NATIONAL QUALITY FORUM

Measure Applications Partnership: 2014 Interim Report from Dual Eligible Beneficiaries Workgroup

DRAFT FOR PUBLIC COMMENT

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Introduction

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

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

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

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

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

Family of Measures for Dual Eligible Beneficiaries

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

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

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

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

MAP considered hundreds of measures for possible inclusion in the family of measures and evaluated their suitability for addressing the needs of the heterogeneous dual eligible population. Selected measures also needed to capture complex care experiences that extend across varied care settings and types of healthcare providers. The Family of Measures for Dual Eligible Beneficiaries is listed in detail in Appendix D. Considered broadly, the family of measures captures concepts of critical importance to the

dual eligible population: care that is responsive to patients' experiences and preferences, the need for follow-up, treatment for behavioral health conditions, and ongoing management of health conditions and risks.

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

As part of MAP's exploration of performance measures as tools to monitor and encourage progress on improving quality and affordability of care, it has discussed unique considerations for high-need beneficiaries. MAP systematically considered several distinct high-need subgroups within the dual eligible beneficiary population with the objective of ensuring that the family of measures was comprehensive enough to be relevant to all of them. The subgroups considered are:

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

Although the groups overlap to some degree, the high-need groups are organized around factors that are predictive of clinical complexity and high expenditures, such as long-term care needs and behavioral health diagnoses. The reasoning underlying this approach is that large gains can be achieved by targeting improvement efforts toward the most costly types of care and subpopulations with the highest levels of inappropriate utilization.

In 2009, 9.2 million dual eligible beneficiaries comprised 19 percent of the Medicare population but 34 percent of Medicare spending, and 14 percent of the Medicaid population but 34 percent of Medicaid spending. More than half of dual eligible beneficiaries have at least one disabling limitation in activities of daily living (ADLs); 24 percent have one to two ADL limitations and 31 percent have three to six ADL limitations.[3] The distribution of chronic health conditions varies greatly across age groups. For example, 23 percent of beneficiaries age 65 and older are diagnosed with Alzheimer's disease or related dementia, more than 5 times the rate for beneficiaries under age 65. Beneficiaries younger than 65 experience significantly higher rates of behavioral health conditions, such as schizophrenia and depression, than older beneficiaries.[4]

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

Using the Family of Measures for Measure Selection

A measure did not need to fulfill all of the seven properties described above to be selected for the family of measures. However, to be considered comprehensive, the family of measures should encompass all of the characteristics when considered as a whole. Because it was not compiled with a single application in mind, the family of measures covers each of the five high-leverage opportunity areas, a range of measure types, and many settings of care. Some measures could be applied to the care delivered to all or most dual eligible beneficiaries. Others are primarily important for a significant subgroup of the

population, such as individuals receiving hospice care or with serious mental illness. In the future, greater fit-for-purpose might be achieved by generating a measure set with specific program goals and capabilities in mind. Until these details emerge, MAP emphasizes the importance of the quality issues addressed by each of the measures in the family.

Stakeholders planning quality measurement programs can use the family of measures as a starting place for measure selection. Because of the many differences in measures' underlying designs and specifications, it is unlikely that a single program would use all of the measures in the family. Once a draft measure set is available, one can apply the MAP Measure Selection Criteria (Appendix E) to evaluate fit-for-purpose and general agreement with MAP principles. The subset of measures selected for use in the field should be implemented according to their endorsed specifications to maintain their scientific properties of validity and reliability.

Starter Set of Measures

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

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

High-Priority Measure Gaps

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

- Goal-directed, person-centered care planning and implementation
- Shared decision-making
- Systems to coordinate healthcare with non-medical community resources and service providers
- Beneficiary sense of control/autonomy/self-determination
- Psychosocial needs

- Community integration/inclusion and participation
- Optimal functioning (e.g., improving when possible, maintaining, managing decline)

In its July 2013 memo, MAP recommended that HHS engage measure developers in creating and publishing a plan to address measurement gaps. MAP will continue to discuss strategies for filling gaps with organizations that fund and perform measure development to facilitate forward progress. Resources are needed for research activities to explore new methodologies for measurement of complex topics, especially non-clinical processes and outcomes.

Cross-Program Alignment

The Medicaid and Medicare programs providing benefits and services to dual eligible beneficiaries were not designed to work together. Moreover, healthcare systems and providers must report data to meet many different requirements for payment, accreditation, quality improvement, and other purposes. When demands of various programs are redundant or in conflict, valuable resources are wasted. MAP emphasizes aligning performance measurement programs to alleviate this type of burden on the health system. Alignment, that is, purposeful use of the same or related measures across programs, can simplify measurement efforts and produce more usable information to drive quality improvement.

During the 2013/2014 MAP Pre-Rulemaking activities, MAP applied the MSC (Appendix E) to evaluate measures under consideration for inclusion in Federal quality reporting programs, including criterion #7: Program measure set promotes parsimony and alignment. MAP considered alignment information, particularly uptake of measures from across MAP's various families of measures. Aligned performance measurement provides clearer direction and stronger incentives to achieve shared goals, while also reducing data collection burden. Analysis shows that the majority of measures in the family of measures for dual eligible beneficiaries are in use across HHS programs. Table 1 quantifies the alignment of measures from the family of measures for dual eligible beneficiaries across Federal quality measurement programs. Specifically:

- 30 of the measures in the family are currently in use in two or more HHS programs.
- Nine additional measures are in use in one HHS program.
- Nine of the measures were under consideration in the 2013/2014 pre-rulemaking cycle for potential inclusion in a Federal program; several were under consideration for use in multiple programs.
- MAP voiced support or conditional support for use of eight of the nine measures under consideration in the 2014 pre-rulemaking report.

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

Federal Programs	Measures from Family Currently Used In Program*	Measures from Family Under Consideration** with MAP Support or Conditional Support
Ambulatory Surgical Centers Quality Reporting Program		
Children's Health Insurance Program Reauthorization Act (CHIPRA)	1	n/a

Federal Programs	Measures from Family Currently Used In Program*	Measures from Family Under Consideration** with MAP Support or Conditional Support
End Stage Renal Disease Quality Initiative Program		3
Home Health Quality Reporting	1	
Hospice Quality Reporting Program		
Hospital-Acquired Condition Reduction Program		
Hospital Inpatient Quality Reporting Program	4	
Hospital Outpatient Quality Reporting		
Hospital Readmissions Reduction Program		1
Hospital Value-Based Purchasing Program	2	
Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults	11	n/a
Inpatient Psychiatric Facilities Quality Reporting	5	1
Inpatient Rehabilitation Facility Quality Reporting		1
Long-Term Care Hospital Quality Reporting	1	
Medicare and Medicaid EHR Incentive Program for Eligible Professionals	13	
Medicare and Medicaid EHR Incentive Program for Hospitals and Critical Access Hospitals (CAHs)		1
Medicare Part C	7	n/a
Medicare Part D	2	n/a
Medicare Shared Savings Program	10	2
Nursing Home Quality Initiative and Nursing Home Compare	2	
Physician Compare		1
Physician Feedback Program	10	1
Physician Quality Reporting System	20	1
PPS-Exempt Cancer Hospital Quality Reporting Program	1	
Value-Based Payment Modifier		1

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

Table 1 includes Federal programs that are beyond the scope of MAP's pre-rulemaking deliberations. Measure use in these programs shows increased alignment but there was not a specific opportunity to consider use of the family of measures within each program measure set. These programs are listed with the designation "n/a" in the column describing MAP's 2014 pre-rulemaking decisions.

