MEASURE APPLICATIONS PARTNERSHIP

2014 Interim Report from the MAP Dual Eligible Beneficiaries Workgroup

INTERIM REPORT

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QUALITY FORUM

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INTRODUCTION

This interim report from the Measure Applications Partnership (MAP) is the latest in a series to describe quality measurement in the Medicare-Medicaid dual eligible beneficiary population. MAP's iterative process has revealed priorities and opportunities to advance the quality of care and improve outcomes for dual eligible beneficiaries through measurement. One of two major topics of the interim report is the creation and use of a family of measures for dual eligible beneficiaries to achieve alignment in measure use across a range of programs. MAP has also continued to think critically about the challenge of performance measurement related to quality of life outcomes. This new area of focus is described within this report and will continue to be a topic of MAP deliberations in 2014.

MAP is a public-private partnership convened by the National Quality Forum (NQF). MAP was created to provide input to the Department of Health and Human Services (HHS) on the selection of performance measures for public reporting and performance-based payment programs. MAP has also been charged with providing input on the use of performance measures to assess and improve the quality of care delivered to individuals who are enrolled in both Medicare and Medicaid. MAP has completed a series of reports to HHS on this topic (see Appendix A).

This report builds on an earlier memo of draft findings completed in July 2013. That memo discussed the process and results of the MAP Dual Eligible Beneficiaries Workgroup's efforts to develop the family of measures, but the results had not yet been reviewed by the MAP Coordinating Committee (see Appendices B and C for rosters). The MAP Coordinating Committee has since affirmed the content and direction of the work to date, encouraging continued focus on improving the quality and affordability of care for vulnerable beneficiaries.

Other important efforts of MAP and its Dual Eligible Beneficiaries Workgroup in 2013 have been well documented elsewhere and are not described in this report. They relate to MAP's role in providing cross-cutting input on measures that are relevant to dually eligible individuals. First, MAP provided an initial round of input on how to strengthen the Initial Core Set of Measures for Medicaid-Eligible Adults. In its expedited review of the measure set, MAP provided measure-specific recommendations intended to fill critical measurement gaps, increase alignment across programs, and bolster the ease of reporting the measure set for participating state Medicaid programs. In addition, MAP considered the potential use of measures in a variety of federal performance measurement programs during the 2014 pre-rulemaking cycle and has recently published its findings. The perspective of vulnerable beneficiaries was present in the pre-rulemaking process through use of the family of measures for dual eligible beneficiaries, liaison participation in meetings, and thorough vetting of recommendations about measure use.

The primary purpose of the 2014 interim report is to summarize the results of activities undertaken in 2013 and make them available for additional input and comments from stakeholders. Specifically, the report formally presents a family of measures for evaluating the quality of care received by the dual eligible beneficiary population and discussion of measurement related to quality of life. Public comments are incorporated throughout the report and compiled in Appendix D. This report also sets the stage for continued activities related to quality measurement for dual eligible beneficiaries to be conducted in 2014 and beyond.

FAMILY OF MEASURES FOR DUAL ELIGIBLE BENEFICIARIES

A “family of measures” is a set of measures that relate to one another and are the best available measures addressing an important quality issue. Measures in a family span the continuum of care. Creation of a family of measures makes it easier to assess important topics (e.g., safety, diabetes) across care settings in a more purposeful way and to identify measurement gaps in specific content areas, levels of analysis, or care settings. A family of measures is intended to be a starting place from which stakeholders can select the most relevant measures for their particular measurement needs.

The first step of MAP’s process for identifying a family of measures is to establish a framework based on the National Quality Strategy and other national standards. Next, MAP identifies high-leverage opportunity areas for improvement for the topic area, setting the frame for measures that would be eligible for inclusion in the family of measures. In this case, MAP’s previous deliberations about a strategic approach for measurement provided all of the necessary background for organizing the topic area. Finally, a measure scan provides potential measures for MAP review and selection for the family of measures. To date, MAP has identified families of measures for seven topics, and new work is underway to complete an additional three: population health, affordable care, and person- and family-centered care.[1,2]

MAP considered seven properties when assessing each measure’s appropriateness for inclusion in the family:

- **NQF endorsement**: Include NQF-endorsed® measures because they have met criteria for importance, scientific rigor, feasibility, and usability.
- **Potential impact**: Include measures with the most power to improve health, such as outcome measures, composite measures, and cross-cutting measures broadly defined to include a large denominator population.
- **Improvability**: Include measures that target areas in which quality improvement would be expected to have a substantial effect or address health risks and conditions known to have disparities in care.
- **Relevance**: Include measures that address health risks and conditions that are highly prevalent, severe, costly, or otherwise particularly burdensome for the dual eligible population.
- **Person-centeredness**: Include measures that are meaningful and important to consumers, such as those that focus on engagement, experience, or other individually reported outcomes. Person-centered care emphasizes access, choice, self-determination, and community integration.
- **Alignment**: Include measures already reported for existing measurement programs to minimize participants’ data collection and reporting burden. Consistent use of measures helps to synchronize public- and private-sector programs around the National Quality Strategy and to amplify the quality signal.
- **Reach**: Include measures relevant to a range of care settings, provider types, and levels of analysis.

MAP considered hundreds of measures for possible inclusion in the family of measures and evaluated their suitability for addressing the needs of the heterogeneous dual eligible population. Selected measures also needed to capture complex care experiences that extend across varied care settings and types of healthcare providers. The Family of Measures for Dual Eligible Beneficiaries is listed in detail in Appendix E. Considered broadly, the family of measures captures concepts of critical importance to the dual eligible population: supports and services that are responsive to patients' experiences and preferences; ongoing, proactive management of health conditions and risks; and coordination across varied provider types.

Input to the Family of Measures: Consideration of High-Need Subgroups

As part of MAP's exploration of performance measures as tools to encourage improvements in quality and affordability of care, it has discussed unique considerations presented by high-need beneficiaries. In 2009, 9.2 million dual eligible beneficiaries comprised 19 percent of the Medicare population but 34 percent of Medicare spending, and 14 percent of the Medicaid population but 34 percent of Medicaid spending. MAP systematically considered several high-need subgroups within the dual eligible beneficiary population with the objective of ensuring that the family of measures was comprehensive enough to be relevant to all of them. The subgroups considered were:

- Adults ages 18 to 64 with physical or sensory disabilities;
- Medically complex adults age 65 and older with functional limitations and co-occurring chronic conditions;
- Beneficiaries with serious mental illness (SMI) and/or substance use disorders; and
- Beneficiaries with cognitive impairment (e.g., dementia, intellectual/developmental disability).

The high-need groups are organized around factors that predict clinical complexity and high expenditures. These factors include the need for long-term services to support activities of daily living (ADLs) or diagnosis with a behavioral health condition. The groups overlap and many dually eligible individuals would fit two or more of the categories above. In one sample, approximately one third of people with a developmental disability had a co-occurring mental illness.[3] The reasoning for creating these rough groupings is that large gains can be achieved by targeting improvement efforts toward subpopulations known to experience deficits in quality of care and those with the highest levels of utilization, such as frequent emergency department visits.

More than half of dual eligible beneficiaries have at least one disabling limitation in activities of daily living (ADLs); 24 percent have one to two ADL limitations and 31 percent have three to six ADL limitations.[4] The distribution of chronic health conditions varies greatly across age groups. For example, 23 percent of beneficiaries age 65 and older are diagnosed with Alzheimer's disease or related dementia, more than 5 times the rate for younger beneficiaries. Beneficiaries younger than 65 experience significantly higher rates of behavioral health conditions, such as schizophrenia and depression, than older beneficiaries.[5]

For each high-need subgroup, MAP systematically reviewed quality improvement opportunities and associated performance measures. Due primarily to the lack of performance measures available to evaluate many aspects of high-quality care for complex beneficiaries, MAP determined that cross-cutting measures are preferred for the time being. Measures that were found to be relevant to more than one high-need subgroup were considered for inclusion in the family of measures.

Using the Family of Measures for Measure Selection

A measure did not need to fulfill all of the seven properties described above to be selected for the family of measures. However, to be considered comprehensive, the family of measures should encompass all of the characteristics when considered as a whole. Because it was not compiled with a single application in mind, the family of measures covers each of the five high-leverage opportunity areas, a range of measure types, and many settings of care. Some measures could be applied to the care delivered to all or most dual eligible beneficiaries. Others are primarily important for a significant subgroup of the population, such as individuals receiving hospice care or with serious mental illness. In the future, greater fit-for-purpose might be achieved by generating a measure set with specific program goals and capabilities in mind. Until these details emerge, MAP emphasizes the importance of the quality issues addressed by each of the measures in the family.

Stakeholders planning quality measurement programs can use the family of measures as a starting place for measure selection. Because of the many differences in measures' underlying designs and specifications, it is unlikely that a single program would use all of the measures in the family. Once a draft measure set is available, one can apply the MAP Measure Selection Criteria (MSC) to evaluate fit-for-purpose and general agreement with MAP principles (see **Appendix F**). The MSC are intended to assist with identifying characteristics that are associated with ideal measure sets used for public reporting and payment programs. The measures selected for use in the field should be implemented according to their endorsed specifications to maintain their scientific properties of validity and reliability. As noted by a commenter, it is also important that stakeholders have access to the complete technical specifications for each measure to ensure uniform implementation and the comparability of performance data.

Starter Set of Measures

To make recommendations more specific and actionable for stakeholders within HHS, MAP identified a "starter set" of measures within the larger family of measures. The starter set is a small number of high-priority measures that MAP has designated as most ready for implementation in the dual eligible population as they are currently specified. That said, the heterogeneity of the beneficiary population challenges efforts to define a small number of measures to accurately reflect their care experiences. As a result, the starter set primarily includes cross-cutting measures and uses condition-specific measures only to the extent that they address critical issues for high-need subpopulations. The starter set does not attempt to include all valid measures of effective clinical care for dual eligible beneficiaries. Measures in the starter set are designated in the table in **Appendix E**.

The starter set provides a necessary sense of prioritization, but evaluating it against the NQS priorities, the MSC, and MAP's own high-leverage opportunity areas reveal important shortcomings. For example, no available measures were thought to adequately address the NQS goal of affordable care. Limited public availability of cost data that encompass both Medicare and Medicaid expenditures is a major factor. In addition, information on beneficiaries' out-of-pocket expenses is not routinely collected. Although a few elements within CAHPS surveys touch on quality of life, the starter set does not adequately address this high-leverage opportunity area. The topic of quality of life measurement will be further discussed both in this report and in future MAP work.

High-Priority Measure Gaps

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

- Goal-directed, person-centered care planning and implementation
- Shared decisionmaking
- Systems to coordinate acute care, long-term

services and supports, and nonmedical community resources

- Beneficiary sense of control/autonomy/ self-determination
- Psychosocial needs
- Community integration/inclusion and participation
- Optimal functioning (e.g., improving when possible, maintaining, managing decline)

In its July 2013 memo, MAP recommended that HHS engage measure developers in creating and publishing a plan to address measurement gaps. MAP will continue to discuss strategies for filling gaps with organizations that fund and perform measure development to facilitate progress. Public comments reinforced the notion that measure development is the most important issue related to performance improvement in the care of individuals with chronic conditions. Current measures fail to capture the complex and dynamic array of conditions that are at play in a chronically ill person's life over time. Resources are needed for research activities to explore new methodologies for measurement of complex topics, especially nonclinical processes and person-centered outcomes.

Public comments also noted that MAP has identified some, but not all, measurement gaps as they apply to home- and community-based services (HCBS). Specifically, comments mentioned that consumer and government groups both see a need for measures of rebalancing long-term services and supports, self-direction of services, person-centered planning, quality of life, employment, family caregiver supports, adequacy of the direct care workforce, and transportation. Comments encouraged development of a more detailed outline of measure gaps with consultation and input from major national aging and disability organizations working on HCBS issues. Further, comments indicated that the measure development field needs guidance about how to achieve NQF endorsement of promising measures already in use in the field (e.g., National Core Indicators and Council for Quality and Leadership's Personal Outcome Measures).

Keeping the principle of parsimonious measurement in mind, other comments suggested that once new and improved measures become available to fill gaps, they should replace weaker existing measures to minimize measurement and reporting burden on health plans and providers.

Cross-Program Alignment

MAP promotes alignment, or use of the same or related measures, as a critical strategy for accelerating improvement in priority areas, reducing duplicative data collection, and enhancing comparability and transparency of healthcare information. Lack of alignment can be observed throughout the health system, but entities providing services and supports to dual eligible beneficiaries experience it acutely when the Medicare and Medicaid programs are not consistent with each other. In addition, healthcare systems and providers must collect, use, and report data to meet many other requirements for performance monitoring, accreditation, payment, and public reporting. When the demands of various programs are redundant or in conflict, valuable resources are wasted. MAP emphasizes aligning performance measurement programs to alleviate this type of burden on the health system.

