NATIONAL QUALITY FORUM

Agenda

Measure Applications Partnership
Dual Eligible Beneficiaries Workgroup In-Person Meeting

March 4-5, 2015

National Quality Forum Conference Center

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: **943618** or for Day 2: **995926**.
- In the "Display Name" field, type in your first and last names and click "Enter Meeting."

Teleconference

- Dial **(888) 802-7237** for workgroup members or **(877) 303-9138** for public participants; use conference ID code for Day 1: **68824138** or Day 2: **71043181** to access the audio platform.

Meeting Objectives

- Explore the use of measures in the dual eligible beneficiary population, including preliminary results of alignment analysis and feedback loops
- Complete the annual update of the MAP Dual Eligible Family of Measures and list of high-priority measure gap areas
- Consider strategies to support the delivery of person-centered care for complex beneficiaries and measurement's role in promoting it

Day 1: March 4, 2015

8:30 am **Breakfast for Workgroup Members**

9:00 am **Welcome**

Alice Lind, Workgroup Co-Chair
Ann Hammersmith, NQF General Counsel
Megan Duevel Anderson, Project Manager, NQF

- Review meeting agenda and objectives
- Introductions and annual disclosures of interest

9:30 am **Reflections from Federal Partners on MAP Contributions**

Venesa Day, CMS Medicare-Medicaid Coordination Office

- How MAP has informed quality measurement, quality improvement, and program alignment activities within CMS
- Goals for 2015 MAP input

10:00 am **Review and Discuss Preliminary Alignment Analysis Results**

Jennie Chin Hansen, Workgroup Co-Chair
Zehra Shahab, Project Analyst, NQF

- Review preliminary results from alignment analysis
- Identify potential actions for updating the Family of Measures based on the alignment analysis
- Develop recommendations for ongoing efforts to assess measure alignment

10:45 am **Opportunity for Public Comment and Break**

11:00 am **Exploring the Experience of Using Measures**

Sarah Lash, Senior Director, NQF

- Findings from NQF Measure Meet-Up on alignment and measure use experience
- Workgroup discussion
    - *Please share your experience of using measures to improve care for vulnerable populations. What works? What doesn't?*
    - *Are you affected by mismatched or redundant measure requirements?*

12:00 pm **Lunch**

12:30 pm **Review and Discuss Preliminary Feedback Loops Results**

Alice Lind
Megan Duevel Anderson

- Review preliminary results from feedback loops analysis
- Identify potential actions for updating the Family of Measures based on the measure use feedback
- Develop recommendations for ongoing efforts to collect stakeholder feedback about measure use

1:30 pm **Maintaining the MAP Dual Eligible Beneficiaries Family of Measures and Gap Areas**

Jennie Chin Hansen
Megan Duevel Anderson

- Review measures in the Family which are no longer NQF-endorsed for potential removal
- Consider recently NQF-endorsed measures for addition to the Family

- Review and update prioritized measure gaps for dual eligible beneficiaries

4:15 pm **Opportunity for Public Comment**

4:30 pm **Summary of Day and Adjourn**

Day 2: March 5, 2015

8:30 am **Breakfast for Workgroup Members**

9:00 am **Day 2 Kick-Off: MAP's History of Person-Centered Care Recommendations**

Sarah Lash

- Establish agreement on MAP's role in promoting person-centered care
- Other available resources from CHCS, IOM, et cetera

9:15 am **Charting a Path Forward on Measuring Person- and Family-Centered Care**

Mitra Ghazinour, Project Manager, NQF
Alice Lind

- Review findings of 2014 project to prioritize measure development needs to support person- and family-centered care
- Workgroup questions and discussion

10:00 am **Socio-demographic Status (SDS) Risk Adjustment of Quality Measures: Summarizing the Debate and Current NQF Policy**

Taroon Amin, Consultant, NQF
Jennie Chin Hansen

- Build understanding of risk-adjustment and stratification as strategies to understand and address health disparities
- Share different viewpoints on the use of risk adjustment and communicate NQF's current approach to reviewing SDS-adjusted measures
- Workgroup questions and discussion

10:45 am **Opportunity for Public Comment**

10:55 am **Break**

11:05 am **Voices from the Field: Complex Beneficiary Engagement Strategies for Health Plans**

Patrick Curran, President and CEO, CareOregon
Richard Bringewatt, SNP Alliance
Alice Lind

- Explore multiple ways in which poverty influences delivery of healthcare
- Showcase strategies used by health plans to engage enrollees
- Workgroup questions and discussion

12:15 pm **Lunch**

12:50 pm **Voices from the Field: Complex Beneficiary Engagement Strategies for Practitioners**

Steve Counsell, America's Essential Hospitals
Sarah Lash
Jennie Chin Hansen

- Learn how the GRACE Primary Care Model is designed to respond to the needs of low-income older adults
- Explore opportunities offered by integrated behavioral health models
- Consider the role of quality measurement and scalability of the models
- Workgroup questions and discussion

2:00 pm **Synthesis and Recommendations**

Gretchen Alkema, Vice President, Policy and Communications, the SCAN Foundation
Alice Lind
Jennie Chin Hansen

- Explore policy changes necessary to allow better health system responses to social needs
- Plot out path forward for accelerating development of gap-filling performance measures
- Other guidance for CMS related to advancing person-centered care

3:30 pm **Opportunity for Public Comment**

3:45 pm **Wrap Up and Next Steps**

4:00 pm **Adjourn**

NATIONAL QUALITY FORUM

Roster

Measure Applications Partnership
Dual Eligible Beneficiaries Workgroup

COMMITTEE CHAIRS (VOTING)

Alice R. Lind, RN, MPH (Chair)

Jennie Chin Hansen, RN, MS, FAAN (Vice-Chair)

ORGANIZATIONAL MEMBERS (VOTING)

AARP Public Policy Institute
Susan Reinhard, RN, PhD, FAAN

American Federation of State, County and Municipal Employees
Sally Tyler, MPA

American Geriatrics Society
Gregg Warshaw, MD

American Medical Directors Association
Gwendolen Buhr, MD, MHS, Med, CMD

America's Essential Hospitals
Steven R. Counsell, MD

Center for Medicare Advocacy
Kata Kertesz, JD

Consortium for Citizens with Disabilities
E. Clarke Ross, DPA

Humana, Inc.
George Andrews, MD, MBA, CPE

iCare
Thomas H. Lutzow, PhD, MBA

National Association of Social Workers
Joan Levy Zlotnik, PhD, ACSW

National PACE Association
Adam Burrows, MD

SNP Alliance
Richard Bringewatt

MATTER EXPERTS (VOTING)

Mady Chalk, MSW, PhD

Anne Cohen, MPH

James Dunford, MD

Nancy Hanrahan, PhD, RN, FAAN

K. Charlie Lakin, PhD

Ruth Perry, MD

Gail Stuart, PhD, RN

FEDERAL GOVERNMENT LIAISONS (NON-VOTING)

Administration for Community Living (ACL)
Jamie Kendall, MPP

Centers for Medicare & Medicaid Services (CMS)
Venesa J. Day

Office of the Assistant Secretary for Planning and Evaluation
D.E.B. Potter, MS

Measure Applications Partnership

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Welcome

Meeting Objectives

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- Consider strategies to support the delivery of person-centered care for complex beneficiaries and measurement's role in promoting it

Day 1 Agenda

- Welcome
- Reflections from Federal Partners on MAP Contributions
- Exploring the Experience of Using Measures
- Review and Discuss Preliminary Alignment Analysis Results
- Review and Discuss Preliminary Feedback Loops Results
- Maintaining the MAP Dual Eligible Beneficiaries Family of Measures and Gap Areas
- Summary of Day and Adjourn

Disclosures of Interest

Dual Eligible Beneficiaries Workgroup Membership

Workgroup Chairs: Jennie Chin Hansen, RN, MS, FAAN and Alice Lind, MPH, BSN

Organizational Members

AARP Public Policy Institute	Susan Reinhard, RN, PhD, FAAN
American Federation of State, County and Municipal Employees	Sally Tyler, MPA
American Geriatrics Society	Gregg Warshaw, MD
American Medical Directors Association	Gwendolen Buhr, MD, MHS, MEd, CMD
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National PACE Association	Adam Burrows, MD
SNP Alliance	Richard Bringewatt

Dual Eligible Beneficiaries Workgroup Membership

Subject Matter Experts

Mady Chalk, MSW, PhD
Anne Cohen, MPH
James Dunford, MD
Nancy Hanrahan, PhD, RN, FAAN
K. Charlie Lakin, PhD
Ruth Perry, MD
Gail Stuart, PhD, RN

Federal Government Members

Office of the Assistant Secretary for Planning and Evaluation	DEB Potter, MS
CMS Medicare Medicaid Coordination Office	Venesa Day, MPA
Administration for Community Living	Jamie Kendall, MPP

Reflections from Federal Partners on MAP Contributions

Review and Discuss Preliminary Alignment Analysis Results

MAP Family of Measures for Dual Eligible Beneficiaries

Overview of current Family of Measures

- Measures identified as best-available to address quality issues across the continuum of care for dual eligible beneficiaries and high-need subgroups
- Intended as a resource to assist the field in the selection of measures for programs, to promote alignment, and define high-priority gaps
- Current family has 58 measures
  - Variety of measure types, care settings, levels of analysis
  - Increasing use in federal programs
- Workgroup will consider updates at this meeting

Alignment Definition

- **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
  - Facilitated by the use of the same measures across multiple programs
- **The goal of MAP's alignment analysis** is to document the use of measures across relevant programs with the goal of understanding the uptake of the family of measures and the degree of alignment

Why Is Alignment Important?

- Using multiple variations of the same or similar measures is both wasteful and burdensome
  - Alignment can help to reduce inefficient resource use
  - Efficiency of measurement preserves valuable $$ for care delivery
- Alignment of measures limits confusion by streamlining information flow and improves the probability of effective performance measurement
  - Increases stakeholder buy-in about measurement and quality improvement efforts

Buying Value Initiative Found Lack of Alignment

Lack of Alignment Across State and Regional Measure Sets

- Buying Value promotes the use of aligned measures, with a focus on ambulatory care and supporting states with measure selection. They found:
  - Current state and regional measure sets are not aligned.
  - There is non-alignment despite the tendency to use NQF-endorsed, Joint Commission and/or HEDIS measures.
  - Even when measures come from standard sources, the specifications or populations are changed.
  - Many states are using their own "homegrown" measures.
    - » MAP will explore the homegrown measures to determine if they have the potential to fill gaps in the family of measures.

http://www.buyingvalue.org/wp-content/uploads/2014/02/Buying-Value-Common-Measures-Bailit-State-Measure-Set-Research-Presentation-PPT-FINAL-9-10-13.pptx

Alignment Analysis

Are measures in the MAP family in use and aligned across programs?

+

Feedback Loops

Are measures in the MAP family able to improve quality?

=

Selection of the best available measures

AF63 | f_x

A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z	AA	AB	AC	AD	AE	AF	AG	AH	AI	AJ	AK	AL	AM	AN	AO	AP	AQ	AR	AS	AT	AU	AV
0004	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)	Endorsed	The percentage of adolescent and adult patients with a new episode of alcohol or other drug (AOD) dependence who received the following. - Initiation of AOD Treatment. The percentage of patients who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis. - Engagement of AOD Treatment. The	National Committee for Quality Assurance	Clinician Office	Administrative claims, Electronic Clinical Data	Health Plan, Integrated Delivery System		1		1			1	1	1	1	1	1	1	1	1	1	1	11	1	1	1	1								1	1	1	1		2		10			1
0005	CAHPS Clinician/Group Surveys - (Adult Primary Care, Pediatric Care, and Specialist Care Surveys)	Endorsed	•Adult Primary Care Survey: 37 core and 64 supplemental question survey of adult outpatient primary care patients. •Pediatric Care Survey: 36 core and 16 supplemental question survey of outpatient pediatric care patients. •Specialist Care Survey: 37 core and 20 supplemental question survey of adult outpatients specialist care patients. Level of analysis for each of the 3 surveys: group practices, sites of care, and/or	Agency for Healthcare Research and Quality	Clinician Office	Survey: Patient Reported Data/Survey	Clinicians: Individual					1													0	1				1								1	1			2	3	9	1	1	1
0006	CAHPS Health Plan Survey v 4.0 - Adult questionnaire	Endorsed	30-question core survey of adult health plan members that assesses the quality of care and services they receive. Level of analysis: health plan – HMO, PPO, Medicare, Medicaid,	Agency for Healthcare Research and Quality	Clinician Office	Survey: Patient Reported Data/Survey	Health Plan					1		1	1	1	1	1	1	1	1	1			9	1	1		1	1								1			1			6	1	1	1
0007	NCQA Supplemental items for CAHPS® 4.0 Adult Questionnaire (CAHPS 4.0H)	Endorsement Removed	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.	National Committee for Quality Assurance	Clinician Office	Clinician: Group/Practice, Clinician: Individual, Health Plan, Integrated Delivery System, Population: National, Population: Regional, Population: State	Patient and family engagement					1		1	1	1	1	1	1	1	1	1			9		1																	1	1	1	1
0008	Experience of Care and Health Outcomes (ECHO) Survey (behavioral health, managed care versions)	Endorsed	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,	Agency for Healthcare Research and Quality	Clinician Office	Survey: Patient Reported Data/Survey	Health Plan					1		1	1	1	1	1	1	1	1	1			9																			0			1
0018	Controlling High Blood Pressure	Endorsed	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.	National Committee for Quality Assurance	Clinician Office	Administrative claims, Electronic Clinical Data, Paper Medical	Health Plan, Integrated Delivery System						1	1	1	1	1	1	1	1	1	1			9	1	1	1	1	1		1					1	1	1	1	1	5	5	21	1	1	1
0022	Use of High-Risk Medications in the Elderly (DAE)	Endorsed	There are two rates for this measure: - The percentage of patients 65 years of age and older who received at least one high-risk medication. - The percentage of patients 65 years of age and older who received at least two different high-risk medications. For both rates, a lower rate represents better performance.	National Committee for Quality Assurance	Clinician Office	Administrative claims, Electronic Clinical Data, Electronic Clinical Data: Pharmacy	Health Plan, Integrated Delivery System				1		1	1	1	1	1	1	1	1	1	1			9												1	1	1	1	1		1	6		1	
0027	Medical Assistance With Smoking and Tobacco Use Cessation (MSC)	Endorsed	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	National Committee for Quality Assurance	Clinician Office	Patient Reported Data/Survey	Health Plan, Integrated Delivery System																																								

Measures in Duals Family

How well is the family working to promote the use of measures relevant to dual eligible beneficiaries?

Can the experience of applying measures in the field inform MAP's updates to the family?

Preliminary Results

Use of Family of Measures for Dual Eligible Beneficiaries in FAD

- 11 State Financial Alignment Demonstrations were considered:
  - Capitated: California, Illinois, Massachusetts, Michigan, New York, South Carolina, Texas, Virginia
  - Fee-for-service: Colorado, Washington
- Out of 58 measures in the Duals Family,
  - 6 (10%) are in all 11 of the State Duals demonstrations
  - 17 (29%) are in 9 or more State Duals demonstrations
  - 18 (31%) are in 4 or more State Duals demonstrations
  - 25 (43%) are in 2 or more State Duals demonstrations
  - 25 (43%) are not in any of the State Duals demonstrations

Which States' Demos have the greatest uptake from the Family of Measures?

- The capitated demonstrations each include between 18-25 measures from the Duals Family.
- In contrast, the fee-for-service demonstrations in Colorado and Washington include 6-8 measures from the Duals Family.
- Is there cause for concern that ~40% of the family of measures is not included in the demonstrations?
  - No. The demonstrations are designed to measure integrated care delivered by health plans; many measures are designed for different levels of analysis, care settings, or are outside the scope of the demonstrations.

Preliminary Results

Use of Family of Measures for Dual Eligible Beneficiaries in Other Programs

- 43 national or other state initiatives were analyzed
- Out of the 58 measures in the Duals Family,
  - 7 (12%) are in 12 or more programs
  - 11 (19%) are in 9 or more programs
  - 24 (41%) are in 4 programs
  - 39 (67%) are in 2 or more programs
  - 13 (22%) are not in use the national or other state initiatives

Which Programs Show Greatest Uptake of the Family?

- Measures from the family are most frequently included in:
  - CMS Physician Quality Reporting System (PQRS) (23); and
  - CMS Physician Value-Based Payment Modifier programs (22).
- Fewest measures from the family are included in the:
  - CMS Nursing Home Quality Initiative and Nursing Home Compare (2)
  - CMS Long-Term Care Hospital Quality Reporting (1); and
  - CMS Home Health Quality Reporting programs (1).
- A variety of other programs do not contain any measures from the family but were excluded from this analysis.

