NATIONAL QUALITY FORUM

Agenda

Measure Applications Partnership

Dual Eligible Beneficiaries Workgroup In-Person Meeting

April 10-11, 2014

NQF Conference Center at 1030 15th Street NW, 9th Floor, Washington, DC 20005

Remote Participation Instructions:

Streaming Audio Online

- Direct your web browser to: http://nqf.commpartners.com
- Under "Enter a meeting" type in the meeting number for Day 1: **232394** or for Day 2: **517098**
- In the "Display Name" field, type in your first and last name and click "Enter Meeting"

Teleconference

- Dial **(888) 802-7237** for workgroup members or **(877) 303-9138** for public members and use conference ID code for Day 1: **8103097** and for Day 2: **8110681** to access the audio platform.

Meeting Objectives:

- Discuss priority measure gap areas in detail, exploring targeted activities to promote progress
- Update MAP's family of measures for dual eligible beneficiaries based on changes in NQF-endorsed® portfolio of measures
- Develop approach to engaging stakeholders in documentation of measure use and alignment
- Formulate recommendations to HHS about use of performance measurement and other strategies to ensure high-quality care for dual eligible beneficiaries

Day 1: April 10, 2014

8:30 am **Breakfast**

9:00 am **Welcome, Review of Meeting Objectives, and Disclosures of Interest**

Alice Lind, Workgroup Chair
Christine Cassel, President and CEO, NQF
Ann Hammersmith, General Counsel, NQF
Cheryl Powell, Centers for Medicare & Medicaid Services (CMS)

- Meeting objectives
- Renew disclosures of interest
- Recap key themes from March web meeting

9:45 am **Measure Gap: Goal-Directed, Person-Centered Care**

Sarah Scholle, NCQA

Erin Giovannetti, NCQA
Jessica French, NCQA

- Structures and workflows to support person-centered care
- Approaches for setting goals
- Documenting and measuring goal attainment
- Workgroup discussion

11:15 am **Break**

11:25 am **Continued Discussion of Goal-Directed, Person-Centered Care**

Wendy Prins, Senior Director, NQF
Lauralei Dorian, Project Manager, NQF

- Updates on related NQF projects
  - Prioritizing measure gaps
  - MAP Person- and Family-Centered Care Task Force
  - Person and Family-Centered Care endorsement project: PAM, CAHPS, and other survey tools
- Workgroup discussion

12:25 pm **Opportunity for Public Comment**

12:30 pm **Lunch**

1:15 pm **Measure Gap: Optimal Functioning**

Stacy Mandl, RN, Technical Advisor, CMS
Tara McMullen, MPH, PhD(c), Analyst, CMS
Anita Yuskauskas, PhD, Technical Director, CMS
Beth Demakos, Government Relations Manager, Uniform Data System for Medical Rehabilitation (UDSMR)

- CMS CARE tool
- UDSMR FIM System®
- What can be done to address this measure gap?
- Workgroup discussion

2:30 pm **Break**

2:45 pm **Measure Gap: Self-Determination and Non-Medical Supports/ Services**

Nancy Thaler, Executive Director, National Association of State Directors of Developmental Disabilities Services (NASDDDS)
Julie Bershadsky, Research Associate, Human Services Research Institute (HSRI)

- National Core Indicators: states' responses to public reporting of quality outcomes and testing expansion to aging and disability populations
- Explore contributions of the "dignity of risk" to person-centeredness and shared decisionmaking

- Workgroup discussion

3:55 pm **Opportunity for Public Comment**

4:00 pm **Summarize Progress and Adjourn for the Day**

Day 2: April 11, 2014

8:30 am **Breakfast**

9:00 am **Review Highlights from Previous Day**

Alice Lind

9:15 am **Measure Gap: Shared Decisionmaking about Medical Care**

Alice Lind

- View illustrative clips about clinical shared decisionmaking
- How should high quality care be defined in this context?
- What can be done to address this measurement gap?
- Workgroup discussion

11:00 am **Break**

11:15 am **Consider Updates to Family of Measures Based on Changes in NQF Portfolio**

Alice Lind
Megan Duevel Anderson, Project Analyst, NQF

- Measures with endorsement removed
- Newly endorsed measures
- Revisit prioritized gaps

12:25 pm **Opportunity for Public Comment**

12:30 pm **Lunch**

1:00 pm **Develop Research Questions to Guide Construction of Stakeholder Feedback Loop**

Alice Lind
Sarah Lash, Senior Director, NQF

- Information priorities for measure alignment
- Approach to involving stakeholder groups
- Workgroup discussion

2:30 pm **Round-Robin Discussion of Topics for Future Work and Themes for Next Report**

3:15 pm **Opportunity for Public Comment**

3:30 pm **Next Steps and Adjourn**

Measure Applications Partnership

Dual Eligible Beneficiaries Workgroup In-Person Meeting

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Welcome

Meeting Objectives

- Discuss priority measure gap areas in detail, exploring targeted activities to promote progress
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- Develop approach to engaging stakeholders in documentation of measure use and alignment through feedback loops
- Formulate recommendations to HHS about use of performance measurement and other strategies to ensure high-quality care for dual eligible beneficiaries

Day 1 Agenda

- Welcome, Review of Meeting Objectives, and Disclosures of Interest
- Measure Gap: Goal-Directed, Person-Centered Care
- Opportunity for Public Comment
- Measure Gap: Optimal Functioning
- Measure Gap: Self-Determination and Non-Medical Supports/Services
- Opportunity for Public Comment

Disclosures of Interest

Dual Eligible Beneficiaries Workgroup Membership

Workgroup Chair: Alice Lind, MPH, BSN

Organizational Members

American Association on Intellectual and Developmental Disabilities	Margaret Nygren, EdD
American Federation of State, County and Municipal Employees	Sally Tyler, MPA
American Geriatrics Society	Jennie Chin Hansen, RN, MS, FAAN
American Medical Directors Association	Gwendolen Buhr, MD, MHS, MEd, CMD
America's Essential Hospitals	Steven Counsell, MD
Center for Medicare Advocacy	Alfred Chiplin Jr., Esq, JD, MDiv
Consortium for Citizens with Disabilities	E. Clarke Ross, DPA
Humana, Inc.	George Andrews, MD, MBA, CPE
L.A. Care Health Plan	Representative to be determined
National Association of Social Workers	Joan Levy Zlotnik, PhD, ACSW
National Health Law Program	Leonardo Cuello, JD
National PACE Association	Adam Burrows, MD
SNP Alliance	Richard Bringewatt

Dual Eligible Beneficiaries Workgroup Membership

Subject Matter Experts

Substance Abuse	Mady Chalk, MSW, PhD
Disability	Anne Cohen, MPH
Emergency Medical Services	James Dunford, MD
Care Coordination	Nancy Hanrahan, PhD, RN, FAAN
Medicaid ACO	Ruth Perry, MD
Measure Methodologist	Juliana Preston, MPA
Home & Community Based Services	Susan Reinhard, RN, PhD, FAAN
Mental Health	Rhonda Robinson-Beale, MD
Nursing	Gail Stuart, PhD, RN

Federal Government Members

Agency for Healthcare Research and Quality	D.E.B. Potter, MS
CMS Federal Coordinated Healthcare Office	Cheryl Powell
Health Resources and Services Administration	Samantha Meklir, MPP
Administration for Community Living	Jamie Kendall
Substance Abuse and Mental Health Services Administration	Lisa Patton, PhD
Veterans Health Administration	Daniel Kivlahan, PhD

Social Media Guidelines

- NQF will tweet to advertise today's conversation
- Workgroup members and the public can join in using hashtag #NQFMAP
- Staff may read tweets received in response during public comment periods
- Follow NQF @NatQualityForum

Join the National Quality Forum interest group

Themes of March Web Meeting

- Further explored key issues in quality of life
- Discussed HCBS rule that incorporated opportunities to support individuals achieving best possible quality of life
  - Workgroup supports provisions for person-centered planning
  - Balance should be found between protecting choices and 'dignity of risk', while protecting vulnerable individuals
- Determined all parts of the health and human services system have accountability for quality of life for beneficiaries
  - Responsibility for quality of life overlaps and varies with populations and individuals served

Measure Gap: Goal-Directed, Person-Centered Care

Prioritized Measure Gaps

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

Goal-Directed, Person-Centered Care and Goal Attainment

April 10, 2014

NCQA
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Overview

- Model for evaluating quality
- Developing new performance measures
  - Assessment and care planning
  - Goal assessment and achievement
- Discussion and feedback

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Person-centered care for Medicare-Medicaid beneficiaries

- Consumer/family perspective
- Coordination of care team across settings
- Issues common across subgroups of dual-eligible population
- Aspirational

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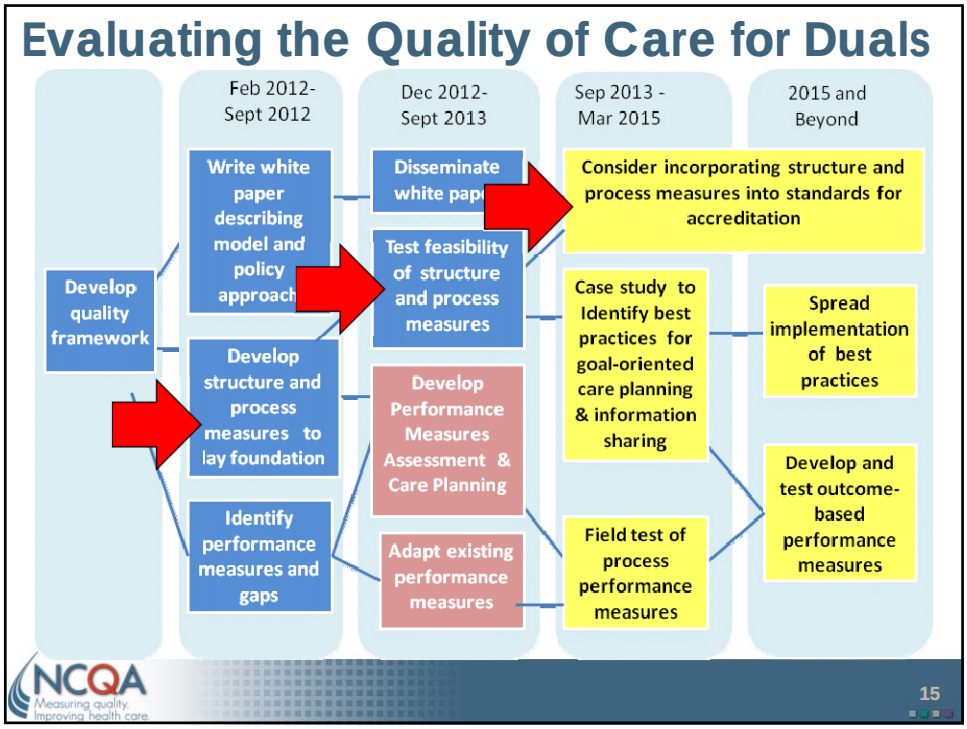
Evaluating the Quality of Care for Duals
Feb 2012-Sept 2012
Dec 2012-Sept 2013
Sep 2013 - Mar 2015
2015 and Beyond
Develop quality framework
Write white paper describing model and policy approach
Develop structure and process measures to lay foundation
Identify performance measures and gaps
Disseminate white pap
Test feasibility of structure and process measures
Develop Performance Measures Assessment & Care Planning
Adapt existing performance measures
Consider incorporating structure and process measures into standards for accreditation
Case study to Identify best practices for goal-oriented care planning & information sharing
Field test of process performance measures
Spread implementation of best practices
Develop and test outcome-based performance measures
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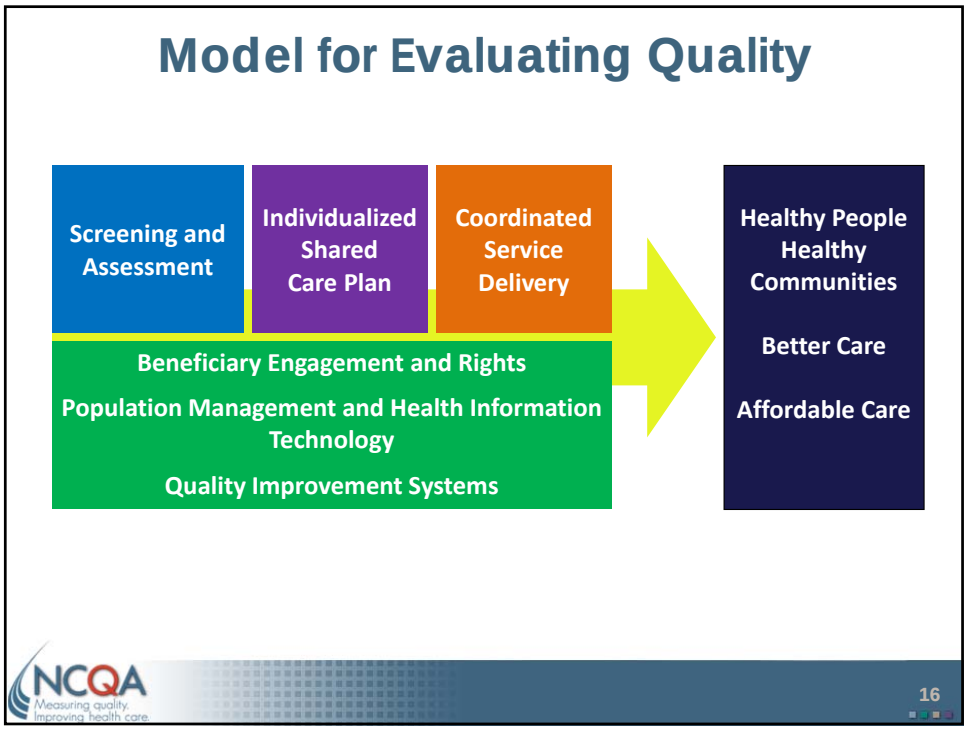
Model for Evaluating Quality
Screening and Assessment
Individualized Shared Care Plan
Coordinated Service Delivery
Beneficiary Engagement and Rights
Population Management and Health Information Technology
Quality Improvement Systems
Healthy People Healthy Communities
Better Care
Affordable Care
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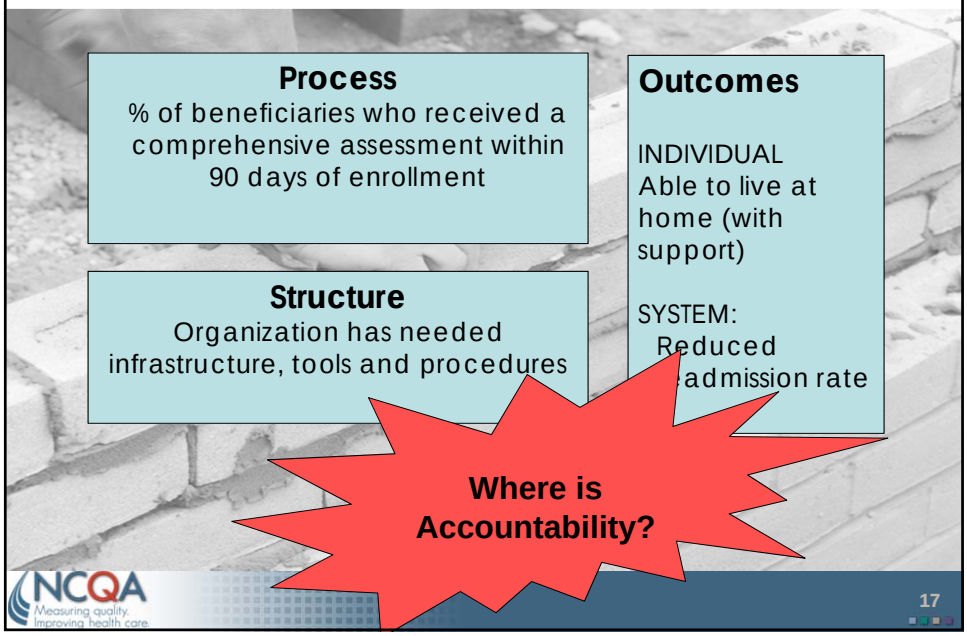
Example: Screening and Assessment



Field Test: Goal Setting Approaches Vary

- **Some organizations identified goals from the assessment**
  - **Any identified need → goal**
  - **Goals often clinical (blood pressure, HbA1c)**
- **Others started with goals generated from the assessment, and negotiated priorities**
- **Fewer asked the person**
  - **Often personal vs. purely clinical (attend church, get out in the community)**