During the most recent MAP pre-rulemaking activities, MAP applied the MSC (**Appendix F**) to evaluate measures under consideration for inclusion in federal quality reporting programs, including the seventh criterion: program measure set promotes parsimony and alignment. MAP considered programmatic use of measures from MAP's various families of measures to be important indicators of alignment success. Analysis shows that the majority of the 55 total measures in the family of measures for dual eligible beneficiaries are in use across HHS programs. Table 1 quantifies the alignment of measures from the family of measures for dual eligible beneficiaries across federal quality measurement programs. Specifically:

- 40 total measures in the family are currently in use in a federal program, 31 of which are used in two or more programs.
- Nine of the measures from the family were under consideration in the 2014 pre-rulemaking cycle for potential inclusion in a federal program; two were under consideration for use in multiple programs.
- MAP voiced support or conditional support for use of eight of the nine measures under consideration in the 2014 pre-rulemaking report. The Dual Eligible Beneficiaries Workgroup agreed with the judgment of the Hospital Workgroup that the unsupported measure (NQF #0028) was inferior to other options available for use in the inpatient psychiatric facility program.

TABLE 1. ALIGNMENT IN USE OF THE FAMILY OF MEASURES FOR DUAL ELIGIBLE BENEFICIARIES ACROSS SELECTED FEDERAL PROGRAMS

Federal Programs	Measures from Family Currently Used In Program*	Measures from Family Under Consideration** with MAP Support or Conditional Support
Ambulatory Surgical Centers Quality Reporting Program		
Children's Health Insurance Program Reauthorization Act (CHIPRA) Pediatric Quality Measures Program	1	n/a
End Stage Renal Disease Quality Initiative Program		3
Home Health Quality Reporting	1	
Hospice Quality Reporting Program		
Hospital-Acquired Condition Reduction Program		
Hospital Inpatient Quality Reporting Program	4	
Hospital Outpatient Quality Reporting		
Hospital Readmissions Reduction Program		1
Hospital Value-Based Purchasing Program	2	
Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults	11	n/a
Inpatient Psychiatric Facilities Quality Reporting	5	1
Inpatient Rehabilitation Facility Quality Reporting		1
Long-Term Care Hospital Quality Reporting	1	
Medicaid Health Home Core Quality measures	6	n/a
Medicare and Medicaid EHR Incentive Program for Eligible Professionals	13	
Medicare and Medicaid EHR Incentive Program for Hospitals and Critical Access Hospitals (CAHs)		1
Medicare Part C	7	n/a
Medicare Part D	2	n/a
Medicare Shared Savings Program	10	2

Federal Programs	Measures from Family Currently Used In Program*	Measures from Family Under Consideration** with MAP Support or Conditional Support
Nursing Home Quality Initiative and Nursing Home Compare	2	
Physician Compare		1
Physician Feedback Program	10	1
Physician Quality Reporting System	20	1
PPS-Exempt Cancer Hospital Quality Reporting Program	1	
Value-Based Payment Modifier		1

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

** Measures "Under Consideration" are being examined by HHS for their potential for future use in one or more federal programs.

Table 1 includes federal programs that are beyond the scope of MAP's pre-rulemaking deliberations. These programs are listed with the designation "n/a" in the column describing MAP's 2014 pre-rulemaking decisions. These programs' use of measures from within the dual eligible beneficiaries family of measures shows increased alignment, but there was not a specific opportunity for MAP to influence the selection of measures within each program measure set.

MAP also endeavors to drive alignment in measure use across state and private-sector programs. Most notably, states are participating in partnership with HHS and health plans to launch demonstrations to better align care for dual eligible beneficiaries. To date, several states have each published a memorandum of understanding that describes a demonstration model, including quality measures to be used. HHS and states have looked to MAP to guide their selection of measures, as indicated by convergence on the use of a small number of key measures within the family that suits the purposes of the demonstrations.

In addition, stakeholders across the measurement enterprise are engaged in measurement efforts to facilitate local public reporting of quality information, value-based purchasing, and other types of quality improvement incentives. These programs include the Buying Value Initiative, Beacon communities, and various health plan initiatives, among others. In addition, an increasing number of state Medicaid programs are requiring NCQA accreditation of participating health plans, further expanding the use of HEDIS measures. In 2012, 136 million individuals were enrolled in health plans reporting HEDIS measures—more than 40 percent of the total U.S. population.[6] Table 2 provides a count of the measures within the family of measures for dual eligible beneficiaries that are in use in state and private programs.

TABLE 2. ALIGNMENT IN USE OF THE FAMILY OF MEASURES FOR DUAL ELIGIBLE BENEFICIARIES ACROSS STATE AND PRIVATE PROGRAMS

State and Private Programs	Measures from Family Currently Used In Program
State Dual Eligible Beneficiaries Alignment Demonstration*	21
Private-Sector Measurement Program**	33

* Data from CA, IL, MA, OH, VA, WA included

** Convenience sample of private-sector programs; see **Appendix E** for more detail.

Updates to the Family of Measures

Families of measures are intended to be moderately flexible and adapt to change over time as new measures become available and/or previously selected measures no longer comport with current evidence. Refinements can be made on an ongoing basis to accommodate the currently available measures and experience with measure use. Throughout its future work, MAP will continue to consider relevant measures that receive NQF endorsement for inclusion in the family and alternatives for measures that do not maintain NQF-endorsed status.

Specifically, two measures currently contained within the family of measures have had NQF endorsement removed since their initial selection. Endorsement was withdrawn at the request of the measures' stewards. According to CMS, there is no longer a programmatic need to maintain their measure of Adoption of Medication e-Prescribing (formerly NQF #0486) because it has been absorbed by the Electronic Prescribing (e-Rx) Incentive Program. Health Benchmarks indicated that they do not have the resources to continue with their endorsement maintenance for HIV Screening: Members at High Risk of HIV (formerly NQF #0573). MAP will consider the removal of these measures from the family at its next meeting.

In addition, three measures selected for the family of measures have just received NQF endorsement through the **Behavioral Health Phase II** Consensus Development Process (CDP). At the time of publication of this report, the measures are available for an appeals period of 30 days, but have been approved by the NQF Board of Directors and are considered endorsed. A revised family of measures will be published as needed periodically going forward to capture these and other changes.

QUALITY OF LIFE MEASUREMENT

Quality of life measurement tools assess outcomes that are extremely important to dual eligible beneficiaries and their families. As such, they are integral in monitoring and encouraging improvement in the quality of healthcare. MAP's work on measures for dual eligible beneficiaries has identified quality of life as a high-leverage opportunity for quality improvement. Quality of life is an especially important outcome for dual eligible beneficiaries because many experience permanent health conditions that are challenging and complex. Many of these conditions are not amenable to clinical intervention and may even be terminal. Thus it is necessary to think about measures' ability to evaluate concepts such as dignity, choice, pain and symptom relief, and other topics that are integral to producing the best possible quality of life rather than clinical cures.

Economists, social scientists, and others have long been interested in quantifying quality of life and have developed many formulas and indexes to compare the relative quality of life across populations and nations. Although there are various definitions and understandings, there is a general agreement that quality of life is multidimensional and that an adequate assessment must include many facets of personal experience. Existing measures tend to incorporate both objective and subjective data in physical, material, social, emotional, and developmental domains.

MAP emphasizes that quality of life measures should reflect a broad view of health and well-being. MAP considered the context provided by the **NQF Patient-Reported Outcome Measurement Framework** along with potential uses and limitations of measurement tools currently in use for other applications. MAP discussed the applicability of these concepts to quality measurement and improvement for dual eligible beneficiaries. In doing so, MAP acknowledged that the term "patient" implies a medical orientation to supports and services and a negative connotation for some stakeholder groups. This report endeavors to use person-centered language to describe individuals when possible, but has not overwritten the terminology used by the previous project described below.

Patient-Reported Outcome Measurement Framework

Patient-reported outcomes (PROs) are defined as "any report of the status of a patient's [or person's] health condition, health behavior, or experience with healthcare that comes directly from the patient, without interpretation of the patient's response by a clinician or anyone else."[7] PRO domains that are highly applicable to dual eligible beneficiaries include:

- Health-related quality of life (including functional status);
- Symptoms and symptom burden (e.g., pain, fatigue);
- Experience with care; and
- Health behaviors (e.g., smoking, exercise).

Various tools that enable researchers, administrators, or others to assess beneficiary-reported health status for physical, mental, and social well-being are referred to as PRO measures (PROMs). PROMs often take the form of instruments, surveys, scales, and single-item measures. In order to more systematically include outcomes from the perspective of the service recipient in assessments of healthcare quality, it is necessary to distinguish between PROMs (i.e., tools) and aggregate-level performance measures that are based on the results of PROMs.

A PRO-based performance measure (PRO-PM) is based on PRO data aggregated for an entity deemed accountable for the quality of care or services delivered. Such entities can include long-term support services providers, hospitals, physician practices, or accountable care organizations (ACOs). NQF endorses PRO-PMs for purposes of performance improvement and accountability; NQF does not endorse PROMs alone. However, the specific PROM(s) used as a data source to calculate a PRO-PM will be identified in the detailed measure specifications to ensure standardization and comparability of performance results. Table 3 describes the differences among PROs, PROMs, and PRO-based performance measures using the example of outcomes for clinical depression.[8]

The PRO measurement framework describes guiding principles for selection of PROMs that resonate with the work of the MAP and its Dual Eligible Beneficiaries Workgroup. The PROM guiding principles call for the measures to be psychometrically sound, person-centered, meaningful, amenable to change, and implementable. The PRO framework details 12 specific steps as a pathway from PRO to NQF-endorsed PRO-PM. This pathway outlines how to identify the issues and outcomes of the PRO for the target population, identify the existing PROMs for measuring the outcome, and select the most suitable PROM for performance measurement that can be applied in real world settings. The PRO-PM must then be measured and tested for reliability, validity, and threats to validity before submission to NQF for endorsement.

TABLE 3. DISTINCTIONS AMONG PRO, PROM, AND PRO-PM

Term	Definition	Example: Patients With Clinical Depression
PRO (patient-reported outcome)	The concept of any report of the status of a patient's health condition that comes directly from the patient, without interpretation of the patient's response by a clinician or anyone else	Symptom: depression
PROM (patient-reported outcome measure)	Instrument, scale, or single-item measure used to assess the PRO concept as perceived by the patient, obtained by directly asking the patient to self-report	PHQ-9©, standardized tool to assess depression
PRO-PM (PRO-based performance measure)	A performance measure that is based on PROM data aggregated for an accountable healthcare entity	Percentage of patients with diagnosis of major depression or dysthymia and initial PHQ-9 score>9 with a follow-up PHQ-9 score <5 at 6 months (NQF #0711)

Performance measures built on information reported by care recipients, their family members, or trusted proxies can be submitted for endorsement through the same mechanism as other performance measures. Fundamentally, they must meet the **NQF Measure Evaluation Criteria**. Again, NQF does not endorse tools or surveys alone but rather specific performance measures embedded within tools or surveys or calculated from their results.

MAP discussions have revealed that the distinctions between PROMs and PRO-PMs are not readily apparent to most stakeholders. This is especially unclear when PROMs are known by the same name as PRO-PMs. NQF has endorsed numerous performance measures drawn from CAHPS surveys, but MAP reports have previously failed to distinguish the measures as separate from the surveys themselves. Only some items within the CAHPS family of surveys are endorsed as stand-alone measures. The endorsed CAHPS measures are due for endorsement maintenance during NQF's current consensus development process on person- and family-centered care. NQF staff will monitor the endorsement maintenance activities to make more detail available for future MAP deliberations. Two other examples of endorsed PRO-PMs calculated from survey results are the Experience of Care and Health Outcomes (ECHO) Survey (NQF #0008) and the Inpatient Consumer Survey (NQF #0726).

Comments requested that MAP consider the number and frequency of surveys currently administered to beneficiaries when determining the measures recommended for use with the dual eligible population. Comments note that beneficiaries are often unable to remember pertinent information when responding to surveys; recall bias is particularly problematic for the elderly and those with behavioral health problems. MAP members have previously discussed the need to gain beneficiaries' perspectives without inundating them with duplicative requests for information.

Current Resources for Measuring Quality of Life

There are many tools to measure quality of life at the macro level for purposes of research,[9,10] but few that attempt to assign responsibility for producing improved quality of life outcomes to an accountable entity. A subset of current quality of life measures focus on health related quality of life. These measures and tools will often survey symptoms, functions, and everyday activity limitations without exploring other domains. In addition, they often inquire about outcomes from a single-disease perspective, as one might do if to assessing the side effects of a clinical treatment. This orientation is entirely too narrow for current measures to adequately serve the heterogeneous and complex dual eligible beneficiary population. From MAP's perspective, an important shortcoming of current methods is the lack of inclusion of person-centered concepts of dignity and self-determination.

MAP reviewed several well-known quality of life measurement tools to gauge their potential to measure quality of life outcomes in the dual eligible beneficiary population. These included the SF-36® and related tools, the World Health Organization's quality of life Instruments, the Patient Reported Outcomes Measurement Information System (PROMIS), and surveys specific to the population receiving Medicaid-funded home- and community-based services (see **Appendix G**).

