MAP Dual Eligible Beneficiaries Workgroup In-Person Meeting #4

NATIONAL QUALITY FORUM

February 21-22, 2012

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

Table of Contents

NATIONAL QUALITY FORUM

MEASURE APPLICATIONS PARTNERSHIP

Dual Eligible Beneficiaries Workgroup: In-Person Meeting #4
February 21-22, 2012

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

Please use the following information to access the meeting remotely:

Public Conference Line: 877-604-9668, Passcode: 1504249

Web Streaming Audio: http://www.MyEventPartner.com/nqfmeetings21

AGENDA

Meeting Objectives:

- Refine and finalize the core measure set for dual eligible beneficiaries
- Ensure alignment of the core measure set with other measurement initiatives and environmental drivers
- Document potential measure modifications, prioritize measure gaps, and delineate potential new measures for development to meet the quality measurement needs for the dual eligible population
- Establish themes and recommendations for the final report

Tuesday, February 21

9:00 am **Welcome and Review of Meeting Objectives**
Alice Lind (Workgroup Chair), Senior Clinical Officer and Director of Long-Term Supports and Services, Center for Health Care Strategies, Inc.
- Review project context and meeting objectives
- Review outline for final report

9:30 am **Using the Core Measure Set: HHS Applications**
Jordan VanLare, Office of Clinical Standards and Quality, CMS
Cheryl Powell, Deputy Director, Medicare-Medicaid Coordination Office, CMS
Sarah Lash, Senior Program Director, Strategic Partnerships, NQF
- Review current draft of core measures for dual eligible beneficiaries
- Significance of core set in MAP pre-rulemaking activities
- Uses anticipated by Medicare-Medicaid Coordination Office

10:00 am **Using the Core Measure Set: Applications Beyond HHS**
Alice Lind
Diane Stollenwerk, Vice President, Community Alliances, NQF
Foster Gesten, Medical Director, New York State Office of Health Insurance Programs
- Potential role of the core set for states and other stakeholders
- Data source challenges and implications

10:45 am **Finalizing the Initial Core Set**
Alice Lind and NQF Staff
- Consider substitutions of selected measures in core set
- Review of core set for potential unintended consequences
- Suggest potential modifications for individual measures
- Identify additional gaps in available measures
- Opportunity for public comment

Noon **Lunch**

12:30 pm **Alignment with Medicaid Adult Core Measures**
Alice Lind
Karen Llanos, Technical Director; Division of Quality, Evaluation, and Health Outcomes; Children and Adult Health Program Group; CMCS; CMS
- Review contents of final rule and relevant lessons learned
- Discuss alignment between measure sets

1:30pm **Potential Approaches to Stratification of Dual Eligible Beneficiaries vs. Other Groups**
Helen Burstin, Senior Vice President, Performance Measures, NQF
- Data requirements for stratification
- Potential strata and reference groups
- Opportunity for public comment

2:30 pm **Break**

2:45 pm **Addressing Measure Gaps in Home and Community-Based Services (HCBS)**
Alice Lind
Anita Yuskauskas, Technical Director for HCBS Quality, Disabled and Elderly Health Programs Group, CMS
- Present state of HCBS measurement
- Examine quality frameworks and discuss areas of emphasis
- Recommendations for path forward
- Opportunity for public comment

3:45 pm **Recap Discussion and Prepare for Day 2**

4:00 pm **Adjourn for the Day**

NATIONAL QUALITY FORUM

MEASURE APPLICATIONS PARTNERSHIP

Wednesday, February 22

9:00 am **Welcome and Recap of Day 1**
Alice Lind

9:15 am **Understanding the Measure Development Process**
Sarah Scholle, Assistant Vice President for Research and Analysis, NCQA
Karen Sepucha, Director of Health Decision Sciences Center at Massachusetts General Hospital; Assistant Professor, Harvard Medical School
Heidi Bossley, Vice President, Performance Measures, NQF
- Measure development pipeline: funding/contracting, measure development, testing
- Measure endorsement and maintenance

10:15 am **Findings from Environmental Scan**
Lisa Green, Founding Principal, L&M Policy Research, LLC
Julia Doherty, Senior Research Director, L&M Policy Research, LLC
- Stakeholder interview themes
- Consider current measures and ideas for measure development
- Opportunity for public comment

11:00 am **Break**

11:15 am **Working Session: Prioritizing Measure Gap Areas**
Alice Lind and Workgroup Members

12:15 pm **Working Session: Potential Measures to Address High-Priority Gaps**
Alice Lind and Workgroup Members
- Work in pairs to edit potential measures

12:45 pm **Working Lunch**

1:15 pm **Report Out: Potential Measures to Address High-Priority Gaps**
Alice Lind and Workgroup Members
- Opportunity for public comment

2:15pm **Final Report Recommendations to Coordinating Committee**
Connie Hwang, Vice President, Measure Applications Partnership, NQF
- Ensure consensus on key themes and recommendations

2:45 pm **Workgroup Feedback on Progress to Date and Future Direction**
Alice Lind and Workgroup Members
- Next steps
- Closing comments from workgroup members
- Opportunity for public comment

3:00 pm **Adjourn**

Measure Applications Partnership

Dual Eligible Beneficiaries Workgroup
In-Person Meeting

February 21-22, 2012

NATIONAL QUALITY FORUM

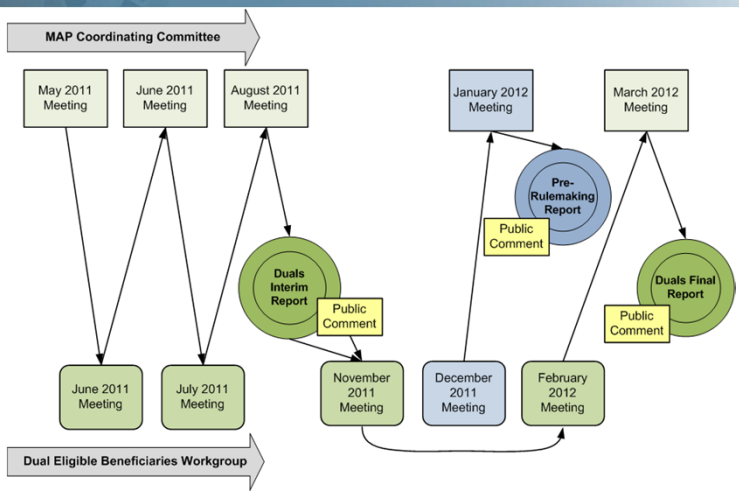
Introductions

Welcome and Review of Meeting Objectives

Meeting Objectives

- Refine and finalize the core measure set for dual eligible beneficiaries
- Ensure alignment of the core measure set with other measurement initiatives and environmental drivers
- Document potential measure modifications, prioritize measure gaps, and delineate potential new measures for development to meet needs for the dual eligible population
- Establish themes and recommendations for the final report

Flow of Information to Inform Reports



Analytic Strategy

Establish vision for improved quality of care and strategic approach to performance measurement	Align with broader initiatives and guiding frameworks	Prioritize high-leverage improvement opportunities for dual eligible population
Consider data source and HIT implications	Identify measures currently in use and map them to high-leverage opportunities	Refine core measure set, identify gaps, and propose modifications or new measure concepts

Agenda: Tuesday, February 21

9:30	Using the Core Measure Set: HHS Applications
10:00	Using the Core Measure Set: Applications Beyond HHS
10:45	Finalizing the Initial Core Set
12:30	Alignment with Medicaid Adult Core Measures
1:30	Potential Approaches to Stratification of Dual Eligible Beneficiaries vs. Other Groups
2:45	Addressing Measure Gaps in Home and Community-Based Services (HCBS)
3:45	Recap Discussion and Prepare for Day 2

Vision for High-Quality Care

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

Guiding Principles

DESIRED EFFECTS

- Promoting Integrated Care
- Ensuring Cultural Competence
- Health Equity

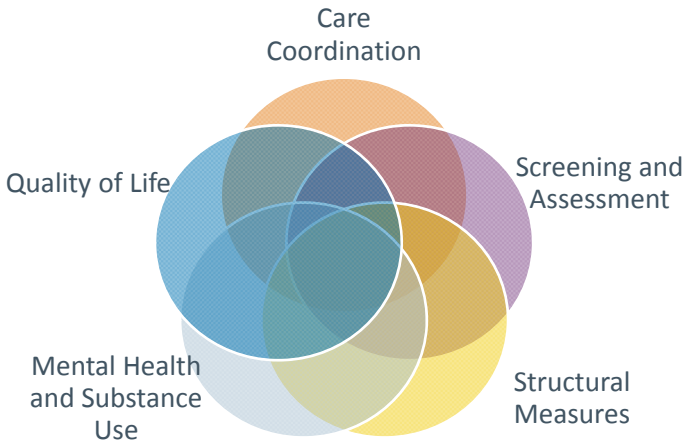
MEASUREMENT DESIGN

- Cascading Levels of Analysis
- Assessing Outcomes Relative to Goals
- Parsimony
- Cross-Cutting Measures
- Inclusivity
- Avoiding Undesirable Consequences

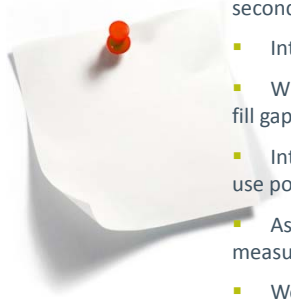
DATA

- Data Sharing
- Using Data Dynamically
- Making the Best Use of Available Data

High-Leverage Opportunities for Improvement Through Measurement



HHS Input on Interim Report and Current Efforts



- Strong support for major themes and messages, plan to use report right away
- Request more emphasis on data sources and potential solutions in second phase of work
- Interest in ways to evaluate "connectedness" of the system for duals
- Where measures do not exist, explore what proxies might be used to fill gaps temporarily
- Interest in needs of sub-groups, particularly mental health/substance use population
- Ask MAP to suggest short-term, medium-term, and long-term steps for measurement
- Work on gaps may influence measure development contracts

Final Report Outline

I. MAP Background
II. Strategic Approach to Performance Measurement
III. Initial Core Set and Primary Measure Gaps
IV. Strategies to Address Measure Gaps
    a. Potential Measure Modifications
    b. Potential Measure Schemas for Future Development
V. Levels of Analysis and Potential Applications of Core Set
VI. Alignment Across Programs

Workgroup Discussion and Questions

Using the Core Measure Set: HHS Applications

Measure Applications Partnership

Statutory Authority

Health reform legislation, the Affordable Care Act (ACA), requires HHS to contract with the consensus-based entity (i.e., NQF) to **"convene multi-stakeholder groups to provide input on the selection of quality measures" for public reporting, payment, and other programs.**

Annual Role for MAP

- Provide input to HHS on the selection of performance measures for use in public reporting, performance-based payment, and other programs
- Identify gaps for measure development, testing, and endorsement
- Encourage alignment of public and private sector programs
- Harmonize measurement across levels of analysis and settings to:
  - Promote coordination of care delivery
  - Reduce data collection burden

How Dual Eligible Beneficiaries Fit in Pre-Rulemaking

- HHS has identified the dual eligible beneficiary population as a priority consideration for all MAP tasks
- One of many populations that could greatly benefit from a purposeful and person-centered approach to care and related quality measurement
- Dual eligible beneficiaries are served in every part of the health and long-term care systems, but they do not have their own Federal measurement program
- In order to expand the use of measures that are relevant to duals' unique needs, those types of measures must be added to existing programs
- MAP considered the types of measures that would make the sets more responsive to the needs of dual eligible beneficiaries

