NATIONAL QUALITY FORUM

Moderator: Shaconna Gorham
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Operator: This is Conference # 31479440breakout

Shaconna Gorham: So, after the meeting yesterday, the project team debriefed and we realized that there were a few differences in how some of the TEPs deliberated on the question to what extent is this measure ready for immediate use.

And there is a change in the handout that I just passed out. So, the handout that you had yesterday, you can trash. OK. So, you have a brand new handout. And what we realized is that there was a typo in the handout that was different from the slide, so we made everything correct.

So, what you have in front of you now – I think Janice has the extra one – so what you have in front of you now, the question and the decision logic is still to what extent is the measure ready for immediate use. But to accommodate some of the discussions in all of the TEPs, we've added a different definition for high, medium and low.

So, if we can go to slide 28, I can discuss the changes and it's also in your handout as well. And while we're moving the slide, you'll notice that on the decision logic, initially the high met the measurable moved as a measure and if you received a medium or low, it moved as a concept.

So, we realized from all of the conversations in the TEPs that the qualifier here for ready for immediate use really should be is the concept or the measure in use in the Medicaid population. So, we made that the qualifier for

high, medium and low. And that really kind of recognizes the variability in the Medicaid populations and acknowledges that a typical NQF measure may not apply to all of the needs of the Medicaid population.

So to do that, we have the high definition as concepts already in use in the Medicaid population or measures that are fully specified and tested and in use in the Medicaid population. So, that means just because you're a measure doesn't mean that you automatically pass as a high; you have to be a measure and be in use in the Medicaid population.

(Off-Mike)

Shaconna Gorham: Yes. Or you could be a concept and we're going to say that those concepts are promising concepts which is a term that was used in the HCBS project. And so, you'll get a high and you'll move along that way.

Rob Schreiber: You can get a high?

Shaconna Gorham: From being a promising concept.

Barbara McCann: … (had) said that we were brilliant yesterday.

Female: Yesterday was ...

Female: Yes.

Barbara McCann: No. It reaffirms our brilliance, because we have some measures that you'll remember we were five and then we hit this one and we'd have to say low and then we'd go back up again. Well, now this allows them to go to at least medium.

Male: Oh, OK. OK.

Shaconna Gorham: And some of them high, exactly. And some of them high because it's used.

(Off-Mike)

Male: … (right – so we're building validity in those TEPS that have been used) in Medicaid populations.

Female: And it hasn't gone through NQF testing. So, it acknowledges that we may have...

Female: That used to be a Medicaid, right, or Medicaid-ready.

Female: Yes.

Shaconna Gorham: So, again, so the qualifier is that it's being used in Medicaid. So, if you're a concept but you're not fully specified meaning you don't have reliable and valid testing, but you are a concept, you are used so some of those measures like the one that we looked at, the adult access to preventive and ambulatory care, for example, we know that Washington State is using this, we know that they have data on this, so it's being used.

But the testing is not complete. It hasn't been endorsed but we are saying that OK, this is a concept and it's a high, it should get a high because it is in use, we know that it works according to Washington State and according to the conversation that we had, so we can move that as a high.

Male: Got it.

Rob Schreiber: So, I have a question.

Shaconna Gorham: Yes.

Rob Schreiber: So, does that change then our final scoring that some of the – what we had eight accepted measures and then four concepts, does any of the concepts move up to...

Shaconna Gorham: Right. So, I'll go through each one individually.

Rob Schreiber: OK. And we do it.

Shaconna Gorham: So, let me just go through the rest of the definitions. So, again, the high if you're a concept, you're already in use in the Medicaid

population, then you can get a high. If you're a measure, fully specified, tested and in use in the population in the Medicaid population, you get a high.

You're a medium if you're a measure but you're not in use in the Medicaid population. So, that would speak to some of the measures that are good but maybe they're only tested in the Medicare population. So, they're not in use in the Medicaid population but we know that it is a measure and you think that the measure is good and it has potential, it could potentially be used, so we'll give that a medium.

If low, it is not in use in the population. It has a numerator and denominator, but no evidence of testing, so that is those concepts kind of like we discussed that you all thought were good, it missed the mandate that CMS has but there's no testing but we want to move it along. It needs more development, so we'll give that a low but it still moves along the process.

So, does that explain that change?

Male: That's OK.

Shaconna Gorham: OK.

Female: Thank you.

(Off-Mike).

Shaconna Gorham: Yes. So, let me discuss those. So, let's go through those. So, right, we had 10 total; six of those were measures, only four were concepts. We had a very robust discussion and the way that you all discussed like Barbara said you were brilliant and you just didn't know how brilliant you were or NQF didn't know how brilliant you were.

So, we actually had the perfect group of experts together because the way you all voted and discussed is exactly that.

Rob Schreiber: So, just for the record, I'd like to know what your criteria for brilliant are, because I'd like to be able to quote that when I go back to Boston.

Female: ... it's NQF, I mean...

Shaconna Gorham: So, the first, the concept that we discussed, again, was that adult access to preventive and ambulatory care.

So, (Desi), if you can go back to the slide I think that was 25 with the definitions.

We said, you all voted that that measure, four of you said four and one said low. So, you voted as a high promising concept. So, that is when we include that into our measure set, just the recommendations to the coordinating committee, we'll note that. So, it was voted high, that is a promising concept, OK?

And so, the next one, the NQF 0647, the transition record will specify elements received by discharged patients, that you all voted high. You had five for high, so that, of course, moves forward as a measure.

And then the one that was very similar, the timely transmission of transition record, NQF 0648, you all agreed that that was a five as well. So, that moved forward as a measure.

Then we had the discussion about the individualized plan of care completed and, Rob, that is the one that you put forward. All five of you voted that as a low. So, I do want to ask do we want to revisit that conversation. Are we good with that, I mean, it will still move forward, it would just move forward as a concept that needs more development. And if helpful, I can read some of the comments that you all made for that.

Female: Can I clarify? We voted it low on just the element that we just discussed?

Shaconna Gorham: Just the ready for immediate use, exactly.

Female: All right.

Shaconna Gorham: So, if helpful, I can go back through all the votes. So, the first question in the decision logic regarding the CMS domains and key concepts, everyone voted a five. And then the question regarding the

opportunity for improvement and, of course, I am summarizing the question, I'm shortening the question, but if you want me to read.

Female: From yesterday, we have it.

Shaconna Gorham: OK. If you wanted me to read the entire question, I could, but to shorten the question, the opportunity for improvement, everyone voted five for that. And then the question regarding the efficient use of resources, there was one high and four medium.

But then we got to ready for immediate use question and it was five, it was a consensus for low. And then we discussed the importance of stakeholder and we had five votes for medium.

Female: So, could you put the new concept for consideration up again, the one that was just revised that we voted low on?

Shaconna Gorham: So, you mean the definition?

Female: Right. Yes.

Shaconna Gorham: OK. So, that's what you just ...

Male: What number was that?

Shaconna Gorham: That...

Female: Twenty-four.

Female: Hey, can I ask a question?

Shaconna Gorham: Yes.

Female: Since this is a concept measure with permission from Rob and Judit, could we add to it the plan of care or person-centric plan that's required by CMS?

Shaconna Gorham: So, again, we have to look at what's in front of us because it is what the developer has submitted as the concept.

Female: That's just the developer, so I'm just wondering.

Shaconna Gorham: Were you the developer, Rob?

(Off-Mike)

Shaconna Gorham: Oh, OK. OK. Yes. I didn't think so. I was like your vote wouldn't count because we would have to...

Female: Recluse you.

Shaconna Gorham: Yes. We have to recluse you.

Female: Yes.

Female: I just wanted to emphasize, again, from our conversation my understanding is we're talking about the same thing, and I wanted to make certain that my comments are reflected that it is an understanding, it's not just a medical plan, it is clinical services articulated, but then it also got the elements of the person-centered plan that we discussed yesterday.

I think that's something that's critical in terms of people who are not medical professionals understanding the intent of the measure.

Shaconna Gorham: So, I did include that in the comments. So, it's important to communicate this measure so a non-medical person understands that language. But with that being said, we can state that in the report, but, again, if in fact that the measure is what it is and it doesn't incorporate what you're asking, then that would be a different concept, meaning the developer would be working with it, start all over and that type of thing.

So, I can't speak for the developer, so I don't know the intentions behind the measure and that type of thing but if you're saying what is in front of you, looks good and you all think is important for the population, then that's fine. But we can't tweak what's in front of us.

Barbara McCann: And I think what we talked about yesterday was that actually from the medical side of the house the standard that's emerged is the patient-centered

plan. But if you're not from the medical side of the house, you wouldn't know that. So that when we say an individualized plan of care it means their stated goals, expected outcomes, et cetera, that's actually now in regulation.

Rob Schreiber: So, that's my question. This is Rob for the record. I was thinking about this yesterday, there's a lot of these terms that are used or phrases that if we went around the room or included the whole panel and you asked what an individualized plan of care, you're going to get 35 different.

So, just in the future as a potential opportunity for improvement for NQF, I really think there needs to be from the developers what they mean by that terminology, because if we're being held to, because trust me, I can switch anything to make it look like I want it to look. I'm very good at doing that.

So, I could say the individualized plan of care from my perspective is patient-centered developed in conjunction with the patient and/or caregiver, I mean, from my perspective because in my world that's what I do. Now, it is high risk, but it's the group that we're talking about but we do that with everybody. But high risk you could actually say high risk, well, what's high risk?

It could be anybody over 65 who has two or more chronic conditions. Well, that's it in 66 percent -- so I think a lot of this is really the specificity which I'm usually not very good about but with stuff like this, you really need it. So, as I'm thinking about this, how we interpret a plan of care is going to really potentially influence how we might vote, I mean, I'm just asking a question, what people think about this.

Shaconna Gorham: I think that's excellent suggestion.

Barbara McCann: I think it's an excellent point. Once you leave an area such as medicine where standards of practice are very defined and you go into the community, you go with people in different situations, without definitions of key terms we can't create the bridges.

Rob Schreiber: And just also to say even in the medical community, you still need that specificity, because I can tell you in the group that I work with that is in ACO,

patient-centered medical home plan of care, the plan of care rarely has the voice of the patient and/or caregiver.

As a matter of fact, I had to stop asking it because they said well, we don't it that way here. It's like well, how do you develop a plan of care for, you're person-centered, this is what a PCMH is about without the voice of the patient.

So, even in medical systems there could that difference.

Female: I agree. I agree.

Rob Schreiber: But you're right they're more likely to have a definition, an agreement. But you will see that practices look at it very differently, so...

Barbara McCann: And CMS now as illustrated by like home care is now running into regulation. Now, they've never touched physician practices so, yes, it's actually in regulation.

Female: Diane.

Diane McComb: I think the other emphasis here is that for the younger population of individuals with disabilities, they're looking at long-term services and supports in a much broader context than the medical arena. Person-centered planning is codified in the CMS rule; it's very specifically defined.

And in support of what Rob just said, if you talk to LTSS providers in the disability world, they're going to have different understandings of what person-centered planning is as well. There's no perfection there.

