NATIONAL QUALITY FORUM

Moderator: Peg Terry
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OPERATOR: This is conference # 39965103

Operator: Welcome to the conference. Please note today's call is being recorded. Please stand by.

Peg Terry: Good morning or good afternoon depending on where you are and I want to welcome everybody to our post-committee call – or post-conference call. And I want to thank people who actually alerted us this morning to our technical glitch. It really helped us deal with it and hopefully everybody will be on the call today. In particular I want to thank the members of the committee for their participation.

I want to welcome those who are on the public line as well as our members and today will conclude the work from the in-person meetings. So with that, I'm going to turn it over to Jennifer Moore, one of our co-chairs, and Bill Golden, our other co-chair. Thank you. Jennifer?

Jennifer Moore: Good morning, everyone, or afternoon or wherever you may be. I have a colleague who's in China right now and I'm not exactly sure what time it is there but welcome to everyone to this call. Bill and I are really excited to have this follow-up call to do a debrief and also complete some of the work that we started last week. And I hope that our member – fellow member who allowed their dog to participate in the call last time will also join us for today's call.

So thank you everyone for joining us and I'll hand it to Bill.

Bill Golden: Oh, just ditto. It's been such a long time since we got together so I'm sure we need to do a lot of refreshing so I'd say let's move forward and get the call underway. And I want to thank everybody for being so engaged in the last meeting so hopefully it will be the same today.

Tara Murphy: Great. Thank you both. This is Tara Murphy with NQF, welcome, everyone. Just quickly want to introduce the staff in the room so you know who's listening in. Again, this is Tara Murphy, I'm joined by my colleagues Peg Terry who you just heard from, (Miranda Kulajara), Kate Buchanan, and Shaconna Gorham. Now we're going to roll into a brief roll call.

No introductions necessary, just a simple yes, I'm here, when I call your name. So I'm just going to go with the guest list you see on the screen. I know there might be a delay if you're getting off mute but just let us know that you're here so we can count all of you. So Karen Amstutz? Sandra Finestone? Andrea Gelzer? Allison Hamblin? Christine Hawkins? Maureen Hennessey?

Maureen Hennessey: Here.

Tara Murphy: Oh, yay. We have one. David Kelley? Deborah Kilstein?

Deborah Kilstein: Here.

Tara Murphy: Joining us from Paris, I believe. How very dedicated, thank you.

Deborah Kilstein: No, no, no, that's not this meeting, that's the meeting in September.

Tara Murphy: OK. SreyRam Kuy? I think I see Dr. Kuy is on the web platform so if you're not on the line, you can just shoot us a little note and we'll mark that you're here. Barbara McCann?

Barbara McCann: I'm here, thanks.

Tara Murphy: Sarita Mohanty? MaryBeth Musumeci?

MaryBeth Musumeci: Here.

Tara Murphy: Michael Phelan? Cheryl Powell?

Cheryl Powell: Here.

Tara Murphy: Sheryl Ryan?

Sheryl Ryan: Here.

Tara Murphy: Jeff Schiff?

Jeff Schiff: Here.

Tara Murphy: John Shaw?

John Shaw: I'm here.

Tara Murphy: Alvia Siddiqi? Susan Wallace?

Susan Wallace: I'm here.

Tara Murphy: And Judy Zerzan? OK, thank you all. If there's anybody who is not on the phone but is listening in on the web platform, please note that in order to participate in the discussion you'll need to also dial in. For the purposes of the roll call, you can shoot us a quick note in the chat function and we'll capture that you're on the call. But if you can, please dial into the number so that everybody can participate in the discussion.

SreyRam Kuy: Hi, this is SreyRam, I just wanted to say I'm here too.

Tara Murphy: Oh, hi, Dr. Kuy. Thank you. Is there anybody else who did not hear their name called?

Michael Phelan: Yes, Mike Phelan, I'm here but I didn't know you couldn't hear me on the computer.

Tara Murphy: Yes, thank you. OK, thank you all. So we'll move on now to our meeting objectives. As you know, the purpose of today's call is to make final recommendations for strengthening states Medicaid delivery system reform.

Unlike our in-person meeting last week, we'll not be spending the majority of our time focusing on specific measures. Rather we'll review the measure sets in their entirety and discuss themes and challenges that members of the (committee) have identified for each of the program areas.

And one last item before we dive into the content of today's meeting. You'll see this timeline that you're very familiar with by now, our timeline on deliverables for this project. Following this call, the next step will be the NQF team drafting the report and posting it for public comment. The report will open for public comment on July 21 and close on August 21.

We encourage all members of the committee to comment if they so choose. And then following the close of public comment, the coordinating committee will convene one last time on September 5 to review the comments received on the report. You should all have this appointment on your calendar already. If you do not, please reach out to a member of the NQF staff.

And the final report will be submitted to CMS on September 14. I'll now turn it over to my colleague Shaconna Gorham.

Shaconna Gorham: Thank you, Tara. So we just want to do a final review of all the measures that – first I want to reiterate the definitions of a performance measure and a measure concept. A performance measure is a fully developed metric that includes detailed specifications and may have undergone scientific testing. Care specifications of the measure allow the measures to be repeated across state health plans, et cetera.

This performance measure definition is used in all of our NQF framework projects. This definition is more suitable for measures used in the Medicaid population. Measures that were not developed with the intention to be submitted with NQF endorsement (while) these measures may never make it to the endorsement process, they are measures nonetheless with results and we should definitely note that and applying this definition to this project will broaden the number of measures versus concepts included in the final set recommended to CMS.

A little later, staff will note which measures initially designated as concepts – which of those concepts have been reassigned as (measures) based on the updated measure definition. And then lastly, the measure concept definition; an ideal for a measure that includes a description of the measure including a plan target numerator and population (the denominator).

The purpose of this web meeting, as Tara stated, and final review is to take a comprehensive look at the (set) so we know from CMS that the measures that's recommended will be a starting place and a resource for the state Medicaid agencies developing measurement strategies for their delivery system reform efforts. The bullets on this slide include some important areas that the (C.C.) will consider for future enhancements of the set.

So they include, are the measure sets balanced representing diversity of measure types including access, structure, process, outcome, (PSPRO), et cetera. Do the measure sets address mostly if not all of the critical issues in the program area? Do the measure concepts add significantly to the measure set? More importantly, where are they in the development process?

Are they near the end of the development process? As we know, CMS requested no more than 30 percent concepts to be included in the set. Have we stayed within those parameters are questions that you would want to ask as we review the final sets. And then finally, do we have measures that can easily be implemented by all states? Next slide.

As Tara stated, the report is due September 14 and will reflect the committee's thoughts on themes for each program area and high-level recommendations for future tweaks to enhance the measures and concepts included in each set. I'll take a few minutes to highlight a few things discussed during the in-person meeting. (The committee) discussed lack of measures addressing pediatric populations and women's health.

Measure variations which as you know are changes to measure specifications and those reasons for variations are varied including implementation challenges, patient demographics, resource limitations, data infrastructure, et cetera. (Purposes) for fully developed measures versus measure concepts, and

then finally necessity for measures that work in both fee for service and managed care states.

