Hi, Gerri. Why don't we do a quick check on your audio?

Helps if you unmute, Sam.

Thank you for telling me. It seems like I have to learn that lesson at least two or three times a week.

Can you hear me OK?

Yep. You sound great.

OK.

Yes.

Did you see my email about-- who did I just send you an email about? One of our committee members has a family emergency.

Oh, dear. OK. Oh yeah, I'm just seeing that. Thank you.

Hi, everyone. Peter Thomas here.

Hi, Peter.

Hey, Peter.

Good to see you.

[INAUDIBLE].

Morning.

I was just going to check in on Dr. Stille to make sure we've got--

Yep.

--good audio on you as well. But it looks like we're doing well.

We're good. Thanks.

All right. Terrific. Hello, everyone. Welcome. We'll be getting started here in just one minute.

Just as a quick update, we're going to be getting started as soon as we iron out some technical difficulties associated with viewing our slides. But I did want to say just how delighted I am to see so many people with their cameras on and that we can have this nice platform where we can see one another. It doesn't beat out seeing each other in person, but it is a lot better than just seeing slides. So thanks, everybody, for joining. Get started in just one moment.

Hello and welcome, everyone. This is Sam Stolpe here with National Quality Forum. And I'm delighted to be facilitating this meeting for the Patient Experience and Function Standing Committee for our fall 2020 measure review cycle. I'm really pleased to be welcoming our co-chairs and each of you, the committee members, to this call, and also being joined by our measure developer, [INAUDIBLE] Colleen, on the line. Thank you so much for jumping on. Let's go ahead and move forward with the slides, please.

At this point, I'm just going to give a couple of housekeeping reminders before I hand it over to our two co-chairs to offer a welcome as well. As you've noted, we're using the RingCentral platform for our meeting today. We have both the option to call in via the web, as well as a dial-in.

If you are joining us, and you are using the platform, we just invite you to please put yourself on mute when you're not speaking and just encourage you to use the chat box, as well as the Raise Hand feature, to be called upon to speak. Now, where you'll find that is if you click on Participants at the center of the screen, you'll see an option on the bottom right from the pop-up window that says Raise Hand. That'll give us an idea that you would like to share an insight.

We'll be conducting a roll call and inviting you to offer your disclosures once we get through just an overview of the agenda, so we have an idea of what we're going to be accomplishing in our meeting this afternoon. And as always, if you're experiencing any technical difficulties, you can contact our project team at patientexperience@qualityforum.org.

I'm going to pivot to the team here in a moment to introduce themselves but did want to thank them for all the preparations putting materials together for our meeting today. So as I mentioned, I'm Sam Stolpe. I'm the Senior Director at NQF. And I'm very pleased to have the opportunity to serve as the project lead. Let me hand it over to Aroma to say hello as well.

Greetings, everyone. My name is Aroma [? Higuey, ?] and I'm the manager on the project. Thank you for joining the call today.

And Udobi?

Hello, everyone. My name is Udobi Onyeuku, and I am the analyst on the project.

All right. Thanks so much. We also have [INAUDIBLE], who supports our work on the project. She's our project manager.

Quick overview of our agenda today. Once we get through our introductions and disclosures of interest, we'll have a brief overview of the evaluation process and voting process. Now, this is a small review of the discussion that we had just about a month ago when we convened for orientation. But it's just really truncated and gives a high level reminder of how we're going to be conducting our process today.

Following that, we'll have a voting test. And then we'll look at the measures that we'll be reviewing this cycle. Once I give a brief overview of those measures, we'll jump into our main focus of our work today, which is the consideration of the two candidate measures that we'll be discussing. Once we've voted on both of those measures, we'll have a related and competing measures discussion. We'll have an opportunity for member and public comment, offer some next steps, and then adjourn.

At this point, I'd like to hand it over to our senior managing director, Michael Haynie, who will be conducting our introductions and disclosures of interest. Michael, over to you.

Hello, everyone. Welcome. And thank you so much for your time today. We really do appreciate it.

So we'll be combining the disclosures of interest and their introductions. So you did receive two disclosure of interest forms from us. One is our annual disclosure of interest, and the other is disclosures specific to the measures we are reviewing this cycle. In those forms, we asked you a number of questions about your professional activities. Today, we'll ask you to verbally disclose any information you provided on either of those forms that you believe is relevant to this committee. We're especially interested in grants, research, or consulting related to this committee's work.

As a few reminders, you do sit on this group as an individual. You do not represent the interests of your employer or anyone who may have nominated you for this committee. We are interested in your disclosures of both paid and unpaid activities that are relevant to the work in front of you. And finally, just because you disclose does not mean that you have a conflict of interest. We do verbal disclosures in the spirit of openness and transparency.

So I will now go around our virtual table here, and starting with our co-chairs, what I'll do is I'll call on

you and ask you to state your name and your organization. And then if you do not have anything to disclose, please just state, "I have nothing to disclose," to keep us moving along. Inevitably, someone has some trouble getting off of mute. If you have technical difficulties with that, please just raise your hand, and we can make sure to circle back to you. So Gerri Lamb?

Thanks, Michael. Welcome, everybody. Delighted you're all here. Looking forward to talking with you. I'm Gerri Lamb. My organization is Arizona State University. And in terms of conflicts of interest, I do do consulting on care coordination. That's in my documents. I also receive royalties on two books related to care coordination.

Christopher Stille?

Good morning, everybody. It's Chris Stille. Good to see you all today. I'm a general academic pediatrician and researcher at the University of Colorado. And I have nothing to disclose today.

Kirk Munsch?

Morning. Professionally, I work for a company called Rare Patient Voice, and we recruit patients and caregivers of all conditions, disabilities, et cetera, to participate in paid market research surveys. Personally, I am here because I am a primary progressive MS patient.

Thank you. And confirming with the team, I understand Desiree Collins Bradley had an emergency and is unable to attend today. Is that correct, Sam?

Yes, that's correct. Oh, and Kirk, can we just ask you if you have any disclosures?

That was it.

OK. OK, thank you.

Yeah. Nothing, yes. But I just wanted everybody to know what I do professionally, is that I touch all patients and caregivers of all conditions.

Got it. And I just wanted to see if you were going to specifically say you had nothing further to disclose. Thank you.

OK, thank you. I'm learning.

All right. Richard Antonelli.

Hello. Rich Antonelli, Medical Director of Integrated Care at Boston Children's Hospital. I have nothing to disclose.

Thank you. Adrienne Boissy?

Adrienne Boissy. Hi. I'm a staff neurologist taking care of primarily MS patients, so hi, Kirk. And I'm the chief experience officer for the Cleveland Clinic Health Care System. I have nothing to disclose. Thanks.

Thank you. Donald Casey?

Good morning. Don Casey, President of the American College of Medical Quality. I'm on the faculty at Jefferson College of Population Health, Rush Medical College in Chicago, and University of Minnesota Institute for Health Care Informatics. I do not have any relationships with industry or conflicts of interest relative to this discussion today. Thank you.

Ariel Cole?

Hello. I'm an academic geriatrician in Orlando area, on faculty with FSU College of Medicine in Loma Linda. And I have no relevant financial relationships to disclose.

Ryan Coller?

Good afternoon. Ryan Coller at University of Wisconsin. I'm a general pediatrician, hospitalist, focus on complex care, and service division chief over here, and do health services research. No conflicts to disclose. Thanks.

Thank you. Sharon Cross?

Hi. Sharon Cross here from Ohio State University Wexner Medical Center. I work in patient experience department, and I have nothing to disclose.

Thank you. Christopher Dezii? Shari Erickson?

Sorry. Sorry. Sorry. I couldn't get off mute. Chris Dezii, CEO, Healthcare Quality Advocacy and Strategy Consultants. Nothing to disclose.

Thank you, Chris. Yeah, I told you it would happen to someone.

I hear you. I hear you.

Shari Erickson?

Hi, I'm Shari Erickson, Vice President for Governmental Affairs and Medical Practice at the American College of Physicians. And I have nothing to disclose.

Don Hall? Sherrie Kaplan?

Sherrie Kaplan, University of California Irvine. I have nothing relevant to disclose on measures under review. Right now, I have two PCORI grants on children's self-reported outcomes and quality of care. And I'm a consultant to the [INAUDIBLE] government on the use of PROs in their national program to evaluate diabetes.

Thank you. Brenda Leath? Brian Lindberg? Brenda, I do see you. Brenda, you want to try again?

Is everyone else having trouble hearing Brenda? OK. So Brenda's going to dial in. We'll make sure we loop back to her. Brian Lindberg? Lisa Morrise?

Hi. This is Lisa Morrise. I'm with Consumers Advancing Patient Safety. We are a small organization that helps connect consumers and clinicians in collaboration for safety and quality. We've done a lot of work with CMS but not specifically in the measures arena. And I have no disclosures. Thanks so much.