So, I think it's very important that there be an understanding and I know I've beat this dead horse but I am concerned that no one read this and then say oh, it's just medical, which is what they're going to read if they're not a medical professional because they won't understand plan of care is a term that younger people with disabilities go I don't need to be cared for; I want to be supported, accommodated, I want to be included. And they're going to see that as medical so...

Rob Schreiber: I agree with that. And that's why with the vitalized 360 program that we developed that we're now piloting in 34 communities, we actually talk about life goals and their life care plan. What is it, their strategies, what are the tactics that they need to do to reach those goals? But it's comprehensive; it may be involved dealing with pain; it may be more involved in terms of getting to walk more and dealing with a knee or having back surgery. That may be part of it but it's not just about the medical issues; it's about what's important to them and what matters most.

Barbara McCann: So, I'm going to ask that we move along to the next measure. Thanks.

Shaconna?

Shaconna Gorham: And so, I just want to clarify are we still OK with the individualized plan of care completed that will move forward as a concept. OK. And that was not so that was a yes for the transcript.

Female: Yes.

Shaconna Gorham: And so, the next one, referral to community-based health resources, again, five for the ready for immediate use, everyone voted five for that. And so, that will move forward as a concept, too. If you want me to back up to this first question in the decision logic, three members voted high and two members of the TEP voted medium.

And then that second question, opportunity for improvement, we had five votes for high. The question regarding the efficient use of resources, we had five votes for medium and then the ready for immediate use, we had five votes for low. And then we had five votes for importance to stakeholders.

And, again, just kind of thinking about the conversation, that measure or concept was not as far along as the other concepts discussed. OK. So, if we're good with that and I will continue.

So, the second one, the home and community-based long-term services and supports use measure definition, we actually had three votes for high and two votes for medium for that. So, that would move along as the promising

concept, so a little higher than the other ones. The conversation deemed that concept worthy of a high and medium. OK.

So, the last three were all NQF-endorse. One was 0326 advanced care plan and that you all voted five for that as well as the CAHPS home and community-based services measure number 2967, it was across the board five for high. That, of course, will move forward as a measure, and then gains and patients activation scores at 12 months, measure 2483, again, it was five votes. And so, that would move forward as a measure. OK.

And so, that sums up the votes for yesterday. We want to move on. Are you all connected to the web now? OK.

Female: Janice, did you get connected?

Janice Tufte: Yes.

Shaconna Gorham: So, we're on measure 44, call center. Yes.

Male: The gentleman over in the corner.

Female: Hello. Hi.

Shaconna Gorham: John, if you can introduce yourself.

John Shaw: Hi. I'm John Shaw from Next Wave up in Albany, New York and I'm on the coordinating committee and I've been going around to several of the different TEPs in order to get ideas on what we deal with and tasks for staff to accomplish between now and June to make it easier for us in June.

Rob Schreiber: Great to meet you, John. So, after were' done, I just want to corroborate that we were all brilliant from your perspective is that's OK.

John Shaw: Absolutely.

Barbara McCann: It's been a long day, John. OK. All right. But welcome, welcome and you'll remember this is the next group to which our recommendations go.

(Off-Mike)

John Shaw: That's fine as long as I can contact you to say, what were you thinking?

Barbara McCann: All right. We're at measure 44 on our list.

Shaconna Gorham: Do you all have your discussion guide open?

Female: Are you on point?

Female: We're on this.

Barbara McCann: Foreign language interpreter and TTY availability, it is the proportion of time that the TTY services and foreign language interpretation were available when prospective members who called the health plans' enrolling customer service phone number.

Right. Are we OK about moving to the first vote?

Female: No. I actually would like to have a conversation about this because this is meant for a Part C and D plans where people are calling before they enroll.

Female: Right. Right.

Female: So, that's not applicable in Medicaid.

Female: But we still need to go through the vote, right?

Female: OK. I just wanted to clarify.

Female: How are you all, we can discuss and...

(Off-Mike)

Barbara McCann: It is the Office of Civil Rights Regulation, right?

Female: Right, about the applicability of the Medicaid for this measure that's all.

Barbara McCann: We appreciate that, yes.

Rob Schreiber: Is it applicable to Medicaid or is it not applicable? It's a federal law; I would assume it's applicable, correct?

Female: It's applicable. I'm just speaking (inaudible) yes, it's not.

Barbara McCann: But when you look at the actual measure and tell me if I'm wrong on this, it relates to a health plan's perspective, not even an active enrollee.

Female: Right. Yes.

Female: Right.

Female: It's federal law, access to health care, I mean, that's how we look at it in Washington State and ...

Female: No. No. It is the federal Office of Civil Rights.

Female: Yes.

Female: Right.

Female: And we're thinking about health plans and not Medicaid offices then it would be applicable because most people ...

Female: Have you ever seen TTY in a Medicaid office? Maybe your state did but lots of states don't.

Female: We have that.

Female: Right. I mean, that's the problem. It's a health plan measure which is perfect, right, a health plan is appropriate. So, it wouldn't be used in lots of states but it's not...

Female: The only thing is (inaudible) more so than TTY in a lot of cases for the different.

Female: Yes. Yes. My only concern is that it's meant for marketing. Really, this is a measure for the plans that Part C and D who can do their own enrollment of people.

Barbara McCann: Right. And please note that it's also limited to a call center for the measure.

Female: Correct.

Janice Tufte: This is Janice. In our Medicaid, we have four different Medicaid plans and we that are involved with health literacy are always making sure that people have the access because there never is enough translation in access really.

And so, we really argue the button should be front and center on the plans, wherever it's easy for people to find and made it blind accessible this year. So, it was according to by pushing the federal law that we were able to get that, but I don't know.

Female: I completely agree. It's just that this isn't the right measure to get to that because it's related to specific health plans before people enroll and Medicaid people are prohibited from talking to their plans before they enroll, they can't. The state handles all the enrollment activities.

Male: They have to go to the state for that.

Female: Right. They have to go to the state first. They can talk to people. If this were a post enrollment in other words, how much is accessible when you need to reach the plan once you join, completely 100 percent makes sense. It's just the way this measure is constructed.

I'm not sure that it would – you could send this forward. I just don't think any states would take it up because it's not relevant.

Barbara McCann: So let's go through the measure and begin the voting process if we're – our discussion. OK. So, to what extent does the measure address critical quality objectives of CMS or program area key concepts?

Can I have a vote for high please? A vote for medium. A vote for low.

Shaconna Gorham: OK. So that's five votes for low and I just want to make sure that I have accurate rationale, so I think what I heard was that this is the

health plan perspective, not individual. It is a federal measure. Lots of states do not have TTY and it's limited to call centers. Does that kind of sum it up?

Barbara McCann: I guess, I hesitate on the issue of TTY and availability, yes or no. But the issue is it's a call center and it's for a prospective enrollee. It doesn't even – it's not even for an actual enrollee.

Shaconna Gorham: OK.

Female: All right. Got it. Thank you.

Barbara McCann: All right. We're ready now to move to measure 50.

(Off-Mike)

Barbara McCann: National Core Indicators – Aging and Disability. This is an in-person consumer survey tool. This is a long description.

(Off-Mike)

Female: That's all the measures I think …

Female: Yes.

Shaconna Gorham: Yes. It's all of the …

Barbara McCann: OK. Discussion?

Diane McComb: This is Diane McComb. I actually asked for the inclusion of both measure 49 and 50, the NCI – National Core Indicators and the National Core Indicators for adults, elderly, aging and disabilities.

I did send an email to everybody earlier this morning, trying to parse out the information on this. And if I could combine with your permission the conversation about both of these, because they were developed by the same entity, HSRI – excuse me.

Female: Can I comment? That would be very confusing to me because I'm not familiar enough with the actual survey.

Diane McComb: OK. OK. They are very similar. The differences are that one is applied to individuals aging and disabilities, physical disabilities. The other is applied to individuals with intellectual and developmental disabilities.

Barbara McCann: And the questions are the same?

(Off-Mike)

Diane McComb: Because NASUAD is the steward for the aging and disabilities survey. Forty percent of them are the same, but clearly, the individuals with IDD have different needs and different access to services, different types of services.

Female: Right.

Diane McComb: So they ask a lot of the same kinds of concepts that the CAP survey does, but this one is generated by the state rather than being developed by CMS, so …

Barbara McCann: OK. So I am going to ask to keep them separate and if they don't …

Diane McComb: OK. And let me just say then. I'll speak broadly in terms of the overarching development of the tool and then drill down more specifically. And I'm glad Camille is here because, of course, NASUAD is the stewards for the NCIAD.

The tool is in use and, Camille, maybe you can say the number of states, I believe eight.

Camille Dobson: For NCIAD?

Female: Yes.

Camille Dobson: Fourteen, fourteen states are using it.

Female: Fourteen states now are using the NCIAD.

Barbara McCann: We're going to – as the steward of the measure, we need you to recuse yourself from comments.

Female: Oh. OK.

Female: OK? Thank you.

(Off-Mike)

Female: I was hoping for clarification with this one.

(Off-Mike)

Female: And if I could, because I have a greater degree of understanding I'd say of the NCI, could we possibly look at measure 49 first instead of 50? Does it matter what order we go in? And then I could speak much more …

Female: It's fine …

Diane McComb: If that's OK. If we could back up then to 49, which is the NCI that would give me – I wouldn't be as hesitant in some of the things I might say. So the NCI, the National Core Indicators is a tool developed by the Human Services Research Institute. The steward in this instance is not identified correctly on the information we have. The steward is the National Association of State Developmental Disability Directors. And this tool is as of today administered in 46 states.

The data is collected and provides states with aggregate information about how well the state is performing in terms of person-centered planning, individuals receiving services that they say they need and want.

It measures things that are primarily non-medical in terms of quality of life, and as you look through this, you can see the domains, does an individual have a job if they want a job. Do they have the supports they need to maintain their job? How long have they been employed.

It talks about integrated employment versus segregated employment, so that an individual is employed in a competitive setting if possible as opposed to a sheltered workshop. Excuse me. And it's really great because all of these measures, if you just read through this, they're all articulated and identified.

It talks about if an individual wants to self-direct their services that they may, that there's a provision that allows them to do so. And self-directing services means in some instances if they choose to hire someone to support them in their home, that they are involved in the hiring process of that individual as opposed to an agency saying this is who you get.

And again, these are all choices that people make, that they have a choice in their housing. And again, if you consider the context for younger people with disabilities, many people are supported in group home settings, congregate settings.

And they – sometimes the appearance is, this is the option and this is what you get as a slot. This tool moves away from the premise of a slot that can be filled to instead an individual chooses to live where they live.

It also looks at things such as the ability to have opportunity to create and maintain relationships. Again, when you have individuals who are living in group home settings, sometimes the social interaction is limited to interaction with other people with intellectual or developmental disability as opposed to having an opportunity to interact with others in the community, with their non-disabled peers.

These things we've learned over time in research supports provide a greater likelihood of an individual achieving their independence potential. We look at how many people are satisfied with the supports that they receive. We look at whether or not individuals feel afraid or do they feel safe. So we're looking at these. As you look through the whole thing, this here, I think you can get an idea of the flavor of this tool.