Dual Eligible Beneficiaries Family of Measures

Most-Aligned Measures

- Six measures are used in 9 or more State FADs **and** 8 or more national or other state initiatives:
  - #0004: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)
  - #0018: Controlling High Blood Pressure
  - #0034: Colorectal Cancer Screening
  - #0105: Antidepressant Medication Management
  - #0418: Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan
  - #1768: Plan All-Cause Readmissions (PCR)

Distribution of Top 15 Aligned Measures

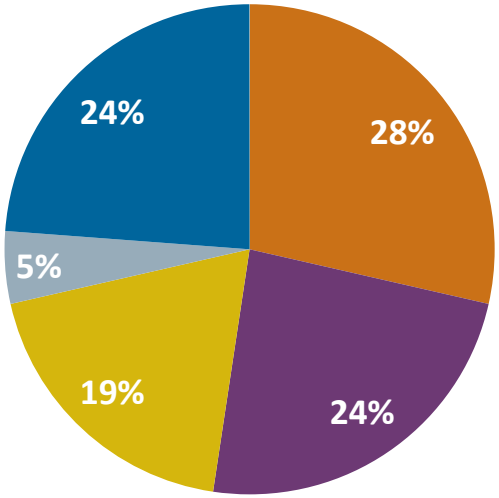
Measures in 3 or more State FADs and 3 National or Other State Initiatives

- **NQS Priorities**
  - Effective Communication and Care Coordination (6)
  - Health and Well-Being (5)
  - Patient Safety (4)
  - Person- and Family-Centered Care (1)
  - Prevention and Treatment of Leading Causes of Mortality (5)

- **Relevance to Dual Eligible High-Need Sub-Groups**
  - People with Disabilities (10)
  - Complex Older Adults (9)
  - Behavioral Health (11)
  - Cognitive Impairment (9)

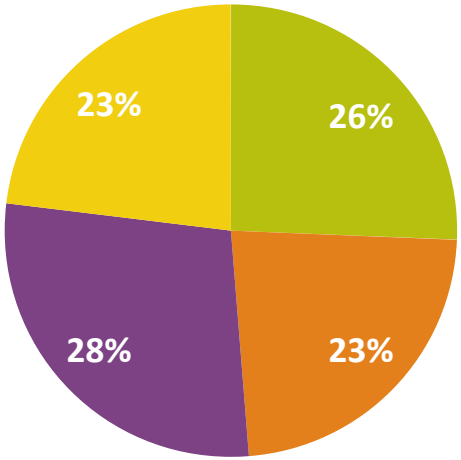
Distribution of Top 15 Aligned Measures

NQS Priority Areas



- Affordable Care
- Effective Communication and Care Coordination
- Health and Well-Being
- Patient Safety
- Person-and Family-Centered Care
- Prevention and Treatment of Leading Causes of Mortality

Population Sub-Groups



- People with Disabilities
- Complex Older Adults
- Behavioral Health
- Cognitive Impairment

Measures that are not in any State Duals Demonstrations or in any National or Other State Initiatives

- **#0111:** Bipolar Disorder: Appraisal for risk of suicide
- **#0646**: Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)
- **#0649**: Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges to Ambulatory Care [Home/Self Care] or Home Health Care)
- **#0709**: Proportion of patients with a chronic condition that have a potentially avoidable complication during a calendar year
- **#1626**: Patients Admitted to ICU who Have Care Preferences Documented
- **#1902**: Clinicians/Groups' Health Literacy Practices Based on the CAHPS Item Set for Addressing Health Literacy
- **#1909**: Medical Home System Survey (MHSS)
- **#2091**: Persistent Indicators of Dementia without a Diagnosis—Long Stay
- **#2092**: Persistent Indicators of Dementia without a Diagnosis—Short Stay
- **#2111**: Antipsychotic Use in Persons with Dementia

Innovative Homegrown Measures Detected by Buying Value Initiative

See "Potential Gap-Filling Measures" tab in Alignment Tool

- Examples:
  - MA PCMH: % of patients who have been seen in the Emergency Room with a documented chronic illness problem, who have clinical telephonic or face to face follow-up interaction with the care team within 2 days of the ER visit
  - TX DSRIP: Improve patient satisfaction and/or quality of life scores in target population with identified disparity
  - NY Dept of Health: Disruptive/Intense Daily Pain
    (* a low rate is desirable)

MAP Actions Suggested by the Analysis

- Retain measures with a high level of alignment within the family of measures
- Explore reasons why some measures in the family are not used in national or state programs
  - AND/OR
- Consider dropping measures with no usage from the family of measures if pattern is persistent
- Evaluate potential of “homegrown” measures to be further developed, tested, endorsed, and used in other programs

Questions?

Opportunity for Public Comment

Exploring the Experience of Using Measures

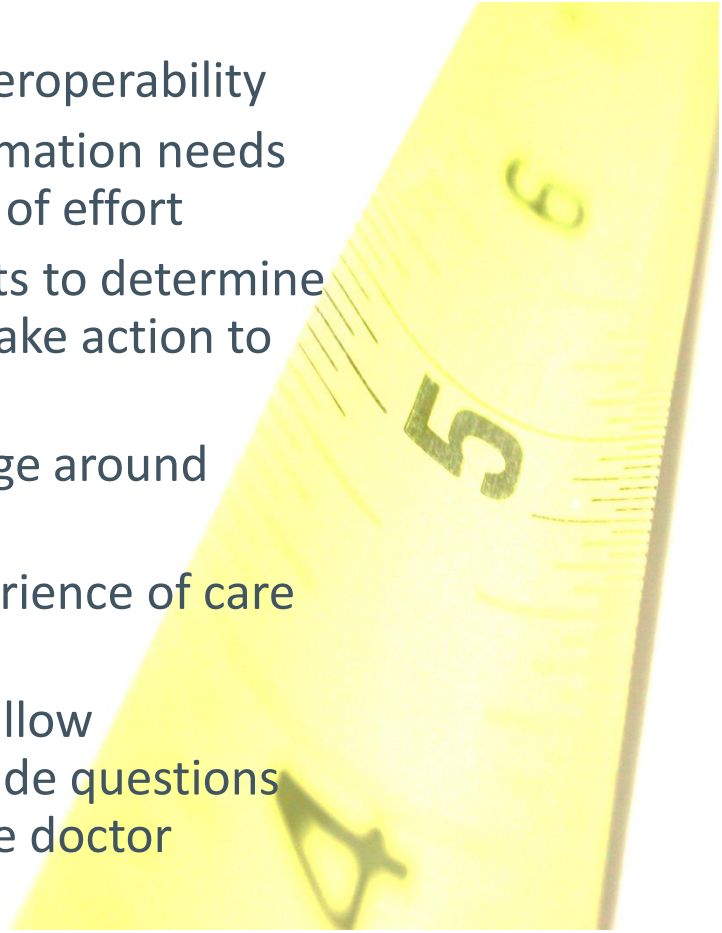
NQF "Member Meet-Up"

NQF hosted a group of its member organizations on January 29

- 80 participants came together to exchange thoughts on the topic of "Vulnerable Populations, Dual Eligibles, and Measures that Matter"
- Staff identified knowledgeable participants for phone interviews
- Reflections on three prompts:
  - Please share your experience of using measures to improve care for vulnerable populations. What works? What doesn't?
  - What information should NQF collect about measure use and alignment? Are you affected by mismatched or redundant measure requirements?
  - How can industry best contribute to ongoing efforts to coordinate care for dual eligible beneficiaries and ensure they have access to the services they need?

Discussion Theme 1: Measure Use Experience

- Data infrastructure challenges abound, e.g., interoperability
- Share more information to fulfill common information needs (e.g., assessment results) to reduce duplication of effort
- Use more information about social determinants to determine if they are adversely affecting outcomes, then take action to address those risk factors
- Measurement is part of a broader culture change around improvement
- Methods to survey consumers about their experience of care need to be improved.
  - Reduce survey length, improve timeliness, allow consumers to have help in responding, include questions about other care team members besides the doctor



Discussion Theme 2: Information to Inform Better Alignment

- An aligned measurement framework = manageable volume, focused on major issues, consistently understood and used
- Build on what is currently working by mapping measures across the continuum of care and finding the most useful information
- Accelerate the slow but important work of applying measures more consistently across programs.
- Create measures that go beyond clinical care and incorporate education, law enforcement, other sectors
- Use mobile technologies to engage consumers and facilitate connections to social services

Discussion Theme 3: Role of Industry in Ensuring Coordination and Access

- Process measures are a good starting place, but we need measures of long-term outcomes that relate to a consumer's longitudinal plan of care.
- Industry may be able to help with research and evidence generation, providing data, and distributing resources like culturally appropriate health education materials.
- Community-based partner organizations are vital but the current payment system rarely allows resources to flow to small agencies that provide wrap-around services.
- More support is needed for the "safety net"

Workgroup Discussion

- Do these themes match your experience and/or that of your professional network?

- Do you think the use of measures is improving care for vulnerable populations like dual eligible beneficiaries?
  - What is working? What's not?
- Is your organization affected by mismatched or redundant measure requirements (i.e., poor alignment)?

Review and Discuss Preliminary Feedback Loops Results

Measure Use Feedback

How can information on the experience of using measures be collected?

- NQF currently collects limited measure use information
  - Endorsement submission requires planned and current measure use
  - MAP Pre-Rulemaking activities track use in federal programs
  - "Submit Feedback" feature on QPS (NQF online measure database)
- Public comments on NQF reports and HHS proposed rules
- Direct, targeted outreach to measure users

Measure Use Feedback

Collecting feedback on the family of measures

- Types of implementation experience sought:
  - Understanding the drivers for measure use (required reporting, quality improvement)
  - General feedback on using measures with different features (e.g., data source, measure type)
  - Detailed feedback on using specific measures
  - Measures that are meaningful and drivers of improvement

Measure Use Feedback

Collecting feedback on the family of measures

- Participation and Engagement Goals:
  - Interviews with measure users from a mix of stakeholder groups
  - Semi-structured questions
  - Targeting 5-10 participants
  - Potential to refine and expand

Measure Use Feedback

Collecting feedback on the family of measures

- Topics of inquiry
  - Adoption: Which measures from the family are you collecting?
  - Alignment: Why are you collecting these measures?
  - Usability: Which measures inform your internal efforts to improve quality?
  - Implementation challenges: Have any measures been particularly difficult to use in the dual eligible beneficiary population?

Measure Use Feedback

Using Results to inform MAP Decision-Making

- Summary of engagement
  - Successfully recruited 8 total participants to date
  - Interviews with 4 participants so far: 2 health plans, 1 leader of a consumer advocacy group, and 1 state financial alignment demonstration quality measurement group
  - Open, in-depth conversations focused on the stakeholder perspectives
  - Prepared, detailed feedback about specific measures in the family
  - Relevant concepts to address population needs and gap areas
  - Visions for the future of measurement

Measure Use Feedback

Preliminary Themes: Adoption

- Measure collection is targeted
  - Fulfill reporting requirements for Federal, State, accreditation, and organization programs
  - Inform quality improvement efforts, including setting priorities, setting targets and goals, and monitoring change
  - Explore important issues and inform research with new measures

Measure Use Feedback

Preliminary Themes: Alignment

- Reasons for measure use can vary, however one specific driver is program reporting requirements
  - Population served has direct impact on measures selected
  - Feedback consistent with preliminary alignment results
- Conflicting and redundant reporting requirements are a concern
  - Stakeholders with population focus report less misaligned and redundant requirements
- Limited, but identifiable program alignment for end user
  - Reported alignment around HEDIS and CAHPS measures
  - Regional and state program differences affect resource requirements

Measure Use Feedback

Preliminary Themes: Usability

- Some measures are only collected for required reporting
  - Do not necessarily align with strategic priorities
  - Effort to improve the measure outweighs the overall benefit, specifically when targets are maintained
  - Appropriateness or perceived difficulty in moving the needle in the population
- Infrequent collection and evaluation of measure results for dual eligible beneficiaries or other vulnerable populations
  - Measures are costly and require significant effort across several stakeholder groups
  - Limited resources devoted to measuring disparities within and across measures
  - Identified need to focus on identification of disparities within measures as a first step to addressing them

Essential to consider appropriate, obtainable goals for providers serving vulnerable or high-need populations

We are seeing progress!

Uncomfortable with poorer/sicker population reasoning for poorer performance

Health plans are overloaded, but yet important information is still missing.

Risk adjustment and exclusions are *part, but not all of,* the answer

Need to understand how to address the needs of at-risk populations

Measure Use Feedback

Preliminary Themes: Implementation Challenges

- Measures of prevention and screening are a priority for different stakeholders
  - Tobacco cessation
  - Cervical cancer and colorectal cancer screening
- Medication reconciliation essential but has perils
  - Difficult to define what that means
  - Collected and reported in a way that it is not meaningful to providers
- Efforts in advanced care planning, though not always measured
- Transition of care measures are difficult
  - Steps are not always being completed or documented
  - Confusing process for consumers

Measure Use Feedback

Preliminary Themes: Implementation Challenges

- Care planning and shared care plan measurement priority for different stakeholders
  - Care plans are helpful for providers
  - Care plans need to be clearly communicated with consumers
- Providers making significant efforts in establishing advanced care planning
  - Not always measuring
- Transition of care measures are difficult
  - Steps are not always being completed or documented
  - Different requirements across settings

Measure Use Feedback

Preliminary Themes: Implementation Challenges

- Collecting the Consumer Perspective
  - Limitations to consumer surveys
  - Limited English proficiency and lack of options in diverse languages spoken across the United States
  - Limited health literacy
  - Risk of repeatedly surveying individuals in small populations
  - Consumers may not know who the “case manager” is on the survey, but they know by name the people who visit and call them

Measure Use Feedback

Preliminary Themes: Implementation Challenges

- Collecting the Consumer Perspective
  - Sample CAHPS supplemental questions to address gaps
    - Access to technology (phone, computer, internet)
    - Access to interpreters
    - How do you rate your health? Overall? In the last year? Emotional health?
    - ED use in the last 6 months
    - How long do you have to wait for an appointment? To see your provider?
    - Staff helpfulness, courtesy, and respect
    - Shared decision-making and beneficiary sense of control and autonomy

Measure Use Feedback

Using Results to inform MAP Decision-Making

- Home and Community Based Services Gap Filling Ideas
  - How many people plan is serving over time in community or institution
  - How many people move out of institution into the community
  - Number and portion of beneficiaries receiving care in community
  - Total of HCBS expenditures compared to LTSS expenditures
  - Number of people who do not return to LTSS setting in a year
  - Increase in authorization of personal care services

Measure Use Feedback

Preliminary Themes: Implementation Challenges

- Measures don't capture everything
  - How do you know what the providers are actually doing
  - Not everything is documented or coded
  - Providers do not report a regular data set
  - Need to synthesize across health plans, populations

Measure Use Feedback

Next Steps

- Incorporate workgroup feedback into upcoming interviews
- Continue conducting stakeholder interviews through Spring 2015
- Pursue avenues to communicate feedback with developers and stewards
- Incorporate results into the 2015 draft report for public and workgroup consideration
- Share final results with all stakeholder participants
- Submit final results in the 2015 final report to HHS

Workgroup Discussion

- Are there other issues regarding measure use that should be explored during these interviews?
- Does this preliminary information point to any actions MAP needs to take regarding recommendations for measure use?
- In what ways would you like to see this information presented in the report?

Maintaining the MAP Dual Eligible Beneficiaries Family of Measures and Gap Areas

MAP Family of Measures for Dual Eligible Beneficiaries

Overview of current Family of Measures

- Measures identified as best-available to address quality issues across the continuum of care for dual eligible beneficiaries and high-need subgroups
- Intended as a resource to assist the field in the selection of measures for programs, to promote alignment, and define high-priority gaps
- Workgroup periodically considers updates to the family
  - Consider changes to the measures
  - Identify relevant newly NQF-endorsed measures

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

- 58 NQF-endorsed, 2 no longer endorsed
- Variety of measure types
  - 39 process
  - 10 outcome
  - 5 patient reported outcome or consumer experience
  - 3 composite
  - 1 cost/resource use
- 14 with e-Measures available
- Measures are applicable across a variety of care settings and levels of analysis

MAP Priority Gap Areas for Dual Eligible Beneficiaries

- 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)

Workgroup Discussion

- Would the workgroup like any of the newly available measures included in the family?
- 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.

Measures No Longer Endorsed

Updating the Family of Measures

Measures No Longer Endorsed

- NQF #0007 NCQA Supplemental items for CAHPS® 4.0 Adult Questionnaire (CAHPS 4.0H) was retired by the measure steward.
  - Substantial revisions of shared decision-making and care coordination questions underway

- NQF staff will bring revised CAHPS measures on these topics for the workgroup consideration when they become available
- Other applicable endorsed CAHPS measures remain in Family (excluding pediatric measures)
- *Would the workgroup like to remove this measure from the family until updates are available?*

Updating the Family of Measures

Measures No Longer Endorsed

- NQF #0111 Bipolar Disorder: Appraisal for risk of suicide
  - Retired by measure steward, no longer maintained
- Potential alternatives:
  - 1 measure to address care related to Bipolar disorder
    - » NQF #1880: Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder
  - 1 measure to address suicide risk:
    - » NQF #0104: Adult Major Depressive Disorder (MDD): Suicide Risk Assessment
- *Would the workgroup like to remove this measure from the Family?*
- *Would you like to include any of the available alternatives?*

Updating the Family of Measures

Potential Alternatives to NQF #0111 Bipolar Disorder: Appraisal for risk of suicide

- NQF #1880: Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder
  - Percentage of individuals 18 years of age or older with bipolar I disorder who are prescribed a mood stabilizer medication, with adherence to the mood stabilizer medication
  - Adherence defined as a Proportion of Days Covered (PDC) of at least 0.8 during the measurement period (12 consecutive months)
  - Process measure
  - Settings include outpatient ambulatory care, urgent, and behavioral health/psychiatric care
  - Level of analysis at the provider, team, group, or practice
  - Not risk adjusted
  - Can be stratified by Dual Beneficiary status, race/ethnicity, etc.