Lisa, you are noted on my agenda as potentially having a recusal on these measures. Team, can we just clarify that? I want to be sure that we're correct here.

We have worked with Lewin in the past. We are not currently working with Lewin, and we have not worked with Lewin on measures. So that may be what keyed that.

OK. Sam, can you hear me?

Yeah, I can. Lisa, I'll just loop back with you, and maybe we can chat about this in the chat.

Sounds good.

OK.

Thank you.

Randi Oster?

Hi. I'm Randi Oster. I'm the president of Help Me Health, and we help health care organizations

improve the patient experience. And I have no conflicts to disclose at this time.

Thank you. Charissa Pacella? Pacella?

Hi. It's Dr. Pacella. I am the chief of emergency services at University of Pittsburgh Medical Center and academic [INAUDIBLE] emergency medicine. I do not have any disclosures.

Thank you. And I just saw a chat from Brenda that she's made it back in. Brenda, do you want to go now? Brenda? All right. Well, we'll loop back around to--

Hello.

There you are. Excellent.

OK. Sorry. I'm Brenda Leath, and I'm president of Leath and Associates. It's a health management consulting firm. I do care coordination, certifications, [INAUDIBLE]. And I have no conflicts of interest to disclose.

Thank you, Brenda. Sorry you had a bit of a rough ride there. We're glad to be able to hear you.

Thank you.

Lenard Parisi? Debra Saliba?

Good morning. I'm Deb Saliba. I'm a geriatrician and health services researcher at the UCLA Borun Center, the Veterans Administration, and RAND. I have had funding in the past from the Centers for Medicare and Medicaid Services. Currently have several projects funded by NIA and the State of California. No specific conflicts related to these measures under consideration.

Excellent. Deb, I also have you flagged as a potential of recusal here. So Sam, if you could also chat with Deb, let's make sure we work that out and figure out who is and isn't recused. Lisa Suter?

Hi, this is Lisa. I'm an internist, and rheumatologist, and health service researcher, and measure developer at Yale. My conflicts are that I direct a large Medicare contract to develop measures, including patient-reported outcome measures, but none of the measures that are in front of us at the moment. We do work with Lewin, but not on these measures, and not on a contract that I personally work on.

I apologize. I am actually on service in the hospital right now and may have to step away. So I will try and chat or notify the NQF staff if that happens.

Thank you, Lisa. Just feel free to chat us. And thank you for your attempt to attend while you're on service. We appreciate that. Peter Thomas?

Hi, everyone. Peter Thomas here. I'm with the Powers Law Firm in Washington, DC. I do healthcare law from a disability perspective, and happy to be here. I have no conflicts of interest.

Thank you. And I understand Tracy has resigned from the committee, so not going to call that. Is there anyone I called, and you couldn't get off of mute or couldn't quite get back in sync, so we need to come back to you now? All right. This is a good sign.

So thank you all for those disclosures of interest. I'd like to let you know that if you believe you might have a conflict of interest at any time during the meeting as topics are discussed, please speak up. You may do so in real time during the web meeting, or you can send a message via chat to your chairs or anyone on the NQF staff. If you believe that a fellow committee member may have a conflict of interest or is behaving in a biased manner, you may point this out during the meeting, send a message to your co-chairs, or to the NQF staff. Does anyone have questions or anything further you'd like to discuss based on the disclosures made today?

All right, then I'd like to give you a final reminder that NQF is a nonpartisan organization. Out of mutual respect for each other, we kindly encourage that we make an effort to refrain from making comments, innuendos, or humor relating to, for example, race, gender, politics, or topics that otherwise may be considered inappropriate during the meeting. While we encourage discussions that are open, constructive, and collaborative, let's all be mindful of how our language and opinions may be perceived by others. With that, I'll turn it back over to the team.

All right. Very good. Thank you so much. Appreciate you walking us through that, Michael. And thanks to the committee for sharing your disclosures. At this time, we'll just do an overview of the evaluation and voting processes. And I'll be handing it over to my colleague, Aroma, to walk us through it. Aroma?

Great. Thank you, Sam. As Sam said, we're going to do a brief overview of the evaluation process and voting. Much of this we covered during the orientation and may look familiar. So a reminder that your role as a standing committee member is to act as a proxy for the NQF multistakeholder membership.

Today, you'll be asked to evaluate the measures against each criterion, and there are five, and also indicate the extent to which each criterion is met and rationale for the rating. As a standing

committee member, you'll also be responsible for responding to any comments that come in during our public commenting period, and just overall, as it concerns the portfolio, making recommendations regarding the endorsement and the status of the portfolio at large.

So some ground rules today. Again, thank you for coming. We have asked that you prepare for this meeting. We sent out a preliminary survey and gave you all an opportunity to review the measures in depth. So we're looking forward to that feedback today. We're also asking that you provide your base evaluation, and at the end, ultimately the recommendation on the measure evaluation itself.

Please remain engaged throughout the entire call. And if, for any reason, you have to step away, use the chat and actively let us know. We're totally fine with that as long as we're able to track who we may anticipate voting from and who may need to step away and be excluded from the vote. Now, I want to remind you all that we are at quorum. We're well above quorum with, I believe, 19 members on the call today. So we're not in jeopardy of not having quorum. But it will be important, just in case we need to track any absences throughout the call.

So the process for measure discussion and voting is as follows. The co-chair will basically open up the discussion and lend the developer three to five minutes to review the measure. From there, we will pivot to the lead discussant. And for 3593, we have Brenda Leaf, who will be leading as the discussant on this measure. We had a couple of absences, unfortunately. So we may ask that, Brenda, you lead that entire discussion, with the supporting maybe or maybe not being able to be present on this call.

But once you do an overview of the criteria, we'll then open up the floor for discussion. And we're going to go criterion by criterion. So while you're doing that, we also ask that you provide a brief summary of the comments that came through from the standing committee members and really pull out any salient points that stood out in the summary of comments. NQF staff also provided a preliminary rating. So as needed, you are also welcome to pull that information out as we discuss it.

The developers are on the call and are welcome to respond to any questions once we call the attention of the developers for any questions that aren't addressed by the standing committee. The full committee will then discuss, vote on the criterion, and move on to the next criterion. Now, discussion may not necessarily take place for each criterion. But if it does, that's totally OK. And then we'll move on to the vote and proceed throughout the call.

So here's a reminder of the five criteria that we'll be covering today. Importance to measure and report. This is a must-pass criteria, as you all know. And we're dealing with two new measures here, so some of the must-pass requirements here will only apply if it's maintenance measures, and it won't

necessarily apply to these two new measures.

But importance to measure report does apply. Scientific acceptability is a must-pass as well. And feasibility, usability and use-- usability and use, not necessarily must-pass for these new measures, but we'll still be voting on these criteria. And then we'll have a discussion on the related and competing measures.

So again, here is a run through here of the voting on the endorsement criteria. The votes will take place after each discussion for each criterion, and we'll go in that order. Again, importance to measure and report has two sub criteria here; evidence, must-pass; performance gap is a must-pass. These are not composite measures, so these qualifiers here do not apply.

You have a scientific acceptability of measured properties. Here, sub criteria are reliability and validity, both must-pass. Then we'll move on to feasibility, usability and use. Sub criteria, use and usability here. And again, not a must-pass for these two new measures, but we'll be voting on them. And again, related and competing discussion will take place. And then we'll have an overall suitability for endorsement vote.

So some procedural notes here. If a measure fails on a must-pass criteria, as you all know, there will be no further discussion or voting of the subsequent criteria, and we will just stop exactly where we are. Now, discussion can resume to the next measure, but we will not necessarily vote on the subsequent criteria.

If consensus is not reached, the discussion will still continue. However, we will not do an overall suitability vote, and we'll have to address that at the post comment call. So we'll still proceed and move on in both of the criteria, but the actual outstanding vote for the measure will not take place on this call.

Here is a chart of the quorum data. So 66% of the active committee members is what is required for us to vote live. Now, our numbers have changed literally as of today. So we have had a standing committee member step down, so we're officially at 23 committee members. And before we start really discussing measures, I will ask Sam to just confirm that we do not or we do have the two recusals that we thought we had because that will also affect what will be considered a passing vote. So here's--

Let me just jump in real quick. We've confirmed with Deb and Lisa that they just mismarked their form, so we'll follow up with them after this call and before our next call to ensure that we finalize

those. So thank you, Lisa and Deb.

OK. So that is bringing us, really, to 23 active members. And we have a few absences, so 19, again, is still our number. We're still well above quorum. And this breakdown here is a little bit different, again, because we did have someone officially step down not too long ago. But just to let you know, we will monitor these numbers so that we understand what is passed, was consensus not reached, and what's not passing. We will be well aware of that as we go.

