Hi, Udobi. How are you?

Hi, Sam. I'm good. How are you?

Doing well. So we are-- are you flying solo on this one?

I am.

All right. So we will be meeting your performance with a lot of understanding here doing this by yourself. So if [INAUDIBLE] and there's a pregnant pause while your shifting between things, totally get it.

Yeah. It should be pretty smooth, but yeah, we'll see.

I think you've got this one down. I do have a lot of confidence, but I just want to add the understanding here and thank you for taking this on by yourself. I appreciate it.

No problem.

Let's see. Randi's on early. Hi, Randi.

Hi, how are you?

Good. How's everything?

Good, good, good. I'm glad it's Friday.

Yeah, it's feels like Friday and thensome, doesn't it?

Well, thanks for joining us.

Hello, this is Brenda.

No problem.

Brenda, how are you?

I'm good, how about yourself?

Doing pretty well. Welcome back to round two of PEF.

Well, I'm ready. Hopefully it'll go smooth.

I think so. We do have quite a bit to get through, but given that these measures are so similar, I think that we've talked through a lot of things that are critically important to understand both of them. So hopefully some of the conversation will carry over into our discussion for the second, given that we have I think a total of about maybe 12 votes that we need to get through today and a two-hour time frame.

Averages out to something not very pretty, quite frankly, but I think that we could be able to punch this out pretty succinctly if we're cognizant.

Thank you. It's been a while since I have been in this role, so I'm almost like a new review [INAUDIBLE] discuss it.

Well no worries, you've been doing a bang up job, so thank you for stepping in and taking that role.

Thank you.

OK. Well, I'm going to go on mute while we're doing some final preparations here and I'll keep an eye on the chat as well as the participant list as people are coming in.

OK.

Hi, everybody. We're getting towards critical mass. We're having some of our committee members still filtering in, so let's just sit tight for a moment before we get started and once we get just a couple more people on board, we'll get going. Thanks very much.

Sam, there's a difference between the Ring Meeting ID in the new annotated agenda and what we're using here. When I used the new annotated agenda, it took me into the all-cause readmission committee.

Oh, right. So we do share our accounts, and I think what we used, the previous one, what's now being used for all-cause readmissions. So Udobi, maybe it would be a good idea for us to just send the link to everybody once again so it's at the top of their emails.

OK. I can send it right now.

All right, very good. Thank you.

Sam, are y'all sending the voting link, is that what you were just talking about, so I don't have to dig and find it?

I think we should perhaps do both. What do you say, Udobi? So we were actually referencing the meeting link itself, but we'll get both out.

Yeah, I was going to start looking if you weren't sending the voting link thing. All right.

Yeah, no worries. So I think we can get going though, and just have our welcomes from our co-chairs, as well as from NQF, and a couple of other items [INAUDIBLE]. Hopefully by then, everyone will have joined and we can do our roll call. But let me just start by [INAUDIBLE] to everyone for this round two of our Fall 2020 Patient Review Cycle virtual meeting.

So just on behalf of NQF, thanks to all of you for the great discussion that we had on our initial measure [INAUDIBLE]. We left off [INAUDIBLE] vote on reliability, so we'll be reinitiating our discussion starting with the [INAUDIBLE] once we complete a couple of items.

Can we go forward to the next slide, please? Udobi, I know you're multitasking here, so can we just go to the agenda? I will recap a couple of things [INAUDIBLE] are housekeeping items, and that is namely that we are using the RingCentral platform. We do have a dial in if you are having trouble with your audio, so feel free to either raise your hand or send a note to NQF staff and we can try to work out any technological issues that you have associated with that. Or share the 800 number that we also have as an option for audio.

Just a reminder to please keep yourselves on mute when we're not speaking, but once we get to the roll call, also be prepared to take yourself off mute so that you can say hi to everybody. As our agenda for the day, we're going to go through not introductions or disclosures of interest, but just a simple roll call since we already did disclosures. I'll give a brief recap of day one, we'll do a voting test, once again to ensure that we're all on the same page and ready to go, and then we'll jump into our measures under review.

So we have the consideration of two measures. We're about halfway through with one. We'll need to get both of those completed before we can say that our business is finalized.

I do want to remind us that we do need to get through 12 votes today. That's actually a fairly tall order, so let's please keep our comments succinct. In conversations with our co-chairs, we think that there's a lot of the important things that we've worked through that relate to both of the measures that we've had in our previous discussions, so let's try to keep from reiterating things that we've effectively covered from the first measure.

We do need to have a related and competing measure discussion, so once we complete our voting on these two measures, we'll have a brief discussion on what we would consider related and competing. But just a reminder, staff didn't actually identify any competing measures per se, but of course, entirely up to the committee to determine for sure.

Then will have public and member comments, go to our next steps, and then adjourn and wish everybody a happy weekend. Well, let me just check in. I know that we have Gerri on the call. Was Chris still able to join, as well?

Yes, I'm here. Thanks.

All right, very good, Chris, so let's start with you for any welcoming remarks before we hand it over to Gerri.

Great. Just welcome, real robust discussion a couple of days ago, and just to reiterate everything Sam said. Hopefully, we will have a good, meaningful, and efficient discussion this morning.

Sorry, Sam. This is Peter Thomas. I just joined the call. Just want to let you know.

Thanks, Peter. Gerri, over to you.

Same for me. Welcome back, everybody. Looking forward to the discussion and also an effective and efficient and-- let's move through it.

All right, terrific. Sounds like marching orders to me. Can we go to our roll call, please? That was it. Think fast. When we [INAUDIBLE] present. Thank you very much. Kirk Munsch.

Kirk Munsch, present.

Thank you. Desiree Bradley.

Desiree is present.

Thank you. Rich Antonelli.

Here.

Adrienne Boissy.

Here.

OK, great. Don Casey.

I'm here.

Thanks, Don. Ariel Cole. Do we have Ariel? I don't see her on our participants list. OK. Ryan Coller.

Here.

Thanks, Ryan. Sharon Cross. Have we seen Sharon? I don't see her in here either. OK. Chris Dezii.

Present. Also, can somebody send me the voting link?

Yeah, you bet. We'll get [INAUDIBLE] Shari Erickson.

I'm here.

Thanks, Shari. Dawn Hohl. Do we have Dawn? I don't see her on list of participants either. OK. Sherri Kaplan. Do we see Dr. Kaplan on? I don't see her either. Brenda Leath.

Here.

Thanks, Brenda. Brian Lindberg. I think we missed Brian last time, too. OK, Lisa Morrise.

I'm here.

Thanks, Lisa. Randi Oster.

I'm here.

Hi, Randi.

Hi.

Charissa Pacella.

I'm here.

Len Parisi. Deb Saliba.

I'm here. Ellen Schultz. I think Ellen mentioned that she wouldn't be joining. Lisa Suter. I don't see Lisa on either. And Peter Thomas.

Last but not least. Sorry, I thought you had already done this. My apologies for interrupting earlier.

Oh, no worries. All right, thanks very much. Udobi, did you get a total account with Gerri? I was kind of flying through this without counting well.

Let's see. I have eight members that are not present on the call. I think we have 24 committee members total--

So that puts us--

--but let me double check.

That would put us right at quorum.

Sam, I have 16.

All right. So let's do a voting check to make sure that we do, indeed, have quorum.

OK. Chris Dezii needs the voting link. Does anyone else think voting link sent to them? I just sent out an email, but I can send it directly to you in the chat.

That would be helpful if you sent it to me, too. Peter Thomas.

Yeah, Chris Stille also. My email is incredibly slow this morning.

This is Shari Erickson. I used the old link. I don't know if it's the same, so I have a page up for it, but I'm not 100% sure it's the right one.

This is Don. I could use it, too.

OK, one moment.

Well because of that, who sent the last email where it was listed in the email? That's how I got on last time. Was that--

It would have come from the patient experience inbox.

OK.

I have an email on the 5th [INAUDIBLE] if that's helpful.

Thank you.

Well, while we're getting that figured out, I think I can comfortably do a recap of the discussion that we've had thus far just to reorient us to the measure that we're going to be discussing today. So we're going to start the discussion by picking up on measure 3593. I just wanted to double check, I think I saw Colleen McKiernan on the line. Colleen, do you have all your colleagues with you today?

Yes. Good afternoon. We're all here.

All right, welcome back. Thanks for joining. So Colleen and her colleagues provided an overview of the measure, as well as a discussion on the functional assessment standardized items instrument, and the committee had a discussion around [INAUDIBLE] needs are critical, and the challenges associated with ensuring that such needs are frequently updated, and that they're honored by providers.

Then the committee also discussed the conditional nature of the [INAUDIBLE], that those who do not [INAUDIBLE] the [INAUDIBLE] won't to be included in the denominator. Then we talked a little bit about the extent to which patient priorities are included when they have a documented deed, and how that's reflected in the measure. So the committee reviewed the rationale behind the measure and talked about this general process associated with-- that despite drawing exclusively on FASI as a [INAUDIBLE] source, that there may prospectively be other options by which the measure developer could arrive at need.

