NATIONAL QUALITY FORUM

Moderator: MAP Dual Eligible Beneficiaries
October 28, 2015
11:00 a.m. ET

OPERATOR: This is Conference #: 41145801

Welcome to the Measure Applications Partnership Dual Eligible Beneficiaries Workgroup Web Meeting. Please note that today's call is being recorded and all public lines will be muted during this broadcast.

Committee members, please note your lines will be open for the duration of today's call. Please be sure to use your mute button when you're not speaking or presenting. Please turn your computer speakers off and please do not place the call on hold.

If you need assistance at any time today, please press star zero and an operator will assist you. For technical support with the web portion of today's program, you may send an e-mail to nqf.commpartner@commpartners.com, or use the text chat box to send a message. The e-mail address will be displayed in the text chat box area throughout today's program.

Today's meeting will include specific question and comment periods. However, you can submit a question at any time during today's presentation using the web conference window. To do so, simply type your question into the text chat box area at the lower left corner of the window. Be sure to click Send to send your questions directly to our presenters.

During the designated public comment period, you will also have an opportunity to ask a live question over the phone by simply pressing star one. These instructions will be repeated later in the program.

I would like to draw your attention to the links area located to the right of the slide window. The links area contains links to the presentation slides and resource information relative to today's program.

Clicking on the links listed will open them in a separate web browser window and will not disrupt the presentation.

And now, it's my pleasure to welcome you to the program. Let's get started.

Jennie Chin Hansen: Well, thank you very much. This is Jennie Chin Hansen. I am the co-chair of the MAP Dual Eligible Beneficiaries Workgroup. And we're delighted to start this new year with the workgroup members as well as many of you who might be from the public who are part of this call.

Normally, we would have a co-chair, Nancy Hanrahan, who would be on the call with us. Regretfully, she has a family emergency, and therefore, she's not here today but she's certainly will be with us for our subsequent meetings.

I want to particularly call out Alice Lind, who I know is on the call, who has actually been our chair for a number of years and we're just so delighted, Alice, that you continue with us as a committee member.

So, I would like to just cover briefly what the essence of the meeting is and those of you who are looking at your slides can see that we're chock-full as usual. But, our key three areas that we're really trying to start with is, as we start this new year, we want to certainly welcome our new members to the workgroup and have a chance to review the MAP activities for this 2015-2016 year.

Secondly, we want the group to consider the impact of the multiple chronic conditions which will be shortcutting as MCC in our discussion, on our Dual Eligible Beneficiaries work which will become a larger emphasis as you'll see in the course of the call.

And then finally, from an area of identifying measurement priorities for this year and to review a potential tool for assessing quality in our dual eligible work with multiple chronic conditions, so that in essence will be that – the work (and field) the opportunities for comment as well.

And I also want to say very upfront, you know, these meetings are so full of substance and content and some of you may be thinking of some questions afterwards. You'll be guided at the end to write to us whether a particular e-mail as a different box perhaps emerged following the call.

So at this point from an area of administrative activity, I want to introduce Ann Hammersmith, who is the general council for NQF to assist us in completing our disclosures of interests.

So, Ann?

Ann Hammersmith: Thank you, Jennie. Today, as Jennie said, we're going to do the oral disclosure of interest. If you recall, you have received some forms from us. If you're an organizational member, it's an extremely brief form and a simple disclosure. If you are a subject matter expert, it is a more involved form. So, we will do the disclosures in groups and I will call on you.

Before we do that, let me just run through a few things for the organizational members who will disclose first.

As an organizational member, obviously, as the name of this group suggests, you are representing an organization, so we do expect you to come to the table with certain opinions and to represent the opinion in views of your organization.

In light of that, we have a much briefer disclosure for you. The only question you need to answer is, do you have an interest of $10,000 or more and something that comes before the committee.

I'll give you an example, for some reason, I always use the defibrillator example, I don't know why. Let's say, you own $100,000 of stock in a company whose main business is making defibrillators. There is something in front of the committee that would directly affect defibrillator companies. You should disclose that. And, recuse yourself from the discussion on that point.

So, with that, I'm going to call the names of the organizational members. And remember, the only thing we're looking for you to disclose is whether you have an interest, a personal interest, not your spouse, not your family, a personal interest of $10,000 or more and something that is before the committee.

So, I'll call your name, tell us who you're with and if you have anything you wish to disclose.

Susan Reinhard? Is Susan Reinhard on the phone? Gregg Warshaw? Is Gregg Warshaw on the phone? Gwendolen Buhr? Is Gwendolen Buhr on the phone? Christine Aguiar?

Christine Aguiar: Yes, this is Christine with the Association for Community Affiliated Plans and I don't have anything to disclose.

Ann Hammersmith: Thank you. Michael Monson?

Michael Monson: Hi. This is Michael Monson with Centene and I don't have anything to disclose.

Ann Hammersmith: Thank you. Clarke Ross?

Clarke Ross: Hi. This is Clarke Ross. I've nothing to disclose. I'm employed by the American Association on Health and Disability. I represent on this workgroup the National Consortium for Citizens with Disabilities Coalition.

Ann Hammersmith: OK. Thank you. Cheryl Irmiter?

Cheryl Irmiter: This is Cheryl Irmiter and I'm with Easter Seals Inc. and I have nothing to disclose.

Ann Hammersmith: Thank you. Jette Hogenmiller?

Jette Hogenmiller: Excellent in Danish. It is indeed Jette and my American-French is the word Jette Hogenmiller. And I'm with Homewatch CareGivers and nothing to disclose.

Ann Hammersmith: Thank you. George Andrews?

George Andrews: Hello. George Andrews, Humana's Corporate Chief of Quality, nothing to disclose.

Ann Hammersmith: Thank you. I'll probably mangle this name, Thomas Lutzow?

Thomas Lutzow: Yes, Tom Lutzow with iCare and nothing to disclose.

Ann Hammersmith: Thank you. Alice Lind?

Alice Lind: Hi. This is Alice employed by Washington State Medicaid Program, and representing the National Association of Medicaid Directors and I have nothing to disclose.

Ann Hammersmith: Thank you. Joan Zlotnik?

Joan Zlotnik: Hi. This is Joan Zlotnik. I am a consultant to the National Association of Social Workers and I have nothing to disclose.

Ann Hammersmith: OK. Aline Holmes?

Aline Holmes: Hi. I'm Aline Holmes, I'm the senior vice president at the New Jersey Hospital Association. I have nothing to disclose.

Ann Hammersmith: OK. Thank you.

Now, we'll move onto the subject matter experts. The subject matter experts, unlike the organizational members, set as individuals. You're on the committee because of your expertise in this area. Because of that, we sent you a more complicated form as we're more interested in your activity and how it may affects the work on the committee.

So, please don’t disclose your resume but we are looking for you to disclose professional activities, research, grants, consulting, speaking, engagements and so on that are relevant to the committee's work, only if it's relevant to the committee's work.

Just because you disclose does not mean that you have a conflict. The part of the point of this exercise is to encourage openness and transparency, and increase the likelihood that people will understand where you are coming from.

Again, want to remind you set as an individual, you do not represent your employer's interest nor do you represent the interest of any organization that may have nominated you for this committee.

So let's start with the chair, Jennie Chin Hansen.

Jennie Chin Hansen: No disclosures.

Ann Hammersmith: OK. Mady Chalk?

Mady Chalk: No disclosures. I work for the Treatment Research Institute in the area of addiction research and the policy development.

Ann Hammersmith: OK. Thank you. James Dunford? Is James Dunford on the line?

Jennie Chin Hansen: He sent an e-mail that he could not make the call.

Ann Hammersmith: OK, thank you. Charlie Lakin?

Charlie Lakin: Hi. I'm a consultant to the new Research and Training Center on Home and Community-Based Services quality measurement funded by NIDILRR. Other than that, no disclosures.

Ann Hammersmith: OK, thank you. Ann Lawthers? Is Ann Lawthers on the line? Ruth Perry? Is Ruth Perry on the line? Kimberly Rask?

Kimberly Rask: Hi, this is Kimberly Rask. And I am employed by Emory University and by Alliant Health Solutions. And Alliant has contracts with several states doing Medicaid utilization review and medical management review services.

Ann Hammersmith: OK, thank you. Gail Stuart?

Gail Stuart: Hi. I have no conflict and I'm at the Medical University of South Carolina College of Nursing.

Ann Hammersmith: OK, thank you.

At this time, I'd like invite our Federal Government participants to introduce themselves. You do not need to disclose. Jamie Kendall.

