MAP Coordinating Committee In-Person Meeting

NATIONAL
QUALITY FORUM

March 15, 2012

National Quality Forum
9th Floor Conference Center
1030 15th Street, NW
Washington, DC 20005

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MEASURE APPLICATIONS PARTNERSHIP

Coordinating Committee
In-Person Meeting #6

March 15, 2012

NQF Conference Center 9th Floor
1030 15th Street, NW
Washington, DC 20005
Dial: **877-852-6583** Passcode: **7499213**
Web Access: **http://www.MyEventPartner.com/nqfmeetings22**

Meeting Objectives:

- *Review proposed MAP scope of work for 2012-13*
- *Review findings of the MAP Hospital, Dual Eligible Beneficiaries, and Post-Acute Care/Long-Term Care Workgroups on measures for PPS-exempt cancer hospitals, the dual eligible beneficiary population, and hospice care*
- *Finalize input to HHS on performance measurement coordination strategies for PPS-exempt cancer hospitals, the dual eligible beneficiary population, and hospice care*

8:30 am	**Breakfast**
9:00 am	**Welcome and Review of Meeting Objectives** *George Isham and Beth McGlynn, Coordinating Committee Co-Chairs*
9:15 am	**Proposed MAP Scope of Work for 2012-13** *George Isham*
10:30 am	**Opportunity for Public Comment**
10:45 am	**Break**
11:00 am	**Performance Measurement Coordination Strategy for PPS-Exempt Cancer Hospitals** *Beth McGlynn* *Frank Opelka, Hospital Workgroup Chair*
12:15 pm	**Opportunity for Public Comment**

12:30 pm	**Lunch**
1:00 pm	**Strategic Approach to Performance Measurement for Dual Eligible Beneficiaries** *Beth McGlynn* *Alice Lind, Dual Eligible Beneficiaries Workgroup Chair*
2:15 pm	**Opportunity for Public Comment**
2:30 pm	**Break**
2:45 pm	**Performance Measurement Coordination Strategy for Hospice Care** *George Isham* *Carol Raphael, PAC/LTC Workgroup Chair*
4:15 pm	**Opportunity for Public Comment**
4:30 pm	**Next Steps** *George Isham*
4:45 pm	**Adjourn**

Measure Applications Partnership

Coordinating Committee

In-Person Meeting

March 15, 2012

NATIONAL QUALITY FORUM

Welcome and Review of Meeting Objectives

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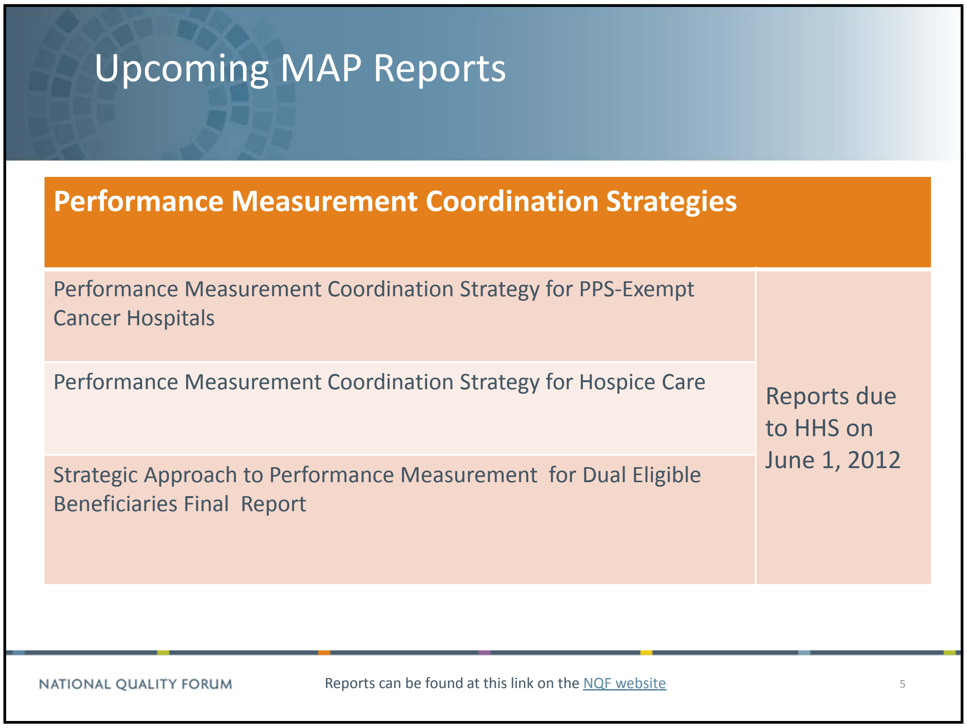
Agenda

- *Welcome and Review of Meeting Objectives*
- *Proposed MAP Scope of Work for 2012-13*
- *Performance Measurement Coordination Strategy for PPS-Exempt Cancer Hospitals*
- *Strategic Approach to Performance Measurement for Dual Eligible Beneficiaries*
- *Performance Measurement Coordination Strategy for Hospice Care*
- *Next Steps*

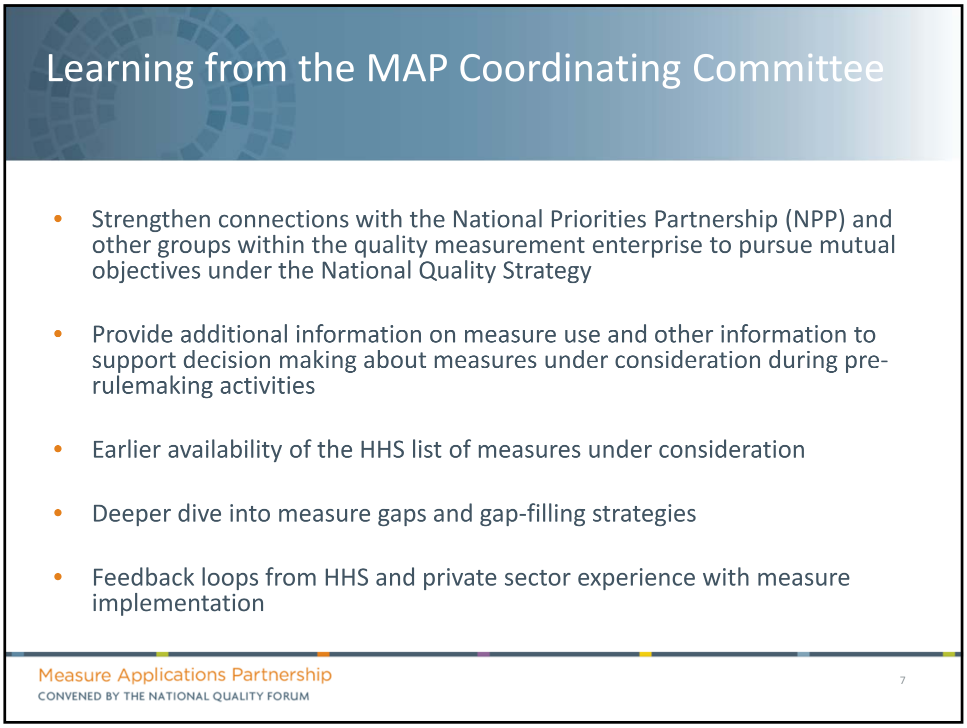


Upcoming MAP Reports

Performance Measurement Coordination Strategies	
Performance Measurement Coordination Strategy for PPS-Exempt Cancer Hospitals	Reports due to HHS on June 1, 2012
Performance Measurement Coordination Strategy for Hospice Care	
Strategic Approach to Performance Measurement for Dual Eligible Beneficiaries Final Report	

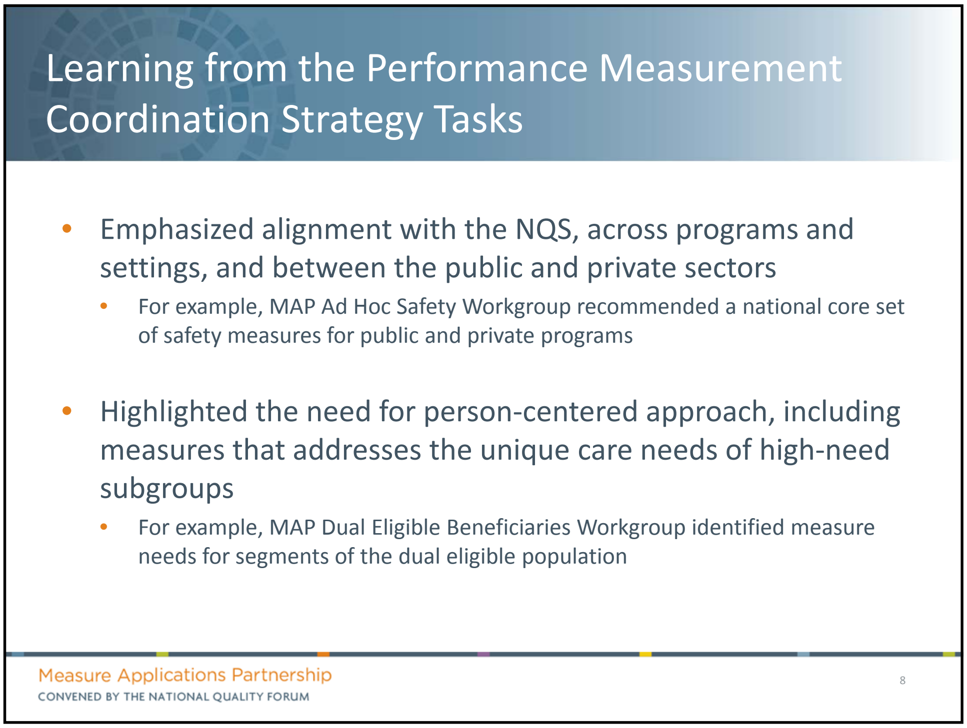
Reports can be found at this link on the NQF website

Proposed MAP Scope of Work for 2012-13



Learning from the MAP Coordinating Committee

- Strengthen connections with the National Priorities Partnership (NPP) and other groups within the quality measurement enterprise to pursue mutual objectives under the National Quality Strategy
- Provide additional information on measure use and other information to support decision making about measures under consideration during pre-rulemaking activities
- Earlier availability of the HHS list of measures under consideration
- Deeper dive into measure gaps and gap-filling strategies
- Feedback loops from HHS and private sector experience with measure implementation



Learning from the Performance Measurement Coordination Strategy Tasks

- Emphasized alignment with the NQS, across programs and settings, and between the public and private sectors
  - For example, MAP Ad Hoc Safety Workgroup recommended a national core set of safety measures for public and private programs
- Highlighted the need for person-centered approach, including measures that addresses the unique care needs of high-need subgroups
  - For example, MAP Dual Eligible Beneficiaries Workgroup identified measure needs for segments of the dual eligible population

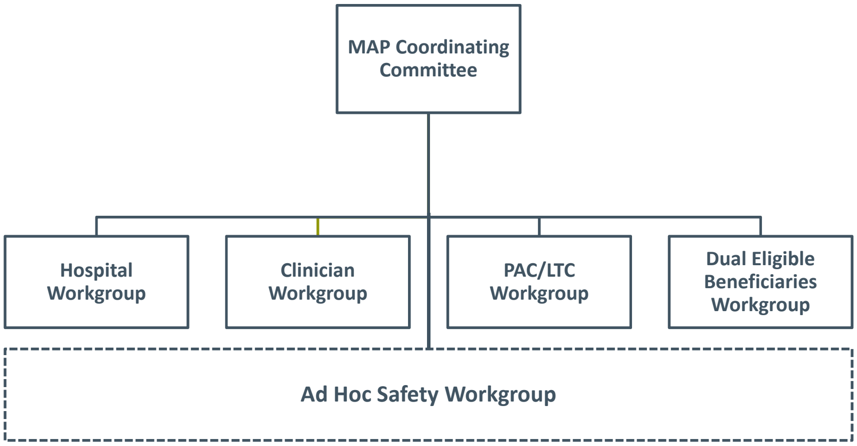
Learning from the Performance Measurement Coordination Strategy Tasks

- All coordination strategy reports identified the need for:
  - Core measure sets across programs, settings, levels of analysis, and populations
  - Common data platform
  - Coordinated approach to filling high priority measure gaps through concerted federal and private support for developing, testing, and endorsing measures

Proposed MAP Work for 2012-13

- Enhance existing two-tiered structure with topic-focused task forces
- Identify families of measures for specific topics and core measure sets composed of available measures and gaps
- Provide pre-making input to HHS on measures under consideration for rulemaking
- Expand decision making support for pre-rulemaking activities
- Delve into measurement issues for dual eligible sub-populations

Current MAP Structure



MAP Coordinating Committee

Hospital Workgroup

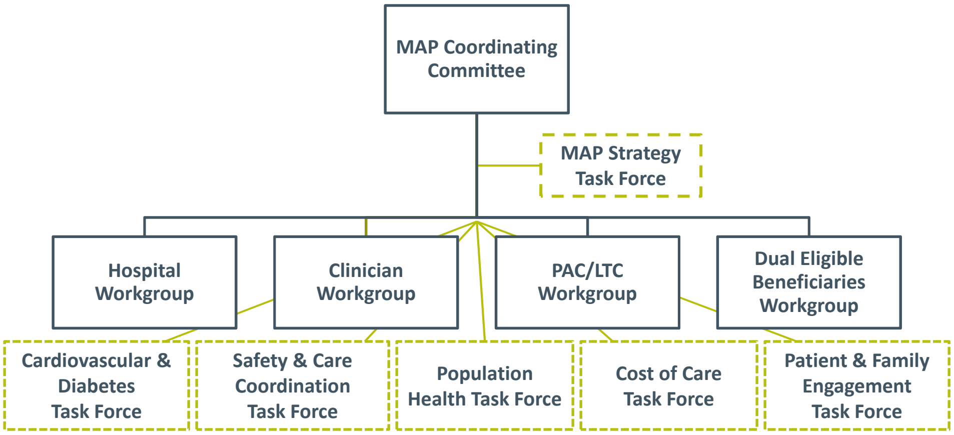
Clinician Workgroup

PAC/LTC Workgroup

Dual Eligible Beneficiaries Workgroup

Ad Hoc Safety Workgroup

Proposed MAP Structure



MAP Coordinating Committee

MAP Strategy Task Force

Hospital Workgroup

Clinician Workgroup

PAC/LTC Workgroup

Dual Eligible Beneficiaries Workgroup

Cardiovascular & Diabetes Task Force

Safety & Care Coordination Task Force

Population Health Task Force

Cost of Care Task Force

Patient & Family Engagement Task Force

Proposed MAP Strategic Planning Approach: Overview

- Establish a MAP Strategy Task Force
- MAP Strategy Task Force membership to include MAP Coordinating Committee and workgroup co-chairs/chairs, NPP co-chairs, and other MAP members to achieve balance and necessary expertise
    - MAP Strategy Task Force advises the Coordinating Committee
- Proposed timeline for work:
    - Outline of approach due to HHS: June 1, 2012
    - Final report due to HHS: October 1, 2012

Proposed MAP Strategic Planning Approach: MAP Strategy Taskforce Membership

- **Chip Kahn, Member of MAP Coordinating Committee (co-chair)**
- **Gerry Shea, Member of MAP Coordinating Committee (co-chair)**
- George Isham, MAP Coordinating Committee co-chair
- Beth McGlynn, MAP Coordinating Committee co-chair
- Helen Darling, National Priorities Partnership co-chair
- Bernie Rosof, National Priorities Partnership co-chair
- Alice Lind, MAP Dual Eligible Beneficiaries Workgroup chair
- Mark McClellan, MAP Clinician Workgroup chair
- Frank Opelka, MAP Hospital Workgroup chair
- Carol Raphael, MAP PAC/LTC Workgroup chair
- Christine Bechtel, MAP Coordinating Committee member
- Nancy Wilson, MAP Coordinating Committee member (federal agency liaison)
- Patrick Conway, MAP Coordinating Committee member (federal agency liaison)

Christine Bechtel, member of MAP Coordinating Committee

Proposed MAP Strategic Planning Approach: Purpose

- Advise Coordinating Committee on a 3-5 year strategic plan for achieving aligned performance measurement
- Further define and enhance MAP's guiding principles and Measure Selection Criteria
- Provide guidance on the development of families of topically-related measures and cores measure sets to support alignment across federal programs and public and private payers

Proposed MAP Strategic Planning Approach: Tactics

Families of Measures and Core Measure Sets to Align Performance Measurement Across Federal Programs and Public and Private Payers

Family of measures – "related available measures and measure gaps for specific topic areas that span programs, care settings, levels of analysis, and populations" (e.g., care coordination family of measures, diabetes care family of measures)

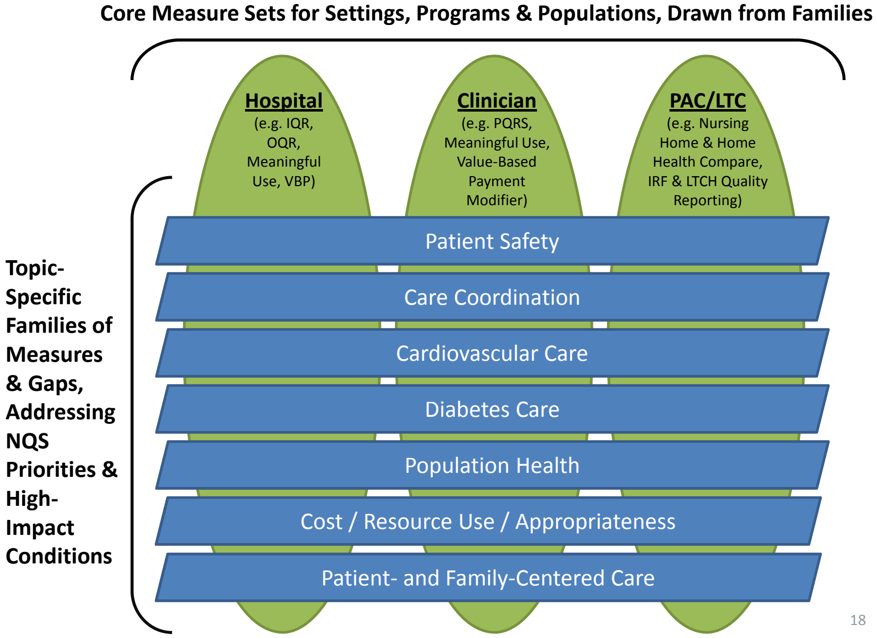
Core measure set – "available measures and gaps drawn from families of measures that should be applied to specified programs, care settings, levels of analysis, and populations" (e.g., PQRS core measure set, hospital core measure set, dual eligible beneficiaries core measure set)

Proposed MAP Work for 2012-13: Families of Measures

Proposed families of measures for NQS priorities and high-impact conditions

- Families of measures identified by task forces
  - Task force membership drawn from existing MAP Coordinating Committee and workgroup membership to achieve balance and necessary expertise
  - Coordinating Committee oversees work of task forces
- Wave 1 – due to HHS October 1, 2012
  - Safety and Care Coordination
  - Cardiovascular and Diabetes Care
- Wave 2 – due to July 1, 2013
  - Population Health (e.g., prevention, key health behaviors, healthy lifestyles, and well- being)
  - Cost of Care (e.g., total cost, resource use, appropriateness)
  - Patient- and Family-Centered Care
- White papers commissioned for the wave 2 topics to support the identification of issues and potential measures

Proposed Families of Measures Illustration:



Core Measure Sets for Settings, Programs & Populations, Drawn from Families

Hospital
(e.g. IQR, OQR, Meaningful Use, VBP)

Clinician
(e.g. PQRS, Meaningful Use, Value-Based Payment Modifier)

PAC/LTC
(e.g. Nursing Home & Home Health Compare, IRF & LTCH Quality Reporting)

Topic-Specific Families of Measures & Gaps, Addressing NQS Priorities & High-Impact Conditions

- Patient Safety
- Care Coordination
- Cardiovascular Care
- Diabetes Care
- Population Health
- Cost / Resource Use / Appropriateness
- Patient- and Family-Centered Care

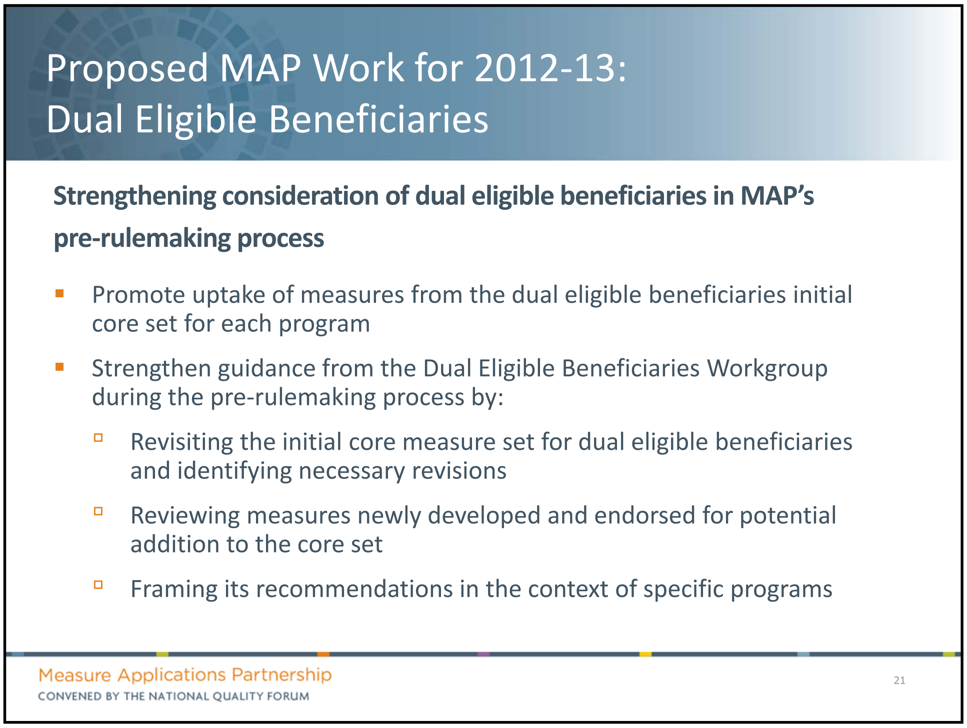
Care Coordination Performance Measures Across Settings

	Clinician	Hospital	Post-Acute Care/Long-Term Care
Care Transitions	Support CTM-3 measure if specified and endorsed at clinician level	Support immediate inclusion of CTM-3 measure for IQR program Support several discharge planning measures	Support CTM-3 measure if specified and endorsed for PAC-LTC settings
Readmissions	Readmission measures are a priority measure gap	Support the inclusion of both a readmission measure that crosses conditions and readmission measures that are condition-specific for IQR program	Avoidable admissions/readmissions are priority measure gaps
Medication Reconciliation	Support inclusion of measures that can be utilized in an HIT environment	Recognize the importance of medication reconciliation upon both admission and discharge, particularly with the dual eligible beneficiaries and psychiatric populations	Identified potential measures for further exploration for use across all PAC/LTC settings

Proposed MAP Work for 2012-13: Dual Eligible Beneficiaries

Measures for high-need sub-populations of dual eligible beneficiaries

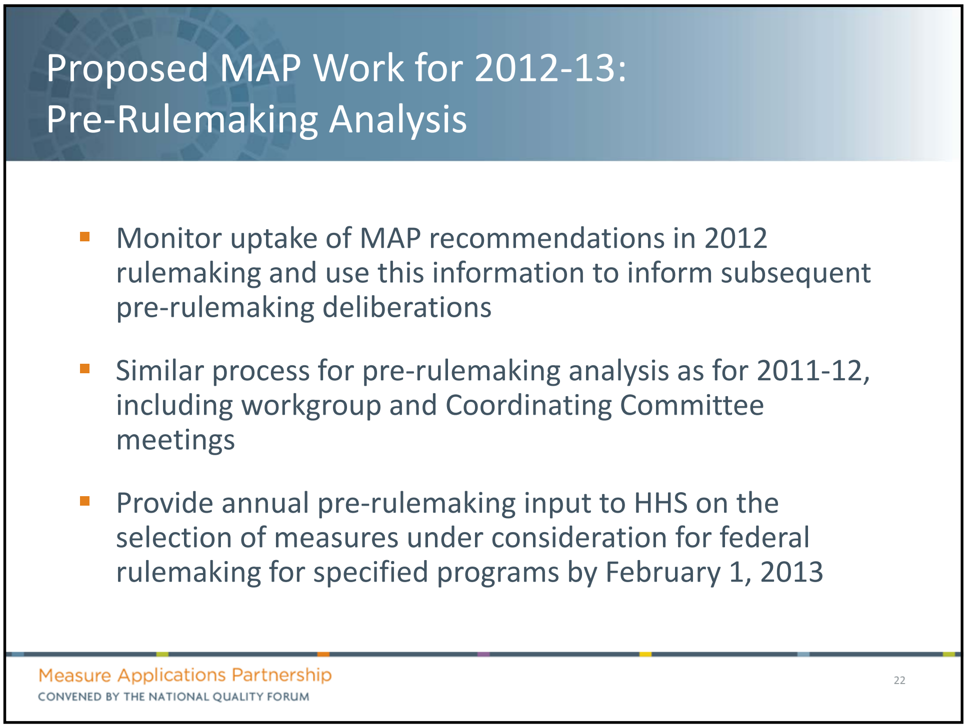
- Analysis of the special measurement considerations presented by high-need sub-populations. These sub-populations would include:
  - Medically complex adults in the community
  - Medically complex older adults in institutional care facilities
  - Individuals with serious mental illness (SMI)
- Within each sub-population, consider current limitations to effective measurement and potential strategies to address identified limitations
- Determine the most suitable performance measures currently available, incorporate them into prior work on core measures, and delineate specific gaps to inform future measure development



Proposed MAP Work for 2012-13: Dual Eligible Beneficiaries

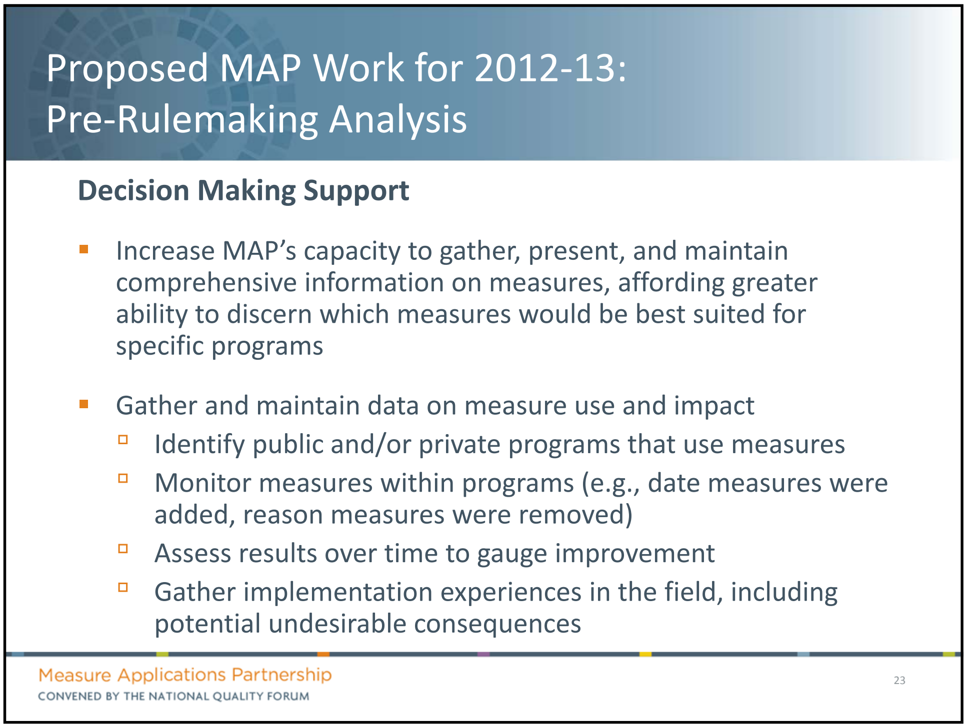
Strengthening consideration of dual eligible beneficiaries in MAP's pre-rulemaking process

- Promote uptake of measures from the dual eligible beneficiaries initial core set for each program
- Strengthen guidance from the Dual Eligible Beneficiaries Workgroup during the pre-rulemaking process by:
  - Revisiting the initial core measure set for dual eligible beneficiaries and identifying necessary revisions
  - Reviewing measures newly developed and endorsed for potential addition to the core set
  - Framing its recommendations in the context of specific programs



Proposed MAP Work for 2012-13: Pre-Rulemaking Analysis

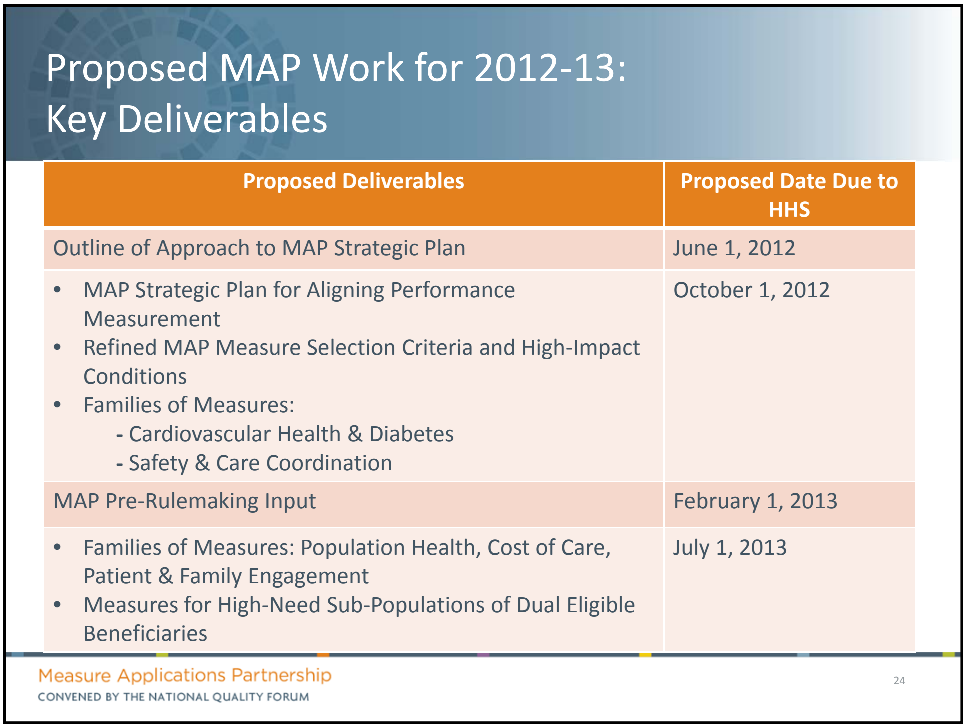
- Monitor uptake of MAP recommendations in 2012 rulemaking and use this information to inform subsequent pre-rulemaking deliberations
- Similar process for pre-rulemaking analysis as for 2011-12, including workgroup and Coordinating Committee meetings
- Provide annual pre-rulemaking input to HHS on the selection of measures under consideration for federal rulemaking for specified programs by February 1, 2013



Proposed MAP Work for 2012-13: Pre-Rulemaking Analysis

Decision Making Support

- Increase MAP's capacity to gather, present, and maintain comprehensive information on measures, affording greater ability to discern which measures would be best suited for specific programs
- Gather and maintain data on measure use and impact
  - Identify public and/or private programs that use measures
  - Monitor measures within programs (e.g., date measures were added, reason measures were removed)
  - Assess results over time to gauge improvement
  - Gather implementation experiences in the field, including potential undesirable consequences



Proposed MAP Work for 2012-13: Key Deliverables

Proposed Deliverables	Proposed Date Due to HHS
Outline of Approach to MAP Strategic Plan	June 1, 2012
• MAP Strategic Plan for Aligning Performance Measurement • Refined MAP Measure Selection Criteria and High-Impact Conditions • Families of Measures: - Cardiovascular Health & Diabetes - Safety & Care Coordination	October 1, 2012
MAP Pre-Rulemaking Input	February 1, 2013
• Families of Measures: Population Health, Cost of Care, Patient & Family Engagement • Measures for High-Need Sub-Populations of Dual Eligible Beneficiaries	July 1, 2013

Discussion

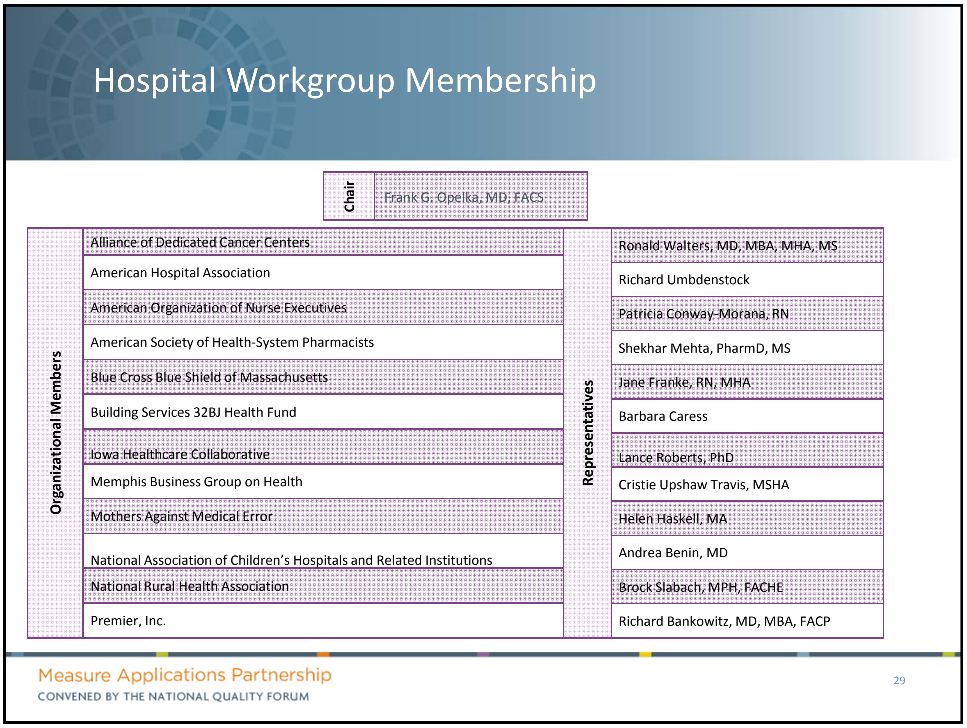
Opportunity for Public Comment

Performance Measurement Coordination Strategy for PPS-Exempt Cancer Hospitals

MAP Hospital Workgroup Charge

The charge of the MAP Hospital Workgroup is to advise the Coordinating Committee on measures to be implemented through the rulemaking process for hospital inpatient and outpatient services, cancer hospitals, the value-based purchasing program, and psychiatric hospitals. The workgroup will:

- Provide input on measures to be implemented through the federal rulemaking process, the manner in which quality problems could be improved, and the related measures for encouraging improvement.
- Identify critical hospital measure development and endorsement gaps.
- **Identify performance measures for PPS-exempt cancer hospital quality reporting by:**
    - **Reviewing available performance measures for cancer hospitals, including clinical quality measures and patient-centered cross-cutting measures;**
    - **Identification of a core set of performance measures for cancer hospital quality reporting; and**
    - **Identification of measure development and endorsement gaps for cancer hospitals.**



Hospital Workgroup Membership

Chair	
Chair	Frank G. Opelka, MD, FACS

Organizational Members	Representatives
Alliance of Dedicated Cancer Centers	Ronald Walters, MD, MBA, MHA, MS
American Hospital Association	Richard Umbdenstock
American Organization of Nurse Executives	Patricia Conway-Morana, RN
American Society of Health-System Pharmacists	Shekhar Mehta, PharmD, MS
Blue Cross Blue Shield of Massachusetts	Jane Franke, RN, MHA
Building Services 32BJ Health Fund	Barbara Caress
Iowa Healthcare Collaborative	Lance Roberts, PhD
Memphis Business Group on Health	Cristie Upshaw Travis, MSHA
Mothers Against Medical Error	Helen Haskell, MA
National Association of Children's Hospitals and Related Institutions	Andrea Benin, MD
National Rural Health Association	Brock Slabach, MPH, FACHE
Premier, Inc.	Richard Bankowitz, MD, MBA, FACP

Measure Applications Partnership
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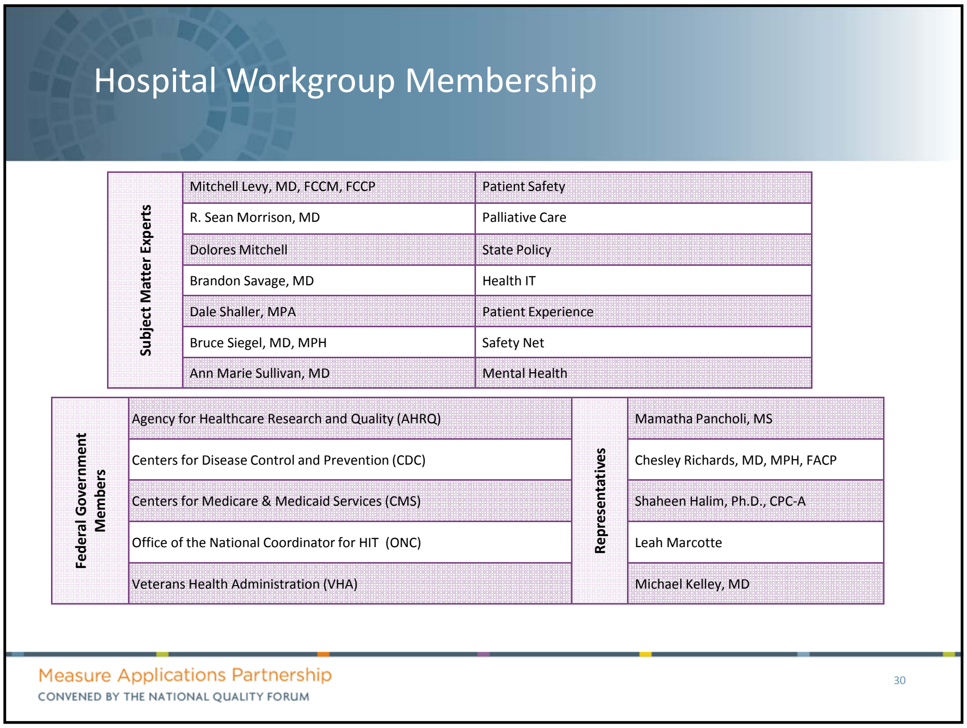

Hospital Workgroup Membership

Subject Matter Experts	
Mitchell Levy, MD, FCCM, FCCP	Patient Safety
R. Sean Morrison, MD	Palliative Care
Dolores Mitchell	State Policy
Brandon Savage, MD	Health IT
Dale Shaller, MPA	Patient Experience
Bruce Siegel, MD, MPH	Safety Net
Ann Marie Sullivan, MD	Mental Health