As a professional in this arena, this tool I think would be a much truer tool to assess the satisfaction of an individual receiving HCBS LTSS and they say over the CAHPS HCBS addendum, because it really gets at the choices that people make in terms of lifestyle and how they live.

I provided a great deal, links if you will to the NCI website which supports the living reliability studies that have been done in the past. And the fact that this

has been used for a number of years and I'm sorry, I don't know the exact number, but I would say …

(Off-Mike)

Diane McComb: Yes. It's been around or at least 10 years, so now 15 years more, 20 years, the NCI. Very slowly, different states have added on each year. So, there is a great deal of information on the NCI website in terms of its applicability. Given that information, I would support this moving forward as a concept.

Barbara McCann: So let me make a few comments and one of the things that we're looking for here are performance measures that can move forward. That's our task with CMS and I have some familiarity, probably not to the extent you do, with NCI and NCIAD.

And the performance measures that come out of these are not questions, but they are measures with the – they have directions. Measures are little different than questions. Now, I'm not saying that patient reported outcomes are not important. They are.

I'm going to clarify with CMS because they're still here just to be sure that they are agreed, because we've had many conversations about many, kind of, areas that we need to kind of confirm with them. And when I did at the beginning presentation to everybody, I was trying to say that there are measures and surveys and there are tools that are used in measures, but the tool itself, one of the other members of the – one of the other TEPs brought up that she wanted us to have some screening tools, but they weren't measures.

So we told her like the depression scale, it's in a measure and that's a measure. It is a direction. So, I don't – I just want to clarify with CMS that they are – I mean we had a conversation with them before I made that presentation and presented that slide and they agreed with it. We read it to them and they said yes. But I don't want to in any way have you feel or anybody here feel that we are not supportive of patient reported outcome measures or whatever it – performance measures because we are.

And we know of a lot of research going on around the country now with Mathematica as well as I think was one of your – with one of the related organizations to NASUAD I think it is, HRSA.

So we know they're actively working on developing performance measures that have directions. And I don't know if that's confusing to people, but I was just trying to – when they look at what they're going to put in their measure set at the end of the day, they're going to want to put in, I believe, performance measures that are part of it.

So I'm just going to clarify with them that they are in agreement with our understanding and what we talked them earlier this week.

Female: So are – excuse me, are you asking us – do you want us to hold our votes on these?

Barbara McCann: Would you just hold? I'm going to try to grab – she's actually in our meeting downstairs. I was just going to pull out …

Female: Karen.

Female: Karen. I'm sorry. And I just see whether Karen …

(Off-Mike)

Female: She was in the meeting I just came from would want to assure – one way or the other because it's our contract. It's not that we don't agree.

Female: Sure.

Female: Or we don't think this is fabulous. So I just wanted to erase that.

Diane McComb: Well, if I could clarify, each of these measures has metrics. They have a numerator. They have a denominator. It's a consumer satisfaction survey. The intent is like the CAHPS survey, but it's focused on long-term services and supports for a very specific population for whom other measures don't work.

I understand your desire to or your need to be in compliance with the contract and so forth, but I guess I am thinking there is not enough information that's been shared to have – to negate this going forward as a concept at least, because I think the information is there that would allow states – I mean, states are using this now.

Female: So …

Diane McComb: Medicaid is using this now.

Barbara McCann: If I could offer, it'd be great if we had clarification. Because I think if we knew then it could even go stronger depending on where it goes …

Diane McComb: So – oh no, I think that's important. I just wanted to say I don't know that all of the information that is needed is presented and because I didn't write this tool I'm not the best one to necessarily defend it one way or the other. But I do know it is in use in 46 states. And that's through waivers, through Medicaid funding. So it's definitely got a history that would substantiate I think the data that you're looking for.

Barbara McCann: I think it's a contract definition.

(Peg Terry): I'm sure they know these surveys.

Female: Yes.

(Peg Terry): I will say the HCBS one that just (inaudible) they did have performance measures that were evaluated and tested within 19 of them, so it is some of the – just so you know. There are surveys that have …

Rob Schreiber: So that's the question I have for you, (Peg). I know it's a survey, but the way I – maybe I'm misunderstanding this. But there are performance measures embedded in the survey. I mean, so with the tool I used is not for Medicaid populations, actually it is for – can be used for Medicaid but the (Inter-I) tools they are surveys that are done.

But they are performance measures. They are actual objective measures embedded in that survey that you pull out. So, in fact, you can make – I

mean, I think you can make the case that even though it's a survey or it's a tool that's being utilized, there are embedded measures in there that you would pull, right? So am I understanding that correctly?

Female: Well …

Rob Schreiber: Or is that …

Barbara McCann: I can't speak here. OK. Now, I can. Sorry, what I'm saying is that some of them are questions and some of them are not questions or not performance measures and some of them may be.

So before this meeting, we were talking, we were saying, do we want to pull out particular performance measures as concepts? And that's something that would really be easily answered, I'd say yes.

But I wanted to just ask them – do you see where I'm going with this?

(Off-Mike)

Shaconna Gorham: Yes. OK. I'll be back and so I just emailed her, so she's coming up.

Female: OK.

Female: Oh, fabulous …

Shaconna Gorham: So the brilliance, (Rob) in what you just said, yes, is that we at NQF when we look at a survey, we are endorsing the measures in the survey, so you are exactly right. So the measures are what are evaluated and looked at. And so those are what are endorsed. The thing with the NCI tools, as I understand it, those are questions and not measures.

(Off-Mike)

Shaconna Gorham: And so that is the difference the CAP survey and the measures that are endorsed. So we can put forth that HCBS recommendation of a survey because we know that those have performance measures in them.

The question here is does the NCI tools have – I'm sorry, performance measures or questions, that is the …

Barbara McCann: Could you give us an example? That might be happy – I mean, helpful if you could just give us an example of how one of, questions would be a measure.

Female: Well – yes, if you could pull it up.

(Off-Mike)

(Peg Terry): If there are performance measures in here – there, even if they're not NQF endorsed, they could go forward as concepts. We don't – so surveys can be tested, but in addition psychometrically, they have to be tested with the measures within them.

It's a separate level. It's the same thing with tools. Tools can have psychometric properties. Are you checking your --?

Female: No I'm not …

(Peg Terry): Yes. And so – but they are not measures necessarily. And so, we're in the business here of measures, but I am saying that if there are some that you think are measures within there, even they're not NQF endorsed that a measure would be the proportion of people who – I don't …

(Off-Mike)

Female: Right. Who are …

Female: ... and define it by the number of people, versus the number of people …

(Peg Terry): Right. So you can have a denominator. You can have a numerator. I mean, having a numerator and a denominator are important for a concept. It doesn't mean that it's been tested anyway. So we could have – it could move, but not the whole survey. That's the point I guess I'm trying to make.

Barbara McCann: All right. Now, I get it.

Rob Schreiber: So we would have to go through and see which of the questions are actually potentially measures that have been tested or are being tested or we would suggest to be tested.

Rob Schreiber: But …

(Peg Terry): Yes. I think you probably are not going to find any – many that are being tested today.

Rob Schreiber: Right.

(Peg Terry): But they may be and written as a numerator and denominator. I don't think all of them are because I remember reading this HCBS, writing this HCBS report we just did and some of them were questions and some of them weren't, so just wanted you to hear that. And …

Rob Schreiber: OK.

(Peg Terry): I don't have it in front of me. I'm just trying to tell you how we see it here.

Janice Tufte: This is Janice. I just want to add one of them I think is in the process of being a measure if not proportion of people making a transition from a hospital, a long-term care facility who had adequate follow up.

(Peg Terry): Perfect.

Janice Tufte: Yes, I mean, that one ...

(Peg Terry): That would have – you know that would have – anything with a percentage of proportion has denominator has a numerator. That's perfect. That would be great. Are you happy today because somebody saw you? Probably not. Do you see what I'm saying?

Sometimes they just have – it's just a question. And I'm just trying to differentiate to help you all.

Barbara McCann: OK.

Female: OK. You wanted to go through the concept …

Female: It could go …

(Off-Mike)

(Peg Terry): What you just said would be a concept if it's not – if we don't know that it's tested.

(Off-Mike)

Female: OK. OK. All right.

(Peg Terry): Does that make any sense?

Female: Yes …

Janice Tufte: In other words, if it's not being tested or being used in a validated area it's just a question and not a concept.

Female: No, no, no.

(Peg Terry): I mean it's written as a question.

Female: Oh, OK …

(Peg Terry): That's – so a question is are you happy today?

(Off-Mike)

(Peg Terry): What?

(Off-Mike)

(Peg Terry): No, I'm just saying if there is a question, I think there are some just questions in here where that's written as the proportion of people that left the – had housing in the community. Well, that would be a numerator and denominator in there somewhere. I don't know …

Female: Oh. I'm just, sort of, coming back to the procedure then. I think I understand your argumentation, that it's a number of individual measures that are individually and independently tested and then pulled into a survey tool, so I got that.

But it's sort of coming back, falling back on our procedure. We are voting on what's in front of us and there is no room at this point to cherry-pick if you wish, that from the 20 bundled measures this committee would vote for picking two and moving forward. That's not in front of us.

Shaconna Gorham: No. So, you are exactly correct. So – and I'll go back to the example of the HCBS survey, because that is the one that I know best. So, again, they have individual performance measures in the role of, for example, the CDP standing committee. They look at each of the measures inside of that survey.

And they evaluate that and they are endorsing. Those measures are eventually endorsed. And so, you have the entire survey. Now what I do understand, some states do, they may not report or use all of the measures in the survey at that point at the state level. They decide what measures they want. But for this particular committee, when we look at a tool, we would be looking at the entire – I'm sorry, look at the survey. We will be looking at that entire survey.

We don't have the luxury of like you said, cherry-picking one measure over another. And this tool, NCI tool because we know that some are questions, some may be measures, but we can't say, well, we want this one over the other one. That is not the role of this particular TEP. So what you would be saying is we're looking at the entire NCI or NCIAD survey or tool.

Barbara McCann: So can I – let me try to express this. So what we're looking at or looking for is a group of measures or measures that have been grouped in a survey using the patient voice as the source, right?

Female: Go ahead …

Barbara McCann: Is that – OK. All right.

Male: The numerator and denominator.

Female: Right.

Female: Numerator and denominator.

Male: That has been tested and validated for …

Female: Not. Right …

Barbara McCann: So it's measures put in a survey. The survey is the mode and the folks are the voice.

(Off-Mike)

Male: It could be really good. We really need it.

Diane McComb: Yes. If I could, I hear everything you're saying. I understand everything you're saying. I just want to point out; I believe this is the only tool that this committee has looked at that speaks in the language of younger people with disabilities. And I understand the logic that has been explained. I hate to think this is the only window that there is for this to go forward.

(Off-Mike)

Diane McComb: I get it. I'm just saying people with disabilities have lived in a system that has been dominated by medical measures and I think every single measure we have proved that of the 10, the concepts, all deal with medical-based performance measures, which are not relevant to LTSS other than the context of if you move from a nursing home into the community, it's good to have a plan of care or the person-centered plan available. But it emanates from that medical place first. So, I ask you to just consider what are we saying to people with disabilities about how we're going to measure as a nation their satisfaction with services they receive.