Jamie Kendall: Good morning, everyone. It's Jamie Kendall from the Administration for Community Living. Glad to be here.

Ann Hammersmith: Thank you. Venesa Day?

Venesa Day: Good morning, everyone. Venesa Day from Medicare Medicaid Coordination Office. Just want to give a quick thank you and welcome to the MAP. Your work is really kind of our toolbox that we use consistently and diligently to navigate within the broader world of HSS and CMS measurement.

And so, thank you for your important work. And, if I may, I just want to take a second to give – let you know a couple of the ways your work has impacted what we do on a daily basis and to give you some good news, I think, about a contract vehicle that we announced.

So, more and more, as we say every time, we're able to use your input and build toward creating a system that reports on and provides better care for duals. And so, as you may be paying attention to, we are, of course, continuing to test measures from the July 2012 starter set, from way back when that you guys gave us this kind of beginning and we test those measures through our demonstrations.

And so, we are constantly evaluating and ensuring that their value – the measures that we select as our core set is – that the value of those measures is maintained and monitored through the integrated model for our duals.

In addition, we're using your work to inform some recommendations for comparative analysis work being done to assess differences and provide a performance for some key indicators across populations and programs in states. And so, we're pretty excited about that work that's currently under development.

And then finally, we're pretty pleased to announce that we have awarded a new contract to support quality measures development for programs serving Medicare and Medicaid enrollees and adult Medicaid enrollees.

So, we are working with the Medicaid IIP as well as the disabled and – I'm sorry, I'm going to say it wrong, DEHPG, Disabled and Elderly Health Programs Group, to put together a contract that is pretty significant in cross-cutting and helps us be able to get to all those or not maybe – maybe not all of the gap areas but certainly helps us to do some work in the gap area that you guys have pointed out for us and pointed to over the past few years.

So, we really appreciate your work in helping us get to that point. And we look forward to working with you moving forward so that we can actually have some good measures to measure for this population that makes sense for us and then actually collectable.

So, thank you.

Ann Hammersmith: OK, thank you. D.E.B. Potter, would you like to introduce yourself?

D.E.B. Potter: Hi, this is D.E.B. Potter from ASPE. And, it's good to be here with all of you and congratulations, Venesa, with getting that contract out to make some measures for the populations of interest here. Looking forward to the meeting today. Thank you.

Ann Hammersmith: Thank you.

I see that Gwendolen Buhr has dialed in. Could you introduce yourself and tell us if you have anything to disclose? And since you're an organizational member, we're only looking for you to disclose if you have an interest of $10,000 or more and something that's likely to come before the committee.

Gwendolen Buhr: OK. So, I'm a geriatrician. I work at Duke. I'm representing AMDA, the society for post-acute and long-term care medicine. And I have nothing to disclose.

Ann Hammersmith: OK, thank you. Has anyone else joined the call since we've started?

(Off-mike)

Ann Hammersmith: OK, thank you for those disclosures and introductions.

Do you have anything that you want to discuss with each other or do you have any questions with me based on the disclosures?

Clarke Ross: Hi, this is Clarke Ross. Venesa mentioned the new CMS contract which I think is the Mathematica contract. And Charlie identified himself as the consultant to a new ACL project on measure development and home and community-based services on a conference call a week ago. A coalition of aging and disability groups want to emphasize the importance of the two contractors working together frequently hand in hand routinely and sharing that with our workgroups.

So I wanted to convey that message that we have these two exciting new contract projects by two different federal agencies. And, there's a great interest that there is routine sharing among those two contractors.

Ann Hammersmith: OK, thank you.

Jamie Kendall: Yes. Hi, this is Jamie Kendall from ACL. Just to respond to that, we wholeheartedly agree, Clarke, and Venesa Day and I and our colleagues at ACL are connecting. And so, we will keep that moving in a positive direction.

Ann Hammersmith: OK, thank you. Anyone else?

All right, thank you very much.

Jennie Chin Hansen: OK. Well, thank you very much for (this all), we have a lot of chockfull of good information. And thank you, Venesa, for adding your welcoming comments in this process.

If there's anything else in the workgroup that the workgroup members may need to add right now? If not, let me then welcome actually our Senior Director, Allen Leavens, who will lay out the map of the year for the MAP.

Allen?

Allen Leavens: Great. Thank you so much, Jennie. And, welcome everybody. Thank you for joining us today.

So, as Jennie mentioned, what I'm hoping to do with the next series of slides is give a little bit more context about the work of the MAP, the Measures Applications Partnership. We do have some new members of the workgroup with us. And we just want to make sure that everybody is on the same page and that all of you are aware of some upcoming activities that we hope you can participate in and provide your input on.

So, again, just to level set a little bit and provide some more context, the Measure Applications Partnership is really focused on furthering the goals of the National Quality Strategy. MAP provides input to HHS on use of performance measures to achieve goals of improvement, transparency and value.

Besides the use of measures and programs, MAP also helps identify gaps and the development of measures as well as the testing and those measures that are submitted to NQF for endorsement.

And, as all of you know, alignment is something that MAP is also been very interested in pursuing both across public programs as well as between public and private programs. And this is across settings, levels of analysis and different populations.

And, alignment is really a critical goal as you all know to the need to promote coordination of care delivery, reduce burden, data collection, as well as to send really strong and consistent messages about what are the most important issues to focus on.

So the Dual Eligible Beneficiaries Workgroup is an important part of MAP. The workgroup provides strategic guidance to CMS and other federal partners as you heard Venesa speak to you earlier about the use of performance measures for this population.

We're fortunate to have such a strong workgroup with all of you providing balance expertise across different areas to help us identify the best available measures, to prioritize the gap areas as well as to provide some ideas for measures that might be coming down the pipeline to fill those gaps.

And, the input is really important on applying the measures to the different federal programs specifically for vulnerable populations.

So, some of the specific activities that the workgroup engages in throughout the year include both keeping up and monitoring the other projects that are ongoing at NQF. And the prime example of that is the pre-rulemaking activities that are ramping up right now and I will talk a little bit more about in just a minute.

Come the spring, we'll be revisiting the MAP Dual Eligible Beneficiaries Family of Measures. And I think as most of you know, that Family of Measures provides a great source of reviewed measures that the work have been taken some time to identify that can be used for multiple programs. As you know, this is a – there are no special programs designated solely for this population.

And so, the Family of Measures serves as a really good resource for other MAP workgroups looking in a cross-cutting way, finding measures that are really important to this population and they can improve achieving the goals for this population.

So again, the next update to that family will occur at the spring 2016 meetings.

And then the last general area of the workgroup activity is providing strategic input to HHS on specific topics. And today, we're going to really be focusing a lot on the Multiple Chronic Conditions issue, but other issues have been touched on in the past and will continue to be an important area that this workgroup can benefit CMS.

So, just as a refresher for those of you who've been on the workgroup and for – and as a – to highlight for some of our newer members, some of the priority gap areas for Dual Eligible Beneficiaries are listed on the slide.

So you can see that really a person-centered approach is important throughout these areas both in care planning, shared decision making, beneficiary sense of control and autonomy, focusing on community integration and inclusion as much as possible, optimal function, and then taking a really strong approach to coordinating care across both acute settings and long-term services and support since we know that this population does tend to experience many care transitions.

So in this slide, we've just highlighted some important dates that you may want to note. Some of these, you probably have received calendar invites for already, but we definitely encourage your participation and as many of these activities as possible.

So you can see the purple area denoting where we are right now in this current meeting. Upcoming, we have some MAP meetings noted, particularly the All-MAP web meeting which will be coming up in a couple of weeks.

We'll be talking a little bit more about the role of the liaisons from this workgroup to the other MAP workgroups in terms of providing pre-rulemaking input. We do have another web meeting for this workgroup coming up in January. We will focus much more on the pre-rulemaking input. Then we have another web meeting scheduled in March, an in-person meeting, April 19th and 20th, where we'll really dive much deeper into some of the issues we'll touch on today as well as additional issues.

And then, as we approach next summer, there'll be public commenting on the 2016 draft report, and followed by the Coordinating Committee meeting in

August, finalizing the 2015 input on this work. And then the final reporting released next September.

So just to step back a bit and provide a little more context for those of you who may not be as familiar with the rulemaking work. Rulemaking refers to the process that government agencies use to create regulations. So, Congress sets fairly broad policy mandates in statutes. But, agencies create more detailed regulations through the rulemaking process. There are proposed rules which are available for public comment. And then considered by the agencies before creating final rules.

