NATIONAL QUALITY FORUM

Moderator: Shaconna Gorham
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Operator: This is Conference # 31476557

Shaconna Gorham: So on the screen we have our dial-in information as well as streaming for the public audience if they would like to participate in the meeting. You will be able to make a public comment at the appropriate time, so we'll discuss that.

But I will turn it over to our chair, Barbara McCann.

Barbara McCann: Thank you, Shaconna. A reminder, these are recommendations; we are going to review measures by measures score. Hopefully we'll have a robust discussion about several of them. We're going to use the decision logic process which is actually a handout at each of your places as we go through the process. Good.

At this point, I want to introduce Camille Dobson who I have served with on another exciting committee beginning this effort and Camille's been invited today to really give us an important context for what we'll be looking at. Camille, it's all yours.

Camille Dobson: Thank you. So I was asked to come and talk about this incredibly important area for measure recommendations. And you can skip through the agenda because I think that's an old agenda; I don't think that's right.

To talk a little bit about what states are doing in the space, why it's important and why I think personally this TEP is slightly different than the other three

and why I think it's important for the members to take a slightly different perspective on the framework that's been outlined. So a little bit about NASUAD, as I said earlier when I introduced myself that we're the membership association forward state aging and disability directors who deliver LTSS.

In some cases, it is the Medicaid agency who's our member, in some cases it's a separate state agency that delivers LTSS, in some states we have both an aging traditional sort of grant-funded aging director as well as a Medicaid person as our member. And really what we're focusing on is home and community-based services, so I was glad to hear the initial context of LTSS is obviously the larger group of services; we focus primarily on home and community-based services.

And all we do as an association is to try and help the states be more efficient and effective, serve as many people as possible, and deliver them the highest quality services as they can. So we do technical assistance, we gather the states together, we do a lot of best practices sharing, and then we represent the states with CMS in terms of their regulatory framework for home and community-based services.

Next slide. I probably don't need to tell you all, but this is one of the things I traditionally do when I talk to folks who may not live and breathe in the LTSS space, is that this is nonmedical services that we're talking about. Fundamentally what the states are delivering in HCBS services are services that help people live the most full and active and fulfilled life they can. The goal is to keep them in the setting of their choice wherever that would be; most people will tell you they prefer to live in whatever they call home, their own home or what is a home to them.

And so these services facilitate that kind of a life to avoid or delay to the extent possible an institutional placement. Unfortunately, the way that federal statutes are set up states -- individuals in order to get those home and community-based services have to meet nursing home level of care which leaves out a whole group of people who could probably be effectively serve

but those are the rules that Medicaid has laid down and so the states follow that process.

So unfortunately, HCBS are limited, most states have waiting lists or slots or some sort of cost control mechanism that limits the access that folks have to these services which is why you still have so many people especially older adults right now getting services in institutional settings.

Next slide. I primarily at NASUAD focus on the capitated form of LTSS which is managed long-term services and support where states are turning over like they have in the acute care space their HCBS and nursing facility services to (health plans) to deliver services. And I know that I noted there are at least two or three health plan medical directors on the TEP which I think is – (the TEPs), which I think is really helpful. So the health plans bring a really positive perspective.

So most states, lots of states, LTSS or HCBS is sort of its own standalone delivery system. It's very siloed, they have a way of delivering services, the staff are not in many cases not in the same case that the Medicaid staff is, there's very little focus typically, on acute and medical care needs of the individuals who get LTSS. It's very focused on sort of those nonmedical, social support needs.

So MLTSS actually provides an opportunity for states to bring those two together and most states, not all states, but in most states health plans are covering both medical services as well as their long-term services supports which basically allows them to focus on the whole person which states who have (deeper) service systems struggle to do that kind of integration.

And so it is a growing trend across the country, if you want to go to the next slide, this is what the current map looks like. All of the states in blue currently have an MLTSS program in place, three states are duals only, but both Ohio and Virginia are expanding beyond just a dual eligible population to look more like the other states in blue. The states in green are under consideration and they're Oklahoma, Pennsylvania, and New Hampshire, in active development to move to managed care.

So you'll see pockets primarily in the plains states, the upper plains states where for example I took note of the Wyoming medical director's, like there are not enough people to put people in health plans in many of the states in the plain states. And then there are scattered pockets sort of across the middle of the country, Kentucky, Indiana, West Virginia, Missouri, Georgia, Mississippi, all have their Medicaid clients in managed care for their acute and medical services, but they don't have their LTSS, they're carved out and still see for service, again, a very bifurcated delivery system.

Maryland too, so Maryland and West Virginia is soon going to be surrounded. Everybody around them is going to have moved to a managed care delivery system except those two. I don't quite figure out why that is. Since I live in Maryland, I continue to question. Maybe I'll have a chance to talk to Tiffany over a couple of days to figure out why it is Maryland isn't moving in that direction.

Anyway, so next slide. So really what I want to talk about is the challenges to quality measurement, because I know the charge for the TEP was to identify measures that are valid, reliable, easily collected, have a high sort of use standard and it just is very challenging in the space.

Barbara and I served on the HCBS quality measurement committee to put out a framework for domains of measurement, and we struggled there to look at, we got a slew of measures and we went through them and most of them are very clinical in nature, weren't really relevant for the work we were doing, and so we came up with just a main sort of recommendations of what measures should happen.

Two years, correct. Two years to figure out that there was not a lot out there and that there needs more measurement work. So I was fascinated to see that this started and so I'm very interested in actually what comes out of it, because the challenges that you don't have the typical things you have in the medical community with professional guidelines and lots of protocols and bodies of knowledge. It's a very state-specific, state-unique, every state's program can be tailored specifically to what they want to do.

So covering people with disabilities in one state doesn't look anything like what people with disabilities, the packages, the services that are delivered not only are different but they're defined differently even if they have the same thing. Attending care, it's personal care, it's home care, we have seven states called the same thing by seven different things makes standardizing measurement very challenging.

And then the last piece I would say is CMS has very specific requirements for their HCBS waiver program which all the states have, most of them deliver their home and community-based services through these waivers where they have to get CMS permission and CMS has got a very strict quality assurances standards that the states have to deliver performance accountability to those pieces.

And so I wanted to throw out there in addition to the key concepts keeping in back of the mind the CMS imperative that states have to respond to about the things that CMS is going to ask the states to show that they're performing on, so those ought to be a consideration also.

Next slide. I don't feel I need to say anything else about number one. The providers that serve HCBS in many cases if they're delivering personal care in a self-directed program they are a person, a family member, a friend, somebody in the community, even those that are larger, they're not large in the medical sense of the word large, they might have a home care agency that might have 25 employees or an adult-based center that operates one center with 10 employees.

So you don't have the mass scale that you do in the medical system, and in many cases they have been operating in some cases on grants, they don't have a good way to report their system. Let's put it this way, the taxonomy around HCPCS codes, they just don't exist in the HCBS space, so there's not a lot of standardization that claims data would, sort of can be mined for good measurement. So back to I think Diane's point is, I'll get there, people's experience because it's so personal as a really critical part.

The states don't have data systems, they're just getting there in the acute care world to deliver measures, they're nowhere near that, if they've done separate systems which many states have to capture their HCBS data. And so what we've come with is sort of all adds up to a lack of standardization and there's lots of barriers to effective quality measurement.

And so it's a much harder task this TEP has frankly than the other three. I know that probably they would say no they don't but really I think they start from at least some accepted science around how to deliver a set of services. Theoretically you could differ on what component or a concept or a domain of that care you measure, but they at least have some place to start. This is a very challenging space.

Next slide. So what is out there today primarily are structure and process measures. Again, most of this is driven by what CMS cares about and right now there are waiver assurances, care about counting things, how many providers were trained, how many care plans were done, not the content of the care plans and whether they really meet the person's need, but were they done in a timely basis. The number of critical incidents that are reported and remediated but without in many cases identifying trends that are in the system.

So what states will call quality measurement in their HCBS system is really a lot of counting, I'll be honest with you. I don't think any state would tell you that they have a really good – well there are a handful of states I think will say they have a very good well-rounded quality measurement program that has structure profits and outcome measures, most don't.

But what people care about, what consumers, advocacy groups care about, providers care about are outcome measures. How does the impact of the services that get delivered to the person impact their lives and that's the place where there's a lot of – if there's very little on structure and process, it's a very nascent I would say way to use it in a systematic approach.

So next slide. So here's the question, so what are the right outcomes? It's not like avoiding the complications from diabetes, right, where you can say there's a protocol and you know that if you've done these three things there's

a success at the end. Because the HCBS services are so person-specific, the service plan is devolved around the person's needs, outcomes are based on the individual's needs, desires, and goals, makes it very challenging to have any kind of systematic measurement process. Which is why back to Diane's point in the HCBS the consumer's perspective is a fundamental core part of the process.

It is the gold standard by which people will tell you if people are satisfied and the services help them to achieve their goals, lead the kind of life they lead, it's been a success. From an outside metric, that might mean nothing to the casual observer, that somebody can actually get up and go to church on Sunday or they can go play Bingo or they can play with their grandchildren or any myriad of things that are individual's goals.

So the measurement of success and the measurement of outcomes I think is really challenging. And I want to point out that it's not satisfaction because that tends to be the term that people – you can even see it's about consumer satisfaction, it's not about satisfaction. People can be very happy with what they get and it still not meet their needs. As a matter of fact, we find individuals because they're so vulnerable, we'll say lots of things about how happy they are and it doesn't do anything to actually achieve the goals that they set out. I like the nodding, thank you.

OK. So we're really clear when we talked about HCBS to not use the word satisfaction but to talk about quality of life because that's the real goal. Go back one second. So moving to managed care, the health plans for sure offer better technology and data systems than the states have, there's no question about it. But even they have issues with how to capture and report the data that comes from HCBS providers. It is a nightmare of state-after-state of understanding the HCBS providers, how they work with the health plans' data systems and their claims reporting system.

The plans do in many cases have electronic care records that can be sort of mined for information better than say a state going through their care manager's files, real time in an officer but even then it's sketchy. And, again, not consistent, every plan has a different system so in a state with five health

plans they've got five different care management systems. They haven't taken the time to define what's in a care plan consistently so you get garbage in, garbage out, I guess that's all I will say about that.

And then last but not least, the tension between the system performance which people care about, how many people are served, how many people avoid an institutional stay, how many people don't go to the ER, how many avoided re-hospitalizations, sort of the broad system performance is a tension against measuring individual outcomes which is about the person itself.

And so states really struggle with how to build a measure set that affects, that is going to meet their larger policy and advocacy needs as well as meeting the client's issues. And so that's a piece that I think that's important that's not just about the person which I think most of the measures are about the person, there's very little in here about how to measure the system and how effective it is.

Next slide. So here are the considerations I would throw out to you, you've already gone through and culled through, done a first cut at the measures. So just maybe moot but I'll tell you if you were starting from scratch and I've done this in January before you started, this is what I would share to you, that quality measures have to be defined relative to the goals or the outcomes, and that means the person, client or consumer, we never call them patients ever, ever, ever patients in the LTSS system, they're not patients, they're people.

So it needs to be at the center of the process. So person-reported outcomes are KPs and they can't be overlooked, they just can't. Any system that comes out that doesn't have person-reported outcomes, somewhere in it will be immediately dismissed, it's not relevant or not effective for HCBS.

Ideally, to be as applicable to many people as possible, as populations as possible, states have waivers for – they slice and dice people in all kinds of different ways, and so individuals and what people who are older adults care about and a young adult with intellectual developmental disability and someone who's had a TBI can be as different as night and day, and so it's very challenging but important to try and get crosscutting measures that would

measure concepts at a level that it won't matter about the individual's disability, how they come into the system.

They clearly need to be manageable and doable for both fee for service and MLTSS space and so we've got just about half-and-half states that are still running a typical fee for service system and even in those states that have managed care, populations are still fee for service. So for example, individuals with intellectual developmental disabilities in those blue states are still in a fee for service waiver system.

So it's important to recognize to not just follow the mode of a health plan perspective, but states need to do if for example – or like Rob said, in Massachusetts they're trying to sort hybrid approach with ACOs where they're going to need both system and person-centered measures right or person-level measures.

And then the last piece if focus on who's the accountable entity, right? QM is only relevant based on who you can measure it against and so the problem, the difficulty in fee for services, you've got thousands of small providers, and building a quality measurement system that affects all these providers is really challenging. Part of the reason the states move to health plans is because their span of control goes from 7,000 to 5 or however many. And so that makes a big difference.

Next slide. I say this but I say this and shake my head to minimize to case review to the extent possible focused on administrative data, that's all well and good, the reality is there are not a lot of systems out there that will enable you to do it. Claims data does not capture the kind of stuff that really matters to people with LTSS.

Barbara McCann: You know what, I feel compelled, we need to bring up…

Camille Dobson: Who? To bring up hope? Oh, hope as in like a concept, yes. OK. I think that was a measurement system I didn't know about Barbara, I'm sorry. Just checking.

(Multiple Speakers)

Barbara McCann: … the 21st Century Cures Act is mandating EVV -- electronic visit verification -- in all states. And so as a provider, I can say to you it's actually one step worse than what Camille has presented.

There is not only the outcome but there is no way to tell who did what on what day. So if you ever with regard looking at resources, you couldn't correlate what seem to make the difference for what population. But with the EVV -- which in some states including Connecticut is now going all the way to the skilled level -- when you check into a home, you will have this device, which -- I'm sorry, my cleaning service does but Medicaid doesn't.

And you check in where you're at and automatically it comes up -- today, you should do bathing, ta da, ta da, and you have to check off that you do it. That alone will change the entire scope of what's going on. So while it is not very pretty now, it is primarily paper that who knows who fills it out, we do have an option going forward, so hope is coming.

Camille Dobson: No, that's a good point. That administrative data is broader than just claims; I think maybe that's a good point, right? Is that you can pull things out of an EVV record if a state has got a self directed program and they've got a fiscal services agency, there's a lot of data there.

I don't know what the states do with them, it's a little unclear, but they collect a lot of data about the providers and persons they serve that could be useful for quality measurement. So thank you. I agree with you. It's, (TEP) is helping the electronic health records for the ELTSS case records because the HRs typically don't exist in the LTSS space, that's not a good use, it's not a source typically, but using a care record I think is promising but, again, only nine states are trying it and it's not live yet.

But back to my point about addressing both service delivery because actually that's just as important as the fact that individuals get the services when they need them, they can't wait. If you need somebody to get you out of bed every day, it's not like I have a two week wait for an appointment with the doctor, OK. Unless it's life threatening, you have some place to go, that's not a life

and death thing that I have to wait two weeks to see a doctor. I could go to an emergency room, I mean there are ways to access services.

Service delivery and timely service delivery is a critical component to LTSS, and it's a piece that doesn't get a lot of measurement focus. There are not a lot of good measurements out there, it would be one I would recommend the TEP focus on.

So I leave it with a good place to start would have been, I don't know if you got this as context, the measurement framework domains, we came up with 11. We went through measures, we developed domain definitions, we identified next needed steps, I did a quick look based on the six quality domains from CMS and from what I can tell, the only ones where there's an overlap would be in care coordination, caregiver support, and I think that's it.

Choice and control probably goes into patient and caregiver experience probably, but of the 11 domains, I can only find three or four that would fit into that CMS because, again, it's highly medical-focused framework driven by Medicare primarily. Go ahead. Sorry.

Female: Given what you just said, would you discount the measures that are before this group that have a medical component?

Camille Dobson: Yes.

Female: Thank you.

Camille Dobson: I look at the list and I was like, "Why are you even looking at those" because that…

Female: We need to get…

Camille Dobson: You could get through this, OK. So that would be my recommending.

Female: We acknowledge that…

Camille Dobson: That's an issue. And I know you are driven to the CMS quality domains and that's what they gave you, so I'm not going to quibble but I was asked to come and give my honest opinion so I gave my honest opinion.

Female: You know an important statement we could make as rationale I think as we get into the actual review of the measures.

Camille Dobson: Measures. Right. Yes. So the last thing I would say is to look for commonality, so I don't know if that was a criteria in terms of how many states use a measure but looking at 17 states I think is a good start.

I don't know all the states they've looked at and frankly looking at all 355 waiver programs is an overwhelming task which I get. But there are a number of states, for example, the MLTSS states are starting to coalesce around 12 to 15 sort of core concepts and not all measuring exactly the same thing in the same way but they are starting to coalesce around care delivery and quality of life outcomes that I think is helpful. I think that's my last slide, I don't know.

Do I have one more? Yes, that was it. So I'll…

Female: I don't know if I have a question or I have a comment, but I'm sort of relating back to the conversation we had earlier on the panel, the aspirational metrics and what is available right now.

And so the health systems that are currently getting strong on the care continuum pieces, whether it's through incentives or whether it's through other metrics, they are forced to reach out to care manager documentation, social work documentation in the electronic health record that's all about beyond the traditional walls, and it's sort of mandated and checked.

And so something like is your client that's not a patient anymore, is your client able to bathe or checking, actually monitoring that at the point of opening a care management encounter, there's an assessment of self-management and skills of managing their own condition, and it's mandated that at 30-day, 60-day, 90-day that's re-checked and that's documented in the record.

I just want to kind of brainstorm on how much of that we can put out there as a measure that is reality for a couple of trailblazer systems and it seems like that's where we are heading. And so the problem is what's the concept and what's readily available in Colorado that's not on your map?

Camille Dobson: We're trying a different approach in Colorado.

Shaconna Gorham: But it's not on the map but there are many pilots. And actually my former colleague James, because he used to work in the Wyoming system. There are regardless of their orientation, they are the thought leaders in this. And so, you would be able to call out self-care, sort of, and the ability to manage conditions.

I'm almost sure Kaiser had, yes, for maybe it's a small pocket of health systems, they are already looking at the non-patient, monitoring of former patients, and sort of putting it on the reality that a patient is coming out from a community and we are reaching it kind of releasing the patient back into being a client. And so, how do we account for that small sub-segment that is also the future?

Female: So the measure would be – for example, measuring whether that follow-up has happened, right? You are not looking at anything substantive, you are checking. So far in other words I guess the concern I have is…

Female: Can I interrupt for a moment, you are going to be with us for both days?

Female: All day.

Female: OK, so what I'd like to do is actually start our process, if we can and work through that and then we, I think the interchange we'll be able to note with regard to specific measures.

Female: OK. I think that would be great. Shaconna, you want to take us through this?

Shaconna Gorham: Sure before I begin if I can just get to you all because we don't have a transcriptionist in the room, so she left us but we do have – yes, we do have a court reporter that is transcribing, so because she can't actually

see you and your name tag, before you speak if you could just say your name for transcript purposes that would be super helpful.

OK, so again, you're familiar with the same slide that we used but this is specific to LTSS. So our threshold score is 1.23. And again, the first box illustrates the measures that equal 1.23 or are above the threshold score, they automatically move to the decision logic review. And then the measures below the threshold score you will have elected to retain some of those measures, and those measures will be discussed and also during the decision logic review.

Barbara McCann: This is Barbara. Shaconna, can you clarify if members have measures that they wanted to bring back up. Is it discussed after all the others are reviewed or while it's in a particular domain?

Shaconna Gorham: So when you say bring it up tell me exactly what that means? That they have already gave us for (words to retain)?

Barbara McCann: Yes, so to reconsider, yes.

Shaconna Gorham: So in that case they are already on the slide.

Barbara McCann: Good.

Shaconna Gorham: So if you told us that you wanted to retain a measure for whatever reason we have already put those measures on the slide. And then what we'll do is when we get to that measure we'll ask you to start the conversations so you'll be the lead discussing for those measures that you have asked, so that you can give a rationale for why you want that measure to possibly be included in the measure set?

Barbara McCann: OK, thank you.

Shaconna Gorham: So it's a breakout of the measures, the measure concepts by domain. And so, you will see that we have measures in every six, going on all of the six domains. And this is just a breakout of kind of how the measures spell out.

So in that LTSS program area we have 32 measures, 31 percent or 21 measures that will categorize this clinical care. Care (coordination) is the second largest category and we have 24 percent or 16 measures in that domain. We have patient and caregiver experience which closely care (coordination) with 23 percent or 15 measures, and then 11 percent or seven measures in the population health and prevention, six percent of four measures in the safety domain, and then four percent or three measures can be access domain. Next slide?

So again you see the main score at 1.23 highlighted in red and that is the cut-out with threshold, if you will, for (measures of our concepts), unless you elected to retain. We collected a total of 66 measures and concepts.

And, Camille, back to your point we did use this (ACBS) framework, so we see some of those measures and concepts that you all discussed within the two-year project.

And so, a total of 22 measures and concepts, 14 measures and eight concepts were included based on the total (mean). And we can go to the next slide.

So again, just stating the total (mean), we have a total of 28 measures as I've said before, 22 measures and concepts, 14 measures, eight concepts were included based on the total mean. And there were six measures or concepts that you all have decided to save, quote, unquote, "save", for future discussion.

So just to give you a breakout of what you've requested, we have two measures that members decided that they both were, quote, unquote, "worthy", in the care (coordination) domain. In the patient caregiver experience domain we have three measures or concepts that were retained, and then the population health and prevention domain we have one measure or concept. Next slide?

So again that is just the decision logic on your screen and we will vote through the measures or concepts, vote each criteria or question.

And again, to reiterate we'll use the hand vote, thus (CNI) will count the votes as you vote. Camille is welcome to participate in discussion. She will not be voting. We need 60 (prints in agreement) which is three members of the TEP.

In order to move forward we will make sure that we provide and support our reasons with a statement of rationale. And then you will go down the path and we will ultimately recommend or not recommend measures and concept. OK. And again, just to remember that we do need at least members present in the room and voting in order to have quorum.

OK, with that we are going to start with the first domain and I will turn it back over to Barbara.

Barbara McCann: OK. I'm going to, if we are able to pull up the measure. My left hand is not working.

Shaconna Gorham: Yes. So we're going to actually (ask you) because we are going to call – go through – to do the (slides), as well as your discussion guide. The discussion guide, again, was e-mailed yesterday, if you can pull that up. The discussion guide is really handy because you had your agenda and the discussion guide along with, if you scroll down you will be able to pull up the actual domain, and we'll start with access.

For those who can use screen-share so that we can kind of go back and forth. OK.

Barbara, you can use, OK.

Barbara McCann: Thank you. All right. We'll begin with this measure. These are only measured in access at this point. And it is adult access to preventive ambulatory care and there are three, if you will, stratifications of adults.

And so, if we take them the logic, yes, go ahead.

Shaconna Gorham: OK, let's give (Desi) a minute so that she can pull both up.