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

In addition, stakeholders across the measurement enterprise are engaged in measurement efforts to facilitate local public reporting of quality information, value-based purchasing, and other types of quality improvement incentives. These programs include NCQA's HEDIS measure set, the Buying Value Initiative, Beacon communities, and various health plan initiatives, among others. Table 2 provides a count of the measures within the family of measures that are in use in state and private programs.

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

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

Updates to the Family of Measures

Families of measures are moderately flexible to adapt to change over time as new measures become available and/or previously selected measures no longer comport with current evidence. Refinements can be made on an ongoing basis to accommodate the currently available measures and experience with measure use. Throughout its future work, MAP will continue to consider relevant measures that receive NQF endorsement for inclusion in the family and alternatives for measures that do not maintain NQF-endorsed status. MAP also welcomes comments on the contents of the current family of measures for consideration by the Dual Eligible Beneficiaries Workgroup and MAP Coordinating Committee. A revised family of measures will be published as needed periodically going forward.

Quality of Life Measurement

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

Economists, social scientists, and others have long been interested in quantifying quality of life and have developed many formulas and indexes to compare the relative quality of life across populations and nations. Although there are various definitions and understandings, there is a general agreement that

quality of life is multidimensional and an adequate assessment must include many facets of personal experience. Existing measures tend to incorporate both objective and subjective data in physical, material, social, emotional, and developmental domains.

MAP emphasizes that quality of life measures should reflect a broad view of health and wellbeing. MAP considered context provided by the NQF Patient-Reported Outcome Measurement Framework along with potential uses and limitations of measurement tools currently in use for other applications. MAP discussed the applicability of these concepts to quality measurement and improvement for dual eligible beneficiaries.

Patient-Reported Outcome Measurement Framework

Patient-reported outcomes (PROs) are defined as "any report of the status of a patient's [or person's] health condition, health behavior, or experience with healthcare that comes directly from the patient, without interpretation of the patient's response by a clinician or anyone else."[5] PRO domains that are highly applicable to dual eligible beneficiaries include:

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

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

A PRO-based performance measure (PRO-PM) is based on PRO data aggregated for an entity deemed accountable for the quality of care or services delivered. Such entities can include long-term support services providers, hospitals, physician practices, or accountable care organizations (ACOs). NQF endorses PRO-PMs for purposes of performance improvement and accountability; NQF does not endorse PROMs alone. However, the specific PROM(s) used as a data source to calculate a PRO-PM will be identified in the detailed measure specifications to ensure standardization and comparability of performance results. Table 3 describes the differences among PROs, PROMs, and PRO-based performance measures using the example of outcomes for clinical depression.[1]

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

Term	Definition	Example: Patients With Clinical Depression
PRO (patient reported outcome)	The concept of any report of the status of a patient's health condition that comes directly from the patient, without interpretation of the patient's response by a clinician or anyone else	Symptom: depression

Term	Definition	Example: Patients With Clinical Depression
PROM (patient reported outcome measure)	Instrument, scale, or single-item measure used to assess the PRO concept as perceived by the patient, obtained by directly asking the patient to self-report	PHC-9©, standardized tool to assess depression
PRO-PM (PRO-based performance measure)	A performance measure that is based on PROM data aggregated for an accountable healthcare entity	Percentage of patients with diagnosis of major depression or dysthymia and initial PHQ-9 score>9 with a follow-up PHQ-9 score <5 at 6 months (NQF #0711).

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

Performance measures built on beneficiary-reported information (such as through a survey) can be submitted for endorsement through the same mechanism as other performance measures. Fundamentally, they must meet the NQF Measure Evaluation Criteria. Again, NQF does not endorse tools or surveys alone but rather specific performance measures embedded within tools or surveys or calculated from their results.

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

Current Resources for Measuring Quality of Life

There are many tools to measure quality of life at the macro level, but relatively few at the micro level. Even fewer attempt to assign responsibility for producing improved quality of life outcomes to an accountable entity. A subset of quality of life measures focus on health related quality of life. These measures and tools will often survey symptoms, functions, and everyday activity limitations without exploring other domains. From MAP's perspective, an important shortcoming of current methods is the

lack of inclusion of person-centered concepts of dignity and self-determination. MAP reviewed several well-known measurement tools to gauge their potential to measure quality of life outcomes in the dual eligible beneficiary population.

SF-36 and Related Tools

The RAND 36-Item Health Survey (SF-36) is a widely used health status questionnaire. The SF-36 includes general components for physical and mental health. Each component has four scales that combine to yield a score. Each of the eight total scales has a portion of the 36 items that contribute to that factor. [6] This measurement tool was constructed for administration by a trained interviewer or self-administration. Shorter versions of the tool have emerged over time, including a 12-item version and 8-item version. The SF-36 is available in many different languages.

The SF-36 and related surveys can be very used to measure health improvement or decline, predict medical expenses, assess treatment effectiveness, or compare disease burden across populations. However, the tools do not target signs and symptoms related to sleeping patterns, memory, concentration, substance abuse, hearing, vision, and many other topics of importance to dual eligible beneficiaries and others with complex care needs.[7]

World Health Organization Quality of Life Instrument (WHOQOL)

The World Health Organization (WHO) has developed a cross-cultural quality of life measurement tool, the WHOQOL, and related resources. The WHOQOL is a self-reported survey that contains 100 items; the WHOQOL-BREF is an abbreviated version containing 26 items. Both score four domains related to quality of life: physical health, psychological health, social relationships, and environment.[8] An additional 32 item module has been developed to assess aspects of spirituality and beliefs. Development involved the participation of 15 field centers worldwide; the tools are available in more than 20 languages.

The WHOQOL and WHOQOL-BREF have been used effectively in vulnerable populations, including cancer patients, older adults, and individuals with HIV/AIDS. The tools have been used in medical practice to assess the effectiveness and relative merits of different treatments, as well as in health services research to determine how diseases affect the subjective wellbeing of a person. However, permission to use the WHOQOL must be obtained for each individual study and this can be limiting when considering scalability.

Patient Reported Outcomes Measurement Information System (PROMIS)

In 2004, the National Institutes of Health established the Patient Reported Outcomes Measurement Information System (PROMIS) as a national resource for accurate and efficient measurement of patient symptoms and other health outcomes in clinical practice. It is a publicly available platform to gather self-reported measures of symptoms, functions, and wellbeing. PROMIS includes common domains and metrics across conditions, allowing for comparisons across domains and diseases.[9]

The PROMIS is organized into broad domains for physical, mental, and social health and specific profile domains contribute to each one. The instrument can be administered through short forms or more dynamically through computerized adaptive testing. Users can mix and match domains as needed, depending on what they want to assess. However, a respondent would need to answer multiple item banks to provide enough data to assess his or her total quality of life. Additionally, some research has shown some accessibility issues for people with disabilities.[10]

Participant Experience Survey for Home- and Community-Based Services

Two of every three recipients of Medicaid home- and community-based services (HCBS) are dual eligible beneficiaries.[11,12] Under funding from HHS, Truven Health Analytics and the American Institutes for Research have developed and are testing a participant experience survey for HCBS. MAP previously noted measures of HCBS as a major development gap area and has underscored their importance for evaluating many of the non-medical aspects of high-quality care. The goal of the survey is to gather feedback on an individual's experience with HCBS at the program level. Some of the survey domains address social and nonmedical factors related to quality of life, such as whether an individual is getting needed services, personal safety, and community inclusion and empowerment. Once testing is complete, the research team plans to pursue a CAHPS trademark for the survey from the Agency for Healthcare Research and Quality (AHRQ). MAP will continue to follow the progress of this effort through testing and refinement of the instrument.

