2014 Input on Quality Measures for Dual Eligible Beneficiaries

FINAL REPORT
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EXECUTIVE SUMMARY

Nearly 10 million Americans are currently covered by both Medicare and Medicaid because they are poor, and are either over the age of 65 or have a disabling condition. These dual eligible beneficiaries often experience a combination of long-lasting healthcare needs in addition to complex social circumstance. Since more than half (55 percent) of these Americans have incomes of $10,000 or less, dual eligibility for both Medicare and Medicaid coverage is essential for this highly disadvantaged population to receive the medical care and social supports they need. Annual Medicare and Medicaid spending for dual eligible beneficiaries is approximately double the expenditures for beneficiaries of just one of these programs, amounting to a staggering $250 billion in 2009. The delivery of high quality care and services is paramount to addressing these healthcare needs and disproportionate costs.

Challenges for Quality Measurement

Improving the quality of healthcare and supportive services has the potential to make significant differences in the health and quality-of-life outcomes experienced by dual eligible beneficiaries. Significant opportunities exist to improve coordination of care and services for this population. Examples of these efforts include the creation of the Medicare-Medicaid Coordination Office within the Department of Health and Human Services (HHS) and the start of its financial alignment initiatives or demonstrations in partnership with states and health plans.

Quality measurement has an essential role to play as an important catalyst to stimulate improvement. Given the realities of this disadvantaged population and the resource-strained systems that care for them, only the most relevant measures of quality should be used to assess provider and system performance. Reported quality information should be meaningful, accessible, and understandable for the individual beneficiaries, their families and caregivers, healthcare and service providers, and involved government agencies. This information will enable all types of stakeholders to make more informed decisions about health and healthcare.

The complex interdependencies of healthcare processes, the impact of healthcare supports and services on individuals, and disparities in quality need continued exploration by the field. To accomplish this in a complex system, efforts need to be aligned and synchronized to measure, communicate, and improve quality of care. Alignment of measures across programs is essential for efficient use of resources and the reduction of redundant or duplicative requirements. Similarly, stakeholders need to be able to identify and apply the most impactful measures to drive improvement in healthcare delivery. The result of these coordinated efforts could be multifold: deeper understanding of what works across healthcare, the ability to make meaningful improvements, and
sharing of this information for broader application and additional benefits.

MAP’s Recommendations

In this report, the Measure Applications Partnership (MAP) provides its latest guidance to HHS on the use of performance measures to evaluate and improve care provided to dual eligible beneficiaries. The NQF-convened MAP brings together stakeholders from across healthcare sectors to provide input on the selection of quality measures for use in more than 30 federal programs. This is the fifth report from MAP on measurement of the quality of care for dual eligible beneficiaries. In this report, MAP builds on its prior work in this area and does the following:

- Updates the Family of Measures for Dual Eligible Beneficiaries and describes persistent gaps in measures;
- Explores strategies to improve health-related quality of life; and
- Describes an initial approach to gathering feedback from stakeholders across the field using measures to inform MAP’s future decisionmaking.

The updated Family of Measures for Dual Eligible Beneficiaries featured in this report is a group of the best available measures to address the needs of this unique population. These findings are especially important to healthcare quality professionals constructing measurement programs. Stakeholders can begin by selecting measures from this family of measures for application in programs involving dual eligible beneficiaries and other at-risk populations. This report also updates findings on measure alignment across programs and persistent measure gaps. These components could be informative to measure developers and stakeholders coordinating measurement across organizations, geographic areas, or settings.

MAP emphasizes the importance of challenging the traditional medical model with a social orientation to providing care and supports. For example, wellness services, pain and symptom management, care coordination, and facilitating connections to nonmedical services are essential for improving outcomes in at-risk populations. Building on findings from prior work, MAP explored specific strategies for improving quality-of-life outcomes for dual eligible beneficiaries. MAP provided input on the importance of models of care to facilitate improved quality of life, including person- and family-centered care, team-based care, shared accountability, and shared decisionmaking. MAP also advised the field on the development of performance measures from available indicators or surveys to assess health-related quality of life. These discussions serve as a jumping off point for consumers, advocates, and providers as well as health services researchers and social scientists who wish to explore these complex issues.

Measures to assess healthcare quality and performance can be complex. They require significant resources to develop, collect, and analyze. However, measures are essential tools to make the delivery system more dynamic, adaptive, accountable, and high-functioning. While the required financial, technological, and human resource investments are significant, so are the potential benefits of quality improvement for this complex and high-cost population. Significant progress in improving the quality and affordability of care cannot be achieved without robust quality measurement as a building block.

Therefore, MAP has described an initial approach to engaging stakeholders that uses measures to inform MAP’s future decisionmaking. MAP seeks to better understand the experience of program implementation and measure use to inform its future recommendations to HHS. All stakeholders are invited to participate by submitting feedback on the use of measures to NQF as this plan is developed and executed. NQF will also follow recommendations from stakeholders in conducting targeted outreach to collect the needed information. These efforts will further MAP’s ongoing work to improve the quality of care for individuals who depend on both Medicare and Medicaid.
INTRODUCTION

The Measure Applications Partnership (MAP) is a public-private partnership convened by the National Quality Forum (NQF). MAP provides input to the Department of Health and Human Services (HHS) on the selection of performance measures for public reporting and performance-based payment programs (Appendix A). MAP also provides input on the use of performance measures to assess and improve the quality of healthcare delivered to individuals who are enrolled in both Medicare and Medicaid.

The Medicare-Medicaid dual eligible population is a unique and heterogeneous group generally characterized as “vulnerable” or “high-risk” because most dual eligible individuals are affected by complex clinical conditions in addition to social disadvantages, including poverty. Keeping the specific needs of this population in mind, MAP convenes a broad range of stakeholders to discuss strategies to improve health outcomes in this population. The MAP Dual Eligible Beneficiaries Workgroup is a 29-member, multistakeholder group which serves as one of four advisory workgroups to the MAP Coordinating Committee (Appendix B). The workgroups are responsible for advising the Coordinating Committee on the use of measures to encourage performance improvement based on the MAP Measure Selection Criteria (MSC) and other inputs (Appendix C). The Coordinating Committee issues all final MAP recommendations.

This is MAP’s fifth report related to quality measurement in the dual eligible beneficiary population. It builds on prior work and also looks ahead to additional topics that warrant further consideration. The first section of this report describes updates to MAP’s Family of Measures for Dual Eligible Beneficiaries, including progress on measure alignment and remaining measure gaps. The report also highlights promising activities related to performance measure development in topic areas relevant to dual eligible beneficiaries and strategies that the workgroup considered to support improved quality of life outcomes. Finally, the report outlines a basic rationale for engaging stakeholders using measures in learning more about their experience to inform MAP’s future decisionmaking.
A family of measures is a set of related measures that best address an important quality issue and span the continuum of care. A family of measures looks purposefully across care settings, within specific content areas, and through varying levels of analysis to assess important quality issues and identify measurement gaps. To date, MAP has identified families of measures for seven topics related to the aims and priorities of the National Quality Strategy (NQS). Measure families for population health, affordable care, and person- and family-centered care were recently finalized and released in the report Finding Common Ground for Healthcare Priorities. As described in the report, “a family of measures is a starting place that stakeholders can use to identify the most relevant measures for their particular measurement needs.” Administrators of measurement programs can use each of the families of measures as a menu of recommended options to select the appropriate measures to fit their program needs. The family of measures is intended as a tool to promote the use of specific measures that capture high-leverage opportunities for quality improvement. The use of all measures within the family in a single program is not required or recommended.

MAP previously considered hundreds of measures for possible inclusion in the Family of Measures for Dual Eligible Beneficiaries and published the first iteration of the family in 2013. The Family of Measures for Dual Eligible Beneficiaries currently consists of 58 NQF-endorsed measures and one measure that is no longer endorsed, including 39 process measures, 11 outcome measures, 5 composite measures, 2 patient engagement/experience measures, and 1 efficiency measure (Appendix D). Measures are applicable across a variety of clinical conditions, care settings, and levels of analysis.

Updates to the Family of Measures
MAP periodically revisits the Family of Measures for Dual Eligible Beneficiaries to ensure that it reflects the best available measures. This section discusses the first revision of the family since it was released last year.

Measures are occasionally removed from the NQF-endorsed portfolio at the request of their stewards. This can happen for a variety of reasons. Since MAP’s last review of the family of measures, two measures within it have had their endorsement removed by request of their stewards. NQF #0486 Adoption of Medication E-Prescribing is a structural measure previously included in the Centers for Medicare & Medicaid Services’ (CMS) E-Prescribing Incentive Program. CMS withdrew the measure because there is no longer a federal program need for it. NQF #0573 HIV Screening Members at High Risk of HIV had endorsement removed because the steward opted out of the NQF endorsement maintenance process. With this context in mind, MAP considered whether the non-endorsed measures should be retired from the family of measures. Ultimately, there was consensus to retire the two measures from the family of measures because the stewards would not be making any updates to them going forward. One public comment noted support for the removal of non-endorsed measures.

In situations where a measure is retired from the family of measures, MAP determines if there is a suitable alternative measure that covers a similar topic. In the case of the structural measure of electronic prescribing, no alternative was available. Rates of e-prescribing have increased dramatically since the measure was first introduced, with one report estimating that 73 percent of office-based
physicians have adopted e-prescribing. MAP also considered alternatives to the measure about the frequency of medical visits for individuals with HIV, described below.

**Alternative Measures Related to HIV/AIDS Care**

When MAP initially selected measures for the family, members expressed the importance of screening all dual eligible beneficiaries for a variety of sexually transmitted infections (STIs), including but not limited to HIV. Specifically, adults with disabilities experience lower rates of STI screening due to factors such as inaccessible exam equipment and provider bias about their sexual activity. A broadly inclusive measure related to STI screening was not available for inclusion in the family, so MAP initially selected NQF #0573 HIV Screening Members at High Risk of HIV as the best available.

Although the ideal STI screening measure is still not available, MAP chose to replace the retired measure with another related to care for individuals with HIV/AIDS. This condition is disproportionately represented among dual eligible beneficiaries, and some Medicare Advantage Special Needs Plans specifically enroll beneficiaries with HIV/AIDS to provide them with specialized care. MAP considered five possible alternative measures that had been preselected by the HHS Measure Policy Council for alignment across federal programs:

- **NQF #0405** HIV/AIDS: Pneumocystis jiroveci pneumonia (PCP) Prophylaxis
- **NQF #0409** HIV/AIDS: Sexually Transmitted Diseases – Screening for Chlamydia, Gonorrhea, and Syphilis
- **NQF #2079** HIV Medical Visit Frequency
- **NQF #2082** Viral Load Suppression
- **NQF #2083** Prescription of HIV Antiretroviral Therapy

MAP reiterated its preference for a broad, upstream screening measure and expressed support for ongoing measure development activities by the Centers for Disease Control and Prevention (CDC) to provide a measure of universal HIV screening based on new guidelines. Until this measure or others are available, MAP decided to include measure #2079 HIV Medical Visit Frequency in the family of measures because of its emphasis on continuity of care. One commenter expressed their support for the inclusion of measure #2079 while also advocating for the inclusion of measures #2082 and #2083. Only measure #2079 has been added to the family of measures, but MAP is not opposed to the use of the other endorsed measures of HIV/AIDS care.

**Addition of Newly Endorsed Measures**

MAP will continue to monitor the NQF portfolio of measures for new additions that could be included in the family. Three measures have gained NQF endorsement since MAP’s last review. MAP briefly considered NQF #1529 Beta Blocker at Discharge for ICD Implant Patients with Left Ventricular Systolic Dysfunction and NQF #2065 Gastrointestinal Hemorrhage Mortality Rate (IQI #18). Both measures were found to be too narrow and would not address any gap areas within the family of measures. Neither measure was recommended for addition to the family. One commenter argued that measure #2065 is important because it addresses a mortality rate, but MAP’s conclusion is unchanged. MAP is not opposed to the use of endorsed measures of mortality, but there was not a compelling reason to include this measure in the family and designate it as a starting place for measurement.

MAP also reviewed NQF #2158 Payment-Standardized Medicare Spending Per Beneficiary (MSPB). This measure addresses the NQS aim of affordable care, a topic that is also a gap area within the family of measures. The measure captures the total cost of care related to a hospital admission, including 3 days prior to and 30 days after discharge. The methodology is very inclusive and captures services such as mental...
health treatment and discharges to skilled nursing facilities. Further, if the beneficiary is readmitted to the hospital within the 30-day window, measured costs will continue to accumulate until 30 days following the subsequent discharge(s). When the measure was reviewed for endorsement, the NQF Steering Committee encouraged the developer to allow for stratification by dual eligible beneficiary status and other markers of socioeconomic status to enable more understanding of potential disparities. Ultimately, MAP decided to include NQF #2158 Payment-Standardized Medicare Spending Per Beneficiary (MSPB) in the family of measures.

While the use of measure #2158 would provide important information about cost, it warrants specific mention that the measure includes only expenses paid by Medicare. Dual eligible beneficiaries also incur significant Medicaid spending. Without this information, one sees only half of the cost picture. Medicaid coverage is especially critical for individuals receiving long-term supports and services. MAP recommends the development of a similar measure of Medicaid spending per beneficiary.

Use of the Family of Measures to Promote Cross-Program Alignment

MAP promotes alignment, or use of the same or related measures, as a critical strategy for accelerating improvement in priority areas, reducing duplicative data collection, and enhancing comparability and transparency of healthcare information. Lack of alignment can be observed throughout the health system, but entities providing services and supports to dual eligible beneficiaries experience it acutely when the Medicare and Medicaid programs are not consistent with each other. MAP intends families of measures to be useful tools around which to create alignment of measures. Appendix E quantifies the use of measures within the Family of Measures for Dual Eligible Beneficiaries across numerous federal quality measurement programs. Of the 58 measures in the family, at least 41 measures are currently used in federal measurement programs.

MAP also endeavors to drive alignment in measure use across state and private-sector programs. Most notably, states are participating in partnership with HHS and health plans to launch and run demonstrations to better align care for dual eligible beneficiaries. To date, several states have each published a memorandum of understanding that describes a demonstration model, including quality measures to be used. HHS and states have looked to MAP to guide their selection of measures, as indicated by convergence on the use of a small number of key measures within the family that suits the purposes of the demonstrations. Currently, 14 measures in the family have been included in the CMS core for the Financial Alignment Initiative—Capitated Demonstrations—and 6 measures in the family have been included in the CMS core for the Financial Alignment Initiative—Managed Fee-for-Service Demonstrations. MAP will continue to monitor the use of measures in the demonstrations.

Comments from the public reflected support for MAP’s focus on alignment as exemplified by the use of a parsimonious family of measures. In pursuing alignment, commenters urged that the field favor use of outcome measures and measures derived from the analysis of claims data because they are more uniform across health plans. Comments also encouraged further testing and feedback on the use of measures in vulnerable populations to understand any potential differences in their performance. Finally, commenters urged MAP and HHS to balance the addition and removal of measures to fit program goals and population needs when making changes to program measure sets.

Refining High-Priority Measure Gaps

MAP has identified high-priority gaps in available performance measures throughout its work and will continue to do so. Measure gaps are an important component of each family of measures
because they indicate measurement needs not met by existing measures. MAP determines the priority measure gaps through deliberations that consider available measures to address high-leverage opportunities and program and population needs. MAP continued to emphasize that new and improved measures are needed to evaluate:

- Goal-directed, person-centered care planning and implementation
- Shared decisionmaking
- Systems to coordinate acute care, long-term services and supports, and nonmedical community resources
- Beneficiary sense of control/autonomy/self-determination
- Psychosocial needs
- Community integration/inclusion and participation
- Optimal functioning (e.g., improving when possible, maintaining, managing decline)

Current measures fail to capture the complex and dynamic array of conditions that are at play in a chronically ill person’s life over time. Resources must be devoted to research activities to explore new methodologies for measurement of complex topics, especially nonclinical processes and person-centered outcomes. As described in the following section, MAP welcomed discussion of ongoing measure development activities related to assessment, care planning, and setting person-centered goals. One commenter emphasized the need for greater focus on social issues that impact health outcomes, particularly sociodemographic characteristics.

MAP members also suggested that the measurement field should do more to address the social issues that affect health outcomes in vulnerable populations, including individuals with a history of incarceration and veterans of military service. MAP will continue to discuss strategies for filling gaps with organizations that fund and perform measure development to facilitate progress. As part of a separate project, NQF issued a series of reports in 2014 on priority measure development needs in areas of high interest to MAP, including care coordination, person-centered care and outcomes, and Alzheimer's disease and related dementias.

Public commenters supported MAP efforts to identify and prioritize measure gaps and offered additional measure gaps for consideration. Multiple comments emphasized the importance of the gap in measures of home- and community-based services. One commenter provided a list of alternative measures for flu vaccinations to be considered for inclusion in the family. Furthermore, commenters encouraged efforts to use measurement to identify and address disparities in care and meaningful outcomes in vulnerable populations. For details on these suggestions, see comments in Appendix F.
MEASURE DEVELOPMENT PROGRESS TO ADDRESS HIGH-PRIORITY GAPS

Performance measure development is complex, painstaking work that can take years from start to finish. Accuracy is paramount when measures are used to publicly report information about quality or influence payments. MAP continues to monitor changes in measurement science and the availability of new measures. While progress on addressing MAP’s measure gap priorities has taken time, there are now clear indications that measure developers and their funding partners have received and responded to that guidance. MAP members felt encouraged to see the influence of their upstream input and continue to offer their perspectives on planned and ongoing measure development efforts.

NCQA Measures in Development

The National Committee for Quality Assurance (NCQA) is an accrediting organization that develops performance measures. NCQA is developing new performance measures in two topic areas of high interest to MAP: assessment and care planning as well as goal assessment and achievement. Their methods to evaluate person-centered care for dual eligible beneficiaries stem from a white paper that described their model for evaluating quality. The model focuses on the consumer and family/caregiver perspective and coordination of a care team across settings.

