

MEASURE APPLICATIONS PARTNERSHIP

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# Promoting Community Connections through Quality Measurement for the Dual Eligible Beneficiary Population, 2016

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NATIONAL  
QUALITY FORUM

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## EXECUTIVE SUMMARY

Nearly 11 million Americans are eligible for both Medicare and Medicaid.<sup>1</sup> These individuals are among the nation's most vulnerable, with more than two-thirds living below the federal poverty level and most having multiple chronic conditions that require high levels of care.<sup>2,3</sup>

Improving healthcare and supportive services for dual eligible individuals has the potential to make significant differences in their health and quality of life and address the disproportionately high costs of their care. About a third of Medicare spending, or \$500 billion, is spent each year on the 20 percent of the beneficiaries that are dually eligible to participate in Medicaid.<sup>4</sup> Similarly, 34 percent of Medicaid spending, or \$340 billion, is spent annually on 14 percent of Medicaid beneficiaries who are dually eligible to participate in Medicare.<sup>5</sup>

Quality measurement is essential to improve the quality and the value of healthcare services for these vulnerable populations. The National Quality Forum (NQF) convenes the Measure Applications Partnership (MAP), a public-private collaboration of healthcare stakeholders, to provide input to the U.S. Department of Health and Human Services (HHS) on the selection of quality measures for use in public reporting and performance-based payment programs. In this report, MAP builds on its previous work to improve care for the dual eligible population and updates the Dual Eligible Beneficiaries Family of Measures (the Family).

The Family is a group of the best available measures that are selected and recommended for use to address the needs of the dual eligible population and to identify high-leverage opportunities for improvement across the continuum of care. With this year's updates, the current Family now contains 74 measures that are a mixture of measure types (e.g., structure, process, outcome) that cross settings and levels of analysis (e.g., individual provider, facility, or population). MAP supports the removal of six

measures from the Family of Measures:

- **NQF #0007** NCQA Supplemental Items for CAHPS 4.0 Adult Questionnaire. This measure addresses the cultural competency of providers, but is no longer being maintained by the measure steward while a new measure is under development.
- **NQF #0201** Pressure Ulcer Prevalence (hospital acquired). This measure was retired by the measure steward and is no longer being maintained.
- **NQF #0554** Medication Reconciliation Post-Discharge. This measure is no longer being maintained as an individual measure. This measure is now combined with another measure from the Family—NQF measure #0097 Medication Reconciliation Post-Discharge.
- **NQF #0692** CAHPS Nursing Home Survey: Long-Stay Resident Instrument; **NQF #1902** Clinician/Groups Health Literacy Practices Based on the CAHPS Item Set for Addressing Health Literacy; and **NQF #1909** Medical Home System Survey. NQF #0692 and NQF #1902 are no longer maintained by the measure steward, and NQF #1909 was withdrawn from re-endorsement consideration by the measure steward. MAP recognizes that removal of these measures results in gap areas related to experience of care, health literacy, and patient-centered medical homes. MAP encourages innovation in the development of performance measures for experience of care across all

settings and populations that would satisfy the rigorous NQF evaluation criteria.

MAP supports the addition of four measures to the Family of Measures:

- **NQF #0678** Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short-Stay) and **NQF #0679** Percent of High Risk Residents with Pressure Ulcers (Long Stay). These measures address an important clinical issue for the dual eligible population that can have major impact on an individual's functioning and quality of life. In addition, a high proportion of dual eligible beneficiaries use nursing facility care.
- **NQF #2624** Functional Outcome Assessment. This measure addresses a priority gap area—measures related to optimal functioning—and specifies that there be a plan of care and follow-up for any measure of assessment, plus identification of necessary resources to execute the plan of care.
- **NQF #1662** Angiotensin Converting Enzyme (ACE) Inhibitor or Angiotensin Receptive Blocker (ARB) Therapy. This measure addresses a performance gap in following appropriate clinical practice guidelines for individuals with significant disease burden.

The report also shares feedback from the MAP Dual Eligible Beneficiaries Workgroup about priority areas for measurement development, namely, measures that address the growing role of community supports and services in helping dual eligible individuals remain as

healthy and independent as possible. A series of discussions at the Workgroup meetings related to the needs of beneficiaries with multiple chronic conditions specifically highlighted the importance of social supports and community services related to transportation, meal delivery, and case management in fostering health and independence. MAP calls for the development of measures that capture the importance of connection to and coordination of both medical and social services for medically complex patients, using data that are portable and accessible by all types of care providers.

Current approaches to quality measurement tend to focus on single clinical topic areas that are important; however, such approaches do not reflect the multiple complex and interrelated clinical and nonclinical needs of the dual eligible beneficiary population. Developing measures that address the complexities within the dual eligible beneficiary population is resource intensive. Future improvements in healthcare and management of dual eligible beneficiaries will require development of measures for patients managing multiple conditions as well as address the connection of these patients to all the necessary supports and services both in the clinical and nonclinical environments. Resources must be devoted to better promoting and measuring the integration and coordination of providers and services and their effectiveness in improving the health and well-being of dual eligible beneficiaries.

## INTRODUCTION

The National Quality Forum (NQF) convenes the Measure Applications Partnership (MAP) as a public-private partnership of healthcare stakeholders. In pursuit of the National Quality Strategy goals of improving the quality, affordability, and community impact of healthcare, 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. MAP also helps to identify gaps in measure development and encourages measure alignment across public and private programs, settings, levels of analysis, and populations. [Appendix A](#) provides information and background on MAP.

The MAP Dual Eligible Beneficiaries Workgroup is a 24-member, multistakeholder group which serves as one of four advisory workgroups to the MAP Coordinating Committee ([Appendix B](#)). The workgroups advise 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 MAP Dual Eligible Beneficiaries Workgroup provides guidance on performance measures to assess and improve healthcare in the population of individuals dually eligible for Medicare and Medicaid.

Dual eligible beneficiaries are a growing population of nearly 11 million individuals with complex needs who require high levels of care.<sup>6</sup> Spending for dual eligible beneficiaries is disproportionately high. Annually, dual eligible beneficiaries comprise 20 percent of Medicare beneficiaries but account for 34 percent of the spending at approximately \$500 billion, and they comprise 14 percent of Medicaid beneficiaries but account for 34 percent of spending at approximately \$340 billion.<sup>7</sup> This population is a diverse group generally characterized as “high-risk” because these individuals have higher

incidence of multiple, complex clinical and behavioral conditions that are compounded by poverty. In this vulnerable population, 77 percent of individuals have diagnoses across two or more condition groups of physical or mental illness; 60 percent have diagnoses across three or more; 41 percent have diagnoses across four or more; and 25 percent have diagnoses across five or more condition groups.

The Centers for Medicare & Medicaid Services (CMS) looks to the Workgroup for guidance and measurement expertise, and Workgroup input helps shape CMS policy and the strategic direction for future programmatic efforts. With input from the Workgroup, CMS has placed increased emphasis on addressing Workgroup-identified priority measurement gap areas for dual eligible beneficiaries including quality of life, outcome measures, person-reported outcomes, person- and family-centered care, and care coordination. Some recent activities include:

**A draft Medicare-Medicaid Plan Quality Rating Strategy report:** a high-level roadmap for quality-ratings strategy for the Medicare-Medicaid plans that was posted for public comment.<sup>8</sup>

**Two evaluation reports on the Financial Alignment Initiative:** (1) an evaluation of the measure implementation in participating states<sup>9</sup>; and (2) an issue brief with early results from the Washington Managed Fee for Service Model demonstration.<sup>10,11</sup> Additional publicly accessible annual reports for the state demonstrations under the Financial Alignment Initiative are forthcoming this year.<sup>12</sup>

**The Quality Measure Development and Maintenance for CMS Programs Serving Medicare and Medicaid Enrollees and Medicaid-only Enrollees:** a measure development contract that involves collaboration across offices

to address gaps for Medicare and Medicaid enrollees and adult Medicaid enrollees.<sup>13</sup> Workgroup input significantly informed this effort, which requires development of six measures tailored to the dual eligible beneficiary population as well as complete testing of 13 Managed Long Term Services and Supports measures.<sup>14</sup> The measures will focus on the priority gap areas for dual beneficiaries of shared care plans and functional status assessment.<sup>15</sup>

This report describes the latest round of Workgroup-informed guidance from MAP on the use of performance measures to assess and

improve healthcare in the population of individuals dually eligible for Medicare and Medicaid. The report includes updates to the MAP Family of Measures for Dual Eligible Beneficiaries, discusses challenges to measure development including remaining measure gaps, and gives an overview of approaches to fostering connections between healthcare and community supports and services that serve dual eligible beneficiaries, particularly those with multiple chronic conditions. As part of its commitment to transparency and collaboration, NQF invited and received several public comments on this report ([Appendix E](#)).

## MAINTAINING THE FAMILY OF MEASURES

The MAP Family of Measures for Dual Eligible Beneficiaries is a group of the best available measures that are selected and recommended for use to address the needs of this population and to identify high-leverage opportunities for improvement across the continuum of care. Since 2012, MAP has identified families of measures across a variety of topics, such as patient safety and affordable care. The Family of Measures for Dual Eligible Beneficiaries was established by MAP in 2013 with the goal of driving improvement in specific areas that affect healthcare quality for dual beneficiaries.<sup>16</sup> In 2014, the MAP Dual Eligible Beneficiaries Workgroup established a starter set of measures meant to guide those selecting and implementing measures in the field by indicating the highest-priority measures for dual beneficiaries.<sup>17</sup>

### Approach

All MAP workgroups, including the MAP Dual Eligible Beneficiaries Workgroup, rely on the Measure Selection Criteria (MSC) ([Appendix C](#)) to serve as a foundation for evaluating measures and developing recommendations across all topics. The measures in the Family of Measures for Dual Eligible Beneficiaries are selected based on the seven criteria of the MSC, with particular attention to criteria addressing person- and family-centered services, and healthcare disparities and cultural competence. In the absence of a specific quality measure reporting program, the MAP Dual Eligible Beneficiaries Workgroup makes recommendations about the use of measures to address the needs of the population.

The Workgroup periodically reviews the Family of Measures to ensure that it contains the best measures currently available. Periodic reviews are important as the dual beneficiary population continues to grow and as measurement science changes to produce new measures with the

potential to address the population's needs. To maintain the Family, Workgroup members provide input, evaluate measures with changes to endorsement, review newly available measures, and work to achieve consensus on any changes to measures included in the Family.

The starter set of measures is a subset of measures in the Family that are most ready for implementation as currently specified. Generally, these measures demonstrate the Workgroup's preference for cross-cutting measures and condition-specific measures that address critical clinical issues across the population. The starter set is periodically reviewed in tandem with the other measures in the Family. The Workgroup updated the starter set this year by making additions and removals based on the priorities for the population and the availability of measures. Public comments specific to a given measure within the Family can be found in ([Appendix D](#)). Additional comments on the updates to the Family highlighted the importance of clarifying measure type (e.g., process, outcome) and appropriate level of analysis (e.g., individual provider versus population level) when implementing these measures in practice.

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### Building Consensus

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The Workgroup's in-person deliberation was informed by Workgroup input via a web meeting and prioritization exercises, as well as preliminary analysis by NQF staff. In advance of the in-person meeting, Workgroup members shared their feedback with staff at a public web meeting and via an independent prioritization exercise that gauged how well the measures in the Family meet the population needs. Staff compiled this input, and the Workgroup used the input to begin discussion of changes to the Family at the in-person meeting. The preliminary analysis by staff took into consideration the MSC, including

alignment and population characteristics, along with the Workgroup's prior input on high-leverage opportunities for improvement and priority gap areas.

Workgroup members discussed removing measures from the Family if they had endorsement status changes since the Workgroup's last in-person meeting in the spring of 2015; the discussion also included measures that were noted as low priority for the population and any available alternatives. Members also considered measures that received NQF endorsement since the Workgroup's last in-person deliberations. In doing so, members reflected on whether these newly endorsed measures address the priorities for measurement or gap areas. The Workgroup approved changes to the Family by a consensus vote in which more than 60 percent of votes supported a change.

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### Monitoring the NQF Trial Period on Risk Adjustment for Socioeconomic Status Factors

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The MAP Dual Eligible Beneficiaries Workgroup has a particular interest in addressing healthcare disparities because dual beneficiaries are, by definition, economically disadvantaged as evidenced by their eligibility for Medicaid supports and services. The Workgroup has been monitoring NQF's Trial Period for SES Risk Adjustment, during which measure submissions for NQF endorsement review may include risk adjustment for SES factors, in addition to the case-mix or clinical risk adjustment that has always been allowed. Measure submissions with risk adjustment for SES factors must include a conceptual rationale as to why risk adjustment is necessary, test results based on risk adjustment methodology, and specifications with stratification instead of risk adjustment for these factors. Individual standing committees at NQF can also identify measures under review for inclusion in the trial period. NQF will review the final results of the trial period in April 2017, after which NQF will determine if it will permanently

adopt the policy that allows the submission of measures that are risk adjusted for SES factors. More information about the trial period can be found on the [project page](#) along with frequently asked questions.<sup>18,19</sup>

The MAP Dual Eligible Beneficiaries Workgroup received an update on the progress of the trial period during the April 2016 in-person meeting. Early findings from the trial period have highlighted the limited availability of patient-level data for SES factors.<sup>20</sup> The Workgroup discussed the importance of robust data on socioeconomic and other factors, as well as the potential of including variables of poverty or community characteristics when individual-level variables are not available. Workgroup members encouraged the development of a standardized framework and methodology for risk adjustment in the field. One member commented on the role that discriminatory practices play in healthcare disparities and stated that such practices should be considered in risk adjustment (e.g., women that use wheelchairs lacking accessible mammography services). The Workgroup reiterated ongoing support for the use of stratification to understand healthcare quality and outcomes in different populations.

### Measures in the Family with Changes to Endorsement Status

The MAP Dual Eligible Beneficiaries Workgroup considered six measures in the Family that have had changes in endorsement status since its last meeting. Changes to endorsement can occur when a measure is harmonized with another measure, a measure is placed on reserve status due to limited opportunities for improvement, or endorsement is removed. Endorsement can be removed for a variety of reasons, including concerns about measure reliability, validity, or other [Measure Evaluation Criteria](#), retirement by the measure steward, or other reasons. When measures are no longer being maintained by their stewards, their specifications are not kept current, and reliability,



validity, and performance data are not submitted to support endorsement. The Workgroup voted to remove all six of the measures that are no longer NQF-endorsed from the Family and emphasized the importance of having reliable, valid, NQF-endorsed measures to use across all populations.

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### Measures Removed from the Family of Measures

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The Workgroup voted to remove measure six measures from the Family of measures. These measures focused on cultural competency, pressure ulcers, medication reconciliation, and patient-reported outcomes.

#### Cultural Competency

NQF #0007 NCQA Supplemental Items for CAHPS 4.0 Adult Questionnaire was removed because the steward is not maintaining the measure. Updated specifications and performance information are not being provided while a new measure is under development. The Workgroup will consider adding the newly specified measure after it is fully developed and evaluated against the NQF endorsement criteria. The Workgroup continues to stress the importance of identifying measures that address the current measure gap related to cultural competency of healthcare providers and systems.

#### Pressure Ulcers

The Workgroup voted to remove measure NQF #0201 Pressure Ulcer Prevalence (hospital acquired) because the steward retired the measure and is no longer maintaining it. Pressure ulcers are highly impactful for the dual beneficiary population as these individuals are more than twice as likely to be hospitalized for a pressure ulcer compared to other Medicare beneficiaries.<sup>21</sup> One public commenter stated that because many long-term pressure ulcers are first acquired in the hospital setting, a measure addressing hospital acquired pressure ulcers is needed within the Family.

#### Medication Reconciliation

The Workgroup voted to remove measure NQF #0554 Medication Reconciliation Post-Discharge since this measure is no longer being maintained as an individual measure. This measure is now combined with another measure from the Family—the updated NQF measure #0097 Medication Reconciliation Post-Discharge (formerly Medication Reconciliation). Therefore, the Workgroup voted to remove NQF #0554 from the Family while retaining NQF #0097.