So it was noted that there were some limitations, namely that there's only two states that have currently adopted the FASI and their HCBS programs. So there was one concern that noted that the measure is not specifically agnostic to how functional needs are identified. The committee also reflected on this interpretation of the measure in terms of performance gap, noting that a gap would indicate that HCBS performers are not ensuring that individuals who identify needs are also identifying a [INAUDIBLE] priorities.

And we looked at some demographic stratification, including the sample that was provided by the developer. The committee vote reflecting this consensus, that [INAUDIBLE] demonstrate adaptive performance. Noting on the reliability, there was some questions where we have reviewed the approach, noting the agreement amongst abstractors, [INAUDIBLE] statistics, [INAUDIBLE] of agreement analysis, and all of this was confirmed by the committee to be appropriate based on the vote that we had.

This is where we left off. So we're getting ready to jump into a discussion around validity. But before we do that, let's go ahead and have a test of voting. [INAUDIBLE], do you want to walk us through that?

Sure. So currently, we have nine people who have voted, so we're still waiting for quite a few votes to come in. Is anyone having trouble accessing the link? OK, I see a lot more coming in. OK, we have 17 votes. I think that's everyone. Sharon has joined the call, Sharon Cross, so that puts us at 17.

OK so the voting question was, "do you like to cook?" Your options were, "yes, I enjoy it," or, "no, it's a chore." And I'm going to share the screen. OK, can everyone see my screen?

Yes.

So we have 16 votes for yes and one for no.

All right, so next time we get together [INAUDIBLE] let's-- we won't be catering, instead we'll actually be cooking. All right. Thanks, Udobi.

All right, well I think we [INAUDIBLE] went back into [INAUDIBLE]. Just to reorient us, I will read the brief measure description, or at least the first part of it. So we're going to be discussing this identifying personal priorities for functional assessment standardized items. And this is the percentage of HCBS recipients aged 18 years or older who have identified at least as many total [INAUDIBLE] priorities-- and up to three-- as needs in the areas of self care, mobility, or instrumental activities [INAUDIBLE] most recent [INAUDIBLE].

Gerri, I'm going to hand it back over to you.

Thanks Sam, Thanks for the overview. And so measure 3595, reminder of our process is we're going to have our lead discussant, Brenda, take us right into validity, and we have a secondary discussant, Adrienne. And I would ask anybody who is not speaking, please mute. We are getting some background noise here. So I'm going to turn it over to Brenda to give us an overview of validity.

Good afternoon, everyone. Generally, colleagues expressed no concern about validity testing, however, there was commentary about the evaluation being limited to face validity and not including empiric validity. Colleagues also remarked of this effort being a positive step toward developing a measure for personal preferences, and also noted limited Latino representation.

Thanks, Brenda. Adrienne, do you have comments you want to add before we open it up?

No. Thank you for checking.

OK. Any comments about validity? And if you would, stay focused on validity.

Gerri, this is Don. Sorry, I meant to put my hand up but I couldn't find it. The question--

That's OK, Don. I can't see it anyway, so go for it.

The question around validity is whether it's clear that we're talking about the measure and not the instrument. I just want to make that distinction. And I think we're talking about the measure, right, not the instrument?

I believe so. Colleen, you want to just clarify that we are talking about 3595, we are not talking about FASI.

Correct, yes. The validity assessment was for the measure, not for the instrument.

Thank you.

Thank you.

Any other comments? All right. Well, let's call for a vote.

OK, the vote for validity is open. Your options are high, moderate, low, and insufficient. I'll just play for a couple more votes to come in. Could change the results.

May I interrupt to ask for a process question? Because I just spoke about testing and not other threats to validity.

So did you feel like we didn't get through the appropriate amount of materials that you wanted to review?

Well I didn't comment. If I could just say-- and I apologize for not having said it earlier, I though we were doing it separately-- most colleagues noted that it was not applicable in terms of threats to validity. Among other comments were measured not risk adjusted, limited Latino representation, exclusions were minimal and appropriate.

There were concerns expressed about the importance of assessing mental status, which is supported by studies in the evidence highlighted, and then the need for risk adjustment strategies-- I should have mentioned that before-- and also that NQF staff were satisfied with the validity testing for the measure and gave a moderate rating.

Sam, given the additions that Brenda just added, I don't know that they influence the vote, but should we open up for discussion since additional material was added since the vote?

Yeah, I think that would be appropriate. Let's just go ahead and open it back up for any further comments based on what Brenda added.

Thank you, Sam. All right. In light of Brenda's additions, does anybody have any comments that they would like to add related to our discussion of validity?

Looks as though Don has his hand raised.

Don?

Yeah, Brenda, thank you for reminding us about the mental status part, and I honestly just have not had time to pinpoint, but I think I did put it in my comments that in one of the subgroups-- or maybe two, it might have been the brain injury and maybe the older adults-- there actually were exclusions to those who were tested based upon their-- and again, I don't have the scientific details because it's buried-- but it appears as though the people that were selected for the evaluation had been screened with-- and I forget the tests-- wasn't the Mini-Mental Status, but another test of cognition-- so the people that were tested passed a screen.

And it just raises the point that-- and again, I can go back and provide the specifics, but unfortunately, we don't get copies of what we submit in the Excel file or online. But you get the point. There is a subgroup in at least one of these that we should pay attention to vis-a-vis generalizability to all people in that category. Again, it's either the geriatric group or the traumatic brain injury group, or maybe it's both. But I just want to highlight that is being of concern.

The other question, Sam, is there a taxonomy for what we mean by the voting categories, high, medium, low and insufficient? I just can't remember.

Sorry, Don. You had a question related to what the high, medium, low distinctions are?

Yeah, is that codified?

Yeah, it's just the level of certainty that the committee has that the measure is-- excuse me-- that we're measuring what we think we measured. And I'll admit that this is a little bit more vague in how we articulate that than some of the very standardized algorithms that we have, for example with evidence. Evidence, we say empirically, if you have five or more randomized controlled trials, we say that that's getting closer to high than moderate.

So it's not as quantitative, per se. But we're talking about the level of confidence that we have that we're measuring what we think we're measuring without any significant threats associated.

OK.

Donna, I'm hearing that you wanted to make that comment and agree with what Brenda had shared. I didn't hear a question, so can we move on then?

Well, maybe I should ask Brenda what her response is to my point about that screening. Did you get the same impression, Brenda?

Not from the comments that I saw. For me personally, I was satisfied with the information that was provided in terms of how they went about collecting information from persons with different kinds of conditions. And so I did not personally have a question about that.

Thanks. Don, anything further?

I think it may have been in one of the references. I apologize. I wish I had my notes from what I put in there, but I did document it so I'll try to go back and reconstruct it. It was of concern to me, at least.

OK. And it will definitely go in the notes, so--

Yeah, Don, actually all of those comments that were made online are captured and put into the preliminary analysis by the staff and then re-sent to the committee. So you'll have everyone's comments, including your own if you look under the individual section. So if you had a validity related comment, it'll be in there.

Thank you. Thanks for that clarification. All right, are there any more comments-- and thank you, Don-- related to validity, or are we ready to vote? OK. And I think your screens should have been cleared. I think, Udobi, they were cleared, right?

Yes, they're clear.

OK. So we are moving into the vote on validity then.

OK, the vote for validity is re-open. Again, your options are high, moderate, low, and insufficient.

And this is Desiree. Just for quick clarification, we're re-voting, correct? This is not an additional, this is a re-vote?

This is a re-vote, correct.

OK, got it. OK.

Right, so you have the option to change your vote. So we have not locked your previous vote.

Udobi, how many--

The vote for validity-- sorry, Sam, go ahead.

I was just going to ask if we're getting close.

Yes, we have all the votes.

Great, thank you.

No problem. The vote for validity is closed. One moment. The view here needs to be altered so I can share the vote with you. Sorry. One moment please.

OK. I'll read out these votes until I can adjust the view. So we received zero votes or high, 11 votes for moderate, six votes for low, and zero votes for insufficient. So this passes on validity.

Should we move on to feasibility?

We will. Brenda, feasibility.

The developer notes that the measure is abstracted from a record by someone other than a person obtaining original information, that an electronic method drawing on FASI is available, though developer notes that some organizations may rely on paper versions. The developer also notes that the FASI set recently was field tested in HCBS programs and found to be reliable and a valid assessment of function.

CMS will make FASI readily available to all HCBS providers through the data element library. All data elements come from defined fields in the FASI. If provider organizations implement the FASI in their electronic health records, then all data elements will be in defined fields and an electronic record. If a paper form is uploaded to the EHR or if the HCBS programs use paper forms, the data can be abstracted for the defined fields on a data abstraction form.