I'll give you a very quick example. When I worked with the State of Maryland, our Medicaid office said that people with disabilities were very happy and satisfied with the medical services they received.

And I said, "OK, what are you – what are you measuring because this is not what I hear from people with disabilities." They were measuring – they were using HEDIS measures. They were measuring the incidence of decubitus ulcers, the number of emergency room visits and the number of readmissions to hospital. That has nothing to do with quality of life in the community for people with disabilities unless you happen to fall into one of those buckets and you have a decubitus ulcer today, you want it fixed. But for the average person with a disability, it's not a relevant measure of their satisfaction. So we are informing our systems with data that's irrelevant to the average person who's younger with a disability.

Rob Schreiber: So, Diane, so I feel your pain, but geriatrics has been dealing with exactly the same scenario for decades. And so I don't – so I want to reframe what you're saying. This is not the only shot.

Diane McComb: Right, right.

Rob Schreiber: I think whoever developed, I would – this is my – what I would say, that the group that developed, whoever developed the core indicators as well as for the next measure that they actually test, take a core group of measures, they do a short form that where they have a numerator-denominator where they can actually test it, put that to a test.

Female: Can I just add a point of information that ACL is funding?

Rob Schreiber: Yes. Oh, I know, I know. That's right.

Female: Right? We do testing and validation to start the NQF endorsement process.

Rob Schreiber: Exactly.

Female: So I think 20 measures within, I don't know, two or three years.

Rob Schreiber: So I think it's a process. So it's a process. Yes.

Female: That's the information.

Rob Schreiber: So whatever – but I would say make certain that those measures…

Shaconna Gorham: Yes. And I'll just add – I'll just add to that, and they have met with us so they are in the process.

Rob Schreiber: OK.

Female: But it's a process.

Rob Schreiber: Right. You have to go through – my point is it's a process and there is an approach. It's methodical, it's painful, but there's a reason for it. And so we did have – so I just want to reframe it. It's not the only shot, in fact, this is moving ahead so that they can actually meet the standard and really advance this. So in one sense, this has not been a futile effort, this is if the ground work, the foundational pillars by which we're actually going to be able to get meaningful person-centered measures for the young disabled.

Barbara McCann: And I would add, the message is nothing to your community. The message is unfortunately there is a process that you have to go through.

Rob Schreiber: Right.

Barbara McCann: The legitimization of that process whether or not we think it's required or whatever else, will bring them so much more benefit in the long run. So it's not a message of pro or con or they're not important. I think that's very important to understand.

Diane McComb: I want to thank the rest of the members for indulging me in the commentary. Thank you.

Shaconna Gorham: It is, again, robust conversation. It was really good. I mean I think what you are expressing is the frustration in the LTSS community. I mean we all know it. We know that measures are in development, they're just not here yet, but in the process.

Barbara McCann: So do you want to go – leave these two and come back?

Shaconna Gorham: Actually, let me grab Karen because she's right outside the door.

Barbara McCann: OK. See what their pleasure is. You did get the brakes put on.

Female: I did what?

Barbara McCann: The brakes put on.

Female: I'm sorry.

Barbara McCann: The brakes were put on.

Female: I'm not sure that's ...

Female: No, it is, it is, it is. This is how this goes.

Rob Schreiber: It's the way the process. We'll leave that.

Female: It's the way the process goes.

(Off-Mike):

Rob Schreiber: No, no, no, no.

(Off-Mike):

Rob Schreiber: No, no.

Female: This isn't United Airlines.

Rob Schreiber: Oh, it happened at Delta, too, the other night.

Female: Oh, it did?

Rob Schreiber: Yes, but that was somebody who really pushed the button. So – but I don't she was beat up or traumatized. She was dragged out. Oh, yes, they dragged her out.

I think the problem is that for LTSS it's really – it has been so siloed, so not understood. It's been so segmented and yet so critical even though started in the 16 on the '60s with the Older Americans Act, the reality is that, in fact, it's just been a poor stepchild and now all of a sudden there is this acceleration of understanding the importance of LTSS in terms of health. Matter of fact, there was an article just in U.S. News and World Report or USA today about comparing us to five countries and about how poorly we perform. And I listened to the…

Female: TED talk?

Rob Schreiber: Yes, the TED talk by Wilkinson and it's like and then there's looking at where we spend money on medical care versus – I mean it's very clear now that this is needed, but we have to have metrics, and if we don't all you're going to do is throw bad money, because we're not going to know what's effective and not unless you measure it. So this process, as painful as it is, is really essential, but ACL has been really behind it and I know they've been they have this business in Aging Institute to help uphold the aging and disability networks together.

So I think this is a real sea change and it has been validated. Most health systems insurers understand that LTSS is needed, but they don't have metrics. So if they want to contract with a group, how are they going to know it's effective, you know? And there needs to be – and those metrics need to be, as you said, Diane, specific to the person. It's really about person centered. So the fact that this is actually happening, I think that if they can get some validity on these, it's going to leapfrog and move in a much faster way than most other metrics have.

Diane McComb: You're right about the methodology not being in place nationally. We know the states that implemented the Medicaid buy-in that allowed people with disabilities to go to work and keep medical assistance, that the people with disabilities had lower claims against healthcare, against Medicaid after they were working. And it didn't matter if they're working 2 hours a week or 40 hours a week.

Rob Schreiber: Yes, yes.

Diane McComb: Working improves health, it improves one's sense of well-being. We know there's a number of studies going on right now about providing housing to people, lowers healthcare costs because of stability of housing. We know that people who report that they are – they have – they're engaged socially and are not lonely have better healthcare outcomes, lower cost against Medicaid.

But there's no systematic way that these measures, these social determinants of health and well-being are being measured in a scientific fashion. But we know and I would think any Medicaid office would want to know these things and understand we have the potential to lower healthcare cost, improve quality, which is the goal that we all would have so…

Barbara McCann: Thank you.

So, Karen, you're going to address us on the method.

(Karen Amstutz): Yes. And so I'll kick it off because I don't have the full context to it. But I think the big note is I think when we talk about the core indicators it is – it meets so many of the different points in decision logic, right? I think like most they tend to fall down on scientific and validity, but I feel like we would be remiss not to acknowledge the importance and the fact that so many states are already using this. It's just a matter of kind of finishing off that tail end of the validity testing which so many Medicaid measures fall into that bucket. But that doesn't mean they're not important or irrelevant.

So I think just based on the definitions, they probably fall under that concept bucket. But I think it's so important to include that in there and to have the state be the ultimate decider, right? Could we move forward with something like that? And I think it sounds like the other issue was the other part that's common which is the efficiency and resources.

And I would say depending on the state, I mean who knows, right, because given where any state is, they could just have a bad EHR. So it's like I feel like data sources are so state-specific, right? So I think that's just a piece – another piece of Medicaid measurement we just need to acknowledge.

So it sounded like it was shading so many of the decision logic points it needed to move through and it sounds like it just doesn't hit the scientific piece which would put it into the concept, which in my mind I think still keeps it on that final list, just with a notation.

Is that right, Shaconna?

Shaconna Gorham: So I think what we should do because we had a lot of discussion, I think what we should do but we didn't actually go through the logic so I think we should run and do the logic and see how folks fall with the vote on each piece. It would eventually, if it passes, would fall as a – as a concept because we are missing some of those testing parts.

Rob Schreiber: So just following up with what Karen said and I don't know the specifics, maybe Camille and Diane do. In terms of testing, there are – some of the survey questions are being tested as measures ACL has actually funded. So the question would be just what percentage like it's a short form type of thing that would pull out those metrics, that would be defining metrics based on the questions that are actually being tested. So even though it's a concept, it's actually potentially – I don't know which ones are being tested as we speak. Correct?

Shaconna Gorham: So, yes, I don't know the answer to how many of the actual questions are being tested as measures. And maybe, Camille, you do know the answer.

Camille Dobson: We're going to – between the two tools...

Shaconna Gorham: Switch your mic on.

Camille Dobson: Oh, sorry. Between the two tools, it's 20. Right now we're – because the states own the tool, we're going back and getting their feedback on what they think would be the most relevant taking into account what HCBS CAHPS has already done. So we'd like to give states, if they wanted, a different set of measure, if they wanted to pick or not picking exactly the same ones that CAHPS had endorsed, got endorsed. But we're not supposed to start the

testing until next year's administration, so what we'll do is go out and while we're doing the survey I think, if I understand it, to do a smaller, take a few of those to do additional validity testing while we're delivering the full survey because the states are, you know…

Barbara McCann: But we can acknowledge that in our remarks, right, and look at it as a concept, correct?

Shaconna Gorham: Exactly. So can I just ask? So the testing is supposed to start next year and you said 20 measures between the two surveys. Can you just tell me how many measures total are on both? I mean how many questions or measures are --?

Camille Dobson: I don't know. We have – I think there are 58 questions on the NCIAD and I think about the same…

(Off-Mike):

Camille Dobson: Yes. So that's why I said there's a tremendous amount of overlap. We differentiate when some of the questions, for example, about employment don't work for older adults, right? So we've got – we've got to opt out and sort of skip logic that doesn't apply for some populations because we're dealing with TBI folks, aging and lots of these. But luckily for NCI, they've got a fairly "heterogeneous" population that they're surveying. OK.

Diane McComb: I don't know if the average individual recognizes the way that funding is differentiated. There's a, 1915C waiver supports six different populations. People with intellectual and developmental disabilities are one of those populations. They're rather large percentage of the way for population. I'll just give you of an idea. The context, $72 billion of state and federal funds go into the publicly-funded system for individuals with IDD. So it's a pretty big chunk of services that are funded by CMS and states.

The NCIAD is looking at the aging population, also elder waivers that are funded against the HCBS 1915C waivers and also other disabilities that would not include people with intellectual and developmental disabilities. They would not necessarily have the same – well, traumatic brain injury, for

instance, can be acquired after the age of 22 so the person wouldn't fall into that developmental disability bucket, if you will. So I think that's the differentiation that's made is those.

Shaconna Gorham: OK. So I think that that is helpful. If we could go to 50, yes, and just go through the logic.

Barbara McCann: We're going to do 50, measure 50, and go through the logic. Any other clarification questions? Fifty rather than 49. We're going to 50.

Female: OK.

Female: I just want to make sure.

Barbara McCann: We're going to 50.

Female: OK.

Barbara McCann: All right. So this is the national core indicators, aging and disability. To what extent does this measure/concept address critical quality objectives or identify key program concepts? May I have a vote for high please?

Shaconna Gorham: Can you cut your mic off please? So for the record, that was five votes for high.

Barbara McCann: OK. The next concept is the extent that the measure or concept addresses an opportunity for improvement and/or significant variation in the program area. May I have a vote for high please?

Shaconna Gorham: OK. That was five votes for high.

Barbara McCann: The next concept is to what extent does the measure demonstrate efficient use of measurement resources? May I have a vote for high, please? Yes?

Rob Schreiber: Point of information. Do we know whether or not any of these or a significant number of these measures or these questions are being asked or how measures or actually are measures, do we have any sense of what's being done now?

Barbara McCann: We're talking about aging and disability.

Rob Schreiber: Right, aging. Yes, I'm just – yes.