Federal Government Members	Representatives
Agency for Healthcare Research and Quality (AHRQ)	Mamatha Pancholi, MS
Centers for Disease Control and Prevention (CDC)	Chesley Richards, MD, MPH, FACP
Centers for Medicare & Medicaid Services (CMS)	Shaheen Halim, Ph.D., CPC-A
Office of the National Coordinator for HIT (ONC)	Leah Marcotte
Veterans Health Administration (VHA)	Michael Kelley, MD

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Performance Measurement Coordination Strategy for PPS-Exempt Cancer Hospitals

Using a patient-centered approach, the workgroup considered the following:

- Priorities for measuring performance in cancer care
- A core set of available measures plus measure development, endorsement, and implementation gaps
- Data and health information technology implications
- Initial steps for moving toward more effective measurement to improve quality of cancer care

PPS-Exempt Cancer Hospital Quality Reporting Program

- Historically, the 11 PPS-exempt cancer hospitals in the United States have not been required to participate in quality data reporting programs
- The Affordable Care Act established the PPS-Exempt Cancer Hospital Quality Reporting Program requiring these hospitals to publicly report quality data on the CMS website
  - Statute requires reporting on measures of process, structure, outcome, patients' perspective on care, efficiency, and cost of care
- Beginning in FY 2014, PPS-exempt cancer hospitals must report quality data to CMS, with no Medicare payment incentive

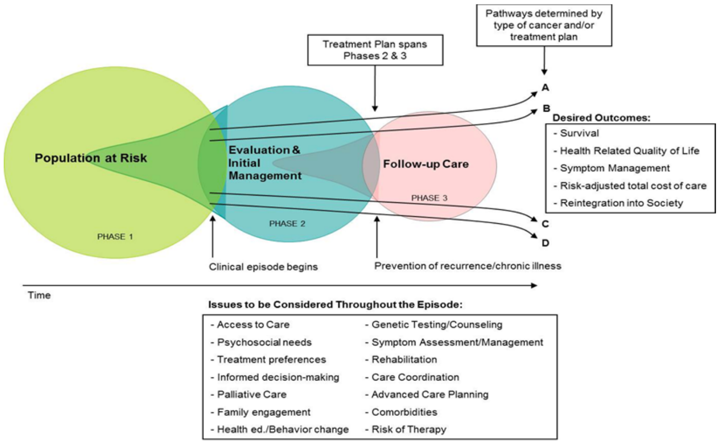
Connection to MAP Pre-Rulemaking Input for PPS-Exempt Cancer Hospitals

MAP previously considered measures for the PPS-exempt Cancer Hospital Quality Reporting Program as part of its pre-rulemaking activities

Condition/ Area	Measure Name	NQF Measure # & Status
Safety	Catheter-associated urinary tract infection	0138 Endorsed
Safety	Central line associated bloodstream infection	0139 Endorsed
Breast	Adjuvant hormonal therapy	0220 Endorsed
Breast	Combination chemotherapy is considered or administered within 4 months (120 days) of diagnosis for women under 70 with AJCC T1c, or Stage II or III hormone receptor negative breast cancer	0559 Endorsed
Colon	Adjuvant chemotherapy is considered or administered within 4 months (120 days) of surgery to patients under the age of 80 with AJCC III (lymph node positive) colon cancer	0223 Endorsed

Patient-Centered Cancer Care

The NQF-endorsed Patient-Focused Episodes of Care model serves as a guide for this work

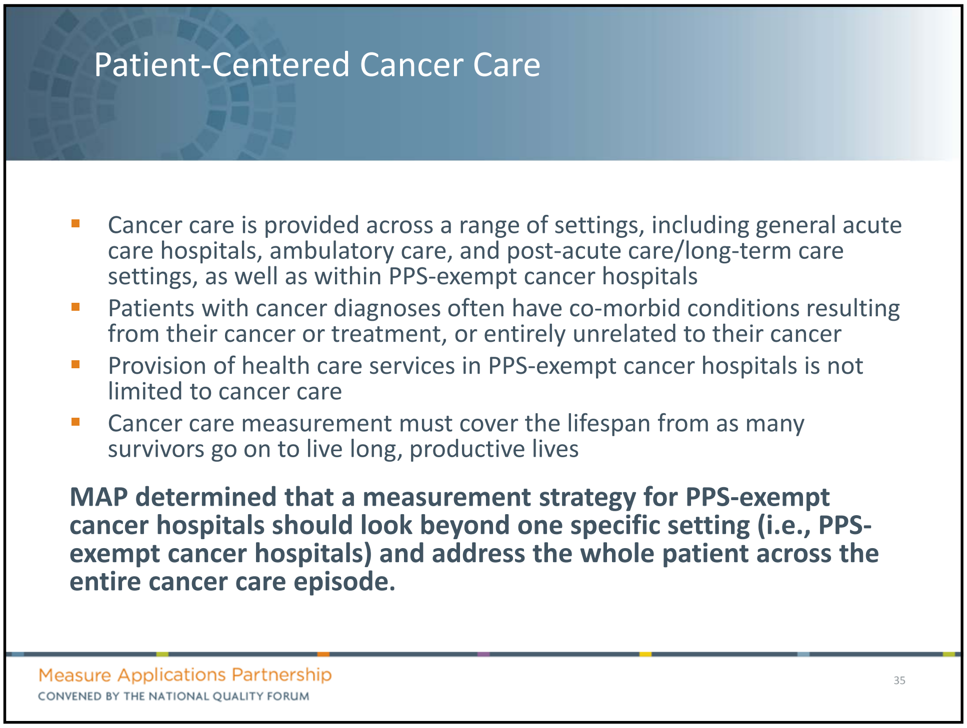


Desired Outcomes:

- Survival
- Health Related Quality of Life
- Symptom Management
- Risk-adjusted total cost of care
- Reintegration into Society

Issues to be Considered Throughout the Episode:

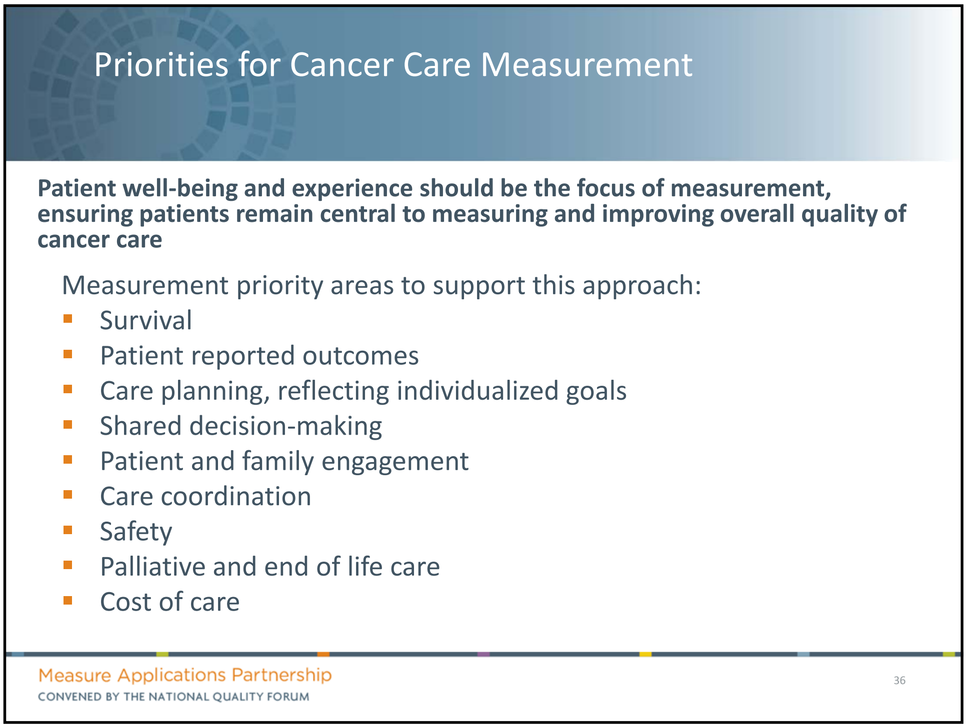
- Access to Care
- Psychosocial needs
- Treatment preferences
- Informed decision-making
- Palliative Care
- Family engagement
- Health ed./Behavior change
- Genetic Testing/Counseling
- Symptom Assessment/Management
- Rehabilitation
- Care Coordination
- Advanced Care Planning
- Comorbidities
- Risk of Therapy



Patient-Centered Cancer Care

- Cancer care is provided across a range of settings, including general acute care hospitals, ambulatory care, and post-acute care/long-term care settings, as well as within PPS-exempt cancer hospitals
- Patients with cancer diagnoses often have co-morbid conditions resulting from their cancer or treatment, or entirely unrelated to their cancer
- Provision of health care services in PPS-exempt cancer hospitals is not limited to cancer care
- Cancer care measurement must cover the lifespan from as many survivors go on to live long, productive lives

MAP determined that a measurement strategy for PPS-exempt cancer hospitals should look beyond one specific setting (i.e., PPS-exempt cancer hospitals) and address the whole patient across the entire cancer care episode.



Priorities for Cancer Care Measurement

Patient well-being and experience should be the focus of measurement, ensuring patients remain central to measuring and improving overall quality of cancer care

Measurement priority areas to support this approach:

- Survival
- Patient reported outcomes
- Care planning, reflecting individualized goals
- Shared decision-making
- Patient and family engagement
- Care coordination
- Safety
- Palliative and end of life care
- Cost of care

Priorities for Cancer Care Measurement

- Survival
    - Most important outcome to patients
    - Should include cancer type and sub-type as well as cancer-specific, stage-for-stage survival curves
    - Survival information should be made available to patients and families to help inform decision-making regarding providers and treatments
- Patient reported outcomes
    - Functional status
    - Experience of care and quality of life, including stress and emotional aspects
    - Standardized, easy-to-use tool for collecting patient-reported information should be implemented across providers

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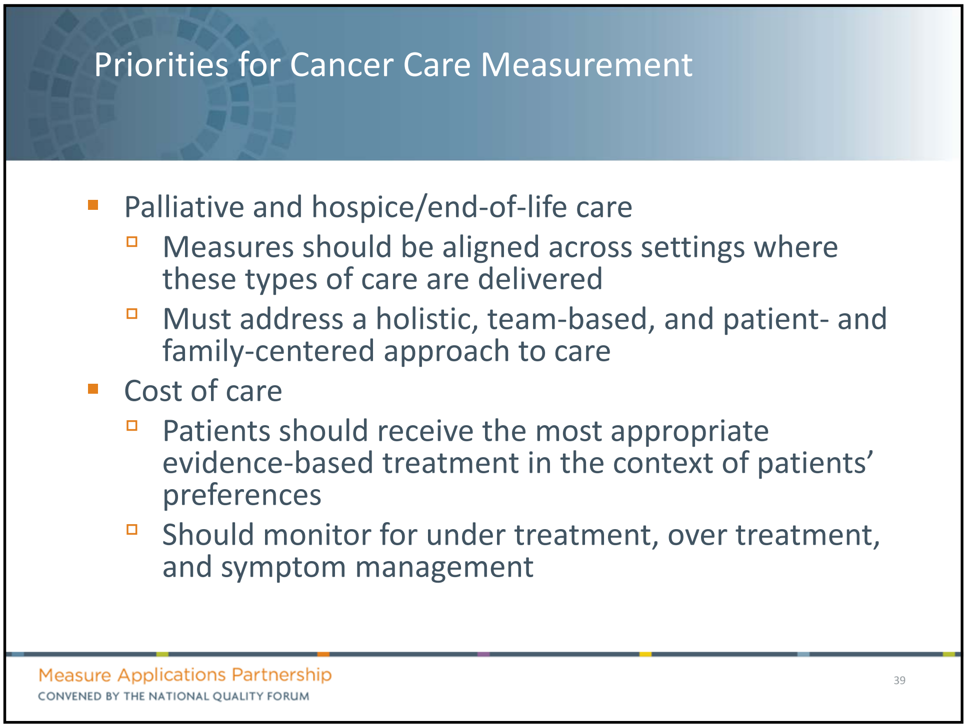
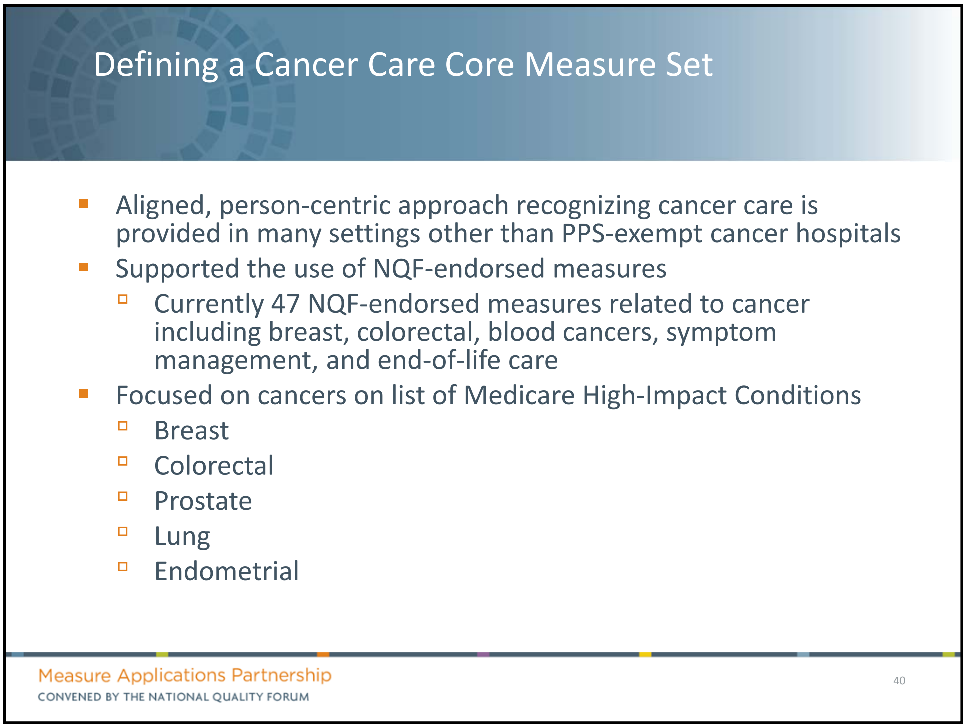
Priorities for Cancer Care Measurement

- Care planning, shared decision-making, patient and family engagement
    - Need information on diagnosis, survival rates, treatment options, and the experiences of other patients
    - Information should be coupled with patients' values and preferences for their care
    - Presence and effectiveness of shared decision-making should be monitored
- Care coordination
    - Effective communication and coordination are essential to safe cancer care and a positive patient experience
- Safety
    - Patients need to understand the risks and side effects of treatment



Priorities for Cancer Care Measurement

- Palliative and hospice/end-of-life care
  - Measures should be aligned across settings where these types of care are delivered
  - Must address a holistic, team-based, and patient- and family-centered approach to care
- Cost of care
  - Patients should receive the most appropriate evidence-based treatment in the context of patients' preferences
  - Should monitor for under treatment, over treatment, and symptom management



Defining a Cancer Care Core Measure Set

- Aligned, person-centric approach recognizing cancer care is provided in many settings other than PPS-exempt cancer hospitals
- Supported the use of NQF-endorsed measures
  - Currently 47 NQF-endorsed measures related to cancer including breast, colorectal, blood cancers, symptom management, and end-of-life care
- Focused on cancers on list of Medicare High-Impact Conditions
  - Breast
  - Colorectal
  - Prostate
  - Lung
  - Endometrial

Defining a Cancer Care Core Measure Set

Related CMS Contracted Work

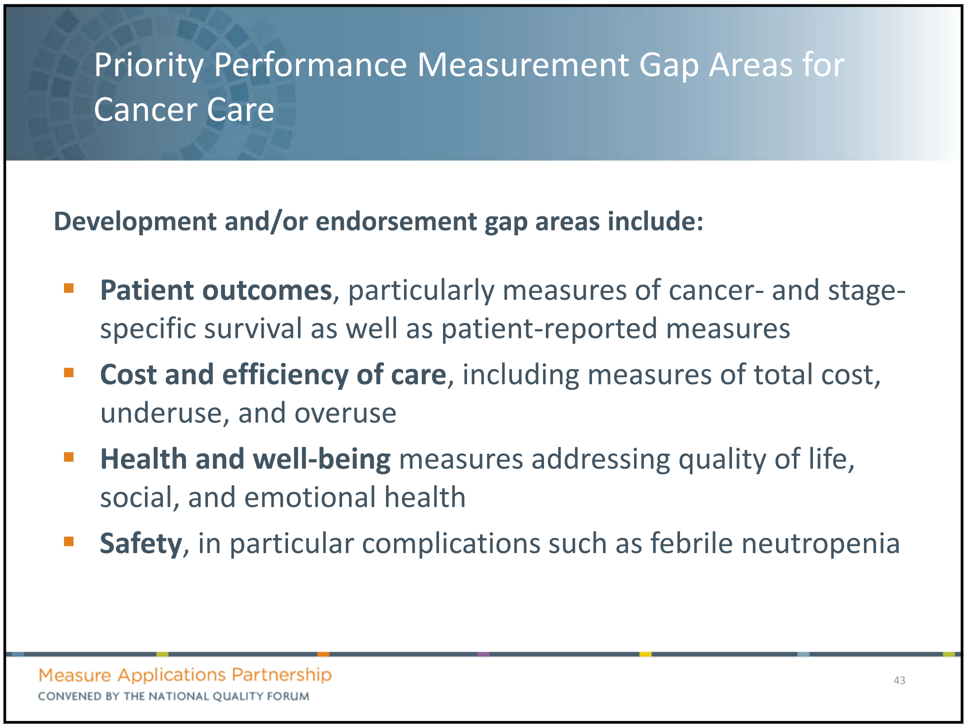
- CMS contracted with Mathematica and NCQA in 2010
- Completed an environmental scan that identified cancer-specific and cross-cutting measures
  - Specifically excluded measures of prevention, screening, and diagnosis
- Convened technical expert panel (TEP) to review and prioritize measures using the following criteria:
  - Relevance to Medicare population with focus on the four most common cancers (lung, breast, colorectal, and prostate)
  - Application to both inpatient and outpatient care
  - Promotion of evidence-based treatment

Initial Cancer Care Core Measure Set

Initial cancer care core measure set consists of 27 measures (see draft report page 7):

Condition/Area	# of Measures
Cross-Cutting Measures:	
Patient & Family Engagement	1
Symptom Management	3
Safety	3
Disease-Specific Measures:	
Breast	7*
Colon	6*
Gynecologic	2
Lung	1
Prostate	3
Other cancers	2

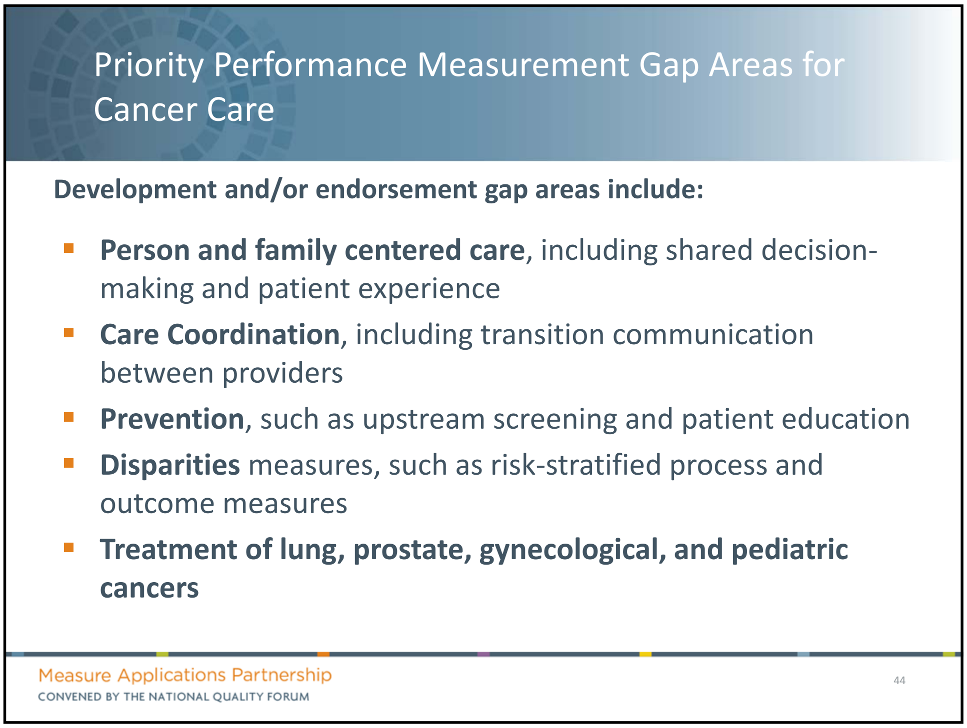
* One measure addresses both breast and colon cancers



Priority Performance Measurement Gap Areas for Cancer Care

Development and/or endorsement gap areas include:

- **Patient outcomes**, particularly measures of cancer- and stage-specific survival as well as patient-reported measures
- **Cost and efficiency of care**, including measures of total cost, underuse, and overuse
- **Health and well-being** measures addressing quality of life, social, and emotional health
- **Safety**, in particular complications such as febrile neutropenia



Priority Performance Measurement Gap Areas for Cancer Care

Development and/or endorsement gap areas include:

- **Person and family centered care**, including shared decision-making and patient experience
- **Care Coordination**, including transition communication between providers
- **Prevention**, such as upstream screening and patient education
- **Disparities** measures, such as risk-stratified process and outcome measures
- **Treatment of lung, prostate, gynecological, and pediatric cancers**

Data and Measurement for Cancer Care: Current Practices

Registries are currently used for most data collection and reporting for cancer care.

Examples reviewed by MAP include:

- American Society of Clinical Oncology’s Quality Oncology Practice Initiative (QOPI)
  - Provides data to physician practices for quality improvement
  - Focuses on processes and covers steps in care from diagnosis to end of life.
- American College of Surgeon’s National Cancer Data Base (NCDB)
  - Collects data from all Commission on Cancer accredited programs
  - Using for comparative effectiveness research, retrospective quality monitoring and reporting, and active quality management

Data and Measurement for Cancer Care: Challenges

Characteristics of cancer care that pose data collection and reporting challenges include:

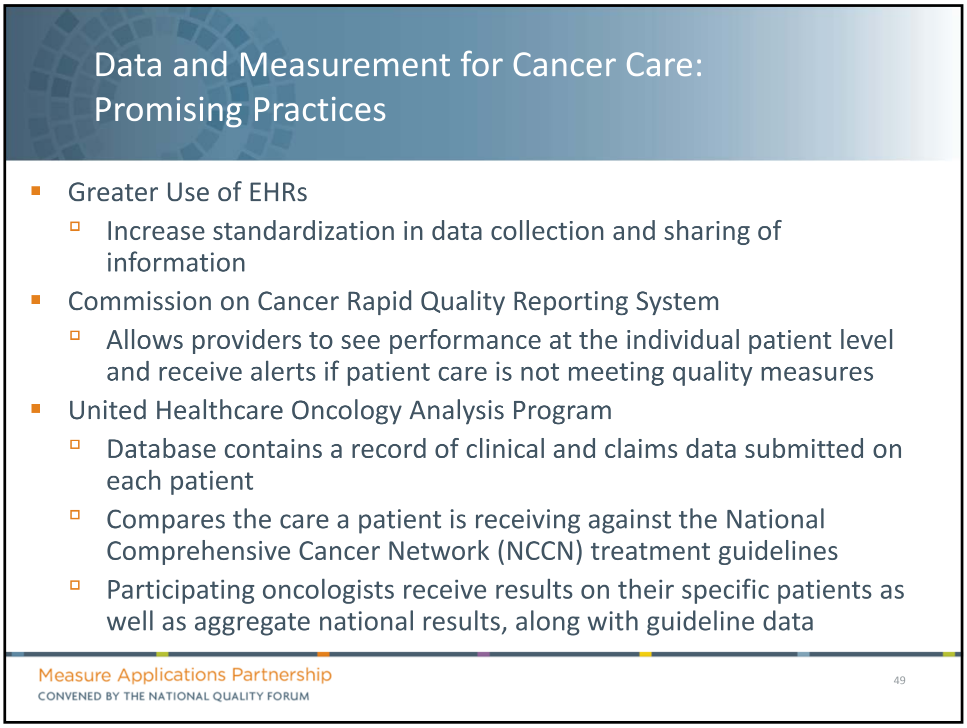
- Various sites and providers of treatment
- Cyclical nature of treatment
- Need for measurement across the lifespan

Data and Measurement for Cancer Care: Challenges

- Inability to collect detailed patient-level data
  - Existing registries are not designed to track unique patients across providers
    - Can lead to missing data on outpatient care and insufficient detail on specific therapies
  - Patient-level data is needed to identify disparities
- Delays in availability of performance scores
  - Lag time in reporting data, as long as 2-3 years, can decrease effective use of information for provider accountability

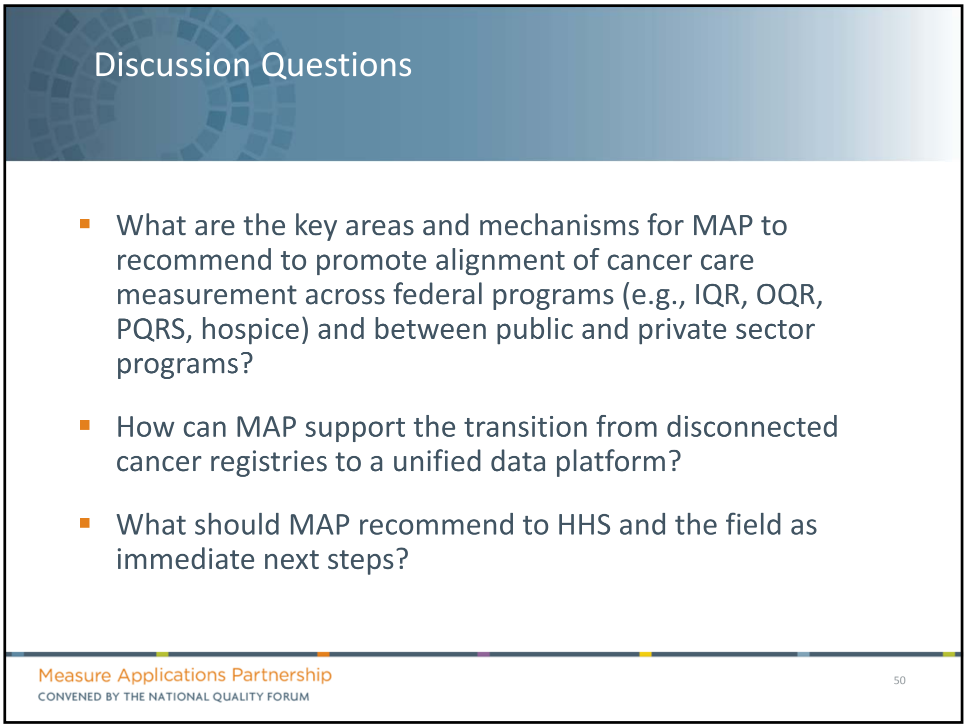
Data and Measurement for Cancer Care: Challenges

- Small sample sizes
  - Small denominators can adversely impact the ability to reach meaningful conclusions regarding quality of care
  - Outliers can disproportionately skew results reflecting an inaccurate representation of the provider’s performance
  - For reporting, need to explain the impact of small numbers on results to ensure information is not misinterpreted
- Patient-reported measures
  - Due to the frequency and cyclical nature of treatment, current data collection approaches can be burdensome on both the patient and provider



Data and Measurement for Cancer Care: Promising Practices

- Greater Use of EHRs
  - Increase standardization in data collection and sharing of information
- Commission on Cancer Rapid Quality Reporting System
  - Allows providers to see performance at the individual patient level and receive alerts if patient care is not meeting quality measures
- United Healthcare Oncology Analysis Program
  - Database contains a record of clinical and claims data submitted on each patient
  - Compares the care a patient is receiving against the National Comprehensive Cancer Network (NCCN) treatment guidelines
  - Participating oncologists receive results on their specific patients as well as aggregate national results, along with guideline data



Discussion Questions

- What are the key areas and mechanisms for MAP to recommend to promote alignment of cancer care measurement across federal programs (e.g., IQR, OQR, PQRS, hospice) and between public and private sector programs?
- How can MAP support the transition from disconnected cancer registries to a unified data platform?
- What should MAP recommend to HHS and the field as immediate next steps?

Opportunity for Public Comment

Strategic Approach to Performance Measurement for Dual Eligible Beneficiaries

Dual Eligible Beneficiaries Workgroup Charge

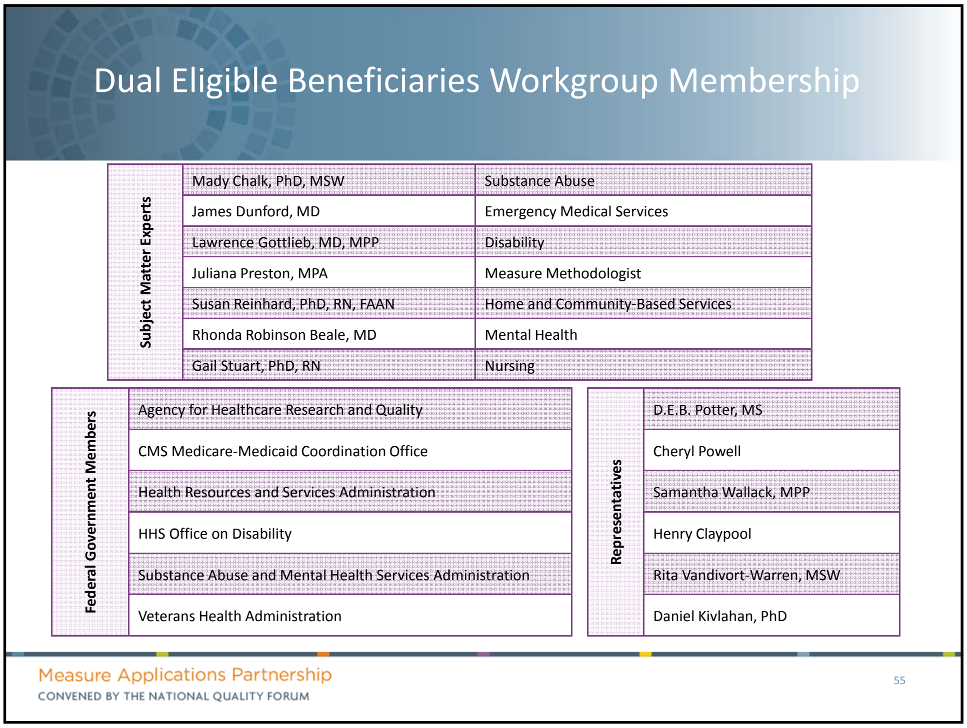
To advise the MAP Coordinating Committee on performance measures to assess and improve the quality of care delivered to Medicare/Medicaid dual eligible beneficiaries. The workgroup will:

- Develop a strategy for performance measurement for this unique population and identify the quality improvement opportunities with the largest potential impact.
- **Identify a core set of current measures that address the identified quality issues and apply to both specific (e.g., Special Needs Plans, PACE) and broader care models (e.g., traditional FFS, ACOs, medical homes).**
- **Identify gaps in available measures for the dual eligible population, and propose modifications and/or new measure concepts to fill those gaps.**
- Advise the Coordinating Committee on a coordination strategy for measuring readmissions and healthcare-acquired conditions across public and private payers and on pre-rulemaking input to HHS on the selection of measures for various care settings.

Dual Eligible Beneficiaries Workgroup Membership

Chair Alice Lind, MPH, BSN

Organizational Members	Representatives
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	David Polakoff, MD, MsC
Better Health Greater Cleveland	Patrick Murray, MD, MS
Center for Medicare Advocacy	Patricia Nemore, JD
National Health Law Program	Leonardo Cuello, JD
Humana, Inc.	Thomas James, III, MD
LA Care Health Plan	Laura Linebach, RN, BSN, MBA
National Association of Public Hospitals and Health Systems	Steven Counsell, MD
National Association of Social Workers	Joan Levy Zlotnik, PhD, ACSW
National PACE Association	Adam Burrows, MD

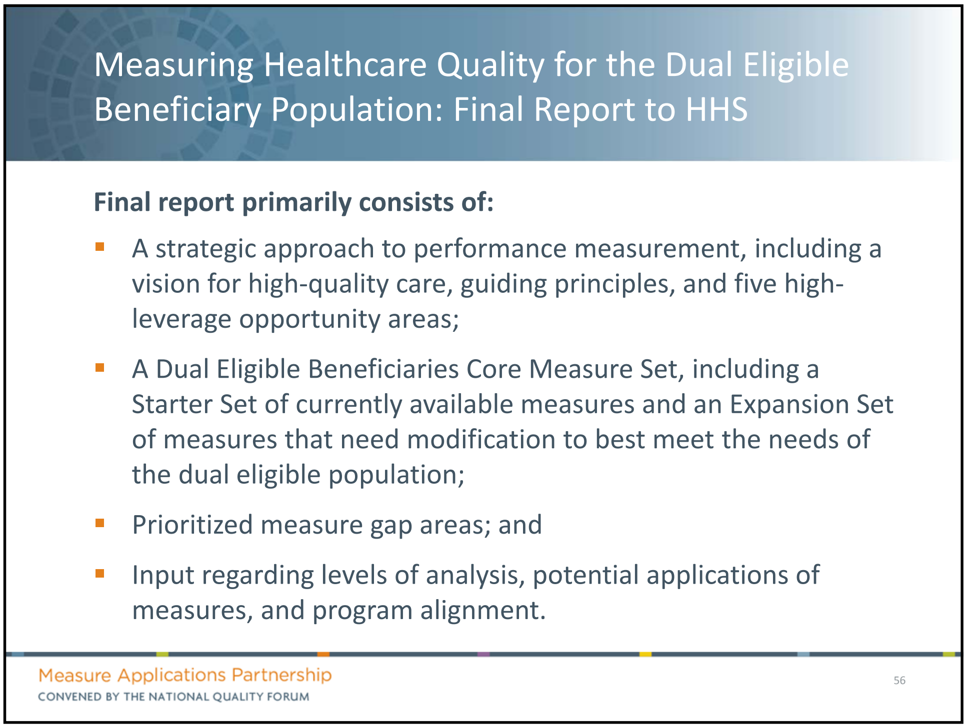


Dual Eligible Beneficiaries Workgroup Membership

Subject Matter Experts	Mady Chalk, PhD, MSW	Substance Abuse
	James Dunford, MD	Emergency Medical Services
	Lawrence Gottlieb, MD, MPP	Disability
	Juliana Preston, MPA	Measure Methodologist
	Susan Reinhard, PhD, RN, FAAN	Home and Community-Based Services
	Rhonda Robinson Beale, MD	Mental Health
	Gail Stuart, PhD, RN	Nursing

Federal Government Members	Agency for Healthcare Research and Quality
	CMS Medicare-Medicaid Coordination Office
	Health Resources and Services Administration
	HHS Office on Disability
	Substance Abuse and Mental Health Services Administration
	Veterans Health Administration

Representatives	D.E.B. Potter, MS
	Cheryl Powell
	Samantha Wallack, MPP
	Henry Claypool
	Rita Vandivort-Warren, MSW
	Daniel Kivlahan, PhD



Measuring Healthcare Quality for the Dual Eligible Beneficiary Population: Final Report to HHS

Final report primarily consists of:

- A strategic approach to performance measurement, including a vision for high-quality care, guiding principles, and five high-leverage opportunity areas;
- A Dual Eligible Beneficiaries Core Measure Set, including a Starter Set of currently available measures and an Expansion Set of measures that need modification to best meet the needs of the dual eligible population;
- Prioritized measure gap areas; and
- Input regarding levels of analysis, potential applications of measures, and program alignment.