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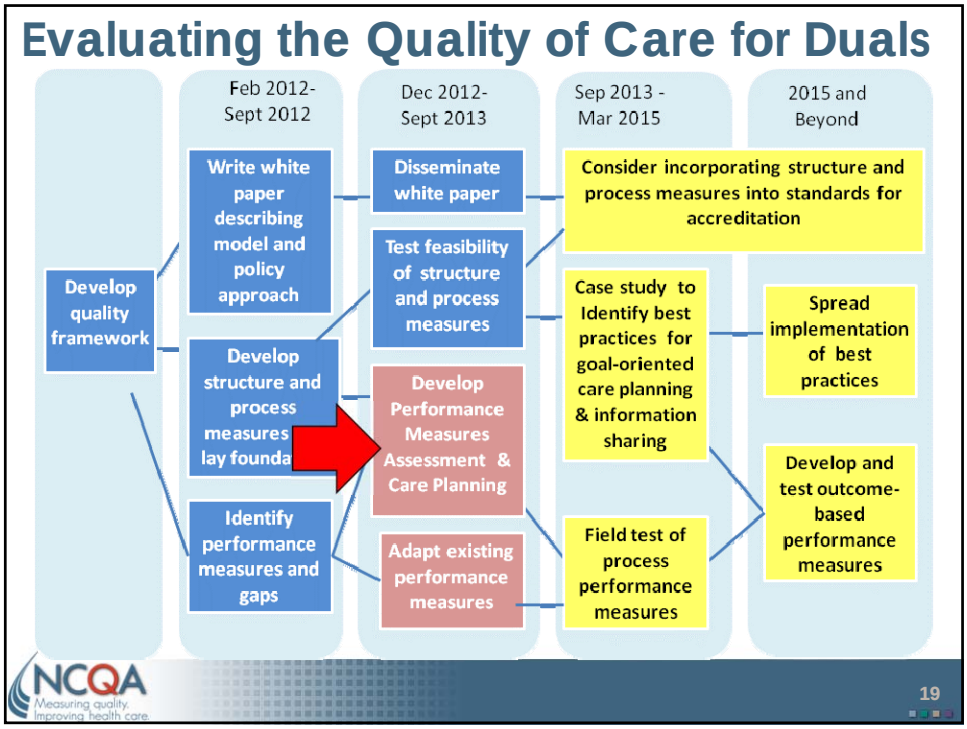
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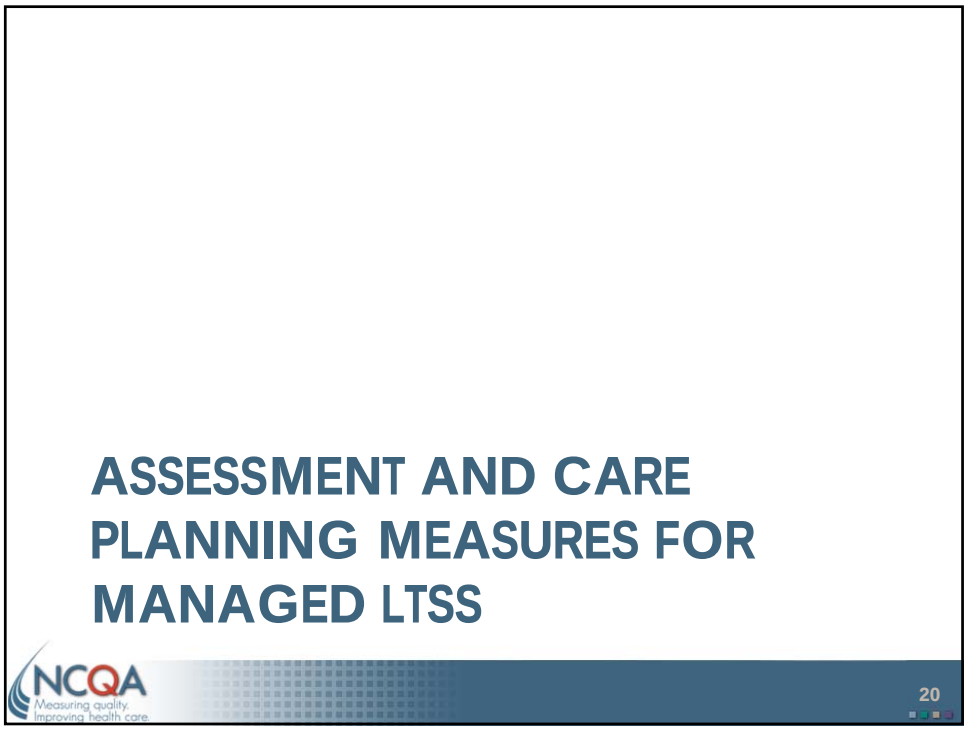
ASSESSMENT AND CARE PLANNING MEASURES FOR MANAGED LTSS
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Measures for Managed Long Term Services and Supports

- Assessment Composite
- Care Plan Composite
- Shared Care Plan
- Assessment Update
- Care Plan Update
- Re-assessment and care plan update after discharge

Assessment Composite

Description: The percentage of newly enrolled MLTSS beneficiaries who have documentation of an in-home assessment with the following components within 90 days of enrollment.

- Assessment of all core domains: Physical functioning and disability, medical conditions, mental and behavioral health, needs and risks, social support, preferences and use of services
- Documentation of involvement of family member, caregiver, guardian, or power of attorney in assessment (with beneficiary consent)

- Exclude beneficiaries who refuse assessment

Care Plan Composite

Description: The percentage of newly enrolled MLTSS beneficiaries who have documentation of a care plan developed face-to-face within 30 days of completed assessment.

- Documentation of beneficiary needs in core domains
- Documentation of beneficiary goals of care and identified barriers to meeting goals.
- Documentation of service plan and providers of services addressing needs including frequency and duration of service.
- Beneficiary signature or that of their guardian or power of attorney (POA)
- Signature of family member or caregiver (if applicable and with beneficiary consent)

Shared Care Plan

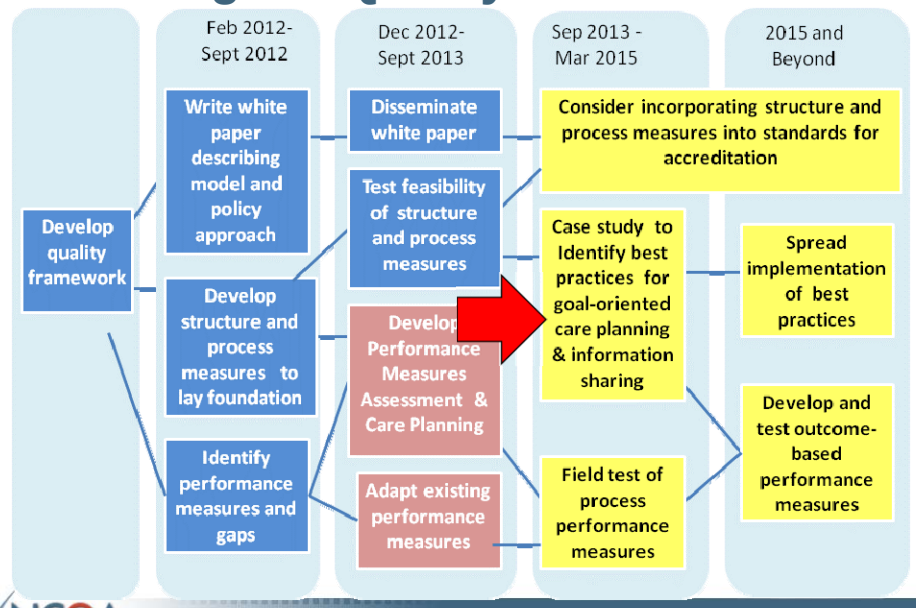
Description: The percentage MLTSS beneficiaries with a care plan for whom all or part of the care plan was transmitted to key long-term services and supports providers and the primary care provider within 30 days of development or update.

- Draft definition of key providers
  - PCP should always receive
  - **Included**: Physical or occupational therapy, skilled nursing, or personal care in the home
  - **Excluded**: Meal delivery, medical supply delivery, homemaker and other services not providing hands-on patient care

Key Decision Points

- Time frame
- Involvement of caregivers
- Mode of assessment and care planning
- No exclusions for not able to contact
- Qualified personnel
- Key providers who should receive elements of the shared care plan

Evaluating the Quality of Care for Duals



CASE STUDY PROJECT

Study Aims

- **Identify best practices in:**
  - **Sharing information about goals, assessment and care plans across providers and settings**
  - **Assessment of person-centered goals and goal attainment**

Study Methods

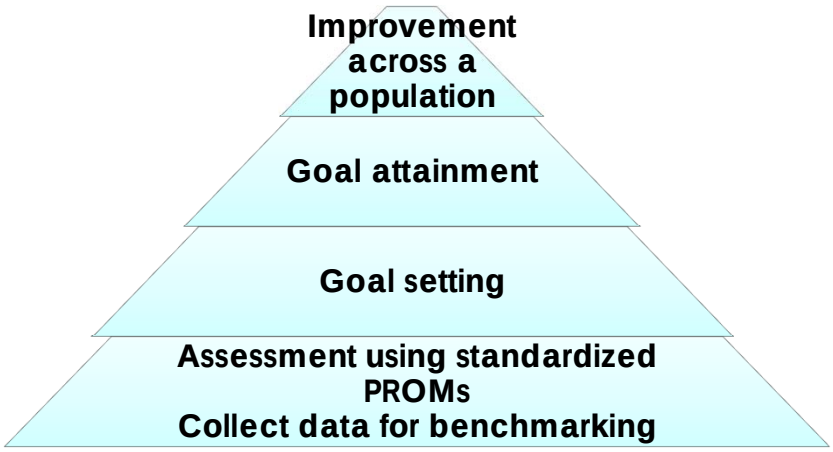
- Case study format
- 8 organizations that provide integrated care (medical/behavioral or medical/LTSS)
- First site visits
  - Interviews, observation and document review
- Second site visits
  - Linked interviews with providers, patients and caregivers, and record review

GOAL SETTING USING PATIENT-REPORTED OUTCOME MEASURES

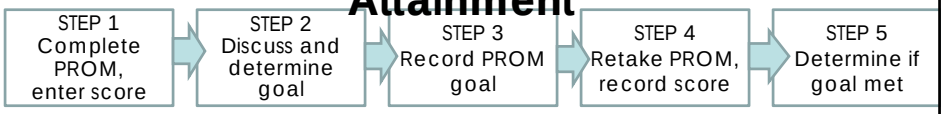
Goal Setting Using Patient-Reported Outcome Measures (PROMs)

- **E-measures for use in Meaningful Use and other CMS eligible professional programs**
  - Hip and knee replacement
  - Congestive heart failure
  - Asthma, rheumatoid arthritis, pain
- **Use validated tools (e.g. PROMIS) to measure outcomes over time**
- **Performance measure looks for attainment of jointly agreed upon goals as measured by patient-reported outcome measure.**

Building to Outcomes: Performance Measures Based on Patient-Reported Outcome Measures (PROMs)



Measuring Goal-Setting and Goal Attainment



- Which PROM?
- How and where is PROM completed?
- Global score?
- Subscale?
- Item?

- Is it possible to relate a qualitative discussion to a PROM score?
- Should we measure one goal or more than one?
- If more than one, should we ask for "importance" and "difficulty"?

- Should we capture the interventions related to achieving the goal?
- If so, how do we do this with structured data?

- What is the appropriate time interval?
- Should it vary by condition?
- If so, how do we do this with structured data?

- May need "yes/no" as well as score

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Patient Focus Groups: Reactions to PROMs and goal-setting

- **Focus groups on goal setting using PROMs for people with different conditions**
- **Very positive responses from participants**
- **"I want the doctor to tell me what the score means to him"**
- **"good way to communicate with doctor"**

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SUMMARY & DISCUSSION

Structure, process & outcome measures all have their place

- Structure and Process measures
- are "building blocks"

- Accountability differs

Next Steps

- **Understanding how individuals and their care team collaborate to identify goals is critical next step**
  - **How to use patient-reported outcomes**
  - **How to align clinical goals with what matters to people**
  - **How to measure and when to hold organizations accountable**

Continued Discussion of Goal-Directed, Person-Centered Care

PFCC: Project Scope

- This multi-phase project will review person and family centered care measures for endorsement
  - Phase 1
    - » Experience of care measures
  - Phase 2
    - » Health-related quality of life, including functional status and clinician-assessed function
  - Phase 3
    - » Patient Communication and symptom/symptom burden

Phase 1 Measures – CAHPS Measures

- 14 CAHPS Surveys
  - Adult/Pediatric/Specialist Care Survey
  - Health Plan Survey
  - Health Plan Survey for Children with Chronic Decisions
  - Hospital Survey
  - Home Health Care Survey
  - Nursing Home Survey for Patients
  - Nursing Home Survey for Family Members

Phase 1 Measures – Other Measures

- Young Adult Health Care Survey (Oregon Health & Science University)
- Promoting Health Development Survey (Oregon Health & Science University)
- Family Evaluation of Hospice Care (National Hospice and Palliative Care Organization)
- Validated family-centered survey questionnaire for parents' and patients' experiences during inpatient pediatric hospital stay (Children's Hospital, Boson)
- Inpatient Consumer Survey of Inpatient Behavioral Healthcare Services (National Association of State Mental Health Program Directors Research Institute)
- Bereaved Family Survey (PROMISE Center)
- CARE – Consumer Assessments and Reports of End of Life (Center for Gerontology and Health Care Research)

PROs

- Definition: "Any report of the status of a patient's health condition that comes directly from the patient."
- Two major challenges to using them for purposes of accountability and performance improvement:
  - They are not in widespread use in clinical practice.
  - Little is known about aggregating these PROs for measuring performance of the healthcare entity delivering care.
- PRO 2012 Project and Report

Distinctions among PRO, PROM, and PRO-PM:

Concept	Patients with Clinical Depression
PRO (patient-reported outcome)	Symptom: depression
PROM (instrument, tool, single-item measure)	PHQ-9©, a standardized *tool* to assess depression
PRO-PM (PRO-based performance measure)	Percentage of patients with diagnosis of major depression or dysthymia and initial PHQ-9 score >9 with a follow-up PHQ-9 score <5 at 6 months (NQF #0711)

PFCC Phase 1: Project Timeline

- Measure submission deadline: May 19, 2014
- In-person meeting: July 28-29, 2014
- Comment: September 4 – October 5, 2014
- Vote: November 7 – November 21
- CSAC/Board: December, 2014
- Appeals: January 6 – February 3

Endocrine Project Contacts

- Senior Director: Karen Pace
- Project Manager: Lauralei Dorian
- Project Analyst: Kaitlynn Robinson-Ector

- Project web page: www.qualityforum.org/projects/person_family_centered_care
- Project email: pfcc@qualityforum.org

Workgroup Discussion

- Are there questions for the presenter?
- What guidance would the workgroup offer for developing and endorsing new performance measures in this critical gap area?
- Are you aware of measures in use or under development in this topic area that need to be connected to NQF efforts?

Prioritizing Measure Gaps:

Person-Centered Care and Outcomes

Specific Tasks for Person-Centered Care and Outcomes Priority Setting Project

1. Convene a multistakeholder committee of experts including patients and patient advocates
2. Identify existing models and core concepts as a basis for envisioning the ideal state or "north star" of person-centered care
   - Draft definition and draft core concepts
3. Seek input from patients (and families) on what information (i.e., performance measures) would be useful for assessing person-centered care (i.e., "nutrition label" or dashboard of person-centered care).
   - Explore what already has been done by groups such as the Institute for Patient and Family Centered Care and Patients Like Me to find out what matters most to patients and families
   - Explore whether there are any existing measures/tools used by patient advocacy groups for assessing person centered care

Specific Tasks for Person-Centered Care and Outcomes Priority Setting Project

4. Conduct an environmental scan of potential performance measures, status of development, and alignment with concepts of person-centered care
   - Draft environmental scan
   - Input of this committee and prior PRO Expert Panel to identify examples where measurement of performance on person-centered care is occurring
5. At the in-person meeting, review the above inputs and create the vision of the ideal state or "north star" of person-centered care and identify how best to measure performance and progress in the delivery of person-centered care.
6. Based on the ideal person-centered care, recommend specific measures for implementation or specific concepts for development of performance measures
   - Short-term and longer-term recommendations
7. Obtain public comment, and then finalize recommendations.

Draft Definition for Person- and Family-Centered Care

Person- and Family-Centered Care is:

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

Draft Core Concepts

1. My care partners strive to know me as a whole person and take into account my priorities and goals for physical, mental, spiritual, and social health.
2. I receive the care I need – no more, no less- when, where, and how I prefer.
3. My care partners treat me and my family with respect, dignity, and compassion.
4. I collaborate in decisions about my care to the extent I desire or am able, or I choose the care partner I prefer to collaborate in those decisions for me.
5. My family care partners include those I choose and their role is supported by other care partners.

Draft Core Concepts- Cont'd

6. My care partners provide information, in a format I prefer, to:
   - answer my questions and help me understand my choices – about my health, health problem, treatment, care, costs, or providers; and
   - increase my confidence and capacity to care for myself to the extent I am able.
7. My care partners value my time and use if efficiently and effectively.
8. Communication with and among my care partners is honest, transparent, and coordinated across settings and time.

MAP Person- and Family-Centered Care and Outcomes

Family of Measures

Task Force Charge and Timeline

March 26: Task Force Web Meeting	• Identify the high-leverage improvement opportunities for person-and family-centered care
May 12: Task Force In-Person Meeting	• Identify measures for inclusion in the family • Identify and prioritize gaps • Identify implementation barriers
June 1-23: Public Comment Draft Report	• Draft report posted to NQF website for a three-week public comment period
June 20: MAP Coordinating Committee Web Meeting	• Review and finalize recommendations
July 1: Final Report	• Submit final report to HHS

Potential High-Leverage Opportunities/Measurement Areas

High-Leverage Opportunities	Measurement Areas
Experience of care (patients, families, caregivers)	• CAHPS • Satisfaction with care • Dignity, respect, compassion • Care coordination
Health-related quality of life	• Functional and cognitive status (assessment and improvement) • Mental health (assessment and improvement) • Physical, social, emotional, and spiritual support and well-being
Burden of illness	• Symptom and symptom burden (e.g., pain, fatigue, dyspnea) • Treatment burden (patients, family/caregiver, sibling, community)
Shared decision-making	• Patient, family and caregiver, and provider communication • Establishment and attainment of patient/family/caregiver goals • Advance care planning • Care concordant with individual values and preferences
Patient navigation and self-management	• Patient activation • Health literacy and cultural and linguistic competency • Caregiver needs and supports

Workgroup Discussion

- Are there questions for the presenter?
- Comments or guidance from workgroup members participating on the MAP Task Force?
- Are you aware of measures in use or under development in this topic area that need to be connected to NQF efforts?