So MAP is designed to create upstream input in advance of proposed rules. And, really, one of the main benefits of this is that MAP brings a really strong multi-stakeholder approach and it's very transparent process. So we have all our meetings that are public and have open public comment periods. And then we synthesize this input to HHS, again, in advance of proposed rules. So it's really trying to get ahead of the curve and get this input in much more upstream.

And hopefully, through this process, we're getting the input that it's closer to the mark and reduces effort of all these individual organizations and stakeholders. And again, kind of collating the themes in the most high priority areas well in advance of the rulemaking efforts.

So, again, specifically for this workgroup, the focus is on Dual Eligible Beneficiaries and making sure that their priorities are being addressed.

The programs that – the rest of MAP weighs in on their much more setting focus as opposed to population focus, so this workgroup really needs to bring that perspective for this population which is tends to be high need and as many challenges that need to be overcome. So the members of this workgroup should be bringing in the perspectives of their organizations or bringing their subject matter expertise to really address the needs of these complex consumers and the specific issues that are most pressing.

So, a little bit more detail about the Dual Eligible Beneficiaries Workgroup liaisons. One workgroup member will be participating as a non-voting representative to each of the setting-specific workgroups so that other MAP workgroups include the clinician, hospital and post-acute care and long-term care workgroups.

So we have one liaison from this workgroup to each of those workgroups. And the liaisons will share both their knowledge of disparities and care for individuals with complex medical and social situations, and also bring in the broader perspective of the rest of the workgroup.

As I mentioned before, in January, we'll be having another web meeting to focus specifically on the cross-cutting input on the selection of measures that are coming before the other MAP committees. And I will be ultimately provided to the MAP Coordinating Committee to produce final recommendation for HHS by February 1st.

On this slide, you see just a schematic of the general layout of how MAP is structured with the Coordinating Committee receiving input from the different workgroups. And you also see the liaisons from this workgroup who are working with those other MAP workgroups to provide the input. And we do want to especially thank Mady, Clarke, and Tom for being willing to serve those roles and we're fortunate to have such strong representatives acting as the liaisons.

So, a broader timeline talking or showing the MAP approach to pre-rulemaking just so that everybody is on the same page. Right now, the workgroup web meetings have been just wrapped up and we're preparing for the release of the measures under consideration which has to happen on or before December 1st.

Once that list is published, there'll be a initial public commenting period where all of you are welcome to provide your comments on these measures.

The workgroups for the settings meet in December to provide their input along with the Dual Eligible Beneficiaries liaison attending those meetings. Then there's another public commenting period after that based on the findings from those workgroups.

In late January, the MAP Coordinating Committee meeting to finalizes that input and produces the input on the measures themselves, February 1st, and then some additional reports with some more cross-cutting input about the settings through March.

So, I'm going to pause there and ask if anybody has any initial questions or comments particularly our liaisons if you have any brief remarks before we move onto the next section.

Charlie Lakin: This is Charlie Lakin. You know, I really understand the whole concepts of the MAP input kind of being upstream in advance of proposed rules. But, I look at things like the new home and community-based services regulation which have been promulgated now. And, it seems too that the MAP work might be really important in terms of assessment of compliance to those kind of regulations. They're largely aspirational when it comes to measurement right now. And it seems one concentrating on whether we can actually measure what is already required.

And also integrating the knowledge that comes from the Dual Eligible Beneficiary workgroups into the differences in terms of what different groups might need in terms of achieving the kinds of outcomes that are envisioned in those regulations. So, I'm just thinking, you know, I understand wanting to be upstream but it seems like there's a lot of downstream work that needs to be done as well.

Allen Leavens: Yes, that's a great comment and we've actually had some both internal discussions in – with our co-chairs about how we can better interface with some of the other projects which may relate to this. So we do have a project related to home and community services at NQF. So, I think to your point about these other areas which beyond, we'll make the MAP measure selection process as a great point and something that we do need to keep considering. And, in the spring is we will have an opportunity to consider other topics for the workgroup to address, I think, that's definitely something we need to keep in mind.

Well, great. So, I want to recognize that we do have a number of other issues to talk about today. So, at this point, I'm going to turn it over to Megan to talk about our main issue today addressing Multiple Chronic Conditions and Dual Eligible Beneficiaries. So, Megan?

Megan Duevel Anderson: Thank you, Allen. Hi, my name is Megan Duevel Anderson. I'm a project manager at NQF. And I'd like to thank our co-chairs, workgroup members and public for joining us today, especially my colleagues at NQF.

I want to lead the workgroup members on a conversation around Multiple Chronic Conditions in Dual Eligible Beneficiaries, how these characteristics interact and how to measure and address the quality issues that are important to the beneficiaries and their families.

Next slide.

Slide 19 gives an overview of this section of the web meeting. We'll start with discussing who dual beneficiaries are and how they're impacted by Multiple Chronic Conditions. We want to discuss the workgroups prior recommendations on high needs subgroups, and how we can build on this prior recommendation. We also will review relevant frameworks for Multiple Chronic Conditions and measurements.

Importantly, I'd like to post two questions for the workgroup to keep in mind throughout the next several slides. Workgroup members, please prepare to discuss the following questions. What are the greatest needs of dual beneficiaries with Multiple Chronic Conditions among their family members and caregiver? What opportunities exist to address the immediate – the need for this high-risk beneficiaries? Also want you to think about, are there Multiple Chronic Conditions framework components that are particularly it's important to consider for dual beneficiaries?

Next slide.

So, we want to make sure everyone is really on the same page. So, just to provide a little information about the total dual beneficiary population. Dual Eligible Beneficiaries are individuals who receive benefits and services through Medicare because they're older 65 or have a very serious condition, and through Medicaid because they have low income and eligibility.

In 2010, there were approximately 9.6 million individuals who received benefits from both of these programs. This is a number that has grown exponentially over those past several years.

Beneficiaries often have a combination of complex clinical conditions compounded by social disadvantages. While all dual beneficiaries have a little income, the population is highly diverse. They represent all ethnicities and lifestyles and come from inner cities as well as rural areas.

That means that this population typically updates this other Medicare and Medicaid population. The three subfigures is totally nearly $8.5 billion annually.

Unfortunately, as described, there is no specific program to assess the quality of care for this beneficiary. And it's quite difficult to uncover information about these groups specifically.

Next slide.

This workgroup previously considered high-needs subgroups of Dual Eligible Beneficiaries. One of the key outcomes of this work featured in the most recently in the 2014 interim report, was that the individuals who are included in this high-needs subgroups were very likely to have other compounding condition.

For example, adults with physical disabilities may also suffer from mental health issues.

In addition, the quality of issues for the high-needs subgroup were much more similar than they were unique. In fact, this workgroup identified very few unique issues for each of these – the four subgroups.

Well, we review the specific – I will review the specific quality issues that they have in common later today and ask for your further refinement on them.

Next slide.

Slide 22 is our Venn diagram, that does not completely represent this concept but does highlight one very important conclusion. This workgroup previously according to the conclusion that the high-needs subgroups have more in common and more similar needs than different at this stage of health care quality and health care quality measurement. And, that not all beneficiaries are the primary subgroups have Multiple Chronic Conditions, but many do. But we'll continue to discuss this workgroup's previous input and we're going to – as we discuss Multiple Chronic Conditions.

Next slide.

The research and data document the commonness of Multiple Chronic Conditions among individuals who are dual beneficiaries. More than three quarters of dual beneficiaries have more than one documented chronic condition. And many have several chronic conditions.

The multiplicity of chronic conditions expands outside of a specific condition group. The impact of the individual – impact on individuals can be overwhelming to consider as one imagine with – imagine the psychological impact of receiving one diagnosis and another diagnosis and then another.

The multiple medication complex instructions (for dial) and lifestyle changes, and potential referral to various specialist offices that may be far away or difficult to find and access, and questions about whether or not your insurance covers all of these different factors.

The chronic conditions also increase the total cost of care for beneficiary. Our (H.P.) for service expenditure has grown with each condition diagnosed.

Next slide.

Just basically want to highlight how Multiple Chronic Conditions affect beneficiaries. The most recently published information about the prevalence and comorbidity of physical and mental health conditions in dual beneficiaries, they found the five most common co-occurring condition groups to be heart conditions, mental health conditions, anemia, musculoskeletal disorders, and diabetes.

Next slide.

One of the most important characteristics of dual beneficiaries is their limited resources. It's important to look at how Multiple Chronic Conditions and sociodemographic status interrelate.