Again, this is just some procedural reminders here. Consensus not reached measures, they do move forward. And we will continue discussing them and voting on the subsequent criteria. But the overall voting will not take place until the post comment meeting. And by then, the standing committee would have made the decision to either pass or fail. There will be no gray zone area at that point throughout the process.

And measures that are not recommended will also move on to public and NQF member comment, but the committee will not vote on the measures during the post comment, unless the committee decides to reconsider them based on comments submitted by the developers or the public. Additionally, a formal reconsideration request applies, too.

All right, so just a reminder about the importance of quorum and voting. If at any point throughout the meeting, you have to step away, just send us a quick chat, and we'll be able to tally those votes. Again, I don't think we'll be in jeopardy of not achieving quorum, but please keep us aware of any absences. If at any point, we are not at quorum, what we'll do is switch to an offline survey link, and we will send that immediately.

And you are definitely welcome to vote along during the call. However, we really will not tally or require those votes to be submitted until 48 hours after this call. So again, I don't think this will be likely to happen, but just in case. All right, and then that last note, again, is just about entering and leaving the meeting.

OK. So before we proceed to measure 3593, does anyone have any questions about the process or the evaluation criteria? OK. I don't hear any, and I don't believe there are any in the chat, so we will proceed to the voting test.

So we're going to take a moment here. I'm going to pivot it to our staff member, Udobi. We're going to just make sure everyone has access to the Poll Everywhere voting link and isn't experiencing any technical difficulties with casting your vote. All right. Udobi, whenever you're ready, you're welcome

to screen share.

All right. Thanks, Aroma. So I'll, again, just quickly walk us through a test to make sure that everyone has access to the survey and is able to submit a vote. So you should have all received an email this afternoon with the Poll Everywhere survey link, so please take a moment and open the survey at this time. I'll just give you a moment to pull that up before we start to test.

OK, so I'm going to go ahead and activate the voting test. So when you pull up the link, you should see the test question, which is, do you prefer coffee or tea? So please go ahead and select your preference. We're looking for a total of 19 votes, as Aroma said.

So if anyone's having any issues at this time accessing or submitting your votes, please let us know. We're looking for a few more votes to come in.

Sorry. I haven't found the link. Who did it come from? Forgive me.

Yeah, same for me. I don't have it.

OK. Who was that that didn't have it? I think I heard Peter Thomas, and who else?

Yes.

And Shari Erickson.

OK.

Looks like Christopher Stille in the--

Yeah, Chris.

--back, also.

I couldn't find the email, either. I thought I saw it.

Yeah, I'm searching in a couple places in my box, and I--

Again, who would it have been from?

It would have come from the Patient Experience box, but I can send you the link directly.

Yeah, that would be great. It probably got bundled with something else.

No problem.

This is Don. Mine came at 10:44 AM Central Time.

Thank you, Don.

Could you just put it in the chat, or is it specific to each of us?

I will be sending it to the committee members individually to make sure that only you all have access. OK, Chris, you should've received a link. Peter, the link is sent to you now.

OK.

And Shari, you should have the link in just a moment. OK, so everyone should have the link. Can you all confirm that you received it?

No, I didn't.

I haven't yet.

OK, and you've checked the chat as well?

Oh.

I sent it directly to chat. Sorry, not email.

Oh, I see it in the chat now. Thank you. Well, I think it'll work. I think I have to copy and paste it or something. It doesn't look like it works as a link, if that makes sense.

I'm sorry. I was going to another computer. I'm using my other computer to do this. I've got to do this on my laptop, right, if I'm plugged into this session on my laptop?

Mm-hmm.

Mine worked off my--

I got it. Thank you.

Yeah.

This is Sherrie Kaplan. Mine worked off my phone. Did you not get it?

Yeah, I didn't get it. Let me check my phone. Why am I always the guy that's got tech problems?

Peter, I often say that I lose at least one technology battle a day. The machines are my nemeses.

This is ridiculous. This is supposed to be so easy.

Whenever I have a tech issue, I tend to ask my grandchildren. They're seven and five, and they always nail it for me.

These digital natives, right? They're just running circles around us. I think everyone can relate to computer problems. Now there's a very successful franchise called the Terminator series for a reason.

[LAUGHTER]

Well, I'm sorry to say that I don't have it in my inbox, in my email. I don't have it. I'm looking at the RingCentral meeting's group chat, and I don't see anything that says Peter Thomas or anything that would lead me to click onto a--

OK. I resent the link one more time in chat.

Peter, I found mine in Gerri Lamb's email yesterday. Can you easily put your fingers on that one, the one that Gerri sent yesterday?

Let me check. Gerri Lamb?

Because there was a link in there. That's how I found it, because I wake up in the morning to 500 emails. It's impossible to find one that came that day.

I got the Gerri Lamb email.

It's there in chat as well.

Yeah, and it's buried in Gerri's email. It's about bullet four or something on there.

Yeah, I see that now. OK, let's see.

That worked for me. Try that one. See if that helps.

You know, I don't want to tie anyone up. I've got a couple of different sources I can go to. Let's move on, and if I have to vote publicly, I'll do it, or I'll chat a vote, too, whenever we do that.

Cool.

Don't want to waste too much time.

Thanks, Peter. All right, let's--

OK. I think that concludes the voting test, Sam, so I'll hand it back over to you. Did we do the test vote? What was the voting question? Was it just test?

Oh, yes. No. The vote question was--

Coffee versus tea.

Do you prefer coffee or tea? We actually got 12 votes for coffee and seven votes for tea. So we did have a total of 19 votes. And Peter, I sent you an email, also, with that link. There's your vote. Was that you?

I just voted for coffee.

All right, so I think we--

OK, so we have 13--

All right.

--for coffee.

So that puts us over 60%, right?

Yeah, right. That's great. I'm glad we achieved consensus on [INAUDIBLE]. And sorry for the minority group.

Sam, this is Gerri. I thought we had 19 people, and 20 people voted.

Did we have somebody join? Let me just check with the team. What was our total count that we were expecting?

It was originally 19, unless someone else joined. I had 19, and Aroma had 19 as well.

Yeah. That looks like that's how many we had, so--

So maybe Dawn Hohl, did she join? Brian Lindberg? Len Parisi?

This is Dawn. I don't know if you heard me at the beginning. I was having a hard time getting in because I was in Explorer, not Chrome, so I was dialing in. So I apologize if maybe I wasn't counted. I'm not sure if you heard me.

Oh, we didn't count you, Dawn.

OK, sorry. So that was me--

I'm delighted to see that you're on.

--trying to get in.

Dawn, did you--

We're glad to have you.

--have anything that you would like to disclose?

I had no disclosures. No.

All right. Very good, and welcome.

And to that effect, just so everyone is aware, Lisa Suter was here for the vote, but has since-- she did flag she might be called away. And sure enough, her pager set off, and she's had to leave the meeting. So that was the 20 there, and now we're back to 19.

OK. All right. Thank you, Michael. All right, I think we're good to move on. Shall we jump into our next section, please? So as I mentioned, we have two measures that we'll be reviewing, both of which are being brought forward by The Lewin Group with CMS. Let me just double check with our colleagues at Lewin that we're able to hear you OK. Colleen?

Yeah. Good afternoon, Sam. Can you hear me?

Yeah, you sound great. Thanks, Colleen.

Excellent.

So we have these two measures, measures 3593 and 94, and I'll just read off the titles for you. This is Identifying Personal Priorities for Functional Assessment Standardized Items, or the FASI, Needs; and Alignment of Person-Centered Service Plan with FASIs.

Next slide. Let's go ahead and jump into our consideration of candidate measures. So I'll be handing it over to our co-chairs here in just a moment after I read the brief measure description for measure 3593. And this is the percentage of home- and community-based services, or HCBS, recipients age 18 years or older who have identified at least as many total personal priorities, and up to three, as needs in the areas of self-care, mobility, or instrumental activities of daily living, combined as determined by the most recent FASI assessment.

For the purposes of this measure application, the term HCBS will also refer to community-based long-term services and support. The definition of HCBS in the September 2019 NQF report, entitled Quality in HCBS to Support Community Living, is consistent with the way that CMS uses CBLTSS. OK. Let me hand it over to our co-chairs to lead our discussion.

OK, this is Gerri, and we're going to start with 3593. Let me do a quick review of our process just to remind everybody how we're going to proceed. We're going to start with the developer from Lewin Group to give us an overview. And she will also talk a little bit about FASI and home- and community-based services to give us some context so that we can move forward. And then we won't have to repeat that when we go to the next measure.

Then we'll move to our lead discussant, Brenda. And Brenda, going to ask you to give an overview of the measure, not to go into detail on the specifics of each of the review criteria. We'll do those one by one. So Brenda will give us an overview, as well as a summary of our committee survey comments. Then we'll have Dawn make her overview comments, open it up to the rest of us for overview comments, not specific details-- I'll remind you all of that-- and then we will go one by one through the criteria.