Male: You're having problems?

Barbara McCann: I know.

Shaconna Gorham: We're having problems, OK.

Male: So you're having problems too, OK.

Barbara McCann: Yes.

Shaconna Gorham: OK, so…

Male: All right.

Female: If you're going to measure at the top you got to click underneath…

Female: Yes.

Female: … measures with spreadsheets up on the top right hand corner.

Shaconna Gorham: Yes. Let's take a quick break and I will walk around to each computer.

Male: That would be good. We'll go back then.

Shaconna Gorham: This is it.

Male: Yes, me, I'm going on to the (inaudible) again.

Shaconna Gorham: It's going to be easy, I've got (domains going on).

Male: The description ...

Shaconna Gorham: And we enter that question and then…

Male: Here it is, so we go on this?

Shaconna Gorham: Yes, yes, and I will just click up there, the measures.

Male: Yes. Great.

Shaconna Gorham: Yes.

Male: Here it is, OK.

Shaconna Gorham: I know.

Male: Looking for a document it was like there wasn't time to get this, really…

Shaconna Gorham: OK. This is different than this, right?

Male: Yes, yes, yes, it's very.

Male: Yes. Interesting.

Shaconna Gorham: This is really (in-depth) isn't it?

Male: Yes.

Shaconna Gorham: I didn't look at it actually.

Male: Basically they're all the measures.

Shaconna Gorham: They are. I don't see what, except here, OK.

Male: No. She is one of the measures, so probably she's going to call out the measures in…

Shaconna Gorham: Like my number on top is different.

Male: I think you're in there. I don't know. Mostly it looks like (two)…

Shaconna Gorham: Maybe my number…

Male: I don't remember the number so I'd have to pull it out.

Female: Well it's not the same that I sent earlier.

Male: Yes.

Female: It's different down there. It's different down there. It's different in here.

Male: Yes.

Female: Or it was for me.

Female: And that (inaudible) right? It was.

Female: Thank you. I got it. I'm good.

Female: OK.

Male: I'm good. I think I got, well, I think I need to go back to where I am.

Female: I can show you how you can kind of make (inaudible). Then you want to (inaudible) (attendance here). And then the…

Female: And we're going to check to make sure.

Female: OK.

Female: So I think (inaudible) wasn't measured. Or wasn't this measured?

Female: Then we get the (back part) of this one.

Female: Thank you.

Shaconna Gorham: OK. You're here?

Male: That's where I am but I don't think I'm...

Shaconna Gorham: OK, so I want to show the agenda.

Male: Get back to the agenda, OK.

Shaconna Gorham: And this is the scroller to the screen, no. So at the bottom of your agenda is where you want to be. And this gives the measures and the orders that we're discussing.

Male: Got you.

Female: OK.

Shaconna Gorham: And then to make this easy you can hit your measures classifications when we get to that measure. So that will give you all the information about the measure.

Male: Got you.

Shaconna Gorham: Then when we want to go back to a new measure you just go back and you'll follow that. OK.

Male: Got you, all right. Thank you.

Female: I've got all this weird lines off every time I click on it.

Shaconna Gorham: So you're in the right place. And then it gives you the order, and then all you want to do is go and see that specification…

Female: All right, thanks.

Shaconna Gorham: To give you all the information.

Female: I've done it from the other ones on there. I think I'll just go back at this way again.

Shaconna Gorham: And then you want to go back here.

Female: I need to go back.

Shaconna Gorham: To go back and it takes you back in there.

(Crosstalk)

Female: But it's no measure and...

Female: So let's see, if everybody is here?

Female: Yes.

Male: Well, OK.

Female: OK, good.

Female: Barbara, we'll give it a try in just the first decision logic question. Does this measure address critical quality objectives, CMS quality measurements?

So this is only access measure, is this critical? Is there discussions? Anybody would like to have…

Female: I will just say that I agree with (inaudible). The only way I'm talking about (inaudible) it could be useful in (plain) and MLTSS programs where the plans are held accountable for acute care. That's, I could see potentially it being a standardized measure rather than having them, they all pick a different set of measures.

It's not an LTSS measure but I could see it being relevant for having a measure for LTSS consumers accessing the medical system. I don't know that they use it in a fee-for-service system necessarily. I don't know that they would.

Female: It wouldn't have access to it.

Female: Right. They wouldn't have the access to the data there.

Shaconna Gorham: And just to remind folks if you could say your name before you…

Rob Schreiber: This is Rob Schreiber. So I want to make certain that I'm on the right one. We're talking about access to preventive ambulatory care?

Barbara McCann: Yes.

Rob Schreiber: OK. I just want to make sure because sometimes they go off on a tangent.

Barbara McCann: Right.

Rob Schreiber: Right. So the way I would look at this, I was just raising the question when you're talking about access to preventive care it's really can you get to that

care, you know? Can the care be set up? Is it coordinated and do you have transportation and capacity to reach that care?

So from an LTSS perspective this could be a proxy for do people get to where they need to get, whether it's acute care or preventive care, i.e. if you're doing preventive care you're hopefully not going to be needing acute care because your issues are getting addressed. So this could be a proxy for whether or not those types of supportive services are available to that population. So that's the way I would – maybe that's another way to frame this, so with the comments, thoughts?

Judit Olah: No, no, no. We're a small group…

Barbara McCann: If you could just raise your hand or introduce yourself will be good.

Judit Olah: I'm going to go?

Barbara McCann: Yes.

Judit Olah: So this is Judit. I agree with Rob. And Camille, from the perspective of proxy again, looking at the long of looking at health outcomes, trending favorably or unfavorably which will be the ultimate goal, then checking as proxy, as I'm looking at the numerators, denominators, that that patient population actually had a preventive touch-point, that will be from my perspective a very good proxy if ultimately those indicators will trend up and down.

Again from the perspective that maybe it is the (MLTS) environment, but that touch-point will say I am now deployed, so bathing and self-care and nutrition and all that other care deliveries will be available.

Female: Barbara, I'd like to make a point of clarification, in the actual description it appears to be limited to Medicaid and Medicare. While I agree with the proxy statement I would not be happy if it was limited only to dual eligible in the process.

Barbara McCann: You're right. Yes.

Female: All right. OK. Diane?

Diane McComb: Diane McComb. If I could mix this conversation a little bit when we're talking about long-term services and supports for younger population people with disabilities I would think of access as access to services that support that individual in choosing where they might live and support and gaining employment if that is appropriate.

In choice of housing arrangements, et cetera, I do not consider long-term services and support access to medical care relevant. It's relevant for their health. I'm not discounting that at all. I would say we do not have any measures that are currently in practice that would measure access to long-term services and support.

Even in the realm of an individual who is elderly do they have access to community programs, do they have access to Meals-on-Wheels, wherever their needs maybe that are not clinical in nature. So I think that it's important.

My passion here would be to make certain that we understand that we're not putting forward measures simply because these are the measures that exist, but rather to identify we don't see measures that are appropriate for long-term services and support in this…

Barbara McCann: This is Barbara. Let me clarify. We are voting, I believe, on the measures we have before us. These are the only measures that made the criteria. We can certainly make a remark that access needs to be much broader defined for future measures.

Diane McComb: Understood.

Barbara McCann: OK. So that the question remains and I am going to call for a vote on this. If you would raise your hand, if this is, if you want to say that this has high or medium, do I have to make a distinction between high or medium?

Shaconna Gorham: So let us just, so one with just (inaudible) (purposes) again stating the question and then the vote.

Barbara McCann: OK. So does this measure as stated here adult access to preventive ambulatory care, to what extent does it address that critical quality objective of CMS quality measurement domains, and or identifies program area key concepts. So how many would say high, it is a measure that addresses CMS quality domains and is a key concept program area?

Female: Can I have some clarification?

Barbara McCann: Given the context of your question are you asking that in general or specifically in the context of long-term services and support?

Female: It is specifically to this measure, to long-term services and support.

Female: No, no, no…

Female: Is it the concept of the (inaudible) right? It is the concept that the ...

Female: Just I want to double check, so when you say it's a quality measurement in domain, right? And the program areas are the top of page two, so can it either be both or one or the other and that's the…?

Shaconna Gorham: OK, that's one of the (MS) quality measurement domains or the six that we discussed is when actually being accessed. And then the key concepts of the first terms are on your sheet that you just pointed out. And of course all of this applies to LTSS, so that would be the program area.

And again, you can say it may just well be that it applies to a domain but perhaps we put it in the wrong domain so that would become the earliest that we would just stress that point. And it could be, and this is not the case with this measure but you could make a note to say, OK, it's currently accessed, right now what we really think it should be in care (coordination).

But (inaudible) knows that you can give as you go through the different measures. But to this particular measure, yes, we are looking at the quality whether or not you think and address the critical quality objective in this domain as it applies to the program area of LTSS.

Female: Just a quick clarification, so we're going to do a high/medium as one category and are both or we're going to…?

Shaconna Gorham: You know what that's a good question because we want to get through a lot of measures. I think that we probably could do, I mean, high and medium will take you along the course. That is very true but just for the sake of our votes and the transcript I would really prefer for you to go high, and then vote medium, and then vote low, so do it separate if you will.

Janice Tufte: This is Janice. And one of the key concepts is access. But I see this as important within the young adults especially with like the way the (1015) waiver because the people will need to have some baseline ambulatory, they will need to be something to follow up from when they are either end of the program or advice to the program, so I think it's important in that aspect.

And this is who had and ambulatory or preventive. So I see it as I guess it's a proxy to that it should be and it appears to be one of the key concepts, so I would suggest it might be high actually.

Barbara McCann: OK. Can I ask for a vote? Raise hands, so how many would support this measure as high? And how many would support this measure as medium? And how many would support the measures as low? OK. Thank you. And we're going to make a note and please me, members, if I'm wrong. We would recommend not to restrict this to only folks who are dual eligible. Right?

And do we believe it would cross all populations?

Male: Yes.

Shaconna Gorham: Yes.

Barbara McCann: OK. Thank you. Right, great.

Shaconna Gorham: OK, just for transcript again, the measure adult access to preventive ambulatory care will move to the next criteria in the decision logic.

Barbara McCann: Now to what extent we are going to evaluate now, does this measure address an opportunity for improvement or addressing signification variation that exist in care for each program area?

So again, think about our populations here. High is it addresses multiple quality challenges and opportunities. Medium, it has the potential to address variation, and low it does not address quality challenges or opportunities for improvement.

So with that in mind can I see the votes for a high designation? Votes, are we good? OK. Votes for a medium designation? Votes for low designation? All right, great. Then we will…

Shaconna Gorham: (Does anyone move up)?

Barbara McCann: When we're voting…?

Shaconna Gorham: We have four members who have voted, two for high, two for medium and zero for low at this point.

Barbara McCann: Diane added to high.

Shaconna Gorham: OK, so three for high and two for medium.

Barbara McCann: Right.

Shaconna Gorham: Thank you.

Barbara McCann: All right, the next level of measurement is to what extent this measure demonstrates efficient use of measurement resources. All right. If you would like me – do you need me to read the entire statement? Thank you.

All right. So capture the broad the broad population, et cetera. High is measured, demonstrates efficient use of resources, broad populations, is not duplicative within our current scope of understanding.

Medium is measured, is not duplicative of other measures and does address some areas of alignment but doesn't encompass broad populations.

Low is no evidence that the measure demonstrates any of the above criteria. Can I have a vote for high? Yes. I'm sorry?

Female: Can I ask a question?

Barbara McCann: Right.

Female: Are we still on the first…

Barbara McCann: Yes. Yes.

Female: I'm sorry, I was on the second one, I thought we had moved on. So I was a low on that first one…

Barbara McCann: No, you mean the second?

Female: It was the question that we just asked why ...

Shaconna Gorham: OK.

Barbara McCann: OK.

Female: I apologize, I thought…

Barbara McCann: No, no, that's OK. So just to reiterate we're going to take each measure, yes, pardon me?

Female: For our measure, (18)?

Barbara McCann: Yes, right, yes, that's OK. We're good.

Shaconna Gorham: OK. So just to go back for the opportunity for improvement we have two votes for high, two for medium and one for low. OK.

Barbara McCann: OK. All right, now we are efficiency measures. Can I have a vote for this measure being high? OK. A vote for medium, a vote for low? Thank you.

Shaconna Gorham: OK. So for measure adult access to preventive and ambulatory care, for the third question decision logic, efficient use of resources we have, four votes for high and one for low.

Barbara McCann: Thank you. Now a measure please for the extent to which this is ready for immediate use. High, it's already in use in Medicaid population.

Female: How would you know that, do you have information about that? Did you get information when you got the measure?

Shaconna Gorham: So the question is to what extent is the measure ready for immediate use? If you scroll down you have your measures specifications, but then you also have your staff preliminary review. And so, we know usability we have a medium, we've rated it as a medium because we know that it is used by states, local and health plan for accountability. And then intended use in federal or state Medicaid recipients.

(Off-Mike)

Shaconna Gorham: Right. So when we look at our sources and looked at the different states, and I believe, but don't quote me, Washington State is using this measure. So, yes, we did that research.

Female: OK.

Rob Schreiber: So this is Rob Schreiber. So it's interesting how it came up to be medium versus high, just thinking that this would be this is a code that would be utilized in terms of billing. So it's just interesting that maybe it's not being utilized or whatever. So I mean not to belabor it but I find that really interesting that it came up with this medium.

Shaconna Gorham: So we can go back to our criteria. And I need to pull that up. High for this particular question, we based that when we actually went back and did the rankings for the individual criteria, high for usability was used in federal programs.

Let me, I mean, let me…

Female: Right.

Female: Already in this, right?

Rob Schreiber: OK, OK.

Shaconna Gorham: Let me pull that up.

Barbara McCann: But essentially when you do that, I think Rob -- this is Barbara -- what maybe the issue is the weighting is so different, right?

Rob Schreiber: Yes.

Barbara McCann: It's 30-30 and I think 15-10, so I agree. It's a HCPCS code off of claims.

Rob Schreiber: Exactly.

Barbara McCann: OK, yes.

Shaconna Gorham: Yes and I'm getting a green light…

Janice Tufte: Yes, this is Janice. And also in Medicare, we have annual visits, right?

Barbara McCann: Right.

Janice Tufte: I mean, so that's really easy, that's why I thought high.

Shaconna Gorham: And so let me just go back to the criteria as we assign the weighting to this specific criteria for usability in order to have a high ranking, it had to have the end use of federal program or used in multiple states for accountability and quality improvement, the medium ranking was given as used by states and local health plans for accountability and quality improvement or plans used in state Medicaid. So that is the distinction that we use for high and medium.

Barbara McCann: OK. So if we're ready now, can I have a vote for immediate use as high? Immediate use as high. OK, all right, there's the Janice shove vote and then ...

Janice Tufte: I don't know why that was…

Barbara McCann: OK, vote medium numerator and denominator, vote low, there's no evidence of testing, OK, did we get it?

Shaconna Gorham: So for the question ready for immediate use for this measure, adult access to preventative and ambulatory care, we have four votes for high and one for low.

Barbara McCann: All right. Yes, we're going to -- it's Barbara, we're going to move to a different domain. It will be care coordination. It's only one under access.

Shaconna Gorham: But there is one more step in the decision margin, yes.

(Off-Mike)

Barbara McCann: OK. What would we do without you Camille, thank you. Yes. Sorry I just skipped over.

Camille Dobson: That's OK. I just thought -- I just want to say this is the first time I was like maybe because you got high, high, high it automatically did it.

Barbara McCann: No, my left thumb, so I appreciate follow up. To what extent do you think this measure is important to state Medicaid agencies and other key stakeholders, MCOs, consumers, providers? A high rating is it's important to state Medicaid agencies and consumer families. Medium, important to two stakeholders, low, important to one stakeholder.

So may I have hands for a rating of high? Votes for rating of medium and votes for a rating of low?

Shaconna Gorham: OK, so for this measure, adult access preventive to ambulatory care, we have for the importance of stakeholder question, three votes for high, one for medium and one for low.

Barbara McCann: OK, great. Now, we will move to ...

Shaconna Gorham: So we just want to use this. So we just want to make this statement that based on the votes, this measure will be recommended for inclusion in the program area measure sets.

Rob Schreiber: So this is Rob. Is there -- so given the fact that we voted on this, but this actually may have crossed applicability to other groups like the complex care group. So we're making this recommendation. I assume they're not dealing with that measure in their discussion. So how does that cross pollination or that sharing and feedback loop occur?

Shaconna Gorham: So they'll make that assumption. It may be that the group and I'm not as familiar with their measure as I am for this group, but it occurred in some cases that the measures that they were looking at because it's filed within the group and it was relevant, they do have those measures on there as choices. But I would say again, that goes back to the rationale because we want to make a statement that we think that this measure if that is the case could also apply to other program areas.

So if is the case that you can make that and we could put that on record.

Rob Schreiber: So this is Rob. I would make that recommendation that it applies to other program areas.

Shaconna Gorham: And which program areas?

Rob Schreiber: I guess the complex care management. I also -- I even think -- what's that?

Female: I think SUD too.

Rob Schreiber: I guess -- I was thinking more of behavioral health, but SUD could be also included. But the least complex, then I think behavioral health because behavioral health, physical and mental integration I think is important and by substance abuse, I think the answer is yes, but I'd need more clarity on that, I'm having difficulty wrapping my mind around that. But I guess access to medications, treatment protocols, counseling, supports in a preventive way people. And so I guess substance abuse would make sense.

Female: To find out where they're at.

Rob Schreiber: To find out where they are and also because there may be impact of substance abuse on their wellness and prevention. So I do think probably it would cut across all.

Shaconna Gorham: OK.

Rob Schreiber: I just thought that out, but ...

Shaconna Gorham: We will make that note. And I just want to make sure for again transcript purposes that you all are including this measure, you think this measure passed all of the criteria, because it is a proxy for whether people get where they need to be, services available, the overall picture. You want to look at that measure that could help health outcomes and you want to make sure that we're not restricting only to dual eligible populations and that it crosses all populations, does that sum it up.

Rob Schreiber: Yes.

Shaconna Gorham: OK.

Female: Would it be appropriate to also include that this measure does not look at access to long-term services and support, but only to preventive and ambulatory care? It's not long-term services. But that's my -- yes, that's my only concern there, if it's – (AUDIO GAP)

Rob Schreiber: -- forward from your perspective.

Female: Yes, it would and I guess my only concern is that as these get pushed out to states as recommendations that we not end up with a state choosing three or four measures that they're going to look at and that access to this prevention or acute care is one of those measures without any consideration to whether or not access to long-term services and supports is available.

It's just where the emphasis is, because too often we see measures that are clinical that they're important if the person has a diagnosis that requires that clinical intervention, but it's not relevant to somebody who doesn't have that

particular diagnosis. So states think they're doing a good job based on those measures, but in reality it's not something that a person might say is relevant in their life. So that was my only caution, so thank you for your broadening of that discussion.

Judit Olah: This is Judit, just a quick question, do we need to sort of second Rob's comment or this is just to show full support of our ...

Shaconna Gorham: No. So I think it's consensus, yes. OK, so we have finished the access domain, so we just want to go to public comment. Operator if you can open the line up for any participants that would like to comment please?

Operator: OK, at this time if you would like to make a public comment, please press star then the number one. And there are no public comments at this time.

Shaconna Gorham: So let's move on to the next domain.

Barbara McCann: This is Barbara. The next domain is care coordination. Do I have? All right, 32 is the measured number. There are 12 measures for our consideration and we will start with the first if we can, follow up after hospitalization for mental illness. That's why I paused.

All right, the description -- pardon me?

Shaconna Gorham: Can I make one point? Barbara just made a very good point which I should have said earlier. So the numbers in front of your measure in your discussion guide is simply for an (assigning) so that we can quickly refer to a measure. So as she just did, measure 32, so that we can quickly refer to the measure. It is not -- you see that they're out of order. They would appear as if they're out of order. So it's not organizing, it is really for us to be able to identify measures quickly.

Barbara McCann: OK, thank you. This measure, as we look at it is the percentage of discharges for patients six years and older who are hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive

outpatient encounter or partial hospitalization with a mental health practitioner. This is a complex measure.

Two rates are reported, the proportion of discharges for which the patient received follow-up within 30 days of discharge and the proportion of discharges for which the patient received follow-up within 7 days. Now, if we could take this measure then through the decision logic to review it -- thank you -- this one is -- this is a complex measure.

Female: I just want to reiterate Diane's comment in the last piece. This is not about LTSS and not only it's not that, how is this care coordination? I mean this is physician follow-up I guess maybe. It doesn't say anything about a care coordinator following up or office staff. I mean I'm lost as to why this is relevant. I'll just share my perspective for LTSS.

Rob Schreiber: Yes, this is Rob. We've addressed the care coordination piece. So it is a care coordination function in the sense that when somebody goes out back into the community to ensure that there're linkages and connection, that somebody is connecting and coordinating to ensure that that person gets access and can get in. I'm not saying it's LTSS. In fact in a morphed system it could be an LTSS function if it was so defined in an integrated approach. But in general, the way it is done, it's usually a care coordination through the clinical office at least from what I see.

Female: No, it is. I would agree. Nationally it's kind of a measure you back into.

Rob Schreiber: That's right.

Female: If the visit did not occur at either of those times, then the assumption is that transitional care coordination did not adequately occur or hand off. Diane.

Diane McComb: I would say too, to have this considered under long-term services and supports, there would need to be an element discussing recovery and what supports would be necessary to support an individual's recovery. To me, reading this, it's all clinical. There's nothing in it that discusses long-term services and supports and again, I would think we would be remiss to

recommend to the state that this would be a measure that would be appropriate for long-term services and supports because it doesn't have that discussion.

Shaconna Gorham: OK, Janice, did you?

Janice Tufte: Thank you, that was ...

Diane McComb: It's important but it's not LTSS.

Janice Tufte: No, it was. I think of LTSS a little bit differently just because I've worked with the homeless population for so long and long-term support and services are people that have been (elders), sometimes for 20 years. I mean I know people that are.

And so in my -- this is something that we see coming from Washington State and I'm kind of a data geek, follow-up has been one of the biggest issues and when we found we had a follow-up call or something to the individual, it didn't necessarily have to be a visit, but a call even within seven days, if we can't do it, two weeks I think is what we're looking at, is that we have a much more lower rate of recidivism in the hospital.

So I mean I'm for this and that matter. And that's just because these people are so compromised. We're dealing with population here, part of the LTSS is to bring them into the community right into, and find them housing and to keep them housed. And so a part of that is a part of this, so thank you.