Money Follows the Person Quality of Life Survey

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

The MFP Quality of Life Survey showed that MFP participants experienced increased quality of life after transitioning to community living. Participants reported the largest improvement in satisfaction with their living arrangements. The MFP Quality of Life Survey assesses satisfaction with care as well as unmet needs for personal care assistance and treatment providers to ensure that individuals are receiving the supports they need to live independently in the community.[13] Workgroup members discussed the importance of self determination and the concept of dignity in contributing to psychological well-being as measured by this survey.

Potential Domains for Measurement of Quality of Life

During this initial phase of work on quality of life, MAP identified four domains of quality of life measured in the tools described above: physical health, mental and psychological health, social relationships, and environment. These domains are represented across the resources currently available to assess quality of life. Measures of health-related quality of life would be captured within the physical health domain. Measureable elements of each of these domains include, but are not limited to, the following:

- **Physical Health**: physical functioning, general health, pain, sleep, fatigue, mobility, activities, access to food, obesity, and work capacity
- **Mental and Psychological Health:** Mental health, behavioral health, substance abuse, depression, anxiety, vitality, spirituality, thinking, body, self-esteem, emotions, positive and negative feelings, choice and control, respect and dignity, and satisfaction

- **Social Relationships:** Social functioning, culture relationships, family and friends, social support, sexual activity, satisfaction in participation with social roles, community integration and inclusion, recreation, relationship building, health literacy, disparities, and violence
- **Environment:** Freedom, safety, home and housing, finances, information, services, environment, leisure, transport, and access to needed services and unmet needs

Challenges and Opportunities for Measurement of Quality of Life

In reviewing current resources that assess quality of life, MAP identified both opportunities and challenges for future measurement in the dual eligible beneficiary population. In general, MAP members observed that assessment of quality of life outcomes is not performed routinely in current models of delivering care and supports. Nearly all structures and processes could do more to promote person-centered service delivery with the goal of improving quality of life outcomes. Performance measurement has a role in assessing progress in these efforts, but needs to be coupled with other strategies including advocacy, regulation, and internal quality improvement activities to be most effective. However, all parts of the system have some responsiblity for quality of life outcomes. Much remains to be done in designing a fair and equitable schema that allows for beneficiaries to express their autonomy and for providers and other entities to share responsibility for such a global indicator.

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

An important element of the domain of mental/psychological health is a sense of control or self-determination. Control over the type of care one receives, when it is available, and where it is administered are important components of self-determination. A recent meta-analysis of studies that utilized self-determination theory in health care and health promotion contexts found a positive correlation between self-determination theory and mental and physical health, as well as satisfaction.[14] The ability to make one's own choices is highly valuable to consumers and repeatedly emphasized in MAP discussions. Important principles of this type have recently been formalized in the final rule released by HHS on January 16, 2014: Medicaid Program for State Plan Home and Community-Based Services Final Rule. The rule describes numerous requirements for home-and community-based settings that will enhance person-centeredness and autonomy in decision-making.

Path Forward

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

of life measurement and begun to explore opportunities and challenges for moving forward from various stakeholder perspectives. In the coming year, MAP will continue to deliberate about gaps in measurement and ways to more quickly fill those voids.

NQF will also facilitate the essential connection between the MAP Dual Eligible Beneficiaries Workgroup and ongoing work to endorse new measures. The MAP Dual Eligible Beneficiaries Workgroup will also closely synchronize efforts and recommendations with the upcoming MAP Medicaid Task Force. NQF and MAP welcome commenters' input on the future direction of measurement for dual eligible beneficiaries and how MAP's multi-stakeholder process can continue to add value to ongoing quality improvement efforts.

Appendix A: MAP Background

Purpose

The Measure Applications Partnership (MAP) is a public-private partnership convened by the National Quality Forum (NQF) for providing input to the Department of Health and Human Services (HHS) on selecting performance measures for public reporting, performance-based payment, and other programs. The statutory authority for MAP is the Affordable Care Act (ACA), which requires HHS to contract with NQF (as the consensus-based entity) to "convene multi-stakeholder groups to provide input on the selection of quality measures" for various uses.[15]

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

MAP is designed to facilitate progress on the aims, priorities, and goals of the National Quality Strategy (NQS)—the national blueprint for providing better care, improving health for people and communities, and making care more affordable.[16] Accordingly, MAP informs the selection of performance measures to achieve the goal of **improvement, transparency, and value for all**.

MAP's objectives are to:

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

Coordination with Other Quality Efforts

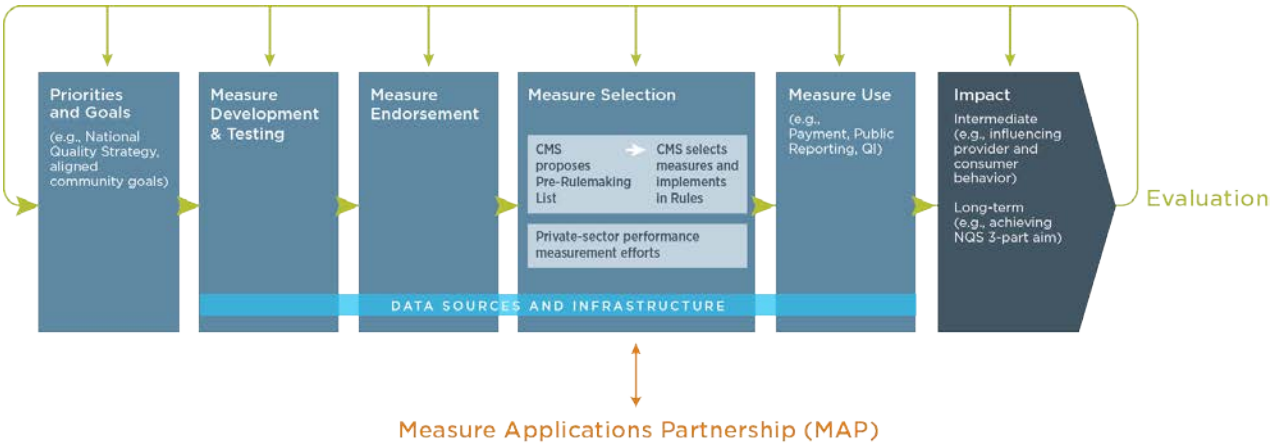
MAP activities are designed to coordinate with and reinforce other efforts for improving health outcomes and healthcare quality. Key strategies for reforming healthcare delivery and financing include publicly reporting performance results for transparency and healthcare decisionmaking, aligning payment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

Foundational to the success of all of these efforts is a robust Quality Enterprise (see Figure 1) that includes:

- **Setting priorities and goals.** The work of the Measure Applications Partnership is predicated on the National Quality Strategy and its three aims of better care, affordable care, and healthy people/healthy communities. The NQS aims and six priorities provide a guiding framework for the work of the MAP, in addition to helping align it with other quality efforts.
- **Developing and testing measures.** Using the established NQS priorities and goals as a guide, various entities develop and test measures (e.g., PCPI, NCQA, The Joint Commission, medical specialty societies).
- **Endorsing measures.** NQF uses its formal Consensus Development Process (CDP) to evaluate and endorse consensus standards, including performance measures, best practices, frameworks, and reporting guidelines. The CDP is designed to call for input and carefully consider the interests of stakeholder groups from across the healthcare industry.
- **Measure selection and measure use.** Measures are selected for use in a variety of performance measurement initiatives conducted by federal, state, and local agencies; regional collaboratives; and private-sector entities. MAP's role within the Quality Enterprise is to consider and recommend measures for public reporting, performance-based payment, and other programs. Through strategic selection, MAP facilitates measure alignment of public- and private-sector uses of performance measures.
- **Impact.** Performance measures are important tools to monitor and encourage progress on closing performance gaps. Determining the intermediate and long-term impact of performance measures will elucidate if measures are having their intended impact and are driving improvement, transparency, and value.
- **Evaluation.** Evaluation and feedback loops for each of the functions of the Quality Enterprise ensure that each of the various activities is driving desired improvements.