I'm going to propose, if this is OK with everybody, that we keep our comments short, to just maybe two or three minutes; and if we have questions for the developer from The Lewin Group, if we can group those so that we can move through those and also do this efficiently. So if that's OK with everybody, that's how we're going to proceed. Any comments, questions?

And I guess you can either talk out, or you can put your hand up, and I will depend on our NQF colleagues to just alert Chris and me to when we've got comments. So with that, then, Colleen McKiernan's with us from The Lewin Group. And if you would, give us the overview of the measure 3593.

Great. Thank you, Gerri. So thank you all for the opportunity to speak today about NQF 3593,

Identifying Personal Priorities for Functional Assessment Standardized Items, otherwise known as FASI, Needs. My name is Colleen McKiernan. I'm a management consultant at the Lewin Group, and I'm joined by our project contracting office representative at the Centers for Medicare and Medicaid Services, [? Carrie ?] [? Reda, ?] as well as several of her colleagues. We have other members of the FASI team on the line, including Lisa Alecxih, our project director from Lewin; Ken Harwood from Marymount University; and Trudy Mallinson from George Washington University.

Before I speak specifically about NQF 3593, as Gerri indicated, I want to share some background information that I hope the standing committee will find helpful in its assessment of both this measure and the next measure you'll discuss. So home and community services, or HCBS, provide opportunities for Medicaid participants to receive services in their own homes or communities rather than requiring them to relocate to institutions or other isolated settings.

As of 2014, Medicaid HCBS has become the dominant Medicaid long-term services and support setting for funding. Although they use different Medicaid authorities to provide HCBS, every state and the District of Columbia offer HCBS as an alternative to institutional care, such as nursing facilities and intermediate care facilities for individuals with intellectual and/or developmental disabilities.

The umbrella of Medicaid HCBS provides support for a breadth of targeted population groups, including older adults, individuals with intellectual and/or developmental disabilities, acquired brain injuries, mental health or substance use diagnoses, and more. Participants whose care is provided through HCBS may receive home health care, durable medical equipment, case management, personal support, caregiver training, Human Services assistance for activities of daily living, hospice care, or other services.

NQF 3593 and NQF 3594 are based on FASI, a person-centered standardized item set, which identifies personal priorities for functioning and assesses for functional status and need for assistance for daily activities. FASI was originally developed by CMS and its contractors through the Testing Experience and Functional Tool, or TEFT grant, which builds on national efforts to create exchangeable data across Medicare and Medicaid programs. It was tested through the TEFT demonstration for individuals receiving community-based long-term services and support.

The FASI represents the first step in developing standardized, interoperable data elements for use in community-based long-term services and support programs. It is one component of a comprehensive standardized assessment that can inform an individual's service plan and identify those supports that are necessary for successful community living. CMS completed testing of the FASI

and its two complementary quality measures in 2018 at the conclusion of the TEFT demonstration. This testing the effort ensured that the set of items and measures were reliable, valid, and usable based on empirical evaluation of quantitative and qualitative data, as well as input from a technical expert panel.

NQF 3593 and NQF 3594, the two FASI performance measures, address gaps identified in NQF September 2016 Quality in Home- and Community-Based Services to Support Community Living final report, and also the July 2020 Person-Centered Planning and Practice final report. Both measures fall under the person-centered planning and coordination gap area, which captures measures that assess, plan, and coordinate services and support to focus on an individual's goals, needs, preferences, and values.

Documentation of personal priorities for functional needs is a key aspect of person-centered planning for individuals receiving HCBS, which is the focus of NQF 3593. Service plans take person-centered principles into account, lead to higher satisfaction and greater engagement of individuals in their own care. NQF 3593 assesses the documented needs of HCBS participants, who are age 18 years and older, who have identified up to three personal priorities as functional needs in the area of self-care, mobility, or instrumental activities of daily living.

CMS believes that NQF 3593 represents an early step to a person-centered approach to service delivery. And so on behalf of CMS, the FASI team performed a series of quantitative and qualitative efforts to assess the measure's current evidence base, performance gap, scientific acceptability, feasibility, and usability. We look forward to the discussion this afternoon and are looking forward to any questions that you all might have for us. Thank you.

Thanks so much. And thanks for the helpful overview of the FASI. So from here, we're going to go into our review. And Brenda Leath is our lead discussant. Brenda, if you would give us just a general overview of the measure and your summary of the comments from our surveys, that would be great.

Brenda, we're having a little trouble hearing you.

I'm not seeing Brenda on the call still. Did we lose Brenda?

She was in by phone, Sam.

Yeah, I wonder if she's one of the phone numbers.

She said she was going to get off video because she was getting feedback. I'm wondering--

This is Dawn. I was on the phone for a while, and you all couldn't hear me. Is the line muted somehow from this end?

All the phone numbers appear to be muted.

Yeah, so I think you have to unmute the phones.

We need to guess what area code Brenda's on.

I'm pretty sure I remember she used the 202, but I could be wrong, or the 703, because I know she lives in and around DC. Can someone--

While we're waiting, should we--

Hello?

Dawn, I don't know if you're prepared.

Hello?

There we go. Hi, Brenda.

Hi. All right. I am leading measure number 3593, Identifying Personal Priorities for Functional Assessment Standardized Items, so the FASI, Needs. And an overview is that the focus of this measure is to assess the percentage of home- and community- based services recipients aged 18 years or older who have identified at least as many total personal priorities, up to 3, as needs in the areas of self-care, mobility, or instrumental activities of daily living, combined as determined by the most recent FASI assessment.

This is a new process measure. It has not yet been implemented. And it is designed to improve person-centered planning and service delivery, and also to improve engagement of persons in their own care.

The numerator statement includes the number of HCBS recipients aged 18 years or older with documented needs in the areas of self-care, mobility, or instrumental activities of daily living, as determined by the most recent FASI assessment, and who have identified at least as many total personal priorities, up to three, as functional needs in the areas of self-care, mobility, or instrumental activities of daily living, combined on the same FASI assessment.

The denominator statement is the number of HCBS recipients aged 18 years or older with documented needs in the areas of self-care, mobility, or IADL, as determined by the most recent FASI assessment. The denominator exclusions, or exclusions inherent in the denominator definition, include individuals younger than 18 years; individuals who have not had a FASI assessment within the chosen time period; and individuals who have had a FASI assessment, but no functional needs were identified in the areas of self-care, mobility, or IADLs.

The data sources are electronic health records, instrument-based data, and paper medical records. And the level of analysis is other. This measure was reviewed by the NQF staff and also the Scientific Methods Panel.

Correction. Brenda, this was not reviewed by the SMP.

OK. I thought there were notes in the document that was sent out. Maybe I misinterpreted that, but I thought that it said the following were notes from the Scientific Review Panel. No?

Yeah, this one--

Those are staff notes?

I noticed it did say that in one place. You're correct, although it was checked off that it was not by, so I was confused by that as well.

Yeah. Apologies if there's an error inside of the materials. But just for clarity, this one was only reviewed by NQF staff.

All right. Thank you. So should I--

Brenda, how about you give us an overview of the major comments on the surveys for the people on our committee who completed them.

OK. So you want me to do it by criterion, or are you wanting me to do it overall?

Overall, please.

There seemed to be general consensus on the committee members' commentary about each of the criterion. There were some specific comments. And I can point them out as we go through each of the criterion. Is that how I should be presenting this?

Yeah, that's good.

That's fine, Brenda. Yeah.

OK.

So that'll work. So that was perfect, Brenda. Thank you. Dawn, do you have any general comments, if you would keep them general? Unmute.

I'm sorry. I'm a little slow. The only general comment was, I saw the folks on the committee really split on whether or not this was truly measuring what we had intended it to measure. So I think there's some discussion out there on that topic. I certainly think it fed into the comments.

Thanks, Dawn. Does anybody have any general comments, not the specific details because we will be getting into criterion by criterion, but anything in general anybody wants to contribute?

I do. I've got a question. I don't want to knock us off track, but I do recall that this committee, I think two years ago, maybe even three years ago, considered four home- and community-based measures at the time, and obviously different than these measures. But at the time, I don't think we approved them. I don't think they made it through the system, the process.

And I remember lamenting the fact that home- and community-based care is so important, and yet we weren't moving those measures along. Just for purposes of context, A, am I remembering that correctly; and B, does that have anything to do at all with-- I know it's home- and community-based care, but where do those fit in compared to these measures today? Can anyone answer that?

NQF? Can you help, Sam?

I'd love to be able to help, but I think those predate my time on this committee, Peter.

OK.

The most recent long-term services setting measures that I recall is when we had that very large volume of measures that came through. We had 15 measures total. And I think that was either Fall '18 or Spring 2019. And within those, there were a number of IMPACT Act-related measures that came through for review. And my recollection is that they did fairly well. And those measures were around communication between care settings to ensure the transfer of appropriate information to the next setting.