So we have noted those themes, again, that were highlighted in the in-person meeting. As you go to review the measure sets, if there are additional themes that you would like to add, definitely do so, as Tara said, if you are on the web but not dialed in, please dial in so that you can participate in the discussion. So with that, I will turn it over to Miranda.

Deborah Kilstein: Hi, this is Deborah Kilstein. Can I make one comment?

Shaconna Gorham: Sure.

Deborah Kilstein: About the necessity for measures that were in both fee for service and managed care states, we may also – we talked a lot about – it won't work in all managed care states depending on whether certain services are carved in or carved out, could also impact the measures that a state chooses.

Shaconna Gorham: Yes, thank you for bringing that up.

Miranda Kuwahara: All right, if there are no other questions we can dive right into our BCN measure set. During the coordinating committee meeting two measures were added to the BCN core site. They include adult access to preventive ambulatory care 20 to 44, 45 to 64, and 65 plus which was added as a referral from the LTFS test.

And N2S number 2483, gains in patient activation scores at 12 months was added as a measure identified for reconsideration by two members of the coordinating committee. Additionally, two measures were removed from the DCN core set. They were follow up after all cause emergency department visit and potentially avoidable emergency department utilization.

In total, the coordinating committee recommended 18 measures and one measure concept for the BCN measure set. This slide reflects a breakdown of the measure variations based on domains, measure type, and data scores. The greatest proportion of measures fell under the safety domain which largely

held re-admissions measures. Process measures were much heavily less defended followed closely by outcome measures.

And finally, more than half of the BCN measures were claims based measures. Over the next three slides, we have what's to be the BCN measure set which reflects the CC's recommendations. This information is also presented in a handout titled "Program Area Measure Set." You can look on to that as well. A handful of measures were originally designated as measure concepts based on the text review.

However, (SASS) reassessed measures using the updated definition of a measure and we have re-designated adult access to preventative ambulatory care 20 to 44, 45 to 54, and 65 plus as well as follow up after emergency department visit for alcohol and other drug dependents as measures per lengthy discussion during the in-person meeting and discussion with CMS following the in-person meeting regarding the importance of alignment with Medicaid core sets.

Measures that have been removed from the core set will not be included in the IEP measure set. Thus in QS measure number 0648, timely transmission of transition record discharges from an in-patient facility at a home, self-care, or any other site of care will be removed from the BCN measure set.

So we have N2S number 0105 anti-depressant medication management and NQF numbers 5 (inaudible) -- follow up after hospitalization for mental illness are included in the adult core set. I also want to bring to your attention that NQF number 2605 follow up after discharge from the emergency department for mental health or alcohol or other drug dependence, as well as NQF number 1768 plan all cause re-admissions are also included in the Medicaid adult core sets.

One finished re-design designated as (inaudible) potentially preventable emergency room visits and potentially preventable readmissions have been re-designated as measures. And before I hand it over to Jennifer, I wanted to acknowledge our CMS colleagues on the call. I believe we have (Catherine Griffin) and Beverly Lofton on the line.

Beverly Lofton: Yes, this is Beverly. Hi.

Miranda Kuwahara: Jennifer?

Jennifer Moore: Thank you for that overview. As everyone can see on this slide, slide 15, these are some of the high level themes that were discussed at part of the BCN discussion during our in-person meeting last week. A few items that we just want to highlight here, we noted that medically complex children represent a large portion of the BCN population.

And recognize that there is a need for more measures addressing this population. When having a discussion about the BCN population, we also discussed continuous -- the need for continuous access to primary and preventive services to reduce hospitalizations and acute events. And following up on the issue in order to adequately serve the BCN population, providers need to look at the whole person and the measures need to reflect this type of work.

We also noted the important role the patient plays in their care and that there should be more patient activation, patient engagement type of measures in this space. Next slide? So based on our discussion and your review of the measures, we also wanted to discuss some specific items and these items are listed here on slide 16 for you to view.

Just a few items to throw out there to get the discussion started, are there recommendations for additional themes other than those mentioned on the previous slide? We reviewed the final sets made available to both on the slides and handouts provided.

But we want to step back and look at the measure set as a whole and see if we can agree that this measure set is balanced for the reverse measure types including process outcome, patient reported outcome pro, et cetera, measures recognizing that there are some measures that do not fit or groups of measures that don't fit in with any of these areas or are lacking.

We want to address most, if not all, the critical issues in the program area and as a reminder the critical issues are key concepts identified in this area include

potentially avoidable hospital and emergency department utilization, self management, coordination of care, continuity of care, transitions across care settings.

And then we want to discuss whether these measured concepts add significantly to the measure set and are they near the end of the development process. For measure concepts, we got to make sure that they can be easily implemented by all states. And finally, are there high level recommendations for future iterations of process measures that's in the BCN program area?

So before we begin the conversation, if we can go back to the previous slide on 15 to see if anyone on the call feels that we may have missed some of the high level themes that we identified as part of the discussion before we start to dive into the questions on slide 16?

Allison Hamblin: Hi, this is Allison Hamblin, this may be intended to be embedded in the theme around whole person, but in case it's not embedded, I would say I think one of the other themes we discussed was an absence of fully developed measures at this point that really reflect the social determinants of health for the BCN population.

Jennifer Moore: Yes. That's a great addition and I think it's important to make sure that we clarify each of these points and add those nuances and contextual information so thank you for bringing that up. And if I recall correctly the concept of activation, engagement, and also socially determinates of health were themes that interspersed through the other measure sets also.

Maureen Hennessey: Yes, this is Maureen Hennessey. I would say that I would agree with that. And with that, I would also really focus in on the fact that NQF is giving further deliberation to the area of measures to determine health equity and certainly that would be a theme within the materials that we're reviewing today too.

Allison Hamblin: Great, thank you.

Jennifer Moore: Additional thoughts on this list? I want to thank NQF staff for pulling this together for each of the measure sets. As you can imagine, they have a lot of

transcripts to work through from the two day meeting and were able to very quickly pull some of the high level themes for this discussion today so thank you to NQF staff for doing that.

If there are no additional items or thoughts on this particular slide, I think we can move on to 16 to discuss some of the other items that we need to cover for this call for the BCN set. Before we jump in, NQF staff, can you let us know how much time we have for this portion of the discussion so that we stay on task? Or will you let us know when we have one minute left?

Shocanna Gorham: We definitely will, we'll let you know when you have two minutes left.

Jennifer Moore: OK, great. Thank you for that. So let's jump into the second bullet item and open it up to the group as to whether or not the measure set includes diversity of access, structure, process, outcome, patient reported outcome -- although, I think as a group we identified that there's a continued need for that and then whether or not it addresses the critical issues in the program areas.

Jeff Schiff: This is Jeff from Minnesota. I just want to -- I think outcome is tricky because I think there are some health outcomes that are in here but I would say that and maybe this is back to the last point. I think some outcomes as far as -- as far as well being, functional status, ability, the worker bee in communities, et cetera like that are not as strongly represented here. Maybe they're more in the other set on (LPSS).

Female: Yes. Thank you for that. Any other observations?

Male: The need for…

(Cheryl): This is…

Male: Oh sorry…

(Cheryl): Go ahead.

Male: Go ahead. No you go.

Female: Ladies first.