Rob Schreiber: This is Rob. So one other -- so I totally am on board with this in terms of this is not being LTSS. However there's always nuance. There is actually -- CMS had actually done a demonstration project working with community-based organizations that provide LTSS on care transitions programs that were being done nationally where the community based LTS provider was the link to ensure the individual landed appropriately and got back in.

Now, that is ...

Female: Right. I knew that then.

Rob Schreiber: No, I agree. No I agree, I'm just saying. So there is a connection to -- you know, there is this ...

Female: It's all connected now.

Rob Schreiber: But it is not.

Camille Dobson: Yes, if it was aimed at Medicare beneficiaries, APTT.

Rob Schreiber: It was aimed at Medicare, it was. But it's also being done in Medicaid beneficiaries, yes.

Camille Dobson: I get it, but it was fundamentally -- most of those folks were Medicare beneficiaries. This is Camille, I'm sorry.

Barbara McCann: This is Barbara. I'm going to ask this to make comments as to where the measure may not be, but we need to make a decision about this measure. So ...

(Off-Mike)

Barbara McCann: I think so. To what extent does this measure address critical quality objectives of CMS' quality measurement domains? High is that it addresses quality measurement domains and program area key concepts, medium, it addresses the CMS quality measurement domains, but does not address program area key concepts and low is measurement doesn't address CMS quality or program areas.

So may I have vote for this measure with regard to high? A vote with regard to medium? A vote with regard to low?

Shaconna Gorham: So for NQF endorse 0576, follow-up after hospitalization for mental illness, we have zero votes for high, two for medium and three for low. So with that, this measure will not be discussed further. We will not include this measure in the measure set.

Barbara McCann: This is Barbara. Let's go to the second measure which is medication reconciliation.

Shaconna Gorham: So before we do that, I just want to make sure when you say behavioral health, we're talking about the physical and mental health TEP?

Female: Yes.

Shaconna Gorham: OK.

Barbara McCann: OK, integration. All right.

Shaconna Gorham: I have one more, I'm sorry, Barbara.

Barbara McCann: Yes, it's all right.

Shaconna Gorham: So one more, so we'll discuss one more measure, but I want to just recognize the time and we have lunch scheduled at 12:30. So we can do one more measure and we can decide whether or not we want to kind of work through lunch and have a working lunch. OK.

Barbara McCann: The next measure, measure 35, medication reconciliation, the percentage of discharges, I'd like to make a comment, I can't tell discharge from where, for patients 18 years and older for the discharge medication list was reconciled with the current medication list in the outpatient medical record by a prescribing practitioner, clinical pharmacist or registered nurse.

Shaconna Gorham: So it may be helpful to quickly mention the specification to answer some of the questions about the measure you may have.

Barbara McCann: Are we ready to go through the -- all right, about -- I know. To what extent this measure addresses critical quality objectives or team program concepts? Can I have a vote for high? A vote for medium? A vote for low? We need -- did everyone vote?

Rob Schreiber: Yes.

Shaconna Gorham: That's five votes for low for medication reconciliation NQF 0097.

Rob Schreiber: This is Rob Schreiber, so again, I would like to refer this to the complex care management group and potentially even to the behavioral health group. But I think this is a critically important issue, and again I think there are places where it's not standard of care, where LTSS could be doing this in niche opportunities with contracts, but you have to have access to the electronic outpatient record.

And so you need whoever those providers are, clinical supports need to have that access and that just does not usually happen. So I just want to put that clarification in.

Barbara McCann: Yes, this is Barbara and I want to make a remark. Consistently we have found that it's reconciliation with what the individuals has in their home and actually outpatient is often insufficient, so that if -- I think this could be of great value across population if it was reconciled with what the individual actually has wherever they choose to live.

Janice Tufte: This is Janice. I just wanted to add, I do think it's important, but I realize that there're always gaps here and I think it gets lost without the patient passport or something where it can carry through with that patient. And also there was another measurement that also included it, so that's why I vote low. Thank you.

Shaconna Gorham: OK, just for transcript purposes, measure 0097 medication reconciliation will not be recommended for inclusion in the program area measure set. And I said one more measure, but since we went through that one so quickly, we might as well do another one.

Barbara McCann: All right, I need your help, my left hand has gone again. I am sorry, I am, thank you, all right. This is measure 40. This is a transition record with specified elements received by discharged patients and clarification here, are discharged from an inpatient facility to home of self-care or any other site of care, proportion of patients regardless of age discharged from an inpatient facility. How nice, observations included.

SNF or rehab to home or any other side of care or their caregivers to receive a transition record in with whom a review of all included information was documented at the time of discharge including at a minimum all of the specified elements.

Shaconna Gorham: And again I would encourage you to click on your measure specifications and as well as the staff preliminary review to find out more information about the measure.

Rob Schreiber: So this is Rob. I see the overall measure score was 2.4. That was on the preliminary review, why is this -- doesn't this meet criteria?

Shaconna Gorham: Yes. So this measure, the mean for this measure is above the threshold score, so that's why we're discussing it. It moved forward to this decision logic review. But just because it met threshold score, you as experts may say that this meets the mean score, however we don't think that is applicable to these different questions through the decision logic.

So that is where the vote would come in. So yes, it met the mean score based on the evidence and the testing and usability and feasibility, but again as experts we look to you to say that this measure would really be good for this program area.

So I will say that the more information and the more information to actually hit our criteria, the score was higher of course. So for NQF endorsed measures we have all the information. We know that it's tested. We know that it's sound, it's reliable and it's valid. We know feasibility information.

We know exactly where issues, I have all of that information so I could score appropriately. But some of the measure concepts, some of the information may not have been available. So even though we reached out to the state and we get as much information as we could, some of the information may not be available, and so that's where you have that unsure category.

So that would automatically -- if something was unsure and it got a zero, it will automatically bring the measure score down, which is why we wanted to give you the option to retain some measures because we didn't want a measure

or a concept to fail just because we could not find enough information about it. So hopefully that answers the question.

Rob Schreiber: So this is Rob. So my question ...

Shaconna Gorham: Here's your mic.

(Off-Mike)

Female: Your mic.

Rob Schreiber: Oh, it's red and red OK, I didn't know it could do that. This is Rob. Yes, this is the doctor, what do you want? And plus I only have about four hours of sleep because I did -- this is off the record, I got to sleep at 2:30 last night when I arrived at the hotel from Boston mind you.

So my question is then, if it hits the criteria. we think this is an important thing, but it doesn't -- it meets criteria for CMS quality and we feel that, could we vote for that and say we vote for this, but we don't feel LTSS -- this is an LTSS domain? I mean can we do that? I'm just asking the question because I'm confused.

Barbara McCann: I'm feeling it.

Rob Schreiber: With what you're doing? OK.

Shaconna Gorham: So you've voting on whether -- but remember all of these measures are -- should apply to your program area. So yes, it meets the CMS quality domain and according to our search terms, it meets that.

But if it doesn't apply to your program area, then it really would not pass that criteria, because again it should apply to your program area for this specific question and also meet a quality domain, for another question and I'll just use stakeholders as an example. The sale has to apply for your program area and also be important for the stakeholders. So for each question, you're applying it to your program area and the question at hand.

Judit Olah: I have a question and maybe I'm just thinking out loud here, and it's something that I'm struggling with, how much of this is aspirational? Like to me, the way I understand transition of care and the way it is defined in the environment that I work in is different than a discharge record.

So a transition of care would include referral to health and community resources because I see it, and so I see as absolutely critical to the subpopulation who was touched by a system. It is different than a discharge summary. But again do we need to caveat it that this is for the subpopulation who was discharged from those points of deliveries of care?

But it is the way -- you know, it is defined for me in my operational reality, it would absolutely include food, nutrition, housing as an internal policy-driven expectation, what needs to be included in there.

Rob Schreiber: So this is Rob again. So I think as a long-term service support provider, I just -- it's interesting. I don't see it listed in here or maybe I'm not reading it, of LTSS supports and I know that that is an opportunity, but I do think if you have LTSS in the home, they're going to want to have this. They need this information, right? This is critically important in order to provide integrated LTSS. So from that perspective, that makes a lot of sense. That's why I was trying to get the clarification, yes.

But I do think from an aspirational perspective, my sense would be is there a focus in the transition record not to say necessarily that they need all these LTSS services, but is there an assessment of LTSS need to a community provider that can do an assessment? Is that part of the transition of care record that that be part of the transition?

Female: I would say in order for this to be relevant to long-term services and supports, I'd want to see things rather than the way this is written, the process measure, it doesn't assess quality of a long-term -- there's no reference to that.

If we look at a person-centered plan that would identify specific to the individual, housing needs, coordination of medication, food, nutrition needs and so forth and we were measuring the outcome of whether or not those were present or a plan was in place to make certain those were present, then it

would be relevant. But as it stands, again, not that it's not important, but I don't think it has the elements of long-term services and supports.

Barbara McCann: This is Barbara. I'd like to disagree with that from the perspective of a provider. As I read this again, and this is an incredibly complex measure statement, I desperately need to have the information from an institution when they come home. I desperately need it. And it says other healthcare professional which I would designate that I am, and I need it within 24 hours because I'm starting care the same day. I'm getting aide back in there, the homemaker et cetera.

So I'm looking at it from a very defined process measure that very often folks come home, we don't know if they're home until they call us and we have no idea why they were in or what went on. So I'm looking at it as if somebody was sick enough to go in to any of these places, these institutions, I desperately need to have that information.

(Off-Mike)

Barbara McCann: Yes, yes, it's desperate. We don't get it usually, but it's a proxy. It could be a piece of paper. It's not saying we actually (inaudible). It's something we get. Yes, Janice.

Janice Tufte: This is Janice. And what drew me to this one and I thought it was very comprehensive and like you said it's something we could actually get this information to people because I hear over and over from primary care physicians that they don't even know, and then the patient is actually upset, "Why don't you know?" So it's important.

But this had two key components to me as a patient or a person advocate is advanced care plan and advanced directives. There's only two measurements that had that and this is one of them and I felt it was the most comprehensive. Thank you.

Barbara McCann: Great.

Judit Olah: And I just want to add I just changed my mind because I'm so -- so my theoretical mind goes right with where Diane is like am I really measuring what I'm defining? So it's the quality of LTSS. But back to are those really proxies that I'm gauging what is needed and then maybe I'm back at the quality of service that we are really focusing on. Because I am gauging how wide I need to open that door. So I just went a full circle I started to nod with you and then I started to nod with ...

Female: Yes.

Barbara McCann: Relative to an individual who is leaving an institutional or an ICF facility, you, in terms of providing care need to know that things are in place. We just need to know it happened, yes.

Rob Schreiber: And this is Rob. This is the holy grail that we have been trying to deal with since 1986 when I first started seeing patients in the real world. And I could not believe we are still having this discussion. So this is like -- this is basic standard that everything else builds upon the medical integration with long-term service and support.

So from that perspective, with LTSS and having worked as a medical director in a AAA and going through cases, when I ask questions, "Why was the patient in the hospital?" "We don't really know. They said they were sick. They were short of breath." OK. So now they're trying to figure out what this person needs with the VNA that doesn't have the record.

So it's really almost a fundamental condition in order to provide quality and LTSS that we need to know the physical, medical side and we need to have standardized information. So from that perspective, again, it's a proxy, but I think it's a critical proxy, so that's real-life experience that I have.

Barbara McCann: Right, just to have the expectations.

Diane McComb: Yes. I am moved by your comment, Barbara, about the need as a health provider to know what the circumstances are and I realize we're not changing measures, Shaconna, but I would want to reference that if such an assessment is done, it would be nice if it also addressed other issues that are not clinical

that would be necessary to stabilize the individual in a long-term service and support setting that aren't really part of this.

When a discharge plan is written from a facility, generally it's written from a medical perspective, although not always, and this is just something that's emerging. I mean I fully understand long-term services and supports are not in the same place as medical services in terms of our ability to assess them, and not all social workers are we're trained to look at that community spectrum as opposed to a medical spectrum.

So just to make that comment, what's listed in this measure in terms of the numerator is important. It's critically important in the short-term, but it doesn't address those long-term supports and services that would stabilize the individual over time.

Barbara McCann: Right.

Rob Schreiber: So is there a way to recommend in maybe not this measure, but to redefine or refine the measure to allow which just Diane stated to be incorporated in generation two of the concept development?

(Off-Mike)

Rob Schreiber: Yes, OK.

Barbara McCann: I think -- no, I think that's a concept because ...

Rob Schreiber: I mean I don't want to lose it. I think it's important to capture it.

Barbara McCann: Right, no, no because what I'm hearing then that measure should hold me accountable as a provider of LTSS right, or home and community-based services that if I got this within 24 hours, I have to get out there and reassess what that person ...

(Off-Mike)

Barbara McCann: That would be a new practice.

(Off-Mike)

Judit Olah: But again the transition of care record is not a discharge record. So we shall determine in stuff health are captured in there. You know, a child of 14 is going back home and is raised by grandparents, single mom, was just discharged going home to take care. So social determinants of health are a part of the transition of care record, it is not a discharge summary.

Barbara McCann: So I think you make a good point and that is the process we may be able to report, there are no standards, if you will, for the content of a variety of things or how they're going. All right, so we're going to try to vote. It seems so easy, all right. The extent to which this measure addresses critical quality objectives of CMS and program area key concepts, can I have a vote for high? A vote for medium? A vote for low? We got everybody?

Shaconna Gorham: Yes, I have everybody.

Barbara McCann: I just want to make sure.

Shaconna Gorham: So for this measure NQF endorse 0647 transition record with specified element. We have five votes for high for the first question on the decision logic.

Barbara McCann: That's cool. That's great. That's great, all right. Now we get to move on to the next, is to what extent the measure addresses an opportunity for improvement and/or significant -- let's say a quality challenge for variation in care? Can I have a vote for high, it addresses multiple quality challenges and opportunities? A vote for medium, has the potential to address variation in care and quality challenges? A vote for low, does not address quality challenges or opportunities?

Shaconna Gorham: So we have three votes for high and two votes for medium on the question regarding opportunity for improvement.

Barbara McCann: The next consideration is to what extent does this measure demonstrate efficient use of resources, contributes to alignment and is not duplicative. May I have a vote for high, measure demonstrates efficient use of

measurement resources? A vote for medium, does not address some areas? A vote for low?

Shaconna Gorham: All right, so we have three votes for high and two for medium on the question of efficient use of resources.

Barbara McCann: OK. So to what extent is this measure ready for immediate use? High, already in Medicaid populations? Medium, it has a numerator and a denominator and has reported testing? Low, it has a numerator and a denominator but there is no evidence of testing? So to what extent is this measure ready for immediate use, can I have a vote for high? A vote for medium?

Shaconna Gorham: We have five votes for ready for immediate use.

Barbara McCann: All right. To what extent do you think this measure is important to state Medicaid agencies and other key stakeholders? Can I have a vote for high, important to agencies and consumers' families?

Shaconna Gorham: OK, so we have five votes for high. So based on the decision logic and the votes, we are recommending this measure for inclusion into the measure set, and that is measure 0647 NQF endorse 0647 transition record would specify elements received by discharge patients. And I just want to make sure that I have captured your reason and your rationale for including the measure. So I'm just going to read back some of my notes.

We think that -- so this measure is critical for primary care physicians. The information is needed, as the patient leaves the institution when they come home, the primary care physician would need this information ASAP. And ...

Barbara McCann: This is Barbara. It's also critical to the LTSS provider when they get home.

Shaconna Gorham: OK, right.

Barbara McCann: So a professional in the community, providing services broader than the PCP, so PCP-plus.

Shaconna Gorham: OK.

Rob Schreiber: Yes, all providers involved in the care of the client or individual as well as family and LTSS supports.

Shaconna Gorham: OK. So does that one sentence of rationale capture your feelings for the measure and why it should be included? OK, all right. So with that said, we want to open up for public comment just before we go to -- before we break for lunch. So operator, can you open the lines please?

Operator: Ladies and gentlemen if you'd like to make a public comment, press star one on your telephone keypad. And currently no public comments.

Shaconna Gorham: Thank you. So let's take about 15 minutes to go grab your lunch and come back and then we'll work through lunch. Lunch is right on the other side of this partition, so we'll grab lunch and come back and take a break if you need to and then come back.

Female: What is the number of the next measure we're doing?

Barbara McCann: I believe it's 37, correct? I'm not sure.

Shaconna Gorham: Thirty-nine.

Barbara McCann: Thirty-nice.

Shaconna Gorham: Yes.

Female: We have (inaudible) coming right after this.

Barbara McCann: Oh right, sorry, 39, I apologize. Thank you. We just did 39, timely.

Shaconna Gorham: No, we just did 40, so there is -- 40 is the transition record, yes.

Barbara McCann: OK, yes.

Female: OK, that makes sense.

(Lunch Break)

Shaconna Gorham: So, it is one o'clock and as agreed we will continue with the discussion during lunch. If I could have everybody's attention, please?

Female: You may have to whistle.

Shaconna Gorham: Attention. I don't have a wine glass to hit so, I can't make that ding-ding noise but we're going to go ahead and get started and we're going to work through lunch.

Barbara McCann: Right. Right. So, we are on number 39.

Shaconna Gorham: Correct. All right.

Barbara McCann: So, folks, let me read the measure.

Female: Back to work.

Barbara McCann: Back to work. Back in your heads. All right. The percentage of discharges from an inpatient facility – oh hold it, we already did 39, correct? We did.

Shaconna Gorham: No.

Barbara McCann: Transition record. We did.

Shaconna Gorham: We did 40. We are on 39 now.

Barbara McCann: All right. So, these are very similar. OK. The percentage of discharges from an inpatient facility includes observations, sniff and rehab to home or any other site of care of patients regardless of age for which a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up within 24 hours of discharge.

Female: How this is this different from number 40? What are the differentiations that …

(Off-Mike)

Shaconna Gorham: Yes. And, again, I would direct you to your measure classification to kind of really pull out the particulars about the measure.

Female: And why would it be consolidated into one measure? I'm asking is there a logical reason why it should be separate.

Barbara McCann: To be separate.

Shaconna Gorham: So that would be an actual question for the developer. We have to take the measure at face value. So, the measure as submitted to NQF and endorsed; it was endorsed as two separate measures, submitted as two separate measures with different specifications, so we have to look at them as separate measures.

Female: If we were to agree to the points of this measure, could we do so but also suggest that the two be consolidated? Then you have a whole different measurement to test in.

(Off-Mike)

Barbara McCann: Yes. So, as somebody who has to look at the results of measures and decide where you focus process improvement, I can understand why they separated it, because otherwise you have one measure that looks at content and the next one looks at timeliness. And it's very difficult in analysis to separate those two out easily.

So, from that perspective...

Female: ... the timeliness ...

Barbara McCann: Well, we did. We added it but we were ahead of ourselves.

(Off-Mike)

Barbara McCann: That's true. All right. So, you can mumble your vote or hold your fork up. All right.

Female: Twenty-four hour, seven-day context...

Barbara McCann: Right. So, the fist element for consideration is to what extent this measure which essentially is the timeliness within 24 hours of discharge address critical quality objectives of CMS or program area key concepts. So, can I have a vote for high CMS quality measurement domain? Right.

So, we'll move to the next element of...

Shaconna Gorham: So, we need one more vote. I have four votes.

Barbara McCann: Oh, I'm sorry, I apologize.

Shaconna Gorham: Yes. Janice, it does discuss transitions which is in the CMS quality measurement domains and referral to self help for consumer-run programs. This is addressing the social determinants out in this one.

Barbara McCann: A question or are you making a comment?

Male: A comment. I think I don't know but I think...

Shaconna Gorham: I think this fills in some of the gaps, Janice, again where we were talking about in the last measure.

Barbara McCann: In the previous measure. OK. And so, may I have a vote for medium.

Female: I voted on high.

Barbara McCann: You were on high? Janice is high.

Shaconna Gorham: OK. So, for NQF endorsement 648 timely transmission of transition records, we have five votes for high on the first question CMS domains and key concepts.

Barbara McCann: So, for the same measure, to what extent will this measure address opportunity for improvement or significant variation in quality. The vote for high, it will address multiple quality challenges and opportunities for improvement. Votes for medium?

Shaconna Gorham: OK. So, for this question, opportunity for improvement, we have two votes for high and three for medium.

Barbara McCann: Right. The next element for consideration is the extent to which this measurement demonstrates efficient use of measurement resources. Can we have a vote for high, demonstrates efficient use of measurement resources, addresses broad populations? A vote for medium?

I'm good. I'm fine.

Shaconna Gorham: Yes. We have four votes for high and one for medium for efficient use of resources.

Barbara McCann: To what extent is this measure ready for immediate use? Can we have a vote for high, please?

Shaconna Gorham: OK. Five votes for high.

Barbara McCann: And to what extent do you believe this measure is important to state Medicaid agencies and other key stakeholders? A vote for high, please.

Shaconna Gorham: We have five votes for high. So, we went through the measure pretty quickly. Can I just make sure I have rationale for why this measure will be recommended for inclusion? I do understand that it is closely related to the previous measure, will the same conversation apply for this measure? I did hear Janice as she mentioned that this discusses transition and it addresses social determinants of health, but do we have other reasoning why this would be a good measure for the set?

Barbara McCann: This is Barbara and I would definitely say because it puts the timeliness within essentially one day of being discharged so, wherever they return in the community that the information is shared.

Shaconna Gorham: OK.

Female: Janice, I also noticed this is one of the only measurements that address that health literacy so that the language is appropriate, our communication and I think that's really important, health literacy.

Shaconna Gorham: Thank you. Any other comments on this measure? OK. You can move to the next measure.

Barbara McCann: Right. The next measure is 37, reconciled medication list. That's the proportion of patients regardless of age discharged from an inpatient facility, observation is included, to home or any other site of care or their caregivers who received a reconciled medication list at the time of discharge including at a minimum medications in specified categories.

Discussion? All right. Yes?

Rob Schreiber: So, again, it's almost like we're doing déjà vu here. So, I guess if we're going to be consistent I think we discuss again the impact of what this is but my sense is, again, although it's really important, I'm not convinced from the LTSS perspective that it's a critical component for LTSS; it's critical for the holistic care of the individual in the community and keeping them in the community, but I do find that, again, it's not the sweet spot that I was hoping we would see.

So, I guess that may be the challenge for LTSS, that we just don't have the refinement of the right types of measures that would be important in those transitions whether it's related to any of the determinants. And so just with that caveat, I think I know how I'm going to vote.

Barbara McCann: It would support the comments.

Female: Yes.