Pre-Rulemaking Process and Timeline

November	• CC reviewed MAP workgroup evaluations of core measure sets and gap concepts • Duals Workgroup provides cross-cutting input to other workgroups
December	• Setting-specific MAP workgroups assess HHS-proposed measures for Federal programs and provide input to CC • Duals workgroup checks progress of other groups
January	• CC reviews setting-specific recommendations from MAP workgroups and cross-cutting recommendations regarding Duals • CC finalizes input to HHS for February 1 report

MAP's Pre-Rulemaking Input

- Provided input on more than 350 measures under consideration by HHS for nearly 20 Federal performance measurement programs:
  - **Support the measure –** MAP supports the measure for inclusion in the associated federal program during the next rulemaking cycle for that program
  - **Support the direction of the measure –** MAP supports the measure concept, however, further development, testing, or implementation feasibility must be addressed before inclusion
  - **Do not support the measure –** Measure is not recommended for inclusion in the association federal program

Pre-Rulemaking Input – General Themes

- MAP adopted a person-centered approach to measure selection, encouraging broader use of patient-reported measures
- Many high priority measurement gaps were identified, including measures of patient experience, functional status, shared decision making, care coordination, cost, appropriateness of care, and mental health
- Measures used in federal programs should promote team-based care and shared accountability through population-level measurement, as exemplified by the Medicare Shared Savings Program
- Program measure sets were generally lacking measures of cost
- MAP needs to establish feedback loops with HHS and the private sector regarding the actual use, implementation experience, and impact of performance measures

Duals' Contribution to Strategic Alignment

- MAP supported for inclusion all measures under consideration that had been identified as core for dual eligible beneficiaries
- To make measures more relevant to the needs of vulnerable populations such as dual eligible beneficiaries, MAP recommends:
  - Take a cross-cutting approach, emphasizing outcome and composite measures
  - Explore stratification of measures to reveal and reduce disparities
  - Push measurement forward in the areas of care coordination and shared accountability, while keeping the individual and his/her goals at the center
  - Increase emphasis on behavioral health issues throughout the system

Take-Away Points

- Influence of input from Dual Eligible Beneficiaries Workgroup was indirect yet powerful
  - PAC/LTC group in strongest alignment, Clinician programs moderate, Hospital programs have most room for improvement
- Valuable information gleaned from MAP participants and commenters about the experience of using specific measures; informs potential revisions to the draft core set
- Opportunity for the Dual Eligible Beneficiaries Workgroup to provide stronger direction to the setting-specific workgroups in future years

Guest Presenters:

Jordan VanLare
Office of Clinical Standards and Quality, CMS

Cheryl Powell
Medicare-Medicaid Coordination Office, CMS

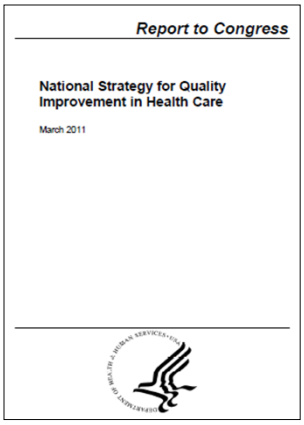
PRELIMINARY

Quality Measurement and Value

Jordan VanLare
Value-Based Purchasing Program Lead
Office of Clinical Standards and Quality
Centers for Medicare & Medicaid Services

National Quality Strategy promotes better health, healthcare, and lower cost

WORKING DRAFT FOR INPUT – PRE-DECISIONAL



Three-part aim:

- **Better Care:** Improve the overall quality, by making health care more patient-centered, reliable, accessible, and safe.
- **Healthy People and Communities:** Improve the health of the U.S. population by supporting proven interventions to address behavioral, social, and environmental determinants of health in addition to delivering higher-quality care.
- **Affordable Care:** Reduce the cost of quality health care for individuals, families, employers, and government.

Six priorities:

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

CMS has a variety of quality reporting and performance programs

WORKING DRAFT FOR INPUT – PRE-DECISIONAL

PRELIMINARY

Hospital Quality	Physician Quality Reporting	PAC and Other Setting Quality Reporting	Payment Model Reporting	"Population" Quality Reporting
•Medicare and Medicaid EHR Incentive Program	•Medicare and Medicaid EHR Incentive Program	•Inpatient Rehabilitation Facility	•Medicare Shared Savings Program	•Medicaid Adult Quality Reporting*
•PPS-Exempt Cancer Hospitals	•PQRS	•Nursing Home Compare Measures	•Hospital Value-based Purchasing	•CHIPRA Quality Reporting*
•Inpatient Psychiatric Facilities	•eRx quality reporting	•LTCH Quality Reporting	•Physician Feedback/Value-based Modifier*	•Health Insurance Exchange Quality Reporting*
•Inpatient Quality Reporting		•ESRD QIP		•Medicare Part C*
•HAC payment reduction program		•Hospice Quality Reporting		•Medicare Part D*
•Readmission reduction program		•Home Health Quality Reporting		
•Outpatient Quality Reporting				
•Ambulatory Surgical Centers				

* Denotes that the program did not meet the statutory inclusion criteria for pre-rulemaking, but was included to foster alignment of program measures.

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OCSQ framework for measurement maps to the six national priorities

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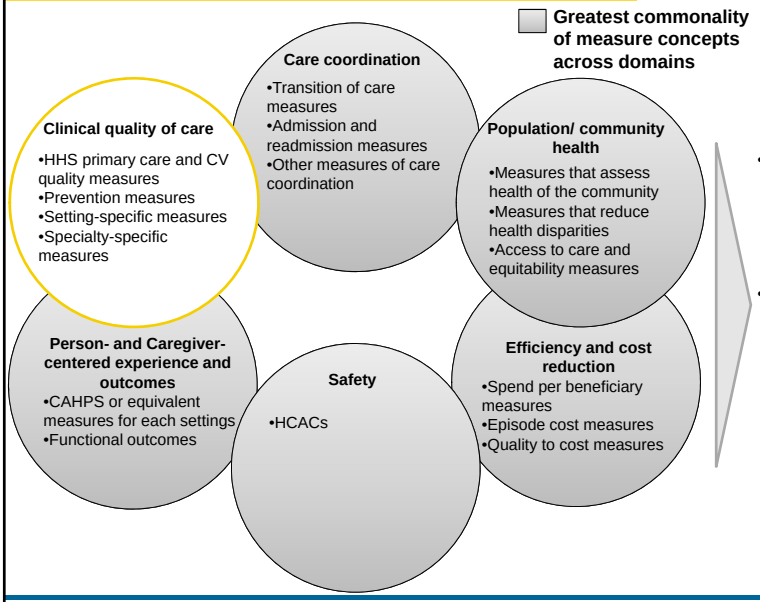

- **Measures should be patient-centered and outcome-oriented whenever possible**
- **Measure concepts in each of the six domains that are common across providers and settings can form a core set of measures**

Quality can be measured and improved at multiple levels

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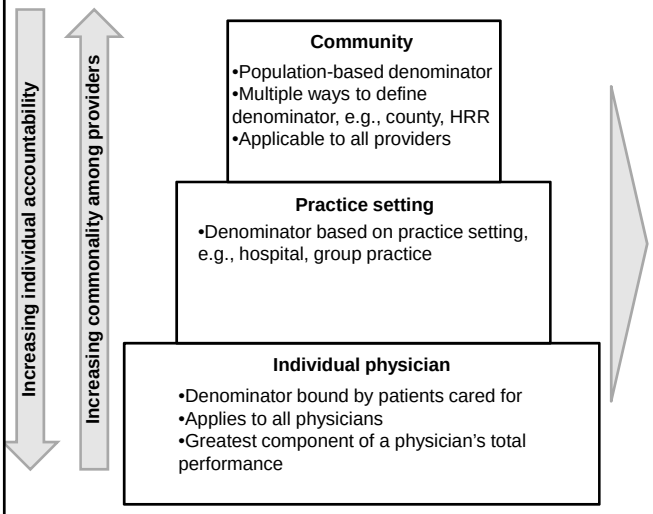
PRELIMINARY



- Three levels of measurement critical to achieving three aims of National Quality Strategy
- Measure concepts should "roll up" to align quality improvement objectives at all levels
- Patient-centric, outcomes oriented measures preferred at all three levels
- The "five domains" can be measured at each of the three levels

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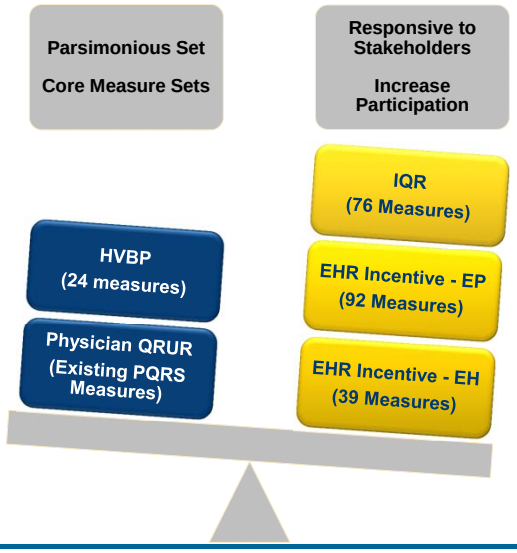
CMS must balancing its goals for measurement and make tradeoffs depending program-specific objectives

WORKING DRAFT FOR INPUT – PRE-DECISIONAL

PRELIMINARY



29

Purpose statement for Value-Based Purchasing

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Value-based purchasing is a tool that allows CMS to link the National Quality Strategy with fee-for-service payments at a national scale. It is an important driver in revamping how services are paid for, moving increasingly toward rewarding providers and health systems that deliver better outcomes in health and health care at lower cost to the beneficiaries and communities they serve.

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30

Thank you

WORKING DRAFT FOR INPUT – PRE-DECISIONAL

Discussion

- What measurement strategies to evaluate the care of dual eligible beneficiaries are most likely to be pursued by HHS?
- What topics should be emphasized in order to maximize the utility of MAP's recommendations to HHS regarding dual eligible beneficiaries?

Using the Core Measure Set: Applications Beyond HHS

Applications Beyond HHS: Considerations

Areas of variation affecting measurement approaches

- Managed care vs. Fee-for-Service
- Structure of data collection and/or sharing within and across settings
  - Ambulatory and hospital
  - Long term care
  - Home and community based services
  - Other
- Areas of shared accountability (ACO, medical homes, insurance / information exchanges)

Guest Presenters:

Foster Gesten & Patrick Roohan

New York State Office of Health Insurance Programs

MAP Dual Eligible Workgroup

Using the Core Measure Set:
Applications Beyond HHS
Foster Gesten, MD
Patrick Roohan
NYS Department of Health

Accountable Entity

- Current configuration includes:
  - Medicaid FFS/Medicare FFS
  - Medicaid FFS/Medicare Advantage
  - Medicaid Partial LTC/Medicare FFS
  - Medicaid Partial LTC/Medicare Advantage
  - PACE
  - Medicaid Advantage Plus/Medicare Advantage
    - Includes LTC services, has to be same plan
  - Medicaid Advantage/Medicare Advantage
    - No LTC services, has to be same plan

Population

- Three groups of dually eligible:
  - Enrollees in institutions (nursing homes)
  - Enrollees with LTC needs living in the community
  - Everyone else (community well)

Measure Implication

- Some measures are appropriate across three populations
  - Measures of chronic care, e.g. diabetes, asthma
  - Measures of prevention, e.g. flu shots
- Measures specific to enrollees with LTC needs, multiple chronic conditions
  - Care Coordination, transition, functional status, cognitive status
  - Goal is prevention of accelerated decline

Current Measures on LTC

- Activities of Daily Living
  - Ambulation, bathing, transferring, dress upper body, dress lower body, toileting, feeding
- Incontinence
- Cognitive status
- Confusion
- Anxiety

- Rates and changes over time

Current Measures on LTC

- Oral Medication Management
- Flu Shots
- Fall Prevention

- Biannual Member Experience of Care Survey

Proposed Full Benefit Measures

- Reduction of Preventable Events
- Reduce PQI Hospital admissions
- Reduce Preventable Readmissions
- Reduce Preventable Hospital Complications
- Reduce Preventable ER

Discussion

- What measurement strategies to evaluate the care of dual eligible beneficiaries are most likely to be pursued by States?
- What topics should be emphasized in order to maximize the utility of MAP's recommendations to States and communities?