(Cheryl): This is (Cheryl). I was just going to reiterate that we really don't have very broad measures for the pediatric population. Especially the population of kids with special healthcare needs. So you know I just really think that from the whole breadth, you know whether you're looking at the access process outcome or satisfaction, sort of patient orientated, so I wanted to reiterate that.

Female: Thank you.

Deborah Kilstein: This is Deborah Kilstein, I would also say to consider (where raising) gets the same measure but stratified by different populations is something worth considering.

Bill Golden: This is Bill Golden. One of the things I've seen locally is complex pediatric cases usually are very disease specific and they get a lot of their care in a specialty clinic and they're often is I would say less than an optimal care coordination done by that specialty clinic which in many ways is the principal care provider as opposed to a primary care provider. So I would like to see some measures looking at the effectiveness of care coordination by that principal care provider. So an example would be the hematology clinic for hemophilia or the pulmonary clinic for Cystic Fibrosis and how well they coordinate and follow up when the child is home or going to an ER, that kind of thing.

Female: Yes.

(Cheryl): This is (Cheryl). I think that's a great, that's a great point. In Connecticut we just recently a couple years ago probably started something called the wrap around services where kids with higher needs either psychiatric or medical or combination were identified through increased use of emergency rooms and also meeting a number of criteria and they were assigned a care coordinator, through the primary care center to sort of just oversee what was going on, whether they were coming to primary care appointments and who was coordinating things.

I don't think there's been any, and this has all done through the Medicaid population, I don't know of any measures that are looking at the effectiveness

of that. So I think that is really important because there are a number—I don't know if there are other states like Connecticut—but there's a significant amount of resources that have been put into that so I would like to just second that statement that was just made because I think that's really important.

Jeff: This is Jeff. Actually that was Bill, so that was pretty good coming from an internal medicine guy.

(Cheryl): Thanks Bill.

Jeff: But I actually just wanted to ask because in this setting we never saw the family experience with care coordination or (inaudible) which is a measure that has been endorsed by (NQF) or a set of measures that we were involved in developing or the Boston Children's Pics Measures, I'm not sure what the acronym is but there are measures of experiences with care coordination for the families that maybe, I'm not sure if they got screened out earlier in the process or not but those kind of measures are actually being developed.

(Allen): Thanks (Allen) here. This is a patient engagement tools that are out there whether or not for future iteration to this, I think measures that are able to capture how well the patents are engaged are going be critically important going forward to identify patients who may need more resources, it's a thought.

(Maureen): Yes, this (Maureen). I would absolutely agree with that. And the other thing I would say is that even beyond that I would look at more broadly at patient-reported outcomes measures and I would suggest that in terms of looking at the measure sets of being able to determine what percentage were processed versus outcome that were developed, that were nominated or recommended for inclusion. My general impression is that we have more process than outcome but I think that it would be helpful just to go through and see how a NQF has classified these to give us a more objective way of doing that. Thank you.

(John): And this is (John). Just re-emphasize the gap we have in the measures that just went in the other ones as well. In the Upstreet measures, the population health and prevention and part of the reason may be that they're tied in with

the social determinants and the need to engage other sectors. And engaging other sectors is difficult at the federal, state, and local level. Although at the local level they seem to be doing the best at it and that maybe a source for looking further.

(Maureen): Hi this is (Maureen). Thank you for putting back up on the screen that categorization. I'm actually pleased to see that we have as many outcome measures as we do there, almost as many as process which I think is positive. Certainly the patient reported outcome is a clear and glaring area of -- or gap. And then I think that just the whole issue of increasing, increased need for electronic measures as well.

Male: A quick question on the slide. They have 11 claim measures and no administrative measures. I thought claims measures were administrative measures. I thought claims measures were administrative measures. Can you define that better for us?

Female: Yes, they are. Claims measures are part of administrative measures. Administrative measures could be not just claims measures, it could be some basic demographic information as well about the patient but that will be part of it but they are a part of claims measures, yes.

Male: Yes, it looks like it's going to be redundant or potentially redundant. My question is pharmacy, you can get a lot of pharmacy stuff is inside the claims. So it depends on how you…

Female: How you're defining it, right?

Male: Yes.

Female: Yes, thank you. Any other thoughts on the, I mean as a reminder some of the critical issues that we want to look at is potential avoidable hospital and emergency department utilization, self management. We've talked about care coordination, continuity of care, transitions across care settings. If you look at the measures…

Dave Kelley: This is Dave Kelley. I actually went back to the original spreadsheet and it looked like there were several transitions across care setting metrics that have an NQF endorsed number. And again when you look at the scoring of fairly high scoring, I'm not sure why it didn't make it on to the second tab. So do you think we should take a look at some of those if folks think that's important enough?

(Tank): Can I just ask are you talking, this is (Tank here at NQF), are you talking about the timely transition of record information or medication information, of those what you're thinking about?

Dave Kelley: Actually I went back to the big, huge spreadsheet and I'm trying to pull up more detail here but it looks like there are several under care coordination.

(Tank): You know, I think we did, you we had this process where we, and if they're NQF endorsed they probably did go through the test because we had a cutoff point is originally how we did it. So anything that was any measure that was NQF endorse clearly was above the cutoff point and we can't really at this point figure out and tell you why someone may have dropped off by the tab. There was an opportunity to actually pull those in at the beginning if you saw that there were some measures that we could have included that the (tab) did not recommend.

And we do know that one of those measures 0648 will be coming off and that is a measure that is a transition measure and the reason is that it has been taken off the Corset and we're trying to align across these Medicaid programs and but after our conversation with CMS, we decided to take that off this list. Just a little update on information and the process we had.

Dave Kelley: OK thanks.

Female: And Jennifer, just as a matter of timing, you have one minute.

Jennifer Moore: OK, thank you. So going to the last bullet point here, are there any additional high level recommendations for future iterations of the measure sets and the BCN program area and before we jump into that I just want to reiterate the discussion that occurred as one of the high level items that was identified by

NQF in a previous slide about the need if additional funding becomes available to really look at these measures and explore opportunities to look at how they're being implemented and the variation from state to state.

And what that impact is on the validity and the reliability of those measures and then thinking about how to then think about in the scope of measure development what we should be looking at to make sure that it can be adapted and not lose its validity and reliability. That would be one of the big I think takeaways that we saw from all of the measure sets that we feel as really important. So I just want to reiterate there.

But wanted to see if there were others that folks have specific to the BCN measure set that we may not have captured in the previous slides?

Jeff Schiff: Can I – this is Jeff – can I just ask that – I think that's a good piece of work to see how states are implementing each of these – but I think something else that would be of significant value and we spend some time on in our state is looking at the suite of measures we implement.

Because a lot of people may implement a re-hospitalization measure or a (PAM) or something like that but it's really taken as a whole (whether) the set is functional in the state. I think that we should ask that that's a high level recommendation as well.

Jennifer Moore: Yes. Absolutely. Thank you for that. Any others? OK. Great. Thank you, guys.

Tara Murphy: Great. Thank you so much, Jennifer.

Hi, again, everyone. This is Tara. We're going to turn our attention now to the reducing substance use disorder program area measures.