Barbara McCann: So, the first element of voting is the extent that this measure addresses critical quality objectives of CMS or identified program area key concepts. And may I have a vote for high? A vote for medium? A vote for low?

Shaconna Gorham: OK. So, for NQF endorse measure 0646, reconcile medication list received by discharged patients, we have zero votes for high; one vote for medium; and four votes for low. So with that, this measure will not be recommended for inclusion into the measure set.

Rob Schreiber: So, this is Rob. I need to let people know, unfortunately, I have a site visit that we're having done by a foundation in 4A in Washington and I'm like critically important to be part of that site visit. So, that starts at 1:30; I'm going to need to leave here about 1:25.

Female: OK.

Rob Schreiber: So, I'm going to be gone for about a half an hour. I will try to get back sooner, so that would only leave us I think with four people on the voting panel. Is that correct?

Female: Yes.

Female: We have a quorum.

Rob Schreiber: So, at least you have a quorum and I will do my best to come back. I do apologize.

Female: Thank you.

Rob Schreiber: I tried to switch it and I thought it was going to overlap with lunch but we switched the time for lunch, so there's nothing I could do.

Barbara McCann: Thank you. We appreciate it and we hope you'll come back.

Rob Schreiber: No, I will come back. I promise. I will come back. As a matter of fact I would suggest strongly that somebody come get me if I am not back because I could say oh, I have to go because...

Barbara McCann: Give us your number, we'll call you.

Female: Give us your number.

Rob Schreiber: Yes, I will. I'll give it to you. I will.

Female: He's probably in the office so...

Female: Yes.

Rob Schreiber: Yes. They know where I'm at.

Barbara McCann: OK. All right. We are going to move to the next measure, number 28 and it's a bit of a long measure. We'll go through that. This measure assesses the proportion of patients 18 and older who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent during the measurement year and at least one therapeutic monitoring event with the therapeutic agent in the measurement year.

Now, the following three rates and a total rate, it looks at annual monitoring for patients on ACE inhibitors or the A or Bs, at least one serum potassium and a serum creatinine therapeutic monitoring test in the measurement year, annual monitoring for patients on digoxin at least one serum potassium, one serum creatinine and a serum digoxin therapeutic monitoring test.

And rate three, annual monitoring for patients on diuretics with the specific monitoring test. And the total rate is the sum of the three numerators divided by the sum of the three denominators.

Any discussion or should we vote, ready to consider? All right. The first issue for consideration is to what extent this measure addresses critical quality objectives of the CMS quality measurement domain or key program areas, key concepts.

May I have a vote for high? A vote for medium? A vote for low?

Shaconna Gorham: OK. So, for measure NQF 2371, annual monitoring for patients on persistent medications, that is five votes for low which will mean this measure would not be recommended for inclusion in the program measure set. Can we have some rationale for that decision?

(Off-Mike)

Male: I'll second that.

Male: Whatever.

Female: I agree.

Female: Yes.

Shaconna Gorham: And it does not fit the LTSS population, why?

Female: It's medical and clinical. It's very important for somebody ...

Diane McComb: I'm sorry. This is Diane. It's medical and clinical in nature and does not address the elements of long-term services and supports.

Barbara McCann: All right. We will move to measure number 27 which is a three-item care transition measure. And I note a popular measure with the group. It's a CTM three is a hospital level measure of performance that reports the average patient reported quality of preparation for self-care response among adult patients discharged from a general acute care hospital within the preceding 30 days. Discussion?

Rob Schreiber: So, this is Rob Schreiber. In full disclosure, the individual who created this measure is a close colleague of mine by the name (Eric Holman), so I am very partial to this measure. I guess again, the question, I guess, that I look at in terms of successful discharge to allow LTSS to provide the best possible support, you need people to understand why they were in the hospital, what their medications are and what to do when there's a problem and have a follow-up.

So, as part of an integrated, holistic plan, this piece is really critical to allow providers along with the timely transition discharge summary to be able to actually provide that care, and for the individual to have the best possible outcome. But, again, as it relates to LTSS, I'm really trying to thread it and I'm struggling with this.

Again, very important, not discounting it, as a matter of fact I would say this is the most critically important aspect even more than medication reconciliation. Because if you have an activated person they got to know their medicines, they're going to go home and say look, I have all these medicines; I need help. They're going to be engaged but I am not certain how it really directly ties to LTSS integration and continuity.

Barbara McCann: This is Barbara. The only way I could make that bridge is if the individual with caregiver or without cannot manage a self-care response, then they may need to be evaluated for a higher level or a short term level higher home and community-based services.

But the measure actually says it's the individual's reported quality of preparation for self-care; it doesn't go to the nest step and say here you have what you should be doing, but it doesn't say could you do it. Could you do it? And do you need to be evaluated. So, I'm struggling with myself because I think this is actually on hospital CAPS, I think, right?

Male: It is a hospital...

Female: It's NQ care.

Female: It's hospital CAPS.

Rob Schreiber: It's NQF, the hospital CAPS measure, correct.

Female: Yes. OK.

Judit Olah: I agree -- this is Judit – because this addresses how well the patient is able to manage their chronic condition. And in my mind there's a big difference from the transition of care record that's mandatory to assess what are your circumstances, your family and social circumstances so that that allows to identify the kind of gaps that this doesn't ask questions about this just asks, are you now able to recognize alarming symptoms of a COPD or something.

Barbara McCann: Are we ready to vote? All right. The first element of the vote is to what extent the measure addresses critical quality objectives of CMS or identified program area key concept. Can I have a vote for high, please? A vote for medium? A vote for low?

Shaconna Gorham: I would say that's definitely consensus. We have five votes for low for the question regarding CMS domains and key concepts for measure 0228, three-item care transition measure and basically the response

or the reason why. Although this is a critical measure, there is no direct correlation to integration and continuity.

All right. So with that, we are going to lose Rob, but we do have quorum so we can continue to the next measure.

Barbara McCann: Thank you. This is measure 25, the percentage of short stay residents who were successfully discharged to the community. So, it is a short stay successful community discharge determine the percentage of all new admissions to a nursing home from a hospital where the resident was discharged to the community within 100 calendar days of entry and for 30 subsequent days they did not die, were not admitted to a hospital for an unplanned inpatient stay and were not readmitted to a nursing home.

Discussion? All right. We will look at our voting criteria. To what extent does this measure address critical quality objectives of CMS or identify program area key concepts? Can I have a vote for high? A vote for medium? A vote for low?

Shaconna Gorham: Measure, percentage of short stay residents who were successfully discharged to the community, we have three votes for low and one for medium on the first question CMS domain and key concepts. Can we have a rationale to why we are not recommending this measure concept for inclusion in the program area?

Janice Tufte: This is Janice. It seems to me that we're really just – somebody was in a nursing home and then they were not readmitted or discharged to the community. So, I'm not quite sure where we're going with it, I guess, is what I'm trying to say. I don't know what the point is, if somebody else could verify.

Judit Olah: To me the rationale is similar that we have done before, that this is an important measure but it's not addressing, or not pertaining to our focus.

Female: OK.

Janice Tufte: Green, oh there it is red. I thought I've never seen green. We have some data in the literature that indicates that a stay over 30 days diminishes the likelihood of the individual returning home. And, again, in the case of a younger person with a disability, they will lose their housing in over 30 days and have nowhere to go home and be stuck in the hospital.

So, for that reason this measure is not a good measure of quality on any level for a younger person with a disability. So, that would be my rationale for voting against it. Thank you.

Barbara McCann: Thank you. We will now go to measure 33, healthy days in the community. This is the average number of days within a year that dual eligible beneficiaries are alive and residing in the community without utilizing acute or post acute health care services.

(Off-Mike)

Female: Yes. Yes.

Female: Yes.

(Off-Mike)

Shaconna Gorham: OK.

(Off-Mike)

Barbara McCann: The specs, yes. Other discussion? It's not in the specs, I guess I'm requesting clarification, is post acute health care services the same definition as CMS so it would include home health services for any period of time?

(Off-Mike)

BFemale1: Right. So in home health, for instance in the bundle is considered a PAC or post-acute health care services. However, under Medicaid, skilled Medicaid could be as simple as setting up medications weekly ,because by virtue of state law and scope of practice, the nurse has to do that.

(Off-Mike)

Female1: It could also be just helping with the wound care, say someone is in a wheelchair and they get a wound and somebody comes out for a short period of time just to make sure it's taken care of. I'm expressing my distress that no post-acute that healthy days with no post-acute. I mean diabetics have tough days.

(Off-Mike)

Female: Right. I mean, gosh, the people working on that are outstanding. I mean …

(Off-Mike)

Barbara McCann: So it's without utilizing acute or post-acute care.

(Off-Mike)

Barbara McCann: And home health is in there. So that would include psych home health. I guess I'm just saying that's a pretty gosh darn healthy person to be in services, to be receiving services.

(Off-Mike)

Barbara McCann: I'm thinking of adults on ventilators have to go in for the checks into the hospital regularly to avoid respiratory infection. Yes, Diane?

Diane McComb: Again, this would be appropriate for a different domain than what we're looking at in long-term services and support because its entire focus is medical versus medical free.

Barbara McCann: Right.

Diane McComb: And I'm not sure that's a relevant measure for long-term services and supports. It's clinical in nature and it's measuring either the presence of or the lack of clinical intervention versus the quality of life a person might be experiencing. A person can live in a long-term services and supports setting,

have a high quality of life, but still have medical intervention. And that doesn't discount their quality because they get that medical intervention.

Barbara McCann: Right.

Diane McComb: So for me this measure isn't appropriate for LTSS. But that's just my concern with it.

Barbara McCann: Right.

Female: I pulled out some information about the measure from CMS's site. So, this particular measure developed for populations of Medicaid beneficiaries, people eligible for Medicare and Medicaid or dual eligible beneficiaries, people with saving long-term services and supports through a managed care organization.

People with substance use disorders, beneficiaries with complex needs, physical and mental health conditions or who receive LTSS in the community corresponding to the priority areas of the Medicaid Innovation Accelerator Program.

Barbara McCann: Does it define post-acute?

(Off-Mike)

Barbara McCann: But if they're able to live in the community. I'm just confused by the basis of the measure safely. Yes?

Diane McComb: And if I could just offer a reverse consideration. If we use this measure to look at quality in LTSS, a person who has a congenital condition who has used a wheelchair their entire life, who requires an attendant to get them out of bed and to prepare their food perhaps and to put – get them back to bed, that individual could be employed, could live with those supports and by virtue of this measure would not have a good quality of LTSS setting.

And to me that's – it's negative. I mean that doesn't have anything to do with their quality of their life.

Barbara McCann: I would agree …

Diane McComb: Still I agree with what you're saying. I don't think this measure – I wouldn't even refer it somewhere, but I don't think this measure is at all appropriate for long-term services and supports, because it's making the assumption that if you use home health services that your quality of life is less than what it should be or could be, and in reality home care services are a vital component for many people with physical disabilities to be able to live a life of quality. So, I mean, yes, it's a false assumption.

Female: Right.

(Off-Mike)

Female: They interpret home health, right? If they mean – I think what they mean with this because it came from a Medicare that they mean skilled home health not home care like you and I would imagine. So in other words, if somebody who – if they are not healthy at home, if they need PT, OT and speech and …

(Off-Mike)

Female: Yes. That's always …

Female: Well …

Female: Right …

(Crosstalk)

Female: Right. That's always the problem, but …

Female: No, no, no. I mean that's the practice act issue because we do get folks up with one nursing visit, deal with the ventilator and they go off to work et cetera during the day, but technically they got skilled care.

Female: But they are good. They are living in the community. They are …

(Off-Mike)

Barbara McCann: And this is also limited to duals.

Female: Yes …

Female: Right. Yes.

Barbara McCann: All right, everybody, or you want to …

Female: No.

Barbara McCann: OK. Go ahead.

Judit Olah: I just wanted to add. This is Judit. To kind of expand on Camille and Diane's comment that improving this number wouldn't from necessarily demonstrate, reflect that we are making any difference to those larger percentage of populations.

(Off-Mike)

Female: Probably development …

Female: Exactly. Right. That's a consideration too.

Female: It was.

Female: Right? It's …

Barbara McCann: I agree. I agree. Does it integrate? So what – well, here we go. To what extent does this measure address critical quality objectives, the CMS quality measurement domains or identified program area key concepts? May I have a vote for high. A vote for medium. A vote for low.

Shaconna Gorham: OK. So we have four votes for low, for healthy days in the community along this first question in the decision logic. So this measure will not be recommended or measure concept actually will not be recommended for inclusion in the program area measure set.

Barbara McCann: I would offer that Judit's last statement, I think was a perfect description of a rationale for that vote. If this improved, what did we actually accomplish within LTSS.

All right. We move to measure 30. Patient's clinical risks have been assessed and scored, rationale, an individual's risk score will speak to degrees of compliance with preventive measure guidelines, cancer screening, addiction screening and also chronic care measurement – or excuse me, management gaps.

We're ready to vote. Any questions, considerations? All right. To what extent does this measure address critical quality objectives of CMS domains and program area key concepts? Can I have a vote for high. A vote for medium. A vote for low.

(Off-Mike)

Female: It can be half and half, right?

Barbara McCann: Yes. I guess I'm – I'll respond from my perspective as to why low. I voted low. We are finally across even health care measures addressing psychosocial barriers as well as these barriers, clinical barriers. And so, I'm almost appalled is what I would say is to see a measure that doesn't include psychosocial barriers. It may not exist, but we're actually better than this in home and community based services right now.

So I'm – yes, Diane.

Diane McComb: And if I could add, the term compliance is a term that is not used in long-term services and support settings. Compliance is you did what I told you to do. And long-term services and supports address where a person lives and choices they may make which may not be good choices sometimes.

And there's a fine line there. I do certainly appreciate when we're talking about individuals who are connected to the substance use disorder realm or homelessness that – but I'm talking about the average person who is in an

LTSS setting who has a disability or as a result of aging needs support, compliance should not be part of our vocabulary as much as education.

Female: Yes.

Diane McComb: And that as a measure that to me again would not be relevant or appropriate for long-term services and support.

Barbara McCann: Judit? Janice?

Female: Again. Me.

Female: Go ahead.

Barbara McCann: Yes. Comments about the measure.

Janice Tufte: This is Janice. And actually, I see this as an access issue too. I mean even if –compliance, I agree, shouldn't be in there. Adherence, we don't use the word compliance anymore as much as possible, but I'm just thinking about the populations that I'm involved but then even myself, like I had a message from my doctor and I missed it, right? And they got a call from me. So, I wasn't compliant because I didn't read the message.

Female: And how did that make you feel?

Janice Tufte: It's stupid, but thank goodness they have excellent system that called me, right? So because I just think cancer is killing so many people like I'm working – what we were discussing before, I work with – I have friends that are blind and low vision, so I'm very close to the blind community.

And there is a lot of problems there and some of them have multiple issues. I mean addiction screening and whatever, a lot of this is in there, but there should just be a standard of care, I think.

Female: Standard of care.

(Off-Mike)

Female: Well, that's certainly …

Janice Tufte: Right. Don't you think?

(Off-Mike)

Female: I think SUD.

Female: I would think maybe more relevant to the other groups. They are looking at measures rather than LTSS complex.

(Off-Mike)

Female: Complex, possible substance use disorder, integration of behavioral health and physical health.

Female: Oh, OK.

Female: I mean, I just don't think it's relevant in our domain that we're looking at.

Shaconna Gorham: So can I just ask that we vote again, because I think I heard that the measure is a standard of care access measure. But I'm not sure that that's consistent with the vote. So if we could just vote one more time on this measure for CMS domains and key concepts.

If we can start the measure with a high. How many would vote high on this measure? OK. And medium? And then low? OK. So with that revote, we have one for high, zero for medium and three for low, so this measure actually would not be included for recommendation into the set for all of the reasons stated.

Barbara McCann: OK. Comments, Judit …

Judit Olah: Oh, just my comment is that the scores currently include social determinants of health. It's not, in the old world it used to be utilization-based of the number of readmissions and the number of ED visits and these days it's families, social circumstances, et cetera.

And there are weighted scores. They are not unanimous by any means, but what is unanimous that those factors are coming in here. So if I have out of control asthma, I'm a higher score then if somebody meets me at my level of literacy and explains to me how not to manage my asthma with in and out of ED rooms, so even with multiple chronic conditions my risk score can be lower if I'm equipped with resources.

So if somebody tells me, go to the local Y to get an education or see what I mean? And so I'm not high because of my conditions. I'm high because I don't manage my life the way I need to, you know? So that was my only concern, that that definition changed in the health care industry.

Female: Yes?

(Off-Mike)

Female: Use your mike.

Female: Sorry. Maybe by tomorrow we'll learn to push the buttons.

Female: Yes.

Female: Would that apply though more so in the – it sounds like the point of intervention though is in the clinical setting where that assessment is made as opposed to assessing – it does improve the quality of someone's long-term services and supports perhaps, but it's not an element – I mean the risk assessment would be done in the medical setting as opposed to the LTSS setting, would it not?

Judit Olah: So I'm thinking out loud here to kind of – yes, I don't know how I'm finishing the sentence.

Female: No. I just wanted to get your thoughts.

Judit Olah: So the risk is these days it's done with social workers and care managers. And the model of care is such currently and maybe it's for the thought leaders and the leading systems and not for nationwide yet, but the model is such that

we believe that social determinants of health directly influence the success of clinical interventions. That's the premise that the risk score is calculated on.

Female: And I agree with that you just said. I didn't read that in this particular description of the clinical risk scores, so maybe the description if it read differently – I think what you said is not what this says. So I'm not sure what to do with that.

Janice Tufte: This is Janice. In Washington State, our accountable communities of health, we are – I mean, we're all developing vulnerable assessments, health assessments, so it's actually could be done – it could be done in the home.

It could be done like at – whatever, a small clinic. It could be done perhaps even a telehealth but at various venues, shelters. So I think that this is something, what you just mentioned was a little bit different than like you said this looked more clinical to me.

Female: Yes.

Shaconna Gorham: And so I will say, just to add to that. This is a measure concept so it's not a fully-baked measure, so all of the questions or information you may need about this measure, we could not find all of that …

Female: Right.

Shaconna Gorham: So just to be fair to the concept, that is what you're looking at.

(Off-Mike)

Female: Shaconna, do feel you have an adequate outline of what our issues are?

Female: OK.

Shaconna Gorham: Yes. Yes.

Female: OK.

Female: Good.

Shaconna Gorham: So with that, the vote is fine. The vote is cast and then we'll go with the vote. OK. All right. So then this just to repeat the clinical risk score will not be recommended for the measure set.

(Off-Mike)

Barbara McCann: All right. We're on to our next measure which is an individualized plan of care completed.

(Off-Mike)

Barbara McCann: Oh, I'm sorry, number 34.

(Off-Mike)

Shaconna Gorham: So can I just take a poll of the group. This measure was actually recommended to be "saved," if you will by Rob.

Female: Oh, sure …

Shaconna Gorham: And we know that he …

Female: So this …

Shaconna Gorham: Yes – was saved by Rob. It actually fell below the main score, but he felt that this measure was important, so we can do one or two things. That we can move on to the next measure. He is scheduled to come back in 10 minutes, so we're happy that will give him time to come back, so that he can provide his rationale for wanting this measure to possibly be included.

Janice Tufte: Now, we're both lead discussants on the next one too, so maybe we should not …

Shaconna Gorham: He is. He is leading the discussion on low for them actually.

Janice Tufte: Yes.

Shaconna Gorham: But, Janice, you are as well.

Janice Tufte: Yes, but we should wait until he comes. That's interesting we both did it …

Female: OK.

Janice Tufte: I'll call him if he's not here. I have his number …

Female: So he doesn't get away.

(Off-Mike)

Janice Tufte: Yes. I'll call him at two.

Shaconna Gorham: OK. So since the group is in agreement, we'll wait for Rob to return before we discuss those two measures. So what I propose is that we move to the next domain. Hold off on opportunity for public comment just – right now and we move to the clinical care domain.

Camille, do you have a question?

Camille Dobson: Judit, it has you as the measure steward for this measure. Is that right?

Judit Olah: I wrote the original proposal. Yes.

Female: You're not the measure steward, so I'm trying to figure out where it came from.

Judit Olah: (Yes).

Female: OK. That's what I was …

Judit Olah: We're still talking about the individual plan of care.

Female: Yes there isn't anything else in there …

Shaconna Gorham: Yes. So we get that measure concept from Judit, but we – I think that that is an electronic glitch if you will, just the spreadsheet kind of did whatever it is. But she shouldn't be …

(Off-Mike)

Shaconna Gorham: Yes. She shouldn't be listed there.

(Off-Mike)

Shaconna Gorham: So we'll leave this domain and move on to the clinical care domain.

Barbara McCann: Right this is measure number 13. Screening for fall risk. This is a clinical process measure that assesses fall prevention in older adults. The measure has three rates. The first is screening for future fall risk, which is the percentage of patients age 65 and older who are screened for future fall risk at least once within 12 months.

The second rate is the percentage of patients age 65 and older with a history of falls who had a risk assessment for falls completed within 12 months. And the third rate is the plan of care for falls, the proportion of patients aged 65 and older with a history of falls who had a plan of care from falls documented within 12 months. Any discussion we can continue to a vote.

Female: I will just offer my only concern is that it's limited to adults over 65, so it's not broadly applicable to people with disabilities who are – and equally strong fall risk.

Female: Yes.

(Off-Mike)

Female: It's not just older adults who fall in the home, I guess that was my point.

Barbara McCann: OK. The first vote relates to whether it addresses a critical quality objective of CMS or identifies a program area key concept. May I have a vote for high. A vote for medium. A vote for low.

Diane McComb: I have ambivalence on – sorry, this is Diane McComb. I have some ambivalence on this one. So I guess I need more information. I do appreciate for a person who is prone to falls, this is incredibly critical to their quality of life.

But it's not necessarily applicable across the board for every individual in a long-term service – in an LTSS setting, so I need more information to make the decision. I mean I think this is really important if you have an issue with falls, but it's an irrelevant – if this is a measure that the states choose as one of three that they're going to use, I don't think it's applicable to a large number of individuals in LTSS settings.

So, I'm not sure that – I mean it's important but it's not individual. It's something that would be very individualized as opposed to broadly applicable to everybody in those settings.

Barbara McCann: So …

Diane McComb: So I just need more information to make my decision. I'm sorry.

Barbara McCann: So I'll speak to that medium vote…

Diane McComb: OK.

Barbara McCann: The change in function and balance at age 65 and older can be significant regardless of psychosocial barriers or anything else, it's called AGE. And falls is the most critical thing from the perspective of what happens at home.