Finalizing the Initial Core Set

Draft Core Set Characteristics

- **23 total measures in five high-leverage domain areas**
- **Measure Types:** Process (12), Patient Experience (3), Outcome (4), Structure (3)
- **Settings of Care:** Ambulatory (12), Hospital (5), PAC/LTC Facility (4), Home Health (3), Dialysis Facility (1), Pharmacy (1), Hospice (1)
- **Levels of Analysis:** Facility (11), Clinician (10), Health Plan (4), Integrated Delivery System (3), Population (2)
- **Data Sources:** Administrative Claims (8), EHR (6), Patient Reported (5), Other Electronic Clinical Data (4), Paper Records (3), Provider Survey (3)

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

Potential Changes: Adding Related/Paired Measures

- Current Measure: *HBIPS-7 Post discharge continuing care plan transmitted to next level of care provider upon discharge (0558)*
- Suggested Addition: *HBIPS-6 Post discharge continuing care plan created (0557)*
  - Measures were endorsed as paired and should be used together to satisfy the developer's intent
- Current Measure: *Transition Record with Specified Elements Received by Discharged Patients (Inpatient Discharges) (0647)*
- Suggested Addition: *Timely Transmission of Transition Record (Inpatient Discharges) (0648)*
  - Related measures, transition record should be transmitted to both patient/caregiver and healthcare provider
  - 0648 Is a Medicaid Adult Core measure

Potential Changes: Capturing Patient Experience

- Current Measures: *CAHPS Clinician/Group Survey (0005)* and *CAHPS Health Plan Survey (0006)*
  - Multiple CAHPS® surveys are endorsed for use in hospitals, home health, hemodialysis, health plans, clinician/group practices, nursing homes, and behavioral health.
  - CAHPS for HCBS and other settings are in development
  - Suggest a general recommendation that CAHPS be used in every setting of care for which it is available.
- Current Measure: *Family Evaluation of Hospice Care (0208)*
  - Suggest addition of *Comfortable Dying: Pain Brought to a Comfortable Level Within 48 Hours of Initial Assessment (0209)*
  - Already widely reported, reduces reliance on time-intensive patient-reported survey data

Potential Changes: Technical Weaknesses

- Current Measure: *Potentially Harmful Drug-Disease Interactions in the Elderly (not endorsed)*
  - Not endorsed because sufficient sample sizes generally not available
  - Suggest removal from the set
- Suggested Addition: *Medication Reconciliation (0097)*
  - Covers similar subject matter with a measure that is more widely in use
  - Measure is e-specified, used in VBP, and proposed by HHS for addition to Meaningful Use
  - MAP also suggested exploration of the measure's use in PAC/LTC settings

Potential Changes: Technical Weaknesses

- Current Measure: *Change in Daily Activity Function as Measured by the AM-PAC (0430)*
  - Exhibits 'floor effects' with complex patients, tool may not be widely used, limited to post-acute care setting
- Option 1: Leave #0430 in the core set
- Option 2: Remove #0430 from the set and replace with one or more home health measures about improvements in ADL status
  - The home health measure of *Improvement in Ambulation/locomotion (0167)* is already in the set
- Option 3: Remove #0430 from the set and recognize functional status measures as an important gap area
  - NQF will begin an endorsement project on functional status measures later in 2012

Potential Changes: Resolving Potential Duplication

- Current Measures:
  - *Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (0004)*
  - *Alcohol Misuse: Screening, Brief Intervention, Referral for Treatment (Not Endorsed)*
- CMS removed the SBIRT measure from the Medicaid Core set citing duplication with the alcohol dependence treatment measure. Should this group do the same?
- NQF's current endorsement project for behavioral health measures is likely to consider this and similar SBIRT measures.

Potential Changes: Difficulty Measuring Readmissions

- Current Measure: *All-Cause Readmission Index (0329)*
  - Recently failed endorsement maintenance, does not account for comorbidity in risk-adjustment model
  - Recommend removal from the set
- 2 measures are currently under revision for endorsement
  - 1786 NCQA – health plan is level of analysis
  - 1789 CMS – hospital is level of analysis
- Does all-cause readmission have more to do with community-level factors than the quality of hospital care?
- If the workgroup wants to include one of the above measures, consider a general recommendation that will allow for the current endorsement process to conclude

Revised Core Set Characteristics

- **Up to 31 total measures in five high-leverage opportunity areas**
- Mix of measure types, most heavily process and outcome
- Range of care settings, most heavily ambulatory, home health, and hospital
- Most measures specified for use at the facility or clinician level, though measures can be more easily "rolled up" than "drilled down"
- Range of data sources, most heavily administrative claims, electronic clinical data/EHR, and patient-reported

Unintended Consequences

- Please review the draft core measure set for potentially harmful unintended consequences of measurement such as…
  - Negative impact on availability of or access to services
  - Undue burden of reporting or analysis
  - Promoting underuse or overuse of services
  - Inappropriate use of 'observation status'
  - Treatment potentially in conflict with patient goals or preferences
  - Others
- Are other revisions necessary?

Measure Modifications

Workgroup previously suggested modifications to existing measures:

- Broaden measures as much as possible with respect to:
  - Age groups
  - Gender
  - Use across settings of care
  - Diagnosis groups
- Account for maintenance as well as improvement of a desired element (e.g. functional status)
- Please review the list provided and discuss additional modifications

Measure Gaps

Workgroup previously suggested measure gaps:

- Multiple gap areas suggested for each of the five high-leverage areas
- Please review the list provided…
- What additional gaps, either major or minor, exist?
- Are there gaps in the core set beyond the five high-leverage opportunities?

Opportunity for Public Comment

Alignment with Medicaid Adult Core Measures

Guest Presenter:

Karen LLanos
CMCS Division of Quality, Evaluation, and Health Outcomes; CMS

Initial Core Set of Medicaid Adult Measures

Timeline

- Draft list released for public comment December 2010
  - Workgroup identified draft set of 51 measures during July 2010 meeting
- Final notice issued January 2011
  - MAP should consider relationship between the final set of 26 Medicaid adult core measures and the dual-eligible beneficiaries core set
- CMS will phase in components of Technical Assistance and Analytic Support Program throughout 2012; reporting by States is voluntary and begins December 2013
- CMS will collect, analyze, and make the information publicly available by September 2014

Lessons Learned in Measure Selection for the Medicaid Program

- Evaluation Criteria:
  - Importance
  - Scientific evidence supporting the measure
  - Scientific soundness of the measure
  - Alignment with other Federal programs
  - Feasibility for State reporting
- Complex Health Needs Subgroup identified challenges:
  - Data collection requirements, e.g. medical record review across time or across sites
  - Narrow applicability of some suggested measures

Discussion Questions: Alignment

- What is the intended relationship between the Medicaid core set and the dual-eligible core set?
- To what extent should the sets overlap?
- Should measures be added or removed to reflect the desired level of alignment?

Extent of Measure Alignment

- 4-6 measures appear in both lists (depends on outcome of morning's core measure set discussion)
- 2 measures in the Medicaid list are similar to proposed duals measures:
  - NCQA measure of *Medical Assistance with Smoking and Tobacco Use Cessation (0027)*
  - NCQA measure *of Adult BMI Assessment (not endorsed)*
- 4 reproductive health measures in the Medicaid list do not apply and the remaining measures in Medicaid core list are largely condition-specific
- Are further changes to the duals core set warranted?

Potential Approaches to Stratification of Dual Eligible Beneficiaries vs. Other Groups

Guest Presenter:

Helen Burstin
Performance Measures Department, NQF

Potential Approaches to Stratification of Dual Eligible Beneficiaries

Helen Burstin, MD, MPH
Senior Vice President, Performance Measures
National Quality Forum

Dual Eligible Beneficiaries Workgroup
February 21, 2012

NATIONAL QUALITY FORUM

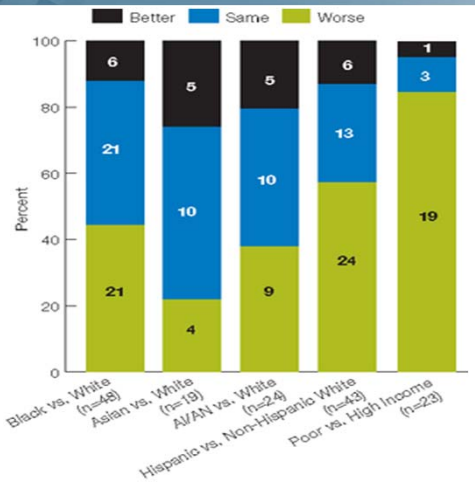
Outline

- Disparities measurement approach as context
- Methodologic approaches to measurement
- Data collection challenges
- Potential measurement approaches for the dual eligible population

Disparities Measurement

- Assessment of quality by race, ethnicity, primary language and socioeconomic status should be a routine and expected part of performance measurement
- Need standardized disparities and cultural competency measures that can be used monitor and achieve equity in health care
- Need data on race, ethnicity, primary language, and socioeconomic status data in order to stratify quality measures
  - Updated disparity-sensitivity criteria

Distribution of core quality measures for which selected groups experienced better, same, or worse quality of care



Examples of Major Disparities

Groups	Measure	RR*
Black compared with White	Hospital admission for lower extremity amputations per 1,000 population age 18+ w/diabetes	2.0
	Emergency department visits where patients left w/o being seen	1.7
	Adults age 65 + who ever received pneumoccocal vaccination	1.5
Hispanic compared with non-Hispanic White	New AIDS cases per 100,000 population age 13 +	3.3
	People under age 65 with health insurance	2.7
Poor compared with High Income	People under age 65 with health insurance	4.7
	People with specific source of ongoing care	2.9

*RR: Rate relative to reference group

First-tier of the Disparities-Sensitive Selection Criteria

- **Prevalence:** how prevalent the condition is among the minority population?
- **Quality gap:** how large the gap in quality *of care* between the disparity population and the group with the highest quality for that measure.
- **Impact:** the influence a condition or topic has financially, publically, and on the community at large.

Second Tier of the Disparities-Sensitive Selection Criteria

- **Care with a High Degree of Discretion:** Many of the disparities described depends on a certain degree of discretion on the part of the clinician.
- **Communication-Sensitive Services:** Disparities are more likely to occur when there are challenges to communication across language and cultures.
- **Social Determinant-Dependent Measures:** Disparities often are seen in areas that relate to behavioral aspects of health, including patient self-management (e.g., diet, exercise, and medication adherence for diabetes or congestive heart failure management).