NCQA develops and uses structure, process, and outcome measures throughout its standards for accreditation. The organization recognizes the relative and progressive difficulty of collecting data, demonstrating improvement, and holding providers accountable for high-quality care across these measure types. They are actively working to determine which structures are needed to underpin evidence-based processes, which in turn contribute to achieving desired outcomes. Further complexity presents itself when deciding how to quantify and measure these structures, processes, and outcomes. NCQA is continuing to develop measures that monitor progress in achieving optimal outcomes of care without misplacing accountability that might lead to unintended consequences (e.g., providers avoiding complex cases).

In collaboration with CMS and Mathematica Policy Research, NCQA is developing six measures for Managed Long Term Services and Supports (MLTSS) programs. These measures include:

- **Assessment Composite**: The percentage of newly enrolled MLTSS beneficiaries who have documentation of an in-home assessment with the following components within 90 days of enrollment
  - Physical functioning and disability, medical conditions, mental and behavioral health, needs and risks, social support, preferences and use of services
  - Documentation of involvement of family member, caregiver, guardian, or power of attorney in assessment (with beneficiary consent)

- **Care Plan Composite**: The percentage of newly enrolled MLTSS beneficiaries who have documentation of a care plan developed face to face within 30 days of completed assessment
  - Documentation of beneficiary needs in core domains
  - Documentation of beneficiary goals of care and identified barriers to meeting goals
  - Documentation of service plan and providers of services addressing needs including frequency and duration of service
- Beneficiary signature or that of their
guardian or power of attorney (POA)
- Signature of family member or caregiver (if
applicable and with beneficiary consent)

- **Shared Care Plan**: The percentage of MLTSS
beneficiaries with a care plan for whom all or
part of the care plan was transmitted to key
long-term services and supports providers and
the primary care provider within 30 days of
development or update

- **Assessment Update**

- **Care Plan Update**

- **Reassessment and Care Plan Update After
Discharge**

To inform testing of these six new measures for
MLTSS, NCQA sought MAP’s feedback to ensure
that these measures target a goal-directed and
person-centered care planning process. A shared,
longitudinal plan of care that is regularly updated
by all members of the care team (including the
beneficiary/family) is essential to improve care
coordination. Discussions revealed tensions
and differences of opinion as to whether the
measures are sufficiently consumer-oriented.

MAP recognizes the ideal process of developing a
shared plan of care to require an open, authentic
interpersonal dialogue between a beneficiary,
his/her family, and his/her team of medical and
nonmedical service providers. The purpose of
this dialogue is to understand the beneficiary’s
ultimate goals and to create a set of services that
will best support those goals. The dialogue is
very likely to extend over a series of interactions
and deepen over time. The care team must focus
on the personal needs of individual beneficiaries
and each person’s vision of how they would like
to live their life. One commenter provided further
recommendations to NCQA regarding the measure
development process.

During preparatory case studies, NCQA found
wide variation in practices for documenting and
monitoring progress related to goals, one of the
most basic aspects of a person-centered plan of
care. The concept of creating patient-reported
outcome measures (PROMs) related to goal
attainment received positive responses from
NCQA focus group participants. Consumers noted
that they would be a “good way to communicate
with my doctor.” More groundwork must be
provided to support standard practices for goal-
directed care and associated measurements, but
current activities show promise.

**MAP Discussion of Measure Development Challenges
and Opportunities**

MAP members asserted that the critical, yet often
intangible, aspects of person-centered beneficiary-
provider interactions (such as respect and
openness) are at odds with the methods available
to create objective measures of quality. Genuine
person-centeredness is not compatible with
measures’ building blocks of standardized data.
Empathy, self-determination, and collaboration are
not as easy to quantify and document as blood
pressure, body mass index, and smoking status. At
the same time, MAP has strongly and repeatedly
recommended that measures need to capture
the beneficiary perspective. It is the opinion of
many MAP members that this is one of the most
critical challenges facing the field of measurement
science; the tension must continue to be explored
with creative solutions in mind.

All measures involve some effort to collect,
calculate, and use for the purposes of improving
quality. Relatively complex measures generally
involve more effort, but the information they
produce can be highly valuable. The complex
medical and social needs of the dual eligible
beneficiary population can complicate data
collection efforts. However, the population’s
complexity, higher average costs of care, and
known deficits in quality and care coordination
also justify greater investment in performance
measurement and quality improvement.
Person-centered care planning is driven by the needs and opinions of the individual receiving services. As such, measurement of the care planning process could require the use of non-traditional measurement methods. Specifically, the field will need to allow for the collection of valid information from proxy respondents and populations from which self-report information has not historically been included, such as those with substance use disorders, serious mental illness, intellectual and developmental disabilities, and cognitive impairments such as dementia.

MAP members recommended that NCQA’s draft measures relating to care plans include beneficiary-identified goals that capture the voice and preferences of that person. Commenters also viewed the perspectives of individuals and their families as fundamental to assessing person-centered care. Requirements that care planning activities take place in person and that agreement with the care plan must be documented with a consumer’s signature are small but significant improvements over the current state of practice. MAP encouraged all types of providers to be innovative in their approaches to engaging beneficiaries and their family members and caregivers. For example, the group suggested that technology solutions like video chat platforms could enable long-distance family members to be part of goal setting and care planning processes.

In addition to balancing standardized versus customized approaches to care planning, stakeholders must be aware of related issues of assigning accountability for meeting goals. Healthcare providers may be comfortable taking partial responsibility for clinical outcomes, but they largely are unable to address social needs that can be equally or more important to beneficiaries. MAP encouraged more deliberate thinking about accountability challenges raised by the use of a common care plan. As part of this consideration, MAP members have advocated for the ownership and locus of control of the care plan to remain with the individual beneficiary. Importantly, the consumer should be in control of identifying the other people with whom portions of the care plan should be shared.
STRATEGIES TO SUPPORT IMPROVED QUALITY OF LIFE OUTCOMES

Quality of life has been identified since the start of MAP’s work as a high-leverage opportunity for improvement through measurement. Adults with lower levels of income or education report higher numbers of unhealthy days, as do adults with chronic illness or disability. Quality of life outcomes are of particular importance for dual eligible beneficiaries because most are affected by long-lasting health conditions that are not expected to improve. In addition, significant numbers of dual eligible beneficiaries need palliative and/or end-of-life care. It is critical that all individuals, especially those in poor or declining health, receive the supports and services necessary to live with dignity, to have their pain and symptoms controlled, and to maximize their functional status.

MAP has previously explored tools to assess quality of life and discussed a variety of definitions, frameworks for measurement, and survey tools in the 2014 Interim Report. In later discussions, MAP continued to emphasize that quality of life measures should reflect a broad view of health and well-being. Through observation MAP identified four domains commonly used across organizing frameworks in healthcare quality of life measurement: physical health, mental and psychological health, social relationships, and environment. Commenters supported the use of these domains and suggested additional domains that may be warranted by specific population needs.

MAP encourages innovation and exploration of strategies to improve and assess quality of life. Summarized broadly, these include maintaining a consumer focus, utilizing team-based care models, shared accountability for outcomes, and shared decisionmaking. Because measurement is a tool to understand and drive improvement of quality of life outcomes, MAP reviewed and offers reflections on some of the currently available surveys, indicators, and measures.

Models and Practices

Person- and Family-Centered Care

The first strategy recommended to support improved quality of life outcomes is to maintain focus of all care and supportive services on the needs of the individual consumer through person- and family-centered care. Person- and family-centered care can be defined as:

Person- and family-centered care is an approach to the planning and delivery of care across settings and time that is centered around collaborative partnerships among individuals, their defined family, and providers of care. It supports health and well-being by being consistent with, respectful of, and responsive to an individual’s preferences, needs, and values.

The individual receiving services must be at the center of all quality of life discussions. Healthcare providers and organizations need to continue to approach consumers as equals and engage them in decisionmaking. MAP encourages all parties involved in providing healthcare or supportive services to consider the consumer first in any healthcare conversation and decision. Public comments reinforced the distinction between methods for person-centered planning and typical clinical care.
Other NQF Projects Related to Person- and Family-Centered Care

Consensus Development Project to review newly submitted measures for endorsement and measures due for endorsement maintenance.

MAP Family of Measures to identify aligned measures, including available measures and measure gaps that span programs, care settings, and levels of analysis.

MAP members recommended continuation of work underway at NQF and elsewhere to address this high-priority measurement issue. Promising activities that could support future measure development include investments being made through the Person-Centered Outcomes Research Institute (PCORI) to expand the evidence base. Additionally, the Institute of Medicine’s (IOM) Living Well with Chronic Illness report could provide a theoretical basis for the discussion of person-centered wellness and related measurement opportunities. The high levels of activity around person- and family-centered care amplify the sense of importance and urgency communicated by MAP. Ongoing coordination is recommended to prevent duplication of effort and realize potential advances in healthcare quality and measurement.

Team-Based Healthcare

To address complex medical and social needs, team-based approaches to delivering care and supports are essential to supporting the consumers’ quality of life outcomes. A proposed definition of team-based healthcare drawn from the Best Practices Innovation Collaborative of the IOM Roundtable is:

*The provision of comprehensive health services to individuals, families, and/or their communities by at least two health professionals who work collaboratively along with patients, family caregivers, and community service providers on shared goals within and across settings to achieve care that is safe, effective, patient-centered, timely, efficient and equitable.*

When multiple healthcare and supportive service providers are tending to the needs of consumers and families, information and interpersonal interactions grow increasingly complex. Without purposeful identification of the team of providers, supports and services systems are more prone to inefficiencies and errors. MAP recognized the immediate need for high-functioning teams and continued to stress that the individual receiving care should be the primary team member. However, the “formula” for effective team-based healthcare is not yet known and will vary based on the needs of the individual and availability of staff and resources. Teams can be fluid as consumers’ needs change over time. In addition, they are not intended to be exclusive to healthcare providers, but could include case managers, community-based service providers, allied health professionals, and direct care workers. Team-based care also supports other strategies to improve quality of life, including shared decisionmaking and shared accountability.

Shared Accountability

Care for the dual eligible beneficiary population is complex because of factors such as the fragmented benefits structure and the diverse health and social needs of beneficiaries. Many individuals and disciplines contribute to supporting this population, and their roles vary with the needs of individual beneficiaries. Because quality of life outcomes are all-encompassing and cumulative, all stakeholders influence them. However, MAP recognized that there are meaningful differences between influence and responsibility or accountability for quality of life outcomes.
While it is not possible to assign overall responsibility to any entity, some portion of responsibility might be attributed to health plans, providers, or others that have ability to change an element that could improve or diminish a beneficiary’s quality of life. Those who share partial accountability for beneficiaries’ quality of life include the individual and his or her family/caregivers, health professionals, provider systems, health plans, community and human services, and state and federal governments. The determination of who is accountable for what tends to be driven by the scope of contracting and payment for specific services. Stakeholders do not feel responsible for outcomes outside of their direct control, but when everyone adheres to this attitude, it creates a vacuum of accountability for overall quality of life outcomes.

MAP discussed barriers to adoption of shared accountability in the health and human services systems. At a basic level, the presence of both Medicare and Medicaid benefits for dual eligible beneficiaries has split responsibility and payment for different types of health and long-term care services. Fragmentation and diffusion of responsibility extends from there, exemplified by strict rules for how health plans can use funds for the benefit of their enrollees, among other things. For example, a beneficiary might be at risk for malnutrition and poor health because he or she has not had proper dental care. Dental services may not be covered by their health plans or affordable out-of-pocket. MAP supports efforts of programs that are able to flexibly use resources for the benefit of the consumer, such as Money Follows the Person and the Program of All-Inclusive Care for the Elderly (PACE).

**Shared Decisionmaking**

Shared decisionmaking (SDM) is an approach to making healthcare choices that respects personal autonomy and gives equal weight to the expertise of the consumer about his or her own life and the expertise of the care team on clinical matters. SDM is particularly important for preference-sensitive conditions or healthcare choices. Dual eligible beneficiaries, their families, and/or caregivers have the right to be fully informed of available care options, including the potential harms and benefits, and to make their own choices with the support and input they need from providers to establish an appropriate care plan.

MAP asserted the importance of several contributing factors to successful shared decisionmaking. These included consumer engagement, team-based care, and access to care supported by appropriate payment. Consumers, particularly high-need individuals, should be engaged in a dialogue with any provider involved in their care, supported in expressing their preferences, and respected as the expert on their healthcare needs and medical history. Team-based care, as discussed above, is particularly important in SDM for dual beneficiaries because they often experience more complex care systems. Furthermore, consumers need easy access to clear information to inform their decisions. Healthcare and service providers need to be allowed time to engage and educate consumers and partner with them to weigh risks and benefits. MAP suggested that providers need to be trained and compensated for providing these navigation services, as they are more time-intensive than a standard office visit.

MAP called for more research and testing of SDM methods. In particular, there is a need to confirm the association between SDM and quality of life outcomes to support development of performance measures on this topic. Other recommended areas of study include the relationship of SDM processes to health and functional status outcomes, providers’ ability to empower consumers, and the usefulness of these methods within diverse populations of all types (e.g., individuals with certain conditions, racial/ethnic minority groups). With sufficient evidence in place, performance measures of the SDM processes and outcomes could be developed in coordination.
Indicators and Surveys

CARE Tool

A major ongoing assessment standardization initiative at the federal level is CMS’ development of the Continuity Assessment Record and Evaluation (CARE) tool item set. The intent of the CARE item set is to create uniformity of information across acute and post-acute care settings to support and focus on the person and understand the impact of providers and models of care. CARE is intended to contain “best in class” items as determined by the best science for measuring concepts common in the three assessment instruments mandated for Medicare post-acute settings: OASIS, MDS, and IRF-PAI.15 MAP was very supportive of the efforts to develop a central repository of elements because it will improve standardization and interoperability.

Assessment data from the CARE tool is designed to be standardized, reusable, and informative because it is drawn from a common language and set of data. The data collected is intended to evaluate improvement or maintenance of cognitive and physiological functional outcomes. It can assess quality across post-acute care settings, including inpatient rehabilitation facilities, skilled nursing facilities, long-term care hospitals, and home health agencies. CMS has developed and is planning to submit for endorsement several measures based on CARE data. Four would apply to inpatient rehabilitation, two to long-term-care hospitals, and four to skilled nursing facilities. CMS plans to evaluate a subset of the CARE items for potential expansion for use in community based long-term supports and services (CB-LTSS). Similarly, other CARE components are being evaluated for use in a standardized Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey across all CB-LTSS settings. MAP has previously discussed the importance and value of CAHPS surveys to gain insight into consumers’ perspectives across CB-LTSS and reiterates its support for the field testing of the CB-LTSS CAPHS tool.

UDSMR FIM® Instrument

The Uniform Data System for Medical Rehabilitation (UDSMR) developed and maintains the Functional Independence Measure (FIM)® instrument, an 18-item tool to assess patient functional status, quality outcomes in rehabilitation facilities, and the level and cost of assistance needed by an individual to carry out usual activities of daily living (ADLs). The instrument may have particular utility for dual eligible beneficiaries who transition between settings and benefit systems because it has been validated across acute-care and long-term care settings, can be administered by any provider, and is applicable across payer populations. The FIM is currently in use in the CMS Inpatient Rehabilitation Facility Prospective Payment System and in program evaluation models for accreditation purposes. MAP looks forward to reviewing the results of endorsement of performance measures based on the FIM and could consider further opportunities for alignment. UDSMR provided additional details about the FIM in the form of public comments, available in Appendix F.

National Core Indicators Surveys

As discussed in MAP’s 2012 Final Report on dual eligible beneficiaries, the National Core Indicators (NCI) present an opportunity for the development of gap-filling measures. NCI is a collaborative effort between the National Association of State Directors of Developmental Disabilities Services (NASDDDS) and the Human Services Research Institute (HSRI).16 The NCI is a nationally recognized set of performance and outcome indicators for developmental disabilities service systems.

National Core Indicators: Intellectual/Developmental Disabilities Survey

Launched in 1997, the NCI survey is currently used in 39 States and the District of Columbia to collect data and evaluate the outcomes of state-funded services for individuals with intellectual/developmental disabilities. The components of the indicators address some of MAP’s priorities...
for person-centered care, such as evaluating experiences of beneficiaries globally across multiple supports and services, allowances for proxy responders for persons who have difficulty communicating, experiences of family members and caregivers, and use of qualitative and quantitative data (Table 1). The results are calculated at the state level of analysis. States use the results for quality assurance and improvement, CMS waiver reporting requirements, comparisons against other states, and public accountability of programs.

Data collected through the NCI survey is collected, submitted, and owned by individual states. The NCI administrators support states to ensure validity of administrative data and inter-rater reliability within each state system and to detect changes over time. They also support states in key uses of the indicators such as identifying outcomes for at-risk populations, examining potential disparities in services, and conducting comparisons across states. MAP has suggested similar applications for quality data on dual eligible beneficiaries. MAP identified that the data already collected from state intellectual/developmental disabilities systems could have many potential uses because it is de-identified and accessible to researchers.

National Core Indicators: Aging and Disability Survey
In response to stakeholder feedback, HSRI, NASDDDS, and the National Association of States United for Aging and Disabilities (NASUAD) are working to translate the NCI survey from an intellectual/developmental disabilities focus to also include older adults and individuals with physical disabilities. The expansion has produced the National Core Indicators Aging and Disability survey (NCI-AD). The goal of this survey is for participating state aging and disabilities agencies to collect data to measure the performance and outcomes of their aging and disability services. The NCI-AD provides an opportunity to assess the impact of long-term services and supports on the aging and physically disabled populations to inform state policy and regulations, drive improvement, and make comparisons between states possible. MAP supported expansion of the survey to the additional populations but cautioned that individuals with mental health and substance use disorders should not be excluded.

The NCI-AD was developed from an extensive databank of potential indicators, steering committee review, and focus groups. Currently in a pilot testing phase, the data analysis, risk-adjustment methodology, and reporting methodology are planned to be completed in early 2015. Regular data collection for the NCI-AD is scheduled to begin in summer of 2015 with 12 participating states.