Opportunity for Public Comment

Measure Gap: Optimal Functioning

The Continuity Assessment Record and Evaluation (CARE) Tool and Functional Status Quality Measures

Stella Mandl, RN, Technical Advisor

Tara McMullen, MPH, PhD(c), Analyst

Anita Yuskauskas, PhD, Technical Director

Data Assessment Elements Goal

When we keep in mind the ultimate goal of

quality care for all

and step back to look at the big picture of what's been done to prepare, it becomes clearer where the work converges; how much of the work is connected and has already been done to achieve

quality care for all

Achieving Uniformity to Facilitate Effective Communication for Better Care of Individuals and Communities

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CARE: Background

- **2000: Benefits Improvement & Protection Act (BIPA)**
  - mandated standardized assessment items across the Medicare program, to supersede current items
- **2005: Deficit Reduction Act (DRA)**
  - Mandated the use of standardized assessments across acute and post-acute settings
  - Established Post-Acute Care Payment Reform Demonstration (PAC-PRD) which included a component testing the reliability of the standardized items when used in each Medicare setting
- **2006: Post-Acute Care Payment Reform Demonstration requirement:**
  - Data to meet federal HIT interoperability standards

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CARE: *Concepts*

Guiding Principles and Goals:

Assessment Data is:

- Standardized
- Reusable
- Informative
- Communicates in the same information across settings
- Ensures data transferability forward and backward allowing for interoperability

Standardization:

- Reduces provider burden
- Increases reliability and validity
- Offers meaningful application to providers
- Facilitates patient centered care, care coordination, improved outcomes, and efficiency
- Fosters seamless care transitions
- Evaluates outcomes for patients that traverse settings
- Allows for measures to follow the patient
- Assesses quality across settings, and Inform payment modeling

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Keeping in Mind, the Ideal State

- Facilities are able to transmit electronic and interoperable Documents and Data Elements
- **Provides convergence** in language/terminology
- Data Elements used are **clinically relevant**
- Care is coordinated using **meaningful information** that is spoken and **understood by all**
- Measures **can evaluate quality across settings and** evaluate **intermittent and long term outcomes**
- **Measures follow the person**
- **Incorporates** needs **beyond healthcare system**

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CMS Vision for Quality Measurement

- Align measures with the **National Quality Strategy and Six Measure Domains**
- Implement measures that **fill critical gaps** within the six domains
- Develop parsimonious sets of measures - **core sets of measures**
- Remove measures that are no longer appropriate (e.g., topped out)
- Align measures with external stakeholders, including private payers and boards and specialty societies
- Continuously improve quality measurement over time
- **Align measures across CMS programs whenever and wherever possible**

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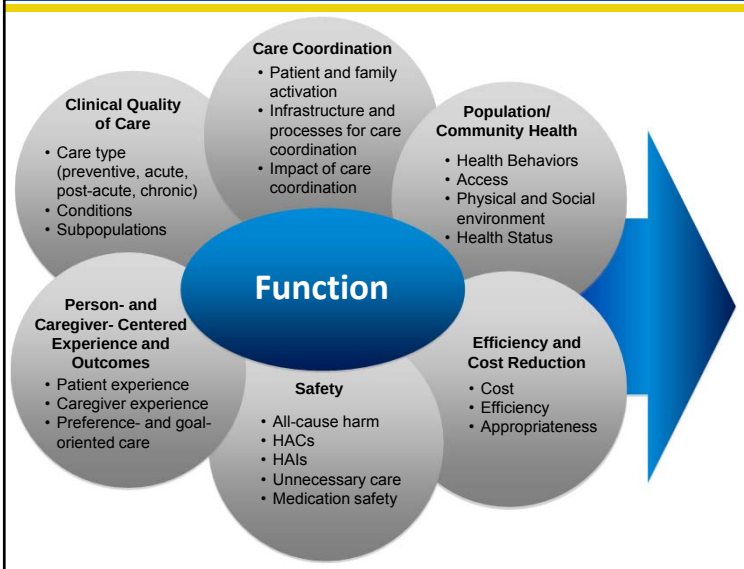
CMS Framework for Measurement



- **Measures should be patient-centered and outcome-oriented whenever possible**
- **Measure concepts in each of the six domains that are common across providers and settings can form a core set of measures**

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Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014

- Requires Standardized Patient Assessment Data that will enable Medicare to:
  1. Compare quality across PAC settings
  2. Improve hospital and PAC discharge planning
  3. Use this information to reform PAC payments (via site neutral or bundled payments or some other reform) while ensuring continued beneficiary access to the most appropriate setting of care.
- Patient Assessment Data Requirement for **Inpatient Hospitals** (medical condition, functional status, cognitive function, living situation, access to care at home, and any other indicators necessary for assessing patient need)

Functional Status

- Function is a measurement area that touches on all 6 Priorities.
- Functional status is relevant to all settings:
  - High priority to consumers
  - Specialized area of care provided by post-acute care providers, including IRFs, LTCHs, SNFs, and HHAs
  - Long term outcomes link to function
- Functional Status data are collected by post acute care providers for payment and quality monitoring: IRFs (payment), SNFs (payment), LTCHs (risk adjustor for quality) and HHAs (payment and quality).
- However, functional status data are currently setting-specific and are not easily compared.

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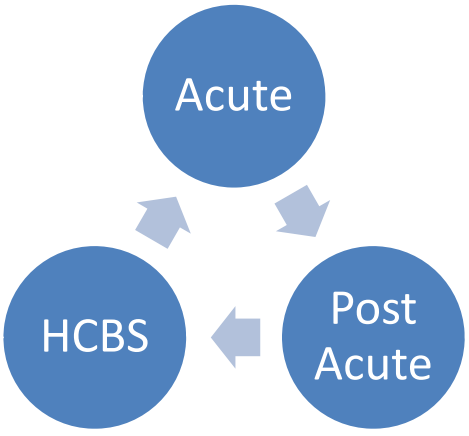
Standardizing Function



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Measures in Development

- **IRF** Functional Outcome Measure: Change in self-care score for medical rehabilitation patients.
- **IRF** Functional Outcome Measure: Change in mobility score for medical rehabilitation patients.
- **IRF** Functional Outcome Measure: Discharge mobility score for medical rehabilitation patients.
- **IRF** Functional Outcome Measure: Discharge self-care score for medical rehabilitation patients.
- Percent of **LTCH** patients with an admission and discharge functional assessment and a care plan that addresses function.
- **LTCH** Functional Outcome Measure: Change in mobility among patients requiring ventilator support.

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Functional Status Quality Measures

- Data collection using the CARE Item Set occurred as part of the Post Acute Care Payment Reform Demonstration and included 206 acute and PAC providers

  http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-Quality-Initiatives/CARE-Item-Set-and-B-CARE.html

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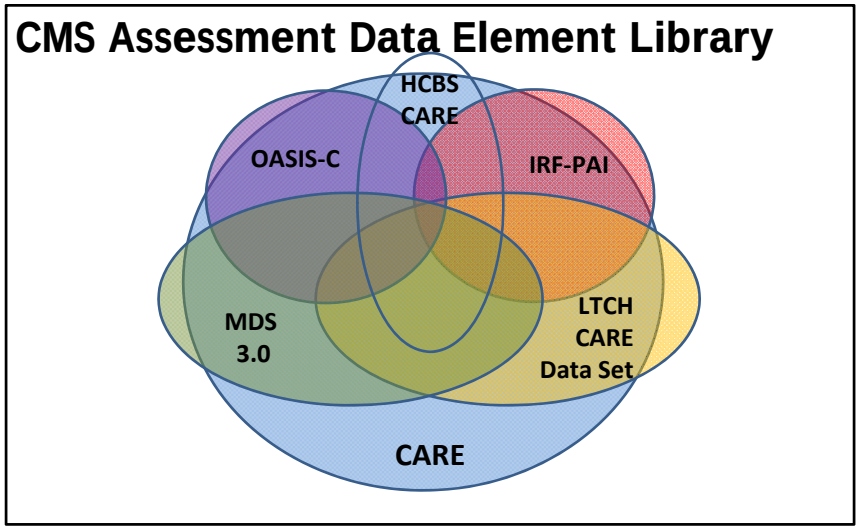
CMS Library Concept & CARE



CMS Vision for Quality Measurement

- Align measures with the **National Quality Strategy and Six Measure Domains**
- Implement measures that **fill critical gaps** within the six domains
- Develop parsimonious sets of measures - **core sets of measures**
- Remove measures that are no longer appropriate (e.g., topped out)
- Align measures with external stakeholders, including private payers and boards and specialty societies
- Continuously improve quality measurement over time
- **Align measures across CMS programs whenever and wherever possible**

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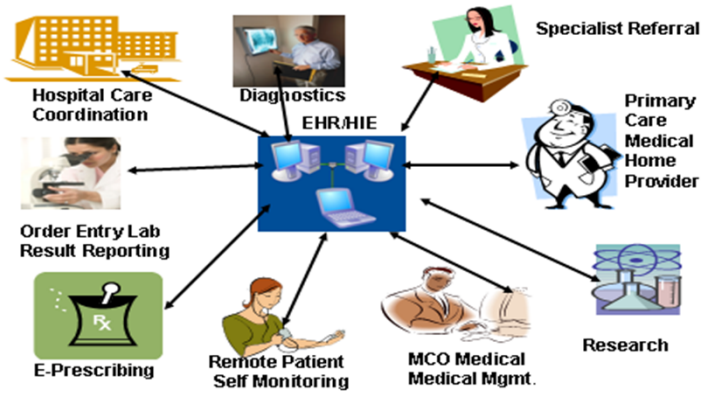
CMS Vision for MU



TEFT Grant Program – Addresses the Vision

Four Components of TEFT

- Test an experience of care survey
- **Test a set of data elements from the functional domain in the Continuity Assessment Record & Evaluation (CARE)**
- Demonstrate personal health records with guidance from the Department of Defense (DoD)
- Identify, evaluate and harmonize standards for electronic long term services and supports (e-LTSS) records in conjunction with the Office of National Coordinator's (ONC) Standards and Interoperability (S&I) Framework

Expansion of CARE to CB-LTSS

Goals for expanding CARE items to CB-LTSS:

- Standardizes assessment concepts across populations and settings of care
- Supports person centered care through transitions
- Facilitates quality monitoring across providers and settings
- Leverages existing standards developed for the interoperable exchange of CARE items, specifically function
- Achieves other administrative benefits such as
  - Aligns with Balancing Incentive Program (BIP) requirements
  - Reduces costs to develop assessment tools
  - Reduces data collection burden
  - Increases ability to report data to CMS
  - Supports bundled payment initiatives

UDSMR FIM® System

The FIM® Instrument

Uniform Data System for Medical Rehabilitation

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History of the FIM® Instrument and Role of UDSMR in Rehabilitation Outcomes

- FIM® instrument and UDSMR developed from a federal grant obtained by researchers from University at Buffalo 27 years ago
  - Original instrument:
    - 18-item (13 motor, 5 cognitive)
    - 4-level (expanded to 7-level for sensitivity)
    - Multidisciplinary
    - Used to assess patient functional status
    - Used by rehabilitation facilities to assess quality outcomes
    - Measures **BURDEN OF CARE** (amount of assistance needed from another person to carry out usual activities of daily living)

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The FIM® Instrument- Past and Present

- FIM instrument or derivative has been used across all venues of care: Acute–PAC- HH
  - Low administrative burden
  - Harmonized- measures same items in the same way in all venues
- Used as part of prospective payment, resource utilization
- Used on all payer populations (Medicare, Medicaid, Veterans Services, Commercial Insurance, Workers Compensation, Private Pay) and all ages (not just age 65+)
- Large historical data repository containing millions of cases
- Severity adjusted- can be adjusted in the acute care so 'like' patients headed to different PAC venues can be compared

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Reliability and Validity

- FIM® instrument has been demonstrated reliable and valid (hundreds of peer reviewed journal articles)
- Demonstrated Content, Construct, Discriminant and Predictive Validity
  - Resource use, functional gain, discharge placement, re-hospitalization, comparative effectiveness
- Referenced over 30 times by RTI in their CARE report to ASPE and FIM data was a significant portion of the CARE report statistical data analysis

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Brief Summarization

- **Considerable science, field experience and utility associated with the FIM® instrument**
  - Nationally recognized (currently used in **all IRFs through royalty free license to CMS for PPS use)**
  - Measures burden of care – directly tied to cost
  - Valid, reliable, and has proven utility to 'get the right patient to the right place at the right time'
  - Demonstrated use for:
    - (1) cost containment needs by Medicare
    - (2) measuring and reporting quality of rehabilitation healthcare nationally
    - (3) serving as an integral, functional component in a value-based purchasing model

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Workgroup Discussion: Functional Status

- Questions for any of the presenters?
- What guidance would the workgroup offer for developing and endorsing new performance measures in this critical gap area?
- Are you aware of measures in use or under development in this topic area that need to be connected to NQF efforts?

Measure Gap: Self-Determination and Non-Medical Supports and Services

National Core Indicators:

Measuring the Performance and Outcomes of State ID/DD Services

National Quality Forum
April 10, 2014

Nancy Thaler, Executive Director, NASDDDS
Julie Bershadsky, Research Associate, HSRI

NASDDDS/HSRI

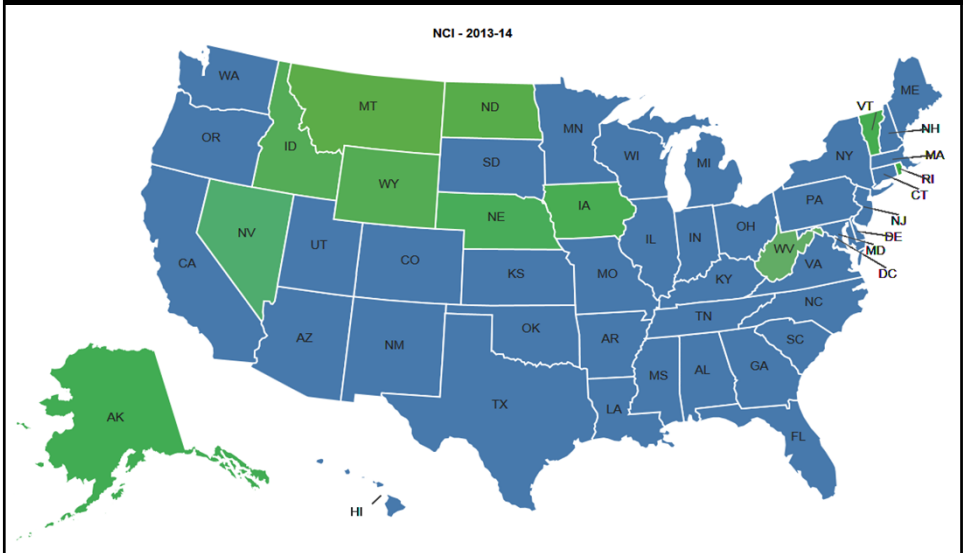
- What is NCI
- How states use NCI
- How others use NCI
- Expansion of NCI-AD

NCI Overview

NCI is a performance measurement system that enable states to make policy and funding decisions to support practices that work for people.

- Launched in 1997 in 13 participating states
- 40 states (including D.C.) and 22 sub-state regions and counties participate
- Data collected annually on 12,000-20,000 people
- Unparalleled 17-year database
- Collaboration between NASDDDS – HSRI – participating state DD agencies

NCI PARTICIPATING STATES



NCI Measures Offer a Unique View

- Person-centered
- Individual characteristics of people receiving services
- The locations where people live
- The activities they engage in during the day including whether they are working
- The nature of their experiences with the supports that they receive (e.g., with case managers, ability to make choices, self-direction)
- The context of their lives – friends, community involvement, safety
- Health and well-being, access to healthcare

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NCI Data Sources

- **Consumer Survey**
  - ✓Random sample of adults
  - ✓In person interviews

- **Family Survey** (mail-in)
  - ✓Adult Family Survey (at home, 18+) JE5
  - ✓Family Guardian Survey (out-of-home)
  - ✓Children Family Survey (at home, <18) JE6

NCI System Performance Measures

Individual Outcomes

- Employment
- Community Participation
- Choice & Decision making
- Personal Relationships

Family Outcomes

- Choice and Control
- Family Involvement
- Information & Planning
- Access, community connections
- Response

Health, Welfare, System

- Health and Welfare
- Respect for Rights
- Medications
- Safety
- Service Coordination
- Staff Stability

National Core Indicators Design

Valid

- Measure what is intended to be measured

Reliable

- Provide consistent results over time and interviewers

Risk Adjusted

- Provides multiple state comparisons

Ways States Use NCI Data

- Quality Assurance and Service Improvement
- Meet CMS Waiver Reporting Requirements
- Compare performance to other states
- Public Accountability – to elected officials, stakeholders and the public

Examples of How States Use NCI Data

New York
- Publishes comparison data against other states
- Targets campaigns to decrease obesity rates

Georgia
- Initiative to reduce the use of psychotropic medication

Arizona
- Prioritizes efforts on case manager choice, health, loneliness, employment

Kentucky
- Issues formal report on service quality and community participation

Washington State
- Issues report back on strategies to address recommendations.

Massachusetts
- Tracks and acts on health and wellness and safety data

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Findings from Georgia Use of Psychotropic Medications

Findings on Psychotropic Drug Use

- NCI Data Brief released in 2012:
  - 53% were taking medication to address at least one of:
    - Mood disorders
    - Anxiety
    - Psychotic disorders
    - Behavior challenges

Taking meds was related to living in group homes, poorer health, overweight and obesity

JE8

Findings on Psychotropic Drug Use

- 88% with psychiatric diagnosis taking med for mood, anxiety or psychotic disorders
- BUT 30% without diagnosis also taking meds for at least one condition
- Of those taking meds for at least one condition, 41% did not have psychiatric diagnosis.

	Did not take medications for mood, anxiety or psychotic disorders	Took medications for mood, anxiety or psychotic disorders
No mental illness/ psychiatric diagnosis	70%	30%
Mental illness/ psychiatric diagnosis	12%	88%

Psychotropic Medication Use

These findings prompted GA to look at their data on psychotropic drug use:

- Georgia NCI data demonstrated an increase in proportion of individuals with I/DD who use these medications; from 36% in fiscal year 2005 – 2006 to 51% in fiscal year 2010-2011.

Georgia Study Findings

- Do IRTC individuals (leaving institutions) have a higher frequency of use than the established community population?
  - Percent of IRTC taking one or more psychotropic meds increase over 20 percentage points to 44% six months after transition.
  - Comparison population also increased but the magnitude was lower, 13 percentage points over the same time period.
- How many IRTC individuals were prescribed psychotropic meds for first time after transitioning?
  - 52 individuals (34%) after transition

Georgia Study Findings

- Has there been an increase in the percent of individuals prescribed this types of meds, particularly after transition to the community?
  - Average number of meds in IRTC group increased from .68 to 1.84 while the average for the Comparion Group increased from 1.01 to 1.98
  - Both are statistically significant changes, but the increase for the IRTC group was greater and faster than the Comparison Group

Georgia Study Findings

- Does higher frequency of use vary based on residential setting, gender, ethnicity, or disability type?
  - IRTC group – African American individuals showed a higher use of medication use than white individuals, both before and after transition.
  - Comparision Group – African Americans showed a lower use than white individuals
  - IRTC group – males had a higher use that females before and after transition. No diffence in the Comparison Group

Georgia Study Findings

- IRTC Group – individuals with profound intellectual disability (PID) had a lower frequency of use than people with mild to moderate disability.
- Comparision Group – individuals with PID had a higher frequency of use.
- IRTC Group – Percent of individuals taking at least one med increased substantially for individuals who moved into a group home or host home. 22% to 42%

Georgia: NEXT STEPS

- Increase Human Rights Councils
- Establish Medication Utilization Board
- Required pharmacy review for individuals on two or more psychotropic medications
- Analysis of current transitioning process

Psychotropic Medication Use

Results:

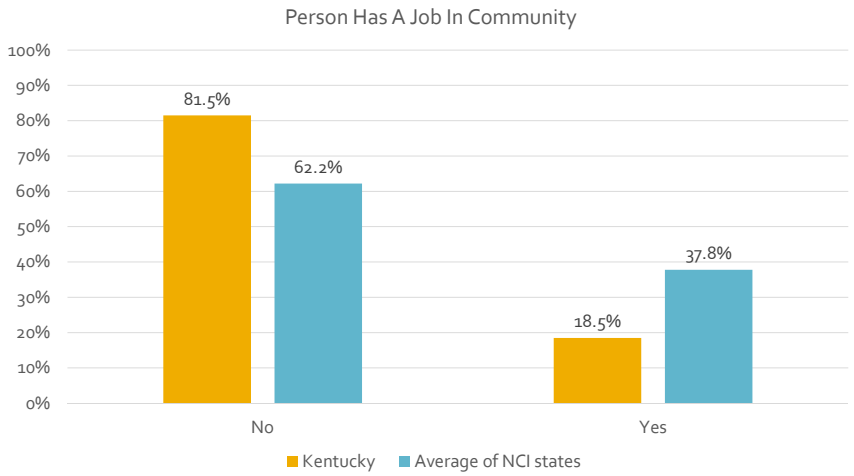
- Percentage dropped for first time in fiscal year 2011 – 2012 to 41%.