Updating the Family of Measures

Potential Alternatives to NQF #0111 Bipolar Disorder: Appraisal for risk of suicide

- NQF #0104 Adult Major Depressive Disorder (MDD): Suicide Risk Assessment
  - Percentage of patients aged 18 years and older with a new diagnosis or recurrent episode of major depressive disorder (MDD) with a suicide risk assessment completed during the visit in which a new diagnosis or recurrent episode was identified
  - Process measure
  - Settings include outpatient ambulatory care, urgent, and behavioral health/psychiatric care
  - Level of analysis at the provider group/practice, Health Plan, Integrated Delivery System, or State
  - Not risk adjusted
  - Encouraged stratification by race/ethnicity, primary language, gender
  - ***Staff Pick***

Newly Endorsed Measures

Updating the Family of Measures

Considering newly available measures

- Several new measures in the NQF portfolio since the workgroup met last Spring
- Staff reviewed available measures and identified 21 for workgroup to consider
- Measures presented address prioritized gaps and population needs
  - Goal-directed, person-centered care planning and implementation
  - Systems to coordinate acute care, long-term services and supports, and nonmedical community resources
  - Psychosocial needs
- *Would the workgroup like to add any of the new measures to the family?*

Updating the Family of Measures

Measures Received Endorsement Recently

- 7 Health and Well Being Measures
  - NQF #2372 Breast Cancer Screening measure with USPSTF guidelines finalized
  - 6 measures of dental care for children
- 8 Cardiovascular Condition Measures
  - Condition-specific, considered too narrow for the Family
- 4 Surgical Care Measures
  - Highly-specific clinical measures that do not target priority gap areas
- 1 Patient Safety Measure
  - Limited to children, not appropriate for the population

Updating the Family of Measures

Measures Received Endorsement Recently

- 1 Care Coordination Measure
  - NQF #2456 Medication Reconciliation: Number of Unintentional Medication Discrepancies per Patient
  - This measure assesses the actual quality of the medication reconciliation process by **identifying errors in admission and discharge medication orders due to problems with the medication reconciliation process**. The target population is any hospitalized adult patient. The time frame is the hospitalization period.
  - Family currently contains 6 other measures related to medication documentation, reconciliation, management, or review

Updating the Family of Measures

Measures Received Steering Committee Approval

- 11 Behavioral Health Measures
- Emergency Department Follow-up
  - NQF #2605 Follow-up after Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence
- Blood Pressure Control for People with Serious Mental illness
  - NQF #2602 Controlling High Blood Pressure for People with Serious Mental Illness
- Screening and Follow-Up for People with Serious Mental illness
  - NQF #2599 Alcohol Screening and Follow-up for People with Serious Mental Illness
  - NQF #2600 Tobacco Use Screening and Follow-up for People with Serious Mental Illness or Alcohol or Other Drug Dependence
  - NQF #2601 Body Mass Index Screening and Follow-Up for People with Serious Mental Illness

Updating the Family of Measures

Measures Received Steering Committee Approval

- Diabetes Care for People with Serious Mental Illness
  - NQF #2603 Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Testing
  - NQF #2604 Diabetes Care for People with Serious Mental Illness: Medical Attention for Nephropathy
  - NQF #2606 Diabetes Care for People with Serious Mental Illness: Blood Pressure Control (<140/90 mm Hg)
  - NQF #2607 Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)
  - NQF #2608 Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Control (<8.0%)
  - NQF #2609 Diabetes Care for People with Serious Mental Illness: Eye Exam

Updating the Family of Measures

New Measures Pending Endorsement – CSAC Supported

- NQF #2605 Follow-up after Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence
  - The percentage of discharges for patients 18 or older who had a visit to the emergency department with a primary diagnosis of mental health or alcohol or other drug dependence AND who had a follow-up visit with any provider with a corresponding primary diagnosis of mental health or alcohol or other drug dependence within 7- and 30-days of discharge. Four rates are reported:
    - » % of ED visits for mental health w/ follow-up within 7 days of discharge.
    - » % of ED visits for mental health w/ follow-up within 30 days of discharge.
    - » % of ED visits for alcohol or other drug dependence w/ follow-up within 30 days of discharge
    - » % of ED visits for alcohol or other drug dependence w/ follow-up within 7 days of discharge.

Updating the Family of Measures

New Measures Pending Endorsement – CSAC Supported

- NQF #2602 Controlling High Blood Pressure for People with Serious Mental Illness
  - The percentage of patients 18-85 years of age with serious mental illness who had a diagnosis of hypertension and whose blood pressure was adequately controlled during the measurement year
  - Health plan measure adapted from general, provider-level measure
    - » Harmonized specifications with NQF #0018: Controlling High Blood Pressure, currently in family of measures
    - » Denominator adapted for individuals with SMI
    - » Measure uses specifications consistent with current guidelines
  - Addresses known health disparities

Updating the Family of Measures

Screening and Follow-up for People with Serious Mental Illness

- 3 Health plan measures adapted from provider-level measures in use for the general population to address needs in SMI population
  - Harmonized measure specifications intended to reduce collection burden
  - Numerator consistent, denominator adapted for individuals with SMI
  - Family of measures includes provider-level harmonized measure
- Process Measures
- Not risk-adjusted or stratified
- Health Plan level of analysis
- Applicable to Ambulatory Care and Outpatient Behavioral Health Care
- Collected via administrative claims, electronic clinical data, or paper medical records
- *Should any of the newly endorsed measures be included in the family pending full NQF endorsement? Should any of the related measures be removed or replaced?*

Updating the Family of Measures

New Measures Pending Endorsement – CSAC Supported

- NQF #2599 Alcohol Screening and Follow-up for People with Serious Mental Illness
  - The percentage of patients 18 years and older with a serious mental illness, who were screened for unhealthy alcohol use and received brief counseling or other follow-up care if identified as an unhealthy alcohol user.
  - Health plan measure adapted from general, provider-level measure
    - » Harmonized specifications with NQF #2152: Preventive Care & Screening: Unhealthy Alcohol Use: Screening & Brief Counseling
  - Tested in Medicare and Medicaid populations

Updating the Family of Measures

New Measures Pending Endorsement – CSAC Supported

- NQF #2600 Tobacco Use Screening and Follow-up for People with Serious Mental Illness or Alcohol or Other Drug Dependence
  - The percentage of patients 18 years and older with a serious mental illness or alcohol or other drug dependence who received a screening for tobacco use and follow-up for those identified as a current tobacco user. Two rates are reported.
    - » Health plan measure adapted from general, provider-level measure
    - » Harmonized specifications with NQF #0028 Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention
  - Addresses known health disparities

Updating the Family of Measures

New Measures Pending Endorsement – CSAC Supported

- NQF #2601 Body Mass Index Screening and Follow-Up for People with Serious Mental Illness
  - The percentage of patients 18 years and older with a serious mental illness who received a screening for body mass index and follow-up for those people who were identified as obese (a body mass index greater than or equal to 30 kg/m2).
  - Health plan measure adapted from general, provider-level measure
    - Harmonized specifications with NQF #0421 Preventive Care & Screening: Body Mass Index: Screening and Follow-Up
    - Denominator adapted for individuals with SMI
  - Addresses known health disparities
  - Tested Medicaid plan, SNP, and D-SNP

Updating the Family of Measures

Diabetes Care for People with Serious Mental Illness

- 6 Health plan measures adapted from provider-level measures in use for the general population to address needs in SMI population
  - Harmonized measure specifications intended to reduce collection burden
  - Numerator consistent, denominator adapted for individuals with SMI
- Outcome Measures
- Not risk-adjusted or stratified
- Applicable to Ambulatory Care and Outpatient Behavioral Health Care
- Collected via administrative claims, electronic clinical data, or paper medical records, and applicable laboratory and pharmacy data
- Family currently includes:
  - NQF #0729 Optimal Diabetes Care (Composite Measure)
  - NQF #1932 Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)
- *Should any of the newly available measures be included in the family pending full NQF endorsement? Should either of the measures of diabetes care be removed or replaced?*

Updating the Family of Measures

New Measures Pending Endorsement – CSAC Supported

- NQF #2603 Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Testing
  - The percentage of patients 18-75 years of age with a serious mental illness and diabetes (type 1 and type 2) who had hemoglobin A1c (HbA1c) testing during the measurement year
  - Health plan measure adapted from general, provider-level measure
    - Harmonized specifications with NQF #0057 Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing
    - Denominator adapted for individuals with SMI
    - Measure uses specifications consistent with current guidelines
  - Addresses known health disparities

Updating the Family of Measures

New Measures Pending Endorsement – CSAC Supported

- NQF #2604 Diabetes Care for People with Serious Mental Illness: Medical Attention for Nephropathy
  - The percentage of patients 18-75 years of age with a serious mental illness and diabetes (type 1 and type 2) who received a nephropathy screening test or had evidence of nephropathy during the measurement year.
  - Health plan measure adapted from general, provider-level measure
    - » Harmonized specifications with NQF #0062: Comprehensive Diabetes Care: Medical Attention for Nephropathy
    - » Denominator adapted for individuals with SMI
    - » Tested in D-SNP, Medicaid plan for disabled adults, and Medicaid plan for non-disabled adults
  - Addresses known health disparities

Updating the Family of Measures

New Measures Pending Endorsement – CSAC Supported

- NQF #2606 Diabetes Care for People with Serious Mental Illness: Blood Pressure Control (<140/90 mm Hg)
  - The percentage of patients 18-75 years of age with a serious mental illness and diabetes (type 1 and type 2) whose most recent blood pressure reading during the measurement year is <140/90 mm Hg
  - Health plan measure adapted from general, provider-level measure
    - Harmonized specifications with NQF #0061: Comprehensive Diabetes Care: Blood Pressure Control <140/90 mm Hg
    - Denominator adapted for individuals with SMI
  - Addresses known health disparities

Updating the Family of Measures

New Measures Pending Endorsement – CSAC Supported

- NQF #2607 Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)
  - The percentage of patients 18-75 years of age with a serious mental illness and diabetes (type 1 and type 2) whose most recent HbA1c level during the measurement year is >9.0%.
  - Health plan measure adapted from general, provider-level measure
    - Harmonized specifications with NQF #0059: Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control >9.0%
    - Denominator adapted for individuals with SMI
  - Addresses known health disparities
  - Tested in D-SNP, Medicaid plan for disabled adults, and Medicaid plan for non-disabled adults

Updating the Family of Measures

New Measures Pending Endorsement – CSAC Supported

- NQF #2608 Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Control (<8.0%)
  - The percentage of patients 18-75 years of age with a serious mental and diabetes (type 1 and type 2) whose most recent HbA1c level during the measurement year is <8.0%.
  - Health plan measure adapted from general, provider-level measure
    - » Harmonized specifications with NQF #0575: Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control <8.0
    - » Denominator adapted for individuals with SMI
  - Addresses known health disparities
  - Tested in D-SNP, Medicaid plan for disabled adults, and Medicaid plan for non-disabled adults

Updating the Family of Measures

New Measures Pending Endorsement – CSAC Supported

- NQF #2609 Diabetes Care for People with Serious Mental Illness: Eye Exam
  - The percentage of patients 18-75 years of age with a serious mental illness and diabetes (type 1 and type 2) who had an eye exam during the measurement year.
  - Health plan measure adapted from general, provider-level measure
    - » Harmonized specifications with NQF #0055: Comprehensive Diabetes Care: Eye Exam
    - » Denominator adapted for individuals with SMI
  - Addresses known health disparities
  - Tested in D-SNP, Medicaid plan for disabled adults, and Medicaid plan for non-disabled adults

Updating the Family of Measures

New Measures Pending Endorsement – CSAC Supported

- 1 Behavioral Health Measure Approved for Trial Use
- NQF #2597 Substance Use Screening and Intervention Composite
  - Percentage of patients aged 18 years and older who were screened at least once within the last 24 months for tobacco use, unhealthy alcohol use, nonmedical prescription drug use, and illicit drug use AND who received an intervention for all positive screening results
    - NQF #0028 Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention
    - NQF #2152 Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling
    - Drug Use Component: Percentage of patients aged 18 years and older who were screened at least once within the last 24 months for tobacco use, unhealthy alcohol use, nonmedical prescription drug use, and illicit drug use AND who received an intervention for all positive screening results
  - Recommended for further testing and re-submission within 3 years for reliability and validity evaluation. Until then, measure will not be used in accountability application

Updating the Family of Measures

Measures Received Endorsement Recently

- 13 new Admission and Readmission Measures
  - 5 found to be too narrow or not appropriate for the population
  - NQF #2375 PointRight ® Pro 30™
  - NQF #2510 Skilled Nursing Facility 30-Day All-Cause Readmission Measure (SNFRM)
  - *NQF #2380 Rehospitalization During the First 30 Days of Home Health* ***(staff pick)***
  - *NQF #2505 Emergency Department Use without Hospital Readmission During the First 30 Days of Home Health* ***(staff pick)***
  - *NQF #2502 All-Cause Unplanned Readmission Measure for 30 Days Post Discharge from Inpatient Rehabilitation Facilities (IRFs)* ***(staff pick)***
  - NQF #2503 Hospitalizations per 1000 Medicare fee-for-service (FFS) Beneficiaries
  - NQF #2504 30-day Rehospitalizations per 1000 Medicare fee-for-service (FFS) Beneficiaries
  - NQF #2496 Standardized Readmission Ratio (SRR) for dialysis facilities

Updating the Family of Measures

Measures Received Endorsement Recently

- 2 Admission and Readmission Measures currently in the family
  - NQF #1768 Plan All-Cause Readmissions (PCR)
  - NQF #1789 Hospital-Wide All-Cause Unplanned Readmission Measure (HWR)

- *Would the workgroup like to include any of the newly endorsed measures to the family?*

Updating the Family of Measures

Admission and Readmission Measures – Endorsed with Conditions

- NQF #2375: PointRight ® Pro 30™
  - All-cause, risk adjusted rehospitalization measure. Rate of all patients who enter skilled nursing facilities (SNFs) from acute hospitals and are subsequently rehospitalized during their SNF stay, within 30 days from their admission to the SNF.
  - Patients of all payer status included
  - MDS admissions assessment data, electronic clinical data source
  - Does not distinguish planned and unplanned readmissions
  - Competes with NQF #2510 – stewards determined the measures should not be harmonized because they are distinct

Updating the Family of Measures

Admission and Readmission Measures – Endorsed with Conditions

- NQF #2510 Skilled Nursing Facility 30-Day All-Cause Readmission Measure (SNFRM)
  - This measure estimates the risk-standardized rate of all-cause, unplanned, hospital readmissions for patients who have been admitted to a SNF
  - Limited to Medicare FFS beneficiaries
  - Readmissions within 30 days of hospital discharge (IPPS hospitals, Critical Access Hospitals (CAH), and Psychiatric hospitals)
  - Reported from administrative claims data
  - Competes with NQF #2375 – stewards determined the measures should not be harmonized because they are distinct

Updating the Family of Measures

Admission and Readmission Measures – Endorsed with Conditions

- NQF #2380 Rehospitalization During the First 30 Days of Home Health
  - Percentage of home health stays in which patients who had an acute inpatient hospitalization in the 5 days before the start of their home health stay were admitted to an acute care hospital during the 30 days following the start of the home health stay
  - Excludes admissions for treatment of cancer, primary psychiatric disease, or rehabilitation care, and admissions ending in patient discharge against medical advice
  - Addresses gap in Home Health Care
  - Planned Home Health Compare Public Reporting
  - Intended use with NQF #2505
  - ***Staff Pick***

Updating the Family of Measures

Admission and Readmission Measures – Endorsed with Conditions

- NQF #2505: Emergency Department Use without Hospital Readmission During the First 30 Days of Home Health
  - Percentage of home health stays in which patients who had an acute inpatient hospitalization in the 5 days before the start of their home health stay used an emergency department but were not admitted to an acute care hospital during the 30 days following the start of the home health stay.
  - Addresses gap in Home Health Care
  - Planned Home Health Compare Public Reporting
  - Intended use with NQF #2380
  - ***Staff Pick***

Updating the Family of Measures

Admission and Readmission Measures – Endorsed with Conditions

- NQF #2502 All-Cause Unplanned Readmission Measure for 30 Days Post Discharge from Inpatient Rehabilitation Facilities (IRFs)
  - Unplanned, all-cause readmissions for patients discharged from an IRF who were readmitted to a short-stay acute-care hospital or a Long-Term Care Hospital, within 30 days of an IRF discharge.
  - Medicare fee-for-service [FFS] beneficiaries only
  - The measure is based on data for 24 months of IRF discharges to non-hospital post-acute levels of care or to the community
  - Planned Inpatient Rehabilitation Facility Program Reporting
  - ***Staff Pick***

Updating the Family of Measures

Admission and Readmission Measures – Endorsed with Conditions

- NQF #2503 Hospitalizations per 1000 Medicare fee-for-service (FFS) Beneficiaries
  - Number of hospital discharges from an acute care hospital (PPS or CAH) per 1000 FFS Medicare beneficiaries at the state and community level by quarter and year.
  - Addresses measure gap of community measurement
  - State and Community population level of analysis
  - Seasonal risk adjustments for quarterly measurement
  - Intended for communities to compare themselves against other like communities

Updating the Family of Measures

Admission and Readmission Measures – Endorsed with Conditions

- NQF #2504 30-day Rehospitalizations per 1000 Medicare fee-for-service (FFS) Beneficiaries
  - Number of rehospitalizations occurring within 30 days of discharge from an acute care hospital per 1000 FFS Medicare beneficiaries at the state and community level by quarter and year.
  - Addresses measure gap of community measurement
  - State and Community population level of analysis
  - Seasonal risk adjustments for quarterly measurement
  - Intended for communities to compare themselves against other like communities

Updating the Family of Measures

Admission and Readmission Measures – Pending Board Ratification

- NQF #2496: Standardized Readmission Ratio (SRR) for dialysis facilities
  - Measures unplanned readmission to an acute care hospital within 30 days of discharge for Medicare-covered dialysis patients treated at a particular dialysis facility
  - Rate of readmissions compared to expected given the discharging hospitals and the characteristics of the patients as well as the national norm for dialysis facilities
  - Only acute care hospital readmissions

Workgroup Discussion

- Would the workgroup like any of the newly available measures included in the family?
- 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.