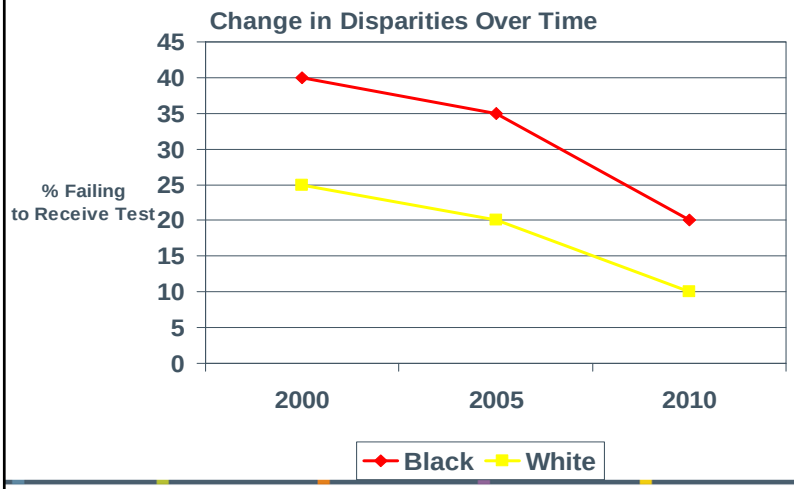
Methodologic Approaches to Measurement

- Reference Points
- Absolute vs. Relative Disparities
- Paired vs. Summary Statistics
- Sample Size Considerations
- Risk Adjustment and Stratification

Methodologic Approaches to Measurement

- Reference Points
  - Choice of the reference group should be the historically advantaged group.
- Absolute vs. Relative Disparities
- Paired vs. Summary Statistics
- Normative Considerations
- Interaction Effects
- Sample Size Considerations
- Risk Adjustment and Stratification

Did Black-White Disparity Get Better or Worse Between 2000-2010?



NATIONAL QUALITY FORUM

Weissman JS 2009

Methodologic Approaches to Measurement

- Reference Points
- Absolute vs. Relative Disparities
  - Absolute and relative changes in disparities can yield different conclusions on whether or not gaps are closing
- Paired vs. Summary Statistics
- Interaction Effects
- Sample Size Considerations
- Risk Adjustment and Stratification

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76

Methodologic Approaches to Measurement

- Reference Points
- Absolute vs. Relative Disparities
- Paired vs. Summary Statistics
  - Pairwise comparisons among multiple groups can be complex and not "report-friendly".
  - Summary statistics can address these issues but obscure important information, e.g., directionality.
- Interaction Effects
- Sample Size Considerations
- Risk Adjustment and Stratification

Methodologic Approaches to Measurement

- Reference Points
- Absolute vs. Relative Disparities
- Paired vs. Summary Statistics
- Sample Size Considerations
  - The smaller the numbers, the more likely disparities will reflect chance rather than true differences
  - Options: summary statistics, composites, combine data over multiple years
- Risk Adjustment and Stratification

Methodologic Approaches to Measurement

- Reference Points
- Absolute vs. Relative Disparities
- Paired vs. Summary Statistics
- Normative Considerations
- Interaction Effects
- Sample Size Considerations
- Risk Adjustment and Stratification
  - Case mix adjustment and stratification are methods to avoid unintended effects of measurement for providers with disproportionately large poor and vulnerable populations.
  - Stratification by population should be performed when there is sufficient data to do so.
  - Risk adjustment may be appropriate when performance is highly dependent on community factors beyond a provider's control.

The Dual Eligible Population(s)

- Seniors and non-elderly people with disabilities
- Generally poorer and have worse health status than other Medicare beneficiaries.
- Tend to use more health care services, and account for a disproportionate share of Medicare spending.
- A major driver for higher spending among dual eligible beneficiaries is their higher use of services, especially hospitalizations.
  - 26% of hospitalizations potentially avoidable*

*CMS Policy Insight Brief, September 2011

Heterogeneity of the Dual Eligible Population

Within the dual-eligible population, there are *distinct groups of beneficiaries with widely different care needs*. They vary considerably in the prevalence of chronic conditions, their physical and cognitive impairments, and whether they are institutionalized. Many have multiple chronic conditions that make care coordination especially important. Other duals have no or one physical impairment and no chronic conditions. Reflecting this wide range in care needs, spending varies by a factor of four according to physical and cognitive impairment. Likewise, spending on specific types of services differs by subgroup, with some having higher spending on nursing home or hospital services than others.

June 2010 Report to the Congress, the Medicare Payment Advisory Commission

Potential Risk Factors

- Limitations in one or more activities of daily living (ADLs) resulting from sensory and/or physical impairments;
- Mental health/substance use disorder;
- Cognitive impairment;
- Intellectual disability/developmental disability;
- Heavy disease burden or pain from one condition or multiple chronic conditions;
- Residential care setting;
- Frail elderly;
- Recipient of home and community-based services (HCBS); and
- Social factors (e.g., low socioeconomic status, homelessness, low education level, social isolation, or lack of social capital).

Stratification and Dual Eligible Beneficiaries

Barriers to Stratification

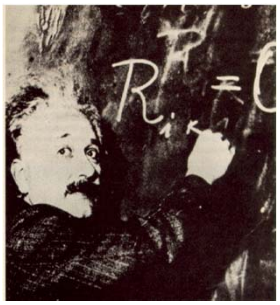
- Appropriate strata have not yet been defined.
- Meaningful strata would likely differ across measures.
- Insufficient numbers of individuals in each band to enable analysis at that level of specificity.
- Linked Medicare and Medicaid encounter data would be required to identify duals with certain risk factors
  - Mental health or substance use disorders
  - Cognitive impairment, intellectual or developmental disability
  - Live in a residential care setting or who receive HCBS.

Potential Measurement Approaches

- **Stratification**:
  - Limited by the heterogeneity of the dual eligible population
  - Would require information on distinct cohorts to understand stratified results (i.e., identify cohort in need of targeted QI efforts)
- **Measure sets for cohorts**:
  - Identify measures most suitable for the quality issues for different cohorts (e.g., behavioral health, nursing homes, home health)
- **Cross-cutting measures:**
  - Consider cross-cutting measures that address functional health and quality of life limitations across cohorts

Not everything that counts can be counted,
and not everything that can be counted counts

~Albert Einstein



But…..

You can't improve what you don't measure
~ W. Edwards Deming

Thank you

Helen Burstin, MD, MPH
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Humana Medicare vs Dual Eligible: 2010 Population Comparison

Brad St. Martin
Thomas James
CODA

February 2012

Humana

Contact: Brad St. Martin: (502)476-9751, Clinical Outcomes Data Analytics (CODA)
CODA_1925

Objectives

1. Assess the distribution of costs across Humana's Total Medicare Population (n=1.8M) compared to Humana's Dual Eligible Population (n=202K)
2. Compare the distribution of members' conditions between the two populations by Hierarchical Condition Category (HCC)
3. Compare the populations by HEDIS Denominator and Numerator Compliance status

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Medicare and Dual Eligible Cost Pyramids

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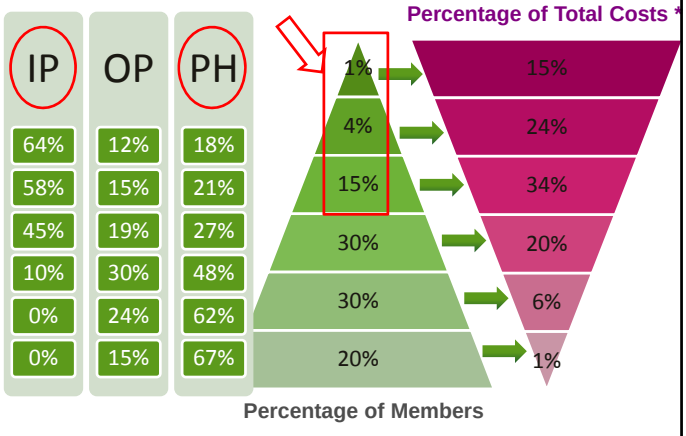
Humana Total Medicare Population Cost Pyramid

Includes 30% of all Duals

Observations:

-20% of the Total Medicare Members account for 73% of the Total Costs

-30% of the Total Dual Population falls within the Top 20% Percent of Total Medicare Members by Total Cost



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IP=Inpatient OP=Outpatient PH=Physician Puerto Rico excluded. Total Cost is calculated by Allowed amounts based on Year 2010. Milliman distribution is confined to medical claims only. Total Medicare Population includes Dual Eligible Population

Humana Dual Eligible Population Cost Pyramid

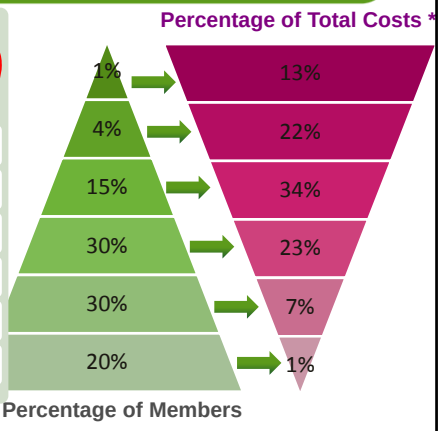
Observations:

-20% of the Dual Eligible Members account for 69% of the Total Cost (73% in Total Medicare)

-The Dual Eligible Population accounts for a higher percentage of total costs coming from IP across all members compared to the Total Medicare Population

-Physician services account for a smaller percentage of Total Cost across all members compared to the Total Medicare Population

IP	OP	PH
71%	8%	15%
62%	12%	18%
50%	17%	23%
22%	26%	37%
2%	29%	55%
0%	20%	64%



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Disease Prevalence

Using Hierarchical Condition Category (HCC)

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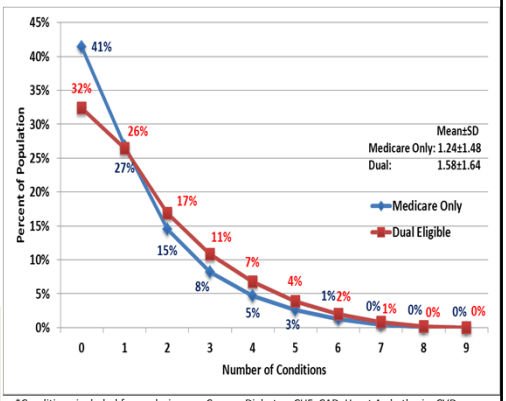
Percent of Members with Condition and Number of Comorbid Conditions

Conditions	Medicare Only (n=1,601,517)	Dual Eligible (n=202,383)	Variation
Cancer	10.9%	9.5%	-12.9%
Diabetes	27.7%	35.8%	29.2%
CHF	12.4%	17.0%	37.3%
CAD	10.3%	13.0%	26.6%
Heart Arrhythmia	12.2%	12.0%	-1.4%
CVD	4.0%	5.9%	47.5%
Vascular Disease	16.1%	20.7%	28.8%
COPD	15.3%	23.5%	53.6%
Renal	14.9%	20.5%	37.6%

*All variation is significant at p<0.01 using Chi-Squared

Observations:
-Dual Eligibles have significantly higher rates of all conditions, except Cancer and Heart Arrhythmia, compared to Medicare Only
-Dual Eligibles have a significantly higher number of Comorbid Conditions compared to Medicare Only

Number of Comorbid Conditions



*Conditions included for analysis were Cancer, Diabetes, CHF, CAD, Heart Arrhythmia, CVD, Vascular Disease, COPD, Renal

*Cancer: HCC 7-10 Diabetes: HCC 15-19 CHF: HCC 80 CAD: HCC 81-83 Heart Arrhythmia: HCC 92 CVD: HCC 95-100 Vascular Disease: HCC 104-105 COPD: HCC 107-108 Renal: HCC 130-132
-These categories were defined in Pope et al, Evaluation of the CMS-HCC Risk Adjustment Model Final Report, *CMS Office of Research, Development and Information.* March 2011

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HEDIS Measures

-Comprehensive Diabetes Care
-Antidepressant Medication Management
-Follow-up After Hospitalization for Mental Illness

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Analysis of HEDIS for 2010 Reporting Year

Comprehensive Diabetes Care

CDC	Medicare Only (n=1,604,816)	Dual Eligible (n=202,464)	Variation
CDC Denominator (% of Total)	232,509 (14.5%)	37,119 (18.3%)	26.5%
NPH % Comp.	83.4%	86.8%	4.1%
LDL Test % Comp.	86.0%	85.3%	-0.9%
LDL Control % Comp.	25.1%	26.1%	4.2%
HbA1c Test % Comp.	88.9%	88.1%	-0.9%
HbA1c % Poor	66.3%	63.3%	-4.5%

