better than I, but I
19 think how do we make sure we measure what matters
20 to clients, patients, and families and the
21 customization of our service plans to priorities.
22 It is not just plug-and-chug with gold, and the

1 care plans cannot just be cut and pasted. How do
2 we think about comfort? How do we think about
3 the need for independence or interdependence,
4 financial controls?

5 These things are not largely captured
6 by measures. They certainly would make a
7 difference in the value of healthcare systems
8 when they are addressed in partnership with the
9 community.

10 And then, the next slide is just,
11 again, measuring what matters. You know this,
12 again, as well as I. And how do we align these
13 services and how do we make sure people have
14 confidence in the care system and that they
15 understand that the care system cuts across the
16 silos? And how do we look at measuring
17 efficiency and waste and dosage and targeting and
18 all those kinds of things?

19 So, to end on my last slide, it is
20 just kind of a little vision for all of us. In a
21 time of major changes to the healthcare delivery
22 and payment systems, connecting clinical work to

1 community partners and resources brings a sense
2 of renewal and hope to the challenges ahead.
3 Going beyond our clinical walls to solve complex
4 problems is a prescription for success.

5 So, on that note, I turn it back to
6 you. Hopefully, we can have a bit of a
7 discussion.

8 CO-CHAIR HANSEN: Thank you. Thank
9 you, Robyn, for really this extensive array of
10 work that you and your colleagues are doing at
11 Rush.

12 So, we will start with some questions
13 here. Tom? Tom Lutzow is a physician.

14 MEMBER LUTZOW: Yes, Robyn, I happen
15 to be from Milwaukee just north of you.

16 MS. GOLDEN: Oh, hi. How are you?

17 MEMBER LUTZOW: Good, good.

18 I have been using an image of Chicago,
19 whether fair or not, for a long time and it
20 derives from an article that I saw -- and I just
21 Googled it; it still exists -- that shows that
22 healthcare workers, home healthcare workers, as

1 they go to those high-rises are accompanied by
2 armed guards.

3 MS. GOLDEN: Uh-hum, uh-hum.

4 MEMBER LUTZOW: And I am wondering if
5 that is true or not. It was pictured in the
6 paper, and I have always kept that because, all
7 along when socioeconomic conditions were
8 dismissed as relevant to the healthcare system, I
9 always thought of those healthcare workers going
10 into those apartments with armed guards and
11 wondering, first of all, the fee schedule, did
12 the reimbursement cover those armed guards?

13 (Laughter.)

14 That was one thing.

15 MS. GOLDEN: Doubtful.

16 MEMBER LUTZOW: Yes. How do you miss
17 the implications of that when it comes to SES
18 determinants of health and the effectiveness of
19 healthcare based on poverty and other social
20 conditions, and so on?

21 MS. GOLDEN: No, it is a great
22 question, and it is hard to miss the degree of

1 violence we have in Chicago that you hear on the
2 news all the time as well. So, that adds that
3 factor, too.

4 You know, as someone who did home
5 visits for 25 years and never went in with an
6 armed guard, just learned to go in in the
7 morning, that it was safer than later in the day,
8 and learned those kinds of tricks of the trade
9 and to be smart and to watch what I was doing,
10 and I went into some not-such-great areas. But I
11 do think there are programs that --
12 unfortunately, we are a very segregated city.
13 So, we make assumptions about where the tougher
14 areas are, I don't know if good, bad, or
15 indifferent as a result. It is hard not to think
16 some of it is racial profiling.

17 But the result is that I am sure a lot
18 of places do go in as duos. So, they are not
19 going in alone per se. I know a lot of our
20 community health workers that come out of our
21 federally-qualified health centers go in pairs
22 until they get to know the situation, and those

1 kinds of things happen.

2 They probably do become friendly with
3 some of the guards that are associated with some
4 of our housing facilities that are in areas that
5 are a little tougher than others. That aside, I
6 am sure it does happen, but I don't think it
7 deters people from trying to at least go out
8 there. I don't know hear that much as the reason
9 an agency won't take on a case, for example.

10 MEMBER LUTZOW: I was going to follow
11 up by saying I think there is an area that may
12 deserve -- it is the no-show rate. I am sure you
13 have a high --

14 MS. GOLDEN: Uh-hum, absolutely.
15 Absolutely.

16 MEMBER LUTZOW: Think about the impact
17 of the no-show rate. First of all, the cost to
18 the system, the providers have staff at the
19 ready. They are being paid, and nobody is there
20 to receive the service. The individual who
21 should be receiving primary care misses it and
22 maybe even misses a test and misses other things.

1 And so, it has implications in that regard, too.

2 How do we solve for that?

3 MS. GOLDEN: Yes.

4 MEMBER LUTZOW: Is that a measurable
5 area?

6 MS. GOLDEN: Yes. It is a very
7 measurable area. We actually were just gathering
8 our no-show rate to make a case during budget
9 time to pay for transportation for people.
10 Absolutely, vouchers, you know, cab fare if
11 needed, developing a relationship with Uber
12 possibly or Lyft, being very creative.

13 Because what we hear and why so many
14 people use the emergency room so often as their
15 primary care site is because they can call 911
16 because they don't have the cab or the car fare
17 or the bus fare to get to the hospital for a
18 primary care visit.

19 When you discover these things, you do
20 have to wonder. So, the no-show rate is
21 something we do focus on. And all of our work,
22 post-hospital, in-between visits, is trying to

1 get people back to their medical home the next
2 time and avoiding any barriers.

3 I mean, we have social workers going
4 down the street and pushing people in a
5 wheelchair to get them to their visits because
6 they know what a difference it will make. And
7 that is part of the plan that they came up with
8 in their coordinating calls that they have with
9 the other providers.

10 So, we kind of do some magical things
11 to get people to those visits. But once you
12 figure out that the barriers are fixable, it
13 really does make a difference, and it helps the
14 providers to recognize, again, it is not just a
15 patient who is not compliant with your
16 recommendations, but there is something really
17 going on. So, you build the empathy by the
18 provider hearing what is going on from a
19 community-based person, from a direct-care
20 worker.

21 I mean, I once heard one of our
22 geriatricians say the best care coordination

1 system would be for the direct-care worker to
2 know what I am thinking and for me to know what
3 the direct-care worker who is spending 20 hours a
4 week in that older person's home or anyone's home
5 what they are thinking and seeing.

6 CO-CHAIR HANSEN: Thank you, Robyn.

7 Is there any other question directly
8 here? Gregg? Okay, yes? Oh, okay, Jim, why
9 don't you just go ahead? And then, we will have
10 Gregg Warshaw.

11 MEMBER DUNFORD: Okay. Thanks.

12 This is just terrific. This is the
13 area that I have spent the last 15 years in.
14 When you talked about the idea of an individual
15 who is has had 70 visits for anti-psychotics to
16 the emergency room without anybody actually
17 knowing about it until recently --

18 MS. GOLDEN: Isn't that amazing?

19 MEMBER DUNFORD: Well, it's not to me.

20 MS. GOLDEN: Yes.

21 MEMBER DUNFORD: As the City of San
22 Diego Medical Director, one of the things that we

1 have that a lot of communities don't have, and we
2 get back to the concept of the systemness of
3 things and measuring, is that there are data
4 sources that could have identified that person,
5 but are not tapped into.

6 And by that, I mean the emergency
7 medical services that are serving, let's say,
8 Chicago or in my case San Diego, we know that
9 patient probably went to the emergency room by
10 ambulance over half the time. When any one
11 hospital looks at their problems from an
12 emergency department, they are failing to
13 probably realize that that psychotic man probably
14 went to the three or four other emergency
15 departments, and the system is not surveilling
16 and looking for those people.

17 And so, on a population level, one of
18 the key things that I continue to emphasize is
19 the idea of using kind of untapped data. That
20 would include emergency medical services data to
21 identify your most expensive needy people.

22 This requires the collective impact

1 model in order to really approach these kinds of
2 people. It is something that we also at AHRQ are
3 certified on. The notion that you can actually
4 see those individuals that are collectively
5 impacting everybody, because they don't just cost
6 the hospitals, they cost Chicago police, fire,
7 EMS --

8 MS. GOLDEN: Yes.

9 MEMBER DUNFORD: -- incredible amounts
10 of money. And so, we lack systems that attempt
11 to assist all the other people that are
12 suffering. And I am literally talking about
13 enormous burnout rates now in firefighters and
14 police officers because of the lack of ability to
15 address these kinds of societal issues, and the
16 need to have some sort of orchestrated governance
17 approach that also helps to reward programs when
18 they try to help.

19 The best social workers probably in
20 Chicago, and I know in San Diego, the best street
21 social workers in my community are the police
22 department's homeless outreach team. And so, the

1 notion of going into communities to take care of
2 your most complex people inherently requires some
3 physical risk at times. I mean, the most
4 expensive 100 people in my community are in jail
5 about a third of the time.

6 So, looking at these novel community
7 partnerships and, also, creating models around
8 them with hospitals that are willing to kind of
9 partner, those are really atypical partnerships
10 when hospitals want to partner with police
11 offices and sheriffs and those kinds of folks,
12 but it is actually really essential to be able to
13 get to the solutions to some of these most
14 complicated people.

15 But congratulations. This is
16 terrific.

17 MS. GOLDEN: Yes, absolutely. I mean,
18 you know, if we had a global budget, I think we
19 could each other's feet to the fire a little more
20 in our world. That would help. But I absolutely
21 agree with you, more of a public health
22 perspective. You know, I kind of look at the

1 Camden Coalition as coming close to some of what
2 you are talking about, too.

3 MEMBER DUNFORD: Very much so, yes,
4 and I work closely with Jeff Brenner, exactly, on
5 this project.

6 MS. GOLDEN: Yes, absolutely.
7 Absolutely.

8 CO-CHAIR HANSEN: All right. Okay.
9 Gregg? Dr. Gregg Warshaw.

10 MEMBER WARSHAW: Hi, Robyn.

11 MS. GOLDEN: Hi, Gregg.

12 MEMBER WARSHAW: This is Gregg
13 Warshaw. Howdy.

14 MS. GOLDEN: Hi, Gregg. How are you
15 doing, Gregg?

16 MEMBER WARSHAW: I'm great, and I
17 appreciate your presentation. I have a comment,
18 then a question.

19 As you know, I'm just totally
20 dependent on my social workers supporters.

21 MS. GOLDEN: Uh-hum, you are.

22 MEMBER WARSHAW: And we have embedded

1 social workers in our offices. One of them is
2 just going to deliver a baby, and we are all
3 having withdrawal. All we have been wanting to
4 know is what her backup plans are. We don't want
5 to show up there one day without social work
6 support.

7 The question I had is in our system --
8 I am now in Chapel Hill at the University of
9 North Carolina.

10 MS. GOLDEN: I know. I know. You
11 left Ohio.

12 MEMBER WARSHAW: In our system we are
13 doing really a good job with social-work-led care
14 transition. Where I am seeing problems, being
15 relatively new there, is with the patients that
16 are discharged to SNFs. We are doing much better
17 with the people who are discharged home.

18 And I wondered in your bridge program
19 how you have succeeded with the SNFs. I find
20 that there is not continuity of medical care and
21 nursing care in the SNFs, and the social work
22 communication with the SNFs is not as effective

1 as with the community-based patients.

2 MS. GOLDEN: I am so glad you raised
3 that because that was a missing component in my
4 presentation. But we have this intensive
5 followup with not only SNFs, Gregg, but we have
6 problems with home health, too, sometimes. But
7 we have weekly phone calls with home health,
8 wherever our patients go, and most of the SNFs
9 where our patients go, to talk about who was
10 discharged that week, how they are doing, what is
11 the plan. Very much our bridge care coordinators
12 are part of those calls and part of those
13 connections to see what the next step will be,
14 because there is that disconnect, we know.

15 We try; we make a difference, I think.
16 The SNF re-admission rates have gone down as a
17 result. But, you know, part of the toughest
18 things with SNFs is we finally get something
19 going with a team there, and the teams change
20 very often in these facilities.

21 We try not to push people to certain
22 facilities in any way possible because they need

1 to have choice, but it is sometimes hard not to
2 have preferred providers because we know some
3 places are providing better care and attentive to
4 this care, and being discharged way too soon very
5 often, too.

6 So, we are on it. We are trying,
7 Gregg. We have made a difference in terms of re-
8 admission and I hope overall well-being, just by
9 constant communication.

10 MEMBER WARSHAW: Thanks.

11 CO-CHAIR HANSEN: Okay. Robyn, I
12 actually have a question relative to the issue of
13 privacy, communication, HIPAA being one cluster.

14 MS. GOLDEN: Yes.

15 CO-CHAIR HANSEN: What kind of
16 measures are you using for the study that you are
17 doing for the Commonwealth Fund?

18 And the other last item is I noticed
19 that your social workers may have kind of
20 advanced training on this. Have you talked about
21 a different combination of workforce, since I
22 know that it is a very small number, frankly, of

1 people who are going into social work are
2 necessarily focusing on complexity and aging.

3 MS. GOLDEN: Right. Well, let me take
4 the first question first, Jennie. We have a
5 whole battery. We have research assistants
6 wrapping around the social workers, doing a whole
7 battery of tests, anything from the patient
8 activation measure to the SF-12, Social Function
9 12, to depression scores. And then, we are very
10 deep into with our QIO knowing what the re-
11 admission rates, the healthcare utilization data
12 as well. We are also looking at caregiver
13 reaction and function and just, also, things like
14 Alc measures, just Alc; I don't think we are
15 looking at cholesterol. So, a fair amount of
16 measures both on the clinical side, the
17 healthcare utilization side, and then, social
18 determinant aspect.

19 On the other question -- it is so
20 interesting you mention this -- we very much view
21 this, because we have a lot of students that come
22 here to train and a lot of people who are

1 interested in these models, and we do a lot of
2 speaking on them. We have stuck to MSWs because
3 we believe they are the best ones to do this kind
4 of work. But we also want to look at social
5 workers with community health workers and, also,
6 try to figure out kind of who should do what,
7 like I mentioned. Should the nurse be the lead,
8 should the navigator, the CHW be the lead?
9 Should the social worker be the lead?

