NATIONAL QUALITY FORUM

Meeting Summary

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

The National Quality Forum (NQF) convened a web meeting of the Measure Applications Partnership (MAP) Dual Eligible Beneficiaries Workgroup on Wednesday, March 4 and Thursday, March 5, 2015. An archive of the meeting is available online.

Workgroup Members in Attendance:

Jennie Chin Hansen, Workgroup Chair	Charlie Lakin, Subject Matter Expert
Alice Lind, Workgroup Chair	Thomas Lutzow, iCare
George Andrews, Humana, Inc.	D.E.B. Potter, Office of the Assistant Secretary for Planning and Evaluation
Richard Bringewatt, SNP Alliance	Susan Reinhard; Subject Matter Expert
Gwendolen Buhr, American Medical Directors Association	Clarke Ross, Consortium for Citizens with Disabilities
Anne Cohen, Subject Matter Expert	Gail Stuart, Subject Matter Expert
Steven Counsell, America's Essential Hospitals	Shawn Terrell, Administration for Community Living (substitute for Jamie Kendall)
Venesa Day, CMS Medicare Medicaid Coordination Office	Sally Tyler, American Federation of State, County, and Municipal Employees
Kata Kertesz, Center for Medicare Advocacy	Joan Zlotnik, National Association of Social Workers

Welcome and Review Meeting Objectives

Session led by Alice Lind, MAP Dual Eligible Beneficiaries Workgroup Chair.

Ms. Lind welcomed the group and public audience to the meeting, and reviewed the 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

Ann Hammersmith, General Counsel, NQF, conducted a roll call and led disclosures of interest of all workgroup members. Ms. Lind invited Venesa Day, Centers for Medicare & Medicaid Services (CMS), to share opening remarks. Ms. Day highlighted the utility and usefulness of the workgroup's recommendations, describing how CMS has used MAP's recommendations. CMS is exploring existing

measures and opportunities to use them in addition to understanding the need for new measure development activities. She also invited the workgroup members to be clever in proposing a strategy for measurement that is comprehensive but not onerous.

Review and Discuss Preliminary Alignment Analysis Results

Presentation by Zehra Shahab, National Quality Forum.

Ms. Shahab began with an overview of the MAP Family of Measures for Dual Eligible Beneficiaries (family) and a description of the draft alignment tool. This alignment tool specifically documents the known use of the measures in the family in 11 state financial alignment demonstrations and 43 national or other state level initiatives. The 9 capitated state financial alignment demonstrations demonstrate the greatest uptake of measures from the family; these programs included 18-25 measures. In contrast, the 2 fee-for-service demonstrations included 6-8 measures from the family. The national initiative with the greatest uptake from the family of measures is the CMS Physician Quality Reporting System (PQRS), currently using 23 measures.

Ms. Shahab compared the top 15 most-used measures in the family with the National Quality Strategy (NQS) priorities and their relevance to high-need subgroups of the dual beneficiary population. Among the 15 most-aligned measures, 5 of 6 NQS priority areas were addressed by measures in the family. Additionally, NQF observed an even distribution of measures addressing issues related to the 4 high-need sub-groups: people with disabilities, complex older adults, behavioral health, and cognitive impairment.

Ms. Chin Hansen facilitated a workgroup discussion on how the alignment analysis results can contribute to updates to the MAP Dual Eligible Family of Measures and what other information on alignment would be helpful in supporting MAP's decisionmaking process.

- Workgroup members encouraged the use of more person-centered care measures and noted that measure concepts do not always need to match health outcomes to be important. One participant suggested that grant funding could support the use of more innovative measures within health plans.
- Members made note that measures that are broadly applicable to the general population (i.e., those that apply to common chronic conditions) are more frequently adopted in programs than those that focus on priorities more unique to the dual eligible beneficiary population. It is important to stratify the broadly applicable measures to discern dual eligible beneficiaries' outcomes and compare them to the general population.
- One workgroup member noted that measure selection is driven by the program focus and model of care. As a result of persistent measure gaps, financial alignment demonstration programs and other stakeholders are developing "homegrown" measures to meet program needs. Other potentially useful measures might emerge from environmental scans being conducted for another NQF project on home- and community-based services (HCBS).
- In addition to the alignment data, the workgroup is interested in further understanding the decision factors regarding why measures are or are not being selected for use.