Potential Domains for Measurement of Quality of Life

In examining current quality of life measurement tools, MAP identified four commonly used domains: physical health, mental and psychological health, social relationships, and environment. Measures of health related quality of life, as described above, would be captured within the physical health domain. The four domains MAP identified may not be fully inclusive of all quality of life concepts; rather, they are the most typical organizing schema in the tools MAP examined. Measureable elements within each of the four domains include, but are not limited to, the following:

- **Physical Health**: physical functioning, general health, pain, sleep, fatigue, mobility, activities, access to food, obesity, and work capacity
- **Mental and Psychological Health:** mental health, behavioral health, substance use, depression, anxiety, vitality, spirituality, thinking, self-esteem, emotions, positive and negative feelings, choice and control, respect and dignity, and satisfaction
- **Social Relationships:** social functioning, culture, relationships, family and friends, social support, sexual activity, satisfaction in participation with social roles, community integration and inclusion, recreation, relationship building, health literacy, disparities, and violence
- **Environment:** freedom, safety, home and housing, finances, information, services, leisure, transport, access to needed services, and unmet needs

Comments received from stakeholders expressed support for the use of these four domains. Health plan stakeholders commented that measurement in the area of quality of life must demonstrate cost effectiveness so that it does not add to total expenditures. Comments also suggested that beneficiary-reported outcome information needs to be fed back to providers as an accountability mechanism. MAP has also suggested that the information would be needed for ongoing care management purposes.

Challenges and Opportunities for Measurement of Quality of Life

In reviewing current resources that assess quality of life, MAP identified both opportunities and challenges for future measurement in the dual eligible beneficiary population. Public comments supported MAP's efforts to advance the difficult but important issues of person-centered planning, shared decisionmaking, and self-determination. In general, MAP members observed that assessment of quality of life outcomes is rarely performed in current models of delivering care and supports. Nearly all structures and processes could do more to promote person-centered service delivery with the goal of improving quality of life outcomes.

MAP members discussed three components that contribute to quality of life: symptom management and palliation, a sense of security, and a sense of control. These components are necessary precursors to achieving a good quality of life. Members explained that beneficiaries' experiences dealing with acute and chronic illnesses are often frightening or overwhelming. A competent and person-centered system of health services and supports can provide reassurance even in the face of serious health issues. Caregivers and community providers also make important contributions to quality of life outcomes; systems should recognize and capitalize on their abilities to provide positive influences.

All parts of the system bear partial responsibility for producing quality of life outcomes. As commenters noted, the healthcare sector is held accountable for wellness through measurement when many other social and human services factors also contribute. Service providers have critical roles, but care recipients and their families are also responsible for identifying needs, expressing preferences, and engaging with recommended services and supports.

Performance measurement has a role in assessing progress in these efforts, but needs to be coupled with other strategies including advocacy, regulation, value-based payments, and internal quality improvement activities to be most effective. Much remains to be done in designing a fair and equitable schema that allows for beneficiaries to express their autonomy and for providers and other entities to share responsibility for such a global indicator. MAP will continue to pursue strategies to support and guide appropriate activities and shared accountability.

Constellations of Health and Social Risk Factors

MAP members discussed the myriad challenges that face dual eligible beneficiaries: physical, financial, mental, and social. These challenges often interact in a way that seriously disadvantages beneficiaries from achieving personal goals. MAP emphasized the importance of culturally competent systems that can understand and cope with complex populations. Quality of life instruments designed for the general population might assume that an individual's basic needs are being met, and this is not always the case in the dual eligible population. Approaches to measuring and addressing quality of life outcomes need to consider factors like food insecurity, homelessness, access to appropriate durable medical equipment, contact with the justice system, and substance use disorders. Once these issues are identified, a more action-oriented and comprehensive person-centered plan of care can be developed between care recipients, caregivers, and their team of service providers.

Person-Centered Care Planning

Person-centered planning and shared decisionmaking are two processes that could potentially set the stage for achieving improved quality of life outcomes. Both enable beneficiaries to engage in choices about their healthcare and other services. However, before care recipients and their families can make informed choices, they must be educated about risks and benefits of the service options available to them. The healthcare system and providers need to take available opportunities to identify unmet health and social needs, identify services and supports to meet those needs, connect the individuals to the available services, and follow-up to ensure that progress is being made.

Self-Determination Is Fundamental

The ability to make one's own choices is highly valuable to consumers and repeatedly emphasized in MAP discussions. Control over the types of services one receives, when those services are available, and where they are obtained all contribute to self-determination. A recent meta-analysis of studies that utilized self-determination theory in healthcare and health promotion contexts found a positive correlation between self-determination theory and mental and physical health, as well as satisfaction.[11]

Important principles of this type have recently been formalized in the final rule released by HHS on January 16, 2014: Medicaid Program for State Plan Home and Community-Based Services Final Rule. The rule describes numerous new requirements for HCBS that will enhance person-centeredness and autonomy in decisionmaking. For example, states must develop written service plans jointly with beneficiaries through a person-centered process driven by the individual. Specifically, "the person-centered service plan must reflect the services and supports that are important for the individual to meet the needs identified through an assessment of functional need, as well as what is important to the individual with regard to preferences for the delivery of such services and supports." The regulation also gives states the capability to offer beneficiaries the option to self-direct HCBS services, meaning that the beneficiary plans and purchases the amount, duration, scope, provider, and location of the HCBS services of their choice. Finally, HCBS providers that operate residential services must allow each person privacy in his or her unit, including doors lockable by the individual, a choice of roommate, and the freedom and support to control his or her own schedule and activities.

At its core, quality of life is a subjective experience. Each person has a unique set of values and preferences; they will sometimes conflict with the values of service providers and family members. In promoting more accountability for quality of life outcomes, it will be important to guard against the creation of well-intentioned but overbearing or paternalistic processes. Consumers must be allowed the "dignity of risk" to make their own choices. As such, any measurement of quality of life must be person-centered and give primary weight to the consumer's perspective rather than imposing pre-determined goals.

PATH FORWARD

MAP's recommendations are based on multistakeholder input and provide guidance to HHS on the use of performance measures to improve the care for the dual eligible population. MAP has considered the unique needs of dual eligible beneficiaries, in general and in specifics related to high-need subgroups. Following that assessment, MAP crafted a family of the best available measures to promote uptake of measures relevant to dual eligible beneficiaries and alignment across programs. MAP has also begun discussion of measurement strategies for quality of life. MAP has defined potential domains for quality of life measurement and begun to explore opportunities and challenges for moving forward from various stakeholder perspectives.

As deliberations continue in 2014, MAP will consider several important topics at the request of HHS and other stakeholders.

Fostering Measure Development to Fill Gaps: In the coming year, MAP will continue to deliberate on gaps in measurement and ways to more quickly fill existing voids. NQF will also facilitate the essential connection between the MAP Dual Eligible Beneficiaries Workgroup and ongoing work to endorse new measures. In addition to gaps previously identified by MAP, public comments offered the following gap areas for special consideration:

- Consumer choice and participant-directed services
- Satisfaction: individual experience with services and supports
- Attainment of employment or meaningful day activity
- Appropriate independent housing (e.g., stable and of the consumer's choice)
- Integrated primary and specialty care
- Access to timely and appropriate care

Understanding Appropriate Risk Adjustment for Socioeconomic Status: The low socioeconomic status of dual eligible beneficiaries has important implications for the healthcare and supportive services they receive. Low SES is correlated with poorer health outcomes, and this is a concern for stakeholders whose performance measures are not risk-adjusted. NQF is currently conducting a project to revisit its policy about including risk adjustment in outcome measures. Relevant results can be shared with MAP and inform future recommendations.

Considering Stratification of Measure Results by Dual Eligible Status: The health system collects large volumes of quality measurement data on many aspects of care funded by Medicare and Medicaid. Data on dual eligible beneficiaries' experiences is a part of these broad efforts to measure quality, but information is pooled with other Medicare-only or Medicaid-only beneficiaries for the purposes of reporting. It is not currently possible to examine results for dual eligible beneficiaries as a separate cohort. MAP may consider if stratified reporting for dual eligible beneficiaries on key indicators from the family of measures is recommended.

Exploring Shared Accountability for Quality of Life Outcomes: MAP will continue to seek strategies for supporting dual eligible beneficiaries to live independently, with dignity, and in pursuit of person-centered quality of life outcomes. This work will continue with the understanding that quality of life outcomes are affected by many factors beyond medical treatment. Where quality of life and medical treatment intersect, there are opportunities for performance measurement. Where the relationships are indirect or absent, other strategies for quality improvement will need to be pursued in partnership with other sectors.

ENDNOTES

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9 Hagerty MR, Cummins RA, Ferriss AL, et al. Quality of life indexes for national policy: review and agenda for research. *Soc Indic Res.* 2001; 55(1):1-96.

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APPENDIX A:

MAP Background

Purpose

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

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

MAP is designed to facilitate progress on the aims, priorities, and goals of the National Quality Strategy (NQS)—the national blueprint for providing better care, improving health for people and communities, and making care more affordable.[2] Accordingly, MAP informs the selection of performance measures to achieve the three-part goal of **improvement, transparency, and value for all**.

MAP's objectives are to:

1. **Improve outcomes in high-leverage areas for patients and their families**. MAP encourages the use of the best available measures that are high-impact, relevant, and actionable. MAP has adopted a person-centered approach to measure selection, promoting broader use of patient-reported outcomes, experience, and shared decisionmaking.
2. **Align performance measurement across programs and sectors to provide consistent and meaningful information that supports provider/clinician improvement, informs consumer choice, and enables purchasers and payers to buy based on value**. MAP promotes the use of measures that are aligned across programs and between the public and private sectors to provide a comprehensive picture of quality for all parts of the healthcare system.
3. **Coordinate measurement efforts to accelerate improvement, enhance system efficiency, and reduce provider data collection burden**. MAP encourages the use of measures that help transform fragmented healthcare delivery into a more integrated system with standardized mechanisms for data collection and transmission.

Coordination with Other Quality Efforts

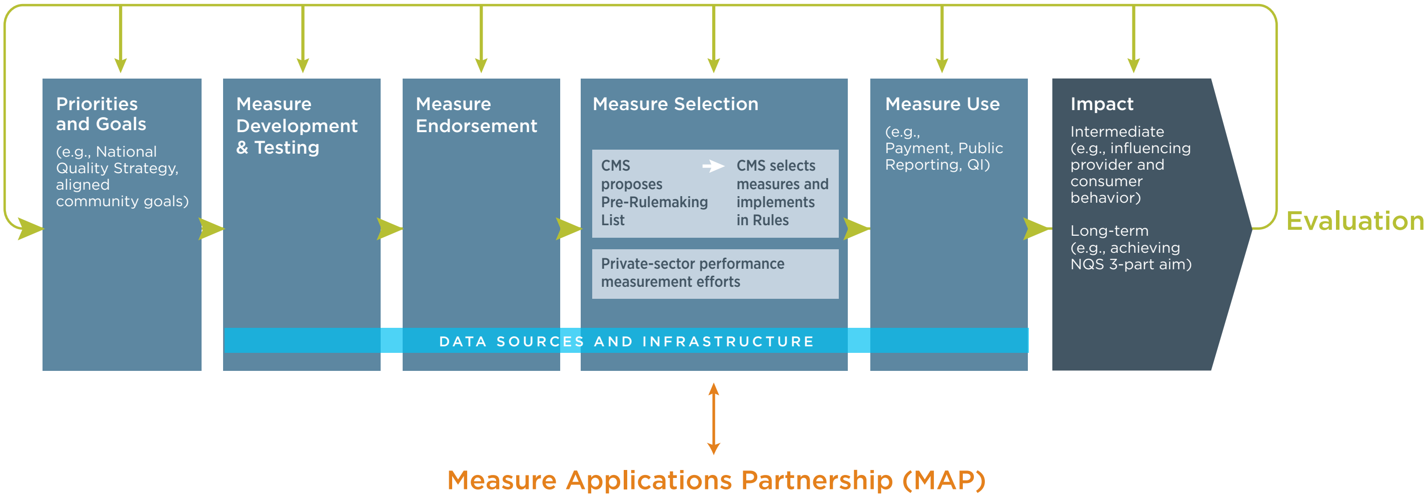
MAP activities are designed to coordinate with and reinforce other efforts for improving health outcomes and healthcare quality. Key strategies for reforming healthcare delivery and financing include publicly reporting performance results for transparency and healthcare decisionmaking, aligning payment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

Foundational to the success of all of these efforts is a robust quality measurement enterprise (see Figure A1) that includes:

- **Setting priorities and goals.** The work of the Measure Applications Partnership is predicated on the National Quality Strategy and its three aims of better care, affordable care, and healthy people/healthy communities. The NQS aims and six priorities provide a guiding framework for the work of MAP, in addition to helping to align it with other quality efforts.
- **Developing and testing measures.** Using the established NQS priorities and goals as a guide, various entities develop and test measures (e.g., PCPI, NCQA, The Joint Commission, medical specialty societies).
- **Endorsing measures.** NQF uses its formal Consensus Development Process (CDP) to evaluate and endorse consensus standards, including performance measures, best practices, frameworks, and reporting guidelines. The CDP is designed to call for input and carefully consider the interests of stakeholder groups from across the healthcare industry.
- **Measure selection and measure use.** Measures are selected for use in a variety of performance measurement initiatives conducted by federal, state, and local agencies; regional collaboratives; and private sector entities. MAP's role within the quality enterprise is to consider and recommend measures for public reporting, performance-based payment, and other programs. Through strategic selection, MAP facilitates measure alignment of public- and private-sector uses of performance measures.
- **Impact.** Performance measures are important tools to monitor and encourage progress on closing performance gaps. Determining the intermediate and long-term impact of performance measures will elucidate whether or not measures are having their intended impact and are driving improvement, transparency, and value.
- **Evaluation.** Evaluation and feedback loops for each of the functions of the quality measurement enterprise ensure that each of the various activities is driving desired improvements.

