Measure Applications Partnership

Coordinating Committee
In-Person Meeting

NATIONAL QUALITY FORUM

March 15, 2012

Welcome and Review of Meeting Objectives

Meeting Objectives

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

Agenda

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

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	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

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	Agency for Healthcare Research and Quality (AHRQ)	Representatives	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

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

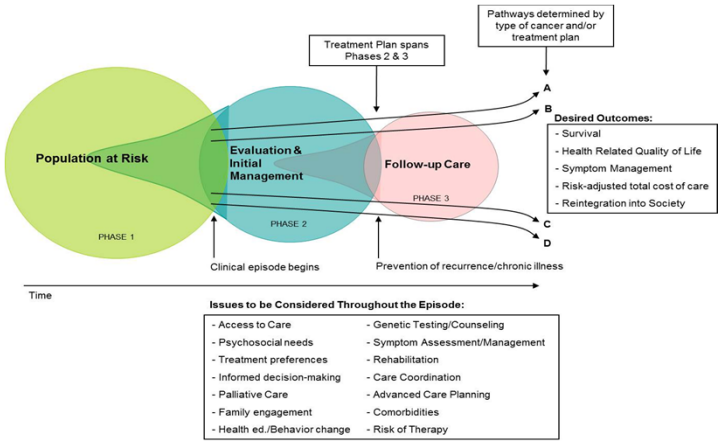
Connection to MAP Pre-Rulemaking Input for PPS-Exempt Cancer Hospitals

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



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

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

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	Representatives
Agency for Healthcare Research and Quality	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

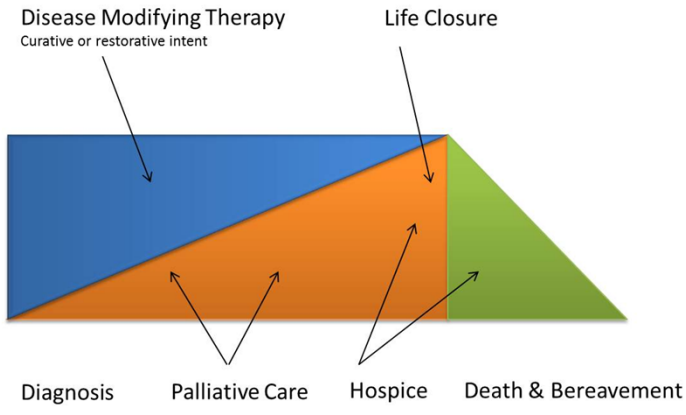
Definitions

- **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



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

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

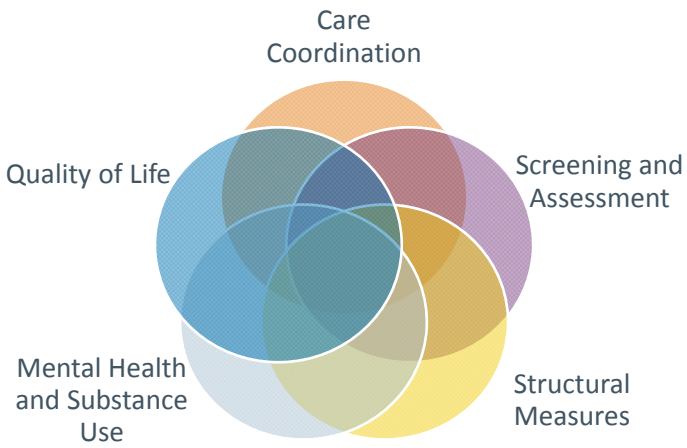
Final report primarily consists of:

- 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.

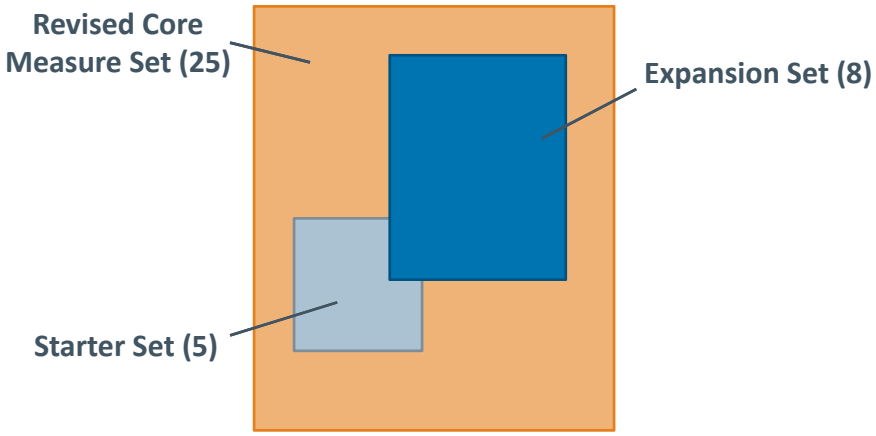
Measuring Quality for Dual Eligible Beneficiaries: Guiding Principles