#### Patient-Reported Outcome Tools and Performance Measures

Patient-reported outcomes (PRO), the tools used to collect them, and the performance measures (PRO-PMs) derived from such tools have received attention as a vitally important but methodologically challenging area in healthcare quality.<sup>22,23</sup> MAP and the Workgroup have previously expressed support for the development of methodologically sound PRO-PMs.<sup>24</sup> One commenter highlighted the need to carefully examine the testing of surveys and tools that are often sources of patient-reported outcomes. The commenter stated such surveys or tools should be specifically tested in the dual-eligible beneficiary population, with individuals who are non-English speaking, have low health literacy, consider themselves of nonmajority culture and ethnic groups, or have cognitive limitations.

The Workgroup discussed three PRO-PMs in the Family of measures: NQF #0692 CAHPS Nursing Home Survey: Long-Stay Resident Instrument; NQF #1902 Clinician/Groups Health Literacy Practices Based on the CAHPS Item Set for Addressing Health Literacy; and NQF #1909 Medical Home System Survey. NQF #0692 and NQF #1902 are no longer maintained by the steward, and NQF #1909 was withdrawn from re-endorsement consideration by the developer. The Workgroup voted to remove these three measures from the Family while recognizing that important gap areas persist with respect to

experience of care for nursing home residents, outpatient care health literacy, and patient-centered medical homes. The Workgroup encouraged innovation in the development of performance measures for experience of care across all settings and populations that would meet the rigorous NQF evaluation criteria.

## Consideration of Newly Endorsed Measures for Addition to the Family

The MAP Dual Eligible Beneficiaries Workgroup considered the measures newly endorsed by NQF since its last meeting. A majority of the measures were not recommended for inclusion into the Family because they do not specifically address a priority gap area or high-leverage opportunity for improvement. In addition, several newly endorsed measures are condition-, procedure-, or population-specific (e.g., end-stage renal disease, carotid stenting, pediatric-only measures).

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### Measures Added to the Family of Measures

#### NQF #0678 Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short-Stay) and NQF #0679 Percent of High Risk Residents with Pressure Ulcers (Long Stay)

After voting to remove NQF #0201 Pressure Ulcer Prevalence (hospital acquired), the Workgroup considered five alternative measures and voted to include in the Family of Measures NQF #0678 Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short-Stay) and NQF #0679 Percent of High Risk Residents with Pressure Ulcers (Long Stay). The Workgroup recommended these measures because of the high proportion of dual beneficiaries using nursing facility care. They also create minimal reporting burden because they are derived from the Minimum Data Set, which nursing facilities are already required to collect. The Workgroup encouraged the use of consistent measures across settings of care and noted that a gap in

measurement of this important condition still exists in hospitals and home health settings.

#### NQF #2624 Functional Outcome Assessment

The Workgroup voted to include in the Family one newly endorsed measure from phase 2 of the Person- and Family-Centered Care (PFCC) Project: NQF #2624 Functional Outcome Assessment. This measure addresses a priority gap area—measures related to optimal functioning—as well as the Workgroup’s preference that there be a plan of care and follow-up for any measure of assessment, plus identification of necessary resources to execute the plan of care. The measure is not viewed as burdensome because it is collected via administrative claims and is currently in use by providers participating in the Physician Quality Reporting System (PQRS). The measure is considered particularly relevant for the significant portion of the dual eligible population receiving care in outpatient settings.

While reviewing all of the measures from phase 2 of the Person- and Family-Centered Care Project, the Workgroup acknowledged the importance of measures that address functional status, particularly given the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014, which, “...requires post-acute care providers to report standardized patient assessment data as well as data on quality, resource use, and other measures.”<sup>25</sup> Functional status is a common and important component of the patient assessment data collected during post-acute care. However, the Workgroup voted to add only one measure from phase 2 to the Family, because the Workgroup agreed that the majority of measures from phase 2 are not appropriate for inclusion in the Family because they were not specified for multiple care settings or levels of analysis. The Workgroup will continue to monitor the progress of phase 3 of the PFCC Project and the endorsement of additional measures to address the priority gap areas for the dual eligible population, specifically measures of experience of care and outcomes that matter to beneficiaries.

### NQF #1662 Angiotensin Converting Enzyme (ACE) Inhibitor or Angiotensin Receptive Blocker (ARB) Therapy

The Workgroup also voted for to include measure NQF# 1662 in the Family of Measures. The Workgroup agreed that the measure addresses a performance gap in following appropriate clinical practice guidelines for individuals with significant disease burden. In particular, this measure addresses the critical impact that medication therapies specified in clinical guidelines have on the high number of individuals who experience multiple chronic conditions and the close link that these therapies have to quality of life and functional outcomes. Workgroup members discussed the importance of this measure across populations and encouraged expansion beyond individuals with chronic kidney disease.

## Updates to the Starter Set of Measures

The Workgroup also updated the starter set of measures for dual beneficiaries based on the changes to endorsement status and measurement priorities for the dual eligible population. The Workgroup voted to add seven measures and remove two measures. Table 1 lists all of the measures in the current starter set; an asterisk (\*) indicates additions to the starter set.

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### Measures Added to the Starter Set

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#### Medication Management

The starter set had contained two measures of medication management: NQF #0554 Medication Reconciliation Post-Discharge and NQF #0097 Medication Reconciliation Post-Discharge (formerly Medication Reconciliation). As noted above, NQF #0554 was removed from the Family because it was combined with NQF #0097. The Workgroup voted to include NQF #0097 Medication Reconciliation Post-Discharge in the starter set because it addresses the important issue of medication reconciliation after a transition in care when individuals are particularly vulnerable.

#### Care Transitions

In addition to NQF #0228: 3-Item Transition Measure currently in the starter set, the Workgroup voted to include NQF #0647 Transition Record with Specified Elements Received by Discharged Patients and NQF #0648 Timely Transition of Transition Record in the starter set. Workgroup members expressed how these measures cumulatively address important aspects of care transitions, such as patients' experience of care, whether patients receive essential information, and whether providers transfer information.

#### Readmission

The Workgroup voted to add measure NQF #2510 Skilled Nursing Facility 30-Day All-Cause Readmission Measure to the starter set as a complement to the current measure of readmissions in the starter set, NQF #1789 Plan All-Cause Readmissions. These measures together demonstrate the importance of shared responsibility across the system of care. Members noted the high proportion of dual beneficiaries who have nursing facility stays as well as the importance of their transition out of the nursing facility. For dual beneficiaries, adequate support during the transition from the nursing facility to home is a vital element of high-quality care.

#### Blood Pressure Control

NQF #0018 Controlling High Blood Pressure was added to the starter set of measures for dual beneficiaries because of the importance of achieving this essential standard of care across all populations. Workgroup members stressed the importance of updating the measure specifications and being compliant with the new clinical practice guidelines.

#### Advance Care Plan

NQF #0326 Advance Care Plan was added to the starter set because the Workgroup was supportive of individuals having their preferences and needs for care at end of life known, while also acknowledging that some individuals may prefer not to have an advance care plan. Members

recognized that views on advance care plans can vary by cultural background, and cultural competence is essential to discussing and obtaining clear information about preferences near the end of life. The Workgroup encouraged the measure steward to consider expanding the measure to all populations by removing the age limitations and expressed the importance of transmitting advance care plans across settings and between providers.

#### [Antipsychotic Use in Vulnerable Populations](#)

The Workgroup voted to include measure NQF #2111 Antipsychotic Use in Persons with Dementia in the starter set because of the importance of addressing overuse and potential harm of unnecessary medications in at-risk populations. Members expressed the importance of preventing unnecessary medication use in all persons who present with behavioral health issues.

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#### **Measures Removed from the Starter Set**

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The Workgroup voted to remove two measures from the starter set: NQF #1909 Medical Home System Survey and NQF #0022 Use of High Risk Medications in the Elderly (DAE). Measure NQF #1909 was automatically removed from the starter set after being removed from the Family of Measures because it was no longer endorsed. NQF #0022 was removed from the starter set because the measure is age-specific; however, it is retained in the Family of Measures as an important indicator for a significant portion of the population.

TABLE 1. STARTER SET OF MEASURES FOR DUAL ELIGIBLE BENEFICIARIES

NQF #	Measure Title	Measure Type	Measure Steward
0004	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)	Process	National Committee for Quality Assurance (NCQA)
0008	Experience of Care and Health Outcomes (ECHO) Survey (behavioral health, managed care versions)	Composite	Agency for Healthcare Research and Quality
0018*	Controlling High Blood Pressure	Outcome	NCQA
0028	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention	Process	AMA-convened Physician Consortium for Performance Improvement
0097*	Medication Reconciliation Post-Discharge	Process	NCQA
0101	Falls: Screening, Risk-Assessment, and Plan of Care to Prevent Future Falls	Process	NCQA
0228	3-Item Care Transition Measure (CTM-3)	PRO	University of Colorado Denver Anschutz Medical Campus
0326*	Advance Care Plan	Process	NCQA
0418	Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan	Process	CMS
0419	Documentation of Current Medications in the Medical Record	Process	CMS
0421	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	Process	CMS
0576	Follow-Up After Hospitalization for Mental Illness (FUH)	Process	NCQA
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)	Process	AMA-convened Physician Consortium for Performance Improvement
0648*	<i>Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/ Self Care or Any Other Site of Care)</i>	Process	AMA-convened Physician Consortium for Performance Improvement
1768	<i>Plan All-Cause Readmissions (PCR)</i>	Process	NCQA
2111*	<i>Antipsychotic Use in Persons with Dementia</i>	Process	Pharmacy Quality Alliance
2510*	<i>Skilled Nursing Facility 30-Day All-Cause Readmission Measure (SNFRM)</i>	Outcome	CMS

Note: An asterisk (\*) indicates additions to the starter set.

## Pursuing High-Priority Gaps

The Workgroup continued to emphasize the importance of the high-priority measure gaps for dual eligible beneficiaries. While progress in measure development continues in some areas, the Workgroup encourages innovation across measurement science to address more of these gap areas. The Workgroup urges stakeholders and experts across disciplines to collaborate, share, and build on available information. In particular, members highlighted the rich source of innovative measures in use by states or in other countries. Measures in use at local, state, or regional levels that address these priorities should be carefully evaluated and supported for further development and testing. High-priority measurement gap areas for dual eligible beneficiaries include the following:

- 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

In addition to these areas, Workgroup members emphasized gaps in measures for home and community-based services (e.g., at-home pressure ulcer monitoring) as well as affordable and cost-effective care. Public comments were supportive of these identified measure gaps and urged the Workgroup to continue working to identify and support efforts addressing these gap areas.

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## NQF Home and Community-Based Care Project

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More than one-quarter of dual beneficiaries use Medicaid waiver or state plan home and community-based services (HCBS).<sup>26</sup> NQF convened the HCBS Quality Committee to provide multistakeholder guidance on the highest priorities for measuring HCBS that support high-quality community living. The NQF HCBS project recently completed an environmental scan that resulted in over 700 measures, measures concepts, and instruments assessing HCBS quality. This scan also identified few measures in priority gap areas for the dual beneficiary population, such as community inclusion. More information on the HCBS Quality Committee is available on its [project page](#).

The Workgroup supported the focus of the HCBS definition and priority domains on the individual, families, and caregivers. Additionally, the Workgroup highlighted the importance of dignity and respect for the individual receiving HCBS and leveraging opportunities to engage individuals and those in their lives in new ways. Members suggested considering opportunities to leverage data commonly used in technology platforms, avenues for individuals to submit feedback on their experiences with HCBS, and information about the use of other benefits and services to further understand beneficiary needs and quality of care. Members stressed the importance of building on the multistakeholder work, such as the HCBS definition and domains, to make progress in addressing measure gaps across healthcare and supportive services.

# ADDRESSING CONNECTIONS ACROSS HEALTHCARE AND COMMUNITY SUPPORTS AND SERVICES

Dual eligible beneficiaries are more likely to have a combination of complex clinical and behavioral conditions, which are usually exacerbated by the individual's social disadvantages. Multiple chronic conditions (MCCs) are common in this population, with 77 percent of beneficiaries having documentation across two or more subgroups of physical and mental conditions.<sup>27,28</sup> The five most common co-occurring conditions are heart conditions, mental health conditions, anemia, musculoskeletal disorders, and diabetes.<sup>29</sup> Given the complex needs and conditions of dual eligible beneficiaries, their healthcare is frequently fragmented with multiple providers, treatments, prescriptions, and limited or no support system for navigating through the intricacies of both healthcare and support services.

Dual eligible beneficiaries are a highly diverse population comprising individuals from most social, ethnic, and geographical groups. Monitoring the quality of care received by dual eligible beneficiaries is challenging as performance measures relevant to this population are not contained within a single federal program (e.g., Medicaid only, or CMS Physician Quality Reporting System [PQRS] only). The MAP Dual Eligible Beneficiaries Workgroup seeks to provide strategic input to overcome the challenge of tracking performance measures for dual eligible beneficiaries and to maximize quality of life for this population.

The Workgroup has previously considered various issues related to the quality of care and outcomes for high-need subgroups of the dual eligible beneficiary population. These issues include shared decisionmaking, psychosocial needs, and community integration, inclusion, and participation. The Workgroup found that most

of the high-priority issues are similar across the subgroups, including individuals with multiple chronic conditions. However, available measures to address these issues were often limited or did not address condition-specific needs, and measurement gap areas were pervasive.

During this year's MAP Dual Eligible Beneficiaries Workgroup web meeting, members reviewed and discussed three frameworks related to MCCs: the Institute of Medicine Living Well with Chronic Illness report,<sup>30</sup> the HHS Strategic Framework,<sup>31</sup> and the NQF MCC Measurement Framework.<sup>32</sup> In reviewing the existing frameworks, the Workgroup discussed the importance of engaging individuals' social support systems and strengthening the connection between traditional medical services and community and nonmedical resources in order to promote overall health and well-being. Services aimed at these issues have the potential to help prevent unhealthy behaviors resulting from isolation, loneliness, and helplessness, and to improve health outcomes such as optimal functioning and improved quality of life for beneficiaries and their families.<sup>33</sup>

Key themes noted by MAP Dual Eligible Beneficiaries Workgroup members included lack of connections and coordination between healthcare providers and providers of supportive services in the community. The group agreed that individuals, family members, providers, and policymakers share the goal of enabling individuals to live as independently as possible in the community. To meet this goal, a dual beneficiary may need or benefit from services and supports from nonmedical and community providers, particularly during transitions—for example, around the time of discharge from a healthcare facility. The lack of coordination during transitions

and the lack of effective communication are often-cited causes for low quality of care and poor outcomes.<sup>34</sup> This highlights the lack of alignment in the foundational structures for different types of providers. Workgroup members observed that the processes, information systems, policies, and incentive structures applicable to healthcare versus nonmedical and community providers are disjointed. Additionally, the Workgroup had observed the inability to measure quality of care during transitions between different types of providers and settings, and indicated a desire to further explore recommendations to address these challenges.

Increasingly, the opportunities for connecting healthcare, supports, and services have taken center stage in discussions regarding the needs of the dual eligible beneficiary population, especially when discussing the role of social services in keeping individuals healthy and functional. Any efforts to enhance connections within and across healthcare, social services, and community depend on being able to collect and analyze necessary data as well as to implement lessons learned through novel models of care. Some new models of care differ in that they address the social and clinical needs of the population outside of the traditional clinical context and setting. This approach addresses health by focusing on whole persons and their needs while addressing basic determinants of health such as shelter, meaningful interactions, and nutrition.

The goal of the MAP Dual Eligible Beneficiaries Workgroup in focusing on concerted efforts of various stakeholders—such as clinical providers, institutions of care, and social services—is to address health from a whole person point of view, such that individuals are empowered to attain their best health state while living in their own communities. Accordingly, the Workgroup accepted a broad definition of health and psychosocial interventions: “interpersonal or informational activities, techniques, or strategies that target biological, behavioral,

cognitive, emotional, interpersonal, social, or environmental factors with the aim of improving health functioning and well-being.”<sup>35</sup> The goal is to recognize and promote the value of the community and individual independence and dignity within the context of population health. Attainment of this goal requires measures that capture the importance of connections across clinical and social settings, data that are portable and accessible by all types of care providers, and a healthcare system that aligns clinical, social, and human services seamlessly within the framework of population health. Commenters emphasized the growing importance of strengthening the connections between health and community supports. One commenter specifically identified the need for improved communication and coordination between providers to decrease the likelihood of duplicative care.