(Off-Mike):

Camille Dobson: I'm sorry. What was the question?

Female: The number of NCIAD's that are considered measures.

Rob Schreiber: I mean the question is ...

Camille Dobson: They're all – they all come out into proportions so they all have numerators and denominators, right?

Rob Schreiber: Yes. So I get that. The question though is is there something in place that's being done now that this is either – that are there other – are there other methodologies being used to assess the type of innovation? I know the NCI had 46 states, this had ...

Camille Dobson: Fourteen.

Rob Schreiber: Fourteen states.

Camille Dobson: Yes.

Rob Schreiber: What are the other 30…

Camille Dobson: They're not surveying their aging and disability.

Rob Schreiber: They're not – OK, that was my question.

Camille Dobson: At all. That's the issue. So they're not giving it at all. It's just an optional activity that, of course, as you know, is expensive and so states have chosen not to do it.

Barbara McCann: OK. Good. All right, so we'll go back. For the concept and measure and this has to do with efficient use of measurement resources. Can I have a vote for

high? Can I have – are we good? OK. Can we have a vote for medium please?

Shaconna Gorham: So for the transcript, Rob, just explain to me your question just to – and why...

Rob Schreiber: Let's see. So for the – for measure 50, I wanted to know if, what was being done in terms of asking similar questions and/or measures by the other states that are not utilizing that survey to see if there was duplication or if this was there was nothing in place of this.

Shaconna Gorham: And the answer was there is not.

Rob Schreiber: There is not.

Shaconna Gorham: OK.

Rob Schreiber: From what I understand from Camille, assuming Camille is correct. I have no reason not to think so.

Camille Dobson: In the nine states who tested with the HCBS CAHPS survey could have had aging and disability folks in there, but of the nine states, five of them are also doing NCIAD so it really – so you say 14 plus 4 so 18 maybe of the states are surveying.

Shaconna Gorham: OK. So for the transcript, that was two votes for high and three for medium.

Barbara McCann: Right. The next concept for voting is to what extent is this measure ready for immediate use. May I have a vote for high?

Shaconna Gorham: And remember we have the new definition for high, medium and low.

Rob Schreiber: And that's definitely right.

Barbara McCann: This is the new definition.

Shaconna Gorham: Yes.

Barbara McCann: All right. So let me do that again. A vote for high. May I have a vote for medium?

Rob Schreiber: Point of information. There's a category here that it's being used in Medicaid populations. Has a numerator and denominator but doesn't have yet evidence of testing. So that's like another bucket. It's another bucket that at least that's the way I'm reading this. So what do – how do I vote?

Barbara McCann: Between medium and low? Is that what you're asking or…

Rob Schreiber: No. I actually think there's like – yes, I think there's like another bucket. So you have used in Medicaid or not used in Medicaid. That's your split.

Barbara McCann: Right, right.

Rob Schreiber: And then if it's not in used in Medicaid, then it's numerator-denominator, but there's not a Medicaid numerator-denominator that does not have evidence of testing. There needs to actually be another bullet here for this measure. Are we – I mean that's because I don't know how to vote on this. I mean – I mean if I had to pick one, I'm going with high because I got two out of three there.

Barbara McCann: It's a minus high, right?

Rob Schreiber: Well, I don't know. I don't know. So I don't know how we feel with that.

Shaconna Gorham: You bring up a really good point because…

Barbara McCann: Once again, our group.

Shaconna Gorham: Right, I mean but that, again, speaks to the variability in the population and how we came up with the definitions. I mean if you – and because we want to be consistent, if you read what is on the screen, this would be a promising concept, because it is a concept already in use in the Medicaid population so…

Barbara McCann: So we can go before the slash.

Shaconna Gorham: Yes.

Barbara McCann: We can make a ...

Shaconna Gorham: It goes up with the slash because remember after the slash you're talking about the measure that is for the specified and tested and used in the Medicaid population.

Barbara McCann: So what is medium, a concept or a measure?

Shaconna Gorham: So medium is actual measure but is not used in the Medicaid population. So that could be a measure that you use in the Medicare population, but you all think that it could be used in Medicaid, it's just not used right now. So I mean when you look at this measure, these NCI and NCIAD…

Barbara McCann: Yes.

Shaconna Gorham: … you are saying if you're voting because we know that it is used in more than one state that is a promising concept so you would be voting for high.

Barbara McCann: OK. Good clarification. Good clarification. We'll begin the vote again. All right. Concept measure is, the concept is ready for immediate use with regard to the definition under high.

Shaconna Gorham: Is the concept already in use in the Medicaid population?

Barbara McCann: OK.

Shaconna Gorham: So for the transcript, that is five votes for high.

Barbara McCann: All right. To what extent do we think this measure is important to state Medicaid agencies and key stakeholders? May I have a vote for high?

Shaconna Gorham: All right, for the transcript, that is five votes for high. So for this measure concept, it will be recommended for inclusion in the program measure set.

Barbara McCann: Right.

Shaconna Gorham: So we can do one of two things. Often, when we have like measures so we have the NCIAD and the NCI, we can let the folks in the conversation carry forward for the next measure, number 49, or you all can have a separate conversation and take it up as a proposal, it's up to you.

Barbara McCann: I know. So that proposal on the table is that the national core indicators is a different population acknowledging there are some population–appropriate questions. Do we want to continue to vote individually or do we feel that the votes that we just cast for the NCIAD should be repeated for measure 49? In other words, do you want to individually vote again.

Rob Schreiber: So my question is given the fact that the NCI has a lesser number of states… I'm sorry. They have the greater. That's right. Thank you.

Barbara McCann: Right. Right, right.

Rob Schreiber: So they actually have a greater number of states so it'd actually be more valid in terms of the reasoning if we're using similar reasoning.

Barbara McCann: Right.

Rob Schreiber: OK. That's…

Barbara McCann: OK. Right. So population…

Rob Schreiber: So I would move that we take a movement here…

Barbara McCann: Right.

Rob Schreiber: … that we utilize the vote previously for the vote – for this indicator.

Barbara McCann: Right. Any members who disagree?

Shaconna Gorham: I'll second it. OK. So for transcript purposes, for measure 49 national core indicators for the first step in the logic, we have five votes for high. For the second step, we have five votes for high. For the third step, we have two votes for high, three for medium. And then we – for the fourth step, we have five votes for high. And the last, very last step, we have five votes for high, so this would move forward in the recommended as a promising measure concept for the measure sets.

And so just indulge me because there was a lot of conversation, give me – excuse me – one or two summary lines of why we want this and, other than the fact that I know that I know that it is used in many states and it definitely addresses the population. Do we need more than that?

Diane McComb: I would say in summary that this is a concept measure that speaks to people with disabilities and people who are aging in LTSS settings and focuses primarily on the elements important to them in their lives versus the medical side driving the measures and important to people with disabilities.

Rob Schreiber: And just to add to that, it's sort of the mirror – well, I'm not going to say mirror image, but it's sort of maybe in parallel track to what types of surveys are being done for people in hospitals the H CAHPS surveys and the insurance plan surveys about patients – well, they're patients, but individuals' experiences, client's experiences with systems of care and that there really needs to be a parallel this is a parallel approach to ensuring that the voice of the client gets heard.

And I think the record should reflect that ACL, understanding with the disability community and aging community that these measures need to have validation or pursuing at least a subset, 20 of these measures to being fully tested and first with validation and then replicability and sensitivity in terms of the measures and then moving it forward to see whether or not they're valid.

So that this is a work in progress, it's actually moving down the highway pretty quickly and that we anticipate in like a year and a half to two that these

measures, we will have an answer whether or not these measures are valid. These questions posed as measures are valid.

Barbara McCann: This is Barbara, I would like our record to reflect that this is an appropriate measure for the populations that we're talking about today. I would not like to include the comment "as opposed to medical."

I don't think it does anything for us to create the visions between measurement, it's good solid measurement is what we're looking for from that perspective. All right. Can we move to the next domain?

Shaconna Gorham: Let's see if we have public comment before we move to the next domain because that ends the patient and caregiver experience domain. Operator?

Operator: At this time, if you'd like to make a public comment please press star then the number one. There are no public comments at this time.

Shaconna Gorham: Thank you. Yes.

John Shaw: Hi, John Shaw from Next Wave. One thing that I think would be useful in June when the coordinating committee looks at this is they have some sense of if it's known at the time, what are the 20 sub-domains that are being evaluated scientifically. And I believe that the overall pool has some sub-domains and then questions within, and how broad are the 20 questions covering those domains.

Barbara McCann: John, would it be helpful to have copies of the survey, is that what you're asking?

John Shaw: I think part of the reason that we're looking at this is accelerating innovation and the most likely areas for that acceleration would be in the 20 areas that we have better validation of if we do this, this is what we validated will be some of the result. So if we're trying to shift things quickly knowing what some of those domains are would be helpful to evaluate.

Barbara McCann: And if they're not available (Camille), what would you think would be a good substitute, because many of the coordinating committee members may not be familiar with this at all.

Camille Dobson: We have summary documents and I know (inaudible) does too for their surveys, they give us snapshots because we have to provide it to states, right?

Before they take it up they want to know what it is that's going to be measured. We have it broken down in domains of assessment and then samples of the measures that are in each one, would that be useful?

John Shaw: I think there's, some of that's online already. For the full 58-plus, some overlap but another 58 which is 100 measures which trying to look at parsimony, looks like a whole lot. Twenty that might be useful in the short-term would be helpful if they're known.

Barbara McCann: Would it be appropriate for us to send that to staff to distribute to the coordinating committee?

Shaconna Gorham: No, I was going to say, so part of the process not only will we have the transcript from the meetings from yesterday and today, but we will also after we have the measures, the list of measures recommended for each TEP, try to find as much information, more information.

So that when we send this information to the coordinating committee, we can embellish even more of what we might have not had initially. So, yes. So if you have more information, please send it to staff and we'll start to collect that.

Barbara McCann: Great. So then let's start with population health and prevention. Two measures, the first is measure 59, which is the percentage of all plan members whose physical health was the same or better than expected after two years. Discussion.

Rob Schreiber: So this is a measure that's being – I'm just trying to think that there are other measures out there as well. I guess my question is, how is this measure being

– is this a self report measure? Is this a physical assessment measure? Is it a timed measure? Anyway…

Barbara McCann: How do you judge its health…

Rob Schreiber: Exactly. And physical health. So I could be physically OK but I could be terrible in terms of mood. So I'm really…

Barbara McCann: I think you make a good point. It is limited to physical health.

Rob Schreiber: So I'm really concerned that this is related to physical because with older adults and disability populations, it's the mental, physical, and spiritual, it's really the whole person and this is really segmenting a measure that should really be more holistic.

Judit Olah: I just want to expand upon that. For the chronic health population, we are not improving the health. We are enabling them to manage their chronic condition better.

Rob Schreiber: It's really about function. It's allowing people to maintain the functions, do the things that they need and want to do and at least the populations that I deal with including disability populations, it's really about the whole person that they're able to meet the needs, they're able to problem-solve, they have the resources to be able to do things they want to do.

So I'm just trying to understand what this is about, why this physical health?