10 But we also are trying to incorporate
11 this kind of thinking in the future training with
12 the Council on Social Work Education and have
13 very much tried to look at these evidence-based
14 approaches, because there is evidence to all of
15 these now, as part of healthcare. As hard as it
16 sometimes is for social workers who believe, like
17 all of us, that maybe more of what they do is an
18 art rather than a science, trying to apply that
19 science throughout their training and after their
20 training, kind of in a retraining way,
21 particularly with thinking about the Affordable
22 Care Act, has been a real mission of ours.

1 And we are doing that a lot. We will
2 be doing that through our Geriatric Workforce
3 Enhancement Program as well, kind of pushing
4 these models forward.

5 CO-CHAIR HANSEN: Great. And how
6 about the issue of sharing information for this
7 coordination?

8 MS. GOLDEN: Oh, it's bad, yes. Well,
9 I feel as if, you know, short of getting
10 permission from the patient themselves that we
11 can talk to other places that were involved, you
12 know, I have a feeling community-based agents is
13 like this one example that I used. I feel like
14 their interpretation is a fairly strict one. And
15 how do we come to some understanding?

16 So, we are applying for that
17 innovation grant that I mentioned, and we are all
18 signing MOUs that will allow us to look like we
19 are entities very much working together.
20 Hopefully, we will be able to share and
21 communicate a little better than what we have
22 been able to do going forward.

1 So, it is a tough one, but so much of
2 it is different agencies' interpretations of it
3 or different hospitals' interpretation of it. I
4 know a lot of work being done at a fairly high
5 level, and I think it was mentioned maybe
6 yesterday, as to what is HIPAA and who has
7 created it and what does that mean in terms of
8 care everywhere.

9 CO-CHAIR HANSEN: Thank you.

10 I notice we have a couple of more tent
11 cards up. I just want to double-check.

12 Gregg, do you have yours up again?

13 Okay.

14 Aline? And then, Nancy.

15 MEMBER HOLMES: Hi. I'm Aline Holmes,
16 but I work at the New Jersey Hospital
17 Association. We have partnered a lot with Jeff
18 Brenner and the Camden Coalition.

19 MS. GOLDEN: Oh, great.

20 MEMBER HOLMES: And just something
21 that might be of interest. About a year ago, we
22 started in our HEN project, which we are one of

1 the CMS 17 HENs, around re-admissions, and we
2 were looking at south Jersey, specifically in the
3 Camden area. So, we ended up hiring about 20 ex-
4 military honorably-discharged veterans to be
5 partnered with nurses and social workers in the
6 community down there, and they were from those
7 communities. Many of them were bilingual.
8 Actually, of the 20 we hired, four had PhDs. So,
9 they are very well-educated, but they are very
10 much into that service mode and really wanting to
11 help their communities because that is part of
12 being in the military culture.

13 They have been very successful as far
14 as most-hard-to-access parts of Camden, which is,
15 arguably, the poorest city in the country and,
16 again, an area that has a high violence and
17 homicide rate. And we have been looking at those
18 data, too.

19 But, just as a thought, they are very
20 eager to serve. It has been a dream. Once they
21 get on something, they will not let go. I mean,
22 trying to find a house for somebody who is in a

1 homeless shelter who is a veteran, they will work
2 unbelievably to get that done. So, we have been
3 very successful.

4 MS. GOLDEN: What a great idea on so
5 many levels. Thank you.

6 MEMBER HOLMES: You're welcome.

7 CO-CHAIR HANRAHAN: So, Robyn, I
8 worked with Phyllis Solomon at Penn, and we did a
9 pilot study for people with serious mental
10 illness using a transitional care model. We
11 first went into the psychiatric hospital to
12 transition and found that the privacy acts were
13 so obstructionistic --

14 MS. GOLDEN: Oh, unbelievable.

15 CO-CHAIR HANRAHAN: -- for us going in
16 working with people. There are 13 hospitals in
17 Philadelphia, and we could get into the medical
18 hospitals and communicate with the medical
19 people, but we could not communicate with anybody
20 on the behavioral health side. And each of these
21 hospitals had their own privacy paperwork that
22 you had to deal with. So, it was really

1 obstructionistic.

2 The thing that we found out, though,
3 is that we really believe that a team that
4 transitions outside of the hospital that could be
5 embedded in the hospital and transition outside
6 of the hospital was a key to transition in care
7 for these very -- and most of them are dual-
8 eligibles or at least represent some of the more
9 complex care people that we work with.

10 And we found that a social worker, and
11 not just a registered nurse, but an advanced
12 practice nurse who could go out into the
13 communities post-hospital and actually work with
14 the medications, because it was very difficult to
15 access the physicians that were working directly
16 with patients they are office-bound; whereas, as
17 these nurses could go out and they had a direct
18 line in for communicating.

19 We didn't have them initiate
20 medication, but we had them alter the medication
21 if it seems appropriate, and often it did because
22 they would get into the homes and all the pill

1 bottles from every possible provider you can
2 imagine were all over the place. It was a mess.
3 And so, having an advanced practitioner I think
4 for this very highly-needy population is very
5 important.

6 The other part that we did is we added
7 in a peer support because engagement is a primary
8 problem. The peer support actually was a big
9 help for us getting into the homes and really
10 making sure that we were meeting the individuals'
11 needs as they perceived them versus our needs as
12 a provider, which is often commonly what happens.

13 So, we did find that the psychiatric
14 hospital transition just was too difficult, but
15 we moved into the medical surgical environment,
16 and we started to pick up people in the emergency
17 room.

18 MS. GOLDEN: Uh-hum.

19 CO-CHAIR HANRAHAN: And often, we
20 would divert admissions --

21 MS. GOLDEN: Absolutely.

22 CO-CHAIR HANRAHAN: -- by engaging

1 this team. But those that got into the
2 hospitals, as you all know, that are providers,
3 these medical surgical environments are rapid
4 turnover and they don't have the specialty
5 expertise to deal with somebody with
6 schizophrenia or bipolar disorder or behavioral
7 symptoms. So, we would be in the settings and
8 they would depend on us. And then, we would
9 transition the person out of the hospital.

10 MS. GOLDEN: Yes, it was the way you
11 resolved the HIPAA issue. That was great. It
12 was continuity of care and continuity of
13 communication.

14 CO-CHAIR HANRAHAN: Yes.

15 MS. GOLDEN: It is perfect.

16 CO-CHAIR HANRAHAN: Yes.

17 MS. GOLDEN: Great work. Thank you.

18 I mean, we have involved APNs and
19 pharmacists because, quite frankly, the
20 medication reconciliation cannot happen
21 telephonically for sure.

22 CO-CHAIR HANSEN: Okay. Well, thank

1 you so much for your time and your preparation of
2 your remarks, Robyn. I think it has been a great
3 exchange to kind of think about ultimately these
4 issues of linkages and different opportunities
5 that many of you have expressed of how we can
6 begin to work through it.

7 Our job collectively is to figure out
8 how do you measure accountability, quality, and
9 help shape the direction for this. But one major
10 overarching thing that we have been talking a lot
11 about that you just conversed on is this whole
12 issue of being able to communicate and
13 coordinate, given the kind of barriers that are
14 interpreted not only by HIPAA, but, Christine,
15 what was the CF --

16 MEMBER AGUIAR: It's 42 CFR Part 2.

17 CO-CHAIR HANSEN: So, things like
18 that.

19 MS. GOLDEN: Yes.

20 MEMBER DUNFORD: Jennie?

21 CO-CHAIR HANSEN: Yes? Sure, Jim.

22 MEMBER DUNFORD: Hi, this is Jim. May

1 I just add one last thing just for everybody to
2 keep on the horizon?

3 There is also another group of
4 healthcare providers that is loosely called the
5 community paramedic that is growing very rapidly
6 in the United States. These are specially-
7 trained paramedics that can fulfill a lot of the
8 roles that you were describing that veterans are
9 fulfilling, but they come with a much deeper
10 knowledge and medical background, and they are
11 connected and they are 24/7/365 in communities.

12 The Office of the National Coordinator
13 has taken a real interest in this, and the State
14 of California recently received the first grant,
15 a demonstration grant, which is going to be
16 happening here in southern California, to build a
17 bidirectional information exchange between
18 hospitals and HIEs, Regional Health Information
19 Exchanges, and EMS.

20 The entire EMS system of the United
21 States is rapidly moving to wireless cloud-based
22 systems. In fact, they are being mandated to do

1 so.

2 In my own community, 125,000 times a
3 year paramedics are in people's homes. They are
4 there and they have the opportunity to capture
5 things that nobody ever would know about until
6 they have the opportunity to push at two
7 hospitals. And so, there is a strong interest in
8 Regional Health Information Exchanges beginning
9 to share data with their EMS systems, and you
10 already see this in Indianapolis and other kinds
11 of pilot programs that are capturing these data
12 and informing.

13 For example, primary care physicians
14 in Indianapolis noticed 25 percent of the time
15 911 calls went without transport, but the
16 physicians had no ideas that their patients with
17 epilepsy or diabetes or repeated fall victims
18 were actually having these incidents occur. And
19 it wouldn't be until the patient suffered a
20 serious injury, broke their hip, that they
21 actually knew that the fire department had been
22 out there 15 times already to put the person back

1 to bed.

2 So, there again is this other really
3 unique opportunity for people to begin to look at
4 these new national EMS information systems that
5 are being built that are already in home and have
6 never really been tapped into until just the last
7 couple of years.

8 Thanks.

9 CO-CHAIR HANSEN: Oh, that is
10 fantastic new information. And it goes back to
11 this whole area of technology being a new area
12 that this group talked about.

13 So, one final comment. Aline?

14 MEMBER HOLMES: Hi, Jim. It is Aline
15 Homes again.

16 I just wanted to say, I mean, we have
17 a couple of areas in our State that have done
18 that, but the vast majority of pre-hospitals,
19 transportation to hospitals in New Jersey,
20 because we are a home rule state, is by voluntary
21 first aid squads. And so, we have little or no
22 control over them.

1 We have tried to engage the
2 paramedics, and some of the cities and the
3 hospitals have been able to do that, but that was
4 our issue upfront.

5 But I forgot to mention we do train
6 our veterans on -- they are all Certified
7 Application Counselors. They all go through the
8 Camden Coalition's Health Coach Model, which is
9 an Americorps-based program, and they all went
10 through training by the Mental Health Association
11 on mental health first aid.

12 CO-CHAIR HANSEN: Thank you, Aline.

13 All right. Robyn, thank you again for
14 your comments.

15 MS. GOLDEN: Thank you all.

16 CO-CHAIR HANSEN: Okay.

17 MS. GOLDEN: The best of luck. Thank
18 you. I would love to hear the results soon.

19 CO-CHAIR HANSEN: Okay. Just a few
20 years.

21 (Laughter.)

22 MS. GOLDEN: Take care. Bye-bye.

1 CO-CHAIR HANSEN: Take care. Bye-bye.

2 CO-CHAIR HANRAHAN: So, we are going
3 to move on to listen as Alice Lind talks about
4 the Washington Health Authority Financial
5 Alignment Demonstration. And I am going to turn
6 this to Debjani to introduce Alice.

7 DR. MUKHERJEE: I'm sure you all have
8 worked with Alice longer than I have. So, I
9 guess she needs no introduction.

10 Our former Chair, Alice Lind.

11 MEMBER LIND: Yes. So, when I
12 started, actually, when I was the former Chair at
13 the beginning of the MAP, I was working for the
14 Center for Health Care Strategies. That was my
15 "five-year" two-year sabbatical. It was on a
16 two-year leave of absence that stretched out from
17 the Washington State Medicaid Agency.

18 And now I'm back. Right after I got
19 back to Washington, the first demonstration of
20 the managed fee for service for dual-eligibles
21 program was implemented. So, I got back in 2013,
22 and right around the same time we started

1 enrolling clients.

2 So, it has been kind of a whirlwind,
3 I have to say, but it has been different being on
4 this side of the measurement experience. That is
5 what I will be mainly talking about today, not so
6 much the program, but I will start off just by
7 introducing the program a little bit.

8 So, the next slide. Who has slides?
9 Hi. The next slide.

10 (Laughter.)

11 So, the Managed Fee-for-Service
12 Demonstration, if you recall, when the demo
13 opportunity was put out by CMS, they allowed
14 states to either put in proposals for managed
15 care demonstrations or managed fee-for-service
16 demonstrations. Washington and Colorado were the
17 only two states that put in for managed fee-for-
18 service.

19 And so, when the question came up on
20 our webinar a few months ago about what is
21 happening on the managed fee-for-service side,
22 that is why I volunteered to just share a little

1 bit about it.

2 The way that we set about this was --
3 and this was when I was still at the Center for
4 Health Care Strategies -- is we provided some
5 technical assistance through CMS, Duals Office,
6 two states who were interested in putting
7 together demos. Washington went around the
8 State, met with clients, providers, advocates to
9 say, you know, in your role helping people who
10 are on both Medicare and Medicaid or in your role
11 as a family member supporting people who have
12 both Medicare and Medicaid, or as a dual
13 yourself, what could we do to help improve the
14 system and put kind of the building blocks
15 together from that?

16 And then, the legislature left it up
17 to counties to decide if they would want to
18 participate in more of a fee-for-service
19 demonstration or a managed care demo. And the
20 only two that stepped up to be managed care demos
21 were King County and Snohomish County, which are
22 actually two of the more populace counties. King

1 is certainly the most populace county in the
2 State where Seattle is, and Snohomish right north
3 of it. They volunteered to be capitated demos,
4 and we worked on that project for another year
5 after the managed fee-for-service demo went into
6 place.

7 By virtue of we just couldn't make the
8 cost equation work out for the health plans to
9 participate, that one fizzled, and the managed
10 fee-for-service demonstration, they are still
11 going strong. I say "strong," but you will hear
12 a couple of caveats to that, as we proceed.