Findings from Kentucky

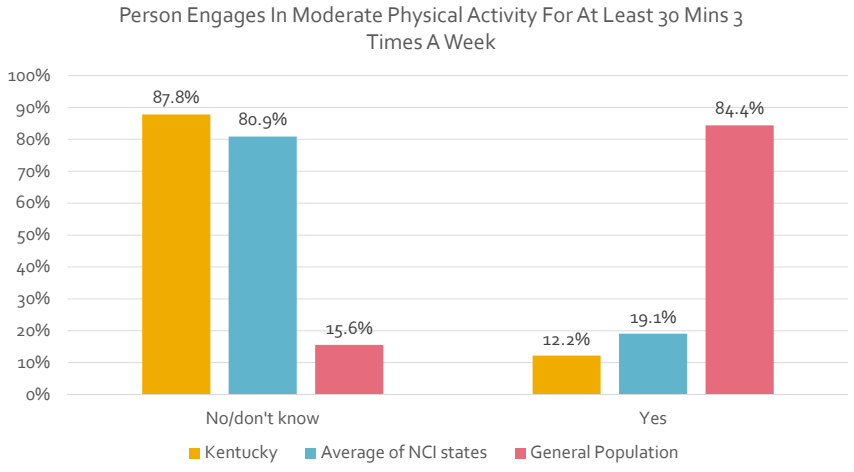
The Kentucky NCI Quality Improvement Committee

- Provides recommendations to KY state based on NCI data.
- Comprised of family members, people with disabilities, KY NCI staff and interviewers, providers, Division of Developmental and Intellectual Disabilities staff, and University of Kentucky researchers.
- The 2010 recommendation report was submitted to the Division of Developmental and Intellectual Disabilities in October, 2010.
- Update – 2013 report

KY: Some of the Data Examined 2010:



KY: Some of the Data Examined 2010:



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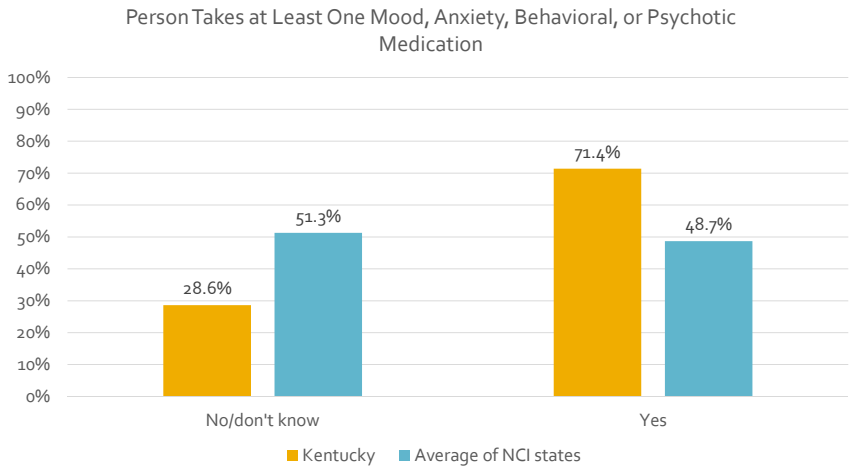
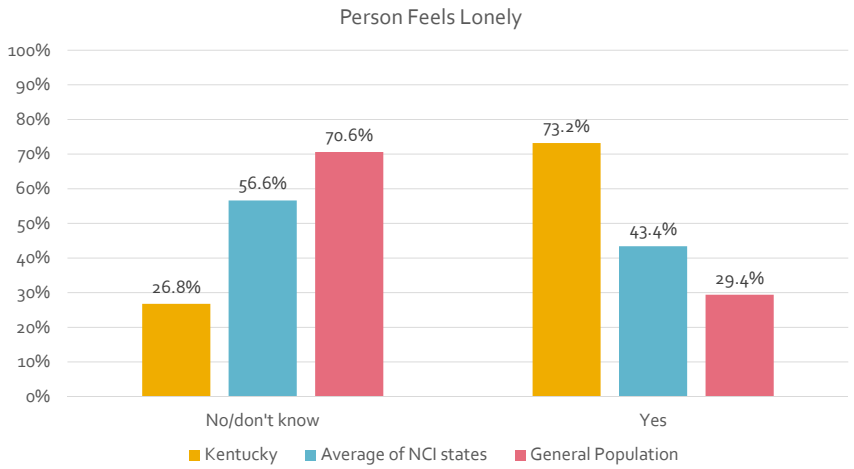


KY: Some of the Data Examined 2010:



KY NCI Quality Improvement Committee Recommendation Report, 2010

- **Goal 1: Employment -** Increase the overall percentage of SCL recipients with jobs in the community by 5% as reported in the next NCI 12 month data cycle.
- **Goal 2: Health & Exercise -** Increase the overall percentage of SCL recipients who engage in moderate physical activity for thirty minutes a day at least three times a week by at least 5%, as reported in the next NCI 12 month data cycle.
- **Goal 3: Medications -** Decrease the overall percentage of psychotropic medications used by SCL recipients in residential settings by 10%, as reported in the next NCI 12 month data cycle.
- **Goal 4: Loneliness -** Increase the overall percentage of SCL recipients who report having friends who are not staff or family by 10%, as reported in the next NCI 12 month data cycle.

http://www.belongingky.org/wp-content/uploads/2013/09/Recommendations-Report_2013final.pdf

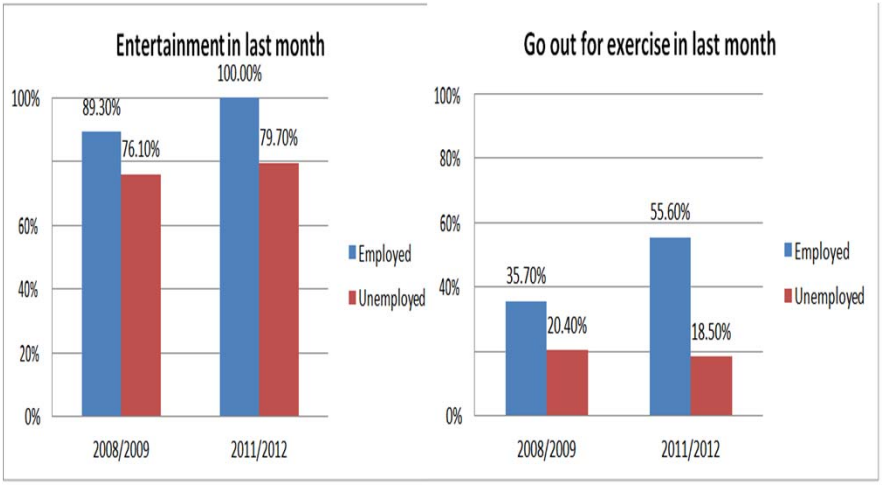
Efforts Related to Recommendation Report 2010

- **Example 1**: In response to the recommendation regarding **employment**
  - Waiver was revised and approved to reflect:
    - 1) a nearly 100% increase for the supported employment rate and,
    - 2) a decrease in the day activity services rate of 11%.
    - Collaboration with the Kentucky Office of Vocational Rehabilitation was increased

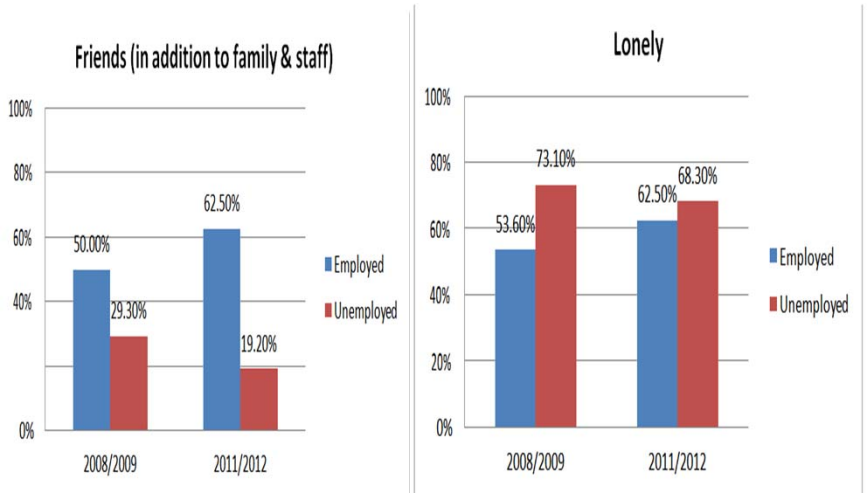
Efforts Related to Recommendation Report, 2010 (Cont'd)

- **Example 2**: In response to the recommendation regarding **health and exercise**:
  - The SCL waiver was revised and approved to include a new service: community access
    - Intended to encourage people with disabilities to engage in community life, on the weekends, in the evenings, and during the day.
    - This will provide opportunities to experience and enjoy varied health and wellness offerings in communities around the Commonwealth.
  - Collaboration with the Human Development Institute at the University of Kentucky and the University of Illinois-Chicago
    - Pilot projects around an evidence based health and wellness curriculum
    - Pilot self-advocate led program at 14 provider agencies, impacting over 100 individuals on the SCL waiver.

KY After Implementing Recommendations 2012



KY After Implementing Recommendations 2012



Findings from California People Leaving Institutions

CA: Movers Analysis

- Movers identified as a person who transitioned from a developmental center in the past five years to a community residence
- Movers are defined as individuals who moved from Lanterman Developmental Center (LDC) into the community after July 1, 2009
  - Due to the small number of Lanterman movers, separate results for Lanterman movers are not presented
- Movers were compared to 'non-movers'
  - Individuals living in the family home were excluded from the non-mover comparison group

CA Movers: Year 1 Data Overview
Adult Consumer Survey

- Total of 8,724 adults surveyed by SCDD between May 2010 and January 2011
- Minimum 400 per Regional Center (95% confidence level, +/-5% margin of error)
- Movers oversampled – yielded a final sample of 494 movers
- All Lanterman Movers since 2009 were contacted – total of 41 interviewed

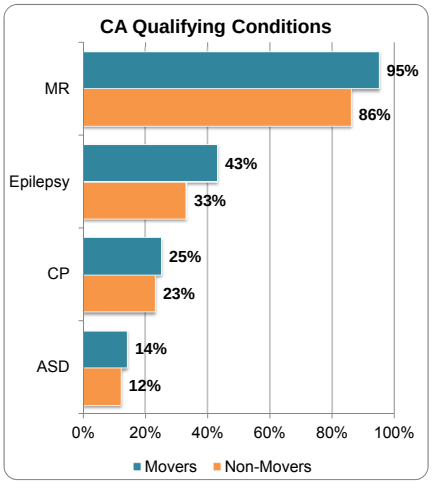
CA: Key Findings for Movers

Adult Consumer Survey – Year 1

- Movers group was older and had more diagnoses in addition to qualifying condition
- Lower results for community inclusion, choice-making, satisfaction, employment
- More access to health exams and screenings, access to services
- Higher rates of psychotropic medication use
- Y1 report did not provide information on Lanterman Movers as the N was too low to report

CA: Demographics

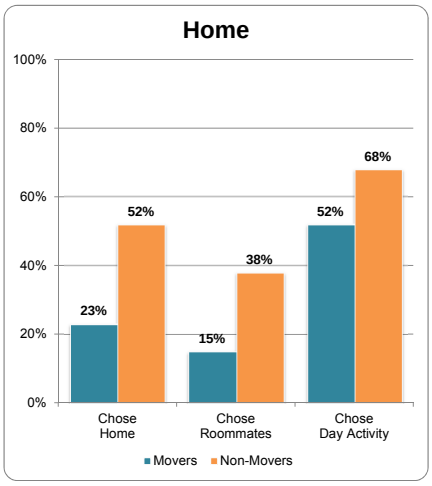
Movers vs. Non-Movers Y1



- Level of ID
  - 5% vs. 14% none
  - 20% vs. 38% mild
  - 10% vs. 20% moderate
  - 12% vs. 13% severe
  - 46% vs. 11% profound
- Other Diagnoses
  - Mental Illness 39% vs. 33%
  - Limited or No Vision 13% vs. 7%
  - Severe or Profound Hearing Loss 7% vs.5%
  - No other 7% vs.13%

CA: Selected Findings:

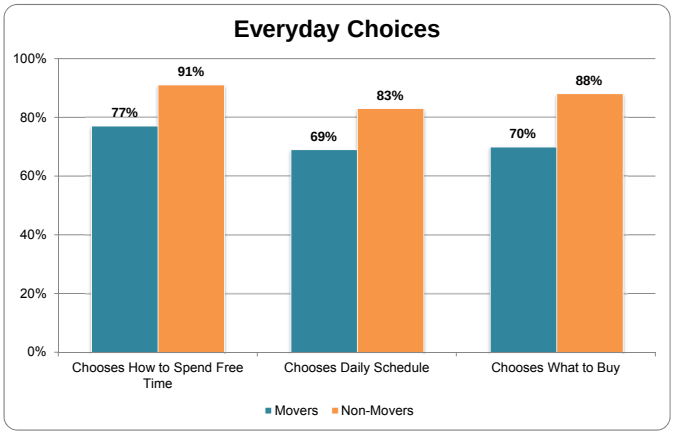
Movers vs. Non-Movers Y1



- **Wants to live somewhere else**
  33% vs.21%
- **Wants to go somewhere else during the day**
  37% vs.22%

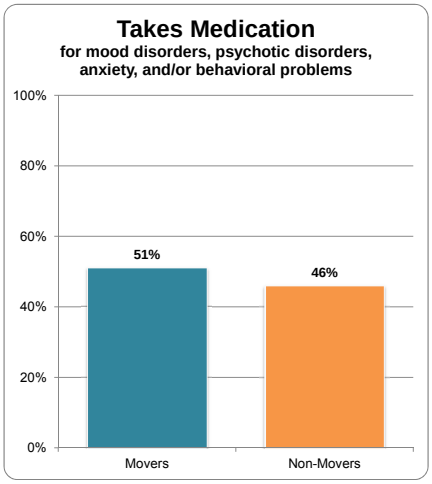
CA: Selected Findings:

Movers vs. Non-Movers Y1



CA: Selected Findings:

Movers vs. Non-Movers Y1



- **Annual physical exam (past year)**
  96% vs. 89%
- **Dental exam (past year)**
  84% vs. 71%
- **Hearing test (past 5 years)**
  67% vs. 53%
- **Flu vaccine (past year)**
  84% vs. 73%
- **Pneumonia vaccine**
  54% vs. 32%

Other Uses of NCI Data

Public Reporting

- Reports:
  - Consumer Outcomes Final Report
  - Family Survey Final Reports
  - State Reports
  - Annual Report
  - User-Friendly Reports
  - Special Reports

Public Reporting

- Data Briefs:
  - Employment
  - Psych meds
  - Dual diagnosis
  - ASD
  - Older adults
  - Living at home
  - Race/ethnicity
  - Etc…

Public Reporting

- Research and collaboration with academia:
  - Bershadsky J, Hiersteiner D, Fay ML, Bradley V. **"Race/Ethnicity and the Use of Preventive Health Care Among Adults with Intellectual and Developmental Disabilities"**. Accepted for publication, Medical Care.
  - Ticha, R., Lakin, K.C., Larson, S., Stancliffe, R.J., Taub, S., Engler, J., Bershadsky, J., Moseley, C.. **"Correlates of Everyday Choice and Support-Related Choice for 8,892 Randomly Sampled Adults with Intellectual and Developmental Disabilities in 19 States"**. *Intellectual and Developmental Disabilities,* 2012 50(6): 486-504.
  - Bershadsky J, Taub S, Engler J, Moseley C, Lakin KC, Stancliffe R, Larson S, Ticha R, Bailey C, Bradley V. **"Place of Residence and Preventive Health Care for Developmental Disabilities Service Recipients in Twenty States"**. *Public Health Reports*, Volume 127: 475-485.
  - Hewitt A, Stancliffe R, Sirek A, Hall-Lande J, Taub S, Engler J, Bershadsky J, Fortune J, Moseley C. **"Characteristics of Adults with Autism Spectrum Disorder Who Use Adult Developmental Disability Services: Results From 25 US States".** *Research in Autism Spectrum Disorders*, 2012 6(2): 741-751.
  - Stancliffe R, Lakin KC, Larson S, Engler J, Bershadsky J, Taub S, Fortune J, Ticha R. **"Overweight and Obesity Among Adults with Intellectual Disabilities Who Use ID/DD Services in 20 U.S. States".** *American Journal of Intellectual and Developmental Disabilities*, 2012 116(6): 401-418.
  - Stancliffe, R. J., Lakin, K. C., Larson, S. A., Engler, J., Taub, S., Fortune, J., & Bershadsky, J. **"Demographic characteristics, health conditions and residential service use in adults with Down syndrome in twenty-five US states"**. Journal *of Intellectual and Developmental Disabilities*, 50(2): 92-108.