Opportunity for Public Comment

MAP's History of Person-Centered Care Recommendations

Recognizing MAP's Successes in Shaping Quality Measurement Approaches

Setting a high bar for quality

- Advancing person-centered approaches
- Providing a forum for strategic discussions with HHS
- Making explicit the unique needs of the dual eligible beneficiary population – for care as well as measurement
- Identifying and publicizing the measures with the best 'fit for purpose'
- Recognizing opportunities to stratify measure results by duals status to explore potential disparities
- Planting the seeds for development of new measures

How can MAP make progress in advancing the agenda of high-quality, person-centered care for dual eligible beneficiaries?

It's the quality improvement that matters most.

Measurement provides evidence of the underlying success.

Low Income Is the Only Common Factor Across All Dual Eligible Beneficiaries

- We can regard as fact that dual eligible beneficiaries experience disparities in quality and continuity of care.
  - Medical and social complexity
  - Fragmentation between payers, providers
  - Vast majority in uncoordinated fee-for-service system
- Measures can help reveal the extent of disparities and opportunities for quality improvement
- **What on-the-ground strategies can plans, providers, and others use to engage these consumers and produce better health outcomes?**

Mental Challenge for Today's Meeting

Suggested by Dr. Adam Burrows after web meeting

- How can consumer-directed services (like personal care) be introduced into integrated care models (like some managed care and PACE)…
  - in a way that respects its core philosophy, honors consumer autonomy?
  - and grounds medical providers in its person-centered principles?
  - while also providing support in terms of education, training, and community?
  - and recognizing the accountability of the plan/provider?

Charting a Path Forward for Providing and Measuring Person-Centered Care

Person-Centered Care and Outcomes: Project Overview

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.

Existing Person-Centered Care Frameworks and Key Attributes

Picker Institute's Principles of patient-centered care	Commonwealth Fund Key Attributes of Patient-Centered Care	Institute for Patient- and Family-Centered Care Core Concepts	Planetree Core Dimensions
• Respect for patients' values, preferences and expressed needs • Coordination and integration of care • Information, communication and education • Physical comfort • Emotional support and alleviation of fear and anxiety • Involvement of family and friends • Continuity and transition • Access to care	• Education and shared knowledge • Involvement of family and friends • Collaboration and team management • Sensitivity to nonmedical and spiritual dimensions of care • Respect for patient needs and preferences • Free flow and accessibility of information	• Respect and dignity • Information sharing • Participation • Collaboration	• Structures and functions necessary for culture change • Human interactions • Patient education and access to information • Family involvement • Nutrition program • Healing environment • Arts program • Spirituality and diversity • Integrative therapies • Healthy communities • Measurement

Definition and Core Concepts for Person- and Family-Centered Care

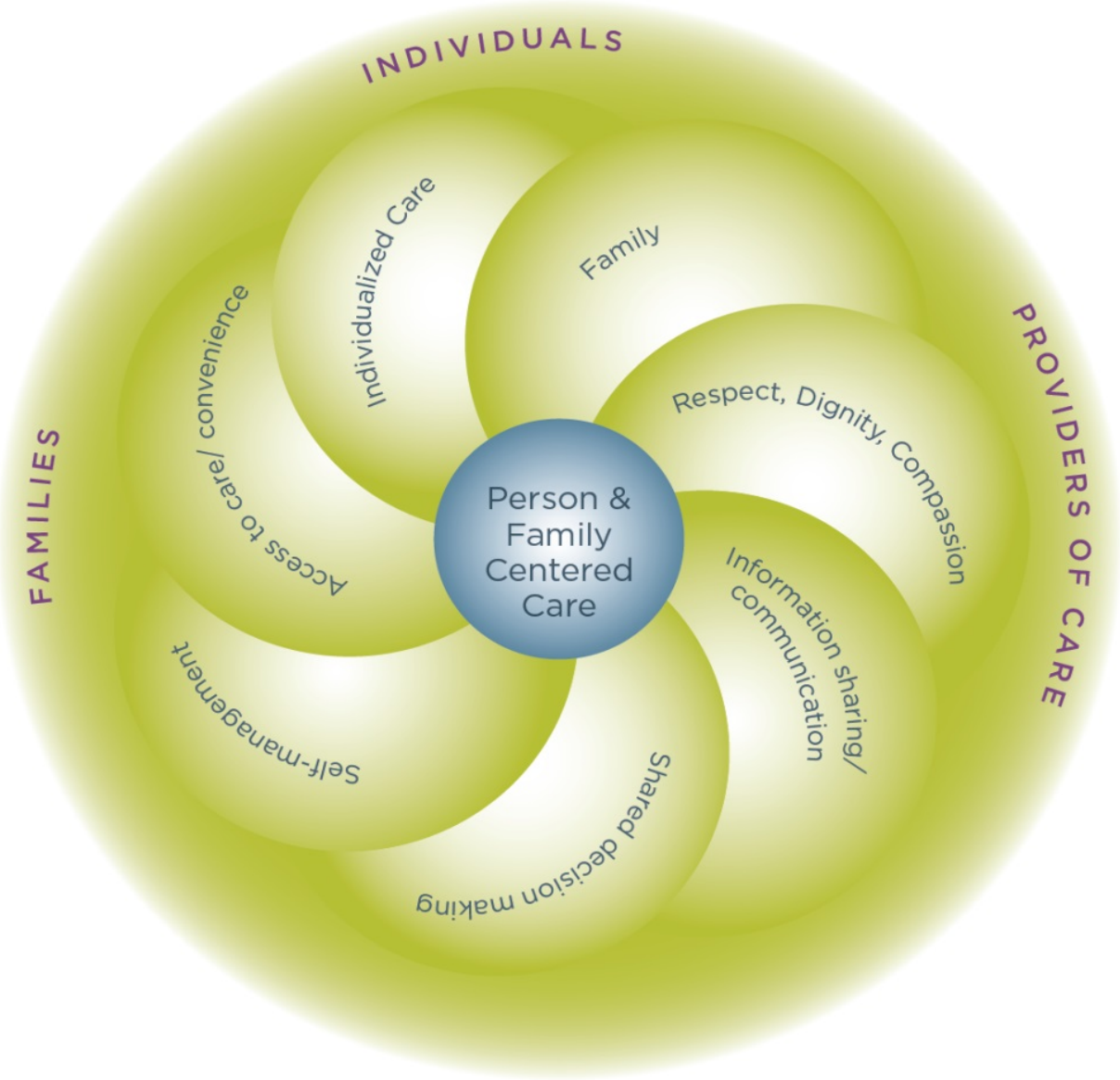
Definition for Person- and Family-Centered Care

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.

Above definition was developed through the Measure Gaps: Person-Centered Care and Outcomes Project.

Person- and Family-Centered Care Core Concepts



Person- and Family-Centered Care Core Concepts

1. Individualized care- I work with other members of my care team so that my needs, priorities, and goals for my physical, mental, spiritual, and social health guide my care.
2. Family- My family is supported and involved in my care as I choose.
3. Respect, dignity, and compassion are always present.
4. Information sharing/communication- There is an open sharing of information with me, my family, and all other members of my care team(s).
5. Shared decisionmaking- I am helped to understand my choices and I make decisions with my care team, to the extent I want or am able.
6. Self-management- I am prepared and supported to care for myself, to the extent I am able.
7. Access to care/convenience- I can obtain care and information, and reach my care team when I need and how I prefer.

Measurement Framework

Principles for Measure Development

- Selected and/or developed in partnership with individuals to ensure measures are meaningful to those receiving care
- Focused on the person's entire care experience, rather than a single setting, program, or point in time; and
- Measured from the person's perspective and experience (i.e., generally person-reported unless the person/consumer is not the best source of the information).

Person- and Family-Centered Care

- Outcome – Desired outcomes of person- and family-centered care (particularly the experience with care)
- Process - Interaction between person/family and the care team that are intended to facilitate achieving the experience reflected in the core concepts
- Structure - Organizational structure or systems that support person- and family-centered care

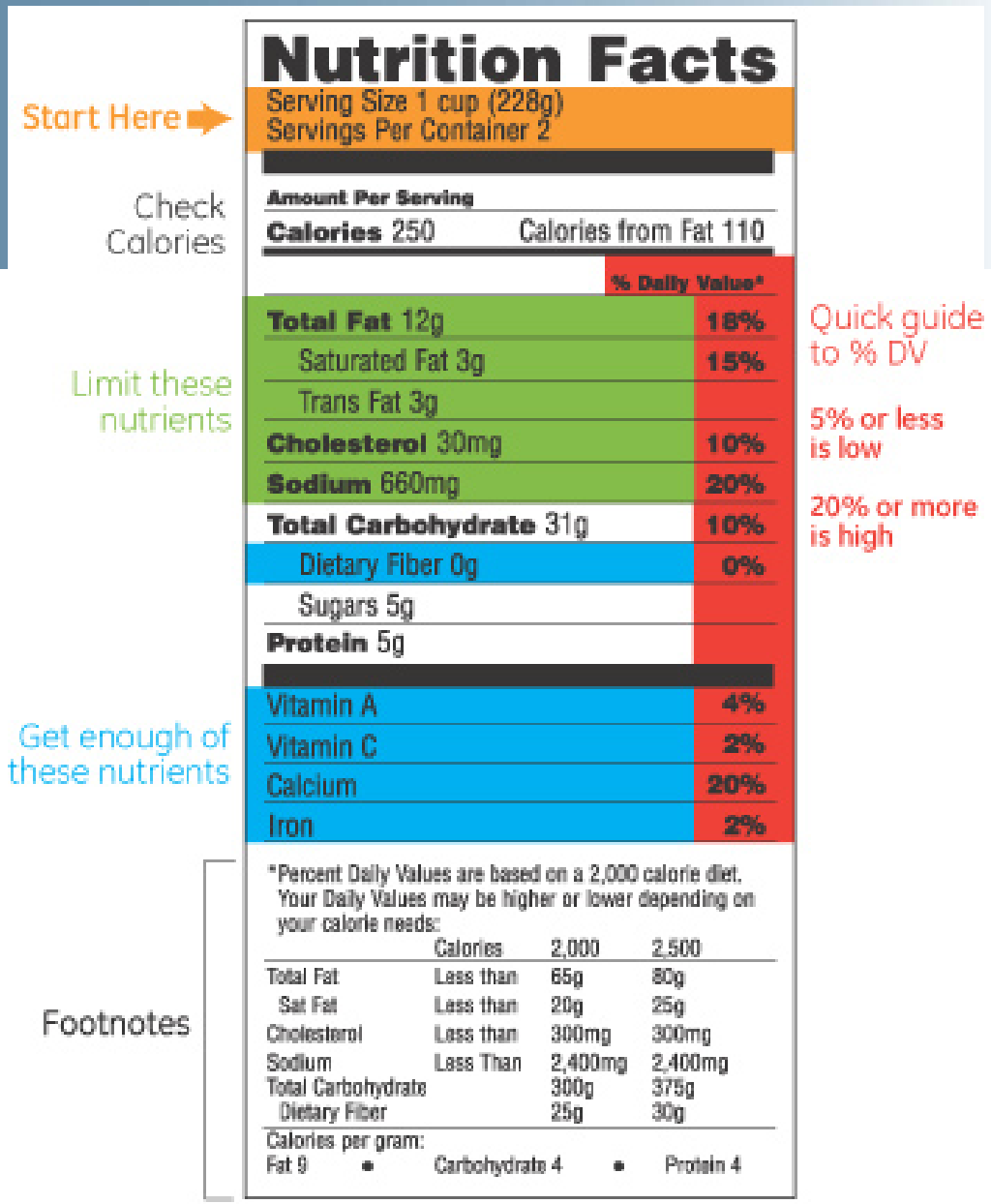
Measurement Framework for Person- and Family-Centered Care

Core Concept	Structure Concepts	Process Concepts	Outcome Concepts
5. Shared decisionmaking – I am helped to understand my choices and I make decisions with my care team, to the extent I want or am able.	• Organization has clear requirements for engagement • Staff training in engagement • System tools to support engagement and shared decisionmaking	• Elicit preferences for shared decisionmaking • Collaborate with individuals to make decisions and to co-produce and implement a care plan that has the best chance of attaining the person's goals • Discuss and obtain advance directives • Ask about surrogate decisionmakers	• I was told about treatment options and their pros and cons and had time to review before making a decision • I was given choices that honored what was important to me and my family • Individual/family understanding of treatment options and their pros and cons • My care team and I agree on my plan of care • Care received matches individual's choices about treatment o Utilization measures (e.g., emergency visits, treatments, procedures, tests) in relation to the individual's decisions about treatment

Label for Person- and Family Centered Care

"Nutrition Label" Idea

- Standard set of items
- Standard definitions
- Standard ways to present information
- Standard format/layout



Label for Person- and Family Centered Care

Person- and Family-Centered Care

Organizational Statement of Person- and Family-Centered Care: 2-3 sentences

Individual/Family Advisory Group: Yes/No, URL link

Individual Portal to Electronic Health Record: Yes/No
- **Entire Record:** Yes/No
- **Partial Access – Test Results:** Yes/No; **Clinical Notes:** Yes/No

Link to Personal Health Record: Yes/No

Non-emergency Communication Options – Phone: Yes/No, **email:** Yes/No, **text:** Yes/No
Languages spoken/translators available:

Hours of Operation: (including extended hours evenings, weekends)
Ease of Scheduling Appointments
- **Same-day appointments:** yes/no
- **Avg. # days to available appointment:** xx days

For Facilities:
- **Open visiting policy:** Yes/No
- **Open staff reports (change of shift, rounds):** Yes/No

Average wait time (from appointment/arrival to see clinician): xx minutes

Individual/Family Support
Navigator/coordinator/coach: Yes/No
Individual support groups: Yes/No, URL link
Family support groups: Yes/No, URL link

Profiles of the Care Team: URL link (education, training, certification, specialties, languages)

Participate in External Quality Performance Measurement: Yes/No
- **Person-centered care measures:** Yes/No, URL link
- **Other quality measures:** Yes/No, URL link

Affordability
Insurance Plans Accepted: URL link
Price List: URL link

Identify Short-Term and Intermediate-Term Recommendations

Overarching recommendations

- Integrate individual and family input into the ongoing dialogue and decisions as performance measures are developed.
- Focus measurement on person-reported experiences and other outcomes over structures and processes.
- Highlight and build on work underway whenever possible.
- Consider the evolving healthcare system.
- Go beyond silos of accountability and measurement.
- Consider actionability by those being measured.

Short-Term Recommendations

- Consider starting with one simple question from the individual's perspective such as "how is your care working out for you?"
- Consider initially focusing on patients with higher levels of need (e.g., individuals with multiple comorbidities, and serious illnesses or those in underserved or disadvantaged populations)
- Consider available CAHPS measures.
- Convene a group comprised of experts on CAHPS and PROMIS for mutual learning and measure development.
- Explore the person-centered care label concept.

Intermediate-Term Recommendations

- Explore developing a “Person-centered Care 10” measure.
- Incorporate the full healthcare experience beyond a single setting.
- Advance family experience measures.
- Fund research to advance measurement of person-and family-centered care.