13 In every county except King and
14 Snohomish, we are assigning to Health Homes now.
15 We started off with half the counties and, then,
16 three months later brought up the other half of
17 the counties, just for kind of ease of
18 implementation.

19 So, the next slide, Health Homes were
20 put out as an opportunity by CMS through the ACA.
21 There is a little section called Section 2703
22 that allowed states to pay for Health Home

1 services, and states could have done this in all
2 kinds of variety of ways. But any state who
3 created this Health Home opportunity through
4 their state plan amendment would get 90 percent
5 federal match. So, there was a big incentive for
6 states to put together a Health Home Program.

7 So, we combined this Health Home
8 opportunity with the duals opportunity to
9 convince the legislature that we could make the
10 math work. Otherwise, it might have been kind of
11 hard for us to sell and remained kind of hard to
12 sell through the life of the program, up until
13 just a few months ago.

14 You know, every state did this a
15 little bit differently. Some states kind of
16 certified Health Homes through like providers.
17 Like they would say to primary care medical home
18 groups, "We'll designate you as a Health Home,"
19 and just funnel money through them.

20 The way that we did it was to build a
21 network of care coordination organizations, and
22 we contract with kind of lead organizations.

1 Some of them are managed care organizations to
2 serve the folks who are not duals, but, then, in
3 the community we contract mainly through
4 community-based organizations that were formed
5 out of coalitions of AAAs or other kinds of CBOs.
6 They sort of in a couple of places sprung up just
7 to serve this population of duals. And then,
8 they, in turn, the Health Home leads provide care
9 coordination through contracts with CCOs or
10 themselves directly, if it is a AAA or a mental
11 health agency.

12 The kinds of things that are allowed
13 to bill under Health Home Model are care
14 transition assistance, care coordination,
15 comprehensive care management, assistance to
16 persons and their families for referrals, and
17 health promotion.

18 We put another kind of layer onto that
19 because of our experience in having run chronic
20 care management programs in the past, where we
21 also require this Health Action Plan. All of the
22 care coordinators have to use the same Health

1 Action Plan. They all have to do a certain set
2 of screenings and, then, create a person-centered
3 care plan that is very much based on what the
4 person wants to do themselves to help manage
5 their own chronic disease. And a hallmark of it
6 is how we integrate Medicare and Medicaid data
7 and make those datasets available to the care
8 coordinators.

9 Of the folks who qualify for the
10 program, we target the folks who are one-and-a-
11 half times the average risk of the Medicaid
12 population to be enrolled, and that is about 40
13 percent of our duals and 20 percent of non-dual
14 population. Out of that group, they become the
15 eligible Health Home population.

16 So, at the end of the day, about a
17 third of the clients we enroll are duals and
18 about two-thirds not. Most of the folks who are
19 not duals are enrolled through managed care
20 plans. Most of the folks who are duals are
21 enrolled through community-based organizations.

22 Because we have integrated data across

1 all the systems of care in the State, we know
2 that the overlap for service needs is about what
3 is shown here on this slide. Most of the folks
4 who are enrolled are eligible for some kind of
5 long-term care service, and a high proportion
6 have serious mental illness, and there are
7 smaller overlaps with people who have alcohol and
8 drug abuse or a substance use disorder or are
9 involved in the developmental disabilities
10 system.

11 Over time we have gradually gotten
12 almost all the eligibles enrolled into the Health
13 Home Program. Then, go to the next slide. A
14 smaller proportion are the folks who are actually
15 engaged.

16 So, this is a completely voluntary
17 program for clients. And so, as one of the
18 Health Home folks represented to me the other
19 day, it is like you are training these care
20 coordinators to be vacuum cleaner sales people.
21 They have to go like cold call these clients.
22 They have no idea that they have been enrolled in

1 the program. We send them letters, but most
2 people don't open the mail from the Medicaid
3 agency.

4 So, we send them a letter and say,
5 "Congratulations. You have a Health Home
6 Coordinator now," but they don't read the mail.
7 The next thing they know somebody is either
8 calling them or knocking on their door and
9 saying, "Hi. I would like you to participate in
10 this wonderful thing." And they are like, "Who
11 are you?", if they even pick up the phone.

12 So, they have to have a real
13 cheerleader kind of aspect to their work of, you
14 know, why we think that this can help you. The
15 engagement rate of 15 percent is much lower than
16 we were hoping for, and the community-based folks
17 who work with the duals, I think the peak that
18 they had gotten to towards fall of last year was
19 40 percent. So, we were very pleased with the
20 community-based folks.

21 On the managed care side, they had a
22 lot of different tools in the toolbox. So, they

1 can engage people through a chronic care
2 management program; they can engage people
3 through the physicians or nurse practitioners.
4 And if they hit 15 percent on this one particular
5 program, they feel like they are doing good. So,
6 I don't know if we will get much above that 15-
7 percent engagement.

8 So, next slide.

9 The successes that I am going to
10 outline next about where we have gotten to with
11 measurement, this is our Research and Data
12 Analysis folks. They call this a rising tide
13 floats all boats because the things that we have
14 been instilling in terms of having linkages in
15 the community between the folks who go out there
16 in person and deliver the Health Home service and
17 the medical system and their other providers has,
18 we think, produced the kind of communication that
19 needs to be in place regardless of whether folks
20 are in Health Home or not.

21 It has really reinforced the need for
22 good emergency department communication. So now,

1 all the health plans have real-time emergency
2 department notification when somebody comes in
3 the door of an ED.

4 And then, just having the access to
5 the integrated data has been really helpful, too,
6 so that they can actually see, when a care
7 coordinator gets engaged with a client, they can
8 pull up this system that shows all the
9 prescriptions that they have had and, then, the
10 gaps, all the times they have been intervened in
11 the ED, and then, the gaps of where they haven't
12 been seen for months at a time. And so, having
13 just the data in their hands has been really
14 valuable, too. Again, it helps whether the
15 client is engaged or not engaged.

16 This is the system that supports that
17 data integration. The guy who started it was not
18 a big fan of the theory that data shouldn't be
19 shared across the Department of Social and Health
20 Services. He had been told no several times when
21 he said, "Could I link this and this?", "Could I
22 link this and this?"

1 And then, one night -- you know, this
2 is a guy who is retired, and he told me this at
3 his retirement party -- one night he just like
4 went in the basement of DSHS and plugged all the
5 computers together. That was like the first
6 model many, many years ago of having an
7 integrated database.

8 And now, of course, it is all above
9 board and all the data use agreements are in
10 place. They have gone from beyond just the data
11 systems that support the services that are paid
12 for by state Medicaid and juvenile rehab, voc
13 rehab, et cetera. Now it is also tied to the
14 corrections database, the Washington State Patrol
15 database, the Department of Health for birth and
16 death records, et cetera. So, it is really quite
17 a rich source of information for care
18 coordinators to use.

19 The name of it is PRISM. This is just
20 a list of all the kinds of data sources, and the
21 data is refreshed on a weekly basis. Because we
22 got into the duals demonstration, we also now

1 have Medicare data, and that is quite an amazing
2 feat. It took a long time to get the data use
3 agreements in place. And now that they are in
4 place, having the data there available for people
5 to use has been quite wonderful.

6 So now, I am going to turn from the
7 kind of underpinnings of what we are doing to the
8 evaluation side. So, we have multiple layers of
9 Health Home evaluation in place. Because the
10 Health Home Program is not just a duals
11 demonstration, it is also authorized by Medicaid
12 under that 2703 rule, we have different ways that
13 the program is evaluated.

14 So, the first one is that CMS has
15 contracted out for an independent evaluation of
16 all the Health Home Programs for different cost
17 savings measures and quality measures that are
18 reported on by the state. The next layer in is
19 the dual-eligible demo demonstration. That
20 evaluation is being done by a different
21 contractor, based on measures collected by CMS
22 and, then, augmented by other data that we

1 supply.

2 And then, the third one, Part 2B, is
3 the shared savings calculation. That comes with
4 its own separate performance measures that we
5 report also to CMS.

6 So, the Health Home's evaluation that
7 is being conducted by the external CMS contractor
8 is only focused on the enrolled population.

9 Again, if you remember that slide that showed
10 only the little 15 percent of folks, they do not
11 look at the big, big population of eligible
12 people, but just the folks who have been
13 enrolled. They look at cost savings that we
14 report and they look at quality measures that we
15 report. We have been back and forth in
16 negotiation about those measures and what they
17 need and when it will go. That is due at the end
18 of this month.

19 The tricky thing about that is that
20 the Health Home measures were basically shared
21 with us as draft measures. Some of them overlap
22 with the duals demo measures, but not entirely.

1 Some of them are just a little bit one-off for
2 technical specifications from the duals
3 demonstration measures.

4 They were not given final technical
5 specs until last August. So, we were running the
6 program for two whole years before the Health
7 Home folks who do the oversight of that program,
8 not Venesa and her colleagues, but in a whole
9 different part of CMS, the Health Homes folks
10 gave us the technical specs two years after the
11 program had been up and running, which meant that
12 we couldn't kind of track along the way to see
13 are we doing well or poorly. How are we going to
14 look in comparison? Is there a benchmark? Can
15 we share anything with the Health Homes folks
16 about how they are doing or not doing? And so,
17 that has been quite the challenge.

18 Another expectation from CMS is that
19 the Health Homes themselves would be able to
20 submit this reports, kind of like the managed
21 care plans are expected to submit HEDIS reports.
22 But our Health Home providers are community-based

1 folks. They don't have claims data. They don't
2 have access to physician-level data. So, it is
3 not like they can actually create a measure of
4 like how well is the blood pressure controlled
5 and stuff like that.

6 So, what we are thinking of doing is
7 our creating the measures, sending them to the
8 Health Homes, and having the Health Homes send
9 them back to us, as ludicrous as that is, but
10 that is the only way we can figure out to meet
11 the requirements of the program.

12 This is a handful of the kinds of
13 measures that are required for the Health Home
14 project. The plan, all-cause re-admission in
15 patient utilization, ED visits, ambulatory care
16 sensitive hospital admissions, and care
17 transitions. The care transitions that we were
18 just talking about today, that is the survey
19 measure; we don't have access to those hospital
20 cap surveys or the care transition surveys. So,
21 that is not possible for us to do.

22 On the prevention side, adult body

1 mass index and, then, controlling high blood
2 pressure also would require us to have access to
3 either EMR data or actual patient records. And
4 so, that is also not possible for us to do.

5 And there is a set of behavioral
6 health measures. The screening for clinical
7 depression would be a great one because we have
8 embedded in our Health Action Plan all of the
9 care coordinators do screen for clinical
10 depression using the PHQ-9, but that is not
11 literally how that measure is written up in the
12 specs. You have to have a clinician do it and
13 document it in the clinical record, for example,
14 in a physician's office. So, that doesn't work
15 for us, either.

16 Follow-up for hospitalization for
17 mental illness is something that we can do just
18 using claims data, and initiation and engagement
19 of alcohol or other drug dependence treatment is
20 one that we follow for all of our populations.
21 And then, nursing facility utilization, we
22 already have some results on that.

1 So, that was part one, one layer of
2 the evaluation. Now on the dual-eligible CMS
3 evaluation, there is, as I said, a couple of
4 different ways that we are evaluating. The
5 external way that Research Triangle Institute is
6 doing for CMS focuses on the whole eligible
7 population. So, it doesn't really take into
8 account the fact that only 15 percent
9 participate. It focuses on all of those targeted
10 for the intervention. They report on many of the
11 same measures, but, again, some are similar and
12 some are different from the ways that they are
13 done by the Health Home evaluator.

14 And then, finally, we have shared
15 savings performance measures. These are used to
16 determine whether or not we will get shared
17 savings from this demonstration. Now again, we
18 could not have possibly offered this service.
19 You know, 1995 was the first time that we started
20 working on disease management for clients. This
21 program that came live in 2013 was the first
22 program since I have worked for Medicaid that we

1 have ever offered a service like this for dual-
2 eligibles.

3 The reason that we were able to do it
4 was because of the promise of shared savings.
5 Otherwise, it is like the Medicaid program
6 invests tons of money into something that is
7 going to save money from Medicare. There is not
8 a return on investment. If you are a state where
9 you are always trying to balance the budget, then
10 it is really difficult to make the case.

11 So, thanks to this program and the
12 promise of shared savings, we were able to sell
13 the program to the legislature. It is a very
14 complicated way that shared savings are
15 evaluated. There is a pre- and post-design.
16 CMS's contractor picked out comparison states.
17 None of the comparison states could be demo
18 states themselves. So, that rules out, you know,
19 how many, 15 maybe, Venesa?

20 And then, besides having to meet a
21 certain minimal savings threshold, then any
22 savings above that threshold would be divided

1 50/50 between Medicare and the state. And we
2 have to meet certain performance measures in
3 order to achieve that.

4 So, year one, we had a set of
5 performance measures that we reported in July of
6 2015 and, year two, those are due in 2016. For
7 the year two and following years, we will be
8 looking at benchmarks that CMS is choosing and we
9 will measure against those benchmarks.

10 So, here are the year one measures.
11 We are feeling pretty happy about these. The
12 plan, all-cause re-admission rate is a hair below
13 the 18-percent benchmark from CMS. ED visits,
14 also a hair below; ambulatory care; sensitive
15 hospital admissions, significantly below, and the
16 care transitions just started being measured in
17 year two.

18 There is a set of these process
19 measures that we chose, Health Action Plans being
20 completed within 90 days; training for care
21 coordinators, and the change in the patient
22 activation level. Those are the measures that we

1 knew that we would have access to electronic data
2 coming in. So, those are the ones that we had
3 picked.

4 We also have a handful in other areas
5 of prevention, behavioral health, and long-term
6 care. Again, some of these have not been
7 benchmarked yet. We know that followup after
8 hospitalization for mental illness is one where
9 we are doing very well, 78 percent in the
10 intervention group versus 60 percent without.
11 And in the long-term care side, we are just
12 following the percentage of people who receive
13 care in the community versus institution.