So here you see another overview slide, this time, for this SUD set. As we can see the CC recommended 27 measures and concepts for this program area. Twenty two measures and five measure concepts. Of these 27 items, three are included in the Medicaid core set. Of the measures in the SUD measure set,

20 items are categorized as clinical care, four were categorized as access measures, two address care coordination and one addressed safety.

The set includes only two outcome measures. NQF staff has noted the comments from both the (SCD-TEPP) as well as the CC that addresses the (dearth) of outcome measures in this area. The SUD measures represent a variety of data sources. As you can see, many measures utilize pharmacy and patient reported outcome data as well as claims and EHRs, and like we said, there's a lot of overlap in those definition.

The discrepancy in the tally you see on this screen for the total number of measures can be attributed to the fact that many of these measures are specified with more than one data source. And all noted data sources are accounted for in this tally.

Next slide. So on the next – this slide and the next three – you can see the measures that are included in the final recommended SUD measure set. Please also refer to the document that was included in the meeting materials called, Medicaid IAP-CC Program Area Sets, which includes a full list of measures for all program areas for your reference.

Two measures listed on this slide are included in the Medicaid core set, reinforcing alignment between the core set and the IAP measure sets. Those measures are NQF number 0004, Initiation and Engagement of Alcohol and Other Drug Dependence Treatment, and NQF measure number 2605, Follow-up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Dependence.

Following the NQF staff re-evaluation of the measure-measure concept designations for all recommended measures, we determined that the measure percent of patients prescribed a medication for alcohol use disorder fits the designation of a measure concept and it has been marked as such.

The change – excuse me – in this designation for this measure is not due to the change in measure definition, but rather due to a previous mis-categorization. On this slide, only one measure is part of the Medicaid core set, and that is

NQF number 2940, Use of Opioids at High Dosages in Persons Without Cancer.

On this third slide of measures, the same change in measure-measure concept designation applies to percent of patients prescribed a medication for opioid use disorders, OUD, which has been changed from a measure to a measure concept designation. This change again comes not from a change in the definition but from a previous mis-designation.

Alternatively, the measure, substance use disorder percentage of patients aged 18 years and older with diagnosis of current alcohol dependence who are counseled regarding psychosocial and pharmacologic treatment options for alcohol dependence within the 12 month reporting period has been changed from measure concept to a measure designation as a result in the change of the measure-measure concept definition.

And likewise on this final slide of measures, the measure, substance use disorders percent of patients age 18 years and older with a diagnosis of current substance abuse or dependence who were screened for depression within the 12 month reporting period has changed from a measure concept to a measure.

The last two measures you see on this screen were added by the CC during our meeting two weeks ago. Those measures are mental health, substance abuse, mean of patients' overall change on the basis-24 survey and NQF number 2951, Use of Opioids at High Dosages from Multiple Providers in Persons with Cancer – (or without Cancer).

OK? Next slide.

So during the in person meeting, the CC identified two additional measures from other sets for inclusion in the SUD measure set. The first measure is number one in your discussion guide if you are referencing back for specification – that is, adult access to preventative ambulatory care, 20 to 44, 45 to 60, for 65-plus, which assesses the percentage of members 20 years and older who had an ambulatory or preventative care visit.

This measure should be very familiar to everyone by now; we discussed it at length in our in-person meeting and as you'll recall, it was recommended to the SUDs program area.

The second measure, number four in the discussion guide, and that is follow-up after emergency department visit for alcohol and other drug dependence – (FUA) – which looks at the percentage of discharges for patients 18 years of age and older who had a visit to the emergency department with a primary diagnosis of mental health or alcohol or other drug dependence during the measurement year and who had a follow-up visit with any provider with a corresponding primary diagnosis of mental health or alcohol or other drug dependence within seven and 30 days of discharge.

Following this meeting staff will send a survey monkey which asks if this measure should be included in the SUD program area. This is a simple yes or no vote and we ask that you respond by COB Friday the 23rd. As with all voting, we will need quorum so it is very important to complete this survey on time. We will also request in this survey that you include a brief rationale of your support of your, to support your vote.

I will now turn it over to Bill to facilitate the committee's discussion on themes identified in this program area, Bill.

Bill Golden: So you know it's a complex area with only now emerging metrics to be used so obviously we have some bullets here that you can read. You get into issues of screening and intervention and sometimes they mix the two together. I think also you might want to talk about the fact that two CMS that be expecting interventions with screening or other activities, that there may be a stress or limitation of resources in local communities to achieve the interventions that would be expected. I have some concerns about medication treatment, assisted treatments.

Again, its carve out privacy and again limitations on availability. Different states have different requirements for people to provide that kind of service. And then the question of (inaudible) of therapy or not was a controversial area

for discussion. Then we have there was a lack of HIV screening measures, poly hepatitis measures as well in this population.

Next slide. Let's go back to the other slide then, does anybody else want to add to, wrong direction. Oh you know, I guess the same slide, I guess not. Does anyone want to add to some of the themes that were there or during our discussions about the measures that you think should be included?

Maureen Hennessey: This is Maureen Hennessey I would add a comment about an additional comment about medication assisted treatment. In some locations there are challenges with having sufficient individuals to provide medication assisted treatment and also in some networks that may be some limitations in that regard. For example at Behavioral Health Network, my only select (F4 provider) membership or participation individuals who are behavior health, for example psychiatry providers, as opposed to also considering individuals who are non psychiatrists such as internists who also have the credentials to provide MAT.

Male: Yes, and then I think you get into also the issue of concomitant use of other medications that could become problematic. So screening for whether there's opioids being prescribed or benzodiazepines concomitantly. There's a variety of activities that could make the could thwart or to make more complicated the MAT activities.

Male: And if I can kind of ride on Maureen's comments there, there's a real, even a structural measure of providing some community resources that are, might be available. It's always bothered me that there's not even that because there's sometimes some of the resources like the MAT and stuff like that are not going to be provided in the clinic they're going to. It may be a local community resource that you need.

So the idea of providing community resources to patients with these issues (could) be an important measure to have.

Male: OK.

Male: …comment on MAT or other aspects of this?

Jeff Schiff: No, this is Jeff and I think one of the themes that we need to put in here is that we don't have any measures that look at addressing prevention of chronic use or prevention of addiction. We have the measure for high dose and in Minnesota and some other states, we've actually working on measure development around what we call new chronic users.

So there's no measure that really hits on the responsibility of the provider community to not (to limit) their prescribing except for the very high dose, high duration measures.

(Cheryl): Yes, this is (Cheryl). I'll second that. You know, we don't have any measures that looked at whether there was inappropriate use of opioids for things that there's not an accepted indication, it was just the high doses, the 90 milligrams, the 120 milligrams (that) people who don't have (cancer). Yes.

And in addition, we didn't -- we really just didn't have any measures on population level prevention or you can see there's nothing here on safety or on patient satisfaction, so we really were limited by what was out there. There's just wasn't even measures that we could even review in those areas.

Jeff Schiff: Yes. Our measure missed the sweep when they look for measures but we have a measure we're using in our system of the number of new chronic users who are opiate naïve and then go on to have chronic use in an enrollment period. So I think -- we're working on that. I think some other states are as well.