Well, data is somewhat limited. There are some interesting findings on this topic.

Women are found to have higher rates of three or more documented chronic condition. Among ethnic groups, individuals and – not – and White non-Hispanic, African American, Hispanic group have the highest rates of four or more documented chronic condition.

Beneficiaries under the age of 40 have the highest documented proportions of mental illness, mental health conditions and the lowest proportion of physical health conditions.

So, I've now completed my presentation about how Multiple Chronic Conditions affect dual beneficiaries specifically and the information that we were able to summarize for your consideration.

We're going to now move onto discuss the three relevant frameworks on Multiple Chronic Conditions.

We're going to start with the Institute of Medicine, Living Well with Chronic Conditions framework and then move onto the HHS Multiple Chronic Conditions Strategic framework and the regulated National Quality Forum Multiple Chronic Condition Measurement framework.

The IOM recently published a report that examined the burden of chronic illness across the nation, and public health actions that could address disability and improve function and quality of life.

This report include a targeted recommendations directly to CMS, (DDC) and other incorporated population-based approaches and consideration for health in all policies.

Next slide.

On slide 27, a figure is taken directly from this 2012 report from the IOM, taken the visual representation of the IOM framework.

On the right, we can see the individual chronic conditions are identified by the green arrows, and some individuals may be part of more than one group.

We can also see the determinants of health in the purple circles, including socio-cultural context, which we briefly described through this dual beneficiary previously. Peers and family, which has long been a focus of this workgroup and individual coping response, behavior and biology. These are more – really, this can be also concretely thought about related healthcare. However, this group could be found in the green area at the bottom related to policies and other intervention.

Next slide.

The IOM report also the role of measurement in addressing chronic conditions as difficult but essential to promote collaboration between public health and health care. They are recommended changes in system design including the use of proactive plan and integrated care engaging individuals and as active participants in their care, collaboration between providers, clinicians and non-clinicians and targeted health promotion at the (VA) prevention strategy.

The IOM has specific recommendations for health care factor, too. They include improving the affordability and incentives to provide high quality care, pushing forward and overcoming no barriers (upon) the payment method.

The report also describes the difficulties with population health and management given the loosely defined setting compared to other health care setting.

The IOM suggest recognizes individuals with chronic conditions are increasingly providing self-care and self-care management wanting more public health initiative. However, there's limited that there are any evidence on the effectiveness of community's organization to address public health issue.

There IOM report emphasizes the potential for leverage infrastructure of high health care such as peer organizations and experiential organization, as well as health and fitness organization.

Next slide.

On slide 29, we wanted to share some key takeaways from the Department of Health and Human Services Multiple Chronic Conditions strategic frameworks published in 2010. A quote from the text on slide 29 captured some of the issues about measurement incredibly well. I'm going to read it briefly.

Multiple chronic conditions can contribute this frailty and disability. Conversely, most older persons who are frail and disabled have Multiple Chronic Conditions. The confluence of Multiple Chronic Conditions and functional limitations, especially the need for assistance with activities of daily living, produces high levels of spending.

The framework emphasized that the importance of addressing high-needs subgroup, disparities and opportunities help individuals, mainly and namely to live in the community as long as possible.

Next slide.

The HHS has four domains that they think are needed to be addressed to benefit the individual. They are, strengthening the health care system and public health system. Empowering the individual to use self-care management. Equipping care providers with tools, information and other intervention. And supporting targeted research about individuals with the Multiple Chronic Conditions and effective interventions.

Next slide.

In coordination with the HHS's effort, NQF took up the topic on Multiple Chronic Conditions and published their measurement framework in 2012. Some of the primary challenges and measurement for individuals and population with Multiple Chronic Conditions include the fact that clinical practice guidelines are readily avail – and readily available measures that rely on this clinical practice guidelines can rarely do consider Multiple Chronic Conditions.

And that following these guidelines, very rigidly, may not work well or have unintended consequences for individual with Multiple Chronic Conditions or other complex situations.

The framework also noted the needs for addressing measure gaps. Standardizing data collection and reporting, and delivery system reform. Since this report was published, we have continued to see progress but not resolution of this identified need.

Next slide.

Key measurement priorities and concepts for individuals with Multiple Chronic Conditions were identified in the NQF 2012 framework. These are listed on slide 32 and have many commonalities with issues this workgroup has identified, specifically high-leverage opportunities for improvement and priority gap areas.

Next slide.

Slide 33 is the depiction of the Multiple Chronic Conditions framework that you may recall seeing previously. This depiction introduces a gentleman named (Javier) who is a hypothetical individual and how the hypothetical individual framework and measures might apply to (Javier), who happens to have COPD, diabetes and has been diagnosed with depression.

We can see that (Javier) travels to the right, that work with (Javier's) care and does happen with primary care and some specialty care provider. And, that treatment and management is a key part of how health care and health care quality measurement come to address (Javier's) issue.

You can see some issues that some measurement domains that might apply to (Javier), our person- and family-centered care and affordable care. And you can see examples of how a person – a patient experience with care measure or a COPD specific measure might apply to person and centered – family-centered care to (Javier). You can also see how there might be specific affordable care measures that would be applicable.

This is just one example and I figure that you may find helpful for understanding those frameworks a little bit better.

Next slide.

The MAP Dual Eligible Beneficiaries Workgroup previously considered this framework and emphasized five high-leverage opportunities for the high-need subgroups.

So, emphasize opportunities were the need for measures of seamless transitions between multiple providers and sites of care, optimizing function, avoiding inappropriate and non-beneficial care, access to care and shared decision making.

We want to make sure we're continuing to build on this workgroup framework and start to address what specific issues and/or components of this framework could be targeted to in dual beneficiaries with Multiple Chronic Conditions.

So I'm going to move onto the slide 35. And I will be turning shortly to Jennie, our co-chair, to be facilitating the conversation with our workgroup.

And, at this time, (Mhen), I'd like you to give instructions for our public comment, public commenters – excuse me, public commenters, please prepare your comments then we'll be holding public comments until the workgroup has finished their discussion. I apologize for my speaking.

So the questions that the workgroup should begin to discuss are about how – what are the most prominent quality of care issues of dual beneficiaries Multiple Chronic Conditions, and among caregivers. And what opportunities exist to address this need. And then also, which Multiple Chronic Conditions framework components are particularly important to consider for dual beneficiaries.

So, public commenters, please prepare your comments and then we will open in public comments for a few minutes until the workgroup has had their discussion.

Jennie, I'd like to turn it over to you to facilitate.

Jennie Chin Hansen: Thanks so much, Megan, for going through this and putting the context of some of the previous work from the IOM, what CMS itself has done and then what NQF has teed up.

And, so, this is an opportunity for our members to ask – raise different elements that they would like to reemphasize or raise any gaps that we may not have covered.

And so now that we have the overlay of the Multiple Chronic Conditions on top of some of the work that we have previously done, I want to integrate the comments of things that are happening currently as mentioned with the home and community-based regulations that have come up.

But, if we go back and maybe if we could turn back to ones – the one slide, to slide number 34 again.

With that particular elements that we just talked about, what the dual eligible group here had elevated these particular five areas. And if we couple that with the questions and approach, as we approach this work with MCC as an overarching framework, are there particular areas that the committee members right now might have for areas of either added emphasis or areas that we may have missed amongst those five areas that were identified in the previous workgroup.

So let me open this up to individuals who would like to share comments or ask questions.

Clarke Ross: Hi, this is Clarke Ross. I'd like to share a comment. I want to reinforce two of our existing high-priority measure gaps and then try to relate it to Multiple Chronic Conditions. And those two high-priority measure gaps already identified by this workgroup and shared with CMS is the area of community integration and inclusion and participation, that's number one. And number two is linkage with non-medical community-based social supports and community-based organizations. So, those are two reference points.

The relationship to multiple chronic disorders, a lot of folks with severe disabilities are experiencing social isolation. They are literally trapped in their place of residence and have few friends, no friends, family may have a lot of other pressures, they don't get out and about. And, so, the dynamic of everyday social isolation leads to behaviors that are unhealthy and lead to possible multiple chronic disorders. So, a tendency to eat way too much, a tendency not to exercise, a tendency to drink alcohol way too much.

So, the theme I'm trying to get at in social isolation, we have already proposed responses to that but rather than being in the emphasized key measurement areas, they are sitting where they appropriately sit at the moment in the high-priority measure gaps.

Jennie Chin Hansen: Thank you, Clarke, for both pointing and emphasizing earlier work and thinking about how we elevate some of these matters into the MCC area of work.