14 So, back up to two slides ago about
15 the savings, the thing that we found out in the
16 savings is that there was a new report that came
17 out from RTI in January of 2016 that points to a
18 savings, because of being able to hit these
19 measures, of \$21 million. So, back to the theory
20 of the rising tide lifts all boats, this is the
21 only explanation that makes sense to us as to how
22 we could have a 15-percent engagement rate and

1 \$21 million in savings. We are just going to say
2 thank you very much. It is being measured
3 against a trend, and we are going to hope for the
4 best.

5 There is a second step that still
6 needs to happen because that was based on seven
7 months of data claims runout, and CMS still needs
8 to evaluate was spending higher on the Medicaid
9 side. And if it was, then that gets taken out of
10 that savings. But the \$21 million savings, if we
11 get \$10 million back out of that, or even a
12 little bit less, it is certainly enough to
13 continue the program. And based on that, the
14 legislature has agreed to continue and actually
15 even expand into the last two counties.

16 So, this is just to highlight again
17 the differences in some of the measures across
18 Health Home and the duals program, just so you
19 see how very much important it is to have
20 endorsed measures. This is part of the course
21 for the duals program. Anything we can do to
22 convince the Health Home people to embrace the

1 same measures as the duals demo would certainly
2 be a help to those of us using Health Homes to
3 run programs for duals.

4 There are substantially different
5 definitions for these asterisked measures. The
6 plan, all-cause re-admission rate, the Health
7 Home version is an unweighted measure versus the
8 one that the duals demos use, which is the
9 weighted measure. Ambulatory care sensitive
10 hospital admission uses two different composites.
11 So, Health Home uses a composite of nine and the
12 duals demo uses a composite of twelve different
13 rates of admits.

14 On the ER side, it is completely
15 different definitions. The HEDIS measure is the
16 Health Home measure and, then, the duals demos
17 use the NYU Emergency Department definition,
18 which kind of follows a little algorithm and
19 makes a lot of sense to clinicians, too.

20 Screening for clinical depression and
21 the followup plan, one allows EHR data to be
22 used; the other one you have to use chart data.

1 The care transition record has two different
2 numerators, depending on if it is a Health Home
3 or the duals demo. And then, initiation of
4 alcohol or other drug dependency treatment, on
5 the one side it is initiation and engagement, and
6 on the other side it is just the initiation.

7 So, you can just kind of see the
8 frustration when you are out there living in the
9 state and you have multiple evaluators and all
10 from the same agency, and no blame at all on the
11 Duals Office, who has worked so tirelessly with
12 us to try to make sense of all this. But, you
13 know, everybody like the Home Health Program
14 people in their little bubble see things in their
15 own unique way, and it is not always possible to
16 bring all of those different interests together.
17 So, just another kind of underlying reason that
18 it is kind of difficult to manage all these
19 different datasets.

20 I talked about this yesterday, and I
21 promised not to talk about it again. So, you can
22 just skip through these little data. These are

1 just, among other sets of measures that we are
2 accountable for, we also have these that came out
3 of our legislature. So, you can skip past this
4 one and that one.

5 Here is the actual state evaluation.
6 So, besides all the other evaluations, we want to
7 see ourselves how we are doing. So, we have done
8 this pre-/post-evaluation from before to after
9 the Health Home Program started for duals.

10 Here is the increase in the patient
11 activation score, which is the way that we track
12 whether people are engaged in their own
13 healthcare; percentage of high-risk duals
14 receiving home- and community-based services,
15 another statistically-significant increase from
16 58 to 64 percent.

17 The number of emergency room visits
18 that were deemed non-emergent based on that NYU
19 algorithm dropped almost 10 percent, and
20 ambulatory care sensitive hospital admissions
21 also has decreased. And that is another
22 statistically-significant result.

1 Here is a kind of nice RTI finding of
2 how the hospital admission rate decreased. And
3 so, it is good to have that external validation
4 of that one measure. And then, the next one is
5 about the impact on skilled nursing facility
6 admits.

7 And so, again, we do our measures
8 ourselves, but it is very nice to have validation
9 from RTI that we can go back to the legislature
10 and say, "We are not cooking the books really.
11 We are showing an impact on these high-priority
12 measures."

13 So, I think that is it, right? Is
14 that my last? Oh, no.

15 The other thing that RTI did for us
16 was they released a focus group study. We have,
17 of course, you know, probably hundreds of these
18 kinds of stories. But, again, it was really nice
19 for RTI to be out there doing focus groups, and
20 this is the one from one client who said, "I was
21 shut up in my house for years. My windows were
22 drawn. I didn't have company. My house was

1 horrible. I'm completely off my psych
2 medications, and I was on a lot of them for many
3 years."

4 And then, since she got involved with
5 the Home Health Program, she says, "I go outside.
6 I interact with my neighbors. I go to church.
7 My cholesterol is down to normal." So, those
8 kinds of stories, of course, make the Health Home
9 care coordinators and all of us know that the
10 program is doing good for people in a way that
11 they, themselves, find valuable. So, that is
12 kind of the bottom line for us.

13 Thanks.

14 CO-CHAIR HANRAHAN: Go ahead, Tom.

15 MEMBER LUTZOW: Yes. Thank you.

16 You know by now that activation and
17 engagement have to be, in our view, a key piece
18 of the managed care formula. It is interesting,
19 the PAM tool has gone a long way toward figuring
20 out how to do that.

21 How did you implement that tool? I
22 mean, it requires patient education. It requires

1 a lot of work in the home, it seems, maybe not.

2 But how was that intervention delivered?

3 MEMBER LIND: So, in my mind, the
4 biggest downside of the patient activation
5 measure is it is a proprietary tool. So, we pay
6 a license fee for it and train the Health Home
7 care coordinators how to use it.

8 So, they deliver it in person in the
9 home and collect that score. And then, it is
10 delivered both to the folks who own the PAMs,
11 which is a company called Insignia. So, they
12 report it to Insignia and, then, they also report
13 it to us in the Health Action Plan. So, we get
14 an electronic version of it whenever they go out
15 and do the assessment, and they reassess it every
16 six months.

17 And I agree. I mean, I think it is a
18 really useful tool. We had a conversation with
19 NCQA about it last week, about whether it is a
20 useful enough thing that we can help sell it. I
21 mean, its real drawback is the proprietary
22 nature, and they collect a lot of data that they

1 don't share back with us, you know. So, that is
2 also kind of bothersome. I mean, I love the
3 tool, but we need to have a publicly-accessible
4 version of something like that.

5 CO-CHAIR HANRAHAN: Thank you, Alice.
6 That was terrific.

7 Kim, do you want to ask a question?

8 MEMBER RASK: A question: when you
9 were talking about all the different measures and
10 the conflict with the different definitions, just
11 out of curiosity, were they all NQF-endorsed
12 measures? As those measures came up, what input
13 do you think -- were people talking about whether
14 or not they should be using NQF-endorsed? Was
15 that even on the table?

16 MEMBER LIND: Well, I think part of
17 the problem is we were the only managed fee-for-
18 service demo when the measures were first on the
19 table on the Health Home side. And on the Health
20 Home side, there were 20 states, 22 states, that
21 were rolling out Health Homes. And so, we were
22 just like one little voice in that sea of people

1 in the Health Home Project saying, "Could we
2 please synchronize these measures?"

3 But which of them were endorsed I
4 couldn't swear to. I think probably some of them
5 were alternative measures that are also endorsed,
6 but I couldn't swear to which ones.

7 CO-CHAIR HANRAHAN: Venesa?

8 MS. DAY: Oh, I don't think I was
9 next, but I will go.

10 In terms of like how the measures end
11 up being not as aligned as we would want them to
12 be, because we worked a lot to try to get
13 measures that worked across all the programs, but
14 the duals program isn't a Health Homes Program.
15 So, it is not the base. When we started out, we
16 had about eight, nine states maybe. Washington
17 and a couple of other states selected Health
18 Homes. Another state that is still in, Colorado,
19 chose to use another platform that it has. It is
20 called RCCOs, and it is kind of like a PCCM
21 model.

22 So, what happened is we are measuring

1 at the demonstration level, at our program level.
2 The Health Homes are measuring at the Health Home
3 level, which would probably be ideal for
4 everybody. Like in my fantasy quality measuring
5 world, everybody would do it at the population
6 level. But, then, when you are doing a program
7 when you are trying to calculate the savings,
8 then, that doesn't help out a state like
9 Washington when they are trying to demonstrate
10 that they can save for this particular
11 population.

12 So, a lot of shenagling goes into what
13 comes out of all of this. When we started, we
14 started with the starter set that we got from
15 this group back in 2012. And so, we from there
16 said, okay, what makes sense? Who is collecting
17 what across our programs and inside of CMS? Were
18 the states collecting? What is it possible for
19 states to collect? And then, what is our MAP
20 telling us that it is important for states to
21 collect?

22 So, two measures, I think maybe three

1 measures that we ultimately selected are those
2 measures that the MAP told us are important, but
3 just right now they are kind of proving
4 impossible for states to collect for different
5 reasons, like Colorado just kind of isn't there.
6 They don't have the same data sophistication as
7 Washington does. But, then, the other side of
8 that is it takes a lot of resources to be able to
9 collect. I mean, I feel like I am telling people
10 who already know.

11 And we are very flexible about it.
12 Like we start with the NQF-endorsed measures.
13 But, by the time we make them right for our
14 program, they are a long way away from what the
15 original measure is, and so forth.

16 But it is not exact science at all.
17 I mean, I don't feel like we ever come out in a
18 good space for everybody on these.

19 CO-CHAIR HANRAHAN: Joan?

20 MEMBER ZLOTNIK: I was struck by some
21 parallels to some of the things that you
22 presented that Robyn had presented, like similar

1 use of evidence-based interventions, like
2 motivational interviewing and things like that.

3 So, I guess one of the questions I had
4 was related to the workforce and how the
5 workforce, because you are dealing across
6 multiple populations in what you are doing, what
7 strategies were used to make sure that the
8 workforce who were helping that woman who had
9 been shut in her house for years, or whatever, go
10 to church and get out, and things like that?

11 MEMBER LIND: So, the lead care
12 coordinator has to either be a nurse or a social
13 worker, but most of the teams also use a
14 community health worker or a health navigator or
15 a peer, depending on the individual. And so,
16 they deploy different members of the team for
17 different purposes.

18 Like that woman was saying how she was
19 a hoarder, there is a lot of that kind of
20 intervention that has to happen. Sometimes it is
21 just like a working with the landlord to make
22 sure that the heat works in the apartment or

1 working with the family to help get some of the
2 garbage out of the house, or whatever.

3 Sometimes it is some really normal
4 day-to-day kinds of things and having just a
5 community health worker help kind of get a bunch
6 of volunteer friends together to do that kind of
7 stuff is enough. And then, you can start working
8 on the health goals a couple of months later,
9 when the person feels good about it.

10 So, yes, they usually use a team, and
11 it is really there is a nursing shortage in
12 Washington. I don't know how widespread it is in
13 the country, but in Washington the nursing
14 shortage has really hit them hard lately for
15 trying to recruit.

16 MEMBER ROSS: I noticed the percent of
17 high-risk duals receiving home- and community-
18 based LTSS services is one of the duals measures.
19 And we learned before lunch that the Home- and
20 Community-Based Service Committee is going to be
21 examining Washington as one of its three states.

22 So, how does their examination of

1 home- and community-based service measures fit
2 into what you presented today?

3 MEMBER LIND: My hunch is probably
4 not, but I could be wrong. But the Health Home,
5 it is kind of funny, the folks who are
6 administering the Health Home Program, half of
7 the staff work for the long-term care
8 administration part of DSHS and half of us work
9 for the Medicaid medical side. We actually work
10 for a completely different agency.

11 And so, that little staff had been
12 part of the long-term services and support, and
13 they got moved to behavioral health. And now, it
14 is back in its little home again in the long-term
15 services and support world. But they are very
16 closely aligned and now they report to the same
17 boss.

18 So, it could start getting linked up
19 more. I mean, I know when I was on the outside
20 of Washington for those few years, when we did an
21 evaluation of Washington State and we said, "We
22 want to come in and do a site visit," there were

1 like 12 people around the table. So, I wouldn't
2 be surprised if NQF goes out to do a site visit
3 or even gets somebody on the phone to do an
4 inventory, that they would bring the Home Health
5 people into the call and they would certainly
6 involve a person who manages the people who
7 manage the program. So, it wouldn't be unheard
8 of that the knowledge gets transmitted across,
9 but it doesn't seem like a one-to-one, if you
10 know what I mean.

11 CO-CHAIR HANRAHAN: So, Tom, go ahead.

12 MEMBER LUTZOW: This comment focuses
13 on PRISM. I have a question to ask about PRISM.
14 Sometimes I get the feeling in our discussions
15 that the healthcare system is now being asked to
16 solve for poverty, and when we are successful at
17 that, we are going to be asked to solve for world
18 peace. In other words, the scope is increasing.

19 But, when you make the point that you
20 have got 15 percent engagement and save \$20
21 million, it sort of speaks to this issue that a
22 small incremental change, if well-targeted, has

1 tremendous impact. I mean, millions of dollars
2 worth of impact.

3 Part of the secret is having a
4 predictive modeling tool that gets you into that
5 space where you can make a difference. Some of
6 those costs, some of the costs for our patients'
7 end-of-life care, there is not a lot you can do,
8 palliative care kinds of things, but you can't
9 really change the course of events. Those costs
10 are going to be incurred.

11 Below that is a set of people where
12 interventions do make a difference if you get
13 there in the right time. And so, is that tool
14 PRISM a sweet-spot tool? I mean, prediction is
15 such an art. The number of false-positives,
16 false-negatives is huge, but where is PRISM on
17 that ability to get you in that space where you
18 can make -- yes?

19 MEMBER LIND: Well, you know, when we
20 first started using it, I think what the
21 statisticians in that group said is they thought
22 it could predict about 40 percent of the future

1 cost. And so, that means that you are missing a
2 lot and you are overguessing a lot.