David Kelley: This is David Kelley. Just to comment -- goes back to the earlier metric (over here) I'm looking at the percent of patients that they're prescribed medication as just a treatment. One of the metrics we've developed -- at least in Pennsylvania and food for thought here is to actually look at the number and percent of individuals in MAT who get any behavioral health service, whether it's drug and alcohol counseling or mental health services.

And I know in our metrics, we've seen it's had some (fortunality). Less than like 40, 45 percent. So that is -- I think -- something we really need to think in terms of in the future for medication assisted treatment because it is --

especially early on -- a key component. And we know that a lot of these individuals have co-occurring diagnoses.

Bill Golden: Other items on this. I guess we can have a little invitational (e-conference here to sound) like the IOM if we keep going. But all sorts of issues here (inaudible) and discuss (it's scenarios), I think. This is William. Just the beginning of what we should be looking at in the future here as well.

Other comments on this before this (or) the next slide? People can circle back, too. So other additional themes, I guess we've kind of talked on that. Do we have diversity, structure process outcome, patient core outcomes, critical issues, other recommendations.

You know, when you talk abut diversity, you talk about diversity of patients, you could even talk about diversity of providers. And I know a number of people now are looking at prescribing habits by dentists versus physicians versus E.R. doctors, that kind of thing. There's all sorts of interesting ways you can slice the prescribing habits of a community.

(Cheryl): This is (Cheryl). I agree. There was just an article that just came out looking at just the distribution of who's getting medication assisted treatment across the United States of young adults and adolescents.

And they found that really, there were areas where the need was high but -- say in metropolitan areas -- but yet kids in rural areas were far more likely to get medication assisted treatment than people who were in metropolitan areas.

So there's a real -- there can be a real mismatch. So being able to stratify by age, by ethnicity and by geographic distribution, I think, are also going to be really important to look at the diversity of access. And we don't really have anything that looks specifically at that.

Bill Golden: I think (down the road), we need something like measures that would specifically target telemedicine interventions on topics such as this or behavioral health. Is that a unique service that needs it's own set of measures?

Female: I think that's a great point. And could we go back to the slide that sort of summarizes the different kinds of measures, please?

Bill Golden: Sure.

Female: So we can see how many were processed versus outcome and so on.

Bill Golden: That was about six slides back unless it's going to come…

Female: I think there are basically two outcome measures in the whole group and the rest were processed. Yes, there we go. Twenty-five were processed, two were outcome.

Female: Well that says a lot about the outcome fees. Although I do have a question. We've got (PROPM=12) and those are outcomes measures, so I wasn't quite sure what the difference was there. If you look at data source, it says (PROPM12). If you look at measure type, it only has two for outcome.

Bill Golden: Anybody from the staff want to make any comments on that?

Female: Yes, we're just looking at that. That, actually, frankly -- we need to look at that a little further, I'm sorry to say. Because it should be part of the measure type, so we need to look at that.

Female: Thank you. Appreciate it.

Bill Golden: Let's go back to the slide. Again, any of the themes people want to bring up or concepts or frameworks?

Did we have anything, specifically about pregnancy in this? I guess not. We talked about a little bit, about the difficulty in screening.

(Cheryl): This is (Cheryl) again. I had voted to add one, I think to the one of the other groups. It might be DCM but it might be the other one, one of the other (text) that looked at screening prenatally and immediately after birth for pregnant women. And that was one of the things that we had identified, that there were no measures that we could even look at.

There were none that we could choose from to discuss that specifically looked at screening during prenatal care. So that was one that was brought into another data set and we thought that that would equally be important for the (substance use tab).

Maureen Hennessey: This is Maureen. I think that that's in the physical and behavioral health integration set and I believe…

(Cheryl): Yes. I think so.

Maureen Hennessey: …different screens for pregnant women in there, including violence but I believe there's also a screen with regard to substance use, including tobacco use as well as alcohol and other drugs. Thanks. But we can check that when we get to that. Thanks.

(Cheryl): Yes, I think we added that one in…

Jennifer Moore: We did. And this is Jennifer. And I remember we had a really interesting conversation about the challenges we've had associated with the state laws that criminalize women who are misusing and seek treatment.

So there's sort of that dichotomy of we're providing you with access and we want you to access treatment but oh, by the way, we may also criminalize you and prosecute you for your use. So I recall that conversation also.

Bill Golden: The other thing -- again, since we visited, I think I saw a report about that Florida now has an explosion of private detox treatment -- or not detox, but rehab centers. And they run through people's insurance and then the kids are kicked out onto the street and now, they're kind of homeless and back addicted again.

We really don't have any outcome measures or persistence of effect measures for people who've had in patient rehab. And perhaps there's a need for some sort of an outcome of patients who remain abstinent or out of the health care system after an in patient stay for drug treatment.

Female: (Think so)…

Female: I mean in that -- oh, go ahead.

Female: You can continue in just a second. I just wanted to let everyone know that in the last four minutes of this SUDs conversation, they also have the option to discuss the two measures that are proposed for inclusion in the SUDs measure set. We can put those back on the screen but those are the measures that will be sent around via survey.

So if there are any comments on including or not including those measures in the SUDs program area, please be sure to bring those forward now.

Male: Why don't you put that (inaudible) up and then people can…

Female: There you go.

Male: …mention it during the rest of the conversation. That'd be fine.

Female: Sure. There, it should on your screen right now.

Bill Golden: Any other comments on this complex area?

Sarita Mohanty: Hi, this is Sarita Mohanty. Just a quick question. In the process measures, can you remind me if there were any (look or) on how cognitive behavioral therapy and it's impact on -- or even just if people are accessing cognitive behavioral therapy.

Was there any discussion of -- I'm trying to -- I just don't remember and I'm looking through my notes here -- if that came up. Because I know there's a lot of emerging literature on (and ending) practice about using CBT, for example, in substance use disorder.

(Cheryl): This is Cheryl. I don't recall anything specific about that. There might have been -- there are things that -- where somebody screened for psychiatric or where somebody provided therapy. But there wasn't anything specifically, if I'm remembering correctly, that looked at CBT specifically, no.

That's a good point, though but I don't think we found any measures or there were none…

Sarita Mohanty: …measure. OK. That was my question. I think I remember looking through this and there were probably no validated measures or measure that we…

(Cheryl): Yes.

Sarita Mohanty: Thank you. Thank you.

Bill Golden: OK. Other comments?

David Kelley: This Dave Kelly. That previous question goes back to my comment about thinking of the future in terms of looking at people that are undergoing treatment with MAT and whether or not they get any behavioral health service and you could certainly specify particular services. That it is something we do measure in Pennsylvania.

I can tell you there's a lot of room for improvement.

Maureen Hennessey: Yes, this is Maureen. I'm looking at the follow up after emergency department visit measure and thinking also about the comments that were made by another person on the committee about outcomes after in patient care. I think you could certainly look at it from an even broader perspective, which is outcomes after an episode of care, whether it be inpatient, outpatient or partial.

There's certainly a need by segmentation in terms of population ages and types of treatment that are delivered to have a better sense of what the outcomes are in that regard. It's a real challenge, however. I will acknowledge that. For example at one time, the joint commission had a measure that looked at follow up after discharge from the hospital just for tobacco sensation and it was a real challenge, too, for them to get that data.