Barbara McCann: We may not know. That would be the measure, the creator. Do we feel we're able to vote? OK. The first vote is the extent to which it addresses critical objectives or key area concepts. May I have a vote for high? May I have a vote for medium? May I have a vote for low?

Shaconna Gorham: OK. Improving or maintaining physical health, we have votes for low. So the measure stops there and it will not be recommended for inclusion.

(Kiana): This is (Kiana), can I just add one thing on this in the blind and low vision community, we talk about this a lot because blindness isn't more than likely going to be cured, and that's considered part of their physical health.

Barbara McCann: All right. The next measure is measure 62 and I'm the lead discussant on asking for that to be reconsidered. I would ask you to look at the measure specifications. I think it's a little bit clearer there.

My primary reason for bringing this up is I am a believer in structure. And this particular, excuse me, concept actually requires that there's physical, mental, and psychosocial considerations in the assessment done by a managed care organization. So while it doesn't define the scope of what those should be, it at least addresses that those three aspects are included, so physical, behavioral, and functional components to determine the member's needs.

Rob Schreiber: Where does that say that? Barbara, you're bringing up information that I'm not, I guess, aware of. So anyway, it's 62, right? I just want to make sure.

Barbara McCann: Sixty two, right.

Female: It's the like previous measurement.

Rob Schreiber: I just want to make sure I'm reading it right.

Barbara McCann: Actually, what I think I recommended was 61 because 62 doesn't make sense.

Rob Schreiber: I'm looking at 62. OK. I'm not seeing physical. I'm sorry, I thought I was…

Barbara McCann: Actually, (inaudible) 61 which is the number and percent of waiver participants who had assessments completed by the MCO that included physical, behavioral, and functional comps from which to determine the needs. I would recommend we vote on 61, because 62 I did not recommend.

Shaconna Gorham: So 62 was obviously a typo on our part. If she recommended 62, we can just correct the typo and discuss 62 and not 61 because that wasn't actually the measure that was before.

Barbara McCann: No, no, no, 62 is the other way, I recommended 61.

Shaconna Gorham: Oh, I'm sorry. OK. So it's 61 is the measure that should have been printed on the log.

Barbara McCann: Right. So that measure is number and percent of waiver participants who had assessments completed by the MCO that include physical, behavioral, and functional component to determine the member's needs.

Rob Schreiber: So point of information, we had talked about the core indicators for example being utilized. So this is really a structural form that if you're going to do whatever the assessments will be, it's not saying what's in the assessment, but these are the domains that need to be.

So my point of information question to Diane and Camille, you came back just in time…

Camille Dobson: Are you in physical health? I missed it.

Rob Schreiber: No.

Camille Dobson: If you're pursuing physical health, that was…

Rob Schreiber: The NCI surveys, questions that are being asked in the AD survey, would they meet the standard, because we're going to make the standard, right, we would want to make certain that whatever else we're recommending is consistent, but does it deal with the physical, behavioral, and what's the other one, functional which I think it does but I just figured I'd ask you.

Diane McComb: I have no problem with assessments being included. I would also say this would give the impression that if an MCO did a physical behavior and functional assessment, their work was done, versus if you added to that measure, a person-centered plan, I could be – we're talking long – I understand the importance but…

Female: No, the measure. So we've got to stick to the measure.

Barbara McCann: OK.

Female: Stick to the measure.

Diane McComb: All right. I guess I'm just expressing my concern that, again, we're talking about long-term services and support and while those three assessments are critical, in my world they would not be any more critical than a person-centered plan and the exclusion of the person-centered plan being named in this what to me trigger a message to a state looking at this measure that this would be enough to do the long-term services and supports assessment versus – I mean it sends a message that these three assessments are adequate versus…

Rob Schreiber: So I have a question to that, though…

Barbara McCann: That's my only question.

Rob Schreiber: So I know they can be perceived that way but could it also be perceived that if you were going to – I mean we do have an individualized plan of care which we put forth as a concept. Couldn't this be foundational though that…

(Off-Mike)

Rob Schreiber: Yes. So…

Camille Dobson: Probably …

Barbara McCann: No, (inaudible) so 61. We already scratched that one.

Rob Schreiber: Yes. So couldn't…

Female: So that's why I left (inaudible) anything? I'm sorry.

Rob Schreiber: Sorry about that non-sequitur connection. So in fact, isn't this that you would want to have these three domains assessed in a validated way to help develop an individualized care plan that's patient-centered.

Diane McComb: I guess my concern would be that for a person with a physical disability or cognitive disability, there may be no evidence of behavioral health needs or involvement.

So would this then say that they have to have that assessment done regardless? And I guess I would recommend go back, why I supported it was that usually if you have a basic structure of minimum content in an assessment, then that's what's considered when you create an individualized plan of care at least that there are no basic standards of practice that have been established for an assessment.

So just like when I have a physical assessment, I'll make you go to medical, right, or psychiatric. I don't come up positive on the PHQ9. So I don't have a behavioral issue although I'm being assessed for it.

Female: But when we're talking about resources, if a person has no indication of needing a behavioral assessment, why would we do that?

Rob Schreiber: Well no, no. There's…

(Off-Mike)

Rob Schreiber: Yes, I'll give you the answer. This is my answer to the question. If you do not screen for these things, you miss these things.

Even if you screen for them, you still may miss them. But for example, we do not screen for cognitive impairment in older populations who have risk factors. Forget about the ones that don't have risk factors. You have diabetes, hypertension, smoked, and you start having functional issues, we do not screen for cognitive impairment. At least 50 percent of those people go undiagnosed. So if you don't screen for it and you don't look for it, it's a screening test.

And we screen everybody for depression now, for example, everybody gets screened and there's even – even for cognitive impairments being recommended everybody be screened for because of the chronic conditions that people have. So if you don't screen for it, you're going to miss it and that's what's been happening for years. And that's why you need to have a comprehensive assessment.

Diane McComb: OK. So I don't disagree with any of that. I'm just saying that I think this list is incomplete and I think it's pretty important, it's critically important in a long-term services and support setting that the person-centered plan is articulated – go ahead.

Camille Dobson: I'm going to say, can I offer a different perspective because the health plans get nailed all the time because they only focus on medical.

In these states who are using this, Kansas isn't the only health managed care state that's doing this, they'll put in a requirement that the plans look at the whole person, for assessment, not planning, this is to look at their assessment. So it's not just medical, right, we get complaints, they don't look at their behavioral health needs and they don't look at their functional needs to determine a full complete person-centered plan that affects everything, this is just the assessment, Diane, not the planning processes. This assessment should inform how the care plan gets developed once they've looked at the whole person and their needs.

I think this is a great – I was glad to see that was brought up because I think it's a great measure and it addresses a frequent complaint from consumers and advocates that the plans aren't looking at the whole person.

Diane McComb: But there are other components to physical, behavioral, and functional that make up who this person is that should be assessed as part of figuring out who the whole person is. This defines the whole person by medical, by physical, functional, and behavioral as opposed to other elements that would define a person.

Camille Dobson: Give you an example that for example, if you look at this assessment that you would see a gap because it would help to see the tool. You don't know what the assessment tool looks like.

Diane McComb: If we use these assessment tools to develop a plan for someone, the only information we have is physical, medical, and behavioral information. We don't have any knowledge about the individual, we don't have any knowledge about their capacity for employment.

Camille Dobson: That's part of the planning process, when you started talking to the person.

Diane McComb: But there are assessments that would be relevant to get a picture of who the whole person is. And I'm speaking about the younger population with disabilities.

Barbara McCann: We understand. So we need to move along. We need to remind ourselves that we need to vote on the components of the measure that's before us. This is what we have.

So let's go to a vote for what extent does the measure address critical quality objectives of CMS quality measurement domains or identified key areas. I shouldn't choose, right, because I recommended it. May I have a vote for high? May I have a vote for medium? May I have a vote for low? You don't have to apologize to vote,'s all right. It's OK. It's OK.

Shaconna Gorham: So for this measure number and percent of waiver participants who had assessments completed by the MCO that included physical, behavioral, and functional components to determine the member's need and I write that because it is different from what is on the decision logic, decision logic had the incorrect measure up there.

We have three votes for high and we have one vote for medium and one vote for low for the first step in the decision logic.

Barbara McCann: All right. The second consideration, to what extent does the measure address an opportunity for improvement or significant variation in care being identified? May I have a vote for high? May I have a vote for medium? May I have a vote for low?

Shaconna Gorham: All right. That is three votes for high, one for medium, and one for low.

Barbara McCann: Next question is the extent that the measure demonstrates efficient use of measurement resources. May I have a vote for high? May I have a vote for medium? May I have a vote for low?

Shaconna Gorham: All right. So that is one vote for high and four for medium.

Barbara McCann: The next consideration is to what extent is this measure ready for immediate use? May I have a vote for high? I'm going to go with high.

Shaconna Gorham: No, that is in use in Kansas.

Barbara McCann: It is in use in – right. In Medicaid populations.

Shaconna Gorham: Yes, in Medicaid populations. It is in use in Medicaid in Kansas according to the information that we have.

(Off-Mike)

Barbara McCann: Yes, I know it's hard. Right. Right.

(Multiple Speakers)

Barbara McCann: We can say that about a lot of states. All right. May I have a vote for medium please? OK. And a vote for low?

Shaconna Gorham: Right above the definition.

Barbara McCann: I know. So what we're struck by is by definition there's one choice, correct?

Shaconna Gorham: No, no, no.

Barbara McCann: No? But we know it's in use. Right. That's what (Rob) was saying. Yes.

(Off-Mike)

Barbara McCann: Right.

(Off-Mike)

Shaconna Gorham: Well, yes. So this is definitely a concept what the four votes were for is that it is a concept already in use in the Medicaid population. So that is the four votes that we have, and the we have one vote for medium.

Barbara McCann: And the final is to what extent do you think this measure is important to Medicaid agencies and key stakeholders. May I have the vote for high please? A vote for medium? A vote for low?

Shaconna Gorham: So that was three votes for high and one for medium and one for low. So this measure of concept will be recommended for inclusion in the program.

Barbara McCann: Could we vote for a physical break?

(Multiple Speakers)

Shaconna Gorham: Yes, we can. Definitely. We'd like to take a, can we say maybe 10 minutes because we have lunch at 1:00 anyway. So can we take a 10-minute break, come back, do the last two measures and then we'll break for lunch?

Barbara McCann: Yes. Yes, yes, yes. Thank you.

(Break)

(Multiple Speakers)

Shaconna Gorham: So what I was trying to do, I actually just sent an email to the other staff to get a quote on where they are with their measures and their voting because I would like to propose, we have lunch at 1:00, I would like to come back after lunch as a whole group for general session and get you all out of here early instead of waiting for general session at 2:30.

Rob Schreiber: That would be great.

Shaconna Gorham: if we can come back right after lunch and just knock it out.

Rob Schreiber: Cool.

Shaconna Gorham: I've only heard back from two of the other TEPS, so once I get a poll from the last one, as long as they're finished with them we can leave early.

(Multiple Speakers)

Barbara McCann: ...Let's start again because regardless of any finite points in people's lives, we have to do these votes. We have -- that's right.