And that's why, although it's a limited population, 65 and older, that's why I voted medium. I'd like to see it across, but for this population and the folks that we provide services to, it can make the difference between a nursing home and staying in the community. That's a big issue, so that's why I voted – if we have to limit it I would like this group to which unfortunately includes myself at this point.

Diane McComb: So our research shows that if this occurs, people have a better quality of life in the community because it keeps them out of a nursing facility, broken bones, et cetera. OK. That's what I needed. Thank you.

Shaconna Gorham: And I'll just say just to go back to the point that measures specifications and staff preliminary analysis will offer you information about the measure itself, but I think what you're looking for is the rich conversation amongst your peers about why this measure would be relevant for the population.

(Off-Mike)

Shaconna Gorham: OK. So do we want to start the votes over again just so I can make sure that that I have an accurate count?

(Off-Mike)

Shaconna Gorham: OK. So we have zero for high. Three for medium. And do we have a vote for low?

Female: No. Medium.

Shaconna Gorham: OK. So we have four votes for medium.

Female: OK.

Shaconna Gorham: So we can move on to the next question.

(Off-Mike)

Shaconna Gorham: That will help the transcript as well.

Barbara McCann: So the next consideration is to what extent the measure addresses an opportunity for improvement and/or significant variation in care. Can we have a vote for high.

Shaconna Gorham: Do we need more discussion before…

Female: Or do we need – I apologize. Do we need more discussion? OK. May we have a vote for high, a vote for medium, a vote for low?

Shaconna Gorham: So, we have four votes for medium for opportunity for improvement.

Barbara McCann: The next consideration is efficient use of measurement resources. May we have a vote for high, a vote for medium, a vote for low?

Shaconna Gorham: Again, we have four votes for medium.

Barbara McCann: To what extent is this measure ready for immediate use? Can we have a vote for high, a vote for medium, a vote for low?

Shaconna Gorham: So we have three votes for high and one for medium on the question ready for immediate use.

Barbara McCann: And then the next concept is to what extent do you think this measure is important to state Medicaid agencies and other key stakeholders? May we have a vote for high, a vote for medium?

Shaconna Gorham: OK. We have three votes for high and one for medium, zero for low. So this measure will be recommended for inclusion in the program area set and to sum it up in one sentence falls makes a difference in staying in the institution versus coming home, and so it matters what they – whether or not that the person would come home.

Janice Tufte: This is Janice. And this would be measured over and over, right, so pre, post, whatever?

Female: Every 12 months.

Janice Tufte: OK. Thank you.

Barbara McCann: All right. We are now – we are now moving measure five, adherence to anti-psychotics for individuals with schizophrenia. The description is the percentage of patients with a schizophrenia diagnosis who received an antipsychotic medication that had a proportion of days covered for

antipsychotic medication. I apologize. I'm looking at the measure specifications, that was a little tough. Any discussion?

(Off-Mike)

Camille Dobson: Relevance, your honor. This is Camille. Relevance, your honor. Not the LTSS domain.

Female: Sorry.

Janice Tufte: This is Janice and I'm a (PCORI) ambassador, too. And one of my first experiences at (PCORI)) was first you have to meet the Board of Governors. And I remember having a long discussion with (Gray Norquest) who's the director and the president and he – we had this discussion with a few other doctors about how elderly adults receive – get schizophrenia diagnosis.

So I imagine that was why this was in there and it's a huge issue with the falls and it still is being prescribed. So I don't know if that's why this was in there, but it's just something to take note about that it should be recognized if we don't vote for it, it should be recognized if elderly are on antipsychotics and for how long and why.

Female: Got you.

Shaconna Gorham: And I'm just checking because, I don't know, call it age, but my memory is not good.

Female: There must be another reason.

Shaconna Gorham: I just want to check because this measure seems really familiar. I want to say it was submitted for endorsement and was not endorsed.

(Off-Mike)

Shaconna Gorham: I just want to check because…

(Off-Mike)

Barbara McCann: And I think I believe it's being done for pharmacy claims which means the drug may have been prescribed, but doesn't mean they take it. I think it's back. Let me go in.

Shaconna Gorham: I mean it may not make a difference in how you vote, but I just recognize the measure. Give us a minute. My password is not going in.

Shaconna Gorham: We don't have a quorum.

Female: We don't have a quorum.

Shaconna Gorham: Oh, yes. Exactly. We don't have quorum.

(Off-Mike)

Female: Oh, that's right.

Female: That's right.

Female: Is this – I'm pushing you (inaudible) for being – instead of being the LTSS framework, there would be a (inaudible). But from the LTSS perspective, the individual may not take medication because of side effects, liver damage, a whole host of reasons that are valid for to that person that might be contraindicated for all the physician's recommendation but in LTSS setting that individual's concern will be at the center of our discussion with the physician's consent.

In the medical or clinical setting, there would be a different balance for that. so I think if we were to vote…

Barbara McCann: Well, I'm also – I'm also thinking even in PTM, which is Pharmacy Therapeutic Management, we've not – so this appears to be based on claims, but in PTM it's not only claims but it's over a longer period of time and whether or not they ever refilled a second prescription, right? It looks over – more over time to see if they even use anything. if they have been appropriately diagnosed schizophrenic.

Female: And adherence, too.

Female: Right, we have no idea about adherence. Yes.

Female: Well, that's the angle that's coming…

Barbara McCann: So it's just based on filling – I can't remember the stuff on filling a prescription, but you never take it. It's pretty high.

Female: Yes. (inaudible) what it is.

Shaconna Gorham: Yes, I can't. My computer is not participating.

(Off-Mike)

Female: I'm sorry, Karen. What – I'm sorry I didn't hear what you said.

(Off-Mike)

Female: Oh, sure. Yes.

Karen Llanos: It says RAND here, but I don't think it's RAND.

Female: Could be like HEDIS or HEDIS.

Female: There's also a CMS measure, Measure 1880 that was endorsed in December of 2016.

Female: With the same title?

Female: With the same title. Yes, it's MPQRS, too.

Shaconna Gorham: For the people on the phone, we are taking a little break until we have quorum. Bear with us for one minute, please.

(Off-Mike)

Female: No, no, no. I agree, but adherence…

(Off-Mike)

Female: We're here to …

Female: Yes, that's the pharmacy approach, yes.

Female: Yes.

(Crosstalk)

Female: It shows up the pharmacy ...

Female: Right.

Female: And a version of this is for the attention deficit kids.

Female: OK.

Female: They have a pretty strict one from the pharmacy ...

(Crosstalk)

Female: Yes. Yes.

Female: Right.

Female: We just killed everything.

Female: We just pull that up.

(Off-Mike)

Female: I can't – I can't pull it up.

Male: Oh, really? All right.

Barbara McCann: Do we – do we want to go ahead and vote for -- OK, we're going to go ahead and vote for number five, adherence to antipsychotics for individuals with schizophrenia. To what extent does this measure address critical quality objectives of CMS or identified program key concept? Can we have a measure for high, a measure for medium, a measure for low?

Shaconna Gorham: And so that would mean that the measure would automatically not be recommended. But can we have – because we did have some conversations, some of it off-record, some on-record. Can we have a reason for why this would not be an appropriate measure?

(Off-Mike)

Female: I have my coat on.

Barbara McCann: One of the rationales is that it's based on a pharmacy claim record only, assuming that a pharmacy claim is equivalent to adherence and there's no indication in the specs that it's refill, that it's more than just the drug went through the pharmacy claim and was filled once.

Male: Yes. Yes.

Female: Based on a pharmacy claim.

Barbara McCann: And I think the other issue is, and correct me if I'm wrong, is its clear applicability to LTSS, the question about that. It may be more appropriate for integration of mental health and physical health. OK.

Shaconna Gorham: So we can move on. Actually, why don't we finish out clinical care and then we'll go back to care coordination.

Barbara McCann: Right. And the next measure is measure six, adherence to mood stabilizers for individuals with bipolar disorder. The percentage of patients with bipolar disorder who received a mood stabilizer medication that had a proportion of days covered for mood stabilizer medication during the measurement period. Concerns? Questions?

Janice Tufte: Yes. This is Janice. The overall score is from all the four domains or is it just LTSS that we scored?

Shaconna Gorham: So the overall score for the individual measures of this score just for the measure. So based on the criteria of the feasibility, usability, accessibility, the score is from that individual measure, exactly.

Janice Tufte: I was thinking our voting on the measures, too, is not included. OK. Thank you.

Barbara McCann: Are there questions or are we ready to vote? OK. Well, vote with the extent to the measure addresses critical quality objectives and CMS quality measurement domain or key program areas. We have a vote for high, a vote for medium, a vote for low.

Shaconna Gorham: All right. So this measure would not be recommended for inclusion. And the reasoning again would be that – would that be the same as with the sort of the adherence.

Barbara McCann: Right and its relevance.

Shaconna Gorham: OK.

Barbara McCann: And likely the other area.

Shaconna Gorham: OK. Perfect.

Barbara McCann: All right. Our last measure in clinical care, home and community-based long-term services and support used. The proportion of months receiving long-term services and support associated with receipt of services in home and community-based settings during the measurement year. I'm sorry. Measure 14. I apologize. No, that's OK. Questions?

Rob Schreiber: So this one had a 1.5, correct? And there was issues regarding the evidence. It was I guess high feasibility, scientific acceptability was unsure, usability median. So I guess because there wasn't an evidence linked and the evidence and gaps, that probably brought the score down.

Is that sort of…

Shaconna Gorham: That's correct. So this again is a measure concept and it was hard to find evidence and measure concept. We could find in numerator, denominator, data source, that type of thing, a description for the concept and whether or not it was in use in most cases and the steward. But to find

evidence was a different story because we were not in direct contact with the developer.

Rob Schreiber: So this is Rob again. So the evidence, this is evidence regarding the impact of the measure, right, by doing this, it's going to have some type on impact. Is that what the evidence is or is it that – I mean I guess what – I guess my question is what is the evidence that we're looking for that would maybe put this on a higher rating.

Shaconna Gorham: So when we look at evidence, when a measure is introduced in NQF, we look at the importance of the measure and whether or not there's guidelines and so forth with the measure. If the measure has clinical trials and that type of thing, we look at that type of evidence to ensure that there is an importance for the measure.

Female: It's a rebalancing measure. I don't know that it fits in clinical care. It doesn't seem like it's the right place for it. But I would certainly say that it is – as I went back to sort of individual versus system outcomes, it is a good system outcome as states moved to standardizing the way they assess.

Rather than just expenditures or people, the person month is a better way of sort of being able to standardize looking at the balance between community services and institutional settings. So I think it's useful in that way, I just don't think it fits here. I don't know where it fits and maybe access would be a better place.

Female: That's what I was going to recommend because it's more like…

Female: But it's not. I think it's useful from a systems level, it's one of the only system level measures that are in the set.

Female: I would – I would agree that since the emphasis is eligibility, it would appear to say if X people are eligible, how many people actually receive services. So I almost see it as an access issue. But I agree, I think it's an important measure from that perspective.

Female: Yes.

Rob Schreiber: So in spite of the fact that there isn't evidence, we feel that from a system perspective it's important to have as an access issue it is a critical – I think it's a critical component in terms of the care for individuals in the community, even though it's not an NQF. I mean I guess we got to go through the process and see where it goes.

But if let's say the committee – the advisory committee says we feel this is important, that doesn't mean it's going to get accepted. We're just saying we feel it needs to be looked at or this doesn't – I mean where does this go? Let's say we did support it I assume because there isn't evidence, scientific validity behind it, what happens to that measure?

Shaconna Gorham: So that's a good question. Remember, it is a measure concept and I'm going to take you back to a statement that CMS, they are looking for measures that are ready for immediate use. With that being said, we can recommend some measure concepts.

Once you recommend a measure or a concept, that will go to the coordinating committee. They will not re-adjudicate what you're doing, but they will look at the number of measures versus concepts, they'll take that broader a step back.

And so it might be after they kind of weigh all of the measures versus the concept that this might fall out based on the selection process that we have for them, but you certainly can recommend it, and, again, that's why we're sharing the rationale with them so you can say that we know that this measure is still under development. But it's important because I do know that the Washington State is using this and so it is in use in a state and so that is also important so.

Rob Schreiber: Right. There is some – there is someone – some state using it so there is at least some basis. OK.

Camille Dobson: I would clarify – this is Camille. I would just clarify that once we get out of the clinical settings you're not going to get a lot of NQF-endorsed measures. So I wasn't sure, Rob, if you were indicating that that was a strike against it…

Rob Schreiber: Well, that's right. Well, that's…

Camille Dobson: … because I would imagine we're going to get to a point where a number of these as we get into patient experience aren't – are going to get or aren't going to have endorsement.

Rob Schreiber: Right.

Camille Dobson: I think the fact that Washington – that's why I wondered if it's a measure concept because if Washington's using it, it's a measure, it's not a concept anymore, right? It's just not – doesn't meet your NQF standards as a measure.

Rob Schreiber: Yes.

Shaconna Gorham: Right, and those are the only standards that that can go by. So our definition of a measure is…

Camille Dobson: Oh, OK.

(Crosstalk)

Shaconna Gorham: And so a concept to us as we described it for this project is we cannot if there is not testing for this measure, then in – at the NQF, I would assume broader NQF that is not necessarily a measure because if you can't test the specifications or properties of the measure then is it really a measure. This is what we based this on.

Camille Dobson: But because it hasn't come to you, that doesn't mean that it isn't being – I'm confused.

Rob Schreiber: Well, the fact ...

Shaconna Gorham: We couldn't find any testing though for this measure.

Camille Dobson: Not testing, but it's in use.

Shaconna Gorham: It is – it is being used.

Camille Dobson: So it's a measure, it's just not a validated measure, right?

Shaconna Gorham: Well, we haven't found testing for it and so that's my – I'm not the best person to…

Camille Dobson: Yes.

Shaconna Gorham: … discuss the difference between or the validity of the concept.

Camille Dobson: OK.

Shaconna Gorham: But I do know that if it is not – if we could not find testing information, then it is considered a concept. We couldn't find evidence behind the measure either. Now, that does not mean that there is no evidence, we just could not find it. But definitely there's no testing and so without testing you really can't say that the measure is valid and reliable.

Rob Schreiber: Do we know if Washington State is testing it or doing an evaluation of it?

Shaconna Gorham: Not that we could find at all, but I can't give the – I will not try. That would be a David question.

Rob Schreiber: And we have David Mancuso.

Shaconna Gorham: Yes.

Rob Schreiber: Maybe we can text him and call him.

Shaconna Gorham: That would, I believe, be a question that he could answer.

Camille Dobson: I mean it's just a counting measure, so I'm not sure how much testing it needs.

Rob Schreiber: Yes, yes.

Camille Dobson: It's just total eligibles, where they're getting their services, divide.

Rob Schreiber: And the other piece just to finish up is I know it's in the clinical bucket. I am concerned that it drops out – because the whole point is for clinicians and there is a push to get clinicians to understand that they can do something about

social determinants of health when they identify them not to just say I don't know what to do, but these are really important, probably the more important, they are more important than clinical care.

So I think there's a need for it to be in there, but you're right, it's more of a system measure and having a system approach rather than putting on necessarily one provider group or another provider group.

It really does need to be a system metric but maybe a clinical system metric that a clinical system has an approach that this is done and that it needs but it is more of a process because it doesn't really tie to – they don't have it done like a PCORI or a CMMI innovation grant to actually look at if we do this and identify this and then bring in the group and pay for this is what happens, here's the outcomes. We don't have that information, but I do feel that at least as a concept it's important.

Diane McComb: This is Diane. I would argue that there's no quality measure inherent in this description. This is simply showing up, it's a measure of attendance and that does not measure quality.

If there's no way to do value-based payments, there's no way to identify whether the person is receiving a setting that is their choice that is consistent with what their needs are, as they define their needs, it's just housing or it's whatever it is. It's just somebody doesn't live in a nursing home so it's OK. That's not quality. So I would just argue there's no element who really define quality by this, it's attendance.

Rob Schreiber: So this is Rob. I just – I might push back on that only because I do believe that if you get LTSS needs assessed and at least addressed, that they're being addressed, I would say that actually is a quality metric. We may not measure it, we may not know what the impact is or the outcome…

Diane McComb: That's not what this says. This just says the – this just says the proportion of months receiving long-term services and support associated with the receipt of HCBS settings during the measurement year. So it's not saying a setting of your choice…

Rob Schreiber: Yes. Yes. Right.

Diane McComb: … or that your day is meaningful to you in any way.

Rob Schreiber: Right.

Diane McComb: It's just that you live somewhere with an address in the community, but it doesn't assess quality in my mind. I don't disagree with anything you're saying.

Rob Schreiber: You know, I think the way it's written, you're right.

Diane McComb: It's just that doesn't have that in there so a person doing the assessment would say, OK, they live at this address, check. But let me offer a different perspective. What it does say to me is within the context of state budgets or availability of caregivers, these are eligible people, but they never got access to community-based services. That's what I'm – in my understanding, that measure is wrong.

Female3: It's a relevant rebalancing measure for states...

Female: My point.

Female3: ...but that does not -- a rebalancing measure is a metric that talks about the percentage of funding for services...

Female: I agree.

Female3: ...in an institutional setting versus a community setting, but it doesn't address quality. We think that rebalancing is a measure overall through states in terms of quality.

Female1: Right.

Female3: But it doesn't assess quality of support or -- thank you. It doesn't express experience of the individual receiving the LTSS.

(Crosstalk)

Barbara McCann: Let me make one more counter -- we can't assess quality if they never get it. So...

(Crosstalk)

Barbara McCann: So if -- so the...

(Crosstalk)

Barbara McCann: But -- well, I -- but I think it does and I remember our friend from the disability community who -- (Mike) -- who had several folks who were in his community who were eligible for services, but there were no caregivers, there were no agencies.

(Crosstalk)

Barbara McCann: So like this is basic structure, but this isn't going to measure that.

Male: You're right.

Barbara McCann: This measure, the way it's written, will not measure that -- what you're talking about.

Female: But it'll say...

Barbara McCann: This doesn't say the number of people who are eligible for services who, if funding were available, would receive it. This just says that the percentage of people who are in service, it doesn't talk about people who don't get service and why they don't get service.

Rob Schreiber: So, (Barbara), I have a point of information here.

(Barbara): Right.

Rob Schreiber: There were two other measures that got more to the quality aspect about home and community-based services, which I don't know if they're on our list that were much broader in scope and scale. I don't remember on the Excel spreadsheet, they were in the 20s.

They were like, well, there were three of them gathered together. I don't know if any of them -- and I thought their scores were in the like 1.7 range or something so I don't know, but that -- those measures -- so I put all three of them together because I didn't know how the decision was going to be made, but I'm just wondering and I don't know if we have the answer to this. Are any of those -- other home community based metrics? And I think one was...

Female: Twenty-three. One of them was...

Rob Schreiber: Yes, 23.

Female: Yes.

(Off-Mike)

Rob Schreiber: Yes, no, there were -- I think it was like...

(Off-Mike)

Rob Schreiber: Yes, but there were two others because I gave the numbers. I could actually pull up my e-mail. So all I'm saying is I don't -- you know, I would tend to agree with Diane at this point. I don't think -- I think it's important but if there was a way to at least look at one or two of those other measures, that's what I would recommend but I don't know if we can do that. Yes.

Shaconna Gorham: If they are measures that you want it to save, Rob…

Rob Schreiber: Yes.

Shaconna Gorham: ...then we are going to discuss them.

Rob Schreiber: Oh.

(Crosstalk)

Janice Tufte: I mean I -- this is...

(Crosstalk)

Janice Tufte: This is (Janice) and I just wanted to add I think part of this has to do with the -- like getting the baseline for the 1115 waiver. And so when they have this to go by when they -- when people do have work, we do focus on workforce shortages and whatever. I mean we're really looking very seriously, we have a problem in our state with it and recognize it.

But with this, and it could possibly end up with a (inaudible) comparative with this data. So it's just -- you're right, it's just a baseline to me, it's what I see it as.

Female: OK.

Janice Tufte: But it's important.

Female: So let's go -- I'm sorry.

Debjani Mukherjee: Hi. My name is Debjani Mukherjee, senior director at NQF. And I just want to say that this measure was -- sometimes when you have a state-specific measure, the measure has been developed for the state's needs and we're bringing it up here because it is looking at sort of the topic area in discussion but that doesn't mean it's going to be as specific as we would like it to be.

Also, this is not an NQF endorsed measure so the testing, sort of specifications haven't gone through sort of our review, and also the other thing I just want to sort of mention about some of these measures that might be dealing with interesting sort of concepts is that a measure concept could be sort of looking at quality.

It might not drill down to sort of quality and rebalancing, quality and sort of the home-based HCBS arena, but it's trying to get to the idea of what should be looked at versus an actual measure that has gone through the endorsement process. We've looked at the testing, the level of analysis, who are we measuring, where is it being measured.

So some of these measures that are not NQF-endorsed are more of a -- are more of a concept, might be more amorphous, so for those -- the group can

definitely say this is a great concept. Rebalancing is something we need to look at, but the caveat is to truly capture it, this is what we need to do either to the numerator or the denominator, and that way this is not going to move forward but you can sort of move forward the true concept that needs to get measured and sort of the caveats that need to go with that concept.

Barbara McCann: All right. Are you ready to vote? OK. For measure number 14, the extent to which the measure addresses critical quality objectives of CMS and/or program area key concepts. Can I have for high? A vote for medium? Vote for low?

Shaconna Gorham: So, I'm sorry. I have four votes. Do we have…

(Crosstalk)

Shaconna Gorham: Five for medium?

Female: Uh-hmm.

Shaconna Gorham: OK.

Barbara McCann: OK. The next concept consideration is the extent to which the measure addresses an opportunity for improvement and/or significant variation in care evidenced by quality challenges. We have a vote for high? I'll go with high. A vote for medium?

Shaconna Gorham: That's two votes for high and three for medium for opportunity for improvement.

Barbara McCann: The next concept is the efficiency of this measure. Can I have a vote for high? A vote for high?

(Crosstalk)

Barbara McCann: Yes. A vote for medium?

Shaconna Gorham: OK. So that's four votes for high and one for medium.

Barbara McCann: To what extent is this measure ready for immediate use? May I have a vote for high?

(Crosstalk)

Barbara McCann: A vote for medium?

Shaconna Gorham: So we have three votes for high and two for medium.

Barbara McCann: The extent to which you think this measure is important state Medicaid agencies and other stakeholders. Can I have a vote for high? A vote for medium? A vote for low.