## Overcoming Barriers to Measure Development

Developing measures that address the complexities and chronic conditions within the dual eligible beneficiary population is resource intensive. The required data gathering and measure testing are costly. The Workgroup members suggested that measure developers look outside of the realm of traditional measurement and seek out innovative measures that cross the clinical-social divide as well as look at how other countries address quality measurement in complex populations. However, Workgroup members emphasized that any measurement development endeavor requires data related to the target populations.

The MAP Dual Eligible Beneficiaries Workgroup acknowledged that data on the dual eligible beneficiary population and subpopulations are lacking and that data specific to complex patients with multiple chronic conditions are even sparser. In addition, clinically relevant information and measures for this population are limited given the lack of randomized clinical trials with clinically



vulnerable populations. Their vulnerability is not only clinical; it crosses over to social and sociodemographic areas as well. Given the sociodemographic landscape for dual eligible beneficiaries and a lack of identifiable data on them, developing appropriate measures for this population requires a concerted effort, an effort that connects clinical and social data. Isolated measurement development focusing on clinical issues would only have minimal impact.

The Workgroup members discussed the difficulties with data collection, gathering appropriately granular data, and maintaining the infrastructure (e.g., staff with training in data collection, management, and analysis) needed to support and store data. The data collected need to represent the population appropriately as well as be actionable and allow for improvements in care or services.

Additionally, measures are often developed based on benefits related to specific programs, such as Medicare or Medicaid. These program-specific measures may result in more narrow improvement efforts, limited care coordination, and increased reporting burden. This lack of coordination in measurement development is particularly relevant for dual eligible beneficiaries, who are subject to two different programs, Medicare and Medicaid.

## Unfunded Mandates

During their deliberations, the Workgroup members discussed the concept of an unfunded mandate that may arise from performance measurement. They defined such a mandate as an expectation that services be provided even though such services are not explicitly covered by a given benefit or program. This expectation often arises as a result of the application of measures focused on the provision of these nonreimbursable services. Examples of unfunded mandates include patient follow-up and care coordination efforts that are expected of providers as standard-of-care processes, but are not paid for as additional services. The Workgroup members expressed

concern that such unfunded mandates will place additional burden on providers, particularly those with limited resources. Workgroup members discussed two examples of unfunded mandates.

The first example highlighted pharmacy services for chronically ill individuals with six or more co-occurring conditions and with multiple medications. These high-need and high-cost patients are covered by a per month, per member benefit that allows pharmacies to provide in-home pharmacy services. Patients receive comprehensive medication reviews in their home setting where they may not only have their current prescriptions, but also older noncurrent prescriptions. These reviews are not explicitly covered under the benefit, but they do promote medication adherence and mitigate any instances of potentially harmful interactions that may arise from taking an older and/or harmful medication. In this example, the per month, per member benefit payment may not suffice to cover the value of services provided. The Workgroup noted that stretching resources and providing additional or enhanced services in this way is not always possible.

In the second example, the Workgroup members noted that in the healthcare arena telehealth is assumed to be a readily available tool for following patients remotely. Providers are thus expected to use telehealth technologies, despite the fact that many providers and states lack resources and infrastructure for adopting and using telehealth. Moreover, there is no payment attached to telehealth services and remote monitoring of patients. Unfunded mandates may also occur when primary care providers are expected to follow up after discharge from the hospital or other setting and provide in-home services through office outreach.

The MAP Dual Eligible Beneficiaries Workgroup members emphasized that applying measures creates expectations of what services the provider should provide, even if there is no payment for those services. Eventually, an expectation

becomes an unfunded mandate, and Workgroup members suggested that the feasibility of adapting, stretching, and maximizing resources to address the expectations set by performance measurement should be considered before the implementation of a given performance measure. The Workgroup recommended that measurement of quality and care be decoupled from requirements for which no incentive or support is provided.

Commenters provided additional insights into the concept of unfunded mandates. One commenter identified screening and assessment measures as potential measurement sources of unfunded mandates because reimbursement is not typically tied to such activities. Another commenter reminded the Workgroup that unfunded mandates are not applicable to all types of systems or payment structures. For example, capitated systems are less likely to experience unfunded mandates because the costs associated with activities such as screening and care coordination are included in the calculation of the capitated payment. Another commenter highlighted the need for quality measures that are not explicitly tied to incentives.

## Measuring What Matters

When considering opportunities for integration, coordination, and data collection, measurement and measure development should not ignore of the most important player in the healthcare arena, the consumer. Representing the consumer's voice requires a different way of measuring quality, one that balances personal preference and needs with a population health perspective, which requires a universal set of measures that apply across the board. The Workgroup members envisioned a healthcare quality dashboard with images like those on the dashboard of a car. This quality dashboard would be universally used and recognizable, with each image representing a familiar parameter of quality. The dashboard model moves the focus from individual experience

to the population level, but measures and payment happen at the individual level.

Given the tension between population and individual level measures, the Workgroup suggested that the national focus be on population level measures and allow for states and individual programs to develop more specific individual level measures. Historically, most measures, whether at the population or individual level, have been defined medically in terms of the measure focus (e.g., disease or procedure) and setting (e.g., hospital, clinic office). Integration among clinical and community services and providers, social support, and consumer voice has not been addressed adequately.

The Workgroup envisioned an approach to measurement with both a national and an individual focus. The national focus could capture the various connections, hand-offs, and touch-points among and between different providers in clinical and community settings as well as larger scale population outcomes (e.g., hospital or nursing facility admissions). The individual focus could capture the consumer's voice and consumer-specific connections to social supports and community services. In order to enact this two-pronged approach to advancing quality measurement for the dual eligible beneficiary population, the lens of measure development must expand its focus to include more of these more community and consumer-centric concepts.

## Data Issues

Successful connection among various care givers, support services, and community resources requires effortless transmission of data with the patient, such that all providers in clinical, social, and community settings have access to all necessary patient data. Many factors affect access to data. These include data infrastructure, platforms, and access points, along with workforce training and availability to capture the data. These are all well-known barriers. However, most discussions about barriers exclude other important

roadblocks such as interoperability of existing data systems and privacy laws such as the Health Insurance Portability and Accountability Act (HIPAA) and 42 CFR Part 2 (commonly referred to as “Part 2”) governing the confidentiality of drug and alcohol abuse treatment and prevention records, which are meant to protect patients.<sup>36</sup>

Promoting integration and connections across healthcare, supports, and services will require assistance and encouragement from policies and regulations, so that patient privacy safeguards do not inadvertently harm patients by placing barriers to data sharing necessary for appropriate care management. Workgroup members noted that social workers in the community often have to coordinate an individual’s care and behavioral health services without the benefit of any previous treatment summaries or clinical consultation records. In such cases, both patients and their advocates are at a disadvantage, and the process hinders efforts to keep patients out of institutions and emergency departments as they transition to community settings and services.

The lack of data connections across various systems and sectors of care providers undermines efforts underway to make care more person-centered and coordinated. However, Workgroup members noted that success stories can be found at the local and state levels.<sup>37</sup> One way forward would be to identify the successes of local work on core issues related to the dual eligible population and then elevate the processes and lessons learned to the national population health level.<sup>38</sup> Ultimately, integration across healthcare, supports, and services should be incentivized with resources and supports at the state or federal level. Currently, most examples of successful integration efforts come from programs funded by federal and or nonprofit grant making organizations and think tanks.

## Improving Connections Between Healthcare, Supports, and Services

The members of the MAP Dual Eligible Beneficiaries Workgroup noted that demonstration projects on care models aiming to improve connections between healthcare, supports and services have been ongoing for some time.<sup>39</sup> Most of these efforts involve partnerships among medical, behavioral, and long-term support services for the dual eligible population, such as PRIDE (Promoting Integrated Care for Dual Eligibles).<sup>40</sup>

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### Models of Integrated Care for People with Complex Needs

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The PRIDE project validated the need for high-quality connections across medical, social, and behavioral services with a dynamic person/family-centered care plan built with patient/caregiver involvement, where comprehensive and frequent assessments and reassessments capture and address changes in an individual’s circumstances and preferences. Given the complex needs of dual eligible beneficiaries, this model addresses integration of care while empowering the individual beneficiary. Empowerment of consumers requires care coordinators who can access multidisciplinary care teams in an environment where data systems are fully integrated and readily available at the point of care. The project also advocated for continuous quality improvement monitoring through performance metrics that are aligned across providers and demonstrate results related to the Triple Aim<sup>41</sup>—results that improve the health and experience of care for individuals while reducing cost.<sup>42</sup>

Sustaining an integrated paradigm of care requires scaling up from efforts focused on individuals and sustaining those scaled efforts over time through incentives and alignment of services. This requires

buy-in from all providers as well as patients and consumers. Given the connections across all spectrums of care, the Workgroup redefined the concept of community: A community is the amalgamation of clinical and nonclinical providers, institutions, social services, supports, and consumers.<sup>43</sup> Under this more inclusive model, health is defined from a systems and population level perspective such that connections and integration are happening at a community level instead of one patient at a time.

Another key component of successful models of integrated care is the “integrator” mechanism. At the individual level, this mechanism can be an actual person, such as a patient navigator and social worker. At the organizational, community, or state levels, the mechanism can be more administrative, such as the interagency agreements that formalize provider and/or organizational relationships and responsibilities for providing care to a specific population of individuals.<sup>44</sup> Through these mechanisms, integration can and should happen at all levels of care. The recognition of the need for integration has led to the development of resources and tools to facilitate integration regardless of the type or model of care.

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### Strategies in the Population Health Action Guide

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While discussing potential models of care, the Workgroup noted that various NQF projects address strategies for successful integration of clinical and social care with support services. For example, the *Action Guide—Improving Population Health by Working with Communities: Action Guide 3.0*—is a tool for maximizing community involvement while moving from individual to population health. Such action guides aim to help providers across settings address social, economic, and environmental factors that affect health, given that current quality improvement and measurement efforts mainly focus on clinical care. Evidence suggests that with a quarter of

healthcare costs related to modifiable health risks, programs, and policies that improve wellness and healthy behaviors could yield a net savings of \$19 billion over 10 years.<sup>45</sup> The *Action Guide* identifies the key elements of population health and addresses elements such as community health needs assessment, resource and asset mapping, selection and implementation of health improvement activities, scalability, and sustainability of efforts within the community setting and outside of the clinical care arena.

The *Action Guide* shifts focus from clinical care to the community setting and acknowledges the importance of social determinants of health that are easily addressed at the community level. Workgroup members noted the value of this shift by mentioning that the connection between housing status and health outcomes is well established, making shelter availability a marker of health.

The following community-focused questions explore how to improve health status and facilitate integration within and across communities and serve as a starting point for addressing community needs in healthcare<sup>46</sup>:

- How can individuals and multistakeholder groups come together to address community health improvement?
- Which individuals and organizations should be at the table?
- What processes and methods should communities use to assess their health?
- What data are available to assess, analyze, and address community health needs and measure improvement?
- What incentives exist that can drive alignment and coordination to improve community health?
- How can communities advance more affordable care by achieving greater alignment, efficiency, and cost savings?

## Field Examples

Field examples offer guidance on how to integrate services and connect individuals, providers, and services across clinical, social, and community at the local and state levels. Two presentations made at the in-person meeting reinforced the role of community and psychosocial factors in optimizing health and overall wellness. Previously, Workgroup members had noted that to address chronic health conditions appropriately, within the context of patient-centered care, measurement frameworks need to connect health outcomes to wellness outside of the clinical context and include quality of life and community integration. Providers and measure developers need to recognize that high-level functioning does not necessarily equate to a high quality of life; similarly, clinical outcomes of physical health do not necessarily indicate that people are living well, and access to physical health services does not prevent loneliness.

The first presenter was Robyn Golden, MA, LCSW, from Rush University, where she is responsible for developing and overseeing health promotion and disease prevention, mental health, care coordination, and transitional care services for older adults, family caregivers, and people with chronic conditions. Her presentation provided information on two programs: (1) Ambulatory Integration of the Medical and Social (AIMS) and (2) the Bridge Model, from Rush University Medical Center. Both are examples of what can be done at the health system level to foster connections across clinical and social services and supports at the local level.

The second presenter was Alice Lind, BSN, MPH, from the Washington State Health Authority. Her presentation focused on Washington Health Authority's Financial Alignment Demonstration Project and some initial results. This presentation addressed how states can provide care coordination through integrated data systems and empower individuals to make decisions about their care needs as well as to participate actively in their care plans.

Both presenters stressed the importance of holistically addressing a patient's needs where social determinants such as food and shelter are just as much indicators of overall health as the prescribed treatment. Themes such as the need for planned and organized integration and alignment of clinical and community services and resources led to discussions around care management teams and the role of nonclinical individuals, such as social workers and patient navigators as change agents and patient empowerment promoters. These types of roles foster care coordination by working across the medical, community, and support service realms. They create a social-service based care model that bridges elements necessary for delivering patient-centric, patient-specific care.

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### Ambulatory Integration of the Medical and Social (AIMS) Model

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The AIMS model addresses fragmentation of care and promotes care coordination by focusing on the patient's needs. Coordination is focused on social factors that are not addressed in the clinical arena and are known to affect physical health outcomes. The AIMS model assesses psychosocial needs and provides risk-focused care coordination, where social workers act as facilitators and assist with any sociodemographic and or biopsychosocial issues that may affect the attainment of health and well-being, while empowering and supporting patients in a patient-centric manner.<sup>47</sup>

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### The Bridge Model—Social Work-Based Transitional Care

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The Bridge Model addresses integration and coordination, but focuses on transitional care and the hospital-community connection where social workers ensure that the care continuum is seamless between hospitals and community-based providers, supports, and services. This interdisciplinary model is led by social workers and provides patient-centric transitional care.

The strengths of this model come from repeated assessments and interviews focused on individual patients and their needs; information gathered is then used to tailor transitional care based on individual care, psychosocial, and behavioral needs.<sup>48</sup>

Both the AIMS model and the Bridge Model address care coordination using social workers as the facilitators of coordination with the ultimate goal of addressing whole-person needs, including social determinants, such as nutrition and shelter along with psychosocial and behavioral needs.

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### Washington Health Authority Financial Alignment

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Along with care coordination, the hallmark of the Washington-based demonstration project is the integration of data across all systems of care. These seamlessly integrated data are available for all providers, both clinical and nonclinical, to facilitate care coordination, transition, and management based on patient needs and preferences using a Home Health model. The availability of integrated data facilitates the recognition and timely intervention for any and all care needs including behavioral and mental health issues that otherwise may go untreated. The ultimate goal is to develop individualized chronic care management plans where patients manage their own care and chronic disease(s) based on personal preferences. Integration of patient data also allows for real-time access for emergency department visits, care coordinator interactions with patients, and tracking of prescriptions and potential gaps in care. The value of the data lies in being able to measure care and correlate it to patient outcomes. However, the most compelling evidence is data collected from actual patients on their experiences within the Home Health program.<sup>49</sup>

RTI International worked with the Washington Demonstration Project team and conducted focus

groups with clients who received care coordination and enrolled in the Home Health program. During these focus groups, the value of coordination facilitated through data integration is validated by one patient who shared a before-and-after care coordination experience:

Before joining the Home Health program:

“I was shut up in my house for years. My windows were drawn. I didn’t have company. My house was horrible. I was completely off my psych medications, and I was on a lot of them for many years.”<sup>50</sup>

After joining the Home Health program: “I go outside. I interact with my neighbors. I go to church. My cholesterol is down to normal.”<sup>51</sup>

All the models and programs presented share core values of care coordination across clinical, social, and behavioral settings using care coordinators, social workers, and/or community health navigators. Therefore, adequate workforce training is essential for capacity building as well as meeting the needs of the dual eligible population, especially given the changing and broadening nature of the definition of health and well-being. Even if staffing is adequate, the measurement enterprise still needs to recalibrate to be able to capture and address patient experiences. Measurement should align measures with elements that directly—or through proxies—capture a patient’s health and well-being from a whole-person perspective. This whole-person approach includes clinical aspects of health along with related social, behavioral, and community elements. Success in addressing whole-patient care ultimately lies in the seamless integration of healthcare, supports, and services across local microcosms of care. Achieving this success will usher in an era of patient-focused care where individuals, including the dual eligible beneficiaries, are empowered to make decisions about their care needs as well as be active participants in their care plan.