Observations:
-The percentage of the total population that ended up in the denominator was higher for the Dual Eligible population in all three measures assessed (CDC, AMM, FUH)
-The Dual Eligible Population has lower compliance in all measures for AMM and FUH

Antidepressant Medication Management

AMM	Medicare Only (n=1,604,816)	Dual Eligible (n=202,464)	Variation
AMM Denominator (% of Total)	10,478 (0.7%)	2,238 (1.1%)	63.9%
Acute AMM % Comp.	64.9%	60.9%	-6.2%
Cont AMM % Comp.	52.5%	48.7%	-7.4%

Follow-up After Hospitalization for Mental Illness

FUH	Medicare Only (n=1,604,816)	Dual Eligible (n=202,464)	Variation
FUH Denominator (% of Total)	4,308 (0.3%)	2,089 (1.0%)	284%
FUH7 % Comp.	51.9%	47.8%	-7.8%
FUH30 % Comp.	30.1%	28.5%	-5.2%

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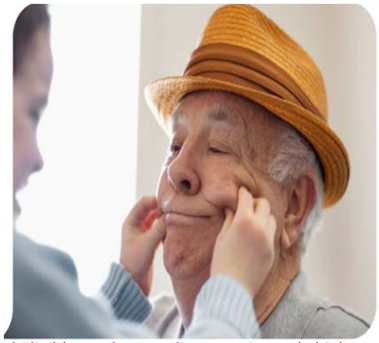
Insights & Conclusions

1. Lower utilization of Physician services may be leading to higher costs due to inpatient visits, and decreased follow-up of mental conditions and Medication Management for the Dual Eligible
2. Dual Eligible Members have a significantly higher number of comorbid conditions compared to the Medicare Only Population
3. The Dual Eligible Population had a larger percentage of their total population in the HEDIS Denominator for CDC, FUH, and AMM compared to the Medicare Only Population



"Dual Eligibles make up a disproportionately high amount of the Top 20% of Total Medicare Members by Total Cost"

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Appendix 1: Geographic Distribution of Members

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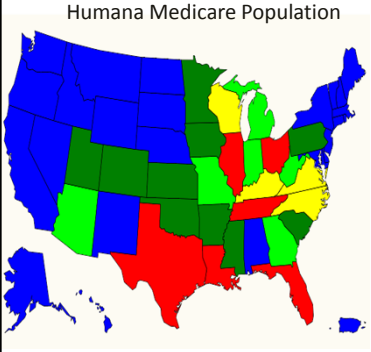
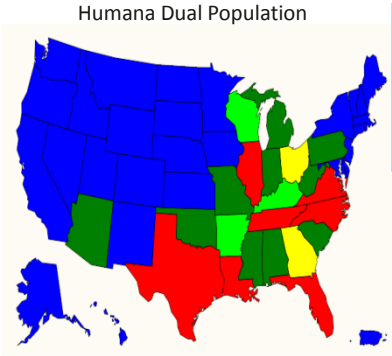
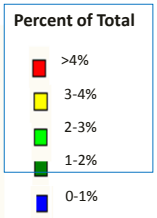
Humana Medicare vs Humana Dual Eligible Population: Geographic Distribution

Humana Medicare Population



Humana Dual Population





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Opportunity for Public Comment

Addressing Measure Gaps in Home and Community Based Services (HCBS)

Guest Presenter:

Anita Yuskauskas
Disabled and Elderly Health Programs Group, CMS

Measures in Medicaid-Funded HCBS

Current context

- 300+ waiver programs serving more than 1 million participants with expenditures exceeding $23 billion
- More than 2/3 of HCBS recipients are dual eligible beneficiaries
- Need-based social service system, enrollees have myriad diagnoses, no standard treatment or service package, delivered in a range of settings, by a range of providers
- State-centric program, no standardization of measures
- Can't compare across states or across HCBS sub-populations

Gaining Traction

Current activities

- Research efforts in both government and private sectors
- CAHPS tool for HCBS services in development
- CARE functional assessment tool being tested for use with HCBS populations
- Indicators of potentially avoidable hospitalizations for HCBS population in development
  - Based on AHRQ PQI measures
- Measure scans have demonstrated that valid measures exist across a wide range of domains, but further development and testing is required

Sources of Measure Information

Report	Source	Purpose
Environmental Scan of Measures for Medicaid Title XIX Home and Community-Based Services (June 2010)	*Funder* – AHRQ *Author* – Sara Galantowicz (Thomson Healthcare)	Provide background information to support the development of HCBS quality measures for the Medicaid program in order to assess the quality of Medicaid HCBS programs nationwide.
Raising Expectations: A State Scorecard on LTSS for Older Adults, People with Disabilities, and Family Caregivers (September 2011)	*Funder* – AARP *Authors* – Susan C. Reinhard, Enid Kassner, Ari Houser, and Robert Mollica	Develop a Scorecard to examine state performance across four key dimensions of LTSS system performance.
National Balancing Indicator Contractor (October 2010)	*Funder* – CMS *Authors* – Oswaldo Urdapiletta, Leanne Clark-Shirley, and Elizabeth Gall (IMPAQ International, LLC); Terry Moore and Deborah Walker (Abt Associates, Inc.); Susan Flanagan and Steven Lutzky (Consultants)	Develop, operationalize, and pilot a set of indicators to measure states' efforts towards a person-centered, balanced system of LTSS.

HCBS Quality of Life and Participant Experience Surveys

Common Person-Centered Measurement Domains

- Access to Needed Services and Supports
- Safety
- Health/Access to Healthcare Services
- Community Inclusion
- Respect and Dignity
- Choice and Control
- Care/Support Coordination
- Cultural Competence

HCBS Quality Assurances and Balancing Indicators

Common Structural Measurement Domains

- Assurances
  - Health and Welfare
  - Level of Care
  - Service Plan
  - Provider Qualifications
  - Financial Accountability
  - Administrative Authority
- Balancing Indicators
  - Sustainability/Expenditures
  - Availability of Options for Self-Determination
  - Coordination and Transparency
  - Community Integration and Inclusion

Measurement Domains: AHRQ Home and Community Based Services Measure Scan

Domain	Subdomain
Client Functioning	• Change in Daily Activity Function • Availability of support with everyday activities when needed • Presence of friendship • Maintenance of family relationships • Employment status • School attendance(children only) • Community integration • Receipt of recommended preventive health care services • Serious reportable adverse health events • Avoidable hospitalizations
Client Experience	• Respectful treatment by direct service providers • Opportunities to make choices about providers • Opportunities to make choices about services • Satisfaction with case management services • Client perception of quality of care • Satisfaction and choice regarding residential setting • Client report of abuse and neglect • Availability of support for resilience and recovery (mental health service recipients only)
Program Performance	• Access to case management services • Availability of care coordination • Receipt of all services in the care plan

Measurement Domains: AARP State Long-Term Services and Supports Scorecard

LTSS Domains

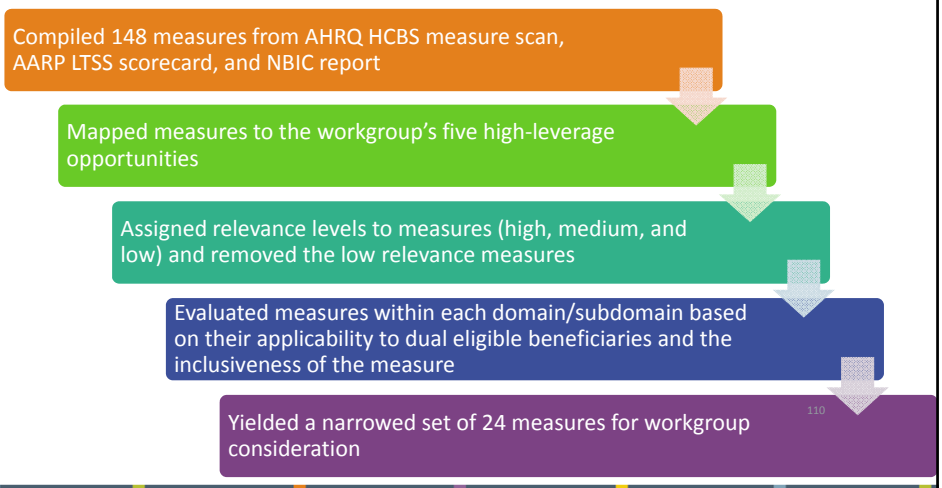
- Affordability and Access
- Choice of Setting and Provider
- Quality of Life and Quality of Care
- Support for Family Caregivers

Measurement Domains: National Balancing Indicator Contractor (NBIC)

NBIC Domains

- Sustainability
- Self-Determination/Person-Centeredness
- Prevention
- Community Integration & Inclusion
- Shared Accountability
- Coordination & Transparency

Methodology for Selecting Candidate Measures



Discussion Questions

Please examine the candidate measures handout…

- Would any HCBS measure domains or sub-domains be particularly important to apply to the dual-eligible population?
- Which of the specific measures appear most promising?
- Are there opportunities to modify the candidate measures for national use?
- How should emerging measures in this area relate to the group's proposed measurement framework for dual-eligible beneficiaries?
- What are the special measurement considerations for HCBS, given Medicaid is the payer source?
  - Data availability for managed care vs. FFS
  - State vs. federal roles

Opportunity for Public Comment

Recap Discussion
Prepare for Tomorrow

Day 1 Themes: General and States

- How to ensure that measures sufficiently address:
  - Connectedness (across all areas, address appropriate services & funding structures)
  - Person-centered (not just health care; health literacy, functional capacity, quality of life)
  - Aligning shared accountability across various entities (be aware and take approaches that motivate greater coordination and alignment)
  - High priority areas for the duals population (stay focused, learn from gaps)
- State's role and engagement
  - Variation in existing structures and related gaps and continuity disruptions, gaps in data, impact of 'payment policy' / degree of State attention to care covered under Medicare
  - Ideas: shared savings for both programs, address data access barriers, standardized measures and benchmark across states, audit State use of data, submit measure concepts to NQF

Day 1 Themes: Core Measure Set

- Core Measure Set focus: what's important, what we are missing, what exists but isn't right
- Types of General Challenges
  - Create a list that is 'short' or 'right' – given Duals core set spans many federal programs
  - Composite measures (e.g., suggest measure concepts) or add measures for different settings (e.g., transition records)
  - Consider measures from person's perspective – consistent with patient preference (QOL)
- Example observations
  - CAHPS – reference periods for Medicare & Medicaid health plan versions are different
  - Pain management and measurement is needed in settings beyond hospice
  - Medication issues – poly-pharmacy, appropriate Rx, reconciliation
  - Readmissions – connectedness, priority (address observation status, co-morbidity impact)
  - Unintended consequences – adverse selection, transitioning out, measurement burden while still being focused on person's needs, evolution of science (outdated measures)

Day 1 Themes: Adult Core Set

- Alignment with Medicaid Adult Core Set
  - Considerations for narrowing the set: measurement burden, data gaps for States
  - Includes 'reach' measures and supplemental questions for Medicaid CAHPS (e.g., addressing care coordination, shared decision-making, care transitions)
  - Funding to develop measures to address gaps in core set based on what States can do (2012 will work with States to understand issues, provide technical assistance)
- Workgroup observations
  - Important to synch measures across core lists
  - Important to assess over time when someone goes from Medicaid to Dual, whether outcomes change
  - Important to make best use of available data to show State comparisons

Day 1 Themes: Disparities / Stratification

- Disparities and stratification
  - Definitions of race and ethnicity need to be used in a standard way
  - Approach to stratification:
    - » Stratify by Dual status to indicate if improvement is happening
    - » Stratify within the Dual population to support different quality improvement strategies
- Humana data is an excellent starting point to tease out questions, such as:
  - 'Super users' – what is driving the 1% to generate 13% of the costs? Where and how is public sources of data (e.g., ambulance) factored into this?
  - What might the data show regarding mental health and length of stay?