So I think we're going to see some issues in that area but it's one that certainly should receive additional attention, particularly given what we're seeing presently in the way of outcomes and mortalities.

Bill Golden: OK. I hear some silence, which is I guess sort of like a jumbo shrimp. And so I think we're almost done here. So why don't we move on to the next topic area.

Kate Buchanan: Great. Thank you so much, Bill. So thanks, everyone. This is Kate Buchanan again and as you (are welcomed, all of you'll) receives breakdown five now. Here, you can see the breakdown of the 29 measures and one measure concept recommended by the C.C. within the physical mental health integration measure set.

And so just want to do a brief summary of what we recommended. So as we mentioned during the in person meeting, the majority of the measures within the PMH program areas follows in the care coordination and clinical care CMS quality domain. There were no measure in patient and caregiver experience or the population health and prevention domain.

And the other two, there were just a few measures. If we move on to the measure type, you can see that two (of) the measures were process measures. So less than 15 percent were outcome measures. We do not have information on the non-NQF endorsed measures, which we indicate on the slide as well.

Lastly, we analyzed the data sources used to report on the measures. As Tara mentioned, measures can have multiple data sources. And the most common sources we found within the PMH program area were claims, the clinic health records, paper and pharmacy records.

So if we move on to look at the PMH measure set -- and as Tara mentioned, this is also in an attachment to the calendar invite, in case you want to be able to see all of the measures in one area. But I want to draw your attention to a couple of things. One, that we reviewed the PMH measure set and found that there are nine measures within this measure set that are also in the Medicaid (in) adult child core sets.

So this really speaks to one of the goals of the project, which is to promote alignment among reporting. And so on this slide, we can see that of the nine, we have two here that are within the adult and child core sets. One is the behavioral health risk assessment for pregnant women, which is the one that

Cheryl had mentioned earlier and the other is NQF 0105 antidepressant medication management.

Moving on to the next slide. There are four measures on here that are within the core set. The first is NQF 0418 preventative care and screening, screening for clinical depression and follow up plan; NQF 0576 follow up after hospitalization for mental illness; NQF 1879 adherence to antipsychotic medication for individuals with schizophrenia and NQF 1932 diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medication.

And actually, if we could go back to the previous slide, there was one other thing I wanted to mention. So if we look at combined behavioral health, physical health and patient 30 day readmission rate for individuals with SMI eligible populations denominator and numerator specifications, the tech had originally recommended this as a measure concept.

But staff analysis based on our updated measure, measure (comp with) definitions, we have reclassified this as a measure as it is fully specified. So I wanted to draw people's attention that this was originally specified as a measure concept, but is now a measure.

OK, and so if we move to the slides beginning with NQF, the 1923. Here there is one measure on clip which is in the core set, which is NQF 2606, controlling high blood pressure for people with serious mental illness.

And then on our last slide we can see that there are two measures which are in the core set, which is NQF 2605, follow up after discharge from the emergency department for mental health or other drug dependents, and NQF 2607, diabetes care for people with serious mental illness hemoglobin A1C port control.

And this also – on this slide you can see the path utilizations for individual schizophrenia. This is the only measure concept that PMH – within the PMH program area. Everything else here is a measure.

And so we can move on.

As was discussed within the FUD program area, the adult access to preventative and ambulatory care is a measure that is also considered for inclusion in the PMH area.

Preventions, for those who have their discussion guide open, which is measure number one.

And I would mention this assess is the percentage of members 20 years or older who had an ambulatory or preventive care visits. And so this is something that will also be included in the SurveyMonkey following the post in-person web meeting.

And was said when this is due – I see it'll be Friday, June 23rd, and we do need quorum on this, so it's very important that everyone vote. This is also something that can be weaved into the discussion when we talk about the themes and overall measure set.

And with that, I'll turn it over to Jennifer to review some of the PMH themes that arose during the in-person meeting. Jennifer?

Jennifer Moore: Thank you. So I think we need slide 33?

Perfect, so some of the key themes that emerged from our in-person meeting, again, and to us quickly going through all of the transcripts to pull some of the key pieces. The first being that lack of measures that addressed social determinants of health within the population. And that goes to the point that was mentioned earlier about the lack of social determinants of health measures in the overall set.

Additionally there's a need for more measures that screen and treat for behavioral health conditions in prenatal and postnatal women. We also agreed as a group that there were challenges collecting data for PMH measures, and that states that carve out the behavioral services.

And that goes back to Deborah's comment earlier about our overall themes that emerged from our discussion about variation that exists with states that

carve out certain services, which makes it difficult to collect, both physical and mental health information specific to the behavioral health services.

And then lastly, the Medicaid behavioral health has benefits exclusive to the Medicaid program as a consequence metrics has to be very specific to not just the population but also the benefit package.

And as Kate was reviewing a high level overview of the PMH measure set, I think that we would agree that patient caregiver experience measures were also glaringly missing. I think of the patient activation, patient engagement from this set, and that there were far more outcome measures than – far more process measures than there were outcome measures. And we may want to note that as some of our overarching themes raised during our discussion.

Before we move to slide 34 to do a deep dive review of the PMH measures, I just want to pause here to see if anyone on the call has any additional observations or thoughts that may not have been captured in this slide?

Maureen Hennessey: This is Maureen. One of the comments that was echoed several times – or actually two comments – echoed several times during our TEP meeting was that, first of all, there's a greater need to have measures that are designed in such a way that segmentation by subpopulation can be more easily conducted, particularly when you're talking about the integration of behavioral health and physical health types of conditions.

The other thing that was certainly noticed – mentioned on any number of occasions was that there is an increased need for the development of measures that are considered to be eMeasures, similar to, for example, the measure that we see on the use of PHQ9 which is in its first year of use within the PDIS 2017 set. Thank you.

Jennifer Moore: Great. Thank you for adding that. Those both were really important to add to this list. So thank you.

Any additional comments? All right, let's move on to the next slide.

So jumping to the second bullet, again, once you have a discussion about the diversity of the measure set in terms of access, structure, process, outcome, patient reported, et cetera measures, as noted by Kate on the previous slide, there's an absence of outcome measures and also patient and family related care giver measures as part of this set.

Any other additional thoughts? If it's helpful, we can return back to that slide that provides an overview of those items.

Maureen Hennessey: This is Maureen. That would be helpful. Thanks. The other thing I would say is that; similar to what we said earlier, the need for measures that are looking at social determinants of health, particularly when you're talking about integration of health with behavioral health, and health equity measures.

Jennifer Moore: Great, thank you. I think that the social (distribution) of health and health equity were definitely one of the overarching themes from all of the measure sets that need to be noted.

Female: And also another glaring oversight is population health and prevention. And certainly safety being only two measures …

Female: Yes.

Female: … is very suggestive of a need for, in the future, to have more of an emphasis on safety and adherence with medication.

Jeff Schiff: This is Jeff from Minnesota. I'm wondering if -- and I may have missed this -- but I'm wondering if we should make a note that there's nothing that looks at whether or not this is -- there's any kind of trauma informed care.

Female: Yes, that's really -- that's a good point.

Jeff Schiff: I think we're -- a lot of us are moving in that direction.

Female: Yes.