The colleagues offered various commentary regarding the feasibility of the measure, ranging from differences in EHR systems and ease of data collection, administrative burden, time to complete the measure, as well as whether individuals were actively involved in identifying personal priorities. NQF staff gave a moderate rating for feasibility.

Thank you, Brenda. Adrienne, do you have additional comments before we open it up?

Thank you. The only comment I would make that struck me probably the most in some of the comments from the reviewers was around, again, how do we make this actionable, recognizing that the feedback to date has been this is a first step and a first effort. My concern is that we collect data that is not actionable or usable because it's not clear what the integration into the care plan is. How does this change our process or treatment?

There's a lot of moderate lift, it sounds like, to extract the data into Epic, much less do something with it. So that's my practical concern.

So Adrienne, just to clarify-- excuse me-- what you are suggesting is a connect there between usability and feasibility? I just want to make sure we're in the right pew.

Well I think they're related. The question is is it feasible. Most of the comments in the review about feasibility are about FASI getting into the EHR. It's not even about the preferences around the FASI, it's around the FASI.

So even if we get the data from the FASI into the EHR, depending on what EHR system you're working with, it's not clear to me whether there's duplicative information and we already know what's in this-- it's not clear to me if this is duplicative of information that's already in the EHR, and then how this connects to how we might actually use it. Because it's a significant lift to get it in there as best I can tell. Paper forms coming into the EHR feels like a non-starter to me. So my comments.

Adrienne, before we move on to opening this up, is that something that you would like to address to Colleen related to the measure developers' assessment of the likelihood of it coming into the EHR?

I welcome comments around it. There are several comments from the reviewers about this issue, and so certainly invite a response.

OK. So Colleen, maybe if you can address it now because it sounds like that was a common concern was the feasibility. And let me remind everybody-- Sam, correct me if I'm wrong-- feasibility is not a must-pass.

That's correct.

Yeah, absolutely. This is Colleen, and I'm going to have my colleague Ken Harwood jump in, as well, once I finish my introduction to the question. So I think that the points that were raised by both of the discussions are well taken. This isn't a measure that's as straight straightforward as one that would use claims.

But really see the value in gathering these data. So as you mentioned, a lot of comments were about the FASI feasibility, not the measure so much. But so speaking to those comments about feasibility of the FASI, it is one component of a comprehensive assessment that's already being performed anyway. The FASI is just a vehicle to do so.

And as the FASI is rolled out to more states, CMS is providing opportunities through things like webinars and other vehicles to encourage quality improvement efforts and simplifying processes to try to reduce some of the burden that was highlighted in the notes and then in the just in the summary that we just covered.

I think that another point I'll lift up is the Data Element Library. So it was in our application that the measures were going into the DEL, they are in the DEL. It happened right around the time of submission, so that's why the tense of what we're doing has changed. And so the Data Element Library will help facilitate a more standardized assessment and collection of data for the FASI.

And then finally, I'll note that as part of the concern about the actionability-- which actually speaks a little bit to the usability, so it does bridge to the next question-- but the actionability on the priorities that are collected, individuals work with case managers, and it's really their role to help act on the priorities that are collected through the FASI and measured in this measure to support their overall growth trajectory and support planning for the individuals whom they're serving.

Thanks, Colleen. Let's open it up for general discussion. Thank you both Brenda and Adrienne for raising those questions. Those were common questions in the review. Are there any other comments specific to feasibility? And if you would share those now. OK. I'm not able to see hands up. Not hearing anything.

Gerri, I'm sorry. It's Don. I had my hand up. I just wanted to remark and point out that there was variability in terms of the intensity of training required amongst the people collecting the data, and that's just something to remark here. There was, for some, more intense training required. So I just want to reflect that.

Thanks, Don. That's a good addition to the consideration of feasibility. Let's see. Any other hands up that you're seeing on the NQF side? OK. Let's vote. Just remember, this is not a must-pass.

The vote for feasibility is open. Your options are high, moderate, low, and insufficient. OK, the vote for feasibility is closed.

We received zero votes for high, 10 votes for moderate, seven votes for low, and zero votes for insufficient. This does not pass on feasibility.

That's consensus not reached.

Sam, is this consensus not reached?

Yes it is. But thanks. So that's a reminder for how consensus not reached works on criteria where they are not must-pass. We can still have a vote for overall endorsement and do not need to resolve the consensus not reached in our post-comment call.

So we'll proceed through the rest of the voting, as well as the discussions, including a vote on overall endorsement.

Thank you, Sam. OK. Back to use. Brenda, if you'd give us an overview.

Yes. Again, this is a new process measure that has not yet been implemented. So it's not currently being used. The developer indicates CMS plans to share information about the measure to support states in evaluating programs within the 1915 HCBS program.

NQF staff gave a pass rating for use. In terms of benefits versus harm, the developer notes that most reviewers agree or strongly agree that the information needed to implement the measure is readily available, 96%. Developer notes that most reviewers agree or strongly agree that the documents needed are clear, 91%. Developer notes that most reviewers agree or strongly agree that the time needed was reasonable, 87%.

In terms of my colleagues, there were various comments regarding the assessment of this measure, ranging from the promise of better documentation of priority, improvements in patient-centered care, and there was caution, though, that the actual priorities may not reflect patient statements completely or accurately. In most instances, comments seem to reflect consensus of benefits outweighing harm. In terms of this aspect of the measure, NQF staff gave a moderate rating for usability and use.

OK. Clarification, Sam. We vote separately on use and usability?

Yeah. Thanks for clarifying that, Gerri. We do, unfortunately, have some terms that sound very similar with usability and use, but we do mean quite different things. So we're going to vote on use first, and what we're specifically talking about, as was very well explained by Brenda is we're talking about whether or not CMS and Lewin have a plan for implementation of this measure given that it hasn't gone into use yet, and that we don't have any unidentified, unintended consequences associated with this. I see that Chris has his hand raised. Chris did you want to comment?

Yeah, that was quick, Sam. Thanks. This untested measure is going to be an accountability measure for program evaluation right off the bat. Is that correct?

I would hesitate to characterize this as untested given that the developer did submit reliability--

OK, I'm sorry, I'm sorry. No, no. Unused. Unused.

Unused. OK, so correct. So presumably CMS developed this measure with the intention of putting it into some programs.

Thank you.

Other comments, questions? Specific to use. Let's hold on usability.

I noticed that Don Casey has his hand raised.

Don?

In follow up to Chris's point, so we're talking about use for public reporting and payment decisions, correct?

So Don, that's a great question. And when we say use, we mean a variety of things. NQF is somewhat agnostic to the sort of way that this is used, meaning that if we want to use it for reporting, that that's an acceptable use. But it could be accountability, including detailed risk models.

So there's a wide range of accountability applications, but it encompasses a fairly broad spectrum of accountability applications, and public reporting is, of course, precisely what it indicates the general public would have access, either for free or for a fairly nominal or inexpensive fee to be able to have access. That's NQF definition of what it means for public use.

NQF isn't the user, CMS would be the user, correct? So that's what I think of. And I think that we're not-- again, we're not talking about the use of FASI or the instruments, but rather the measure. So I just put that out there for the group to think about.

Thanks for that clarification, Don. It's good for us to keep remembering where we are focused, on 3593, not the FASI. Other comments? OK, I think we're ready to vote on use, and this is a must pass criterion.

I have a correction, Gerri. It's a must-pass only for maintenance measures, not for new measures.

Thank you, Sam. OK.

OK, the vote for use is open. Your options are pass or no pass. The vote for use is closed.

We received 11 votes for pass and six votes for no pass. This passes on use.

Thank you. OK, and then the final criterion, usability. Brenda, if you would only focus on usability. You don't need to repeat the use criteria, OK?

All right. Excuse me. In summary, the notes from the developer indicated that there was strong agreement about the information needed to implement the measure, and that most reviewers agreed the documents needed were clear, and that most agreed that the time needed was reasonable.

There were comments among my colleagues regarding the assessment of the measure, ranging from the promise of better documentation, of priorities, and improvements in patient-centered care. There was caution noted about the actual priorities, which may not reflect patient statements completely or accurately. In most instances, the comments seem to reflect consensus of benefits outweighing harm. NQF staff gave a moderate rating.

Thank you. Adrienne, do you have additions?

No, thank you.

OK. Comments on usability? Not hearing any. Let's go to a vote.

Gerri, I'm sorry. You must not see my hand. I'm sorry.

I can't. I can't see the hands up, Don. So thanks for jumping in.

So usability by who? I think it's clear it would be usable to agencies overseeing these programs, as well as we hope and think usable to the institution delivering the care. I haven't heard much from the measure developers about how patients and families have practically used the information. I'll just use my own N-of-1 family situation as-- one of my relatives who's in mid-50s lives in a group home and is subject to this because of developmental disabilities, and the family has never heard or seen one piece of information about these types of assessments. So what's your what's your thought about that?