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

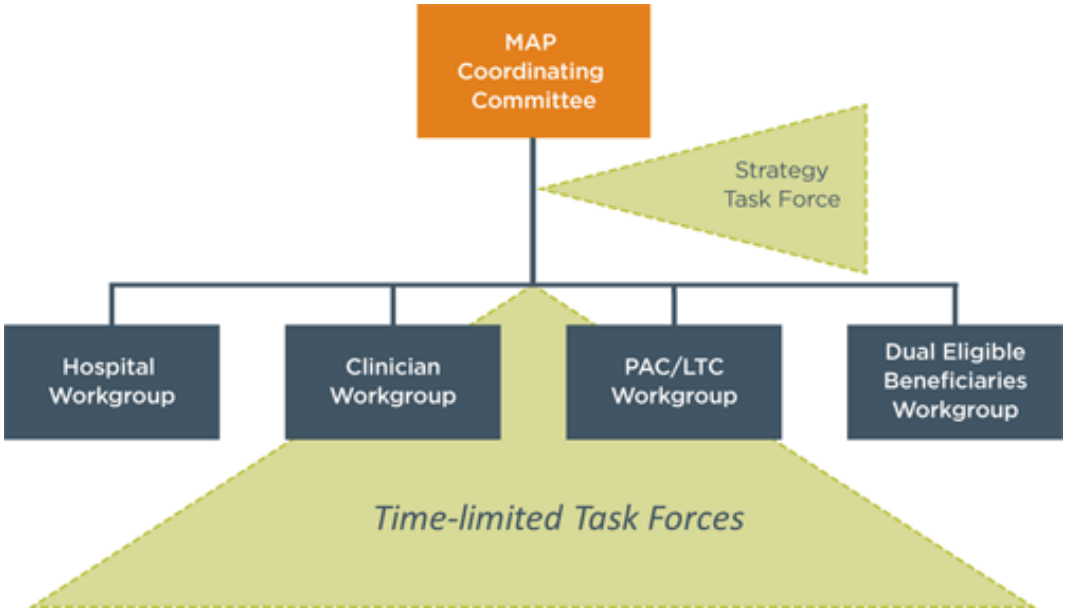
Figure A1. Quality Measurement Enterprise



Structure

MAP operates through a two-tiered structure (see Figure 2). The MAP Coordinating Committee provides direction to the MAP workgroups and task forces and final input to HHS. MAP workgroups advise the Coordinating Committee on measures needed for specific care settings, care providers, and patient populations. Time-limited task forces charged with developing "families of measures"—related measures that cross settings and populations—and a multiyear strategic plan provide further information to the MAP Coordinating Committee and workgroups. Each multistakeholder group includes representatives from public- and private-sector organizations particularly affected by the work and individuals with content expertise.

Figure A2. MAP Structure



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

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

MAP decisionmaking is based on a foundation of established guiding frameworks. The NQS is the primary basis for the overall MAP strategy. Additional frameworks include the NQF-endorsed® Patient-Focused Episodes of Care framework,[17] the HHS Partnership for Patients safety initiative,[18] the HHS Prevention and Health Promotion Strategy, [19] the HHS Disparities Strategy,[20] and the HHS Multiple Chronic Conditions framework.[21]

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

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

Timeline and Deliverables

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

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

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

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

Appendix B: Dual Eligible Beneficiaries Workgroup Roster

CHAIR (VOTING)
Alice Lind, MPH, BSN

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

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

FEDERAL GOVERNMENT MEMBERS (NON-VOTING, EX OFFICIO)	REPRESENTATIVE
Agency for Healthcare Research and Quality	D.E.B. Potter, MS
CMS Federal Coordinated Healthcare Office	Cheryl Powell
Health Resources and Services Administration	Samantha Meklir, MPP
Administration for Community Living	Jamie Kendall, MPP
Substance Abuse and Mental Health Services Administration	Lisa Patton, PhD

Veterans Health Administration	Daniel Kivlahan, PhD

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

Appendix C: MAP Coordinating Committee Roster

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

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

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

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

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

Appendix D. Family of Measures for Dual Eligible Beneficiaries

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

NQF Measure Number, Endorsement Status, Title, and Steward	Measure Type	Measure Description	Level of Analysis	Other Known Uses and Program Alignment	Workgroup Comments
		1. Shared Decision Making Composite 1. Health Promotion and Education item 2. Coordination of Care item			
0008 Endorsed Experience of Care and Health Outcomes (ECHO) Survey (behavioral health, managed care versions) Measure Steward: AHRQ **Starter Set Measure**	Composite	52 questions including patient demographic information. The survey measures patient experiences with behavioral health care (mental health and substance abuse treatment) and the organization that provides or manages the treatment and health outcomes. Level of analysis: health plan- HMO, PPO, Medicare, Medicaid, commercial	Health Plan	State Duals Demonstrations: CA, IL, MA, OH	Expand care setting to include Behavioral Health Care; Surveys restricting proxy respondents may exclude disabled consumers who have difficulties communicating
0018 Endorsed Controlling High Blood Pressure Measure Steward: NCQA **Starter Set Measure**	Outcome	The percentage of patients 18 to 85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/ 90) during the measurement year.	Health Plan; Integrated Delivery System	Federal and State Programs: Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults; Meaningful Use-EP; Medicare Part C Plan Rating; Medicare Shared Savings Program; PQRS; HRSA; Medicaid Health Home, Special Needs Plan State Duals Demonstrations:: CA, IL, MA, OH, VA Private Programs: eValue8; at least 1 Beacon community; HEDIS; Wellpoint; Buying Value core	Quality issue of particular importance to address access to preventive services needed to reduce disproportionate effect of chronic conditions; Incorporate chronic disease management and preventive services into person-centered care plan

NQF Measure Number, Endorsement Status, Title, and Steward	Measure Type	Measure Description	Level of Analysis	Other Known Uses and Program Alignment	Workgroup Comments
				ambulatory measure	
0022 Endorsed Use of High Risk Medications in the Elderly Measure Steward: NCQA **Starter Set Measure**	Process	a: Percentage of Medicare members 66 years of age and older who received at least one high-risk medication. b: Percentage of Medicare members 66 years of age and older who received at least two different high-risk medications. For both rates, a lower rate represents better performance.	Health Plan; Integrated Delivery System	Federal and State Programs: Meaningful Use-EP; Medicare Part D Plan Rating; Physician Feedback; PQRS; Value-Based Payment Modifier Program; Special Needs Plan State Duals Demonstration: MA Private Programs: HEDIS; Buying Value core ambulatory measure	Important due to the possibility of drug/disease and drug/drug interactions; Expand age range of measure to apply to younger at-risk groups
0027 Endorsed Medical Assistance With Smoking and Tobacco Use Cessation Measure Steward: NCQA	Process	Assesses different facets of providing medical assistance with smoking and tobacco use cessation: Advising Smokers and Tobacco Users to Quit: A rolling average represents the percentage of members 18 years of age and older who were current smokers or tobacco users and who received advice to quit during the measurement year. Discussing Cessation Medications: A rolling average represents the percentage of members 18 years of age and older who were current smokers or tobacco users and who discussed or were recommended cessation medications during the measurement year. Discussing Cessation Strategies: A rolling	Health Plan	Federal and State Programs: Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults; Meaningful Use-EP; PQRS Private Programs: HEDIS; Wellpoint	Encourage health plans to use this measure; Surveys restricting proxy respondents may exclude disabled consumers who have difficulties communicating; Incorporate cessation services into person-centered care plan; Particularly important for population with behavioral health needs because of historical misuse of cigarettes as incentives