Public Reporting

- Data available to other researchers

Interactive Website
www.nationalcoreindicators.org

- Annual Data Reports
- State Summary Reports
- Data Briefs
- Articles
- National State Data
- Make a Chart function
- Technical Reports

NCI-AD: National Core Indicators for Aging and Disability

NCI-AD
NATIONAL CORE INDICATORS-
Aging and Disabilities

Impetus for Expansion

- In 2012, NASUAD's Board voted to begin work to expand the scope of the current NCI to include older adults and adults with physical disabilities receiving services in their state.
- Grew out of a concern about the limited information currently available to help states assess the quality of LTSS services for seniors, adults with physical disabilities, and their caregivers
- NASUAD, with support from their Steering Committee (comprised of members of NASUAD's Board), began working with HSRI and NASDDDS to expand NCI to include this new focus.

Why the Need for NCI-AD

- Need solid information to appraise service system performance, including the extent to which critical outcomes are being achieved.
- Network counts the number of services provided, but does not have a universal evaluation tool that measures whether or not services improve the lives of consumers and allow them to stay in their homes and communities longer.
- Very few tools available that are designed to both measure the consumers' quality of life and help state leaders compare their state's systems performance against other states' performance.
- NCI is the only quality benchmarking tool that provides a voice for the consumer and caregiver.
- For states moving to Medicaid Managed LTSS, can be used to measure quality.

Goals

- Participating state aging and disabilities agencies collect data to measure the performance and outcomes of their aging and disability services.
- The Indicators:
  - Reflective of the mission, vision, and values of the field
  - Measurable
  - Practical to implement
  - Reliable and valid
  - Sensitive to changes in the system
  - Representative of issues the states had
  - Reflective of outcomes that are important to all individuals regardless of level of disability or residence

Goals

- Build on a tested, successful, sustainable initiative (NCI).
- Generate data on additional populations receiving LTSS (including seniors and adults with physical disabilities), allowing for analysis across all populations receiving LTSS.
- Provide data on LTSS services regardless of both funding source (Medicaid/non-Medicaid) and setting.
- Enable cross-agency comparisons of consumers' quality of life, for example, looking at the experience of consumers receiving LTSS through the state aging and disability agency and consumers receiving LTSS through the state agency on intellectual/ developmental disabilities.
- Provide rapid access to quality data for seniors, adults with physical disabilities, and their caregivers.

Goals

- Document the effect of services on the day-to-day lives of the people who receive them
- Document the experience of program participants
- Manage service delivery and improve policy and practice
- Track key performance goals and outcomes
- Assess the impact of regulatory activities on individual experience
- Respond to the demands of consumers and families for information on system responsiveness
- Assess the impact of financial actions

Development Process

- Start:
  - NCI indicators
  - Other tools
  - Brainstorm
- Result:
  - Approx. 120 indicators
  - 17 domains

Development Process

- June 2013 – meeting with Steering Committee
  - Discuss each potential indicator
  - Long day……
- Homework: Rankings
  - Rank each indicator from 0 (not important) to 3 (critical)
  - 12 states - sets of rankings

Development Process

- Delphi method
- Summary rankings:
  - Weighted score for each indicator: (N of 0s)*0 + (N of 1s)*1 + (N of 2s)*2 + (N of 3s)*3 = Total score
  - Possible range: 0 to 36
  - Observed range: 10 to 35
  - Mean: 20.9, Median: 21
- Number of indicators cut by half:
  - 1) Above median
  - 2) Different look: exclude total score less than 16, no 3s and fewer than 8 2s, total number of 2s and 3s less than 8
  - Expert opinion
- Result: 61 indicators, 17 domains

Development Process

- 61 indicators → Draft survey questions
- Draft "background" section
  - Risk-adjustment – level the playing field
  - Describing the population
  - Focus/drill down into sub-populations
- Meeting with Steering Committee and Board on 9/7/2013
  - Discuss first draft

Development Process

- 2 Focus groups
- In-person testing
  - Validity
  - Cognitive testing
  - Inter-rater reliability
- Total of 7 revisions
- After in-person testing – last revision
- December 2013 – final draft of NCI-AD Consumer Survey, version 1

Development Process - Pilot

- 3 pilot states: MN, GA, OH
- Recipients of aging services through HCBS Waiver
- Recipients of aging services through OAA
- Recipients of non-DD disability services through HCBS Waiver
- Each state to collect at least 400

Development Process - Pilot

- MN: over 300 interviews completed
- GA: approximately 100 interviews completed
- OH: training to be held in April, will begin data collection immediately
- Designing reliability studies
  - Inter-rater
  - Intra-rater
  - Test-retest
  - Construct validity
  - Internal consistency
- All data collection to be completed by September 2014

Timeline

- All data collected by September 2014
- Data analysis, risk-adjustment methodology, reporting methodology – by March 2015
- Revision of survey – version 2 by April 2015
- Regular data collection to begin June 2015 in 12 states
- Year-long cycle of data collection, followed by 6 months of analysis. Reports released 6-8 months after data collection is completed.

FOR MORE INFORMATION

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Workgroup Discussion

- Questions for presenters?
- Could use of this or a similar measurement system make person-centered care planning more widespread?
- Are there special considerations for implementing use of NCI or a similar system in the dual eligible beneficiary population?
- Are there other strategies to promote the importance of informed choice and the dignity of risk?

Opportunity for Public Comment

Summarize Progress and Adjourn for the Day

Day 2 Agenda

- Review Themes from Yesterday's Discussion
- Measure Gap: Shared Decisionmaking about Medical Care
- Consider Updates to Family of Measures Based on Changes in NQF Portfolio
- Opportunity for Public Comment
- Develop Research Questions to Guide Construction of Stakeholder Feedback Loop
- Round-Robin Discussion of Topics for Future Work and Themes for Next Report
- Opportunity for Public Comment

Highlights of Yesterday's Discussion

Strategies to Support Improved Quality of Life Outcomes

- "Authentic" person-centered care planning and services
  - Critical, yet intangible nature makes difficult to measure
  - Need **one** shared, longitudinal plan of care
  - Embrace technology like Skype and cloud EHR to involve more community providers and family in care planning
- Measure testing is a barrier; potential role for incubator in making connections
- Need uniformity in functional outcomes measures, especially across states
- As new measures are constructed, design should be **broad**
- NCI-AD very promising as a data source; people value the same quality of life outcomes

Measure Gap: Shared Decisionmaking About Medical Care

Shared Decisionmaking – What is it?

- Shared Decisionmaking (SDM) between a physician and consumer is "the practical reconciliation of respect for a person's autonomy and the expertise of the physician."
- SDM is a meeting of two experts – the **physician** as an expert in medicine and the **consumer** as the expert in their own life, values, and circumstances.
- This discussion will focus on clinical SDM.
  - Medical decisions made together by consumer and physician
  - Management of an individual's conditions based on clinical assessments and their self-reported outcomes
  - SDM considers both current and future medical needs

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

Shared Decisionmaking

Contributing Factors to SDM

- Respect for consumer values
- Preferences and expressed needs
- Coordinated and integrated care
- Clear, high-quality information and education for the consumer and family
- Physical comfort, including pain management
- Emotional support and alleviation of fear and anxiety
- Involvement of family members and friends
- Continuity, including through care site transitions
- Access to care

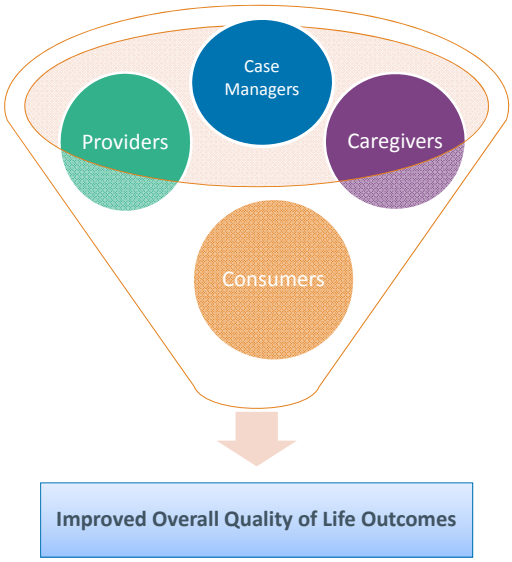
Barry MJ, Edgman-Levian S. Shared decision-making-the pinnacle of patient centered care. *N Engl J Med.* 2012;366(9): 780-781.

Shared Decisionmaking as a Strategy

SDM is a strategy to support implementation of concepts from previous meetings - enhancing quality of life, establishing shared accountability, and promoting understanding of "dignity of risk."

- SDM is particularly important for preference-sensitive conditions or choices.
- These decisions require an understanding of a consumer's needs, desires, and lifestyle that are gathered through open communication.
  - Dual eligible beneficiaries have the right to be fully informed of all care options, including the potential harms and benefits.
  - SDM provides consumers with the support they need to make their own choices while allowing clinicians to provide input and feel confident in the care plan.

Measure Applications Partnership
CONVENED BY THE NATIONAL QUALITY FORUM



Measure Applications Partnership
CONVENED BY THE NATIONAL QUALITY FORUM

Patient/Provider Disconnect on Preferences

Among patients and providers considering options for breast cancer treatment, different preferences about what is important:

Goal	Patient	Provider
Keep your breast?	7%	71%
Live as long as possible?	59%	96%
Look natural without clothes?	33%	80%
Avoid using prosthesis?	33%	0%

http://iom.edu/~/media/Files/Activity%20Files/Disease/NCPF/2011-Feb-28-Treatment-Planning/Sepucha%20Presentation.pdf
Research by Karen Sepucha, Health Decision Sciences Center, MGH and Harvard Medical School and Clara Lee, New York Weill Cornell Medical Center

Shared Decisionmaking

Shared Decisionmaking – Salzburg Global Seminar

- How do we incorporate the process of SDM effectively for consumers with complex needs?
  - How can consumers with cognitive impairment participate in SDM?
- Is there a connection between the outcomes consumers experience and SDM? If so, what is the connection?

Shared Decisionmaking

Shared Decision-Making: The importance of being actively involved in your healthcare

- What are some of the barriers providers experience to implement SDM?
- What are some of the barriers consumers experience to implement SDM?
- What strategies could make this practice more widespread?

Consider Updates to Family of Measures Based on Changes to NQF Portfolio

Current MAP Measure Selection Criteria

1. NQF-endorsed measures are required for program measure sets, unless no relevant endorsed measures are available to achieve a critical program objective
2. Program measure set adequately addresses each of the National Quality Strategy's three aims
3. Program measure set is responsive to specific program goals and requirements
4. Program measure set includes an appropriate mix of measure types
5. Program measure set enables measurement of person- and family-centered care and services
6. Program measure set includes considerations for healthcare disparities and cultural competency
7. Program measure set promotes parsimony and alignment

Updating the Family of Measures

Overview of current Family of Measures

- 55 NQF-endorsed, 2 no longer endorsed
- Variety of measure types
  - 38 process, 11 outcome, 5 composite, and 1 structural
- 34 measures are in use in with Federal programs
- 19 measures are in use in State programs
- Measures are applicable across a variety of care settings and levels of analysis

Updating the Family of Measures

Endorsement Withdrawn for 2 Measures

- NQF #0486 Adoption of Medication e-Prescribing
  - CMS is not maintaining this measure because there is no longer a federal program need for it
- NQF #0573 HIV Screening: Members at High Risk of HIV
  - Health Benchmarks indicated that they do not have the resources to continue with their endorsement maintenance
- Should the measures that have lost endorsement be retired from the family of measures?

Updating the Family of Measures
Available measures to address care for individuals with HIV/AIDS

Please see materials for more details on these measures

- Potential measures from HHS Measure Policy Council for public program alignment around HIV/AIDS care:
  - NQF #2082: Viral load suppression
  - NQF #0405: HIV/AIDS: Pneumocystis jiroveci pneumonia (PCP) Prophylaxis
  - NQF #2083: Prescription of HIV Antiretroviral Therapy
  - NQF #0409: HIV/AIDS: Sexually Transmitted Diseases – Screening for Chlamydia, Gonorrhea, and Syphilis
  - NQF #2079: HIV medical visit frequency

Updating the Family of Measures

3 Measures Received Endorsement Recently

- NQF #1529 Beta Blocker at Discharge for ICD implant patients with Left Ventricular Systolic Dysfunction
- NQF #2065 Gastrointestinal Hemorrhage Mortality Rate (IQI #18)
- **NQF #2158 Payment-Standardized Medicare Spending Per Beneficiary (MSPB)**

- Which of the newly endorsed measures, if any, should be included in the Family of Measures?

#2158 Payment-Standardized Medicare Spending Per Beneficiary

Please see materials for more details on this measure

- Cost of services performed by hospitals and other healthcare providers during an MSPB hospitalization episode
  - Episode includes costs 3 days prior to hospital admission through 30 days post-discharge
  - Does not include post-acute care or long-term care hospitals
- Medicare beneficiaries enrolled in Medicare Parts A and B who were discharged from short-term acute hospitals
  - No risk adjustment for dual eligibility, measure performance was not impacted
  - More work is needed on the use of SES variables in outcome and resource use measures
- Aims to improve care coordination
  - Excludes transfers because of feasibility determining attribution

Further Workgroup Discussion of the Family of Measures

- Does the family of measures to have the right mix and type of measures to meet the needs of dual beneficiaries and their providers?
- Are workgroup members aware of any other measures that should be considered for inclusion in the family?
- Would anyone like to suggest that other measures be retired from the family of measures?
  - Please explain your rationale.
  - Workgroup will vote.

Updating the Family of Measures

Current High-Priority Measure Gaps

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

Opportunity for Public Comment

Develop Research Questions to Guide Construction of Stakeholder Feedback Loop

Stakeholder Feedback Loop

Definitions

- **Measure Alignment:** when sets of measures work well across settings or programs to produce meaningful information without creating extra work for those responsible for the measurement.
- **Fit-for-purpose:** measures' specifications match the goals, target population, care setting, and other features of the program in which they are used.
- **Feedback Loop:** method to collect and share insights about measurement successes, impact, and opportunities for revision;
  - Sharing information between NQF and groups using measures promotes continuous learning and improvement across the entire healthcare system.

Stakeholder Feedback Loop

Current Efforts to Document and Address Alignment

- Internal HHS Efforts
- NQF's Community Tool to Align Measures
  - Developed in collaboration with the 16 Robert Wood Johnson Foundation - Aligning Forces for Quality (AF4Q) communities
  - Illustrates measure use across programs and identifies measures for possible alignment or expansion
- Buying Value Initiative
  - Research on Alignment of Existing Measure Sets conducted an analysis of hundreds of measure sets across 48 states.
  - Key questions included: to what extent are measures used and which are the most frequently shared measures across programs?

Research Questions to Guide Stakeholder Feedback Loop

- Measures that are widely used, to promote further alignment
- Measures that have contributed to a significant positive impact on healthcare quality
- Measures not functioning as intended, to convey desired modifications to measures' stewards
- Measures that are a poor fit for a program's goals, to potentially reduce burden by recommending their use be discontinued
- Measures that perform well and drive improvement, to explore encouraging broader use
- Measures that evaluate similar topics, to consider for harmonization
- Measures that function as a group, to consider developing into a composite measure

Stakeholder Feedback Loop

What information is needed to support MAP decisionmaking?

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

Round-Robin Discussion of Topics for Future Work and Themes for Next Report

Outline for August 2014 Final Report

Major sections anticipated to include:

I. MAP Strategy for Quality Improvement for Dual Eligible Beneficiaries
II. Updates to the Family of Measures
III. Importance of Filling High-Priority Measure Gaps
IV. Strategies to Support Improved Quality of Life Outcomes
   - Goal-directed care
   - Shared decisionmaking / self-determination
   - Shared accountability
V. Approach to Constructing a Stakeholder Feedback Loop

Round Robin

Each workgroup member provides comments on:

- Considering the discussion at this meeting and at the previous web meeting, what themes and recommendations are most important to include in MAP's next report to HHS?
- What discussion topics will be most important to explore in future work?

Opportunity for Public Comment

Next Steps

- **June:** NQF Member and public comment on draft final report
- **July:** MAP Coordinating Committee review of draft final report via web meeting
- **July:** Dual Eligible Beneficiaries Workgroup teleconference to consider public comments and Coordinating Committee feedback
- **August:** Next final report due to HHS

Thank You!

APPENDIX E:
Family of Measures for Dual Eligible Beneficiaries

Please refer to the NQF glossary for definitions of many terms used within this table.