Thanks, Don. Colleen, could you talk about-- knowing that this measure is not in use yet-- to anticipate how families and patients may be able to use this?

Absolutely. I think the data that underlie this measure are what will be most important to Medicaid, HCBS participants, their families, and other individuals in that space because as we talked about on Tuesday, the need to create person-centeredness and ensure that there's a conversation that happens about when we talk about the care provided to individuals-- [AUDIO OUT] --we're hopeful that by implementing a measure like this one that highlights personal priorities based on the FASI assessment that the individuals that are being assessed and their families will feel more engaged in the process of deciding what are the things that are most important to them, how are those things addressed, how do they work with their case managers and other staff with whom they engage to improve their quality of life.

And so we really foresee these measures first and foremost as making the data explicit that the person is important, that their priorities are important, and that they enter into a conversation on how to decide on what two or three things to focus from their FASI assessment for goals to improve over the measurement year.

Gerri, may I just quickly respond to what Colleen said, if that's OK? Just 10 seconds--

Don, if you would keep it short.

So Colleen, it's true, then, that you're stating these are expectations, but there is no-- that I saw-- empiric evidence that this is reaching much-- at least the developmental disability families and patients-- from my own N-of-1.

So I can't speak to your example specifically, and I'm sorry that you haven't had that engagement thus far. I'm going to have Ken Harwood-- let's see if he's able to come off of mute. He was having some issues with audio. So Ken, if you're able to jump in, he has some additional data to add to respond to your question, Don. I know he's a call-in user, and so I know we were having some issues with that yesterday. We cannot hear you, Ken, if you're speaking.

Sam, if he's not able to call in, is that data that we can get into the record to respond to?

I just became unmuted, can you hear me now?

Yes, and if you would, please be concise.

Certainly. I think it's a great question, Don, but I would certainly say at this point, what we can anecdotally say is when data was collected, the people that are receiving home and community based services and their caregivers did say that in many cases, this was the first time that these types of questions like priorities was given to them. Certainly, we don't have hard data on that, but I would certainly say as a part of the data collection period, we did hear this not only from the assessors, but also from the TEP members that came to our TEPs.

Thank you. That's very helpful, and it sounds like it will be important to move forward in looking at that. Any other comments on usability?

I noted that Chris Dezii has his hand raised.

Chris?

Yeah, thanks. Just so I'm understanding clearly, to riff on Don's point about sort of usability to whom, does Adrienne's point about actionability-- does that extend in this consideration? That is, is it usable for addressing and working its way into the care plan for the patient, not as it usable that can the user implement it? You follow me on that? Am I clear?

Yeah. I think, Chris, that's an excellent question. I think when we differentiated use and usability, Colleen responded to that usability. Colleen, do you have any addition to what you said before about that?

I don't have anything to add specifically here. I know we're going to talk about service plans in the next measure, and so perhaps, Chris, that's when we would address it. If you want to expand a little bit on your question, I can try to clarify, however.

No, I can't say it any-- that's as simple as I could get it out there.

If I could take a stab, I'm hearing you differentiate between usability of the data that's incorporated, meaning access to it and the implementation into a care plan, and that it actually changes the care that we provide.

Yes.

I'll just-- a quick comment to Gerri, please-- currently, we ask 18 different preferences of patients in the EHR, none of which are connected to anything. So we run the unintended consequence of collecting more preferences that are disconnected from any implementation or care plan, and that's nobody's intent, but it is worth raising in this setting.

Thank you for the translation, Adrienne.

And if I could just add one thing, we discussed this at length inside of our Person-Centered Planning and Practice Committee, and we met with a series of individuals who were instrumental in developing some of the fundamental ideas associated with collecting care, particularly those that are impacting those who are in marginalized and at-risk populations. That if you even just look back a couple of generations, and not even that far, many of these individuals would have been institutionalized instead of being allowed to remain in their homes. And so it's really a disenfranchised population.

And the characterization of this was that documenting needs and making sure that they're inside of service plans so that those needs are met is necessary but not sufficient. This is the first step in a process that really-- this point that you're making Chris-- that when we go through that process of documenting care needs and making sure that they're inside of a service this plan is somewhat risky because you are doing a severe disservice to a person by telling them that-- you should tell them what their wants, their needs, their desires are, and their goals, and then not meeting them.

But the first step is to take that risk. You have to document it, you have to go through that conversation. So the view on this type of measure, as articulated by that committee, was extremely positive because it was-- but noted to carry exactly the risk that I think that you're identifying.

Sam, in addition to what you just described in relationship to Chris's question, thinking about what Adrienne just said, which is there is the potential here to identify multiple priorities. This measure just looks at whether those priorities have been identified, but part of the usability-- Adrienne, if I'm understanding your comment correctly-- is we could do lots of pieces and parts and not have anything addressed. Adrienne, Chris, did I get that right?

So did that committee talk about how do you make sense when you have multiple priorities that actually something happens?

Yeah, so that's a great question, Gerri, and thank you for framing that up. The way that the committee viewed it was that measures of this type belong inside of a constellation of measures that are really intended to ensure that we get to that end goal associated with actionability. And it's a stepwise process, and that this is an important step, but the final outcome, from their perspective, was really capturing the voice of the individual and ensuring that they have a high quality of life associated with this type of service planning.

So the end goal is important, and there are great underpinning process measures that we could prospectively get in place to ensure that we're getting to that end goal. And this, in their description, aligns very closely with the sort of process measures that they thought would be important for an actionable plan at the end, and good outcomes, as articulated by the individual in both identifying and meeting their goals and aspirations.

Thank you. And Adrienne, Chris, and Don, thank you for kind of getting that discussion going. Any other comments to usability? I think this will be a continuing dialogue. But specific to 3593, anything else that anybody wants to bring up?

Gerri, this is Rich Antonelli. I'm struggling with this because I think at the-- I agree conceptually with everything that's been said, but where I'm struggling-- and this likely will apply more to 3594, but it is rooted in some of the discussion of 3593-- is it's the final vetting authority, if you will, here is actually not the patient. It's an extra-- external to the patient-- interpretation on 3593 that those three or more priorities mapped to the FASI. And then 3594, while admirable, is the care plan meet those.

I've had the privilege of spending a lot of time with HCBS adults advocates, and there's an overall sense of fatigue of having those folks be told by an external agent what their priorities are. So I feel some tension. I want to pull that out. It's not as big a point as 3593 as it will be for 3594, but I do want to suggest-- and this is a little bit of the tension that I'm feeling around the validity side-- to the extent that somebody is interpreting the patient's view in terms of the elements of the FASI and then a subsequent care plan without actually having the ultimate arbiter of the validity of that be the patient themselves is-- I'm really struggling with that.

That said, I'm OK starting somewhere to move the field forward, but I just want to make a statement, and I would welcome anybody-- measure developers-- to tell me that I've gotten this wrong, but I see this not truly the voice of the patient, but in fact, an external agent's interpretation of the voice of the patient through the use of the FASI. But please tell me if I'm wrong.

This is Colleen. I can jump in and tell you that you're wrong, Dr. Antonelli.

Good, bring it up on. It'll help my chest pain. Please.

Perfect. So within the training that's built for the FASI, we ask that the data that are extracted for both this measure and the one we'll discuss next, that they use the words of the person being served. And so, while there is an independent third party that could be aggregating the data for the state or for the managed care plan, they're just really serving as a mouthpiece through which the information for the individual receiving HCBS documented their preferences or the items that go into their service plan.

So it's really just more of a logistical thing about getting the data out of wherever they are and into the calculation of the measures, and less about them interpreting or deciding what the priorities are. So it is designed that is the verbatim words of the individual being served are repeated to identify the priorities and create a service plan.

So then a follow-up-- and for full disclosure, I've been pinging back and forth with the chairs and Sam since the first session here-- it comes at that. So Colleen, what you just said gives me assurance, but you couched your response in terms of this is the guidance for implementation of the FASI. That's not what we're being asked to assess here. In fact, I'm going to quote everybody-- my granddaughter, who's six years old-- the more better way of thinking about these measures would not call out the FASI at all. It would say, the following domains or questions would be used, and here's how to do that.

That could be as close to a home run as we could get. So Don has asked this question a couple of times. I'm struggling with this, as well. Because your answer, I totally get it, but in the context of not being asked to evaluate FASI and being asked to evaluate 3593 and then eventually 3594, without that critical information that is FASI-specific, there is a gap in the logic model that I'm having crossing that bridge.

Having said that, I'm one of the proponents that we have to do something about HCBS. Please bring it on. But Sam, she basically affirmed what I've been pestering you and Gerri and Chris for the last couple of days. So are we talking about FASI and how it should be appropriately administered, or are we talking about 3593, 3594, using an instrument that needs to be implemented, using the very critical information that Colleen just shared, whether it's FASI or not?