MAP seeks to engage in bidirectional exchange (i.e., feedback loops) with key stakeholders involved in each of the functions of the quality measurement enterprise.

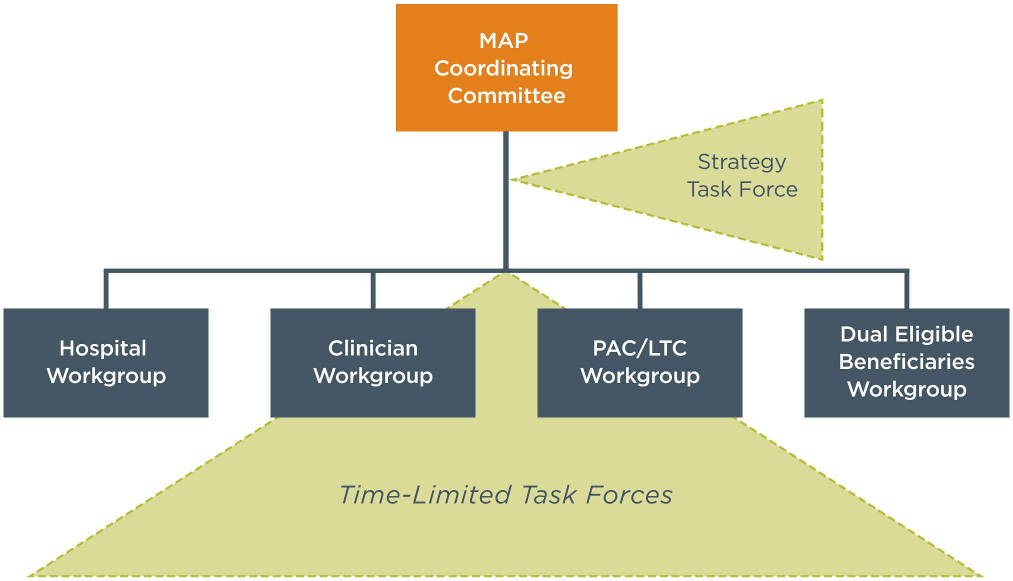
FIGURE A1. QUALITY MEASUREMENT ENTERPRISE



Structure

MAP operates through a two-tiered structure (see Figure A2). The MAP Coordinating Committee provides direction to the MAP workgroups and task forces and final input to HHS. MAP workgroups advise the Coordinating Committee on measures needed for specific care settings, care providers, and patient populations. Time-limited task forces charged with developing "families of measures"—related measures that cross settings and populations—and a multiyear strategic plan provide further information to the MAP Coordinating Committee and workgroups. Each multistakeholder group includes representatives from public- and private-sector organizations particularly affected by the work and individuals with content expertise.

FIGURE A2. MAP STRUCTURE



The NQF Board of Directors oversees MAP. The Board will review any procedural questions and periodically evaluate MAP's structure, function, and effectiveness, but will not review the Coordinating Committee's input to HHS. The Board selected the Coordinating Committee and workgroups based on Board-adopted selection criteria. Balance among stakeholder groups was paramount. Because MAP's tasks are so complex, including individual subject matter experts in the groups also was imperative.

All MAP activities are conducted in an open and transparent manner. The appointment process includes open nominations and a public comment period. MAP meetings are broadcast, materials and summaries are posted on the NQF website, and public comments are solicited on recommendations.

MAP decisionmaking is based on a foundation of established guiding frameworks. The NQS is the primary basis for the overall MAP strategy. Additional frameworks include the NQF-endorsed® Patient-Focused Episodes of Care framework,[3] the HHS Partnership for Patients safety initiative,[4] the HHS Prevention and Health Promotion Strategy,[5] the HHS Disparities Strategy,[6] and the HHS Multiple Chronic Conditions framework.[7]

Additionally, the MAP Coordinating Committee has developed Measure Selection Criteria (see Appendix F) to help guide MAP decisionmaking. The MAP Measure Selection Criteria are intended to build on, not duplicate, the NQF endorsement criteria. In 2013, MAP updated the MSC to incorporate lessons learned from the previous pre-rulemaking cycles and to incorporate the guiding principles that the Clinician and Hospital Workgroups had developed during their 2012-2013 pre-rulemaking input.

The Measure Selection Criteria provide decisionmaking guidance for MAP members as they are considering the appropriateness of measures for specific programs. They call attention to aspects of the measure such as endorsement status, alignment with an NQS aim or priority, alignment with other programs (if applicable), whether it is disparities sensitive, and other important considerations. The criteria are intended to act as guidance, rather than absolute rules.

Timeline and Deliverables

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

Additionally, MAP engages in strategic activities throughout the spring, summer, and fall to inform MAP's pre-rulemaking input. To date MAP has published **final reports** that detail strategic planning, families of measures, input on program considerations and specific measures for federal programs that are not included in MAP's annual pre-rulemaking review, and measurement coordination strategies. Among these reports are a series of deliverables specifically related to measurement for dual eligible beneficiaries. Table A1 details the contributions of each report.

TABLE A1. MAP DUAL ELIGIBLE BENEFICIARIES WORKGROUP REPORTS, KEY INPUTS, AND KEY OUTPUTS

Report	Key Inputs and Processes	Key Outputs
Strategic Approach to Performance Measurement for Dual Eligible Beneficiaries October 1, 2011	Targeted literature review, data on population characteristics, and National Quality Strategy framework informed workgroup deliberations on vision for quality improvement and high-leverage opportunities for measurement.	MAP identified a vision for high-quality care, guiding principles for measurement, and five high-leverage opportunity areas to improve care for dual eligible beneficiaries.
Measuring Healthcare Quality for the Dual Eligible Beneficiary Population June 1, 2012	Scan of available measures identified potential measures to address the high-leverage opportunities for workgroup evaluation.	MAP published a list of 26 recommended measures and documented many gaps in existing measures for future development.
Further Exploration of Healthcare Quality Measurement for the Dual Eligible Beneficiary Population December 21, 2012	Considered characteristics of two high-need subgroups of dual eligible beneficiaries: younger adults with physical or sensory disabilities and medically complex older adults; discussed stakeholder experience with recommended measures.	MAP provided additional implementation guidance, published a refined set of measures and measure gaps, and identified specialized needs of the two subgroups.
Family of Measures for Dual Eligible Beneficiaries: Preliminary Findings from the MAP Dual Eligible Beneficiaries Workgroup July 12, 2013	Considered characteristics of additional high-need subgroups of dual eligible beneficiaries: individuals with serious mental illness (SMI), substance use disorders (SUD), acquired cognitive impairment (e.g., dementia), or intellectual/developmental disability; applied the concept of a family of measures to previously identified measure sets.	MAP produced a draft family of measures for dual eligible beneficiaries that includes options relevant to heterogeneous subgroups and updated prioritization of measure gaps.

ENDNOTES

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7 HHS. HHS Initiative on Multiple Chronic Conditions website. Available at http://www.hhs.gov/ash/initiatives/mcc/. Last accessed March 2012.

APPENDIX B:

Dual Eligible Beneficiaries Workgroup Roster

CHAIR (VOTING)
Alice Lind, MPH, BSN

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

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

FEDERAL GOVERNMENT MEMBERS (NONVOTING, EX OFFICIO)	REPRESENTATIVE
Agency for Healthcare Research and Quality	D.E.B. Potter, MS
CMS Federal Coordinated Healthcare Office	Cheryl Powell
Health Resources and Services Administration	Samantha Meklir, MPP
Administration for Community Living	Jamie Kendall, MPP

FEDERAL GOVERNMENT MEMBERS (NONVOTING, EX OFFICIO)	REPRESENTATIVE
Substance Abuse and Mental Health Services Administration	Lisa Patton, PhD
Veterans Health Administration	Daniel Kivlahan, PhD

MAP COORDINATING COMMITTEE CO-CHAIRS (NON-VOTING, EX OFFICIO)
George Isham, MD, MS
Elizabeth McGlynn, PhD, MPP

APPENDIX C:

MAP Coordinating Committee Roster

CO-CHAIRS (VOTING)
George Isham, MD, MS
Elizabeth McGlynn, PhD, MPP

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

EXPERTISE	INDIVIDUAL SUBJECT MATTER EXPERT MEMBERS (VOTING)
Child Health	Richard Antonelli, MD, MS
Population Health	Bobbie Berkowitz, PhD, RN, CNAA, FAAN
Disparities	Marshall Chin, MD, MPH, FACP
Rural Health	Ira Moscovice, PhD
Mental Health	Harold Pincus, MD
Post-Acute Care/Home Health/Hospice	Carol Raphael, MPA

FEDERAL GOVERNMENT MEMBERS (NONVOTING, EX OFFICIO)	REPRESENTATIVES
Agency for Healthcare Research and Quality (AHRQ)	Nancy Wilson, MD, MPH
Centers for Disease Control and Prevention (CDC)	Gail James, PhD, MS
Centers for Medicare & Medicaid Services (CMS)	Patrick Conway, MD, MSc
Health Resources and Services Administration (HRSA)	John Snyder, MD, MS, MPH (FACP)
Office of Personnel Management/FEHBP (OPM)	Edward Lennard, PharmD, MBA
Office of the National Coordinator for HIT (ONC)	Kevin Larsen, MD, FACP

ACCREDITATION/CERTIFICATION LIAISONS (NONVOTING)	REPRESENTATIVES
American Board of Medical Specialties	Lois Margaret Nora, MD, JD, MBA
National Committee for Quality Assurance	Peggy O’Kane, MHS
The Joint Commission	Mark Chassin, MD, FACP, MPP, MPH

APPENDIX D:
Public Comments Received on the Draft Report

Section 1: General Comments

America's Health Insurance Plans

Carmella Bocchino

We applaud the MAP's efforts to focus its work on quality of life, patient reported outcomes, behavioral health, and social impacts. We support the high-priority measure gaps, however, we recommend adding language to recognize that as measure gaps are addressed, CMS should consider including such measures in federal quality programs and retiring existing measures to minimize measurement burden.

MAP should continue to recommend a parsimonious measure set that builds on existing measures (e.g. NCQA, CMS Star Ratings, etc.). Utilizing measures that have been widely accepted and that are feasible, reliable, and valid, will minimize burden of data collection and administrative costs. The MAP should consider the number and frequency of surveys currently administered to health plan members and patients when determining what types of measures are most appropriate for the Dual Eligible population. Oftentimes members and patients are unable to remember pertinent information when responding to surveys. Recall bias is particularly problematic for the elderly and those with behavioral health problems.

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

This report also highlights the potential uses of patient reported outcome measures (PROM) and patient-reported outcome based performance measures (PRO-PM). The use of PROM and PRO-PMs are still in the nascent stage and their utility is not well understood. However, information on PROM/PRO-PMs must be gathered and used to improve performance and provide patients with important outcomes information.

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

Lastly, it would be helpful if MAP provided definitions for what is considered a facility (e.g. hospital, nursing home, etc.), clinical provider, etc. under the "Level of Analysis" column for the proposed measures.

AmeriHealth Caritas

Chelsea Newhall

AmeriHealth Caritas Family of Companies respectfully submits comments on the Measure Application Partnership: 2014 Interim Report from Dual Eligible Beneficiaries Workgroup. AmeriHealth Caritas Family of Companies has 30 years of serving low-income and chronically ill individuals and families through managed care programs designed to help members get care and stay well. We serve over 5 million members across 15 states and the District of Columbia.

Unlike the prior MAP reports, the focus here has moved more toward patient focus (QOL, PROM), behavioral health and social impacts on the Dual Eligible. This is a good direction.

Support high-priority measure gaps. Recommend adding language to recognize that as measure gaps are filled, CMS will need to include in federal quality programs as quickly as possible to address critical areas such as behavioral health and psychosocial needs.

Association of University Centers on Disabilities

Rachel Patterson

The co-chairs of the Consortium for Citizens with Disabilities (CCD) task force on Long-Term Services and Supports (LTSS) are writing to submit comments on the National Quality Forum (NQF) Measure Applications Partnership (MAP): 2014 Interim Report from the Dual Eligible Beneficiaries Workgroup.