## Opportunities and Lessons Learned

A person-centered approach to health and wellness for the dual eligible population has been addressed in previous Workgroup reports from 2014 and 2015. However, the role of novel community partnerships and connections with the medical field add a facilitative layer of wrap-around services that promote health and well-being while addressing the unique needs of each individual beneficiary. These novel partnerships use social workers and community paramedics as a new type of healthcare worker who facilitates connections within and across the medical and

community settings. However, these partnerships require an adequately trained workforce that can be easily accessed by all beneficiaries.

The role of nontraditional providers in optimizing health and accessing resources in the community may currently be underused in many communities. Conversely, communities and social services may feel stretched by the increased demand for their services and resources, especially given the needs of the population. The examples shared with and from the Workgroup indicate that dual eligible beneficiaries would benefit from contributions of both medical and community services and supports.

## FUTURE CONSIDERATIONS

Dual eligible beneficiaries are a diverse population with complex needs, and much of the complexity relates to social determinants of health. The deliberations and discussions of the Workgroup focused on the growing recognition that integration of care, supports, and services across the healthcare and community spectrum is essential to adequately address the needs of these individuals. Members of the MAP Dual Eligible Beneficiaries Workgroup noted that a new nonclinical model of care is possible where the lens of health expands its focus to address the myriad of clinical and nonclinical, psychosocial, and behavioral issues affecting the dual eligible beneficiary population.

The Workgroup's 2016 discussions emphasized the growing role of community in keeping the dual eligible beneficiary population healthy, given that health needs to encompass more than clinical care. Health is being redefined as a composite of clinical factors, sociodemographic factors such as nutrition and shelter, and psychosocial factors such as loneliness and isolation. This integrative model of health promotion emphasizes the work being done to empower patients in a patient-centric model. The challenge is to harness the power generated by the integration of healthcare and community supports and services through appropriate measure development and eventual measurement efforts.

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## 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.

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, affordable care, and healthy people/healthy communities. 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

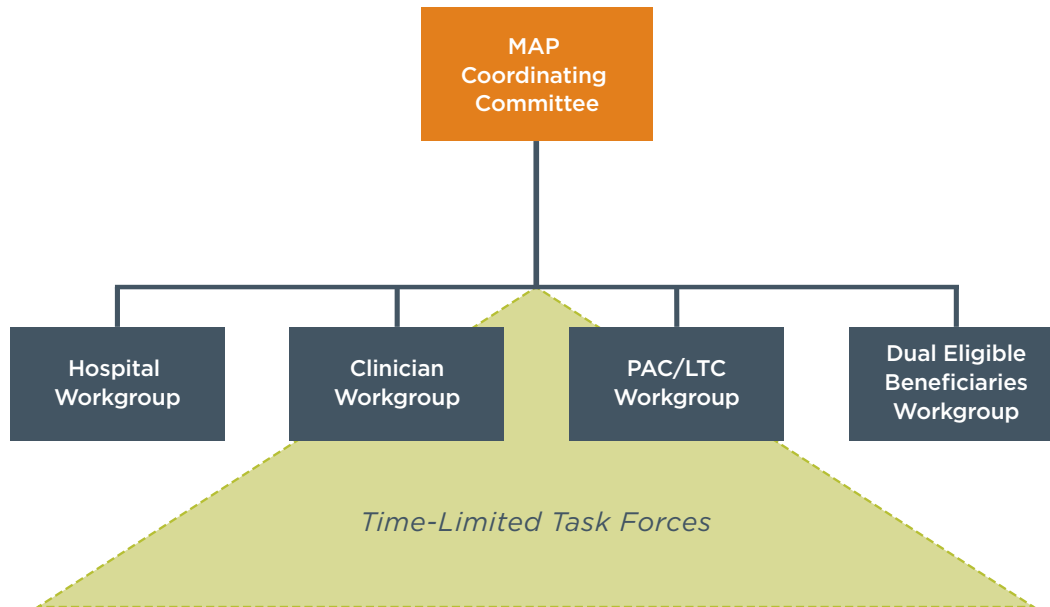
quality enterprise is to consider and recommend measures for public reporting, performance-based payment, and other programs. Through strategic selection, MAP facilitates measure alignment of public- and private-sector uses of performance measures.

**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 specific topics 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.

FIGURE A1. MAP STRUCTURE



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 broadcasted, 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 2015 Pre-Rulemaking Deliberations](#)). Additionally, MAP engages in strategic activities throughout the year to inform MAP's pre-rulemaking input. To date MAP has issued a series of reports that:

- 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 and Child Core Sets and the Quality Rating System for Qualified Health Plans in the Health Insurance Marketplaces.
- Developed the **MAP Strategic Plan** to establish MAP's goal and objectives. This process identified strategies and tactics that will enhance MAP's input.

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

### MAP Dual Eligible Beneficiaries Workgroup

#### WORKGROUP CO-CHAIRS (VOTING)

**Jennie Chin Hansen, RN, MS, FAAN**

**Nancy Hanrahan, PhD, RN, FAAN**

#### ORGANIZATIONAL MEMBERS (VOTING)

**AARP Public Policy Institute**

Susan Reinhard, RN, PhD, FAAN

**AMDA – The Society for Post-Acute and Long-Term  
Care Medicine**

Gwendolen Buhr, MD, MHS, Med, CMD

**American Geriatrics Society**

Gregg Warshaw, MD

**Association for Community Affiliated Health Plans**

Christine Aguiar

**Centene Corporation**

Michael Monson

**Consortium for Citizens with Disabilities**

E. Clarke Ross, DPA

**Easter Seals**

Cheryl Irmiter, PhD

**Homewatch CareGivers**

Jette Hogenmiller, PhD, MN, APN, CDE, TNCC

**Humana, Inc.**

George Andrews, MD, MBA, CPE

**iCare**

Thomas H. Lutzow, PhD, MBA

**National Association of Medicaid Directors**

Alice Lind, BSN, MPH

**National Association of Social Workers**

Joan Levy Zlotnik, PhD, ACSW

**New Jersey Hospital Association**

Aline Holmes, DNP, MSN, RN

#### INDIVIDUAL SUBJECT MATTER EXPERTS (VOTING)

**Mady Chalk, MSW, PhD**

**James Dunford, MD**

**K. Charlie Lakin, PhD**

**Ruth Perry, MD**

**Kimberly Rask, MD PhD**

**Gail Stuart, PhD, RN**

#### FEDERAL GOVERNMENT LIAISONS (NON-VOTING)

**Administration for Community Living (ACL)**

Eliza Bangit, JD, MA

**Centers for Medicare & Medicaid Services (CMS),  
Medicare-Medicaid Coordination Office**

Vanesa J. Day

**Office of the Assistant Secretary for Planning and  
Evaluation**

D.E.B. Potter, MS

## MAP Coordinating Committee

### CO-CHAIRS (VOTING)

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**Elizabeth McGlynn, PhD, MPP**

**Harold Pincus, MD**

### ORGANIZATIONAL MEMBERS (VOTING)

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#### **AARP**

Lynda Flowers, JD, MSN, RN

#### **Academy of Managed Care Pharmacy**

Marissa Schlaifer, RPh, MS

#### **AdvaMed**

Steven Brotman, MD, JD

#### **AFL-CIO**

Shaun O'Brien

#### **America's Health Insurance Plans**

Aparna Higgins, MA

#### **American Board of Medical Specialties**

R. Barrett Noone, MD, FAcS

#### **American College of Physicians**

Amir Qaseem, MD, PhD, MHA

#### **American College of Surgeons**

Frank Opelka, MD, FACS

#### **American HealthCare Association**

David Gifford, MD, MPH

#### **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

#### **Blue Cross and Blue Shield Association**

Trent T. Haywood, MD, JD

#### **Consumers Union**

Lisa McGiffert

#### **Federation of American Hospitals**

Chip N. Kahn, III, MPH

#### **Healthcare Financial Management Association**

Richard Gundling, FHFMA, CMA

#### **The Joint Commission**

Mark R. Chassin, MD, FACP, MPP, MPH

#### **The Leapfrog Group**

Melissa Danforth

#### **National Alliance for Caregiving**

Gail Hunt

#### **National Association of Medicaid Directors**

Foster Gesten, MD, FACP

#### **National Business Group on Health**

Steve Wojcik

#### **National Committee for Quality Assurance**

Mary Barton, MD, MPP

#### **National Partnership for Women and Families**

Carol Sakala, PhD, MSPH

#### **Network for Regional Healthcare Improvement**

Elizabeth Mitchell

#### **Pacific Business Group on Health**

William E. Kramer, MBA

#### **Pharmaceutical Research and Manufacturers of America (PhRMA)**

Christopher M. Dezii, RN, MBA, CPHQ

### INDIVIDUAL SUBJECT MATTER EXPERT MEMBERS (VOTING)

---

#### **Child Health**

Richard Antonelli, MD, MS

#### **Population Health**

Bobbie Berkowitz, PhD, RN, CNAA, FAAN

#### **Disparities**

Marshall Chin, MD, MPH, FACP

### FEDERAL GOVERNMENT MEMBERS (NON-VOTING)

---

#### **Agency for Healthcare Research and Quality (AHRQ)**

Richard Kronick, PhD/Nancy J. Wilson, MD, MPH

#### **Centers for Disease Control and Prevention (CDC)**

Chesley Richards, MD, MH, FACP

#### **Centers for Medicare & Medicaid Services (CMS)**

Patrick Conway, MD, MSc

#### **Office of the National Coordinator for HIT (ONC)**

Kevin Larsen, MD, FACP

## NQF Staff

**Debjani Mukherjee**  
Senior Director

**Megan Duevel Anderson**  
Project Manager

**Janine Amirault**  
Project Analyst



## 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.

### 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.*

- Subcriterion 1.1** Measures that are not NQF-endorsed should be submitted for endorsement if selected to meet a specific program need
- Subcriterion 1.2** Measures that have had endorsement removed or have been submitted for endorsement and were not endorsed should be removed from programs
- Subcriterion 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:*

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

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

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

- Subcriterion 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)
- Subcriterion 3.2** Measure sets for public reporting programs should be meaningful for consumers and purchasers
- Subcriterion 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)
- Subcriterion 3.4** Avoid selection of measures that are likely to create significant adverse consequences when used in a specific program
- Subcriterion 3.5** Emphasize inclusion of endorsed measures that have eMeasure specifications available

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

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*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*

- Subcriterion 4.1** In general, preference should be given to measure types that address specific program needs
- Subcriterion 4.2** Public reporting program measure sets should emphasize outcomes that matter to patients, including patient- and caregiver-reported outcomes
- Subcriterion 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

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

- Subcriterion 5.1** Measure set addresses patient/family/caregiver experience, including aspects of communication and care coordination
- Subcriterion 5.2** Measure set addresses shared decisionmaking, such as for care and service planning and establishing advance directives
- Subcriterion 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

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*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).*

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

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*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.*

- Subcriterion 7.1** Program measure set demonstrates efficiency (i.e., minimum number of measures and the least burdensome measures that achieve program goals)
- Subcriterion 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, Meaningful Use for Eligible Professionals)

## APPENDIX D: MAP Dual Eligible Beneficiaries Family of Measures (2016 Update)

The Family of Measures for Dual Eligible Beneficiaries is a group of the best available measures to address the unique needs of the dual eligible beneficiary population. The Family of measures functions like a menu that stakeholders can consult to select subsets of measures that best suit the needs of particular programs. The current Family of measures was selected based on the MAP Measure Selection Criteria

(Appendix C) and refined over time. Additional details about each measure are available on the **NQF Quality Positioning System (QPS)**. The Family of measures is also available in the spreadsheet accompanying this report on the [project page](#).

An asterisk (\*) indicates a measure in the Starter Set for Dual Eligible Beneficiaries. For information on the starter set see table 1 of the report.

Measure Status, Title, and Steward	Measure Type	Measure Description	Data Source	Level of Analysis	Public Comments Received
<b>0004* Endorsed</b> Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) <i>National Committee for Quality Assurance (NCQA)</i>	Process	The percentage of adolescent and adult patients with a new episode of alcohol or other drug (AOD) dependence who received the following. <ul style="list-style-type: none"> <li>Initiation of AOD Treatment. The percentage of patients who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis.</li> <li>Engagement of AOD Treatment. The percentage of patients who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.</li> </ul>	Administrative claims, Electronic Clinical Data	Health Plan, Integrated Delivery System	None
<b>0005 Endorsed</b> CAHPS Clinician & Group Surveys (CG-CAHPS)-Adult, Child <i>Agency for Healthcare Research and Quality (AHRQ)</i>	Patient-Reported Outcome Measure	The Consumer Assessment of Healthcare Providers and Systems Clinician & Group Survey (CG-CAHPS) is a standardized survey instrument that asks patients to report on their experiences with primary or specialty care received from providers and their staff in ambulatory care settings over the preceding 12 months.	Patient Reported Data/ Survey	Clinician: Group/ Practice, Clinician: Individual	None
<b>0006 Endorsed</b> Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey, Version 5.0 (Medicaid and Commercial) <i>AHRQ</i>	Patient-Reported Outcome Measure	The CAHPS Health Plan Survey is a standardized survey instrument which asks enrollees to report on their experiences accessing care and health plan information, and the quality of care received by physicians. HP-CAHPS Version 4.0 was endorsed by NQF in July 2007 (NQF #0006). The survey is part of the CAHPS family of patient experience surveys and is available in the public domain at <a href="https://cahps.ahrq.gov/surveys-guidance/hp/index.html">https://cahps.ahrq.gov/surveys-guidance/hp/index.html</a> .	Patient Reported Data/ Survey	Health Plan	None

Measure Status, Title, and Steward	Measure Type	Measure Description	Data Source	Level of Analysis	Public Comments Received
<b>0008* Endorsed</b> Experience of Care and Health Outcomes (ECHO) Survey (behavioral health, managed care versions) <i>AHRQ</i>	Composite	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	Survey: Patient Reported Data/ Survey	Health Plan	None
<b>0018* Endorsed</b> Controlling High Blood Pressure <i>NCQA</i>	Outcome	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 (<140/ 90) during the measurement year.	Administrative claims, Electronic Clinical Data, Paper Medical Records	Health Plan, Integrated Delivery System	None
<b>0022 Endorsed</b> Use of High-Risk Medications in the Elderly (DAE) <i>NCQA</i>	Process	There are two rates for this measure: <ul style="list-style-type: none"> <li>• The percentage of patients 65 years of age and older who received at least one high-risk medication.</li> <li>• The percentage of patients 65 years of age and older who received at least two different high-risk medications.</li> </ul> For both rates, a lower rate represents better performance.	Administrative claims, Electronic Clinical Data, Electronic Clinical Data: Pharmacy	Health Plan, Integrated Delivery System	None
<b>0027 Endorsed</b> Medical Assistance With Smoking and Tobacco Use Cessation (MSC) <i>NCQA</i>	Process	Assesses different facets of providing medical assistance with smoking and tobacco use cessation: <p>Advising Smokers and Tobacco Users to Quit: A rolling average represents the percentage of patients 18 years of age and older who were current smokers or tobacco users and who received advice to quit during the measurement year.</p> <p>Discussing Cessation Medications: A rolling average represents the percentage of patients 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.</p> <p>Discussing Cessation Strategies: A rolling average represents the percentage of patients 18 years of age and older who were current smokers or tobacco users who discussed or were provided smoking cessation methods or strategies during the measurement year.</p>	Patient Reported Data/ Survey	Health Plan, Integrated Delivery System	None