NQF Measure Number, Endorsement Status, Title, and Steward	Measure Type	Measure Description	Level of Analysis	Other Known Uses and Program Alignment	Workgroup Comments and Public Comments
0004 Endorsed Initiation and Engagement of Alcohol and Other Drug Dependence Treatment Measure Steward: NCQA **Starter Set Measure**	Process	The percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) dependence who received the following. a. Initiation of AOD Treatment. The percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis. b. Engagement of AOD Treatment. The percentage of members who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.	Health Plan; Integrated Delivery System; Population: County or City, National, Regional	Federal and State Programs: Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults; Meaningful Use-EP; PQRS; Medicaid Health Home State Duals Demonstrations: CA, IL, MA, OH, VA, WA Private Programs: HEDIS	Emphasis on coordination with detox facilities and incorporating alcohol and other drug dependence treatment into person-centered care plan; Particularly important for population with behavioral health needs
0007 Endorsed NCQA Supplemental items for CAHPS® 4.0 Adult Questionnaire Measure Steward: NCQA **Starter Set Measure**	Composite	This supplemental set of items was developed jointly by NCQA and the AHRQ-sponsored CAHPS Consortium and is intended for use with the CAHPS 4.0 Health Plan survey. Some items are intended for Commercial health plan members only and are not included here. This measure provides information on the experiences of Medicaid health plan members with the organization. Results summarize member experiences through composites and question summary rates. In addition to the 4 core composites from the CAHPS 4.0 Health Plan survey and two composites for commercial populations only, the HEDIS supplemental set includes one composite score and two item-specific summary rates. • Shared Decision Making Composite • Health Promotion and Education item • Coordination of Care item	Clinician: Group/ Practice, Health Plan, Individual; Integrated Delivery System; Population: National, Regional, State	Federal and State Programs: Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults; Medicare Part D Plan Rating; State Duals Demonstration: VA Private Programs: HEDIS	Surveys restricting proxy respondents may exclude disabled consumers who have difficulties communicating

Family of Measures for Dual Eligible Beneficiaries (continued)

NQF Measure Number, Endorsement Status, Title, and Steward	Measure Type	Measure Description	Level of Analysis	Other Known Uses and Program Alignment	Workgroup Comments and Public Comments
0008 Endorsed Experience of Care and Health Outcomes (ECHO) Survey (behavioral health, managed care versions) Measure Steward: AHRQ **Starter Set Measure**	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	Health Plan	State Duals Demonstrations: CA, IL, MA, OH	Expand care setting to include Behavioral Health Care; Surveys restricting proxy respondents may exclude disabled consumers who have difficulties communicating
0018 Endorsed Controlling High Blood Pressure Measure Steward: NCQA **Starter Set Measure**	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.	Health Plan; Integrated Delivery System	Federal and State Programs: Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults; Meaningful Use-EP; Medicare Part C Plan Rating; Medicare Shared Savings Program; PQRS; HRSA; Medicaid Health Home, Special Needs Plan State Duals Demonstrations: CA, IL, MA, OH, VA Private Programs: eValue8; at least 1 Beacon community; HEDIS; WellPoint; Buying Value core ambulatory measure	Quality issue of particular importance to address access to preventive services needed to reduce disproportionate effect of chronic conditions; Incorporate chronic disease management and preventive services into person-centered care plan
0022 Endorsed Use of High Risk Medications in the Elderly Measure Steward: NCQA **Starter Set Measure**	Process	a: Percentage of Medicare members 66 years of age and older who received at least one high-risk medication. b: Percentage of Medicare members 66 years of age and older who received at least two different high-risk medications. For both rates, a lower rate represents better performance.	Health Plan; Integrated Delivery System	Federal and State Programs: Meaningful Use-EP; Medicare Part D Plan Rating; Physician Feedback; PQRS; Value-Based Payment Modifier Program; Special Needs Plan State Duals Demonstration: MA Private Programs: HEDIS; Buying Value core ambulatory measure	Important due to the possibility of drug/disease and drug/drug interactions; Expand age range of measure to apply to younger at-risk groups

Family of Measures for Dual Eligible Beneficiaries (continued)

NQF Measure Number, Endorsement Status, Title, and Steward	Measure Type	Measure Description	Level of Analysis	Other Known Uses and Program Alignment	Workgroup Comments and Public Comments
0027 Endorsed Medical Assistance With Smoking and Tobacco Use Cessation Measure Steward: NCQA	Process	Assesses different facets of providing medical assistance with smoking and tobacco use cessation: Advising Smokers and Tobacco Users to Quit: A rolling average represents the percentage of members 18 years of age and older who were current smokers or tobacco users and who received advice to quit during the measurement year. Discussing Cessation Medications: A rolling average represents the percentage of members 18 years of age and older who were current smokers or tobacco users and who discussed or were recommended cessation medications during the measurement year. Discussing Cessation Strategies: A rolling average represents the percentage of members 18 years of age and older who were current smokers or tobacco users and who discussed or were provided smoking cessation methods or strategies during the measurement year.	Health Plan	Federal and State Programs: Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults; Meaningful Use-EP; PQRS Private Programs: HEDIS; WellPoint	Encourage health plans to use this measure; Surveys restricting proxy respondents may exclude disabled consumers who have difficulties communicating; Incorporate cessation services into person-centered care plan; Particularly important for population with behavioral health needs because of historical misuse of cigarettes as incentives Public comments note that some Medicaid programs may not cover this service.
0028 Endorsed Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention Measure Steward: AMA-PCPI **Starter Set Measure**	Process	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	Clinician: Group/ Practice, Individual, Team	Federal and State Programs: Meaningful Use-EP; Medicare Shared Savings Program; PQRS State Duals Demonstration: MA Private Programs: eValue8 At least 1 Beacon community; Buying Value core ambulatory measure	Screening every two years may not be sufficient; Only measures clinicians despite other opportunities for tobacco use interventions; Incorporate chronic disease management and preventive services into person-centered care plan; Particularly important for population with behavioral health needs Public comment notes need for more details on data collection methodology; MAP notes that this is not a health plan measure.

Family of Measures for Dual Eligible Beneficiaries (continued)

NQF Measure Number, Endorsement Status, Title, and Steward	Measure Type	Measure Description	Level of Analysis	Other Known Uses and Program Alignment	Workgroup Comments and Public Comments
0032 Endorsed Cervical Cancer Screening Measure Steward: NCQA	Process	Percentage of women 21–64 years of age who received one or more Pap tests to screen for cervical cancer.	Clinician: Group/ Practice, Individual; Health Plan	Federal and State Programs: Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults; Meaningful Use-EP; PQRS; HRSA State Duals Demonstrations: IL, MA Private Programs: HEDIS; WellPoint; Aetna; AmeriHealth Mercy Family of Companies; Cigna; IHA; AHIP survey - Measures used by a Majority of Health Plans; Buying Value core ambulatory measure	Quality issue of particular importance to address access to care and accessible services/equipment for individuals with disabilities and/ or SMI; Access to preventive services needed to reduce disproportionate effect of chronic conditions; Incorporate chronic disease management and preventive services into person-centered care plan
0034 Endorsed Colorectal Cancer Screening Measure Steward: NCQA	Process	The percentage of members 50–75 years of age who had appropriate screening for colorectal cancer.	Clinician: Group/ Practice, Individual, Team; Health Plan	Federal and State Programs: Meaningful Use-EP; Medicare Part C Plan Rating; Medicare Shared Savings Program; Physician Feedback; PQRS; HRSA; Special Needs Plan State Duals Demonstrations: CA, IL, MA, OH, VA Private Programs: eValue8; at least 1 Beacon community; HEDIS ; WellPoint; Aetna; Community Health Alliance; IHA; AHIP survey - Measures used by a Majority of Health Plans; Buying Value core ambulatory measure	Quality issue of particular importance to address access to care and accessible services/equipment for individuals with disabilities and/ or SMI; Access to preventive services needed to reduce disproportionate effect of chronic conditions; Incorporate chronic disease management and preventive services into person-centered care plan

Family of Measures for Dual Eligible Beneficiaries (continued)

NQF Measure Number, Endorsement Status, Title, and Steward	Measure Type	Measure Description	Level of Analysis	Other Known Uses and Program Alignment	Workgroup Comments and Public Comments
0043 Endorsed Pneumonia vaccination status for older adults Measure Steward: NCQA	Process	Percentage of patients 65 years of age and older who ever received a pneumococcal vaccination	Population: County or City; Facility; Health Plan; Integrated Delivery System; Clinician: Group/ Practice, Individual, Team	Federal and State Programs: Meaningful Use-EP, Medicare Part C Plan Rating, Medicare Shared Savings Program, Physician Feedback, PQRS Private Programs: At least 1 Beacon community; HEDIS; WellPoint; Buying Value core ambulatory measure	Vaccinations are especially important for persons living in institutional settings or otherwise at high risk of infection
0097 Endorsed Medication Reconciliation Measure Steward: NCQA	Process	Percentage of patients aged 65 years and older discharged from any inpatient facility (e.g., hospital, skilled nursing facility, or rehabilitation facility) and seen within 60 days following discharge in the office by the physician providing on-going care who had a reconciliation of the discharge medications with the current medication list in the medical record documented.	Population: County or City; Clinician: Group/ Practice, Individual; Integrated Delivery System	Federal and State Programs: Medicare Shared Savings Program; Physician Feedback; PQRS State Duals Demonstrations: CA, IL, MA, OH, VA Private Programs: Buying Value core ambulatory measure	Most recent version of measure in development requires reconciliation within a shorter time frame of 30 days; Important due to the possibility of drug/ drug and drug/disease interactions; Expand age of population included to apply to other at-risk groups
0101 Endorsed Falls: Screening, Risk-Assessment, and Plan of Care to Prevent Future Falls Measure Steward: NCQA **Starter Set Measure**	Process	This is a clinical process measure that assesses falls prevention in older adults. The measure has three rates: A) Screening for Future Fall Risk: Percentage of patients aged 65 years and older who were screened for fall risk (2 or more falls in the past year or any fall with injury in the past year) at least once within 12 months B) Multifactorial Risk Assessment for Falls: Percentage of patients aged 65 years and older with a history of falls who had a risk assessment for falls completed within 12 months C) Plan of Care to Prevent Future Falls: Percentage of patients aged 65 years and older with a history of falls who had a plan of care for falls documented within 12 months	Clinician: Group/ Practice, Individual, Team	State Duals Demonstrations: WA	Suggest that the measure be expanded to include anyone at risk for a fall even if younger than 65 (e.g., individuals with mobility impairments, cognitive impairments, or prescribed disorienting medication therapies); Others noted that individuals may be comfortable with some risk of falling and shared decisionmaking about fall prevention methods is important

Family of Measures for Dual Eligible Beneficiaries (continued)

NQF Measure Number, Endorsement Status, Title, and Steward	Measure Type	Measure Description	Level of Analysis	Other Known Uses and Program Alignment	Workgroup Comments and Public Comments
0105 Endorsed Antidepressant Medication Management (AMM) Measure Steward: NCQA	Process	The percentage of members 18 years of age and older with a diagnosis of major depression and were newly treated with antidepressant medication, and who remained on an antidepressant medication treatment. Two rates are reported. a) Effective Acute Phase Treatment. The percentage of newly diagnosed and treated members who remained on an antidepressant medication for at least 84 days (12 weeks). b) Effective Continuation Phase Treatment. The percentage of newly diagnosed and treated members who remained on an antidepressant medication for at least 180 days (6 months).	Clinician: Group/ Practice, Individual; Health Plan; Integrated Delivery System; Population: National, Regional, State	Federal and State Programs: Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults; Meaningful Use-EP; Medicare Part C Plan Rating; Physician Feedback; PQRS; Value-Based Payment; Special Needs Plan State Duals Demonstrations: CA, IL, MA, OH, VA Private Programs: HEDIS; Cigna; AHIP survey - Measures used by a Majority of Health Plans; Buying Value core ambulatory measure	Important due to the possibility of drug/ drug and drug/ disease interactions; Incorporate medication management into person-centered care plan Public comment supports this measurement for the health plan and clinician levels of analysis.
0111 Endorsed Bipolar Disorder: Appraisal for risk of suicide Measure Steward: Center for Quality Assessment and Improvement in Mental Health	Process	Percentage of patients with bipolar disorder with evidence of an initial assessment that includes an appraisal for risk of suicide.	Clinician: Group/ Practice, Individual		Expand suicide risk screening to entire SMI population; Incorporate assessment into person-centered care plan and conduct appropriate follow-up Public comment notes need for more details on data collection methodology; MAP notes that this is not a health plan measure.
0176 Endorsed Improvement in management of oral medications Measure Steward: CMS	Outcome	Percentage of home health episodes of care during which the patient improved in ability to take their medicines correctly, by mouth.	Facility	Federal and State Programs: Home Health Quality Reporting	Measure should include a patient and/ or caregiver education component to ensure they understand the medications; Important due to the possibility of drug/ drug and drug/disease interactions
0201 Endorsed Pressure ulcer prevalence (hospital acquired) Measure Steward: The Joint Commission	Outcome	The total number of patients that have hospital-acquired (nosocomial) category/ stage II or greater pressure ulcers on the day of the prevalence measurement episode.	Facility; Clinician: Team	Private Programs: National Database of Nursing Quality Indicators (NDNQI); Alternative Quality Contract; WellPoint	Emphasized importance for individuals with limited mobility and/or cognitive impairments

Family of Measures for Dual Eligible Beneficiaries (continued)

NQF Measure Number, Endorsement Status, Title, and Steward	Measure Type	Measure Description	Level of Analysis	Other Known Uses and Program Alignment	Workgroup Comments and Public Comments
0202 Endorsed Falls with injury Measure Steward: American Nurses Association	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.	Clinician: Team		Some thought measure should include all injuries rather than being limited to major injuries; Others noted that individuals may be comfortable with some risk of falling and shared decisionmaking about fall prevention methods is important
0228 Endorsed 3-Item Care Transition Measure (CTM-3) Measure Steward: University of Colorado Health Sciences Center **Starter Set Measure**	Composite	Uni-dimensional self-reported survey that measures the quality of preparation for care transitions.	Facility	Federal and State Programs: Hospital Inpatient Quality Reporting State Duals Demonstration: MA	Expand care settings to include post-acute/long-term care settings; Measure selected because it captures person/caregiver experience during care transitions but it may not be discrete enough in its assessment of individual/caregiver understanding of discharge instructions Public comment cautions against over-surveying beneficiaries.
0326 Endorsed Advance Care Plan Measure Steward: NCQA	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.	Clinician: Group/ Practice, Individual	Federal and State Programs: Physician Feedback; PQRS; Special Needs Plan	Measure strongly supported for widespread use; Suggested expansion of denominator age group and application in all care settings; Measure promotes inclusion of personal preferences in care plan and this should be encouraged whenever possible

Family of Measures for Dual Eligible Beneficiaries (continued)

NQF Measure Number, Endorsement Status, Title, and Steward	Measure Type	Measure Description	Level of Analysis	Other Known Uses and Program Alignment	Workgroup Comments and Public Comments
0418 Endorsed Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan Measure Steward: CMS **Starter Set Measure**	Process	Percentage of patients aged 12 years and older screened for clinical depression using an age appropriate standardized tool AND follow-up plan documented	Clinician: Group/ Practice, Team, Individual; Population: National, Regional, State, County or City, Community	Federal and State Programs: Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults; Meaningful Use-EP; Medicare Shared Savings Program; Physician Feedback; PQRS; HRSA; Medicaid Health Home State Duals Demonstrations: CA, IL, MA, OH, VA, WA Private Programs: Bridges to Excellence	Measure supported because it includes follow-up after screening; Incorporate behavioral health management and preventive services into person-centered care plan; USPSTF recommends measure for adults only
0419 Endorsed Documentation of Current Medications in the Medical Record Measure Steward: CMS **Starter Set Measure**	Process	Percentage of specified visits for patients aged 18 years and older for which the eligible professional attests to documenting a list of current medications to the best of his/ her knowledge and ability. This list must include ALL prescriptions, over-the-counters, herbals, vitamin/ mineral/ dietary (nutritional) supplements AND must contain the medications' name, dosage, frequency and route ALL MEASURE SPECIFICATION DETAILS REFERENCE THE 2012 PHYSICIAN QUALITY REPORTING SYSTEM MEASURE SPECIFICATION.	Clinician: Individual; Population: National	Federal and State Programs: Meaningful Use-EP; Physician Feedback; PQRS	Measure excludes individuals with cognitive impairment without authorized representative so workgroup recommends providers make extra effort to include caregiver in the process; Measure should include an education component to ensure individual and caregiver understand the medications
0420 Endorsed Pain Assessment and Follow-Up Measure Steward: CMS	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	Clinician: Individual	Federal and State Programs: Physician Feedback; PQRS	Appropriate instruments and tools are available to assess for pain experienced by persons with communication impairments and their use should be expanded; Incorporate assessment and follow-up into person-centered care plan

Family of Measures for Dual Eligible Beneficiaries (continued)

NQF Measure Number, Endorsement Status, Title, and Steward	Measure Type	Measure Description	Level of Analysis	Other Known Uses and Program Alignment	Workgroup Comments and Public Comments
0421 Endorsed Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Measure Steward: CMS **Starter Set Measure**	Process	Percentage of patients aged 18 years and older with a calculated BMI in the past six months or during the current visit documented in the medical record AND if the most recent BMI is outside of normal parameters, a follow-up plan is documented within the past six months or during the current visit Normal Parameters: Age 65 years and older BMI > = to 23 and <30 Age 18 – 64 years BMI > = to 18.5 and <25	Clinician: Group/ Practice, Individual; Population: National, Regional, State, County or City	Federal and State Programs: Meaningful Use-EP; Medicare Shared Savings Program; Physician Feedback; PQRS; HRSA State Duals Demonstration: MA Private Programs: At least 1 Beacon community; WellPoint; Buying Value core ambulatory measure	Quality issue of particular importance to address access to preventive services needed to reduce disproportionate effect of chronic conditions; Incorporate chronic disease management and preventive services into person-centered care plan
Formerly 0486, Endorsement Removed Adoption of Medication e-Prescribing Measure Steward: CMS **Starter Set Measure**	Structure	Documents whether provider has adopted a qualified e-Prescribing system and the extent of use in the ambulatory setting.	Clinicians: Group, Individual	Federal and State Programs: E-Prescribing Incentive Program; Physician Feedback Private Programs: Aetna	e-Prescribing has been shown to improve medication safety; Measure demonstrates important structural capability
0553 Endorsed Care for Older Adults – Medication Review Measure Steward: NCQA	Process	Percentage of adults 66 years and older who had a medication review; a review of all a member's medications, including prescription medications, over-the-counter (OTC) medications and herbal or supplemental therapies by a prescribing practitioner or clinical pharmacist.	Clinician: Group/ Practice, Individual; Health Plan; Integrated Delivery System; Population: National, Regional, State	Federal and State Programs: Medicare Part C Plan Rating Private Programs: HEDIS; IHA	Important due to the possibility of drug/ drug and drug/disease interactions; Measure could benefit other complex patients, so recommend expansion to other age groups and care settings
0554 Endorsed Medication Reconciliation Post-Discharge Measure Steward: NCQA	Process	The percentage of discharges from January 1–December 1 of the measurement year for members 66 years of age and older for whom medications were reconciled on or within 30 days of discharge.	Health Plan; Integrated Delivery System; Population: National, Regional, County or City	Federal and State Programs: Special Needs Plan State Duals Demonstration: CA Private Programs: HEDIS	Important because medications are often changed during inpatient stay; Measure could benefit other complex patients, so recommend expansion to other age groups and care settings Public comment notes that the process is not within health plans' capacity. Public comment notes that pharmacy benefit carve-out complicates data collection.