A majority of the NCI-AD indicators and questions are aligned with the original NCI for individuals

### Table 1. NCI Evaluation of State-Funded Services

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<tr>
<th>Key Components</th>
<th>Data Collection</th>
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<tr>
<td>• Individual characteristics</td>
<td>• Random samples of in-person interviews of consumers</td>
<td>• Individual outcomes</td>
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<td>• Locations where people live</td>
<td>• Three types of family surveys collected via mail</td>
<td>• Family outcomes</td>
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<tr>
<td>• Preferred activities for engagement</td>
<td>- Adult Family Survey</td>
<td>• Health, welfare, and system outcomes</td>
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<tr>
<td>• Experience across the supports and services received</td>
<td>- Family Guardian Survey</td>
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<tr>
<td>• Context of their life (e.g. friends, community involvement, safety, etc.)</td>
<td>- Children Family Survey</td>
<td></td>
</tr>
<tr>
<td>• Health, healthcare, and well-being</td>
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with intellectual/developmental disabilities. One significant early finding of this effort is that the quality of life outcomes valued by individuals are largely the same despite the diversity of health and social challenges each person may experience. MAP has come to the same conclusion during its deliberations and the NCI-AD expansion work reinforces this thinking. MAP looks forward to implementation of the survey and additional opportunities to learn from the use of quantitative and qualitative data to assess quality of life.

Future Collaboration on Addressing Measure Gaps

MAP members voiced their appreciation for the hard work underway to develop strategies and solutions to improve the quality of care for dual eligible beneficiaries and other high-need adults. MAP encourages stakeholders to continue developing gap-filling measures and implementation strategies to drive improvement in outcomes. In particular, efforts to embed person-centeredness in the healthcare system should be redoubled.

It is essential to capture the voices of consumers across all types of care and support systems. This has been lacking in quality measurement to date. MAP has reviewed many different surveys and tools that are contributing to a better understanding of the beneficiary experience. However, the existence of multiple surveys, particularly the many variations of CAHPS, could be redundant and confusing to beneficiaries if they receive more than one. CAHPS surveys are expensive to administer and response rates are variable. Repeatedly surveying the same small population could be negatively affecting individuals’ willingness to respond. MAP has previously stated its concern about the format of these mailed instruments not being appropriate to vulnerable individuals for a variety of reasons. As part of measure development, other methods of capturing consumers’ input should be explored.

MAP acknowledges that developing and testing measures is a complex and time-consuming activity. Developers are invited to contact NQF for support with the process of submitting measures for potential endorsement as consensus standards. This collaboration will be especially necessary to transform surveys and tools, which are not endorsed by NQF, into performance measures. NQF encourages upstream dialogue to strengthen measures and increase their chances of gaining endorsement.
Together with its partners and members, NQF seeks ways to transform healthcare and health outcomes through performance measurement. Measurement has the potential to drive healthcare system change when used to identify opportunities for improvement and subsequent gains in performance. MAP is seeking more direct information on the experience of using measures to inform future decisionmaking. When gathering this information, MAP will emphasize two features: alignment and impact of measures.

**Measure Alignment**

Alignment is achieved when sets of measures function well across settings or programs to produce meaningful information without creating extra work for those responsible for the measurement. Use of the same measures across programs reduces conflicting or redundant requirements. MAP has identified alignment as an important characteristic of measure sets in the MAP Measure Selection Criteria: sub-criterion 7.2 states, “Program measure set places strong emphasis on measures that can be used across multiple programs or applications.”

MAP has increasingly recognized poorly aligned program requirements as a source of frustration for stakeholders. Specifically, healthcare systems, payers, and providers can find participation in measurement programs onerous when they are compelled to invest resources in reporting requirements that are duplicative, conflicting, or especially labor intensive. Providers and health plans that offer services to dual eligible beneficiaries are particularly affected by fragmented program requirements. Although the extent of this problem varies by provider or health plan type, it is common for Medicare, Medicaid, multiple private payers, and other local programs to each dictate separate requirements. Poor alignment scatters scarce resources away from true quality improvement priorities.

MAP recommends that the first research question to be explored through stakeholder feedback loops is “To what extent are program measure requirements aligned with one another?” A more concrete understanding of this issue can illuminate any opportunities for MAP to recommend that different measures be used in programs to improve alignment. MAP already emphasizes the importance of using the same measures in multiple programs when making its annual pre-rulemaking recommendations on the use of measures in federal programs. One commenter noted the additional importance of stakeholders’ access to the complete technical specifications for each measure to achieve alignment through uniform implementation.

MAP has promoted alignment of measurement programs that relate to the care and supports accessed by dual eligible beneficiaries. The Family of Measures for Dual Eligible Beneficiaries is an important driver of alignment. As described previously, the family of measures is a group of the best available measures to address the unique needs of the dual eligible beneficiary population. The family functions like a menu that stakeholders can consult to select subsets of measures that best suit the needs of particular programs. If more stakeholder groups and programs join MAP in selecting measures from within families, alignment will be improved. While progress has been made on aligning key federal programs (Appendix E), much remains to be learned about the landscape of other public and private programs.
Measure Impact

The concept of fit-for-purpose complements alignment. Measure designs and specifications should match the goals, target population, care setting, and other features of the program in which they are used. Sometimes development of a new, innovative measure is better than using an existing measure beyond the scope of its original design. A healthcare system that maintains a balance of a small number of well-aligned measures that have strong fit-for-purpose will reduce measurement effort that is currently wasted by re-work and duplication. Further, quality improvement efforts can be concentrated on a select few priority areas and have greater impact. This leads to MAP’s second recommendation that stakeholder feedback loops also seek to answer the question, “Are measures used in programs fulfilling their intended purpose of producing improved quality?”

MAP seeks to provide input on the potential impact of quality measures that MAP recommends for future use in federal programs. MAP has been collaborating with HHS to refine an approach for these assessments based on the data and resources available. More sophisticated analysis and assessment of potential measure impact presents an opportunity for MAP to provide better guidance to HHS on the selection of measures having the highest potential to achieve programmatic goals, and ultimately improve health outcomes. This type of prospective analysis will be very challenging; working with stakeholders to understand their measure use experience retrospectively may shed light on features of measures that correlate with improved results. Alternatively, MAP may glean important contextual information related to promising program structures, implementation approaches, incentives, or other broad features of measurement programs.

Building Feedback Mechanisms

Creating more structured feedback mechanisms for gathering information from stakeholders using measures is a way to collect and share insights about measurement successes and opportunities for revision. Such an exchange of information between NQF and groups directly involved in using measures promotes ongoing learning and improvement across the entire healthcare system. MAP has suggested the types of information that should be collected from entities using measures for the purpose of this analysis. Potential topics of interest include the identification of:

- Measures that are widely used, to promote further alignment
- Measures that have contributed to a significant positive impact on healthcare quality, to explore encouraging broader use
- Measures not functioning as intended, to convey desired modifications to measure stewards
- Measures that are a poor fit for a program’s goals, to potentially reduce burden by recommending that their use be discontinued

Some information on alignment of measures is already available, and MAP plans to build from this base when creating and strengthening feedback loops. NQF currently invites feedback on the usage experience of measures through the Quality Positioning System and commenting opportunities on measures undergoing endorsement review. The NQF Community Tool to Align Measures also provides a snapshot of measure alignment. This tool, developed in collaboration with the 16 Aligning Forces for Quality (AF4Q) communities, illustrates measure use across programs and identifies measures for possible alignment or expansion. In addition, the Buying Value Project research on Alignment of Existing Measure Sets conducted an analysis of hundreds of measure sets across the states. The analysis sought answers to several questions, including: to what extent are measures used and which are the most frequently shared measures? The Buying Value Project has begun development of technical assistance resources on constructing measure sets that NQF
will review and utilize when possible.

MAP considered the information needed to support its decisionmaking process about the use of measures and will continue to ask stakeholders to provide guidance on the following issues.

- Is alignment among certain programs of particular interest?
- From what types of stakeholders should MAP gather feedback about measure use?
- What additional data on measure use could help to refine the family of measures?
- Do stakeholders beyond MAP have information needs that could be satisfied by this analysis?

MAP discussion and public comments encouraged more deliberate engagement of state, regional, and local-level partners in the creation of feedback loops. Commenters suggested outreach to the network of consumer advocates active in addressing the quality of services and supports funded by Medicaid. To be successful, these efforts must be purposeful and sustained by ongoing communication.

**PATH FORWARD**

MAP looks forward to future opportunities to explore healthcare quality and performance measurement issues germane to dual eligible beneficiaries. As reflected in this report, NQF will continue to facilitate the connection between the endorsement and application of healthcare performance measures. Specifically, MAP will monitor connections to development of other families of measures, the 2014 report from the MAP Medicaid Task Force, and evolving NQF guidance on risk adjustment of measures for socio-demographic factors.

The Dual Eligible Beneficiaries Workgroup, in consultation with the MAP Coordinating Committee, considered the topics listed in Table 2 for its next iteration of work. MAP members expressed interest in many of the potential topics; the strongest consensus emerged on the topic area and components of “other factors related to quality of care and outcomes.”
TABLE 2. POTENTIAL TOPICS FOR FUTURE CONSIDERATION BY MAP

<table>
<thead>
<tr>
<th>General Topic Areas</th>
<th>Specific Components Suggested by MAP Members</th>
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| Conceptual work to revisit high-leverage opportunities and explore person-centered wellness | • Visioning a future state for quality measurement  
• Conceptual models of system change and individual behavior change  
• Discussion of research priorities with PCORI  
• Shift to a wellness-directed model over a disease-focused model using IOM model of living well with chronic illness and social/behavioral domains  
• Identification of interim measures to use in nonmedical domains  
• Levels of beneficiary capacity to engage in shared decisionmaking and choice |
| Additional topics on measure development and application                             | • How to engage private sector and provider organizations in measure development, review, and endorsement processes to enhance adoption, participation, and buy-in  
• Linking public/private data, involving other disciplines, and using “big data” analytics to accelerate measure development  
• Creating structural measures to evaluate the degree of integration of Medicare/Medicaid benefits and services  
• Identifying a core data set for the financial alignment demonstrations that honors person-centered values |
| Other factors related to quality of care and outcomes                                | • Primary care/behavioral health integration models  
• Coordination of medical and non-medical care  
• Measures for advanced illness care (e.g., IOM recommendations on palliative care)  
• Employment outcomes for dual eligible beneficiaries  
• Implications of measurement activities on the workforce  
• Potential for risk adjustment of measures within the Dual Eligible Beneficiaries Family of Measures |

Commenters generally agreed with the topic areas proposed for future discussion and action by MAP. They voiced support for the concept of a “wellness-directed model over a disease-focused model” with specific attention to the self-management of chronic conditions and health promotion for individuals with disabilities. Multiple comments encouraged consideration of employment outcomes for beneficiaries. One comment supported primary care/behavioral health integration models because of their relationship to improved outcomes and suggested resources from the National Alliance for Mental Illness.

The issue of workforce measurement generated discussion among commenters and MAP members. One comment urged a specific focus on measures of the direct care workforce providing HCBS. In response, multiple MAP members agreed that the direct care workforce is important but that other professions are equally in need of measurement. In addition, MAP members discussed that it is necessary to understand the effects that participation in performance measurement might be having on the workforce in general. For example, do measurement efforts improve competency, turnover, or productivity?
CONCLUSION

In this report, MAP provides its latest guidance to HHS on the use of performance measures to improve care for dual eligible beneficiaries. For the first time since its official publication, MAP has provided an update to the Family of Measures for Dual Eligible Beneficiaries. This report also updated findings on measure alignment across programs and persistent measure gaps. MAP joined with other measurement stakeholders to advise the field on several performance measure development and application issues that relate to care for dual eligible beneficiaries. Building on findings from its last report, MAP explored strategies to support improved quality of life outcomes for the population. Lastly, MAP has gathered feedback on a basic approach to engaging stakeholders using measures to inform MAP’s future decisionmaking.
ENDNOTES


14 Godolphin W. Shared decision-making. Healthc Q. 2009;12(Spec No Patient):e186-e190


APPENDIX A:
MAP Background

Purpose

The Measure Applications Partnership (MAP) is a public-private partnership convened by the National Quality Forum (NQF) for providing input to the Department of Health and Human Services (HHS) on selecting performance measures for public reporting, performance-based payment, and other programs. The statutory authority for MAP is the Affordable Care Act (ACA), which requires HHS to contract with NQF (as the consensus-based entity) to “convene multi-stakeholder groups to provide input on the selection of quality measures” for various uses.¹

MAP’s careful balance of interests—across consumers, businesses and purchasers, labor, health plans, clinicians, providers, communities and states, and suppliers—ensures that HHS will receive varied and thoughtful input on performance measure selection. In particular, the ACA-mandated annual publication of measures under consideration for future federal rulemaking allows MAP to evaluate and provide upstream input to HHS in a global and strategic way.

MAP is designed to facilitate progress on the aims, priorities, and goals of the National Quality Strategy (NQS)—the national blueprint for providing better care, improving health for people and communities, and making care more affordable. Accordingly, MAP informs the selection of performance measures to achieve the goal of improvement, transparency, and value for all.

MAP’s objectives are to:

1. Improve outcomes in high-leverage areas for patients and their families. MAP encourages the use of the best available measures that are high-impact, relevant, and actionable. MAP has adopted a person-centered approach to measure selection, promoting broader use of patient-reported outcomes, experience, and shared decisionmaking.

2. Align performance measurement across programs and sectors to provide consistent and meaningful information that supports provider/clinician improvement, informs consumer choice, and enables purchasers and payers to buy based on value. MAP promotes the use of measures that are aligned across programs and between public and private sectors to provide a comprehensive picture of quality for all parts of the healthcare system.

3. Coordinate measurement efforts to accelerate improvement, enhance system efficiency, and reduce provider data collection burden. MAP encourages the use of measures that help transform fragmented healthcare delivery into a more integrated system with standardized mechanisms for data collection and transmission.

Coordination with Other Quality Efforts

MAP activities are designed to coordinate with and reinforce other efforts for improving health outcomes and healthcare quality. Key strategies for reforming healthcare delivery and financing include publicly reporting performance results for transparency and healthcare decisionmaking, aligning payment with value, rewarding providers and professionals for using health information technology to improve patient care, and providing knowledge and tools to healthcare providers and professionals to help them improve performance. Many public- and private-sector organizations have important responsibilities in implementing these strategies, including federal and state agencies, private purchasers, measure developers,
groups convened by NQF, accreditation and certification entities, various quality alliances at the national and community levels, as well as the professionals and providers of healthcare. Foundational to the success of all of these efforts is a robust quality enterprise that includes:

**Setting priorities and goals.** The work of the Measure Applications Partnership is predicated on the National Quality Strategy and its three aims of better care, affordable care, and healthy people/healthy communities. The NQS aims and six priorities provide a guiding framework for the work of the MAP, in addition to helping align it with other quality efforts.

**Developing and testing measures.** Using the established NQS priorities and goals as a guide, various entities develop and test measures (e.g., PCPI, NCQA, The Joint Commission, medical specialty societies).

**Endorsing measures.** NQF uses its formal Consensus Development Process (CDP) to evaluate and endorse consensus standards, including performance measures, best practices, frameworks, and reporting guidelines. The CDP is designed to call for input and carefully consider the interests of stakeholder groups from across the healthcare industry.

**Measure selection and measure use.** Measures are selected for use in a variety of performance measurement initiatives conducted by federal, state, and local agencies; regional collaboratives; and private-sector entities. MAP's role within the quality enterprise is to consider and recommend measures for public reporting, performance-based payment, and other programs. Through strategic selection, MAP facilitates measure alignment of public- and private-sector uses of performance measures.

**Impact and Evaluation.** Performance measures are important tools to monitor and encourage progress on closing performance gaps. Determining the intermediate and long-term impact of performance measures will elucidate whether measures are having their intended impact and are driving improvement, transparency, and value. Evaluation and feedback loops for each of the functions of the Quality Enterprise ensure that each of the various activities is driving desired improvements. MAP seeks to engage in bidirectional exchange (i.e., feedback loops) with key stakeholders involved in each of the functions of the Quality Enterprise.

**Structure**

MAP operates through a two-tiered structure (see Figure A1). The MAP Coordinating Committee provides direction to the MAP workgroups and task forces and provides final input to HHS. MAP workgroups advise the Coordinating Committee on measures needed for specific care settings, care providers, and patient populations. Time-limited task forces charged with developing “families of measures”—related measures that cross settings and populations—and a multiyear strategic plan provide further information to the MAP Coordinating Committee and workgroups. Each multistakeholder group includes representatives from public- and private-sector organizations particularly affected by the work and individuals with content expertise.
All MAP activities are conducted in an open and transparent manner. The appointment process includes open nominations and a public comment period. MAP meetings are broadcast, materials and summaries are posted on the NQF website, and public comments are solicited on recommendations.

Timeline and Deliverables
MAP convenes each winter to fulfill its statutory requirement of providing input to HHS on measures under consideration for use in federal programs. MAP workgroups and the Coordinating Committee meet in December and January to provide program-specific recommendations to HHS by February 1 (see MAP 2014 Pre-Rulemaking Report).

Additionally, MAP engages in strategic activities throughout the spring, summer, and fall to inform MAP’s pre-rulemaking input. To date MAP has issued a series of reports that:

- Developed the MAP Strategic Plan to establish MAP’s goal and objectives. This process identified strategies and tactics that will enhance MAP’s input.

- Identified Families of Measures—sets of related available measures and measure gaps that span programs, care settings, levels of analysis, and populations for specific topic areas related to the NQS priorities—to facilitate coordination of measurement efforts.

- Provided input on program considerations and specific measures for federal programs that are not included in MAP’s annual pre-rulemaking review, including the Medicaid Adult Core Set and the Quality Rating System for Qualified Health Plans in the Health Insurance Marketplaces.

- Developed Coordination Strategies intended to elucidate opportunities for public and private stakeholders to accelerate improvement and synchronize measurement initiatives.