Comments and Questions

Socio-demographic Status (SDS) Risk Adjustment of Quality Measures: Summarizing the Debate and Current NQF Policy

Outline

- Background
- Various Perspectives
- Policy Change
- Trial Period
- Discussion Questions

Background

NQF has been working to identify and examine the issues related to risk adjusting measures for SES or related demographic factors

In particular, NQF convened an expert panel to consider if, when, for what, and how outcome performance measures should be adjusted for SES or related demographic factors

Background
Why risk adjust?

- Consumers are not randomly assigned to healthcare units and the characteristics of the consumers treated varies across healthcare unit
- Avoid incorrect inferences
- In the context of comparative performance assessment, the general question being addressed is:
  - ***How would the performance compare if hypothetically they had the same mix of consumers*?**

Background
Current Policy on Sociodemographic Factors

- Consumer sociodemographic factors influence outcomes through a variety of pathways
- Sociodemographic factors may also be related to disparities in health and healthcare
- NQF policy to date has prohibited consideration of sociodemographic factors in risk adjustment, preferring stratification based on these variables
  - Sociodemographic factors =
    - » Socioeconomic (e.g., income, education, occupation)
    - » Demographic factors (e.g., age, race, ethnicity, primary language)

*Race/ethnicity should not be used as a proxy for SES.

Risk Adjustment vs. Stratification

- **Risk adjustment (or case-mix adjustment)** refers to statistical methods to control or account for patient-related factors when computing performance measure scores; methods include multivariable modeling, indirect standardization, or direct standardization. These methods can be used to produce a ratio of observed-to-expected, a risk-adjusted rate, or other estimate of performance.
- **Stratification** refers to computing performance scores separately for different strata or groupings of patients based on some characteristics(s)—i.e., each healthcare unit has multiple performance scores (one for each stratum) rather than one overall performance score.

Background
Core Principles

1. Outcome performance measurement is critical to the aims of the National Quality Strategy.
2. Disparities in health and healthcare should be identified and reduced.
3. Performance measurement should not lead to increased disparities in health and healthcare.
4. Outcomes may be influenced by patient health status, clinical, and sociodemographic factors, in addition to the quality and effectiveness of healthcare services, treatments, and interventions.

Background
Core Principles

5. When used in accountability applications, performance measures that are influenced by factors other than the care received, particularly outcomes, need to be adjusted for relevant differences in case mix to avoid incorrect inferences about performance.
6. Risk adjustment may be constrained by data limitations and data collection burden.
7. The methods, factors, and rationale for risk adjustment should be transparent.

Various Perspectives
At Least Two Divergent Views on SDS Adjustment

- Adjusting for sociodemographic factors will mask disparities

- Adjusting for sociodemographic factors is necessary to avoid making incorrect inferences in the context of comparative performance assessment

Oppose Adjustment for Sociodemographic Factors

- Some providers may deliver worse quality care to disadvantaged consumers
- Adjustment could make meaningful differences in quality disappear
- Worse outcomes could be expected
  - No expectation to improve
  - Implies or sets a different standard
- Lack of adequate data for SDS adjustment
- Prefer payment approach to help safety net

Support Adjustment for Sociodemographic Factors

- Risk adjustment allows for comparative performance
- A performance score alone (whether or not adjusted for sociodemographic factors) cannot identify disparities.
- Hospitals caring for the disadvantaged are already being penalized.
- No evidence that disparities would be reduced through further negative financial incentives.
- Lack of adjustment would continue to create a disincentive to care for the poor.

NQF Policy Change

- Each measure must be assessed individually to determine if SDS adjustment appropriate.
- Not all outcomes should be adjusted for SDS factors (e.g., central line infection would not be adjusted)
  - Need conceptual basis (logical rationale, theory) and empirical evidence
- The recommendations apply to any level of analysis including health plans, facilities, and individual clinicians.

Reinforce Guidelines for Selecting Risk Factors

- ✓ Clinical/conceptual relationship with the outcome of interest
- ✓ Empirical association with the outcome of interest
- ✓ Variation in prevalence of the factor across the measured entities
- ✓ Present at the start of care
- ✓ Is not an indicator or characteristic of the care provided (e.g., treatments, expertise of staff)
- ✓ Resistant to manipulation or gaming
- ✓ Accurate data that can be reliably and feasibly captured
- ✓ Contribution of unique variation in the outcome (i.e., not redundant)
- ✓ Potentially, improvement of the risk model (e.g., risk model metrics of discrimination, calibration)
- ✓ Potentially, face validity and acceptability

Trial Period

- NQF will undergo a two-year trial period prior to a permanent change in NQF policy.
- During the trial period if SDS adjustment is determined to be appropriate for a given measure, NQF will endorse one measure with specifications to compute:
  - SDS-adjusted measure
  - Non-SDS version of the measure (clinically adjusted only)
  - Stratification of the non-SDS-adjusted version

Intersections with MAP Duals Work

- When measurement programs use a national average (rather than peer groups) to determine a benchmark or performance threshold and measures within the programs are not risk-adjusted, entities that serve a higher proportion of dual eligible beneficiaries may be disadvantaged.
  - Medicare Advantage Star Ratings
  - Hospital Readmission Reduction Program
- BUT employing risk adjustment and stratification will not address the underlying problem of poor care for complex consumers.

Discussion Questions

- None of the measures available for today's discussion have SDS risk adjustment present, but measures of this type are expected to emerge in the coming year.
  - Are there considerations for this project associated with the NQF policy change?
- How can we avoid misuse of measures for this population?
  - For health plans that enroll dual eligible beneficiaries?
  - For hospitals and other providers that care for dual eligible beneficiaries?
- What delivery system changes are needed to improve care for populations with low SDS?

Opportunity for Public Comment

Voices from the Field: Complex Beneficiary Engagement Strategies for Health Plans

- Slides from CareOregon are forthcoming.

Voices from the Field: Complex Beneficiary Engagement Strategies for Practitioners

- Slides from Steve Counsell are forthcoming.

Integrated Behavioral Health: Overview

Content in this section developed by Jürgen Unützer, MD, MPH, MA; Chair, Psychiatry and Behavioral Sciences; University of Washington

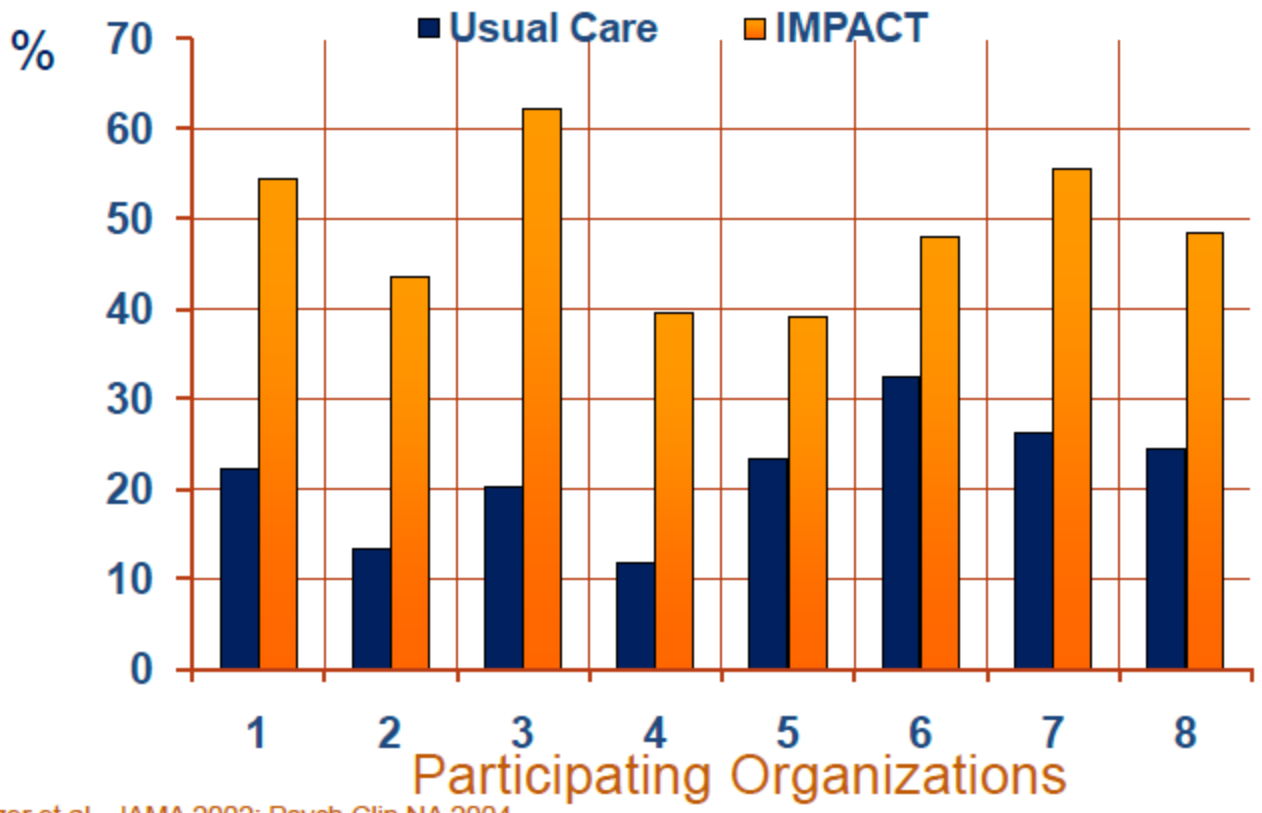
- Mental illness and substance use are major drivers of disability (25% worldwide) and costs (>250% increase with a BH diagnosis)
- Fewer than half of consumers in need have access to effective specialty behavioral health care.
- Mental and medical disorders are tightly linked
- Integration of behavioral health with primary care provides better access, better outcomes, and lower costs

Integrated Behavioral Health: Current Lack of Access

- 6/10 get no care at all
- Of those who get care:
  - Only 2/10 see a trained mental health professional
  - Most receive treatment in primary care
  - 30 million receive a prescription for a psychiatric medication in primary care
  - Only 1 in 4 improve
- 2 out of 3 primary care providers report poor access to mental health services for their patients

IC doubles effectiveness of care for depression

50 % or greater improvement in depression at 12 months



Unützer et al., JAMA 2002; Psych Clin NA 2004

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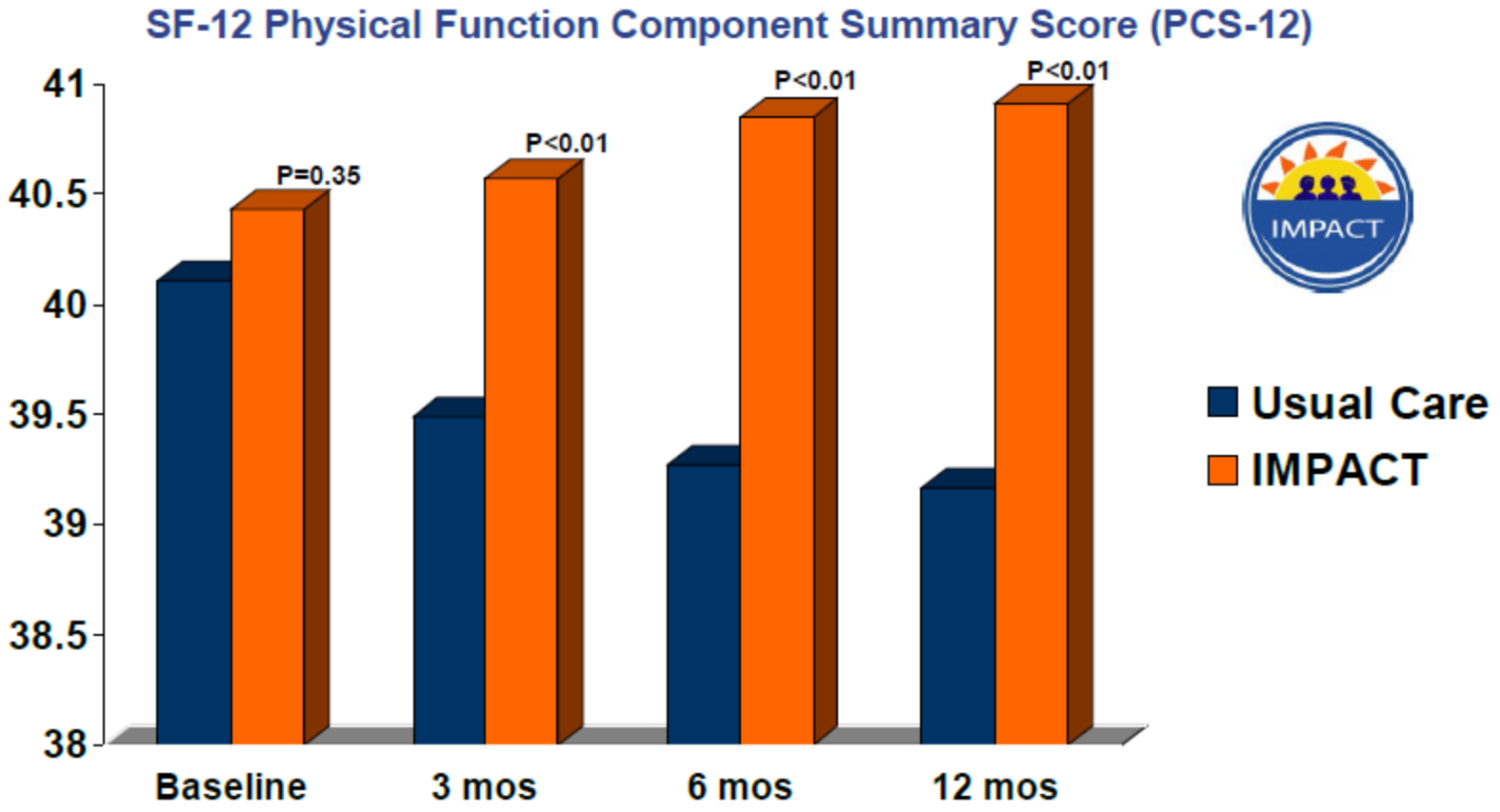
IC improves physical function



Callahan et al., *JAGS* 2005; 53:367-373

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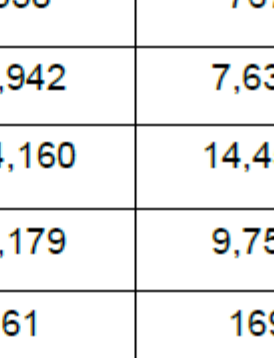
IC reduces health care costs

ROI: $ 6.5 saved / $ 1 invested

Cost Category	4-year costs in $	Intervention group cost in $	Usual care group cost in $	Difference in $
IMPACT program cost		522	0	522
Outpatient mental health costs	661	558	767	-210
Pharmacy costs	7,284	6,942	7,636	-694
Other outpatient costs	14,306	14,160	14,456	-296
Inpatient medical costs	8,452	7,179	9,757	-2578
Inpatient mental health / substance abuse costs	114	61	169	-108
Total health care cost	31,082	29,422	32,785	-$3363

Savings



Unützer et al., *Am J Managed Care 2008.*

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- Replication studies of integrated care show the model can translate
- Other approaches are demonstrated to be ineffective:
  - Screening without adequate treatment
  - Referral to specialty care without close coordination (or 50% will fall through the cracks)
  - Co-located behavioral health specialists without effective oversight

Principles of Effective Integrated Behavioral Health Care

- Person-Centered Team Care / Collaborative Care
  - Colocation is not collaboration. Team members have to learn new skills.
- Population-Based Care
  - Consumers are tracked in a registry and monitored
- Measurement-Based Treatment to Target
  - Treatments are actively changed until the clinical goals are achieved
- Evidence-Based Care
- Accountable Care

Workgroup Discussion

- How do these models respond to the unique needs of dual eligible beneficiaries?
- Is there sufficient evidence that they improve quality?
- What can be done to spread the adoption of evidence-based practices such as these?

Synthesis and Recommendations

- Slides from Gretchen Alkema are forthcoming.

Workgroup Discussion

- Which measure gap areas have the most relevance to the broadest range of stakeholders?
  - Quality of life outcomes?
  - Functional status outcomes?
  - Community residence?
  - Others?
- What is needed to accelerate measure development in these areas?

Workgroup Discussion

- What discussion themes raised over the course of the meeting warrant further exploration?

- Does MAP recommend any specific course of action to accelerate the adoption of evidence-based practices that support person-centered care?

Opportunity for Public Comment

Next Steps

- Draft Report for workgroup review and commenting: spring/summer 2015
- Public comment period of 30 days will follow workgroup review
- Final Report: by August 31, 2015

Thank You!

Maintaining the Family of Measures and Gap Areas

MAP Dual Eligible Beneficiaries Workgroup In-Person Meeting
March 4-5, 2015

Overview

Family of Measures for Dual Eligible Beneficiaries

MAP published the first iteration of the Family of Measures for Dual Eligible Beneficiaries in 2013 and an update last year, in 2014. A family of measures is a set of related measures that best address an important quality issue and span the continuum of care. The family serves as a starting place for any stakeholder operating a measurement program to identify measures that fit their program needs. It also promotes the use of measures that address high leverage opportunities for quality improvement in the dual eligible beneficiary population. Ultimately, as use of the family of measures as a selection tool increases, the family facilitates alignment of measure use across programs. This workgroup has looked purposefully across care settings, within specific content areas, and through varying levels of analysis to assess important quality issues and identify measurement gaps. Periodic updates of the family are intended to ensure the Family reflects the best available measures to address the population needs and the most important measure gaps.