Family of Measures for Dual Eligible Beneficiaries (continued)

NQF Measure Number, Endorsement Status, Title, and Steward	Measure Type	Measure Description	Level of Analysis	Other Known Uses and Program Alignment	Workgroup Comments and Public Comments
0557 Endorsed HBIPS-6 Post discharge continuing care plan created Measure Steward: The Joint Commission	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).	Facility	Federal and State Programs: Inpatient Psychiatric Facility Quality Reporting	Paired measure to be used with 0558; This type of transition planning/ communication is universally important and should apply to all discharges, not just psychiatric; At a minimum, the measure should include inpatient detox Public comment noted measure 0576 is in use and preferred; MAP notes that the level of analysis is different.
0558 Endorsed HBIPS-7 Post discharge continuing care plan transmitted to next level of care provider upon discharge Measure Steward: The Joint Commission	Process	Patients discharged from a hospital-based inpatient psychiatric setting with a continuing care plan provided to the next level of care clinician or entity overall and stratified by age groups: Children (Age 1 through 12 years), Adolescents (Age 13 through 17 years), Adults (Age 18 through 64 years), Older Adults (Age greater than and equal to 65 years). Note: this is a paired measure with HBIPS-6: Post discharge continuing care plan created.	Facility	Federal and State Programs: Inpatient Psychiatric Facility Quality Reporting	This type of transition planning/ communication is universally important and should apply to all discharges; At a minimum, the measure should include inpatient detox; Addresses care coordination through creating and transmitting care plan; Important to also communicate plan to the individual and caregiver Public comment noted measure 0576 is in use and preferred; MAP notes that the level of analysis is different.

Family of Measures for Dual Eligible Beneficiaries (continued)

NQF Measure Number, Endorsement Status, Title, and Steward	Measure Type	Measure Description	Level of Analysis	Other Known Uses and Program Alignment	Workgroup Comments and Public Comments
Formerly 0573 Endorsement Removed HIV Screening: Members at High Risk of HIV Measure Steward: Health Benchmarks-IMS Health	Process	To ensure that members diagnosed or seeking treatment for sexually transmitted diseases be screened for HIV.	Health Plan; Clinician: Individual	Private Programs: Health Benchmarks	Dual eligible beneficiaries may be at high risk for HIV for a variety of reasons; Access to screening and treatment services needed Public comment noted privacy concern.
0576 Endorsed Follow-Up After Hospitalization for Mental Illness Measure Steward: NCQA **Starter Set Measure**	Process	This measure assesses the percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported. Rate 1. The percentage of members who received follow-up within 30 days of discharge Rate 2. The percentage of members who received follow-up within 7 days of discharge.	Clinician: Team; Health Plan; Integrated Delivery System; Population: National, Regional, State, County or City	Federal and State Programs: Children's Health Insurance Program Reauthorization Act Quality Reporting; Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults; Medicare Part C Plan Rating; Physician Feedback; PQRS; Medicaid Health Home, Special Needs Plan State Duals Demonstrations: CA, IL, MA, OH, VA, WA Private Programs: WellPoint; HEDIS; Buying Value core ambulatory measure	Expand to include care settings where substance use/detox services are provided; Follow up within 30 days is too long of a time frame to address complex care needs for persons hospitalized for mental illness
0640 Endorsed HBIPS-2 Hours of physical restraint use Measure Steward: The Joint Commission	Process	The number of hours that all patients admitted to a hospital-based inpatient psychiatric setting were maintained in physical restraint per 1000 psychiatric inpatient hours, overall and stratified by age groups: : Children (Age 1 through 12 years), Adolescents (Age 13 through 17 years), Adults (Age 18 through 64 years), Older Adults (Age greater than and equal to 65 years).	Facility	Federal and State Programs: Inpatient Psychiatric Facility Quality Reporting	This measure is only a minimum threshold and absence of restraints does not guarantee high-quality care; Emphasized importance of measure for individuals with SMI and cognitive impairments
0641 Endorsed HBIPS-3 Hours of seclusion use Measure Steward: The Joint Commission	Process	The number of hours that all patients admitted to a hospital-based inpatient psychiatric setting were held in seclusion per 1000 psychiatric inpatient hours, overall and stratified by age groups: Children (Age 1 through 12 years), Adolescents (Age 13 through 17 years), Adults (Age 18 through 64 years), Older Adults (Age greater than and equal to 65 years).	Facility	Federal and State Programs: Inpatient Psychiatric Facility Quality Reporting	This measure is only a minimum threshold and absence of seclusion use does not guarantee high-quality care; Emphasized importance of measure for individuals with SMI and cognitive impairments

Family of Measures for Dual Eligible Beneficiaries (continued)

NQF Measure Number, Endorsement Status, Title, and Steward	Measure Type	Measure Description	Level of Analysis	Other Known Uses and Program Alignment	Workgroup Comments and Public Comments
0646 Endorsed Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/ Self Care or Any Other Site of Care) Measure Steward: AMA-PCPI	Process	Percentage of patients, regardless of age, discharged from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home or any other site of care, or their caregiver(s), who received a reconciled medication list at the time of discharge including, at a minimum, medications in the specified categories	Facility; Integrated Delivery System	Private Programs: ABIM MOC; Highmark	Measure addresses importance of communicating reconciled medication list from inpatient facility to individual/ caregiver/ next site of care but it does not go far enough to assess recipients' understanding of reconciled medication list
0647 Endorsed Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/ Self Care or Any Other Site of Care) Measure Steward: AMA-PCPI	Process	Percentage of patients, regardless of age, discharged from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home or any other site of care, or their caregiver(s), who received a transition record (and with whom a review of all included information was documented) at the time of discharge including, at a minimum, all of the specified elements	Facility; Integrated Delivery System	State Duals Demonstrations: CA, MA Private Programs: ABIM MOC; Highmark	Measure selected to address care transitions but it does not go far enough to assess recipients' understanding of discharge instructions; Suggest broadening beyond specified care sites/ settings
0648 Endorsed Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/ Self Care or Any Other Site of Care) Measure Steward: AMA-PCPI	Process	Percentage of patients, regardless of age, discharged from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home or any other site of care for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge	Facility; Integrated Delivery System	Federal and State Programs: Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults State Duals Demonstrations: MA, WA Private Programs: ABIM MOC; Highmark; Buying Value core ambulatory measure	Measure selected to address vital issue of care transitions and continuity; Suggest broadening beyond specified care sites/ settings
0649 Endorsed Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges to Ambulatory Care [Home/ Self Care] or Home Health Care) Measure Steward: AMA-PCPI	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	Facility, Integrated Delivery System	Private Programs: ABIM MOC; Highmark	Measure selected to address care transitions but it does not go far enough to assess recipients' understanding of discharge instructions; Suggest broadening beyond specified care sites/ settings

Family of Measures for Dual Eligible Beneficiaries (continued)

NQF Measure Number, Endorsement Status, Title, and Steward	Measure Type	Measure Description	Level of Analysis	Other Known Uses and Program Alignment	Workgroup Comments and Public Comments
0674 Endorsed Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) Measure Steward: CMS	Outcome	This measure is based on data from all non-admission MDS 3.0 assessments of long-stay nursing facility residents which may be annual, quarterly, significant change, significant correction, or discharge assessment. It reports the percent of residents who experienced one or more falls with major injury (e.g., bone fractures, joint dislocations, closed head injuries with altered consciousness, and subdural hematoma) in the last year (12-month period). The measure is based on MDS 3.0 item J1900C, which indicates whether any falls that occurred were associated with major injury.	Facility; Population: National	Federal and State Programs: Nursing Home Quality Initiative and Nursing Home Compare	Some thought measure should include all injuries rather than being limited to major injuries; Others noted that individuals may be comfortable with some risk of falling and shared decisionmaking about fall prevention methods is important
0682 Endorsed Percent of Residents or Patients Assessed and Appropriately Given the Pneumococcal Vaccine (Short-Stay) Measure Steward: CMS	Process	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.	Facility; Population: National	Federal and State Programs: Nursing Home Quality Initiative and Nursing Home Compare	Incorporate preventive services such as vaccination into person-centered care plan; Vaccinations are especially important for persons living in institutional settings or otherwise at high risk of infection

Family of Measures for Dual Eligible Beneficiaries (continued)

NQF Measure Number, Endorsement Status, Title, and Steward	Measure Type	Measure Description	Level of Analysis	Other Known Uses and Program Alignment	Workgroup Comments and Public Comments
0692 Endorsed Consumer Assessment of Health Providers and Systems (CAHPS®) Nursing Home Survey: Long-Stay Resident Instrument Measure Steward: AHRQ	Outcome	The CAHPS® Nursing Home Survey: Long-Stay Resident Instrument is an in-person survey instrument to gather information on the experience of long stay (greater than 100 days) residents currently in nursing homes. The Centers for Medicare & Medicaid Services requested development of this survey, and can be used in conjunction with the CAHPS Nursing Home Survey: Family Member Instrument and Discharged Resident Instrument. The survey instrument provides nursing home level scores on 5 topics valued by residents: (1) Environment; (2) Care; (3) Communication & Respect; (4) Autonomy and (5) Activities. In addition, the survey provides nursing home level scores on 3 global items.	Facility	State Duals Demonstration: VA Private Programs: Health Quality Council of Alberta, Canada	Surveys restricting proxy respondents may exclude disabled consumers who have difficulties communicating
0709 Endorsed Proportion of patients with a chronic condition that have a potentially avoidable complication during a calendar year. Measure Steward: Bridges to Excellence	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.	Clinician: Group/ Practice; Health Plan; Population: National, Regional, County or City, State	Private Programs: Prometheus	These chronic conditions are common among dual eligible beneficiaries and regular access to services is needed to prevent complications; Incorporate chronic disease management and preventive services into person-centered care plan Public comment notes that the measure does not adequately consider psychosocial determinants of health, would prefer a measure validated for the Medicaid population. Public comment requests clarification of 'potentially avoidable' terminology or excluding this measure from the family.

Family of Measures for Dual Eligible Beneficiaries (continued)

NQF Measure Number, Endorsement Status, Title, and Steward	Measure Type	Measure Description	Level of Analysis	Other Known Uses and Program Alignment	Workgroup Comments and Public Comments
0710 Endorsed Depression Remission at Twelve Months Measure Steward: MN Community Measurement	Outcome	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. The Patient Health Questionnaire (PHQ-9) tool is a widely accepted, standardized tool [Copyright © 2005 Pfizer, Inc. All rights reserved] that is completed by the patient, ideally at each visit, and utilized by the provider to monitor treatment progress. This measure additionally promotes ongoing contact between the patient and provider as patients who do not have a follow-up PHQ-9 score at twelve months (+/- 30 days) are also included in the denominator.	Facility, Clinician: Group/ Practice	Federal and State Programs: Meaningful Use-EP; PQRS Private Programs: MN Community Measurement	Remission at 12 months preferred to remission at 6 months because outcome is more fully sustained; Concerns about reporting burden and duplicative measurement if 0712 is also implemented independently Public comment notes need for more details on data collection methodology; MAP notes that this is not a health plan measure.

Family of Measures for Dual Eligible Beneficiaries (continued)

NQF Measure Number, Endorsement Status, Title, and Steward	Measure Type	Measure Description	Level of Analysis	Other Known Uses and Program Alignment	Workgroup Comments and Public Comments
0712 Endorsed Depression Utilization of the PHQ-9 Tool Measure Steward: MN Community Measurement	Process	Adult patients age 18 and older with the diagnosis of major depression or dysthymia (ICD-9 296.2x, 296.3x or 300.4) who have a PHQ-9 tool administered at least once during the four month measurement period. The Patient Health Questionnaire (PHQ-9) tool is a widely accepted, standardized tool [Copyright © 2005 Pfizer, Inc. All rights reserved] that is completed by the patient, ideally at each visit, and utilized by the provider to monitor treatment progress. This process measure is related to the outcome measures of "Depression Remission at Six Months" and "Depression Remission at Twelve Months". This measure was selected by stakeholders for public reporting to promote the implementation of processes within the provider's office to insure that the patient is being assessed on a routine basis with a standardized tool that supports the outcome measures for depression. Currently, only about 20% of the patients eligible for the denominator of remission at 6 or 12 months actually have a follow-up PHQ-9 score for calculating remission (PHQ-9 score < 5).	Facility; Clinician: Group/ Practice	Federal and State Programs: Meaningful Use-EP; PQRS Private Programs: MN Community Measurement	An additional measure is needed for use of PHQ-9 in long-term care facilities; Concerns about reporting burden and duplicative measurement if 0710 is also implemented independently

Family of Measures for Dual Eligible Beneficiaries (continued)

NQF Measure Number, Endorsement Status, Title, and Steward	Measure Type	Measure Description	Level of Analysis	Other Known Uses and Program Alignment	Workgroup Comments and Public Comments
0729 Endorsed Optimal Diabetes Care Measure Steward: MN Community Measurement	Composite	The percentage of adult diabetes patients who have optimally managed modifiable risk factors (A1c, LDL, blood pressure, tobacco non-use and daily aspirin usage for patients with diagnosis of ischemic vascular disease) with the intent of preventing or reducing future complications associated with poorly managed diabetes. Patients ages 18 - 75 with a diagnosis of diabetes, who meet all the numerator targets of this composite measure: A1c < 8.0, LDL < 100, Blood Pressure < 140/ 90, Tobacco non-user and for patients with diagnosis of ischemic vascular disease daily aspirin use unless contraindicated. Please note that while the all-or-none composite measure is considered to be the gold standard, reflecting best patient outcomes, the individual components may be measured as well. This is particularly helpful in quality improvement efforts to better understand where opportunities exist in moving the patients toward achieving all of the desired outcomes. Please refer to the additional numerator logic provided for each component.	Clinician: Group/ Practice; Integrated Delivery System	Federal and State Programs: Medicare Shared Savings Program; PQRS Private Programs: At least 1 Beacon community	Workgroup generally supports use of composite measures; Some concern that targets within this measure are too aggressive for medically complex beneficiaries and such individuals would need to be excluded
1626 Endorsed Patients Admitted to ICU who Have Care Preferences Documented Measure Steward: The RAND Corporation	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.	Facility; Health Plan; Integrated Delivery System		All beneficiaries should have preferences documented in all settings of care; Intense level of care and interventions provided in the ICU amplifies the importance of personal care preferences Public comment notes that codes are not available for this process and burden will be added by auditing records.

Family of Measures for Dual Eligible Beneficiaries (continued)

NQF Measure Number, Endorsement Status, Title, and Steward	Measure Type	Measure Description	Level of Analysis	Other Known Uses and Program Alignment	Workgroup Comments and Public Comments
1659 Endorsed Influenza Immunization Measure Steward: CMS	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.	Facility; Population: National, Regional, State	Federal and State Programs: Hospital Inpatient Quality Reporting	Expand care setting beyond acute care or harmonize with other measures — a single measure operationalized across all levels would be preferred; Incorporate preventive services into person-centered care plan; Vaccinations are especially important for persons living in institutional settings or otherwise at high risk of infection
1768 Endorsed Plan All-Cause Readmissions Measure Steward: NCQA **Starter Set Measure**	Outcome	For members 18 years of age and older, the number of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. Data are reported in the following categories: 1. Count of Index Hospital Stays (IHS) (denominator) 2. Count of 30-Day Readmissions (numerator) 3. Average Adjusted Probability of Readmission 4. Observed Readmission (Numerator/ Denominator) 5. Total Variance Note: For commercial, only members 18–64 years of age are collected and reported; for Medicare, only members 18 and older are collected, and only members 65 and older are reported.	Health Plan	Federal and State Programs: Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults; Medicare Part C Plan Rating; Special Needs Plan State Duals Demonstrations: CA, IL, MA, OH, VA Private Programs: WellPoint; HEDIS; IHA; AHIP survey — Measures used by a Majority of Health Plans; Buying Value core ambulatory measure	Does not exclude planned readmissions, however, it is important to measure readmissions at the health plan level of analysis

Family of Measures for Dual Eligible Beneficiaries (continued)

NQF Measure Number, Endorsement Status, Title, and Steward	Measure Type	Measure Description	Level of Analysis	Other Known Uses and Program Alignment	Workgroup Comments and Public Comments
1789 Endorsed Hospital-Wide All-Cause Unplanned Readmission Measure (HWR) Measure Steward: CMS	Outcome	This measure estimates the hospital-level, risk-standardized rate of unplanned, all-cause readmission after admission for any eligible condition within 30 days of hospital discharge (RSRR) for patients aged 18 and older. The measure reports a single summary RSRR, derived from the volume-weighted results of five different models, one for each of the following specialty cohorts (groups of discharge condition categories or procedure categories): surgery/ gynecology, general medicine, cardiorespiratory, cardiovascular, and neurology, each of which will be described in greater detail below. The measure also indicates the hospital standardized risk ratios (SRR) for each of these five specialty cohorts. We developed the measure for patients 65 years and older using Medicare fee-for-service (FFS) claims and subsequently tested and specified the measure for patients aged 18 years and older using all-payer data. We used the California Patient Discharge Data (CPDD), a large database of patient hospital admissions, for our all-payer data.	Facility	Federal and State Programs: Hospital Inpatient Quality Reporting	Measure does exclude planned readmissions, depending on scope of program it may be important to evaluate at the facility level

Family of Measures for Dual Eligible Beneficiaries (continued)

NQF Measure Number, Endorsement Status, Title, and Steward	Measure Type	Measure Description	Level of Analysis	Other Known Uses and Program Alignment	Workgroup Comments and Public Comments
1902 Endorsed Clinicians/ Groups' Health Literacy Practices Based on the CAHPS Item Set for Addressing Health Literacy Measure Steward: AHRQ	Outcome	These measures are based on the CAHPS Item Set for Addressing Health Literacy, a set of supplemental items for the CAHPS Clinician & Group Survey. The item set includes the following domains: Communication with Provider (Doctor), Disease Self-Management, Communication about Medicines, Communication about Test Results, and Communication about Forms. Samples for the survey are drawn from adults who have had at least one provider's visit within the past year. Measures can be calculated at the individual clinician level, or at the group (e.g., practice, clinic) level. We have included in this submission items from the core Clinician/ Group CAHPS instrument that are required for these supplemental items to be fielded (e.g., screeners, stratifiers). Two composites can be calculated from the item set: 1) Communication to improve health literacy (5 items), and 2) Communication about medicines (3 items)	Clinician: Group/ Practice, Individual	Private Programs: Highmark; Buying Value core ambulatory measure	Health literacy is especially important among vulnerable beneficiaries; Surveys restricting proxy respondents may exclude disabled consumers who have difficulties communicating
1909 Endorsed Medical Home System Survey (MHSS) Measure Steward: NCQA **Starter Set Measure**	Composite	The Medical Home System Survey (MHSS) assesses the degree to which an individual primary-care practice or provider has in place the structures and processes of an evidence-based Patient Centered Medical Home. The survey is composed of six composites. Each measure is used to assess a particular domain of the patient-centered medical home. Composite 1: Enhance access and continuity Composite 2: Identify and manage patient populations Composite 3: Plan and manage care Composite 4: Provide self-care support and community resources Composite 5: Track and coordinate care Composite 6: Measure and improve performance	Clinician: Group/ Practice, Individual		Selected due to the importance of care coordination; This structural measure is very complex and labor-intensive to report yet it exemplifies features of coordinated care sought for dual eligible beneficiaries