Sam, do you want to weigh in? It seems to me we're circling the PRO-PM discussion again, and I think Rich's point is an important one. Do you want to just kind of give us a place to launch from so that we can keep moving?

Yeah. And Dr. Antonelli, I really appreciate your perspective on this. I think it's a thing that we need to be very considerate of as we're thinking about moving a measure forward with NQF endorsement and what that means. So when we say that a measure is NQF-endorsed, the reason that we make a distinction between endorsing an instrument and endorsing a measure-- because one, we want to make sure that those who use this measure understand that we are agnostic as an organization to the data source for it, and if there's a better one out there, great. Let that one come forward and go head-to-head with any other data source.

So that's the point that I want to emphasize here is that the FASI instrument is serving as a data source to identifying needs and matching those with priorities, and we don't care where that comes from for the purpose of this measure. What we're actually looking at is the measurement itself. Is it important for us to measure needs and accompanying priorities? If the answer to that question is yes, NQF does not require a measure developer to analyze every available approach, only to recommend one, or to come forward with one. And if theirs works, then we're OK with that.

So if there's other ways to come forward that are better, great. They should bring them forward. And the market needs associated with it may drive something else to come to the forefront. But at least from the staff point of view when we were looking at this, we didn't see that as a particularly problematic related to it. In fact, there's a dearth of good instruments that are available-- specifically, a standardized instrument-- that can extract this information for use.

So personally, I didn't feel uncomfortable about the FASI being used because there's just so few things in HCBS that are appropriately serving the needs of that population. And there's a strong message that we've received from outside stakeholders that this needs to be documented, it needs to be part of service plans. And so we at least-- as staff, when we were analyzing this-- felt that the measure developer's approach both aligned with NQF priorities and policy, and wasn't stepping out from that.

But again, the overall emphasis is that we don't endorse this based on the underlying measure and we are agnostic to the data source, and if at some point the measure developer comes back and says something to the effect of, OK, well we'll accept any instrument that includes this capturing of needs and priorities and it doesn't matter, or you can use this list of instruments that we've looked at, that's also fine for appropriate updating. But the staff are OK with this as a starting point.

But I guess I just--

My suggestion here, Rich-- hang on just a sec-- is that this is a critical issue, and I think it needs to be recognized. We have spent a good part of three hours now on this issue, so I'm wondering if-- first off, I don't know that we're going to resolve this tension. I just need some guidance here because it has garnered a significant amount of our time and attention, and it's an important issue. Do we go forward on a vote, do we table? Because we're going to hit this again in 3594. Please guide here.

Are you asking me?

No, I'm asking Sam.

I was going to say, that sounds like a Sam question.

I'm sorry, I was thinking it was a Rich question.

No I'm just thinking--

Sam, I'll arm wrestle you. Let's figure it out.

This is a critical question, but we have spent a huge amount of time, and I don't know that we're going to resolve it. So do we bring it now to the committee to-- hang on, Rich, just a sec-- do we bring it to the group to say are you ready to vote one way or another? Because we could be discussing this for the next hour.

I think you're right, and we do have quite a bit more to cover. Rich, anything else you wanted to say about it before we move forward?

Literally, I'll say one thing, but I'll keep it to 60 seconds or less. I don't see this as a PRO-PM issue, which is why I'm bringing it up. I think what Colleen just shared about the way the instrument-- whose name we won't use-- needs to be used to inform this measure is critically important. And I don't know that I've heard those words in the day and a half that we've been debating this, and that's what I'm struggling with. If Colleen can say, Rich, you can't do the FASI without this, and/or if that language could migrate into 3593, and especially in 3594, then we fix the whole thing.

And I just think the magic four or six words that Colleen just shared is critical. Otherwise, I actually can't say we're getting the voice of the patient in either of these measures, and that's why I say I'm politely but directly pushing back on that observation. This is an interpretation of the voice of the patient, and we should discuss the validity of that. That's a different issue. But I need to know that what Colleen said about administering the four-letter instrument, whose name won't be used, is critical to the role of 3593 and 3594.

I'm stuck. But maybe we could fix it that easily. But I absolutely, as always, will defer to the NQF team as to how to go forward. But do not call this the voice of the patient, I completely disagree with that. It's an interpretation by an outside entity of the presumed voice of the patient, especially for NDD patients, IDD patients, and possibly others.

Colleen, you want to say anything in response? And then Sam, I'm thinking Rich's point is really well taken. I don't know where to go but to vote after Colleen says something.

Oh my goodness. There's a lot to unpack there. I would turn it over to my colleague Ken to see if he has anything to add. I could talk a lot about this, but I know Ken had a point he wanted to make.

Thank you. I agree, Colleen, that this needs to be unpacked a lot. But what I can say at this point is two points as when we were collecting data. Number one was that in many cases, individuals who were eligible for or becoming eligible for home and community based services might not necessarily understand the questions of the areas that we were looking at.

Again, this PM works specifically on function, the functional level of a person. So therefore, when we were describing things like self-care and we were asking them what is their priority in this area, it actually became very important that they had initial triggers to say, oh, I understand the area that you're asking me about. So I think on the very highest end that in asking the question, what are your priorities-- it's a very global question-- I think in some cases can be very challenging for anyone.

But the second thing, if we're only looking at function, the items themselves become-- how should I say-- a guideline of those areas that one might want to be very specific about when it comes down to the priorities. And then in its relationship to individual service planning, it becomes very important for everyone to understand what specific area in self-care is this person really prioritizing, what do they really want to work on.

Don, I have to say, I probably would disagree with you also. It actually provide-- in the training, it was very clear that they were asked to document specifically the words that they used, that the individual used. So I think that's the best explanation that I can give for this system. Just to the point, lastly, is we have to begin-- again, my opinion, and it's biased-- we have to begin the process of patient-centered care. This is one way of doing it. It is our suggestion that it's an appropriate way of moving forward.

Thank you, Ken. I think this is a tough issue, and I appreciate, Rich, your emphasis. I'm wondering-- and I'm going to reach out to the committee now-- are you all comfortable to vote on what you're hearing, what you understand to be the issues right now? Can we take a straw vote? Sam, I don't know whether there's a choice in there that gives us inadequate or whatever that we can get a sense of things. I'm just concerned that we continue with such a complex issue in this venue.

Right. So we're going to vote on usability, which is not a must-pass criteria. One of the things that the developers offered is to issue a public comment during the course of the public comment period that's response to Dr. Antonelli's concern. Namely, are we capturing the voice of the patient truly, and is that reflected in this process measure. It sounds like this has been responded to by the developer to some extent, but maybe time doesn't permit us to go into the full level of detail that we might find helpful.

So nonetheless, I don't want to ask Dr. Antonelli or anyone else to suspend disbelief. So we are at kind of a tricky spot, but at the same time, we do need to move forward from where we are. So what I would suggest we do is that we do make a vote on usability and see where we land with that, and have that be essentially our straw poll. If it passes on usability-- again, not a must-pass-- so that if we don't reach consensus and we don't reach consensus on the final vote, we'll need to have a much more in-depth discussion on the [INAUDIBLE].

With that-- and I think we'll take the straw vote-- and I think, Sam, you're also saying this is not going to be the end of that discussion and we just need to see where we're at right now and that we can go forward. So why don't we take the vote and just move forward.

That sounds great. Udobi, can you open up the vote on usability?

Yes. The vote on usability is open. Your options are high, moderate, low, and insufficient. The vote on usability is closed.

We received zero votes for high, eight votes-- the votes just updated. One moment. OK, we have an additional vote that came in. One moment.

OK. We have zero votes for high, nine votes for moderate, seven votes for low, and two votes for insufficient. So I believe this is consensus not reached, Sam.

OK. Clearly, we have identified several issues in the course of the discussion about 3593 that are relevant to 3594. I just would like to close the voting-- Sam, I'm assuming you'll share where we're at-- with a big thank you to the committee for your thoughtful comments to the measure developers. You have been with us every step of the way, and that is just so appreciated.

And Brenda and Adrienne, excellent job. Nice reviews. Thank you for that, as well. Sam, back to you.

Sam, can I just say something real quick? This is Peter Thomas. Real quick, this is now the second time we've considered home and community based measures, and we've essentially said no. And I've got to tell you-- I mentioned this earlier in the week when I couldn't remember exactly when we did this-- but we've done this before. Not this exact measure, but the same subject matter. And this is becoming more and more of a way of delivering care in this country, and it's the predominant and the preferred method of delivering care for particularly people with disabilities and chronic conditions.

So I guess I'm more pragmatic than the people who are voting here because I recognize their arguments, but I think we desperately need to get some of these measures in place, and whatever NQF could do to work with the developers to ultimately get this across the finish line would be strongly endorsed by me. Thank you.