Day 1 Themes: HCBS

- Gaps in Home and Community Based Services
  - System is state specific with very little standardization
  - Everything in HCBS starts with the person's individual needs (patient autonomy)
    - » HCBS testing CAHPS and CARE functional assessment tool
    - » Need individually based measures; shared accountability presents a dilemma
- Workgroup observations
  - Individualized care plans are core
  - Social / human services domain being developed – National Health Information Exchange – to connect with health info exchange (look up NIEM model: human services domain)
  - Need to address workforce capacity and dependability (paid and unpaid workers)
  - Priority gaps: assess impediments to access, connectedness to health care, financial construct undermines improvement (get better = lose coverage), data to measure gaps
  - Overall, concepts on gaps list are strongly supported

Adjourn

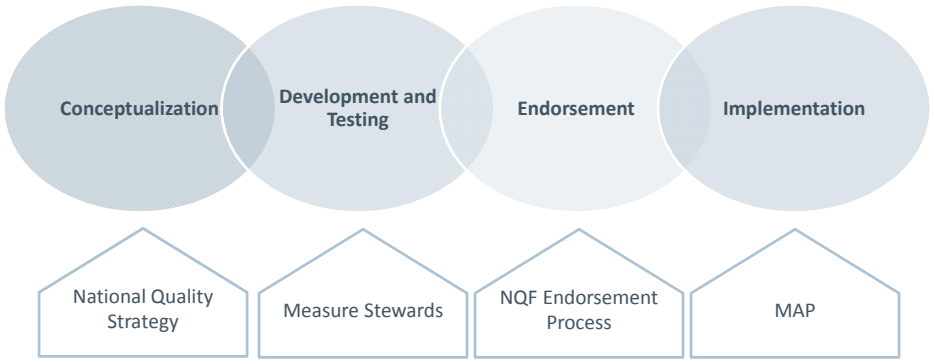
Welcome and Recap of Discussion

Agenda: Wednesday, February 22

9:15	Understanding the Measure Development Process
10:15	Findings from Environmental Scan
11:15	Working Session: Prioritizing Measure Gap Areas
12:15	Working Session: Potential Measures to Address High-Priority Gaps
1:15	Report Out: Potential Measures to Address High-Priority Gaps
2:15	Final Report Recommendations to Coordinating Committee
2:45	Workgroup Feedback on Progress to Date and Future Direction
3:00	Adjourn

Understanding the Measure Development Process

Measure Development and Application



Guest Presenters:

Sarah Scholle
National Committee for Quality Assurance (NCQA)

Karen Sepucha
Harvard University / Massachusetts General Hospital

Heidi Bossley
Performance Measures Department, NQF

Evaluating Person-Centered, Integrated Care for People Who are Dually Eligible for Medicare and Medicaid

NQF MAP Duals

Overview

- Describe ongoing efforts to articulate model of care and measures for evaluating integrated care for people with dual eligibility
- Issues/steps in moving from measure concept to actual measures for this population

Standardizing the Expectations and Evaluation of Integrated Care Models for Persons who are Dually Eligible for Medicare and Medicaid

- **Phase I**
  - **Environmental scan**
  - **Stakeholder discussions**
  - **Draft model**
- **Phase 2**
  - **Identify states and models to evaluate feasibility**
  - **Develop draft standards/measures**
  - **Test draft measures in 3-5 organizations with different service delivery models**
- ***Supported by the SCAN Foundation***

Priority Domains

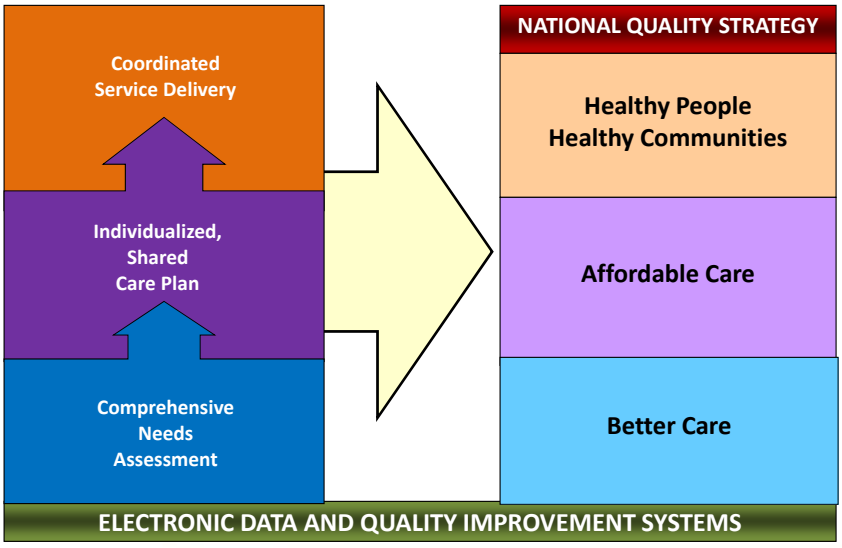
- **Comprehensive Needs Assessment**

  Holistic; addresses medical, mental/behavioral and psycho-social needs (e.g., food, housing, transportation, personal care)
- **Individualized, Shared Care Plan**

  Iterative; developed in collaboration with the person and their caregiver; reflects their goals, values, and preferences; operationalizes the needs assessment; accessible by providers, person, and caregiver(s)
- **Coordinated Service Delivery**

  Supported by EHR/HIT; includes accountability for tracking and followup of services and referrals, managing care transitions, and engaging people in self-care

Quality Care for People with Dual Eligibility



Overview of Measure Development Process

Development of Measure Concepts
- Perform environmental scan/gap analysis of measures
- Identify preliminary measures/measure concepts
- Obtain feedback from advisory groups
- Develop draft specifications

Measure Testing/ Validation
- Convene various focus groups to discuss measure importance , feasibility and usability
- Conduct public comment on measure specifications and major issues
- Conduct field testing
- Obtain feedback from advisory groups and ASPE

Creation of Final Product
- Summarize findings from measure testing/validation
- Finalize measure specifications
- Prepare NQF submission forms

Issues in Measurement

- **Evidence base**
- **Small numbers**
- **Availability of data, workflow**
- **Accountability**
- **Patient and family centered approach**
- **Cognition, literacy, use of proxies**

Schizophrenia Measure Development Project

- To develop measures to assess the quality of care provided to Medicaid beneficiaries with schizophrenia in ambulatory care settings
- The measures are designed to:
  - Represent evidence-based practices
  - Address the following domains: pharmacotherapy, psychosocial services, and physical health
  - **Use claims data only**
- *Funded by ASPE*

Developing Measures for Schizophrenia

Domain	Measure Concept	Specified Measure
Pharmacotherapy	• Use of antipsychotics • Continuity of antipsychotics • Clozapine for treatment resistant patients • Polypharmacy of antipsychotics	• Use and Continuity of Antipsychotic Medications for Treatment of Schizophrenia
Psychosocial	• Use of Assertive Community Treatment • Use of case management • Use of family therapy • Use of supported employment • Use of any psychosocial • Use of cognitive behavioral therapy • Use of social education	• Psychosocial Treatment for People with Schizophrenia
Physical Health	• Preventive screenings • Infectious disease screening • Substance abuse screening • Tobacco counseling	• Cervical Cancer Screening for People with Schizophrenia • HIV Screening for People with Schizophrenia
Cross-cutting	• Metabolic screening for patients with antipsychotics • Weight counseling for patients using antipsychotics • Use of antipsychotics and psychosocial • Outpatient follow-up after inpatient	• Cardiovascular Health and Diabetes Screening for People with Schizophrenia • Emergency Department Utilization • Follow-Up After Hospitalization for Schizophrenia
System/Access	• Medicaid enrollment • Availability of psychosocial • Waiting list for psychosocial	

Patient-reported outcomes

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MGH 1811

FOUNDATION FOR INFORMED MEDICAL DECISION MAKING

VE RI TAS

Documenting the patients' voice…

Information

I have two small children and want to live as long as possible.

↓

What are my options? I want to do everything possible.

↓

What is the impact for each option on 10 yr survival? 20 yr?

Documenting the patients' voice…

Information

I am concerned that my desire to forego treatment is discouraging and frustrating for you.

↓

Involvement

I want to watch this recurrence and check it in 3 months. If it is growing then I will consider treatment.

↓

Your support is important to me. Are you willing to support me in this alternative?

Documenting the patients' voice…

Information

Involvement

Concordance

I am afraid of chemotherapy. It doesn't make sense to me.

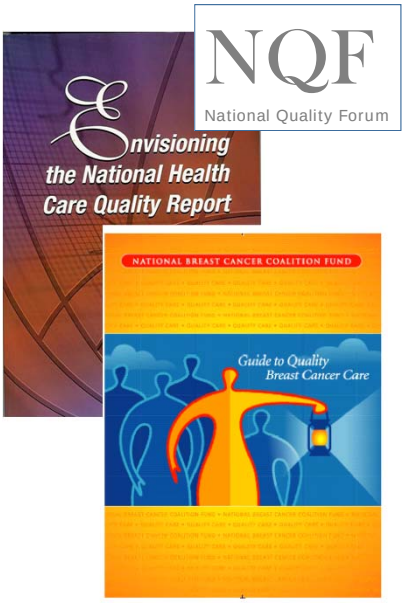
↓

I don't understand how poisoning my body can make me better.

↓

I need my immune system to fight the cancer, but chemo weakens my immune system.

High quality, patient-centered care



Core Themes:

- fully informed
- play a key role in making healthcare decisions
- treatments reflect patients' want, needs and preferences

"Outcomes that matter to people"

- Understand benefits and harms of preventive, diagnostic, therapeutic, or health delivery system interventions to inform decision making
  - Focusing on outcomes that people notice and care about such as survival, function, symptoms, and health-related quality of life;
  - Includes extent to which treatments reflect individual's preferences, autonomy and needs,
  - Includes patients' experience with care

pcori

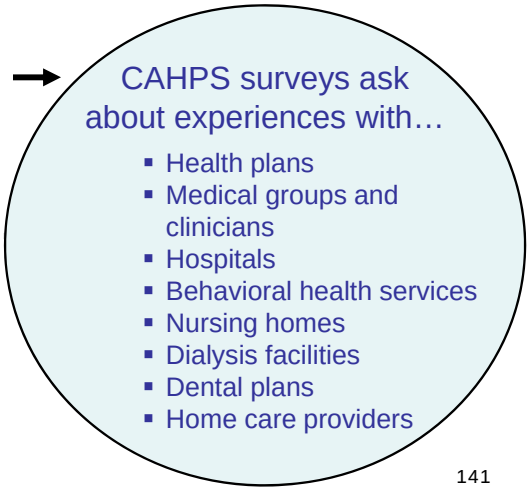
The Importance of Patient Reported Outcomes

- Patients are the only source of information about many critical aspects of quality.
- Administrative data, medical notes, test results, or provider reports not good replacement
- The patient's experience is linked to clinical outcomes, and reduced medical error.

IS5

The CAHPS Family of Surveys

- *Family of surveys: comprehensive and evolving*
- *Patients evaluate their experiences with health care*
- *All surveys are in the public domain*



141

CAHPS Design Principles

- *Emphasis on patients*
  - What patients value with respect to the setting of care
  - Aspects of care for which patients are the best or only source of information
  - Extensive testing with patients and families
- *Reports and ratings about experiences*
- *Standardization*
  - Surveys, data collection, analysis, reporting, benchmarking
- *Multiple versions for diverse populations: adult, child, languages*
- *All CAHPS surveys and products are in the public domain.*

142

Development process

- *Literature review*
- *Technical Expert Panel review*
- *Focus group feedback*
- *Cognitive testing* ***(English and Spanish)***
  - Patients and families in medical home practices and regular primary care practices
- *Field testing* ***(English and Spanish)***
- *Psychometric analysis*
- *Public release*

143

Who made the decision about treatment of your …?