ENDNOTES

APPENDIX B:
Rosters for the MAP Dual Eligible Beneficiaries Workgroup and MAP Coordinating Committee

MAP Dual Eligible Beneficiaries Workgroup

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<tr>
<th>CHAIR (VOTING)</th>
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<td>Alice Lind, MPH, BSN</td>
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<tr>
<td>America’s Essential Hospitals</td>
<td>Steven Counsell, MD</td>
</tr>
<tr>
<td>American Association on Intellectual and Developmental Disabilities</td>
<td>Margaret Nygren, EdD</td>
</tr>
<tr>
<td>American Federation of State, County and Municipal Employees</td>
<td>Sally Tyler, MPA</td>
</tr>
<tr>
<td>American Geriatrics Society</td>
<td>Jennie Chin Hansen, RN, MS, FAAN</td>
</tr>
<tr>
<td>American Medical Directors Association</td>
<td>Gwendolen Buhr, MD, MHS, MEd, CMD</td>
</tr>
<tr>
<td>Center for Medicare Advocacy</td>
<td>Alfred J. Chiplin, JD, MDiv</td>
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<td>Consortium for Citizens with Disabilities</td>
<td>E. Clarke Ross, DPA</td>
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<tr>
<td>Humana, Inc.</td>
<td>George Andrews, MD, MBA, CPE</td>
</tr>
<tr>
<td>L.A. Care Health Plan</td>
<td>Representative to be determined</td>
</tr>
<tr>
<td>National Association of Social Workers</td>
<td>Joan Levy Zlotnik, PhD, ACSW</td>
</tr>
<tr>
<td>National Health Law Program</td>
<td>Leonardo Cuello, JD</td>
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<tr>
<td>National PACE Association</td>
<td>Adam Burrows, MD</td>
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<td>SNP Alliance</td>
<td>Richard Bringewatt</td>
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<tr>
<td>Substance Abuse</td>
<td>Mady Chalk, MSW, PhD</td>
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<tr>
<td>Disability</td>
<td>Anne Cohen, MPH</td>
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<tr>
<td>Emergency Medical Services</td>
<td>James Dunford, MD</td>
</tr>
<tr>
<td>Care Coordination</td>
<td>Nancy Hanrahan, PhD, RN, FAAN</td>
</tr>
<tr>
<td>Medicaid ACO</td>
<td>Ruth Perry, MD</td>
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<tr>
<td>Measure Methodologist</td>
<td>Juliana Preston, MPA</td>
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<tr>
<td>Home &amp; Community Based Services</td>
<td>Susan Reinhard, RN, PhD, FAAN</td>
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<tr>
<td>Mental Health</td>
<td>Rhonda Robinson-Beale, MD</td>
</tr>
<tr>
<td>Nursing</td>
<td>Gail Stuart, PhD, RN</td>
</tr>
</tbody>
</table>
**Federal Government Members** (Non-Voting, Ex Officio)  | Representative
--- | ---
Agency for Healthcare Research and Quality  | D.E.B. Potter, MS
CMS Federal Coordinated Healthcare Office  | Cheryl Powell
Health Resources and Services Administration  | Samantha Meklir, MPP
Administration for Community Living  | Jamie Kendall, MPP
Substance Abuse and Mental Health Services Administration  | Lisa Patton, PhD
Veterans Health Administration  | Daniel Kivlahan, PhD

**MAP Coordinating Committee Co-Chairs** (Non-Voting, Ex Officio)

George Isham, MD, MS  
Elizabeth McGlynn, PhD, MPP

**MAP Coordinating Committee**

**Co-Chairs (Voting)**

George Isham, MD, MS  
Elizabeth McGlynn, PhD, MPP

**Organizational Members** (Voting)  | Representatives
--- | ---
AARP  | Joyce Dubow, MUP
Academy of Managed Care Pharmacy  | Marissa Schlaifer, RPh, MS
AdvaMed  | Steven Brotman, MD, JD
AFL-CIO  | Gerry Shea
America’s Health Insurance Plans  | Aparna Higgins, MA
American College of Physicians  | David Baker, MD, MPH, FACP
American College of Surgeons  | Frank Opelka, MD, FACS
American Hospital Association  | Rhonda Anderson, RN, DNSc, FAAN
American Medical Association  | Carl Sirio, MD
American Medical Group Association  | Sam Lin, MD, PhD, MBA
American Nurses Association  | Marla Weston, PhD, RN
Catalyst for Payment Reform  | Suzanne Delbanco, PhD
Consumers Union  | Lisa McGiffert
Federation of American Hospitals  | Chip Kahn
LeadingAge (formerly AAHSA)  | Cheryl Phillips, MD, AGSF
Maine Health Management Coalition  | Elizabeth Mitchell
National Alliance for Caregiving  | Gail Hunt
National Association of Medicaid Directors  | Foster Gesten, MD, FACP
National Business Group on Health  | Shari Davidson
National Partnership for Women and Families  | Alison Shippy
Pacific Business Group on Health  | William Kramer, MBA
Pharmaceutical Research and Manufacturers of America (PhRMA)  | Christopher Dezii, RN, MBA, CPHQ
## Expertise

<table>
<thead>
<tr>
<th>Expertise</th>
<th>Individual Subject Matter Expert Members (Voting)</th>
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<tbody>
<tr>
<td>Child Health</td>
<td>Richard Antonelli, MD, MS</td>
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<tr>
<td>Population Health</td>
<td>Bobbie Berkowitz, PhD, RN, CNAA, FAAN</td>
</tr>
<tr>
<td>Disparities</td>
<td>Marshall Chin, MD, MPH, FACP</td>
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<tr>
<td>Rural Health</td>
<td>Ira Moscovice, PhD</td>
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<tr>
<td>Mental Health</td>
<td>Harold Pincus, MD</td>
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<tr>
<td>Post-Acute Care/ Home Health/ Hospice</td>
<td>Carol Raphael, MPA</td>
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## Federal Government Members (Non-Voting, Ex Officio)

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<tr>
<th>Federal Government Member</th>
<th>Representatives</th>
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<tbody>
<tr>
<td>Agency for Healthcare Research and Quality (AHRQ)</td>
<td>Nancy Wilson, MD, MPH</td>
</tr>
<tr>
<td>Centers for Disease Control and Prevention (CDC)</td>
<td>Chesley Richards, MD, MPH</td>
</tr>
<tr>
<td>Centers for Medicare &amp; Medicaid Services (CMS)</td>
<td>Patrick Conway, MD, MSc</td>
</tr>
<tr>
<td>Health Resources and Services Administration (HRSA)</td>
<td>John E. Snyder, MD, MS, MPH (FACP)</td>
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<tr>
<td>Office of Personnel Management/FEHBP (OPM)</td>
<td>Edward Lennard, PharmD, MBA</td>
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<tr>
<td>Office of the National Coordinator for HIT (ONC)</td>
<td>Kevin Larsen, MD, FACP</td>
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## Accreditation/Certification Liaisons (Non-Voting)

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<tr>
<th>Accreditation/Certification Liaison</th>
<th>Representatives</th>
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<tbody>
<tr>
<td>American Board of Medical Specialties</td>
<td>Lois Margaret Nora, MD, JD, MBA</td>
</tr>
<tr>
<td>National Committee for Quality Assurance</td>
<td>Peggy O’Kane, MHS</td>
</tr>
<tr>
<td>The Joint Commission</td>
<td>Mark Chassin, MD, FACP, MPP, MPH</td>
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## NQF Project Staff

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
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<tbody>
<tr>
<td>Sarah Lash</td>
<td>Senior Director</td>
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<tr>
<td>Megan Duevel Anderson</td>
<td>Project Manager</td>
</tr>
<tr>
<td>Laura Ibragimova</td>
<td>Project Analyst</td>
</tr>
<tr>
<td>Yetunde Alexandra Ogungbemi</td>
<td>Project Analyst</td>
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APPENDIX C: 
MAP Measure Selection Criteria

The Measure Selection Criteria (MSC) are intended to assist MAP with identifying characteristics that are associated with ideal measure sets used for public reporting and payment programs. The MSC are not absolute rules; rather, they are meant to provide general guidance on measure selection decisions and to complement program-specific statutory and regulatory requirements. Central focus should be on the selection of high-quality measures that optimally address the National Quality Strategy’s three aims, fill critical measurement gaps, and increase alignment. Although competing priorities often need to be weighed against one another, the MSC can be used as a reference when evaluating the relative strengths and weaknesses of a program measure set, and how the addition of an individual measure would contribute to the set.

Criteria

1. NQF-endorsed® measures are required for program measure sets, unless no relevant endorsed measures are available to achieve a critical program objective

Demonstrated by a program measure set that contains measures that meet the NQF endorsement criteria, including: importance to measure and report, scientific acceptability of measure properties, feasibility, usability and use, and harmonization of competing and related measures.

- **Sub-criterion 1.1** Measures that are not NQF-endorsed should be submitted for endorsement if selected to meet a specific program need
- **Sub-criterion 1.2** Measures that have had endorsement removed or have been submitted for endorsement and were not endorsed should be removed from programs
- **Sub-criterion 1.3** Measures that are in reserve status (i.e., topped out) should be considered for removal from programs

2. Program measure set adequately addresses each of the National Quality Strategy’s three aims

Demonstrated by a program measure set that addresses each of the National Quality Strategy (NQS) aims and corresponding priorities. The NQS provides a common framework for focusing efforts of diverse stakeholders on:

- **Sub-criterion 2.1** Better care, demonstrated by patient- and family-centeredness, care coordination, safety, and effective treatment
- **Sub-criterion 2.2** Healthy people/healthy communities, demonstrated by prevention and well-being
- **Sub-criterion 2.3** Affordable care


3. Program measure set is responsive to specific program goals and requirements

Demonstrated by a program measure set that is “fit for purpose” for the particular program.

Sub-criterion 3.1 Program measure set includes measures that are applicable to and appropriately tested for the program’s intended care setting(s), level(s) of analysis, and population(s)

Sub-criterion 3.2 Measure sets for public reporting programs should be meaningful for consumers and purchasers

Sub-criterion 3.3 Measure sets for payment incentive programs should contain measures for which there is broad experience demonstrating usability and usefulness (Note: For some Medicare payment programs, statute requires that measures must first be implemented in a public reporting program for a designated period)

Sub-criterion 3.4 Avoid selection of measures that are likely to create significant adverse consequences when used in a specific program

Sub-criterion 3.5 Emphasize inclusion of endorsed measures that have eMeasure specifications available

4. Program measure set includes an appropriate mix of measure types

Demonstrated by a program measure set that includes an appropriate mix of process, outcome, experience of care, cost/resource use/appropriateness, composite, and structural measures necessary for the specific program

Sub-criterion 4.1 In general, preference should be given to measure types that address specific program needs

Sub-criterion 4.2 Public reporting program measure sets should emphasize outcomes that matter to patients, including patient- and caregiver-reported outcomes

Sub-criterion 4.3 Payment program measure sets should include outcome measures linked to cost measures to capture value

5. Program measure set enables measurement of person- and family-centered care and services

Demonstrated by a program measure set that addresses access, choice, self-determination, and community integration

Sub-criterion 5.1 Measure set addresses patient/family/caregiver experience, including aspects of communication and care coordination

Sub-criterion 5.2 Measure set addresses shared decisionmaking, such as for care and service planning and establishing advance directives

Sub-criterion 5.3 Measure set enables assessment of the person’s care and services across providers, settings, and time
6. Program measure set includes considerations for healthcare disparities and cultural competency

Demonstrated by a program measure set that promotes equitable access and treatment by considering healthcare disparities. Factors include addressing race, ethnicity, socioeconomic status, language, gender, sexual orientation, age, or geographical considerations (e.g., urban vs. rural). Program measure set also can address populations at risk for healthcare disparities (e.g., people with behavioral/mental illness).

**Sub-criterion 6.1** Program measure set includes measures that directly assess healthcare disparities (e.g., interpreter services)

**Sub-criterion 6.2** Program measure set includes measures that are sensitive to disparities measurement (e.g., beta blocker treatment after a heart attack), and that facilitate stratification of results to better understand differences among vulnerable populations

7. Program measure set promotes parsimony and alignment

Demonstrated by a program measure set that supports efficient use of resources for data collection and reporting, and supports alignment across programs. The program measure set should balance the degree of effort associated with measurement and its opportunity to improve quality.

**Sub-criterion 7.1** Program measure set demonstrates efficiency (i.e., minimum number of measures and the least burdensome measures that achieve program goals)

**Sub-criterion 7.2** Program measure set places strong emphasis on measures that can be used across multiple programs or applications (e.g., Physician Quality Reporting System [PQRS], Meaningful Use for Eligible Professionals, Physician Compare)
### APPENDIX D: CURRENT FAMILY OF MEASURES FOR DUAL ELIGIBLE BENEFICIARIES