(Crosstalk)

Barbara McCann: It'd be somewhere between low and medium.

Shaconna Gorham: So that was five for medium. OK. OK.

Diane McComb: Now, can we -- now, can we offer comments and clarifications?

Shaconna Gorham: Please.

Diane McComb: I think that this measure is a good measure to assess states' effort at rebalancing but it does not measure quality in any way. Although rebalancing -- you're talking about the quality of the states' effort to move people from institutional settings to community settings.

I think it would be a good measure potentially for a state to consider also if they were including nursing facilities and ICFs, institutional placements for people with disabilities. It would be a good measure for managed care companies perhaps to achieve a higher level of rebalancing. But, again, it doesn't not address quality of supports. It addresses the placement of individuals from an institutional setting to community which I think the field in general perceives as a more likely place for quality to occur.

Female: And I would also like to add. The focus on eligibility among those eligible for community-based LTSS, how many had access -- well, how many actually received it?

(Crosstalk)

Male: Yes.

Janice Tufte: As a -- just as a response to that comment, we know that among people with disabilities that we're -- in our waivers, we're probably serving 25 percent of eligible individuals, 75 percent of individuals are waiting for service, awaiting services.

Female: Yes, I think that is very important to know.

Janice Tufte: So that -- I mean that piece of information isn't really relevant to quality of individual care, but it is relevant if you're not getting any and you're eligible for it.

Rob Schreiber: So you could also reframe that and say that is a quality of care issue because if in fact there is that type of waiting list and this is where the marker is and it's not moving and it's not being addressed in fact, that is impacting the health outcomes of the individual...

Female: Yes, absolutely.

Rob Schreiber: ...which indirectly is a result -- is a is a measure of quality. So the content is really important. The way it's framed we're really struggling with.

Female: Right. Right. So we'll be happy to tell (David).

(Crosstalk)

Rob Schreiber: I mean I just -- I want to make sure Diane's -- you know, Diane's point is really getting across that is...

Female: No, it is. It's important.

Rob Schreiber: You know, that it's not really truly a quality metric the way it's written even though we feel the concept is a true quality metric.

Janice Tufte: You could also add that it would speak volumes if -- I guess it would have to be Congress would change the provision that state plan services require nursing home care, but does not requirement community support. So that -- that's -- that is what is at the heart of the rebalancing issue is that everything under the waiver is a waiver. It's...

Male: Yes.

Female: It's not -- it's optional.

Female: Right.

Male: Right.

Janice Tufte: States are not required to provide those services so -- I mean that just might be worth weighing in on as long as we're getting political here.

Male: New policy.

(Crosstalk)

Male: Hide the policy. There you go.

(Crosstalk)

Shaconna Gorham: So let me ask a question, and this is just for me and for my understanding. I know that when we look at measures, we base the measures on performance and can they improve. But what I just heard was this is important for states' effort of rebalancing but does not necessarily address quality.

Female: Right.

Shaconna Gorham: So, again...

Male: The way it's written.

Shaconna Gorham: Right. So, again, we're going back to the difference between how we see concepts and how we see actual measures. I guess this is a question for (Karen) just kind of what you're looking for. Are you looking for measures that address quality or you're -- are you looking for what we just said in more it will address or help states in that rebalancing but not necessarily ...

Female: Yes.

(Crosstalk)

Female: It's a great point. So if -- so we think of these different types of measure, let's think of strategy for how a state is going to better understand how its program is performing. So that could include quality issues, but it can also include kind of overall performance. So I think that's important. Not all measures can be quality measures, particularly for a nascent measurement field like this where you almost have to start off, process and structural with a nod to outcomes or quality focused areas. So it's broader than that and I think that's OK, particularly when we're thinking about this particular topic area.

(Crosstalk)

Female: Oh, sorry. Can I also add that this is one of the domains from the HCBS quality measurement framework around system performance? And so we talked about the fact that it's -- right, that we wanted data, how to assess waiting lists, and access to community services. And that fits in the larger quality domain although it's not a typical person, it's system level quality as opposed to an outcome than it is an individual.

So it fits in -- it will be -- it's one of the only measures that fits in one of those domains that hasn't been touched by the measures that are here today.

Rob Schreiber: And just to -- you know, getting back to what was just talked about. There is another -- I don't if we -- I don't know if you did 43, the CAP C home and community-based service measures.

Well, that has a lot of meat and has scales and -- so it gets more to really a quality outcome perspective so I think -- again, I don't know what -- how this could be bundled or if there would be -- you know, it goes back to the committee, how they would look at that but there is some other substance to inform that decision making that we're talking about. So maybe when we get to it.

Shaconna Gorham: So just to -- again, transcript purposes, the home and community-based long term services and supports use measure definition, will be recommended for inclusion as a measure concept into the program area measure set. I will also make a note in addition to some of the other points made that we think this concept is more suitable for the access domain versus the clinical care domain.

Female: Yes, that would be appropriate.

Female: OK.

Male: Cool.

(Crosstalk)

Rob Schreiber: Just get it in there. Go put it -- just get it available.

Female: We have the clinical measures in the...

(Crosstalk)

Rob Schreiber: That's right. That's right.

Shaconna Gorham: All right. So we're going to open it up for public comment, operator.

Operator: At this time, if you'd like to ask a question, please press star then the number one. And at this time, there are no public comments.

Shaconna Gorham: Thank you. OK. So we are going to go back, Rob, just for you, we saved two measures for discussion because you happened to refer

these measures for -- so you're going to be the lead discussant. And so the first one is about individualized plan of care completed. And I'll turn it back over to (Barbara).

Rob Schreiber: Where is that?

(Crosstalk)

Female: Measure -- measure 34.

Female: Care coordination, right?

Female: Yes.

Barbara McCann: Yes. Measure 34, the last two measures.

Rob Schreiber: You know, I'm having problems finding it. Hold on.

(Crosstalk)

Rob Schreiber: I think I moved down, right?

(Crosstalk)

Barbara McCann: So I'll read the measure at this point. It is those with high risk score to have an individualized plan of care. The rationale is having an IPC will be a proxy for being connected to community-based health resources as well as the care coordination continuum.

Rob Schreiber: So the reason I chose this is that in a lot of the work I've done specifically around developing a community-based wellness prevention approach to people with complex medical needs, whether it's behavioral, et cetera, not having a care plan is almost like just setting this individual up for willy-nilly care.

There's not an understanding and we -- hopefully there's a recent approach to have the care plan of having the person's voice and/or caregiver's voice heard, understanding what their goals are and then aligning care preferences with the

care plan. So that when people transition across different settings, oftentimes what's important to them, what is their -- you know, what -- how they live, what they need is not really -- not only it's not understood, it's oftentimes totally ignored.

And the fact is that if you're going to develop a sustainable health system, my feeling is that there needs to be care plans that help drive care versus care that drive care plans. And I really think that this is almost putting a marker and a stake in the ground that what we've allowed to happen in the past cannot be allowed to happen in the future.

That if we're going to truly make a difference in terms of this arena about complex care for populations, that we really need to have care plans that are person-centered and person-driven or -- and/or caregiver-driven based on the preferences, the goals and values of the individual drive the care preferences.

And I find that that's why we have the four outcomes we do because we don't really understand truly what people's values and goals are and as a result we do things they -- we think they want based on their illness burden, not based on what their life goals and life plan is. And so as a result of that, that's why I put that down. At least to have the discussion, whether or not it can hit the criteria with another thing. But this -- so that was -- that's the plan that I bring here.

Judit Olah: I just want to add because I have a totally guilty conscience. My concepts that I put forward are very undeveloped. I guess I needed this education of where this goes but completely second what you're saying, the individualized care plan has mandatory pieces and I just -- you know, you said it but I just want to repeat it for all of us to kind of think it over one more time, that it's -- it goes far beyond treatment goals. It now addresses individual's lifestyle goals, barriers.

And all barriers are social determinants of health. It's not barriers of having an adverse reaction to a clinical treatment. It is about barriers of money or distance or transportation or whatever. And assessment like a react -- I'm

using the wrong word but reaction. A strategy to correct to address those barriers. Those are all mandatory pieces to an individualized care plan.

So it's sort of a terminology that maybe only exists again in the thought leader health systems, but it's certainly -- I feel very LTSS, if that's a good way of expressing it.

Female: Diane?

Diane McComb: First, just want to -- I had an aha moment when you were talking.

Male: Oh, you did?

Diane McComb: We call this -- what you just said, not a care plan but a person-centered plan which focuses on what is important to the person and what is important for the person. The important for is the health and safety side. The important to is the dreams and aspirations that an individual has and it is a requirement in the new HCBS community rule that all services offered under the waiver, 1115 or 1915 waivers, would have a person-centered plan. So for a person who has come up in that arena, that -- we have the silos, when you say individual plan of care, I think medical. You've just explained to me that that's not what that means. So I would support fully what you've just shared, but I would add to it.

Individual plan of care, person-centered plan. You know, add the language that those of us who aren't medical professionals can understand and relate to and we still may not be on the same page as to exactly what the components are but if you put person-centered plan in there, anyone who works with HCBS settings will immediately know what that means.

And then they have a place to start a dialogue with medical professionals connected to that individual where we're on the same -- we want the same thing. And so I think the semantics of that is very interesting to me. I never would have imagined plan of care would mean...

Female: So let me -- so let me give you hope again. The new conditions of participation of home health requires a person-centered care. We must have

statements of their goals. So we actually are on the verge of creating the bridge.

Rob Schreiber: Meaningful use -- this is (Rob). Meaningful use III if it ever goes into effect in terms of electronic health records has as part of that a person-centered care plan based on the person's own words.

Female: Right. That's what we have to use in our plans of care now.

Rob Schreiber: And you have the same thing. So that's -- so that is the meaningful use.

Female: Except ours is on paper -- sorry.

Rob Schreiber: Right.

(Crosstalk)

Janice Tufte: This is Janice. And at lovely group health Kaiser, we do have this and have had it for many years and you can update it and change it as you like and put in whatever you like so it's really important.

I saw this, too, and I was turned off by the IPC, the name, thinking back to individual care plans that I worked with challenged cognitively, physically challenged adults when I was younger. But I want to mention that the project that I was on with PCORI where I was a patient co-investigator, we developed a clinical liaison role called the community resource specialist and it was at two clinics.

I just want to say something I probably shouldn't say but the truth is it's so hard to measure, this we're talking about, it's very hard. There's no measurements to evidence to fall back on and when you're for -- when you're the people breaking in the field, somebody has to start the measuring.

So something like this and changing it to (PCP) I think is important but it's so important that Kaiser Permanente is thinking about putting it through our -- all of Washington State. And that's their funding, right, not PCORI. We'll see what happens but that's -- you know, it's important they realize it's all about

goal setting sitting down and you can be referred from within the clinic and you get referred to outside the clinic, so.

Rob Schreiber: So in terms of disclosure, I guess I have to disclose something, which I didn't really think about disclosing but now it came up and they told me I need to disclose. So the reason -- one of the other reasons I've been involved, there are two groups.

I'm part of some called Medicaring which was developed by (Joanne Lynne), which is a community-driven model for healthcare, where care plans are central and core. I also am the medical director of something called the Vitalize 360 program which develops life goals for older adults and life care plans that they then take to their primary care provider to implement. And so the medical care plan integrates to that life care plan, and there's actually a measurement system that goes along with that. So in fact -- so I do actually have a vested interest in this I guess, but so with that disclosure, I rest.

(Crosstalk)

Barbara McCann: So Shaconna, do we go through the same voting process or...

Shaconna Gorham: You do. You go through the same voting process. Again, this is a measure concept. We, the staff, could not find a lot of information about this concept in the sources that we reviewed, however you all have shared some more light on the concept, so I would that you will go through the process and vote according to conversation and what your peers have shared.

Barbara McCann: OK. Thank you. Again, we'll start with the first vote. The extent the measure addresses critical quality objectives of CMS and/or identified program key concepts. May I have a vote for high?

Female: Well, you get points for that.

Male: Maybe person-centered...

Female: Yes, care.

Male: There has to be a home for that. It has to be ...

Female: You used the words important to and important for the individual.

(Crosstalk)

Judit Olah: There's no way to amend the language of this at this point, right?

Female: Well, it's a concept so we could, couldn't we?

Female: Well, we can -- we can...

(Crosstalk)

Shaconna Gorham: Yes. So it is a concept and what we will do when write the rationale for inclusion, we will include your recommendations and your comments. And so that will be in the report that we submit to CMS and so I would like to say that the developers behind these concepts would also pick up that report and read your recommendations.

(Crosstalk)

Barbara McCann: All right. The second concept for consideration is the extent that the measure address an opportunity for improvement and/or significant variation in care. May I have a vote for high?

Shaconna Gorham: We have five votes for high.

Barbara McCann: The next consideration is the extent that the measurement demonstrates efficient use of measurement resources. May I have a vote for high? Vote for medium? A vote for low?

Shaconna Gorham: All right. So for efficient use of resources, we have one vote for high and four for medium.

Barbara McCann: The next consideration is to what extent this measure is ready immediate use. A vote for high please?

Female: It's actually already being used by Allstate Medicaid offices …

Rob Schreiber: So is it -- so it is (inaudible) my question?

(Crosstalk)

Female: Yes. All right.

Female: It's already being done. I mean we're already measuring that.

(Crosstalk)

Shaconna Gorham: So this particular concept is already being used, so we just want to be clear about whether it's already in use in Medicaid populations.

Female: The language -- the language is different. (inaudible) requires waivers that every participant with a waiver has a person-centered plan. And they sort of require …

(Crosstalk)

Male: It is ready for immediate use.

(Crosstalk)

Female: I think the language -- the language...

Female: Yes.

Female: Actually right now, they just say that somebody has (inaudible) check the boxes …

(Crosstalk)

Female: There's a way to identify whether or not (inaudible) and that's not necessarily being done yet but...

Rob Schreiber: So it would, by definition though, it could be done is not really being done. It would -- it definitely would the medium criteria, correct, in terms of the way we're...

Barbara McCann: It has a numerator and denominator.

Rob Schreiber: And the numerator, denominator, right?

Shaconna Gorham: So the numerator is those with completed IPC and the denominator that we found is population by ZIP code, by gender, et cetera.

Rob Schreiber: I'm just trying to see because I know when they say person-centered plan, it may not involve even the person. It may be based...

Female: Well, it's not person-centered plan if it doesn't involve the person and that's one of the criteria that would be assessed if one was measuring for the presence of person-centered plan, if a person was not involved in the development, it's not a person-centered plan.

Rob Schreiber: Uh-huh. Right, right, by definition. It should be defined that way. So I'm still -- I'm still -- is this -- is what we're talking about being used I guess is the...

Female: This is the -- based on what this says and it's based on claims and it's done at the clinician level, it is not a person-centered plan the way we're talking about it, because those are done by the HCBS system itself. This looks like a traditional medical plan of care that would essentially say when you go home, these are the things you need to have.

Rob Schreiber: Yes.

Female: Right? Which means you've touched them. I think that's what is meant.

Judit Olah: So it would specifically address what is my lifestyle goal.

(Crosstalk)

Female: To clinicians...

Judit Olah: It's not just I'm going home and whether I understand my medication...

Female: Yes.

Judit Olah: It specifically says, what is my lifestyle goal (inaudible) and I would need to capture it in my words. I want to need to -- I want to walk around 10 blocks.

Female: So an individualized plan of care in home care, home health.

Judit Olah: In addition. So it has...

(Crosstalk)

Female: It has to have the treatment plan, it has to have the patient-stated...

Judit Olah: Lifestyle.

Female: We wouldn't say lifestyle but patient-stated goal. It must -- you have to address physical, structural, and psychosocial barriers in the process and you have to state the outcome of intervention, the anticipated outcome of intervention, which could relate to function, could relate to medication management. So that has just recently changed.

Female: Yes.

(Crosstalk)

Female: That's what I said -- I had the same problem, I was like, if (inaudible) says claims, that's not going to -- claims aren't going to get there.

Female: You have to do face-to-face interview with the individual.

Female: Actually, we pull -- you have to pull up Medicare...

Rob Schreiber: The record.

Female: Yes, you have to pull...

(Crosstalk)

Female: Yes, you can't get this out of claims. It says...

Female: Yes. Claims stated I don't even see how that will (inaudible) I don't see how that would give us the information.

Rob Schreiber: Yes, no.

Female: You would have to have the interview people being supported in the setting. You have to actually talk to those people to find out what's important to you and then you look at that...

(Crosstalk)

Female: So what's interesting is home health does that. They make home visits.

Female: OK.

Rob Schreiber: Yes.

(Crosstalk)

Female: But that's the thing you'd have to have the validation of whether it (inaudible) looking at the record, it's by talking to the person and ask them, "What is important to you?" And then ...

Female: But this is the people – it's not looking at the content of the plan. Do you in fact have one, right? The counting, it's a structure measure or actually process measure.

Rob Schreiber: Well it is a process measure but you could go into the record. Like Massachusetts Medicaid is going to mandate person-centered care plans in the full extent and they are going to be paid based on an audit that's done where they go in and review a sample. Now that would be the way, now it's not administrative so the burden is higher but you could do a sample and then…

Female: What managed care plans have to do too.

Rob Schreiber: Exactly. Right. So it's actually a methodology that's accepted.

Female: This actually is the same thing. I mean, the comprehensive care plan that has both their medical and their social and their LTSS needs in one place. But right now this is just I thought an accounting exercise, right, how many have them.

Diane McComb: So let me interrupt, so from a voting standpoint, we love this concept and we don't want to kill it here, because it is right now just a numerator and denominator with no evidence of testing.

I guess disclosure. Delmarva Foundation does work a in number of states looking at the waiver assurances required by CMS for individuals with intellectual and development disabilities. We assess the presence of the person-centered plan by doing a sample of the individuals the state has in their waiver and that's the core, that person, that first interview is with the person receiving supports. If they state that something is important to them and it is not found in the plan, then we do not see evidence of a person-centered plan, and we do have data on it.

We've been in Florida since 2001, so have probably the most data in Florida. But if the person identifies various components of support in their life, they go to a job coach to help them with employment, they have someone who helps them in their home, a physician who helps them with their medical or whatever, we then would interview all those different components that are identified in the person-centered plan in supporting this person to determine that that plan is in place. So it's not focused just on medical but it's the person's whole…

Rob Schreiber: So has it been reported? Has that approach been reported by any chance?

Diane McComb: It's been reported to the State of Florida…

Rob Schreiber: Oh.

Diane McComb: …in this instance. And I don't know how Florida would then file their evidentiary reporting with CMS, but I don't know what form that takes.

Barbara McCann: So I think we're down to we really, really like the idea of a patient-centered individualized plan of care that may not be exactly where this measure is at this point. And so how can we…

Shaconna Gorham: So let me just kind of go back for a minute because what I hear is we really, really, really like this concept for exactly what it is or what we want it to be is what I can't really kind of determine from the conversation.

So what we want it to be but for what it can be but is that actually what it's stating right now? Because we have to vote on the measure or the concept for what it is right now. And so that's what I'm not…

Female: This is a low vote, correct, if we follow the criteria?

Shaconna Gorham: Yes. But with that being said, I just, again, want to make the point that I just want to make sure that we – because what we're saying is we're changing what the concept is, I mean the developers will have to start all over. And so that's a different concept.

And so I just want to remind you that you want to vote on what is actually here, not what you want, because that would be a whole different concept. You can vote at this point for immediate use, it won't fail either way because if you vote high or medium, that's saying it is a measure which we know it is not. If you vote low, you're saying that the concept, so it would continue on the path of the decision logic. So I just want us to be clear that we want to vote on the concept of here, not what we want the concept to be.

And then with that being said, it will go either way and then you will vote on that last question in the logic which will say is it important to stakeholders? But, again, you're voting on, is it important to stakeholders for what it is, not for what we want it to be, so.

Barbara McCann: And the actual measure statement is it is a proxy for being connected to community-based health resources. Yes. So let's vote on as stated, is this a high for immediate use? A medium, a low?

Shaconna Gorham: So that's five votes for low and then we'll go to the next one, importance to stakeholders but, again, we want to vote on what we actually see here for this ...

Barbara McCann: Right. Which is a proxy. So what the actual measure is that in an individualized care plan is a proxy.

Female: I see it but…

Barbara McCann: Yes. No, no, I know. But measure it, we'll see if it's in measure specification.

Female: If you don't get – if you don't have an individual plan of care…

Barbara McCann: No, it says if you have an individualized plan of care, it becomes a proxy for being connected to community-based resources. So the very existence would assume is how I'm understanding it.

It's like you didn't get the right care if you're readmitted to the hospital. Yes. This is like being in love but they won't date you, right? I mean this is like – all right.

Rob Schreiber: Anyway, I have to step out again and (inaudible) and is that the last measure?

Shaconna Gorham: Well so with that said, can we finish the vote on this particular concept? So we need to…

Rob Schreiber: Have you guys like taken a break?

Shaconna Gorham: We will take a break but let's do this last vote.

Rob Schreiber: Yes. We'll go to the vote.

Barbara McCann: All right. What is the extent that this measure is important to state Medicaid agencies and stakeholders? High? Medium? At least two?

Shaconna Gorham: OK. So that is five votes for high. And so what we're saying is we are recommending this measure…

Peg Terry: It's medium.

Shaconna Gorham: I'm sorry, I apologize. Five votes for medium. And so we are recommending this measure concept for inclusion into the measure set.

With that, we will take a break. We'll take a 15 minute break and come back at 3:15.

Barbara McCann: OK. Thank you. You know I just have to note as a social worker that this morning, we were in a totally different place and by 3:00 we're all together, that's pretty good. That's pretty good.

(Break)

Shaconna Gorham: OK. For those on the phone, we are going to start in exactly one minute.

Female: All right. We're ready. We're ready, folks. We're ready.

Shaconna Gorham: All right. We are going to discuss the very last care coordination measure and that is referral to community-based health resources, and again, our lead discussion on that measures, Rob and Janice.

Barbara McCann: Yes, number 38, the referral of high-risk score patients to address social determinants of health. This is a proxy indicator for health behaviors at large. So it's referral to community-based health resources. Thirty-eight, correct, measured 38.

Shaconna Gorham: Now, remember the numbers are assigning numbers, not order. But it is the very last measure, it's the very last measure in your care coordination domain.

Male: So this is ...

Barbara McCann: Right, right.

Male: Well, I'm going to let you…

Barbara McCann: Yes, really, don't try that here, Schreiber.

Male: I think she knows me.

Janice Tufte: We've known each other before. So I just felt that because I believe -- this is Janice. The social determinants are so important, and if we don't, I think more broadly address it or directly address it that we're going to regret it in a few years, I guess is the best way to put it.