- ❑ Mainly the doctor
- ☒ Both equally
- ❑ Mainly you

"they didn't say to me, "Well, we could remove the breast, we could do this, we could do that." They just said, "This is what we're going to do." …I wasn't in on the decision. That's what I'm trying to say. I wasn't in on the decision."

"She [the doctor] was competent and compassionate, …she gave me the data that I needed to take the emotion out of the decision. We talked statistics and sizes and things that helped me to be analytical with my decision."

"I made the decision. I'm very happy with that because that's what I wanted to do from the beginning. It was fine. They [my doctors] didn't disagree. They didn't agree. They just said, "Okay." They understood."

Some challenges

- We need high quality surveys to cover critical areas
- What if patients do not want the most effective care? Or want something different than the clinical guideline?
- This type of info isn't collected as part of routine care, not available in administrative data sets

The future…redefining appropriateness

- "Appropriateness does not equate to medical necessity. **Shared patient/physician decision making for many scenarios would be expected** and may result in the patient deferring coronary revascularization while maintaining medical therapy."

American Heart Association®
Learn and Live℠

Key questions

- What matters to patients?
- When informed and given a voice, what option do they feel is best?
- How can the health care system improve the chances of achieving the outcomes patients' prefer?
- What kind of measures would we need to ensure this is happening?

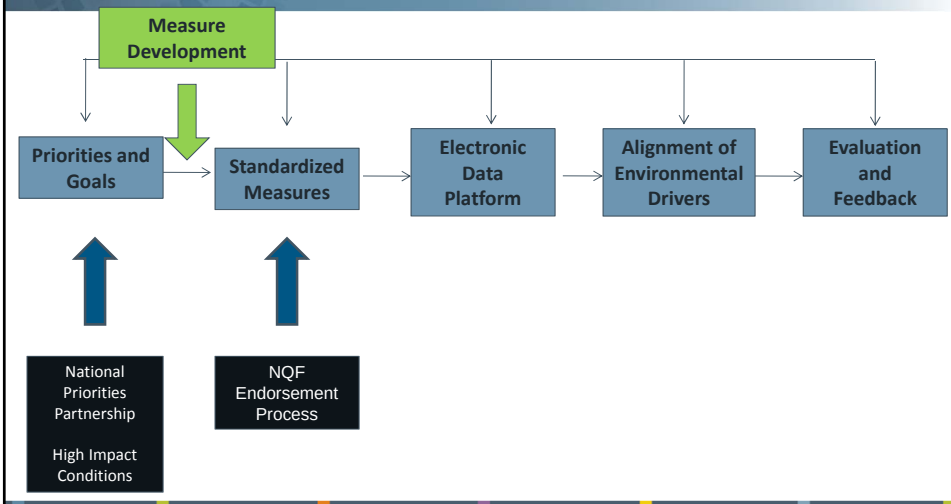
Consensus Development Process

NATIONAL QUALITY FORUM

Measurement Facilitates Improvement

- Measurement is necessary, but insufficient to achieve quality
- Provides information about performance useful for selecting providers with high quality (consumers, purchasers, health plans)
- Provides information about outcomes and processes useful to providers for identifying areas that need improvement and changes in care processes/systems

Quality Measurement Enterprise



Quality Measurement in Evolution

- Drive toward higher performance
- Shift toward composite measures (all/none and weighted composite)
- Harmonize measures across sites and providers
- Measurement across longitudinal patient-focused episodes
- Measure disparities in all we do

Patient-Focused Episode Model

- Promote shared accountability & longitudinal measurement across patient-focused episodes of care:
  - Outcome measures
  - Appropriateness measures
  - Cost/resource use measures coupled with quality measures, including overuse

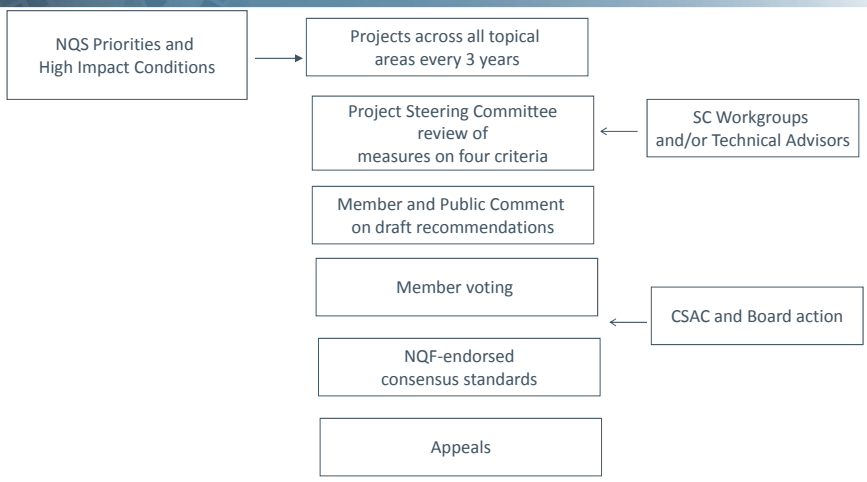
Ensuring Currency of Measures

- Three avenues to ensure currency of the measures and the NQF portfolio:
  - Endorsement maintenance process
  - Annual updates
  - Ad hoc reviews

Endorsement Maintenance Process

- Purpose: To ensure the currency and relevance of NQF-endorsed consensus standards through a regular schedule of reviewing measures for continued endorsement
- Timeline: Review of endorsed measures every three years
- Process:
  - Implementation comments are sought and considered
  - Measures are reviewed against all the evaluation criteria
  - New and endorsed measures are reviewed within same project
    - » Harmonize measure specifications
    - » Endorse "best in class" measures

Current NQF Measure Endorsement Process



NQF Evaluation Criteria

- **Importance to measure and report**
  - What is the level of evidence for the measures?
  - Is there an opportunity for improvement?
  - Relation to a priority area or high impact area of care?
- **Scientific acceptability of the measurement properties**
  - What is the reliability and validity of the measure?
- **Usability**
  - Are the measure results meaningful and understandable to intended audiences and useful for both public reporting and informing quality improvement?
- **Feasibility**
  - Can the measure be implemented without undue burden, capture with electronic data/EHRs?
- **Assess related and competing measures**

Annual Updates

- Ensures the measure information is current and accurate
- Any changes will be reviewed for material changes
  - May initiate ad hoc review process
- Required only during off-cycle years and will not be requested during the year of a measure's endorsement review
- Each measure is assigned to a quarter during which updates may be submitted
- NQF may phase review depending on the number and type of updates received

Ad Hoc Review

- May be conducted on an endorsed measure, practice, or event at any time with adequate justification to substantiate the review
- Considered by NQF on a case-by-case basis and must be justified by specific criteria, including material changes to a measure
- Ad hoc reviews can be requested at any time by any party, and requester(s) should indicate under which criterion they are requesting the ad hoc review and submit adequate evidence to justify the review.

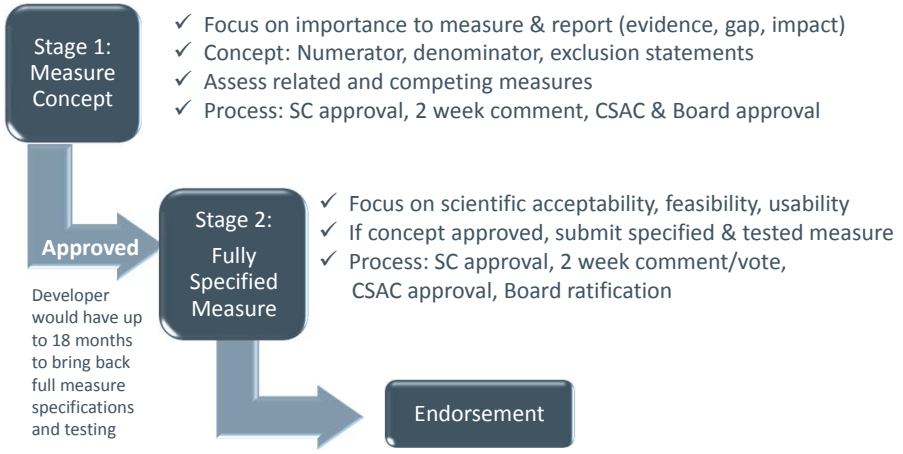
Feedback on Current CDP Process

- ***Need for earlier decision on Importance criterion***
  - A "must pass" criterion on which many measures can fail
  - Considerable investment of development resources without guarantee of completing endorsement
  - Limited guidance on / knowledge of competing measures and harmonization
- ***Need for more timely and flexible review of fully specified and tested measures***
  - Developers could wait two years to submit to next maintenance cycle if testing data are not available for a project submission deadline
- Consistent application of measure evaluation criteria by Steering Committees
- Need clarity around when tested EHR specifications will be required

Proposed Endorsement Process Redesign

- NQF is considering a two-stage CDP process to accomplish two objectives:
  - Provide measure stewards with a determination of whether a *measure concept* satisfies the *Importance to Measure & Report* criterion prior to full development and testing of the measure
  - Provide greater flexibility for stewards to bring fully developed and tested measures back to NQF at any point in time to complete the endorsement process after the measure is fully specified and tested

Proposed Two-Stage Endorsement Process



Thank You

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Analytic Support for the Measure Applications Partnership (MAP)

Summary Findings
L&M Policy Research, LLC
Subcontractor to Avalere Health, LLC
February 2012

L&M POLICY RESEARCH, LLC

Introduction and Methodology

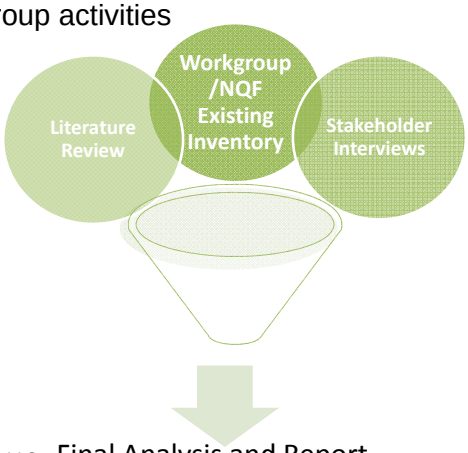
L&M POLICY RESEARCH, LLC

Purpose

To identify quality measures and issues for the dually eligible (duals) across all settings of care, as part of Avalere Health's work with NQF on the Analytic Support for the Measure Applications Partnership (MAP). This work is meant to inform and corroborate the duals measure prioritization and gaps within the five high-leverage domains identified by the MAP (MAP Task 15.3).