We have reviewed and fully support the comments submitted by Clarke Ross on behalf of the American Association on Health and Disability (AAHD). On behalf of the CCD LTSS task force, we are writing to endorse the AAHD comments and urge the forum to consider them in the final report.

The Consortium for Citizens with Disabilities is a coalition of over 100 national consumer, advocacy, provider and professional organizations headquartered in Washington, D.C. Since 1973, the CCD has advocated on behalf of people of all ages with disabilities and their families. CCD works to achieve federal legislation and regulations that assure that the 54 million children and adults with disabilities are fully integrated into the mainstream of society.

Consortium for Citizens with Disabilities, American Association on Health and Disability

Dan Berland, Maureen Fitzgerald, Rachel Patterson, Laura Weidner, E. Clarke Ross

While as a member of the workgroup on persons dually eligible for Medicare and Medicaid, I had input into the report, and while I greatly appreciate the professionalism and responsiveness of the NQF staff, some national disability organizations have expressed a desire to directly comment on the interim report. This letter is intended to assist these organizations in submitting their comments, while sharing my comments directly with NQF. AAHD comments follow: 1. The interim report is a completely accurate and insightful summary of the work group's discussions and deliberations.

2. As stated on page 2: the report sets the stage for continued activities related to quality measurement for dual eligible beneficiaries to be conducted in 2014 and beyond.

3. AAHD acknowledges the page 3 MAP seven properties and particularly commends the property of "person-centeredness" – "measures that are meaningful and important to consumers, such as those that focus on engagement, experience, or other individually reported outcomes. Person-centered care emphasizes access, choice, self-determination, and community integration."

4. AAHD appreciates the page 4 recognition of the overlap in the four subgroups considered. A helpful addition to the interim report would be data on the co-occurrence of disabilities and conditions among the four subgroups.

5. AAHD commends the interim report pages 5-6 identification of the need for new and improved measures to address the "high priority measure gaps." Each of these is of significant importance to persons with disabilities: (a) goal directed, person-centered care planning and implementation; (b) shared decision-making; (c) systems to coordinate healthcare with nonmedical community resources and service providers; (d) beneficiary sense of control, autonomy, self-determination; (e) psychosocial needs; (f) community integration, inclusion, and participation; and (g) optimal functioning.

In spring 2012, the Consortium for Citizens with Disabilities (CCD) Task Force on Long Term Services and Supports identified six gaps in existing quality standards as they directly relate to persons with disabilities, with a focus on home and community-based services and settings, to be pursued within NQF:

Consumer Choice and Participant-Directed Services

Satisfaction: Individual Experience with Services and Supports

% in employment or meaningful day activity

% in independent housing – Consumer choice, housing appropriateness, stability

Integrated primary and specialty care

Access to timely and appropriate care

We remain disappointed that the National Quality Forum has not addressed employment as a performance and quality objective for persons dually eligible for Medicare and Medicaid, particularly given the non-elderly population with disabilities. We request the NQF staff outline the key questions and needed research references in order to effectively bring employment into the discussion.

6. We commend the page 6 effort in discussion to meaningfully address “cross-program alignment.”

7. We commend the report (starting on page 8 and continuing on page 10) recognition and discussion that “quality of life measurement tools assess outcomes that are extremely important to care recipients and their families.”

Thank you for the page 12 discussion of the “Money Follows the Person” initiative.

Missing from the pages 12-13 discussion is the importance of self-determination, personal autonomy, and personal direction as “potential domains for measurement of quality of life.” We appreciate the page 13 observation: “Nearly all structures and processes could do more to promote person-centered delivery with the goal of improving quality of life outcomes.” We agree with the page 13 observation: “Person-centered planning and shared decision-making are two processes that could potentially set the stage for achieving improved quality of life outcomes.” And thank you for the page 13 statement: “an important element of the domain of mental/psychological health is a sense of control or self-determination.”

Thank you for acknowledging:” important principles of this type have recently been formalized in the final rule released by HHS on January 16, 2014 - Medicaid program for state plan home and community-based services final rule. The rule describes numerous requirements for home and community-based settings that will enhance person-centeredness and autonomy in decision-making.” As we have discussed with NQF staff, a few concrete examples from the rule would help illustrate this.

8. We discussed with NQF staff the concept of “dignity of risk.” Some of the January home and community-based settings rule addresses “dignity of risk.” As this concept is not addressed in the interim report, it is obvious that the disability community needs to provide more explicit, precise, clear examples and explanations of the concept. This is a task for the disability field to bring forward to NQF.

9. Regarding the page 9 discussion of “patient-reported outcomes (PROs)”, we’d like to repeat to observations previously made on several occasions in NQF meetings. (a) the term “patient” connotes a “medical model” managed and dominated by medically credentialed personnel working in medical settings, frequently with paternalistic attitudes. We acknowledge the common use of the word “patient.” But in the disability field, term person and sometimes consumer is a more appropriate term. (b) Previous NQF draft reports have acknowledged the study and replication of independent consumer and family operated monitoring and evaluating organizations. Independent consumer and family operated monitoring and evaluating organizations currently function in the mental health system in Maryland, Massachusetts, Pennsylvania, and Wisconsin. We respectfully request such recognition be reinserted into the interim report. An important underlying concept is the idea of “peers” as an important component and partner in delivery of services and supports.

10. Previous NQF draft reports have acknowledged that two quality measurement systems currently operate across the nation, focused on persons with intellectual and other developmental disabilities (ID/DD). These are the National Core Indicators (NCI) and the Personal Outcome Measures. We strongly recommend the reinsertion from the July 2013 NQF preliminary findings to CMS acknowledging that these approaches (NCI and POM) “have been proven to accurately assess quality of ID/DD services and individual outcomes.” Expansion of these approaches to other cohorts of persons with disabilities needs to be adapted and piloted, and at least one such three state pilot project is underway.

Thank you again for a comprehensive, very informative, and accurate report. We admire and appreciate the professionalism and responsiveness of the NQF staff. We hope you can make our suggested additions and reinsertions.

National Council on Aging

Joe Caldwell

The National Council on Aging (NCOA) applauds the work of NQF in identifying a starter set of high-priority measures. In particular, we support the inclusion of measures in the starter set on falls screening, risk-assessment, and plan of care to prevent future falls.

NCOA also appreciates the work of NQF in identifying high-priority measure gaps, including identified gaps in person-centered planning, self-determination, and community participation. NQF has begun to take steps towards filling these gaps. The interim report provides an overview of quality of life measures and highlights some promising work being done to fill gaps, such as testing of the Home and Community-Based Services (HCBS) Experience survey.

We believe more emphasis needs to be placed on charting a clear path forward on development of HCBS measures and endorsement of measures. First, NQF has identified some HCBS measurement gaps, but there are other priority areas that have not been recognized. While the quality paradigm for HCBS is more challenging to define, there is a lot of common ground on core elements. Rebalancing, self-direction, person-centered planning, quality of life, employment, family caregiver supports, and adequacy of the direct care workforce are some areas where we see consistency in desired outcomes by advocates, states, and CMS. We encourage development of a more detailed outline of measure gaps with consultation and input from major national aging and disability organizations working on HCBS issues.

Second, a clearer path is needed to promote development of HCBS measures. In many areas where there are promising measures being used or developed, it is unclear what additional work is needed to achieve the criteria for NQF endorsement. For example, in the area of rebalancing there are a number of measures that states have used in MLTSS programs and the duals demonstrations. Many of these are simple calculations of individuals in HCBS settings versus institutional settings or tracking of discharges. It would be helpful if NQF could identify what additional work needs to be done to eventually secure endorsement and make specific recommendations to CMS.

The National Core Indicators (NCI) and Council for Quality and Leadership's Personal Outcome Measures are two areas where we see potential for quality of life measure development. Even though these have been developed for individuals with I/DD, they embrace the right paradigm of HCBS and contain many core elements desired across populations. In the case of NCI, work is already underway to pilot test a version for seniors and people with physical disabilities. We recommend that NQF explore these measures and outline specific steps that should be taken to achieve NQF endorsement. Specific information on steps needed for endorsement would be helpful to advocates and CMS.

SNP Alliance

Rich Bringewatt

I wanted to offer some comments on the 2014 Interim Report from the Dual Eligible Beneficiaries Workgroup on behalf of the SNP Alliance. We greatly appreciate what NQF is doing in advancing performance measurement for dual beneficiaries as well as the opportunity to be an integral part of the effort. The report itself reflects many of the interests and concerns we have had in advancing improvements to performance metrics for duals in general, so I don't feel a need to respond to this Report in depth. However, I do have a few comments to share that I hope are helpful.

First, I want to reinforce the Report's recognition of the need to improve metrics development for high-need subgroups, as outlined on page 4. The subgroups noted fit very well with many of the beneficiaries enrolled in SNPs and represent what we believe are the key conditions that require a special focus among the dually eligible.

Third, we want to reinforce the importance of paying particularly attention to advancing measures supportive of patient-centered planning, shared decision-making and self-determination. These are difficult but important issues to address. Much of what is in the report is consistent with the general thinking of the SNP Alliance.

Fourth, I want to make a comment about the importance of developing “systems to coordinate healthcare and non-medical community resources and service providers.” This is obviously an ongoing issue of importance for improving health outcome. However, the point of nexus coordination is bigger than a better relationship between medical and non-medical providers. For me, the most important point of emphasis on aligning provider relationships is to link provider decisions and activities where their interdependence is most important to optimize health outcomes for any given person,, at any point in time. Connections among physicians treating the same person for a common medical condition, relating multiple prescribers and dispensers of drugs and pharmaceuticals, linking acute and long-term care, linking primary care and acute care, linking hospitals and rehabilitation therapies. These are all important nexuses of care that require coordination; and linking acute and long-term care may as, if not more, important than linking medical and nonmedical providers.

For me, the framework that has proven most beneficial in thinking about advancing care coordination from a “systems perspective” is to identify the connecting points of care where decisions are made and interventions are performed in addressing the multi-dimensional, interdependent, and ongoing nature of one or more chronic conditions of concern to any given person, as their condition evolves over time and across care settings. Recognizing the interdependence among the various environmental, psych-social, functional, and medical aspects of a person’s state of being are all important for improving health outcomes. They also don’t all fit neatly into a medical-social dichotomy. That is why, over the years, I have come to embrace the goal of creating systems that: 1) connect the dots among the multi-dimensional, interdependent, and ongoing nature of the problem to be addressed, and 2) connect the dots among related providers as a person’s care needs evolve over time and across care settings. For me, system redesign also needs to be person-centered and a little more organic and dynamic than what is often assumed.

When I was with the National Chronic Care Consortium, we talked about advancing “extended care pathways”…across time place and profession…in relation to the unique set of needs and circumstances for any given person…as the trajectory of a person’s illness/condition unfolds…and in response to the ongoing changes that occur in a person’s life. All these changes, all these interrelated conditions and circumstances, need to be coordinated, when and where they occur, and in relationship to the dynamic that is at play, whether that is interaction between two drugs dispensed by two different prescribers or filled by two different pharmacies; between a physician or group of physicians, hospital, rehab agencies, and home health agency involved in treating a person with a hip fracture; or among all the people that get involved at one time or another in care of frail elders.

Fifth, we want to reinforce the recommendation that HHS engage measurement developers to develop a plan to address measurement gaps. It seems to us that gap filling is perhaps THE MOST IMPORTANT issue of performance measurement for persons with chronic conditions. We’re still deeply rooted in an acute care/medical model paradigm. I don’t want to discount the importance of medical care; but current measurement is almost universally focused on metrics that relate to a specific medical intervention, at a specific place, by a specific healthcare professional, at a specific point in time. They fail to capture the volatile, complex, dynamic, and ongoing array of conditions that are at play in a chronically ill person’s life. Current metrics and methods fail to capture the systemic nature of chronic illness and multi-dimensional dynamic of chronic disease and disability. Our performance metrics and methods are in perhaps as much need for transformation as our care systems. Moreover, I believe our care systems can’t/won’t be fully transformed without transformation of performance measurement.

The composition and construct of Stars is a perfect example. Each of the measures that exist there are important, but they do not reflect what is MOST important, in caring for persons with multiple, complex, chronic conditions, such as frail elderly, adults with disabilities, and persons with complex medical conditions, such as HIV-AIDS, SPMI, etc. THIS is where the vast majority of cost and care complications exist, and unless and until we come to terms with these issues, in payment, in policy, and in performance evaluation, we won’t come close to achieving the kind of cost and quality improvements we all hope to achieve. We need to build on what we have, but we simply don't have the metrics and processes in place to address what's MOST important in their care. Thus, it is critical for measurement experts to point the light on the problem and expedite the process of transforming performance measurement as well as care.

Congress did not create SNPs and CMS is not demonstrating MMPs to be super MA plans – they authorized these programs to create different specialty care models that focus on the unique needs of various high-risk/high-need Medicare subsets. Accordingly, SNPs, MMPs and other specialty managed care plans should not be judged successful if they get 5.0 Star ratings on measures that don't evaluate whether they are meeting their specialty care mandate. It diverts increasingly scarce resources away from developing innovative specialty care models and interventions and toward the establishment of multiple teams of professionals who are each focused on getting to 4.0 or higher on a single measure. The incentives in the current Star rating system and related bonus payment demonstration are antithetical to advancing specialty care for special needs populations.