I think those were different. I think I'm talking about an earlier time. I've been on this committee for a

while.

I know. Yeah.

The committee changed its name in the time that I've been on this committee. So anyway, point is I just wanted to try to get us a better sense of that for context, but that's fine. Maybe it's too old to worry about. CMS doesn't know, do they?

I have a general comment I'd like to make, if now is a good time.

And who's speaking? I'm sorry. If you could share your names, because we can't see everybody at the same time.

Yep. It's Adrienne Boissy.

Please go ahead, Adrienne.

I think that we've been trying to crack this nut around patient preferences for some time. And if you think back to the original Crossing the Quality Chasm report, this was advanced as the definition of patient centeredness. So it's an important topic.

Two big questions that I have, just as global comments, perhaps; one is around the dynamic nature of patient preferences, and how do we capture that, right? Your preferences today may not be your preferences tomorrow; or when challenged by convenience or urgency, they also change pretty quickly.

The second one is around honoring them. In health care, we are very far from actually capturing and honoring preferences. And I always have caution around capturing preferences we don't do anything about, which is a failure of health care. So how do we set ourselves up for success and set organizations up for success as we consider this measure?

I'm glad you raised that because one of the questions-- this is Brenda speaking. One of the questions that I was going to have was whether or not preferences and priorities are being used interchangeably, because I make a distinction between a preference being akin to an option or choice, and a priority relating to importance.

So to me, there's some nuanced difference in those two terms. And at some point, I'd like the developer to let me know whether or not the definition for them in this measure is synonymous, or is there a distinction?

Yeah.

OK.

Yeah, and this is Chris Stille. I think these are really important points that people have just made because this could be a process measure that leads to outcome measures that are actually more meaningful in terms of patients. But you need to start somewhere with measuring.

Yeah.

OK. Dr. McKiernan, while we have touched on this, because that seems like an important issue that Brenda Leath is raising, the issue of preferences and priorities, could you respond briefly to that in terms of the thinking on this measure?

Absolutely. I'm actually going to defer to other members of our team who are really the [INAUDIBLE] in this preference space. So we have Ken Harwood and Trudy Mallinson on the phone. And so if either of them would like to jump in and answer that question, I think they would be the best to do so.

Hi. This is Ken Harwood. Can everyone hear me now?

We can hear you, Ken.

OK, great. Thank you. So I'll start the discussion. And certainly, Trudy can join me. In writing the FASI, or developing the FASI, obviously, we were very tied to our technical expert panels. And at the time, when we were discussing the language that would go on the FASI, priorities was specifically selected, mainly because in-- again, I think to take a step back, the FASI was developed to assess the functional aspect of each of these population groups and each of these individuals.

So therefore, when this section came up, it was specifically asked, "Of this category, like self-care or mobility, in this category, what would your priority be to be working on to improve upon or to get a service plan developed from?" So at the time when we developed it, priority was the preferred language.

And therefore, in the development of the performance measures, we, along with the technical expert panels and the state representatives, all believed that this term, priorities, was an important concept, and in fact, really the beginning steps of making sure not only that we are asking individuals if they have priorities in these important areas, but also that second measure, which is aligned to this, to determine if the priorities were, in fact, coordinated to the individual service plans.

So I would certainly agree that this is a first step toward that. However, it is in our opinion, and the opinion of the TEFT, that this is an important first step.

Thank you.

I have nothing more to add. I think that reflected the process of development well.

Thank you. So Brenda, let's start moving through the criteria, starting with evidence.

Gerri, this is Sherrie Kaplan. Can I interrupt? I did that raise your hand thing, but it-- this is relevant to some things that actually come through the Scientific Methods Panel. This is one of those measures where if you don't do the FASI, you're then excluded from the denominator.

But if that is a reflection of quality of care, you're excluding people who did not do the basic step. And it's come up, that conditional nature. You must do this before you can actually act on it and provide services, which comes up in the next measure. So with the conditional nature, can we get some clarification about what, going forward? Or is that premature from The Lewin Group? If you're excluded because you didn't do it, is that bad quality?

And Sherrie, are you also asking the developer to speak, too, like how frequently FASIs are completed?

Yeah. There's some methodological issues involved in the conditional nature of these things. But in general, is a FASI completion supposed to be part of good quality? And how many people do it?

So this is Colleen McKiernan. I can get us started, and then, again, I welcome my colleagues to jump in on items that I miss. But so the FASI is an optional instrument that can be used. Right now, there are two states that are using it. But we hope that there will be additional that pick it up over time. And we actually think that endorsement of measures will help get the word out that there are measures that address these personal priorities and then person-centered service planning areas.

I do recognize your point that if an individual did not complete the FASI at all, that potentially, there would be the opportunity to gain. So they could just not complete it, and then they don't have to worry about priorities because they didn't do it at all. But I think that really gets to the issue of how are we assessing, how are we doing functional assessments, and what pieces feed into it?

I think that FASI is but one step, as I mentioned earlier, that addresses a comprehensive assessment of all of the needs of an individual who seeks services through HCBS. And so again, there is no

guarantee. I think that as the FASI is implemented in more states, and we gather more data, we will definitely monitor for potential negative unintended consequences that occur as a result of things like you described. But it's not something that we have seen or that we have documented in our package to date.

Thank you.

Thanks, Sherrie. That's an important point. If I might, Sam, ask for assistance for both Chris and me, that if you see hands raised, alert us. Plus, I'm seeing a lot of comments going on in the chat. If these are things that you believe need to come forward, please say them so that we're not missing things as well. Don Casey, I think you have your hand up.

Yes. Thank you. Just quickly, remind me of the decision not to put this through the Scientific Methods Panel. I must have forgotten the technical aspect of this.

Sure. So the staff took a look at this particular measure in our assessment. Because it is not using the instrument in a way that traditionally would be used for a patient-reported outcome performance measure, we wouldn't classify it with the same level of complexity that we would a measure that is relying fully on an instrument like the FASI as the source of the outcome.

Rather, it's taking a documented portion of it as the data source for it and using it to inform a second part of the measure. So we thought that this didn't warrant a full consideration by the SMP, given that it didn't have the same level of complexity associated with PRO-PMs.

Thank you. That's a nuance I did not understand.

Thanks, Sam. Anybody else have their hand up before we go into criteria?

Yeah, Chris Dezii.

Go ahead, Chris.

Thank you. I don't know if this belongs in evidence or reliability, but when I looked at the categories of severely mentally disabled, intellectual disability, and brain injury, I thought back to my hospital days, that these aren't necessarily individuals we'd go to gain consent for anything. So I'm not sure how accurate their communication of what their needs are.

Maybe I'm missing something here, but if somebody can reassure me that the input you get from folks is reliable-- and I don't know if it touches on the transient nature. No, it doesn't. Well, it could, I

guess. That was mentioned earlier by Adrienne. But at any rate, you catch my point there?

Chris, may I ask you to hold that--

Yes.

--for the discussion of reliability and validity?

Yes.

Because it's important, but let's get into the criteria.

Let's do it.

And then we'll do that. But don't forget to--

Oh no, I won't.

--come back in.

Thank you.

OK. Thanks. OK, any other general comments?

Kirk Munsch here. As a patient, all of my preferences are priorities. But I also am open-minded enough to realize I'd prefer to be upright and mobile. Being able to run up a hill, I realize that that's not possible. So the priority is to at least get me to where I can function upright, mobile without hurting myself. In somebody's mind here, what is an example of a preference, or what is an example of a priority when it comes to a patient?

Are you asking the--

[INAUDIBLE].

--measure developer, Kirk?

Yes, asking anyone, because we were talking about preferences versus priority. What is an example of a preference, and what is an example of a priority, just what you guys look at when you see a patient?

Yep, this is Colleen McKiernan again. I'm going to turn it back over to Ken to give an example from

some things we saw and to field test.

I don't know if I'm going to be able to address your specific question. But I can certainly say, given the purpose of the FASI, which was actually to assess the functional level of individuals in these populations, that it became clear that a record of a very long list of preferences might be considered very differently from the specific priorities that that state plan needs to work on.

So I think basically, the development of an assessment form and to looking at what a state really should focus on was really the decision to use the word priority. However, it's incumbent upon me to associate the results of the measure. And I don't know if this is going beyond it. But what we did find is that the states don't seem-- or are inconsistently even asking the question.

So I certainly agree that the difference between priority and preference is an important distinction. However, a measure like this increases the awareness of its importance. That is, asking the person what their desires are; and second of all, to making sure that they're identified and addressed in the service plan. So I guess what we found was, if you look at the results, states are very inconsistent in even asking the question.

So I'll stop there. Maybe another person would like to comment further on that.

I think let's move into the criteria, and we can wrap back around as this comes forward.

Gerri?

Yeah?