Family of Measures for Dual Eligible Beneficiaries (continued)

NQF Measure Number, Endorsement Status, Title, and Steward	Measure Type	Measure Description	Level of Analysis	Other Known Uses and Program Alignment	Workgroup Comments and Public Comments
1927 Endorsed Cardiovascular Health Screening for People With Schizophrenia or Bipolar Disorder Who Are Prescribed Antipsychotic Medications Measure Steward: NCQA	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.	Health Plan; Integrated Delivery System; Population: State		Quality issue of particular importance to address access to preventive services needed to reduce disproportionate effect of chronic conditions; Incorporate chronic disease management and preventive services into person-centered care plan Public comment notes that annual performance of this process has not demonstrated better outcomes.
1932 Endorsed Diabetes screening for people with schizophrenia or bipolar disorder who are prescribed antipsychotic medications (SSD) Measure Steward: NCQA	Process	The percentage of individuals 18 – 64 years of age with schizophrenia or bipolar disorder, who were dispensed any antipsychotic medication and had a diabetes screening during the measurement year.	Health Plan; Population: State	State Duals Demonstration: IL	Quality issue of particular importance to address access to preventive services needed to reduce disproportionate effect of chronic conditions; Incorporate chronic disease management and preventive services into person-centered care plan
2091 Endorsed Persistent Indicators of Dementia without a Diagnosis - Long Stay Measure Steward: American Medical Directors Association	Process	Percentage of nursing home residents age 65+ with persistent indicators of dementia and no diagnosis of dementia.	Facility		Addresses cases of misdiagnosis or underdiagnoses of dementia within long-term care facilities as well as communication among facility's care team
2092 Endorsed Persistent Indicators of Dementia without a Diagnosis - Short Stay Measure Steward: American Medical Directors Association	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.	Facility		Addresses cases of misdiagnosis or underdiagnoses of dementia within long-term care facilities as well as communication among facility's care team

Family of Measures for Dual Eligible Beneficiaries (continued)

NQF Measure Number, Endorsement Status, Title, and Steward	Measure Type	Measure Description	Level of Analysis	Other Known Uses and Program Alignment	Workgroup Comments and Public Comments
2111 Endorsed Antipsychotic Use in Persons with Dementia Measure Steward: Pharmacy Quality Alliance, Inc.	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.	Health Plan		Overuse of antipsychotics among persons with dementia is a well-documented problem with quality; contributes to clinical complications and higher costs. Public comment notes that this is no longer collected for HEDIS.
2152 Endorsed Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling Measure Steward: AMA-PCPI	Process	Percentage of patients aged 18 years and older who were screened for unhealthy alcohol use at least once during the two-year measurement period using a systematic screening method AND who received brief counseling if identified as an unhealthy alcohol user	Clinician: Group/ Practice, Individual, Team		Support for inclusion in family pending final endorsement by NQF; Recommend expanding care setting to emergency department; Emphasis on incorporating alcohol and other drug treatment into person-centered care plan; Particularly important for population with behavioral health needs

NQF # 0405 **HIV/AIDS: Pneumocystis jiroveci pneumonia (PCP) Prophylaxis**

Measure Status

Endorsement Type: Endorsed

Endorsement Date: Jul 31, 2008

Last Updated Date: Apr 01, 2014

eMeasure Available: Yes

Measure Details

Measure Steward: National Committee for Quality Assurance

Measure Description: Percentage of patients aged 6 weeks or older with a diagnosis of HIV/AIDS, who were prescribed Pneumocystis jiroveci pneumonia (PCP) prophylaxis

Numerator Statement: Numerator 1: Patients who were prescribed Pneumocystis jiroveci pneumonia (PCP) prophylaxis within 3 months of CD4 count below 200 cells/mm3

Numerator 2: Patients who were prescribed Pneumocystis jiroveci pneumonia (PCP) prophylaxis within 3 months of CD4 count below 500 cells/mm3 or a CD4 percentage below 15%

Numerator 3: Patients who were prescribed Pneumocystis jiroveci pneumonia (PCP) prophylaxis at the time of HIV diagnosis

Report a rate for each numerator (e.g., Numerator 1/Denominator 1, etc.) and a total rate (Total Numerator/Total Denominator)

Denominator Statement: Denominator 1. All patients aged 6 years and older with a diagnosis of HIV/AIDS and a CD4 count below 200 cells/mm3, who had at least two visits during the measurement year, with at least 90 days in between each visit; and,

Denominator 2. All patients aged 1 through 5 years of age with a diagnosis of HIV/AIDS and a CD4 count below 500 cells/mm3 or a CD4 percentage below 15%, who had at least two visits during the measurement year, with at least 90 days in between each visit; and,

Denominator 3. All patients aged 6 weeks through 12 months with a diagnosis of HIV, who had at least two visits during the measurement year, with at least 90 days in between each visit

Total denominator: The sum of the three denominators

Exclusions: Denominator 1 Exclusion: Patient did not receive PCP prophylaxis because there was a CD4 count above 200 cells/mm3 during the three months after a CD4 count below 200 cells/mm3

Denominator 2 Exclusion: Patient did not receive PCP prophylaxis because there was a CD4 count above 500 cells/mm3 or CD4 percentage above 15% during the three months after a CD4 count below 500 cells/mm3 or CD4 percentage below 15%

Risk Adjustment: No

Harmonization Requested

Harmonization Action:

Measure(s) Considered in Harmonization Request:

Classification

National Quality Strategy Priorities: Health and Well-Being

Use in Federal Program: Meaningful Use Stage 2 (EHR Incentive Program) - Eligible Professionals, Physician Quality Reporting System (PQRS)

Actual/Planned Use:

Care Setting: Ambulatory Care: Clinician Office/Clinic

Condition: Infectious Diseases, Infectious Diseases: Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS), Infectious Diseases: Respiratory

Cross-Cutting Area:

Data Source: Electronic Clinical Data: Electronic Health Record

Level of Analysis: Clinician: Group/Practice, Clinician: Individual

Measure Type: Process

Target Population: Children's Health, Populations at Risk, Senior Care

Measure Steward Contact Information

Organization Name: National Committee for Quality Assurance

Email Address: nqf@ncqa.org

Website URL (general):

Measure Disclaimer

These performance measures are not clinical guidelines and do not establish a standard of medical care, and have not been tested for all potential applications.

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NQF # 2079 HIV medical visit frequency

Measure Status

Endorsement Type: Endorsed

Endorsement Date: Jan 07, 2013

Last Updated Date: Jan 07, 2013

eMeasure Available: No

Measure Details

Measure Steward: Health Resources and Services Administration - HIV/AIDS Bureau

Measure Description: 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.

Numerator Statement: Number of patients in the denominator 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 first medical visit in the prior 6-month period and the last medical visit in the subsequent 6-month period. (Measurement period is a consecutive 24-month period of time.)

Denominator Statement: Number of patients, regardless of age, with a diagnosis of HIV with at least one medical visit in the first 6 months of the 24-month measurement period.

Exclusions: Patients who died at any time during the 24-month measurement period.

Risk Adjustment: No

Harmonization Requested

Harmonization Action:

Measure(s) Considered in Harmonization Request:

Classification

National Quality Strategy Priorities: Health and Well-Being

Use in Federal Program:

Actual/Planned Use: Public Health/Disease Surveillance, Public Reporting, Quality Improvement with Benchmarking (external benchmarking to multiple organizations)

Care Setting: Ambulatory Care: Clinician Office/Clinic

Condition: Infectious Diseases: Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS)

Cross-Cutting Area: Access

Data Source: Electronic Clinical Data: Electronic Health Record, Paper Medical Records

Level of Analysis: Clinician: Group/Practice, Facility

Measure Type: Process

Target Population: Populations at Risk

Measure Steward Contact Information

Organization Name: Health Resources and Services Administration - HIV/AIDS Bureau

Email Address: mmatosky@hrsa.gov

Website URL (general):

Measure Disclaimer

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NQF # 2082 HIV viral load suppression

Measure Status

Endorsement Type: Endorsed

Endorsement Date: Jan 07, 2013

Last Updated Date: Jan 07, 2013

Measure Under Review: Annual Update

eMeasure Available: No

Measure Details

Measure Steward: Health Resources and Services Administration - HIV/AIDS Bureau

Measure Description: Percentage of patients, regardless of age, with a diagnosis of HIV with a HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year

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.

Numerator Statement: Number of patients in the denominator with a HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year

Denominator Statement: Number of patients, regardless of age, with a diagnosis of HIV with at least one medical visit in the measurement year

Exclusions: There are no patient exclusions.

Risk Adjustment: No

Harmonization Requested

Harmonization Action:

Measure(s) Considered in Harmonization Request:

Classification

National Quality Strategy Priorities: Health and Well-Being

Use in Federal Program:

Actual/Planned Use: Public Health/Disease Surveillance, Public Reporting, Quality Improvement with Benchmarking (external benchmarking to multiple organizations)

Care Setting: Ambulatory Care: Clinician Office/Clinic

Condition: Infectious Diseases: Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS)

Cross-Cutting Area: Health and Functional Status, Population Health, Prevention

Data Source: Electronic Clinical Data: Electronic Health Record, Electronic Clinical Data: Laboratory, Paper Medical Records

Level of Analysis: Clinician: Group/Practice, Facility

Measure Type: Outcome

Target Population: Populations at Risk

Measure Steward Contact Information

Organization Name: Health Resources and Services Administration - HIV/AIDS Bureau

Email Address: mmatosky@hrsa.gov

Website URL (general):

Measure Disclaimer

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NQF # 2083 Prescription of HIV Antiretroviral Therapy

Measure Status

Endorsement Type: Endorsed

Endorsement Date: Jan 07, 2013

Last Updated Date: Jan 07, 2013

Measure Under Review: Annual Update

eMeasure Available: No

Measure Details

Measure Steward: Health Resources and Services Administration - HIV/AIDS Bureau

Measure Description: Percentage of patients, regardless of age, with a diagnosis of HIV prescribed antiretroviral therapy for the treatment of HIV infection during the measurement year

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.

Numerator Statement: Number of patients from the denominator prescribed HIV antiretroviral therapy during the measurement year.

Denominator Statement: Number of patients, regardless of age, with a diagnosis of HIV with at least one medical visit in the measurement year

Exclusions: There are no patient exclusions.

Risk Adjustment: No

Harmonization Requested

Harmonization Action:

Measure(s) Considered in Harmonization Request:

Classification

National Quality Strategy Priorities: Health and Well-Being

Use in Federal Program:

Actual/Planned Use: Public Health/Disease Surveillance, Public Reporting, Quality Improvement with Benchmarking (external benchmarking to multiple organizations)

Care Setting: Ambulatory Care: Clinician Office/Clinic

Condition: Infectious Diseases: Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS)

Cross-Cutting Area: Population Health, Prevention

Data Source: Electronic Clinical Data: Electronic Health Record, Electronic Clinical Data: Pharmacy, Paper Medical Records

Level of Analysis: Clinician: Group/Practice, Facility, Population: Community, Population: County or City, Population: National, Population: Regional, Population: State

Measure Type: Process

Target Population: Populations at Risk

Measure Steward Contact Information

Organization Name: Health Resources and Services Administration - HIV/AIDS Bureau

Email Address: mmatosky@hrsa.gov

Website URL (general):

Measure Disclaimer

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NQF # 2158 Payment-Standardized Medicare Spending Per Beneficiary (MSPB)

Measure Status

Endorsement Type: Endorsed

Endorsement Date: Dec 09, 2013

Last Updated Date: Dec 09, 2013

eMeasure Available: No

Measure Details

Measure Steward: Centers for Medicare & Medicaid

Measure Description: 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.

Type of Resource Use Measure:

- Per episode

Resource Use Service Categories:

- Inpatient services: Inpatient facility services
- Inpatient services: Evaluation and management
- Inpatient services: Procedures and surgeries
- Inpatient services: Imaging and diagnostic
- Inpatient services: Lab services
- Inpatient services: Admissions/discharges

- Ambulatory services: Outpatient facility services
- Ambulatory services: Emergency Department
- Ambulatory services: Evaluation and management
- Ambulatory services: Procedures and surgeries
- Ambulatory services: Imaging and diagnostic
- Ambulatory services: Lab services
- Durable Medical Equipment (DME)

Description of Measure Clinical Logic: Objective: The MSPB Measure aims to improve care coordination in the period between 3 days prior to an acute inpatient hospital admission through the period 30 days after discharge.

Clinical Topic Area: Inpatient Admissions, all conditions

Accounting for Comorbidities: Application of a variant of the CMS-HCC risk adjustment model. The model includes a select number of interaction terms between comorbidities.

Measure of Episode Severity: Risk Adjustment model includes indicators for the MS-DRG of the index admission.

Concurrency of Clinical Events. The MSPB Episode spans the period 3 days prior to the index hospital admission through 30 days post-discharge. All events that occur during this time period are included in the MSPB episode.

Harmonization Requested

Harmonization Action:

Measure(s) Considered in Harmonization Request:

Classification

National Quality Strategy Priorities: Affordable Care, Affordable Care: Cost/Resource Use

Use in Federal Program:

Actual/Planned Use:

Care Setting: Hospital/Acute Care Facility

Condition:

Cross-Cutting Area: Care Coordination, Overuse

Data Source: Administrative claims

Level of Analysis: Facility

Measure Type: Cost/Resource Use

Target Population: Senior Care

Measure Steward Contact Information

Organization Name: Centers for Medicare & Medicaid

Email Address: corette.byrd@cms.hhs.gov

Website URL (general):
https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier4&cid=1228772057350

Measure Disclaimer

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Facilitating Alignment through Feedback Loops

Together with its partners and members, the National Quality Forum (NQF) is constantly looking for ways to transform healthcare through performance measurement. Measurement has the potential to drive healthcare system change when used to identify opportunities for improvement and subsequent gains in performance. However, healthcare systems and providers can find participation in measurement programs burdensome when they are compelled to invest resources to comply with increased, duplicative, or especially labor-intensive requirements.

The Workgroup is asked to provide guidance on how information on the experience of using NQF-endorsed measures should be gathered to support MAP decision-making and promote alignment.

What is measure alignment?

Measure alignment has been identified as one of the opportunities to enhance the positive impact of performance measures. Alignment is achieved when a set of measures works well across settings or programs to produce meaningful information without creating extra work for those responsible for the measurement. Use of the same measures across programs can reduce conflicting or redundant requirements. Alignment must be balanced with innovation, particularly for measure development to fill high-priority gaps. The related concept of **fit-for-purpose** complements alignment. Measure designs and specifications should match the goals, target population, care setting, and other features of the program in which they are used. A healthcare system that maintains a balance of a small number of well-aligned measures that have strong fit-for-purpose will avoid placing unintended measurement on participants.

> *Example: NQF #0018 Controlling High Blood Pressure is a well-aligned outcome measure because it is in use across three Federal measurement programs for clinicians in addition to NCQA accreditation programs for health plans. However, the current version of the measure is not suitable, or fit-for-purpose, to hold providers accountable for pediatric blood pressure outcomes because it is not specified for a population younger than 18 years old.*

How can MAP influence alignment?

The Measure Applications Partnership (MAP) has identified alignment as one of the most important characteristics of measures in a set used for public reporting and payment programs in the MAP Measure Selection Criteria (MSC). MAP emphasizes the importance of alignment when making recommendations on the use of measures in Federal programs (see the 2014 Pre-Rulemaking Report). MAP members prefer measures that are well-aligned, often citing alignment as a condition for support.

> *MSC sub-criterion 7.2 states: Program measure set places strong emphasis on measures that can be used across multiple programs or applications (e.g., Physician Quality Reporting System [PQRS], Meaningful Use for Eligible Professionals, and Physician Compare).*

The MAP Dual Eligible Beneficiaries Workgroup has identified a set of the best available measures addressing important healthcare quality issues for dual eligible beneficiaries. This “family of measures” is intended to be a starting place for measure selection; it is a menu stakeholders can consult to select

subsets of measures that best suit the needs of particular programs. If more stakeholder groups and programs select measures from within families, alignment will be improved.

NQF invites feedback on the usage experience of all endorsed measures through the Quality Positioning System and commenting opportunities. NQF staff members are early in the process of identifying other avenues to gather information on measure use, alignment of measures across programs/uses, and feedback on the use of measures. The identification of opportunities to improve alignment can serve as an avenue to streamline reporting programs and increase the value and effectiveness of measurement. There may be particular value in gathering this information from the health plan perspective because of the large volume of programs and measures required of plans.

How should feedback loops be created?

MAP and the Dual Eligible Beneficiaries Workgroup are exploring methods improve alignment and the utility of measures across programs. Creating continuous **feedback loops** of information from stakeholders using measures is a way to collect and share insights about measurement successes and opportunities for revision. Such an exchange of information between NQF and groups directly involved in using measures promotes ongoing learning and improvement across the entire healthcare system. MAP has the opportunity to define what information should be collected via feedback loops from entities that use measures for the purpose of this analysis. Potential topics of interest include the identification of:

- Measures that are widely used, to promote further alignment
- Measures in need of modification, to convey desired changes to measures' stewards
- Measures that are a poor fit for a program's goals, to potentially reduce burden by recommending their use be discontinued
- Measures that perform well and drive improvement, to explore encouraging broader use
- Measures that work well together, to consider for harmonization or a composite measure

The MAP Dual Eligible Beneficiaries Workgroup is asked to consider what information is needed to support its decisionmaking process about the use of measures.

- Would additional data help to refine the family of measures?
- Is alignment among certain programs of particular interest?
- Do other stakeholders have information needs that could be satisfied by this analysis?

What information about measure use is already available?

Some information on alignment of measures is already available and MAP plans to build from this base when creating and strengthening feedback loops. NQF's Community Tool to Align Measures is one currently available source on measure use and alignment. This tool, developed in collaboration with the 16 Aligning Forces for Quality (AF4Q) communities, illustrates measure use across programs and identifies measures for possible alignment or expansion. In addition, the Buying Value Project research on Alignment of Existing Measure Sets conducted an analysis of hundreds of measure sets across the states. The analysis sought answers to several questions, including: to what extent are measures used and which are the most frequently shared measures? NQF will learn from these other efforts to collect and report measure use information.