Other comments from members.

Jette Hogenmiller: This is Jette Hogenmiller from Homewatch CareGivers. And just for s little reference, we have over 200 offices across the country that provide care giving to individuals in the home. And this would be trained home health aides staff and nurses aides along that order.

But I want to piggyback on what Clarke said, where (he's been) specifically looking and measuring loneliness, helplessness and boredom because your point, Clarke, that impact on functioning and actually diminishing physical ability is certainly associated with those two.

And like I've said, they've actually been working on developing some reliable and valid measures in conjunction with those of you that are familiar with the Eden Alternative, Dr. Thomas. So, I just want to kind of piggyback on that comment.

Jennie Chin Hansen: Thank you for that.

And, let me turn – with your two comments turn back to our staff team. And relative to (some of) the starter set was depression. At this point, the topics that both speakers have raised really are not captured in that element of depression. So, is there any particular work that we know of relative to this whole topic of engaged socialization?

Allen Leavens: Thanks, Jennie. And I think it's really a critical issue. Some of these topics do come up in our other endorsement projects, particularly I think with behavioral health and perhaps health and well-being. So these are the things that we do want to keep in mind and note for kind of across fertilization across project. So, we're definitely taking a lot of notes here. And we'll be thinking about ways that we can emphasize that input in our other work.

Jennie Chin Hansen: Thank you. Thank you, Allen.

Megan Duevel Anderson: Hey, Jennie, this is Megan.

Jennie Chin Hansen: Yes, Megan.

Megan Duevel Anderson: I just – I want to thank both Jette and Clarke for their comments. And tie this back to a framework that we – that I presented briefly, which is the IOM framework which really does highlight this need for the whole community support and integration and a true potential for community organization to be involved. And the public health potential to address individuals with chronic conditions and help them live well.

That is also a theme that was expound in the HHS framework, but I think it really is called out well in the IOM framework. So, I would ask if we can go back to perhaps 20 – slide 27.

Great. And so, I'm going to highlight a little bit here on the social determinants of health. And ask the workgroup if they can continue to think about, if this framework or portions of this framework are highly relevant to your thinking, or if there are other portions of this framework or other frameworks that address the needs of beneficiaries with Multiple Chronic Conditions particularly well.

Jennie Chin Hansen: Great. So we would invite the commenters to respond to that.

Cheryl Irmiter: This is Cheryl Irmiter from Easter Seals. Thank you, everybody. This is exciting work and a wonderful opportunity on behalf of Easter Seals. And as some of you may know, others may not, Easter Seals was one of the largest non-profit serving a variety of populations across the lifespan. Everything from med rehabilitation to transportation, workforce issues as well as mental health and housing.

The – when I looked at the spectrum of health and living well with chronic illness, the realities of some those at risk and this may fall into there, but the concern that I would get is the realities that some of their social determinants with regard to finance as well as housing, as well as access to environmental and the socialization piece.

So, I'm seeing the health outcomes and distribution in the population, but it looks as though they are references to – and I'm a little confused by that. The reference is to level of health and rather than levels of living, or opportunities for living, working and playing. And the spectrum of health includes those social determinants regarding to finance, regarding to housing, regarding to mobility, and as well as access to food.

So how can that be considered under this?

Jette Hogenmiller: Cheryl, this is Jette. I think you bring up an excellent point that because we've got the spectrum of health, some of the impairment might be functioning better than – or I mean, some of the disability might be functioning better than an impairment. It's not necessarily equal to quality of life.

Cheryl Irmiter: Exactly, that's where I'm going. So thank you for picking that up, Jette.

Jette Hogenmiller: Yes.

Charlie Lakin: This is Charlie. I think there's some conflicting labeling there. We label the strategies for – to achieve living well. And then we equate living well to health, which is certainly an important part of it. But it is not living well all on its own.

One thing I would also like to kind of return to is the discussions that we had before that I thought were fairly well-reflected in the interim – the 2014 interim report. That really recognized that like dual eligible, chronic condition is sort of a very broadly inclusive category and has a lot of complexity to it. There are shared aspects of quality for all people in terms of, again, using that label living well.

But there are some unique aspects that different subpopulations need to be assessed against. And I think on the discussion starting on page 12 of the interim report, really recognizes both on the categories that relate to the unique needs of people who were within this chronic condition category, but also, those things that are shared. And that's sort of missing from the slide on, what, it was at 34 or whatever. We talk an awful lot about social relationship, social support, community integration, recreation, relationships, freedom, (inaudible), all those things. And they're just really not reflected on the key measurement concept listed on slide 34.

And I was just sort of wondering where all that went. It seems like we devoted a great deal of time to that. And, there was a consensus that we recognize that all of that really was really crucial again to use that (in this) as well.

Jennie Chin Hansen: Sure. Clarke, this is Jennie. I think the conversation that we've just had over the last number of minutes, you know, expands that component if we look at – of the five leveraging points optimizing function. And perhaps that efficiency truncates the texture of what all of you have been relating to about social function connectivity belonging to that community. And what I do here is somewhat missing is the, you know, again, implied under the fourth item which is access to care is the affordability component area.

So, perhaps these are, right now, turns that we can once again build out a little bit more that reflect the – I think the important texture and probably the specifics that you have mentioned in the course of this conversation thus far. So, with that …

Joan Zlotnik: This is …

Jennie Chin Hansen: Go ahead.

Joan Zlotnik: Yes, so this is Joan Zlotnik. I just kind of want to chime in on this also.

Many of you may be aware, there's also a new Institute of Medicine report that came out this summer addressing psychosocial issues and their measures are lack thereof. And it addresses many of the same issues and also sort of what is the – there was a meeting yesterday related to sort of implementation of the recommendations from that report. And, this sort of issue about where the line is between sort of quality of life, and what people want for living well, and what are the sort of more medical aspects are, you know, sort of broadly unresolved issues.

And, you know, in the Dual Eligible Beneficiaries reports, we've kind to use the word psychosocial with no definition. And I know one of the things that I commented on in the draft report we looked at this summer was to really kind of begin to flash out what that means that encompasses many of these broader issues that people are talking about on the call.

Jennie Chin Hansen: Thank you, Joan. I think that is very timely relative to the, you know, the report on psychosocial. And perhaps we can use this season as a way to build out that with the quality of living component with greater detail.

We have about five more minutes for this segment before we move to another. And so, I definitely want to make sure that we hear from a couple other people if people would like to raise something different that we can also add to this.

Thomas Lutzow: Yes, Tom Lutzow with iCare. I certainly agree that social engagement is a key value and isolations, the enemy of health and parent of depression and all of that is absolutely true.

The point the gentleman – the first gentleman made about integrating medical and social care, it's certainly a weakness in the system. And we have day care centers and assisted living centers that are not really aligned with the acute and primary system. There's a lack of information still. And I know that the meaningful use at one point had a fourth level. And that fourth level was integration of social and medical care.

And with this population, it's especially important in managing chronic conditions that who's ever doing day care and assisted living and in home services, there needs to be a more perfect alignment with the acute and primary side of things.

So, how we do that, it's a tricky deal information, but even alignment of incentives and funding, sometimes, the source of funding is very different and it is often very different for the social side as opposed to the medical side and somehow, overtime, that funding system, those funding systems have to become aligned.

So, you know, that's the second point that I wanted to make from the gentleman's comment.

The other concern I have is this issue with medication, certainly Multiple Chronic Conditions lead to multiple medications.

And, we are really ignorant of the soup that's created when someone is on 10 meds. And, we sort of leave it to their reactions in the field than of, you know, there is a reaction then we take a look at the meds. That is not the right way to – that can't be the right way to do it. That's – I guess, we're going to make cars and we're not going to, you know, unless somebody complains about the car, we're going to assume the car is OK.

There needs to be more work on the soup that we're creating as a pharmacy of service that's affecting people in ways we have no idea of knowing. And it's, you know, we're experimenting with people's lives in the pharmacy front. And some more work needs to be done there.

Jennie Chin Hansen: Well, thank you, Thomas. I think this is definitely an area that the committee has looked at relative to medications. One is the – some of the measures for reconciliation review. You're broad – speaking in a broader aspect of how coordination of people with Multiple Chronic Conditions may be living and how to have system that have a total line of sight as to what the prescribing results are.

So, it's like to kind of go back to acknowledge your comment, but are also knowing that one of the, I think, early areas is looking at the medication profile. But I know that's a (post-facto) though, what you're saying is there needs to be better coordinated, understanding of conditions plus prescribing. And so that's the context issue for us to continue to work on.