3 The folks that were overpredicting I
4 think are the ones who don't get engaged, and the
5 ones who were underpredicting come through in
6 different ways. So, we have this other referral
7 pathway where a physician or a social worker or
8 an ER person could say, "Gosh, I don't know why
9 this person is not in the Health Home Program.
10 It seems like they could really benefit from it."
11 They fill out a clinical eligibility tool and
12 send it in, and then, first, it hits a staff
13 person who goes into the data and says, "Oh, yes,
14 it looks like the claims just haven't caught up
15 yet. So, let's go ahead and put them in."

16 And if that is not true, she brings it
17 to me and says, what do you think? Does this
18 person look like they would benefit? And so,
19 there is that other referral pathway.

20 But, yes, I am sure it's getting
21 there, but it's certainly not an exact science.
22 I think I have probably said this in this group

1 before, that Aetna's care management folks said
2 to me once that they thought one of the best
3 predictors of future utilization was stable
4 housing in the past 12 months, and that if you
5 just added that one question to a health risk
6 assessment, that you could pick up a huge
7 proportion of the people who are going to be
8 high-cost, high-needs people in the next year.

9 CO-CHAIR HANRAHAN: Christine?

10 MEMBER AGUIAR: So, I think the \$21
11 million in savings and the 15-percent engagement,
12 that is a huge finding. What worries me a little
13 bit is I hope that the state is not expecting
14 that to be achieved every year. I mean, I think
15 at some point you are going to sort of level off.
16 You can attack the low-hanging fruit and you
17 could right-size care and achieve savings.

18 So, it strikes me as -- and then you
19 have this great example from the focus group.
20 That really captures a lot of the beauty of these
21 programs.

22 I guess I have a two-part question.

1 One is, do you think that experience and that
2 improvement in quality of care is being currently
3 captured by any of the measures you are asked to
4 report either to the state or to CMS? And then,
5 do you think that if you start to see a decline
6 in the savings that the state will still be
7 committed to the program?

8 MEMBER LIND: So, we do participate in
9 the client survey. I think the first client
10 survey is going to come out in the next few
11 weeks, right? So, because we're a demo state, we
12 will have client survey results. Hopefully, that
13 will help answer that first question.

14 But, no, we almost lost the program
15 because, by the end of the second year of the
16 program, when we knew the 90-percent match was
17 going away, the legislature said, we just can't
18 keep floating this program on the hope that
19 savings will be achieved. They actually wrote
20 into last year's budget that the program would
21 end in December, two months, three months ago
22 December.

1 And so, we had a little bit of a
2 downturn in engagement as a result because the
3 staff started looking for other jobs, and
4 whatever. There is just not as much push, push,
5 push. It is hard to get the vacuum cleaner sales
6 people out there, you know, to knock on doors.

7 And so, no, if we don't keep on having
8 at least some level of savings, and all they are
9 asking for at this point is for us to break even,
10 if we don't have enough savings to break even,
11 the legislature would probably kill the program
12 again, which would be very sad.

13 CO-CHAIR HANRAHAN: Joan?

14 MEMBER ZLOTNIK: Yes, I just wanted to
15 kind of follow up on your comment about housing.
16 I actually have a conference call now that I am
17 not taking because I wanted to be part of this
18 discussion. So, I was glancing through the
19 slides and it said, Transitions of Care for
20 PCORI-Funded Project.

21 And one of the critical issues, they
22 have a follow-up protocol they are creating, and

1 one of the critical issues they have encountered
2 has been related to people with unstable housing.
3 So, it's just kind of a funny reinforcement for
4 the kinds of things that we're not capturing in
5 all of the more sort of medically-oriented
6 protocols.

7 CO-CHAIR HANRAHAN: I have a question
8 for you, Alice. I am thinking nuts and bolts
9 here. Who were the key figures in pulling this
10 off? What were the professional groups and non-
11 professional employees that really made this
12 work?

13 MEMBER LIND: Well, I mean, there is
14 certainly like different layers. I would say
15 that it couldn't have happened without the
16 particular leaders in the Medicaid agency and
17 DSHS. So, we were lucky enough to have -- I
18 mean, the person who sweet talked me into coming
19 back, MaryAnne Lindeblad, who is a nurse, a
20 master's, an NPA nurse, and then, Jane Beyer, who
21 was the head of DSHS at the time or the DSHS
22 section that was in charge of long-term care and

1 mental health at the time, those two women by
2 themselves I think probably sold it to the
3 legislature. Without them, I don't think it
4 could have happened.

5 But, then, in the community it was a
6 lot the AAAs. I know that the Health Home
7 community leads, at least one of them said the
8 other day that they lost \$250,000 in the first
9 six months of the program, and it took all of two
10 years for them to start making money on the
11 program, to start paying back.

12 So, the fact that the AAAs and the
13 county boards that kind of support -- the
14 community-based boards that support those AAAs,
15 they had to also support the program enough to
16 say, we're convinced that this is the right thing
17 to do and we are willing for you to take a loss
18 to get it off the ground.

19 Because, you know, even with the 90-
20 percent match, it's like we are not paying enough
21 to try to engage the 85 percent of people who say
22 no. You know what I mean? When you have a 15-

1 percent engagement rate, it means that you are
2 doing a tremendous amount of work that's not
3 being funded.

4 New York has done it a little
5 differently. New York kind of prepays for a few
6 months to try to get people engaged, and I guess
7 we could have employed that model if we had done
8 the math a little differently.

9 CO-CHAIR HANRAHAN: What about the
10 analytics? Because, clearly, you had to have
11 some really experienced people that could program
12 and do the analytics.

13 MEMBER LIND: Yes. So, the PRISM
14 system lives in the Research and Data Analysis
15 Division of DSHS, and there is a genius guy
16 there, David Mancuso. The only reason that he
17 lives in Washington and works for DSHS is because
18 he loves living in Washington. You know, he
19 would have been snapped up by a million different
20 people by now, but he lives on the water in the
21 nice little part of Thurston County.

22 So, yes, we're really lucky to have

1 that, too, like the infrastructure that connects
2 all the data and, then, a really genius guy with
3 a really good team of analytic people to support
4 us.

5 CO-CHAIR HANRAHAN: How about anybody
6 on the phone? Do you have questions?

7 Operator, is there anybody that would
8 like to contribute from the public?

9 OPERATOR: At this time, if you would
10 like to make a comment, please press *, then the
11 number 1.

12 (No response.)

13 And there are no public comments at
14 this time.

15 MEMBER DUNFORD: Hi. This is Jim one
16 last time.

17 I think this is my last meeting on the
18 committee. When I first met the current
19 presenter a number of years ago, I was just
20 struck with how powerful she was. Alice, just
21 congratulations on how far you continue to carry
22 the ball here. It is really impressive. So,

1 once again, seeing you no longer as chair of our
2 committee, but still as Honorary Chair,
3 congratulations.

4 MEMBER LIND: Thanks. I hope to keep
5 connected to you somehow, Jim.

6 CO-CHAIR HANRAHAN: Yes, I, too, want
7 to ditto that. It was a fabulous example of
8 where we could go and what we need to do. So,
9 congratulations. Thank you for doing that.

10 CO-CHAIR HANSEN: Do folks want to
11 take a 10-minute break? Okay. Why don't we do
12 that and come back at 3:00?

13 Thank you, Alice, for a great
14 presentation.

15 MS. ANDERSON: And for those of you on
16 the phone, we are going to take a 10-minute break
17 and come back at three o'clock.

18 (Whereupon, the above-entitled matter
19 went off the record at 2:51 p.m. and resumed at
20 3:01 p.m.)

21 CO-CHAIR HANSEN: Hi, everybody. I
22 know that people have travel plans and all. And

1 so, it was asked whether or not we are really
2 going to go until five o'clock. The answer is
3 no. So, I think that what we would like to do is
4 get started here. Let's set a goal of leaving by
5 4:00, okay, in terms of our moving ahead?

6 So, I am sorry that I have lost our
7 Co-Chair. Actually, Nancy and I met for the very
8 first time yesterday. So, we have only been on
9 the phone together.

10 But one of the things that we would
11 like to do is we have this opportunity to refresh
12 the committee. And so, as it turns out, when I
13 asked you all how many of you were new for this
14 particular in-person meeting, there were four of
15 you.

16 So, this last period is really kind of
17 summing-up what strategically some of the issues
18 that we heard that both are on the parking lot as
19 well as things that you all have felt strongly
20 about. Is it time to kind of say, you know, what
21 is it that our group, in particular, after these
22 two days, really can think about in terms of

1 moving ahead?

2 But, since we also have four new
3 people, I have actually asked each of them to
4 make a little bit of a comment about what brought
5 them to really choose to work on this MAP. Some
6 of you have had experiences in other MAPs. But
7 what were you hoping for by being a part of this
8 MAP group, in particular? And what were you
9 hoping to achieve by your participation broadly?
10 And then, how does that tie into the experience
11 that you've actually had with the content that we
12 have covered over the past day-and-a-half?

13 We hope to kind of listen, then, to
14 the whole group together, given the kinds of
15 themes that we will touch base on, a couple of
16 notes I have taken, but things that we put on the
17 parking lot, and see if we can weave together for
18 ourselves and for the staff to really think about
19 what should our biggest focus be, and are there
20 some low-hanging fruit that we need to do? Are
21 there some other areas we should design for even
22 our phone meetings that we could bring people in

1 on?

2 So, this is meant to be this last
3 particular session here. We'll have the operator
4 later on offer the opportunity for any public
5 comment. And then, we'll have a chance to close
6 the meeting. Janine will give us some logistical
7 instructions. And now that Debjani is going to
8 be one of our key staff people, she will have a
9 chance to have a couple of comments.

10 So, that is what I would like to do
11 for the next 55 minutes. Why don't I just kind
12 of start down the line and go this way? So, Kim,
13 I think you were one of our four newer people.

14 MEMBER RASK: I didn't know I was down
15 the line. I was looking further.

16 (Laughter.)

17 Thank you.

18 Why I was interested in joining this
19 group is I have spent a lot of my career
20 originally on the research side looking at
21 quality improvement, outcomes of measurement.
22 And as I moved to trying to work now more

1 practically with organizations that are trying to
2 measure quality, I have a real interest in being
3 able to measure quality for our more complex
4 members, beneficiaries, which dual-eligibles
5 truly fit.

6 I'm optimistic enough or naive enough
7 to still believe that there really can be good
8 quality measurement and that it's tricky and
9 there are a lot of different things we need to be
10 able to put into account, but that, ultimately,
11 if we really want to improve health and we really
12 want to improve health outcomes, we have to be
13 able to evaluate and measure what we do as
14 providers, as caregivers, as health plans, as
15 organizations that monitor quality. So, I think
16 that made this piece very interesting or made me
17 very interested in wanting to be a part of it.

18 Also, now that I work with the State
19 Medicaid Plan, I am kind of a consumer of NQF
20 measures. And I can't tell you how many times,
21 when people come to me and say, we're going to
22 monitor this and monitor that, I say, have you

1 looked to see is there a measure?"

2 And they Google it. So, everybody
3 googles. Well, I found this, Joe's measure, and
4 you are going to do this. I am like, no, I want
5 you to look at the NQF. Is there an endorsed
6 measure that gets at what we are trying to do?

7 When I do that, quite often, people
8 will go and look at the many measures that are
9 there, and they can't kind of get through to find
10 what they're looking for, what it relates. It
11 takes a somewhat sophisticated evaluator, not an
12 evaluator but a person to kind of go through all
13 the stuff and find out where the match is.

14 After having gone through yesterday
15 and today, I have a better understanding of why
16 and just how complicated this is. But part of
17 what I would love to see for this workgroup,
18 also, in addition to having a family of measures
19 that we highlight as being appropriate for the
20 dual-eligible community, to also slice and dice
21 them a little bit maybe, so that someone can do
22 like a quick search.

1 I'm looking for measures that would be
2 applicable to the dual-eligible community that
3 are only admin because all I have got is claims
4 data. Or I'm looking for measures that are
5 patient-reported. We are going to be doing a
6 survey, and I want to add some questions to it.
7 Or I'm looking for things that relate to dual-
8 eligibles, but I'm a hospital. So, I want to
9 know where the hospital-specific measures are.
10 Something like that, in addition to the domain,
11 that kind of would let people point to make it
12 more bite-sized piece of what you are looking
13 for.

14 And then, the other benefit I think to
15 doing that is it would help us as a group to say,
16 Uh-oh, here we are. Do you realize we don't have
17 a single home health measure that is patient-
18 reported or we don't have a single home health
19 measure that is admin, or something like that,
20 that it would help us identify gaps that we can,
21 then, put out there in a more digestible form for
22 other people who use this information.

1 CO-CHAIR HANSEN: Thank you. I think
2 your background as well as pragmatic ways to help
3 navigate and really find an easier human-centered
4 design to kind of glom onto something that gets
5 you going more quickly. Great. Thank you.

6 Thank you.

7 Michael?

8 MEMBER MONSON: So, it's kind of an
9 old axiom that what gets measured gets done, but
10 it's totally true. It's overused, but it's
11 totally true.

12 And so, from a reason of to join, you
13 know, I think when you think about how you are
14 going to make changes in the system that are
15 going to help improve the system and help people
16 lead better lives, if you don't get the measures
17 right, you are not going to get anywhere. I
18 think as we move more and more into a pay-for-
19 performance world, it is like measures on
20 steroids. And what it also means is that, if you
21 pick the wrong measures, you will incent the
22 wrong behaviors, and you will move down the wrong

1 path. So, that would be probably the main reason
2 that I personally was interested in joining and
3 we, as a company, are interested in being
4 involved as well.

5 And I would say that, from a strategic
6 viewpoint of where we would want to go next, I
7 would be really interested, especially as the
8 HCBS measures work comes out, broadening that to
9 actually all of LTSS because there will be
10 applicable measures from HCBS that will cross
11 over. I think there are some measures that may
12 not, that won't be on there, that we will need to
13 think about how we add those.