Gerri, this is Rich Antonelli. Before we jump into the criteria, can I just take a minute and raise this issue that Sam and I have been pinging back and forth? Because I think it's really, really important. The way I interpreted this, and I thank you for the floor for just a moment, is it's really anchored to the FASI. And I think it's great to do an assessment. The measures, though, take it beyond, is the FASI being used?

And as Sherrie pointed out, you get into the denominator because you did the FASI. And as the measure developer pointed out, FASI is being used in two states right now. And Sam, I think that the concise but elegant discussion and distinction that you made about PRO-PMs versus endorsing the measure probably bears a little bit of discussion because if this measure got endorsed, then you could imagine the universe. All of a sudden, people are going to say, "Oh, we've got to use the FASI."

And I feel like that gives us the conundrum of pseudo-endorsing the FASI if we endorse the measure. That said, I'm in favor of this kind of a process because we need to get somewhere. There is a big gaping hole in home- and community-based services, and LTSS, et cetera, et cetera. But I don't know. Sam, could you unpack, for a moment, what your thoughts are, reflection, or call on somebody in the committee to do so?

Yep. Thanks for taking that up, Rich. I appreciate it. I think there is likely not an NQF committee with the level of familiarity with patient-reported outcomes performance measures as this one, given that so many measures inside of the NQF portfolio are housed specifically here for PRO-PMs. And such a high proportion of the measures that we have under our purview are ones that we regularly see, so for example, the CAPS measures and others that come through.

So I know many of you know this, but we do make a fairly clear distinction at NQF between the instrument, the patient-reported outcome measure, and a performance measure that is based on that instrument or a patient-reported outcome performance measure. So the PROM, if you will, is going to capture patient-reported outcomes, but of just the instrument. And the patient-reported outcome performance measure is something that holds a set of providers accountable to performance longitudinally, according to some measure specifications related to that instrument.

Now, I know we all know this, but I do want to be very clear that NQF does not endorse PROMs. We don't endorse instruments, though we do regularly endorse performance measures based on those instruments. And Rich, I think you're right that there is a corollary that comes with that.

So when we endorse a patient-reported outcome performance measure, we're essentially saying that we took a hard look at this, and the method that was used to tie together a score-level performance with an instrument is reliable and valid, and it makes sense. And this is really a gold standard in the marketplace. So by extension, there may be some assumptions made by people about what NQF's community, broadly, whom we're representing as this committee, thinks about that particular PROM.

But to the point that we're making previously-- and also want to be clear about this, as this is something that Shari Erickson asked me to expand on just a little bit. So Gerri, sorry for taking us away from the evidence discussion which we need to get to shortly. But I do think it's really important for us to be clear for why this was not evaluated by the SMP and why we consider this to be a process measure instead of a PRO-PM.

So the FASI is actually capturing inside of it elements where it's determining, specifically, as you can see from the slide in front of you, personal priorities by looking at identified self-care, mobility, and

instrumental activities of daily living. Those are not reflected in this measure. It's just a tally of how many were actually documented. And ensuring that those are reflected inside of service plans or the like is what's actually going to be the nature of these two measures.

So they're very much process measures, in the sense that we're just saying, "Did you document them? Were they in the FASI, and were they documented in the service plan against this other measure?" And this one is just looking at how many people identified actual needs. So that's a little bit different than a patient-reported outcome, where we would say what those outcomes actually are rather than just counting them.

Gerri, this is--

There's a lot of nuance in that. I'm really glad you brought that forward because I think that's really important to understand that distinction. That was a lot to follow. Does anybody have questions about that?

Sam, anything you wanted to add to that? That was a great description of distinguishing them.

Yeah. Thank you, Sam. That was really helpful.

All right. Thanks, everybody. I think we can move on. I don't have anything else to add.

OK. Let me just check. Any other general comments before we go into criteria? Any hands up? Because I can't see them. OK.

I think we're actually good.

Brenda, you're on.

Yes. OK. So criterion one is relating to the importance to measure and report and the evidence. This is, again, a new process measure that has not yet been implemented. It's [INAUDIBLE]. The evidence is limited to a targeted literature review. The developer asserts using standardized functional assessment items to capture personal priorities and needs is valuable to the shared decision-making process and to achieving patient-centered care.

Most of my colleagues seem to be in agreement about the measure's value and the need for it. There was concern expressed about some respondents' competency to communicate their preferences. And I believe we started that conversation a few minutes ago. And I think this might be where you wanted to follow up on that with one of the committee members.

I believe that was--

Or did you want me to--

--Chris Dezii, or did you want to complete your overview, Brenda, first? And then we can open it up for folks.

OK. All right. So then in terms of performance gap, there is this information-- I'm sorry?

We're going to vote separately on that, I believe. Let me just check.

All right.

Sam, that's a separate vote, right?

Yes, it is. That's right, Gerri.

All right. So let's stay with evidence, Brenda.

OK. Well, that's my overview for the evidence. I think that generally, there was consensus about the importance of the measure and agreement that it was limited to the targeted review. And I can go into more specific comments. I just need a little direction there.

I think we're good. Why don't we open this up? Comments? And please keep it specific to the evidence criteria. Are there hands up?

Gerri, this is Don. Yeah, I have my hand up. Can I--

Go for it, Don.

Yeah, so briefly, Brenda, thank you for the great summary. We're on 1A, right, Gerri?

Yes.

Yes.

So as I look at page seven of the worksheet, the full page, there are 10 comments. And six of them talk about evidence not being super robust, limited, no systemic review. The number of studies was small. The rating of evidence, low to moderate. I think that's back of the envelope. Another low.

And then, and this is for 1B, too, but one noted that there was only 41.7% agreement on the

statement performance on this measure provides important information for assessing whether groups of HCBS recipients receiving high-quality services-- I'm reading from page seven. So 60% of the comments question the level of evidence.

Sam, this is Sherrie Kaplan. Can I ask a question about NQF's decision on when a measure's early in the phase of development? We've talked about tiering these measures before. You wouldn't expect a systematic review if the measure's this new. So can you give us a little guidance about where in the development process-- how the group should be thinking about this?

Sorry. Can you rephrase your question? I want to make sure I understand it, Sherrie.

Yeah. It's a new measure. So if it's being used in two states, is the body of evidence generated sufficient to do, for example, a systematic review? And the odds are probably no. And so if this is a new measure, how early in the development-- how should we be thinking about body of evidence that needs to be generated before you move this to the next phase, whatever that is? And should we be holding it, therefore, to a little lower bar than a measure that's been around for a long time?

Got it. So this is a tricky area in general related to research. NQF just recently completed a person-centered planning related project where we were jumping into the history of person-centered planning and evidence-based practices inside of person-centered planning. And so I led that project, and so I can say, just from my firsthand experience, that there's just a dearth of evidence related to HCBS. And it's still very much an emerging field.

We know that, increasingly, people who are receiving long-term services and supports are receiving them in their own homes and that states are looking to offset costs associated with long-term services and supports for places that patients really don't want to be anyway. And with that being said, there's still a lot of emerging things related to it. So for example, whether or not a set of services received in the community that focuses on priorities and needs has a robust presence and a direct hypothesis-testing literature about their overall outcomes and satisfaction with the services that they receive is not super well-established.

In fact, the group that we worked with just identified a ton of research gaps in our assessment. We did our own comprehensive review of the literature and just found a huge amount of gaps. So the staff assessed this as one of these areas where needs and priorities, of themselves to a certain extent, are outcomes. They're desirable things to have documented. And so this is a very tricky gray area for us to take a look at as far as the evidence base is concerned.

So I don't actually have a really strong statement that I think I can make about the evidence from the staff's perspective, unfortunately. But where we should be landing is that importance to measure and report, actually at the initial review, tends to have a higher importance. And the reason is that what typically happens is that evidence, over time, tends to reinforce what we already knew.

So we expect measures to come in with a pretty good evidence base to begin with. And we have a process by which we can do exceptions to evidence if we feel it's appropriate. But for this particular research topic and research area, the staff just weren't able to identify a lot of articles and previous research that we've done.

And I neglected to say that the staff review gave a moderate rating for evidence. But I want to also go back on Don's comments on page seven. Yes, there is some specific commentary that the reviewers made. But generally, at the end of their comments, they're indicating that this is progress in the right direction. The two could be very helpful metrics.

This is a new measure, and the evidence is to support its development and implementation. "Can see evidence to ensure reporting is accurate," is perhaps one, along with the percentage that you gave in another comment about 41.7% agreement on the statement, "Performance on this measure provides important information for assessing whether groups of HCBS recipients are receiving high-quality services."

I mentioned that my assessment was that there was a general consensus that most saw this measure's value, that it was noted that the evidence cited by the developer was limited to a targeted review. There was agreement that more evidence is needed. And I guess, again, I want to reiterate, this is a new measure that has not been implemented yet.

Thank you, Brenda, for that addition. Other comments about evidence?

This is Randi Oster. I have my hand up.