Sixth, we want to express our appreciation for the Report's recognizing the need for cross-program alignment of measurement for Medicare and Medicaid. I won't go into any detail here, but if you would like, we can share lots of examples where there continues to be disconnects in performance measurement. While we had hoped that the FAD would begin to make inroads in this area, we are hearing that, for a number of reasons, MMPs will submit all of what's currently required plus new measures related to the demonstration itself. It does not fell very integrated and it is definitely not streamlined—through no fault of the MMCO as we understand it. As a result, we have a long way to go before we have a truly aligned set of performance measures for duals.

Finally, I want to say a few things about the relationship of social determinants of health and duals. I recognize there is a separate NQF effort in this regard and we're very pleased with the direction this is taking. However, we also want to note it is virtually impossible to uncouple social-economic status (SES) from care of duals. This also is another area where there is a huge gap in performance measurement.

While this has been an issue of concern to the SNP Alliance for years, there now is increased evidence that the mere presence of social determinants of health results in perhaps a half a percent or more reduction in a dual plan's star scores. Failure to recognize that percentage difference is costing some companies literally millions of dollars and driving some companies to reconsider specializing in care of duals, not because they don't want to address the problem but because our approach to performance measurement ignores the issues. Plans that are particularly affected, such as plans with a high concentration of homeless persons, not only are seriously undercompensated for the added costs required to achieve a comparable outcome to persons in a more normal circumstance, but they also are penalized by performance measurement methods. This is an issue the SNP Alliance is going to be giving more attention to in 2014 and we would welcome the opportunity to work with the NQF in exploring options for development meaningful SES-related metrics and/or adjustments to other dual-related measures.

United Spinal Association

Carol Tyson

United Spinal Association is writing to submit comments on the National Quality Forum (NQF) Measure Applications Partnership (MAP): 2014 Interim Report from the Dual Eligible Beneficiaries Workgroup.

United Spinal is a member of the Consortium for Citizens with Disabilities (CCD). We support the CCD LTSS Task Force endorsement of the comments submitted by Clarke Ross on behalf of the American Association on Health and Disability (AAHD). We are providing 2 additional comments of our own and including the AAHD comments in the comment boxes, though the Quality of Life comments are slightly edited as to meet the 3000 character maximum.

Founded in 1946 by paralyzed veterans, United Spinal Association is the largest disability-led nonprofit organization serving and representing the interests of more than a million Americans living with spinal cord injuries and disorders (SCI/D). It has approximately 40,000 members in all 50 states and reaches out to these individuals through its 44 chapters and approximately 200 support groups. United Spinal Association has dedicated its energy, and programs, to improving the quality of life for these Americans of all ages and advancing their independence.

WellCare Health Plans, Inc.

Steven Goldberg

WellCare Health Plans ("WellCare") is pleased to submit the enclosed comment in response to the Measure Applications Partnership: 2014 Interim Report from Dual Eligible Beneficiaries Workgroup. We appreciate the opportunity to partner with NQF and MAP as they move forward in developing and implementing quality measures.

Nationally, WellCare is one of the country's largest health care companies dedicated solely to serving public program beneficiaries. We currently serve over two million enrollees nationwide and offer a variety of products including prescription drug, Medicare Advantage, Medicaid, and Children's Health Insurance Program (CHIP) plans for families, children, and the aged, blind, and disabled. WellCare's mission is to be the leader in government sponsored health care programs in partnership with enrollees, providers, and the government agencies we serve. This mission drives our business and we design our products and support services in accordance with that mission. We have a long-standing commitment to our federal and state partners to deliver value, access, quality, cost savings, and budget predictability. It is from this vantage point that we offer these comments.

In the report, the workgroup is proposing four new measures to be endorsed by NQF. With over one thousand measures currently endorsed, we ask the MAP to consider alignment across the various measure sets in selecting measures to be included in this family. More specifically, the MAP submitted two measures, 0557 and 0558, which pertain to post-discharge continuing care plans from a hospital-based inpatient psychiatric setting. These two measures, set to work in tandem, measure for the creation of a continuing care plan and the transmission of a continuing care plan to the next level of care provider. HEDIS currently measures whether or not a patient received follow-up care within 7 days of discharge for mental illness and again within 30 days of discharge. The measures currently employed by HEDIS are stronger measures because they require action on the part of a medical provider. The submitted measures only call for the creation and the passage of a continuing care plan, whereas the HEDIS measures require interaction between provider and patient at two different points in time. Therefore, we encourage the MAP to consider utilizing the existing HEDIS measures rather than creating new measures upon which providers will be measured.

Section 2: Comments on the Family of Measures for Dual Eligible Beneficiaries

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America's Health Insurance Plans

Carmella Bocchino

We offer the following measure specific comments:

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

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

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

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

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

0709: The terminology used in this measure e.g. "potentially avoidable complication" is open to interpretation and is not specific enough for reliable and consistent reporting. For chronic conditions such as CHF and COPD, health plans would be assessed based on an individual's health status progression, even though deterioration in health status is expected. This measure does not consider psychosocial determinants of health that impact the Dual Eligible population and is more appropriate for commercial and Medicare populations. We recommend that the terminology be precisely defined, or excluding this measure.

1626: Data for this measure cannot be obtained using the administrative claims reporting method and health plans will have to conduct burdensome chart reviews.

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

2111: This measure is no longer collected for HEDIS. It is challenging to influence and educate providers on the overuse of anti-psychotics among persons with dementia. We recommend that this measure be excluded.

AmeriHealth Caritas

Chelsea Newhall

A number of the measures that include health plans in the analysis may be impacted by limitations in Medicaid coverage by various states e.g. Measure #0027—"Medical assistance with smoking and tobacco use cessation".

Measure #0105 Support measurement of antidepressant medication management at health plan and physician level of analysis.

Measure #0554 Medication reconciliation post-discharge, calls for percentage of discharges in measurement year for those >65 years that were reconciled within 30 days. This level of reconciliation is not within the health plans' real capacity.

Measure #0573 HIV screening: members at high risk of HIV (Health Benchmarks-IMS Health as stewards). We encourage MAP to be mindful of issues such as state regulations and HIPAA compliance which could be problematic for health plans.

Measure #0709 Proportion of patients with a chronic condition that have a potentially avoidable complication during a calendar year (Bridges to Excellence is steward)— We do not support inclusion of this measure in the MAP dual eligible starter set. We agree it is important to include a measure that focuses on multiple chronic conditions that are common among dual eligible beneficiaries, but do not believe that this measure considers psychosocial determinants of health that impact this population. While this measure is well-intentioned, it may be more appropriate for commercial and Medicare populations. For measures such as this, we encourage MAP to look for other measures that are tested in Medicaid populations.

Measure #1626 Patient admitted to ICU who have care preferences documented—Since there is no coding for this, achievement of higher scores will require health plans to put that into the contracting with hospitals and have an audit function performed. This becomes additional administrative costs by incorrectly assigning accountability to health plans.

Measure #1927 Cardiovascular health screening for people with schizophrenia or bipolar disorder who are prescribed antipsychotic medications (there are several other sister measures such as #1932, 2091, 2092, 2111) where requiring annual use of resources is not predicated upon evidence based medicine for the frequency of the studies. There should be at least a one-time measurement but performance annually has not demonstrated better outcomes.

United Spinal Association

Carol Tyson

United Spinal supports the following comments submitted by AAHD:

"3. AAHD acknowledges the page 3 MAP seven properties and particularly commends the property of "person-centeredness" – "measures that are meaningful and important to consumers, such as those that focus on engagement, experience, or other individually reported outcomes. Person-centered care emphasizes access, choice, self-determination, and community integration."

4. AAHD appreciates the page 4 recognition of the overlap in the four subgroups considered. A helpful addition to the interim report would be data on the co-occurrence of disabilities and conditions among the four subgroups.

6. We commend the page 6 effort in discussion to meaningfully address "cross-program alignment."

5. AAHD commends the interim report pages 5-6 identification of the need for new and improved measures to address the "high priority measure gaps." Each of these is of significant importance to persons with disabilities: (a) goal directed, person-centered care planning and implementation; (b) shared decision-making; (c) systems to coordinate healthcare with nonmedical community resources and service providers; (d) beneficiary sense of control, autonomy, self-determination; (e) psychosocial needs; (f) community integration, inclusion, and participation; and (g) optimal functioning.

In spring 2012, the Consortium for Citizens with Disabilities (CCD) Task Force on Long Term Services and Supports identified six gaps in existing quality standards as they directly relate to persons with disabilities, with a focus on home and community-based services and settings, to be pursued within NQF:

Consumer Choice and Participant-Directed Services

Satisfaction: Individual Experience with Services and Supports

% in employment or meaningful day activity

% in independent housing – Consumer choice, housing appropriateness, stability

Integrated primary and specialty care

Access to timely and appropriate care

We remain disappointed that the National Quality Forum has not addressed employment as a performance and quality objective for persons dually eligible for Medicare and Medicaid, particularly given the non-elderly population with disabilities. We request the NQF staff outline the key questions and needed research references in order to effectively bring employment into the discussion."

In addition, United Spinal recommends that the high priority measure gap (c) include language to ensure access to necessary equipment so that it reads" (c) systems to coordinate healthcare with nonmedical community resources, medical equipment, supports and services and service providers United Spinal also recommends consideration of access to transportation as a measure gap.

Section 3: Comments on Performance Measurement Related to Quality of Life

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America's Health Insurance Plans

Carmella Bocchino

We are supportive of the four domains for measurement of quality of life; however, measurement in this area must demonstrate a cost benefit so that it does not add to the total cost of care and to the cost of achieving good health and wellbeing. In addition, the measures should provide insight into interventions that target all determinants of health and that drive accountability for results beyond the health care system. Communication about the broad set of drivers (care and non-care related) that contribute to patient reported outcomes and quality of life will be critical as the health care sector oftentimes is seen wholly accountable when other contributors exist. In addition, we recommend developing a measure that provides patient-reported outcome feedback to providers, similar to the CAHPS instrument that impacts health plans.

AmeriHealth Caritas

Chelsea Newhall

Support proposed four domains for measurement of quality of life.

There should also be a Patient Reported Outcome Feedback to Physician/Provider metric. This would be akin to the CAHPS instrument that impacts health plans.

SNP Alliance

Rich Bringewatt

Second, we want to offer our support for identifying appropriate quality of life metrics, while acknowledging the difficulty of addressing this issue. Obviously, everyone needs to have the beneficiary's quality of life at heart; but, as you know, there is not always a clear nexus between quality of life and medical treatment. Where there is, it should be addressed. Where there is not, it needs to be understood that someone else beside a healthcare provider needs to be the focus of performance measurement. As stated in the report, "much remains to be done in designing a fair and equitable schema that allows for beneficiaries to express their autonomy and for providers and other entities to share responsibility for such global indicators."

United Spinal Association

Carol Tyson

United Spinal supports AAHD's comments #7-10 regarding Performance Measurement Related to Quality of Life. In particular, we feel strongly that, as noted by AAHD, "the term "patient" connotes a "medical model" managed and dominated by medically credentialed personnel working in medical settings, frequently with paternalistic attitudes. We acknowledge the common use of the word "patient." But in the disability field, (the) term person and sometimes consumer is a more appropriate term."

In addition, we highly recommend that the National Core Indicators (NCI) and the Personal Outcome Measures be reinserted. AAHD points out that these measures were mentioned in the July 2013 NQF preliminary findings to CMS acknowledging that these approaches (NCI and POM) "have been proven to accurately assess quality of ID/DD services and individual outcomes." United Spinal notes a National Association of States United for Disabilities and Aging National Core Indicators pilot project will be providing measures for the aging and physical disability community that will prove important to our members.

Thank you for the opportunity to provide comments. United Spinal looks forward to future reports and to supporting the work of the National Quality Forum.