- Multiple workgroup members echoed that stakeholders need to work together to resolve the issue of alignment. Collective effort in designated areas, such as readmission, has demonstrated more positive results than disorganized quality improvement efforts.

Exploring the Experience of Using Measures

Presentation by Sarah Lash, National Quality Forum.

Ms. Lash summarized the results of the NQF MAP Member "Meet-Up" on January 29, 2015, exploring measure use experience in vulnerable populations. She described the three discussion questions posed to NQF members in attendance and themes of the conversations related to measure use experience, information for better alignment, and the role of industry in ensuring coordination and access. Ms. Lash then facilitated a workgroup discussion on the experience of using measures.

- Workgroup members agreed with the themes from the MAP Member Meet-Up and noted that many of the challenges are linked to communication with beneficiaries (e.g., enrollees change place of residence frequently or may be homeless, language barriers, cognitive difficulties). Creativity and flexibility, including capitalizing on the use of mobile technology, is needed when engaging beneficiaries about their healthcare.
- Several workgroup members acknowledged the importance of access to care and wrap-around resources to beneficiaries' health and quality of life.
- Prioritization is important in the measurement enterprise, so that the information produced is valuable and actionable.

Review and Discuss Preliminary Feedback Loops Results

Presentation by Megan Duevel Anderson, National Quality Forum.

Ms. Anderson shared the strategic activities underway by NQF staff to collect direct feedback about measure use in dual eligible beneficiary populations. Staff have conducted 4 interviews, with 4 additional interviews planned in the coming weeks. Staff are targeting measure use topics of adoption, alignment, usability, and implementation challenges in the interviews.

Ms. Anderson described preliminary results and requested workgroup guidance for the next stage of interviews, as well as the presentation of the results in the upcoming report. Though reasons for measure collection varied among the participants, the feedback from interview participants is consistent with the preliminary alignment analysis results. Participants shared program reporting requirements are a common driver for measure selection and expressed concern about conflicting and redundant reporting requirements. Notably, measures requiring completion and documentation of specific processes (such as those assessing transition of care) are difficult, especially when these requirements vary across settings. In addition, the interview participants conveyed that gaining an understanding of the quality of care through the use of current measures remains difficult.

Ms. Lind facilitated a workgroup discussion on the preliminary feedback loops results.

- Workgroup members added their thoughts on additional issues to be explored during the interviews, specifically regarding the CAHPS surveys and potential alternatives to understanding consumer experience.
- They acknowledged that based on these preliminary feedback loops results, the measures are making a difference and would like more information about which specific measures are most valued by users and successful in producing improved quality of care.

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

Presentation by Megan Duevel Anderson, National Quality Forum.

Ms. Anderson opened this session with a detailed description of the current MAP Dual Eligible Beneficiaries Family of Measures, including the priority gap areas where measures are lacking. She described the process the workgroup undertakes to periodically maintain the family by considering measures that have had changes to endorsement and newly available measures to address priority gap areas. The workgroup considered two measures that recently lost endorsement, and available alternatives.

- NQF #0007 CAHPS Health Plan Supplement was retired by the measure steward because it is no longer maintained. Different measures of shared decisionmaking and coordination of care are in development and will be submitted by the steward when complete. Despite a lack of NQF endorsement, the workgroup voted to retain the measure in the family until the replacement measures are available because it may still be in use and is highly relevant to the population.
- NQF #0111 Bipolar Disorder: Appraisal for risk of suicide was retired by the steward and is no longer being maintained. Two alternatives were considered by the workgroup: NQF #0104: Adult Major Depressive Disorder (MDD): Suicide Risk Assessment and NQF #1880: Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder. The workgroup voted to include NQF #0104 to measure suicide risk assessment, though the measure does not completely fill the gap.

The workgroup reviewed measures endorsed by NQF since the 2014 update to the family and voted on the inclusion of relevant measures. The workgroup decided to include 11 new behavioral health measures, 1 care coordination measure, and 5 admission/readmission measures. The additions to the family are listed in Table 1, below.