Go for it, Randi, please.

Thank you. When it comes to evidence, I want us to think about the fact that we are looking at the transition to patient-centered care and the flipping of how services are delivered. And it is important for us to know and to understand that when something is new, and something is changing, we might not have all the answers up front. But that doesn't mean that we shouldn't move forward.

And then, in my mind, we would then, as things evolve, get more and more evidence. So just because

the evidence isn't as crystal clear based on current business practices or hospital practices, that doesn't mean we shouldn't move forward, because in my mind, this is about the transition of how care is given.

Thank you, Randi.

When it was read, I was like yes, yes, yes, I agree, all that. And then when Don started talking about page seven, first thing that popped in my mind was the concept is there. I agree with it. But somebody just didn't implement it correctly. So that's how I looked at it.

Any other comments on evidence? And if your hand is up, I can't see it. So just call out. OK, I'm not hearing anything. Are you ready to vote? Let's go. Let's do it. Rich, do you want to say what you've got in chat?

OK, yeah, I'll do that. This is Rich Antonelli. So Randi, I very much want to acknowledge the importance of what you just said and recognize that this whole arena, LTSS, home and community services, is really in an emerging state. And so lack of evidence is not the same thing as no evidence. But what I'm struggling with right now is NQF endorsement.

Is it necessary to gather more evidence in order to meet the criteria of evidence for endorsement? So it's a little bit circular. I recognize that. And that's actually what I'm struggling with. Is this important? Absolutely. Is limited evidence sufficient to move it forward because it's an important thing to do? And for me, that's the tension that I'm feeling.

A question, Gerri; if we're about to vote, then I would defer to how the committee proceeds. But I wonder if I could ask the measure developer just to comment on this. And what I'm not going to ask them is, is it important to get endorsement? They've made the decision to apply for endorsement. But I'm wondering what their view is of uptake of this in the field, independent of whether NQF gives its endorsement in 2021.

If it's not fair to ask that question, I'll withhold it. But if it is, I'd love to hear the measure developers address it if it's reasonable.

My thought committee is that tension that Rich is speaking about is one that was in the comments, which is there was no question, as Brendan mentioned, that people feel this is an important area. The lack of evidence is a tension point related to the criteria. Colleen, would you like to weigh in on that?

Sure. Thank you. So I totally understand everything you all have mentioned. Personally, my

background is in developing clinical measures, through which we have strong clinical practice guidelines off of which we're able to base them. And so moving into the HCBS space, you just see a totally different volume of evidence in terms of quantity, consistency, and availability. And so definitely appreciate the comments you all have made.

My concern is that idiom, don't let the perfect be the enemy of the good. And so I worry that there may never be a systematic review or an equivalent high-quality source to which we can point that would be equivalent to a clinical practice guideline. And I worry that the bar that's being set is really difficult to compare the volume of evidence you see for other measures that are more clinically based versus those that are in this long-term services and support setting.

I'm hopeful that the evidence base, as Randi, and Richard, and everyone was describing, will grow over time. But we can't guarantee that. And I think that the evidence we were able to present, in conjunction with the evidence from our expert panel, and then the users of the instrument whom we also surveyed, is sufficient to demonstrate nascency in the importance that we hope will grow over time.

And so I'll just underscore with, finally, the point that Sam made about when NQF performed a very similar assessment of the literature for person centeredness for their report, there was also just not a lot. And so I just think that this space is really difficult to point to specific either systematic assessments of the literature or even standalone articles. And we can't read the future, and we don't know what will be published in the future. We've presented what's available now.

Thank you. I'm going to suggest that we move to vote and see where we're at.

OK. Udobi, could you go ahead and open up the voting for evidence, please?

Yes. I was muted. The vote for evidence for 3593 is open. Your options are moderate, low, and insufficient.

And if you're having any trouble with the voting platform, feel free to send any of the staff a note in the chat, and we can record your vote separately or help to assist you with any technological difficulties with the platform.

Sam, would you also remind people about whether this is a must-pass?

Thank you. Yes. This is a must-pass criterion, as are the next three.

OK. Voting for evidence closed. I'm going to share my screen and show the vote in just a moment. So we need at least 12 votes of a combination between moderate and high for this to pass. So we received 12 votes for moderate, four votes for low, and two votes for insufficient. So this matter passes on evidence.

OK. Thank you. Then we will move on to gap. Brenda?

Yes. The performance gap is based on test results for a measure in 10 organizations and five states. Findings revealed variation in documentation. There were 684 unique individuals. 675 had a FASI need, and 296 had as many personal priorities. In terms of disparities, there was variation in data by race and ethnicity, where race was unknown, particularly.

The measure scores across groups was typically below 50%, except in cases where race was unknown. Such variations suggest the occurrence of inadequate documentation, which could translate into missed opportunities to address specific needs of the HCBS recipient. There seems to be general consensus among my colleagues that a performance gap is well-documented.

There were some specific commentary regarding the-- how personal preferences dictate choices for care is one. There's a sizeable description of that on page eight of the document that we received. And there was also a comment regarding the unclear given response of the TEFT. Only 41.7% agreement on the statement, "Performance on this measure provides important information for assessing whether groups of HCBS recipients are receiving high-quality services."

This was reviewed by the NQF staff, who recommended a moderate rating for performance improvement.

Thank you, Brenda. We're going to open it up now for general comments, or specific comments related to gap.

Don's hand is raised.

Don?

Yeah. So Brenda, thanks for noting that the technical expert panel only had 41.7% agreement. I don't know because I haven't looked back at the kappa statistics about the strength of that agreement; but fact remains, less than 50%. And remember, we're not voting on whether using FASI, for example, the Functional Assessment Standardized Items, in relationship to a person-centered service plan that is delivered by home- and community-based services is important or essential. No one would argue with

that.

The question is whether, given that we're rather loose about this, a measure that occurs, as I understand it, at the provider level for public reporting and probable payment policy delivery is ready. And I just personally don't see that it's ready. Not that you couldn't use the measure or try it, but it needs more field testing in terms of this.

And remember, we're talking about five different populations at once, which are all heterogeneous. My sister-in-law is actually in one of these, in specific, the intellectual and developmental disabilities category. And I can tell you, my wife's family has never received any question or asked for input into whatever this is that she's receiving. So I just have concerns at that end.

Thanks, Don. Other questions, comments?

Yeah, Chris Dezii. I found the sample seemed to be a bit light on Hispanic surveys. They have about approximately 3%. And of those 3%, 97% of them either have brain injury, serious mental illness, or intellectual and developmental disability, which we'll get into. And I'll get into that in the reliability section. But just seems to be a bit light on the Hispanic.

Chris, did you want to ask anything further about that?

Is that a problem? Yeah. Then I guess the specific question, is that an issue? And is that a significant underrepresentation for general use?

OK. Colleen?

Sure. So I know that there were a couple of comments for this measure and the next one related to the demographics. And so I'm glad that that's been brought up. Unfortunately, this was somewhat of a convenient sample. The five states that participated in pilot testing had their specific HCBS populations that were represented. And so unfortunately, I wish the data were higher for both those that identify as Hispanic or Latino, and then also for the comment related to individuals who are Asian or Indigenous Americans.

And so I wish all the numbers were higher, but we really just had what we had. Certainly as part of implementation, we're hopeful that when we bring this back in three years, if it is endorsed, that we'll be able to present additional, more robust data that reflect some of the groups that are potentially underrepresented in our initial pilot testing.

All right. Got you. Understood.

May I ask a question? In terms of the patients or clients that receive the FASI, and they are not considered competent to complete the priority part of the questions, is that question, to their knowledge, asked of their legal representative? Or is there a surrogate decision-maker that is helping to complete this for them?

Colleen, I can take this if you want me to.

Yes, so please go ahead, Ken.

OK, thanks. When we were doing the initial testing of FASI, actually, with anyone the individual caregiver felt that needed additional information, in the training that we gave to the assessors, we asked them to use as many sources of data as possible. So if an individual was unable to provide their own opinions on the priorities, the caregiver and/or any medical or documentation that they had before was used.

So in essence, for anyone who basically assented to be part of the process, meaning the individual didn't object to it, so that was asked at the beginning, we then asked the caregiver to consent to help us in this initiative. So basically, the assessor would then ask the provider, the legal provider that was provided, that was given.

However, it is important that I do say that there was great attempt to try to get as much information from the person served during the process. So the instructions always were ask them first and then get verification, if you will, or affirmation from individuals who were providing care.

Thank you.

Thank you.

Other comments about gaps? I would like to just acknowledge, it was really good to see the disparities information, considering that that's been a topic of considerable discussion in our previous meetings. Other comments on performance gaps?

Yeah. Gerri, this is Chris Dezii again. I want to quickly get through. Who was speaking, the measure developer, that last response?

Yes. Yeah, that was.