Thanks, Peter. And actually to your point, we do still need to take a vote on overall endorsement. So having this final discussion actually is-- that's right in line with the sort of conversation that we should have before we make that final vote. So Gerri, did you want to open it up to any other further comments from the group, either in support of an overall endorsement of the measure or against before we move forward with that final vote?

Certainly. Anyone who wishes to speak in favor or not. Thank you Peter for stepping in. And I would just ask if you can keep your comments short so we can move into this.

Gerri, this is Chris Stille. I'm going to agree with Peter here. I think-- great discussions. Absolutely great discussions, but I think it's important to move forward.

Thanks, Chris.

Gerri, I [INAUDIBLE] have my hand up. Just quickly, I totally agree with Peter. I think the issue at question is whether-- everything that we have here is usable. The question is is it important to put it right into public reporting and payment immediately without further work. That's all.

Thanks, Don. Randi, did you want to say something?

Yes. From the patient perspective, I think it's important for us to think about the functional needs and realize that the differences between patients might be minute, that on the grand scale, when we're looking at function, there's not that much change, and for us to be concerned about the exception to the rule and to make sure that we have everything perfectly aligned I think will do a disservice in the overall process of what we can actually be putting out there. And so therefore, I'm very much excited about this measure and I think that it could really move things forward.

Thanks, Randi.

This is Brenda. Can I just add that I also support Peter's views. I understand the importance of having the patient's voice, but I think that there's so much inconsistency in terms of how information is collected and used that this would be a good first step to move the field forward.

Thank you, Brenda. Any other comments before we move to a final vote?

I would love to make a comment just around-- let's take lesson. We're all united around patient-centered care-- I'm making that implicit assumption, otherwise we wouldn't be on this committee, I hope-- and yet, the realities that clinicians face are there's a ton of great questions we could be asking you about preferences. We need to be asking the most important ones that patients should be defining.

We know from other lessons like advanced directives that family members and other interpreters of patient preferences are invariably poor. Even when you know and love that person, you are not an effective communicator of end of life wishes. And so I'd love us to be learning and iterating on what we really know about best practices in the patient preference basis, rather than just trying without the promise of failing fast, trying again. These are some permanent, it feels, committed decisions we're making about how we're going to do it. And that gives me chest pain.

We're not fast and iterative enough to learn and fail, learn and fail as we probably should be in the space, which makes it hard to commit to out of the gate. So recognizing incredibly important field, but this argument of let's just start somewhere doesn't work with me as much. We've tried in advanced directives and I think we haven't learned our lessons there yet.

Thank you. Any other comments? Incredibly thoughtful comments. All right, let's go for it. Udobi, you want to put the vote up?

Yes. The vote for overall endorsement is open. The question is, does this measure meet NQF criteria for endorsement? Your options are yes and no.

OK, The vote for overall endorsement is closed. There were eight votes for yes and nine votes for no. So this does not pass.

That would be consensus not reached.

OK. Thanks, Sam. Consensus not reached.

No worries. OK, well we will be revisiting this. To the measure developer, of course, we hope that the concerns that the committee had were well understood. It seems like there's a lot of emphasis particularly on the patient-centeredness of this measure and is it actually capturing the voice of the patient, and is this what patients would find desirable in the sort of measures that were to put out there. So we'd welcome your public comments in the meantime, but we'll give you the opportunity to discuss this with the committee when we reconvene in May after our public commentary period on the report.

All right, let's move on to our next measure. I believe this will be led by Dr. Stille. And this is measure 3594, Alignment of Person-Centered Service Plan with the FASI Needs. The brief description is the percentage of HCBS recipients aged 18 years or older whose person-centered service plan documentation addresses needs in the areas of self-care, mobility, and instrumental activities of daily living as determined by the most recent assessment. Handing it over to you, Chris.

Great. Thanks, Sam. And just to the group, it would be really great to try and get some closure before we finish in another 37 minutes. As Sam said, this is somewhat similar to 3593, except instead of talking about priorities, it talks about documentation of needs in the service plan. Ryan Coller is the primary discussant. Oh, first-- sorry, Colleen-- let's give you a few minutes to talk about this measure.

Excellent. I'm going to be very quick because a lot of the information I presented on Tuesday for NQF 3593 applies here, so this speaks specifically to the intent of NQF 3594. And so it is to improve alignment of service plans for individuals receiving HCBS with functional needs based on the FASI. And in this context, service plans focus on determination of a participant's needs, and that the participant receives services that are consistent with what is documented in their plan.

Doing so can improve outcomes for the individual and addresses the gap within the person-centered supports and services measure portfolio more broadly. And so this measure assesses the percent of

HCBS recipients who are aged 18 years and older, whose person-centered service plan addresses the needs in the areas of self-care mobility, and IADL as determined by the most recent FASI assessment.

Use of a person-centered service plan may lead to breadth of improvements in participant outcomes, including increased responsivity from providers for his or her unmet needs, enhancement and documentation of participant needs within a service plan, and more broadly, increased standardization of functional needs assessments within the HCBS environment. So as I noted on Tuesday for NQF 3593, our team performed a series of qualitative and quantitative efforts to assess the measure's evidence base, distribution of performance, scientific acceptability, feasibility and usability. I hope this discussion is just as robust, and we look forward to hearing your questions on NQF 3594.

Great, thanks. Ryan, are you ready to present an overview of the measure?

Sure. I'll be brief because I do think a lot of where we left off is extremely relevant and will come up in the specific sections as we go forward. And I think as far as the overview goes, I think the general consensus across the pre-review comments and the staff comments were that on its face, the concepts that are really being sought after with this measure are important and in really a high priority.

Two questions I was hoping Colleen maybe you could speak to that might preempt some of the conversation as we get into the sections. I think building on some of the notion that we left off on with the last measure, one of the key distinctions here is that this measure reflects that needs were addressed in the service plan. And the word "addressed" seems to be really a critical piece. And to some extent, it felt like-- to me-- I wanted to hear more about how that judgment gets made because it does feel like it is a judgment that has to be made.

So a little more detail on an abstractor or making that call. How do they do it, what's that like? I know we have data on reliability, validity that we'll get to, but maybe just at a high level, you could walk us through that. And then I had one other comment after that.

Absolutely. I'm actually going to turn it right over to my colleague, Ken, to talk about both of those things, the needs addressed in the service plan and how the judgments are made if they are addressed.

Sure, thanks. So I think it's important to note that at the time-- when we tested it, actually-- that they had an abstract form where actually they had the written words that were used by the individual who was receiving those services, in addition to what their service plan was in existence. So they basically compared what they had already.

It's also important to note that the individuals who are doing it, that's actually their job, to determine the level of services that are required based on the assessments that an individual would go through to determine both eligibility and the levels of services that they would need. So I think when it comes down to it, basically part of this is the job that they do, that these administrators on a daily basis look at the alignment between the need for service and the service plan that's eligible within that state and within the contractors themselves.

So I guess what I would suggest at this point is this is the kind of job that they have, is to look at the services that they need to provide. And I do need to say one thing. I think sometimes we're using the term patient, and we're using this term almost in a medical or health systems framework. I think it's probably important to realize that we're really outside of that framework now, but really look at those individuals who are requiring services to live their life at home. So therefore, that kind of determination of the types of equipment that they need, the services that they will need, those kind of paid and unpaid services, are in fact determined by these case study case assessors within the state.

So it isn't like high blood pressure, here's your medication, you're taken care of. It's very much more complex when they're looking at-- OK, we have functional measures of mobility that shows deficits, and therefore I can have the individual's priority, what do they really want us to take care of, and then have the services that are be able to provide that within that state. I'm not exactly sure if I answered your question, and I'd be certainly able to answer follow-up questions if I can help you with that.

I'd be happy to wait. I think this sort of gets at validity and some of the other downstream sections, so I think we could probably table the rest. I think probably at the root of my question is this issue around a judgment that a need was, quote unquote, "addressed," which may have shades of gray or differences of opinion in the frame of reference of who's making that call. But I think we can get into that in validity. Chris Stille, I don't know if you wanted to talk more about that now or later.

Yeah, I think that's fine, Ryan. It does seem like a validity question, specifically, is this really how is this judged.

And then the last overview question I had-- again, just making sure understanding the measure and everyone on the call is thinking about it the same way-- kind of an area when I was reading the specifications, I got a little confused and wanted to just clarify that I'm understanding it right. For a moment, I was wondering if the measure was actually looking at the number of needs matching the number of needs addressed as the core issue, and I think instead-- I just want to confirm it's right-- is that actually every identified need does have a matching service plan item that demonstrates that the need was met or addressed. Is the latter the correct interpretation?

Yes.

Yes. OK.

Yeah, Chris, I think Dawn was the secondary--

Dawn Hohl's the secondary. So Dawn, did you have some overview comments?

I really didn't, and I'm driving so I don't have my notes with me, but I really don't. There's been such great discussion. I don't think I have anything to add.