Allen and Megan, any other comment on that?

Allen Leavens: Jennie, I think you make some really good – some really good points and we're – again, we're taking lots of notes and I think we can – we'll circle back with some of these issues. Right now, just in terms of our times, it's a little compressive. Hey, Jennie, if OK with everybody, I think we'd like to open up for public comment just to make sure that we're respectful of our other – you know, people who are joining us today.

Jennie Chin Hansen: Thank you, Allen, for the reminder. Operator.

Operator: Thank you. Ladies and gentlemen, if you have a question or comment, you may simply type your question into the text chat box area at the lower left corner of the window.

Please be sure to click Send to send your questions directly to our presenters.

To ask a live question over the phone, please press star one on your telephone keypad. We'll pause for just a moment to compile the roster.

And you have a comment from Tom James.

Tom James: Hi, good morning. And, sorry, I can't be there with you all.

There were two comments that I send over the chat function. One of them had to do with whether with a stratification that we're discussing geographical issues should be considered as somebody who's moved from Philadelphia to Kentucky. I've seen the impact of various kinds of geography as one more factor in the determinations.

And the second comment had to do with the discussion of affordability. And at least in what I have seen in my own personal experience and the various health plans I've been in, affordability and the dual eligibles really relates to personal expenses like for transportation or for peoples who go with a – to (account) the individual since between the two government programs, there is hardly any out-of-pocket expense medically. So those were my two comments.

Jennie Chin Hansen: Thanks. Thank you, Tom.

Tom James: Sure.

Operator: And there are no further comments at this time.

Jennie Chin Hansen: Thank you.

And I think that Tom, I'm sure our staff are taking some notes about your two points. One, relative to geographic disparity and as well as the – and other dimension of the affordability component, and especially if you are dual eligible.

OK. I think that helps conclude this particular segment at this point. And as I mentioned at the top of the call is, there may be some of you who have some additional comments, please make sure you send us your notes on this because that will definitely be incorporated.

At this point, we have the next section that I'm going to turn over to Allen to do the introduction relative to our guests. Allen.

Allen Leavens: Thank you, Jennie.

And, so I just like to provide a quick overview of the next section on what we hope to accomplish.

So, we've talked a little bit about identifying priority measurement areas for dual beneficiaries with Multiple Chronic Conditions. And what we're hoping with the next segment is to really get more specific.

So, we'll – I'll briefly review some of the priority topic areas that have been raised by the workgroup. And then, we'll talk about specific tool, the National Core Indicators-Aging and Disability tool. As Jennie mentioned, we have special guest with us today to talk a little bit more about that.

As we go through the next set of slides in here from our presenters, we'd like you to keep in mind these two questions that you see on the slide right now in terms of which issues and topics are most important to measure. And, considering that we'll have more time at our meetings in the spring to dive deeper in some of these issues, which specific types of measures and tools should we explore further?

So, we do want to be cognizant of the prior input from this workgroup and build on the prior recommendations. So I know that some of our committee members raised the importance of some of that content that was included in our prior reports, so that's an important thing to keep in mind.

And we do want to focus on the potential high-leverage opportunities for this population. And make sure that we're prioritizing the topic areas and the appropriate measures that will be most useful to address those topic areas.

So, I'm not going to go through this in any detail but this is just a reminder of some of the high-leverage opportunity areas that have been previously identified by the workgroup for Dual Eligible Beneficiaries, and specifically addressing Multiple Chronic Conditions. So you can see in the left hand column the broad categories along with some of the specific quality issues that were identified as common and across the different subgroups. So again, continuing on with the additional high-leverage opportunities and specific issues.

So, hopefully, we've captured some of that prior input that was in the priority reports here for you to reference. But certainly, we do want everyone to refresh themselves to that content particularly the newer members so that you are familiar with the prior input of the workgroups that we continued to build on those recommendations.

So, again, as we go through the next segment, we'd like you to keep in mind which issues and topics are most important to assess for improvement among Dual Eligible Benefices with Multiple Chronic Conditions. Since we've touched on some of these issues already and in the interest of time, I think we can move onto the next section.

And so, Jennie, I'll hand it off to you to introduce the specific topic and our speakers.

Jennie Chin Hansen: OK. Thank you.

One of the things that we end up doing is the ability to look at other resources and tools. And the MAP regularly actually does review potential tools that will have a way to help leverage movement and recognize priority gap areas.

Back in 2013, this workgroup actually considered the use of the National Core Indicators survey for individuals with developmental disabilities. As part of that discussion, the workgroup encourage further development of what was then in concept in early development of the similar tool for both the aging and disabilities population.

Today, we really are fortunate to have the opportunity to learn more about how that survey developed.

So, after this presentation, this workgroup is going to be asked to weigh in on how this or similar tools could be used by CMS to address the need of beneficiaries and priority measurement gap areas. Please think also of other tools or strategies, or resources that you might know about that we could consider at a future meeting.

So at this point, we are very fortunate to have the NCI-AD presenters, Camille Dobson, who is deputy executive director, and Kelsey Walter, who is the director of NCI-AD and National Association of States United for Aging and Disabilities, NASAUD. And Julie Bershadsky, who is the project director, also the organization on Health Services Research – within the Health Services Research Institute.

So, I will then invite our guests to start the presentation.

Camille Dobson: Great. Thank you so much. This is Camille Dobson, Deputy Execute Director at NASAUD. Recently arrived from CMS where I spent 10 years working with my colleagues on Medicaid managed care and with the Medicare-Medicaid Coordination Office working on quality. So, I'm excited to be here today. I've heard a lot about the work of the MAP over my years with CMS.

Just for quick background before we jump into the presentation, Kelsey and Julie will be doing – going through the slide deck because they are the directors of the project and have more in-depth experience. But I did want to just remind everyone that our association does represent the state, aging and disability directors across the country.

Our directors represent a variety of constituents, individuals with elderly, the elderly, obviously, people with physical disabilities. But also, up to – about 40 percent of our state directors also have responsibility for either behavioral health programs or programs for those with intellectual and developmental disabilities.

So, a broad swath of responsibility and the great interest in improving the outcomes for the beneficiaries that they serve, and improving the quality of life for people and making sure that the services make a difference.

So, with that in mind, NASAUD really pushed forward to take the work that have been developed by our sister organization with the National Core Indicators and build a tool that would survey the same types of domains that NCI does for those populations that our members serve.

So, we'll be happy to answer questions at the end. But now, I will turn it over to Kelsey for her to walk through with Julie, the slide deck we have for you today.

Kelsey Walter: Great. Thank you, Camille.

So, as Camille mentioned, this is, of course, a quality of life survey for older adults and adults with physical disabilities. When we began development of this looking at the NCI work that has been done, we realized that our long-term supports and services system is a bit more complex than the system with the IDD population. So, of course, we're looking to assess outcomes with people living in nursing facilities, also people on Medicaid waivers and state plans, the managed care population, Older Americans Acts programming, as well as any state-funded program.

So, we're really trying to get that entire LTSS support system within each state. And, of course, that means these are kind of complex samples which we'll talk about a little bit later.

Then states work with us to design their samples. So this can allow for comparison state to state for those that are participating in the project. They can also design a sample allowing them to compare across the program, and then potentially even regionally if they build a large enough sample.

In the handouts that you received, there is a crosswalk that shows the overlap between the NCI survey and the NCI-AD survey. So they can also potentially compare between those programs if they're doing both surveys.

Just like NCI, this is gathering information directly from consumers through face-to-face interviews. It's a state-developed initiative. So the states own their own data. And the states can also work with us to add on some state-specific questions or questions they feel haven't been covered in the survey and they'd like to know more about.

So, with this first year rollout which started June 1st of this year, we've had three states, Tennessee, Mississippi and Texas, add some specific questions. And so, we are tracking those, and other states are considering doing something similar.

Once data has been collected, they report for each state. And then also a final national report are going to be published online and available to the public at our forthcoming NCI-AD website.

Next slide.

So, looking at the measure – can you go to the next slide?

Thank you. So, looking at the measures, you also have a handout, the NCI-AD indicators document. And it really breaks the survey down by domain and then indicator and shows which questions kind of fit within this domain and indicators.

Specifically, we're looking at community participation, so people's ability to do things outside of their home when they want to. Choice and decision-making, asking questions like if they are able to choose when they get up and when they go to bed, when they want to eat their meals. Looking at relationships, so asking questions about their ability to see or talk to their family and friends when they want to. So, satisfaction was well and this is beyond just service satisfaction, but looking at things like how – do you like how you usually spend your time during the day, and do the people who are paid to help you do the things the way you want them to be done.