Great. Great. I was heartened to hear that. Was that same process in filling out the FASI addressed, utilized in soliciting preferences or priorities?

Yes. That is part of the process.

Perfect.

Yes, that's all part of that process.

Thank you. Thank you. Good.

And in the future, if we need to reach out to more, there are groups out there. That's what I do for a living. So there are ways to really increase your respondents here, too.

Thanks, Kirk. OK. Anybody else have their hand up?

This is Sherrie Kaplan. I don't want to delay us right now, but the gap concept is a little bit curious because the way I read the numerator, it's the number of recipients, the HCBS recipients, with documented needs and who have identified at least as many total personal priorities as functional needs. And then the denominator is just the total number of HCBS recipients with documented needs.

So the gap is a strange concept. You've got people saying between 33% and 50%, which suggests that that's a big gap, whatever that means. Can we get a little clarification on what exactly the gap concept is from The Lewin Group, or from the developer?

Sure. Happy to jump in. This is Colleen McKiernan again. So as you stated, the denominator contains individuals over 18 who have documented needs for self-care, mobility, and/or IADLs. And then so we're saying that an individual has a documented need for one or more of those areas. Of those, have they created priorities that can build off of the needs?

And so the gap is we have a pool of individuals who have needs. Are they creating an action item off of which they can build to improve on the need? So that's how you get to the numerator, and that's how you would identify a gap.

So the gap is, you've got priorities, and you fill this thing out, and you have priorities? So the gap is, you don't-- it's not that you haven't addressed them. Tell me again.

Have you identified them? Right.

[INAUDIBLE].

So if you have a need documented, you're only included if you have a need that's located through completion of the FASI. From there, the next step, the action item, is to create a documented need, so it's to take the documented need and identify the priority. So say you have a need for mobility, you have a need for IADLs. You say, "Here is my action item, my action statement, that I'm going to take to address the need."

OK. Thank you.

OK. Thanks, Sherrie. That's important. That really gets to the heart of what this is measuring and not measuring. Any other comments?

Looks like for Randi has her hand raised.

Thank you.

Who does?

This is Randi Oster.

Randi.

I just want to tie together the concept of gap in care and disparities. And I think it's important for the recognition that we did not have a complete look at all ethnicities. And there is research that shows-- and I cited in my comments articles such as *Racism in Healthcare: Its Relationship to Shared Decision-Making and Health Disparities.* And therefore, when we look at the gaps in care and the fact that we didn't have a robust sample, I think that speaks to not only the gaps that we did see, but the other gaps that literature shows exists.

That's great. OK. Any other comments?

Rich has his hand raised again.

Yeah. I'm sorry. It probably riffs off of what Randi just said, but I was thinking about this as the FASI is administered, and then the at least as many total personal priorities then inform a plan. The way I'm interpreting that dynamic is the patient basically says, "Yes, I agree." So if you will, it's an internal validation.

And I'm going to reflect back to the conversation we had just a few minutes ago. To the extent that the FASI has everything that's important to the patients themselves and their caregivers is-- and this

will beg the question-- not so much a gap, but the validity.

If it's really important, for example, for the patient, I don't know, to have access to a source of music therapy, but if that's not queried-- so I'm just wondering about that idea of, if this is an endorsement of the patient to prioritize FASI items, what's missing in the FASI that might be important for the patients?

Would you like me to answer that? This is Colleen from Lewin.

Please.

So the FASI is one step into the space of assessing functional needs. So Richard, the point you made about music therapy, that's absolutely true. If that were a priority for the individual, definitely important to document. And honestly, the person who's completing the FASI is probably assessing multiple dimensions, those that fall in the FASI, and then other things that are outside the guardrails that we set with this current instrument.

But right now, what we're really assessing are self-care, mobility, and instrumental activities of daily living. And so we really see this as a first step to get to a place where an individual is having all dimensions of their needs assessed. And we think that this could be a really good building block for future instruments that have equivalent but more things or different things in showing how priorities can be documented.

Thank you.

Thank you.

All right. Are we ready for a vote?

Let's vote.

This is performance gaps.

The vote for performance gap is open. Your options are high, moderate, low, and insufficient.

OK. The vote is now closed. We received two votes for high, 12 votes for moderate, two votes for low, and one vote for insufficient. This passes on performance gap.

Thank you. And committee, I am going to hand the baton over to Chris. And I will see you all on Friday.

Sounds great. Thanks, Gerri.

I believe we're moving to reliability and validity now. Is that right, Sam?

It is. Thanks, Chris.

Brenda, would you like to talk about what you found and what the consensus of the group was for reliability?

Yes. OK. And just as a reminder, the NQF staff did review this measure, and they provided notes in our materials on pages 9 to 11. One of the comments that I do want to highlight is that I noted the developer conducted reliability testing for each critical element, and that same testing was satisfactory for assessing validity as well in this staff [INAUDIBLE].

And I'm just trying to see. Rather than read all that's on pages 9 through 11, I did want to highlight one of the committee comments, which was that the developer evaluated consistency between raters in determining the number of needs noted in each of the records and the limits of agreement, which were defined as the average difference between two reviewers plus 1.96 times the standard deviation of the differences.

And the limits of agreements for total pairs records, between 3.47 and 2.58, the percentage of records that fell within the limits of agreement by HCBS program type ranged from 90.6% to 95.3%, indicating high agreement. And 71% of records that fell outside of the limits of agreement were from one reviewer. Excluding that reviewer, only 2.9% of total records fell out of the limits of agreement with a 95% confidence interval.

There were many personal priorities as needs identified. The developer used the kappa statistics, an inter-rater agreement statistic calculated with a 95% confidence interval to determine concordance between the number of identifying priorities, and a reviewer's assessment of whether the numerator definition was met. And I think that the committee members don't need me to read everything that they have already read, so I will jump to the general comments that I saw.

There were no concerns indicated in the reviewer's comments for this. However, there was a few comments that expressed concern, one of which was related to how the comparative reliability and validity relate to heterogeneity of the five HCBS program types used for testing on the measure.

And another indicated that data element reliability was demonstrated, but no measure score-level reliability testing performed. And another was, as stated, the results demonstrated that strong

agreement was found on all high-quality questions.

OK, great. I'm sorry.

I'm sorry. The staff's rating for this part of reliability was moderate.

OK. Many of us have a hard stop in about four minutes. It'd be really good if we could get through maybe one more vote. Rich, I'm seeing your hand is still raised. Was that from before? That was from before. OK.

Don, your hand is newly raised. Don Casey?

Yeah, sorry. I just wanted to point out, on table 1.7 on page 46, the Asian-American number percentage is incorrect. I don't have it in front of me, but it looks like a typo or a miscalculation.

OK.

It's a lot lower, in other words, percentage-wise, as I read the table.

What should that be? Developers, are you looking at what Don's talking about?

So unfortunately, I only have the testing form, not the full worksheet. So we have different page numbers. But I'm happy to answer that on Friday.

OK. Sounds good. And Sherrie, your hand is raised. Sherrie Kaplan?

Yeah. This is probably more for Sam again, but this is only at the data element level, the reliability. And the unit of analysis is listed as other on the front. I'm assuming the HCBS program is the unit of analysis. But that's not what the reliability, so far, testing has done. And so the question is, do we have sufficient-- and then I think it was Adrienne raised the issue of stability over time on these personal preferences, which is a different issue.

But if the unit of analysis is the HCBS program, and the testing was only done at the data element level, is this early in the phase of development so far, this new measure, so that that's not a concern for NQF?

Thanks, Sherrie. It's [INAUDIBLE] determination that this is just data element testing. That's actually still OK, given that this is a process measure. The highest we could get would be a moderate on the vote, however, if score-level reliability isn't present.

OK. OK. Any more comments on reliability? All right. See if we can squeeze in one last vote and then adjourn until Friday.

OK. Udobi, would you like open up the vote?

Yes. It's open now, so your options for reliability are high, moderate, low and insufficient.

OK. The vote for reliability is closed. We received zero votes for high, 13 votes for moderate, two vote for low, and two votes for insufficient. This passes on reliability.

Great. Thanks, everybody. We'll pick up with validity for 3593 on Friday.

Great. I understand some of you need to drop, but we do need to open for public comment. So public comment is now open. If you'd like to make a comment as an NQF member or as a member of the public, you may do so now. If you'd like the staff to read your comment, you may enter it into the chat. Public comment is now open.

All right, hearing none. Just remains for me to give a very big thank you to Chris and Gerri, who has now departed, and to each of you, our committee members, for your participation today. At this point, we are going to adjourn, but we will reconvene in just a couple of days to continue our discussion beginning with validity. We are adjourned for now. Chris, any parting words?

No, just thanks very much for a very robust discussion. Hopefully, we can keep some of this in mind, as some of it will apply to the following measure as well, and maybe be a little more efficient on Friday. Thanks.

All right. Thanks, everyone. Take care for now.

We will.