<table>
<thead>
<tr>
<th>NQF Measure Number, Endorsement Status, Title, and Steward</th>
<th>Measure Type</th>
<th>Measure Description</th>
<th>Level of Analysis</th>
<th>Other Known Uses and Program Alignment</th>
<th>Public Comments</th>
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<tbody>
<tr>
<td><strong>0004 Endorsed</strong> Initiation and Engagement of Alcohol and Other Drug Dependence Treatment Measure Steward: NCQA “Starter Set Measure”</td>
<td>Process</td>
<td>The percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) dependence who received the following. a. Initiation of AOD Treatment. The percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis. b. Engagement of AOD Treatment. The percentage of members who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.</td>
<td>Health Plan; Integrated Delivery System; Population: County or City, National, Regional</td>
<td>Federal and State Programs: Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults; Meaningful Use-EP; PQRS; Medicaid Health Home State Duals Demonstrations: CA, IL, MA, OH, VA, WA Private Programs: HEDIS</td>
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<tr>
<td><strong>0005 Endorsed</strong> CAHPS Clinician/Group Surveys - (Adult Primary Care, Pediatric Care, and Specialist Care Surveys) Measure Steward: NCQA</td>
<td>Patient Engagement/Experience</td>
<td>Adult Primary Care Survey: 37 core and 64 supplemental question survey of adult outpatient primary care patients. Pediatric Care Survey: 36 core and 16 supplemental question survey of outpatient pediatric care patients. Specialist Care Survey: 37 core and 20 supplemental question survey of adult outpatients specialist care patients. Level of analysis for each of the 3 surveys: group practices, sites of care, and/or individual clinicians</td>
<td>Health Plan; Integrated Delivery System</td>
<td></td>
<td>One commenter supported the inclusion of this measure indicating that experience surveys are a good way to measure quality of care.</td>
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<tr>
<td>Measure Number</td>
<td>Measure Description</td>
<td>Level of Analysis</td>
<td>Other Known Uses and Program Alignment</td>
<td>Public Comments</td>
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<tr>
<td>0006 Endorsed</td>
<td>CAHPS Health Plan Survey v 4.0 - Adult questionnaire</td>
<td>Patient Engagement/Experience</td>
<td>Health Plan - Federal and State Programs: Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults; Medicare Part C Plan Rating; Medicare Shared Savings Program; PQRS; Private Programs: eValue8; Wellpoint; HEDIS; Buying Value core ambulatory measure; URAC Health Plan with Health Insurance Exchange</td>
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<td></td>
<td>30-question core survey of adult health plan members that assesses the quality of care and services they receive. Level of analysis: health plan – HMO, PPO, Medicare, Medicaid, commercial</td>
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<tr>
<td>0007 Not Endorsed</td>
<td>NCQA Supplemental items for CAHPS® 4.0 Adult Questionnaire (CAHPS 4.0H)</td>
<td>Composite</td>
<td>Federal and State Programs: Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults; Medicare Part D Plan Rating; State Duals Demonstration: VA Private Programs: HEDIS</td>
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<td></td>
<td>This supplemental set of items was developed jointly by NCQA and the AHRQ-sponsored CAHPS Consortium and is intended for use with the CAHPS 4.0 Health Plan survey. Some items are intended for Commercial health plan members only and are not included here. This measure provides information on the experiences of Medicaid health plan members with the organization. Results summarize member experiences through composites and question summary rates. In addition to the 4 core composites from the CAHPS 4.0 Health Plan survey and two composites for commercial populations only, the HEDIS supplemental set includes one composite score and two item-specific summary rates. 1. Shared Decision Making Composite 1. Health Promotion and Education item 2. Coordination of Care item</td>
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<tr>
<td>NQF Measure Number, Endorsement Status, Title, and Steward</td>
<td>Measure Type</td>
<td>Measure Description</td>
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<td>Other Known Uses and Program Alignment</td>
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<tr>
<td>0008 Endorsed Experience of Care and Health Outcomes (ECHO) Survey (behavioral health, managed care versions) Measure Steward: AHRQ <em>Starter Set Measure</em></td>
<td>Composite</td>
<td>52 questions including patient demographic information. The survey measures patient experiences with behavioral health care (mental health and substance abuse treatment) and the organization that provides or manages the treatment and health outcomes. Level of analysis: health plan- HMO, PPO, Medicare, Medicaid, commercial</td>
<td>Health Plan</td>
<td>State Duals Demonstrations: CA, IL, MA, OH</td>
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<tr>
<td>0018 Endorsed Controlling High Blood Pressure Measure Steward: NCQA <em>Starter Set Measure</em></td>
<td>Outcome</td>
<td>The percentage of patients 18 to 85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (&lt;140/90) during the measurement year.</td>
<td>Health Plan; Integrated Delivery System</td>
<td>Federal and State Programs: Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults; Meaningful Use-EP; Medicare Part C Plan Rating; Medicare Shared Savings Program; PQRS; HRSA; Medicaid Health Home, Special Needs Plan State Duals Demonstrations: CA, IL, MA, OH, VA Private Programs: eValue8; at least 1 Beacon community; HEDIS; Wellpoint; Buying Value core ambulatory measure</td>
<td>One commenter asserted that additional measures of chronic disease care are necessary to supplement this measure, such as asthma and COPD.</td>
</tr>
<tr>
<td>0022 Endorsed Use of High Risk Medications in the Elderly Measure Steward: NCQA <em>Starter Set Measure</em></td>
<td>Process</td>
<td>a: Percentage of Medicare members 66 years of age and older who received at least one high-risk medication. b: Percentage of Medicare members 66 years of age and older who received at least two different high-risk medications. For both rates, a lower rate represents better performance.</td>
<td>Health Plan; Integrated Delivery System</td>
<td>Federal and State Programs: Meaningful Use-EP; Medicare Part D Plan Rating; Physician Feedback; PQRS; Value-Based Payment Modifier Program; Special Needs Plan State Duals Demonstration: MA Private Programs: HEDIS; Buying Value core ambulatory measure</td>
<td>A public comment expressed concern about the unintended consequence of leading to under-treatment of pain and depression in the elderly; the commenter recommended monitoring the use of the measure.</td>
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<tr>
<td>NQF Measure Number, Endorsement Status, Title, and Steward</td>
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<tr>
<td><strong>0027 Endorsed</strong> Medical Assistance With Smoking and Tobacco Use Cessation Measure Steward: NCQA</td>
<td>Process</td>
<td>Assesses different facets of providing medical assistance with smoking and tobacco use cessation: Advising Smokers and Tobacco Users to Quit: A rolling average represents the percentage of members 18 years of age and older who were current smokers or tobacco users and who received advice to quit during the measurement year. Discussing Cessation Medications: A rolling average represents the percentage of members 18 years of age and older who were current smokers or tobacco users and who discussed or were recommended cessation medications during the measurement year. Discussing Cessation Strategies: A rolling average represents the percentage of members 18 years of age and older who were current smokers or tobacco users and who discussed or were provided smoking cessation methods or strategies during the measurement year.</td>
<td>Health Plan</td>
<td>Federal and State Programs: Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults; Meaningful Use-EP; PQRS Private Programs: HEDIS; Wellpoint</td>
<td>One commenter noted that tobacco cessation is not a Medicaid-funded service in all states. MAP members acknowledged this and decided to keep the measure within the family because of its importance as a quality issue.</td>
</tr>
<tr>
<td><strong>0028 Endorsed</strong> Preventive Care &amp; Screening: Tobacco Use: Screening &amp; Cessation Intervention Measure Steward: AMA-PCPI “Starter Set Measure”</td>
<td>Process</td>
<td>Percentage of patients aged 18 years and older who were screened for tobacco use at least once during the two-year measurement period AND who received cessation counseling intervention if identified as a tobacco user</td>
<td>Clinician: Group/Practice, Individual, Team</td>
<td>Federal and State Programs: Meaningful Use-EP; Medicare Shared Savings Program; PQRS State Duals Demonstration: MA Private Programs: eValue8 At least 1 Beacon community; Buying Value core ambulatory measure</td>
<td>One commenter requested further clarification on data collection procedures for programs that choose to use this measure.</td>
</tr>
<tr>
<td>NQF Measure Number, Endorsement Status, Title, and Steward</td>
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<tr>
<td>0032 Endorsed Cervical Cancer Screening Measure Steward: NCQA</td>
<td>Process</td>
<td>Percentage of women 21-64 years of age received one or more Pap tests to screen for cervical cancer.</td>
<td>Clinician: Group/Practice, Individual; Health Plan</td>
<td>Federal and State Programs: Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults; Meaningful Use-EP; PQRS; HRSA State Duals Demonstrations: IL, MA Private Programs: HEDIS; Wellpoint; Aetna; AmeriHealth Mercy Family of Companies; Cigna; IHA; AHIP survey - Measures used by a Majority of Health Plans; Buying Value core ambulatory measure</td>
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<tr>
<td>0034 Endorsed Colorectal Cancer Screening Measure Steward: NCQA</td>
<td>Process</td>
<td>The percentage of members 50-75 years of age who had appropriate screening for colorectal cancer.</td>
<td>Clinician: Group/Practice, Individual, Team; Health Plan</td>
<td>Federal and State Programs: Meaningful Use-EP; Medicare Part C Plan Rating; Medicare Shared Savings Program; Physician Feedback; PQRS; HRSA; Special Needs Plan State Duals Demonstrations: CA, IL, MA, OH, VA Private Programs: eValue8; at least 1 Beacon community; HEDIS; Wellpoint; Aetna; Community Health Alliance; IHA; AHIP survey - Measures used by a Majority of Health Plans; Buying Value core ambulatory measure</td>
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<tr>
<td>0043 Endorsed Pneumonia vaccination status for older adults Measure Steward: NCQA</td>
<td>Process</td>
<td>Percentage of patients 65 years of age and older who ever received a pneumococcal vaccination</td>
<td>Population: County or City; Facility; Health Plan; Integrated Delivery System; Clinician: Group/Practice, Individual, Team</td>
<td>Federal and State Programs: Meaningful Use-EP, Medicare Part C Plan Rating, Medicare Shared Savings Program, Physician Feedback, PQRS Private Programs: At least 1 Beacon community; HEDIS; Wellpoint; Buying Value core ambulatory measure</td>
<td>One commenter supported the inclusion of this measure.</td>
</tr>
<tr>
<td>0097 Endorsed Medication Reconciliation Measure Steward: NCQA</td>
<td>Process</td>
<td>Percentage of patients aged 65 years and older discharged from any inpatient facility (e.g. hospital, skilled nursing facility, or rehabilitation facility) and seen within 60 days following discharge in the office by the physician providing on-going care who had a reconciliation of the discharge medications with the current medication list in the medical record documented.</td>
<td>Population: County or City; Clinician: Group/Practice, Individual; Integrated Delivery System</td>
<td>Federal and State Programs: Medicare Shared Savings Program; Physician Feedback; PQRS State Duals Demonstrations: CA, IL, MA, OH, VA Private Programs: Buying Value core ambulatory measure</td>
<td>One commenter supported the inclusion of this measure because medication errors cause morbidity and re-hospitalization.</td>
</tr>
<tr>
<td>0101 Endorsed Falls: Screening, Risk-Assessment, and Plan of Care to Prevent Future Falls Measure Steward: NCQA “Starter Set Measure”</td>
<td>Process</td>
<td>This is a clinical process measure that assesses falls prevention in older adults. The measure has three rates: A) Screening for Future Fall Risk: Percentage of patients aged 65 years and older who were screened for fall risk (2 or more falls in the past year or any fall with injury in the past year) at least once within 12 months B) Multifactorial Risk Assessment for Falls: Percentage of patients aged 65 years and older with a history of falls who had a risk assessment for falls completed within 12 months C) Plan of Care to Prevent Future Falls: Percentage of patients aged 65 years and older with a history of falls who had a plan of care for falls documented within 12 months</td>
<td>Clinician: Group/Practice, Individual, Team</td>
<td>State Duals Demonstrations: WA</td>
<td>One commenter supported the inclusion of this measure because it addresses a major safety concern.</td>
</tr>
<tr>
<td>NQF Measure Number, Endorsement Status, Title, and Steward</td>
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<tr>
<td>0105 Endorsed Antidepressant Medication Management (AMM)</td>
<td>Process</td>
<td>The percentage of members 18 years of age and older with a diagnosis of major depression and were newly treated with antidepressant medication, and who remained on an antidepressant medication treatment. Two rates are reported. a) Effective Acute Phase Treatment. The percentage of newly diagnosed and treated members who remained on an antidepressant medication for at least 84 days (12 weeks). b) Effective Continuation Phase Treatment. The percentage of newly diagnosed and treated members who remained on an antidepressant medication for at least 180 days (6 months).</td>
<td>Clinician: Group/Practice, Individual; Health Plan; Integrated Delivery System; Population: National, Regional, State</td>
<td>Federal and State Programs: Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults; Meaningful Use-EP; Medicare Part C Plan Rating; Physician Feedback; PQRS; Value-Based Payment; Special Needs Plan State Duals Demonstrations: CA, IL, MA, OH, VA Private Programs: HEDIS; Cigna; AHIP survey - Measures used by a Majority of Health Plans; Buying Value core ambulatory measure</td>
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<tr>
<td>0111 Endorsed Bipolar Disorder: Appraisal for risk of suicide</td>
<td>Process</td>
<td>Percentage of patients with bipolar disorder with evidence of an initial assessment that includes an appraisal for risk of suicide.</td>
<td>Clinician: Group/Practice, Individual</td>
<td></td>
<td>One commenter requested further clarification on data collection procedures for programs that choose to use this measure.</td>
</tr>
<tr>
<td>0166 Endorsed HCAHPS</td>
<td>Patient Engagement/Experience</td>
<td>27-items survey instrument with 7 domain-level composites including: communication with doctors, communication with nurses, responsiveness of hospital staff, pain control, communication about medicines, cleanliness and quiet of the hospital environment, and discharge information.</td>
<td>Facility</td>
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<tr>
<td>0176 Endorsed Improvement in management of oral medications</td>
<td>Outcome</td>
<td>Percentage of home health episodes of care during which the patient improved in ability to take their medicines correctly, by mouth.</td>
<td>Facility</td>
<td>Federal and State Programs: Home Health Quality Reporting</td>
<td></td>
</tr>
<tr>
<td>NQF Measure Number, Endorsement Status, Title, and Steward</td>
<td>Measure Type</td>
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<td><strong>0201 Endorsed</strong> Pressure ulcer prevalence (hospital acquired) Measure Steward: The Joint Commission</td>
<td>Outcome</td>
<td>The total number of patients that have hospital-acquired (nosocomial) category/ stage II or greater pressure ulcers on the day of the prevalence measurement episode.</td>
<td>Facility; Clinician: Team</td>
<td>Private Programs: National Database of Nursing Quality Indicators (NDNQI); Alternative Quality Contract Wellpoint</td>
<td>One commenter supported the inclusion of this measure because it addresses a major safety concern.</td>
</tr>
<tr>
<td><strong>0202 Endorsed</strong> Falls with injury Measure Steward: American Nurses Association</td>
<td>Outcome</td>
<td>All documented patient falls with an injury level of minor or greater on eligible unit types in a calendar quarter. Reported as Injury falls per 1000 Patient Days. (Total number of injury falls / Patient days) X 1000 Measure focus is safety. Target population is adult acute care inpatient and adult rehabilitation patients.</td>
<td>Clinician: Team</td>
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<tr>
<td><strong>0228 Endorsed</strong> 3-Item Care Transition Measure (CTM-3) Measure Steward: University of Colorado Health Sciences Center “Starter Set Measure”</td>
<td>Composite</td>
<td>Uni-dimensional self-reported survey that measures the quality of preparation for care transitions.</td>
<td>Facility</td>
<td>Federal and State Programs: Hospital Inpatient Quality Reporting State Duals Demonstration: MA</td>
<td>One commenter expressed concern that beneficiaries receive too many surveys about their experience of care; this could suppress response rates.</td>
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<td><strong>0326 Endorsed</strong> Advance Care Plan Measure Steward: NCQA</td>
<td>Process</td>
<td>Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan.</td>
<td>Clinician: Group/ Practice, Individual</td>
<td>Federal and State Programs: Physician Feedback; PQRS; Special Needs Plan</td>
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<td><strong>0418 Endorsed</strong> Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan Measure Steward: CMS “Starter Set Measure”</td>
<td>Process</td>
<td>Percentage of patients aged 12 years and older screened for clinical depression using an age appropriate standardized tool AND follow-up plan documented</td>
<td>Clinician: Group/Practice, Team, Individual; Population: National, Regional, State, County or City, Community</td>
<td>Federal and State Programs: Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults; Meaningful Use-EP; Medicare Shared Savings Program; Physician Feedback; PQRS; HRSA; Medicaid Health Home State Duals Demonstrations: CA, IL, MA, OH, VA, WA Private Programs: Bridges to Excellence</td>
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<td><strong>0419 Endorsed</strong> Documentation of Current Medications in the Medical Record Measure Steward: CMS “Starter Set Measure”</td>
<td>Process</td>
<td>Percentage of specified visits for patients aged 18 years and older for which the eligible professional attests to documenting a list of current medications to the best of his/her knowledge and ability. This list must include ALL prescriptions, over-the-counters, herbals, vitamin/mineral/dietary (nutritional) supplements AND must contain the medications’ name, dosage, frequency and route. ALL MEASURE SPECIFICATION DETAILS REFERENCE THE 2012 PHYSICIAN QUALITY REPORTING SYSTEM MEASURE SPECIFICATION.</td>
<td>Clinician: Individual; Population: National</td>
<td>Federal and State Programs: Meaningful Use-EP; Physician Feedback; PQRS</td>
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<td><strong>0420 Endorsed</strong> Pain Assessment and Follow-Up Measure Steward: CMS</td>
<td>Process</td>
<td>Percentage of patients aged 18 years and older with documentation of a pain assessment through discussion with the patient including the use of a standardized tool(s) on each visit AND documentation of a follow-up plan when pain is present</td>
<td>Clinician: Individual</td>
<td>Federal and State Programs: Physician Feedback; PQRS</td>
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<td><strong>O421 Endorsed</strong> Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Measure Steward: CMS “Starter Set Measure”</td>
<td>Process</td>
<td>Percentage of patients aged 18 years and older with a calculated BMI in the past six months or during the current visit documented in the medical record AND if the most recent BMI is outside of normal parameters, a follow-up plan is documented within the past six months or during the current visit Normal Parameters: Age 65 years and older BMI ≥ to 23 and &lt;30 Age 18 – 64 years BMI ≥ to 18.5 and &lt;25</td>
<td>Clinician: Group/Practice, Individual; Population: National, Regional, State, County or City</td>
<td>Federal and State Programs: Meaningful Use-EP; Medicare Shared Savings Program; Physician Feedback; PQRS; HRSA State Duals Demonstration: MA Private Programs: At least 1 Beacon community; Wellpoint; Buying Value core ambulatory measure</td>
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<tr>
<td><strong>O553 Endorsed</strong> Care for Older Adults – Medication Review Measure Steward: NCQA</td>
<td>Process</td>
<td>Percentage of adults 66 years and older who had a medication review; a review of all a member’s medications, including prescription medications, over-the-counter (OTC) medications and herbal or supplemental therapies by a prescribing practitioner or clinical pharmacist.</td>
<td>Clinician: Group/Practice, Individual; Health Plan; Integrated Delivery System; Population: National, Regional, State</td>
<td>Federal and State Programs: Medicare Part C Plan Rating Private Programs: HEDIS; IHA</td>
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<td><strong>O554 Endorsed</strong> Medication Reconciliation Post-Discharge Measure Steward: NCQA</td>
<td>Process</td>
<td>The percentage of discharges from January 1–December 1 of the measurement year for members 66 years of age and older for whom medications were reconciled on or within 30 days of discharge.</td>
<td>Health Plan; Integrated Delivery System; Population: National, Regional, State</td>
<td>Federal and State Programs: Special Needs Plan State Duals Demonstration: CA Private Programs: HEDIS</td>
<td>One commenter identified challenges associated with collecting pharmacy benefits information; sampling and chart review is sometimes needed.</td>
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<td><strong>0557 Endorsed</strong></td>
<td>Process</td>
<td>The proportion of patients discharged from a hospital-based inpatient psychiatric setting with a post discharge continuing care plan created. This measure is a part of a set of seven nationally implemented measures that address hospital-based inpatient psychiatric services (HBIPS-1: Admission Screening for Violence Risk, Substance Use, Psychological Trauma History and Patient Strengths completed, HBIPS-2: Physical Restraint, HBIPS-3: Seclusion, HBIPS-4: Multiple Antipsychotic Medications at Discharge, HBIPS-5: Multiple Antipsychotic Medications at Discharge with Appropriate Justification and HBIPS-7: Post Discharge Continuing Care Plan Transmitted) that are used in The Joint Commission’s accreditation process. Note that this is a paired measure with HBIPS-7 (Post Discharge Continuing Care Plan Transmitted).</td>
<td>Facility</td>
<td>Federal and State Programs: Inpatient Psychiatric Facility Quality Reporting</td>
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<td><strong>0558 Endorsed</strong></td>
<td>Process</td>
<td>Patients discharged from a hospital-based inpatient psychiatric setting with a continuing care plan provided to the next level of care clinician or entity overall and stratified by age groups: Children (Age 1 through 12 years), Adolescents (Age 13 through 17 years), Adults (Age 18 through 64 years), Older Adults (Age greater than and equal to 65 years). Note: this is a paired measure with HBIPS-6: Post discharge continuing care plan created.</td>
<td>Facility</td>
<td>Federal and State Programs: Inpatient Psychiatric Facility Quality Reporting</td>
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Note: HBIPS-6 and HBIPS-7 are paired measures.
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<thead>
<tr>
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<tr>
<td><strong>0576 Endorsed</strong> Follow-Up After Hospitalization for Mental Illness</td>
<td>Process</td>
<td>This measure assesses the percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported. Rate 1. The percentage of members who received follow-up within 30 days of discharge Rate 2. The percentage of members who received follow-up within 7 days of discharge.</td>
<td>Clinician: Team; Health Plan; Integrated Delivery System; Population: National, Regional, State, County or City</td>
<td>Federal and State Programs: Children's Health Insurance Program Reauthorization Act Quality Reporting; Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults; Medicare Part C Plan Rating; Physician Feedback; PQRS; Medicaid Health Home, Special Needs Plan State Duals Demonstrations: CA, IL, MA, OH, VA, WA Private Programs: Wellpoint; HEDIS; Buying Value core ambulatory measure</td>
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<td><strong>0640 Endorsed</strong> HBIPS-2 Hours of physical restraint use</td>
<td>Process</td>
<td>The number of hours that all patients admitted to a hospital-based inpatient psychiatric setting were maintained in physical restraint per 1000 psychiatric inpatient hours, overall and stratified by age groups: Children (Age 1 through 12 years), Adolescents (Age 13 through 17 years), Adults (Age 18 through 64 years), Older Adults (Age greater than and equal to 65 years).</td>
<td>Facility</td>
<td>Federal and State Programs: Inpatient Psychiatric Facility Quality Reporting</td>
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<tr>
<td><strong>0641 Endorsed</strong> HBIPS-3 Hours of seclusion use</td>
<td>Process</td>
<td>The number of hours that all patients admitted to a hospital-based inpatient psychiatric setting were held in seclusion per 1000 psychiatric inpatient hours, overall and stratified by age groups: Children (Age 1 through 12 years), Adolescents (Age 13 through 17 years), Adults (Age 18 through 64 years), Older Adults (Age greater than and equal to 65 years).</td>
<td>Facility</td>
<td>Federal and State Programs: Inpatient Psychiatric Facility Quality Reporting</td>
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<td><strong>0646 Endorsed</strong> Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/ Self Care or Any Other Site of Care) Measure Steward: AMA-PCPI</td>
<td>Process</td>
<td>Percentage of patients, regardless of age, discharged from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home or any other site of care, or their caregiver(s), who received a reconciled medication list at the time of discharge including, at a minimum, medications in the specified categories</td>
<td>Facility; Integrated Delivery System</td>
<td>Private Programs: ABIM MOC; Highmark</td>
<td>One commenter supported the inclusion of this measure because it addresses a major safety concern.</td>
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<tr>
<td><strong>0647 Endorsed</strong> Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/ Self Care or Any Other Site of Care) Measure Steward: AMA-PCPI</td>
<td>Process</td>
<td>Percentage of patients, regardless of age, discharged from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home or any other site of care, or their caregiver(s), who received a transition record (and with whom a review of all included information was documented) at the time of discharge including, at a minimum, all of the specified elements</td>
<td>Facility; Integrated Delivery System</td>
<td>State Duals Demonstrations: CA, MA Private Programs: ABIM MOC; Highmark</td>
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<td><strong>0648 Endorsed</strong> Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/ Self Care or Any Other Site of Care) Measure Steward: AMA-PCPI</td>
<td>Process</td>
<td>Percentage of patients, regardless of age, discharged from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home or any other site of care for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge</td>
<td>Facility; Integrated Delivery System</td>
<td>Federal and State Programs: Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults State Duals Demonstrations: MA, WA Private Programs: ABIM MOC; Highmark; Buying Value core ambulatory measure</td>
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<tr>
<td><strong>0649 Endorsed</strong> Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges to Ambulatory Care [Home/ Self Care] or Home Health Care) Measure Steward: AMA-PCPI</td>
<td>Process</td>
<td>Percentage of patients, regardless of age, discharged from an emergency department (ED) to ambulatory care or home health care, or their caregiver(s), who received a transition record at the time of ED discharge including, at a minimum, all of the specified elements</td>
<td>Facility, Integrated Delivery System</td>
<td>Private Programs: ABIM MOC; Highmark</td>
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<td><strong>0674 Endorsed</strong> Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) Measure Steward: CMS</td>
<td>Outcome</td>
<td>This measure is based on data from all non-admission MDS 3.0 assessments of long-stay nursing facility residents which may be annual, quarterly, significant change, significant correction, or discharge assessment. It reports the percent of residents who experienced one or more falls with major injury (e.g., bone fractures, joint dislocations, closed head injuries with altered consciousness, and subdural hematoma) in the last year (12-month period). The measure is based on MDS 3.0 item J1900C, which indicates whether any falls that occurred were associated with major injury.</td>
<td>Facility; Population: National</td>
<td>Federal and State Programs: Nursing Home Quality Initiative and Nursing Home Compare</td>
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<tr>
<td><strong>0682 Endorsed</strong> Percent of Residents or Patients Assessed and Appropriately Given the Pneumococcal Vaccine (Short-Stay) Measure Steward: CMS</td>
<td>Process</td>
<td>The measure reports the percentage of short stay nursing home residents or IRF or LTCH patients who were assessed and appropriately given the pneumococcal vaccine during the 12-month reporting period. This measure is based on data from Minimum Data Set (MDS) 3.0 assessments of nursing home residents, the Inpatient Rehabilitation Facilities Patient Assessment Instrument (IRF-PAI) for IRF patients, and the Long Term Care Hospital (LTCH) Continuity Assessment Record and Evaluation (CARE) Data Set for long-term care hospital patients, using items that have been harmonized across the three assessment instruments. Short-stay nursing home residents are those residents who are discharged within the first 100 days of their nursing home stay.</td>
<td>Facility; Population: National</td>
<td>Federal and State Programs: Nursing Home Quality Initiative and Nursing Home Compare</td>
<td>One commenter supported the inclusion of this measure.</td>
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<tr>
<td>0692 Endorsed Consumer Assessment of Health Providers and Systems (CAHPS®) Nursing Home Survey: Long-Stay Resident Instrument Measure Steward: AHRQ</td>
<td>Outcome</td>
<td>The CAHPS® Nursing Home Survey: Long-Stay Resident Instrument is an in-person survey instrument to gather information on the experience of long stay (greater than 100 days) residents currently in nursing homes. The Centers for Medicare &amp; Medicaid Services requested development of this survey, and can be used in conjunction with the CAHPS Nursing Home Survey: Family Member Instrument and Discharged Resident Instrument. The survey instrument provides nursing home level scores on 5 topics valued by residents: (1) Environment; (2) Care; (3) Communication &amp; Respect; (4) Autonomy and (5) Activities. In addition, the survey provides nursing home level scores on 3 global items.</td>
<td>Facility</td>
<td>State Duals Demonstration: VA Private Programs: Health Quality Council of Alberta, Canada</td>
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<tr>
<td>0709 Endorsed Proportion of patients with a chronic condition that have a potentially avoidable complication during a calendar year. Measure Steward: Bridges to Excellence</td>
<td>Outcome</td>
<td>Percent of adult population aged 18 – 65 years who were identified as having at least one of the following six chronic conditions: Diabetes Mellitus (DM), Congestive Heart Failure (CHF), Coronary Artery Disease (CAD), Hypertension (HTN), Chronic Obstructive Pulmonary Disease (COPD) or Asthma, were followed for one-year, and had one or more potentially avoidable complications (PACs). A Potentially Avoidable Complication is any event that negatively impacts the patient and is potentially controllable by the physicians and hospitals that manage and co-manage the patient. Generally, any hospitalization related to the patient’s core chronic condition or any co-morbidity is considered a potentially avoidable complication, unless that hospitalization is considered to be a typical service for a patient with that condition. Additional PACs that can occur during the calendar year include those related to emergency room visits, as well as other professional or ancillary services tied to a potentially avoidable complication.</td>
<td>Clinician: Group/Practice; Health Plan; Population: National, Regional, County or City, State</td>
<td>Private Programs: Prometheus</td>
<td>One commenter argued that this measure is a better fit for healthier populations, stating that a poor clinical prognosis could reflect poorly on the entity being measured.</td>
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<td><strong>0710 Endorsed</strong>&lt;br&gt;Depression Remission at Twelve Months&lt;br&gt;Measure Steward: MN Community Measurement</td>
<td>Outcome</td>
<td>Adult patients age 18 and older with major depression or dysthymia and an initial PHQ-9 score &gt; 9 who demonstrate remission at twelve months defined as a PHQ-9 score less than 5. This measure applies to both patients with newly diagnosed and existing depression whose current PHQ-9 score indicates a need for treatment. The Patient Health Questionnaire (PHQ-9) tool is a widely accepted, standardized tool [Copyright © 2005 Pfizer, Inc. All rights reserved] that is completed by the patient, ideally at each visit, and utilized by the provider to monitor treatment progress. This measure additionally promotes ongoing contact between the patient and provider as patients who do not have a follow-up PHQ-9 score at twelve months (+/- 30 days) are also included in the denominator.</td>
<td>Facility, Clinician: Group/Practice</td>
<td>Federal and State Programs: Meaningful Use-EP; PQRS Private Programs: MN Community Measurement</td>
<td>One commenter requested further clarification on data collection procedures for programs that choose to use this measure.</td>
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<td><strong>0712 Endorsed</strong> Depression Utilization of the PHQ-9 Tool</td>
<td>Process</td>
<td>Adult patients age 18 and older with the diagnosis of major depression or dysthymia (ICD-9 296.2x, 296.3x or 300.4) who have a PHQ-9 tool administered at least once during the four month measurement period. The Patient Health Questionnaire (PHQ-9) tool is a widely accepted, standardized tool [Copyright © 2005 Pfizer, Inc. All rights reserved] that is completed by the patient, ideally at each visit, and utilized by the provider to monitor treatment progress. This process measure is related to the outcome measures of “Depression Remission at Six Months” and “Depression Remission at Twelve Months”. This measure was selected by stakeholders for public reporting to promote the implementation of processes within the provider’s office to insure that the patient is being assessed on a routine basis with a standardized tool that supports the outcome measures for depression. Currently, only about 20% of the patients eligible for the denominator of remission at 6 or 12 months actually have a follow-up PHQ-9 score for calculating remission (PHQ-9 score &lt; 5).</td>
<td>Facility; Clinician: Group/Practice</td>
<td>Federal and State Programs: Meaningful Use-EP; PQRS Private Programs: MN Community Measurement</td>
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<td><strong>0729 Endorsed</strong> Optimal Diabetes Care Measure Steward: MN Community Measurement</td>
<td>Composite</td>
<td>The percentage of adult diabetes patients who have optimally managed modifiable risk factors (A1c, LDL, blood pressure, tobacco non-use and daily aspirin usage for patients with diagnosis of ischemic vascular disease) with the intent of preventing or reducing future complications associated with poorly managed diabetes. Patients ages 18 - 75 with a diagnosis of diabetes, who meet all the numerator targets of this composite measure: A1c &lt; 8.0, LDL &lt; 100, Blood Pressure &lt; 140/ 90, Tobacco non-user and for patients with diagnosis of ischemic vascular disease daily aspirin use unless contraindicated. Please note that while the all-or-none composite measure is considered to be the gold standard, reflecting best patient outcomes, the individual components may be measured as well. This is particularly helpful in quality improvement efforts to better understand where opportunities exist in moving the patients toward achieving all of the desired outcomes. Please refer to the additional numerator logic provided for each component.</td>
<td>Clinician: Group/ Practice; Integrated Delivery System</td>
<td>Federal and State Programs: Medicare Shared Savings Program; PQRS Private Programs: At least 1 Beacon community</td>
<td>One commenter asserted that additional measures of chronic disease care are necessary to supplement this measure.</td>
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<tr>
<td><strong>1626 Endorsed</strong> Patients Admitted to ICU who Have Care Preferences Documented Measure Steward: The RAND Corporation</td>
<td>Process</td>
<td>Percentage of vulnerable adults admitted to ICU who survive at least 48 hours who have their care preferences documented within 48 hours OR documentation as to why this was not done.</td>
<td>Facility; Health Plan; Integrated Delivery System</td>
<td></td>
<td>One commenter did not support the inclusion of this measure and expressed concerns about the availability of data to calculate it.</td>
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<tr>
<td><strong>1659 Endorsed</strong> Influenza Immunization Measure Steward: CMS</td>
<td>Process</td>
<td>Inpatients age 6 months and older discharged during October, November, December, January, February or March who are screened for influenza vaccine status and vaccinated prior to discharge if indicated.</td>
<td>Facility; Population: National, Regional, State</td>
<td>Federal and State Programs: Hospital Inpatient Quality Reporting</td>
<td>One commenter supported the inclusion of this measure.</td>
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<td>1768 Endorsed Plan All-Cause Readmissions Measure Steward: NCQA “Starter Set Measure”</td>
<td>Outcome</td>
<td>For members 18 years of age and older, the number of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. Data are reported in the following categories: 1. Count of Index Hospital Stays (IHS) (denominator) 2. Count of 30-Day Readmissions (numerator) 3. Average Adjusted Probability of Readmission 4. Observed Readmission (Numerator/Denominator) 5. Total Variance Note: For commercial, only members 18–64 years of age are collected and reported; for Medicare, only members 18 and older are collected, and only members 65 and older are reported.</td>
<td>Health Plan</td>
<td>Federal and State Programs: Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults; Medicare Part C Plan Rating; Special Needs Plan State Duals Demonstrations: CA, IL, MA, OH, VA Private Programs: Wellpoint; HEDIS; IHA; AHIP survey - Measures used by a Majority of Health Plans; Buying Value core ambulatory measure</td>
<td>One commenter supported the inclusion of this measure because it addresses a major, avoidable safety concern.</td>
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<td><strong>1789 Endorsed</strong> Hospital-Wide All-Cause Unplanned Readmission Measure (HWR) Measure Steward: CMS</td>
<td>Outcome</td>
<td>This measure estimates the hospital-level, risk-standardized rate of unplanned, all-cause readmission after admission for any eligible condition within 30 days of hospital discharge (RSRR) for patients aged 18 and older. The measure reports a single summary RSRR, derived from the volume-weighted results of five different models, one for each of the following specialty cohorts (groups of discharge condition categories or procedure categories): surgery/ gynecology, general medicine, cardiorespiratory, cardiovascular, and neurology, each of which will be described in greater detail below. The measure also indicates the hospital standardized risk ratios (SRR) for each of these five specialty cohorts. We developed the measure for patients 65 years and older using Medicare fee-for-service (FFS) claims and subsequently tested and specified the measure for patients aged 18 years and older using all-payer data. We used the California Patient Discharge Data (CPDD), a large database of patient hospital admissions, for our all-payer data.</td>
<td>Facility</td>
<td>Federal and State Programs: Hospital Inpatient Quality Reporting</td>
<td></td>
</tr>
<tr>
<td>NQF Measure Number, Endorsement Status, Title, and Steward</td>
<td>Measure Type</td>
<td>Measure Description</td>
<td>Level of Analysis</td>
<td>Other Known Uses and Program Alignment</td>
<td>Public Comments</td>
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<tr>
<td>1902 Endorsed Clinicians/ Groups’ Health Literacy Practices Based on the CAHPS Item Set for Addressing Health Literacy Measure Steward: AHRQ</td>
<td>Outcome</td>
<td>These measures are based on the CAHPS Item Set for Addressing Health Literacy, a set of supplemental items for the CAHPS Clinician &amp; Group Survey. The item set includes the following domains: Communication with Provider (Doctor), Disease Self-Management, Communication about Medicines, Communication about Test Results, and Communication about Forms. Samples for the survey are drawn from adults who have had at least one provider’s visit within the past year. Measures can be calculated at the individual clinician level, or at the group (e.g., practice, clinic) level. We have included in this submission items from the core Clinician/ Group CAHPS instrument that are required for these supplemental items to be fielded (e.g., screeners, stratifies). Two composites can be calculated from the item set: 1) Communication to improve health literacy (5 items), and 2) Communication about medicines (3 items)</td>
<td>Clinician: Group/ Practice, Individual</td>
<td>Private Programs: Highmark; Buying Value core ambulatory measure</td>
<td>One commenter strongly supported the inclusion of this measure because health literacy is a major barrier to healthcare access.</td>
</tr>
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</table>
| 1909 Endorsed Medical Home System Survey (MHSS) Measure Steward: NCQA “Starter Set Measure” | Composite | The Medical Home System Survey (MHSS) assesses the degree to which an individual primary-care practice or provider has in place the structures and processes of an evidence-based Patient Centered Medical Home. The survey is composed of six composites. Each measure is used to assess a particular domain of the patient-centered medical home.  
Composite 1: Enhance access and continuity  
Composite 2: Identify and manage patient populations  
Composite 3: Plan and manage care  
Composite 4: Provide self-care support and community resources  
Composite 5: Track and coordinate care  
Composite 6: Measure and improve performance | Clinician: Group/ Practice, Individual | | |
<table>
<thead>
<tr>
<th>NQF Measure Number, Endorsement Status, Title, and Steward</th>
<th>Measure Type</th>
<th>Measure Description</th>
<th>Level of Analysis</th>
<th>Other Known Uses and Program Alignment</th>
<th>Public Comments</th>
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<tbody>
<tr>
<td>1927 Endorsed Cardiovascular Health Screening for People With Schizophrenia or Bipolar Disorder Who Are Prescribed Antipsychotic Medications Measure Steward: NCQA</td>
<td>Process</td>
<td>The percentage of individuals 25 to 64 years of age with schizophrenia or bipolar disorder who were prescribed any antipsychotic medication and who received a cardiovascular health screening during the measurement year.</td>
<td>Health Plan; Integrated Delivery System; Population: State</td>
<td></td>
<td>One commenter expressed concerns regarding the evidence underlying this measure.</td>
</tr>
<tr>
<td>1932 Endorsed Diabetes screening for people with schizophrenia or bipolar disorder who are prescribed antipsychotic medications (SSD) Measure Steward: NCQA</td>
<td>Process</td>
<td>The percentage of individuals 18 – 64 years of age with schizophrenia or bipolar disorder, who were dispensed any antipsychotic medication and had a diabetes screening during the measurement year.</td>
<td>Health Plan; Population: State</td>
<td>State Duals Demonstration: IL</td>
<td></td>
</tr>
<tr>
<td>2079 Endorsed HIV medical visit frequency Measure Steward: HRSA - HIV/AIDS Bureau</td>
<td>Process</td>
<td>Percentage of patients, regardless of age, with a diagnosis of HIV who had at least one medical visit in each 6-month period of the 24-month measurement period with a minimum of 60 days between medical visits. A medical visit is any visit in an outpatient/ambulatory care setting with a nurse practitioner, physician, and/or a physician assistant who provides comprehensive HIV care.</td>
<td>Clinician: Group/Practice, Facility</td>
<td></td>
<td></td>
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<tr>
<td>2091 Endorsed Persistent Indicators of Dementia without a Diagnosis - Long Stay Measure Steward: American Medical Directors Association</td>
<td>Process</td>
<td>Percentage of nursing home residents age 65+ with persistent indicators of dementia and no diagnosis of dementia.</td>
<td>Facility</td>
<td>One commenter did not understand MAP’s rationale for including this measure in the family.</td>
<td></td>
</tr>
<tr>
<td>NQF Measure Number, Endorsement Status, Title, and Steward</td>
<td>Measure Type</td>
<td>Measure Description</td>
<td>Level of Analysis</td>
<td>Other Known Uses and Program Alignment</td>
<td>Public Comments</td>
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<tr>
<td><strong>2092 Endorsed</strong> Persistent Indicators of Dementia without a Diagnosis - Short Stay Measure Steward: American Medical Directors Association</td>
<td>Process</td>
<td>Number of adult patients 65 and older who are included in the denominator (i.e., have persistent signs and symptoms of dementia) and who do not have a diagnosis of dementia on any MDS assessment.</td>
<td>Facility</td>
<td></td>
<td>One commenter did not understand MAP’s rationale for including this measure in the family.</td>
</tr>
<tr>
<td><strong>2111 Endorsed</strong> Antipsychotic Use in Persons with Dementia Measure Steward: Pharmacy Quality Alliance, Inc.</td>
<td>Process</td>
<td>The percentage of individuals 65 years of age and older with dementia who are receiving an antipsychotic medication without evidence of a psychotic disorder or related condition.</td>
<td>Health Plan</td>
<td></td>
<td>One commenter did not support the use of this measure, citing the difficulty of educating providers about antipsychotic overuse.</td>
</tr>
<tr>
<td><strong>2152 Endorsed</strong> Preventive Care and Screening: Unhealthy Alcohol Use: Screening &amp; Brief Counseling Measure Steward: AMA-PCPI</td>
<td>Process</td>
<td>Percentage of patients aged 18 years and older who were screened for unhealthy alcohol use at least once during the two-year measurement period using a systematic screening method AND who received brief counseling if identified as an unhealthy alcohol user.</td>
<td>Clinician: Group/Practice, Individual, Team</td>
<td></td>
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<tr>
<td><strong>2158 Endorsed</strong> Payment-Standardized Medicare Spending Per Beneficiary (MSPB) Measure Steward: CMS</td>
<td>Cost/Resource Use</td>
<td>The MSPB Measure assesses the cost of services performed by hospitals and other healthcare providers during an MSPB hospitalization episode, which comprises the period immediately prior to, during, and following a patient’s hospital stay. Beneficiary populations eligible for the MSPB calculation include Medicare beneficiaries enrolled in Medicare Parts A and B who were discharged from short-term acute hospitals during the period of performance.</td>
<td>Facility</td>
<td></td>
<td>One commenter recommended that the measure include risk adjustment and stratification for socioeconomic status and health status for the dual eligible population.</td>
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</tbody>
</table>
APPENDIX E: Alignment in Use of Family of Measures for Dual Eligible Beneficiaries Across Selected Federal Programs