14 But, importantly is matching those
15 with the other measures we already have, because
16 those measures will largely reflect the Medicaid
17 measures, if you think about it from just the
18 system perspective.

19 CO-CHAIR HANSEN: Right.

20 MEMBER MONSON: And they'll represent,
21 you know, they are a different set of measures.
22 And I think the interactivity between the medical

1 and the social measures -- in fact, if I look at
2 the set we have today, it is largely a set of
3 medical measures, by the by, not that those
4 medical measures aren't indicative of quality of
5 life, as we all know. But I think mapping that
6 along with the social measures that are going to
7 come out of the HCBS work and, then, coming up
8 with the pairings that make sense, it actually
9 allows us to potentially think about what a
10 revised starter set could even look like, because
11 you would actually have the full picture.

12 It would be that, if you are going to
13 start measuring Measure A on the medical side,
14 then you also want to be measuring Z, Y, and X on
15 the social side, and vice versa. So, kind of
16 thinking about how the interactivity between them
17 would be very interesting.

18 CO-CHAIR HANSEN: Yes. Thank you.
19 Thank you, Michael.

20 Let's see. Thanks. Eliza?

21 MEMBER BANGIT: Hi. So, why am I
22 here? Primarily, it is driven by my involvement

1 to the NQF HCBS Quality Gaps Task Order.

2 And we talked heavily today and
3 yesterday about integration and care
4 coordination. I see my role really as sort of
5 like that liaison; talk about workgroup
6 coordination.

7 So, I would like to be able to not
8 only take things to this workgroup that we learn
9 from the HCBS Committee and provide you all with
10 updates, but I would certainly like to be able to
11 also create that bridge to the HCBS Committee
12 about the work that we all are doing here.

13 And what else would I like to achieve?
14 I am really learning from all of you. I am very
15 new to this area. So, I have learned
16 tremendously the last couple of days, and I am
17 sure I would learn a whole lot more in the
18 following months and years to come. So, I am
19 really thrilled about that and I look forward to
20 that.

21 My last observation really was that --
22 and this came out of one of the discussions, the

1 HCBS Committee in-person meeting, and that was a
2 few of our members indicated that there really
3 should be, that there is an important -- it's
4 really important to have an infrastructure in
5 place and to be able to make the infrastructure
6 and the systems that we have work better. And
7 that's why we have process measures.

8 But I am thrilled and glad to hear a
9 few of the conversations and the discussions here
10 the last couple of days that really emphasize and
11 underscore the need for outcome measures. So,
12 that, to me, I thought was one of the great sort
13 of outcomes in my participation the last couple
14 of days.

15 CO-CHAIR HANSEN: Great. Thanks so
16 much.

17 MEMBER HOLMES: And I want to thank
18 you, also, for all I have learned. I come out of
19 mostly the acute care hospital wing and that's
20 where I have practiced for years. But,
21 obviously, the hospitals across the country have
22 been inundated with metrics and measures. And it

1 was really to be here to have a better
2 understanding of how that comes about and how
3 those measures are developed and tested and
4 implemented. I think is just a wonderful
5 experience and, also, something that I can take
6 back to my colleagues.

7 We have a group of all the quality
8 people from all the state hospital associations.
9 So, that will be information that will be very
10 helpful for them as they move forward, because
11 this is certainly a big-time measurement.

12 I am also the Co-Director of the
13 Robert-Wood-Johnson-Foundation-funded New Jersey
14 Nursing Initiative, and with the Executive Dean
15 at Rutgers University. What we have been trying
16 to look at is how do we identify the competencies
17 of the nursing staff of the future, given where
18 healthcare is going, and how do we bring together
19 academia and practice together in our state to
20 really look at those competencies, identify them?
21 And how do we change or pilot different concepts
22 in the curriculum to achieve those?

1 So, this will be very helpful because,
2 when I go back to a lot of the faculty, they
3 really don't have an understanding of how these
4 kinds of measures are developed and how to use
5 them. So, we've been giving them practice
6 exercises, but I think it's been very
7 advantageous for us.

8 And then, lastly, I have personal
9 experience. I have two siblings who have been
10 dual-eligibles because of intellectual and
11 disease-related disabilities. And so, I really
12 do understand well the difficult path that it is,
13 and we have to make it better because it is an
14 impossible trip to navigate for our citizens and
15 our residents.

16 So, thank you very much for this.

17 CO-CHAIR HANSEN: Thank you. Offline
18 I will talk to you about a couple of nursing
19 resources for the school as well. Thank you.

20 Christine?

21 MEMBER AGUIAR: Thank you.

22 So, I wanted to be on the MAP because

1 working with our member plans around quality
2 measurement and stars, and how they can improve,
3 is one of the things that we do. I did not know
4 to expect, and I was very nervous because I am
5 not a measurement expert, and so I thank you all
6 for your expertise. I really appreciated that.
7 That was very helpful for me when we were
8 thinking through voting, particularly around the
9 clinical decisions.

10 In terms of the strategic direction,
11 you know, I think that NQF is really well-poised.
12 I understand you have the bread and butter that
13 you have to do, you know, nominating which
14 measures and having the family of measures. But
15 I think the group is also really well-poised to
16 be thinking about the future and where we want
17 population health and care delivery and Medicare
18 and Medicaid and social services and value-based
19 care, and all of that, going.

20 And quality measurement, it is a very
21 strong signal, more so as it keeps getting picked
22 up in the payment systems. And that's going to

1 be happening even more, not just in the big
2 Medicare and Medicaid payment systems, but in the
3 value-based contracting, that we are going to see
4 plans and ECOs doing.

5 And so, I think it would be
6 interesting if -- you know, I understand that
7 there are measures that don't exist and there are
8 gaps and things like that, but I think there is
9 also an opportunity for NQF to put information
10 out there about the importance of person-centered
11 care, the importance of care delivery across all
12 these systems and the gaps in that.

13 In a way to say that we would love to
14 measure it, but we can't because of all these
15 limitations, but here's where we think this field
16 should be going, I think that would be very
17 helpful.

18 CO-CHAIR HANSEN: Uh-hum. Thank you.

19 Thank you for those of you who are
20 joining us for this first meeting in person. And
21 for my seasoned colleagues here, you know, a
22 number of you have made some consistent points

1 that this committee should do. But I would love
2 to kind of have a chance to give people the
3 opportunity to say something directly now, as we
4 are doing some share. And that would be also, if
5 the two of you are still online in your
6 respective places, we would love to hear from you
7 as well.

8 So, let me just open it to see who is
9 willing to kind of say, strategically, let's
10 reemphasize some points that you have made before
11 that we can kind of do in this summation right
12 now.

13 Clarke?

14 MEMBER ROSS: So, I'm a father of a
15 25-year-old son with autism and co-occurring
16 disabilities, and he has trouble letting things
17 go.

18 And he must have inherited it from me
19 because I'm still frustrated with our discussion
20 of community integration right before lunch, when
21 we ignored the prior committee presentation on
22 home- and community-based services. The larger

1 issue is that there are multiple -- I think there
2 are like 35 committees and workgroups of the
3 National Quality Forum, and half a dozen of them
4 are directly related to this population.

5 We all operate in silos, and it is
6 easy as an outsider to see the silos. But all
7 the work that is done by one committee that does
8 not get translated -- you know, we had the 15-
9 minute or 20-minute presentation by Drew, which
10 was a good overview. But they've grappled for
11 two face-to-face meetings with community
12 integration. And yet, our discussion pretended
13 like that reference base wasn't there.

14 So, how do we integrate the Person-
15 and Family-Centered Committee focus on Medicaid
16 home- and community-based experience survey, and
17 how will we integrate the Home- and Community-
18 Based Services Committee? And you mentioned
19 population health. There is the framework for
20 population health.

21 And the MAP is not going to do this.
22 I mean, you look at the MAP, and Bernie Sanders

1 would say that's the establishment. I mean, they
2 are the big money, big powerful players,
3 hospitals, for-profit nursing homes, physician
4 groups.

5 And so, how do we meaningfully
6 integrate between the silos, so that we are
7 learning? I mean, I really don't want to have
8 another debate here from scratch on community
9 integration when the Home- and Community-Based
10 Services Committee has defined that. So, okay,
11 let's start with that, and we might want to
12 refine it, change it, edit it.

13 So, that is my frustration and
14 strategic challenge, is there's all this
15 exciting, really important stuff happening in all
16 these silos. And how do we meaningfully
17 integrate it into not only our work, but how do
18 we integrate our work into these other National
19 Quality Forum committees?

20 So, thank you for listening.

21 CO-CHAIR HANSEN: Sure. Thanks,
22 Clarke. I think that was part of the attempt,

1 and I have some calls in between any of our phone
2 calls with my staff colleagues here. And the
3 home- and community-based discussion, as well as
4 the population health, as well as the patient-
5 and family-centered, you know, how do we connect
6 that together?

7 So, I think you saw the home- and
8 community-based piece here, but there may be some
9 important need to kind of think about how our
10 Venn diagram comes together for some of these
11 areas that are relatively new for NQF. They have
12 not been the traditional.

13 You know, we are using the metaphor of
14 lifting this boulder, of a different way in
15 framing, and the conversation I had with Venesa
16 before she left, and she is also trying to do
17 this from her CMS side as well. So, there is a
18 way that that may be part of our strategic
19 discussion of how we try to do that.

20 And ideally, it's the time when we
21 have what I call face time, because the kind of
22 interactions we can do is just a lot easier when

1 these things are complex and there are nuances,
2 there are people's reactions that you don't hear
3 on the phone. So, I'm not saying we are going to
4 wait until next year, but I think that we take
5 next year's in-person meeting in a way that we
6 really think together how do we use the
7 preciousness of time that we have face-to-face,
8 and how much kind of prep work we will do in
9 advance personally and come ready to roll up our
10 sleeves and make a pie.

11 So, thank you. Thank you very much
12 for that.

13 Other people who want to make -- Tom?

14 MEMBER LUTZOW: Yes, I got here
15 because I stopped in one day to complain to the
16 National Quality Forum.

17 (Laughter.)

18 This is maybe three years ago when SES
19 was being ignored and people were saying it
20 didn't make a difference in health outcomes, and
21 so on. And so, I actually made an appointment
22 here and complained to the NQF that they weren't

1 sensitive enough to the impact of SES and it
2 wasn't reflective in their measurements, and so
3 on.

4 And I get an email a couple of days
5 later inviting me to sit on the MAP. So, I mean,
6 it just goes to show that.

7 But here I do have some concerns. I
8 have a sense that the measures that are promoted
9 by MAP are more successfully adopted in the
10 managed care environment than the fee-for-service
11 environment. And I am wondering if we should be
12 concerned about that. In other words, are we
13 working on a paradigm that doesn't fit well with
14 the fee-for-service environment and that we need
15 to consider the needs of that environment to
16 measure itself? So, it's just a question. I
17 think the adoption of NQF measures in the managed
18 care environment is just easier and maybe more
19 difficult. Why is that? Just a question.

20 I would also suggest that the NQF not
21 ignore the social service environment, even
22 though it is not CMS-funded directly. It is

1 indirectly in some cases through the Medicaid
2 program. And I want to say that, even if it
3 isn't funded by CMS directly or indirectly, NQF
4 has a bully pulpit that can influence how
5 privately-funded services are delivered.

6 For instance, where it says setting,
7 a nursing home facility integrated plan, there is
8 never social service setting daycare program.
9 Those kinds of settings are not mentioned. And
10 yet, don't we want to call them to be responsible
11 partners in the effective delivery of healthcare?

12 So, I had mentioned before daycare
13 programs, typically, very commonly dispense
14 medications. That's where those meds are
15 dispensed. They have a responsibility, then, for
16 adherence, it seems to me. And there should be a
17 standard of performance around that.

18 All of them, all of those social
19 service providers have a deep impact on no-shows.
20 They arrange for transportation. They should be
21 responsible to make sure that their group home
22 members and CBRF patients, and so on, get to see

1 primary care when those appointments are
2 scheduled. They're responsible for that.

3 So, is that something that NQF needs
4 to look at as part of the integration process?
5 Setting the standard, is that within the scope,
6 outside the scope? And what impact if NQF
7 decided, no, it is inside the scope, and even
8 though those services are privately-funded, we
9 want to have a say into how they are measured and
10 what their responsibilities are. Just a
11 question.

12 CO-CHAIR HANSEN: Uh-hum.

13 MEMBER LUTZOW: I think there is
14 something that sticks in my head and I think it
15 should stick in all of our heads. It was a
16 report, I believe this was the summer of 2014
17 where MedPAC came out and said, on this matter of
18 measures, CMS has lost its way. That was the
19 quote, lost its way.

20 And they didn't have in mind 50
21 measures or 600 measures or 900 measures. They
22 had in mind 11 measures. Are we measuring so

1 many things that we are really aiding and
2 abetting the lack of focus and the lack of real
3 impact? Just a question.

4 It would be interesting to bring NQF
5 here -- excuse me -- MedPAC here and ask them,
6 what did you mean by -- I mean, talk about
7 parsimony in the extreme, 11 measures compared to
8 what we have now, not just NQF measures, but all
9 the other sponsored measures.

10 What would Deming say about that? Is
11 that anyway to run a company? Do we have to take
12 another look at what our purpose is in focusing
13 energy, effort, impact, and intervention? I
14 don't think we're done with this story. I think
15 we're going to hear about it more. Maybe not
16 this generation, but the next generation is going
17 to have the question raised, are you really
18 making deep impact on the efficient use of
19 healthcare dollars? So, that consideration needs
20 to be thought through, I think.

21 CO-CHAIR HANSEN: Well, I think it's
22 been great. We have had Marcia sitting with us

1 these two days. Again, it was really something
2 nice to realize the commitment you have, as well
3 as the fact that, in view of your last point,
4 Tom, the fact that the NQF Board is looking
5 precisely at what's it all about.