Measuring Quality for Dual Eligible Beneficiaries: Guiding Principles

DESIRED EFFECTS

Promoting Integrated Care
Ensuring Cultural Competence
Health Equity

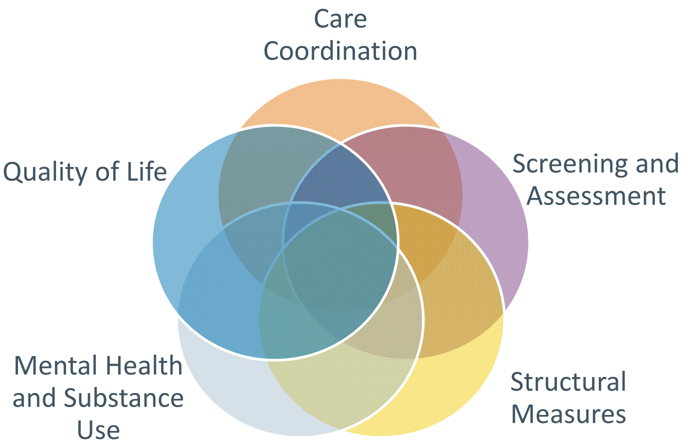
MEASUREMENT DESIGN

Assessing Outcomes Relative to Goals
Parsimony
Cross-Cutting Measures
Inclusivity
Avoiding Undesirable Consequences

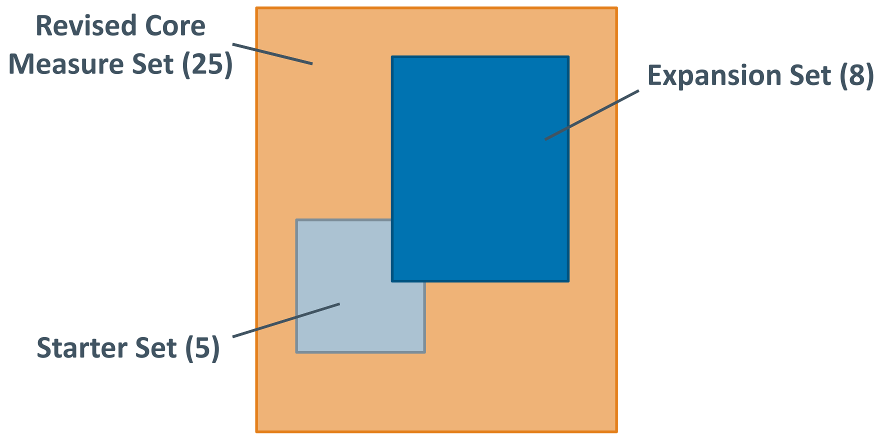
DATA

Data Sharing
Using Data for Multiple Purposes
Making the Best Use of Available Data

Measuring Quality for Dual Eligible Beneficiaries: High-Leverage Opportunities for Improvement



Measuring Quality for Dual Eligible Beneficiaries: 3 Related Sets of Measures



Measuring Quality for Dual Eligible Beneficiaries: Topics in Revised Core Measure Set

High-Leverage Opportunity Area	Measure Topics
Quality of Life	Functional Status Assessment Health-Related Quality of Life Palliative Care
Care Coordination	Care Transition Experience Communication with Patient/Caregiver Communication with Healthcare Providers Hospital Readmission Medication Management
Screening and Assessment	BMI Screening Falls Management of Diabetes Pain Management
Mental Health and Substance Use	Alcohol Screening and Intervention Depression Screening Substance Use Treatment Tobacco Cessation
Structural Measures	Health IT Infrastructure Medical Home Adequacy Medicare / Medicaid Coordination
Other	Patient Experience

Measuring Quality for Dual Eligible Beneficiaries: Starter Set of Measures

- *Screening for Clinical Depression and Follow-up Plan*: #0418 Endorsed
- *Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey*: Multiple Measures Endorsed
- *Medical Home System Survey*: #0494 Endorsed
- *Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: (a) Initiation, (b) Engagement:* #0004 Endorsed
- Pending Endorsement, either:
  - *Hospital-Wide All-Cause Unplanned Readmission Measure (HWR): #1789*, In Process
  - *Plan All-cause Readmission: #1768*, In Process

Measuring Quality for Dual Eligible Beneficiaries: Expansion Set of Measures Needing Modification to Best Meet the Needs

- *Assessment of Health Related Quality of Life (Physical & Mental Functioning)*: #0260 Endorsed
  - Expand care setting/population beyond ESRD
- *Medical Home System Survey*: #0494 Endorsed
  - Apply beyond current use as NCQA accreditation tool
- *HBIPS-6: Post Discharge Continuing Care Plan Created: #0557* Endorsed and *HBIPS-7: Post Discharge Continuing Care Plan Transmitted to Next Level of Care Provider on Discharge: #0558* Endorsed
  - Expand to include discharges from detox
  - Use these or similar measures across all discharges

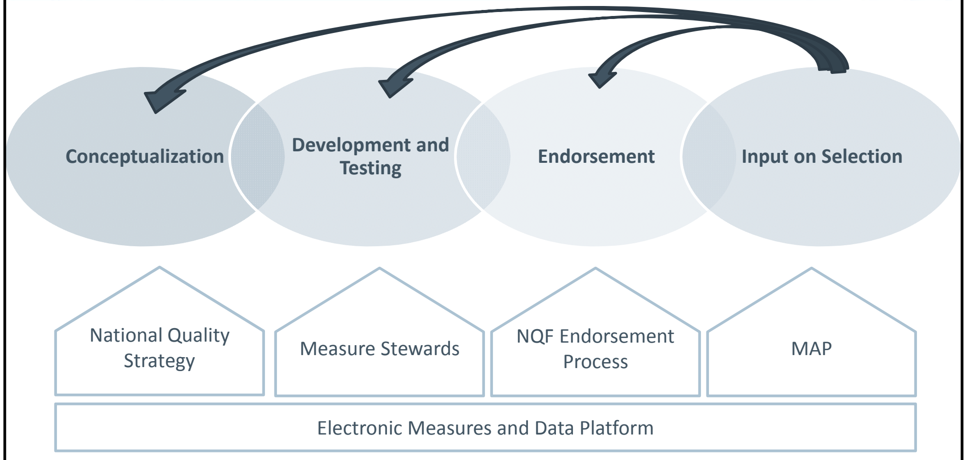
Measuring Quality for Dual Eligible Beneficiaries: Expansion Set of Measures Needing Modification to Best Meet the Needs

- *Falls: Screening for Fall Risk:* #0101 Endorsed
  - Consider other groups at risk of a fall in denominator (e.g., mobility limitations, obesity)
- *3-Item Care Transition Measure (CTM-3)*: #0228 Endorsed
  - Broaden to other types of transitions (e.g., from ER, from nursing facility)
- *Comfortable Dying: Pain Brought to a Comfortable Level Within 48 Hours of Initial* Assessment: #0209 Endorsed
  - Consider a more universal measure of pain assessment and management
- *Change in Daily Activity Function as Measured by the AM-PAC*: #0430 Endorsed
  - Account for maintenance of functional status, address floor effects, broaden beyond post-acute care

Measuring Quality for Dual Eligible Beneficiaries: *Ex Post Facto* Review of Measure Sets

- Additional measures may be ready for short-term implementation
- Coordinating Committee may choose to re-categorize selected measures within the sets:
  - Promote *3-Item Care Transition Measure (CTM-3) (#0228 Endorsed)* from the Expansion Set to the Starter Set?
  - Promote *Optimal Diabetes Care (#0729 Endorsed)* from the core measure set to the Starter Set?
    - » Measure description: The percentage of adult diabetes patients who have optimally managed modifiable risk factors (A1c < 8, LDL <100, blood pressure < 140/90, tobacco non-use, and daily aspirin usage for patients with diagnosis of ischemic vascular disease (unless contraindicated)). Composite is preferred, but each risk factor may be evaluated separately.

Addressing Gaps in Measurement



Conceptualization

Development and Testing

Endorsement

Input on Selection

National Quality Strategy

Measure Stewards

NQF Endorsement Process

MAP

Electronic Measures and Data Platform

Measuring Quality for Dual Eligible Beneficiaries: Prioritized Gaps in Measurement

Measure Development Gap Concepts	Votes
Goal-directed person-centered care planning/implementation	18
System structures to connect health system and long-term services and supports	17
Appropriate prescribing and medication management	13
Screening for cognitive impairment and poor psychosocial health	11
Appropriateness of hospitalization (e.g., avoidable)	9
Optimal functioning (e.g., improving when possible, maintaining, managing decline)	9
Sense of control/autonomy/self-determination	8
Level of beneficiary assistance navigating Medicare/Medicaid	8
Presence of coordinated or blended payment streams	7
Screening for poor health literacy	6
Utilization benchmarking (e.g., outpatient/ED)	6

Measuring Quality for Dual Eligible Beneficiaries: Gaps in Medicaid Home and Community-Based Services (HCBS)

- 300 Medicaid waiver programs
- Expenditures > $23 billion
- 1 million participants, 2 out of 3 are duals
- Social (not medical) model
- Promising measure concepts found in scans, but no standardization across states or HCBS sub-populations
- Suggest HHS explore the feasibility of an NQF endorsement project

Degree to which consumers report that staff are sensitive to their cultural, ethnic, or linguistic backgrounds and degree to which consumers felt they were respected by staff

Percent of caregivers usually or always getting needed support

Unmet need in ADLs/IADLs

Satisfaction with relationships with parents, siblings, and other relatives

Degree of active consumer participation in decisions concerning their treatment

Percent of adults 18+ with disabilities in the community usually or always getting needed support

Measuring Quality for Dual Eligible Beneficiaries: Levels of Analysis and Potential Applications

While the CMS Medicare-Medicaid Coordination Office will play a dominant role in directing large-scale quality improvement activities for the foreseeable future, no single entity is fully accountable for or in control of care for dual eligible beneficiaries.

Given the diffuse accountability, the workgroup grappled with the questions of where and how measurement should occur. Each stakeholder group has a different role to play:

- Federal Government, including CMS, MedPAC, and MACPAC
- State Government
- Private Health Plans, Providers, and Researchers

Measuring Quality for Dual Eligible Beneficiaries: Measure Alignment

- Contributions of the Duals Eligible Beneficiary Perspective to MAP's Pre-Rulemaking Deliberations
- Complementing Medicaid Adult Core Measure Set
  - Both sets specialized to meet different population needs
  - Six measures overlap between Medicaid Adult Core Measure Set and Dual Eligible Beneficiaries Core Measure Set
  - Long-term care services not a focus of Medicaid Adult Core Set
- Future Opportunities
  - Improve alignment and update Dual Eligible Beneficiaries Core Measure Set
  - Consider measurement needs of high-need dual eligible beneficiaries population subgroups

Discussion Questions

- How should MAP promote adoption of the Dual Eligible Beneficiaries Core Measures across programs?
- How can MAP stimulate development of measures for care planning and long-term services and supports?
- What should MAP recommend to HHS as immediate next steps?

Opportunity for Public Comment

Performance Measurement Coordination Strategy for Hospice Care

MAP PAC/LTC Workgroup Charge

The charge of the MAP Post-Acute Care/Long-Term Care Workgroup is to advise on quality reporting for post-acute care and long-term care settings. The workgroup will:

- Develop a coordination strategy for quality reporting that is aligned across post-acute care and long-term care settings by:
  - Identifying a core set of available measures, including clinical quality measures and patient-centered cross cutting measures
  - Identifying critical measure development and endorsement gaps
- **Identify measures for quality reporting for hospice programs and facilities**
- Provide input on measures to be implemented through the federal rulemaking process that are applicable to post-acute settings

MAP PAC/LTC Workgroup Membership

Chair Carol Raphael, MPA

Organizational Members	Representatives
Aetna	Randall Krakauer, MD
American Rehabilitation Provides Association	Suzanne Snyder, PT
American Physical Therapy Association	Roger Herr, PT, MPA, COS-C
Family Caregiver Alliance	Kathleen Kelly, MPA
HealthInsight	Juliana Preston, MPA
Kindred Healthcare	Sean Muldoon, MD
National Consumer Voice for Quality Long-Term Care	Lisa Tripp
National Hospice and Palliative Care Organization	Carol Spence
National Transitions of Care Organization	James Lett II, MD, CMD
Providence Health and Services	Robert Hellrigel
Service Employee International Union	Charissa Raynor
Visiting Nurses Association of American	Margaret Terry, PhD, RN

MAP PAC/LTC Workgroup Membership

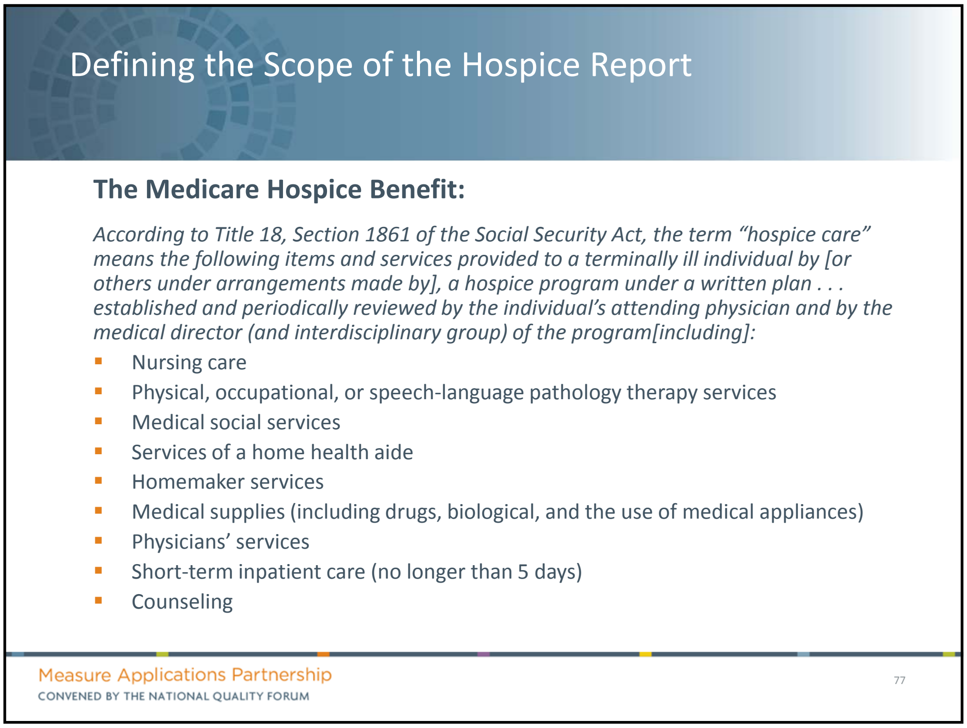
Subject Matter Experts	Care Coordination	Gerri Lamb, PhD
	Clinician/Geriatrics	Bruce Leff, MD
	State Medicaid	MaryAnne Lindeblad, MPH
	Measure Methodologist	Debra Saliba, MD, MPH
	Health Information Technology	Thomas von Sternberg, MD
	Clinician/Nursing	Charlene Harrington, PhD, RN, FAAN

Federal Government Members	Agency for Healthcare Research and Quality	**Representatives**	Judy Sangl, ScD
	Centers for Medicare & Medicaid Services		Shari Ling, MD
	Veterans Health Administration		Scott Shreve, MD

Performance Measurement Coordination Strategy for Hospice Quality Reporting

Overall theme: Hospice care as an opportunity to emphasize two National Priorities: ***Person- and Family-Centered Care*** *and* ***Effective Communication and Care Coordination***

- Executive Summary, MAP Background, Introduction, Approach
  - Establishing that the scope of the report includes palliative care, as well as hospice care
- High-Leverage Measure Concepts
  - Defining high-leverage measure concepts to align hospice and palliative care performance measures and to promote common goals across initiatives
- Applying and Refining Existing Measures
  - Identifying measures that can be readily incorporated into performance measurement programs to address hospice and palliative care
- Pathway for Improving Measure Application
  - Improving measure applications, including identifying measure gaps and promising ways to fill those gaps to meet current and emerging needs

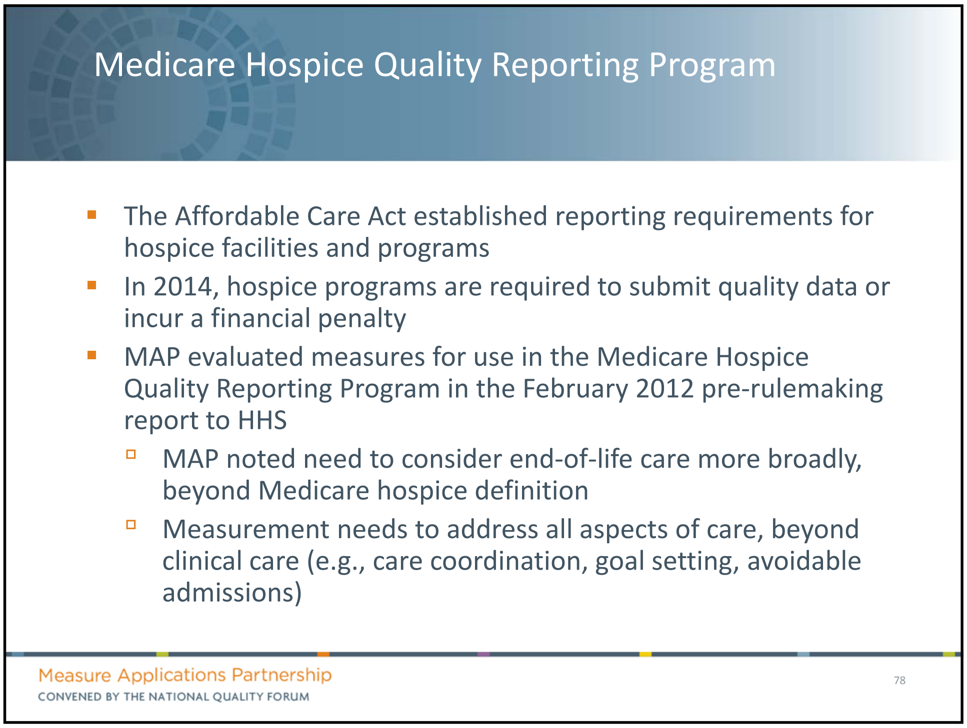


Defining the Scope of the Hospice Report

The Medicare Hospice Benefit:

According to Title 18, Section 1861 of the Social Security Act, the term "hospice care" means the following items and services provided to a terminally ill individual by [or others under arrangements made by], a hospice program under a written plan . . . established and periodically reviewed by the individual's attending physician and by the medical director (and interdisciplinary group) of the program[including]:

- Nursing care
- Physical, occupational, or speech-language pathology therapy services
- Medical social services
- Services of a home health aide
- Homemaker services
- Medical supplies (including drugs, biological, and the use of medical appliances)
- Physicians' services
- Short-term inpatient care (no longer than 5 days)
- Counseling



Medicare Hospice Quality Reporting Program

- The Affordable Care Act established reporting requirements for hospice facilities and programs
- In 2014, hospice programs are required to submit quality data or incur a financial penalty
- MAP evaluated measures for use in the Medicare Hospice Quality Reporting Program in the February 2012 pre-rulemaking report to HHS
  - MAP noted need to consider end-of-life care more broadly, beyond Medicare hospice definition
  - Measurement needs to address all aspects of care, beyond clinical care (e.g., care coordination, goal setting, avoidable admissions)

Medicare Hospice Quality Reporting Program Measures

MAP evaluated 2 finalized measures and 6 measures under consideration

Measure #/Title	CMS Status
0209 Comfortable Dying	Finalized
Hospice administers a QAPI program containing at least three indicators related to patient care (Not Endorsed)	Finalized
0208 Family Evaluation of Hospice Care	Under Consideration- MAP Supported
1617 Patient Treated with an Opioid Who Are Given a Bowl Regimen	
1634 Hospice and Palliative Care – Pain Screening	
1637 Hospice and Palliative Care – Pain Assessment	
1638 Hospice and Palliative Care – Dyspnea Treatment	
1639 Hospice and Palliative Care – Dyspnea Screening	

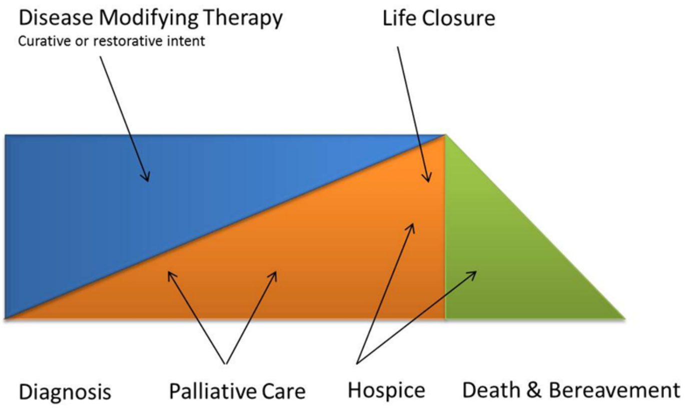
Defining the Scope of the Hospice Report

Definitions

- **Hospice care**: a service delivery system that provides palliative care for patients who have a limited life expectancy and require comprehensive biomedical, psychosocial, and spiritual support as they enter the terminal stage of an illness or condition. It also supports family members coping with the complex consequences of illness, disability, and aging as death nears; and addresses the bereavement needs of the family following the death of the patient.
- **Palliative care:** patient- and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs; and facilitating patient autonomy, access to information, and choice.

Defining the Scope of the Hospice Report

Hospice and Palliative Care along the Continuum of Care



Disease Modifying Therapy
Curative or restorative intent

Life Closure

Diagnosis

Palliative Care

Hospice

Death & Bereavement

Unique Aspects of Hospice and Palliative Care

Measure concepts for hospice and palliative care should consider the following characteristics:

- Holistic (e.g., physical, mental, emotional, spiritual, psychosocial)
- Patient-centered (i.e., driven by patients' individual preferences)
  - Family is considered part of the unit of care
- Team-based, increasing the need for effective care coordination
- Can occur in multiple settings (e.g., hospitals, home, LTC facilities, clinician office)
- Lack of access and availability of services persist, though utilization of the Medicare hospice benefit is growing
  - On average, patients enter hospice 6 weeks before death, despite a 6 month benefit
  - Providing palliative care upstream creates more awareness of hospice as an option and familiarizes patients with the type of care

High-Leverage Measure Concepts for Hospice and Palliative Care

- Identified 28 measure concepts that address:
  - Access/Availability of Services
  - Patient- and Family-Centered Care
  - Goals and Care Planning
  - Care Coordination
  - Provider Competency
  - Appropriateness/Affordable Care
- 10 of the 28 measure concepts are highly prioritized
  - 7 highly prioritized for both hospice and palliative care
  - 3 highly prioritized specific to hospice
  - 3 highly prioritized specific to palliative care
- Identified 24 available measures that address the measure concepts

Available Measures that Address High-Leverage Hospice and Palliative Care Measure Concepts

Considerations when identifying measures:

- Both clinical quality and patient-centered, cross-cutting measures are needed
- Evidence is still growing in this field, with only a small number of currently available measures (e.g., symptom management)
- In areas with less evidence (e.g., goals of care, spiritual counseling) begin with process and structural measures until more robust evidence exists for outcome measures
- ACOVE end-of-life quality indicators can address some gaps for hospice measurement with additional development and testing
  - Indicators have not been previously used as quality measures due to difficulty in specifying the end of life population as the denominator, but the entire Medicare hospice benefit population could be considered end of life
- Potential for undesirable consequences noted
  - For example, measures should encourage movement of patients to hospice by choice, rather than last minute transfers so hospitals will perform better on hospice utilization or inpatient mortality measures

Available Measures for Hospice and Palliative Care

Refer to pages 8-11 of the draft report for measures. The measure table contains the following:

- Measures are categorized by the list of 28 measure concepts
  - Measures are not available to address some measure concepts
- Measures are indicated as ready for use for either hospice or a particular palliative care setting (designated with an X)
  - Goal of aligned hospice and palliative care measures across all settings; need testing and developing to expand measures to additional settings
- Additional considerations for refining measures
  - Expand beyond certain settings or populations

Measure Concepts of Highest Priority for Hospice and Palliative Care

Experience of care (3 available measures)

- General comments
  - Should include many aspects (e.g., timeliness, meeting goals, care coordination, education provided)
  - Necessary to determine if needs are being met
  - Should include both patients and family/caregiver experience
- Priority for Medicare Hospice Quality Reporting Program
  - Should incorporate the unique aspects of hospice-trusting staff, level/availability of support
- Priority for palliative care across settings

Measure Concepts of Highest Priority for Hospice and Palliative Care

Comprehensive assessment– including physical, psychological, spiritual aspects of care (no available measures)

- General comments
  - Should incorporate social aspects of care
  - Should address ongoing reassessment
- Priority for Medicare Hospice Quality Reporting Program
  - Starting point for hospice care; essential to establish care plan and understand patient/family preferences
  - May be the only way to address emotional and spiritual aspects of care, given the difficulty in developing measures for these areas
- Priority for palliative care across settings
  - Should be paired with care planning, advance directive discussions, and sharing medical records across providers
  - Comprehensive assessment ensures all issues are addressed and facilitates coordinate care

Measure Concepts of Highest Priority for Hospice and Palliative Care

Physical aspects of care–treating pain, dyspnea, constipation and other symptoms (8 available measures)

- General comments
  - Must include re-evaluation and a plan for management documented in the care plan
- Priority for Medicare Hospice Quality Reporting Program
  - Largest evidence base for practice; logical initial focus for performance measurement
  - Managing pain and symptoms is important to the patient
  - Avoids unwanted treatments and hospital/ED admissions
- Priority for palliative care across settings
  - Symptom management is an indicator of effective care and can avoid unwanted treatments and hospital/ED admissions

Measure Concepts of Highest Priority for Hospice and Palliative Care

Access/availability of services

- Access to palliative care (no available measures)
  - Priority for palliative care across settings
    - Essential to patients having a choice in their care
    - Must be available at all sites of care
- Access to the healthcare team on a 24-hour basis (no available measures)
  - Priority for Medicare Hospice Quality Reporting Program
    - Important for patients and families who have complicated health care and comfort issues; access reduces their anxiety
    - Necessary to provide timely intervention
    - Improves care coordination and decreases unnecessary hospitalizations
- Timeliness/responsiveness of care (no available measures)
  - Priority for Medicare Hospice Quality Reporting Program
    - Average length of stay for hospice is so short that timeliness is essential
    - Care must be timely to support patients and caregivers, enhance autonomy, prevent unwanted admissions to hospital/ED, and improve experience of care

Measure Concepts of Highest Priority for Hospice and Palliative Care

Patient- and family-centered care

- Psychological and psychiatric aspects of care–managing anxiety, depression, delirium, behavioral disturbances, and other common psychological symptoms (1 available measure)
  - Priority for Medicare Hospice Quality Reporting Program
    - Essential to compassionate care of the dying; can lead to better decision making and increased comfort
    - Behavior changes significantly add to burden and can lead to unstable care, hospital admissions, and crisis interventions
  - Priority for palliative care across settings
    - Behavior changes significantly add to burden and can lead to unstable care plan, hospital admissions, and crisis interventions
- Patient education and support (no available measures)
  - Priority for palliative care across settings

Measure Concepts of Highest Priority for Hospice and Palliative Care

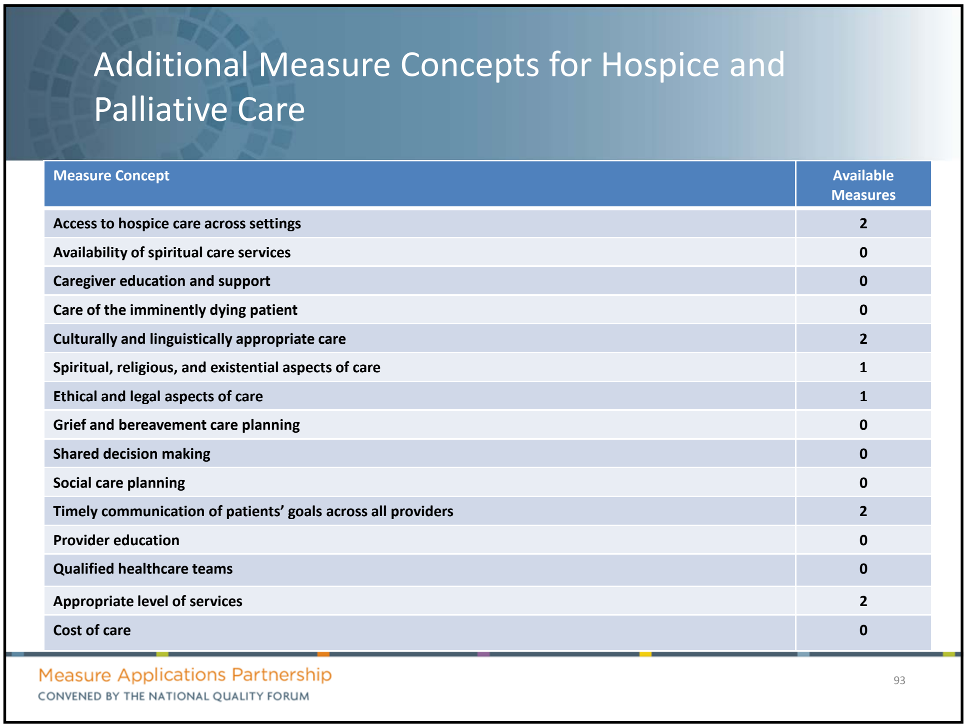
Goals and care planning

- Care planning–establishing and periodically reviewing patient/family/caregiver goals (3 available measures) and
- Implementing patient/family/caregiver goals (no available measures)
  - General comments
    - Should be done in tandem with comprehensive assessment
    - Need continuity of care plans across settings
    - Emphasis should be placed on communication with patient, family, and other providers
  - Priority for Medicare Hospice Quality Reporting Program
    - Should include a process for determining preferences, reviewing preferences at regular intervals, and a plan for addressing each of the core areas of assessment
  - Priority for palliative care across settings
    - Focus on continually reassessing patient goals; patients are not imminently dying so goals may change over time

Measure Concepts of Highest Priority for Hospice and Palliative Care

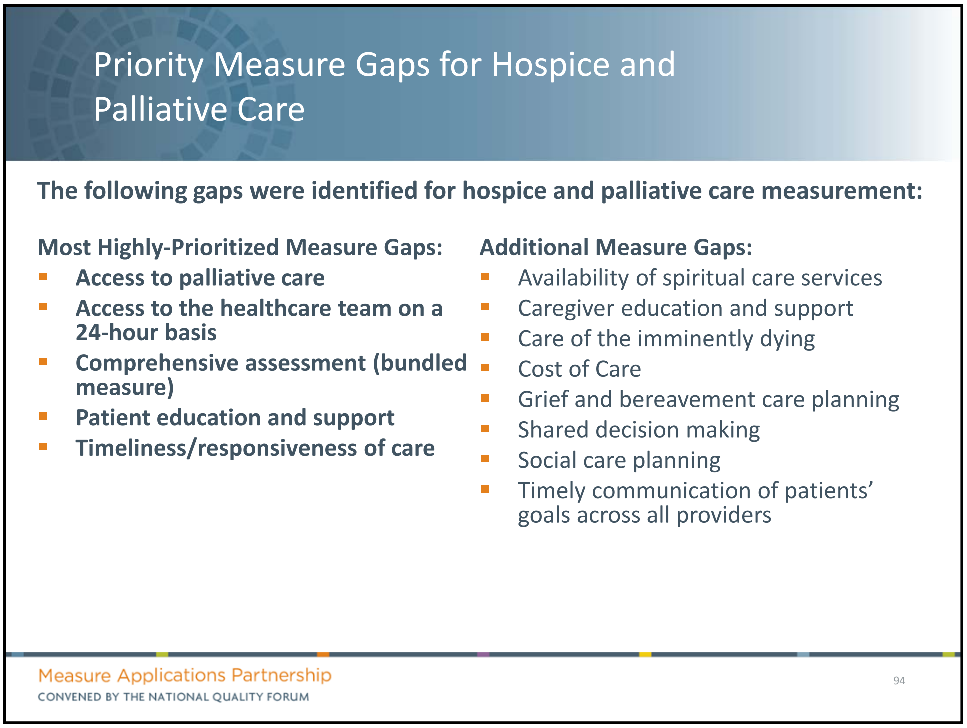
Care coordination/appropriateness/affordability

- Sharing medical records, including advance directives across all providers (no available measures)
  - Priority for palliative care across settings
    - Improves continuity of care and decreases avoidable hospitalizations
- Avoiding unwanted treatments (2 available measures)
  - General comments
    - Implies good communication and care planning
    - Could encompass unnecessary ED/hospital admissions
  - Priority for Medicare Hospice Quality Reporting Program
  - Priority for palliative care across settings
- Avoiding hospital and ED admissions (4 available measures)
  - General comments
    - Important across the care continuum
    - Proxy for meeting patient needs
    - If needs are met admissions/readmissions are reduced
  - Priority for Medicare Hospice Quality Reporting Program
  - Priority for palliative care across settings



Additional Measure Concepts for Hospice and Palliative Care

Measure Concept	Available Measures
Access to hospice care across settings	2
Availability of spiritual care services	0
Caregiver education and support	0
Care of the imminently dying patient	0
Culturally and linguistically appropriate care	2
Spiritual, religious, and existential aspects of care	1
Ethical and legal aspects of care	1
Grief and bereavement care planning	0
Shared decision making	0
Social care planning	0
Timely communication of patients' goals across all providers	2
Provider education	0
Qualified healthcare teams	0
Appropriate level of services	2
Cost of care	0



Priority Measure Gaps for Hospice and Palliative Care

The following gaps were identified for hospice and palliative care measurement:

Most Highly-Prioritized Measure Gaps:
- **Access to palliative care**
- **Access to the healthcare team on a 24-hour basis**
- **Comprehensive assessment (bundled measure)**
- **Patient education and support**
- **Timeliness/responsiveness of care**

Additional Measure Gaps:
- Availability of spiritual care services
- Caregiver education and support
- Care of the imminently dying
- Cost of Care
- Grief and bereavement care planning
- Shared decision making
- Social care planning
- Timely communication of patients' goals across all providers

Discussion Questions

- How can MAP move measurement forward in the critical areas of patient-centeredness (care planning, patient education, shared decision making) and care coordination, which are highlighted as measure gaps across MAP reports?
- What barriers do hospitals, clinicians, and PAC/LTC providers need to have addressed to promote and provide effective hospice and palliative care?
- What should MAP recommend to HHS and the field as immediate next steps?

Opportunity for Public Comment

Next Steps

Upcoming Meetings

Coordinating Committee Web Meeting
TBD April/May, 2012

All MAP Orientation Web Meeting
TBD May , 2012

Performance Measurement Coordination Strategy for PPS-Exempt Cancer Hospitals

Summary

In developing a performance measurement coordination strategy for PPS-exempt cancer hospitals, MAP is providing specific guidance to the Department of Health and Human Services (HHS) and the field in three major areas:

- Priorities for measuring performance in cancer care
- A core set of available measures plus measure development, endorsement, and implementation gaps
- Data and health information technology (health IT) considerations

MAP has identified initial steps regarding these recommendations to move toward more effective measurement and improved quality of cancer care.

Background

The Measure Applications Partnership (MAP) is a public-private partnership convened by the National Quality Forum (NQF) for the primary purpose of providing input to 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 a consensus-based entity (i.e., NQF) to "convene multi-stakeholder groups to provide input on the selection of quality measures" for various uses.[i]

MAP's careful balance of interests—across consumers, businesses and purchasers, labor, health plans, clinicians, providers, communities and states, and suppliers—is designed to provide HHS with thoughtful input on performance measure selection from a broad array of affected stakeholders. Particularly, MAP has been charged with developing a measurement strategy for Prospective Payment System (PPS)-exempt cancer hospital performance measurement. Previously, the 11 PPS-exempt cancer hospitals in the United States have not been required to participate in quality data reporting programs such as the Hospital Inpatient Quality Reporting (IQR) and Outpatient Quality Reporting (OQR) Programs. However, the Affordable Care Act established the PPS-Exempt Cancer Hospital Quality Reporting Program requiring PPS-exempt cancer hospitals to publicly report quality data. The statute requires that measures of process, structure, outcomes, patients' perspective on care, efficiency, and cost of care be included in the reporting program. Beginning in FY 2014, these cancer hospitals must report quality data to CMS, with no Medicare payment penalty or incentive.

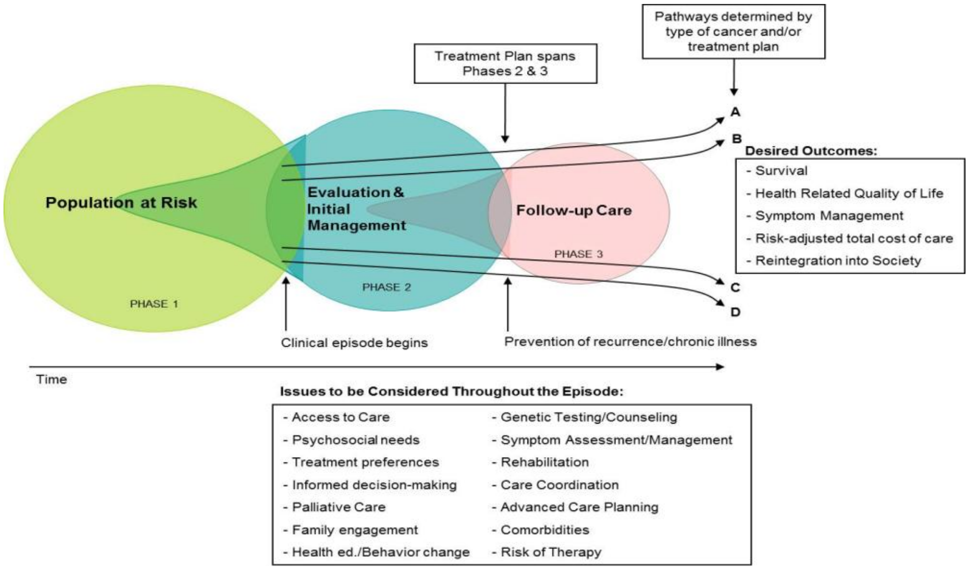
This task involved review of available performance measures for cancer care, including both clinical quality and person-centered cross-cutting measures, to identify a core set of measures for quality reporting. Additionally, MAP identified opportunities for alignment of measurement efforts as well as for measure development and endorsement needed to fill cancer care performance measurement gaps. Though the specific task focused on measures for PPS-exempt cancer hospitals, MAP took a person-centered view to assess care provided across settings to people at-risk for and diagnosed with cancer.

Patient-Centered Cancer Care

MAP stresses the importance of establishing an approach to cancer care measurement that is person-centric and aligned across various providers. Cancer care is provided across a range of settings, including general acute care hospitals and ambulatory care settings, as well as within PPS-exempt cancer hospitals. Additionally, patients with cancer diagnoses often have co-morbid conditions resulting from their cancer or treatment, or entirely unrelated to their cancer. Consequently, the provision of health care services in PPS-exempt cancer hospitals is not limited to cancer care. Given the movement of cancer patients among these environments and the importance of measuring outcomes for co-morbid conditions, MAP determined that a measurement strategy for PPS-exempt cancer hospitals should look beyond one specific setting and address the whole patient across the entire patient episode.

In developing a strategy for PPS-exempt cancer hospital quality measurement, MAP sought to build on prior NQF work addressing cancer care quality measurement. MAP preferred NQF-endorsed measures for inclusion within a cancer care core measure set. In addition, MAP built on recommendations from the Value-Based Episodes of Care project for cancer quality measurement, which applied the NQF-endorsed Patient-Focused Episodes of Care model to cancer care. The major recommendations from this project include taking a person-centered approach to measurement and prioritizing outcomes and cross-cutting issues such as symptom management, clear communication, shared decision making, and end-of-life care with specific attention being given to psychosocial care needs of patients and families. The figure below illustrates a trajectory of cancer care from prevention through remission aligned with corresponding patient-centered issues for consideration, demonstrating key opportunities for performance measurement and quality improvement and identifying desired patient outcomes.[ii]

Figure 1. Patient-Focused Episode of Care Model for Cancer Care



The first phase, cancer screening and prevention, comes prior to diagnosis. Though this initial phase of care does not usually occur within a PPS-exempt cancer hospital, it is important to address when considering the entire episode of cancer care. Once patients receive a cancer diagnosis, they typically move across phases of care from treatment to maintenance to surveillance and, at times, on to palliative and end-of-life phases.

MAP noted that the cyclical nature of cancer care requires a unique approach to quality measurement. Within the treatment phase, the patient often receives frequently recurring doses of therapy over a discrete period of time. Additionally, patients' health status and care expectations can vary greatly depending on their phase of care. This baseline should be reflected in measurement as patients repeatedly return to their providers for care. Following successful treatment for a cancer diagnosis, many survivors go on to live long, productive lives. For this reason, it is important that cancer care measurement extend across the lifespan from childhood to older adulthood.

Using the Patient-Focused Episodes of Care model as a guide, MAP began its work to identify priorities for cancer care measurement, establish a set of core measures and measurement gaps, and outline unique data and health IT considerations.

Priorities for Cancer Care Measurement

MAP continues to use the priorities outlined in the National Quality Strategy (NQS) to drive toward greater alignment by promoting the use of cross-cutting measures in all aspects of its work. The current cancer care measurement landscape consists of predominantly provider-focused disease-specific process of care measures. While those measures are important for making operational improvements in care, they do not cross various patients and settings to afford a better understanding of healthcare quality. The well-being and experience of patients should be the primary focus of measurement, helping to ensure that patients remain central to measuring and improving the overall quality of cancer care. MAP identified a number of priorities areas to support this approach:

Priorities for Cancer Care Measurement
Survival
Patient reported outcomes (e.g., experience of care, functional status, quality of life)
Care planning, reflecting individualized goals
Shared decision-making
Patient and Family engagement
Care coordination
Safety
Palliative and End-of-life care
Cost of care

Survival is the most important outcome to patients, and as such, measures of patient survivorship are at the top of the list of priorities for cancer care measurement. Measurement and reporting on survival should include cancer type and sub-type as well as cancer-specific, stage-for-stage survival curves. There are many factors that contribute to variation in survival curves by stage, and only by measuring by stage can providers begin to define those determinants and establish which ones to target for improvement. Additionally, survival information should be made available to patients and families to help inform decision-making regarding providers and treatments, as well as overall understanding of their illness. Members of MAP identified a list of cancer diagnoses that they believed should be addressed in the initial core measure set, expanding slightly beyond the Medicare High-Impact Conditions,[iii] to include breast, colon, lung, prostate, gynecological, and pediatric cancers. As the measure set continues to evolve, MAP suggested that other types of cancers, such as esophageal, pancreatic, multiple myeloma, leukemia, melanoma and other skin cancers, brain, and adrenal, should be included as measures become available.