<table>
<thead>
<tr>
<th>Federal Quality Measurement Programs</th>
<th>Measures from Family Currently Used In Program*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulatory Surgical Centers Quality Reporting Program</td>
<td></td>
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<tr>
<td>End Stage Renal Disease Quality Initiative Program</td>
<td></td>
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<tr>
<td>Home Health Quality Reporting</td>
<td>1</td>
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<tr>
<td>Hospice Quality Reporting Program</td>
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<tr>
<td>Hospital-Acquired Condition Reduction Program</td>
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<tr>
<td>Hospital Inpatient Quality Reporting Program</td>
<td>4</td>
</tr>
<tr>
<td>Hospital Outpatient Quality Reporting Program</td>
<td></td>
</tr>
<tr>
<td>Hospital Readmissions Reduction Program</td>
<td></td>
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<tr>
<td>Hospital Value-Based Purchasing Program</td>
<td>2</td>
</tr>
<tr>
<td>Inpatient Psychiatric Facilities Quality Reporting</td>
<td></td>
</tr>
<tr>
<td>Inpatient Rehabilitation Facility Quality Reporting</td>
<td>5</td>
</tr>
<tr>
<td>Long-Term Care Hospital Quality Reporting</td>
<td>1</td>
</tr>
<tr>
<td>Medicaid Adult Core Quality Measures Program</td>
<td>11</td>
</tr>
<tr>
<td>Medicaid Children’s Quality Measures Program</td>
<td>1</td>
</tr>
<tr>
<td>Medicaid Health Home Core Quality Measures</td>
<td>6</td>
</tr>
<tr>
<td>Medicare and Medicaid EHR Incentive Program for Eligible Professionals</td>
<td>13</td>
</tr>
<tr>
<td>Medicare and Medicaid EHR Incentive Program for Hospitals and Critical Access Hospitals</td>
<td></td>
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<tr>
<td>Medicare Part C</td>
<td>7</td>
</tr>
<tr>
<td>Medicare Part D</td>
<td>2</td>
</tr>
<tr>
<td>Medicare Shared Savings Program</td>
<td>10</td>
</tr>
<tr>
<td>Nursing Home Quality Initiative and Nursing Home Compare</td>
<td>2</td>
</tr>
<tr>
<td>Physician Compare</td>
<td></td>
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<tr>
<td>Physician Feedback Program</td>
<td>10</td>
</tr>
<tr>
<td>Physician Quality Reporting System</td>
<td>20</td>
</tr>
<tr>
<td>PPS-Exempt Cancer Hospital Quality Reporting Program</td>
<td>1</td>
</tr>
<tr>
<td>Value-Based Payment Modifier</td>
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</tbody>
</table>