Jennifer Moore: Yes, I think that's a good point. What I did see was that certainly for the pregnancy screening test there was one screen that involved violence --

partner violence if I recall. But that's really a very basic level in terms of addressing trauma. Thank you for that comment.

Sarita Mohanty: Hi, this is Sarita Mohanty, just dovetailing on that. We are -- there's a lot of work right now that's going on -- and folks maybe from California can speak to this with some familiarity -- but they're -- I'm talking about screening -- part of the EPSDT screening for trauma.

And there is a question right now about the possibility of incorporating ACES screening and I know there's been some discussion on this. I don't know if -- talking about trauma informed care but also kind of looking at ACES as we move forward. I think that's starting to come to the forefront in discussion.

Allison Hamblin: And this is Allison Hamblin. And I would suggest -- just given that we're having this conversation in the PMH measures specifically -- I would, I guess, put on the table that sort of notion around screening for and treating trauma be referenced in both the (BCM) and the (FCD) sections as well.

Jennifer Moore: Thank you.

John Shaw: Yes, this is John. I want to just strongly agree with looking at ACES for the future. That's sort of the ultimate prevention population health type measure because you're talking whole generations of impact there.

Jennifer Moore: Great point. Any other items? And as a reminder, we want to look at whether or not the measures address the critical issues in the program area, including potentially avoidable hospital emergency department utilization, self-management, coordination of care, continuity of care and transitions across care settings.

Maureen Hennessey: This is Maureen. I think one other that I would consider is, in the future, looking further at measures that determine whether or not individuals with serious (and specific) mental illness also have a relationship with a primary care physician. For example, have they had at least one visit with a primary care physician in the last year.

Jennifer Moore: Thank you. And then finally, are there any high level recommendations for future iterations of the measures that -- for the PMH program area? I think we did a good job of covering a lot of that.

Maureen Hennessey: But that was my sense, thanks.

Jennifer Moore: OK, great. Hearing no other comments or thoughts we will hand it back over -- does it go to Bill now or Shaconna?

Shaconna Gorham: Thank you, Jennifer.

Jennifer Moore: Yes, no problem.

Shaconna Gorham: Now, we'll look at the LTSS measure set. Thank you. We have a total of 10 measures and four concepts that the Coordinating Committee will recommend to CMS in this program area. Of course, this is the smallest of the four sets. If you consider the break down of the measures in each of the CMS domains.

The majority (inaudible) patient caregiver experience and care coordination; five measures in patient caregiver experience and four in care coordination with two measures in clinical care domain and one measure in access and population health and prevention as well as safety domain.

(This) includes mostly process measures followed by (CROs) and there are a few concepts with no affirmation on measure type. The LTSS measure and concepts represent a revised (sea) of data sources. As you can, the majority use claims data and some measures are (supplied) with more than one data source.

Next slide; all right, on this and the next two slides you will see the measures that are included in the final recommended set. And as Tara and also Kate mentioned, you also have the reference document that was included in your meeting materials with all of the measures and concepts in each program area.

There are a total of three measures previously designated as concepts that were updated and designated correctly as measures based on the updated

measure definition. And they are the adult access to preventative and ambulatory care, as well as the home and community based long term services and support (for) use measure definition.

And lastly, the percentage of short stay residents who were successfully discharged to the community. And that is listed on slide 39. But before we move on, there are a total of four measure concepts recommended in this set. Three are included on this slide and one on the next. On this slide, we have the individualized plan of care completed, the National Core Indicators-Aging and Disability survey, and the National Core Indicators survey.

And then, if we move to the next slide, you will see the number and percent of waiver participants who had assessments completed by the MCO that included physical, behavioral and functional components to determine the members need. That is also a measure concept.

And then, I just want to highlight as Miranda mentioned while discussing the BCN measure set, NQF-0648 will also be removed from the LTSS measure set to reinforce the importance of alignment with the Medicaid core set. There are no core set measures included in this measure set.

And I will say as a side note, in our Medicaid adult and child task forces (where we) review the core (as) the lack of LTSS and home and community based measures weren't listed as gap areas for the Medicaid (core set). With that, I will turn it over to Bill.

Bill Golden: And I think if we had any theme from our discussion it was that there weren't too many standards in existence and that we need some more concentrated thought on metrics, process and expectations of performance. The field is pretty much wide open.

It's a diverse field depending on -- you can go from care of the disabled in the community, which is a whole separate area to the frail and elderly, there's a whole lack of measures and probably a lack of definitions. They are not particularly (on ones) that exist.

And again, practice standard and the need for -- I guess in many ways we have a lot of free range chickens out there we need to start to organize and put things into much more of a structured environment considering the importance of this area and the priority to move more people into community settings and less institutional care.

Let me open it up for other people to chime in, but I would think if anything we should suggest that this would be an area of focused investment by CMS and others for potential very valuable outcomes in terms of the metric community.

Barbara McCann: Hi, this is Barbara McCann, and I would like to take a few of the recommendations just a step further. There are defined populations for LTSS and each of those populations deserve attention from the measurement field to consider not only the unique characteristics. For example, developmentally disabled versus special needs children, versus those with congenital anomalies, versus the primary reason that they're receiving care, to the elderly.

So not only very significant differences inherently in the population, but also significant differences in the level and type of service provided. So for instance, if you look at readmission and E.R. and you -- then, if you will, work yourself backwards to the waiver and what services are prepared -- being provided rather, you begin to get feeling for perhaps those servants -- those services aren't intense enough, or there's more intervention.

The other one I wanted to ask about and I know it's a home based measure. But the NQF endorsed measure on timely start of service. Have we -- was that ever hit upon? And I apologize for not remembering myself as that's a big issue in (LTSS) especially in community.

Peg Terry: Barbara, this is Peg. Is that the home health measure (inaudible). The one you're talking about.

Barbara McCann: Right. And it's used with skilled Medicaid right now, also.

Peg Terry: Right. Right. I don't think that we -- if we did, I know it's not used anymore in the home health, I don't believe it's used a measure that is looked at in home health, I know it's still a measure there. But I don't believe that -- I'm not sure. So I probably shouldn't…

Barbara McCann: Right. Right. And just so folks are aware, it's not publically reported because the industry reportedly reached the level of 98, 99 percent. So it didn't meet the provisions of what is publically reported. But that tells a lot. And in our home and community (basers as) framework, that was an issue that was brought up (on off) about timely start of service.

Peg Terry: Barbara, I do know what happened to the measure, it had lost endorsement, and measures that had lost endorsement, initially we did not include in the measure that…

Barbara McCann: Thanks.

Male: Other comments on this area?

David Kelley: Dave Kelley, I think in general there is kind of a lack of measurements around those care plans and care plan delivery and whether or not those services are actually delivered. So that I think we did talk about one or two measures and decided not vote them on the island.

But I think that's definitely an area that I'm certainly hoping our managed care plans in Pennsylvania are paying attention to as -- are they getting a care plan put into place? And then what is the timeliness -- previous persons comments, what's the timeliness whether or not those services actually get delivered. So hopefully there's some metrics in the future that are developed that help to fill that gap.

Male: Yes, I mean, you get into the wait list, David, and the issues also of the capacity of the different agencies to consistently provide the workers. Having received those services for my own family, I can tell you that is often a problem of having schedules being met and clients having gaps in their expected visitations by people. So what percentage of the timeslots actually get filled by the agency given their workforce issues.