We're also looking at service and care coordination. And in care coordination specifically for people who have been in a hospital or rehab facility. We're asking questions like, do you – did you feel comfortable and supported enough to go home? Was there any follow up to make sure that you have the services and supports you needed? And asking questions about whether they know how to manage their chronic condition.

We're also asking questions around access. So, if they have transportation to do things outside of their homes when they want to, but also transportation to get the medical appointments when they need to.

We ask series of questions around self-direction of care. We ask some questions around work and employment which is especially important for the disability populations that we're serving.

And then, we ask questions about rights and respect as well. So questions like, do you have enough privacy in your home? Do you feel that people who are paid to help you treat you with respect?

We're also asking questions around health care and medications, safety and wellness. Questions about everyday living, planning for their future and also control. So, asking people if they feel that they have control in their life.

Next slide, please.

So, we've gone through a series of testing to make sure that the survey is actually valid and reliable. So, we've done some validity and reliability testing now as you can see. And we're planning some in the future as well so as we were going through to pilot this, because some of these tests working around the face validity and inter-rater reliability and we're planning to do more in the future with the final survey as we've rolled out this year.

Next slide, please.

So, how does this work? States basically commits to working with us for about a year and a half to two years for the first year that they join. They commit to a technical assistance here. So, we help them to prepare for implementation of the survey. We help them with planning. There's a lot of technical assistance call that happen. And then we come out and do an in-person training with the interviewers before they begin surveying. And we also sit down with the states just to talk about kind of their planning process and what they're planning to do with the data.

States develop a project team and we ask this to work across agencies. So, we've been approached by both Medicaid agencies and also agencies primarily doing aging and disability work. But we ask the state work across these agencies so that they can really get at their entire LTSS system.

Then we have our monthly technical assistance calls as I mentioned. And we work with them very specifically to design a sample that will get at the populations that they would like to have some specific data about.

At minimum, we ask states to collect 400 surveys to be a part of the project but many states choose to collect more so that they can over sample in certain populations.

We also work with states to gather background information from their administrative records. So, the survey, we have a background information section of the survey that specifically is looking at what we can pull from state administrative records, what's not available, we ask the surveyors to add these questions on at the end of the survey.

We have our interviewer training, and then once the data has been collected at the state level, interviewers are asked to enter that data into an online data collection system in ODESA, which sends the data directly to HSRI. And HSRI then cleans up the data and provides the state-by-state reports and also national reports. So we work with states on those.

And then as I mentioned, the data will be published nationally on the NCI-AD website.

So next slide.

So, how are states using this data? We really work with states to think about this as they're starting the project. And then, we'll be talking with them as their reports come out to think about really their quality improvement at first.

We want them to use this data to help identify service needs and gaps, allocation of services. We've heard with some of the NCI states that they've used this for budget justifications to their state legislatures. Of course, this data is useful in describing a state's service delivery system. So, that's also helpful in communicating with family and advocates and then also across departments in your states.

States are excited to do some benchmarking and be able to compare their data nationally and more states join. And we've also had several states looking at quality assurance in their managed care system. So, designing samples where they can look specifically at their managed care organization and kind of start to see how they're doing compared to one another.

And then, of course, compliance with waiver performance, Olmstead planning, BIP, and the new HCBS settings rule.

Next slide, please.

So, this is a map of the states that are participating this year, so the 2015 and '16 year. As you can see, there are 14 states. We, in our pilot, had Minnesota, Ohio and Georgia participating. They've continued on for the first year. We also have Maine and Pennsylvania, New Jersey, Delaware, Indiana, North Carolina, Mississippi, Tennessee, Texas, Kansas and Colorado.

Next slide, please.

So as I mentioned, we work very closely with the states to design their samples. And so, this was kind of giving you an idea of what the samples look like from this first group of states, on the first 14 states. So, we have been looking at their different waivers, specifically their waivers for their managed care organizations. We have one state that actually, I believe, over sampled so their money follows the person initiative.

Many of our states are sampling their Older American Acts programming. We have many states that have specifics state plan that they're sampling. Also looking at their PACE program, and a few of our states have included their skilled nursing facilities as well.

When I explained these populations that can be included in the sample, we do not force the states to include any specific population. We ask that they work towards including all of these so they really can't see their full LTSS system and what it looks like. But we do work with them to design specifically what they're looking for.

Next slide, please.

So, I'm going to hand it over to Julie Bershadsky, who's the project director for – or the director for NCI-AD at HSRI, to talk to you a little bit about our pilot.

Julie Bershadsky: Thanks, Kelsey.

So, the pilots, we actually had two pilots. One was a large scale pilot which took place last year, last winter, in fact, and involved three states, Minnesota, Georgia, and Ohio.

Next slide, please.

This is how large the pilot was. It consisted of a total of about 1,600 interviews that were conducted on the three states. We're not going to identify the states in what we're about to show. So we're just referring on the state as – referring to them as State 1, State 2, and State 3. You can see the numbers that were collected on each of the three pilot states. So, State 1, just over 800 interviews, State 2, just under three – under 400, and State 3, a little over 400.

The – also, the three pilot states did differ in the makeup of their sample and you can see those numbers in the slide as well. So State 1, for example, had only 50 percent of their sample in the Old American Act that is compared to State 2, which had 20 – less than 20 percent and State 3 which is even fewer, 9 percent.

So, we are keeping track of this information. We kept track of it for the pilot. We will be – we are keeping track of it for the regular implementation of the survey as well, because, of course, this will influence our interpretation of the results. So when we do the reporting, we will be breaking out the results by not only for each state, by state, but also by the type of programming.

Next slide, please.

Thank you. We just wanted to show you a couple of select result tables from the pilot. The survey has changed since this large scale pilot. The pilot was done after about the seventh revision of the survey. The final version is the 13th revision of this survey. So, there is, you know, that some other questions did change since the pilot. So, some of these data are not exactly the same as they're going to be during – for the regular implementation of the survey. However, they are indicative of the kind of data that we are collecting, the kind of data that will be available.

So, these are results. The first table is the percentage of people who said that they are ready or comfortable to go home if they have had a rehab or hospital stay. So, 91 percent of people in State 1 said, "Yes", completely as compared to 83 percent and 85 percent of state 2 and 3. So, there are some stay differences there.

We also asked whether somebody is followed up with the person after a rehab or hospital stay. And that's the second table on that slide. Again, some stay differences where 70 percent of people in State 1 said, "Yes." as compared to 79 in State 2 and 73 in State 3.

Next slide, please.

These are some of the choice and decision making questions. These relate to the HCBS regs on the settings, especially we've added a number of questions to the survey since then. But, these are the two questions that we sort of think are most indicative of having a choice in control over your everyday schedule.

And that is, can you eat your meals when you want to, and can you get up and go to bed when you want to. And also, as a part of the question is, if you need assistance to do these things, do you have that assistance when you need it as well? So, that's all part of the question as well.

You can see the results there. State 1, 23 percent of people said that no, they cannot eat their meals when they want to as compared to State – to 9 percent in State 2 and 4 percent in State 3.

Interestingly, and we didn't show this data here, but State 1 had the largest proportion of people who are living and – who are in the sample, who are living in assisted living facilities. So, there's probably correlation there.

All right. So, the second table is can you get up and go to bed when you want to, and the percentages of people who said no was lower there in all three states.

Next slide, please.

We asked the question in a survey whether – about whether the services that the person gets meet all of their needs and goals. And, that's the first table there. 90 percent of people in State 1 said yes completely compared to 84 percent in State 2, and only 80 percent in State 3.

The biggest difference is we're not in the number of people who said no, not at all but in the numbers of people who said some needs or only some needs or only some services.

Then we can also – the second table on the slide is breaking out those results from table one by the type of program in each state. So this is the number of people who said that all of their services are being met, but not broken out by the type of program.

And the interesting thing here to point out is that on State 3, a drastically lower percentage of people who were – who had a physical disability and were in a waiver said that all of their needs are being met.

This is, of course – next slide, please.

This is, of course, just a very, very short snapshot. The survey itself contains a lot more information. There is a pilot report that is not available on nonexisting website yet but it is available on NASAUD's website. So, you can access it there.

I mentioned that there were actually two pilots. There was a small scale pilot done right before the final version of the survey and that was about 50 cases. Just – you know, just – we're not really publishing those results because it was so small relative to these data.