6 And so, perhaps whatever you would
7 like to share, Marcia?

8 DR. WILSON: Yes, I would just like to
9 make a brief comment. So many of your comments
10 resonate with us here at NQF. And I will tell
11 you that last summer our Board of Directors
12 charged us with developing a strategic plan in
13 response to a lot of similar comments that we
14 have got.

15 You know, if you look at our database
16 of 600 measures, if that were a library, you
17 would say, yahoo, more books to check out. The
18 problem is it doesn't function like a library.
19 Somebody else is telling you what books to check
20 out, and they are all slightly different.

21 We heard the variation from -- you
22 know, Alice so eloquently talked about it in

1 Washington State, the incredible variation in all
2 the measures that have to be reported and all the
3 different programs. There are many reasons for
4 that. We won't solve that today.

5 But I just want you to know that, as
6 part of that strategic planning, we have been
7 looking at very much these same issues, which is,
8 one, how do you define those parsimonious
9 clusters of measures that are going to be most
10 meaningful in which situation? We talk a lot
11 about measures that matter. Matter to whom?

12 I can tell you, from sitting through
13 the HCBS Committee versus half a dozen other
14 committees here, there are very different
15 perspectives on which measures matter for what
16 purpose. And I think that's what we need to be
17 clear about, is to whom do these measures matter
18 and for what purpose are they going to be used.
19 So, we are looking at that.

20 And there was another comment someone
21 else made, and I am just lapsing on it. I'm
22 sorry.

1 But I want you to know the Board just
2 approved the strategic plan this past month, and
3 a lot of these issues are going to come up. And
4 it is also what I hear you saying, which
5 reinforces what we have been talking, is NQF
6 using their position to have a voice, to have an
7 opinion, to say, from all the experts that we
8 bring around the table, from what we have learned
9 from workgroups like this one and all the others,
10 here's what we're hearing, and thinking about how
11 we can use our influence, if you will, to help
12 move some of these things along.

13 Because, for us, a lot of this is out
14 of our purview. We don't develop measures, but
15 we sit here and identify gaps. So, what can we
16 do about that? What can we, as NQF, and you all,
17 as a workgroup or other committees, do about
18 helping -- kind of being a forcing function to
19 help people move in that direction?

20 So, I will pause there. It was
21 actually longer than I meant to take.

22 But, Charlie, do you have a specific

1 comment?

2 MEMBER LAKIN: Well, maybe it was sort
3 of what you just said. But my reaction to my
4 experience here has been that NQF just needs to
5 be a lot more proactive. It can't do what needs
6 to be done in a reactive mode. There are too
7 many gaps to fill. There are too many things out
8 there that are pretty good, but they are
9 narrowly-defined. If it's a good measure in a
10 rehab facility, is it a good measure that we can
11 extend to other populations? There is so much
12 out there that is being used that has so much
13 promise and so much being done.

14 There aren't incentives for people to
15 bring it to NQF. It's not going to add three
16 more states to the 30 states that are using it
17 right now. So, what can NQF do to go out and get
18 those things?

19 I think, too, there needs to be some
20 clarity in what we are talking about with regard
21 to measures and composites and instruments.
22 People are confused by that, and it is a

1 disincentive for them to even think about whether
2 this is a place for them to send their work.

3 And then, the other thing is I think
4 we settle for far too little in some of the areas
5 that we have created families around. I sat in
6 on the Care Coordination Subcommittee. You know,
7 in the last analysis, the measures within that
8 family are pretty much about timely transfer of
9 medical records. That is not care coordination.
10 That is timely transfer of medical records.
11 There is so much more to it.

12 And there is so much out there that is
13 being done to see whether people's service
14 brokers or case managers, or whatever, are
15 providing them the kind of support they need.
16 But, again, I don't know that it's going to get
17 here without somebody pulling it in. I would
18 love to have somebody just sit down and think
19 about the future of NQF, if it's going to attract
20 more of what we need.

21 DR. WILSON: We agree, completely
22 agree, and especially on the reactive versus the

1 proactive. What we are looking at through the
2 Strategic Plan is, where is it appropriate for us
3 to be proactive? What is the best use of our
4 expertise?

5 And I would agree with you,
6 historically, I have known NQF for a long time; I
7 have not worked here very long, and I always
8 thought they were a very reactive organization.
9 Measures were brought forward and the
10 organization would look at them.

11 I can tell you that mindset is
12 definitely changing. Culture is going to have to
13 change with it, which will be, as you all know,
14 more challenging. That is an understatement.

15 But I agree with you 100 percent. And
16 that is, as bits and pieces of this strategic
17 plan are rolled out, I think you will see that
18 very evident.

19 I would also charge you with telling
20 us the ways -- and we have already heard some of
21 this; I have taken some notes -- the ways in
22 which we can be proactive. How can we be most

1 helpful on pushing on those levers?

2 Someone mentioned it before. It costs
3 a boatload of money to develop a measure. This
4 is not a cheap enterprise. So, how can we help
5 bring this to the attention of the people with
6 the money, that have the money to fund the
7 measures? How can we work with people like the
8 government? I mean, the government right now,
9 sections of the government have some money for
10 measure development. We should be telling them
11 measures that we think are very important that
12 should be developed.

13 But we would welcome suggestions from
14 you of how we can be more proactive and help move
15 things forward. So, thank you for bringing that
16 up, Charlie.

17 CO-CHAIR HANSEN: Okay. We have
18 Christine as well as Joan. Perhaps one of the
19 things we'll do is we'll kind of summarize the
20 particular mark here, with your representing
21 essentially part of the leadership of NQF itself,
22 and for us as a committee on certain things.

1 Again, I think I hear the recurrence coming up.

2 So, Christine?

3 MEMBER AGUIAR: Just to respond to the
4 question that you posed, when I was saying my
5 comments earlier that I think NQF is really well-
6 positioned to drive policy and all the actors to
7 work together, I think of it almost as I guess
8 three things.

9 One thing is, do you know how CBO --
10 CBO scores the legislation. That is what they
11 do. But every now and then they come up with a
12 policy options document. And that is CBO going
13 outside of their bread and butter and thinking
14 about what policy should look like. And that is
15 not always associated with a cost, but they don't
16 usually score that.

17 So, I think something akin to that.
18 You know, what we do here is what we do every day
19 and, then, here is sort of where the field should
20 go, using quality measures as incentives.

21 The other thing, another opportunity,
22 I think, for NQF is, again, as I said before, you

1 have the payers. You have Medicare and Medicaid
2 and commercial payers that are looking at quality
3 for monitoring; also, quality for payment
4 incentives. But, then, you also have this push
5 towards value-based payments, so for individual
6 providers and health plans and ACOs.

7 And so, I think, actually, it would be
8 really helpful if NQF could say, of the measures
9 that we already have endorsed, they are not
10 trying to develop new measures -- you know,
11 health plans, the Medicare Advantage plans, plans
12 that take duals, plans for different populations
13 -- here is some you may want to use in your
14 value-based contracting. That, actually, I think
15 would be incredibly helpful.

16 I know our plans are organically
17 developing that. But to have NQF's blessing, if you
18 will, some measures for the use of value-based
19 purchasing I think would be very helpful.

20 CO-CHAIR HANSEN: Well, it seems like
21 your comment ties to Kim's comment as well. The
22 way to help facilitate the best use of

1 identifying because for most places you don't
2 have the specialists who are in measure
3 development to realize, you know, a boatload of
4 money goes into this one thing. But, then, how
5 do we use it? How do we test it? How do we have
6 reliability to these issues?

7 Having NQF perhaps evaluate this there
8 and use the CBO -- that's a fantastic thing. And
9 many of you may not know that Christine was a
10 MedPAC staff for many years, and her special
11 focus was dual-eligibles.

12 You know, we've got to use ourselves
13 amongst us for the kind of talent, experience,
14 and, frankly, the passion that you have in a way
15 to leverage this much more.

16 So, I think the proactiveness and
17 making things easier and useful. I think the
18 comment about are there 11 measures, you know, in
19 some way can they be aligned? After we hear your
20 presentation, Alice, to see just the time you
21 spend to kind of make it copacetic between these
22 things, is there a way that NQF can help take a

1 lead?

2 When you see excellent providers who
3 are struggling, is there a way to use them as
4 your positive deviant example to see is there a
5 different way to do this, to expedite that? You
6 know, hearing from you to the state, you know,
7 the state probably would pay attention, knowing
8 that the phone call is from NQF.

9 DR. WILSON: And I would just mention
10 CMS has given us funding to do a project which is
11 underway on measure variation. It is this exact
12 issue, looking at when NQF endorses a measure, it
13 goes out into the field and there is just
14 immediately 25 permutations, and then, it keeps
15 growing exponentially, it seems like. And we end
16 up with a situation where you have the same
17 measure. There is a slightly different
18 denominator. Okay, now I've got to collect it
19 two different ways.

20 So, this committee is looking at the
21 causes of variation and when is that a bad thing,
22 because, then, you can't compare. The measures

1 are too different. And when is variation
2 actually a good thing?

3 So, that's underway right now. They
4 just, I think held their -- yes, one of the first
5 reports is out. It's just going out for
6 commenting, but that is an ongoing one. I think
7 that is one contribution that NQF can make, is we
8 have an expertise in what we would call
9 measurement science, these cross-cutting issues
10 like variation or attribution. And that, I
11 think, is one place where we can make a
12 contribution.

13 CO-CHAIR HANSEN: Joan?

14 MEMBER ZLOTNIK: I guess one of the
15 things -- this is a great conversation, and I
16 think many of the suggestions people have are
17 really helpful. There are a few things that are
18 going through my mind.

19 One of them, you know, I keep thinking
20 about money follows the person. And it is sort
21 of like money follows the activity, and they get
22 very segmented because of that.

1 Part of it is thinking about
2 collaborations. There is a lot going on, for
3 instance, at the Patient-Centered Outcome
4 Research Institute related to different things
5 related to patient and family member engagement.
6 Are there things that could be learned or are
7 there ways that collaborations with PCORI could
8 help promote the use of measures, or vice versa,
9 help inform where there are gaps in measures?
10 Because there's a lot of the same conversations
11 going on in different places.

12 Another thing that comes to my mind is
13 how does a committee get constituted. So, you
14 went and complained to NQF and you got on the
15 committee. For this particular committee, NQF
16 came to NISW and said, we're having this
17 committee on dual-eligibles. We think social
18 work should be there. But, on care coordination,
19 it's a totally medical care coordination
20 conversation. So, it's very different. It's not
21 a stakeholder.

22 I think there are also issues about

1 language. There are some of the same acronyms.
2 You know, people talk about PRIDE. Well, there
3 is a child welfare training program called PRIDE,
4 you know, or different things.

5 So, making sure because it is such a
6 diverse audience of people just even sitting in
7 the room and on the phone, to make sure that
8 we're talking in a language that we all
9 understand because we're coming from different
10 places.

11 I think this has been, actually, a
12 really helpful meeting because it has been this
13 combination of people kind of focused on
14 population and quality of life and sort of
15 professional issues with people who are actually
16 using measures and really thinking about it. I
17 think that's been incredibly useful.

18 But really thinking about what gets
19 constituted, how much people who are sort of
20 members and sort of buying into NQF control
21 things versus how to have a broader view of this.
22 Just like in healthcare people are thinking,

1 well, we need to be more engaged with the social
2 service sector, the conversations that are going
3 on in the social service sector are about how we
4 need to have a more population health approach to
5 eliminating child fatalities from child abuse or
6 child welfare issues, or things like that.

7 So, there are some of these
8 commonalities. NQF itself is not going to solve
9 all those issues, but the places where there can
10 be synergy I think are really important.

11 And then, the other piece really kind
12 of goes back to some of the workforce issues.
13 Some of the things we've heard in some of these
14 presentations really has to do with what the
15 quality and capacity and knowledge is. You just
16 talked an effort going on in New Jersey. There
17 are similar efforts going on in social work. But
18 how do those workforce issues really play?

19 Rhonda Robinson Beale used to be on
20 the committee. She would bring that up, you
21 know, kind of from the beginning. So now, it's
22 four years later. Where does that fit into NQF's

1 thinking overall?

2 CO-CHAIR HANSEN: Thank you.

3 Michael?

4 MEMBER MONSON: One of the things I
5 think in the proactive vein that we could be
6 thinking about doing is, you know, dual-
7 eligibles, we say that word. There are 9 million
8 people that are dual-eligibles, and they are very
9 different. I mean, obviously, everyone is
10 different, but there are also very different
11 substrata and subpopulations.

12 A set of measures that may be
13 applicable to individuals with intellectual and
14 developmental disabilities may not be the same
15 set of measures that are appropriate to measure
16 for individuals with substance abuse or frail
17 elders or individuals under 65 with disabilities.

18 So, I think that there's an
19 opportunity for us to say, maybe again to think
20 about, if we already have our starter set, right,
21 maybe there is a starter set for the different
22 types of populations. And obviously, there is

1 danger around that. I acknowledge that. I
2 acknowledge that, as you put people into groups,
3 that not everyone fits into that group.

4 However, we have the same danger on
5 the flip. It is that we haven't recognized
6 anyone's differences right now. So, we have to
7 figure out how to balance that out.

8 But I think that there would be great
9 benefit to thinking about how do we account for
10 what would be the right set of measures for a
11 certain population and maybe even in certain use
12 cases, right? Because, right now, the measures
13 are very focused around setting as opposed to
14 people.

15 CO-CHAIR HANSEN: Uh-hum.

16 Yes, Marcia?

17 DR. WILSON: We just last week held
18 our population health meeting, and it was the
19 final in-person meeting of that project. I think
20 Debjani showed you the action guide that came out
21 of that.

22 But we were talking about next steps

1 where we could build on what that committee did.
2 That was kind of where we went, Michael, was we
3 called it like either a pyramid or a cascade of
4 measures because, you know, Tom, I think you were
5 talking about the core set of measures. You
6 know, you want to get to that parsimonious core
7 set of measures.

8 And I think at a certain level that's
9 a very attractive idea. But, then, when you come
10 down into different areas of care, then the
11 measures need to be supplemented or in some way
12 more detailed.