Measure Status, Title, and Steward	Measure Type	Measure Description	Data Source	Level of Analysis	Public Comments Received
<p><b>0028* Endorsed</b> Preventive Care &amp; Screening: Tobacco Use: Screening &amp; Cessation Intervention <i>AMA-convened Physician Consortium for Performance Improvement</i></p>	Process	<p>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</p>	<p>Administrative claims, Electronic Clinical Data, Electronic Clinical Data: Electronic Health Record, Electronic Clinical Data: Registry, Paper Medical Records</p>	<p>Clinician: Group/ Practice, Clinician: Individual, Clinician: Team</p>	None
<p><b>0032 Endorsed</b> Cervical Cancer Screening (CCS) <i>NCQA</i></p>	Process	<p>Percentage of women 21-64 years of age who were screened for cervical cancer using either of the following criteria:</p> <ul style="list-style-type: none"> <li>• Women age 21-64 who had cervical cytology performed every 3 years.</li> <li>• Women age 30-64 who had cervical cytology/ human papillomavirus (HPV) co-testing performed every 5 years.</li> </ul>	<p>Administrative claims, Electronic Clinical Data, Paper Medical Records</p>	<p>Health Plan, Integrated Delivery System</p>	None
<p><b>0034 Endorsed</b> Colorectal Cancer Screening (COL) <i>NCQA</i></p>	Process	<p>The percentage of patients 50-75 years of age who had appropriate screening for colorectal cancer.</p>	<p>Administrative claims, Electronic Clinical Data: Imaging/ Diagnostic Study, Electronic Clinical Data: Laboratory, Paper Medical Records</p>	<p>Health Plan, Integrated Delivery System</p>	None
<p><b>0043 Endorsed</b> Pneumococcal Vaccination Status for Older Adults (PNU) <i>NCQA</i></p>	Process	<p>Percentage of patients 65 years of age and older who ever received a pneumococcal vaccination.</p>	<p>Patient Reported Data/ Survey</p>	<p>Health Plan, Integrated Delivery System</p>	None
<p><b>0097* Endorsed</b> Medication Reconciliation Post-Discharge <i>NCQA</i></p>	Process	<p>The percentage of discharges for patients 18 years of age and older for whom the discharge medication list was reconciled with the current medication list in the outpatient medical record by a prescribing practitioner, clinical pharmacist or registered nurse.</p>	<p>Administrative claims, Electronic Clinical Data, Paper Medical Records</p>	<p>Clinician: Group/ Practice, Clinician: Individual, Health Plan, Integrated Delivery System</p>	None

Measure Status, Title, and Steward	Measure Type	Measure Description	Data Source	Level of Analysis	Public Comments Received
<p><b>0101 * Endorsed</b></p> <p>Falls: Screening, Risk-Assessment, and Plan of Care to Prevent Future Falls</p> <p>NCQA</p>	Process	<p>This is a clinical process measure that assesses falls prevention in older adults. The measure has three rates:</p> <p>A) Screening for Future Fall Risk:</p> <p>Percentage of patients aged 65 years and older who were screened for future fall risk at least once within 12 months</p> <p>B) Falls Risk Assessment:</p> <p>Percentage of patients aged 65 years and older with a history of falls who had a risk assessment for falls completed within 12 months</p> <p>C) Plan of Care for Falls:</p> <p>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</p>	Administrative claims, Electronic Clinical Data, Paper Medical Records	Clinician: Group/ Practice, Clinician: Individual	None
<p><b>0104 Endorsed</b></p> <p>Adult Major Depressive Disorder (MDD): Suicide Risk Assessment</p> <p>AMA-convened Physician Consortium for Performance Improvement</p>	Process	<p>Percentage of patients aged 18 years and older with a new diagnosis or recurrent episode of major depressive disorder (MDD) with a suicide risk assessment completed during the visit in which a new diagnosis or recurrent episode was identified</p>	Electronic Clinical Data: Electronic Health Record, Electronic Clinical Data: Registry	Clinician: Group/ Practice, Clinician: Individual, Clinician: Team	None
<p><b>0105 Endorsed</b></p> <p>Antidepressant Medication Management (AMM)</p> <p>NCQA</p>	Process	<p>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.</p> <p>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).</p> <p>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).</p>	Administrative claims, Electronic Clinical Data, Electronic Clinical Data: Pharmacy	Health Plan, Integrated Delivery System	None

Measure Status, Title, and Steward	Measure Type	Measure Description	Data Source	Level of Analysis	Public Comments Received
<b>0166 Endorsed</b> HCAHPS <i>Centers for Medicare &amp; Medicaid Services (CMS)</i>	Outcome	HCAHPS (NQF #0166) is a 32-item survey instrument that produces 11 publicly reported measures:  7 multi-item measures (communication with doctors, communication with nurses, responsiveness of hospital staff, pain control, communication about medicines, discharge information and care transition); and  4 single-item measures (cleanliness of the hospital environment, quietness of the hospital environment, overall rating of the hospital, and recommendation of hospital)	Patient Reported Data/ Survey	Facility	None
<b>0176 Endorsed</b> Improvement in management of oral medications <i>CMS</i>	Outcome	Percentage of home health episodes of care during which the patient improved in ability to take their medicines correctly, by mouth.	Electronic Clinical Data	Facility	None
<b>0202 Endorsed</b> Falls with injury <i>American Nurses Association</i>	Outcome	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.	Electronic Clinical Data, Other, Paper Medical Records	Clinician: Team, Facility	None
<b>0228* Endorsed</b> 3-Item Care Transition Measure (CTM-3) <i>University of Colorado Denver Anschutz Medical Campus</i>	Patient-Reported Outcome Measure	The CTM-3 is a hospital level measure of performance that reports the average patient reported quality of preparation for self-care response among adult patients discharged from general acute care hospitals within the past 30 days.	Patient Reported Data/ Survey	Facility	None
<b>0326* Endorsed</b> Advance Care Plan <i>NCQA</i>	Process	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.	Administrative claims, Electronic Clinical Data	Clinician: Group/ Practice, Clinician: Individual	One commenter expressed concern about applying this measure at the health plan level given advance care planning discussions occur at the physician and patient level.



Measure Status, Title, and Steward	Measure Type	Measure Description	Data Source	Level of Analysis	Public Comments Received
<b>0418* Endorsed</b> Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan <i>CMS</i>	Process	Percentage of patients aged 12 years and older screened for clinical depression using an age appropriate standardized tool AND follow-up plan documented	Administrative claims, Electronic Clinical Data: Electronic Health Record, Paper Medical Records	Clinician: Group/ Practice, Clinician: Individual, Clinician: Team, Population: Community, Population: County or City, Population: National, Population: Regional, Population: State	None
<b>0419* Endorsed</b> Documentation of Current Medications in the Medical Record <i>CMS</i>	Process	Percentage of visits for patients aged 18 years and older for which the eligible professional attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list must include ALL known prescriptions, over-the-counters, herbals, and vitamin/ mineral/ dietary (nutritional) supplements AND must contain the medications' name, dosage, frequency and route of administration	Administrative claims, Electronic Clinical Data: Electronic Health Record, Electronic Clinical Data: Registry	Clinician: Group/ Practice, Clinician: Individual	None
<b>0420 Endorsed</b> Pain Assessment and Follow-Up <i>CMS</i>	Process	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	Administrative claims, Electronic Clinical Data, Electronic Clinical Data: Electronic Health Record	Clinician: Individual	None
<b>0421* Endorsed</b> Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up <i>CMS</i>	Process	Percentage of patients aged 18 years and older with a documented BMI during the current encounter or during the previous six months AND when the BMI is outside of normal parameters, a follow-up plan is documented during the encounter or during the previous six months of the encounter.  Normal Parameters: Age 65 years and older BMI > or = 23 and < 30 Age 18 – 64 years BMI > or = 18.5 and < 25	Administrative claims, Electronic Clinical Data: Electronic Health Record, Electronic Clinical Data: Registry, Paper Medical Records	Clinician: Group/ Practice, Clinician: Individual, Population: County or City, Population: National, Population: Regional, Population: State	None

Measure Status, Title, and Steward	Measure Type	Measure Description	Data Source	Level of Analysis	Public Comments Received
<b>0553 Endorsed</b> Care for Older Adults (COA) – Medication Review <i>NCQA</i>	Process	Percentage of adults 66 years and older who had a medication review during the measurement year; a review of all a patient's medications, including prescription medications, over-the-counter (OTC) medications and herbal or supplemental therapies by a prescribing practitioner or clinical pharmacist.	Administrative claims, Electronic Clinical Data, Paper Medical Records	Health Plan, Integrated Delivery System	None
<b>0557 Endorsed</b> HBIPS-6 Post discharge continuing care plan created <i>The Joint Commission</i>	Process	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).	Electronic Clinical Data, Paper Medical Records	Facility, Population: National	None
<b>0558 Endorsed</b> HBIPS-7 Post discharge continuing care plan transmitted to next level of care provider upon discharge <i>The Joint Commission</i>	Process	The proportion of patients discharged from a hospital-based inpatient psychiatric setting with a complete post discharge continuing care plan, all the components of which are transmitted to the next level of care provider upon discharge. 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-6: Post Discharge Continuing Care Plan Created) that are used in The Joint Commission's accreditation process. Note that this is a paired measure with HBIPS-6 (Post Discharge Continuing Care Plan Created).	Electronic Clinical Data, Paper Medical Records	Facility, Population: National	None

Measure Status, Title, and Steward	Measure Type	Measure Description	Data Source	Level of Analysis	Public Comments Received
<b>0576* Endorsed</b> Follow-Up After Hospitalization for Mental Illness (FUH) <i>NCQA</i>	Process	The percentage of discharges for patients 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported: <ul style="list-style-type: none"> <li>• The percentage of discharges for which the patient received follow-up within 30 days of discharge</li> <li>• The percentage of discharges for which the patient received follow-up within 7 days of discharge.</li> </ul>	Administrative claims, Electronic Clinical Data	Health Plan, Integrated Delivery System	None
<b>0640 Endorsed</b> HBIPS-2 Hours of physical restraint use <i>The Joint Commission</i>	Process	The total number of hours that all patients admitted to a hospital-based inpatient psychiatric setting were maintained in physical restraint. 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-3: Seclusion, HBIPS-4: Multiple Antipsychotic Medications at Discharge, HBIPS-5: Multiple Antipsychotic Medications at Discharge with Appropriate Justification, HBIPS-6: Post Discharge Continuing Care Plan Created and HBIPS-7: Post Discharge Continuing Care Plan Transmitted) that are used in The Joint Commission's accreditation process.	Electronic Clinical Data, Paper Medical Records	Facility, Population: National	None
<b>0641 Endorsed</b> HBIPS-3 Hours of seclusion use <i>The Joint Commission</i>	Process	The total number of hours that all patients admitted to a hospital-based inpatient psychiatric setting were held in seclusion. 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-4: Multiple Antipsychotic Medications at Discharge, HBIPS-5: Multiple Antipsychotic Medications at Discharge with Appropriate Justification, HBIPS-6: Post Discharge Continuing Care Plan Created and HBIPS-7: Post Discharge Continuing Care Plan Transmitted) that are used in The Joint Commission's accreditation process.	Electronic Clinical Data, Paper Medical Records	Facility, Population: National	None

Measure Status, Title, and Steward	Measure Type	Measure Description	Data Source	Level of Analysis	Public Comments Received
<p><b>0646 Endorsed</b>                      Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/ Self Care or Any Other Site of Care)  <i>AMA-convened Physician Consortium for Performance Improvement</i></p>	Process	Percentage of patients, regardless of age, discharged from an inpatient facility (e.g., 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	Administrative claims, Electronic Clinical Data: Electronic Health Record, Paper Medical Records	Facility, Integrated Delivery System	None
<p><b>0647* Endorsed</b>                      Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/ Self Care or Any Other Site of Care)  <i>AMA-convened Physician Consortium for Performance Improvement</i></p>	Process	Percentage of patients, regardless of age, discharged from an inpatient facility (e.g., 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	Administrative claims, Electronic Clinical Data: Electronic Health Record, Paper Medical Records	Facility, Integrated Delivery System	None
<p><b>0648* Endorsed</b>                      Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/ Self Care or Any Other Site of Care)  <i>AMA-convened Physician Consortium for Performance Improvement</i></p>	Process	Percentage of patients, regardless of age, discharged from an inpatient facility (e.g., 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	Administrative claims, Electronic Clinical Data: Electronic Health Record, Paper Medical Records	Facility, Integrated Delivery System	None
<p><b>0649 Endorsed</b>                      Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges to Ambulatory Care [Home/ Self Care] or Home Health Care)  <i>AMA-convened Physician Consortium for Performance Improvement</i></p>	Process	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	Administrative claims, Electronic Clinical Data: Electronic Health Record, Paper Medical Records	Facility, Integrated Delivery System	None

Measure Status, Title, and Steward	Measure Type	Measure Description	Data Source	Level of Analysis	Public Comments Received
<p><b>0674 Endorsed</b></p> <p>Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay)</p> <p><i>CMS</i></p>	Outcome	<p>This measure reports the percentage of residents who have experienced one or more falls with major injury during their episode of nursing home care ending in the target quarter (3-month period). Major injury is defined as bone fractures, joint dislocations, closed head injuries with altered consciousness, or subdural hematoma. The measure is based on MDS 3.0 item J1900C, which indicates whether any falls that occurred were associated with major injury. Long-stay residents are identified as residents who have had at least 101 cumulative days of nursing facility care.</p>	Electronic Clinical Data	Facility	None
<p><b>0678 Endorsed</b></p> <p>Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short-Stay)</p> <p><i>CMS</i></p>	Outcome	<p>This quality measure reports the percent of patients or short-stay residents with Stage 2-4 pressure ulcers that are new or worsened since admission. The measure is based on data from the Minimum Data Set (MDS) 3.0 assessments for Skilled Nursing Facility (SNF) / Nursing Home (NH) residents, the Long-Term Care Hospital (LTCH) Continuity Assessment Record &amp; Evaluation (CARE) Data Set for LTCH patients, and the Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI) for Inpatient Rehabilitation Facility (IRF) patients. Data are collected separately in each of the three settings using standardized items that have been harmonized across the MDS, LTCH CARE Data Set, and IRF-PAI. For residents in a SNF/NH, the measure is calculated by examining all assessments during an episode of care for reports of Stage 2-4 pressure ulcers that were not present or were at a lesser stage since admission. For patients in LTCHs and IRFs, this measure reports the percent of patients with reports of Stage 2-4 pressure ulcers that were not present or were at a lesser stage on admission.</p> <p>Of note, data collection and calculation for this measure are conducted and reported separately for each of the three provider settings and will not be combined across settings.</p> <p>For SNF/NH residents, this measure is restricted to the short-stay population defined as those who have accumulated 100 or fewer days in the SNF/NH as of the end of the measure time window. In IRFs, this measure is restricted to IRF Medicare (Part A and Part C) patients. In LTCHs, this measure includes all patients.</p>	Electronic Clinical Data, Electronic Clinical Data: Laboratory	Facility, Population: National	None

Measure Status, Title, and Steward	Measure Type	Measure Description	Data Source	Level of Analysis	Public Comments Received
<p><b>0679 Endorsed</b>                      Percent of High Risk Residents with Pressure Ulcers (Long Stay)                      CMS</p>	<p>Outcome</p>	<p>This measure reports the percentage of long-stay residents identified as at high risk for pressure ulcers in a nursing facility who have one or more Stage 2-4 or unstageable pressure ulcer(s) reported on a target Minimum Data Set (MDS) assessment (OBRA, PPS, and/or discharge) during their episode during the selected target quarter. High risk populations are defined as those who are comatose, or impaired in bed mobility or transfer, or suffering from malnutrition.</p> <p>Long-stay residents are identified as residents who have had at least 101 cumulative days of nursing facility care. A separate measure (NQF#0678, Percent of Residents With Pressure Ulcers That are New or Worsened (Short-Stay)) is to be used for residents whose length of stay is less than or equal to 100 days.</p>	<p>Electronic Clinical Data</p>	<p>Facility</p>	<p>None</p>
<p><b>0682 Endorsed</b>                      Percent of Residents or Patients Assessed and Appropriately Given the Pneumococcal Vaccine (Short-Stay)                      CMS</p>	<p>Process</p>	<p>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.</p> <p>National Quality Forum (2008a, June). Revised voting draft for national voluntary consensus standards for influenza and pneumococcal immunizations. Received from the Health Services Advisory Group on August 19, 2011.</p>	<p>Electronic Clinical Data</p>	<p>Facility, Population: National</p>	<p>None</p>