* A measure is “in use” when a final decision has been made to implement a measure in one or more federal programs. At least one of the following actions occurs: 1) data collection for computing the measure begins; and/or 2) measure results are computed using data that was previously collected.
APPENDIX F:
Public Comments Received on Draft Report

General Comments

America's Health Insurance Plans
Carmella Bocchino

We applaud the MAP's efforts to focus its work on performance measure development in topic areas relevant to dual eligible beneficiaries and that support quality of life outcomes. We support the high-priority measure gaps, however, we recommend adding language to recognize that as measure gaps are addressed CMS should consider including such measures in federal quality programs and retiring existing measures to minimize measurement burden.

MAP should continue to recommend a parsimonious measure set that builds on existing measures (e.g. NCQA, CMS Star Ratings, etc.). Utilizing measures that have been widely accepted and that are feasible, reliable, and valid, will minimize burden of data collection and administrative costs. We also recommend that the MAP focus measurement efforts on direct outcomes measures, instead of survey measures. Survey responses are often not specific enough for health plans to translate into actionable or targeted improvements. The MAP should also consider the number and frequency of surveys currently administered to health plan members and patients when determining what types of measures are most appropriate for the Dual Eligible population. Oftentimes members and patients are unable to remember pertinent information when responding to surveys. Recall bias is particularly problematic for the elderly and those with behavioral health problems.

American's Health Insurance Plans
Carmella Bocchino

We support MAP's efforts to improve measure alignment across the Medicare and Medicaid programs, as well as across private-sector programs. Such alignment is important for ensuring that measurement is both meaningful and manageable and for reducing the overall measurement burden. Measures also should be tested and selected based on their ability to better identify, understand, and close the disparities that exist between and within target populations. In addition, while we encourage efforts to expand measurement of vulnerable populations, the operational bandwidth required to accommodate any new efforts must be kept in mind. One specific area of opportunity is to condense a given family of measures to those most connected to meaningful outcomes and eliminating measures that represent minor variations on the same measure concept.

It is also important that stakeholders have access to the complete technical specification for each measure to ensure uniform measure implementation and the comparability of performance data.

Consortium for Citizens with Disabilities
E. Clarke Ross

Presentation of measures is complex and daunting. We suggest that measures be ordered into major categories (e.g., community living, prevention of chronic illness, beneficiary choice and self-direction, etc.). Color coding of measures by major category might help in the understanding and presentation.

Suggest this report include language from the NQF MAP May 30, 2014 draft report - “one single term cannot apply to all individuals in all situations; in actuality, an individual with many needs may self-identify as a person, client, or patient at a single point in time...Use the word ‘person’ as an over-arching term to encompass the health and healthcare needs of all individuals, regardless of age, setting, or health status.”
Disability Health Access, LLC
Anne Cohen
I appreciate NQF’s efforts to organize the complex set of potential measures into a “family of Measures set,” this has made a difficult task more meaningful. I encourage NQF to continue to look at additional ways to make the reports more meaningful and usable to non-academic and industry representatives. I suggest reorganizing the appendix chart to create a color coded system indicating the measures that are in the 7 topic family measures and indicating the additional family measurement areas (population health, affordable care, and person- and family-centered care) currently being finalized. I also suggest further explanation of the concept of process measures, outcome measure, composite measures, engagement/experience measures, and efficiency measure. In particular as we continue to put emphasis on person-centered measures it would be useful to also indicate if an individual measure or a family of measures fulfills that concept.

Family Voices NJ
Lauren Agoratus
We understand that “MAP briefly considered... NQF #2065 Gastrointestinal Hemorrhage Mortality Rate (IQI #18)… found to be too narrow and would not address any gap areas” which is disappointing due to its importance as a high risk measure due to mortality rates. We urge NQF to reconsider this decision.

GlaxoSmithKline
Deborah Fritz
We commend MAPs efforts to improve the use of performance measures to assess and improve the quality of care delivered to this complex and vulnerable population of Dual Eligible patients. We support the approach taken to include the development of measures across the spectrum of care encompassing a holistic approach for the patient needs and outcomes. The gaps identified on page 6 of the report go well beyond the traditional clinical goals of care and represent important areas to address related to the quality of care provided to individuals.

The efforts and consideration towards the harmonization of measures is also appreciated as the burden to provider organizations to meet disparate reporting requirements represents a tremendous strain on resources. We support your continued work to simplify measures recommendations across measures set where possible. Last, we applaud the diligence NQF and MAP display in maintaining a transparent and multi-stakeholder process to drive improvement in patient care.

Healthfirst
Joyce Chan
There is significant variation among dual eligible members. We recommend that measures be tested across those elements with great variability (i.e., primary language, residence in Health Professional Shortage Areas, residence in urban vs. rural communities, etc.).

In addition, we encourage MAP to ensure that all measures are able to be evaluated without undue burden to stakeholders.

We support MAP’s recommendation to align reporting requirements and measures across programs and stakeholder groups. This alignment will better focus stakeholder efforts on improvement and reduce resource burden. It will also support collaborative efforts among stakeholders (e.g., payors and providers) as they work on improving the same measures.

National Council on Aging
Joe Caldwell
Thank you for the opportunity to provide public comment on the National Quality Forum (NQF) Measure Applications Partnership (MAP): 2014 Report from Dual Eligible Workgroup.

The National Council on Aging (NCOA) supports the work NQF has done in identifying high-priority measure gaps, including identified gaps in person-centered planning, self-determination, and community participation. We appreciate the work of NQF in highlighting work being done to attempt to fill these gaps. In particular, we acknowledge efforts to develop quality of life and consumer experience...
measures (e.g. National Core Indicators, Council on Quality and Leadership Personal Outcomes Measures, and Home and Community-Based Experience Survey).

However, we remain deeply concerned that about the lack of any endorsed HCBS measures as states rapidly move forward with implementation of duals integration demonstrations and expansion of MLTSS programs. The path forward to endorsement of HCBS measures is unclear. We believe NQF should play a stronger leadership role in making specific recommendations to CMS about investments needed in HCBS quality measure development to expedite endorsement and guidance to states in this area.

In addition, we believe there are many important domains missing from the list of priority measure gaps that reflect the paradigm of quality within HCBS. Rebalancing, self-direction, employment, family caregiver supports, and adequacy of the direct care workforce are some areas we believe deserve more attention.

NCOA leads a coalition of 37 national aging and disability organizations (known as the Friday Morning Collaborative). The coalition focuses on HCBS issues and meets regularly. There is a lot of collective knowledge and expertise within the collaborative across the spectrum of individuals who are dual eligible and need long-term services and supports. We encourage you to consider us a resource and would be happy to offer additional assistance in the areas of HCBS quality measures.

SNP Alliance
Valerie Wilbur

The SNP Alliance appreciates the thoughtful work of the Dual Eligible Work Group. We urge NQF to continue to clarify that (1) the Family of Measures is intended to serve as a set of options -- not an all-inclusive measure set mandated for all plans/providers; and (2) when several measures are included for a particular category, such as medication management or care transitions, the idea is to offer options, not for plans/providers to report all measures. This is especially important for many of the CAHPS measures which have multiple questions and which could lead to significant duplication of reporting if, for example, CAHPS, HCAHPS, and CAHPS 4.0 were all required. Data fatigue is as important a consideration for enrollees as for plans and could reduce beneficiary submission rates.

We strongly support the proposed focus for the path forward on alignment, impact of measures and fit-for-purpose embodied in the two key questions raised in the Report. Current Medicare measures are biased toward average Medicare beneficiaries, not high-risk/high-need populations. There are few MA Stars measures of unique importance to duals, no system-level measures that evaluate aggregate performance across time and care settings, and few outcome measures. There are also no measures to evaluate the degree to which Medicare and Medicaid benefits and services are being integrated. The need for risk adjustment of measures for high-risk beneficiaries also is needed to better align measures and expected outcomes with population specific needs and limitations. Below are SNP Alliance priorities for the 4 areas addressed in the path forward:

• High Leverage Opportunities: We would prioritize "visioning a future state for quality measurement." For healthcare to move from a provider-based, component-driven approach to a person-centered, system-oriented approach, with priority on advancing care for frail, disabled, chronically-ill persons, it is as important for the state of quality measurement to change as for health care delivery structures to change.

• Additional Measure Topics: Prioritize development of structural measures to evaluate the degree of integration of Medicare/Medicaid benefits and services, distinguishing between care integration and program integration.

• Other factors: Priority should be given to advancing risk adjustment of measures within the Dual Eligible Beneficiary Family of Measures. We strongly support performance measurement and accountability. We also know that performance is affected by the complexity of medical conditions and by social determinants of health, as recognized by the NQF SES Panel. Risk adjustment or stratification of measures is critical to performance measurement and the future of specialized care for the most needy, high-risk, and costly service groups. Primary care/behavioral health integration
models also critical for duals, given the prevalence of behavioral health diagnoses among duals.

- We support identification of a new HIV-AIDS screening measure and inclusion of NQF #2079 as compliance with medical visits strongly influences morbidity and mortality. We strongly recommend adding NQF #2082 and NQF #2083. Viral load suppression and antiretroviral therapy can help prevent HIV from advancing to AIDS, assess the risk of disease progression and help guide initiation of therapy. These two measures were included in a set core indicators recommended by HHS and are consistent with the Institute of Medicine’s recommendations for monitoring HIV services and those developed by the NQF and the NCQA. Another indicator on the HHS list that we strongly support is Retention in HIV Medical Care.

- We strongly support MAP’s objective to align measures across programs. More emphasis is needed on aligning metric selection, definitions, and oversight requirements for Medicare and Medicaid in measuring performance of the same service or function for plans and providers.

- We agree that current measures fail to capture the complex array of conditions at play in chronically ill persons’ lives over time or to respond to the systemic nature of chronic illness care as a condition evolves over time and across settings. Current measures focus on specific interventions, health professionals and points in time. We also support greater focus social issues that affect health outcomes in vulnerable populations and recommend that the Dual Work Group build on the work of the SES Risk Adjustment Panel by (1) reviewing the Dual Family of Measures to determine which should be adjusted or stratified for SES impacts; (2) identifying a “core group” of measures from the Dual Family that are particularly relevant in accounting for SES factors; and (3) identifying SES measurement gaps.

- We urge the Dual Work Group to evaluate the validity and reliability of self-reported data from persons with behavioral, mental health or cognitive impairment diagnoses.

- We support the development of Care Planning and Assessment measures, but recommend that they cover the full continuum of primary, acute, and long-term care services. Separate assessments and care planning for primary, acute and long-term care services fail to recognize the interdependence among the many unique service providers caring for individuals with complex medical problems covered by separate benefit programs. An integrated approach to assessment and care planning is needed to maximize financial and clinical outcomes and minimize the potential for adverse outcomes during care transitions. An integrated process also is consistent with the goal of patient centeredness since it reduces the burden of multiple assessments for the beneficiary and multiple meetings for family caregivers.

- We agree that for persons with complex care needs, a face-to-face, in-home assessment is ideal, but not necessary for all beneficiaries and is inconsistent with telehealth trends. For those without complex health problems whose conditions are stable, a telephonic or mailed assessment may be appropriate and could increase the number of assessments performed as well as family/guardian participation in care planning. We suggest consideration of risk-stratifying in-home, telephonic and mail assessments by patient needs and preferences.

- We suggest the following modifications to the proposed measures: (1) for all measures refer to “beneficiaries,” not MLTSS beneficiaries; (2) add medication review to the core group of domains in the Assessment Composite measure; (3) change “shared” care plan to “common” care plan that is jointly developed among relevant providers and add a “care coordination” function that assesses provider collaboration around a common care plan; and (4) transmit the common care plan to relevant providers and health professionals. We urge NCQA to put the measures out for public comment before finalizing.

### Uniform Data System for Medical Rehabilitation

**Elizabeth Demakos**

UDSMR welcomes the opportunity to comment on the National Quality Forum’s Measure Applications Partnership: 2014 Report from the Dual Eligible Beneficiaries Workgroup Draft Report from
Comment, June 13, 2014. We appreciate the work that the NQF is doing to improve the health outcomes of the dual eligible population. UDSMR was pleased to present the FIM® instrument to the Dual Eligible Workgroup and continues to maintain that the FIM® instrument and its derivatives are the best tools to measure function for this population across all venues of post-acute care.

The Measures Application Partnership (MAP) has identified alignment as an important characteristic in measure selection criteria. MAP has also acknowledged that developing and testing measures is complex and time-consuming (and therefore can be costly).

As you may be aware, Research Triangle Institute’s (RTI’s) November 2012 report, Analysis of Crosscutting Medicare Functional Status Quality Metrics Using the Continuity and Assessment Record and Evaluation (CARE) Item Set, referred to the well-respected FIM® instrument more than thirty times. One could surmise from this report that function was the only predictive measure across all settings of care.

Function would not be the only measure necessary to measure quality in each venue, but it is a sound anchor that cuts across all settings of care and can be easily compared and risk-adjusted to align quality measurement. The FIM® instrument has been used for over twenty-five years in the rehabilitation industry, has been tested for reliability and validity in all venues of care, imposes a low data collection burden, and has been used in the Medicare program for inpatient rehabilitation as a payment system for over ten years. Using an instrument with a proven, successful implementation reduces the cost and time of recreating or developing new measures.