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

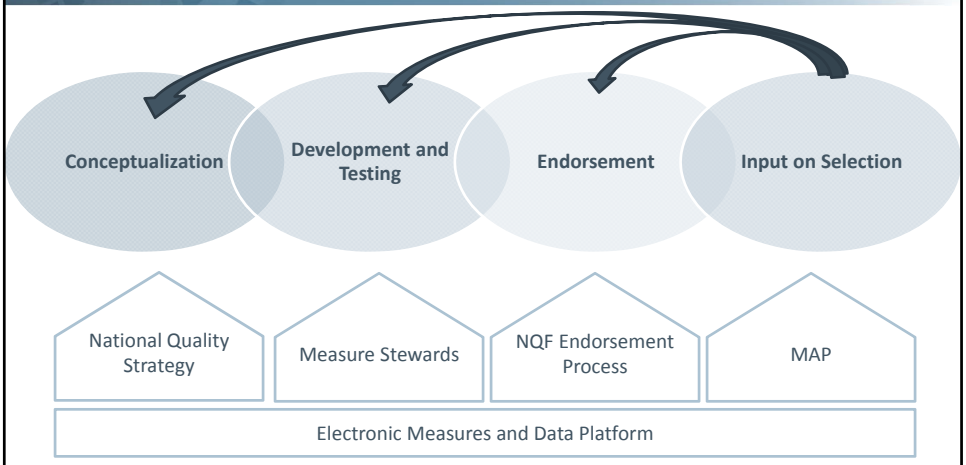
Measuring Quality for Dual Eligible Beneficiaries: Expansion Set of Measures Needing Modification to Best Meet the Needs

- *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



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

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

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

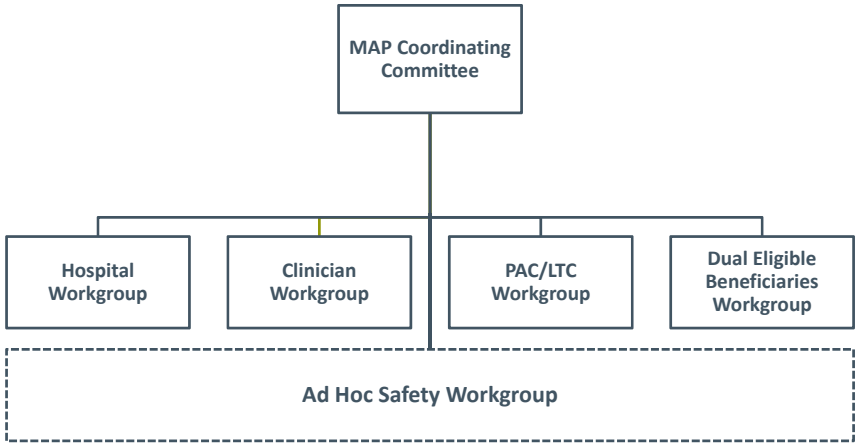
Learning from the Performance Measurement Coordination Strategy Tasks

- 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



Measure Applications Partnership
CONVENED BY THE NATIONAL QUALITY FORUM

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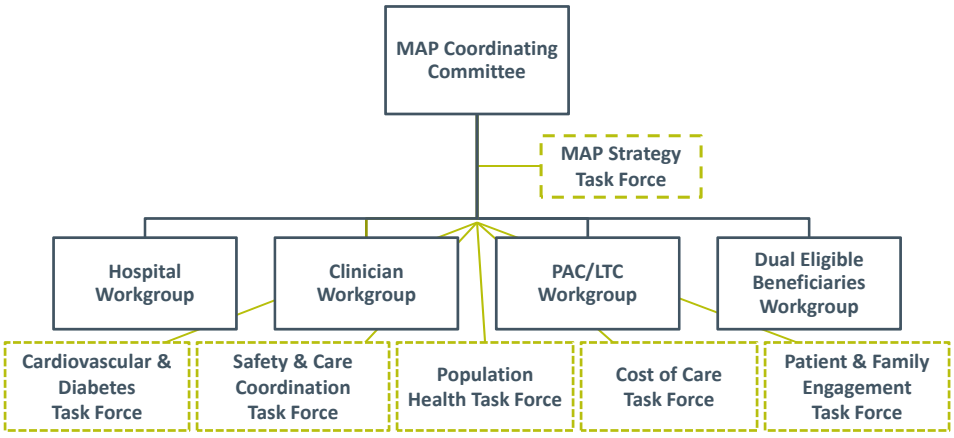
Proposed MAP Structure



Measure Applications Partnership
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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)

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)

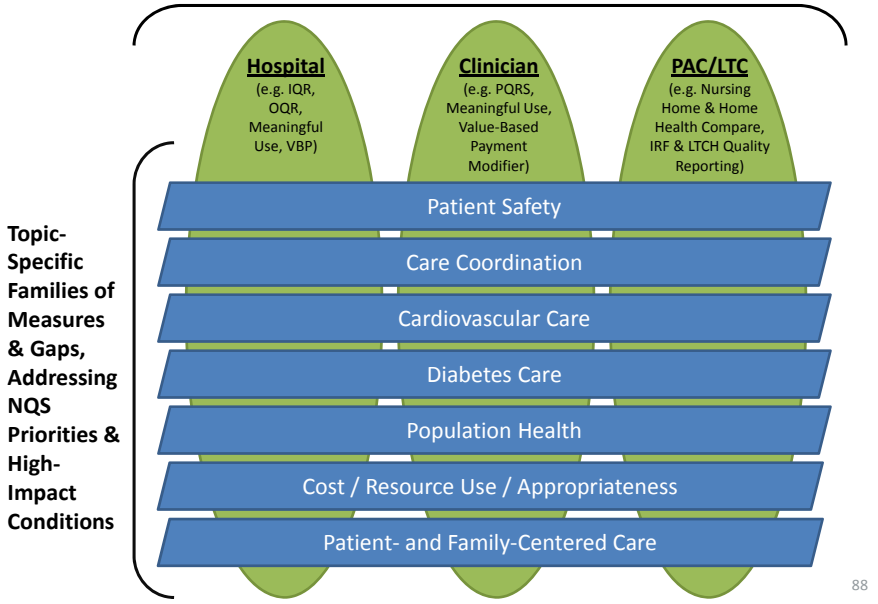
Proposed MAP Work for 2012-13: Families of Measures

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



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

Next Steps

Upcoming Meetings

Coordinating Committee Web Meeting
TBD April/May, 2012

All MAP Orientation Web Meeting
TBD May , 2012