Measure Status, Title, and Steward	Measure Type	Measure Description	Data Source	Level of Analysis	Public Comments Received
<b>0709 Endorsed</b> Proportion of patients with a chronic condition that have a potentially avoidable complication during a calendar year. <i>Bridges To Excellence</i>	Outcome	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. (Please reference attached document labeled NQF_Chronic_Care_PACs_Risk_Adjustment_2.9.10.xls).	Administrative claims, Electronic Clinical Data: Pharmacy	Clinician: Group/ Practice, Health Plan, Population: County or City, Population: National, Population: Regional, Population: State	None
<b>0710 Endorsed</b> Depression Remission at Twelve Months <i>MN Community Measurement</i>	Patient-Reported Outcome Measure	Adult patients age 18 and older with major depression or dysthymia and an initial PHQ-9 score > 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.  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.	Electronic Clinical Data, Electronic Clinical Data: Electronic Health Record, Paper Medical Records	Clinician: Group/ Practice, Facility	None
<b>0712 Endorsed</b> Depression Utilization of the PHQ-9 Tool <i>MN Community Measurement</i>	Process	Adult patients age 18 and older with the diagnosis of major depression or dysthymia 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 that is completed by the patient, ideally at each visit, and utilized by the provider to monitor treatment progress.	Electronic Clinical Data, Electronic Clinical Data: Electronic Health Record, Paper Medical Records	Clinician: Group/ Practice, Facility	None

Measure Status, Title, and Steward	Measure Type	Measure Description	Data Source	Level of Analysis	Public Comments Received
<p><b>0729 Endorsed</b> Optimal Diabetes Care <i>MN Community Measurement</i></p>	Composite	<p>The percentage of adult diabetes patients who have optimally managed modifiable risk factors (A1c, blood pressure, statin use, tobacco non-use and daily aspirin or anti-platelet use for patients with diagnosis of ischemic vascular disease) with the intent of preventing or reducing future complications associated with poorly managed diabetes.</p> <p>Patients ages 18 - 75 with a diagnosis of diabetes, who meet all the numerator targets of this composite measure: A1c less than 8.0, Blood Pressure less than 140 systolic and less than 90 diastolic, Statin use unless contraindications or exceptions, Tobacco-free (non-user) and for patients with diagnosis of ischemic vascular disease daily aspirin or antiplatelet use unless contraindicated.</p> <p>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.</p>	Electronic Clinical Data, Electronic Clinical Data: Electronic Health Record, Paper Medical Records	Clinician: Group/ Practice	None
<p><b>1626 Endorsed</b> Patients Admitted to ICU who Have Care Preferences Documented <i>RAND Corporation</i></p>	Process	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.	Electronic Clinical Data: Electronic Health Record, Paper Medical Records	Facility, Health Plan, Integrated Delivery System	None
<p><b>1659 Endorsed</b> Influenza Immunization <i>CMS</i></p>	Process	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.	Administrative claims, Paper Medical Records	Facility, Population: National, Population: Regional, Population: State	None
<p><b>1662 Endorsed</b> Angiotensin Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy <i>Renal Physicians Association</i></p>	Process	Percentage of patients aged 18 years and older with a diagnosis of CKD (not receiving RRT) and proteinuria who were prescribed ACE inhibitor or ARB therapy within a 12-month period	Administrative claims, Electronic Clinical Data, Electronic Clinical Data: Electronic Health Record, Electronic Clinical Data: Registry, Paper Medical Records	Clinician: Group/ Practice, Clinician: Individual, Clinician: Team	None



Measure Status, Title, and Steward	Measure Type	Measure Description	Data Source	Level of Analysis	Public Comments Received
<p><b>1768* Endorsed</b> Plan All-Cause Readmissions (PCR) NCQA</p>	Process	<p>For patients 18 years of age and older, the number of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. Data are reported in the following categories:</p> <ol style="list-style-type: none"> <li>1. Count of Index Hospital Stays* (denominator)</li> <li>2. Count of 30-Day Readmissions (numerator)</li> <li>3. Average Adjusted Probability of Readmission</li> </ol> <p>*An acute inpatient stay with a discharge during the first 11 months of the measurement year (e.g., on or between January 1 and December 1).</p>	Patient Reported Data/Survey	Health Plan, Integrated Delivery System	None
<p><b>1789 Endorsed</b> Hospital-Wide All-Cause Unplanned Readmission Measure (HWR) CMS</p>	Outcome	<p>The measure estimates a hospital-level risk-standardized readmission rate (RSRR) of unplanned, all-cause readmission after admission for any eligible condition within 30 days of hospital discharge. The measure reports a single summary risk-standardized readmission rate (RSRR), derived from the volume-weighted results of five different models, one for each of the following specialty cohorts based on 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-level standardized risk ratios (SRR) for each of these five specialty cohorts. The outcome is defined as unplanned readmission for any cause within 30 days of the discharge date for the index admission. Admissions for planned procedures that are not accompanied by an acute diagnosis do not count as readmissions in the measure outcome. The target population is patients 18 and over. CMS annually reports the measure for patients who are 65 years or older and are enrolled in fee-for-service (FFS) Medicare and hospitalized in non-federal hospitals.</p>	Administrative claims	Facility	None

Measure Status, Title, and Steward	Measure Type	Measure Description	Data Source	Level of Analysis	Public Comments Received
<b>1927 Endorsed</b> Cardiovascular Health Screening for People With Schizophrenia or Bipolar Disorder Who Are Prescribed Antipsychotic Medications <i>NCQA</i>	Process	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.	Administrative claims, Electronic Clinical Data, Electronic Clinical Data: Pharmacy	Health Plan, Integrated Delivery System, Population: State	None
<b>1932 Endorsed</b> Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD) <i>NCQA</i>	Process	The percentage of patients 18 – 64 years of age with schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.	Administrative claims, Electronic Clinical Data, Electronic Clinical Data: Laboratory, Electronic Clinical Data: Pharmacy	Health Plan, Integrated Delivery System, Population: State	None
<b>2079 Endorsed</b> HIV medical visit frequency <i>Health Resources and Services Administration - HIV/ AIDS Bureau</i>	Process	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.	Electronic Clinical Data: Electronic Health Record, Paper Medical Records	Clinician: Group/ Practice, Facility	None
<b>2091 Endorsed</b> Persistent Indicators of Dementia without a Diagnosis—Long Stay <i>American Medical Directors Association</i>	Process	Percentage of nursing home residents age 65+ with persistent indicators of dementia and no diagnosis of dementia.	Electronic Clinical Data	Facility	None
<b>2092 Endorsed</b> Persistent Indicators of Dementia without a Diagnosis—Short Stay <i>American Medical Directors Association</i>	Process	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.	Electronic Clinical Data	Facility	None

Measure Status, Title, and Steward	Measure Type	Measure Description	Data Source	Level of Analysis	Public Comments Received
<p><b>2111* Endorsed</b> Antipsychotic Use in Persons with Dementia <i>Pharmacy Quality Alliance</i></p>	Process	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.	Administrative claims	Health Plan	<p>One commenter supported the inclusion of this measure stating that older individuals with dementia who are prescribed antipsychotics are at greater risk for death and other serious harm.</p> <p>Another commenter expressed concern over this measure and the insinuation that the use of antipsychotics in individuals with dementia is always inappropriate, despite evidence to the contrary.</p>
<p><b>2152 Endorsed</b> Preventive Care and Screening: Unhealthy Alcohol Use: Screening &amp; Brief Counseling <i>AMA-convened Physician Consortium for Performance Improvement</i></p>	Process	Percentage of patients aged 18 years and older who were screened at least once within the last 24 months for unhealthy alcohol use using a systematic screening method AND who received brief counseling if identified as an unhealthy alcohol user	Electronic Clinical Data: Electronic Health Record, Electronic Clinical Data: Registry	Clinician: Group/ Practice, Clinician: Individual, Clinician: Team	None
<p><b>2158 Endorsed</b> Payment-Standardized Medicare Spending Per Beneficiary (MSPB) <i>CMS</i></p>	Cost/ Resource Use	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.	Administrative Claims	Hospital/ facility/ agency	None

Measure Status, Title, and Steward	Measure Type	Measure Description	Data Source	Level of Analysis	Public Comments Received
<b>2380 Endorsed</b> Rehospitalization During the First 30 Days of Home Health <i>CMS</i>	Outcome	Percentage of home health stays in which patients who had an acute inpatient hospitalization in the 5 days before the start of their home health stay were admitted to an acute care hospital during the 30 days following the start of the home health stay.	Administrative claims	Facility	None
<b>2456 Endorsed</b> Medication Reconciliation: Number of Unintentional Medication Discrepancies per Patient <i>Brigham and Women's Hospital</i>	Outcome	This measure assesses the actual quality of the medication reconciliation process by identifying errors in admission and discharge medication orders due to problems with the medication reconciliation process. The target population is any hospitalized adult patient. The time frame is the hospitalization period.  At the time of admission, the admission orders are compared to the preadmission medication list (PAML) compiled by trained pharmacist (i.e., the gold standard) to look for discrepancies and identify which discrepancies were unintentional using brief medical record review. This process is repeated at the time of discharge where the discharge medication list is compared to the PAML and medications ordered during the hospitalization.	Electronic Clinical Data, Electronic Clinical Data: Electronic Health Record, Electronic Clinical Data: Pharmacy, Healthcare Provider Survey, Other, Paper Medical Records, Patient Reported Data/ Survey	Facility	None
<b>2502 Endorsed</b> All-Cause Unplanned Readmission Measure for 30 Days Post Discharge from Inpatient Rehabilitation Facilities (IRFs) <i>CMS</i>	Outcome	This measure estimates the risk-standardized rate of unplanned, all-cause readmissions for patients (Medicare fee-for-service [FFS] beneficiaries) discharged from an Inpatient Rehabilitation Facility (IRF) who were readmitted to a short-stay acute-care hospital or a Long-Term Care Hospital (LTCH), within 30 days of an IRF discharge. The measure is based on data for 24 months of IRF discharges to non-hospital post-acute levels of care or to the community.	Administrative claims, Other	Facility	None
<b>2505 Endorsed</b> Emergency Department Use without Hospital Readmission During the First 30 Days of Home Health <i>CMS</i>	Outcome	Percentage of home health stays in which patients who had an acute inpatient hospitalization in the 5 days before the start of their home health stay used an emergency department but were not admitted to an acute care hospital during the 30 days following the start of the home health stay.	Administrative claims	Facility	None

Measure Status, Title, and Steward	Measure Type	Measure Description	Data Source	Level of Analysis	Public Comments Received
<b>2510* Endorsed</b> Skilled Nursing Facility 30-Day All-Cause Readmission Measure (SNFRM) CMS	Outcome	This measure estimates the risk-standardized rate of all-cause, unplanned, hospital readmissions for patients who have been admitted to a Skilled Nursing Facility (SNF) (Medicare fee-for-service [FFS] beneficiaries) within 30 days of discharge from their prior proximal hospitalization. The prior proximal hospitalization is defined as an admission to an IPPS, CAH, or a psychiatric hospital. The measure is based on data for 12 months of SNF admissions.	Administrative claims, Other	Facility	None
<b>2512 Endorsed</b> All-Cause Unplanned Readmission Measure for 30 Days Post Discharge from Long-Term Care Hospitals (LTCHs) CMS	Outcome	This measure estimates the risk-standardized rate of unplanned, all-cause readmissions for patients (Medicare fee-for-service [FFS] beneficiaries) discharged from a Long-Term Care Hospital (LTCH) who were readmitted to a short-stay acute-care hospital or a Long-Term Care Hospital (LTCH), within 30 days of an LTCH discharge. The measure is based on data for 24 months of LTCH discharges to non-hospital post-acute levels of care or to the community.	Administrative claims, Other	Facility	None
<b>2597 Endorsed</b> <b>eMeasure Approved for Trial Use</b> Substance Use Screening and Intervention Composite American Society of Addiction Medicine	Composite	Percentage of patients aged 18 years and older who were screened at least once within the last 24 months for tobacco use, unhealthy alcohol use, nonmedical prescription drug use, and illicit drug use AND who received an intervention for all positive screening results	Electronic Clinical Data, Electronic Clinical Data: Electronic Health Record	Clinician: Group/ Practice, Clinician: Individual	None
<b>2599 Endorsed</b> Alcohol Screening and Follow-up for People with Serious Mental Illness NCQA	Process	The percentage of patients 18 years and older with a serious mental illness, who were screened for unhealthy alcohol use and received brief counseling or other follow-up care if identified as an unhealthy alcohol user.  Note: The proposed health plan measure is adapted from an existing provider-level measure for the general population (NQF #2152: Preventive Care & Screening: Unhealthy Alcohol Use: Screening & Brief Counseling). It was originally endorsed in 2014 and is currently stewarded by the American Medical Association (AMA-PCPI).	Administrative claims, Electronic Clinical Data, Paper Medical Records	Health Plan	None

Measure Status, Title, and Steward	Measure Type	Measure Description	Data Source	Level of Analysis	Public Comments Received
<p><b>2600 Endorsed</b> Tobacco Use Screening and Follow-up for People with Serious Mental Illness or Alcohol or Other Drug Dependence NCQA</p>	<p>Process</p>	<p>The percentage of patients 18 years and older with a serious mental illness or alcohol or other drug dependence who received a screening for tobacco use and follow-up for those identified as a current tobacco user. Two rates are reported.</p> <p>Rate 1: The percentage of patients 18 years and older with a diagnosis of serious mental illness who received a screening for tobacco use and follow-up for those identified as a current tobacco user.</p> <p>Rate 2: The percentage of adults 18 years and older with a diagnosis of alcohol or other drug dependence who received a screening for tobacco use and follow-up for those identified as a current tobacco user.</p> <p>Note: The proposed health plan measure is adapted from an existing provider-level measure for the general population (Preventive Care &amp; Screening: Tobacco Use: Screening &amp; Cessation Intervention NQF #0028). This measure is currently stewarded by the AMA-PCPI and used in the Physician Quality Reporting System.</p>	<p>Administrative claims, Electronic Clinical Data, Paper Medical Records</p>	<p>Health Plan</p>	<p>None</p>
<p><b>2601 Endorsed</b> Body Mass Index Screening and Follow-Up for People with Serious Mental Illness NCQA</p>	<p>Process</p>	<p>The percentage of patients 18 years and older with a serious mental illness who received a screening for body mass index and follow-up for those people who were identified as obese (a body mass index greater than or equal to 30 kg/ m<sup>2</sup>).</p> <p>Note: The proposed health plan measure is adapted from an existing provider-level measure for the general population (Preventive Care &amp; Screening: Body Mass Index: Screening and Follow-Up NQF #0421). It is currently stewarded by CMS and used in the Physician Quality Reporting System.</p>	<p>Administrative claims, Electronic Clinical Data, Paper Medical Records</p>	<p>Health Plan</p>	<p>None</p>

Measure Status, Title, and Steward	Measure Type	Measure Description	Data Source	Level of Analysis	Public Comments Received
<b>2602 Endorsed</b> Controlling High Blood Pressure for People with Serious Mental Illness NCQA	Outcome	The percentage of patients 18-85 years of age with serious mental illness who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled during the measurement year.  Note: This measure is adapted from an existing health plan measure used in a variety of reporting programs for the general population (NQF #0018: Controlling High Blood Pressure). It was originally endorsed in 2009 and is owned and stewarded by NCQA. The specifications for the existing measure (Controlling High Blood Pressure NQF #0018) have been updated based on 2013 JNC-8 guideline. NCQA will submit the revised specification for Controlling High Blood Pressure NQF #0018 in the 4th quarter 2014 during NQF's scheduled measure update period. This measure uses the new specification to be consistent with the current guideline.	Administrative claims, Electronic Clinical Data, Paper Medical Records	Health Plan	None
<b>2603 Endorsed</b> Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Testing NCQA	Process	The percentage of patients 18-75 years of age with a serious mental illness and diabetes (type 1 and type 2) who had hemoglobin A1c (HbA1c) testing during the measurement year.  Note: This measure is adapted from an existing health plan measure used in a variety of reporting programs for the general population (NQF #0057: Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing). This measure is endorsed by NQF and is stewarded by NCQA.	Administrative claims, Electronic Clinical Data, Electronic Clinical Data: Laboratory, Electronic Clinical Data: Pharmacy, Paper Medical Records	Health Plan	None
<b>2604 Endorsed</b> Diabetes Care for People with Serious Mental Illness: Medical Attention for Nephropathy NCQA	Process	The percentage of patients 18-75 years of age with a serious mental illness and diabetes (type 1 and type 2) who received a nephropathy screening test or had evidence of nephropathy during the measurement year.  Note: This measure is adapted from an existing health plan measure used in a variety of reporting programs for the general population (NQF #0062: Comprehensive Diabetes Care: Medical Attention for Nephropathy). It is endorsed by NQF and is stewarded by NCQA.	Administrative claims, Electronic Clinical Data, Electronic Clinical Data: Laboratory, Electronic Clinical Data: Pharmacy, Paper Medical Records	Health Plan	None