APPENDIX E:

Family of Measures for Dual Eligible Beneficiaries

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

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

Family of Measures for Dual Eligible Beneficiaries (continued)

NQF Measure Number, Endorsement Status, Title, and Steward	Measure Type	Measure Description	Level of Analysis	Other Known Uses and Program Alignment	Workgroup Comments and Public Comments
0008 Endorsed Experience of Care and Health Outcomes (ECHO) Survey (behavioral health, managed care versions) Measure Steward: AHRQ **Starter Set Measure**	Composite	52 questions including patient demographic information. The survey measures patient experiences with behavioral health care (mental health and substance abuse treatment) and the organization that provides or manages the treatment and health outcomes. Level of analysis: health plan- HMO, PPO, Medicare, Medicaid, commercial	Health Plan	State Duals Demonstrations: CA, IL, MA, OH	Expand care setting to include Behavioral Health Care; Surveys restricting proxy respondents may exclude disabled consumers who have difficulties communicating
0018 Endorsed Controlling High Blood Pressure Measure Steward: NCQA **Starter Set Measure**	Outcome	The percentage of patients 18 to 85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/ 90) during the measurement year.	Health Plan; Integrated Delivery System	Federal and State Programs: Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults; Meaningful Use-EP; Medicare Part C Plan Rating; Medicare Shared Savings Program; PQRS; HRSA; Medicaid Health Home, Special Needs Plan State Duals Demonstrations: CA, IL, MA, OH, VA Private Programs: eValue8; at least 1 Beacon community; HEDIS; WellPoint; Buying Value core ambulatory measure	Quality issue of particular importance to address access to preventive services needed to reduce disproportionate effect of chronic conditions; Incorporate chronic disease management and preventive services into person-centered care plan
0022 Endorsed Use of High Risk Medications in the Elderly Measure Steward: NCQA **Starter Set Measure**	Process	a: Percentage of Medicare members 66 years of age and older who received at least one high-risk medication. b: Percentage of Medicare members 66 years of age and older who received at least two different high-risk medications. For both rates, a lower rate represents better performance.	Health Plan; Integrated Delivery System	Federal and State Programs: Meaningful Use-EP; Medicare Part D Plan Rating; Physician Feedback; PQRS; Value-Based Payment Modifier Program; Special Needs Plan State Duals Demonstration: MA Private Programs: HEDIS; Buying Value core ambulatory measure	Important due to the possibility of drug/disease and drug/drug interactions; Expand age range of measure to apply to younger at-risk groups

Family of Measures for Dual Eligible Beneficiaries (continued)

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

Family of Measures for Dual Eligible Beneficiaries (continued)

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

Family of Measures for Dual Eligible Beneficiaries (continued)

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

Family of Measures for Dual Eligible Beneficiaries (continued)

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

Family of Measures for Dual Eligible Beneficiaries (continued)

NQF Measure Number, Endorsement Status, Title, and Steward	Measure Type	Measure Description	Level of Analysis	Other Known Uses and Program Alignment	Workgroup Comments and Public Comments
0202 Endorsed Falls with injury Measure Steward: American Nurses Association	Outcome	All documented patient falls with an injury level of minor or greater on eligible unit types in a calendar quarter. Reported as Injury falls per 1000 Patient Days. (Total number of injury falls / Patient days) X 1000 Measure focus is safety. Target population is adult acute care inpatient and adult rehabilitation patients.	Clinician: Team		Some thought measure should include all injuries rather than being limited to major injuries; Others noted that individuals may be comfortable with some risk of falling and shared decisionmaking about fall prevention methods is important
0228 Endorsed 3-Item Care Transition Measure (CTM-3) Measure Steward: University of Colorado Health Sciences Center **Starter Set Measure**	Composite	Uni-dimensional self-reported survey that measures the quality of preparation for care transitions.	Facility	Federal and State Programs: Hospital Inpatient Quality Reporting State Duals Demonstration: MA	Expand care settings to include post-acute/long-term care settings; Measure selected because it captures person/caregiver experience during care transitions but it may not be discrete enough in its assessment of individual/caregiver understanding of discharge instructions Public comment cautions against over-surveying beneficiaries.
0326 Endorsed Advance Care Plan Measure Steward: NCQA	Process	Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan.	Clinician: Group/ Practice, Individual	Federal and State Programs: Physician Feedback; PQRS; Special Needs Plan	Measure strongly supported for widespread use; Suggested expansion of denominator age group and application in all care settings; Measure promotes inclusion of personal preferences in care plan and this should be encouraged whenever possible

Family of Measures for Dual Eligible Beneficiaries (continued)

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

Family of Measures for Dual Eligible Beneficiaries (continued)

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

Family of Measures for Dual Eligible Beneficiaries (continued)

NQF Measure Number, Endorsement Status, Title, and Steward	Measure Type	Measure Description	Level of Analysis	Other Known Uses and Program Alignment	Workgroup Comments and Public Comments
0557 Endorsed HBIPS-6 Post discharge continuing care plan created Measure Steward: The Joint Commission	Process	The proportion of patients discharged from a hospital-based inpatient psychiatric setting with a post discharge continuing care plan created. This measure is a part of a set of seven nationally implemented measures that address hospital-based inpatient psychiatric services (HBIPS-1: Admission Screening for Violence Risk, Substance Use, Psychological Trauma History and Patient Strengths completed, HBIPS-2: Physical Restraint, HBIPS-3: Seclusion, HBIPS-4: Multiple Antipsychotic Medications at Discharge, HBIPS-5: Multiple Antipsychotic Medications at Discharge with Appropriate Justification and HBIPS-7: Post Discharge Continuing Care Plan Transmitted) that are used in The Joint Commission's accreditation process. Note that this is a paired measure with HBIPS-7 (Post Discharge Continuing Care Plan Transmitted).	Facility	Federal and State Programs: Inpatient Psychiatric Facility Quality Reporting	Paired measure to be used with 0558; This type of transition planning/communication is universally important and should apply to all discharges, not just psychiatric; At a minimum, the measure should include inpatient detox Public comment noted measure 0576 is in use and preferred; MAP notes that the level of analysis is different.
0558 Endorsed HBIPS-7 Post discharge continuing care plan transmitted to next level of care provider upon discharge Measure Steward: The Joint Commission	Process	Patients discharged from a hospital-based inpatient psychiatric setting with a continuing care plan provided to the next level of care clinician or entity overall and stratified by age groups: Children (Age 1 through 12 years), Adolescents (Age 13 through 17 years), Adults (Age 18 through 64 years), Older Adults (Age greater than and equal to 65 years). Note: this is a paired measure with HBIPS-6: Post discharge continuing care plan created.	Facility	Federal and State Programs: Inpatient Psychiatric Facility Quality Reporting	This type of transition planning/communication is universally important and should apply to all discharges; At a minimum, the measure should include inpatient detox; Addresses care coordination through creating and transmitting care plan; Important to also communicate plan to the individual and caregiver Public comment noted measure 0576 is in use and preferred; MAP notes that the level of analysis is different.

Family of Measures for Dual Eligible Beneficiaries (continued)

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

Family of Measures for Dual Eligible Beneficiaries (continued)

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

Family of Measures for Dual Eligible Beneficiaries (continued)

NQF Measure Number, Endorsement Status, Title, and Steward	Measure Type	Measure Description	Level of Analysis	Other Known Uses and Program Alignment	Workgroup Comments and Public Comments
0674 Endorsed Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) Measure Steward: CMS	Outcome	This measure is based on data from all non-admission MDS 3.0 assessments of long-stay nursing facility residents which may be annual, quarterly, significant change, significant correction, or discharge assessment. It reports the percent of residents who experienced one or more falls with major injury (e.g., bone fractures, joint dislocations, closed head injuries with altered consciousness, and subdural hematoma) in the last year (12-month period). The measure is based on MDS 3.0 item J1900C, which indicates whether any falls that occurred were associated with major injury.	Facility; Population: National	Federal and State Programs: Nursing Home Quality Initiative and Nursing Home Compare	Some thought measure should include all injuries rather than being limited to major injuries; Others noted that individuals may be comfortable with some risk of falling and shared decisionmaking about fall prevention methods is important
0682 Endorsed Percent of Residents or Patients Assessed and Appropriately Given the Pneumococcal Vaccine (Short-Stay) Measure Steward: CMS	Process	The measure reports the percentage of short stay nursing home residents or IRF or LTCH patients who were assessed and appropriately given the pneumococcal vaccine during the 12-month reporting period. This measure is based on data from Minimum Data Set (MDS) 3.0 assessments of nursing home residents, the Inpatient Rehabilitation Facilities Patient Assessment Instrument (IRF-PAI) for IRF patients, and the Long Term Care Hospital (LTCH) Continuity Assessment Record and Evaluation (CARE) Data Set for long-term care hospital patients, using items that have been harmonized across the three assessment instruments. Short-stay nursing home residents are those residents who are discharged within the first 100 days of their nursing home stay.	Facility; Population: National	Federal and State Programs: Nursing Home Quality Initiative and Nursing Home Compare	Incorporate preventive services such as vaccination into person-centered care plan; Vaccinations are especially important for persons living in institutional settings or otherwise at high risk of infection

Family of Measures for Dual Eligible Beneficiaries (continued)

NQF Measure Number, Endorsement Status, Title, and Steward	Measure Type	Measure Description	Level of Analysis	Other Known Uses and Program Alignment	Workgroup Comments and Public Comments
0692 Endorsed Consumer Assessment of Health Providers and Systems (CAHPS®) Nursing Home Survey: Long-Stay Resident Instrument Measure Steward: AHRQ	Outcome	The CAHPS® Nursing Home Survey: Long-Stay Resident Instrument is an in-person survey instrument to gather information on the experience of long stay (greater than 100 days) residents currently in nursing homes. The Centers for Medicare & Medicaid Services requested development of this survey, and can be used in conjunction with the CAHPS Nursing Home Survey: Family Member Instrument and Discharged Resident Instrument. The survey instrument provides nursing home level scores on 5 topics valued by residents: (1) Environment; (2) Care; (3) Communication & Respect; (4) Autonomy and (5) Activities. In addition, the survey provides nursing home level scores on 3 global items.	Facility	State Duals Demonstration: VA Private Programs: Health Quality Council of Alberta, Canada	Surveys restricting proxy respondents may exclude disabled consumers who have difficulties communicating
0709 Endorsed Proportion of patients with a chronic condition that have a potentially avoidable complication during a calendar year. Measure Steward: Bridges to Excellence	Outcome	Percent of adult population aged 18 – 65 years who were identified as having at least one of the following six chronic conditions: Diabetes Mellitus (DM), Congestive Heart Failure (CHF), Coronary Artery Disease (CAD), Hypertension (HTN), Chronic Obstructive Pulmonary Disease (COPD) or Asthma, were followed for one-year, and had one or more potentially avoidable complications (PACs). A Potentially Avoidable Complication is any event that negatively impacts the patient and is potentially controllable by the physicians and hospitals that manage and co-manage the patient. Generally, any hospitalization related to the patient's core chronic condition or any co-morbidity is considered a potentially avoidable complication, unless that hospitalization is considered to be a typical service for a patient with that condition. Additional PACs that can occur during the calendar year include those related to emergency room visits, as well as other professional or ancillary services tied to a potentially avoidable complication.	Clinician: Group/ Practice; Health Plan; Population: National, Regional, County or City, State	Private Programs: Prometheus	These chronic conditions are common among dual eligible beneficiaries and regular access to services is needed to prevent complications; Incorporate chronic disease management and preventive services into person-centered care plan Public comment notes that the measure does not adequately consider psychosocial determinants of health, would prefer a measure validated for the Medicaid population. Public comment requests clarification of 'potentially avoidable' terminology or excluding this measure from the family.

Family of Measures for Dual Eligible Beneficiaries (continued)

NQF Measure Number, Endorsement Status, Title, and Steward	Measure Type	Measure Description	Level of Analysis	Other Known Uses and Program Alignment	Workgroup Comments and Public Comments
0710 Endorsed Depression Remission at Twelve Months Measure Steward: MN Community Measurement	Outcome	Adult patients age 18 and older with major depression or dysthymia and an initial PHQ-9 score > 9 who demonstrate remission at twelve months defined as a PHQ-9 score less than 5. This measure applies to both patients with newly diagnosed and existing depression whose current PHQ-9 score indicates a need for treatment. The Patient Health Questionnaire (PHQ-9) tool is a widely accepted, standardized tool [Copyright © 2005 Pfizer, Inc. All rights reserved] that is completed by the patient, ideally at each visit, and utilized by the provider to monitor treatment progress. This measure additionally promotes ongoing contact between the patient and provider as patients who do not have a follow-up PHQ-9 score at twelve months (+/- 30 days) are also included in the denominator.	Facility, Clinician: Group/ Practice	Federal and State Programs: Meaningful Use-EP; PQRS Private Programs: MN Community Measurement	Remission at 12 months preferred to remission at 6 months because outcome is more fully sustained; Concerns about reporting burden and duplicative measurement if 0712 is also implemented independently Public comment notes need for more details on data collection methodology; MAP notes that this is not a health plan measure.

Family of Measures for Dual Eligible Beneficiaries (continued)

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

Family of Measures for Dual Eligible Beneficiaries (continued)

NQF Measure Number, Endorsement Status, Title, and Steward	Measure Type	Measure Description	Level of Analysis	Other Known Uses and Program Alignment	Workgroup Comments and Public Comments
0729 Endorsed Optimal Diabetes Care Measure Steward: MN Community Measurement	Composite	The percentage of adult diabetes patients who have optimally managed modifiable risk factors (A1c, LDL, blood pressure, tobacco non-use and daily aspirin usage for patients with diagnosis of ischemic vascular disease) with the intent of preventing or reducing future complications associated with poorly managed diabetes. Patients ages 18 - 75 with a diagnosis of diabetes, who meet all the numerator targets of this composite measure: A1c < 8.0, LDL < 100, Blood Pressure < 140/ 90, Tobacco non-user and for patients with diagnosis of ischemic vascular disease daily aspirin use unless contraindicated. Please note that while the all-or-none composite measure is considered to be the gold standard, reflecting best patient outcomes, the individual components may be measured as well. This is particularly helpful in quality improvement efforts to better understand where opportunities exist in moving the patients toward achieving all of the desired outcomes. Please refer to the additional numerator logic provided for each component.	Clinician: Group/ Practice; Integrated Delivery System	Federal and State Programs: Medicare Shared Savings Program; PQRS Private Programs: At least 1 Beacon community	Workgroup generally supports use of composite measures; Some concern that targets within this measure are too aggressive for medically complex beneficiaries and such individuals would need to be excluded
1626 Endorsed Patients Admitted to ICU who Have Care Preferences Documented Measure Steward: The RAND Corporation	Process	Percentage of vulnerable adults admitted to ICU who survive at least 48 hours who have their care preferences documented within 48 hours OR documentation as to why this was not done.	Facility; Health Plan; Integrated Delivery System		All beneficiaries should have preferences documented in all settings of care; Intense level of care and interventions provided in the ICU amplifies the importance of personal care preferences Public comment notes that codes are not available for this process and burden will be added by auditing records.