So this it wasn't necessarily just this measurement but I felt it was really important for, like it says it's a proxy. I felt it was really important but I also had written on, if you have my note, forget that I said that it could have been incorporated into another one. I think it was 32 or something but anyway I'm going to let you go from there but I just felt it was extremely important.

Rob Schreiber: So this is Rob. So I think the, although I am the only male voice on this recording so it should be…

Janice Tufte: And it just dawned on you.

Rob Schreiber: Yes, it just dawned on me that I'm the only guy here.

Female: That's 3:30, OK. OK.

Rob Schreiber: Yes. So the thing that, so I'm going to actually leverage what I have learned from clinical care actually in the trenches. And what has always amazed me over the last four years where I work in a co-management model. So I'm not a primary care physician but I co-manage primary care patients with primary-care physicians that are very – this high complexity, rising risk scores, people that we know are going to get ill or end up in the hospital or even die.

What I have been amazed at is how often there are social determinants. There are social determinants that are preventing them from living and getting the care they need, how they want to get it. And that it's not really being addressed.

Now there are care managers that we utilized, but again it's more of a nursing lens. It is, they are connecting with community but they are not getting to

really that patient-driven goal and we're also focusing on the caregiver needs. So when you're talking about really these high risk score patients, they should just, as good standard of care that should be a proxy metric because almost all of them do have some type of issues with health behaviors and or social determinants, or depression that are driven by social determinants.

And so, as a result of that just in my own experience, the hit rates of unidentified needs I should really write this up and do a retrospective review, but I would say it's at least 50 to 60 percent. I mean, it's high-yield. And it makes a huge difference in terms of decision making and the care that's delivered downstream from once that's been identified. So that was the reasoning behind bringing it up to have a discussion. The problem is, it's not done as standard of care, you know.

And my feeling it's just because it's not done it doesn't mean it shouldn't become the standard of care, so it maybe more of a measurement concept at this point but I actually do think that there are – I know for a fact there are organizations doing this type of care that actually directly deal with this.

Barbara McCann: And sometimes measures help drive the standards.

Rob Schreiber: That's right.

Female: Well, you get what you measure.

Rob Schreiber: And you get what you measure, that's right, and it's not the right measure. So that was the reasoning behind it. At least having the discussion whether or not it hits the metrics, I get that, but I just thought it was important if we're really going to advance the LTSS measurement system. This should be something that if we think it's not agreed upon would be something that would be continued to be evolving in the measurement development.

Janice Tufte: This is Janice. If I could add to it because I was like half asleep when I mentioned that, but when you weren't here, but the project that it worked on, so it's a full disclosure. It was a community resource specialist, so that's what we did, people we referred to the community resource specialists in the clinic. And then they were connected, goal setting what they wanted.

They were self-referred, and or most of them were referred from anybody in the clinic and then sent out to the community working with the individual interviewing and techniques where they might like to go for more exercise, grief counseling, whatever was being addressed.

And I had mentioned earlier before you were here that Kaiser is now thinking about picking it up and going statewide with it. So we did the pilot in three clinics actually, two clinics full that were measured but it's very hard to measure but it's very important and everybody was pleased with it.

Barbara McCann: All right, so then let's get to the vote. I'm sorry.

Janice Tufte: Or I just wanted to add that it is an assumption. So if the deferral exists then we are going to say the behavior improves so there is movement, so there is more referrals, then there's the volume of people who have healthy habits. So it's that kind of assumption, not accounting for that some people will decline or never make that follow-up appointment or whatever.

But, yes, ultimately it would work, if the measure moves up or down, that should stand for healthy behaviors, followed or not followed in a particular community or demographic.

Janice: The problem is you have is that organizations shut down there's a lot of factors that are involved and patients might not follow up. And there's soft touch versus many times meeting with the individuals…

Rob Schreiber: In policy, this is Rob again, policy people oftentimes, I've had debates with policy people about what drives what. And so, I often have taken it that, I you give people healthy if they have the ability to manage their health they're going to figure out ways to deal with social determinants and they go no, no, no, no.

It's social determinants that drive healthy behaviors. So I think if we're really going to try to get into a system that is prevention and health, you have to address social determinants from at least a policy, I mean, there are questions about what drives what but they're both mutually synergistic. So again, from

that perspective in terms of what we're trying to promote in terms of transformation this is a critical core component in that thinking.

Female: But you are measuring referrals with this as opposed to anything else?

Rob Schreiber: Yes, right.

Barbara McCann: Right, this is proxy.

Rob Schreiber: Yes.

Female: We're not measuring a change in health status…

Rob Schreiber: No, not yet, not yet. That's right, referrals. And what I am saying is that just that referral piece by getting the referral connected what we see is dramatic changes that there are things that are picked up, not everything but people are aware. And it gives people resources that they can leverage either now or in the future that will help them impact on the healthy behavior.

Barbara McCann: Like a cue that if you are high risk you got to do this, so you build a cue in the measure.

Female: I would prefer the gym membership.

Barbara McCann: Yes. Silver sneakers, yes. So let's vote. This is the extent measure, addresses critical quality objectives or program area key concepts. May I have a vote for high please? OK, a vote for medium?

(Crosstalk)

Shaconna Gorham: So that is three votes for high and two for medium.

Barbara McCann: Yes we're moving ahead. The next concept is the extent to which the measure addresses an opportunity for improvement or significant variation in care. A vote for high. A vote for medium? You're between high and medium? OK. Thank you.

(Off-Mike)

Barbara McCann: Right, right, this is just the referral occurred, yes.

Male: So moving back to high

Shaconna Gorham: So we have five votes for high.

(Off-Mike)

Female: Yes.

Female: No.

Barbara McCann: All right, the extent to which the measure demonstrates efficient use of measurement resources. High, medium, vote for medium, yes, you have to pull it. Vote for low?

Shaconna Gorham: So that was five votes for medium, correct?

Barbara McCann: The extent to which this measure is ready for immediate use. Vote for high?

Rob Schreiber: I'm really not sure with this. So where is the Medicaid waiver, there are Medicaid waivers that this does occur in…

Barbara McCann: Yes, constantly. Yes.

Rob Schreiber: So when you get in already, it's usually like, in Massachusetts we have a frail elder waiver.

Barbara McCann: Right.

Rob Schreiber: And that's like baked in, you're in that, you qualify, you go right to long term service support. So it's already in use, so there's other states that I know are doing that.

Janice Tufte: And electronic (concepts) because you can pull referrals. And is it referral to the cardiovascular or is it referral to the community resources, it's equal, it's not…

Barbara McCann: OK. There's not the evidence that's necessary.

Female: Right.

Barbara McCann: … a numerator and a denominator.

Rob Schreiber: And there is testing we've done, the pilots, right, in terms of – it may not be testing…

Janice Tufte: I don't know testing in terms of scientifically, it's used.

Rob Schreiber: It is used but I think it is ...

Janice Tufte: It's used.

Rob Schreiber: You're saying it is in use, OK.

Female: This is collecting metrics, and…

Rob Schreiber: Yes, no, yes.

Diane McComb: The new accountable care, the accountable health community's model from (CMMI) that just came out it's exactly this. They've got tracks that are just referrals, tracks that are referral in integration so it's a measure that's going to be built for that pilot anyway, that would be a good use.

Barbara McCann: So do we have a vote for high?

Rob Schreiber: High.

Female: High.

(Crosstalk)

Rob Schreiber: You hit it right on the head.

Shaconna Gorham: So just again, for transcript purposes can you clarify the high vote, so because if we're saying high we're saying that this is already in use in the Medicaid population. And if we give this recommendation to CMS

it's ready to go, it's fully baked, it's ready to go. They can put this on their list and states can pick it up and roll with it.

Female: They have to call Rob though…

Rob Schreiber: So when you say it's baked, so again, there's measures that are outcome value-based if you do X you're going to get Y definitively. I don't know if it's that it's usually multi, there's multiple factors that result in outcomes including the medical care-by by chance.

But I do think that there is now approaches where this is being measured. It is being implemented. It is part and parcel of the care system. I know like I said the Massachusetts (ACO) that's coming up, the Medicaid (ACO), this is baked in, this is part of the demonstration. You know, the RFPs are out and there are other states that are doing managed long-term service support.

So I think the answer is yes there is a measurement. It's being used. The question is do you do you actually have outcomes of this. And I think that's what's been lacking. But I think the data is there. It's a matter if somebody is going to look at it and do it and compare…

Barbara McCann: So with that be more medium because it has reported testing?

Rob Schreiber: It's reported testing, it doesn't have definitive outcomes.

Camille Dobson: This is a referral right?

Rob Schreiber: Yes.

Camille Dobson: If you're looking for the existence of a referral you're not getting it – sorry, this is Camille. It's just accounting. And like if a referral happens they're not looking at the content of the referral, how thorough it is. It's really a proxy for…

Rob Schreiber: No, they're actually looking not only in the…

Camille Dobson: At this measure?

Rob Schreiber: This measure, yes.

Camille Dobson: Yes, yes.

Rob Schreiber: Yes, I'm sorry, yes.

Camille Dobson: So for right now it's a process measure to make sure something is happening at the proxy, you hope that something is percolating underneath of it, right. So there are states that are doing that now if they've got integrated system happening. It wouldn't be a surprise if Colorado doesn't do it with your…

Female: Yes, we actually report it…

Janice: And this was a project, so it's totally recorded.

Camille Dobson: Right. There are states doing it whether or not where you've got the concern about a drop-off from the medical system to the LTSS system.

Shaconna Gorham: Again this is another example of, I will go back to something Camille said that every measure will not be suitable for NQF endorsement. So that is a known fact, we know that.

But what we want to see now because at this point again the measure concept is not going to fail. But we want to know are we recommending this as an actual measure. And in my world it would not be an actual measure. Are we recommending it as an actual measure, are we recommending it to CMS or to the coordinating committee as a measure concept?

And so, by saying high and medium I believe we are saying measure, by saying low, we are saying concept, so that is what we are saying now. So if you're saying to me that there is reported testing, then it could be medium. And if you are saying that there is no evidence of testing but this is a concept that has a numerator and denominator then it would be low.

Rob Schreiber: So my question to your comment there is reported testing but I'm not (inaudible) with the definition of reporting tested, I just wanted to make sense there with the (inaudible). How would you define reported testing if we are going to go through that?

Shaconna Gorham: Right. So again, testing would be something that is reliable and valid for a measure.

Rob Schreiber: So there is a reported testing, is it also outcome based, in terms of like full (outcome). Like this is I suppose (inaudible), so would reported testing be that there is a validated testing reporting system and impact that has been shown to impact ...

Barbara McCann: Nothing that is measured.

Female: And I think, Shaconna, isn't it also, and I think there are probably a lot of this collecting in measures similar to this but when you talk about is this already in use in reporting, it's about this particular measure as specified, it's not measures like it that are used by other states.

And I think the answer to that is yes. There's a lot of states using a measure like this. There doesn't seem to be sufficient evidence that this measure is in use and has testing.

Shaconna Gorham: Right. Exactly. And again we are looking at the measure or concepts for what it is. And we're going to be at this individual measures as is stated. So, yes.

Barbara McCann: And that would be a low. I mean technically there is…

Female: I would do an evaluation of them so I'm sure that they've got measures, they just haven't published, I don't think, right. So they haven't put out measures about what they're going to report on but you know they're going to have them. And it's got to be one of them.

Shaconna Gorham: But it this particular measure a concept?

Barbara McCann: No.

Shaconna Gorham: So that's what we're…

Barbara McCann: OK. So then we're essentially by definition…

Diane McComb: OK. I'm going to be really unpleasant at the end of the day but if we like a measure concept, can we go out and find one that is more reliable than this one that matches this? I mean I hate to be difficult, but if we like the concept, I'm not wedded to the fact that because it just doesn't fit in the box of what we've got in front of us that we don't find another state that maybe has one more valid because they…

Female: But we've been…

Female: I mean with all due respect they only looked at 17 states. We didn't look at every single state.

Barbara McCann: But we have addressed this before in a previous measure where when it doesn't meet NQF requirements we went ahead and made the recommendation that it was important to the state and stakeholders, et cetera, right. OK.

All right, yes.

Rob Schreiber: The other question I guess I have is if there's something important, I think we have key measures that we think really are very important. Isn't there both the opportunity as measures, that maybe not directly but indirectly that these measures, put them out, you know. And you test these measures, that you actually try to test the validity and see if you can actually do this and see if it does make an impact.

I guess we just don't – if the concept is there, right, every measure has to start somewhere, right, it starts with no evidence, right, there is somebody says, I see these are connected and if we did this and did this, and measured this, then chances are we are going to see changes.
So what I guess we don't want this to die on the vine and we want to make certain it gets pushed forward but we just, I guess, maybe it's our insecurity in not understanding the process, how would this be kept alive in terms of at least discussing it or trying to push it out to organizations to actually develop a measurement approach.

Shaconna Gorham: But let me make one clarification, so NQF does not test measures, so that would be up to the developer. And so, what you're saying to me is the developer being able to test and do exactly this particular measurement to do. So I want to just kind of draw you back to the goal of the project and that is to recommend a measure or some measure concepts that are close to being baked.

So I can't see, and again, you all are the experts. I can't see where this measure as stated or this measure concept is stated it's where you need it to be or where CMS would need it to be to actually put on their list as the starting place for states.

Now what I've heard is that there are measures like this that the states are using, but is it this particular measure that we're recommending for the set.

Female: So, Shaconna, just because this is a tough topic, I know the next step is the coordinating committee and you're asking us rationale or you're asking the TEP rationale. I think it would be really nice at the end of this to have some of that flavor of the conversations baked into the final list that gets put forward whether it's – and I don't know how you guys are going to handle that here are some areas to explore, but I think it is such rich conversation that it would be nice to capture somewhere whether or not the coordinating committee decides. I feel like that would be a nice end product to include that.

Rob Schreiber: I want to add to add also. Geriatrics, a lot of the measures that originally NQF had developed were not applicable to geriatric frail elders or older adults. I mean, they just were not relevant because people had limited life expectancy and their goals weren't treating their diabetes or their cholesterol, or their – whatever. Well, it's diabetes, cholesterol, whatever it is.

It really was about quality of life and function and actually some of the metrics now are moving towards that. So, I think again, this is – we saw the timeline. This is really the beginning. It's not the end. It's just the question is, so, how do we get this out. So, even if the measurement concept is not – we can't get the measurement but the concept's there, then, maybe it's up to us to

bring this out to the developers of measures to really come back with other measures, right, because there could be other measures that get brought in and that's what geriatrics has done actually, is trying to do, is to bring in the measures that are truly relevant, so you could segment your population and apply different metrics depending on the population.

So, I think maybe that's our opportunity, but it would be nice to know what that process is, so when we do put with concepts that we can actually feed this back to the researchers, developers of these metrics to see if there's something that can be done, so they don't drop, because these are important things. I think we all agree with that.

Shaconna Gorham: I certainly agree with both of Rob and (inaudible) comment. So, the beauty of the report is that we can capture all of this robust conversation, the beauty of the rationale and then having the coordinating committee look at this again because we will have the transcript by then and then we will write up some of this rationale and we can – when we recommend the sets and goals of the conversation and the highlights of the conversation here, they will have the opportunity to look at that and to consider those points.

And so, again, I do want to stress that we want to look at what we have in front of us. But, with that said, we also want to look at that robust conversation and what we can move forward to the coordinating committee and then to eventually developers or CMS.

Rob Schreiber: I guess we're ready to vote.

Shaconna Gorham: So, can we actually just take this because...

Barbara McCann: All right.

Female: ...I think I missed the actual vote. So, can we vote the (rules) ready for immediate use?

Barbara McCann: Right. Can I have a vote for high, a vote for medium, a vote for low?

Shaconna Gorham: And so, that's five for low and that simply means that it will continue – it would just continue as a measure concept.

Barbara McCann: OK, all right. So, we said we think this measure is important to state Medicaid agencies and other stakeholders. Can I have a vote?

Shaconna Gorham: So, that is five for importance to stakeholders. That is five votes for high. So, this measure concept will be recommended for inclusion to the program measure set.

Janice Tufte: This is Janice. I also think that this could be effective in the behavioral health and physician health integration as well, in BCN, probably all of them.

Rob Schreiber: Yes. Yes. We could vote.

Shaconna Gorham: And so, just again, we will get the transcript, but we said a lot about this particular concept. So, just for the benefit for our summary tomorrow, can you sum up the discussion for this particular measure and the rationale for moving it forward, because Barbara will present to the larger group tomorrow. So, if we can have one or two syntheses that you think captures your rationale for moving this forward. That was a hard ask after all of that conversation.

Janice Tufte: I just wanted to ask this and you mentioned it's not just high risk, this is Janice, because we had individuals come in, elderly that just weren't isolated and they weren't aware where the community center was. And so, it's a really easy and wonderful opportunity to connect people.

Rob Schreiber: Rob, I just want to echo the echo, that this is – it's really – people who are relatively low risk or moderate risk can become high risk if their behaviors are not being addressed. So, this actually becomes actually an avoidance strategy for people in terms of identifying the more upstream and putting those interventions in place at a time where you can really impact the outcomes in a positive way. So, it really should be a population strategy, not just a segmented strategy.

Shaconna Gorham: All right. Thank you.

All right, so, we want to open up for public comment on this domain.

Operator: At this time, if you would like to make a public comment, please press star then the number one. And there are no public comments at this time.

Shaconna Gorham: OK. So, we'll move to our next domain and that is patient and caregiver experience.

Barbara McCann: So, the first measure is measure 45 and there are seven measures. And, Robert, I believe you are the lead on measure 45. This is the (CAP) health plan survey.

Rob Schreiber: Right.

Female: The standardized survey instrument to report on the experience, access in care and health plan information and the quality of care received by physicians.

Rob Schreiber: Yes. Let me actually get the numbers.

So, the reason I said – what was the score on this one?

Female: I was looking for it.

Rob Schreiber: Was it 2.1?

Female: It's 2.1.

Rob Schreiber: All right. So, it actually meets criteria, right? OK. So, I don't have to push that hard on this. Not that my pushing is making any difference because that's why – whatever.

Female: But I don't know – I don't see any ...

Rob Schreiber: Yes. Yes. Well, OK, so – yes. So, yes, I do appreciate that. I do think the patient experience though and caregiver voice is really critical, but you're right. It does not have the LTSS focus which I think is really like should be what's there. My only question would be – and the reason I wanted to understand this more is whether or not there were – and I didn't have a chance

to look through the CAP surveys, but to see if there was any way to connect the two. If there isn't, then, I would respectfully say this is probably not going to be a measure we should address. But I just I think understand you know, the whole point of patient's voice and caregiver's voice being front and center is why I thought this was important to at least bring in front of the group.

Diane McComb: I would just – in response to your comment, there is an HCBS add on to the CAP survey which I think we're going to talk about tomorrow. I don't support that slot either necessarily for all populations because it's very much focused on a service model rather than a full robust life in the community, so to speak.

Rob Schreiber: Right.

Diane McComb: But I would say that this particular part of it is really good for medical components but I don't think it addresses the LTSS side.

Female: I was going to say the same thing. There are other tools out there that get to the patient.

Rob Schreiber: Well, you said it.

Female: Hey, you say said patient first.

Rob Schreiber: She said it. I didn't say that.

Female: I said relative to the medical...

Female: The person and their caregivers to the extent they're interested in it. I think we will talk about the other patient reported outcomes, person-reported outcome surveys that are there that are better than – that are more useful for CAPS and relevant I think. Caps is great and, well, should be used and as for states that are to doing managed care, the plans do CAP...

Rob Schreiber: Right.

Female: ...to address how they're doing on the medical component and they're also doing something that addresses their success in delivering in LTSS. So, they get double surveys.

Rob Schreiber: Yes.

Barbara McCann: So, let's move to the vote. To the extent that this measures addresses critical objective (inaudible). Can have I vote for high, a vote for medium?

Shaconna Gorham: All right. So, that is five votes for low, for NQF endorse 006 the CAP health plan survey. So, this measure will not be recommended for inclusion in the program measure set.

Barbara McCann: OK. The next measure for consideration is number 42, the advanced care plan. It is the (percentage) of (inaudible) aged 65 and over who have an advanced care plan or surrogate (inaudible) record. Or was not able (inaudible). Any questions, suggestions)?

Janice Tufte: This is Janice and once again, that 65 years and older, especially for working with Medicaid, too, it could happen any time, right? So, I'm just questioning the age.

Rob Schreiber: Just to add to what Janice said, healthcare, advanced directives need to be happening when people are of legal age.

Janice Tufte: Right.

Rob Schreiber: Because once you have somebody who's 18, in most states, unless they appoint a proxy or have that discussion, good luck in terms of – so, I don't think – I mean, I think this is almost ageist in a sense because it really should not be age limited and really should be baked in for – at least for the population 18 and older.

So, I have a problem with supporting just that alone. I do think though having advanced directive discussion and understanding goals is absolutely paramount and done in a way that is, again, patient centered and patient directed. But, I just – I have a problem with this 65.

Barbara McCann: So, looking at (inaudible)? I just wanted to ask in terms of relevance to LTSS specifically...

Rob Schreiber: Yes.

Diane McComb: ...and measurement of quality in LTSS. I mean, I can see where this is important, but again, if we're looking at the state picking a couple of measures that they're really going to focus on, does this really get at the quality of life for an individual in an LTSS setting or is it – I know it's now always related just to medical, but is it more so related to medical than it is to a clinical setting than it is to the LTSS setting. And I'm asking for my own clarification.

Barbara McCann: What I guess I would offer is that among the elderly, so, a higher risk population and those who receive Medicaid services so they can remain at home, the absence of this may take them out of the house before they wish to go. That's the only perspective I would offer. Yes.

Rob Schreiber: And the other thing I would say is that in terms of long term service support providers, having – in fact, a lot of times, advanced directives occur as a result of discussions with the LTSS providers by having people – by being comfortable and having relationships.

I mean, you can have a discussion and just broach the topic where people start thinking about it, but it's when they start having discussions and reflecting, having LTSS be there is something that I think would be consistent with person-centered care and care plans. So – but it's not typically what's been done or has what's be considered part of LTSS in spite of the fact that there are many LTSS providers doing it.

Diane McComb: I think it's being done in LTSS settings, I just question whether or not it's a quality indicator. It may be important in that person's life to have it in place, but is it one of those things that we – is it part of a checklist of more of a medical piece of all – it doesn't matter where the decision is made or the discussion takes place. Is it an LTSS quality issue though and I guess that's where I'm kind of straddling offense here.