FIM® instrument benefits:

1. It predicts outcomes. Determines a patient’s expected functional improvement, identify risk factors for readmission, and predicts many outcomes.
2. It is easy to monitor and audit. The rating criteria are easily identified in the patient’s chart.
3. It classifies patients with similar resource needs. The tool assigns patients to case-mix groups; it can be used to establish payment categories for like patients.
4. It enhances facilities’ quality improvement initiatives. FIM® gain, length-of-stay efficiency, and community discharge rates can be used to measure quality improvement initiatives.
5. It helps clinicians and administrators manage their cases. Regional and national benchmarks available for managing care.
6. It can be used as the basis of a P4P system. Efficiency and quality metrics make an excellent starting point for a pay-for-performance initiative.
7. Reduces the data collection burden. Easier to use than other current and proposed instruments. Reducing data collection time increases time spent providing care improving efficiency and outcomes.

UDSMR has offered CMS a royalty-free license for the use of the FIM® instrument for inpatient rehabilitation and is willing to do the same for other venues of care as well. UDSMR has submitted two functional change measures—Change in Mobility Score and Change in Self Care—to the NQF Person- and Family-Centered Care for endorsement. These measures are subsets of the FIM® instrument.

We look forward to further discussions with NQF including the results of our research into the use of the FIM® instrument and its derivatives in acute and post-acute care, as well as assisting NQF improve the quality of health care.
Updates to Family of Measures for Dual Eligible Beneficiaries and Measure Gaps

America's Health Insurance Plans
Carmella Bocchino

NCQA is developing measures for Managed Long Term Services and Supports, and we recommend considering adding these to the Family of Measures once fully specified and tested.

We also offer the following measure specific comments:

0022: This measure may result in the under-treatment of pain and depression in the elderly and thus should be monitored. Also, we recommend assessing whether high-risk medications are being appropriately prescribed.

0027: Health plan use of this measure is dependent upon state-specific Medicaid benefits. Smoking and tobacco use cessation is not a benefit in some states thus this measure is only useful for in-state comparisons.

0028, 0111, & 0710: It is unclear how data for these measures will be collected and from what sources. CMS must provide additional specifications to ensure standardized data collection.

0228: Given the numerous surveys (CTM-3 and HCAHPS) used to measure patient satisfaction with care transitions, we are concerned with the additional burden on members self-reporting care experience and its potential impact on the other surveys being used.

0554: Data for this measure can be difficult for plans to collect if pharmacy benefits information is unavailable due to carve-outs thus requiring burdensome sampling and chart review.

0573: Screening members for HIV is important, but barriers exist in transferring STD and HIV screening data among providers, health plans, and ASOs. The primary barrier is privacy restrictions requiring health plans to obtain consent before providing this information to others making it difficult to report complete data. We recommend excluding this measure or reporting by clinicians in the aggregate.

0709: For conditions such as CHF and COPD, health plans would be assessed based on an individual’s health status progression, even though deterioration in health status is expected. This measure does not consider psychosocial determinants of health that impact the Dual Eligible population and is more appropriate for commercial and Medicare populations.

1626: Data for this measure cannot be obtained using the administrative claims reporting method and health plans will have to conduct burdensome chart reviews; often this material is not included in the chart but may be retained by the family. It would also be helpful to understand the Committee’s reasoning for including this measure, as we question its value to the measure family.

1927: This measure requires annual screening and resource use that is not predicated upon evidence based medicine. Annual screening has not demonstrated better outcomes.

2111: It is challenging to influence and educate providers on the overuse of anti-psychotics among persons with dementia. We recommend excluding this measure.

Association for Community Affiliated Plans
Mary Kennedy

The Association for Community Affiliated Plans (ACAP) is an association of 58 nonprofit and community-based Safety Net Health Plans (SNHPs) located in 24 states. Our member plans provide coverage to over 12 million individuals enrolled in Medicaid, the Children's Health Insurance Program (CHIP) and Medicare Special Needs Plans and Medicare-Medicaid Plans for dually-eligible individuals.

Overview. We appreciated the update to the Family of Measures and, as in previous comments, urge parsimony as new measures are considered. We support your exclusion of measures deemed to be too narrow as narrow measures can lead to an
unwarranted and counter-productive proliferation of measures.

NQF #2158-Payment Standardized Medicare Spending per Beneficiary

We believe there should be risk adjustment and/or stratification where necessary for duals eligibles, SES markers, and health status. We were surprised at your recommendation to include the measure before these factors are developed.

Promote Cross-Program Alignment across State and Private-Sector Programs

In addition to alignment across Medicare and Medicaid, we urge that you also look at reporting requirements for the Exchange’s Qualified Health Plans.

Measurement Gap

We appreciate that you are looking at measurement gaps and look forward to NQF’s upcoming work on care coordination and Alzheimer’s disease and other dementias. We urge that NQF focus on evidence-based outcome measures over process measures. We especially support the inclusion of the optimal functioning measure as this is one of the most important factors in assessing the care received by the dual eligible population.

MLTSS Measures

There must be an accommodation in measures for people who actively refuse care assessment. We also ask that those people for whom the state does not have a current contact address or phone number, be excluded from the 90 day contact measure.

We note that many care management systems are not standardized and it would be difficult to pull data from those systems. We urge NQF to support measures which use standardized, administrative data.

We welcomed the discussion of new survey instruments. These measurements should be stratified and not have the biases inherent in current CAHPS tools.

Research Priorities for PCORI

We suggest that PCORI considers a measure that would assess the readiness of institutionalized individuals to return to their community. The current assessments focus on entry to care especially if institutional care is used. The Duals demonstrations have a goal to re-balance care towards use of community based MLTSS.

Dual eligible individuals are a key group for research on socioeconomic status in healthcare

**Consortium for Citizens with Disabilities**

**E. Clarke Ross**

Recommend deleting from this report - UDSMR FIM. They made a brief telephone presentation to the workgroup. They provided no measures. They provided no data. They provided no outcomes. They also expressed an attitude - why is NQF doing this work when the UDSMR FIM exists and no changes are needed. Inclusion of USSMR FIM at this point in time is premature. UDSMR FIM could be cited in the list of future topics fo the workgroup to consider.

Recommend adding to the report - Council on Quality and Leadership (CQL) Personal Outcome Measures (POM). They made an in-person meeting presentation. They provided their measures. They provided their data. They provided outcomes. CQL POM has been included in previous NQF reports and should be recognized again.

Add to the future topics for workgroup consideration - CMS-AHRQ pilot Medicaid home and community-based services personal experience approach.

Delighted to see the stated need for the authentic beneficiary experience into the quality measurement process. The observation that directly asking people involved is “burdensome and subjective” was made by some workgroup members but was not a decision or consensus of the workgroup. Current use of National Core Indicators, Council on Quality and Leadership Personal Outcome Measures, and CMS HCBS personal experience approach affirm that such approaches are not automatically “burdensome and subjective.” ADA, particularly the Supreme Court Olmstead decision, requires a person centered planning that begins with the authentic beneficiary experience.

We affirm the high priority measure gaps and affirm the report’s observation that resources be devoted to research acitivities for these activities, especially...
non-clinical processes and person-centered outcomes. We affirm the observation that the field do more to address the social issues that affect health outcomes of vulnerable populations.

We agree with the observation that discussions revealed tensions and differences of opinion as to whether the NCQA measures are sufficiently consumer-oriented. We believe that the current NCQA work is “not” sufficiently consumer-oriented.

**Family Voices NJ**

**Lauren Agoratus**

We understand that NQF is collaborating with CMS and Mathematica to develop 6 measures for MLTSS (Managed Long Term Services and Supports) including:

- Assessment Composite which requires in-home assessment with the following components within 90 days of enrollment which we support.
- Care Plan Composite which requires documentation of a care plan developed face-to-face within 30 days of completed assessment which we also support.
- Shared Care Plan in which the care plan was transmitted to key long-term services and supports providers and the primary care provider within 30 days of development. We would hope this would even be done within 7 days for continuity of care.

Other key measures we support include Assessment Update, Care Plan Update, and Reassessment and Care Plan Update After Discharge and we look forward to details on these.

**GlaxoSmithKline**

**Deborah Fritz**

We commend the hard work and effort put forth by the multi-stakeholder committee dedicated to improving the care of the Dual Eligible patients.

The set of proposed measures is robust in many ways including addressing preventative measures of smoking cessation, cancer screenings, fall prevention, mental health and medication use evaluations. The inclusion of these measures is to be commended.

The inclusion of several immunization measures is applauded including 0043 Pneumonia vaccination status for older adults, 0682 Percent of Residents Assessed and Appropriately Given the Pneumococcal Vaccine, and 1659 Influenza Immunization.

Additionally, we offer for consideration the following Immunization measures:

- 0041 Influenza Immunization – This measure provides an immunization measure for all patients seen for a visit during the flu season, not just those admitted to an in-patient facility
- 0399 and 0400 Paired Measure Hepatitis C: Hepatitis B Vaccination with high risk chronic conditions

An observed gap within the Dual Eligible Family of Measures is around high-prevalent chronic diseases to this population. While a few measures do address chronic disease states including 0018 Controlling High Blood Pressure and 0729 Optimal Diabetes Care, measures for many of the most prevalent chronic disease states are absent. While not an exhaustive list of highly prevalent chronic diseases in this patient population, we offer the following measures for consideration for inclusion representing prevalent respiratory chronic disease states:

**COPD**

- 0091 COPD: Spirometry Evaluation
- 0102 COPD: Inhaled Bronchodilatory therapy
- 1825 COPD: Management of Poorly Controlled COPD

**Asthma**

- 1800 Asthma Medication Ratio
- 1799 Medication Management for People with Asthma
- 0047 Pharmacologic Therapy for Persistent Asthma
- 0548 Respiratory – Suboptimal Control of Asthma

**National Council on Aging**

**Joe Caldwell**

On page 8, of the report, we recommend striking the following sentence, “It might be preferable to directly question the people involved in the care-planning process to gauge their experience, but this would be burdensome and subjective.” The perspectives of consumers and family members are essential and the most valid way to assess true person-centeredness.
Strategies to Support Improved Quality of Life Outcomes

SNP Alliance
Valerie Wilbur
• The SNP Alliance strongly supports movement toward improving quality of life measurement. While we see a strong relationship between quality of life and the four areas identified as the focus for performance measurement, we’re not ready to say these are THE vehicles for addressing this issue. We share a strong sense of caution that researchers and public administrators should not get ahead of their clear thinking by implementing new measures in this area too quickly.

• We agree that the beneficiary should be the primary team member and final arbiter of the care plan and goals. We support advancing motivational interviewing skills as discussed at the Dual Work Group meeting to help clarify which goals are most important to consumers as part of the shared decision making process. We also believe that a single health professional should be accountable for health care oversight on the delivery side. The professional may change as a person’s condition evolves.

• We fully agree that providers need to be trained and compensated for providing navigation services as part of the shared decision making process. MAP should consider recommending that the provisions in the recent federal SRG legislation (S. 2110) that would have established CPT codes for care coordination be sufficiently broad to encompass these activities.

America’s Health Insurance Plans
Carmella Bocchino
We are supportive of the four domains for measurement of quality of life; however, measurement in this area must demonstrate a cost benefit so that it does not add to the total cost of care and to the cost of achieving good health and well-being.

In addition, the strategies to improve and assess the quality of life outcomes should focus on all determinants of health and drive accountability for results beyond the health care system. Targeting a broad set of drivers (care and non-care related) that contribute to patient reported outcomes and quality of life will be critical, as the health care sector oftentimes is seen wholly accountable when other contributors exist.

Family Voices NJ
Lauren Agoratus
We also urge inclusion of the perspectives of consumers – both adults and parents of dual eligible youth – and organizations representing families of consumers (especially youth) in development of the measures. The MAP membership appears to be very heavily weighted toward adults.
Approach to Constructing a Stakeholder Feedback Loop

**America’s Health Insurance Plans**  
*Carmella Bocchino*

We support the MAP’s recommendation to align reporting requirements and measures across programs and stakeholder groups. Alignment will focus resources, help achieve improved outcomes, and reduce measurement “noise” or redundant reporting requirements.

**Consortium for Citizens with Disabilities**  
*E. Clarke Ross*

We appreciate the identification of employment as a future topic of consideration.

We recommend that the workgroup further consider the application of the concept of “dignity of risk.”

**Disability Health Access, LLC**  
*Anne Cohen*

It’s critical for NQF to engage stakeholders that represent consumer voices. In order to do this I suggest creating a short usable and meaningful document that explains why different categories (family measures) are critical to ensure quality care for Dual Eligibles. I also encourage having an annual call with these consumer groups explaining NQF’s mission and to seek feedback on the Family of Measures categories. NQF may also consider conducting interviews with Dual Eligible consumers, health plans, providers and state officials in pilot states to share the efforts of the workgroup and to identify possible quality areas that would indicate measurement gaps.

**Family Voices NJ**  
*Lauren Agoratus*

Regarding Table 2: Potential Topics for Future Consideration by MAP, we strongly support person-centered wellness. The Affordable Care Act focuses on shared decision-making and the importance of prevention/wellness, particularly the pediatric Bright Futures guidelines endorsed by the American Academy of Pediatrics. Under “Other factors related to quality of care” we strongly support “Primary care/behavioral health integrations models” as resulting in best outcomes. The National Alliance for Mental Illness has an initiative “Integrating Mental Health in Pediatric Primary Care” which has a study on efficacy, and materials for providers and families, at [http://www.nami.org/Template.cfm?Section=child_and_teen_support&Template=/ContentManagement/ContentDisplay.cfm&ContentID=120673](http://www.nami.org/Template.cfm?Section=child_and_teen_support&Template=/ContentManagement/ContentDisplay.cfm&ContentID=120673).

Regarding “Appendix D: Current Family of Measures for Dual Eligible Beneficiaries,” we continue to support the endorsed measures. These include:

- **0005 CAHPS Clinician/Group Surveys** - (Adult Primary Care, Pediatric Care, and Specialist Care Surveys) The consumer satisfaction surveys are good measures of quality of care.

- **0097 Medication Reconciliation** This is important as the primary cause of medical errors resulting in increased morbidity and rehospitalization.

- **0101 Falls: Screening, Risk-Assessment, and Plan of Care to Prevent Future Falls** This is an important safety measure to prevent injury and improve outcomes.

- **0201 Pressure ulcer prevalence (hospital acquired)** Again, this is another measure that prevents injury and promotes better outcomes.

- **0647 Transition Record with Specified Elements Received by Discharged Patients** (Discharges from an Inpatient Facility to Home/ Self Care or Any Other Site of Care) The use of health information technology will decrease medical errors, and prevent emergency room use and hospitalization.

- **1768 Plan All-Cause Readmissions.** This measure is important in examining inappropriate early discharge as well as preventable hospital acquired conditions.

- **1902 Clinicians/ Groups’ Health Literacy Practices Based on the CAHPS Item Set for Addressing Health Literacy** We strongly support this as the single largest barrier to healthcare access.
National Council on Aging
Joe Caldwell

On page 18, “Table 2: Potential Topics for Future Consideration by MAP,” we recommend the following:

We applaud a focus on “wellness-directed model over a disease-focused model.” We recommend inclusion self-management of chronic conditions and health promotion for individuals with disabilities. (Fourth bullet in first section)

We also support the consideration of interim measures in non-medical domains. We recommend a specific focus on HCBS measures because of the pressing need for measure. We recommend greater consultation with national aging and disability consumer organizations and coalitions about HCBS interim measures (Fifth bullet in first section).

In addition, we also recommend greater consultation with national aging and disability consumer organizations and coalitions about measure gaps.

We support the consideration of employment and workforce outcomes. However, recommend a specific focus on measures for the direct care workforce providing HCBS as well as measures to support family caregivers.

SNP Alliance
Valerie Wilbur

1. We strongly support the focus on alignment, impact of measures and fit-for-purpose as well as the focus on the 4 areas identified on page 17 of the report – identification of measures that are widely used, that have contributed to significant positive impact on quality, that are not functioning as intended, and that are a poor fit for a program’s goals. We would support a specific recommendation that in the case of poor fit, the measure be discontinued. The SNP Alliance is particularly interested in addressing alignment requirements between Medicare and Medicaid and among SNPs, MMPs, general MA plans, and managed care and fee-for-service providers serving a similar population segment.

2. We request that MAP gather feedback from SNPs, MMPs, consumers, family caregivers, providers and state Medicaid and related entities. Since 85-100% of SNP and MMP enrollment, respectively, is composed of duals, the perspectives of these plans and their state partners is critical. Consumers should weigh in on which measures are most important to them and should address the burden produced by multiple consumer surveys. Providers should be polled on measure “fit-for-purpose” relative to the populations they serve and about the increasing reporting burden and what they recommend to reduce this burden relative to serving duals. NQF also should consider how to ensure accurate representation across consumers, recognizing the inherent bias of surveys toward healthier respondents, including having better recall of information such as procedures performed and satisfaction measures. Some plans, including the dual demos, have Consumer Advisory Committees that could serve as a source of information. Providers and plans also could help provide access to consumer input.

3. Additional measure refinement should include: (1) Measures related to social determinants of health such as health literacy, homeless and substance abuse; (2) Identification of additional behavioral health measures; (3) Examining and documenting the validity and reliability of self-report measures for persons with intellectual and/or cognitive impairments; and identifying alternative data collection methods, including clear rules for the use of proxy reporting, and the need for further risk adjustment of measures. (4) Modifications to the MA Star rating system that could include exclusion of selected irrelevant measures for specific dual subsets; addition of dual-relevant measures; allocation of greater weight to the Star measures most relevant to enrolled beneficiaries; and establishment of different cut points for Star rating thresholds for duals. (5) Identifying “core measures” within the Family of Measures of particular relevance to specific dual subsets.

4. These issues would be relevant to MAP, CMS, consumers and family caregivers; state Medicaid and related agencies with responsibilities related to the dual population; to SNPs and Medicare-Medicaid Plans; and to providers.