While including disease-specific measures related to cancer, a core set should also include patient-reported outcomes, such as experience of care and quality of life. Quality of life includes stress and emotional aspects of receiving a cancer diagnosis and undergoing treatment. An example of an existing tool that captures patient perspectives is the Functional Assessment of Cancer Therapy-General (FACT-G) questionnaire, part of the Functional Assessment of Chronic Illness Therapy measurement system. The FACT-G is a quality of life questionnaire that evaluates a patient’s physical, social, emotional, and functional well-being. This is a well-validated tool for assessing an individual patient’s experience; however, the tool has not been used to measure the quality of care at a clinician or practice level.[iv] MAP suggests that it could be modified for facility-level performance measurement. A standardized, easy-to-use tool for collecting patient-reported information should be implemented across providers to enable comparisons and progress in improving patient experience.

MAP also emphasized the importance of cross-cutting measures that address shared decision-making and patient and family engagement. Painting an overall picture for patients, including diagnosis, survival rates, treatment options, and the experiences of other patients leads to more informed decision-making by patients and families. Coupling this information with patients’ values and preferences for their care enables a patient-provider relationship involving true shared decision-making. The presence and effectiveness of shared decision-making should be monitored as well.

Two additional areas of importance for cancer care measurement are care coordination and patient safety. Navigating the health care system and intricate cancer treatment protocols can be overwhelming for patients and caregivers. Patients need a solid understanding of the risks and side effects of treatment to stay as safe as possible through the course of care. As patients transition across settings and providers, effective communication and coordination are essential to safe cancer care and a positive patient experience.

MAP's Performance Measurement Coordination Strategy for Hospice Care[v] report contains specific information about measures for hospice and palliative care. Considering the continuum of hospice and palliative care, MAP noted that performance measures must be aligned across settings where these types of care are delivered and address a holistic, team-based, and patient- and family-centered approach to care. Patient and family engagement and care coordination are recognized as the highest priorities for measurement in these areas. When reviewing existing measures for this work, MAP determined that a number of measures currently available for hospice and palliative care are specified for the cancer population (noted in Appendix A). While continuing to refine measurement in both areas, these available measures could be expanded more broadly.

Cost of care is an important consideration for the cancer population with their often complex and expensive treatment regimens and increased susceptibility to complications. Measures of initial diagnosis and treatment should ensure patients receive the correct diagnosis, including staging, followed by the most appropriate evidence-based treatment in the context of patients' preferences. Cancer care often requires resource intensive services, particularly at the end of life, which can lead to unwanted treatment if care is misaligned with patients' goals. Monitoring for under treatment, over treatment, and symptom management are also key components to ensuring care is provided in a safe and effective manner.

Defining a Cancer Care Core Measure Set

When establishing the core set of measures, MAP continued to emphasize the importance of taking an aligned, person-centric approach to cancer care measurement and recognized that cancer care is provided in many more settings than PPS-exempt cancer hospitals. In creating an initial core measure set, MAP aimed to focus on cancer care specifically through inclusion of disease-specific measures, but also to address patient care overall, incorporating cross-cutting measures.

NQF has engaged in a number of projects in the area of cancer care measurement, including the specific adaptation of the Patient-Focused Episodes of Care model to cancer as well as NQF measure endorsement projects. There are currently 47 NQF-endorsed measures (Appendix A) related to cancer covering a range of topic areas, including breast, colorectal, and blood cancers, as well as symptom management and end-of-life care. NQF is currently conducting an endorsement maintenance review that began in October 2011 where new measures will be reviewed.

In 2010, the Centers for Medicare & Medicaid Services (CMS) contracted with Mathematica and National Committee for Quality Assurance (NCQA) to identify possible measures for the new PPS-Exempt Cancer Hospital Quality Reporting Program. This contract included an environmental scan that identified cancer-specific and cross-cutting measures—specifically excluding measures of prevention, screening, and diagnosis—followed by the convening of a technical expert panel (TEP) to review and prioritize the measures. The TEP evaluated measures on the basis of relevance to a Medicare population focusing on the four most common cancers found in the Medicare population (lung, breast, colorectal, and prostate), application to both inpatient and outpatient care, and promotion of evidence-based treatment. The TEP favored measures that are NQF-endorsed, already reported or collected by hospitals, available through claims or registry data, and appropriate for reporting by all hospitals that treat cancer patients, not just PPS-exempt cancer hospitals. The TEP decided on three chemotherapy/hormone therapy for breast and colon measures developed by the Commission on Cancer and two hospital-acquired condition (HAC) measures developed by the Centers for Disease Control and Prevention (CDC) (Table 1).

Table 1. CMS TEP Cancer Care Measure Starter Set

Condition/Area	Measure Name	NQF Measure Number and Status
Safety	Catheter-Associated Urinary Tract Infection	0138 Endorsed
Safety	Central line associated bloodstream infection	0139 Endorsed
Breast	Adjuvant hormonal therapy	0220 Endorsed
Breast	Combination chemotherapy is considered or administered within 4 months (120 days) of diagnosis for women under 70 with AJCC T1c, or Stage II or III hormone receptor negative breast cancer	0559 Endorsed
Colon	Adjuvant chemotherapy is considered or administered within 4 months (120 days) of surgery to patients under the age of 80 with AJCC III (lymph node positive) colon cancer	0223 Endorsed

These five measures were then proposed for consideration by MAP during its 2012 pre-rulemaking activities as the initial set of measures for the PPS-Exempt Cancer Hospital Quality Reporting Program. In its Pre-Rulemaking Report: Input on Measures Under Consideration by HHS for 2012 Rulemaking, MAP supported the inclusion of these measures within the program while recognizing they are a good, albeit limited, starter set. MAP encouraged swift expansion beyond these measures in the coming years for more comprehensive assessment of cancer care and to hold PPS-exempt cancer hospitals to the same high standards as general acute care facilities. During MAP's discussion of measure alignment opportunities with PPS-exempt cancer hospitals, a specific issue was raised regarding appropriate specifications for the central line-associated bloodstream infection (CLABSI) measure to differentiate between temporary and permanent central lines, the latter commonly found in cancer patients. Evidence-based protocols for the placement and care of permanent central lines differ from those of temporary central lines, particularly for cancer patients who, by the nature of their treatment, may be more prone to infections.

Consistent with other MAP recommendations, MAP supported the use of NQF-endorsed measures within the PPS-Exempt Cancer Hospital Quality Reporting Program. MAP focused on the cancer types identified as priorities in the list of Medicare High-Impact Conditions[vi] and the priorities of the National Quality Strategy. MAP developed the following list of existing measures to serve as an initial cancer care core measure set (Table 2).

Table 2. Cancer Care Initial Core Measures List

Condition / Area	Measure Name	NQF Measure Number & Status
Patient & Family Engagement	Family Evaluation of Hospice Care	0208 Endorsed
Symptom Management	Comfortable dying: pain brought to a comfortable level within 48 hours of initial assessment	0209 Endorsed
Symptom Management	Oncology: plan of care for pain – medical oncology and radiation oncology (paired with 0384)	0383 Endorsed
Symptom Management	Oncology: pain intensity quantified – medical oncology and radiation oncology (paired with 0383)	0384 Endorsed
Safety	Catheter-Associated Urinary Tract Infection	0138 Endorsed*
Safety	Central line associated bloodstream infection	0139 Endorsed*
Safety	Oncology: radiation dose limits to normal tissues	0382 Endorsed
Breast	Breast cancer screening	0031 Endorsed
Breast	Post breast conserving surgery irradiation	0219 Endorsed
Breast	Adjuvant hormonal therapy	0220 Endorsed*
Breast	Needle biopsy to establish diagnosis of cancer precedes surgical excision/resection	0221 Endorsed
Breast	Patients with early stage breast cancer who have evaluation of the axilla	0222 Endorsed
Breast	Combination chemotherapy is considered or administered within 4 months (120 days) of diagnosis for women under 70 with AJCC T1c, or Stage II or III hormone receptor negative breast cancer	0559 Endorsed*
Breast, Colon	Oncology: cancer stage documented	0386 Endorsed
Colon	Colorectal cancer screening	0034 Endorsed
Colon	Adjuvant chemotherapy is considered or administered within 4 months (120 days) of surgery to patients under the age of 80 with AJCC III (lymph node positive) colon cancer	0223 Endorsed*
Colon	Completeness of pathology reporting	0224 Endorsed
Colon	At least 12 regional lymph nodes are removed and pathologically examined for resected colon cancer	0225 Endorsed
Colon	Follow-up after initial diagnosis and treatment of colorectal cancer: colonoscopy	0572 Endorsed
Gynecologic	Cervical cancer screening	0032 Endorsed
Gynecologic	Annual cervical cancer screening for high-risk patients	0579 Endorsed
Lung	Risk-adjusted morbidity after lobectomy for lung cancer	0459 Endorsed
Prostate	Prostate cancer: three-dimensional radiotherapy	0388 Endorsed
Prostate	Prostate cancer: avoidance of overuse measure – isotope bone scan for staging low-risk patients	0389 Endorsed
Prostate	Prostate Cancer: adjuvant hormonal therapy for high-risk patients	0390 Endorsed
Other cancers	Multiple myeloma – treatment with bisphosphonates	0380 Endorsed
Other cancers	Risk-adjusted morbidity and mortality for esophagectomy for cancer	0460 Endorsed

** Measures supported in MAP Pre-rulemaking input on the PPS-Exempt Cancer Hospital Quality Reporting Program*

MAP identified the measures in the table above as an initial core set, but recognizes that these available measures are not broad enough to comprehensively assess the quality of cancer care. In addition to these measures, MAP identified priority performance measurement gaps. It is necessary to develop, test, endorse, and implement measures in these identified gap areas to create a comprehensive cancer care core measure set. The highest priority gap areas identified by MAP, and also noted within the 2012 MAP pre-rulemaking report, include the following:

- Patient outcomes, particularly measures of cancer- and stage-specific survival as well as patient-reported measures
- Cost and efficiency of care, including measures of total cost, underuse, and overuse
- Health and well-being measures addressing quality of life, social, and emotional health
- Safety, in particular complications such as febrile neutropenia
- Person and family centered care, including shared decision-making and patient experience
- Care Coordination, including transition communication between providers
- Prevention, such as upstream screening and patient education
- Disparities measures, such as risk-stratified process and outcome measures
- Treatment of lung, prostate, gynecological, and pediatric cancers

The initial cancer care measure set is not static, but should evolve over time as performance measurement improves and shortfalls in quality of care are identified. The set should be reevaluated periodically to obtain multi-stakeholder input on measures that should be added and removed as new, better measures become available, with an eye toward greater alignment across settings and programs. MAP continues to support the minimization of data collection burden while maximizing efficiencies in performance measurement among providers.

Data Source and Health Information Technology Implications

Unique characteristics of cancer care such as the various sites and providers of treatment, cyclical nature of treatment, and presence across the lifespan pose a number of operational challenges for data collection and reporting. In previous reports discussing safety and clinician performance measurement coordination strategies, MAP identified a pressing need for a common data collection and reporting platform to support performance measurement across the quality measurement enterprise. A common data platform would allow for collection of the data needed to efficiently calculate quality measures. Data entered at the point of care could flow from electronic health records (EHR) to a recognized national platform for aggregation, analysis, reporting, and mining for research. Given the unique characteristics of cancer care, this approach is particularly useful for quality measurement in cancer care.

For this report, MAP reviewed the current collection and reporting processes for several cancer-related registries as a starting place to highlight potential opportunities and concerns for measurement in this area. Particular challenges include difficulty in collecting detailed patient-level data, delays in the availability of performance scores, concerns regarding the impact of small patient sample sizes, and challenges in collecting patient-reported measures. While noting a number of obstacles for cancer care measurement, MAP did identify promising practices that could demonstrate the feasibility of providing patient-level quality improvement data in a timely manner.

Currently, much of the information captured regarding the quality of cancer care is done through registries such as the American Society of Clinical Oncology's (ASCO) Quality Oncology Practice Initiative (QOPI)[vii] and the American College of Surgeon's (ACS) National Cancer Data Base (NCDB).[viii] QOPI provides registry abstracted data for physician practices for quality improvement focusing on care processes and covers steps in care from diagnosis through end of life. The NCDB collects cancer registry data from all Commission on Cancer[ix] accredited programs to be used for comparative effectiveness research, retrospective quality monitoring and reporting, and active quality management. Registries such as these are very useful to providers and currently serve as the most common mechanism for cancer performance measurement and reporting.

While registries play an important role in quality measurement and improvement, current cancer databases are limited in their ability to provide specific and timely data. The aggregate level at which data is currently being collected lacks specificity and is not conducive to providing an overall picture of the patient's care across the continuum. Existing cancer data registries are not designed to track unique patients across health care providers, leading to missing data on outpatient care and insufficient detail about specific therapies. Additionally, more patient-level detail is needed for identifying disparities in care while implementing controls to ensure data is captured in a uniform manner. The greater use of electronic health records (EHRs) by providers could increase standardization in data collection and documentation and lead to greater sharing of information across the continuum; however, challenges to the widespread adoption of EHRs still exist including the cost of implementation and variation between systems developed by different vendors.

Another major concern about registries is timely availability of data. MAP recognized that providers need performance information as close to real time as possible to support better care decisions. When information is funneled through a registry, the delay in the accessibility of this data can be significant. In some instances there is a 2-3 year lag time in reporting data. A long lapse in time between the provision of care and the availability of performance scores can decrease provider accountability for the quality of their care. However, the development of new systems such as the Commission on Cancer Rapid Quality Reporting System[x] could allow for ongoing reporting of quality metrics and more proactive care management. This system allows providers to see performance at the individual patient level and receive alerts if a patient's care is not meeting quality measures, supporting proactive improvement in patient care.

MAP acknowledges that the issue of small sample sizes can be a major measurement challenge in the context of public reporting for PPS-exempt cancer hospitals. As providers try to measure the quality of care for patients with less common forms or more specific types of cancer, the number of appropriate patients to include within the denominator shrinks rapidly. Very small denominators adversely impact the ability of providers to reach meaningful clinical conclusions regarding quality of care. With a small data set, outliers can disproportionately skew results reflecting an inaccurate representation of a provider's performance. The small numbers problem is particularly applicable to PPS-exempt cancer hospitals as these facilities often provide treatment for the rarest forms of cancers. As this information begins to be publicly reported, correct messaging will be necessary to explain the impact of small sample sizes on results to ensure that the information is not misinterpreted. Concerns about small denominators could be mitigated by reporting results over a longer timeframe or at health system, state, or regional levels. These concerns also support the need to report cross-cutting and structural measures, as well as clinical quality measures, when assessing the overall quality of care provided within a facility. These types of measures are applicable to the majority, if not all, patients receiving health care services, affording more accurate performance scores.

Although necessary to ensuring a person-centered cancer care measurement approach, the cyclical nature of cancer care can make the collection of patient-reported measures difficult. Accurately capturing the quality of a patient's care and his/her experience can be challenging when patients are returning repeatedly to the hospital or outpatient facility for treatments. Continually assessing patient experience through surveys and questionnaires poses additional burden on patients who are already working to manage a difficult illness and complex treatment regimen. Additionally, data gathering processes and mechanisms currently used by providers are not designed to support efficient data collection and measure calculation of patient-reported information placing additional strains on providers.

While cancer quality measurement presents a number of data issues, the United Healthcare Oncology Analysis Program is an example of a private sector program that demonstrates the feasibility of quality measurement for cancer care. This database of clinical and claims data creates a record for each patient that compares the care a patient is receiving against the National Comprehensive Cancer Network (NCCN) treatment guidelines. Participating oncologists receive aggregate national results in addition to results on their specific patients, along with guideline data. United Healthcare is also working with tumor registries to share data on tumors and treatment. However, issues of privacy around data sharing and the cost of data collection and reporting need to be more fully examined before a wide-scale adoption of a similar system would be possible.

Path Forward

The cancer care core measure set put forth in this report can serve as a fundamental initial list to benchmark cancer care across providers. MAP suggests that cancer hospitals could be measured by their results on the core set of measures to inform consumer and purchaser decision-making.

Moving forward, MAP believes it is important that quality measurement for PPS-exempt cancer hospitals be patient-centered and align with measurement in other settings where patients with cancer receive care. As MAP has noted in its previous performance measurement coordination strategies, setting-specific silos can inhibit effective care coordination and aligned performance measurement.

Specifically, MAP advises that cancer care measures should be included within the IQR measure set and that appropriate IQR measures should be applied to PPS-exempt cancer hospitals as a first step to aligning cancer care quality measurement. As shown in the initial core set, cancer care spans the entire continuum, extending beyond treatment and management received in a hospital setting. Cancer care begins with screening and prevention, care which typically occurs in the ambulatory setting, and measures addressing these concepts should be included in related measurement programs. Moreover, as surveillance cancer care and palliative care can extend to post-acute, long-term care and hospice settings, applicable cancer measures should be integrated into those related programs as well. Additional work is needed to promote further alignment across programs in different settings, particularly exploring opportunities to harmonize existing measures as well as to develop measures that span settings and provider types.

Although data collection and reporting present a number of challenges to cancer care quality measurement, systems such as the Commission on Cancer Rapid Quality Reporting System and the United Healthcare Oncology Analysis Program show the feasibility and potential of providing quality data at an individual patient level and in real time. Additionally, with the increased use and integration of EHRs by providers, more accurate and timely data will become available to uncover opportunities for improvement. While small numbers can make quality measurement for rare cancers difficult, the use of expanded timeframes and geographic populations as well as cross-cutting and structural measures can allow for more accurate measurement.

The guidance MAP offers through this report serves as a starting place to better coordinate performance measurement efforts for cancer care. Applying this core measure set for PPS-exempt cancer hospitals and other cancer care providers will promote a more person-centered approach to better prevention and treatment of this disease.

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[i] U.S. Government Printing Office (GPO), Patient Protection and Affordable Care Act (ACA), PL 111-148 Sec. 3014, Washington, DC: GPO; 2010, p.260. Available at www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf. Last accessed August 2011.

[ii] NQF, Measurement Framework: Evaluating Efficiency Across Patient-Focused Episodes of Care, Washington, DC: NQF, 2010. Available at www.qualityforum.org/Publications/2010/01/Measurement_Framework__Evaluating_Efficiency_Across_Patient-Focused_Episodes_of_Care.aspx. Last accessed March 2012.

[iii] NQF, *Measurement Prioritization Advisory Committee Report, Measure Development and Endorsement Agenda*, Washington, DC: NQF, 2011. Available at www.qualityforum.org/News_And_Resources/Press_Releases/2011/ National_Quality_Forum_Releases_Measure_ Development_and_Endorsement_Agenda__Prioritized_ List_of_Measure_Gaps.aspx. Last accessed December 2011.

[iv] NQF, *National Voluntary Consensus Standards for Patient Outcomes 2009: A Consensus Report,* Washington, DC:NQF, 2011.

[v] NQF, *Performance Measurement Coordination Strategy for Hospice Care*, Washington, DC: NQF, 2011.

[vi] NQF, *Measurement Prioritization Advisory Committee Report, Measure Development and Endorsement Agenda*, Washington, DC: NQF, 2011. Available at www.qualityforum.org/News_And_Resources/Press_Releases/2011/ National_Quality_Forum_Releases_Measure_ Development_and_Endorsement_Agenda__Prioritized_ List_of_Measure_Gaps.aspx. Last accessed December 2011.

[vii] http://qopi.asco.org/

[viii] http://www.facs.org/cancer/ncdb/index.html

[ix] http://www.facs.org/cancer/

[x] http://www.facs.org/cancer/ncdb/rqrs.html

Appendix A. NQF-Endorsed Measures Related to Cancer Care

NQF Measure # and Status	Measure Name	Description
0031 Endorsed	Breast cancer screening	Percentage of eligible women 40-69 who receive a mammogram in a two year period
0032 Endorsed	Cervical cancer screening	Percentage of women 21–64 years of age received one or more Pap tests to screen for cervical cancer
0034 Endorsed	Colorectal cancer screening	The percentage of members 50–75 years of age who had appropriate screening for colorectal cancer
0208 Endorsed	Family Evaluation of Hospice Care	Composite Score: Derived from responses to 17 items on the Family Evaluation of Hospice Care (FEHC) survey presented as a single score ranging from 0 to 100. Global Score: Percentage of best possible response (Excellent) to the overall rating question on the FEHC survey Target Population: The FEHC survey is an after-death survey administered to bereaved family caregivers of individuals who died while enrolled in hospice. Timeframe: The survey measures family members perception of the quality of hospice care for the entire enrollment period, regardless of length of service
0209 Endorsed	Comfortable dying: pain brought to a comfortable level within 48 hours of initial assessment	Number of patients who report being uncomfortable because of pain at the initial assessment (after admission to hospice services) who report pain was brought to a comfortable level within 48 hours
0210 Endorsed	Proportion receiving chemotherapy in the last 14 days of life	Patients who died from cancer and received chemotherapy in the last 14 days of life
0211 Endorsed*	Proportion with more than one emergency room visit in the last days of life	Percentage of patients who died from cancer with more than one emergency room visit in the last days of life
0212 Endorsed*	Proportion with more than one hospitalization in the last 30 days of life	Percentage of patients who died from cancer with more than one hospitalization in the last 30 days of life
0213 Endorsed*	Proportion admitted to the ICU in the last 30 days of life	Percentage of patients who died from cancer admitted to the ICU in the last 30 days of life
0214 Endorsed*	Proportion dying from cancer in an acute care setting	Percentage of patients who died from cancer dying in an acute care setting
0215 Endorsed*	Proportion not admitted to hospice	Percentage of patients who died from cancer not admitted to hospice
0216 Endorsed*	Proportion admitted to hospice for less than 3 days	Percentage of patients who died from cancer, and admitted to hospice and spent less than 3 days there

NQF Measure # and Status	Measure Name	Description
0219 Endorsed	Post breast conserving surgery irradiation	Percentage of female patients, age 18-69, who have their first diagnosis of breast cancer (epithelial malignancy), at AJCC stage I, II, or III, receiving breast conserving surgery who receive radiation therapy within 1 year (365 days) of diagnosis
0220 Endorsed	Adjuvant hormonal therapy	Percentage of female patients, age >18 at diagnosis, who have their first diagnosis of breast cancer (epithelial malignancy), at AJCC stage I, II, or III, who's primary tumor is progesterone or estrogen receptor positive recommended for (No Suggestions) or third generation aromatase inhibitor (considered or administered) within 1 year (365 days) of diagnosis
0221 Endorsed	Needle biopsy to establish diagnosis of cancer precedes surgical excision/resection	Percentage of patients presenting with AJCC Stage Group 0, I, II, or III disease, who undergo surgical excision/resection of a primary breast tumor who undergo a needle biopsy to establish diagnosis of cancer preceding surgical excision/resection
0222 Endorsed	Patients with early stage breast cancer who have evaluation of the axilla	Percentage of women with Stage I-IIb breast cancer that received either axillary node dissection or Sentinel Lymph Node Biopsy (SLNB) at the time of surgery (lumpectomy or mastectomy)
0223 Endorsed	Adjuvant chemotherapy is considered or administered within 4 months (120 days) of surgery to patients under the age of 80 with AJCC III (lymph node positive) colon cancer	Percentage of patients under the age of 80 with AJCC III (lymph node positive) colon cancer for whom adjuvant chemotherapy is considered or administered within 4 months (120 days) of surgery
0224 Endorsed	Completeness of pathology reporting	Percentage of patients with audited colorectal cancer resection pathology complete reports
0225 Endorsed	At least 12 regional lymph nodes are removed and pathologically examined for resected colon cancer	Percentage of patients >18yrs of age, who have primary colon tumors (epithelial malignancies only), experiencing their first diagnosis, at AJCC stage I, II or III who have at least 12 regional lymph nodes removed and pathologically examined for resected colon cancer
0377 Endorsed	Myelodysplastic syndrome (MDS) and acute leukemias – baseline cytogenetic testing performed on bone marrow	Percentage of patients aged 18 years and older with a diagnosis of MDS or an acute leukemia who had baseline cytogenic testing performed on bone marrow.
0378 Endorsed	Documentation of iron stores in patients receiving erythropoietin therapy	Percentage of patients aged 18 years and older with a diagnosis of MDS who are receiving erythropoietin therapy with documentation of iron stores prior to initiating erythropoietin therapy
0379 Endorsed	Chronic lymphocytic leukemia (CLL) – baseline flow cytometry	Percentage of patients aged 18 years and older with a diagnosis of CLL who had baseline flow cytometry studies performed

NQF Measure # and Status	Measure Name	Description
0380 Endorsed	Multiple myeloma – treatment with bisphosphonates	Percentage of patients aged 18 years and older with a diagnosis of multiple myeloma, not in remission, who were prescribed or received intravenous bisphosphonates within the 12 month reporting period
0381 Endorsed	Oncology: treatment summary documented and communicated – radiation oncology	Percentage of patients with a diagnosis of cancer who have undergone brachytherapy or external beam radiation therapy who have a treatment summary report in the chart that was communicated to the physician(s) providing continuing care within one month of completing treatment
0382 Endorsed	Oncology: radiation dose limits to normal tissues	Percentage of patients with a diagnosis of cancer receiving 3D conformal radiation therapy with documentation in medical record that normal tissue dose constraints were established within five treatment days for a minimum of one tissue
0383 Endorsed	Oncology: plan of care for pain – medical oncology and radiation oncology (paired with 0384)	Percentage of visits for patients with a diagnosis of cancer currently receiving intravenous chemotherapy or radiation therapy who report having pain with a documented plan of care to address pain
0384 Endorsed	Oncology: pain intensity quantified – medical oncology and radiation oncology (paired with 0383)	Percentage of visits for patients with a diagnosis of cancer currently receiving intravenous chemotherapy or radiation therapy in which pain intensity is quantified
0385 Endorsed	Oncology: chemotherapy for stage IIIA through IIIC colon cancer patients	Percentage of patients aged 18 years and older with Stage IIIA through IIIC colon cancer who are prescribed or who have received adjuvant chemotherapy within the 12 month reporting period
0386 Endorsed	Oncology: cancer stage documented	Percentage of patients with a diagnosis of breast, colon, or rectal cancer seen in the ambulatory setting who have a baseline AJCC cancer stage or documentation that the cancer is metastatic in the medical record at least once during the 12 month reporting period
0387 Endorsed	Oncology: hormonal therapy for stage IC through IIIC, ER/PR positive breast cancer	Percentage of female patients aged 18 years and older with Stage IC through IIIC, estrogen receptor (ER) or progesterone receptor (PR) positive breast cancer who were prescribed (No Suggestions) or aromatase inhibitor (AI) within the 12 month reporting period
0388 Endorsed	Prostate cancer: three-dimensional radiotherapy	Percentage of patients with prostate cancer receiving external beam radiotherapy to the prostate only who receive 3D-CRT (three-dimensional conformal radiotherapy) or IMRT (intensity modulated radiation therapy

NQF Measure # and Status	Measure Name	Description
0389 Endorsed	Prostate cancer: avoidance of overuse measure – isotope bone scan for staging low-risk patients	Percentage of patients with a diagnosis of prostate cancer, at low risk of recurrence, receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy, OR cryotherapy who did not have a bone scan performed at any time since diagnosis of prostate cancer
0390 Endorsed	Prostate cancer: adjuvant hormonal therapy for high-risk patients	Percentage of patients with a diagnosis of prostate cancer, at high risk of recurrence, receiving external beam radiotherapy to the prostate who were prescribed adjuvant hormonal therapy (GnRH agonist or antagonist)
0391 Endorsed	Breast cancer resection pathology reporting- pT category (primary tumor) and pN category (regional lymph nodes) with histologic grade	Percentage of breast cancer resection pathology reports that include the pT category (primary tumor), the pN category (regional lymph nodes) and the histologic grade
0392 Endorsed	Colorectal cancer resection pathology reporting- pT category (primary tumor) and pN category (regional lymph nodes) with histologic grade	Percentage of colon and rectum cancer resection pathology reports that include the pT category (primary tumor), the pN category (regional lymph nodes) and the histologic grade
0455 Endorsed	Recording of clinical stage for lung cancer and esophageal cancer resection	Percentage of all surgical patients undergoing treatment procedures for lung or esophageal cancer that have clinical TNM staging provided
0457 Endorsed	Recording of performance status (Zubrod, Karnofsky, WHO or ECOG Performance Status) prior to lung or esophageal cancer resection	Percentage of patients undergoing resection of a lung or esophageal cancer who had their performance status recorded within two weeks of the surgery date
0459 Endorsed	Risk-adjusted morbidity after lobectomy for lung cancer	Percentage of patients undergoing elective lobectomy for lung cancer that have a prolonged length of stay (>14 days)
0460 Endorsed	Risk-adjusted morbidity and mortality for esophagectomy for cancer	The percentage of patients undergoing elective esophagectomy for cancer that had a prolonged length of stay (>14 days)
0559 Endorsed	Combination chemotherapy is considered or administered within 4 months (120 days) of diagnosis for women under 70 with AJCC T1c, or Stage II or III hormone receptor negative breast cancer	Percentage of female patients, age >18 at diagnosis, who have their first diagnosis of breast cancer (epithelial malignancy), at AJCC stage I, II, or III, who's primary tumor is progesterone and estrogen receptor negative recommended for multiagent chemotherapy (considered or administered) within 4 months (120 days) of diagnosis
0561 Endorsed	Melanoma coordination of care	Percentage of patients seen with a new occurrence of melanoma who have a treatment plan documented in the chart that was communicated to the physician(s) providing continuing care within one month of diagnosis

NQF Measure # and Status	Measure Name	Description
0562 Endorsed	Over-utilization of imaging studies in stage 0-IA melanoma	Percentage of patients with stage 0 or IA melanoma, without signs or symptoms, for whom no diagnostic imaging studies were ordered
0572 Endorsed	Follow-up after initial diagnosis and treatment of colorectal cancer: colonoscopy	To ensure that all eligible members who have been newly diagnosed and resected with colorectal cancer receive a follow-up colonoscopy within 15 months of resection
0579 Endorsed	Annual cervical cancer screening for high-risk patients	This measure identifies women age 12 to 65 diagnosed with cervical dysplasia (CIN 2), cervical carcinoma-in-situ, or HIV/AIDS prior to the measurement year, and who still have a cervix, who had a cervical CA screen during the measurement year
0623 Endorsed	Breast cancer - cancer surveillance	Percentage of female patients with breast cancer who had breast cancer surveillance in the past 12 months
0625 Endorsed	Prostate cancer - cancer surveillance	Percentage of males with prostate cancer that have had their PSA monitored in the past 12 months
0650 Endorsed	Melanoma continuity of care – recall system	Percentage of patients with a current diagnosis of melanoma or a history of melanoma who were entered into a recall system with the date for the next complete physical skin exam specified, at least once within the 12 month reporting period

* *NQF-endorsed hospice and palliative care measures specified for the cancer population*

Measuring Healthcare Quality for the Dual Eligible Beneficiary Population: Final Report to HHS

Summary

MAP's final report on measuring healthcare quality for the dual eligible beneficiary population provides guidance regarding the selection of appropriate performance measures for use with this unique and heterogeneous group. The input to HHS is comprised of:

- A strategic approach to performance measurement, including a vision for high-quality care, guiding principles, and five high-leverage opportunity areas;
- A set of potential measures, including a Starter Set of current measures and an Expansion Set of measures in need of modification;
- Prioritized measure gap areas; and
- Input regarding levels of analysis, potential applications of measures, and program alignment.

MAP Background

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 programs, and other purposes. The statutory authority for MAP is the Affordable Care Act (ACA), which requires HHS to contract with the "consensus-based entity" (i.e., NQF) to "convene multi-stakeholder groups to provide input on the selection of quality measures" for various uses.[i]

MAP's careful balance of interests—across consumers, businesses and purchasers, labor, health plans, clinicians, providers, communities and states, and suppliers—ensures 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 alignment of public- and private-sector uses of performance measures to further the National Quality Strategy's (NQS) three-part aim of creating better, more affordable care, and healthier people.[ii] Anticipated outcomes from MAP's work include:

- coordination of care delivery around the patient;
- consistent provision of evidence-based care;
- generation of meaningful information to support consumer and purchaser decision-making;
- higher value for spending by aligning payment with performance;
- heightened accountability for clinicians and providers; and
- reduction of data collection and reporting burden through coordination of measurement requirements.

Further information about MAP's coordination with other quality efforts, function, timeline, and deliverables is provided in Appendix A.

Introduction

MAP has been charged with providing multi-stakeholder input on performance measures to assess and improve the quality of care delivered to individuals who are eligible for both Medicare and Medicaid. The dual eligible population is notable for its heterogeneity, the particularly intense service needs and vulnerabilities of some sub-groups, and the fragmented nature of healthcare and supportive services they receive.

About 9 million people are dually-eligible for and enrolled in both the Medicare and Medicaid programs.[iii] Low-income seniors make up roughly two-thirds of the dual eligible population, and people with disabilities under age 65 account for the remaining third.[iv] The population includes many of the poorest and sickest individuals covered by either Medicare or Medicaid. The two programs were created separately and for different purposes, leaving beneficiaries, providers, health plans, and other stakeholders struggling to navigate differing rules, provider networks, and a bifurcated benefits structure. These misalignments can complicate care coordination, lead to cost-shifting, and severely undermine the quality of care.

MAP considered quality measurement for dual eligible beneficiaries specifically, but some findings could be generalized to similar Medicare- or Medicaid-only populations with characteristics such as low income, complex chronic conditions, disability, and advanced age.

MAP regarded the Medicare-Medicaid Coordination Office (MMCO) within CMS the primary audience for its work. Established under ACA, the MMCO has many goals related to improving dual eligible beneficiaries' experience of care, including assessing and improving the quality of performance of Medicare and Medicaid providers. This office will be a primary user of measures that MAP supports for use with the dual eligible beneficiary population. In addition, the MMCO is currently working with States to design and implement demonstration programs to better integrate and coordinate care for dual eligible beneficiaries. This report also considers the measurement needs of States and local stakeholders in evaluating their success in improving beneficiaries' experience of care and controlling costs.

Terminology

For purposes of this report, a *dual eligible beneficiary* is an individual who qualifies for, and is enrolled in, health insurance through both Medicare and Medicaid. The term is policy-centric in order to refer to a specific group of people who qualify for a particular array of public benefits. While these benefits fundamentally influence how a dual eligible beneficiary interacts with the health system, most individuals with that status would not readily identify themselves as duals. Furthermore, providers of care and supports may not be aware of individuals' status as dually eligible or the associated implications for service delivery. Lacking a more precise alternative, MAP refers to *dual eligible beneficiaries*, *individuals who are dually eligible*, and *duals* throughout this report.

Methods

The MAP Dual Eligible Beneficiaries Workgroup advised the MAP Coordinating Committee on developing the strategic approach to performance measurement and measures recommended for use with the dual eligible population. The MAP Dual Eligible Beneficiaries Workgroup is a 27-member, multi-stakeholder group (see Appendix B for the workgroup roster, Appendix C for the Coordinating Committee roster). The workgroup held a total of four in-person meetings and one web meeting to fully develop the contents of this final report. The agendas and materials for the Dual Eligible Beneficiaries Workgroup meetings can be found on the NQF website.

MAP's task to identify performance measures appropriate for use with the dual eligible beneficiary population was divided into two phases. An October 2011 interim report described the first phase, which focused on understanding the unique qualities of the population, identifying deficits in quality that affect the group, defining a strategic approach to measurement, and characterizing appropriate measures.[v] The second phase of the work is described in this final report. Building on the strategic approach to measurement, MAP prioritized current measures, proposed potential measure modifications, and considered critical gaps in available measures.

Strategic Approach to Performance Measurement for Dual Eligible Beneficiaries

Vision for High-Quality Care

MAP established a vision for high-quality care for dual eligible beneficiaries to provide the foundation for the strategic approach to performance measurement.

> *In order to promote a system that is both sustainable and person- and family-centered, individuals eligible for both Medicare and Medicaid should have timely access to appropriate, coordinated healthcare services and community resources that enable them to attain or maintain personal health goals*.

As a part of the vision and the strategic approach to performance measurement, MAP espouses a definition of health that broadly accounts for health outcomes, determinants of health, and personal wellness. The far-reaching nature of the vision and its multi-factorial view of health are both fundamental to MAP's overall approach to quality measurement for the dual eligible population. The vision aspires to high-value care that is centered on the needs and preferences of an individual and that relies on a range of supports to maximize function and quality of life. This is especially important given the complex range of mental, physical, and socioeconomic challenges facing the dual eligible population.

Guiding Principles

In considering how to achieve the desired vision, MAP established guiding principles for the approach to measurement. While measurement alone cannot fix underlying fragmentation in the health system, it can signal the aspects of care that are most highly valued. The guiding principles inform and direct the design of measurement programs. Once a program has been established, the guiding principles and MAP's Measure Selection Criteria (Appendix D) can be applied to evaluate the appropriateness of potential measures to meet the program's goals. Because the guiding principles were previously presented in MAP's interim report, they are briefly summarized in the table below and fully discussed in Appendix E.