Measure Status, Title, and Steward	Measure Type	Measure Description	Data Source	Level of Analysis	Public Comments Received
<p><b>2605 Endorsed</b> Follow-up after Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence NCQA</p>	<p>Process</p>	<p>The percentage of discharges for patients 18 years of age and older who had a visit to the emergency department with a primary diagnosis of mental health or alcohol or other drug dependence during the measurement year AND who had a follow-up visit with any provider with a corresponding primary diagnosis of mental health or alcohol or other drug dependence within 7- and 30-days of discharge.</p> <p>Four rates are reported:</p> <ul style="list-style-type: none"> <li>• The percentage of emergency department visits for mental health for which the patient received follow-up within 7 days of discharge.</li> <li>• The percentage of emergency department visits for mental health for which the patient received follow-up within 30 days of discharge.</li> <li>• The percentage of emergency department visits for alcohol or other drug dependence for which the patient received follow-up within 7 days of discharge.</li> <li>• The percentage of emergency department visits for alcohol or other drug dependence for which the patient received follow-up within 30 days of discharge.</li> </ul>	<p>Administrative claims</p>	<p>Health Plan, Population: State</p>	<p>None</p>
<p><b>2606 Endorsed</b> Diabetes Care for People with Serious Mental Illness: Blood Pressure Control (&lt;140/90 mm Hg) NCQA</p>	<p>Outcome</p>	<p>The percentage of patients 18-75 years of age with a serious mental illness and diabetes (type 1 and type 2) whose most recent blood pressure (BP) reading during the measurement year is &lt;140/ 90 mm Hg.</p> <p>Note: This measure is adapted from an existing health plan measure used in a variety of reporting programs for the general population (NQF #0061: Comprehensive Diabetes Care: Blood Pressure Control &lt;140/ 90 mm Hg) which is endorsed by NQF and is stewarded by NCQA.</p>	<p>Administrative claims, Electronic Clinical Data, Electronic Clinical Data: Pharmacy, Paper Medical Records</p>	<p>Health Plan</p>	<p>None</p>
<p><b>2607 Endorsed</b> Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (&gt;9.0%) NCQA</p>	<p>Outcome</p>	<p>The percentage of patients 18-75 years of age with a serious mental illness and diabetes (type 1 and type 2) whose most recent HbA1c level during the measurement year is &gt;9.0%.</p> <p>Note: This measure is adapted from an existing health plan measure used in a variety of reporting programs for the general population (NQF #0059: Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control &gt;9.0%). This measure is endorsed by NQF and is stewarded by NCQA.</p>	<p>Administrative claims, Electronic Clinical Data, Electronic Clinical Data: Laboratory, Electronic Clinical Data: Pharmacy, Paper Medical Records</p>	<p>Health Plan</p>	<p>None</p>



Measure Status, Title, and Steward	Measure Type	Measure Description	Data Source	Level of Analysis	Public Comments Received
<b>2608 Endorsed</b> Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Control (<8.0%) NCQA	Outcome	The percentage of patients 18-75 years of age with a serious mental and diabetes (type 1 and type 2) whose most recent HbA1c level during the measurement year is <8.0%.  Note: This measure is adapted from an existing health plan measure used in a variety of reporting programs for the general population (NQF #0575: Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control <8.0). This measure is endorsed by NQF and is currently stewarded by NCQA.	Administrative claims, Electronic Clinical Data, Electronic Clinical Data: Laboratory, Electronic Clinical Data: Pharmacy, Paper Medical Records	Health Plan	None
<b>2609 Endorsed</b> Diabetes Care for People with Serious Mental Illness: Eye Exam NCQA	Process	The percentage of patients 18-75 years of age with a serious mental illness and diabetes (type 1 and type 2) who had an eye exam during the measurement year.  Note: This measure is adapted from an existing health plan measure used in a variety of reporting programs for the general population (NQF #0055: Comprehensive Diabetes Care: Eye Exam). This measure is endorsed by NQF and is stewarded by NCQA.	Administrative claims, Electronic Clinical Data, Electronic Clinical Data: Pharmacy, Paper Medical Records	Health Plan	One commenter expressed concern that this measure is too narrowly focused in terms of population because eye care is an important component of clinical care for all individuals with diabetes, not just those with mental illness.
<b>2624 Endorsed</b> Functional Outcome Assessment CMS	Process	NOTE: Specification information in this section is from the 2014 Physician Quality Reporting System Manual. Note that Testing Information is based on the specification in the 2012 Physician Quality Reporting System Manual. Both 2012 and 2014 Specifications are included in the attached "NQF Endorsement Measurement Submission Summary Materials"  Percentage of visits for patients aged 18 years and older with documentation of a current functional outcome assessment using a standardized functional outcome assessment tool on the date of the encounter AND documentation of a care plan based on identified functional outcome deficiencies on the date of the identified deficiencies.	Administrative claims, Paper Medical Records	Clinician: Group/ Practice, Clinician: Individual	One commenter stated this measure is not sufficiently person-centered as it does not capture whether an individual's goal and preferences were addressed during the development of the care plan.

An asterisk (\*) indicates a measure in the Starter Set for Dual Eligible Beneficiaries. For information on the starter set see table 1 of the report.

# APPENDIX E: Public Comments

## General Comments

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### **America's Health Insurance Plans**

#### **Carmella Bocchino**

We support efforts to improve care for the duals population and underscore the need to apply measures at the appropriate level of analysis. For example, new measures proposed for the the starter set such as #0647 and #0648 are specified and endorsed at the provider level and are best suited to measure provider quality as they involve transition of a patient's medical record. Such types of measures should not be used for health plans assessment. NQF should more clearly articulate that these measures are more applicable to assessing provider level performance. In addition, we recommend that the recommended measure set be more parsimonious to minimize reporting burden on plans and providers. We underscore the importance of SES adjustments to measures to account for the fact that it is more complex to manage patients with low SES status. Finally, there are numerous efforts to survey patients on their experience of care. Better and more streamlined instruments are needed to ensure we assess patient experience while also improving response rates for patient surveys.

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### **Center for Medicare Advocacy, Inc.**

#### **Kata Kertesz**

The Center for Medicare Advocacy appreciates the opportunity to comment on the NQF MAP Dual Eligible Workgroup Report.

As NQF reviews the trial period on risk-adjustment for socioeconomic factors (SES), we would like to reiterate our concerns regarding this type of risk-adjustment in quality measurement.

We are concerned that risk adjustment for quality reporting and pay-for-performance programs based on SES factors will lead to several harmful unintended consequences for disadvantaged patients. First of all, risk adjustment has the potential to mask existing disparities in care that low income patients receive,

rather than expose and address these disparities. Simply adjusting away these real differences only perpetuates the inequities.

Also, risk adjustment could create two divergent standards of care for healthcare units based on the wealth or poverty of the populations they serve. Adjusting scores for healthcare units with significant proportions of disadvantaged patient populations would in effect lower the bar for healthcare units that treat these populations. This type of adjustment would allow distinct and unequal quality standards for poor patients and wealthy patients.

Also, the root of the disparities in care is not likely to be addressed if the differences are concealed through the automatic and inaccurate inflation of performance scores.

We would also like to underscore a major obstacle in determining the effectiveness of risk adjustment for SES: the lack of comprehensive data for SES factors. As mentioned in the NQF report, patient-level data for SES factors is "limited,"[1] with specific data relating to complex patients with multiple chronic conditions being "even sparser." [2] Without adequate data available to support allowing measures that are risk adjusted for SES, it is reckless to potentially mask disparities and thereby institutionalize these disparities. This data is essential to determining if SES risk adjustment will meet the objective of quality measurement by improving care for those vulnerable populations.

We urge NQF to review HHS' Office of the Assistant Secretary for Planning and Evaluation (ASPE) study regarding the issue of risk adjustment for SES in quality measures, prepared as required by the IMPACT Act, prior to making any permanent policy changes regarding SES risk adjustment.

[1] NQF report at 7.

[2] NQF report at 16.

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## Consortium for Citizens with Disabilities

### E. Clarke Ross

Page 4 - some recent pertinent activities. We suggest 3 additions: CMS HCBS “Settings” final regulation; CMS IMPACT Act regulations and announcements; and NQF PAC-LTC workgroup activities. Thank you for the many cross-references (HCBS pg 13, risk adjustment pg 7, disparities pg 4, person & family-centered care pg 9, PROS & Consumer’s Voice pg 8 & 17, & High Priority gaps pg 12. Page 4 -missing is the word “person” in person & family centered. Clarke Ross, American Association on Health and Disability & Lakeshore Foundation

RE: pages 16-17 Unfunded Mandates. Please insert the word “some” throughout this section; i.e., rather than “the Workgroup members,” state “some of the Workgroup members.” There was never a vote of action on this point. Some of the workgroup members expressed this concern. Not all of the workgroup members prioritize this as a concern. Clarke Ross, American Association on Health and Disability and Lakeshore Foundation.

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### Leena Sharma

We appreciate the opportunity to provide comments on the 2016 draft report of the MAP Workgroup. Overall, we are very pleased with the report and would like to both reinforce many of your findings and recommendations and strongly urge NQF to move ahead with work on the high-priority measure gaps documented. We are also commenting on the committee’s third interim report on measure gaps in Home and Community-Based Services and encourage you to read those comments, which also are relevant for the dual eligible population.

We would like to reinforce some of the important themes noted in this report and provide recommendations to further strengthen these areas:

We greatly appreciate the MAP Workgroup’s interest in addressing healthcare disparities in the dual eligible population, including understanding whether risk adjusting measures for socioeconomic status (SES) factors is warranted. We agree with the MAP Workgroup that robust data on socioeconomic and other factors are limited and therefore strongly urge the MAP workgroup to continue monitoring NQF’s

Trial Period on Risk-Adjustment for Socioeconomic Factors. We also suggest NQF carefully consider the results of the forthcoming report from the Assistant Secretary for Planning and Evaluation with respect to risk adjustment for SES before making any policy changes on this issue.

The report notes the MAP Workgroup members voted to remove three patient-reported outcome-performance measures (PRO-PMs)[1]. We recommend the workgroup place stronger emphasis on PRO-PMs, including ones related to health literacy, which was voted to be removed.[2]

[1] See page 9 of the 2016 draft report of the Measure Application Partnership Dual Eligible Beneficiaries Workgroup

[2] Community Catalyst presentation at the IOM Roundtable on “The Intersections Among Health Disparities, Disabilities, Health Equity, and Health Literacy” June 2016.

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## Paone and Associates

### Deborah Paone

The Dual Workgroup is to be commended for considering the issue of cross-site and ongoing chronic care needs that characterize the dual population. We also value the attention to community integration/connection to community resources and integrated care that extends beyond medical care to the social and community settings.

As the Workgroup is doing, dual beneficiary/population needs and characteristics should drive the choice of measures of quality and evaluation of performance. Among the dual population, particularly those served by SNP Alliance members, many are under age 65, have mental and behavioral health conditions as well as multiple comorbidities and social support needs which impacts their ability to participate in self-care and treatment. We endorse the pursuit of identifying and utilizing measures that reflect this population.

We greatly value the Workgroup focus on the importance of socioeconomic (SES) and social determinants of health (SDOH) risk factors.

Dual beneficiaries often face significant SDOH risk factors, such as transient housing, unstable home environments, food and transportation insecurity,

underemployment, and social isolation or living in low resource neighborhoods. Health care policy makers and those practicing in the medical and social services fields increasingly recognize that these risk factors affect health outcomes observed from care and services provided—even when the standards of medical care and social services are met.

We call for stronger emphasis on adjusting measures for SES/SDOH and ask the Workgroup to include this in their recommendations.

Unadjusted measures used in the field can yield inaccurate results about providers and plans who serve a disproportionate number of individuals with these characteristics. These quality ratings, which

can influence consumer behavior and are tied to payment, may then inadvertently negatively impact consumers, providers, and plans serving the most vulnerable population subgroups by providing inaccurate information regarding the quality of care.

We wish to share with NQF and this MAP Dual Workgroup that the SNP Alliance has developed a set of recommended guidelines for measure developers/measure stewards to use when considering SES/SDOH and evaluating their measures for adjustment. We believe that CMS should provide guidance to ensure consistency and thoroughness across measure developers and in measure testing to recognize SES/SDOH. The Workgroup has an important opportunity to make this recommendation.

## Updated Measures in the Family

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### **American Academy of Family Physicians**

#### **Sandy Pogones**

In general the measures selected seem reasonable and in line with current thinking from surrounding dual eligible patients.

There are concerns regarding the checkbox approach to capturing action of measures (e.g., smoking cessation counseling and medication reconciliation). However, we understand that until more intelligent electronic systems are developed and more appropriate payment is made for services rendered, checkboxes may be the best approach to reduce administrative burden.

The AAFP is continuing discussion on the appropriateness of measures that are highly influenced by factors out of the control of physicians—for example, A1c and BP control. Such measures, while popular, may be more dependent on lifestyle, socioeconomic status, medication adherence, culture and patient engagement than on physician-driven care.

While screening and assessment measures are important, primary care physicians struggle to perform and receive reimbursement for many of these services. The wellness visit is an opportunity to conduct such assessments but many dual-eligibles refuse the visit or do not keep appointments. Attempting to complete assessments, such as

depression screening, fall risk, substance abuse, and pain, during an acute visit is difficult due to time constraints and reimbursement is inconsistent.

The pneumococcal vaccine measure frequently results in overuse since outpatient and inpatient facilities often don't communicate with the primary care physician prior to administering the vaccine and patient recall is often poor. Unfortunately, the solution for this is limited.

The AAFP thanks the Committee for their work on Dual Eligible population measures and looks forward to continued progress in the future.

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### **American Optometric Association**

#### **Jensen Jose**

Doctors of optometry play a major role in the overall health of many dual-eligible beneficiaries by detecting systemic diseases—such as diabetes—monitoring complications and participating in team care. The AOA supports focusing on the need for eye care for patients with diabetes in the dual eligible family of measures, as recent research has shown associations between diabetes-related eye complications and psychological well-being (<http://archophth.jamanetwork.com/article.aspx?articleid=2531482>).

However, for this family of measures—particularly

for measure # 2609 (Diabetes Care for People with Serious Mental Illness: Eye Exam)—the AOA recommends that NQF rely on the broader NQF measure #0055 (Comprehensive Diabetes Care: Eye Exam), rather than use a measure limited to patients with diabetes AND mental illness.

Because dual eligible beneficiaries with both diabetes and mental conditions is a subset of dual eligible beneficiaries with diabetes, promoting eye exams for all diabetic dual eligible beneficiaries still benefits the measure’s targeted population. However, many early complications of diabetes, such as diabetic macular edema (DME), requires treatment but are often not associated with depression or anxiety. Waiting for the secondary diagnoses of a mental condition gives more time for beneficiaries’ eye and mental conditions to worsen, thereby making it harder to treat both conditions. Administering eye exams when diagnosed with diabetes allows beneficiaries to manage their eye-related diabetic conditions before their eye and/or mental conditions worsen.