NQF Measure Number, Endorsement Status, Title, and Steward	Measure Type	Measure Description	Level of Analysis	Other Known Uses and Program Alignment	Workgroup Comments
		average represents the percentage of members 18 years of age and older who were current smokers or tobacco users and who discussed or were provided smoking cessation methods or strategies during the measurement year.			
0028 Endorsed Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention Measure Steward: AMA-PCPI **Starter Set Measure**	Process	Percentage of patients aged 18 years and older who were screened for tobacco use at least once during the two-year measurement period AND who received cessation counseling intervention if identified as a tobacco user	Clinician: Group/ Practice, Individual, Team	Federal and State Programs: Meaningful Use-EP; Medicare Shared Savings Program; PQRS State Duals Demonstration: MA Private Programs: eValue8 At least 1 Beacon community; Buying Value core ambulatory measure	Screening every two years may not be sufficient; Only measures clinicians despite other opportunities for tobacco use interventions; Incorporate chronic disease management and preventive services into person-centered care plan; Particularly important for population with behavioral health needs
0032 Endorsed Cervical Cancer Screening Measure Steward: NCQA	Process	Percentage of women 21–64 years of age received one or more Pap tests to screen for cervical cancer.	Clinician: Group/ Practice, Individual; Health Plan	Federal and State Programs: Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults; Meaningful Use-EP; PQRS; HRSA State Duals Demonstrations: IL, MA Private Programs: HEDIS; Wellpoint; Aetna; AmeriHealth Mercy Family of	Quality issue of particular importance to address access to care and accessible services/equipment for individuals with disabilities and/or SMI; Access to preventive services needed to reduce disproportionate effect of chronic conditions; Incorporate chronic disease

NQF Measure Number, Endorsement Status, Title, and Steward	Measure Type	Measure Description	Level of Analysis	Other Known Uses and Program Alignment	Workgroup Comments
				Companies; Cigna; IHA; AHIP survey - Measures used by a Majority of Health Plans; Buying Value core ambulatory measure	management and preventive services into person-centered care plan
0034 Endorsed Colorectal Cancer Screening Measure Steward: NCQA	Process	The percentage of members 50–75 years of age who had appropriate screening for colorectal cancer.	Clinician: Group/ Practice, Individual, Team; Health Plan	Federal and State Programs: Meaningful Use-EP; Medicare Part C Plan Rating; Medicare Shared Savings Program; Physician Feedback; PQRS; HRSA; Special Needs Plan State Duals Demonstrations: CA, IL, MA, OH, VA Private Programs: eValue8; at least 1 Beacon community; HEDIS ; Wellpoint; Aetna; Community Health Alliance; IHA; AHIP survey - Measures used by a Majority of Health Plans; Buying Value core ambulatory measure	Quality issue of particular importance to address access to care and accessible services/equipment for individuals with disabilities and/or SMI; Access to preventive services needed to reduce disproportionate effect of chronic conditions; Incorporate chronic disease management and preventive services into person-centered care plan
0043 Endorsed Pneumonia vaccination status for older adults Measure Steward: NCQA	Process	Percentage of patients 65 years of age and older who ever received a pneumococcal vaccination	Population: County or City; Facility; Health Plan; Integrated Delivery System; Clinician: Group/	Federal and State Programs: Meaningful Use-EP, Medicare Part C Plan Rating, Medicare Shared Savings Program, Physician Feedback,	Vaccinations are especially important for persons living in institutional settings or otherwise at high risk of

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

NQF Measure Number, Endorsement Status, Title, and Steward	Measure Type	Measure Description	Level of Analysis	Other Known Uses and Program Alignment	Workgroup Comments
		C) Plan of Care to Prevent Future Falls: Percentage of patients aged 65 years and older with a history of falls who had a plan of care for falls documented within 12 months			decision-making about fall prevention methods is important
0105 Endorsed Antidepressant Medication Management (AMM) Measure Steward: NCQA	Process	The percentage of members 18 years of age and older with a diagnosis of major depression and were newly treated with antidepressant medication, and who remained on an antidepressant medication treatment. Two rates are reported. a) Effective Acute Phase Treatment. The percentage of newly diagnosed and treated members who remained on an antidepressant medication for at least 84 days (12 weeks). b) Effective Continuation Phase Treatment. The percentage of newly diagnosed and treated members who remained on an antidepressant medication for at least 180 days (6 months).	Clinician: Group/ Practice, Individual; Health Plan; Integrated Delivery System; Population: National, Regional, State	Federal and State Programs: Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults; Meaningful Use-EP; Medicare Part C Plan Rating; Physician Feedback; PQRS; Value-Based Payment; Special Needs Plan State Duals Demonstrations: CA, IL, MA, OH, VA Private Programs: HEDIS; Cigna; AHIP survey - Measures used by a Majority of Health Plans; Buying Value core ambulatory measure	Important due to the possibility of drug/drug and drug/disease interactions; Incorporate medication management into person-centered care plan
0111 Endorsed Bipolar Disorder: Appraisal for risk of suicide Measure Steward: Center for Quality Assessment and Improvement in Mental	Process	Percentage of patients with bipolar disorder with evidence of an initial assessment that includes an appraisal for risk of suicide.	Clinician: Group/ Practice, Individual		Expand suicide risk screening to entire SMI population; Incorporate assessment into person-centered care plan and conduct appropriate follow-up

NQF Measure Number, Endorsement Status, Title, and Steward	Measure Type	Measure Description	Level of Analysis	Other Known Uses and Program Alignment	Workgroup Comments
Health					
0176 Endorsed Improvement in management of oral medications Measure Steward: CMS	Outcome	Percentage of home health episodes of care during which the patient improved in ability to take their medicines correctly, by mouth.	Facility	Federal and State Programs: Home Health Quality Reporting	Measure should include a patients and/or caregiver education component to ensure they understand the medications; Important due to the possibility of drug/drug and drug/disease interactions
0201 Endorsed Pressure ulcer prevalence (hospital acquired) Measure Steward: The Joint Commission	Outcome	The total number of patients that have hospital-acquired (nosocomial) category/ stage II or greater pressure ulcers on the day of the prevalence measurement episode.	Facility; Clinician: Team	Private Programs: National Database of Nursing Quality Indicators (NDNQI); Alternative Quality Contract Wellpoint	Emphasized importance for individuals with limited mobility and/or cognitive impairments
0202 Endorsed Falls with injury Measure Steward: American Nurses Association	Outcome	All documented patient falls with an injury level of minor or greater on eligible unit types in a calendar quarter. Reported as Injury falls per 1000 Patient Days. (Total number of injury falls / Patient days) X 1000 Measure focus is safety. Target population is adult acute care inpatient and adult rehabilitation patients.	Clinician: Team		Some thought measure should include all injuries rather than being limited to major injuries; Others noted that individuals may be comfortable with some risk of falling and shared decision-making about fall prevention methods is important
0228 Endorsed 3-Item Care Transition Measure (CTM-3)	Composite	Uni-dimensional self-reported survey that measures the quality of preparation for care transitions.	Facility	Federal and State Programs: Hospital Inpatient Quality	Expand care settings to include post-acute/long-term care settings;