(Multiple Speakers)

Barbara McCann: All right.

(Multiple Speakers)

Barbara McCann: OK. Folks, we're going to ask that we move to measure 66 please.

Shaconna Gorham: But before we do that, because we're moving into a new domain, if we can go to public comment and take any comments on the domain that we just finished, population health and prevention. Operator, can you open the lines please?

Operator: At this time, if you would like to make a public comment, press star one on telephone keypad.

(Multiple Speakers)

Barbara McCann: OK. We're going to look at measure 66, which is workforce development derived from the workforce development domain, and I am looking at the numerator and denominator. Is anyone in here an expert or well-informed about the CCAT staff -- this is a staff survey that requires a minimum of 100 client responses and 50 staff responses. And it is an assessment, I guess, of the perception of patient-centered communication. An organization should ensure that the structure and capability of its workforce meets the communication needs of the population it serves, including by employing and training a workforce that reflects and appreciates the diversity of these populations. I have...

(Multiple Speakers)

Diane McComb: I am not familiar with it but I also raised a question when it talks about building environmental services, food services, et cetera, it doesn't sound like long term services and support setting. It sounds more like a facility-based ICF or nursing facility.

Female: Right.

(Multiple Speakers)

Diane McComb: Minimum 50 staff, a lot of agencies wouldn't have 50 staff even.

Barbara McCann: But so it says the level of analysis is a facility analysis. The care setting is the clinician office, physician practice, hospital, clinic, other.

Female: University of Colorado.

(Multiple Speakers)

Female: OK. All right.

Diane McComb: So I would just question whether or not it's relevant for long term services and supports or it would be better suited in a different workgroup.

Rob Schreiber: So (Janice) has some specificity around the...

Female: Oh, good. Thank you.

Janice Tufte: I just read about it. But it's a cognitive criteria test, a 50-point question around -- it looks like it's sort of holistic regarding the ability for people to be working or how work-ready they are.

Female: So it doesn't sound like workforce, right? I don't know. Well, workforce development, yes.

Janice Tufte: And so I see it in our Washington State, the waiver, 115 waiver, this is -- could be important.

Female: But you could say that anywhere. I mean it talks about staff who work for the facility.

(Multiple Speakers)

Barbara McCann: The majority of respondents are individual patients in this case. Twice as many as staff. And I'm not sure it's a performance measure.

Shaconna Gorham: So this is a performance measure, NQF-endorsed. We are talking about workforce development measure derived from workforce development domain of the CCAT. This is an NQF-endorsed measure, so it is a measure and if we need more information, I can definitely pull it.

Diane McComb: Could we -- could we get additional information? I'm confused by the way it's presented as to whether or not it deals with workforce development of the individuals that are receiving services in the facility or if it's about the workforce supporting individuals with disabilities. I also just don't think we're the right area to be reviewing it because of the nature of it being facility-based.

Shaconna Gorham: If you give me one minute and I'll pull it.

Diane McComb: OK. Great.

Barbara McCann: I do agree it could address an important area. Their training with regard to patient-centered communication and their ability to deliver on it but I'm not sure...

Diane McComb: Any facility that would have 50 staff would not be considered an HCBS or long term services and support. Well, that's not true. Long term services and supports can be a nursing facility certainly. But...

Barbara McCann: What we're addressing, it's only community-based services in this effort, so no.

Diane McComb: I just don’t see it matching up with what we're charged to look at.

Barbara McCann: Unless we're missing something.

(Multiple Speakers)

Shaconna Gorham: So it is the outcome measure. You have the description, it says zero to 100 measure of workforce development related to patient-centered communication derived from items on the staff and patient surveys of the communication climate assessment toolkit.

Rob Schreiber: It seems like they tested it in multiple languages so that's a novel measure. So it just -- anyway. But it is NQF-endorsed, right?

Female: Yes.

Rob Schreiber: And it is -- this is -- we haven't had really any workforce development measures whatsoever.

Shaconna Gorham: Not sure if this answers your question, Diane, but the workforce development component of the patient-centered communication, the organization shall ensure that the structure and capability of its workforce meets the communication needs of the population it serves, including by employing and training a workforce that reflects and appreciates the diversity of these populations.

Diane McComb: Thank you. That's helpful. I guess it's a criteria that would be important. I, again, would question the relevance to long-term services and supports for the numerator and the denominator being 50 employees. It just seems like we're talking about a facility-based setting as opposed to an LTSS setting but...

Shaconna Gorham: So according to this, the target population is the elderly population. You are right. The sites using this measure must obtain at least 50 staff responses and at least 100 patient responses.

Barbara McCann: Wow.

Shaconna Gorham: Five languages, English, Spanish, Chinese, Polish, and Vietnamese.

Barbara McCann: Can we -- yes, assume it -- can we address it as a concept although it's already...

Shaconna Gorham: The actual measure.

Female: OK.

Barbara McCann: Can you tell us where it's in use now, Shaconna?

Rob Schreiber: So University of Colorado Center of Bioethics and Humanities is the steward, but you're talking about clinical offices, clinic physician practices, hospitals and other care settings where this would apply to. So this would actually be cross-cutting, more clinical setting -- it's interesting I would think maybe most assisted livings may not have 50 staff but there are -- you know, there are supportive housing but they would -- again, wouldn't have probably 50 staff there.

Diane McComb: Just from the home care standpoint. You may -- it doesn't say full time and that's critical. So you could easily have 50 staff but they're not full time.

Rob Schreiber: This really seems to be cross-cutting across all domain -- I mean all types of -- any type of organization impacting I guess older adults would be applicable if they have -- meet these criteria. If you have 100 clients and you have 50 staff full and/or part-time.

Barbara McCann: Uh-hmm. And it doesn't say over what time. So for instance...

Rob Schreiber: Right.

Barbara McCann: ...when you look at the CAHPS in home care as an example, you have to have 100 over a certain period of time, not in any one example, so.

Shaconna Gorham: To answer the question about in use for some reason, I can't -- it says that it's for quality improvement internal to specific organization but it does not tell me anything more than that.

Barbara McCann: Any of the population. OK. Do we think we have enough information to vote? All right. Our first consideration is if the measure addresses critical

quality objectives or key concepts in the program area. May I have a vote for high? May I have a vote for medium? May I have a vote for low?

(Multiple Speakers)

Diane McComb: I'm sorry. I just was looking it up online and there were four references to CCAT. They're all different. So I don't know even what -- I guess it's OK. I just feel like I don't have enough information -- I don't have a problem with the overall objective of this measure but, again, looking at long-term services and supports, I don't understand its applicability given the numerator and denominator to the LTSS arena. But that's OK. I'm sorry about my confusion. I guess I would say low based on that lack of...

Janice Tufte: This is (Janice). And I see it as individuals who have served quite a bit of time or have served time in institutions for behavioral health. And this is where this could come in to this amount and number. And people and working coming back into workforce. So that's for -- I think it could be, I don't know.

Diane McComb: But I guess if it was a workforce assessment tool, there are plenty that are direct workforce assessment tools if we're talking about the capacity of an individual who is in the behavioral health setting to work. I'm -- that -- you know, all of this is good. I just don't see it as applicable in the LTSS arena.

Rob Schreiber: So I just went online and I found a presentation, I assume this is what it's about. But it was developed actually by the American Medical Association multiple stakeholder body in consultation with expert panel, was validated multi-year national field test. Seven of the nine domains were recommended for endorsement by NQF health disparities and cultural competency steering committee. So I'm wondering if they're taking those and applying it to LTSS because if it applies in healthcare, this should be a standard that should be cross-cutting across all settings. And so I'm wondering if that may be the -- and that's why LTSS is being included.

Barbara McCann: Right. And, Rob, does it address patient-centered communication? Is that...

Rob Schreiber: I'm getting through it, I don't see that actually.

Barbara McCann: Because that's in the measure description.

Rob Schreiber: Yes, it says the domains are correlated with patient-reported quality and trust. So it gets to the patient's voice but I don't -- I don't have -- I'm just going through these slides and...

Barbara McCann: Right.

Rob Schreiber: Anyway. But I guess Diane does have a point. It's hard to really be endorsing something when you're absolutely not certain about what the intent is and the approach. So it's...

Barbara McCann: We're almost -- yes, what we're voting on.

Rob Schreiber: Yes. Yes, we're voting on really -- I wonder what do you do with that when you really don't understand it.

Female: Yes.

Shaconna Gorham: I have the measure in front of me so if it's a specific question that you want me to look at.

Rob Schreiber: No, it -- it's more than -- it's like what's the basis of the -- like the NCI we had people who understood it. I mean those -- there were questions in there that made sense to us. This is like this tool that's been validated and deals with cultural competence but we're really not certain the intent -- there's not enough specificity here to really say, "Oh, we get this." And, again, we want to make certain we're all looking at it and understanding it the same way. So it's really hard -- I mean Diane's point is well-taken whether do we really understand what we're voting on.

Female: Right. (Judit)?

(Judit): And how much are we influence by the staff preliminary review that has no indication of any use in fields or in programs. Is that -- is that a helpful...

Rob Schreiber: Can we ever table an -- can we ever table a measure for consideration?

Shaconna Gorham: The only thing I can add is that for the usability, we had that because what we I have for the use is what I read so not a -- we put it as low because we didn't have -- we know that developer says that it is in use for quality improvement, but I don't know exactly.

Diane McComb: The information that we were given in the material -- the care setting is identified as a clinician office, a clinic, a physician practice, a hospital, or other. None of that speaks to LTSS, so for that reason, I would...

(Multiple Speakers)

Rob Schreiber: Assuming I'm reading it correctly.

Shaconna Gorham: So I can say that the level of analysis for this measure is facility. A care setting is clinician office, clinic, hospital, and urgent care and ambulatory.

Barbara McCann: Let me clarify first. Do people feel they can make a vote on this measure?

Rob Schreiber: I can't.

Barbara McCann: Are we able to make proposal to -- I don't know if we table it or take other action that we're unable to assess its relevance. Would that be a fair statement? Well, to what we're doing, right, yes.

Female: ... very relevant to another -- to a hospital physician practice.

(Multiple Speakers)

Rob Schreiber: Just one example, I could see the -- one of the other committees, this would be really appropriate potentially. Like...

Female: Oh, behavioral.

Rob Schreiber: Yes, behavioral and also complex chronic with -- I mean -- I mean I do -- I do think there is a corollary that is very pertinent to LTSS but the way it's framed...

Barbara McCann: You can't see how...

Rob Schreiber: I can't -- right. We're making a jump. We're assuming things and I don't think we -- we've been told we can't do that.

Female: Oh, sure, sure.

(Multiple Speakers)

Male: Doctor follows the rules.

(Multiple Speakers)

Shaconna Gorham: So that's very appropriate. What we can do is make a note. Remember, the coordinating committee will see this. And so we can make a note of your concern and they can look at it and perhaps by then we will find be able to answer some of those questions and also be able to present that.

Rob Schreiber: So my other question is, there will be other phone calls, right? We have other -- would this ever -- could we table this and then could we just have a separate call to actually just discuss this? Is that legitimate?

Female: I don't think that's on the…

Female: We're just going to bump it up to the really important...