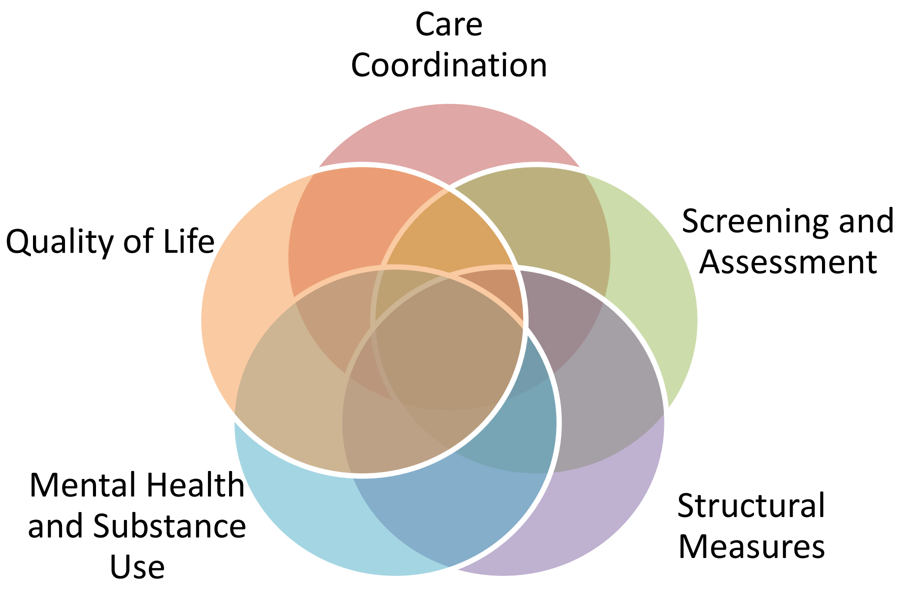
Table 1: Guiding Principles for Measurement in the Dual Eligible Beneficiary Population

Desired Effects of Measurement	Promoting Integrated Care
	Ensuring Cultural Competence
	Health Equity
Measurement Design	Assessing Outcomes Relative to Goals
	Parsimony
	Cross-Cutting Measures
	Inclusivity
	Avoiding Undesirable Consequences of Measurement
Data Platform Principles	Data Sharing
	Using Data Dynamically
	Making the Best Use of Available Data

High-Leverage Opportunities for Improvement Through Measurement

Countless opportunities exist to improve the quality of care delivered to dual eligible beneficiaries. In recognition that a measurement strategy should be parsimonious and focused on areas with substantial room for improvement, MAP reached consensus on five domains where measurement can drive significant positive change. The high-leverage opportunity areas are quality of life, care coordination, screening and assessment, mental health and substance use, and structural measures. As depicted in Figure 1, the topics are heavily inter-related.

Figure 1: High-Leverage Opportunities for Improvement Through Measurement



MAP concluded that, wherever possible, selection of measures to fit these areas should drive broad improvements in healthcare delivery and community supports by promoting shared accountability, addressing affordability along with quality, encouraging health IT uptake, and pushing toward longitudinal measurement.

Quality of Life

The measurement strategy should promote a broad view of health and wellness, encouraging the development of a person-centered plan of care that establishes goals and preferences for each individual. Ideally, that care plan and its goals would form the basis for measurement. For example, in situations in which an individual who is near the end of life has stated health-related goals oriented toward palliative care instead of interventions to extend life, the measurement strategy should accommodate that choice. In the short term, measurement can focus on discrete opportunities to elicit health-related goals, for example, ensuring assessments include information about wishes for end-of-life care.

Measures in this care domain should focus on outcomes, such as functional status. Other facets of quality of life might include an individual's ability to determine his or her home environment, participate in the community, develop meaningful relationships, and meet employment and education goals. MAP also considered measures related to comfort, pain management, and symptom control under this domain. While some quality-of-life measures may be more difficult to determine for dual eligible beneficiaries who cannot self-report objectively, assessing progress toward treatment and recovery goals remains appropriate.

Care Coordination

Care coordination is a vital feature of high-quality care for dual eligible beneficiaries. NQF has previously endorsed preferred practices and performance measures related to care coordination.[vi] MAP discussed that measures in this domain should promote coordination across multiple dimensions, such as across care settings, between the healthcare system and community supports, across provider types, and across Medicare and Medicaid program benefit structures.

To ensure adequate care coordination, measures should address desired components of such coordination. MAP emphasized the importance of a shared plan of care developed jointly between providers and beneficiaries, proactive medication management, access to an inter-professional team across settings of care, advance care planning, and palliative care. A thorough approach to care coordination would account for patient engagement and relevant factors (e.g., symptom control) in the span between encounters with the health system.

Measurement in this area could be oriented to identifying missed opportunities or breakdowns in care. Some warning signs of poor care coordination are incidents in which patients are transferred across settings without appropriate medical records, a Medicaid case manager has not been notified that a beneficiary has been hospitalized, or a clinician has prescribed a medication contraindicated by the plan of care.

Screening and Assessment

Approaches to screening and assessment should be thorough and tailored to address the complex care needs of the dual eligible beneficiary population. MAP regarded the routinely recommended clinical preventive screenings as generally necessary but not sufficient for this group. The measurement approach should encourage providers to screen for factors that particularly affect vulnerable populations, such as poor nutrition, drug and alcohol use, housing insecurity, falls, underlying mental and cognitive conditions, and HIV/AIDS.

Assessment goes hand in hand with screening but does not have to occur in a single clinical encounter. The ongoing assessment process should use person-centered principles and go beyond the basics to account for the home environment, economic insecurity, availability of family and community supports, capacity of formal and informal caregivers, caregiver stress, access to healthful food, transportation, and consideration of whether the individual is receiving care in the most appropriate, least restrictive setting. After screening and assessment is complete, the results should be incorporated into an individual's person-centered plan of care.

Mental Health and Substance Use

Mental health conditions such as depression are highly prevalent in the dual eligible population. Other serious psychiatric conditions such as schizophrenia are less common but heavily concentrated in the dual eligible population less than 65 years old.

Mental health conditions commonly co-occur with substance use disorders and chronic medical conditions such as diabetes and cardiovascular disease. As such, behavioral health cannot be considered and measured in isolation. MAP echoed a recommendation from the Institute of Medicine (IOM) that mental health and substance abuse treatment should be more closely coordinated with primary care. MAP also discussed that measures in this domain should be able to evaluate care across the continuum, including screening, treatment, outcomes, and patient experience. Approaches to both treatment and performance measurement should be grounded in the recovery model, as appropriate.

Structural Measures

Structural measures are necessary to provide a sense of the capacity, systems, and processes that exist to provide care and supports for dual eligible beneficiaries. In particular, MAP views structural measures as a critical part of a parsimonious measure set and a high-leverage opportunity because they can assess disconnects between Medicare, Medicaid, and the other supports that are necessary for the well-being of high-need beneficiaries. It will be necessary to identify the extent of current problems and attempt to fix underlying structures and processes before providers and other stakeholders will be comfortable being held accountable for outcome measures in the other high-leverage opportunity areas.

Structural measures can reflect the presence of elements that relate to other high-leverage opportunities such as quality of life and care coordination. For example, structural elements related to quality of life include the availability of Medicaid-funded home- and community-based services (HCBS) within a state and an individual's ability to self-direct those services. Additional structural measures related to care coordination might assess: the presence of contracts between state Medicaid agencies and Medicare Advantage Special Needs Plans (SNP) to coordinate care, health IT uptake among Medicaid providers in a region, or capacity for information sharing within and across health provider and community support services organizations.

Appropriate Measures for Use with the Dual Eligible Beneficiary Population

In the interim report *Strategic Approach to Performance Measurement for Dual Eligible Beneficiaries,* MAP presented a set of illustrative measures to highlight the high-leverage measurement opportunities. Building on that work, MAP undertook a series of activities to generate a list of available measures appropriate for use with the dual eligible beneficiary population. MAP examined hundreds of currently available measures, gradually winnowing and revising the set until a core of 25 measures emerged (Appendix F). A draft version of the core set was used as an input to MAP's pre-rulemaking process.

It is important to note that unlike other programs for which MAP has provided input on measures, there is not a federal measurement program devoted to monitoring the quality of care for dual eligible beneficiaries. Thus, MAP anticipates that its guidance regarding appropriate measures for use with this population may be applied to multiple programs. Stakeholders are still in the process of defining the purpose, goals, data platform, and levels of analysis for new initiatives.

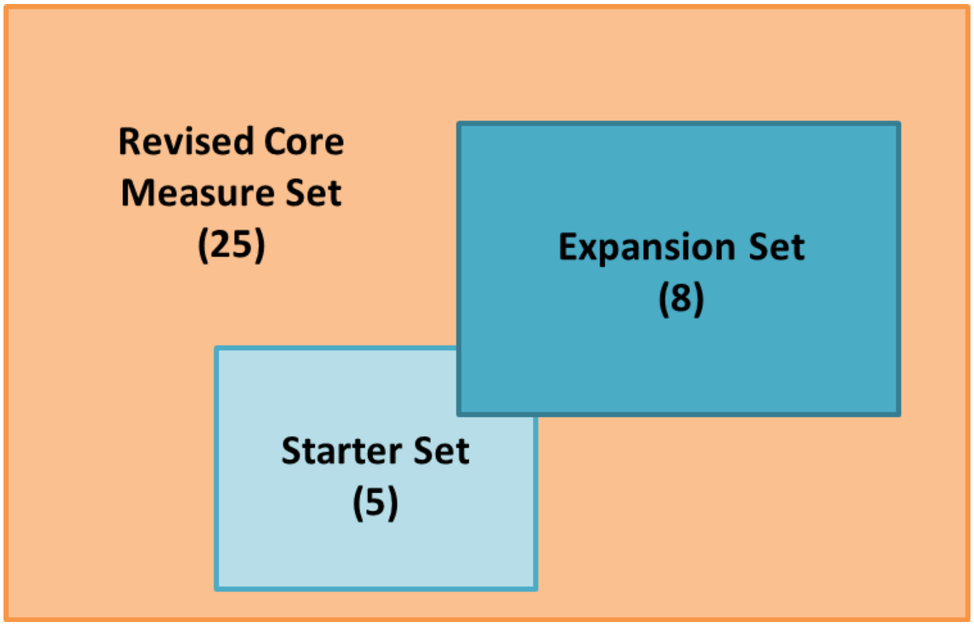
Because it was not compiled with a single application in mind, the set covers each of the five high-leverage opportunity areas, a range of measure types, and many settings of care. Some measures could be applied to all or most dual eligible beneficiaries. Others are primarily important for a significant subgroup of the population, such as individuals receiving hospice care or individuals 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 core measures, presented in Table 2.

Table 2: Quality Issues Addressed by Revised Core Measure Set

High-Leverage Opportunity Area	Measure Topics
Quality of Life	Functional Status Assessment Health-Related Quality of Life Palliative Care
Care Coordination	Care Transition Experience Communication with Patient/Caregiver Communication with Healthcare Providers Hospital Readmission Medication Management
Screening and Assessment	BMI Screening Falls Management of Diabetes Pain Management
Mental Health and Substance Use	Alcohol Screening and Intervention Depression Screening Substance Use Treatment Tobacco Cessation
Structural Measures	Health IT Infrastructure Medical Home Adequacy Medicare / Medicaid Coordination
Other	Patient Experience

Within the revised core set, MAP identified subsets of measures with potential for either short-term (Starter Set) or phased (Expansion Set) implementation. Figure 2 illustrates the relationship between the three sets of measures. The following sections describe the process and results of MAP's further deliberations.

Figure 2: Appropriate Measures for Use with the Dual Eligible Beneficiary Population: 3 Related Sets



Starter Set of Measures

MAP concluded that a small number of measures within the set should be called out as the most promising for use in the short term. MAP considered and ranked measures that would work well as they are currently specified, without modification. This process balanced MAP's desire to be thorough and inclusive with its desire to provide HHS with a specific, actionable, and parsimonious list of measures. Table 3 presents the prioritization's top tier of results, in descending order, as a Starter Set of Measures.

Table 3: Starter Set of Measures

Measure Name, NQF Measure Number & Status	Data Source	High-leverage Opportunities	Setting of Care	Level of Analysis	Use in Current Programs
Screening for Clinical Depression and Follow-up Plan #0418 Endorsed	Administrative Claims and Other Electronic Clinical Data	Screening and Assessment, Mental Health/Substance Use	Ambulatory Care, Hospital, PAC/LTC Facility	Clinician	Finalized for use in PQRS, Medicare Shared Savings Program, Medicaid Adult Core Set. Proposed for Meaningful Use Stage 2
Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey Multiple Numbers Endorsed	Patient Survey	N/A	Various, including: • Health Plan • Clinician & Group • Experience of Care and Health Outcomes (ECHO) for Behavioral Health • Home Health Care • Hospital • In-Center Hemodialysis • Nursing Home • Supplemental Item Sets, topics including: o People with Mobility Impairments o Cultural Competence o Health IT o Health Literacy o Patient-Centered Medical Home	Clinician, Facility, Health Plan, Integrated Delivery System, Population	Multiple programs, depending on version
Medical Home System Survey #0494 Endorsed	Provider Survey, EHR, Other Electronic Clinical Data, Paper Records, and Patient Reported Data	Care Coordination, Structural	Ambulatory Care	Clinician	NCQA Accreditation
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: (a) Initiation, (b) Engagement #0004 Endorsed	Administrative Claims, EHR, and Paper Records	Care Coordination, Mental Health/Substance Use	Ambulatory Care	Clinician, Health Plan, Integrated Delivery System, Population	Finalized for use in PQRS, Meaningful Use, Value Modifier, Medicaid Adult Core Set, and Health Homes Core

Measure Name, NQF Measure Number & Status	Data Source	High-leverage Opportunities	Setting of Care	Level of Analysis	Use in Current Programs
Hospital-Wide All-Cause Unplanned Readmission Measure (HWR) #1789 In Process **OR**	Administrative Claims	Care Coordination	Hospital/Acute Care Facility	Facility	Under consideration for Inpatient Quality Reporting (MAP Supported)
Plan All-cause Readmission #1768 In Process	Administrative Claims	Care Coordination	Hospital/Acute Care Facility, Behavioral Health/Psychiatric: Inpatient	Health Plan	Finalized for use in Medicaid Adult Core Set

In prioritizing the measures, MAP considered their suitability for addressing the heterogeneous dual eligible population. Priority measures also needed to capture complex care experiences that extend across varied settings of care and types of healthcare providers. Considered broadly, the prioritized list demonstrates concepts are of critical importance to the dual eligible population: care that is responsive to patients' experiences and preferences, the need for follow-up care, and treatment for behavioral health conditions.

The highest-ranked measure in the Starter Set is *Screening for Clinical Depression and Follow-up Plan (#0418)*. This measure addresses two high-leverage opportunity areas (screening and assessment, mental health and substance use) while also focusing on a condition that is highly prevalent in the dual eligible population. It can be used in many care settings in which dual eligible beneficiaries receive services. Further, use of this measure would promote alignment with other measurement programs in which it is used, including the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults and the Medicare Shared Savings Program.

MAP also recommends that CAHPS® surveys be used in every setting of care for which they are available. These patient experience surveys capture actionable feedback from patients and their families and are deemed vital to promoting a person- and family- centered measurement enterprise. Measure developers and the Agency for Healthcare Research and Quality (AHRQ) are actively enhancing CAHPS tools, including efforts to draft and test a CAHPS survey for Medicaid HCBS. Once complete, a participant experience survey of HCBS would be an important complement to more typical measures of the clinical aspects of long-term supports and services.

Other highly ranked measures touch on the important topics of care coordination and patient engagement. MAP has supported the concept of a health home for dual eligible beneficiaries from the outset of its deliberations. Reflecting that desire, the structural measure *Medical Home System Survey (#0494)* was ranked highly as it is one of the only available measures to promote health homes. *Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (#0004)* was also recognized for addressing critical steps in treating substance use conditions. This measure not only encourages the initial referral to treatment, but also evaluates the individual's continued engagement in treatment over time. Finally, measures of hospital readmission rates were thought to be important proxies for the level of care coordination, communication, and community supports available to dual eligible beneficiaries. Two similar measures of readmissions are currently in the NQF endorsement process, with the recommendation that the measure developers work to harmonize these metrics (#1768 and #1789). MAP defers judgment about which of the measures is preferred until the endorsement process has concluded, but emphasizes the primary importance of this topic in evaluating the "connectedness" of care for dual eligible beneficiaries.

While it provides a necessary starting place, evaluating the Starter Set against the NQS priorities and the MAP's own high-leverage opportunity areas reveals important shortcomings. For example, no available measures were thought to adequately address the NQS goal of affordable care for dual eligible beneficiaries. Similarly, the set lacks measures related to the quality of life high-leverage opportunity area. These gaps in available measures will be more fully discussed in a later section of this report.

Expansion Set of Measures Needing Modification

MAP also sought to provide specific guidance regarding opportunities to improve existing measures. Participants voiced many suggestions for broadening and improving measures' specifications for use with dual eligible beneficiaries. Following the initial ranking exercise that yielded the Starter Set, members performed a second ranking to indicate the measures that would be preferred *if the suggested modifications could be made*. This group of measures would build on the Starter Set discussed above, expanding the range of quality issues addressed. Table 4 presents the top tier of results from this prioritization as an Expansion Set of Measures.

Table 4: Expansion Set of Measures Needing Modification

Measure Name, NQF Measure Number & Status	Measure Description	Suggested Modifications and Other Considerations
Assessment of Health Related Quality of Life (Physical & Mental Functioning) #0260 Endorsed	Percentage of dialysis patients who receive a quality of life assessment using the KDQOL-36 (36-question survey that assesses patients' functioning and well-being) at least once per year. • Data Source: Patient Reported • Care Setting: Dialysis Facility • Current Programs: MAP supported for ESRD Quality Improvement Program	• Emphasized for its consideration of quality of life, a rarity among available measures • Suggested expansion beyond ESRD setting to include other types of care • Construction of this concept as a process measure is not ideal
Medical Home System Survey #0494 Endorsed	Percentage of practices functioning as a patient-centered medical home by providing ongoing coordinated patient care. Meeting Medical Home System Survey standards demonstrates that practices have physician-led teams that provide patients with: a. Improved access and communication b. Care management using evidence-based guidelines c. Patient tracking and registry functions d. Support for patient self-management e. Test and referral tracking f. Practice performance and improvement functions • Data Source: Provider Survey, EHR, Other Electronic Clinical Data, Paper Records, and Patient Reported Data • Care Setting: Ambulatory Care • Current Programs: None	• Current application is NCQA accreditation • A health home's approach to care management must be designed for duals and consider both Medicaid and Medicare benefits • Care management might be appropriately conducted by other parties besides primary care physician (e.g., family member, clinical specialist) • Consider broader application in shared accountability models such as ACOs and health homes

HBIPS-6: Post Discharge Continuing Care Plan Created #0557 Endorsed	Patients discharged from a hospital-based inpatient psychiatric setting with a continuing care plan created 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-7: Post discharge continuing care plan transmitted to next level of care provider upon discharge*. • Data Sources: Administrative Claims, Paper Records, Other Electronic Clinical Data • Care Setting: Hospital, Behavioral Health/Psychiatric: Inpatient • Current Programs: Under Consideration for Inpatient Psychiatric Facility Quality Reporting (MAP Supported)	• This type of transition planning/communication is universally important • Suggested expansion to all discharges, not just psychiatric. At a minimum, the measure should include inpatient detox
HBIPS-7: Post discharge continuing care plan transmitted to next level of care provider upon discharge #0558 Endorsed	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*. • Data Sources: Administrative claims, Other Electronic Clinical Data, and Paper Records • Care Setting: Hospital, Behavioral Health/Psychiatric: Inpatient • Current Programs: Under Consideration for Inpatient Psychiatric Facility Quality Reporting (MAP Supported)	• This type of transition planning/communication is universally important • Suggested expansion to all discharges, not just psychiatric. At a minimum, the measure should include inpatient detox • Information should be transmitted to both nursing facility and primary care provider, if applicable
Falls: Screening for Fall Risk #0101 Endorsed	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. • Data Sources: Administrative Claims, Other Electronic Clinical Data, and Paper Records • Care Setting: Ambulatory Care, Home Health, Hospice, PAC/LTC Facilities • Current Programs: Finalized for use in PQRS, Medicare Shared Savings Program, and Value Modifier and Under Consideration for PQRS (MAP Supported)	• Important risk factor for dual eligible beneficiaries, as mobility limitations are common • Suggested that obesity be considered a fall risk • Suggested that the measure be expanded to include anyone at risk for a fall, not just individuals older than 65 • Suggested that patients could report if they received counseling on falls rather than relying on claims data
3-Item Care Transition Measure (CTM-3) #0228 Endorsed	Uni-dimensional self-reported survey that measures the quality of preparation for care transitions. • Data Sources: Patient Reported • Care Setting: Hospital • Current Programs: Under Consideration for Hospital Inpatient Reporting (MAP Supported)	• Support for this being a patient-reported measure of a care transitions experience • Broaden to additional settings beyond inpatient, such as ER and nursing facility discharges

Comfortable Dying: Pain Brought to a Comfortable Level Within 48 Hours of Initial Assessment #0209 Endorsed	Number of patients who report being uncomfortable because of pain at the initial assessment (after admission to hospice services) who report pain was brought to a comfortable level within 48 hours. • Data Sources: Patient Reported • Care Setting: Hospice • Current Programs: Finalized for use in Hospice Quality Reporting	• Give consideration to operationalizing this measure as pain assessment across settings, at a minimum could be applied more broadly to other types of palliative care
Change in Daily Activity Function as Measured by the AM-PAC #0430 Endorsed	The Activity Measure for Post-Acute Care (AM-PAC) is a functional status assessment instrument developed specifically for use in facility and community dwelling post-acute care (PAC) patients. A Daily Activity domain has been identified which consists of functional tasks that cover in the following areas: feeding, meal preparation, hygiene, grooming, and dressing. • Data Sources: Other Electronic Clinical Data • Care Setting: Hospital, PAC/LTC Facilities, Home Health, Ambulatory Care • Current Programs: None	• Broaden beyond post-acute care • Include maintenance of functional status if this is all that can be realistically expected • Address floor effects observed when tool is applied to frail/complex patients • Incorporate community services in supporting post-acute recovery

The concepts and best practices represented within the Expansion Set measures are merely a starting point in the long path toward developing a comprehensive set of appropriate measures. MAP's discussion of the expansion set revealed a range of shortcomings in existing measures from the perspective of measuring quality in a defined population. Many of the proposed modifications related to broadening the denominator populations of measures to increase their applicability to other patient groups. MAP also proposed expansion of measures to account for multiple settings of care and community supports, as well as emphasizing functional outcomes.

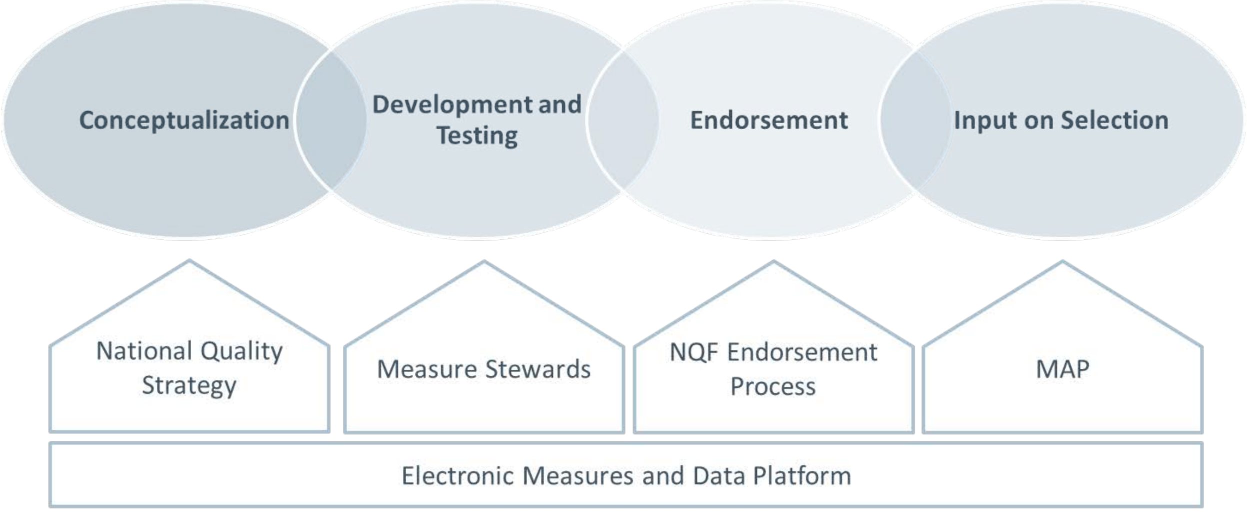
Each version of the measure list contains one or more measures related to care transitions, a vital quality issue in the dual eligible beneficiary population. The Expansion Set contains two process measures specified for use in behavioral health (#0557, #0558) that are conceptually similar to two measures specified for a general hospital admission (#0647, #0648). Measure #0228 also relates to transitions, though it captures the patient's experience. Some of these measures may be candidates for harmonization or expansion. Short of that, MAP urges that quality measures be applied to all transitions in care for which they are available, including discharges to home, to/from a nursing facility, or to/from any other setting.

Because the majority of available performance measures were developed for specific programs or purposes, there is difficulty in retrospectively applying them to care for dual eligible beneficiaries. Measure developers are asked to consider MAP's suggested modifications and evaluate the strength of evidence, data availability, and other requirements to support the proposed changes.

Addressing Gaps in Measurement

MAP's activities are designed to coordinate with and reinforce other efforts for improving health outcomes and healthcare quality through performance measurement. Measure development and standardization of measures are essential upstream inputs to these efforts. Figure 3 broadly depicts the pathway from the conceptualization and development of measures to their selection for specific applications by MAP.

Figure 3: Illustration of Measure Development and Application



The NQS provides national priorities and goals for quality improvement, influencing the conceptualization of measures that would evaluate progress in each area. Once measurement priorities are clear, measure stewards must secure funding for development, explore the evidence base, develop numerator and denominator statements, identify data, specify the measures, and test prototype measures in the field. Stewards then submit their measures to the National Quality Forum for endorsement as consensus standards. Endorsement provides an avenue for measure harmonization while enhancing measures' credibility and likelihood of adoption. Finally, recommendations from MAP influence the application of individual measures in specific public- and private-sector programs. Gaps and suggested modifications revealed by MAP processes can also follow multiple avenues to inform preceding steps in the pathway.

MAP's effort to compile a set of performance measures appropriate for assessing and improving the quality of care for dual eligible beneficiaries was constrained by gaps in available measures. This report documents many modifications suggested to improve existing measures, but countless other concepts one might wish to evaluate cannot currently be measured.

Measure gaps identified by MAP consist of two general types:

- **Development Gaps:** Desired measures do not currently exist or are extremely limited in scope. For example, MAP would like to evaluate the quality and comprehensiveness of an individual's person-centered plan of care, but no measures are available to do so.
- **Implementation Gaps:** Appropriate measures exist but are not included in a given performance measurement program. For example, standardized measures of patient experience are available but not currently applied in many public reporting and performance-based payment programs.

Measure gaps can be found at any stage of measure development and implementation. Most gaps in measurement for dual eligible beneficiaries are development gaps. Because the dual eligible beneficiary population is defined by the happenstance of two overlapping public insurance programs, they have lacked traditional interest groups to advocate for their unique needs related to healthcare quality. This sharply contrasts to well-organized medical boards, specialty societies, providers, quality alliances, and consumer groups that have promoted and funded measurement in specific areas, such as cardiovascular care, pharmacy, and dialysis, to name a few. While measures have proliferated in other areas, the needs of dual eligible beneficiaries have gone unaddressed.

In considering the landscape of currently available measures applicable to dual eligible beneficiaries, MAP identified and categorized a large number of measure development gaps (Table 5).

Table 5: Categorized Measure Gaps Applicable to Dual Eligible Beneficiaries

STRUCTURAL MEASURES	Ability to capture encounter data with Health IT
	Access to services (e.g., transportation, appointment availability)
	Capacity to serve as a medical home or health home
	Cultural competence
	Frequency of change in eligibility
	Harmonization of program benefits
	Level of beneficiary assistance navigating Medicare/Medicaid
	Presence of coordinated or blended payment streams
	Rating system for level of integration between health and community services
	Workforce capacity
CARE COORDINATION	Appropriateness of hospitalization (e.g., avoidable admission/readmission)
	Effective communication (e.g., provider-to-patient, provider-to-provider)
	Fidelity to care plan
	Follow-up visit
	Goal-directed, person-centered, care planning and implementation
	System structures to connect health system and long-term supports and services
	Timely communication of discharge info to all parties
QUALITY OF LIFE	Caregiver support
	Choice of support provider
	Community inclusion/participation
	Life enjoyment
	Optimal functioning (e.g., improving when possible, maintaining, managing decline)
	Pain and symptom management
	Sense of control/autonomy/self-determination
MENTAL HEALTH AND SUBSTANCE USE	Initiation of pharmacotherapy after diagnosis of substance dependence
	Medication adherence and persistence for all behavioral health conditions
	Outcome measures for smoking cessation
	Regular assessment of weight/BMI for all patients on anti-psychotic medication
	Suicide risk assessment for any type of depression diagnosis
SCREENING AND ASSESSMENT	Assessment for rehabilitative therapies
	Appropriate follow-up intervals
	Appropriate prescribing and medication management
	Cardiovascular disease management
	More “optimal care” composite measures (e.g., NQF #0076)
	Safety risk assessment
	Screening for cognitive impairment and poor psychosocial health
	Screening for poor health literacy
	Screening population for diabetes and cardiovascular risks
	Sexual health screenings for disenfranchised groups
OTHER	Consideration of global costs
	Utilization benchmarking (e.g., outpatient/ED)

The lengthy list of measure development gaps reveals that many concepts considered core to improving quality for dual eligible beneficiaries are not yet able to be measured. Very few desired measurement topics apply to specific diseases or conditions. Indeed, few desired concepts are fully within the purview of a single entity in the health system. Instead the measurement gaps reflect MAP's desire to emphasize cross-cutting aspects of high-quality care.

MAP acknowledged the resource-intensive nature of measure development and prioritized the measure gaps to provide the measure development community with more specific guidance and a sense of importance. The top tier of prioritized results is presented in Table 6.

Table 6: Top Tier of Prioritized Measure Gaps

Measure Development Gap Concepts	Votes
Goal-directed person-centered care planning/implementation	18
System structures to connect health system and long-term supports and services	17
Appropriate prescribing and medication management	13
Screening for cognitive impairment and poor psychosocial health	11
Appropriateness of hospitalization (e.g., avoidable admission/readmission)	9
Optimal functioning (e.g., improving when possible, maintaining, managing decline)	9
Sense of control/autonomy/self-determination	8
Level of beneficiary assistance navigating Medicare/Medicaid	8
Presence of coordinated or blended payment streams	7
Screening for poor health literacy	6
Utilization benchmarking (e.g., outpatient/ED)	6

Given that "Assessing Outcomes Relative to Goals" is one the guiding principles for this measurement framework, it is not surprising that MAP members prioritized measurement around goal-directed care planning and implementation of that plan of care. Similarly, MAP expressed a strong desire for structure and process measures to assess connections between the health system and the long-term supports and services system, including Medicaid HCBS. These topics are emblematic of the comprehensive, coordinated care that would benefit high-need beneficiaries. However, these types of measure gaps present particularly significant challenges to developers. In many ways, they aspire to measure aspects of integrated healthcare that are still the exception rather than the rule in clinical practice. Similarly, the evidence base may be limited, workflows may be non-standard, and the data sources may be inconsistent.

Other topics more amenable to measure development are also among the top results. For example, the concepts of appropriate prescribing behavior and medication management to reduce poly-pharmacy risks could be operationalized as process measures. MAP also recommended routine screening of dual eligible beneficiaries for cognitive impairment and psychosocial risk factors. While it may be challenging to define a denominator population for these measure topics, the experience of developing and using screening and referral measures in other areas will be instructive.

Measures of Quality in Home and Community-Based Services

MAP separately considered measures of quality in Medicaid-funded home and community-based services as a major development gap area. Nationally, more than 300 Medicaid waiver programs provide services to more than 1 million participants, with expenditures exceeding $23 billion.[vii] More than two out of every three HCBS recipients are dual eligible beneficiaries.

Because HCBS services are largely non-medical, they necessarily operate within a different quality paradigm than the health system. Many of the primary domains of high-quality, person-centered HCBS can be traced back to the disability rights movement and the historical need to assure adequate quality of life for individuals with disabilities leaving institutional care settings. Dominant constructs include access to services, community inclusion, choice and control, respect and dignity, cultural competence, and safety.

Compared to quality measurement in clinical settings, performance measures in HCBS are in the early stages of development and standardization. Many factors contribute to the limited availability of measures. Variation across states in the diagnoses of enrollees, the service package each beneficiary receives, the settings in which supports are delivered, and the providers who furnish services have made it impossible to apply measures across states or across HCBS sub-populations to date.

Government and private sector research efforts are gradually pushing the field forward. For example, AHRQ has funded an effort to develop indicators of potentially avoidable hospitalizations for the HCBS population.[viii] As risk adjustment models become more sophisticated, this promising work can be taken much further. A number of prominent measure scans have also demonstrated that valid measures exist across a wide range of domains, but further development and testing will be required to broaden their applicability.

MAP suggests that HHS explore the feasibility of funding an NQF measure endorsement effort for HCBS measures. Measure developers may need significant support in broadening and standardizing current metrics. To provide more specificity around this request, MAP examined a total of 148 candidate HCBS measures from three primary sources:

- *Environmental Scan of Measures for Medicaid Title XIX Home and Community-Based Services* (June 2010)[ix]
- *Raising Expectations: A State Scorecard on LTSS for Older Adults, People with Disabilities, and Family Caregivers* (September 2011)[x]
- *National Balancing Indicator Contractor* (October 2010)[xi]

Following a stepwise approach that considered the five high-leverage opportunity areas, the inclusiveness of the candidate measures, and their potential applicability to dual eligible beneficiaries, MAP narrowed the universe to 24 selected measures particularly worthy of further attention (Appendix G). Though they rely on surveys and attestations as data sources, many of the measures reflect concepts that ring true for evaluating quality in the dual eligible population (Figure 4).

Figure 4: HCBS Measures Show Promise for Application to the Dual Eligible Population

Measures of Functional Status

Appropriate functional status measures comprise a second major gap area. As outcome indicators, they are fundamental to demonstrating high-quality care. MAP is interested in measuring an individual's level of ability in multiple physical, mental, and social domains. A small number of functional status measures are currently available, but they failed to gain MAP's support for use with dual eligible beneficiaries. For example, six measures are specified for use in the home health program, assessing improvement in: bathing, bed transferring, management of oral medications, the status of surgical wounds, dyspnea, and ambulation/locomotion. In the context of assuring home health care quality, the existing measures are adequate. However, the assumption that an individual would *improve* may be inappropriate if these home health functional status measures were applied to the heterogeneous and medically complex dual eligible population. Individuals who are older and/or who have advanced diseases are likely to have care goals that emphasize maintenance of function or slowing of decline. Moreover, the home health measures of functional status rely on an assessment tool that is not intended for use in any other context.

MAP would be interested in composite measures that provide an overall sense of functional status. Though not currently specified or endorsed as a performance measure, MedPAC has published data that approximates this concept. Using the Health Outcomes Survey (HOS) and the Medicare Advantage population, MedPAC calculated the percentage of enrollees "Improving or maintaining physical health" and “Improving or maintaining mental health.”[xii] If the data source and denominator population can be altered, this construct may be useful in broadly assessing functional status.

Measure Gaps Revealed by Environmental Scan

NQF contracted with Avalere Health and L&M Policy Research to conduct an environmental scan to glean further insights regarding the future direction of measurement in the dual eligible beneficiary population. This scan included a series of expert stakeholder discussions and a targeted literature review. In general, interviewees felt that it was necessary to measure the extent that person-centered care planning and management occurs when needed as well as the degree to which the processes and structures in place support this as an ongoing activity. Using seven specific areas of focus, the environmental scan highlighted example measures, measure gaps, implementation barriers, and recommendations. Findings are summarized in Appendix H.

Resolving Prioritized Measure Gaps

Many measurement gaps exist because of the difficulties inherent in measurement. The field is still evolving strategies to address data reliability, risk-adjustment, small sample sizes, insufficient or evolving evidence base, reducing reporting burden, and other challenges. Resolving the gaps will require a mix of short-term and long-term strategies. NQF and MAP offer a multiple avenues through which to guide the quality measurement enterprise in being more responsive to the needs of vulnerable populations. These avenues include new calls for measures through the Consensus Development Process (CDP), annual measure updates, and measure maintenance reviews. Appendix I provides further information about those processes.

Levels of Analysis and Potential Applications of Measures

MAP’s work in identifying appropriate measures for use with the dual eligible beneficiary population has been challenged by the fact that there are many potential ways to apply measures. Each potential use of measures has its own purpose, resource constraints, type of authority or influence, and data capabilities. While the MMCO will play a dominant role in directing large-scale quality improvement activities for the foreseeable future, no single entity is fully accountable for the delivery of care to dual eligible beneficiaries. Given the diffuse accountability, MAP has grappled with the questions of where and how measurement currently occurs and might occur in the future to align incentives and create shared accountability. A number of likely scenarios have emerged.

Federal Government

At the federal level, the MMCO has expressed multiple needs for measurement. MAP proposes the measures presented in this report as candidates for these initiatives. First, the Office will continue to pursue its Congressional mandate to improve the experience of care for dual eligible beneficiaries. They are likely to use year-over-year comparisons to monitor progress and direct continuing activities to the most fruitful areas. Efforts have been underway at CMS to link a comprehensive database of Medicare and Medicaid claims data from which to draw measurement information. The MMCO has also proposed the addition of 13 new condition flags in the CMS Chronic Condition Warehouse (CCW). These new flags will allow for a better understanding of conditions affecting the dual eligible population, including many prominent mental illnesses, substance use, and HIV/AIDS. The MMCO may also consider stratifying information about dual eligible beneficiaries within measures reported for other programs. Current programs include nursing homes, dialysis facilities, home health agencies, and many other types of care.

The MMCO and selected states have also established demonstration grants to integrate care and improve quality for the population. As an accompaniment to a broader evaluation strategy that will evaluate cost-effectiveness, measures will be needed to evaluate the success of the new models and to ensure that beneficiaries are not negatively affected by the new programs. In parallel to a broad evaluation, individual states are likely to use individualized sets of measures for quality assurance. Each state is expected to select measures that reflect the unique design of its demonstration and its data capabilities. This is an important opportunity for state initiatives to act as test beds for evaluating new and emerging quality measures.

National Research Entities

To date, most of the strongest research and analysis on dual eligible beneficiaries has been performed by independent national organizations. For example, MedPAC has begun to routinely publish data on duals as part of its role in advising Congress on Medicare payment policy. These rich analyses have drawn on claims data, the CCW, the HOS, site visits, and other sources. Similarly, private foundations such as The Henry J. Kaiser Family Foundation, The SCAN Foundation, and The Commonwealth Fund have also taken up the charge to monitor duals' access, quality, and expenditures to inform policymakers. The foundation of gray literature and background information generated by these organizations was indispensable to MAP's early deliberations and understanding of quality issues affecting the population. MAP is hopeful that the recommendations in this report will inform their future work.

State Government

The cost-sharing and long-term care benefits provided by Medicaid are crucial to dual eligible beneficiaries. However, state governments have been particularly challenged in identifying quality measurement strategies. Resources are strictly limited and healthcare insurance and delivery systems are in the process of being thoroughly redesigned. States often have their own data collection tools, surveys, forms, and procedures. Many may even use homegrown quality measures. Though each state's approach will need to be customized based on these factors, MAP offers the information in this report as a potential framework and a starting place for measure selection. In addition, this report begins to provide a foundation for aligning improvement efforts and the ability to benchmark outcomes. States would be encouraged to focus on measures related to long-term supports and services, beginning with those that are already publicly reported before branching into other areas.