Measures are occasionally removed from the NQF-endorsed® portfolio at the request of their stewards or because they are found to no longer meet the endorsement criteria. Since MAP's last review of the Family, two measures within it have had their endorsement removed:

> NQF #0111 *Bipolar Disorder: Appraisal for risk of suicide* was retired by the measure steward. Two potential alternatives are listed below and further described in a following section:
>
> - NQF #0104: *Adult Major Depressive Disorder (MDD): Suicide Risk Assessment* **(staff pick)**
> - NQF #1880: Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder
>
> NQF #0007 *NCQA Supplemental items for CAHPS® 4.0 Adult Questionnaire (CAHPS 4.0H)* was retired by the measure steward. Substantial revisions of shared decision-making and care coordination questions are underway but not yet available for MAP review.

Prioritized Gap Areas for Dual Eligible Beneficiaries

The workgroup has prioritized measure gaps to address dual eligible beneficiary needs listed below. A complete list of all the gaps identified by the workgroup is available in the 2012 report.

- 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)

Newly Endorsed Measures for Workgroup Consideration

Several measures have been endorsed since the workgroup last met. NQF staff have conducted a review and identified potential gap-filling measures to consider for inclusion in the Family. The 21 measures included primarily address two gap areas: 1) goal-directed, person-centered care planning and implementation; and 2) systems to coordinate acute care, long-term services and supports, and nonmedical community resources. They are listed by endorsement project and topic area below. Other measures that received endorsement in the last year were judged by staff to be irrelevant to the prioritized gap areas.

Endorsement Project and Topic	Measures for MAP Review
Care Coordination	NQF # 2456 Medication Reconciliation: Number of Unintentional Medication Discrepancies per Patient
Admission and Readmission	NQF #2375: PointRight ® Pro 30™ NQF #2510 Skilled Nursing Facility 30-Day All-Cause Readmission Measure (SNFRM) NQF #2380: Rehospitalization During the First 30 Days of Home Health NQF #2380: Rehospitalization During the First 30 Days of Home Health NQF #2505: Emergency Department Use without Hospital Readmission During the First 30 Days of Home Health NQF #2502: All-Cause Unplanned Readmission Measure for 30 Days Post Discharge from Inpatient Rehabilitation Facilities (IRFs) NQF #2503: Hospitalizations per 1000 Medicare fee-for-service (FFS) Beneficiaries NQF #2504: 30-day Rehospitalizations per 1000 Medicare fee-for-service (FFS) Beneficiaries NQF #2496: Standardized Readmission Ratio (SRR) for dialysis facilities

Endorsement Project and Topic	Measures for MAP Review
Behavioral Health	NQF #2605 Follow-up after Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence NQF #2599 Alcohol Screening and Follow-up for People with Serious Mental Illness NQF #2602 Controlling High Blood Pressure for People with Serious Mental Illness NQF #2600 Tobacco Use Screening and Follow-up for People with Serious Mental Illness or Alcohol or Other Drug Dependence NQF #2601 Body Mass Index Screening and Follow-Up for People with Serious Mental Illness NQF #2603 Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Testing NQF #2604 Diabetes Care for People with Serious Mental Illness: Medical Attention for Nephropathy NQF #2606 Diabetes Care for People with Serious Mental Illness: Blood Pressure Control (<140/90 mm Hg) NQF #2607 Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) NQF #2608 Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Control (<8.0%) NQF #2609 Diabetes Care for People with Serious Mental Illness: Eye Exam NQF #2597 Substance Use Screening and Intervention Composite

Measures to Consider to Update the Family

Two potential measures to replace the retired measure NQF #0111 Bipolar Disorder: Appraisal for risk of suicide are present in the NQF portfolio

- NQF #0104: *Adult Major Depressive Disorder (MDD): Suicide Risk Assessment (AMA-PCPI)* ***(staff pick)***
- NQF #1880: Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder (Centers for Medicare & Medicaid Services)

	Measure 0104: Adult Major Depressive Disorder (MDD): Suicide Risk Assessment (American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI))
Description	Percentage of patients aged 18 years and older with a new diagnosis or recurrent episode of major depressive disorder (MDD) with a suicide risk assessment completed during the visit in which a new diagnosis or recurrent episode was identified
Numerator	Patients with a suicide risk assessment completed during the visit in which a new diagnosis or recurrent episode was identified
Denominator	All patients aged 18 years and older with a new diagnosis or recurrent episode of major depressive disorder (MDD)
Exclusions	None
Risk Adjustment	No risk adjustment or risk stratification
Stratification	We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.
Type	Process
Data Source	Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Registry
Level	Clinician : Group/Practice, Clinician : Individual, Clinician : Team
Setting	Ambulatory Care : Clinician Office/Clinic, Ambulatory Care : Urgent Care, Behavioral Health/Psychiatric : Outpatient, Other

	Measure 1880: Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder (Centers for Medicare & Medicaid Services)
Description	The measure calculates the percentage of individuals 18 years of age or greater as of the beginning of the measurement period with bipolar I disorder who are prescribed a mood stabilizer medication, with adherence to the mood stabilizer medication [defined as a Proportion of Days Covered (PDC)] of at least 0.8 during the measurement period (12 consecutive months).
Numerator	Individuals with bipolar I disorder who filled at least two prescriptions for any mood stabilizer medication and have a Proportion of Days Covered (PDC) for mood stabilizer medications of at least 0.8.
Denominator	Individuals at least 18 years of age as of the beginning of the measurement period with bipolar I disorder with at least two claims for any mood stabilizer medication during the measurement period (12 consecutive months).
Exclusions	Not Applicable
Risk Adjustment	No risk adjustment or risk stratification

Stratification	Depending on the operational use of the measure, measure results may be stratified by: • State • Accountable Care Organizations (ACOs)* • Plan • Physician Group** • Age- Divided into 6 categories: 18-24, 25-44, 45-64, 65-74, 75-84, and 85+ years • Race/Ethnicity • Dual Eligibility *ACO attribution methodology is based on where the beneficiary is receiving the plurality of his/her primary care services and subsequently assigned to the participating providers. **See attachment referenced in Section 2a.1.21 for the physician group attribution methodology used for this measure.
Type	Process
Type of Score	Rate/proportion
Data Source	Administrative claims, Electronic Clinical Data : Pharmacy, Other
Level	Clinician : Group/Practice, Health Plan, Integrated Delivery System, Population : State
Setting	Ambulatory Care : Clinician Office/Clinic, Behavioral Health/Psychiatric : Outpatient

Gap Areas: Systems to coordinate acute care, long-term services and supports, and nonmedical community resources; Goal-directed, person-centered care planning and implementation

Care Coordination Measure

- NQF # 2456 Medication Reconciliation: Number of Unintentional Medication Discrepancies per Patient

	Measure 2456: Medication Reconciliation: Number of Unintentional Medication Discrepancies per Patient (Brigham and Women's Hospital)
Description	This measure assesses the actual quality of the medication reconciliation process by identifying errors in admission and discharge medication orders due to problems with the medication reconciliation process. The target population is any hospitalized adult patient. The time frame is the hospitalization period. At the time of admission, the admission orders are compared to the preadmission medication list (PAML) compiled by trained pharmacist (i.e., the gold standard) to look for discrepancies and identify which discrepancies were unintentional using brief medical record review. This process is repeated at the time of discharge where the discharge medication list is compared to the PAML and medications ordered during the hospitalization.
Numerator	For each sampled inpatient in the denominator, the total number of unintentional medication discrepancies in admission orders plus the total number of unintentional medication discrepancies in discharge orders.
Denominator	The patient denominator includes a random sample of all potential adults admitted to the hospital. Our recommendation is that 25 patients are sampled per month, or approximately 1 patient per weekday. So, for example, if among those 25 patients, 75 unintentional discrepancies are identified, the measure outcome would be 3 discrepancies per patient for that hospital for that month.
Exclusions	Patients that are discharged or expire before a gold standard medication list can be obtained.
Risk Adjustment	No risk adjustment or risk stratification
Stratification	Stratification could be done by service if desired by NQF, for example: non-ICU medicine, non-ICU surgery, ICU, and other.
Numerator Time window	The time period is from the time of hospital admission to discharge.
Type	Outcome
Type of Score	Continuous variable, e.g. average
Data Source	Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Pharmacy, Healthcare Provider Survey, Other, Paper Medical Records, Patient Reported Data/Survey
Level	Facility
Setting	Hospital/Acute Care Facility

Gap Areas: Systems to coordinate acute care, long-term services and supports, and nonmedical community resources; Goal-directed, person-centered care planning and implementation

Admission and Readmissions Measures

- Skilled Nursing Facilities:
    - NQF #2375: PointRight ® Pro 30™
    - NQF #2510 Skilled Nursing Facility 30-Day All-Cause Readmission Measure (SNFRM)
- Home Health
    - *NQF #2380: Rehospitalization During the First 30 Days of Home Health* ***(staff pick)***
    - *NQF #2505: Emergency Department Use without Hospital Readmission During the First 30 Days of Home Health* ***(staff pick)***
- Inpatient Rehabilitation Facilities
    - *NQF #2502: All-Cause Unplanned Readmission Measure for 30 Days Post Discharge from Inpatient Rehabilitation Facilities (IRFs)* ***(staff pick)***
- Population Measures:
    - NQF #2503: Hospitalizations per 1000 Medicare fee-for-service (FFS) Beneficiaries
    - NQF #2504: 30-day Rehospitalizations per 1000 Medicare fee-for-service (FFS) Beneficiaries
- Dialysis
    - NQF #2496: Standardized Readmission Ratio (SRR) for dialysis facilities

	Measure 2375: PointRight ® Pro 30™ (American Health Care Association)
Description	PointRight OnPoint-30 is an all-cause, risk adjusted rehospitalization measure. It provides the rate at which all patients (regardless of payer status or diagnosis) who enter skilled nursing facilities (SNFs) from acute hospitals and are subsequently rehospitalized during their SNF stay, within 30 days from their admission to the SNF.
Numerator	The numerator is the number of patients sent back to any acute care hospital (excluding emergency room only visits) during their SNF stay within 30 days from a SNF admission, as indicated on the MDS 3.0 discharge assessment during the 12 month measurement period.
Denominator	The denominator is the number of all admissions,regardless of payer status and diagnosis, with an MDS 3.0 admission assessment to a SNF from an acute hospital during the target rolling 12 month period.
Exclusions	The denominator has 2 different exclusions: individual level and provider level. At the individual level the exclusion is related to incomplete assessments. At the provider level the exclusion is related to the amount of data necessary to calculate the measure that is missing. Payer status and clinical conditions are not used for any exclusions.
Risk Adjustment	Statistical risk model
Stratification	N/A
Type	Outcome
Data Source	Electronic Clinical Data
Level	Facility
Setting	Post Acute/Long Term Care Facility : Nursing Home/Skilled Nursing Facility

	Measure 2510: Skilled Nursing Facility 30-Day All-Cause Readmission Measure (SNFRM) (Centers for Medicare & Medicaid Services)
Description	This measure estimates the risk-standardized rate of all-cause, unplanned, hospital readmissions for patients who have been admitted to a Skilled Nursing Facility (SNF) (Medicare fee-for-service [FFS] beneficiaries) within 30 days of discharge from their prior proximal hospitalization. The prior proximal hospitalization is defined as an admission to an IPPS, CAH, or a psychiatric hospital. The measure is based on data for 12 months of SNF admissions. A risk-adjusted readmission rate for each facility is calculated as follows: Step 1: Calculate the standardized risk ratio of the predicted number of readmissions at the facility divided by the expected number of readmissions for the same patients if treated at the average facility. The magnitude of the risk-standardized ratio is the indicator of a facility's effects on readmission rates. Step 2: The standardized risk ratio is then multiplied by the mean rate of readmission in the population (i.e., all Medicare FFS patients included in the measure) to generate the facility-level standardized readmission rate. For this measure, readmissions that are usually for planned procedures are excluded. Please refer to the Appendix, Tables 1 - 5 for a list of planned procedures. The measure specifications are designed to harmonize with CMS' hospital-wide readmission (HWR) measure to the greatest extent possible. The HWR (NQF #1789) estimates the hospital-level, risk-standardize rate of unplanned, all-cause readmissions within 30 days of a hospital discharge and uses the same 30-day risk window as the SNFRM.
Numerator	This measure is designed to capture the outcome of unplanned all-cause hospital readmissions (IPPS or CAH) of SNF patients occurring within 30 days of discharge from the patient's prior proximal acute hospitalization. The numerator is more specifically defined as the risk-adjusted estimate of the number of unplanned readmissions that occurred within 30 days from discharge from the prior proximal acute hospitalization. The numerator is mathematically related to the number of SNF stays where there was hospitalization readmission, but the measure does not have a simple form for the numerator and denominator—that is, the risk adjustment method used does not make the observed number of readmissions the numerator and a predicted number the denominator. The numerator, as defined, includes risk adjustment for patient characteristics and a statistical estimate of the facility effect beyond patient mix. Hospital readmissions that occur after discharge from the SNF stay but within 30 days of the proximal hospitalization are also included in the numerator. Readmissions identified using the Planned Readmission algorithm (see Section S.6) are excluded from the numerator. This measure does not include observation stays as a readmission (see Section S.6).
Denominator	The denominator is computed with the same model used for the numerator. It is the model developed using all non-excluded SNF stays in the national data. For a particular facility the model is applied to the patient population, but the facility effect term is 0. In effect, it is the number of SNF admissions within 1 day of a prior proximal hospital discharge during a target year, taking denominator exclusions into account. Prior proximal hospitalizations are defined as admissions to an IPPS acute-care hospital, CAH, or psychiatric hospital.
Exclusions	The following are excluded from the denominator: 1. SNF stays where the patient had one or more intervening post-acute care (PAC) admissions (inpatient rehabilitation facility [IRF] or long-term care hospital [LTCH]) which occurred either between the prior

	proximal hospital discharge and SNF admission or after the SNF discharge, within the 30-day risk window. Also excluded are SNF admissions where the patient had multiple SNF admissions after the prior proximal hospitalization, within the 30-day risk window. Rationale: For patients who have IRF or LTCH admissions prior to their first SNF admission, these patients are starting their SNF admission later in the 30-day risk window and receiving other additional types of services as compared to patients admitted directly to the SNF from the prior proximal hospitalization. They are clinically different and their risk for readmission is different than the rest of SNF admissions. Additionally, when patients have multiple PAC admissions, evaluating quality of care coordination is confounded and even controversial in terms of attributing responsibility for a readmission among multiple PAC providers. Similarly, assigning responsibility for a readmission for patients who have multiple SNF admissions subsequent to their prior proximal hospitalization is also controversial. 2. SNF stays with a gap of greater than 1 day between discharge from the prior proximal hospitalization and the SNF admission. Rationale: These patients are starting their SNF admissions later in the 30-day risk window than patients admitted directly to the SNF from the prior proximal hospitalization. They are clinically different and their risk for readmission is different than the rest of SNF admissions. 3.SNF stays where the patient did not have at least 12 months of FFS Medicare enrollment prior to the proximal hospital discharge (measured as enrollment during the month of proximal hospital discharge and the for 11 months prior to that discharge). Rationale: FFS Medicare claims are used to identify comorbidities during the 12-month period prior to the proximal hospital discharge for risk adjustment. Multiple studies have shown that using lookback scans of a year or more of claims data provide superior predictive power for outcomes including rehospitalization as compared to using data from a single hospitalization (e.g., Klabunde et al., 2000; Preen et al, 2006; Zhang et al., 1999). 4.SNF stays in which the patient did not have FFS Medicare enrollment for the entire risk period (measured as enrollment during the month of proximal hospital discharge and the month following the month of discharge). Rationale: Readmissions occurring within the 30-day risk window when the patient does not have FFS Medicare coverage cannot be detected using claims. 5.SNF stays in which the principal diagnosis for the prior proximal hospitalization was for the medical treatment of cancer. Patients with cancer whose principal diagnosis from the prior proximal hospitalization was for other diagnoses or for surgical treatment of their cancer remain in the measure. Rationale: These admissions have a very different mortality and readmission risk than the rest of the Medicare population, and outcomes for these admissions do not correlate well with outcomes for other admissions. 6.SNF stays where the patient was discharged from the SNF against medical advice. Rationale: The SNF was not able to complete care as needed. 7.SNF stays in which the principal primary diagnosis for the prior proximal hospitalization was for "rehabilitation care; fitting of prostheses and for the adjustment of devices". Rationale: Hospital admissions for these conditions are not for acute care.
Risk Adjustment	Statistical risk model
Stratification	Not applicable
Type	Outcome
Data Source	Administrative claims, Other

Level	Facility
Setting	Post Acute/Long Term Care Facility : Nursing Home/Skilled Nursing Facility