(Multiple Speakers)

Rob Schreiber: OK. All right. So I was just thinking about options out of the box.

(Multiple Speakers)

Shaconna Gorham: Yes. We do have a -- and I think we discussed this -- I can't remember. But we do have a post in-person meeting scheduled I believe in a week or two. May 3rd, May 2nd, one of those if it is necessary. So if you all say that that is a reason for us to convene, we can do that. It is on the schedule, it is on your schedule. You have time blocked off for us. We definitely can. If that is a reason to reconvene, we can.

(Multiple Speakers)

Rob Schreiber: So maybe the answer is no.

Shaconna Gorham: So in that case, what we'll do is, again, make a note of it and we can -- you all can recommend that maybe the coordinating committee look at the measure.

Diane McComb: I would also just say I don't think we're questioning the validity of the measure but it just is the -- to me, that's not appropriate in the LTSS domain.

Shaconna Gorham: OK. So I'll make a note of that. I'm assuming we have a second on that motion. You made the motion, Rob, you can't second.

Female: No, I made the motion so we're good. We're good.

(Multiple Speakers)

Female: OK. So noted.

(Multiple Speakers)

Barbara McCann: All right. So we have what I believe is the last measure for our consideration today. All right. Measure 63, emergency department visit resulting in an inpatient stay. Now, the description is percentage of people with physical disabilities participating in Money Follows The Person. So another stratification down whose emergency department visit resulted in an in-patient stay. I assume this is a claims measure. Could you -- we can't hear you, (Karen). Sorry.

(Karen Amstutz): Yes. Sorry. I don't mean to interrupt.

Female: That's OK. We appreciate your comment.

(Karen Amstutz): The Money Follows The Person is ending if it hasn't already so I don't know if it's only tied to that. I don't know that measure that well but it's a -- it's a little worrisome that -- if it's tied to an initiative or only collected as part of an initiative that...

Barbara McCann: Right. The actual numerator and denominator is tied to Money Follows The Person.

Female: I mean it's focused on people who have been transitioned out of the -- you know, to the community, right?

Female: Right, right. Right.

Female: So I mean it's not a bad concept for broad applicability for people living in the community.

Barbara McCann: But it looks like it's never been tested outside of…

Female: No, not that. They were done...

Female: I think there's like a huge of states under Money Follows The Person, right?

Female: Yes.

(Multiple Speakers)

Barbara McCann: Right. So I'm -- but all of them -- if it's only been tested in that...

Diane McComb: The way the measure is written it refers specifically to Money Follows The Person program and the funding for that is ending. It has ended or it's going to end in months, less than a year.

Female: 2017.

Diane McComb: Yes, so it's -- I think the way numerator and denominator are written, it wouldn't even apply because there will be no new participants. Unless one is always branded when they leave a nursing home and move to the community or an ICF. But...

Barbara McCann: I guess that's what we would recommend is in view of the -- I guess making it a valid measure is based on a program that is ending. The concept may have merit but we question whether it's a measure that should go forward.

(Multiple Speakers)

Female: Right.

Shaconna Gorham: Can we take it through the logic because it doesn't even sound like this should go to the coordinating committee because...

(Multiple Speakers)

Barbara McCann: Yes. All right. So let's look at a vote, for the first consideration as to whether it addresses a critical quality objective or a key program area. Key concept in our program area. May I have a vote for high please? A vote for medium? A vote for low?

Shaconna Gorham: So the concept is bad, we will not be recommending this concept for...

(Multiple Speakers)

Shaconna Gorham: So if we can have a public comment please, operator?

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

Shaconna Gorham: OK. We do have a public comment in the room.

Male: We need to turn off another mic so -- there we go.

John Shaw: Hi. (John Shaw) from Next Wave. Since you just delegated consideration of a measure to us and we're all going to be looking to Barbara to present that so the sense of what I heard on the CCAT workforce measure was that you're just not sure of the applicability to the setting. And particularly concerns over how many of the organizations in the setting have sufficient size to make it meaningful.

Barbara McCann: Right. And I think, (John), also that it was based on patient-centered communication in the description, but we weren't able to see how that actually fit in since staff was going to find out more information. Did I understand that

-- recall that correctly? Try and then I would hopefully have that to present. And then if it's -- what I'd like to recommend is if it looks like something we should consider, then I would email you all and say, "Hey," or "Hi."

John Shaw: So we just wanted to make sure that we had the sense of the group coming to us.

Female: All right.

Barbara McCann: All right. That concludes our incredible deliberation.

Shaconna Gorham: So what I'll do is write up the measures that we -- that you all have voted for inclusion, align it to a rationale. Barbara will present that during the general session. We'll come back together because we have finished and the other three TEPs are almost finished. We think that we can have lunch at 1:00, come back at 1:30 and start general session at that time. So that way you all should be able to get out an hour or hour and a half or so early. But there's no need to keep you until 2:30.

(Multiple Speakers)

Barbara McCann: OK. The votes are high.

(Multiple Speakers)

Shaconna Gorham: So I have -- I have the rationales for the individual measures. We have about eight minutes before lunch. Is there any -- I heard some themes throughout the two days. One that we really want to not -- we want to move past maybe is the way to say it, just having clinical measures for this population would be one thing.

And then also kind of a lessons learned, we want to have certain terminology that really define and it would help the conversation as we move along, especially for this population. And so an example of that is the individual plan of care. We need specificity in the language. So those two really stuck out for me. But if you all have other themes that you would like to -- others to know or Barbara to raise in the general session.

Rob Schreiber: So the -- I guess the other piece that maybe I missed the process, so I knew we were going to be going through these measures but I think it would've been helpful to have like for the NCI to actually have some background, like a link or a document for each one of these.

Some background information that people could avail themselves of just so that we would -- we'd have that information, but I wasn't really certain about how that was going to be discussed like -- you know, we didn't -- I'm not certain I knew which measures we were going to be discussing either. Maybe that was all part of the process but -- so those two things would have been helpful to me to let me focus on -- because I don't know if we went through -- I mean there are a lot of measures, right? Did we go through all those measures that was in the Excel spreadsheet or...

Female: No.

Rob Schreiber: No.

Shaconna Gorham: So -- right. So only the measures that were in your discussion guide that were slotted for discussion and were separate in the discussion.

Rob Schreiber: So if we could have that a little bit before -- I'm just trying to think up -- you know, it would be nice to know for LTSS -- I mean were there any of us who chose measures that were not discussed in this session though?

Shaconna Gorham: No. All of the measures that were retained by TEP members were discussed.

Rob Schreiber: OK.

Shaconna Gorham: So you had the information beforehand but I think what I'm hearing from you is you want to ever more tie...

Male: Right.

Shaconna Gorham: OK.

Rob Schreiber: Just because my time was -- I mean I looked at it quickly but I didn't -- at least that's my -- I don't know if others have that...

Shaconna Gorham: Fair enough.

Rob Schreiber: ...that concern but that was my -- that's...

Shaconna Gorham: OK.

Rob Schreiber: You're asking for feedback, so.

Shaconna Gorham: OK.

(Multiple Speakers)

Shaconna Gorham: (Janice).

Janice Tufte: Yes, this is (Janice). I believe I backed up like all the information (Diane) had (inaudible) this morning was informational, so links to like the CCAT because all of us came up with different slides on that. So when there's -- if there is information that's deeper on the measures and I know that we can -- I know that you did provide it in some of surveys or some measurements but -- and a few of them that we have that available so we're able to look it up quickly. Thank you.

(Multiple Speakers)

Female: Yes, so that's -- oh, I'm sorry.

(Multiple Speakers)

Barbara McCann: Sorry. It may be unique to this population or to this topic. We have so many different populations represented and there are populations that we didn't even talk about over the last couple of days. There seems to be nothing for them. Special needs children, et cetera. So we may -- I don't know how you could have enough people in the room that would have that kind of expertise.

So we probably need a little extra work or support in that regard because really without the people here, we wouldn't have any insight on some of the populations. So that -- that would be my other issue going forward is, if so, for instance I'll use the Medicaid reform should it ever occur actually addresses calculations for five minimum different populations.

We didn't cover those -- even those five populations today. So it's -- there is a -- I guess to go forward, to say please come up, please measurement developers, I mean we're -- the age of accountability is coming but we have very little to go forward with it. Other comments?

(Multiple Speakers)

Camille Dobson: …area and that's the challenge with the space of having -- even I don't -- I mean Diane and I together probably makes a full person in terms of knowledge because she comes from -- right, she comes from a different perspective than I come but bringing the state perspective I think and the understand of the programs is really challenging.

You guys did an amazing job of grasping all of these nuances really fast in a day and a half. So I -- it'll be a challenge I think for the coordinating committee to sort of absorb all of that expertise. Unfortunately, it puts a lot of pressure on you, Barbara, to carry the water for the group. So if there's any way that we could be helpful in materials or better, more detailed explanations or whatever, we're happy to do that, so.

Shaconna Gorham: Yes. I just want to say that you all did a fabulous job. We came in with a lot of work to do. You did a lot of pre-work and then, again, a lot of work here. And all of what you said, I have definitely noted. I think that -- to echo Camille that this is a diverse and complex population. And then when you look at all of the experts needed at the table, what we tried to do was combine -- and I think we did a good job at bringing together experts that could bring a lot of different perspectives and knowledge. And what you're saying is that we need it even more.

But I think that you all did a good -- very good job of considering the population and just what is needed, especially because this is kind of difficult

because there's not a lot of measures available. And so we know that we still do need that development. Everything has been noted. Again, I think excellent job, you made my job easier which I'll always appreciate and (Karen) is sitting in the room, so if you want to make some comments.

(Karen Amstutz): Yes, just to echo Shaconna's thank you. I think this was -- well, I've been in the other ones. All of them have been complicated. It's a big ask. It's a huge expectation and I think certainly the evolution of the conversation over the past day and a half has reflected all of that. So I thank you for putting your state hat on because that's the ultimate implementers of this and helping us think about how you take the existing measures and translate that into what's ready to be used by states. So thank you.

Shaconna Gorham: With that being said, I definitely want to give a special thanks to Barbara, an excellent job as chair. Thank you so much.

(Multiple Speakers)

Female: Thank you for being so open (inaudible) for being so open and bringing your passions to the table. That's the only way we're ever going to get across this bridge.

Female: So we'll take all of this and Barbara again will present it to the coordinating committee and we will have a draft report posted in -- again, I charge this to age, my memory. But we will, in the general session, let you know when the draft report will be posted. The final report is due to CMS on September 14, I do know that date. And we'll go over that in general session, but it is 1:00, lunch is in the next room. We'll come back at 1:30 and convene as a whole.

Barbara McCann: Can I ask one clarifying question? Is -- will the group be commenting on the draft report?

Shaconna Gorham: Yes. The draft report will be open for the public. You all can definitely comment on that. We definitely ask you to review that and comment. There's a 30-day commentary. So we'll let you know. I'll send an email letting you when the comment is open and I will attach the report to the

email that I send you. But I ask that you go and do the public site and actually make the comment so that we can make sure that it's recorded.

(Off-Mike)

Shaconna Gorham: Let's break for lunch.

Female: Thank you.

END