13 And now, Michael, you've just brought
14 up a really important point. It was, even within
15 duals, when you have all the different
16 populations -- and, Charlie, we saw this play out
17 in Home- and Community-Based Services. So many
18 times, at some point at some level, you want to
19 have a very specific set of measures that works
20 for your people, you know, the group for which
21 you are responsible. And we talked about at this
22 population health meeting, is there a way to

1 think about those measures that they could roll
2 up and roll down, where at the higher level you
3 are going to have a more aggregate, maybe more a
4 national or population-level picture, but, then,
5 you would have subsets of measures?

6 I used to work in another project and
7 we said all the time, national problems, local
8 solutions. So, there would be some of these
9 higher-level measures by which we, as a nation or
10 in a larger group, could have a sense of how we
11 are doing. But, for groups on the ground, there
12 needs to be a different set of measures. But can
13 we think about the ways in which those measures
14 might be aggregated and, then, disaggregated?
15 And maybe there is a national measure that is a
16 composite. There are several components. And
17 you are working in this particular area, which
18 actually goes up to that aggregate.

19 So, just a conversation we had just
20 literally last week in population health.

21 CO-CHAIR HANSEN: Okay. Clarke?

22 MEMBER ROSS: Yes, Michael's point

1 made me think maybe the staff should put together
2 a two-pager on what the workgroup and committees
3 have done previously. Because this is my fourth
4 year here. We have focused on four major
5 subpopulations. So, the focus on persons with
6 multiple chronic conditions was the fourth of
7 four. So, we went through this discussion in
8 2012 and 2013, and they may not have been the
9 right four groups, but the committee at the time
10 said these are four major cohorts. And we have
11 meetings dedicated to one of the cohorts and,
12 then, the next one.

13 So, there is an archive, and there are
14 all these reports submitted to CMS that address
15 three of the four cohorts. And you don't know
16 that. So, what meaning does it have in 2016 that
17 this work has been done and is it still relevant?
18 And you can't just say, read this 250-page
19 report. You have to say, here's a page-and-a-
20 half summary.

21 And so, that's something for all the
22 committees. It's more staff work, but I think it

1 is important.

2 MS. ANDERSON: Yes. Do you have any
3 further questions on that? Would you like me to
4 further describe the resources available? No?
5 Okay.

6 CO-CHAIR HANSEN: No. It is just that
7 -- and it was funny -- right now, she wrote me a
8 note. She is going to send you the report from
9 2014 relative to this.

10 But the idea of having a very tight
11 executive summary of a couple of pages would be
12 really helpful, so that people can look at this.

13 The other comment -- before I say, let
14 me ask our colleagues on the phone. Jim and
15 Mady, if you are there, would you like to ask or
16 add anything?

17 MEMBER CHALK: Yes, this is Mady. I'm
18 here; I have been here all day on the phone.

19 I wanted to echo a lot of what Clarke
20 said and what some other people have talked
21 about. That has to do with there are two issues.

22 One is integrating across the

1 different committees that have been set up by
2 NQF, Home- and Community-Based, Health Home.
3 What Alice was talking about, in effect, I
4 thought, is how much the linkages, when you talk
5 about local solutions, in every state, the
6 linkages across all of these different types of
7 measures for any particular population depend on
8 what is happening in a particular state, who is
9 in what agency, how are they working together,
10 how are they not.

11 In addition to details about how
12 measures get implemented, I would be very
13 interested in seeing what the committee that is
14 talking about variation and measure
15 implementation comes up with. Because, on the
16 one hand, of course, we want accountability from
17 the different sites, settings, and in relation to
18 the populations we are talking about. We want
19 accountability. On the other hand, we want to
20 learn more about the barriers to implementation
21 and what the variation is measuring.

22 I do think both frameworks from other

1 groups ought to be brought into the Dual-
2 Eligibles group, whether it is Population Health
3 or the HCBS. And I do think collaboration with
4 PCORI or other groups that are doing
5 accountability, a project on measurement, would
6 be very useful. PCORI is focused in a particular
7 way on patient-reported outcomes often, and that
8 has been less the focus in our Committee, despite
9 some of us talking about it a lot. So, I think
10 we are at a point where we really need not the
11 space so siloed.

12 And that is all I have to say.

13 CO-CHAIR HANSEN: Thank you, Mady. I
14 think you are helping to corroborate some of the
15 comments that were made, as you noted, and the
16 whole sense of crossover here for alignment.

17 Jim, do you have anything to add, if
18 you are on the call?

19 MEMBER DUNFORD: Hi, guys. I'm still
20 here.

21 And thank you. Again, it has been my
22 pleasure to kind of represent in some way the

1 voice of emergency medicine on the Committee for
2 the last four years.

3 I spent 35 years in a public safety
4 net emergency department here at the University
5 of California, San Diego. For a long time, I
6 thought I was the only guy seeing everything
7 broken in the world kind of flowing at me. But
8 that is really what you see when you are in an
9 emergency department. All the issues that we are
10 dealing with really flow through that final
11 common pathway.

12 I think it is important to keep that
13 in mind, that you can identify a lot of things
14 early on that are happening in the emergency
15 department. Even though they may begin out in
16 the skilled nursing homes, or wherever, they
17 finally come to the ED.

18 And one of the things that I would
19 hope that you guys would do would be to continue
20 to look at the evolving role of the emergency
21 department and new measures of quality that are
22 going to inevitably come. There is a very

1 significant and I think important move to move
2 people who require admission to the hospital to
3 home, where they would rather be. Particularly
4 for seniors, this is going to save billions of
5 dollars and make people happier.

6 And so, new measures of the safety and
7 the effectiveness, and whether or not people get
8 to have their wish to go home or not, are going
9 to be important things in the future. And so,
10 how you also get to the emergency department,
11 increasingly, it is an ambulance. That is why I
12 have felt that I wanted to bring the role of EMS
13 to the attention of people who may not have
14 really thought about emergency medical services
15 before as an important part of the healthcare
16 system. In fact, it is rapidly becoming so.

17 The third thing I think I just would
18 continue to emphasize is data and the technology.
19 Having been very involved in the development of
20 our Beacon Health Information System here in San
21 Diego, I am constantly reminded of what
22 meaningful use means. And it is all about the

1 duals. If you really think, the definition of
2 meaningful use of data is to improve safety,
3 efficiency, to reduce disparity, engage patients,
4 family, improve care coordination, population,
5 public health. It is everything that we are
6 talking about.

7 So, I think it is very important for
8 NQF to be keeping one finger on the pulse at all
9 times of the new technologies that are going to
10 be gathering these data and incorporating them
11 into health information, of looking at the new
12 streams of data, and then, kind of leveraging
13 those to be able to take advantage of this.

14 If you make the use of social data
15 meaningful use, people are incentivized and
16 tarnished if they don't use it. I think it is
17 kind of an important thing to keep in mind in
18 terms of how we actually really effect the things
19 that we are hoping to accomplish, is to continue
20 to kind of promote the meaningful use of the
21 kinds of data that we think are important.

22 Anyway, thanks again for having me.

1 I have felt like 99 percent of the time I was a
2 passive observer, but I sure learned a lot. And
3 I would encourage you to invite other people from
4 emergency medicine to come in, particularly young
5 people. I just turned 66 the other day, so I
6 don't know how meaningful I am anymore. But,
7 honestly, there is a tremendous array of young
8 people of all stripes and diversities who really
9 want to get engaged in this process. I don't
10 know; I think they are pretty much outside of it.

11 When I tried to explain to one of my
12 sons, a 32-year-old guy who is health navigator
13 here in San Diego working for 211 San Diego,
14 which is the largest aggregator of social
15 community-based organizations, nearly 6,000 -- he
16 is the lead health navigator. It is difficult
17 for him to really figure out how in the world
18 would I ever get involved in the National Quality
19 Forum, even though he is the No. 1 guy to try to
20 point people to services in our community.

21 So, I think that there needs to be a
22 way to kind of get a hold of this entire

1 generation of youthful people who are just
2 striving so hard to be able to make things
3 better, but they don't really know how to get
4 engaged.

5 So, anyway, thanks again.

6 CO-CHAIR HANSEN: Thank you for your
7 clarion voice and your fabulous examples that you
8 provide.

9 I think there is one more comment
10 before I close up.

11 MEMBER LUTZOW: Yes, I know I brought
12 up this 11-measure thing. I think that is maybe
13 so impossible.

14 (Laughter.)

15 What is possible, though, is a core
16 set that can spread across estates, and I will
17 use it in the French sense, spread across
18 physician groups and hospitals and nursing homes.
19 So, when there is a meeting, it is about how are
20 we going to solve this. It is not just your
21 problem; it is my problem, too. We are in the
22 same boat here. We have to solve this together.

1 Right now, I think a lot of the
2 quality programs that -- for instance, nursing
3 homes, they have a staffing ratio domain. I
4 think if a staffing ratio measure were brought to
5 this group, it would be dismissed as, "What is
6 this?" And I had nothing to do with the nursing
7 home staffing ratio; neither does the hospital;
8 neither does the physician.

9 I would like that nursing home to be
10 responsible for diabetes. It is a condition that
11 doesn't care what your disability is. It doesn't
12 care how old you are. It attacks kidneys. It
13 attacks the soft organs. It is a disease that
14 crosses boundaries. I would like the nursing
15 home industry to be as concerned about it as I
16 am. And when I meet with a doctor, I want him to
17 be as concerned about it as I am. I want him
18 measured on it, so that we are in this
19 conversation, how do we work together to deal
20 with it?

21 That is the value that the Common Core
22 would bring to the party. It would join the

1 party. And now, what we have is a little bit of
2 a fractured system. Everybody is pursuing their
3 own measures. They have their own set.

4 And this idea of could that core set
5 be recommended as the basis for value-based
6 contracting, I think that has got some potential.
7 CMS is on this bandwagon that they want all
8 contracts to be value-based. Well, yes, let's
9 get to that high-impact set that can make a real
10 difference in the quality of life and the cost of
11 care. And diabetes is a huge cost-driver.

12 I think we have 11 people -- excuse me
13 -- 100 people in our plan with diabetes as their
14 primary condition, each attached to another
15 comorbidity, that are driving about \$8 million a
16 year in cost. So, 100 people, it is huge, huge.

17 So, 11? You know, I don't know; maybe
18 somebody else's lifetime, not mine. But the
19 Common Core I think is possible.

20 CO-CHAIR HANSEN: Okay. Great.

21 I think that this has been a very rich
22 discussion. For those of you who are new, I hope

1 this was useful. For those of us who have been
2 around for a while and those of us leaving, the
3 ability to have some thoughts, given the
4 experience that you have had, having the
5 leadership here of a senior executive of NQF
6 sharing with us and spending the time, and the
7 fact that we would love to leverage this
8 organization. What is it that you can provide an
9 opportunity like no other system can do? And
10 using these elements that are about basics, but
11 maybe this is a transformational time.

12 Issues of diabetes affecting the
13 entire country, the ability to have voice and
14 shaping this, which is actually moving. Is there
15 a new way to begin to do this, so that when we
16 spend time on measurement or accountability for
17 performance and payment and for setting what the
18 best health might be, is there a different way
19 that we can do that together?

20 You all have expressed yourselves so
21 well. I think Debjani as well as Megan have been
22 keeping some notes. So, perhaps what we can do

1 is take a look at the summary of the meeting and
2 we can put it back out, and maybe we can kind of
3 organize it in a way that is focus for some of
4 the rest of our meetings for this year, and, you
5 know, rolling up to the future.

6 The final comment I have is what Jim
7 was saying on the phone: how do we construct a
8 strategic group? And he was saying be sure you
9 get an ER-type person. But it is a thought that
10 we have that perhaps would be guided by NQF as to
11 what we are trying to achieve that lines up
12 together.

13 So, it is good because we are glad you
14 are here, Tom, that you do that. But, like any
15 kind of leadership group, there should be a
16 strategy behind it. Who needs to be on the bus
17 for what period of time before we may need a
18 different kind of team member? And so, some
19 different thought about constructing committees
20 and all would be there.

21 With that, I have broken my promise to
22 you that we would be out of here by 4:00.

1 But I thank you for everybody's robust
2 participation at this meeting.

3 I really thank the staff who worked so
4 hard. I can't tell you how many times they have
5 wrung their hands over different things and all.

6 So, Janine has joined in the past
7 since October, is it?

8 And, Megan, any final comments to your
9 audience here?

10 MS. ANDERSON: Thank you all so very
11 much, again, for your input today and throughout
12 the years. Please keep in touch, and I know that
13 I will continue to use the experiences that I
14 learned here. And I am looking forward to
15 writing this report and getting your feedback.

16 And again, thank you to my colleagues
17 and our Co-Chairs and NQF leadership for their
18 guidance.

19 CO-CHAIR HANSEN: Thank you.

20 And, Debjani, you are going to be the
21 person who is going to help carry us, continue --

22 DR. MUKHERJEE: Yes, it is a daunting

1 task.

2 It was very nice meeting all of you
3 today, and I look forward to working with all of
4 you in the future.

5 And I would like to thank Megan for
6 all her work this year, and we will miss her, but
7 she is moving on to bigger and better things.
8 And we will always keep in touch. So,
9 congratulations and a fond farewell and good
10 luck.

11 CO-CHAIR HANSEN: Thank you.

12 And, Marcia, any last comments from
13 you?

14 DR. WILSON: No, just your feedback is
15 invaluable because, believe me, your voice is
16 being heard at NQF. That is all I can say. So,
17 thank you for your feedback.

18 You probably have my email address,
19 but any other comments you want to make, shoot me
20 an email. I welcome the input of this Committee.

21 CO-CHAIR HANSEN: Great. Thank you.

22 DR. WILSON: Thank you.

1 CO-CHAIR HANSEN: Safe travels,
2 everybody. Okay. See you on the phone.

3 (Laughter.)

4 (Whereupon, at 4:03 p.m., the meeting
5 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

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