The current consensus and evidence state that all diabetic patients should be administered an eye exam. NQF itself has already acknowledged the importance of providing eye exams for all diabetic patients. Specifically, the rationale for NQF measure #0055 (Comprehensive Diabetes Care: Eye Exam) states, “The consensus among established clinical guidelines is that patients with both types of diabetes should have an initial dilated and comprehensive eye exam soon after diagnosis (ADA 2009).” The AOA’s guidelines for eye care of the patient with diabetes mellitus, also state, “As diabetes may go undiagnosed for many years, any individual with type 2 diabetes should have a comprehensive dilated eye examination soon after the diagnosis of diabetes... Individuals with diabetes should receive at least annual dilated eye examinations.” There is no evidence to suggest that quality of care will improve by promoting eye exams only to diabetic dual eligible beneficiaries with mental illness. In fact, by not promoting eye exams upon a diagnosis of diabetes, this measure would only decrease quality of care for the overall diabetic dual eligible beneficiary population.

The AOA notes that it continues to have concerns with the specifications for NQF measure #0055, but this does not diminish the importance of this measure.

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## American Psychiatric Foundation

### Samantha Shugarman

The APA sees the value and applauds the inclusion of mental health focused measures; however, we have concerns over the recommended “Antipsychotic Use in Persons with Dementia.” There are several reasons for concern, including this measure’s implicit assumption that any use of these medications in individuals with dementia is “inappropriate”. In writing the recent APA Antipsychotics in Dementia guideline, great lengths went to emphasizing that other approaches should be tried first, that antipsychotics (if used at all) should be used in the minimal necessary dose and for a limited duration of time, whenever that is possible. The overall focus is on using antipsychotic medications judiciously, which is not the same as never using them at all. It was surprising (4c.1.) that no unintended negative consequences were identified. This is in stark contrast to the concerns and experiences that the guideline writing group heard expressed by psychiatrists and also by advocates such as the Alzheimer’s Association during the comment process. There was a considerable sense that there are clearly individuals for whom the use of these drugs has produced a significant benefit, despite the lack of a statistical benefit in clinical trials (which tend to have less severely ill patients). The fact that a sizeable proportion of individuals in discontinuation studies had a return of symptoms with tapering also suggests that a subset of individuals do experience benefit. In terms of unintended negative consequences, there were clearly reports that the forced review and the use of draconian benefits management (by CMS, insurers and others) via metrics such as this created significant worsening (sometimes dangerously so) for some patients. We advocate that the integration of this measure be reconsidered.

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## America’s Health Insurance Plans

### Carmella Bocchino

While we support efforts to measure quality of care for duals, we have concerns about applying measures such as NQF# 0326 Advance Care Plan at the health plan level. Decisions that are part of an Advance Care Plan should be based on interactions

between a physician and a patient and are therefore not appropriate for health plan level measurement. Also, the report discusses the challenges with unfunded mandates and this issue extends to the area of Advance Care Planning. Medicare Advantage Plans are currently not funded appropriately for this benefit. Moreover, to add a new quality measure to a new unfunded benefit exacerbates the “Unfunded Mandates” issue. New measures arising from new benefits need to be introduced with a transition period.

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**Center for Medicare Advocacy, Inc.**

**Kata Kertesz**

The Center for Medicare Advocacy supports the inclusion of measure NQF #2111 Antipsychotic Use in Person with Dementia. We echo NQF’s concern regarding the potential harm from overuse of unnecessary medications in at-risk populations, and applaud the inclusion of this measure.

The FDA gave its highest level of warning to the public about antipsychotic medications and warned that older people with dementia who were prescribed these drugs are at greater risk for death and other serious harm.[1] In November 2015, the American Geriatrics Society’s evidence-based update of its Beers Criteria for “potentially inappropriate medication use in older adults” stated unequivocally that that antipsychotic medications should be avoided for older people, “except for schizophrenia, bipolar disorder, or short-term use as an antiemetic during chemotherapy.”[2] Citing “increasing evidence of harm associated with antipsychotics and conflicting evidence on their effectiveness in delirium and dementia, the rationale to avoid was modified to ‘avoid antipsychotics for behavioral problems unless nonpharmacological options (e.g., behavioral interventions) have failed or are not possible, and the older adult is threatening substantial harm to self or others [italics in original].”[3] Thus, there is a very limited category of people for whom the drugs could be appropriate.

[1] In April 2005, the FDA issued “black box” warnings against prescribing atypical antipsychotic drugs for patients with dementia, cautioning that the drugs increased dementia patients’ mortality. FDA, “Public Health Advisory: Deaths

with Antipsychotics in Elderly Patients with Behavioral Disturbances” (April 11, 2005), <http://www.fda.gov/drugs/drugsafety/postmarketdrug-safetyinformationforpatientsandproviders/ucm05317>. In June 2008, the FDA extended its warning to all categories of antipsychotic drugs, conventional as well as atypical, and directly and unequivocally advised health care professionals, “Antipsychotics are not indicated for the treatment of dementia-related psychosis.” FDA, “Information for Healthcare Professionals: Conventional Antipsychotics,” FDA Alert (June 16, 2008), <http://www.fda.gov/Drugs/DrugSafety/PostmarketDrug-SafetyInformationforPatientsandProviders/ucm124830.htm>.

[2] The American Geriatrics Society 2015 Beers Criteria Update Expert Panel, “American Geriatrics Society 2015 Updated Beers Criteria for Potentially Inappropriate Medication Use in Older Adults,” *Journal of the American Geriatrics Society*, Vol. 63, No. 11, page 2233, Table 2 (Nov. 2015), <http://onlinelibrary.wiley.com/doi/10.1111/jgs.13702/pdf>

[3] Id.2242.

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**Leena Sharma**

**Leena Sharma**

We would like to reinforce some of the important themes noted in this report and provide recommendations to further strengthen these areas:

We appreciate the updates made to the starter set of measures but caution the MAP Workgroup against using too many process-oriented measures. Process measures do not shed light on the gaps in quality of care that is experienced by the dual eligible population, especially older adults with multiple chronic conditions. We recommend the MAP Workgroup strongly consider endorsing outcome measures that will provide insight into care experiences. We urge the Workgroup to continue to consider the high-priority measurement gap area identified in the draft report for future endorsement.[1]

We are pleased to see the MAP Workgroup’s attention to community supports and services. It is imperative that NQF continue to support and monitor development of measures that will help collect, track and evaluate performance around connecting health care services and community supports and services.

Community supports and services are critical to quality of life for dual eligibles, including their ability to maintain independence and meaningfully participate in work, relationships and community activities, if desired, as well as live in their preferred setting.[2]

We are aware that the development of measures is a multi-year effort and would urge NQF to support additional government funding to move forward on the high priority areas. Further, we hope NQF will continue to take the lessons learned from the Financial Alignment Initiative in measure development.

[1]See page 12 of the 2016 draft report of the Measure Application Partnership Dual Eligible Beneficiaries Workgroup

[2]The Bridge Model discussed in the report is a great example of integration of health and community supports.

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## Paone and Associates

### Deborah Paone

While many measures are discussed in the Technical Report, we focus on the “Starter Set” of measures (Table 1). We agree that this should be the starting point for use in the field. This smaller set provides the value of building cross-site accountability with plans and providers on elements of care that are consistently shown to be important.

We are not commenting on the full set of measures listed in Appendix D, as we understand this is a repository of reviewed and endorsed measures, but that the Workgroup is not suggesting these measures all be utilized at this time.

As the Workgroup moves forward, we would like to draw attention to potential validity and reliability issues as well as potential data collection issues of instruments currently in use for obtaining dual beneficiary input/consumer perspective about care. We particularly have concerns about self-report measures from the Health Outcomes Survey (HOS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS). We believe that these instruments and methods have not been adequately tested among dual beneficiaries who are non-English speaking, are of low health literacy, and/or who

consider themselves of non-majority cultural and ethnic groups or who have cognitive limitations. We also note that there is concern that the way items are worded, beneficiaries or proxies may not distinguish between issues with a medical provider or facility from those that are within the health plan’s purview. Measures and survey administration/data collection methods may likewise not accommodate beneficiaries who have significant social risk factors, such as housing instability, low telephone access, low education levels, low English proficiency, or other factors that serve as barriers to their participation in the process, such as cognitive limitations or memory disorders.

Dual beneficiaries are not similar to the majority Medicare population on which the survey instruments and methods were first tested and validated. This is particularly important with regard to the quality rating system, since the self-report measures are so highly weighted and integral to performance evaluation results in the current measurement set and system. As the Dual Workgroup moves forward, we urge the members to consider these issues.

We provide a note of caution around the use of the ECHO instrument in that it may need more testing in the dual population.

We recognize and agree that additional outcome measures are needed and that connecting the work of the Dual Workgroup to both the HCBS Committee and the Disparities/SES Workgroup is essential. Thank you for making that a priority—tying the work of these expert committees and workgroups together.

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## The SCAN Foundation

### Megan Burke

The SCAN Foundation commends the workgroup’s consideration of measures addressing functional status and outcomes endorsed through the Person- and Family-Centered Care Project. Research (<http://avalere.com/news/avalere-issues-white-paper-on-the-management-of-high-risk-medicare-populati>) shows that health risk assessments (HRAs) identifying functional needs enable health plans to better identify an individual’s needs by targeting care coordination and transition programs and, in so doing, improve quality and lower health

costs. We believe that the selected measure, NQF #2624 Functional Outcome Assessment, is not sufficiently person centered. While the measure requires that a plan of care be developed around a functional assessment with identification of resources to implement the plan of care, it does not consider individual goals and preferences. Instead, we recommend that the workgroup seek measures that consider outcomes of import to the individual receiving care. National Committee for Quality Assurance has produced three documents, *Setting Goals with People with Complex Needs: A Collaborative Approach* (<http://www.ncqa.org/hedis-quality-measurement/research/setting-goals-with-vulnerable-people>), *Policy Approaches to Advancing Person-Centered Outcome Measurement* ([http://www.ncqa.org/Portals/0/HEDISQM/Research/Policy%20Report\\_Final%20Report\\_TSF%202-1.pdf](http://www.ncqa.org/Portals/0/HEDISQM/Research/Policy%20Report_Final%20Report_TSF%202-1.pdf)), and *Person-Centered Care Planning: Eliciting and Negotiating Goals* (<http://blog.ncqa.org/person-centered-care-planning-eliciting-and-negotiating-goals/>) that examine goal setting and tracking to inform person-centered care and outcome measurement.

The SCAN Foundation agrees with the workgroup's identified measurement gap priority areas, and appreciates the call for collaboration and innovation. Performance measures that provide individuals with a voice in establishing goals and outcomes holds the system accountable for helping people achieve their goals and preferences. A 2013 report from National Committee on Quality Assurance outlines

a quality framework for integrated care, and could be a resource for identifying quality measures. In addition, the Foundation, in partnership with the John A. Hartford Foundation, is partnering with NCQA on two complementary efforts to develop person-centered quality measures that focus on coordination and delivery of LTSS. The first body of work entails piloting standards for the development of two new accreditation products, one for health plans and the other for community providers that coordinate and deliver LTSS in 2017. The second body of work will test two promising methods for documenting person-centered outcomes in a standardized format. These methods will be designed for eventual use in NCQA accreditation programs and could form a basis for building person-centered quality metrics. Additionally, California is in the process of implementing a CMS Financial Alignment Demonstration (Cal MediConnect) integrating Medicare and Medicaid services, requiring plans to coordinate care while allowing flexibility to provide additional services beyond the required benefits. Early evaluation results and success stories show that individuals receiving care coordination are satisfied with their care, accessing services they did not previously know existed, and seeing improvements in their quality of life. We believe that information from these demonstrations can be used to inform quality measure development for care coordination that serve Medicare and/or Medicaid-eligible populations, ensuring that delivery systems measure what matters most to the people receiving care.

## Connection to Community

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### Consortium for Citizens with Disabilities

#### E. Clarke Ross

Thank you for the pg 14-15 Connections, pg 18-19 Improving Connections, and pg 19-21 Models of Integration. Should these sections follow one another? Clarke Ross, American Association on Health and Disability and Lakeshore Foundation.

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#### Leena Sharma

We understand the concern raised by some MAP Workgroup members about the potential burden

of "unfunded mandates," but believe this is not a concern that applies universally. In particular, in capitated payment systems, the issue is far more complex. Serving dual eligible beneficiaries requires an expanded scope of primary care and care coordination practices that should be accounted for in a capitated rate. While these expanded practices do require more resources, they also improve care and reduce costs. Thus, added investments should be borne by the Medicare-Medicaid Plan and/or any downstream risk-bearing provider entities in the normal course of business and should not be



viewed as “unfunded mandates.” We believe the Workgroup’s recommendation that “measurement of quality and care should be decoupled from requirements for which no incentive and/or support is provided” should clarify that this does not apply to capitated payment approaches. We also suggest that the recommendation particularly emphasize the burden that unfunded measurement mandates impose on community-based providers in underserved, ethnically-diverse communities and rural communities. These providers have fewer resources available to them to implement quality measurement and practice change.

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### **Paone and Associates**

#### **Deborah Paone**

We are encouraged by this Workgroup’s recognition of the importance of connection to community for the dual population. The task of identifying measures that will cross sites of care, settings, disciplines, and service sectors is daunting, but we applaud this Workgroup for their approach that moves beyond the clinical and medical measures and addresses other settings, including home. We also strongly support their attention to social and socio-demographic issues. Finally, we agree that looking beyond the U.S. to other countries that have a more well-developed social support service system makes sense.

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### **The SCAN Foundation**

#### **Megan Burke**

The SCAN Foundation is pleased to see robust discussion of the importance of connecting quality measures across various health care and LTSS systems to support quality care for people with complex care needs, and the challenges presented in measuring quality during transitions between different types of providers. One example focused on connecting health care and LTSS during transition from a health care facility. As people with complex care needs are particularly vulnerable when transitioning from hospital to home, we acknowledge the importance of examining how to improve connections between healthcare and LTSS. However, we would challenge the workgroup to consider how services can be targeted to support an individual with complex care needs living in the

community before a crisis occurs that results in hospitalization. A suite of reports from California’s Medicaid Research Institute (CAMRI) highlight the importance of identifying people at critical times to determine the right set of coordinated services. A report from Avalere Health explores how gathering and using non-medical data to better coordinate care for high-risk Medicare beneficiaries can improve person-centered care and be cost effective. Avalere looked closely at how health risk assessments (HRAs) that include LTSS needs can provide a broader picture of the person receiving care, and in turn, allow health plans to best target care coordination and transitions programs. Building on this work, The Foundation recently convened a workgroup in partnership with the Alliance for Health Reform to develop a consensus document on the essential attributes of a quality system of care and supports for adults with complex needs. This quality framework will help guide current and future quality measure development and implementation, and will be released by the Foundation in summer 2016.

The workgroup recommended decoupling quality measurement from requirements that have no incentive or support provided. While the Foundation recognizes the barriers presented by unfunded mandates, we believe that limiting quality measures to only those items directly connected to incentives and support can slow progress in improving quality of care. Work supported by the Foundation – an issue brief, *Person-Centered Care: In Today’s Health Care Environment, the Business Case Is Stronger than Ever* and the full report, *Person-Centered Care: The Business Case* – show how well-targeted person-centered care models can result in fewer costly services (e.g., hospitalizations and emergency room visits) at the same time as increasing one’s quality of care and life. Measures associated with person-centered care characteristics can help bridge this knowledge gap and feed into a comprehensive financial analysis to make the business case for these models, including calculating the return on investment (ROI). The ROI Calculator is designed to help health care organizations and others design, develop, and operate person-centered care models that serve high need older adults and are sustainable.

The workgroup acknowledges the barriers in person-centered care due to lack of data across various

systems and sectors of care. As such, the report highlights the use of integrated care success stories and evaluation at the local level to elevate processes and lessons learned to the national population health level. California is in the process of implementing a CMS Financial Alignment Demonstration (Cal MediConnect) integrating Medicare and Medicaid services, requiring plans to coordinate care while providing flexibility to furnish additional services. Early evaluation results and success stories show that individuals receiving care coordination are satisfied with their care, accessing services they did not previously know existed, and seeing improvements in their quality of life. We believe that information from these demonstrations can inform quality measure development for care coordination that serve Medicare and/or Medicaid-eligible populations, ensuring that delivery systems measure what matters most to the people receiving care.

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