Health Plans and Providers

Private-sector entities such as health plans and provider networks work in partnership with Medicare and Medicaid to serve dual eligible beneficiaries. Emerging accountable care organizations offer promising models for serving dual eligible beneficiaries in a coordinated, integrated way. Managed care plans, particularly Medicare Advantage Special Needs Plans (SNPs) that target this population, are also important partners in assuring high-quality care. Current measurement activities in SNPs are focused on applying HEDIS and Structure and Process Measures established by the National Committee for Quality Assurance (NCQA). One of those measures, *SNP 6: Coordination of Medicare and Medicaid Coverage,* is included in the core measure set with the suggestion that the concept be examined for potential use in broader applications.

Measure Alignment Across Federal Programs

Contributions of the Dual Eligible Beneficiary Perspective to MAP's Pre-Rulemaking Deliberations

HHS identified the dual eligible beneficiary population as a priority consideration for MAP's first round pre-rulemaking deliberations. While this is just one of many populations that could greatly benefit from a purposeful person- and family-centered approach to care and quality measurement, the perspective of dual eligible beneficiaries provided an enlightening case study in promoting aligned performance measurement.

Federal measurement programs have traditionally focused on a single setting or type of healthcare, such as inpatient hospital care or skilled nursing facility care, rather than a population of consumers. In recognition that numerous, isolated programs have limited ability to reflect healthcare quality across the continuum, newer initiatives such as the Medicare Shared Savings Program have expanded the scope of measurement across settings and time while promoting shared accountability for a defined population. This is the beginning of a vital shift toward integrated healthcare delivery and performance-based payment policy.

Dual eligible beneficiaries are served in every part of the health and long-term care systems, but there is not currently a dedicated federal measurement program to monitor the overall quality of their care. Many measures are applied to care provided to the dual eligible population, but they are deployed through a variety of isolated programs run by government entities and private health plans. While CMS' Medicare-Medicaid Coordination Office and state demonstration grantees explore measurement options, MAP has helped to drive alignment across existing programs by considering the population's needs across settings of care. Specifically, MAP has examined measures under consideration for addition to 18 existing programs and favored the use of those relevant to dual eligible beneficiaries. This guidance was summarized in MAP's pre-rulemaking input to HHS.[xiii] In its continuing role of providing pre-rulemaking input, MAP will pursue alignment across federal programs while ensuring that the unique needs of Medicare-Medicaid dual eligible beneficiaries receive attention and measurement.

Complementing Efforts on Medicaid Adult Measures

Until recently, federal performance measurement programs have primarily related to the Medicare program. In an important step forward, ACA required HHS to establish an initial core set of health care quality measures for Medicaid-eligible adults. Seeking to complement, but not duplicate, efforts in Medicaid measurement, MAP followed the progress of this initiative from the outset. After publication of the Medicaid adult core measure set in January 2012, MAP further considered the relationship between the two efforts.[xiv]

While any effort to measure Medicaid beneficiaries would involve the dual-eligible population by definition, it is important to note that duals account for fewer than one in three Medicaid enrollees. Logically, the core measure set reflects the different healthcare needs of these low-income adults in addition to more complex dual eligible beneficiaries. For example, the set includes four measures of reproductive health services that are very important to Medicaid-only enrollees but of limited utility in the dual-eligible population. In terms of overlap between the two sets of measures, six measures do appear in both the Medicaid adult core list and MAP's list of appropriate measures for dual eligible beneficiaries (NQF #0418, #0576, #0006/#0007, #0648, #0004, and #1768). Where possible, MAP recommends stratification of these measures to enable comparison between dual eligible beneficiaries and Medicaid-only beneficiaries.

A second consideration for the Medicaid measurement effort is that it is largely focused on ambulatory and hospital services, including prevention and health promotion, management of acute conditions, and management of chronic conditions. However, dual eligible beneficiaries receive coverage for those services through Medicare. Medicaid only serves as the primary payor for long-term services and supports. This benefit design complicates the availability of data to evaluate dual eligible beneficiaries' care experience through the Medicaid quality measurement program. There are no long-term care measures in the Medicaid adult core set.

Future Opportunities

Much work remains before MAP's vision for high-quality care for dual eligible beneficiaries will be fully realized. Understanding the limitations of the current environment, this report seeks to jump-start a long-term effort to ensure that all major points in the health care system accessed by dual eligible beneficiaries are using performance measures that motivate providers to address the unique needs of this population.

Going forward, MAP will seek to provide more clarity around program alignment and the current and potential uses of measures in the field, updating its guidance as necessary to inform the many stakeholders working to improve quality. MAP will continue to search for answers to implementation questions, increasing transparency around why, where, and how public and private sector stakeholders use measures to improve quality. With concerted effort, one day it will be possible to form a complete picture of the quality of care that dual eligible beneficiaries receive, drawing on measures from different sources and combining them in a meaningful whole.

Appendix A: MAP Background

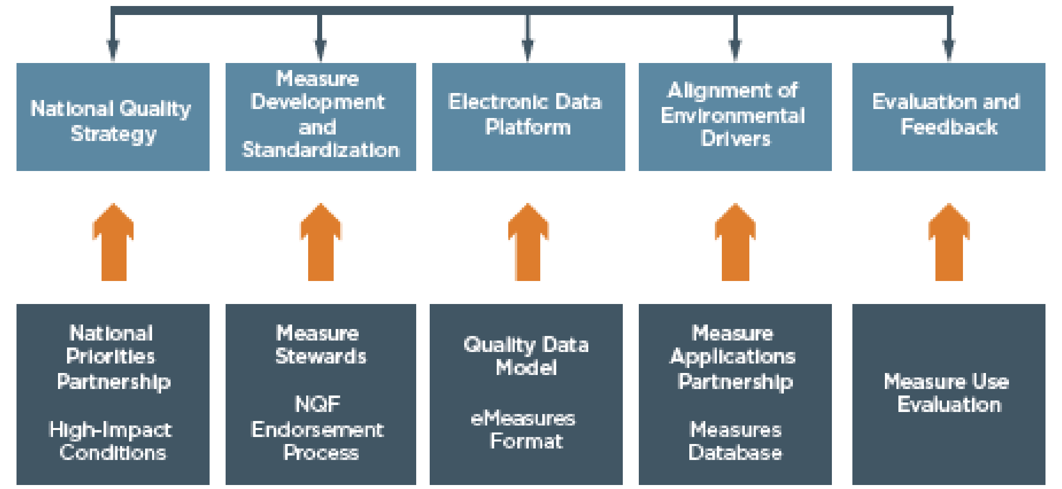
Coordination with Other Quality Efforts

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; 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" (Figure A1) that includes:

- setting priorities and goals for improvement;
- standardizing performance measures;
- constructing a common data platform that supports measurement and improvement;
- applying measures to public reporting, performance-based payment, health IT meaningful use programs, and other areas; and
- promoting performance improvement in all healthcare settings.

Figure 1. Functions of the Quality Measurement Enterprise



The National Priorities Partnership (NPP) is a multi-stakeholder group convened by NQF to provide input to HHS on the NQS, by identifying priorities, goals, and global measures of progress.[xv] Another NQF-convened group, the Measure Prioritization Advisory Committee, has defined high-impact conditions for the Medicare and child health populations.[xvi] Cross-cutting priorities and high-impact conditions provide the foundation for all of the subsequent work within the quality measurement enterprise.

Standardized measures are necessary to assess the baseline relative to the NQS priorities and goals, determine the current state and opportunities for improvement, and monitor progress. The NQF endorsement process meets certain statutory requirements for setting consensus standards and also provides the resources and expertise necessary to accomplish the task. A platform of data sources, with increasing emphasis on electronic collection and transmission, provides the data needed to calculate measures for use in accountability programs and to provide immediate feedback and clinical decision-support to providers for performance improvement.

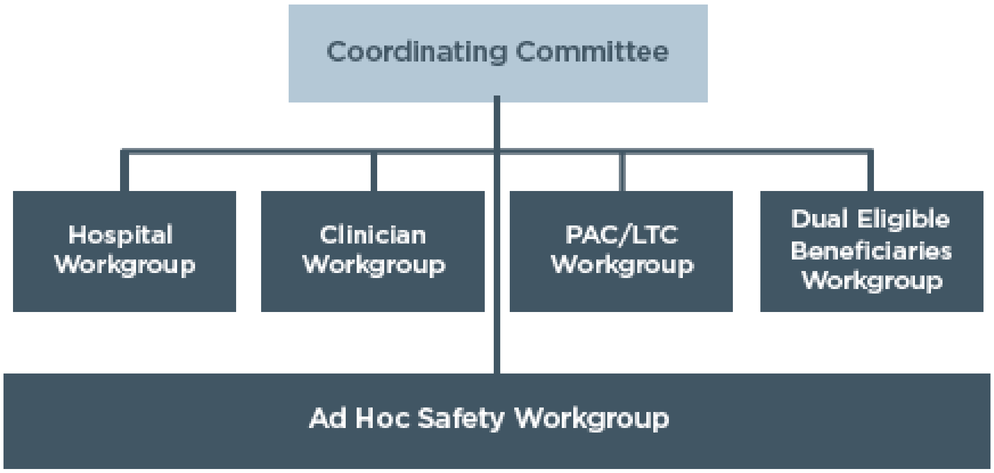
Alignment around environmental drivers, such as public reporting and performance-payment, is MAP's role in the quality measurement enterprise. By considering and recommending measures for use in specific applications, MAP will facilitate the alignment of public- and private-sector programs and harmonization of measurement efforts under the NQS.

Finally, 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.[xvii] Further, the evaluation function monitors for potential unintended consequences that may result.

Function

Composed of a two-tiered structure, MAP's overall strategy is set by the Coordinating Committee, which provides final input to HHS. Working directly under the Coordinating Committee are five advisory workgroups responsible for advising the Committee on using measures to encourage performance improvement in specific care settings, providers, and patient populations (Figure A2). More than 60 organizations representing major stakeholder groups, 40 individual experts, and 9 federal agencies (*ex officio* members) are represented on the Coordinating Committee and workgroups.

Figure 2. 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 included 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 decision-making is based on a foundation of established guiding frameworks. The NQS is the primary basis for the overall MAP strategy. Additional frameworks include the high-impact conditions determined by the NQF-convened Measure Prioritization Advisory Committee, the NQF-endorsed Patient-Focused Episodes of Care framework,[xviii] the HHS Partnership for Patients safety initiative,[xix] the HHS Prevention and Health Promotion Strategy,[xx] the HHS Disparities Strategy,[xxi] and the HHS Multiple Chronic Conditions framework.[xxii]

One of MAP's early activities has been the development of measure selection criteria. The selection criteria are intended to build on, not duplicate, the NQF endorsement criteria. The measure selection criteria characterize the fitness of a measure set for use in a specific program by, among other things, how closely they align with the NQS's priority areas and address the High-Impact Conditions, and by the extent to which the measure set advances the purpose of the specific program without creating undesirable consequences.

Timeline and Deliverables

MAP's initial work includes performance measurement coordination strategies and pre-rulemaking input on the selection of measures for public reporting and performance-based payment programs. Each of the coordination strategies addresses:

- measures and measurement issues, including measure gaps;
- data sources and health IT implications, including the need for a common data platform;
- alignment across settings and across public- and private-sector programs;
- special considerations for dual eligible beneficiaries; and
- path forward for improving measure applications.

On October 1, 2011, MAP issued three coordination strategy reports. The report on coordinating readmissions and healthcare-acquired conditions focuses on alignment of measurement, data collection, and other efforts to address these safety issues across public and private payers.[xxiii] The report on coordinating clinician performance measurement identifies the characteristics of an ideal measure set for assessing clinician performance, advances measure selection criteria as a tool, and provides input on a recommended measure set and priority gaps for clinician public reporting and performance-based payment programs.[xxiv] An interim report on performance measurement for dual eligible beneficiaries offered a strategic approach that includes a vision, guiding principles, characteristics of high-need subgroups, and high-leverage opportunities for improvement, all of which informed the content of this final report.[xxv]

On February 1, 2012, MAP issued an additional coordination strategy for performance measurement in post-acute and long-term care settings.[xxvi] The strategy focuses on alignment across settings by delineating a core set of measure concepts for PAC and LTC providers and their patients. Additional coordination strategies for hospice care and cancer care will be released in June 2012, concurrent with this report.

Through a separate annual task, MAP will provide pre-rulemaking input to HHS on the selection of measures for public reporting and performance-based payment programs. MAP will submit its report in February of each year, beginning with 2012, based on a list of measures under consideration provided by HHS. MAP's inaugural pre-rulemaking report is publicly available for review.[xxvii]

Appendix B

Roster for the MAP Dual Eligible Beneficiaries Workgroup

CHAIR (VOTING)
Alice Lind, MPH, BSN

ORGANIZATIONAL MEMBERS (VOTING)	REPRESENTATIVE
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	David Polakoff, MD, MsC
Better Health Greater Cleveland	Patrick Murray, MD, MS
Center for Medicare Advocacy	Patricia Nemore, JD
National Health Law Program	Leonardo Cuello, JD
Humana, Inc.	Thomas James, III, MD
L.A. Care Health Plan	Laura Linebach, RN, BSN, MBA
National Association of Public Hospitals and Health Systems	Steven Counsell, MD
National Association of Social Workers	Joan Levy Zlotnik, PhD, ACSW
National PACE Association	Adam Burrows, MD
EXPERTISE	**INDIVIDUAL SUBJECT MATTER EXPERT MEMBERS (VOTING)**
Substance Abuse	Mady Chalk, MSW, PhD
Emergency Medical Services	James Dunford, MD
Disability	Lawrence Gottlieb, MD, MPP
Measure Methodologist	Juliana Preston, MPA
Home & Community Based Services	Susan Reinhard, RN, PhD, FAAN
Mental Health	Rhonda Robinson-Beale, MD
Nursing	Gail Stuart, PhD, RN

FEDERAL GOVERNMENT MEMBERS (NON-VOTING, EX OFFICIO)	REPRESENTATIVE
Agency for Healthcare Research and Quality	D.E.B. Potter, MS
CMS Medicare-Medicaid Coordination Office	Cheryl Powell
Health Resources and Services Administration	Samantha Wallack Meklir, MPP
HHS Office on Disability	Henry Claypool
Substance Abuse and Mental Health Services Administration	Rita Vandivort-Warren, MSW
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

Roster for the MAP Coordinating Committee

CHAIR (VOTING)
George Isham, MD, MS
Elizabeth McGlynn, PhD, MPPs

ORGANIZATIONAL MEMBERS (VOTING)	REPRESENTATIVES
AARP	Joyce Dubow, MUP
Academy of Managed Care Pharmacy	Marissa Schlaifer, RPh, MS
AdvaMed	Michael Mussallem
AFL-CIO	Gerald 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	Doris Peter, PhD
Federation of American Hospitals	Chip N. Kahn
LeadingAge (formerly AAHSA)	Cheryl Phillips, MD, AGSF
Maine Health Management Coalition	Elizabeth Mitchell
National Association of Medicaid Directors	Foster Gesten, MD
National Partnership for Women and Families	Christine Bechtel, MA
Pacific Business Group on Health	William Kramer, MBA

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

FEDERAL GOVERNMENT MEMBERS (NON-VOTING, EX OFFICIO)	REPRESENTATIVES
Agency for Healthcare Research and Quality (AHRQ)	Nancy Wilson, MD, MPH
Centers for Disease Control and Prevention (CDC)	Chesley Richards, MD, MPH
Centers for Medicare & Medicaid Services (CMS)	Patrick Conway, MD MSc
Health Resources and Services Administration (HRSA)	Ahmed Calvo, MD, MPH
Office of Personnel Management/FEHBP (OPM)	John O'Brien
Office of the National Coordinator for HIT (ONC)	Joshua Seidman, MD, PhD
ACCREDITATION/CERTIFICATION LIAISONS (NON-VOTING)	REPRESENTATIVES
American Board of Medical Specialties	Christine Cassel, MD
National Committee for Quality Assurance	Peggy O'Kane, MPH
The Joint Commission	Mark Chassin, MD, FACP, MPP, MPH

Appendix D

MAP MEASURE SELECTION CRITERIA AND INTERPRETIVE GUIDE

1. Measures within the program measure set are NQF endorsed or meet the requirements for expedited review

Measures within the program measure set are NQF endorsed, indicating that they have met the following criteria: important to measure and report, scientifically acceptable measure properties, usable, and feasible. Measures within the program measure set that are not NQF endorsed but meet requirements for expedited review, including measures in widespread use and/or tested, may be recommended by MAP, contingent on subsequent endorsement. These measures will be submitted for expedited review.

Response option: Strongly Agree / Agree / Disagree / Strongly Disagree

Measures within the program measure set are NQF endorsed or meet requirements for expedited review (including measures in widespread use and/or tested)

Additional Implementation Consideration: Individual endorsed measures may require additional discussion and may be excluded from the program measure set if there is evidence that implementing the measure would result in undesirable unintended consequences.

2. Program measure set adequately addresses each of the National Quality Strategy (NQS) priorities

Demonstrated by measures addressing each of the National Quality Strategy priorities:

Subcriterion 2.1	Safer care
Subcriterion 2.2	Effective care coordination
Subcriterion 2.3	Preventing and treating leading causes of mortality and morbidity
Subcriterion 2.4	Person- and family-centered care
Subcriterion 2.5	Supporting better health in communities
Subcriterion 2.6	Making care more affordable

Response option for each subcriterion: Strongly Agree / Agree / Disagree / Strongly Disagree:

NQS priority is adequately addressed in the program measure set

3. Program measure set adequately addresses high-impact conditions relevant to the program's intended population(s) (e.g., children, adult non-Medicare, older adults, dual eligible beneficiaries)

Demonstrated by the program measure set addressing Medicare High-Impact Conditions; Child Health Conditions and risks; or conditions of high prevalence, high disease burden, and high cost relevant to the program's intended population(s). (Refer to Tables 1 and 2 for Medicare High-Impact Conditions and Child Health Conditions determined by the NQF Measure Prioritization Advisory Committee.)

Response option: Strongly Agree / Agree / Disagree / Strongly Disagree:

Program measure set adequately addresses high-impact conditions relevant to the program.

4. Program measure set promotes alignment with specific program attributes, as well as alignment across programs

Demonstrated by a program measure set that is applicable to the intended care setting(s), level(s) of analysis, and population(s) relevant to the program.

Response option for each subcriterion: Strongly Agree / Agree / Disagree / Strongly Disagree

Subcriterion 4.1	Program measure set is applicable to the program's intended care setting(s)
Subcriterion 4.2	Program measure set is applicable to the program's intended level(s) of analysis
Subcriterion 4.3	Program measure set is applicable to the program's population(s)

5. 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, and structural measures necessary for the specific program attributes.

Response option for each subcriterion: Strongly Agree / Agree / Disagree / Strongly Disagree

Subcriterion 5.1	Outcome measures are adequately represented in the program measure set
Subcriterion 5.2	Process measures are adequately represented in the program measure set
Subcriterion 5.3	Experience of care measures are adequately represented in the program measure set (e.g., patient, family, caregiver)
Subcriterion 5.4	Cost/resource use/appropriateness measures are adequately represented in the program measure set
Subcriterion 5.5	Structural measures and measures of access are represented in the program measure set when appropriate

6. Program measure set enables measurement across the person-centered episode of care[1]

Demonstrated by assessment of the person's trajectory across providers, settings, and time.

Response option for each subcriterion: Strongly Agree / Agree / Disagree / Strongly Disagree

Subcriterion 6.1	Measures within the program measure set are applicable across relevant providers
Subcriterion 6.2	Measures within the program measure set are applicable across relevant settings
Subcriterion 6.3	Program measure set adequately measures patient care across time

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[1] National Quality Forum (NQF), *Measurement Framework: Evaluating Efficiency Across Patient-Focused Episodes of Care,* Washington, DC: NQF; 2010.

7. Program measure set includes considerations for healthcare disparities[2]

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, age disparities, 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).

Response option for each subcriterion: Strongly Agree / Agree / Disagree / Strongly Disagree

Subcriterion 7.1	Program measure set includes measures that directly assess healthcare disparities (e.g., interpreter services)
Subcriterion 7.2	Program measure set includes measures that are sensitive to disparities measurement (e.g., beta blocker treatment after a heart attack)

8. Program measure set promotes parsimony

Demonstrated by a program measure set that supports efficient (i.e., minimum number of measures and the least effort) use of resources for data collection and reporting and supports multiple programs and measurement applications. The program measure set should balance the degree of effort associated with measurement and its opportunity to improve quality.

Response option for each subcriterion: Strongly Agree / Agree / Disagree / Strongly Disagree

Subcriterion 8.1	Program measure set demonstrates efficiency (i.e., minimum number of measures and the least burdensome)
Subcriterion 8.2	Program measure set can be used across multiple programs or applications (e.g., Meaningful Use, Physician Quality Reporting System [PQRS])

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[2] NQF, *Healthcare Disparities Measurement*, Washington, DC: NQF; 2011.

Table 1: National Quality Strategy Priorities

1. Making care safer by reducing harm caused in the delivery of care.
2. Ensuring that each person and family is engaged as partners in their care.
3. Promoting effective communication and coordination of care.
4. Promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease.
5. Working with communities to promote wide use of best practices to enable healthy living.
6. Making quality care more affordable for individuals, families, employers, and governments by developing and spreading new healthcare delivery models.

Table 2: High-Impact Conditions

Medicare Conditions
1. Major Depression
2. Congestive Heart Failure
3. Ischemic Heart Disease
4. Diabetes
5. Stroke/Transient Ischemic Attack
6. Alzheimer’s Disease
7. Breast Cancer
8. Chronic Obstructive Pulmonary Disease
9. Acute Myocardial Infarction
10. Colorectal Cancer
11. Hip/Pelvic Fracture
12. Chronic Renal Disease
13. Prostate Cancer
14. Rheumatoid Arthritis/Osteoarthritis
15. Atrial Fibrillation
16. Lung Cancer
17. Cataract
18. Osteoporosis
19. Glaucoma
20. Endometrial Cancer

Child Health Conditions and Risks
1. Tobacco Use
2. Overweight/Obese (≥85th percentile BMI for age)
3. Risk of Developmental Delays or Behavioral Problems
4. Oral Health
5. Diabetes
6. Asthma
7. Depression
8. Behavior or Conduct Problems
9. Chronic Ear Infections (3 or more in the past year)
10. Autism, Asperger’s, PDD, ASD
11. Developmental Delay (diag.)
12. Environmental Allergies (hay fever, respiratory or skin allergies)
13. Learning Disability
14. Anxiety Problems
15. ADD/ADHD
16. Vision Problems Not Corrected by Glasses
17. Bone, Joint, or Muscle Problems
18. Migraine Headaches
19. Food or Digestive Allergy
20. Hearing Problems
21. Stuttering, Stammering, or Other Speech Problems
22. Brain Injury or Concussion
23. Epilepsy or Seizure Disorder
24. Tourette Syndrome

MAP MEASURE SELECTION CRITERIA INTERPRETIVE GUIDE

Instructions for applying the measure selection criteria:

The measure selection criteria are designed to assist MAP Coordinating Committee and workgroup members in assessing measure sets used in payment and public reporting programs. The criteria have been developed with feedback from the MAP Coordinating Committee, workgroups, and public comment. The criteria are intended to facilitate a structured thought process that results in generating discussion. A rating scale of *Strongly Agree, Agree, Disagree, Strongly Disagree* is offered for each criterion or sub-criterion. An open text box is included in the response tool to capture reflections on the rationale for ratings.

The eight criteria areas are designed to assist in determining whether a measure set is aligned with its intended use and whether the set best reflects "quality" health and healthcare. The term "measure set" can refer to a collection of measures—for a program, condition, procedure, topic, or population. For the purposes of MAP moving forward, we will qualify all uses of the term measure set to refer to either a "program measure set," a "core measure set" for a setting, or a "condition measure set." The following eight criteria apply to the evaluation of program measure sets; a subset of the criteria apply to condition measure sets.

FOR CRITERION 1—NQF ENDORSEMENT:

The optimal option is for all measures in the program measure set to be NQF endorsed or ready for NQF expedited review. The endorsement process evaluates individual measures against four main criteria:

1. **Importance to measure and report**—how well the measure addresses a specific national health goal/priority, addresses an area where a performance gap exists, and demonstrates evidence to support the measure focus.
2. **Scientific acceptability of the measurement properties**—evaluates the extent to which each measure produces consistent (reliable) and credible (valid) results about the quality of care.
3. **Usability-** the extent to which intended audiences (e.g., consumers, purchasers, providers, and policymakers) can understand the results of the measure and are likely to find the measure results useful for decision-making.
4. **Feasibility**—the extent to which the required data are readily available, retrievable without undue burden, and can be implemented for performance measures.

To be recommended by MAP, a measure that is not NQF endorsed must meet the following requirements, so that it can be submitted for expedited review:

- the extent to which the measure(s) under consideration has been sufficiently tested and/or in widespread use.
- whether the scope of the project/measure set is relatively narrow.
- time-sensitive legislative/regulatory mandate for the measure(s).
- Measures that are NQF endorsed are broadly available for quality improvement and public accountability

programs. In some instances, there may be evidence that implementation challenges and/or unintended negative consequences of measurement to individuals or populations may outweigh benefits associated with the use of the performance measure. Additional consideration and discussion by the MAP workgroup or Coordinating Committee may be appropriate prior to selection. To raise concerns on particular measures, please make a note in the included text box under this criterion.

FOR CRITERION 2—PROGRAM MEASURE SET ADDRESSES THE NATIONAL QUALITY STRATEGY PRIORITIES

The program's set of measures is expected to adequately address each of the NQS priorities as described in criterion 2.1-2.6. The definition of "adequate" rests on the expert judgment of the Coordinating Committee or workgroup member using the selection criteria. This assessment should consider the current landscape of NQF-endorsed measures available for selection within each of the priority areas.

FOR CRITERION 3—PROGRAM MEASURE SET ADDRESSES HIGH-IMPACT CONDITIONS

When evaluating the program measure set, measures that adequately capture information on high-impact conditions should be included based on their relevance to the program's intended population. High-priority Medicare and Child Health Conditions have been determined by NQF's Measure Prioritization Advisory Committee and are included to provide guidance. For programs intended to address high-impact conditions for populations other than Medicare beneficiaries and children (e.g., adult non-Medicare and dual eligible beneficiaries), high-impact conditions can be demonstrated by their high prevalence, high disease burden, and high costs relevant to the program. Examples of other ongoing efforts may include research or literature on the adult Medicaid population or other common populations. The definition of "adequate" rests on the expert judgment of the Coordinating Committee or workgroup member using the selection criteria.

FOR CRITERION 4—PROGRAM MEASURE SET PROMOTES ALIGNMENT WITH SPECIFIC PROGRAM ATTRIBUTES, AS WELL AS ALIGNMENT ACROSS PROGRAMS

The program measure sets should align with the attributes of the specific program for which they intend to be used. Background material on the program being evaluated and its intended purpose are provided to help with applying the criteria. This should assist with making discernments about the intended care setting(s), level(s) of analysis, and population(s). While the program measure set should address the unique aims of a given program, the overall goal is to harmonize measurement across programs, settings, and between the public and private sectors.

- **Care settings include:** Ambulatory Care, Ambulatory Surgery Center, Clinician Office, Clinic/Urgent Care, Behavioral Health/Psychiatric, Dialysis Facility, Emergency Medical Services—Ambulance, Home Health, Hospice, Hospital- Acute Care Facility, Imaging Facility, Laboratory, Pharmacy, Post-Acute/Long Term Care, Facility, Nursing Home/Skilled Nursing Facility, Rehabilitation.

- **Level of analysis includes:** Clinicians/Individual, Group/Practice, Team, Facility, Health Plan, Integrated Delivery System.

- **Populations include:** Community, County/City, National, Regional, or States.

- Population includes: Adult/Elderly Care, Children's Health, Disparities Sensitive, Maternal Care, and Special Healthcare Needs.

FOR CRITERION 5—PROGRAM MEASURE SET INCLUDES AN APPROPRIATE MIX OF MEASURE TYPES

The program measure set should be evaluated for an appropriate mix of measure types. The definition of "appropriate" rests on the expert judgment of the Coordinating Committee or workgroup member using the selection criteria. The evaluated measure types include:

1. **Outcome measures**—Clinical outcome measures reflect the actual results of care.[3] Patient-reported measures assess outcomes and effectiveness of care as experienced by patients and their families. Patient reported measures include measures of patients' understanding of treatment options and care plans, and their feedback on whether care made a difference.[4]
2. **Process measures—**Process denotes what is actually done in giving and receiving care. [5] NQF endorsement seeks to ensure that process measures have a systematic assessment of the quantity, quality, and consistency of the body of evidence that the measure focus leads to the desired health outcome.[6]

3 **Experience of care measures**—Defined as patients' perspective on their care.[7]

4. **Cost/resource use/appropriateness measures**—

a. Cost measures—Total cost of care.

b. Resource use measures—Resource use measures are defined as broadly applicable and comparable measures of health services counts (in terms of units or dollars) that are applied to a population or event (broadly defined to include diagnoses, procedures, or encounters).[8]

c. Appropriateness measures—Measures that examine the significant clinical, systems, and care coordination aspects involved in the efficient delivery of high-quality services and thereby effectively improve the care of patients and reduce excessive healthcare costs.[9]

5 **Structure measures**—Reflect the conditions in which providers care for patients.[10] This includes the attributes of material resources (such as facilities, equipment, and money), of human resources (such as the number and qualifications of personnel), and of organizational structure.

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[3] NQF, 2011, The right tools for the job. Available at http://www.qualityforum.org/Measuring_Performance/ABCs/The_Right_Tools_for_the_Job.aspx.

[4] Consumer-Purchases Disclosure Project, 2011. Ten Criteria for Meaningful and Usable Measures of Performance

[5] Donabedian, A., The quality of care, *JAMA*, 1998; 260: 1743-1748.

[6] NQF, 2011, Consensus development process. Available at http://www.qualityforum.org/Measuring_Performance/Consensus_Development_Process.aspx.

[5] NQF, 2011, The right tools for the job. Available at http://www.qualityforum.org/Measuring_Performance/ABCs/The_Right_Tools_for_the_Job.aspx.

[6] NQF, 2009, National voluntary consensus standards for outpatient imaging efficiency. Available at http://www.qualityforum.org/Publications/2009/08/National_Voluntary_Consensus_Standards_for_Outpatient_Imaging_Efficiency__A_Consensus_Report.aspx

[7] NQF, 2011, The right tools for the job. Available at http://www.qualityforum.org/Measuring_Performance/ABCs/The_Right_Tools_for_the_Job.aspx.

[8] NQF, 2011, The right tools for the job. Available at http://www.qualityforum.org/Measuring_Performance/ABCs/The_Right_Tools_for_the_Job.aspx.

Appendix E: Guiding Principles

In considering how to achieve the desired vision, MAP established guiding principles for the approach to measurement. Measurement programs can be designed for many purposes, and at many levels of accountability and analysis. Individual measures are also generally designed for specific uses. Defining a purpose, goals, data platform, and levels of analysis for a measurement initiative are precursors to the selection and application of specific measures within a program. Individual measures must be chosen with the program goals and capabilities in mind. This concept of fit-for-purpose is so fundamental that MAP was limited in its ability to fully define federal and state-level measure sets for dual eligible beneficiaries. To do so, MAP would require detailed information about the aspects of the measurement programs that are still in the process of being established. Despite these constraints, MAP's Measure Selection Criteria (Appendix D), and the guiding principles below can assist in evaluating the appropriateness of potential measures to meet the goals of any initiative.

The guiding principles regarding measurement in the dual eligible beneficiary population fall into three general categories: desired effects of measurement, measurement design, and data platform principles.

Desired Effects of Measurement:

Promoting Integrated Care: Measurement has the ability to drive clinical practice and provision of community supports toward desired models of integrated, collaborative, and coordinated care. Improving the health of dual eligible beneficiaries will require wide-scale cooperation, systematic communication, and shared accountability.

Ensuring Cultural Competence: The measurement approach also should promote culturally competent care that is responsive to dimensions of race, ethnicity, age, functional status, language, level of health literacy, environmental factors, and accessibility of the environment for people with different types of disability.

Health Equity: Stratifying measures by such factors as race, ethnicity, or socio-economic status allows for identification of potential healthcare disparities and related opportunities to address them. Moreover, it is important to measure the experiences of dual eligible beneficiaries year-over-year and in contrast to Medicare-only and Medicaid-only beneficiaries in order to assess any differences in program access.

Measurement Design:

Assessing Outcomes Relative to Goals: The measurement approach should evaluate person-level outcomes relative to goals that are defined in the process of developing a person- and family-centered plan of care. Such goals might include maintaining or improving function, longevity, palliative care, or a combination of factors. It also is vital to include outcome measures related to the individual's or family's assessment of the care and supports received.

Parsimony: To minimize the resources required to conduct performance measurement and reporting, a core measure set should be parsimonious. The set should include the smallest possible number of measures to achieve the intended purpose of the measurement program.

Cross-Cutting Measures: The heterogeneity of the dual-eligible population complicates efforts to select a small number of measures that would accurately reflect their care experience. Thus, a parsimonious measure set should rely primarily on cross-cutting measures and use condition-specific measures only to the extent they address critical issues for high-need subpopulations.

Inclusivity: The measurement strategy should span the continuum of care and include both Medicare and Medicaid services. It should include measures that are broadly applicable across age groups, disease groups, or other cohorts, as opposed to measures with narrowly defined denominator populations.

Avoiding Undesirable Consequences: The methodology should anticipate and mitigate potential undesirable consequences of measurement. This might include overuse or underuse of services as well as adverse selection. For example, the measurement approach could use strategies such as stratification or risk adjustment to account for the increased difficulty of caring for complex patients and to ensure that such individuals would have access to providers willing to treat them.

Data Platform Principles:

Data Sharing: The measurement strategy should encourage dynamic data exchange and shared accountability. Interoperable health records that enable portability of information across providers can assist greatly in delivering timely, appropriate services that are aligned with a shared plan of care.

Using Data Dynamically: A robust data exchange platform also would assist providers in gathering information from the individual receiving care or his or her caregivers, and circulating feedback, as appropriate, to improve quality. Tracking data over time also enables longitudinal measurement and tracking “delta measures” of change in outcomes of interest.

Making the Best Use of Available Data: While our nation’s health IT infrastructure develops, the measurement strategy must make the best use of all available data sources, including administrative claims, registries, and community-level information.