NQF Measure Number, Endorsement Status, Title, and Steward	Measure Type	Measure Description	Level of Analysis	Other Known Uses and Program Alignment	Workgroup Comments
Measure Steward: University of Colorado Health Sciences Center **Starter Set Measure**				Reporting State Duals Demonstration: MA	Measure selected because it captures person/caregiver experience during care transitions but it may not be discrete enough in its assessment of individual/caregiver understanding of discharge instructions
0326 Endorsed Advance Care Plan Measure Steward: NCQA	Process	Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan.	Clinician: Group/ Practice, Individual	Federal and State Programs: Physician Feedback; PQRS; Special Needs Plan	Measure strongly supported for widespread use; Suggested expansion of denominator age group and application in all care settings; Measure promotes inclusion of personal preferences in care plan and this should be encouraged whenever possible
0418 Submitted Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan Measure Steward: CMS **Starter Set Measure**	Process	Percentage of patients aged 12 years and older screened for clinical depression using an age appropriate standardized tool AND follow-up plan documented	Clinician: Group/ Practice, Team, Individual; Population: National, Regional, State, County or City, Community	Federal and State Programs: Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults; Meaningful Use-EP; Medicare Shared Savings Program; Physician Feedback; PQRS; HRSA; Medicaid Health Home State Duals	Measure supported because it includes follow-up after screening; Incorporate behavioral health management and preventive services into person-centered care plan; USPSTF recommends measure for adults only

NQF Measure Number, Endorsement Status, Title, and Steward	Measure Type	Measure Description	Level of Analysis	Other Known Uses and Program Alignment	Workgroup Comments
				Demonstrations: CA, IL, MA, OH, VA, WA Private Programs: Bridges to Excellence	
0419 Endorsed Documentation of Current Medications in the Medical Record Measure Steward: CMS **Starter Set Measure**	Process	Percentage of specified visits for patients aged 18 years and older for which the eligible professional attests to documenting a list of current medications to the best of his/ her knowledge and ability. This list must include ALL prescriptions, over-the-counters, herbals, vitamin/ mineral/ dietary (nutritional) supplements AND must contain the medications' name, dosage, frequency and route ALL MEASURE SPECIFICATION DETAILS REFERENCE THE 2012 PHYSICIAN QUALITY REPORTING SYSTEM MEASURE SPECIFICATION.	Clinician: Individual; Population: National	Federal and State Programs: Meaningful Use-EP; Physician Feedback; PQRS	Measure excludes individuals with cognitive impairment without authorized representative so workgroup recommends providers make extra effort to include caregiver in the process; Measure should include an education component to ensure individual and caregiver understand the medications
0420 Endorsed Pain Assessment and Follow-Up Measure Steward: CMS	Process	Percentage of patients aged 18 years and older with documentation of a pain assessment through discussion with the patient including the use of a standardized tool(s) on each visit AND documentation of a follow-up plan when pain is present	Clinician: Individual	Federal and State Programs: Physician Feedback; PQRS	Appropriate instruments and tools are available to assess for pain experienced by persons with communication impairments and their use should be expanded; Incorporate assessment and follow-up into person-centered care plan
0421 Endorsed Preventive Care and Screening: Body Mass	Process	Percentage of patients aged 18 years and older with a calculated BMI in the past six months or during the current visit documented in the medical record AND if the most recent BMI is	Clinician: Group/ Practice, Individual; Population:	Federal and State Programs: Meaningful Use-EP; Medicare Shared Savings Program;	Quality issue of particular importance to address access to preventive services

NQF Measure Number, Endorsement Status, Title, and Steward	Measure Type	Measure Description	Level of Analysis	Other Known Uses and Program Alignment	Workgroup Comments
Index (BMI) Screening and Follow-Up Measure Steward: CMS **Starter Set Measure**		outside of normal parameters, a follow-up plan is documented within the past six months or during the current visit Normal Parameters: Age 65 years and older BMI > = to 23 and <30 Age 18 – 64 years BMI > = to 18.5 and <25	National, Regional, State, County or City	Physician Feedback; PQRS; HRSA State Duals Demonstration: MA Private Programs: At least 1 Beacon community; Wellpoint; Buying Value core ambulatory measure	needed to reduce disproportionate effect of chronic conditions; Incorporate chronic disease management and preventive services into person-centered care plan
0486 Endorsed Adoption of Medication e-Prescribing Measure Steward: CMS **Starter Set Measure**	Structure	Documents whether provider has adopted a qualified e-Prescribing system and the extent of use in the ambulatory setting.	Clinicians: Group, Individual	Federal and State Programs: E-Prescribing Incentive Program; Physician Feedback Private Programs: Aetna	e-Prescribing has been shown to improve medication safety; Measure demonstrates important structural capability
0553 Endorsed Care for Older Adults – Medication Review Measure Steward: NCQA	Process	Percentage of adults 66 years and older who had a medication review; a review of all a member's medications, including prescription medications, over-the-counter (OTC) medications and herbal or supplemental therapies by a prescribing practitioner or clinical pharmacist.	Clinician: Group/ Practice, Individual; Health Plan; Integrated Delivery System; Population: National, Regional, State	Federal and State Programs: Medicare Part C Plan Rating Private Programs: HEDIS; IHA	Important due to the possibility of drug/drug and drug/disease interactions; Measure could benefit other complex patients, so recommend expansion to other age groups and care settings
0554 Endorsed Medication Reconciliation Post-Discharge Measure Steward: NCQA	Process	The percentage of discharges from January 1– December 1 of the measurement year for members 66 years of age and older for whom medications were reconciled on or within 30 days of discharge.	Health Plan; Integrated Delivery System; Population: National, Regional, County or City	Federal and State Programs: Special Needs Plan State Duals Demonstration: CA Private Programs: HEDIS	Important because medications are often changed during inpatient stay; Measure could benefit other complex patients, so recommend expansion to other age groups and care settings

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

NQF Measure Number, Endorsement Status, Title, and Steward	Measure Type	Measure Description	Level of Analysis	Other Known Uses and Program Alignment	Workgroup Comments
					caregiver
0573 Endorsed HIV Screening: Members at High Risk of HIV Measure Steward: Health Benchmarks-IMS Health	Process	To ensure that members diagnosed or seeking treatment for sexually transmitted diseases be screened for HIV.	Health Plan; Clinician: Individual	Private Programs: Health Benchmarks	Dual eligible beneficiaries may be at high risk for HIV for a variety of reasons; Access to screening and treatment services needed
0576 Endorsed Follow-Up After Hospitalization for Mental Illness Measure Steward: NCQA **Starter Set Measure**	Process	This measure assesses the percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported. Rate 1. The percentage of members who received follow-up within 30 days of discharge Rate 2. The percentage of members who received follow-up within 7 days of discharge.	Clinician: Team; Health Plan; Integrated Delivery System; Population: National, Regional, State, County or City	Federal and State Programs: Children's Health Insurance Program Reauthorization Act Quality Reporting; Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults; Medicare Part C Plan Rating; Physician Feedback; PQRS; Medicaid Health Home, Special Needs Plan State Duals Demonstrations: CA, IL, MA, OH, VA, WA Private Programs: Wellpoint; HEDIS; Buying Value core ambulatory measure	Expand to include care settings where substance use/detox services are provided; Follow up within 30 days is too long of a time frame to address complex care needs for persons hospitalized for mental illness