John Shaw: Hi, this is John. I wanted to follow up on Barbara's comments on the subpopulations. And LTSS particularly with a focus on home based care were really incorporating the community and family informal care givers in all of this. And as part of these sensitivity and follow up with the sub populations, I think there's a need for a focused effort to get their voices at the table to discuss measures that are important to them, not just to the care delivery folks.

Male: Other comments on this almost blank slate of opportunity here? We have another slide here so people can think about while they're viewing this? So are there other themes? We've kind of asked about that. Issues of diversity, access structure process, we've -- we're touching on those issues. Messages to CMS about what's needed. Any other comments on this area?

Maureen Hennessey: One question I would ask about, this is Maureen, is whether there's been thoughts given in this area to development of measures or selection of measures from other areas that deal with advanced care plans for example?

Male: I mean that's basically if there's documentation of plans and coordination of those plans.

Maureen Hennessy: Yes, and advanced care plans which really focus on what is the care that these individuals who are LTSS programming have preferences regarding -- particularly in the area for example (vendle vikecare). I also found myself thinking about the fact that there doesn't seem to be much in the way of assessment of individuals in LTSS from a -- really a physiological or behavioral health functioning perspective. But those are potential gaps.

Male: Yes.

David Kelley: This is Dave Kelly. I don't know if NQF0326, advance care plan that may address some of those issues but not all.

Male: Other items for LTSS? Does (Chip) have any comments on this? He's been pretty quiet. Let's go to the next -- go to the next slide. I guess we can go toward our sum ups here I guess.

Female: Great. Thank you so much. So before we open the public comments, I want to give our CMS colleagues an opportunity if there is anything that they would like to reflect upon or ask any questions based on our conversation so far.

(Karen Ianis): Hi everyone. This is (Karen Ianis). I was able to join about half way through. I don't have any questions or comments to raise, this has been really helpful.

Female: Wonderful. Thank you, (Karen). I'm glad you were able to join us. So with that, (Kathy), we will now hear from any members of the public who would like to offer comments. If you are not connected via phone, you may also type a comment into the chat and we will read them aloud. And additionally we're going to open this public (comment) period for about 20 seconds. So (Kathy), I'll turn it over to you.

Operator: OK. At this time, if you would like to make a comment, please press star then the number one. And you do have a comment from the line of (Camile Dobson).

(Camile Dobson): Yes, hi. This is (Camile Dobson). Deputy executive director of (Naswid) which represents state aging and disability agencies and I just wanted to thank the committee again for their hard work. And just share -- given the conversations that's happening about LTSS measure set that (states) our measuring quality everyday in their program. They may not be NQF endorsed measures.

They may not have the significant methodological support (but) I think, and documentation that you're looking for for endorsed measure. But they are in fact measuring quality all the time. They use it for quality improvement.

And so there's a lot going on at the state level that I'm not sure (that) committee got a full appreciation for. I think probably the medical directors from the state have a pretty good sense of the work that's going on in their LTSS programs. But we appreciation the fact that they'll be a (fat) albeit skinny (shoot) for CMS to (share with the states) as they're looking for ways to measure.

But I hope you understand that there's a vast universe of other measurement work that's going on out there and that hopefully, we'll continue to evolve to the point where they can meet those sort of standardized thresholds that you have in place for endorsed measures. Thank you.

Operator: OK. At this time there are no public comments from the phone line.

Kate Buchanan: Thank you very much. I will now turn it over to Maranda to walk us through our next step.

Maranda Kuwahara: Thank you Kate. So as Tara and Kate mentioned, we will be distributing a short four question survey regarding measures for inclusion for the (FDD) and PMH measure sets. That will go out immediately following this call. The link is also included on this slide.

We ask that you please complete this by 6 pm Eastern time on Friday, June 23rd. Then we will post our draft report which will contain the Test and Coordinating Committee measure recommendations.

This draft report will be published for public comments between July 21st and August 21st. And then finally we will be submitting our final report no later than September 14th, 2017.

As always, please feel free to reach out to the project team via our email which is reflected on this slide. Project staff names are also included here if you wish to reach out to any of us individually. And all meeting materials will be posted to the committee share point site are reflected on the project web page.

And with that, I'll turn it back over to Bill and…

(Cheryl Powell): I just have a quick question Tara, this is (Cheryl). Hello?

Tara Murphy: Hi (Cheryl), yes hi.

(Cheryl Powell): Could you explain the measure that you want us to vote for the SUD cap. I'm confused on where that came from and why -- why we hadn't -- is it a new

measure or is it something we missed voting on? I just wanted to clarify where it came from.

Tara Murphy: Sure, that's a great question (Cheryl). So, no these measures aren't new, they would just be new to the F2D Program Area. So as you'll recall during the in-person meeting going through the other program area sets, these are measures that members of the CCA identified that they thought would also be applicable to SUD. So…

(Cheryl Powell): Oh…

Tara Murphy: …we've all discussed these measures, just not in the context of the SUDs Program Area. So what we need your vote for is on whether or not you want to include it in the SUD Program Area.

(Cheryl Powell): OK. That's fine. I would…

Male: And you'll be sending that link in an email soon?

Tara Murphy: Yes. The survey link will go out today.

Male: And I -- this is just to clarify also since it's not a slide, when the public comment period is over, does this committee reconvene by phone or is this our last gathering of the committee of…

Tara Murphy: So, we will be reconvening on September 5th for another call following the comment period.

Male: Thank you. OK, just clarifying. People can't go home yet and put their feet up. OK, good.

Tara Murphy: And this should be reflected on all of you calendars. If it isn't, at this time then please reach out and we'll send that out shortly.

Female: OK. Kate can I just ask you -- this is Debbie Kilstein. The other measures that we discussed earlier that we need to vote on, will we be getting links for each of those and will there be separate links for each of the groups of measures or are they all going to be on one link that we have to vote on.

Kate Buchanan: So, hi Debbie. Thank you so much for your question. This is Kate. So, I just want to clarify. So there are -- it's going to be one survey monkey, it's going to be four questions that have the up or down votes for each of the measure we discussed.

So, it will be two measures for the SUD Program Area and one measure for the PMH Area. So, it will just be one link and it will be an up or down vote and then with opportunity and encouragement to provide some rational.

Debbie Kilstein: Thank you.

Male: Hey, are we in our final stages of this phone call or does the NQF staff have other housekeeping or other issues that we need to review.

Female: No, I think we are at the end of the call. Do you want to make any comments? I have a few additional comments to make after that.

Bill Golden: I have no comments, except to thank everybody for their continued engagement and constructive participation. So, thank you all.

Female: I just want to reiterate Bill's comment. Thank you to everybody.

Female: And I just want to thank everybody for the commitment of the committee and the co-chairs in particular for your work. Especially for the conversation today, which was very rich. For you recommendations, for you discussion of (Gaps) and recommendations for future measured development.

I think the team here has a lot of work to do following this meeting and we look forward to having you complete the work going forward. So again, and thank you to the public as well as our members. Have a great day.

Female: Thanks to…

Female: Thank you everybody.

Male: Thank you.

Female: You're welcome.

Female: Bye-bye.

END