I mean, it's important and I really appreciate your comment about that if somebody does become unable to make decisions for themselves, OK – exactly, my children might say "No, mom. You're gone. We're taking--"

Female: (Correct). That's right.

Diane McComb: (Or something), "We're going to put mom away." But if I have decision – well, and I do have – I do have this done. So – but my question is, is it a quality indicator for long term services and supports or is it more of a medical – your explanation gave me some – I think – yes.

Rob Schreiber: Yes. I would go with Barbara's explanation.

Janice Tufte: It's...

Female: I can see it part of their decision if that's their main...

(Crosstalk)

Janice Tufte: OK. Yes.

Rob Schreiber: Yes. Yes.

(Crosstalk)

Rob Schreiber: Yes. These discussions actually mostly happen outside of medical settings and...

Female: Sure. Yes. (They're like) introduced in the medical setting but they occur outside.

Rob Schreiber: Exactly. They've actually – if you really talk to people, it is amazing to me – amazing to me. If you ask the right – so, it's all about asking the right questions and have you had discussions – have you had a discussion with your mom when you're dad died?

People have had these discussions, but when you ask "What do you want", it's like "Wait a minute. Where is that coming from? I'm here to be getting whatever – my car problems taken care of. Why are you asking about death?

Janice Tufte: But you may have told your aide.

Rob Schreiber: That's right and that's what happens. I've had aides come in and say, "No. She's talked to me about this. You asked me. What..."

Female: That's what most of the evaluations ...

Female: Yes.

Rob Schreiber: Yes. It should be happening in all settings. Anybody who's a part of that care team should be...

Janice Tufte: OK.

Rob Schreiber: ...should have that as a metric.

Janice Tufte: Thank you.

Female: No. No. No.

Janice Tufte: I needed to understand ...

(Crosstalk)

Rob Schreiber: Yes.

Female: So, let's go to the first vote.

Rob Schreiber: Yes. Yes.

Barbara McCann: The extent that the measure addresses critical quality objectives or identified program key concepts. May I have a vote for high...

Rob Schreiber: Yes.

Barbara McCann: ...vote for medium?

Shaconna Gorham: All right. So, for measure NQF endorse 036) – I'm sorry, (0326) advanced care plan, we have four votes for high and one for medium, and that is the first question in the decision logic.

Barbara McCann: Thank you. The next vote addresses whether this measure addresses an opportunity for an improvement or significant variation in care. Can I have a vote for high, please? This is measure 42 again, advanced care planning.

Female: Sorry. Sorry. OK.

Barbara McCann: Right, right, right.

Female: Sorry.

Barbara McCann: So, can I have a vote for high, a vote for medium?

Shaconna Gorham: Right. So, that is four votes for high and one vote for medium.

Barbara McCann: The next concept is the extent that this measure demonstrates efficient use of measurement resources. May I have a vote for high, please, a vote for medium?

Shaconna Gorham: All right. So, that is three votes for high and two for medium.

Barbara McCann: To what extent is this measure ready for immediate use? Is there a vote for high?

Rob Schreiber: No. OK.

(Crosstalk)

Rob Schreiber: Well, I mean...

Female: You can just look on the Internet for it.

Rob Schreiber: I mean, I know it's addressed. But it is already in use, but I mean, at least in populations I know of, but I don't speak for the whole population.

Shaconna Gorham: So, if you look at your specification.

Female: It's in MIPS.

(Off-Mike)

Rob Schreiber: It is part of MIPS.

Female: This is why the 65 bothers me, too.

Female: Yes. Yes.

Rob Schreiber: Yes, part of macro.

Female: So, Rob could get his vote.

Rob Schreiber: My vote.

Barbara McCann: So, to what extent does this measure ready for immediately use, a vote for high, please, medium.

Shaconna Gorham: So, we have four votes for high. We have five votes for high. OK. So, then, this measure will move on to the next question.

Barbara McCann: To what extent do you think this measure is important to Medicaid agencies and other key stakeholders? May I have a vote for high?

Shaconna Gorham: All right. So, this measure – we had five votes for high and this measure will be recommended for inclusion into the program area measure set, and this is measure 0326 advanced care plans, and the rationale that I have is you noted 65-plus population is higher risk. And so, this measure helps to maintain personal choice and keeps them in the home.

Janice Tufte: You're leaving the 65 and high risk?

Female: Well, that's what the measure tells me. So...

Janice Tufte: But could you add that – sorry. Could it be recommended that this could be widely used across all populations and recommended?

Shaconna Gorham: So, this measure again is in use as is. So, I mean, we're looking at measures as is. This measure has been through endorsement and it

is in use and so, although we can include that that will be preferable for the report, again, this measure is what it is and it has been used for some time now.

Rob Schreiber: Now, it's just interesting. How did they come up with 65? It's Medicaid – I mean, I get the Medicaid piece for the 65, but what about the rest of the – I mean, we have substance abuse. We have behavioral health. We're dealing with all these other populations. It's just my commentary on this. They're just for the record that I find it unusual that we're trying to do it for the whole population and for some reason, this was segmented, because there haven't been that many over 65 measures that have been put forth per se. As a matter of fact, that seems to be the first one that actually had an age...

(Crosstalk)

Rob Schreiber: Yes, but – right.

(Crosstalk)

Rob Schreiber: Right. So, anyway, it's just interesting how they came up with it. But, they should just be – when they're thinking about maybe looking at these, maybe make certain that they talk to consider the age and whether or not it should be age blind, so to speak.

(Off-Mike)

Rob Schreiber: Yes.

Barbara McCann: All right. We have a new launch, measure 40 C which is (inaudible) service measure. This is derived from the (inaudible) about the quality of long term (inaudible). This is, as I understand, is – sorry. This, as I understand it, is a somewhat newly developed segment of the CAP survey that could be used for long term services and support settings.

In the view of a person-centered focus, we look at a service life versus a full robust life in the community. This is more getting at the service end of things.

It does ask the questions that are relevant to staff that support an individual care – it's not just caregiver. It's somebody that comes into the home.

It's in the absence of anything else. It does ask some questions that other tools don't ask. I have some concerns with at the very end of all of this. It talks to individuals who are unable to answer these cognitive screening items are excluded. That may be fine for a person with dementia that you might exclude them. You might talk to a caregiver for answers. But I think it would be important to identify individuals who communicate in ways other than using words, which in the LTSS (arena) for folks with cognitive disability or other physical – cerebral palsy, there's a number of disabilities where a person cannot communicate using words.

There alternative methods for communication, they are more onerous to survey the individual. They are more costly to the survey process, but very important, obviously, if they want to get that segment of the individual who is receiving support to weigh in on the quality of their care. To me, it's not the best thing that could be out there, but it may be the only thing that's out there that's been tested.

Female: Yes. I think the benefit is that they've gone through, they've extracted measures and have gone through to endorsement process. I agree with Diane from a state perspective. It's got a lot of usefulness because states are already familiar with CAPS if they've got managed care, right? So, it's part of the CAP suite.

I get it. I agree with Diane. The concern about doing things by telephone, I think there are a number of individuals where they said they tested it to make sure it's relevant for people to answer by phone. We're not convinced necessarily. And my other issue is that it only speaks to Medicaid. Now, considering this work is only Medicaid, that's probably not a consideration from a state perspective. There are lots of states that have programs that aren't funded by Medicaid that deliver services to people who are older, people with disabilities that this won't address because it's specific. You have to be in a Medicaid funded program.

So, there are other tools that are broader. It doesn't quite get at quality of life. It's really related to...

Rob Schreiber: Yes.

Female: ...how does the service you got impact you. But in the absence of nothing, it's definitely more relevant than, say, the regular CAPS, the health plan CAPS, for sure, because it's getting at the service. CMS has put it out as an optional tool for states to use and we encourage states who are doing no quality measurement at all about quality of life and how services are impacting people. Do this. Pick this to start with. We have – there are other tools that have been in – that the states have developed along the way that are a little bit more comprehensive I think than this tool.

Female: More robust.

Female: More robust, but it's certainly a good starting spot than not having anything at all to address quality.

Barbara McCann: OK. So, let's go forward with that.

(Off-Mike)

May I have a vote for high, a vote for medium?

Shaconna Gorham: That is five votes for medium.

Barbara McCann: The next consideration is the extent that the measure addresses opportunity for improvement and/or significant variation in care, may I have a vote for high, a vote for medium?

Shaconna Gorham: OK. So, for the CAPS HCBS measure, that was four votes for high and one vote for medium for opportunity for improvement.

Barbara McCann: All right. The extent this measure demonstrates efficient use of measurement resources, may I have a vote for high, a vote for medium?

Shaconna Gorham: OK. That was five votes for medium for efficient use of resources.

Rob Schreiber: Yes.

Barbara McCann: The extent this measure is ready for immediate use, may I have for high?

Shaconna Gorham: OK. That was five votes.

Barbara McCann: And the concept is – the final one is the extent to which you think this measure is important to state Medicaid agencies and other stakeholders, the high vote, medium?

Shaconna Gorham: OK. That was four votes for high and one for medium. Did you have a comment?

Female: I just wanted to comment that I think that where it falls down is the use of a telephone survey which for a person with a cognitive disability, it's not going to work and/or communication issue of any sort. So, I just think that's really important that that be noted.

Rob Schreiber: So, I guess, my question is would the survey – could the survey be done or when the survey is done, I know that we oftentimes will do surveys with cognitively impaired older adults with their family members who will be there to facilitate that discussion. So, I guess, the question would be how would that apply.

Female: The way that we would do that is if – we would ask the individual if they would like to have a family member present to help them communicate. If not, there may be a person who provides support to them, a direct support professional, if it's a group home or even their own apartment and they have support staff.

People with cognitive disabilities often do not want their family present in these kinds of situations, because parents may choose to say what they want. So, they feel good about care and support and it may be different than what their son or daughter who's an adult might say. So, I mean, just like any of us.

We may not want our parents deciding for us where we're going to live and how we're going to go through the day.

So, I think the critical issue is who does the individual identify as someone who can help them articulate and there's ways to do that.

Rob Schreiber: Yes.

Female: It's just it's not as cost efficient. It's not as easy, but it's certainly doable and we do it all the time. But you have to make that known. So, if states choose to do this, they need to know they're excluding people who don't communicate over the telephone and it's not OK just to assume that family members are OK to speak in their behalf.

Shaconna Gorham: OK. So, based on the votes, measure 2967, the CAP HCBS measure will be recommended for inclusion in the measure set. So, just for transcript purposes and the rationale, I understand that the downfall of the measure is the use of the telephone, but give me the rationale for inclusion.

Female: I would say the rationale is that it is, I think Camille mentioned it, yes, it's part of the suite of the CAP surveys. It's totally widely accepted and used throughout the country in terms of managed care assessment. It is one of the first tools that's available to look at home and community-based services quality from the perspectives of the individuals who receive that support. And it does not focus on clinical and medical care. It focuses on the support to live independently or as independently as possible.

Rob Schreiber: True.

Female: Yes.

Janice Tufte: This is Janice. The blind and low vision people could certainly use the phone and may prefer it actually rather than traveling.

Female: Yes. But then, again, I'm sorry, Janice. Say that one more time.

Janice Tufte: The blind and low vision population may prefer using the phone if given the option.

Rob Schreiber: And I think the other caveat is the cognitively impaired population could be – it could be a challenge if they don't have the spokesperson that they're comfortable with or identifying a spokesperson that they would be comfortable with. You may be excluding a population. So, that's – there needs to be some acknowledgement or workaround for that.

Barbara McCann: All right. Moving to the next measure, number 47, gains in patient activation score or what's called PAM. This is – the PAM is a 10 or 13 item questionnaire that assesses an individual's knowledge, skill, and confidence for managing their health and healthcare. Do we need to have more questions or concerns?

Shaconna Gorham: So, let me just check. I think that someone actually asked for this measure. I'm wrong. No. It's actually fell above the measure that I showed, so we're fine.

Barbara McCann: All right. Are we ready to vote? The extent that this measure addresses critical quality objectives or key concepts, may I have a vote for high, a vote for medium, a vote for low?

The next vote is the extent to which this measure addresses an opportunity for improvement or significant variation in care. Do we have a vote for high, a vote for medium, a vote for low?

Shaconna Gorham: Can I ask a question just for the transcript? So, we had a question raised, what is the relevance to the LTSS population, can someone answer that for me please.

Rob Schreiber: So, I'll take a gander at this because I'm all about activating populations. So, in terms of long term service supports, you're providing services based on patient's goals and values. One of the big challenges is social determinants that we're dealing with, right?

So, if you're helping people deal with their social determinant challenges and their low activation, they feel overwhelmed, one of the measures is if you're providing the right suite of services that an individual needs to meet their

goals, they should, by definition, become activated such as they adopt healthy behaviors or are more inclined to be engaged in their care.

So, I actually, I was going to say something, but I didn't want – there was a flow here. So, I didn't want to break it up. But I do think that a lot of what we do clinically and with the long term home and community based services, if you look at the administration in community living for ageing and disability, a lot of what – one of the big buckets for long term service supports is educating and activating individuals, giving them the tools that they need so that they can become the captain of their health, whatever metaphor you want to use.

So, I think in fact if you're having LTSS in there and there's need for education, support, whatever, if those things are being applied appropriately, we should see a population of individuals actually improve their activation scores. So, that actually is a proxy of the impact and we know for a fact – actually, there's been studies that have come out through this measure that shows that people that are highest activation have lower hospitalization rates and they're less likely to develop new chronic illnesses.

Female: But wouldn't that fall more to a primary care domain?

Rob Schreiber: So, what's interesting is I would say no.

Female: Because it impacts on a person's quality of life. I understand that fully.

Rob Schreiber: Yes. So, home and community based services I think is the place where this falls. And so, if you take evidence-based programs, the chronic disease, self-management, have you heard of those?

Female: Yes. I'm not arguing that that's where they take place.

Rob Schreiber: Yes.

Female: But is that the quality measure for LTSS? Is that a quality measure of primary care that takes place in the home?

Rob Schreiber: I think it's both. I think it applies to both. And when you look at the chronic care model for a population or just the chronic care model, it's the community

and health system, and when you look at self management and activating the patient, it applies to both the health system and the community.

So, my perspective, my bias, is we should make it both, and actually, in the area agency on aging, a lot of the work I'm doing with (N4A), that is one of their goals. They actually say, "This is what we do. We help activate and give people the tools that they need to take control." So, I personally think that's a real sweet spot, because people feel safe around their peers and in the community where they live. That's where they need to be activated because that's where they spend most of their time and who is spending more time with that individual than the LTSS providers? So, that's my bias. But that's coming from a physician.

Female: Yes. Yes. I am really happy to have to have your quality of care assessment in a primary setting for that activation.

Rob Schreiber: Yes.

Shaconna Gorham: Please talk into your mics.

Rob Schreiber: OK.

Female: OK. I appreciate your explanation. So, thank you for that.

Rob Schreiber: You're welcome.

Female: Yes.

Female: But from the social standpoint, if we don't activate them, we don't live with them. The only way we can stay in the community is to be activating and take more self management.

Janice Tufte: I wanted to add that we did do this in our community-based community resource specialist. So, PAM was part of it, if they were activated to take advantage of the resources that are made available to them.

Barbara McCann: OK. We'll proceed with a vote. The extent to which measure moves – OK, addresses an opportunity for improvement or a significant variation in care. May I have a vote for high, please, a vote for medium, a vote for low?

Female: I really think it's a great measure. I think it's something that belongs to long term care services support. So, I say low for long term services and support. I think it belongs to primary care. It is a health measure.

Rob Schreiber: So, I'm going to show her a presentation that I did where it actually has it as part of long-term service supports. We'll do it afterwards.

Female: OK.

Shaconna Gorham: So, actually, we took a vote on...

Female: I'll say medium. I'll say medium.

Female: OK. So, we took a vote...

(Crosstalk)

Shaconna Gorham: So, vote how you feel. I just want to make that statement that we have voted on this particular question.

Female: OK.

Shaconna Gorham: And that vote, we have four for medium and one vote for low. So, is that where we remain or – OK. So, that's the vote. So, now, we're going to move on to the efficient use of resource.

Barbara McCann: OK. The extent to which the measure demonstrates efficient use of measurement resources, may I have a vote for high, a vote for medium, a vote for low?

Shaconna Gorham: OK. So, that's four votes for medium and one for low.

Female: The extent to which this measure is ready for immediate use, can we have a vote for high?

(Crosstalk)

Female: Yes.

Female: It is.

Rob Schreiber: It is. OK.

Barbara McCann: Yes, right, even me – a vote for – did we get...

Shaconna Gorham: I'm sorry. It's high. So, we have five for high.

Barbara McCann: To what extent this measure is important to state Medicaid agencies and key stakeholder, a vote for high, a vote for medium?

Shaconna Gorham: So, Rob, I just want to answer your question about the use. So, we have that a few organizations are using PAM as a performance metric. Among those using PAM chain score as a performance metric is Monroe Health in New York State. They use it with their Medicaid program and their coaching service. The DSRIP program in New York State is requiring the PAM in their Medicaid program. Their policies state that gains in PAM will be used as a performance measure. However, the exact amount of change in PAM is not yet determined, blah, blah, blah.

So, planned uses for the measure include Washington State, Medicaid health homes, South Carolina, DHSS health outcomes plan program, and then Oregon, not used in federal programs.

Shaconna Gorham: So, as a result of the vote are recommending this measure for inclusion in this program measure set.

OK. So, let me just make sure my notes are right. So, it is 4:30 and according to the agenda, we are going to start to wrap up for the day. I will say that you all did an excellent job in going through our measures. One of the things that we were really concerned about as we were kind of doing the agenda and looking at the different measures and, of course, every program area had a different number of measures, but we were really concerned whether or not

we would able to have discussion and vote and get through all of the measures.

So, you all did most of the measures with only a few left. So, we have I think about eight measures to discuss tomorrow which if you think about the fact that we started with 28, we did really good today, a lot of hard work was done and we successfully completed over half of our, almost all of our measures.

With that said, (Desi) will give us a report of the measures and concepts that we have or that you all have voted for inclusion.

(Desi): Thank you, Shaconna.

So, it looks like we have accepted six measures for the measure set and also four concepts. And so, that in access, in the domain of access, you've accepted adult access to preventative ambulatory care 20 to 44 and 45 to 64 and 65 plus. That has been accepted.

You've also accepted in care coordination, transition record with specified elements received by discharged patients, discharges from an inpatient facility to home and self-care or any other site of care and that was measure – that's a measure that is accepted. You've also accepted in care coordination timely transmission of transition records, discharges from inpatient facilities to home, self-care, or any other site of care and that's another measure.

You've also accepted in care coordination, individualized plan of care completed and that is a measure concept. In care coordination, you've also accepted referral to community-based health resources, and that's another measure concept. In clinical care, you've accepted falls, screening for fall risk as a measure. In clinical care, you've also accepted home and community-based long term services and supports use measure and support use measure definition of HCBS as a measure.

You've also accepted in patient and caregiver experience, advanced care plan with this measure number 42 as a measure, as well as patient and caregiver experience domain, you've accepted CAP, home, and community-based service of measures which was measure 43 as a measure. And lastly, for

today, in patient and caregiver experience, you've accepted gains in patient activation, the PAM scores at 12 months which was measure number 47 as a measure.

Shaconna Gorham: (So, obviously a lot of work was done). So, I want to give you a few options. Tomorrow, we are supposed to start breakfast at 8:30 and immediately move to our breakout session. And the breakout session is scheduled to run until 2:30. I don't think it will take us from nine o'clock to 2:30 to actually discuss our remaining eight measures or measure concepts.

So, you have a few options. You're definitely welcome to come at 8:30 and we can just go ahead and discuss our measures and concepts and get those over with, and then you all are welcome to either kind of sit in on another TEP if that's what you so choose. Of course, you can't vote but you definitely can observe. Or you can take some time and walk around. I think the weather will be nice tomorrow, walk around D.C. and come back.

And – what did I say, two o'clock, 2:30 – it just, we can kind of get the pulse of the group to see what you want to do. It's up to you.

(off-mic)

Shaconna Gorham: You can come later. I will say that of course NQF will reimburse any meals that we do not provide here. Since we provide breakfast here tomorrow, if you decide to come later and you have breakfast outside of NQF, you will not be reimbursed for that meal. But that is another option as well.

(off-mic)

(Multiple Speakers)

Shaconna Gorham: I'm really flexible. I have to be here at eight o'clock anyway, so it's really up to you all.

(Multiple Speakers)

Female: So 10:30 you think would give us enough time?

Shaconna Gorham: I think that if we move at the speed and rate that we did today, I don't see why we can't get through our measures if we start at 10:30 and the general session is not scheduled to begin until 12:30 – I mean, I'm sorry, until 2:30. I don't see why we could not have time. Yes.

(Multiple Speakers)

Shaconna Gorham: And as a bonus we might start at 10:30, finish our measures and you still get to observe another (staff), so. And there is lunch.

(off-mic)

Shaconna Gorham: So I think consensus, we agree that 10:30 will be our starting time for tomorrow? OK so I just want to reiterate that we will not cover your breakfast but understand it's covered by the hotel and so that's perfect. We definitely can do that. I will ask you when you come in at 10:30 to convene here. We'll meet here in the breakout session.

So beautiful. If there's no questions or concerns – I'm so glad (Kate) joined us.

(Kate): Hi, so the dinner is going to be at 6:00 p.m. at PJ Clarke's – P.J. Clarke's which is caddy corner to – well, wrong hotel but I'll be walking over at – I'll probably be leaving in the lobby about 10 minutes to 6:00 so if people want to come with me, it's at the corner of 16th and K Northwest so it's about a block and a half away.

Shaconna Gorham: And so it's really easy. If you're standing in front of our building in front of the front door on 15th Street and you're actually – your back is towards the door, you're going to make a right and you're just going to go to the corner and make another right and that's K street and you walk down until you see the restaurant on your left hand side.

(Kate): But yes and I will be at the main building lobby at 5:50 if anyone would like to walk over with me.

(off-mic)

(Kate): So it will be – it's – what they'll do is it'll be separate checks and then you can use the per diem.

Shaconna Gorham: If there are no other questions, I thank you very much for your participation today and we will see you tomorrow at 10:30. Oh, I'm sorry, I'm jumping ahead of myself. We just want to open up one more time for public comment.

Operator: If you'd like to make a public comment at this time, please press star 1. And there are no public comments.

Shaconna Gorham: OK, so no public comments so yes, we are adjourned for the day. Have a wonderful night.

END