Good. Thanks. Thanks very much. So let's go through the different criteria, evidence, I guess, being the first. Ryan were there any comments that you had related to evidence, or an overview of what the pre-evaluation comments were?

Sure. I think essentially what applied to the last measure applies to this measure, frankly. The prelim rating was moderate, and all of what applied to the past applies to the current. So in the interest of time, I'm happy to leave it at that. The pre-review comments were largely reiterating I think the things that we've discussed, and then there were some positive mentions, as well, that deserve note. Somebody highlighted this as a key to reducing overuse in their opinion and so forth.

Dawn, anything from you related to evidence?

No.

OK, great. Good. Let's--

Don Casey has his hand raised.

OK. I was just going to say, let's open it up to the group, and Don, I see your hand.

Yeah, I wanted to ask the reviewers if they read my email from Monday or not. And maybe what I'll do is go back to asking-- I assume the measure developers were the ones that did this-- but as I pointed out on page six at the end of the second full paragraph, the reference that was given for the statement that said that majority of participants reported high program satisfaction was incorrect. In fact, the reference, the DOI, was for travel time to clinic, but not neighborhood crime rate is associated with a retention in care among HIV-positive patients.

So I actually found the right Kirk reference, and I've read it over and over again and I'm trying to find the language that was quoted here on page six. But to quote the end of the study, "the study underlines that satisfaction seems an insufficient guiding factor when evaluating care programs for older adults, as it appears to have no link to the experienced effects of the assessment program." So I assume this was a mistake, but I just think that the reference that's presented here is not reflective, in my opinion, in the document of what the reference actually says, and in fact, to me, my interpretation it says something that seems much more opposed to what is stated in the report.

And I sent [INAUDIBLE] on Monday, so you should have it. But it begs the question about our ability as a committee to watch over and curate this, and I'm concerned about this because it's not the first time it's happened to me in one of these forms, where a reference was misplaced, and actually when you changed it or took it out, it changed the entire coloring of the evidence, so to speak. So I raise this also as a larger concern relative to the fidelity of the process.

Colleen, why don't you go ahead and respond.

Yeah. Thank you, Don, for highlighting that. I have what seems like a ream of paper here that has all the items, and yet I cannot find the specific point that you're referencing. And so I do apologize if there was a mis-cited--

It's reference 15, Colleen. It's reference 15 in the report.

OK. Still-- OK, so acknowledging that if it is a misquotation, again, apologies for that. That's something into which I want to look after the call today. I don't feel comfortable providing-- I now see where you're referencing, it's on page five in my attachment-- and so I would like to go back and make sure that we're providing you the correct information, and so I take your comment as you've as you've phrased it, that there might be a misinterpretation of what we describe, and we'll make sure that that is corrected in all future documentation.

Great, thanks. OK. Fair enough. Others' concerns about evidence?

This is Shari Erickson. I guess I would just speak of-- I think it's a little problematic to me in terms of voting on evidence when we have an issue such as what Don raised. I don't know if others share that concern, but I certainly do with what Don raised. I think it's an important point.

From what Don sent me, and from what-- I took a look at the paper, and basically, that one paper didn't really-- it said something different from what was described in the evaluation, from what I could tell. But obviously we need to look into that.

Sorry, I muted myself. With what we have, are there any other thoughts about evidence before we proceed to a vote on that? OK. Well, let's go ahead then.

OK, the vote for evidence is open. Your options are moderate, low, or insufficient.

OK, the vote for evidence is closed. One moment. Sharing my screen.

OK, there were six votes for moderate, six votes for low, and six votes for insufficient. Sam, I believe this actually-- let's see-- does this pass, Sam? I'm sorry, I'm getting my numbers mixed up.

No, so this would be 66% are voting not to pass it, so we did reach consensus on this that it does not pass evidence. So this is actually where the conversation stops then related to this measure.

OK. So Sam, tell us what we should do then.

Yeah. Colleen, I know this is not the result that you were hoping for, so that never feels good. So just wanted to one, recognize that you've been through a challenging conversation with our committee today, and thank you for persevering. This doesn't mean that this is the end of the conversation because we do have our post-comment call. So we will be revisiting both these measures, as well as any public comments that we receive related to them, and going through any adjudication of those comments that need to occur.

The committee does have the option to reopen voting based on comments that we receive. Sounds like there's some very serious concerns, Colleen, associated with the nature of the evidence that has been presented, so perhaps the best thing for you to consider is one, submitting a public comment for the first measure, especially related to capturing the voice of the patient and ensuring that it's not an interpretation of the voice of the patient that's being represented by the measure. I think that that would go some way to assuaging the concerns that have been expressed that resulted in the consensus not reached.

And if any committee members would like to emphasize some other points that Colleen and her colleagues could address through their public comments-- especially related to that first measure, and then we'll come back to 3594-- but anything else that you would like them to address before we convene? I just want to open it up for the committee for any comments along those lines.

Sam, this is Chris Stille. I'm trying to think of what would help us make the best informed decision given that there's a lot of lack of consensus. And I don't know that this is ever done, but just kind of walking us through an example of what this would be like for a patient, what the FASI is like, really digging into how you decide, OK, does this does this constitute needs being addressed or not, and what would and what wouldn't.

For me, I think that would be really helpful. Just some concrete example with some representative but made up data would really help.

I have to share that I'm struggling here. I'm still thinking about the previous measure along with this one, and also reflecting on my experience co-chairing care coordination for a long time, in that while I appreciate not moving forward because of some of these issues, I also struggle with getting things moving and that we're not going to have perfect measures, but what is good enough to keep going forward?

And I'm concerned. I'm disturbed, I'm concerned. I think these are important issues, and I think we need to continue to dialogue together because I think we all share deep, deep passion and concern for the patient's voice and how do we move through this. So I'm feeling unsettled.

I think that that's characterizing how a lot of members of the committee are feeling, Gerri. And of course, the reservations that are held by others related to ensuring that we get this right are no less valid. The thing that I find particularly disconcerting is that these sorts of measures were specifically called for on an NQF committee that consisted of representatives that have people living in home and community based settings, both from IBD from the older population, as well as those with severe mental illness and the like.

So that is concerning to me, that another NQF committee specifically called for measures like this, and we have a very different take. Not to say that it's wrong to have reservations, but it is something that we clearly need to come to terms with. So let me just not overstate this-- Don, I see that you have your hand raised. What did you have in mind?

Let's divide the question because I think we're-- look, I'm just I'm disappointed as all of you. I want my family to get really good care, especially one of the people that I love that is getting these services. I think that's not the issue. The issue relates to the usability and the readiness for prime time of the measure, and I think that's a different question here, and I'm not convinced yet that putting it out like this, especially with the error in 94 is going to make a change yet.

So we're not saying forget about it. We're just saying go back to the drawing board and let's make it better. I hope everyone agrees with me.

So, Don, I guess the question that I have then is is there something about the submission, either for the first measure or the second-- you clearly identified the issue associated with the evidence, so we don't need to dive in too far with the rest of the measure on 94-- but anything from 93 you think in the submission that the developer could do better?

I think several people have already said what I've said, and that is we want to see more understanding of how meaningful this is to the end users, i.e. the patient-- and I can understand that this is not in a medical sense-- but many of these people are getting medical services within the health system unfortunately living at home. So the issue isn't whether it's medical or non-medical, it's the system. And so we're just asking-- I think I speak on behalf for a lot of people-- to see a lot more-- I won't use the word evidence-- significant view from a patient and family standpoint, which is where it needs to meet the road. So I think that's lamely what we're trying to say here, Sam.

Thanks, Don.

Sam, can I offer a comment?

Well let me just recognize Chris Dezii, he had his hand up. Can we start with Chris?

Thank you, Sam. I just wanted to start by saying don't get too down in the dumps that this was referred to us by another committee because I'm sure the reference was more about a feeling and a title and this kind of stuff. We dig into this and we look at all the parameters, and like Gerri said, we gave an hour and a half on a topic to really dig in deep. My gut says this is great as QI.

I agree with Don's point about it's not ready for prime time yet. What bothered me is the fact that all the findings we would get if we did this-- really, it's not ready for accountability yet. But for the learnings and to pass it forward, I think that's great. That's all.

And I happen to think-- I'd like to think that the approach that I was looking at this was a pragmatic one, into actually making sure it's fit for purpose and represents the patient's voice. I'm torn. But that's all.

OK. Dr. Boissy?

Thank you. I learned how to put my hand up, so that's--

Good job.

Thank you. So Gerri, I hear in your voice a shared sadness. I think the sadness is around if we're committed to a person-centered care, patient-centered care, defined as respecting the needs, values, and preferences of patients, we as an industry are not making huge strides there yet. And this singular measure discussion is reflective of that national, I would submit, opportunity/failing.