Here's our contact info. And I think that's all we wanted to cover in those brief period of time, but we're certainly available for more information and thank you for having us on.

I think that's it for us.

Camille Dobson: Yes. We're happy to answer questions if there's time available, Allen.

Jennie Chin Hansen: Thank you so much for this really highlights of very substantive presentation. And as you pointed out, I know we're a little compressed for time. Perhaps it's – there – perhaps one question from the committee that we might raise or comment and what we'll do is, frankly, move into an opportunity for public comment as committed.

So, is there any particular comment somebody would like to offer right now?

Clarke Ross: Hi. This is Clarke Ross. In Susan Reinhard's absence, I wanted to bring up the issue when we're talking about social isolation of stay burden and stress on families and family caregivers. So, ask it in the context of the National Core Indicators project, do you have a component that deals with family support and family stress?

Julie Bershadsky: This is Julie. I can address that.

So, for the National Core Indicators, the IDD National Core Indicators, we do have a number of family surveys that are aimed at caregivers. For NCI-AD, we're planning to develop one. We haven't, you know, because this is year one, our focus has been on getting the consumer survey out and rolling. However, we do know that family care giving is a priority and a big, big issue.

So we are certainly going to be working on developing a survey aimed at caregivers.

Kelsey?

Kelsey Walter: Right. And that's a good point, Clarke. I think also, the NCI is kind of a suite of tools, right. So they also have a survey looking at staff ability. That's another thing that our members have mentioned they may be interested in. So, both of those, the family caregivers are and then also the staff's ability tool are something that we are thinking about for the future. But as Julie said, we're working on the launch of the project right now.

Clarke Ross: Thank you.

Jennie Chin Hansen: Right. Thank you.

It takes far more conversation but I do know that we need to move on at this point. And I would hope, again, and ask our members to raise questions and I would ask our staff to help us, perhaps, put the opportunity of what, you know, our presenters have done relative to things that the committee can think about.

So, at this point, what I'd like to do is ask our operator to give instructions to our public with any comment.

Operator: Thank you. At this time, if you have a comment or a question and would like to ask it live over the phone, please press star one.

You may also type your questions or comments into the text chat box area in the lower left corner of your window. Be sure to click Send to send your questions or comments directly to our presenters. We'll pause for just a moment.

Allen Leavens: Jennie, while we're waiting for any public comments to come in, perhaps we could see if there – you know, we have a couple of minutes to see if there are one or two other – any other comments from the workgroup.

Jennie Chin Hansen: Perfect. Thank you, Allen.

Charlie Lakin: This is Charlie Lakin. I think this is so promising.

One of the questions I have is kind of relates to how the NQF typically focuses on measures as opposed to instruments and wondering whether there will be some effort within this effort to identify items that might be more useful as measures rather than part of the large scale, either as composites or single items.

I'm struck with how many of those – many of the items have positive responses, top and positive responses at or near 90 percent and how measurement error alone would probably negate any assessment of positive change overtime. But, just those general kinds of considerations that might go on in terms of using items within the NQ – within the NCI-AD as individual measures.

The other thing, what about – what is going on in terms of discussing how these items or the full scale could be used for assessing the quality of individual providers as opposed to the state system?

Elisa Munthali: Hi. This is Elisa Munthali with NQF and that's a great comment.

Right now, we are just looking at performance measures and standards. But, one of the things we have been considering as it relates to survey and measurement is thinking about the individual items and surveys and perhaps looking at a taskforce to endorsement. We're not there yet but it is something that we're talking about at NQF.

Camille Dobson: Hi. This is Camille. I just wanted to add, Charlie, that we've also forwarded the NCI-AD and NCI indicators to (Drew) and the staffs at the HCBS measurements team that we're on for their consideration in identifying measured gaps and hopefully, moving that process forward so that individual indicators, perhaps, in the survey could get endorsed.

Clarke Ross: Charlie, this is Clarke. The slides make reference to the Council on Quality and Leadership personal outcome measures. Those are measures that were presented to us a few years ago and they focused on individual community providers for persons with developmental disabilities.

Julie Bershadsky: This is Julie. Just to add to that. Charlie, your question about the providers is definitely very relevant, given the state transition plans and, you know, the settings rules.

On the NCI side, we've been talking to states. The problem is, of course, if they want to use NCI to evaluate providers, then the samples would have to be completely differently designed. So we have been not recommending the states to do that, I mean, if they wanted to for a number of reasons.

But in terms of the capacity or the ability to make for these questions to be applicable to – or for some of these questions to be applicable to providers, there's really – I don't think we see an issue with that. We'd just have not gotten – we haven't gotten to having those conversations yet or starting to have those conversations yet.

Charlie Lakin: Thanks.

Jennie Chin Hansen: OK. Thank you for …

(Crosstalk)

Jennie Chin Hansen: Yes, Megan?

Megan Duevel Anderson: Can we go back to (Mhen) to see if anyone has joined us for public comment?

Operator: And there are no public comments at this time.

Megan Duevel Anderson: Thank you so much, (Mhen). Thanks, Jennie, for letting me jump in.

Jennie Chin Hansen: Of course. Thank you.

Well, we have probably maybe another couple of minutes if there's one other comment before we have our summary statement?

Cheryl Irmiter: This is Cheryl Irmiter with Easter Seals.

Regarding this last conversation, I was – I'm so glad you brought up about the NCI. The indicators being from a different perspective because from my experience with working with quality measures coming from the Physician Consortium for Performance Improvement, where I was at the American Medical Association and now, being in the home community-based sector.

The issues of the social and psychological processes that occur with those dual beneficiaries have to be captured in a different way. And the processing content aspect in the medical setting is defined differently than the process and content aspect designed in the community study.

And I'm hoping that we could think about that as we go forward with quality measures. And maybe that is one gap that needs to be addressed because it's been discussed. And it's been discussed among physicians that actually processing quality vary. And there's a challenge for physicians to do that depending on how they approach it. But it's going to be even a wider gap and a bigger issue in the home community-based settings. And I hope we can consider that.

Jennie Chin Hansen: Well, thank you, Cheryl, for that comment for the committee. I think your point and your expertise having worked at the American Medical Association and with physicians as we talk about the gap between clinical measures and medical measurement measures to that of the rest of the world.

This is, you know, by and far, one of the biggest areas that we need to bring back together. And I know that this is a readable profile this committee along with others at NQF. So, yes, I think you've pinpointed another level of specificity that will allow us to look at what we have to bridge and how we might do this.

At this point, I – well, I would like to turn it over to one of our other key staff, that's Janine Amirault, show – summarized the next steps that we're going to be addressing in this body of work this year. Janine?

Janine Amirault: Hi, there. Thank you, Jennie.

So I'm Janine and I'm a project analyst at NQF. And I just want to share couple of items with the group – workgroup and public participants.

So first, we will have a meeting summary available on the project website next week. And I also wanted to mention some upcoming meetings for you to keep in mind. On Friday, November 13th will be an All-MAP webinar. And then, followed by two dual webinar as the first thing on January 13th, and that will be to provide 2015 and 2106 pre-rulemaking input to the Coordinating Committee. And then there will be a March webinar on Tuesday, March 8th.

And then we'll have an April in-person meeting and that will on April 19th and 20th.

So, we will send out a travel memo to workgroup members several weeks prior to the in-person meetings.

And, just to remind everybody that we're always available for your questions and please feel free to contact us directly via e-mail. The project e-mail address is mapduals@qualityform.org and you can find additional information and register for upcoming events on the project webpage.

So, on behalf of the staff, thank you to our co-chair for facilitating today's meeting, and thank you to the workgroup members for their participations and for providing great discussions.

Back to you, Jennie.

Jennie Chin Hansen: And, well, thank you again. We thank you all for taking the time to review the materials, participate, offer your expertise as well as raise some points that the committee as a whole needs to look at.

We thank – we deeply thank Allen and Megan for their intense preparation throughout the materials in gathering our speakers here for our learning in the course of this meeting.

So again, thank you to interesting members of the committee and our newer members. And I know these promises could be a very fruitful year. We thank our CMS contacts for setting the stage, giving us a sense of some of the projects that they've been able to move.

And, at this point again, I'd emphasize do not hesitate to use the e-mails to continue to communicate with us.

So with that, I would like to thank you all and adjourn the meeting.

Allen Leavens: Thank you very much, Jennie. And thank you to all our workgroup members.

Jennie Chin Hansen: Yes, OK.

Operator: And ladies and gentlemen, this does conclude today's conference call. You may now disconnect.

END