Appendix F

MAP Dual Eligible Beneficiaries Workgroup
Revised Core Set of Measures

NQF Measure # and Status	Measure Name	Measure Description	Potential Modifications	NQS Prioirity	High-Leverage Opportunities
0004 Endorsed (eMeasure specification available)	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: (a) Initiation, (b) Engagement	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.	Separate Identification, Initiation, Engagement	Effective Communication and Care Coordination, Health and Well-Being	Care Coordination, Mental Health and Substance Use
Not Endorsed	Alcohol Misuse: Screening, Brief Intervention, Referral for Treatment	a. Patients screened annually for alcohol misuse with the 3-item AUDIT-C with item-wise recording of item responses, total score and positive or negative result of the AUDIT-C in the medical record. B. Patients who screen for alcohol misuse with AUDIT-C who meet or exceed a threshold score who have brief alcohol counseling documented in the medical record within 14 days of the positive screening.	Beyond just a single condition/setting	Effective Communication and Care Coordination, Health and Well-Being	Screening & Assessment, Mental Health and Substance Use
Multiple Numbers Endorsed	CAHPS Surveys	Many versions of CAHPS patient experience surveys have been endorsed for use across the health system. Surveys are available for: • Health Plan • Clinician & Group • Experience of Care and Health Outcomes (ECHO) for Behavioral Health • Home Health Care • Hospital • In-Center Hemodialysis • Nursing Home • Supplemental Item Sets, topics including: o People with Mobility Impairments o Cultural Competence o Health IT o Health Literacy o Patient-Centered Medical Home		Person- and Family-Centered Care	N/A
0028 Endorsed (eMeasure specification available)	Measure pair: a. Tobacco Use Assessment, b. Tobacco Cessation Intervention	Percentage of patients who were queried about tobacco use one or more times during the two-year measurement period Percentage of patients identified as tobacco users who received cessation intervention during the two-year measurement period		Prevention and Treatment of Leading Causes of Mortality, Health and Well-Being	Screening & Assessment, Mental Health and Substance Use
0101 Endorsed	Falls: Screening for 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	• Suggested that obesity be considered a fall risk • Suggested that the measure be expanded to include anyone at risk for a fall, not just individuals older than 65 • Suggested that patients could report if they received counseling on falls rather than relying on claims data	Patient Safety, Health and Well-Being	Screening & Assessment
0208 Endorsed	Family Evaluation of Hospice Care	The survey measures family members perception of the quality of hospice care for the entire enrollment period, regardless of length of service.	Expand beyond just hospice care	Person- and Family-Centered Care	Quality of Life

NQF Measure # and Status	Measure Name	Data Source	Measure Type	Setting	Level of Analysis	Measure Steward	Current Programs
0004 Endorsed (eMeasure specification available)	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: (a) Initiation, (b) Engagement	Administrative Claims, Electronic Health Record, Paper Records	Process	Ambulatory Care, Hospital/Acute Care Facility	Clinician, Health Plan, Integrated Delivery System, Clinician, Population	NCQA	Finalized for use in PQRS, Meaningful Use, Value Modifier, Medicaid Adult Core Measures
Not Endorsed	Alcohol Misuse: Screening, Brief Intervention, Referral for Treatment		Process			VHA	None.
Multiple Numbers Endorsed	CAHPS Surveys	Patient Reported Survey	Patient Engagement/ Experience	Ambulatory Care	Clinician, Facility, Health Plan, Integrated Delivery System, Population	AHRQ	Finalized for use in Medicare Shared Savings Program
0028 Endorsed (eMeasure specification available)	Measure pair: a. Tobacco Use Assessment, b. Tobacco Cessation Intervention	Administrative Claims	Process	Ambulatory Care	Clinician	AMA-PCPI	Finalized for use in PQRS, Meaningful Use, Medicare Shared Savings Program, and Value Modifier
0101 Endorsed	Falls: Screening for Fall Risk	Administrative Claims, Other Electronic Clinical Data	Process	Ambulatory Care, Home Health, Hospice, PAC/LTC Facility	Clinician	NCQA	Finalized for use in PQRS, Medicare Shared Savings Program, and Value Modifier Under consinderation for MU **(MAP Supported)**
0208 Endorsed	Family Evaluation of Hospice Care	Patient Reported Survey	Composite	Hospice	Facility, Population	National Hospice and Palliative Care Org.	Under consideration for Hospice Quality Reporting **(MAP Supported)**

NQF Measure # and Status	Measure Name	Measure Description	Potential Modifications	NQS Prioirity	High-Leverage Opportunities
0209 Endorsed	Comfortable Dying	Percentage of patients who were uncomfortable because of pain on admission to hospice whose pain was brought under control within 48 hours	• Give consideration to operationalizing this measure as pain assessment across settings, at a minimum could be applied more broadly to other types of palliative care	Effective Communication and Care Coordination, Person- and Family-Centered Care	Quality of Life
0228 Endorsed	3-Item Care Transition Measure (CTM-3)	Uni-dimensional self-reported survey that measure the quality of preparation for care transitions.	• Broaden to additional settings beyond inpatient, such as ER and nursing facility discharges	Effective Communication and Care Coordination, Person- and Family-Centered Care	Care Coordination
0260 Endorsed	Assessment of Health-related Quality of Life (Physical & Mental Functioning)	Percentage of dialysis patients who receive a quality of life assessment using the KDQOL-36 (36-question survey that assesses patients' functioning and well-being) at least once per year.	• Suggested expansion beyond ESRD setting to include other types of care • Construction of this concept as a process measure is not ideal	Person- and Family-Centered Care	Quality of Life
1768 In Process	Plan all-cause readmissions	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.		Patient Safety, Effective Communication and Care Coordination	Care Coordination
1789 In Process	Hospital-Wide All-Cause Unplanned Readmission Measure (HWR)	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.		Patient Safety, Effective Communication and Care Coordination	Care Coordination

NQF Measure # and Status	Measure Name	Data Source	Measure Type	Setting	Level of Analysis	Measure Steward	Current Programs
0209 Endorsed	Comfortable Dying	Patient Reported Survey	Outcome	Hospice	Facility, Population	National Hospice and Palliative Care Org.	Finalized for use in Hospice Quality Reporting
0228 Endorsed	3-Item Care Transition Measure (CTM-3)	Patient Reported Survey	Patient Engagement/Experience	Hospital	Facility	University of Colorado Health Sciences Center	Under consideration for Hospital Inpatient Reporting **(MAP Supported)**
0260 Endorsed	Assessment of Health-related Quality of Life (Physical & Mental Functioning)	Patient Reported Survey	Process	Dialysis Facility	Facility	RAND	**MAP Supported** for ESRD Quality Reporting
1768 In Process	Plan all-cause readmissions	Administrative Claims	Outcome	Hospital, Behavioral Health/ Psychiatric (Inpatient)	Health Plan	NCQA	None.
1789 In Process	Hospital-Wide All-Cause Unplanned Readmission Measure (HWR)	Administrative Claims	Outcome	Hospital	Facility	CMS, Yale	Under consideration for Inpatient Quality Reporting **(MAP Supported)**

NQF Measure # and Status	Measure Name	Measure Description	Potential Modifications	NQS Prioirity	High-Leverage Opportunities
0418 Endorsed	Screening for Clinical Depression and Follow-up Plan	Percentage of patients aged 18 years and older screened for clinical depression using a standardized tool AND follow-up documented		Health and Well-Being	Screening & Assessment, Mental Health and Substance Use
0421 Endorsed (eMeasure specification available)	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-up	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 Normal Parameters: Age 65 and older BMI ≥23 and <30; Age 18 – 64 BMI ≥18.5 and <25		Health and Well-Being	Screening & Assessment
0490 Endorsed	The Ability to use Health Information Technology to Perform Care Management at the Point of Care	Documents the extent to which a provider uses a certified/qualified electronic health record (EHR) system capable of enhancing care management at the point of care. To qualify, the facility must have implemented processes within their EHR for disease management that incorporate the principles of care management at the point of care which include: a. The ability to identify specific patients by diagnosis or medication use b. The capacity to present alerts to the clinician for disease management, preventive services and wellness c. The ability to provide support for standard care plans, practice guidelines, and protocol	• Could also capture this concept as a % of providers achieving Meaningful Use incentives.	N/A	Care Coordination, Structural
0494 Endorsed	Medical Home System Survey	Percentage of practices functioning as a patient-centered medical home by providing ongoing, coordinated patient care. Meeting Medical Home System Survey standards demonstrates that practices have physician-led teams that provide patients with: a. Improved access and communication b. Care management using evidence-based guidelines c. Patient tracking and registry functions d. Support for patient self-management e. Test and referral tracking f. Practice performance and improvement functions	• A health home's approach to care management must be designed for duals and consider both Medicaid and Medicare benefits • Care management might be appropriately conducted by other parties besides primary care physician (e.g., family member, clinical specialist) • Consider broader application in shared accountability models such as ACOs and health homes	Effective Communication and Care Coordination, Person- and Family-Centered Care	Care Coordination, Structural
0523 Endorsed	Pain Assessment Conducted	Percent of patients who were assessed for pain, using a standardized pain assessment tool, at start/resumption of home health care	Expand beyond just home health care	Effective Communication and Care Coordination	Quality of Life, Screening & Assessment
0557 Endorsed	HBIPS-6 Post discharge continuing care plan created	Patients discharged from a hospital-based inpatient psychiatric setting with a continuing care plan created 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-7: Post discharge continuing care plan transmitted to next level of care provider upon discharge.	• Suggested expansion to all discharges, not just psychiatric. At a minimum, the measure should include inpatient detox.	Effective Communication and Care Coordination	Care Coordination, Mental Health and Substance Use

NQF Measure # and Status	Measure Name	Data Source	Measure Type	Setting	Level of Analysis	Measure Steward	Current Programs
0418 Endorsed	Screening for Clinical Depression and Follow-up Plan	Administrative Claims	Process	Ambulatory Care, Hospital, PAC/LTC Facility	Clinician	CMS/QIP	Finalized for use in PQRS, Medicare Shared Savings Program, Medicaid Adult Core Under consideration for Meaningful Use **(MAP Supported)**
0421 Endorsed (eMeasure specification available)	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-up	Administrative Claims, Other Electronic Clinical Data	Process	Ambulatory Care	Clinician, Population	CMS/QIP	Finalized for use in PQRS, Meaningful Use, Medicare Shared Savings Program, and Value Modifier
0490 Endorsed	The Ability to use Health Information Technology to Perform Care Management at the Point of Care	Administrative Claims, Electronic Health Record	Structure	Ambulatory Care	Clinician	CMS	None.
0494 Endorsed	Medical Home System Survey	Provider Survey, patient reported Survey, Other Electronic Clinical Data, Electronic Health Record, Paper Records	Structure	Ambulatory Care	Facility, Clinician	NCQA	None.
0523 Endorsed	Pain Assessment Conducted	Other Electronic Clinical Data	Process	Home Health	Facility	CMS	Finalized for use in Home Health
0557 Endorsed	HBIPS-6 Post discharge continuing care plan created	Administrative Claims, Paper Records, Other Electronic Clinical Data	Process	Hospital, Behavioral Health/ Psychiatric (Inpatient)	Facility	The Joint Commission	Under consideration for Inpatient Psychiatric Facility Quality Reporting **(MAP Supported)**

NQF Measure # and Status	Measure Name	Measure Description	Potential Modifications	NQS Prioirity	High-Leverage Opportunities
0558 Endorsed	HBIPS-7 Post discharge continuing care plan transmitted to next level of care provider upon discharge	Patients discharged from a hospital-based inpatient psychiatric setting with a continuing care plan provided to the next level of care clinician or entity.	• Suggested expansion to all discharges, not just psychiatric. At a minimum, the measure should include inpatient detox. • Information should be transmitted to both nursing facility and primary care provider, if applicable.	Effective Communication and Care Coordination	Care Coordination, Mental Health and Substance Use
0576 Endorsed	Follow-up after hospitalization for mental illness	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.	• Suggested expansion to incorporate substance use disorders/detox	Effective Communication and Care Coordination	Care Coordination, Mental Health and Substance Use
0647 Endorsed	Transition Record with Specified Elements Received by Discharged Patients (Inpatient Discharges to Home/Self Care or Any Other Site of Care)	Percentage of patients, regardless of age, discharged from an inpatient 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.	Do not limit to certain transition sites/settings	Effective Communication and Care Coordination	Care Coordination
0648 Endorsed	Timely Transmission of Transition Record (Inpatient Discharges to Home/Self Care or Any Other Site of Care)	Percentage of patients, regardless of age, discharged from an inpatient 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	Do not limit to certain transition sites/settings	Effective Communication and Care Coordination	Care Coordination
0729 Endorsed	Optimal Diabetes Care	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.		Effective Communication and Care Coordination, Prevention and Treatment of Leading Causes of Mortality	Screening & Assessment
0097 Endorsed (eMeasure specification available)	Medication Reconciliation	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.		Effective Communication and Care Coordination, Patient Safety	Care Coordination, Screening & Assessment

MAP Dual Eligible Beneficiaries Workgroup
Revised Core Set of Measures

NQF Measure # and Status	Measure Name	Data Source	Measure Type	Setting	Level of Analysis	Measure Steward	Current Programs
0558 Endorsed	HBIPS-7 Post discharge continuing care plan transmitted to next level of care provider upon discharge	Administrative Claims, Paper Records, Other Electronic Clinical Data	Process	Hospital, Behavioral Health/ Psychiatric (Inpatient)	Facility	The Joint Commission	Under consideration for Inpatient Psychiatric Facility Quality Reporting **(MAP Supported)**
0576 Endorsed	Follow-up after hospitalization for mental illness	Administrative Claims, Electronic Health Record	Process	Ambulatory Care, Behavioral Health/ Psychiatric Outpatient, Inpatient)	Health Plan, Integrated Delivery System, Clinician, Population	NCQA	Finalized for use in Medicaid Adult Core Measures, CHIPRA Core Measures
0647 Endorsed	Transition Record with Specified Elements Received by Discharged Patients (Inpatient Discharges to Home/Self Care or Any Other Site of Care)	Paper Records, Electronic Health Record, Administrative Claims	Process	Hospital, PAC/LTC Facility, Ambulatory Care	Facility, Integrated Delivery System	AMA-PCPI	None.
0648 Endorsed	Timely Transmission of Transition Record (Inpatient Discharges to Home/Self Care or Any Other Site of Care)	Administrative Claims, Paper Records, EHR	Process	Hospital, PAC/LTC Facility, Ambulatory Care	Facility, Integrated Delivery System	AMA-PCPI	Finalized for use in Medicaid Adult Core Measures
0729 Endorsed	Optimal Diabetes Care	Paper Records, Other Electronic Clinical Data, Eleoctronic Health Record	Outcome	Ambulatory Care	Integrated Delivery System, Clinician	MN Community Measure-ment	Components for this composite are finalized for use in Medicare Shared Savings and Value Modifier, Under consideration for PQRS **(MAP Supported)**
0097 Endorsed (eMeasure specification available)	Medication Reconciliation	Administrative Claims, Other Electronic Clinical Data, Paper Records	Process	Ambulatory Care	Clinician, Integrated Delivery System, Population	NCQA	Finalized for use in PQRS, Medicare Shared Savings Program, VBPM and under consideraton for Meaningful Use. **(MAP Supported)**

NQF Measure # and Status	Measure Name	Measure Description	Potential Modifications	NQS Prioirity	High-Leverage Opportunities
0430 Endorsed	Change in Daily Activity Function as Measured by the AM-PAC:	The Activity Measure for Post Acute Care (AM-PAC) is a functional status assessment instrument developed specifically for use in facility and community dwelling post acute care (PAC) patients. A Daily Activity domain has been identified which consists of functional tasks that cover in the following areas: feeding, meal preparation, hygiene, grooming, and dressing.	• Broaden beyond post-acute care • Include maintenance of functional status if this is all that can be realistically expected • Address floor effects observed when tool is applied to frail/complex patients • Incorporate community services in supporting post-acute recovery	N/A	Quality of Life
Not Endorsed	SNP 6: Coordination of Medicare and Medicaid coverage.	Intent: The organization helps members obtain services they are eligible to receive regardless of payer, by coordinating Medicare and Medicaid coverage. This is necessary because the two programs have different rules and benefit structures and can be confusing for both members and providers.		Effective Communication and Care Coordination	Structural

NQF Measure # and Status	Measure Name	Data Source	Measure Type	Setting	Level of Analysis	Measure Steward	Current Programs
0430 Endorsed	Change in Daily Activity Function as Measured by the AM-PAC:	Electronic Health Record	Outcome	Ambulatory Care, Home Health, Hospital, PAC/LTC Facility	Facility, Clinician	CREcare	None.
Not Endorsed	SNP 6: Coordination of Medicare and Medicaid coverage.	(not available)	Structure		Health Plan	NCQA	None.

MAP Dual Eligible Beneficiaries Workgroup
Selected Measures for HCBS

Framework	Domain	Sub-domain	Measure	Source	Notes	High-Leverage Opportunities
HCBS Scan (AHRQ, Thomson Reuters)	*Client Functioning*	Change in daily activitiy function	Degree to which consumers experience an increased level of functioning	Commission on Accreditation of Rehabilitation Facilities	Tested with multiple disabilities populations	Quality of Life, Screening/ Assessment
HCBS Scan (AHRQ, Thomson Reuters)	*Client Functioning*	Availability of support with everyday activities when needed	Unmet need in ADLs/IADLs (11 measures total)	Participant Experience Survey	Item present in all three versions (elderly/disabled, mental retardation/developmental disabilities, and acquired brain injury); additional money management item in brain injury tool.	Quality of Life, Structural
HCBS Scan (AHRQ, Thomson Reuters)	*Client Functioning*	Presence of friendships	Degree to which people express satisfaction with relationships	Commission on Accreditation of Rehabilitation Facilities	Tested with multiple disabilities populations	Quality of Life
HCBS Scan (AHRQ, Thomson Reuters)	*Client Functioning*	Presence of friendships	Satisfaction with close friends	Quality of Life Scale (modified by Burkhardt)	Developed and tested with populations with chronic illness	Quality of Life
HCBS Scan (AHRQ, Thomson Reuters)	*Client Functioning*	Maintenance of family relationships	Satisfaction with relationships with parents, siblings, and other relatives	Quality of Life Scale (Burkhardt version for chronic illness)	Developed and tested with populations with chronic illness	Quality of Life
HCBS Scan (AHRQ, Thomson Reuters)	*Client Functioning*	Community integration	Participants reporting unmet need for community involvement	Participant Experience Survey	Item supported by all three versions; additional community involvement measures related to specific activities such as shopping present in brain injury and mental retardation/developmental disabilities versions	Quality of Life
HCBS Scan (AHRQ, Thomson Reuters)	*Client Functioning*	Receipt of recommended preventive health care services	Degree to which people with identified physical health problems obtain appropriate services and degree to which health status is maintained and improved	Commission on Accreditation of Rehabilitation Facilities	Tested with multiple disabilities populations	Screening/ Assessment, Structural
HCBS Scan (AHRQ, Thomson Reuters)	*Client Experience*	Respectful treatment by direct service providers	Degree to which consumers report that staff are sensitive to their cultural, ethnic, or linguistic backgrounds and degree to which consumers felt they were respected by staff	Commission on Accreditation of Rehabilitation Facilities	Developed and tested with multiple disability populations	Care Coordination
HCBS Scan (AHRQ, Thomson Reuters)	*Client Experience*	Opportunities to make choices about Services	Degree of active consumer participation in decisions concerning their treatment	Commission on Accreditation of Rehabilitation Facilities	Tested with multiple disability populations	Care Coordination, Structural
HCBS Scan (AHRQ, Thomson Reuters)	*Client Experience*	Satisfaction with case management services	Case manager helpfulness	Participant Experience Survey	Item present in all three survey versions	Care Coordination
HCBS Scan (AHRQ, Thomson Reuters)	*Client Experience*	Client perception of quality of care	Degree to which consumers were satisfied with overall services	Commission on Accreditation of Rehabilitation Facilities	Developed and tested with multiple disability populations	Quality of Life
HCBS Scan (AHRQ, Thomson Reuters)	*Client Experience*	Client perception of quality of care	Service satisfaction scales: home worker; personal care; home-delivered meals	Service Adequacy and Satisfaction Instrument	Developed and tested with service recipients age 60 and older	Quality of Life

AHRQ: http://www.ahrq.gov/research/ltc/hcbsreport/
AARP: http://www.aarp.org/relationships/caregiving/info-09-2011/ltss-scorecard.html
NBIC: http://nationalbalancingindicators.com/

MAP Dual Eligible Beneficiaries Workgroup
Selected Measures for HCBS

Framework	Domain	Sub-domain	Measure	Source	Notes	High-Leverage Opportunities
HCBS Scan (AHRQ, Thomson Reuters)	*Program Performance*	Access to case management services	Ability to identify case manager	Participant Experience Survey	Supported by all three survey versions	Care Coordination, Structural
HCBS Scan (AHRQ, Thomson Reuters)	*Program Performance*	Access to case management services	Ability to contact case manager	Participant Experience Survey	Supported by all three survey versions	Care Coordination, Structural
LTSS Scorecard (AARP)	*Choice of Setting and Provider*	N/A	Tools and programs to facilitate consumer choice (composite indicator, scale 0-4)	AARP conducted a state survey to collect information about states' single entry point systems and various functions that facilitate consumer choice. Data from State LTSS Scorecard Survey (AARP PPI, Scorecard 2010).	States were scored from 0 (no use of tool or program) to 1 (full use of tool or program) in each of four categories: 1. Presumptive eligibility (scoring: 1 point) 2. Uniform assessment (scoring: proportion of Medicaid and state-funded programs that use a uniform assessment tool, with multiple HCBS waivers counting as two programs regardless of the number of waivers) 3. Money Follows the Person and other nursing facility transition programs (scoring: 1/3 point if a program exists, 1/3 point if statewide, 1/3 point if it pays for one-time costs to establish community residence) 4. Options counseling (scoring: whether offered to individuals using each of five types of payment source)	Quality of Life, Structural
LTSS Scorecard (AARP)	*Quality of Life and Quality of Care*	N/A	Percent of adults age 18+ with disabilities in the community usually or always getting needed support	Data from 2009 BRFSS (NCCDPHP, BRFSS 2009)	Percent of adults limited in any way in any activities because of physical, mental, or emotional problems who usually or always received needed social and emotional support.	Structural
LTSS Scorecard (AARP)	*Quality of Life and Quality of Care*	N/A	Percent of adults age 18+ with disabilities in the community satisfied or very satisfied with life	Data from 2009 BRFSS (NCCDPHP, BRFSS 2009)	Percent of adults limited in any way in any activities because of physical, mental, or emotional problems who were satisfied or very satisfied with their life.	Quality of Life, Structural
LTSS Scorecard (AARP)	Support for Family Caregivers	N/A	Percent of caregivers usually or always getting needed support	Institute analysis of 2009 BRFSS (NCCDPHP, BRFSS 2009)	Percent of adults who provided regular care or assistance to a friend or family member during the past month and who usually or always received needed social and emotional support.	Structural
National Balancing Indicators (Abt, IMPAQ)	*Sustainability*	N/A	Proportion of Medicaid HCBS Spending of the Total Medicaid LTC Spending	NBIC using Thomson Reuters	The proportion of Medicaid HCBS spending of the total Medicaid long-term care spending	Structural
National Balancing Indicators (Abt, IMPAQ)	*Self-determination/ Person-centeredness*	N/A	Availabilityof Self-Direction Options	NBIC using CMS Medicaid Waiver Database, and State Self-Assessment	Does the State have one or more Medicaid waivers that offer participant-directed services? If yes, what is the employer status of participant? • Employer authority –Yes/No; Co-employer option, common law employer option • Budget authority –Yes/No; participant exercises decision-making authority and management responsibility; participant afforded flexibility to shift funds; participant authorizes purchase of approved waiver goods and services.	Quality of Life, Structural

AHRQ: http://www.ahrq.gov/research/ltc/hcbsreport/
AARP: http://www.aarp.org/relationships/caregiving/info-09-2011/ltss-scorecard.html
NBIC: http://nationalbalancingindicators.com/

MAP Dual Eligible Beneficiaries Workgroup
Selected Measures for HCBS

Framework	Domain	Sub-domain	Measure	Source	Notes	High-Leverage Opportunities
National Balancing Indicators (Abt, IMPAQ)	Community Integration & Inclusion	N/A	Waiver Waitlist	NBIC using CMS Medicaid Waiver Database, and State Self-Assessment	There is a process for tracking people who are unable to gain access to services (e.g., waiting list management and protocols).	Structural
National Balancing Indicators (Abt, IMPAQ)	Prevention	N/A	Proportion of People with Disabilities Reporting Recent Preventive Health Care Visits(Individual-level)	NBIC calculations using the Centers for Disease Control and Prevention Behavioral Risk Factor Surveillance System (BRFSS) data	The proportion of individuals with disabilities who report having had a preventive health care visit within the past year	Screening/ Assessment
National Balancing Indicators (Abt, IMPAQ)	Coordination & transparency	N/A	Proportion of People Reporting That Service Coordinators Help Them Get What They Need (Individual-level)	NBIC using National Core Indicators (NCI) Data	The proportion of people reporting that service coordinators help them get what they need	Care Coordination, Structural
National Balancing Indicators (Abt, IMPAQ)	Coordination & transparency	N/A	Coordination Between HCBS and Institutional Services	State Self-Assessment	Coordinated Policymaking: The State coordinates budgetary, programmatic, and oversight responsibility for institutional and home and community-based services	Care Coordination

AHRQ: http://www.ahrq.gov/research/ltc/hcbsreport/
AARP: http://www.aarp.org/relationships/caregiving/info-09-2011/ltss-scorecard.html
NBIC: http://nationalbalancingindicators.com/

L&M POLICY RESEARCH

Appendix H

Memorandum

To: National Quality Forum

From: Lisa Green, Ph.D., Julia Doherty, M.H.S.A., and Rachel Dolin

Date: January 27, 2012

Re: Analytic Support for the Measures Application Partnership (MAP), Task 3

As part of its larger contract with Avalere Health, LLC (Avalere), the National Quality Forum (NQF) subcontracted L&M Policy Research, LLC (L&M), to focus on Task 3 of the project, Analytic Support for the Measure Applications Partnership (MAP). In particular, this task focused on identifying quality issues for dually eligible beneficiaries (duals) and related measure analysis across all settings of care through a review of existing measures and discussions with nine groups of key informants.

Methods

The team began the task by reviewing a compendium of more than 150 NQF-endorsed measures that each fell into at least one of the five high-leverage domains the MAP workgroup had previously identified as being of particular importance to duals: quality of life, care coordination, screening and assessment, mental health and substance use, and structural measures. To create a working set of measures limited enough so as to be useful as a starting point for one to one-and-a-half hour discussions with informants, while still representing the scope of available measures, the research team developed a five-step filtering process to reduce the working set of measures. In general, the project team chose measures that fell into the areas of care delivery it deemed most relevant to duals (i.e. discharges and follow-ups, transitions, medication management/reconciliation, end-of-life planning, etc.) and, within each of those groups, identified measures that best represented coordinated and comprehensive care. For example, the team chose a measure that included identification of a condition, documentation, management, and follow-up rather than one that just measured the frequency for which providers screened for a condition.

Following review of the initial measure cull with NQF, the team solicited the expertise of key informants to further delve into the existing as well as ideal or potential measures. In doing so, the team presented each interviewee with a table of the measures identified through the filtering process and used a protocol with open-ended questions to gauge the informant's insights about the areas most relevant to capture when measuring the quality of care delivered to duals, as well as the strengths and weaknesses of the currently available measures. As directed and specified by NQF, the project team conducted up to nine interactions with key informants representing a range of perspectives during December and January. Table 1 below lists interviewees, their organizations, and the perspective they offered. The team spoke with a range of interviewees representing different backgrounds so as to acquire a more robust picture of current gaps and barriers in measurement as well as areas that should be emphasized the most when dealing with duals.

Table 1: Expert discussions

Organization	Individuals	Perspective
Health Management Associates	Jack Meyer	Access issues for special needs populations
State of Minnesota	Pam Parker, Jeff Schiff, Scott Leitz	State concerns
Senior Whole Health/SNP	John Charde, M.D.	Medical director, SNP, NY
National PACE Association	Adam Burrows, M.D., Maureen Amos	Medical director and VP of quality and performance
NCQA	Sarah Scholle, Jennifer French	Measurement expertise
State of North Carolina	Denise Levis and Co.	State concerns
CMS	Cheryl Powell and Co.	Federal policy priorities
Kaiser Family Foundation	MaryBeth Musumeci, Barbara Lyons	Data expertise
NASHP	Neva Kaye, Diane Justice	State health policy expertise

General findings

Interviewees across the board emphasized that, when caring for this highly vulnerable population with complex needs, ongoing person-centered care that focuses resources on those most in need is the paramount goal. And when creating a compendium of measures best suited to gauge the quality of care delivered to duals, the compendium must be structured with this in mind. More specifically, interviewees said, it must measure: 1.) the extent that "high-touch" person-centered care planning and management occurs when needed and 2.) the extent to which the processes and structures in place support this as an on-going activity. Using person-centered health and well-being as the focal point of measures relevant to duals, interviewees generally expressed the importance of seven key measures areas vital to creating a robust set of measures for duals:

- **Consumer-based assessment of goal-oriented planning and care delivery –** Patient/caregiver/family perception of extent to which care plan (if needed) and care delivered reflect goals and desires of the individual and/or care plan[1]

- **Management and monitoring of specific conditions and disabilities –** Provider and patient active awareness of and engagement with signs and symptoms related to conditions (and clusters of them) to achieve individual's care plan goals

- **Medication management/reconciliation across settings –** Shared management of medications among provider and patient/caregiver focusing on goals of care plan to optimize appropriate use of medication and minimize negative drug interactions

- **Transition management –** Interactions that occur within and across settings among providers with patients and their families to ensure individuals receive comprehensive and streamlined care without duplication

- **Integration and coordination of community social supports and health delivery –** Ability to identify need for and ultimately integrate community social supports into care plan based on individual/caregiver needs

- **Utilization benchmarking –** Gauge the extent of service use among duals and their subpopulations across settings

- **Process improvement across settings –** Ensure quality improvement programs are in place within and across settings and organizations that serve duals and their subpopulations

It is important to note that while not all of these focus areas speak directly to quality, the interviewees emphasized the importance of considering some indirect indicators of the status of services delivered to duals in order to highlight the importance of focusing on the improvement of service delivery across the continuum for this very vulnerable population. Taken together, such areas represent a more robust and interconnected picture of the desired delivery system that will encourage "systemness", ongoing monitoring and feedback, with an on-going focus on individuals' goals recognized by a team of primary service providers.

Still, all seven areas fit within the five-high leverage areas the MAP developed as a framework to assess measures of particular importance to duals, as shown in Figure 1 below.

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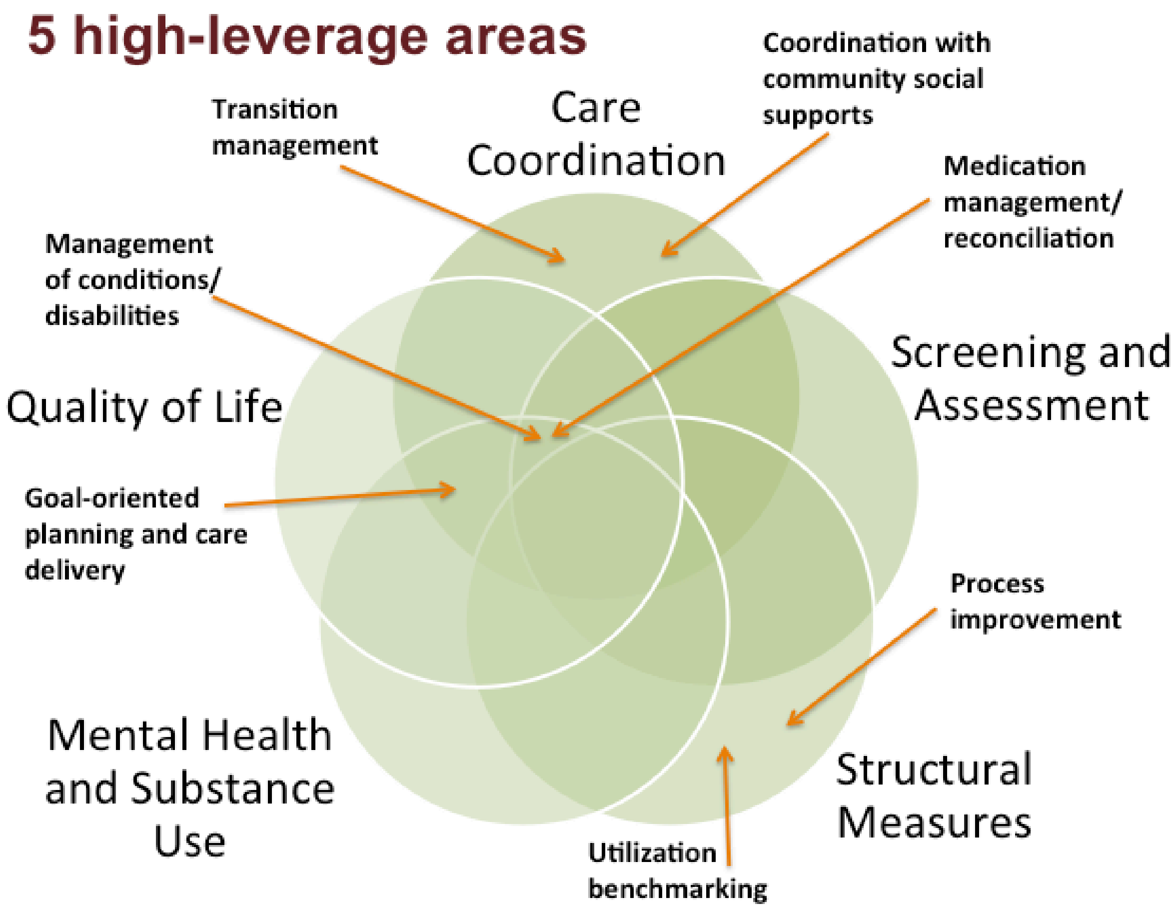
[1] Multiple interviewees emphasized the importance of not "over-medicalizing" this assessment process for duals, given their many non-medical priorities.

Figure 1: Relationship between five high-leverage areas and key measure areas



To capture all aspects of care delivery, it is important to recognize the focus of measures by dividing them into national-, state-, and provider-level areas. This can help to clarify which aspects of care delivery are the responsibility of any given involved entity to capture and monitor on an on-going basis. Interviewees emphasized that a particular measure captured at the state level could look drastically different from a measure captured at the regional level or even the county or provider level, each telling a different story about the nature of care delivery.

To get a sense of how the existing measures (NQF-endorsed and others from the AHRQ Clearinghouse) fit into the measure areas informants highlighted, the research team created Table 2 below. For each of the seven measure areas, the team chose a combination of measures most reflective of findings from discussions with key informants and pointed out their limitations for future application, therein suggesting areas that require further evolution in quality measurement. Although the team included non-NQF-endorsed measures in the table, it, first, reviewed and used NQF measures pulled from the initial filtering process and, second, pulled additional measures as needed to round out the picture of currently available measures that fit within each of the seven measure areas.

In general, the major shortcoming of the existing group of measures was the lack of cross-setting, cross-organization applicability and the general clinical orientation of the measures. While certain measures gauge key components of health care delivery, they would often benefit from an expansion to cover multiple settings (including behavioral health as well as non-medical social supports), or more than one patient condition, to truly work toward measuring the extent of person-centered care delivered to this population. Furthermore, interviewees emphasized that this population is not homogenous – at the very least there are three distinct groups (the frail elderly and the younger disabled, and those with behavioral or substance abuse issues driving the bulk of their needs) – and some measures must be considered differently from one subpopulation to another. The ultimate compendium of measures must reflect this reality to truly gauge person-centered care, in which, for example, the goal of a frail elderly individual may not be to avoid falls but, rather, to achieve the best quality of life possible, therein staying mobile (and possibly enduring falls). Thus, the measures and associated targets need to take into account the individual's goals, level of functionality, and level of cognition, which vary significantly depending on the individual's personal circumstances.

Limitations

Table 2 does not represent an exhaustive list of measures that must be applied to duals but, rather, detailed examples of selected existing measures related to the seven areas interviewees identified as key to gauging the extent of person-centered care delivery as well as the limitations and gaps that currently exist. Measures related to a specific condition/disability are meant to illustrate the limits of a single-condition measure and are not meant to suggest that one condition is more important to monitor than another. For this exercise, the research team chose measures reflective of the conversations with interviewees, which included focus on mental health conditions, substance use issues, and diabetes. Ideally, however, rather than backing into a measure set by measuring a number of individual more readily and easy-to-capture areas, the process of developing a measure set would begin with the availability and use of primary care providers (PCPs) within some form of a "medical home" and span outward – toward screening and evaluation to determine those most in need of a care plan, the subsequent use of a care plan for those individuals, and, ultimately, improved outcomes in relation to the individuals goals as identified through assessment and screening and outlined in the care plan when needed. Of course these measures would ideally cover all settings and the full continuum of care provided to duals. This approach would recognize the importance of duals having an identified primary service provider who is acknowledged as their lead advisor and team member, helping them achieve their individual goals – in essence, ensuring that each dual (or ideally all beneficiaries) has a "primary home." This would even go beyond a "medical home" since the team would take into account more than just medical needs – the focal point of this primary service provider would be the first proxy for quality care. On the medical side, this would signal an ideal shift to a broader perspective on quality – one that focuses on routine check-ups, management, monitoring, and prevention, which, in turn, avoids frequent cycling in and out of the emergency department (ED), a pattern that oftentimes impacts duals in greater numbers than other populations. Interviewees recognized that this desired outcome is not currently supported by current health system design or, in some instances, mandated benefits. Nonetheless. an evolving and more sophisticated measure set would view the use of this primary care giving team in the context of the system as a whole, gauging its frequency of use and availability related to other care settings.