	Measure 2380: Rehospitalization During the First 30 Days of Home Health (Centers for Medicare & Medicaid Services)
Description	Percentage of home health stays in which patients who had an acute inpatient hospitalization in the 5 days before the start of their home health stay were admitted to an acute care hospital during the 30 days following the start of the home health stay.
Numerator	Number of home health stays for patients who have a Medicare claim for an admission to an acute care hospital in the 30 days following the start of the home health stay.
Denominator	Number of home health stays that begin during the relevant observation period for patients who had an acute inpatient hospitalization in the five days prior to the start of the home health stay. A home health stay is a sequence of home health payment episodes separated from other home health payment episodes by at least 60 days.
Exclusions	The measure denominator excludes several types of home health stays: First, the measure denominator for the Rehospitalization During the First 30 Days of Home Health measure excludes the following home health stays that are also excluded from the all-patient claims-based NQF 0171 Acute Care Hospitalization measure: (i) Stays for patients who are not continuously enrolled in fee-for-service Medicare during the measure numerator window; (ii) Stays that begin with a Low-Utilization Payment Adjustment (LUPA). Stays with four or fewer visits to the beneficiary qualify for LUPAs; (iii) Stays in which the patient is transferred to another home health agency within a home health payment episode (60 days); and (iv) Stays in which the patient is not continuously enrolled in Medicare fee-for-service during the previous six months. Second, to be consistent with the Hospital-Wide All-Cause Unplanned Readmission measure (as of January 2013), the measure denominator excludes stays in which the hospitalization occurring within 5 days of the start of home health care is not a qualifying inpatient stay. Hospitalizations that do not qualify as index hospitalizations include admissions for the medical treatment of cancer, primary psychiatric disease, or rehabilitation care, and admissions ending in patient discharge against medical advice. Third, the measure denominator excludes stays in which the patient receives treatment in another setting in the 5 days between hospital discharge and the start of home health. Finally, stays with missing payment-episode authorization strings (needed for risk-adjustment) are excluded.
Risk Adjustment	Statistical risk model
Stratification	The measure is not stratified.
Type	Outcome
Data Source	Administrative claims
Level	Facility
Setting	Home Health

	Measure 2505: Emergency Department Use without Hospital Readmission During the First 30 Days of Home Health (Centers for Medicare & Medicaid Services)
Description	Percentage of home health stays in which patients who had an acute inpatient hospitalization in the 5 days before the start of their home health stay used an emergency department but were not admitted to an acute care hospital during the 30 days following the start of the home health stay.
Numerator	Number of home health stays for patients who have a Medicare claim for outpatient emergency department use and no claims for acute care hospitalization in the 30 days following the start of the home health stay.
Denominator	Number of home health stays that begin during the relevant observation period for patients who had an acute inpatient hospitalization in the five days prior to the start of the home health stay. A home health stay is a sequence of home health payment episodes separated from other home health payment episodes by at least 60 days.
Exclusions	The measure denominator excludes several types of home health stays: First, the measure denominator for the Rehospitalization During the First 30 Days of Home Health measure excludes the following home health stays that are also excluded from the all-patient claims-based NQF 0171 Acute Care Hospitalization measure: (i) Stays for patients who are not continuously enrolled in fee-for-service Medicare during the measure numerator window; (ii) Stays that begin with a Low-Utilization Payment Adjustment (LUPA). Stays with four or fewer visits to the beneficiary qualify for LUPAs; (iii) Stays in which the patient is transferred to another home health agency within a home health payment episode (60 days); and (iv) Stays in which the patient is not continuously enrolled in Medicare fee-for-service during the previous six months. Second, to be consistent with the Hospital-Wide All-Cause Unplanned Readmission measure (as of January 2013), the measure denominator excludes stays in which the hospitalization occurring within 5 days of the start of home health care is not a qualifying inpatient stay. Hospitalizations that do not qualify as index hospitalizations include admissions for the medical treatment of cancer, primary psychiatric disease, or rehabilitation care, and admissions ending in patient discharge against medical advice. Third, the measure denominator excludes stays in which the patient receives treatment in another setting in the 5 days between hospital discharge and the start of home health. Finally, stays with missing payment-episode authorization strings (needed for risk-adjustment) are excluded.
Risk Adjustment	Statistical risk model
Stratification	The measure is not stratified.
Type	Outcome
Data Source	Administrative claims
Level	Facility
Setting	Home Health

	Measure 2502: All-Cause Unplanned Readmission Measure for 30 Days Post Discharge from Inpatient Rehabilitation Facilities (IRFs) (Centers for Medicare & Medicaid Services)
Description	This measure estimates the risk-standardized rate of unplanned, all-cause readmissions for patients (Medicare fee-for-service [FFS] beneficiaries) discharged from an Inpatient Rehabilitation Facility (IRF) who were readmitted to a short-stay acute-care hospital or a Long-Term Care Hospital (LTCH), within 30 days of an IRF discharge. The measure is based on data for 24 months of IRF discharges to non-hospital post-acute levels of care or to the community. A risk-adjusted readmission rate for each facility is calculated as follows: Step 1: Calculate the standardized risk ratio of the predicted number of readmissions at the facility divided by the expected number of readmissions for the same patients if treated at the average facility. The magnitude of the risk-standardized ratio is the indicator of a facility's effects on readmission rates. Step 2: The standardized risk ratio is then multiplied by the mean rate of readmission in the population (i.e., all Medicare FFS patients included in the measure) to generate the facility-level standardized readmission rate. For this measure, readmissions that are usually for planned procedures are excluded. Please refer to Appendix Tables A1-A5 for a list of planned procedures. The measure specifications are designed to harmonize with CMS' hospital-wide readmission (HWR) measure to a great extent. The HWR (NQF #1789) estimates the hospital-level, risk-standardized rate of unplanned, all-cause readmissions within 30 days of a hospital discharge, similar to this IRF readmission measure.
Numerator	The numerator is mathematically related to the number of patients in the target population who have the event of an unplanned readmission in the 30- day post-discharge window. The measure does not have a simple form for the numerator and denominator—that is, the risk adjustment method used does not make the observed number of readmissions the numerator and a predicted number the denominator. Instead, the numerator is the risk-adjusted estimate of the number of unplanned readmissions that occurred within 30 days from discharge. This estimate includes risk adjustment for patient characteristics and a statistical estimate of the facility effect beyond patient mix.
Denominator	The denominator is computed with the same model used for the numerator. It is the model developed using all non-excluded IRF stays in the national data. For a particular facility the model is applied to the patient population, but the facility effect term is 0. In effect, it is the number of readmissions that would be expected for that patient population at the average IRF. The measure includes all the IRF stays in the measurement period that are observed in national Medicare FFS data and do not fall into an excluded category.
Exclusions	The measure excludes some IRF patient stays; some of these exclusions result from data limitations. The following are the measure's denominator exclusions, including the rationale for exclusion: 1. IRF patients who died during the IRF stay. Rationale: A post-discharge readmission measure is not relevant for patients who died during their IRF stay. 2. IRF patients less than 18 years old. Rationale: IRF patients under 18 years old are not included in the target population for this measure. Pediatric patients are relatively few and may have different patterns of care from adults.

	3. IRF patients who were transferred at the end of a stay to another IRF or short-term acute care hospital. Rationale: Patients who were transferred to another IRF or short-term acute-care hospital are excluded from this measure because the transfer suggests that either their IRF treatment has not been completed or that their condition worsened, requiring a transfer back to the acute care setting. The intent of the measure is to follow patients deemed well enough to be discharged to a less intensive care setting (i.e., discharged to less intense levels of care or to the community). 4. Patients who were not continuously enrolled in Part A FFS Medicare for the 12 months prior to the IRF stay admission date, and at least 30 days after IRF stay discharge date. Rationale: The adjustment for certain comorbid conditions in the measure requires information on acute inpatient bills for 1 year prior to the IRF admission, and readmissions must be observable in the observation window following discharge. Patients without Part A coverage or who are enrolled in Medicare Advantage plans will not have complete inpatient claims in the system. 5. Patients who did not have a short-term acute-care stay within 30 days prior to an IRF stay admission date. Rationale: This measure requires information from the prior short-term acute-care stay in the elements used for risk adjustment. 6. IRF patients discharged against medical advice (AMA). Rationale: Patients discharged AMA are excluded because these patients have not completed their full course of treatment in the opinion of the facility. 7. IRF patients for whom the prior short-term acute-care stay was for nonsurgical treatment of cancer. Rationale: Consistent with the HWR Measure, patients for whom the prior short-term acute-care stay was for nonsurgical treatment of cancer are excluded because these patients were identified as following a very different trajectory after discharge, with a particularly high mortality rate. 8. IRF stays with data that are problematic (e.g., anomalous records for hospital stays that overlap wholly or in part or are otherwise erroneous or contradictory). Rationale: This measure requires accurate information from the IRF stay and prior short-term acute-care stays in the elements used for risk adjustment. No-pay IRF stays involving exhaustion of Part A benefits are also excluded.
Risk Adjustment	Statistical risk model
Stratification	N/A
Type	Outcome
Data Source	Administrative claims, Other
Level	Facility
Setting	Post Acute/Long Term Care Facility : Inpatient Rehabilitation Facility

	Measure 2503: Hospitalizations per 1000 Medicare fee-for-service (FFS) Beneficiaries (Centers for Medicare & Medicaid Services)
Description	Number of hospital discharges from an acute care hospital (PPS or CAH) per 1000 FFS Medicare beneficiaries at the state and community level by quarter and year.
Numerator	Number of hospital discharges from an acute care hospital (PPS or CAH)
Numerator Details	Inclusions: Any discharge from a PPS or CAH Exclusions: Hospitalizations having a discharge date that is the same as the admission date on a subsequent claim
Denominator	Medicare FFS beneficiaries, prorated based on the number of days of FFS eligibility in the time period (quarter or year).
Denominator Details	To calculate the denominator, count the days each beneficiary was enrolled in FFS Medicare in the time period (quarter or year). For each beneficiary, the number of days of FFS Medicare eligibility is determined by evaluating HMO enrollment (BENE_HMO_IND_XX) and time to death (BENE_DEATH_DT). Days enrolled in HMO and days after death are not counted. Eligible days for each beneficiary are summed over all beneficiaries. The total number of eligible days is then divided by the number of days in the time period to obtain the prorated number of beneficiaries. The denominator is the prorated number of beneficiaries divided by 1,000.
Exclusions	None
Risk Adjustment	Other Seasonal adjustment for quarterly measurement
Stratification	N/A. This measure could be easily stratified.
Type	Outcome
Data Source	Administrative claims, Other
Level	Population : Community, Population : State
Setting	Other

	Measure 2504: 30-day Rehospitalizations per 1000 Medicare fee-for-service (FFS) Beneficiaries (Centers for Medicare & Medicaid Services)
Description	Number of rehospitalizations occurring within 30 days of discharge from an acute care hospital (prospective payment system (PPS) or critical access hospital (CAH)) per 1000 FFS Medicare beneficiaries at the state and community level by quarter and year.
Numerator	Number of rehospitalizations within 30 days of discharge from an acute care hospital (PPS or CAH).
Denominator	Medicare FFS beneficiaries, prorated based on the number of days of FFS eligibility in the time period (quarter or year).
Exclusions	None
Risk Adjustment	Other Seasonal adjustment for quarterly measurement
Stratification	N/A. This measure could be easily stratified.
Type	Outcome
Data Source	Administrative claims, Other
Level	Population : Community, Population : State
Setting	Other

	Measure 2496: Standardized Readmission Ratio (SRR) for dialysis facilities (Centers for Medicare & Medicaid Services)
Description	The Standardized Readmission Ratio (SRR) is defined to be the ratio of the number of index discharges from acute care hospitals that resulted in an unplanned readmission to an acute care hospital within 30 days of discharge for Medicare-covered dialysis patients treated at a particular dialysis facility to the number of readmissions that would be expected given the discharging hospitals and the characteristics of the patients as well as the national norm for dialysis facilities. Note that in this document, "hospital" always refers to acute care hospital.
Numerator	Each facility's observed number of hospital discharges that are followed by an unplanned hospital readmission within 30 days of discharge
Denominator	The expected number of unplanned readmissions in each facility, which is derived from a model that accounts for patient characteristics and discharging acute care hospitals.
Exclusions	Hospital discharges that: • Are not live discharges • Result in a patient dying within 30 days with no readmission • Are against medical advice • Include a primary diagnosis for cancer, mental health or rehabilitation • Occur after a patient's 12th admission in the calendar year • Are from a PPS-exempt cancer hospital • Result in a transfer to another hospital on the same day
Risk Adjustment	Statistical risk model
Stratification	N/A
Type	Outcome
Type of Score	Ratio
Data Source	Administrative claims
Level	Facility
Setting	Dialysis Facility

Gap Areas: Psychosocial needs; Systems to coordinate acute care, long-term services and supports, and nonmedical community resources

11 Newly Endorsed Behavioral Health Measures

- Emergency Department Follow-up
    - NQF #2605 Follow-up after Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence
- Blood Pressure Control for People with Serious Mental illness
    - NQF #2602 Controlling High Blood Pressure for People with Serious Mental Illness
- Screening and Follow-Up for People with Serious Mental illness
    - NQF #2599 Alcohol Screening and Follow-up for People with Serious Mental Illness
    - NQF #2600 Tobacco Use Screening and Follow-up for People with Serious Mental Illness or Alcohol or Other Drug Dependence
    - NQF #2601 Body Mass Index Screening and Follow-Up for People with Serious Mental Illness
- Diabetes Care for People with Serious Mental Illness
    - NQF #2603 Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Testing
    - NQF #2604 Diabetes Care for People with Serious Mental Illness: Medical Attention for Nephropathy
    - NQF #2606 Diabetes Care for People with Serious Mental Illness: Blood Pressure Control (<140/90 mm Hg)
    - NQF #2607 Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)
    - NQF #2608 Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Control (<8.0%)
    - NQF #2609 Diabetes Care for People with Serious Mental Illness: Eye Exam

1 Behavioral Health Measure Approved for Trial Use

- NQF #2597 Substance Use Screening and Intervention Composite

	Measure 2599: Alcohol Screening and Follow-up for People with Serious Mental Illness (National Committee for Quality Assurance)
Description	The percentage of patients 18 years and older with a serious mental illness, who were screened for unhealthy alcohol use and received brief counseling or other follow-up care if identified as an unhealthy alcohol user. Note: The proposed health plan measure is adapted from an existing provider-level measure for the general population (NQF #2152: Preventive Care & Screening: Unhealthy Alcohol Use: Screening & Brief Counseling). It was originally endorsed in 2014 and is currently stewarded by the American Medical Association (AMA-PCPI).
Numerator	Patients 18 years and older who are screened for unhealthy alcohol use during the last 3 months of the year prior to the measurement year through the first 9 months of the measurement year and received two events of counseling if identified as an unhealthy alcohol user.
Denominator	All patients 18 years of age or older as of December 31 of the measurement year with at least one inpatient visit or two outpatient visits for schizophrenia or bipolar I disorder, or at least one inpatient visit for major depression during the measurement year.
Exclusions	Active diagnosis of alcohol abuse or dependence during the first nine months of the year prior to the measurement year (see Alcohol Disorders Value Set).
Risk Adjustment	No risk adjustment or risk stratification
Stratification	Not applicable.
Type	Process
Type of Score	Rate/proportion
Data Source	Administrative claims, Electronic Clinical Data, Paper Medical Records
Level	Health Plan
Setting	Ambulatory Care : Clinician Office/Clinic, Behavioral Health/Psychiatric : Outpatient

	Measure 2602: Controlling High Blood Pressure for People with Serious Mental Illness (National Committee for Quality Assurance)
Description	The percentage of patients 18-85 years of age with serious mental illness who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled during the measurement year. Note: This measure is adapted from an existing health plan measure used in a variety of reporting programs for the general population (NQF #0018: Controlling High Blood Pressure). It was originally endorsed in 2009 and is owned and stewarded by NCQA. The specifications for the existing measure (Controlling High Blood Pressure NQF #0018) have been updated based on 2013 JNC-8 guideline. NCQA will submit the revised specification for Controlling High Blood Pressure NQF #0018 in the 4th quarter 2014 during NQF's scheduled measure update period. This measure uses the new specification to be consistent with the current guideline.
Numerator	Patients whose most recent blood pressure (BP) is adequately controlled during the measurement year (after the diagnosis of hypertension) based on the following criteria: -Patients 18-59 years of age as of December 31 of the measurement year whose BP was <140/90 mm Hg. -Patients 60-85 years of age as of December 31 of the measurement year and flagged with a diagnosis of diabetes whose BP was <140/90 mm Hg. -Patients 60-85 years of age as of December 31 of the measurement year and flagged as not having a diagnosis of diabetes whose BP was <150/90 mm Hg.