Family of Measures for Dual Eligible Beneficiaries (continued)

NQF Measure Number, Endorsement Status, Title, and Steward	Measure Type	Measure Description	Level of Analysis	Other Known Uses and Program Alignment	Workgroup Comments and Public Comments
1659 Endorsed Influenza Immunization Measure Steward: CMS	Process	Inpatients age 6 months and older discharged during October, November, December, January, February or March who are screened for influenza vaccine status and vaccinated prior to discharge if indicated.	Facility; Population: National, Regional, State	Federal and State Programs: Hospital Inpatient Quality Reporting	Expand care setting beyond acute care or harmonize with other measures — a single measure operationalized across all levels would be preferred; Incorporate preventive services into person-centered care plan; Vaccinations are especially important for persons living in institutional settings or otherwise at high risk of infection
1768 Endorsed Plan All-Cause Readmissions Measure Steward: NCQA **Starter Set Measure**	Outcome	For members 18 years of age and older, the number of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. Data are reported in the following categories: 1. Count of Index Hospital Stays (IHS) (denominator) 2. Count of 30-Day Readmissions (numerator) 3. Average Adjusted Probability of Readmission 4. Observed Readmission (Numerator/ Denominator) 5. Total Variance Note: For commercial, only members 18–64 years of age are collected and reported; for Medicare, only members 18 and older are collected, and only members 65 and older are reported.	Health Plan	Federal and State Programs: Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults; Medicare Part C Plan Rating; Special Needs Plan State Duals Demonstrations: CA, IL, MA, OH, VA Private Programs: WellPoint; HEDIS; IHA; AHIP survey — Measures used by a Majority of Health Plans; Buying Value core ambulatory measure	Does not exclude planned readmissions, however, it is important to measure readmissions at the health plan level of analysis

Family of Measures for Dual Eligible Beneficiaries (continued)

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

Family of Measures for Dual Eligible Beneficiaries (continued)

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

Family of Measures for Dual Eligible Beneficiaries (continued)

NQF Measure Number, Endorsement Status, Title, and Steward	Measure Type	Measure Description	Level of Analysis	Other Known Uses and Program Alignment	Workgroup Comments and Public Comments
1927 Endorsed Cardiovascular Health Screening for People With Schizophrenia or Bipolar Disorder Who Are Prescribed Antipsychotic Medications Measure Steward: NCQA	Process	The percentage of individuals 25 to 64 years of age with schizophrenia or bipolar disorder who were prescribed any antipsychotic medication and who received a cardiovascular health screening during the measurement year.	Health Plan; Integrated Delivery System; Population: State		Quality issue of particular importance to address access to preventive services needed to reduce disproportionate effect of chronic conditions; Incorporate chronic disease management and preventive services into person-centered care plan Public comment notes that annual performance of this process has not demonstrated better outcomes.
1932 Endorsed Diabetes screening for people with schizophrenia or bipolar disorder who are prescribed antipsychotic medications (SSD) Measure Steward: NCQA	Process	The percentage of individuals 18 – 64 years of age with schizophrenia or bipolar disorder, who were dispensed any antipsychotic medication and had a diabetes screening during the measurement year.	Health Plan; Population: State	State Duals Demonstration: IL	Quality issue of particular importance to address access to preventive services needed to reduce disproportionate effect of chronic conditions; Incorporate chronic disease management and preventive services into person-centered care plan
2091 Endorsed Persistent Indicators of Dementia without a Diagnosis - Long Stay Measure Steward: American Medical Directors Association	Process	Percentage of nursing home residents age 65+ with persistent indicators of dementia and no diagnosis of dementia.	Facility		Addresses cases of misdiagnosis or underdiagnoses of dementia within long-term care facilities as well as communication among facility's care team
2092 Endorsed Persistent Indicators of Dementia without a Diagnosis - Short Stay Measure Steward: American Medical Directors Association	Process	Number of adult patients 65 and older who are included in the denominator (i.e., have persistent signs and symptoms of dementia) and who do not have a diagnosis of dementia on any MDS assessment.	Facility		Addresses cases of misdiagnosis or underdiagnoses of dementia within long-term care facilities as well as communication among facility's care team

Family of Measures for Dual Eligible Beneficiaries (continued)

NQF Measure Number, Endorsement Status, Title, and Steward	Measure Type	Measure Description	Level of Analysis	Other Known Uses and Program Alignment	Workgroup Comments and Public Comments
2111 Endorsed Antipsychotic Use in Persons with Dementia Measure Steward: Pharmacy Quality Alliance, Inc.	Process	The percentage of individuals 65 years of age and older with dementia who are receiving an antipsychotic medication without evidence of a psychotic disorder or related condition.	Health Plan		Overuse of antipsychotics among persons with dementia is a well-documented problem with quality; contributes to clinical complications and higher costs. Public comment notes that this is no longer collected for HEDIS.
2152 Endorsed Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling Measure Steward: AMA-PCPI	Process	Percentage of patients aged 18 years and older who were screened for unhealthy alcohol use at least once during the two-year measurement period using a systematic screening method AND who received brief counseling if identified as an unhealthy alcohol user	Clinician: Group/ Practice, Individual, Team		Support for inclusion in family pending final endorsement by NQF; Recommend expanding care setting to emergency department; Emphasis on incorporating alcohol and other drug treatment into person-centered care plan; Particularly important for population with behavioral health needs

APPENDIX F:

MAP Measure Selection Criteria

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

Criteria

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

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

Sub-criterion 1.1 Measures that are not NQF-endorsed should be submitted for endorsement if selected to meet a specific program need

Sub-criterion 1.2 Measures that have had endorsement removed or have been submitted for endorsement and were not endorsed should be removed from programs

Sub-criterion 1.3 Measures that are in reserve status (i.e., topped out) should be considered for removal from programs

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

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

Sub-criterion 2.1 Better care, demonstrated by patient- and family-centeredness, care coordination, safety, and effective treatment

Sub-criterion 2.2 Healthy people/healthy communities, demonstrated by prevention and well-being

Sub-criterion 2.3 Affordable care

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sub-criterion 5.3 Measure set enables assessment of the person's care and services across providers, settings, and time

6. Program measure set includes considerations for healthcare disparities and cultural competency

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

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

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

7. Program measure set promotes parsimony and alignment

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

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

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

APPENDIX G:
Current Quality of Life Measurement Tools

The MAP Dual Eligible Beneficiaries Workgroup discussed the strengths and limitations of the quality of life measurement tools listed below. These specific tools were explored because of their broad use in the field and/or their potential applicability to the dual eligible beneficiary population. The Workgroup has previously discussed the National Core Indicators (NCI), Personal Outcome Measures (POM), and the use of independent consumer- and family-operated monitoring organizations to ensure quality behavioral health services. MAP will continue to discuss these and other measurement opportunities, especially as potential expansion of the NCI and POM to additional populations is tested. Please refer to the **December 2012 final report** for more information.

SF-36 and Related Tools

The RAND 36-Item Health Survey (SF-36) is a widely used health status questionnaire. The SF-36 includes general components for physical and mental health. Each component has four scales that combine to yield a score. Each of the 8 total scales has a portion of the 36 items that contribute to that factor.[1] This measurement tool was constructed for administration by anyone older than 14 years and, and by a trained interviewer or self-administration. Shorter versions of the tool have emerged over time, including a 12-item version and 8-item version. The SF-36 is available in many different languages.

The SF-36 and related surveys can be very useful in measuring health improvement or decline, predicting medical expenses, assessing treatment effectiveness, or comparing disease burden across populations. However, the tools do not target signs and symptoms related to sleeping patterns, memory, concentration, substance abuse, hearing, vision, and many other topics of importance to dual eligible beneficiaries and others with complex care needs.[2]

World Health Organization Quality of Life Instrument (WHOQOL)

The World Health Organization (WHO) has developed a cross-cultural quality of life measurement tool, the WHOQOL, and related resources. The WHOQOL is a self-reported survey that contains 100 items; the WHOQOL-BREF is an abbreviated version containing 26 items. Both score four domains related to quality of life: physical health, psychological health, social relationships, and environment.[3] An additional 32-item module has been developed to assess aspects of spirituality and beliefs.

Development of the WHOQOL involved the participation of 15 field centers worldwide; the tools are available in more than 20 languages. The strengths of the tools lie in their potential to be applied in a wide range of studies including cross cultural investigations, population epidemiology, health monitoring, service development, and clinical intervention trials. However, permission to use the WHOQOL must be obtained for each individual study and this can be limiting when considering scalability.

The WHOQOL and WHOQOL-BREF have been used effectively in vulnerable populations, including cancer patients, older adults, and individuals with HIV/AIDS. The tools have been used in medical practice to assess the effectiveness and relative merits of different treatments, as well as in health services research to determine how diseases affect the subjective well-being of a person.

The WHO also developed a WHOQOL-OLD

module to assess specific areas of quality of life pertaining to the elderly population. This tool is an extension of the WHOQOL and WHOQOL-BREF and is available in multiple languages. The WHOQOL-OLD can be used in conjunction with the WHOQOL or the BREF version, depending on which is more appropriate for the population under study. The WHOQOL-OLD consists of 6 facets comprised of 4 items each, for a total of 24 items. The survey evaluates: sensory abilities; autonomy; past, present, and future activities; social participation; death and dying; and intimacy. The OLD module allows for the assessment of care structures, policy implications, and provides a better understanding of best practices for improved outcomes for quality of life in older adults.[4]

Patient Reported Outcomes Measurement Information System (PROMIS)

In 2004, the National Institutes of Health established the Patient Reported Outcomes Measurement Information System (PROMIS) as a national resource for accurate and efficient measurement of patient symptoms and other health outcomes in clinical practice. It is a publicly available platform to gather self-reported measures of symptoms, functions, and well-being. PROMIS includes common domains and metrics across conditions, allowing for comparisons across domains and diseases.[5]

The PROMIS is organized into broad domains for physical, mental, and social health and specific profile domains contribute to each one. The instrument can be administered through short forms or more dynamically through computerized adaptive testing. Users can mix and match domains as needed, depending on what they want to assess. However, a respondent would need to answer multiple item banks to provide enough data to assess his or her total quality of life. Additionally, some research has shown some accessibility issues for people with disabilities.[6]

Participant Experience Survey for Home- and Community-Based Services

Two of every three recipients of Medicaid home- and community-based services (HCBS) are dual eligible beneficiaries.[7,8] Under funding from HHS, Truven Health Analytics and the American Institutes for Research have developed and are testing a participant experience survey for HCBS. MAP previously noted measures of HCBS as a major development gap area and has underscored their importance for evaluating many of the nonmedical aspects of high-quality care. The goal of the survey is to gather feedback on an individual's experience with HCBS at the program level. Some of the survey domains address social and nonmedical factors related to quality of life, such as whether an individual is getting needed services, personal safety, and community inclusion and empowerment. Once testing is complete, the research team plans to pursue a CAHPS trademark for the survey from the Agency for Healthcare Research and Quality (AHRQ). MAP will continue to follow the progress of this effort through testing and refinement of the instrument.

Money Follows the Person Quality of Life Survey

The Money Follows the Person (MFP) Demonstration aims to transition people from nursing homes and other long-term care facilities to independent living in the community. The operating premise of the MFP program is highly applicable to the dual eligible beneficiary population and serves some of the same beneficiaries. MFP also seeks to change state policies so that Medicaid funds for LTC services and supports can "follow the person" to the setting of their choice. The demonstration's evaluation was partially based on a survey that measures quality of life outcomes and asks about the respondent's health, housing, access to care, community involvement, and well-being. Participants in the survey can be assisted by another person in responding or can be represented by a proxy.

The MFP Quality of Life Survey showed that MFP participants experienced increased quality of life after transitioning to community living. Participants reported the largest improvement in satisfaction with their living arrangements. The MFP Quality of Life Survey assesses satisfaction with care as well as unmet needs for personal care assistance and treatment providers to ensure that individuals are receiving the supports they need to live independently in the community.[9] Workgroup members discussed the importance of self-determination and the concept of dignity in contributing to psychological well-being as measured by this survey.

ENDNOTES

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