Table 1: New Additions to the MAP Family of Measures for Dual Eligible Beneficiaries

NQF #	Title
0104	Adult Major Depressive Disorder (MDD): Suicide Risk Assessment *replaced #0111: Bipolar Disorder: Appraisal for risk of suicide
2380	Rehospitalization During the First 30 Days of Home Health
2456	Medication Reconciliation: Number of Unintentional Medication Discrepancies per Patient
2502	All-Cause Unplanned Readmission Measure for 30 Days Post Discharge from Inpatient Rehabilitation Facilities (IRFs)
2505	Emergency Department Use without Hospital Readmission During the First 30 Days of Home Health
2510	Skilled Nursing Facility 30-Day All-Cause Readmission Measure (SNFRM)

NQF #	Title
2512	All-Cause Unplanned Readmission Measure for 30 Days Post Discharge from Long-Term Care Hospitals (LTCHs)
2597	Substance Use Screening and Intervention Composite
2599	Alcohol Screening and Follow-up for People with Serious Mental Illness
2600	Tobacco Use Screening and Follow-up for People with Serious Mental Illness or Alcohol or Other Drug Dependence
2601	Body Mass Index Screening and Follow-Up for People with Serious Mental Illness
2602	Controlling High Blood Pressure for People with Serious Mental Illness
2603	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Testing
2604	Diabetes Care for People with Serious Mental Illness: Medical Attention for Nephropathy
2605	Follow-up after Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence
2606	Diabetes Care for People with Serious Mental Illness: Blood Pressure Control (<140/90 mm Hg)
2607	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)
2608	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Control (<8.0%)
2609	Diabetes Care for People with Serious Mental Illness: Eye Exam

Charting a Path Forward on Measuring Person- and Family-Centered Care

Presentation by Mitra Ghazinour, National Quality Forum.

Ms. Ghazinour shared a summary of the recently concluded NQF Person-Centered Care and Outcomes Priority Setting Project. The committee identified a definition, core concepts, and a measurement framework for person- and family-centered care. She described the overarching, short-, intermediate-, and long-term recommendations from the project. Ms. Chin Hansen then facilitated a workgroup discussion on person-and family-centered care.

- Several workgroup members agreed with the findings of the project, applauded the work that has been done so far, and emphasized the applicability of these recommendations for dual beneficiary populations. The workgroup also acknowledged that the terminology of "care" is not appropriate for people with disabilities who generally prefer a social orientation to "supports."
- Workgroup members discussed the importance of healthcare as one of the many contributing factors to quality of life. Other supports are needed to help consumers live the lives they want.
- Members emphasized keeping the person and their family members at the center of all care. The healthcare workforce needs improved education and skill-building on methods to achieve person- and family-centered care, such as shared decisionmaking.
- The workgroup discussed the balance between provider and consumer responsibility for outcomes, beneficiary sense of autonomy and empowerment, as well as provider relationships with beneficiaries and family members.

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

Presentation by Taroon Amin, National Quality Forum.

Mr. Amin presented background information on risk adjustment in performance measurement, various perspectives on the issue, a recent NQF policy change, and an ongoing SDS trial period. He described the need for risk adjustment for a variety of clinical and other factors in healthcare quality measurement. Mr. Amin illustrated different viewpoints held in the field about adjusting for SDS factors, including concerns that this adjustment can mask disparities, in contrast to concerns that measures could lead to incorrect conclusions without sufficient risk adjustment. NQF policy recently changed with the implementation of a two-year trial period during which the appropriateness of SDS adjustment of measures submitted for endorsement will be evaluated. NQF and others recognize that it is important to have accurate measures, but also that risk adjustment and stratification alone will not address the underlying problem of poor care for complex consumers.

Ms. Chin Hansen facilitated a workgroup discussion on the SDS Risk Adjustment of Quality Measures.

- Several workgroup members acknowledged the importance of the issue of risk adjustment for the dual beneficiary population and the providers and health plans serving the population.
- Workgroup members recognized the impact of social, economic, demographic, geographic, functional, and clinical factors in care for dual beneficiaries.
- Members expressed viewpoints ranging from encouragement to discouragement of risk adjustment for SDS factors in the dual beneficiary and at-risk populations.
- The workgroup will continue to follow this important issue, the results of trial period, and changes to measures relevant to dual eligible beneficiaries and other vulnerable populations.