NQF Measure Number, Endorsement Status, Title, and Steward	Measure Type	Measure Description	Level of Analysis	Other Known Uses and Program Alignment	Workgroup Comments
0640 Endorsed HBIPS-2 Hours of physical restraint use Measure Steward: The Joint Commission	Process	The number of hours that all patients admitted to a hospital-based inpatient psychiatric setting were maintained in physical restraint per 1000 psychiatric inpatient hours, overall and stratified by age groups: : Children (Age 1 through 12 years), Adolescents (Age 13 through 17 years), Adults (Age 18 through 64 years), Older Adults (Age greater than and equal to 65 years).	Facility	Federal and State Programs: Inpatient Psychiatric Facility Quality Reporting	This measure is only a minimum threshold and absence of restraints does not guarantee high-quality care; Emphasized importance of measure for individuals with SMI and cognitive impairments
0641 Endorsed HBIPS-3 Hours of seclusion use Measure Steward: The Joint Commission	Process	The number of hours that all patients admitted to a hospital-based inpatient psychiatric setting were held in seclusion per 1000 psychiatric inpatient hours, overall and stratified by age groups: Children (Age 1 through 12 years), Adolescents (Age 13 through 17 years), Adults (Age 18 through 64 years), Older Adults (Age greater than and equal to 65 years).	Facility	Federal and State Programs: Inpatient Psychiatric Facility Quality Reporting	This measure is only a minimum threshold and absence of seclusion use does not guarantee high-quality care; Emphasized importance of measure for individuals with SMI and cognitive impairments
0646 Endorsed Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/ Self Care or Any Other Site of Care) Measure Steward: AMA-PCPI	Process	Percentage of patients, regardless of age, discharged from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home or any other site of care, or their caregiver(s), who received a reconciled medication list at the time of discharge including, at a minimum, medications in the specified categories	Facility; Integrated Delivery System	Private Programs: ABIM MOC; Highmark	Measure addresses importance of communicating reconciled medication list from inpatient facility to individual/ caregiver/ next site of care but it does not go far enough to assess recipients' understanding of reconciled medication list

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

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

NQF Measure Number, Endorsement Status, Title, and Steward	Measure Type	Measure Description	Level of Analysis	Other Known Uses and Program Alignment	Workgroup Comments
0692 Endorsed Consumer Assessment of Health Providers and Systems (CAHPS®) Nursing Home Survey: Long-Stay Resident Instrument Measure Steward: AHRQ	Outcome	The CAHPS® Nursing Home Survey: Long-Stay Resident Instrument is an in-person survey instrument to gather information on the experience of long stay (greater than 100 days) residents currently in nursing homes. The Centers for Medicare & Medicaid Services requested development of this survey, and can be used in conjunction with the CAHPS Nursing Home Survey: Family Member Instrument and Discharged Resident Instrument. The survey instrument provides nursing home level scores on 5 topics valued by residents: (1) Environment; (2) Care; (3) Communication & Respect; (4) Autonomy and (5) Activities. In addition, the survey provides nursing home level scores on 3 global items.	Facility	State Duals Demonstration: VA Private Programs: Health Quality Council of Alberta, Canada	Surveys restricting proxy respondents may exclude disabled consumers who have difficulties communicating
0709 Endorsed Proportion of patients with a chronic condition that have a potentially avoidable complication during a calendar year. Measure Steward: Bridges to Excellence	Outcome	Percent of adult population aged 18 – 65 years who were identified as having at least one of the following six chronic conditions: Diabetes Mellitus (DM), Congestive Heart Failure (CHF), Coronary Artery Disease (CAD), Hypertension (HTN), Chronic Obstructive Pulmonary Disease (COPD) or Asthma, were followed for one-year, and had one or more potentially avoidable complications (PACs). A Potentially Avoidable Complication is any event that negatively impacts the patient and is potentially controllable by the physicians and hospitals that manage and co-manage the patient. Generally, any hospitalization related to the patient's core chronic condition or any co-morbidity is considered a potentially avoidable complication, unless that hospitalization is considered to be a typical service for a patient with that condition. Additional PACs that can	Clinician: Group/ Practice; Health Plan; Population: National, Regional, County or City, State	Private Programs: Prometheus	These chronic conditions are common among dual eligible beneficiaries and regular access to services is needed to prevent complications; Incorporate chronic disease management and preventive services into person-centered care plan

NQF Measure Number, Endorsement Status, Title, and Steward	Measure Type	Measure Description	Level of Analysis	Other Known Uses and Program Alignment	Workgroup Comments
		occur during the calendar year include those related to emergency room visits, as well as other professional or ancillary services tied to a potentially avoidable complication.			
0710 Endorsed Depression Remission at Twelve Months Measure Steward: MN Community Measurement	Outcome	Adult patients age 18 and older with major depression or dysthymia and an initial PHQ-9 score > 9 who demonstrate remission at twelve months defined as a PHQ-9 score less than 5. This measure applies to both patients with newly diagnosed and existing depression whose current PHQ-9 score indicates a need for treatment. The Patient Health Questionnaire (PHQ-9) tool is a widely accepted, standardized tool [Copyright © 2005 Pfizer, Inc. All rights reserved] that is completed by the patient, ideally at each visit, and utilized by the provider to monitor treatment progress. This measure additionally promotes ongoing contact between the patient and provider as patients who do not have a follow-up PHQ-9 score at twelve months (+/ - 30 days) are also included in the denominator.	Facility, Clinician: Group/ Practice	Federal and State Programs: Meaningful Use-EP; PQRS Private Programs: MN Community Measurement	Remission at 12 months preferred to remission at 6 months because outcome is more fully sustained; Concerns about reporting burden and duplicative measurement if 0712 is also implemented independently
0712 Endorsed Depression Utilization of the PHQ-9 Tool Measure Steward: MN Community Measurement	Process	Adult patients age 18 and older with the diagnosis of major depression or dysthymia (ICD-9 296.2x, 296.3x or 300.4) who have a PHQ-9 tool administered at least once during the four month measurement period. The Patient Health Questionnaire (PHQ-9) tool is a widely accepted, standardized tool [Copyright © 2005 Pfizer, Inc. All rights reserved] that is completed by the patient, ideally at each visit, and utilized by the provider to monitor	Facility; Clinician: Group/ Practice	Federal and State Programs: Meaningful Use-EP; PQRS Private Programs: MN Community Measurement	An additional measure is needed for use of PHQ-9 in long-term care facilities; Concerns about reporting burden and duplicative measurement if 0710 is also implemented independently

NQF Measure Number, Endorsement Status, Title, and Steward	Measure Type	Measure Description	Level of Analysis	Other Known Uses and Program Alignment	Workgroup Comments
		treatment progress. This process measure is related to the outcome measures of "Depression Remission at Six Months" and "Depression Remission at Twelve Months". This measure was selected by stakeholders for public reporting to promote the implementation of processes within the provider's office to insure that the patient is being assessed on a routine basis with a standardized tool that supports the outcome measures for depression. Currently, only about 20% of the patients eligible for the denominator of remission at 6 or 12 months actually have a follow-up PHQ-9 score for calculating remission (PHQ-9 score < 5).			
0729 Endorsed Optimal Diabetes Care Measure Steward: MN Community Measurement	Composite	The percentage of adult diabetes patients who have optimally managed modifiable risk factors (A1c, LDL, blood pressure, tobacco non-use and daily aspirin usage for patients with diagnosis of ischemic vascular disease) with the intent of preventing or reducing future complications associated with poorly managed diabetes. Patients ages 18 - 75 with a diagnosis of diabetes, who meet all the numerator targets of this composite measure: A1c < 8.0, LDL < 100, Blood Pressure < 140/ 90, Tobacco non-user and for patients with diagnosis of ischemic vascular disease daily aspirin use unless contraindicated. Please note that while the all-or-none composite measure is considered to be the gold standard, reflecting best patient outcomes, the individual components may be measured as well. This is particularly helpful in quality	Clinician: Group/ Practice; Integrated Delivery System	Federal and State Programs: Medicare Shared Savings Program; PQRS Private Programs: At least 1 Beacon community	Workgroup generally supports use of composite measures; Some concern that targets within this measure are too aggressive for medically complex beneficiaries and such individuals would need to be excluded