And so I'm not one to criticize without offering a solution. I actually think rather than spending time on one measure or another measure or Coleen's revision, there's an opportunity to have a national discussion, perhaps within NQF, as to how should we be measuring patient-centered care as a national agreement. Can we come to national agreement around what that really is. And if we could agree there, it would make these discussions much easier. But we don't have the forest, and therefore we're stuck in the trees.

And so I would offer my time. I'd give you days of my energy and brain power to contribute and solve for that. So that is my offer. I also want to honor Colleen because when a measure fails on person-centeredness, I think we've all failed. And the system has failed in supporting what this represents and what you're trying to accomplish, and I take ownership of that, too. I think we all have to shift this dialogue.

And Colleen, I honor that you're much smarter than me. I can't spend my life working on the evidence around these measures and the right evaluation. I can't imagine the number of hours and drafts and energy that goes into creating them, and I want to honor that in you because this is an opportunity for all of us to do much greater. And if you spark that conversation, kudos to you because we have an opportunity right at our fingertips, and boy, I hope NQF grabs it because this is indicative of a much larger discussion.

Thanks, Adrienne. So we had two hands raised-- sorry, three. We've got Shari Erickson and then Rich Antonelli and then Randi Oster.

Thanks, Sam. This is Shari. I really I think want to echo what was just said by Dr. Boissy, as well as Chris before her and others. Gosh, I really want us to figure out how to do this stuff. I feel so strongly that we need to figure out-- and I know that this isn't technically a PROM or patient reported outcome measure-- but we need to figure out how to get these things right and how to get them more robustly incorporated into the programs.

The challenge is getting to the place where we can feel really comfortable that they can be used meaningfully for accountability and payment. And that's part of the problem. It almost is like it comes to NQF and-- there's definitely some evidence around it and some testing that has happened, but when you really compare it to some of the clinical measures, the ability to do that or the processes around doing that just aren't as robust, and so it's really challenging to get it to that same level, to feel comfortable that you can hold-- these will hold physicians or their practices accountable in terms of reporting or payment.

I recognize that this hasn't been used for that purpose yet. One of the challenges, quite frankly-- and this is, again, a higher level conversation outside of this measure this committee-- is that NQF endorsement implies readiness for use, for reporting and accountability and payment. And that may or may not be the case, and I wish you know it didn't do that, in a sense. I wish that we had a way of really saying, this would be a great measure to use for QI-- getting at what Chris was saying earlier-- and we need to do that.

There need to be a more robust set of measures like this that are used for QI, and then we develop the data behind them to really then think, OK, well these are the best subset of those that we could layer into reporting and accountability. And unfortunately the nuances around the NQF process, at least to date, don't really allow for that. And it's almost-- it's like black or white. It's either endorsed and then you can use it for QI or accountability, or it's not and then it has to go back to the drawing board, so to speak.

And I just-- I don't think that it should be that, particularly for these types of measures. So, sorry, I'm on my soapbox about this. I just feel so strongly we need to figure out how to do this, and it seems like it lands on the NQF process to fix it. And that's not what-- there's upstream places where this could more ideally be addressed, but resources around that and investment in doing that is challenging. It costs a lot of money to do those things. So I'll stop there.

Thank you. Dr. Antonelli, you're up.

Thank you. I'll be brief. I think I've got just three quick bullet points to make. The first one is I am profoundly disappointed. But Colleen, let me be very clear, I actually think 3593-- I would have embraced it if it was framed as an interpretation of the voice of the patient. I have no problems with it at all. Dr. Boissy, I'm applauding you because I couldn't be half as eloquent as you are. You sure you're not a pediatrician? Just saying.

But I want to make the following point. As we have this national debate and try to come together with what is the North Star, there's no reason that intermediate steps shouldn't be taken in this area. These patients need us. The LTSS population needs something. Sam, to your point about-- there was a gap there, there was a group at the NQF that made these recommendations. In fact, the person that I was channeling today with my comments was on that group, and what he said to me is, Rich, I don't want other people telling me what my priorities are. I want to tell them, I want them to record my priorities.

So that doesn't mean that one is more important than the other, although it is arguable that the true patient voice is, but to the extent that 3593 is a step in that direction, that's great. And then Colleen and team, that whole notion of if we give it a thumbs up and it moves quickly into accountability and uses up all the oxygen so that we can't have the more robust debate about the North Star measure, patient experience, we've actually done harm to this population.

So I feel strongly, it's not an either/or, NQF colleagues, it needs to be a both. We can do them sequentially. And I guess I will stop there and just acknowledge the tremendous work that's done by the team, Collen, by the Lewin group and the CMS stuff. Bring it back and let's segment. It I'm ready to hear it again.

All right. And Randi Oster, you're up next. Randi, you're muted.

So I just wanted to say I agree with everything that has been said and the desire for us to find the solution. I want to share that the obstacle that we have is we're challenged with coming up with a measure for a process that starts with the patient, and therefore, we're starting at the end trying to go to the start and understand what that true north is. What I'd like to leave with the group today is to know that there are best practices that exist that we can leverage to take that North Star, which is called the patient experience, which turns into satisfaction, which can then turn into the measurements, and that I, like Dr. Boissy, would like to say I've done this.

Please reach out and I can share what those best practices are. They're done in industry over and over and over again, and the challenge that we have is that we're flipping a system, and it can be done and we shouldn't give up. And so that just because this didn't work today does not mean it's not important, and it does not mean we don't have to look at it again.

OK. I think we need to curtail our conversation at this point. Thank you for that last point, Randi. We have about three minutes left in our call. We are going to go through some next steps, as well as open for public comment. So let's go to that phase.

One other thing that I'll say about this, for those of you that have remaining questions that you'd like the measure developer to ensured that they are captured, you may feel free to send those to the staff and we can pass those along to the developer to ensure that the public comments that they put forward in advance of our post-comment meeting are addressing the needs that you have to resolve any internal issues related to where you want to land on our final decision making associated with our recommendations for these measures.

At this point, we are now open for public comment for both NQF members and members of the public. Please feel free to speak up-- no need to raise your hand-- and if you'd like to have a comment read by the NQF staff, you can put it in the chat and we will read it. Public comment is now open.

OK. When I say, "awkward," you say, "silence." Awkward. All right. Let's go ahead and move on and finalize our meeting. Just a couple of next steps for us to review, we will be preparing a draft report detailing this discussion, as well as the recommendations that were prompted by the committee. This will be released for public comment for 30 days, then we'll reconvene for a post-comment call, specifically to adjudicate those comments.

The final recommendations that will be made and finalized by our committee will be passed along to our consensus standards approval committee, CSAC, and they will finalize any endorsement decisions or potentially refer measures back if they feel like we have had significant departures from process, which I don't think we've departed from process, so to speak. Anyway, there's also an opportunity for the public to appeal endorsement decisions, but those are only for measures that have achieved an endorsement of finalization.

Just to look at our timeline coming up, our draft report will be completed by March 24, and then we'll have the commentary period for the 24th through the 22nd. Committee post-comment meeting is slated for June 1. So sorry for misspeaking, I thought it was the end of the May, but it's going to be June 1. CSAC review will be on the 29th and 30th of June, and then the appeals period will open on July 7.

I just want to also update that we have a upcoming new cycle for Spring 2021. We did have two new measures submitted, both of which were deemed complex, meaning they will be reviewed by a scientific methods panel, will be convening at the end of the month. The topic areas associated with intellectual and developmental disabilities, as well as other issues related to HCBS. So more measures in this domain for us to be considering for our next cycle.

Just want to open up for a couple of final items here. Just any time you'd like to send us an email, you may do so. Our-- sorry, go back a slide please, Udobi-- is patientexperience@qualityforum.org. If you'd like to speak with staff, you can also reach us by phone, and we have the links included for both our project page, as well as our SharePoint page. Any questions from the committee before we adjourn?

Thanks to the chairs, they did a great job, and the reviewers.

Wow. Thanks for saying that, Don. I just want to re-emphasize that. Really big thanks to Chris and Gerri for excellent facilitation of a complex and very thoughtful discussion on the part of our committee. Big thanks to the committee. And Colleen and team, you are the Acme of perseverance. Thanks so much for sticking with us and for the very informative discussion that we had with you.

And so on behalf of the staff, thanks, everybody, and we'll sign off for now. Let me hand it over to our co-chairs for any parting words.

I'd like just to say thank you so much, Sam, for your great leadership, as always. Thanks to Gerri for really navigating tremendously interesting waters. Thanks to the group for a robust discussion, and thanks, especially, to the measure developers for being gracious and informative.

I would echo Chris. Well said, and I look forward to continuing this discussion and navigating a path forward for all of us.

Great. Thanks very much, everyone. We'll hang it up for now and just say have a great weekend, and we are adjourned.

Thank you everyone.

Thank you.

Bye now.

Nice job, Sam.

Thanks. Bye now.