Denominator	All patients 18-85 years of age as of December 31 of the measurement year with at least one acute inpatient visit or two outpatient visits for schizophrenia or bipolar I disorder, or at least one inpatient visit for major depression during the measurement year AND a diagnosis of hypertension on or before June 30th of the measurement year.
Exclusions	All patients who meet one or more of the following criteria should be excluded from the measure: - Evidence of end-stage renal disease (ESRD) or kidney transplant - A diagnosis of pregnancy
Risk Adjustment	No risk adjustment or risk stratification
Stratification	Not applicable.
Type	Outcome
Type of Score	Rate/proportion
Data Source	Administrative claims, Electronic Clinical Data, Paper Medical Records
Level	Health Plan
Setting	Ambulatory Care : Clinician Office/Clinic, Behavioral Health/Psychiatric : Outpatient

	Measure 2600: Tobacco Use Screening and Follow-up for People with Serious Mental Illness or Alcohol or Other Drug Dependence (National Committee for Quality Assurance)
Description	The percentage of patients 18 years and older with a serious mental illness or alcohol or other drug dependence who received a screening for tobacco use and follow-up for those identified as a current tobacco user. Two rates are reported. Rate 1: The percentage of patients 18 years and older with a diagnosis of serious mental illness who received a screening for tobacco use and follow-up for those identified as a current tobacco user. Rate 2: The percentage of adults 18 years and older with a diagnosis of alcohol or other drug dependence who received a screening for tobacco use and follow-up for those identified as a current tobacco user. Note: The proposed health plan measure is adapted from an existing provider-level measure for the general population (Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention NQF #0028). This measure is currently stewarded by the AMA-PCPI and used in the Physician Quality Reporting System.
Numerator	Rate 1: Screening for tobacco use in patients with serious mental illness during the measurement year or year prior to the measurement year and received follow-up care if identified as a current tobacco user. Rate 2: Screening for tobacco use in patients with alcohol or other drug dependence during the measurement year or year prior to the measurement year and received follow-up care if identified as a current tobacco user.
Denominator	Rate 1: All patients 18 years of age or older as of December 31 of the measurement year with at least one inpatient visit or two outpatient visits for schizophrenia or bipolar I disorder, or at least one inpatient visit for major depression during the measurement year. Rate 2: All patients 18 years of age or older as of December 31 of the measurement year with any diagnosis of alcohol or other drug dependence during the measurement year.
Exclusions	Not applicable.
Risk Adjustment	No risk adjustment or risk stratification

Stratification	Not applicable.
Type	Process
Data Source	Administrative claims, Electronic Clinical Data, Paper Medical Records
Level	Health Plan
Setting	Ambulatory Care : Clinician Office/Clinic, Behavioral Health/Psychiatric : Outpatient

	Measure 2601: Body Mass Index Screening and Follow-Up for People with Serious Mental Illness (National Committee for Quality Assurance)
Description	The percentage of patients 18 years and older with a serious mental illness who received a screening for body mass index and follow-up for those people who were identified as obese (a body mass index greater than or equal to 30 kg/m2). Note: The proposed health plan measure is adapted from an existing provider-level measure for the general population (Preventive Care & Screening: Body Mass Index: Screening and Follow-Up NQF #0421). It is currently stewarded by CMS and used in the Physician Quality Reporting System.
Numerator	Patients 18 years and older with calculated body mass index documented during the measurement year or year prior to the measurement year and follow-up care is provided if a person's body mass index is greater than or equal to 30 kg/m2.
Denominator	All patients 18 years of age or older as of December 31 of the measurement year with at least one inpatient visit or two outpatient visits for schizophrenia or bipolar I disorder, or at least one inpatient visit for major depression during the measurement year.
Exclusions	Active diagnosis of pregnancy during the measurement year or the year prior to the measurement year.
Risk Adjustment	No risk adjustment or risk stratification
Stratification	Not applicable.
Type	Process
Type of Score	Rate/proportion
Data Source	Administrative claims, Electronic Clinical Data, Paper Medical Records
Level	Health Plan
Setting	Ambulatory Care : Clinician Office/Clinic, Behavioral Health/Psychiatric : Outpatient

	Measure 2603: Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Testing (National Committee for Quality Assurance)
Description	The percentage of patients 18-75 years of age with a serious mental illness and diabetes (type 1 and type 2) who had hemoglobin A1c (HbA1c) testing during the measurement year. Note: This measure is adapted from an existing health plan measure used in a variety of reporting programs for the general population (NQF #0057: Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing). This measure is endorsed by NQF and is stewarded by NCQA.
Numerator	Patients who had Hemoglobin A1c (HbA1c) testing during the measurement year.
Denominator	Patients 18-75 years of age as of December 31 of the measurement year with at least one acute inpatient visit or two outpatient visits for schizophrenia or bipolar I disorder, or at least one inpatient visit for major

	depression during the measurement year AND diabetes (type 1 and type 2) during the measurement year or year before.
Exclusions	Patients who do not have a diagnosis of diabetes and meet one of the following criteria are excluded from the measure: -Patients with a diagnosis of polycystic ovaries. -Patients with gestational or steroid-induced diabetes.
Risk Adjustment	No risk adjustment or risk stratification
Stratification	Not applicable.
Type	Process
Data Source	Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Laboratory, Electronic Clinical Data : Pharmacy, Paper Medical Records
Level	Health Plan
Setting	Ambulatory Care : Clinician Office/Clinic, Behavioral Health/Psychiatric : Outpatient

	Measure 2604: Diabetes Care for People with Serious Mental Illness: Medical Attention for Nephropathy (National Committee for Quality Assurance)
Description	The percentage of patients 18-75 years of age with a serious mental illness and diabetes (type 1 and type 2) who received a nephropathy screening test or had evidence of nephropathy during the measurement year. Note: This measure is adapted from an existing health plan measure used in a variety of reporting programs for the general population (NQF #0062: Comprehensive Diabetes Care: Medical Attention for Nephropathy). It is endorsed by NQF and is stewarded by NCQA.
Numerator	Patients who received a nephropathy screening test or had evidence of nephropathy during the measurement year.
Denominator	All patients 18-75 years as of December 31st of the measurement year with at least one acute inpatient visit or two outpatient visits for schizophrenia or bipolar I disorder, or at least one inpatient visit for major depression during the measurement year AND diagnosis of diabetes (type 1 and type 2) during the measurement year or the year before.
Exclusions	Patients who do not have a diagnosis of diabetes and meet one of the following criteria may be excluded from the measure: -Patients with a diagnosis of polycystic ovaries. -Patients with gestational or steroid-induced diabetes.
Risk Adjustment	No risk adjustment or risk stratification
Stratification	Not applicable.
Type	Process
Type of Score	Rate/proportion
Data Source	Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Laboratory, Electronic Clinical Data : Pharmacy, Paper Medical Records
Level	Health Plan
Setting	Ambulatory Care : Clinician Office/Clinic

	Measure 2605: Follow-up after Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence (National Committee for Quality Assurrance)
Description	The percentage of discharges for patients 18 years of age and older who had a visit to the emergency department with a primary diagnosis of mental health or alcohol or other drug dependence during the measurement year AND who had a follow-up visit with any provider with a corresponding primary diagnosis of mental health or alcohol or other drug dependence within 7- and 30-days of discharge. Four rates are reported: - The percentage of emergency department visits for mental health for which the patient received follow-up within 7 days of discharge. - The percentage of emergency department visits for mental health for which the patient received follow-up within 30 days of discharge. - The percentage of emergency department visits for alcohol or other drug dependence for which the patient received follow-up within 7 days of discharge. - The percentage of emergency department visits for alcohol or other drug dependence for which the patient received follow-up within 30 days of discharge.
Numerator	The numerator for each denominator population consists of two rates: Mental Health - Rate 1: An outpatient visit, intensive outpatient encounter or partial hospitalization with any provider with a primary diagnosis of mental health within 7 days after emergency department discharge - Rate 2: An outpatient visit, intensive outpatient encounter or partial hospitalization with any provider with a primary diagnosis of mental health within 30 days after emergency department discharge Alcohol or Other Drug Dependence - Rate 1: An outpatient visit, intensive outpatient encounter or partial hospitalization with any provider with a primary diagnosis of alcohol or other drug dependence within 7 days after emergency department discharge - Rate 2: An outpatient visit, intensive outpatient encounter or partial hospitalization with any provider with a primary diagnosis of alcohol or other drug dependence within 30 days after emergency department discharge
Denominator	Patients who were treated and discharged from an emergency department with a primary diagnosis of mental health or alcohol or other drug dependence on or between January 1 and December 1 of the measurement year.
Exclusions	The following are exclusions from the denominator: -If the discharge is followed by readmission or direct transfer to an emergency department for a principal diagnosis of mental health or alchohol or other drug dependence within the 30-day follow-up period, count only the readmission discharge or the discharge from the emegenecy department to which the patient was transferred. -Exclude discharges followed by admission or direct transfer to an acute or nonacute facility within the 30-day follow-up period, regardless of primary diagnosis for the admission. These discharges are excluded from the measure because hospitalization or transfer may prevent an outpatient follow-up visit from taking place.
Risk Adjustment	No risk adjustment or risk stratification

Stratification	Not applicable.
Type	Process
Type of Score	Rate/proportion
Data Source	Administrative claims
Level	Health Plan, Population : State
Setting	Ambulatory Care : Clinician Office/Clinic, Behavioral Health/Psychiatric : Outpatient, Hospital/Acute Care Facility

	Measure 2606: Diabetes Care for People with Serious Mental Illness: Blood Pressure Control (<140/90 mm Hg) (National Committee for Quality Assurance)
Description	The percentage of patients 18-75 years of age with a serious mental illness and diabetes (type 1 and type 2) whose most recent blood pressure (BP) reading during the measurement year is <140/90 mm Hg. Note: This measure is adapted from an existing health plan measure used in a variety of reporting programs for the general population (NQF #0061: Comprehensive Diabetes Care: Blood Pressure Control <140/90 mm Hg) which is endorsed by NQF and is stewarded by NCQA.
Numerator	Patients whose most recent BP reading is less than 140/90 mm Hg during the measurement year. This intermediate outcome is a result of blood pressure control (<140/90 mm Hg). Blood pressure control reduce the risk of cardiovascular diseases. There is no need for risk adjustment for this intermediate outcome measure.
Denominator	All patients 18-75 years of age as of December 31 of the measurement year with at least one acute inpatient visit or two outpatient visits for schizophrenia or bipolar I disorder, or at least one inpatient visit for major depression during the measurement year AND diabetes (type 1 and type 2) during the measurement year or year prior to the measurement year.
Exclusions	Patients who do not have a diagnosis of diabetes and meet one of the following criteria may be excluded from the measure: -Patients with a diagnosis of polycystic ovaries. -Patients with gestational or steroid-induced diabetes.
Risk Adjustment	No risk adjustment or risk stratification
Stratification	Not applicable.
Type	Outcome
Type of Score	Rate/proportion
Data Source	Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Pharmacy, Paper Medical Records
Level	Health Plan
Setting	Ambulatory Care : Clinician Office/Clinic, Behavioral Health/Psychiatric : Outpatient

	Measure 2607: Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (National Committee for Quality Assurance)
Description	The percentage of patients 18-75 years of age with a serious mental illness and diabetes (type 1 and type 2) whose most recent HbA1c level during the measurement year is >9.0%. Note: This measure is adapted from an existing health plan measure used in a variety of reporting programs for the general population (NQF #0059: Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control >9.0%). This measure is endorsed by NQF and is stewarded by NCQA.
Numerator	Patients whose most recent HbA1c level is greater than 9.0% (poor control) during the measurement year. The intermediate outcome is an out of range result of an HbA1c test, indicating poor control of diabetes. Poor control puts the individual at risk for complications including renal failure, blindness, and neurologic damage. There is no need for risk adjustment for this intermediate outcome measure.
Denominator	Patients 18-75 years of age as of December 31 of the measurement year with at least one acute inpatient visit or two outpatient visits for schizophrenia or bipolar I disorder, or at least one inpatient visit for major depression during the measurement year AND diabetes (type 1 and type 2) during the measurement year or the year before.
Exclusions	Patients who do not have a diagnosis of diabetes and meet one of the following criteria are excluded from the measure: -Patients with a diagnosis of polycystic ovaries. -Patients with gestational or steroid-induced diabetes.
Risk Adjustment	No risk adjustment or risk stratification
Stratification	Not applicable.
Type	Outcome
Type of Score	Rate/proportion
Data Source	Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Laboratory, Electronic Clinical Data : Pharmacy, Paper Medical Records
Level	Health Plan
Setting	Ambulatory Care : Clinician Office/Clinic, Behavioral Health/Psychiatric : Outpatient

	Measure 2608: Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Control (<8.0%) (National Committee for Quality Assurance)
Description	The percentage of patients 18-75 years of age with a serious mental and diabetes (type 1 and type 2) whose most recent HbA1c level during the measurement year is <8.0%. Note: This measure is adapted from an existing health plan measure used in a variety of reporting programs for the general population (NQF #0575: Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control <8.0). This measure is endorsed by NQF and is currently stewarded by NCQA.
Numerator	Patients whose most recent HbA1c level was less than 8.0% during the measurement year. The outcome is an out of range result of an HbA1c test, indicating good control of diabetes. Good control reduces the risk for complications including renal failure, blindness, and neurologic damage. There is no need for risk adjustment for this intermediate outcome measure.

Denominator	Patients 18-75 years as of December 31st of the measurement year with at least one acute inpatient visit or two outpatient visits for schizophrenia or bipolar I disorder, or at least one inpatient visit for major depression during the measurement year AND diagnosis of diabetes (type 1 and type 2) during the measurement year or the year before.
Exclusions	Patients who do not have a diagnosis of diabetes and meet one of the following criteria are excluded from the measure: Patients with a diagnosis of polycystic ovaries. Patients with gestational or steroid-induced diabetes.
Risk Adjustment	No risk adjustment or risk stratification
Stratification	Not applicable
Type	Outcome
Type of Score	Rate/proportion
Data Source	Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Laboratory, Electronic Clinical Data : Pharmacy, Paper Medical Records
Level	Health Plan
Setting	Ambulatory Care : Clinician Office/Clinic, Behavioral Health/Psychiatric : Outpatient

	Measure 2609: Diabetes Care for People with Serious Mental Illness: Eye Exam (National Committee of Quality Assurance)
Description	The percentage of patients 18-75 years of age with a serious mental illness and diabetes (type 1 and type 2) who had an eye exam during the measurement year. Note: This measure is adapted from an existing health plan measure used in a variety of reporting programs for the general population (NQF #0055: Comprehensive Diabetes Care: Eye Exam). This measure is endorsed by NQF and is stewarded by NCQA.
Numerator	Patients who received an eye exam during the measurement year.
Denominator	All patients 18-75 years as of December 31 of the measurement year with at least one acute inpatient visit or two outpatient visits for schizophrenia or bipolar I disorder, or at least one inpatient visit for major depression during the measurement year AND diagnosis of diabetes (type 1 and type 2) during the measurement year or the year before.
Exclusions	Patients who do not have a diagnosis of diabetes and meet one of the following criteria may be excluded from the measure: - Patients with a diagnosis of polycystic ovaries. - Patients with gestational or steroid-induced diabetes.
Risk Adjustment	No risk adjustment or risk stratification
Stratification	Not applicable.
Type	Process
Type of Score	Rate/proportion
Data Source	Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Pharmacy, Paper Medical Records

Level	Health Plan
Setting	Ambulatory Care : Clinician Office/Clinic, Behavioral Health/Psychiatric : Outpatient

	Measure 2597: Substance Use Screening and Intervention Composite (American Society of Addiction Medicine)
Description	Percentage of patients aged 18 years and older who were screened at least once within the last 24 months for tobacco use, unhealthy alcohol use, nonmedical prescription drug use, and illicit drug use AND who received an intervention for all positive screening results
Numerator	Patients who received the following substance use screenings at least once within the last 24 months AND who received an intervention for all positive screening results: Tobacco use component Patients who were screened for tobacco use at least once within the last 24 months AND who received tobacco cessation intervention if identified as a tobacco user Unhealthy alcohol use component Patients who were screened for unhealthy alcohol use using a systematic screening method at least once within the last 24 months AND who received brief counseling if identified as an unhealthy alcohol user Drug use component (nonmedical prescription drug use and illicit drug use) Patients who were screened for nonmedical prescription drug use and illicit drug use at least once within the last 24 months using a systematic screening method AND who received brief counseling if identified as a nonmedical prescription drug user or illicit drug user
Denominator	All patients aged 18 years and older who were seen twice for any visits or who had at least one preventive care visit during the 12 month measurement period
Exclusions	Denominator exceptions include documentation of medical reason(s) for not screening for tobacco use, unhealthy alcohol use, or nonmedical prescription drug/illicit drug use (eg, limited life expectancy, other medical reasons)
Risk Adjustment	No risk adjustment or risk stratification
Stratification	We encourage the results of this measure to be stratified by race, ethnicity, payer, and administrative sex, and have included these variables as supplemental data elements to be collected in the HQMF eMeasure.
Type	Composite
Type of Score	Rate/proportion
Data Source	Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record
Level	Clinician : Group/Practice, Clinician : Individual
Setting	Ambulatory Care : Clinician Office/Clinic, Behavioral Health/Psychiatric : Outpatient