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

Presentation by Patrick Curran, CareOregon.

Mr. Curran presented quality improvement work underway at CareOregon, a non-profit health plan serving 240,000 Medicaid members and 11,000 Medicare members. He shared examples of CareOregon's innovations that support their mission to cultivate individual well-being and community health through shared learning. CareOregon has embedded social workers within primary care health homes and specialty practices to provide community-oriented support. The social workers assist in serving the members with complex medical and social needs and work one-on-one to improve these members' resilience. CareOregon also created "My Easy Drug System" or MEDS tool to facilitate the consumer and care team's communication about how to improve, simplify, change or reduce medications. Mr. Curran also shared challenges and barriers experienced at Care Oregon to improving quality.

Ms. Chin Hansen facilitated a workgroup discussion on CareOregon's model.

- Workgroup members discussed current assessment tools available to understand the needs of vulnerable populations. Current assessment tools may need to be expanded or made more inclusive to address the supports needed for all types of beneficiaries and different methods of engaging consumers.

- Members were interested in several aspects of recruiting and training the workforce needed to implement this model of care. They explored peer mentoring programs, the available workforce of social workers and clinical pharmacists, and training needs.
- The group discussed the effect of the current reimbursement structure on efforts to improve care and increase beneficiary engagement. CareOregon's model is financially sustainable. The workgroup also discussed the ability of improvement efforts to influence STAR rating scores that are publicly reported health plan quality results.

Voices from the Field: Complex Beneficiary Engagement Strategies for Practitioners

Presentation by Steven Counsell, GRACE Team Care.

Dr. Counsell described the Geriatric Resources for Assessment and Care of Elders (GRACE) Team Care model, which is focused on improving outcomes for older persons with multiple chronic illnesses and functional limitations. The GRACE Team Care model is a collaborative approach of multidisciplinary teams (including social workers, nurse practitioners, pharmacists, and geriatricians) working with primary care providers to manage common geriatric conditions. The model has been well-studied and evaluated across several locations and consumer populations. The model demonstrated success using in-home assessments and care management, standard care protocols, care coordination, and connection to community-based services. Overall, the GRACE Team Care model achieved better performance on ACOVE quality indicators, enhanced quality of life, reduced emergency department visits and hospitalizations, and a sustainable return on investment.

Ms. Chin Hansen facilitated a workgroup discussion on the GRACE Team Care model.

- The workgroup discussed the reaction and perceptions of the healthcare providers and workforce to this non-traditional care model. As with any change, there were some initial hurdles to overcome, however, the benefits to all stakeholders became apparent and adoption is growing.
- The workgroup discussed the importance of communication and relationship building between providers and beneficiaries, and between the provider groups involved with each consumer.
- Workgroup members are interested in strategies to spread this and other innovative, successful models to other locations.

Synthesis and Recommendations

Presentation by Gretchen Alkema, The SCAN Foundation.

Ms. Alkema offered closing remarks about person- and family-centered care and the shifting measurement paradigm. She described how stakeholder visions of success and high-quality care differ across perspectives. These varied visions of success from consumer, system, health plan, provider, and the regulator perspectives contribute to the healthcare that is delivered and how it is measured. Ms. Alkema emphasized the importance of keeping an individual's experience and their needs at the center of healthcare. New measures are needed to respond to that imperative.

Ms. Chin Hansen facilitated a workgroup discussion of closing thoughts from the meeting.

- Workgroup members emphasized the importance of the healthcare system working together to achieve common goals and objectives. Measurement of "systemness" warrants further exploration.

- Members encouraged collaboration and sharing of best practices across fields to advance person- and family-centered care.
- Members reiterated the need for the field to address priority gap areas in measurement and increase the use of the best available measures to drive improvement. Measurement demands must be manageable, lest they detract from the delivery of care for high-need beneficiaries.

Next Steps

- June: public comment on draft final report
- July/August: MAP Coordinating Committee reviews public comments and finalizes report
- August: final version of 2015 MAP recommendations due to HHS