Table 2: Delivery system areas and measures related to duals

Measure area	Measures	Sample gaps, barriers, & challenges	Comments
Consumer-based assessment of goal-oriented planning in care delivery	**0557-**0558 NQF Endorsed:** Patients discharged from a hospital-based inpatient psychiatric setting with a continuing care plan created/ provided to the next level of care clinician or entity.	• Does not include patient perspective in creation of care plan; does not take into account that not all discharged patients may not need care plan • Only gauges whether or not care plan exists – not what it is composed of and to what extent it is referenced	• Ideally, a measure set for this area would gauge consumer satisfaction with cross-setting care and/or of the care plan (if needed) to meet quality of life and quality of service needs • To have measures that include goal planning documented in care plan, one must first identify population in need of care plan. • Such measures run the risk of providers simply checking off the box rather than developing meaningful care plans. Important to have consumer perspective to reflect extent to which individual feels care needs are being met. • Importance of including “goal-oriented planning” because personal desires/goals may be different from what physician deems “clinically correct” or “appropriate.” Such goals and priorities may be driven by healthy literacy of patient, circumstances of patient/family/caregiver, patient’s age and medical and home conditions • *“When we sit down to develop participant-centered plan with goals, we think of what’s important with this person’s life – and it’s not*
	CAHPS NQF Endorsed (NQMC:000849, ECHO® Survey 3.0 Adult Questionnaire): Behavioral health care patients' experiences: percentage of adult patients who reported whether someone talked to them about including family or friends in their counseling or treatment.	• Does not include Medicare (only commercial and Medicaid members) and only includes those in an MCO or MBHO • Not available at the provider level	
	CAHPS NQF Endorsed (NQMC:000843, ECHO® Survey 3.0 Adult Questionnaire): Behavioral health care patients' experiences: percentage of adult patients who rated how much improvement they perceived in themselves.	• Includes behavioral health patients – large group of duals. But denominator only includes those in an MCO or MBHO • Patients’ perceived improvement – but does not necessarily imply existence of care plan that outlines goals	
	****CAHPS NQF Endorsed** (NQMC:006293, CAHPS® Health	• Only includes those in MCO – limited population	

	Plan Survey 4.0H, Adult Questionnaire): Health plan members' experiences: percentage of adult health plan members who reported whether a doctor or other health provider included them in shared decision making	• Not available at the provider level or for specific settings	*necessarily medical at all. It may have to do with establishing meaning in life – and we don't have much to assess."* • *"There are ways I look at care plans to see they are multidimensional ... The broad domains are medical, social, functional, and nutritional. I'm looking to see that it's member-centered, it identifies patient goals, and then I want to see some reflection of interdisciplinary medication, problem solving – contributions from multiple disciplines… And the participant signs off on it. That's the real work of interdisciplinary care."*
	****CAHPS NQF Endorsed** (NQMC:004536, CAHPS® Health Plan Survey 4.0, Adult Questionnaire): Health plan members' satisfaction with care: adult health plan members' overall ratings of their health care**.**	• Purely based on 1 to 10 rating of general care received. Lacking in specific areas of care (i.e. individualized care planning) that would really indicate the nature of satisfaction with care • Only includes those in MCO – limited population • Not available at the provider level or for specific settings	
	PSS-HIV (NQMC:002046): HIV ambulatory care satisfaction: percentage of HIV positive adolescent and adult patients who reported how often their case manager went over their service plan and updated it with them every 3 months.	• Limited to one setting (ambulatory) for one patient population (HIV) • Worthwhile to couple measure with measure gauging contents and "meaningfulness" of service plan	
	PSS-HIV (NQMC:002046): HIV ambulatory care satisfaction: percentage of HIV positive adolescent and adult patients who reported how often they wanted to be more involved in making decisions about their service plan and goals.	• Limited to one setting (ambulatory) for one patient population (HIV)	

	PSS-HIV (NQMC:002077): HIV ambulatory care satisfaction: percentage of HIV positive adult patients who reported whether their substance use counselors helped them to achieve their substance use treatment plan goals.	• Concept of measure is important – but is limited to one patient population in one setting. • Measure could be coupled with existence of “meaningful” care plan that is includes goals of individual	
	Non-U.S., Ministry of Health, Spain (NQMC:004978, AHRQ Clearinghouse) End-of-life care: percentage of healthcare professionals who affirm that in their unit or area enquiries are always made about terminal patients' preferences regarding life-support procedures and treatment.	• Limited to one provider’s perspective – process measure as opposed to experience measure. But concept of including documentation of inquiries around end-of-life preferences in individualized care plan is important • Measure limited to “terminal patients” – in ideal world, would extend beyond that population to include advanced care planning • Non-U.S. measure	
	Non-U.S., British Medical Association (NQMC:005100, AHRQ Clearinghouse): Mental health: the percentage of patients on the mental health register who have a comprehensive care plan documented in the records agreed between individuals, their family and/or carers as appropriate**.**	• Sentiment of measure is important (existence of care plan agreed upon by individual/family/caregiver) • U.S. has no mental health register. Emphasizes importance of first having a designated patient population in need of care plan before developing a measure gauging extent of care plans’ existence	

		• Does not include patient perspective • Only measures the existence of care plan – not its component parts or the extent to which it is followed • Non-U.S. measure	
Management and monitoring of specific conditions and disabilities	**0105 NQF Endorsed:** Percentage of patients who were diagnosed with a new episode of depression and treated with antidepressant medication, and who had at least three follow-up contacts with a practitioner during the 84-day (12-week) Acute Treatment Phase. b. Percentage of patients who were diagnosed with a new episode of depression, were treated with antidepressant medication and remained on an antidepressant drug during the entire 84-day Acute Treatment Phase. c. Percentage of patients who were diagnosed with a new episode of depression and treated with antidepressant medication and who remained on an antidepressant drug for at least 180 days.	• Single-condition process measure – no sense of whether course of treatment was correct for individual patient or whether patient adhered to treatment plan; no sense of patient improvement as result of treatment	• Ideally, a measure set for this area would consist of a tailored compendium of measures (composites when feasible) that focus on person-centered care planning (when needed) • The compendium would not only include single-conditions/diseases but also composites that couple screening of multiple conditions or condition clusters – that often present themselves together – at once. • Measures will also ideally integrate management and monitoring of physical, behavioral and social risk factors and conditions • For duals, particularly important conditions and risk factors to assess/measure include but are not limited to: o COPD o Cardiovascular disease o Diabetes o Depression and other serious mental illnesses
	****0418 NQF Endorsed:** Percentage of patients aged 18 years and older screened for clinical depression using a standardized tool AND follow-up documented	• Limited to single condition – useful to screen for depression and other conditions that often present with it, particularly for duals	
	0544 NQF Endorsed: Assess the use of and the adherence of	• Limited – better to base on care plan (if it exists) and	

	antipsychotics among members with schizophrenia during the measurement year	adherence to all medications taken based on goals of plan	o Substance use disorders o Intellectual/developmental disabilities or conditions o Multiple chronic conditions/polymedicine • *“Take cardiovascular disease and diabetes. I’m finding that in the poor people with Medicaid, there’s a huge cross-over between diabetes and cardiovascular disease – and those two and depression. So it would be nice if we were measuring whether people who have diabetes and cardiovascular disease are evaluated for depression.”*
	0111 NQF Endorsed: Percentage of patients with bipolar disorder with evidence of an initial assessment that includes an appraisal for risk of suicide.	• No sense of follow-up across settings, communication with other providers and development of plan with patient moving forward	
	0112 NQF Endorsed: Percentage of patients treated for bipolar disorder with evidence of level-of-function evaluation at the time of the initial assessment and again within 12 weeks of initiating treatment	• Limited to the evaluation – does not include goals of patient related to function	
	0110 NQF Endorsed: Percentage of patients with depression or bipolar disorder with evidence of an initial assessment that includes an appraisal for alcohol or chemical substance use	• No sense of follow-up across settings, communication with other providers and development of plan with patient moving forward	
	0077 NQF Endorsed: Percentage of patient visits for those patients aged 18 years and older with a diagnosis of heart failure with quantitative results of an evaluation of both current level of activity and clinical symptoms documented	• Single-condition measure with no sense of follow-up or long-term management	
	0076 NQF Endorsed: Percentage of adult patients ages 18 to 75 who have ischemic vascular disease with optimally managed modifiable risk factors (LDL, blood pressure, tobacco-free status, daily aspirin use).	• Single-condition measure with only one standard for “optimally managed” – no sense that patients vary in needs and goals	

	CAHPS NQF Endorsed (NQMC:000850, ECHO® Survey 3.0) Behavioral health care patients' experiences: percentage of adult patients who reported whether they were given enough information to manage their condition.	• Does not account for whether the information given to them was in line with care goals	
Medication management /reconciliation across settings	**0554 NQF Endorsed:** Percentage of discharges from January 1 to December 1 of the measurement year for patients 65 years of age and older for whom medications were reconciled on or within 30 days of discharge.	• Limited to single act of “reconciliation” – no sense of whether patients have a plan for managing or understanding of how to manage medications; no sense of provider follow-up in management	• Ideally, a measure set for this area would focus on management of medications across providers and settings so as to ensure appropriate use of medications and avoid duplications/unnecessary side effects • It is important to capture documentation and continued management of medications across settings, which includes communication among multiple providers and continued awareness and engagement of patients/caregivers. Measures must extend well beyond walls of hospitals and primary care physician offices, especially given the number of specialists with whom duals typically interact. • *“We simplify medication management a bit too much. Hospitals might be doing a good job, but a lot of times they don’t*
	0419 NQF Endorsed: Percentage of patients aged 18 years and older with a list of current medications with dosages (includes prescription, over-the-counter, herbals, vitamin/mineral/dietary [nutritional] supplements) and verified with the patient or authorized representative documented by the provider.	• No sense of whether patient actually takes the medications and whether that list is communicated to all relevant providers	
	0553 NQF Endorsed: Percentage of adults 65 years and older who had a medication review	• Does not cross settings/providers or measure the extent to which medications are actually managed following review – no sense of follow-up beyond initial review	

	0520 NQF Endorsed: Percent of patients or caregivers who were instructed during their episode of home health care on how to monitor the effectiveness of drug therapy, how to recognize potential adverse effects, and how and when to report problems	• No patient perspective – important to gauge whether patient actually understood instructions so as to manage own medications	*know what drugs patients are on when they come in, then the patients leave with new drugs. It's a much more complex problem we're getting at right now."*
	CAHPS NQF Endorsed (NQMC:002460, CAHPS Hospital Survey (HCAHPS)): Hospital inpatients' experiences: percentage of adult inpatients who reported how often the hospital staff communicated well about medications.	• Limited to experience in hospital setting	
	NCQA (NQMC:002922) Geriatrics: 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 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 outpatient medical record documented.	• No sense of whether medication list was explained to and understood by patient and whether there was follow-up to make sure patient was managing medications. Documentation does not signal adherence to medication list	
Transition management	**0646-**0647 NQF Endorsed:** Percentage of patients, regardless of age, discharged from an inpatient facility to home or any other site of care, or their caregiver(s), who	• Limited to measuring transition from acute care setting but stops there. • Missing component of reinforcement – either a visit	• Ideally, a measure for this area would track a patient's transition within and across multiple settings, throughout the full continuum of care - noting communication among

	received a reconciled medication list/ transition record/ at the time of discharge including, at a minimum, medications in the specified categories	to home to make sure management of medications is occurring properly or, at least, reinforcement through communication with PCP	providers, services agencies, and patients/families/caregivers; documentation of conditions; and follow-up • Transition management tends to stop when patient is discharged from hospital and not extend to other settings. Measures for this area must encourage and capture whether communication and documentation occur among multiple providers in various settings.
	0648 NQF Endorsed: Percentage of patients, regardless of age, discharged from an inpatient 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	• Important in that it measures level of communication among providers and follow-up but only focuses on movement from inpatient facility	
	0649 NQF Endorsed: 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	• Limited to transition from hospital setting; no sense of whether follow-up regularly occurs (despite existence of transition record) • Still, important measure for duals because many enter system through ED	
	0291-0297 NQF Endorsed: Percentage of patients transferred to another acute hospitals whose medical record documentation indicated that administrative information/ vital signs/ medication information/ patient information/ physician information/ nursing information/ procedures and tests was communicated to the receiving hospital within 60 minutes of departure.	• Does not include Medicare (only commercial and Medicaid members)	

	0291-0297 NQF Endorsed: Percentage of patients transferred to another acute hospitals whose medical record documentation indicated that administrative information/ vital signs/ medication information/ patient information/ physician information/ nursing information/ procedures and tests was communicated to the receiving hospital within 60 minutes of departure.	• Only focuses on transfer of information in acute care setting	
	****CAHPS NQF Endorsed** (NQMC:006296, CAHPS® Health Plan Survey 4.0H, Adult Questionnaire): Health plan members' experiences: percentage of adult health plan members who reported how often their personal doctor seemed informed and up-to-date about care they got from other doctors or other health providers.	• Limited to those in MCO (might mean a limited group of physicians as well as patient population)	
Integration and coordination of community social supports and health delivery	**Non-U.S., British Medical Association** (NQMC:003014) Management: the practice has a protocol for the identification of [caregivers] and a mechanism for the referral of [caregivers] for social services assessment.	• Only applies to one practice at a time – no sense of larger community presence and integration of community social supports • Non-U.S. measure	• Ideally, a measure set for this area would gauge the extent of community and social supports available and the ease with which an individual can access those services

	PSS-HIV (NQMC:002031): HIV ambulatory care satisfaction: percentage of HIV positive adolescent and adult patients who reported whether their providers or case managers asked them how they were feeling emotionally and made a referral to a mental health provider, counselor, or support group if needed.	• Limited to HIV patients in ambulatory setting and only includes a couple specific types of supports; additionally, no sense that the patient actually accessed the service or that there was follow-up	• Examples include availability of and connections with: o Transportation services to and from appointments o Safe and clean low-income housing o Translation services for non-English speakers o Employment counseling/training
Utilization benchmarking	****0329 NQF Endorsed:** Overall inpatient 30-day hospital readmission rate	• Need state and national benchmarks for this to be useful and translate into actionable process improvements	• Ideally, a measure set for this area would track overall utilization trends and those for subpopulations across all settings and develop comprehensive set of national benchmarks for states, regions, and providers • Utilization trending at each level would offer a profile of patterns which states and providers could use in comparing their own care delivery for important areas of service use beyond overall spending per beneficiary (Medicare and Medicaid) hospital days and length of stay but also focusing on high leverage areas such as: readmissions, ED visits, number of PCP and specialty visits, number of specialists per beneficiary, condition-specific costs, etc. • *"There's a huge unmet need for meaningful measures…In an effort like this I'd be more inclined to get coordination around the ultimate*
	0330 NQF Endorsed: Hospital-specific, risk-standardized, 30-day all-cause readmission rates for Medicare fee-for-service patients discharged from the hospital with a principal diagnosis of heart failure (HF).	• Need state and national benchmarks for this to be useful and translate into actionable process improvements	
	NCQA HEDIS (NQMC:006257): Ambulatory care: summary of utilization of ambulatory care in the following categories: outpatient visits and emergency department visits.	• Only includes outpatient and ED visits • Medicaid, Medicare, commercial managed care	
	NCQA Hedis (NQMC:006258, AHRQ Clearinghouse): Inpatient utilization--general hospital/acute care: summary of utilization of acute inpatient care and services in the following categories: total inpatient, medicine, surgery, and maternity.	• Only includes managed care plans and not duals who may have no medical home	

			outcomes – institutionalization, end-of -life care costs, cost utilization measures. I think I feel more passionate about needing that for benchmarking rather than micro-managing process measures within a program."
Process improvement across settings	****0490 NQF Endorsed:** Documents the extent to which a provider uses a certified/qualified electronic health record (EHR) system capable of enhancing care management at the point of care. To qualify, the facility must have implemented processes within their EHR for disease management that incorporate the principles of care management at the point of care which include: (a.) The ability to identify specific patients by diagnosis or medication use (b.) The capacity to present alerts to the clinician for disease management, preventive services and wellness (c.) The ability to provide support for standard care plans, practice guidelines, and protocol	• Process improvement measures generally need to be pinpointed by and tailored to individual organizations/settings • Must determine which types of organizations are required to undertake certain processes and determine which types of processes are most important for which kinds of organizations	• Ideally, a measure set for this area would incorporate multiple provider settings and human service settings/organizations to ultimately address population health • Measures in this set represent areas where there is room for innovation and improvement in and among individual settings • Challenging measure area because process improvement is oftentimes identified by a single organization or even within a single hospital or social service department. Represents importance of identifying and solving problems across, among, and within a setting, but needs to be encouraged across the full continuum of duals care delivery.
	****0494 NQF Endorsed:** Percentage of practices functioning as a patient-centered medical home by providing ongoing, coordinated patient care. Meeting Medical Home System Survey standards demonstrates that practices have physician-led teams that provide patients with: (a.) Improved access and communication (b.) Care	• *"Measuring the number of practices in there that have a medical home is not the way to go. People are not equally distributed among all practices. There are some other proxies. Some things around identifying usual sources of care – softer areas – might get at the patient*	

	management using evidence-based guidelines (c.) Patient tracking and registry functions (d.) Support for patient self-management (e.) Test and referral tracking (f.) Practice performance and improvement functions	*perspective."* - *"Yes, this is what the medical home should do, but the question is how do you check it?"*	

**MAP workgroup measure

Appendix I: Measure Endorsement and Maintenance

NQF offers three primary opportunities for communication with measure developers to improve the applicability of measures to the dual eligible population. These opportunities include new calls for measures, annual measure updates, and measure maintenance reviews.

NQF uses its formal Consensus Development Process (CDP) to evaluate and endorse consensus standards, including performance measures, best practices, frameworks, and reporting guidelines. The Consensus Development Process is designed to call for input and carefully consider the interests of stakeholder groups from across the healthcare industry. NQF's measure endorsement activities are standardized in a regular cycle of topic-based measure evaluation. NQF follows a three year schedule that outlines the review and endorsement of measures in 22 topic areas, such as cardiology, behavioral health, and functional status. As the need arises, the topic areas may be revised to account for measures that may require a new or more appropriate topic area.

As an endorsing body, NQF is committed to ensuring the performance measures it endorses continue to meet the rigorous NQF measure evaluation criteria. Every three years, endorsed measures are re-evaluated against these criteria and are reviewed alongside newly submitted (but not yet endorsed) measures. This head-to-head comparison of new and previously endorsed measures fosters harmonization and helps ensure NQF is endorsing the best available measures.

NQF also facilitates a process through which measures can be updated on an annual basis. Prior to the scheduled three-year maintenance review, stewards of endorsed measures provide NQF with any modifications to the measure specifications, current evidence supporting the measure, data supporting use of the measure, testing results, and other relevant information. NQF also solicits stakeholder input on implementation and use of the measure, changes in evidence, scientific soundness, and feasibility.

In the two years when an endorsed measure is not being re-evaluated for continued endorsement, measure stewards will submit a status report of the measure specifications to NQF. This report will either reaffirm that the measure specifications remain the same as those at the time of endorsement or last update, or outline any changes or updates made to the endorsed measure. An ad hoc review will be conducted if the changes materially affect the measure's original concept or logic.

Endnotes

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Performance Measurement Coordination Strategy for Hospice and Palliative Care

Summary

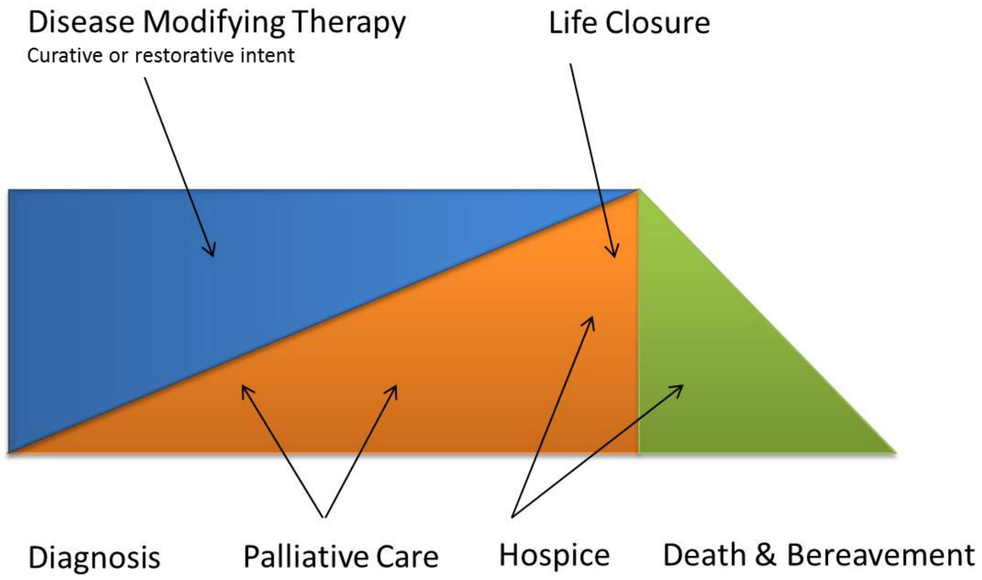
The hospice and palliative care performance measurement coordination strategy aims to enhance alignment across federal programs and between public and private initiatives with a focus on three key areas:

- Defining high-leverage measure concepts for hospice and palliative care performance measurement to promote measure alignment and common goals across programs;
- Identifying measures that can be readily incorporated into performance measurement programs to address hospice and palliative care; and
- Determining a pathway for improving measure application that includes identifying measure gaps and promising ways to fill those gaps, to meet current and emerging needs.

Introduction

The Measure Applications Partnership (MAP) has been charged with developing a performance measurement strategy for hospice and palliative care. Hospice is a Medicare benefit that provides palliative care for patients who are in the last six months of a terminal illness and require comprehensive biomedical, psychosocial, and spiritual support. Hospice also provides support to family members in coping with the complex consequences that are associated with illness as death nears, and addresses the bereavement needs of the family after the death of the patient.[i] Palliative care may be provided well in advance of the final stages of an illness and seeks to optimize quality of life by addressing physical, intellectual, emotional, social, and spiritual needs throughout the illness trajectory and by facilitating patient autonomy, choice, and access to information.[ii] Palliative care can be provided within and beyond hospice programs. Figure 1 depicts hospice and palliative care along the trajectory of illness. Palliative care can occur in collaboration with disease modifying therapy that has curative intent, while hospice care occurs once a physician determines that the patient will not survive past six months and the patient ceases curative therapies. Hospice care also addresses bereavement.

Figure 1: Hospice and Palliative Care along the Continuum of Care



Enrollment in hospice programs has risen by over 50% in the last decade,[iii] increasing the focus on this option for end-of-life care. Compared with other approaches to care typically provided in acute care and long-term care settings, hospice care is more attuned to the patient's individual preferences. Honoring patients' preferences has been shown to lead to reduced costs and enhanced experience of care, since patients often choose to stay in their homes and avoid expensive medical procedures they would otherwise have undergone in other settings.[iv] This is particularly salient for high-cost populations such as dual eligible beneficiaries and people with multiple chronic conditions. Providing palliative care options to individuals as they approach the end-of-life improves value by increasing their quality of life and reducing expensive, unwanted, and often unnecessary procedures.[v]

As for all care, performance measurement is essential to continually evaluate whether the care provided is appropriate, high quality, patient-centered, and effectively coordinated across providers. Both hospice and palliative care often occur across multiple settings: home, nursing home, assisted living facility, clinician office, hospital, and others. The average Medicare hospice enrollee is in the home for 56% of the time, but also is in an assisted living facility for 11% of the time, a nursing home for 17% of the time, and so on.[vi] A well-coordinated system of care, centered on patients and families and their needs, is the goal for effective hospice and palliative care.

Publicly reporting performance measurement information for hospice care providers is new. Section 3004 of the Affordable Care Act directs the Department of Health and Human Services (HHS) to establish reporting requirements for hospice programs. In fiscal year 2014, hospice programs will be required to submit quality data or incur a financial penalty. MAP's role is to provide input on performance measures for hospice care with an eye toward alignment of measurement across various settings. In MAP's inaugural pre-rulemaking report, *Input on Measures Under Consideration by HHS for 2012 Rulemaking*, MAP provided input on an initial set of measures under consideration for hospice public reporting, noting that performance measurement in this program needs to expand beyond clinically-focused measures to address all aims and priorities of the National Quality Strategy (NQS). Recognizing that hospice and palliative care are holistic approaches inextricably connected on the continuum of care, MAP provides input on high-leverage measure concepts and specific measures that address both hospice and palliative care in this report. MAP also recognizes opportunities to enhance measurement by identifying measure gaps where measures are not currently available.

Approach

The MAP PAC/LTC Workgroup advised the Coordinating Committee on identifying measures for quality reporting for hospice programs and facilities and for palliative care. The MAP PAC/LTC Workgroup is a 22-member, multi-stakeholder group. The workgroup held one in-person meeting and one web meeting to finalize the measure concepts and identify existing measures for application and measure gaps. The agendas and materials for the PAC/LTC Workgroup meetings can be found on the NQF website.

To inform planning for the PAC/LTC Workgroup hospice meeting and the development of this report, NQF provided the workgroup with background information gleaned from existing studies and reports on hospice and palliative care. The following were fundamental in shaping this work:

- *A National Framework and Preferred Practices for Palliative and Hospice Care Quality,* a 2006 NQF consensus report that provides a comprehensive landscape of hospice and palliative care quality measurement efforts and presents 38 preferred practices.[vii]
- *National Voluntary Consensus Standards: Palliative Care and End-of-Life Care*, which includes the results of the evaluation of 22 measures submitted for endorsement under NQF's Consensus Development Process.[viii]

- *Input to the Secretary of Health and Human Services on Priorities for the 2011 National Quality Strategy* and the *Palliative Care and End-of-Life Care Convening Meeting-Synthesis Report,* two efforts of the National Priorities Partnership that explore priorities and strategic opportunities to address palliative care.[ix]
- *Increased Access to Palliative Care and Hospice Services: Opportunities to Improve Value* published in the Milbank Quarterly, which offers perspectives on ways to improve the delivery of hospice and palliative care.[xxi]

The MAP PAC/LTC Workgroup developed priority measurement areas for hospice and palliative care during their in-person meeting and further refined this list through a subsequent survey and web meeting. The workgroup process identified 28 highly prioritized measure concepts for hospice and palliative care. Establishing these measure concepts led to the identification of clinical quality and patient-centered cross-cutting measures for the Medicare Hospice Quality Reporting Program and for palliative care across settings, including measures for immediate application and measures for further exploration. To support the identification of measures, NQF staff conducted a scan of NQF-endorsed measures and measures in the development and endorsement pipeline that could potentially address the highly prioritized measurement areas for hospice and palliative care. Moreover, measure identification highlighted gaps in available measures, prompting discussion on a strategy for addressing the gaps. Finally, the workgroup revisited the MAP data platform principles (see MAP clinician, safety, dual eligible beneficiaries, and PAC/LTC performance measurement coordination strategy reports) to identify data considerations specific to hospice and palliative care.

High-Leverage Measure Concepts

In considering the continuum of hospice and palliative care, MAP established high-leverage measure concepts, noting that performance measures must recognize an approach to care that is holistic, team-based, and patient- and family-centered. As MAP has signaled in its previous performance measurement coordination strategies (see MAP clinician, safety, dual eligible beneficiaries, and PAC/LTC reports), setting-specific silos inhibit care coordination and aligned performance measurement. Many of the existing performance measures for hospice are condition-specific (e.g., cancer) or setting-specific (e.g., nursing home). Performance measures must assess if providers honor patient preference and coordinate care effectively. Additionally, if high quality, patient-focused care is to be achieved, a performance measurement strategy should include both clinical quality measures and cross-cutting measures that assess care across settings and over time.

While enrollment in hospice continues to increase, the average length of stay is still relatively brief, with the majority of people utilizing the Medicare Hospice Benefit for less than 6 weeks. Additionally, while regional prevalence of hospice care programs is comparable, regional variation in utilization of hospice care persists.[xii] These statistics signal a lack of awareness among patients about hospice care as an option. Clinician prognostication of end of life impacts referrals to hospice and the timing of referrals; however, MAP members noted that providing patients with information about hospice earlier in their stages of illness leads to a significant increase in the number of patients who elect hospice as a benefit. Integrating palliative services into care upstream allows patients to become familiar with the approach and increases their awareness of the hospice benefit option. Population-level access and availability of care measures are necessary to understand and address referral and length of stay issues.

Another notable distinction is that hospice and palliative care are the only types of care in which family is consistently viewed as a critical component of the unit of care, since families are both caregivers and recipients of this care. Therefore, measurement of hospice and palliative care provides an opportunity to emphasize true person- and family-centered care. Additionally, a patient-centered performance measurement strategy must address the specific needs and preferences of an individual in care planning and goal setting. Hospice and palliative care are also uniquely team-based, requiring a group of providers, health care professionals, and caregivers (e.g., pharmacists, social workers, spiritual counselors) to coordinate patient care and family involvement.

MAP identified 28 measure concepts that are important for hospice and palliative care. These measure concepts represent areas that address the need to provide access to affordable palliative and hospice services; the person- and family-centered nature of care, which focus on individual goal setting and preferences; the team-based aspects of care coordination; and the holistic process of care that emphasizes not only the treatment of physical illness, but also emotional, mental, spiritual, and psychological well-being. These areas align with the measurement priorities and measure concepts identified in the *MAP Post-Acute Care and Long-Term Care Coordination Strategy,* the *MAP Dual Eligible Beneficiaries Interim and Final Reports,* the *MAP Cancer Hospitals Coordination Strategy*, and the NQF-endorsed *Multiple Chronic Conditions Measurement Framework*. Of the 28 measure concepts, MAP prioritized seven measure concepts for both hospice and palliative care, three measure concepts specific to hospice care, and three measure concepts specific to palliative care. The three priority measure concepts specific to hospice care reflect patients' needs for increased access and communication; the three priority measure concepts specific to palliative care reflect patients' needs for education and care coordination.

Highly Prioritized Measure Concepts for both Hospice and Palliative Care

Experience of care is essential for understanding whether care was timely, coordinated, and met patient and family goals. Specifically applicable to hospice, experience of care evaluation should incorporate unique aspects of hospice care, such as availability/access to the hospice care team and family/caregiver experience after patient death. The Family Evaluation of Hospice Care (FEHC) survey addresses the unique aspects of hospice care after patient death; however, MAP notes that the evaluation could be further enriched by assessing experience earlier in the care continuum and during transitions of care.

Comprehensive assessment—including physical, psychological, spiritual, and social aspects of care should also incorporate ongoing reassessments. Comprehensive assessment can serve as a starting point for hospice care, facilitating care planning and assessment of patient/family preferences. It would also provide an opportunity to address emotional and spiritual aspects of care, given the difficulty in developing measures for these areas. Within the context of palliative care, comprehensive assessment should be paired with care planning, advance directive discussions, and sharing medical records across providers to facilitate care coordination.

Physical aspects of care—treating pain, dyspnea, constipation, and other symptoms using standardized scale should be periodically re-evaluated and incorporated into the care plan. Managing physical aspects of care is the logical initial focus for performance measurement as it has the largest evidence base and helps avoid unwanted treatments and hospital/ED admissions and readmissions.

Care Planning—establishing and periodically reviewing patient/family/caregiver goals should be done in conjunction with a comprehensive assessment. Care planning requires ongoing communication with patients, families, and other providers to ensure alignment of goals and care coordination. Within hospice, care planning should include a process for determining and reviewing preferences at regular intervals, as well as a plan for addressing each of the core areas of assessment. For palliative care programs, a focus should be on continually reassessing patient goals, as patients are not imminently dying so their goals may change over time.

Implementing patient/family/caregiver goals occurs once the care plan has been established. It is imperative that there is a process in place to respond to evolving goals.

Avoiding hospital and ED admissions is an important indicator across the care continuum and a proxy for meeting patient needs that would potentially lead to reduced admissions and readmissions.

Psychological and psychiatric aspects of care—managing anxiety, depression, delirium, behavioral disturbances, and other common psychological symptoms is essential to compassionate care of the dying as behavioral changes significantly add to burden and can lead to an unstable care plan, hospital admissions, and crisis interventions.

Highly Prioritized Measure Concepts for Hospice Care

Timeliness/responsiveness of care is vital to providing optimal hospice care as it prevents unnecessary ED visits and hospital admissions and readmissions. Given that the average of length of stay for hospice care is relatively brief, timely care is essential to support patients and caregivers, enhance autonomy, prevent unwanted admissions to hospital/ED, and improve experience of care. Further, a time factor should be incorporated into other measurement areas such as assessments and care planning.

Access to the healthcare team on a 24-hour basis is important for hospice patients with complicated health care and comfort issues and their caregivers, as it emphasizes the importance of the team being available to assist when needed, to reduce anxiety. Timely intervention improves care coordination and limits unnecessary hospitalizations.

Avoiding unwanted treatments, when measured, serves as a proxy for appropriate levels of communication and care planning in hospice programs. Unwanted treatments also include unnecessary hospital/ED admissions and readmissions.

Highly Prioritized Measure Concepts for Palliative Care

Sharing medical records (including advance directives) across all providers is deemed important to improve continuity of care and prevent unnecessary events such as hospitalization in palliative care.

Patient education and support as part of palliative care leads to more effective self/caregiver-management and reduces the need for care interventions.

Access to palliative care addresses access across settings, beyond acute care. In addition, ensuring better access to palliative care helps patients make more informed decisions regarding hospice care.

Table 1 notes the 28 measure concepts, highlighting the ten most highly prioritized measure concepts for the Medicare hospice program and the ten most highly prioritized measure concepts for palliative care (indicated with check marks).

Table 1 Medicare Hospice Program and Palliative Care Measurement Concepts

High-Leverage Measurement Areas	**High Priority Concept**	
	Medicare Hospice Program	**Palliative Care**
Access/Availability of Services		
Access to hospice care across settings		
Access to palliative care across settings		✓
Access to the healthcare team on a 24-hour basis with a goal of providing timely and appropriate intervention	✓	
Availability of spiritual care services		
Timeliness/responsiveness of care	✓	
Patient- and Family – Centered Care		
Caregiver education and support		
Care of the imminently dying patient – assess that appropriate care is provided to patient as death nears		
Comprehensive assessment—including physical, psychological, spiritual, and social aspects of care	✓	✓
Culturally and linguistically appropriate care		
Experience of care—can encompass many domains of care including timeliness, meeting patient/family goals, and care coordination	✓	✓
Patient education and support		✓
Psychological and psychiatric aspects of care—managing anxiety, depression, delirium, behavioral disturbances, and other common psychological symptoms	✓	✓
Physical aspects of care—treating pain, dyspnea, constipation, and other symptoms using standardized scale	✓	✓
Spiritual, religious, and existential aspects of care—assessing concerns		
Goals and Care Planning		
Care planning—establishing and periodically reviewing patient/family/caregiver goals	✓	✓
Ethical and legal aspects of care—including advance directives and surrogate decision makers		
Implementing patient/family/caregiver goals	✓	✓
Grief and bereavement care planning		
Shared decision making—facilitates patient autonomy, control, and choice		
Social care planning—addressing social, practical, and legal needs of patient and caregivers		

High-Leverage Measurement Areas	High Priority Concept	
	Medicare Hospice Program	Palliative Care
Care Coordination		
Sharing medical records (including advance directives) across all providers		✓
Timely communication of patients' goals across all providers		
Provider Competency		
Provider education		
Qualified healthcare teams		
Appropriateness/Affordable Care		
Appropriate level of services		
Avoiding hospital and ED admissions	✓	✓
Avoiding unwanted treatments	✓	
Cost of care		

Applying and Refining Existing Measures

To begin to address the highly-prioritized measure concepts, MAP identified NQF-endorsed measures that could potentially be used to assess hospice and palliative care across settings, and identified measures in the pipeline that could potentially fill measure gaps. Additional testing and development of the ACOVE indicators represent an opportunity to fill measure gaps. For example, the end-of-life ACOVE indicators have not previously been applied to performance measurement because of limitations in identifying end-of-life patients through claims data; however, these indicators may be more easily specified for the Medicare Hospice Quality Measurement Program as the program's entire population is considered to be at the end of life.

In identifying measures for hospice and palliative care, MAP noted the possibility of undesirable consequences from applying certain measures. For example, measures of hospital mortality could lead to patients being transferred to hospice shortly before death to decrease mortality rates. Measures assessing weight loss for patients in long-term care facilities could lead to inappropriate provision of tube feeding for palliative patients and an increase in transfers to hospitals. Instead, performance measures should assess adherence to patient preferences and timely transfer to hospice care.

Performance measurement for hospice and palliative care should include both clinical quality measures and patient-focused cross-cutting measures. MAP recognizes that the field of hospice care quality measurement is still new and evidence is growing in critical areas (e.g., goals of care, spiritual counseling). Evidence is most prominent in physical symptom management (e.g., pain, dyspnea), creating a small pool of measures. Meanwhile, MAP suggests starting with process and structural measures until more robust evidence exists for outcome measures.

Table 2 below highlights measures that are ready for immediate application to the Medicare Hospice Quality Measurement Program or to palliative care. Of the two measures already finalized for the Hospice Program, one is NQF-endorsed, Comfortable Dying (NQF #0209), and included in the table below (marked as "Finalized"; a second finalized measure, Hospice Administers a Quality Assessment and Performance Improvement [QAPI] Program Containing at Least Three Indicators Related to Patient Care, is not NQF-endorsed). An additional six measures were recommended by MAP in its pre-rulemaking report as additions to the Hospice Program (noted in table as “MAP supported in pre-rulemaking”). The remaining measures in the table are marked by an “X” as ready for application for either hospice or a particular palliative care setting. MAP encourages additional development and testing of these measures so that they are applicable across multiple hospice and palliative care settings. MAP has also identified potential opportunities to refine measures to more closely address priorities for hospice and palliative care. These refinements, which would require additional development and testing, are noted in the “Additional Considerations” column. Suggested refinements include expanding measures to address multiple conditions or bundling measures to create composites.

Table 2. Measures for Application or Refinement in Hospice and Palliative Care

High Leverage Measure Area/ Measures	Medicare Hospice Program	Palliative Care				Additional Considerations
		Hospital	Clinician Office Setting	PAC/LTC Settings (facilities)	Home	
Access to palliative care						No available measures
Access to hospice care						
0215 Proportion not admitted to hospice	X					Explore expanding beyond cancer population
0216 Proportion admitted to hospice for less than 3 days		X				Explore expanding beyond cancer population
Access to the healthcare team on a 24-hour basis						No available measures
Timeliness/responsiveness of care						No available measures
Availability of spiritual care services						No available measures
Comprehensive assessment—including physical, psychological, spiritual, and social aspects of care						No available measures
Psychological and psychiatric aspects of care—managing anxiety, depression, delirium, behavioral disturbances, and other common psychological symptoms						
0518 Depression assessment conducted					X	
Spiritual, religious, and existential aspects of care—assessing concerns						
1647 Percentage of hospice patients with documentation in the clinical record of a discussion of spiritual/religious concerns or documentation that the patient/caregiver did not want to discuss.	X					
Physical aspects of care—treating pain, dyspnea, constipation, and other symptoms using standardized scale						

High Leverage Measure Area/ Measures	Medicare Hospice Program	Palliative Care				Additional Considerations
		Hospital	Clinician Office Setting	PAC/LTC Settings (facilities)	Home	
0209 Comfortable dying: pain brought to a comfortable level within 48 hours of initial assessment	Finalized					
1634 Hospice and palliative care – pain screening (paired with 1637)	MAP supported in pre-rulemaking					
1637 Hospice and palliative care – pain assessment (paired with 1634)	MAP supported in pre-rulemaking					
1638 Hospice and palliative care – dyspnea treatment (paired with 1639)	MAP supported in pre-rulemaking					
1639 Hospice and palliative care – dyspnea screening (paired with 1638)	MAP supported in pre-rulemaking					
1617 Patients treated with an opioid who are given a bowel regimen	MAP supported in pre-rulemaking					
0179 Improvement in dyspnea					X	Explore expanding to other settings
0384 Oncology: pain intensity quantified – medical oncology and radiation oncology (paired with 0383)			X			
Care of the imminently dying patient						No available measures
Culturally and linguistically appropriate care						
1894 Cross-cultural communication domain of the Communication Climate Assessment Toolkit			X			
1898 Health literacy domain of Communication Climate Assessment Toolkit			X			
Patient education and support						No available measures
Caregiver education and support						No available measures

High Leverage Measure Area/ Measures	Medicare Hospice Program	Palliative Care				Additional Considerations
		Hospital	Clinician Office Setting	PAC/LTC Settings (facilities)	Home	
Experience of care						
0208 Family Evaluation of Hospice Care	MAP supported in pre-rulemaking					
1623 Bereaved Family Survey	X			X		VA measure; should be expanded to include other settings
1632 CARE - Consumer Assessments and Reports of End of Life	X	X		X	X	
Care planning—establishing and periodically reviewing patient/family/caregiver goals						
0383 Oncology: plan of care for pain – medical oncology and radiation oncology (paired with 0384)			X			
1626 Patients admitted to ICU who have care preferences documented		X				
1641 Hospice and palliative care – treatment preferences	X					
Implementing patient/family/caregiver goals						No available measures
Shared decision making						No available measures
Grief and bereavement care planning						No available measures
Social care planning—addressing social, practical, and legal needs of patient and caregivers						No available measures
Ethical and legal aspects of care—including advance directives and surrogate decision makers						
0326 Advance care plan		X				Should be expanded beyond a particular age group
Timely communication of patients' goals across all providers						
0097 Medication reconciliation			X			
0648 Timely transition of transmission record (inpatient discharges to home/self-care or any other site of care)			X			
Sharing medical records (including advance directives) across all providers						No available measures
Provider education						No available measures
Qualified healthcare teams						No available measures
Appropriate level of services						

High Leverage Measure Area/ Measures	Medicare Hospice Program	Palliative Care				Additional Considerations
		Hospital	Clinician Office Setting	PAC/LTC Settings (facilities)	Home	
0213 (under review) Proportion admitted to the ICU in the last 30 days of life		X				Should be expanded beyond the cancer population
0214 (under review) Proportion dying from cancer in an acute care setting		X				
Avoiding unwanted treatments						
0210 (under review) Proportion receiving chemotherapy in the last 14 days of life		X				Should be expanded beyond the cancer population
1625 Hospitalized patients who die an expected death with an ICD that has been deactivated		X				
Avoiding hospital and ED admissions						
0211 (under review) Proportion with more than one emergency room visit in the last days of life		X				Should be expanded beyond the cancer population
0212 (under review) Proportion with more than one hospitalization in the last 30 days of life		X				Should be expanded beyond the cancer population
0171 Acute care hospitalization (risk-adjusted)					X	Should be expanded beyond a specific setting
0173 Emergency department use without Hospitalization					X	Should be expanded beyond a specific setting
Cost of care						No available measures

Pathway for Improving Measure Application for Hospice and Palliative Care

Significant measure gaps will need to be addressed to provide a comprehensive picture of quality for hospice and palliative care. For some of these gaps, MAP has identified potential pathways for filling them, through development, testing, endorsement, and implementation. Most importantly, an aligned set of quality measures for hospice and palliative care should represent the cross-setting nature of this type of care, across diseases and settings. MAP recommends creating core measure sets that can be applied across settings and levels of analysis to ensure a patient-focused, cross-cutting assessment of quality.

The need for a common data platform and electronic exchange of information is particularly pertinent as hospice and palliative care often occurs across multiple settings and highlights the need for effective care transitions. MAP's data platform principles (see MAP clinician, safety, and PAC/LTC reports) remain key issues that will need to be resolved to move performance measurement forward.

Hospice and palliative care provide the opportunity to emphasize two significant priorities of the NQS: person- and family-centered care, and care coordination. A holistic approach to the entire well-being of the patient – physical, mental, emotional, psychosocial, and spiritual – and inclusive of family and the team of caregivers into the process of care, is a shift in how care has typically been delivered. MAP recognizes that a performance measurement strategy for hospice care provides a unique opportunity to pave the way for positive changes for all health care, leading to a better coordinated, team-based approach emphasizing patients' values and preferences.

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[i] National Quality Forum, A National Framework and Preferred Practices for Palliative and Hospice Care Quality; 2006

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[x] Meier, Diane E. *Increased Access to Palliative Care and Hospice Services: Opportunities to Improve Value in Health Care.* The Milbank Quarterly. 2011.

[xii] Meier, Diane E. *Increased Access to Palliative Care and Hospice Services: Opportunities to Improve Value in Health Care.* The Milbank Quarterly. 2011.