NQF Measure Number, Endorsement Status, Title, and Steward	Measure Type	Measure Description	Level of Analysis	Other Known Uses and Program Alignment	Workgroup Comments
		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.			
1626 Endorsed Patients Admitted to ICU who Have Care Preferences Documented Measure Steward: The RAND Corporation	Process	Percentage of vulnerable adults admitted to ICU who survive at least 48 hours who have their care preferences documented within 48 hours OR documentation as to why this was not done.	Facility; Health Plan; Integrated Delivery System		All beneficiaries should have preferences documented in all settings of care; Intense level of care and interventions provided in the ICU amplifies the importance of personal care preferences
1659 Endorsed Influenza Immunization Measure Steward: CMS	Process	Inpatients age 6 months and older discharged during October, November, December, January, February or March who are screened for influenza vaccine status and vaccinated prior to discharge if indicated.	Facility; Population: National, Regional, State	Federal and State Programs: Hospital Inpatient Quality Reporting	Expand care setting beyond acute care or harmonize with other measures - a single measure operationalized across all levels would be preferred; Incorporate preventive services into person-centered care plan; Vaccinations are especially important for persons living in institutional settings or otherwise at high risk of infection
1768 Endorsed Plan All-Cause Readmissions	Outcome	For members 18 years of age and older, the number of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30	Health Plan	Federal and State Programs: Initial Core Set of Health Care Quality Measures for	Does not exclude planned readmissions, however it is important to measure

NQF Measure Number, Endorsement Status, Title, and Steward	Measure Type	Measure Description	Level of Analysis	Other Known Uses and Program Alignment	Workgroup Comments
Measure Steward: NCQA **Starter Set Measure**		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.		Medicaid-Eligible Adults; Medicare Part C Plan Rating; Special Needs Plan State Duals Demonstrations: CA, IL, MA, OH, VA Private Programs: Wellpoint; HEDIS; IHA; AHIP survey - Measures used by a Majority of Health Plans; Buying Value core ambulatory measure	readmissions at the health plan level of analysis
1789 Endorsed Hospital-Wide All-Cause Unplanned Readmission Measure (HWR) Measure Steward: CMS	Outcome	This measure estimates the hospital-level, risk-standardized rate of unplanned, all-cause readmission after admission for any eligible condition within 30 days of hospital discharge (RSRR) for patients aged 18 and older. The measure reports a single summary RSRR, derived from the volume-weighted results of five different models, one for each of the following specialty cohorts (groups of discharge condition categories or procedure categories): surgery/ gynecology, general medicine, cardiorespiratory, cardiovascular, and neurology, each of which will be described in greater detail below. The measure also indicates the hospital standardized risk ratios (SRR) for each of these five specialty cohorts. We developed the measure for patients 65 years and older using Medicare fee-for-service	Facility	Federal and State Programs: Hospital Inpatient Quality Reporting	Measure does exclude planned readmissions, depending on scope of program it may be important to evaluate at the facility level

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

NQF Measure Number, Endorsement Status, Title, and Steward	Measure Type	Measure Description	Level of Analysis	Other Known Uses and Program Alignment	Workgroup Comments
		of the patient-centered medical home. Composite 1: Enhance access and continuity Composite 2: Identify and manage patient populations Composite 3: Plan and manage care Composite 4: Provide self-care support and community resources Composite 5: Track and coordinate care Composite 6: Measure and improve performance			coordinated care sought for dual eligible beneficiaries
1927 Endorsed Cardiovascular Health Screening for People With Schizophrenia or Bipolar Disorder Who Are Prescribed Antipsychotic Medications Measure Steward: NCQA	Process	The percentage of individuals 25 to 64 years of age with schizophrenia or bipolar disorder who were prescribed any antipsychotic medication and who received a cardiovascular health screening during the measurement year.	Health Plan; Integrated Delivery System; Population: State		Quality issue of particular importance to address access to preventive services needed to reduce disproportionate effect of chronic conditions; Incorporate chronic disease management and preventive services into person-centered care plan
1932 Endorsed Diabetes screening for people with schizophrenia or bipolar disorder who are prescribed antipsychotic medications (SSD) Measure Steward:	Process	The percentage of individuals 18 – 64 years of age with schizophrenia or bipolar disorder, who were dispensed any antipsychotic medication and had a diabetes screening during the measurement year.	Health Plan; Population: State	State Duals Demonstration: IL	Quality issue of particular importance to address access to preventive services needed to reduce disproportionate effect of chronic conditions; Incorporate chronic disease management and preventive services

NQF Measure Number, Endorsement Status, Title, and Steward	Measure Type	Measure Description	Level of Analysis	Other Known Uses and Program Alignment	Workgroup Comments
NCQA					into person-centered care plan
2091 Endorsed Persistent Indicators of Dementia without a Diagnosis - Long Stay Measure Steward: American Medical Directors Association	Process	Percentage of nursing home residents age 65+ with persistent indicators of dementia and no diagnosis of dementia.	Facility		Addresses cases of misdiagnosis or underdiagnoses of dementia within long-term care facilities as well as communication among facility's care team
2092 Endorsed Persistent Indicators of Dementia without a Diagnosis - Short Stay Measure Steward: American Medical Directors Association	Process	Number of adult patients 65 and older who are included in the denominator (i.e., have persistent signs and symptoms of dementia) and who do not have a diagnosis of dementia on any MDS assessment.	Facility		Addresses cases of misdiagnosis or underdiagnoses of dementia within long-term care facilities as well as communication among facility's care team
2111 Endorsed Antipsychotic Use in Persons with Dementia Measure Steward: Pharmacy Quality Alliance, Inc.	Process	The percentage of individuals 65 years of age and older with dementia who are receiving an antipsychotic medication without evidence of a psychotic disorder or related condition.	Health Plan		Overuse of antipsychotics among persons with dementia is a well-documented problem with quality; contributes to clinical complications and higher costs
2152 Submitted Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling Measure Steward:	Process	Percentage of patients aged 18 years and older who were screened for unhealthy alcohol use at least once during the two-year measurement period using a systematic screening method AND who received brief counseling if identified as an unhealthy alcohol user	Clinician: Group/ Practice, Individual, Team		Support for inclusion in family pending endorsement by NQF; Recommend expanding care setting to emergency department; Emphasis on

NQF Measure Number, Endorsement Status, Title, and Steward	Measure Type	Measure Description	Level of Analysis	Other Known Uses and Program Alignment	Workgroup Comments
AMA-PCPI					incorporating alcohol and other drug treatment into person-centered care plan; Particularly important for population with behavioral health needs

*Support for inclusion in family pending endorsement by NQF.

Appendix E: MAP Measure Selection Criteria

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

Criteria

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

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

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

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

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

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

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

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

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

Sub-criterion 2.3 Affordable care

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

7. Program measure set promotes parsimony and alignment

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

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

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

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