Methods

- L&M's overall approach
  - An environmental scan most prominently including discussions with experts
  - A literature scan that builds on the Duals Workgroup activities



Methods

1. Identify list of NQF-endorsed measures of special importance to duals through filtering process to discuss with expert stakeholders
2. Conduct nine discussions with key informants (1 to 1 ½ hours each)
3. Supplement findings with literature review
4. Present preliminary findings to NQF

Methods: Expert discussions

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

Findings

Key measure areas and practical concerns

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Summary of Findings

- Ongoing, person-centered care focusing resources on those most in need is key to providing quality care to this vulnerable population with complex needs
  - To gauge quality of care, must measure:
    1. Extent that "high-touch" person-centered care planning and management process occurs when needed
    2. Processes and structures in place to support this as an on-going activity

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170

Key measure areas supporting person-centered health

- Consumer-based assessment of goal-oriented planning and care delivery
- Management and monitoring of specific conditions and disabilities
- Medication management/reconciliation across settings
- Transition management
- Integration and coordination of community social supports and health delivery
- Utilization benchmarking
- Process improvement across settings and organizations

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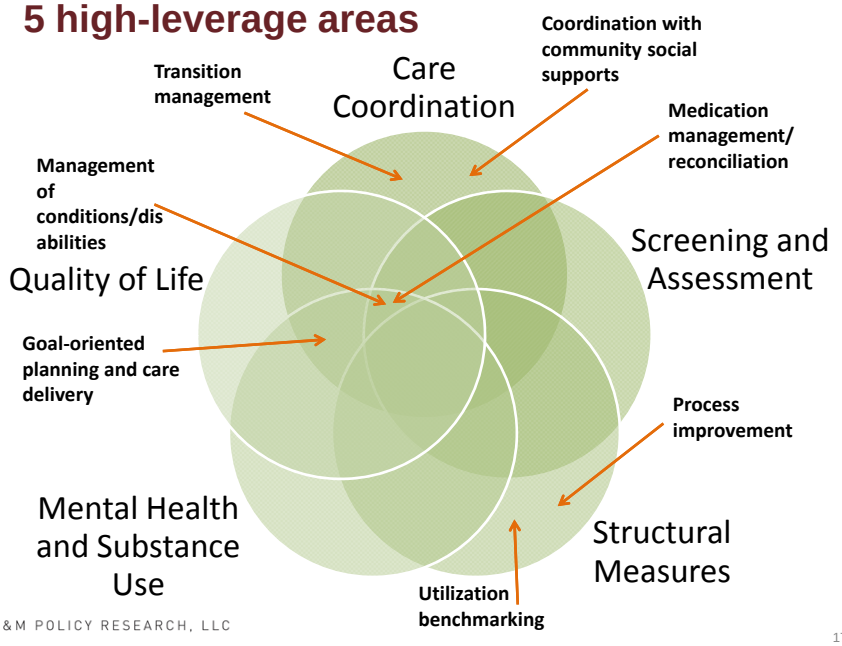
171

5 high-leverage areas



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172

Key measure areas: Consumer-based assessment of goal-oriented planning and care delivery

- **Measure schema**
  - Patient/caregiver/family perception of extent to which care plan (if needed) and care delivered reflect goals and desires of the individual and/or care plan
- **Existing measures**
  - National and state-level data limited (CAHPS surveys)
  - Sporadic use of other consumer and quality of life surveys
  - **Example**: 0557-0558 NQF Endorsed – Patients discharged from a hospital-based inpatient psychiatric setting with a continuing care plan created/ provided to the next level of care clinician or entity.
  - **GAPS**: For those that include care plan, hard to gauge whether it's actually being followed and extent to which patient is involved; issues with measures spanning multiple settings

Key measure areas: Consumer-based assessment of goal-oriented planning and care delivery

- **Ideal/potential measures**
  - Gauge consumer satisfaction of cross-setting care and/or of care plan (if needed) in meeting quality of life and quality of service needs

"When we sit down to develop a participant-centered plan with goals, we think of what's important with this person's life – and it's not necessarily medical at all. It may have to do with establishing meaning in life – and we don't have much to assess."

Key measure areas: Management and monitoring of specific conditions and disabilities

- **Measure schema**
  - Provider and patient active awareness of and engagement with signs and symptoms related to conditions (or clusters of them) to achieve individual's care plan goals
- **Existing measures**
  - Condition-specific measures often designed for single settings, with little evidence base for important combinations of chronic (mental and physical) conditions
  - **Example**: 0418 NQF Endorsed – Percentage of patients aged 18 years and older screened for clinical depression using a standardized tool AND follow-up documented
  - **GAPS**: Most measures are single-condition process measures confined to one setting

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175

Key measure areas: Management and monitoring of specific conditions and disabilities

- **Ideal/potential measures**
  - Tailored compendium of measures (composites when feasible) that focus on person-centered care planning

"The science of disease-related quality measurement is not caught up with the complex dual population."

"We tend to measure these things one at a time whereas the person presents very frequently a cluster of problems."

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176

Key measure areas: Medication management/reconciliation across settings

- **Measure schema**
  - Shared management of medications among provider and patient/caregiver focusing on goals of care plan to optimize appropriate use of medication and minimize negative drug interactions
- **Existing measures**
  - Focus on whether a "medication review" occurs within a setting (particularly hospital) and occasional reconciliation during transitions
  - **Example:** 0553 NQF Endorsed – Percentage of adults 65 years and older who had a medication review
  - **GAPS:** Mostly limited to single setting (hospital) and without sense of patient input or management plan

Key measure areas: Medication management/reconciliation across settings

- **Ideal/potential measures**
  - Focus on management of medications across providers and settings especially when many medications involved

"Medication management is probably one of the lowest hanging fruits for this population."

"We simplify medication management a bit too much. Hospitals might be doing a good job, but a lot of times they don't know what drugs patients are on when they come in, then the patients leave with new drugs. It's a much more complex problem we're getting at right now."

Key measure areas: Transition management

- **Measure schema**
  - Interactions that occur within and across settings/organizations, among providers with patients and their families, to ensure patients receive comprehensive and streamlined care without duplication
- **Existing measures**
  - Primarily focus on transition from acute setting to the community
  - **Example:** 0648 NQF Endorsed – Percentage of patients, regardless of age, discharged from an inpatient facility to home or any other site of care for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge
  - **GAPS:** Mostly limited to transition from hospital – not across multiple settings; little focus on follow-up

Key measure areas: Transition management

- **Ideal/potential measures**
  - Track patient's transitions within and across multiple settings, noting communication among providers, services agencies, and patients; documentation of conditions; and follow-up

"The quality measurement approach tends to work within a setting. That ignores critical handoffs that happen between settings – it's challenging to measure that."

Key measure areas: Integration and coordination of community social supports and health delivery

- **Measure schema**
  - Ability to identify need for and ultimately integrate community social supports into care plan based on patient/caregiver needs
- **Existing measures**
  - Generally limited to use of checklists that identify patient needs of social supports
  - **Example:** Non-U.S., British Medical Association (NQMC:003014) Management: the practice has a protocol for the identification of [caregivers] and a mechanism for the referral of [caregivers] for social services assessment.
  - **GAPS**: No currently available measure set assessing this area

Key measure areas: Integration and coordination of community social supports and health delivery

- **Ideal/potential measures**
  - Gauge the extent of community and social supports available and the ease with which an individual can access those services
    - Particularly, covered benefits such as HCBS
  - Examples relevant to duals (although not covered benefits, and not direct quality measures) include availability of:
    - Transportation services to and from appointments
    - Safe and clean low-income housing
    - Translation services for non-English speakers
    - Employment counseling/training

Key measure areas: Utilization benchmarking

- **Measure schema**
  - Gauge the extent of and variation in service use among duals and their subpopulations across settings
- **Existing measures**
  - Focus primarily in acute care setting without tracking individuals' specific service use across delivery system or recognition of case mix differences/risk adjustments
  - **Example:** NCQA HEDIS (NQMC:006257) – Ambulatory care: summary of utilization of ambulatory care in the following categories: outpatient visits and emergency department visits.
  - **GAPS:** Limited to certain populations and certain settings

Key measure areas: Utilization benchmarking

- **Ideal/potential measures**
  - Track overall utilization trends and those for subpopulations across all settings and develop comprehensive set of national benchmarks for states and regions
    - Beyond cost per beneficiary and service types, examine indicators such as: admission and readmission rates for duals by diagnoses, ED visits, # specialist and PCP visits per beneficiary, # specialists seen by a given beneficiary in set period, condition-specific costs, etc.

"In an effort like this I'd be more inclined to get coordination around the ultimate outcomes – institutionalization, end-of-life care costs, cost utilization measures. I think I feel more passionate about needing that for benchmarking rather than micro-managing process measures within a program."

Key measure areas: Process improvement across settings

- **Measure schema**
  - Ensure quality improvement programs in place within and across settings and organizations focusing on duals and their subpopulations
- **Existing measures**
  - Primarily limited to integrated delivery systems focusing on medical homes and "systemness"
  - **Example:** 0494 NQF Endorsed – Percentage of practices functioning as a patient-centered medical home by providing ongoing, coordinated patient care. Meeting Medical Home System Survey standards demonstrates that practices have physician-led teams that provide patients with: (a.) Improved access and communication (b.) Care management using evidence-based guidelines (c.) Patient tracking and registry functions (d.) Support for patient self-management (e.) Test and referral tracking (f.) Practice performance and improvement functions
  - **GAPS:** Tendency to exist for individual settings/organizations

Key measure areas: Process improvement across settings

- **Ideal/potential measures**
  - Incorporate multiple provider settings and human service settings/organizations to ultimately address population health
  - Represent importance of identifying and solving problems across, among, and within a setting, but needs to be encouraged across the full continuum of duals care delivery.

Practical issues across all settings

- Measures should consider differences in subpopulations such as
  - Intellectually/developmentally disabled (younger)
  - Frail elderly
- Current work of the MAP not focused on such measures, however

"We're talking 1/3 and 2/3 – we're going to have to [measure] both. There are going to be more and more combinations of the two, and they are very different populations."

Practical issues across all settings: Data issues

- EHRs in different states –
  - Varying ability to capture advanced data
- Separate Medicare/Medicaid datasets–
  - Medicare and Medicaid data not together in one place
- States issues getting Part D claims –
  - Crucial for medication management (CMS just in beginning of making A, B, D claims available to states upon request)
- Privacy issues for substance abuse data –
  - States having trouble accessing data without patient consent

Practical issues across all settings: Methods and adoption

- When comparing duals across states –
  - Compare same subpopulations, apples to apples
  - Recognize differences in states' focus, resources, Medicaid benefits
- Issues with sample size of measures –
  - Dealing with diverse population where relatively few meet criteria for inclusion in specific measure
- In creating and adopting measures, states need:
  - Limited number of measures considered "meaningful"
  - Clear and specific criteria for each measure – "apples to apples" comparisons
  - Awareness of each measure's source(s) of data – difficult to pull from different agencies
  - Consistent requirements across programs – taking into account meaningful use requirements to minimize duplication

Practical issues across all settings

"I think one of the messages I'm hearing is the need for a national prescriptive definition so that when you're trying to look at our rates for duals that that definition is an endorsed definition when we compare it to other states – we need apples to apples. And we're just not doing that. If we could see here's a similar population… we don't have that ability to compare."

Practical issues across all settings

Ideally, to truly deliver quality care, a system must be integrated to meet beneficiary needs. To gauge the success of that system, one must examine the extent to which processes occur across settings at the appropriate times and in meaningful ways.

- *This requires an evolution in measure development beyond simply identifying existing single-setting, single-condition measures*

Discussion

Discussion Questions

- What are key components of 'systemness' that would be critical to capture in a measure set?
- To measure the extent to which duals receive quality care, we must first identify those in need of a care plan. How?

Contact Us

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Working Session: Prioritizing Measures and Gap Areas

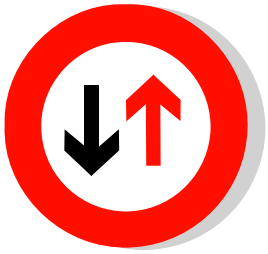
Core Measure Prioritization Activity

- Yesterday the workgroup discussed changes to the draft core measure set
- Members want to evaluate comprehensiveness vs. parsimony in the set
- Prioritization helps to direct emphasis to critical areas within a broad set
- Lists on flip charts reflect yesterday's discussion of core measures, at the topic level

What do the results of the core measure prioritization exercise tell us?

Measure Gap Prioritization Activity

- The Workgroup has identified an extensive list of measure gaps related to the needs of dual-eligible beneficiaries
- Prioritization helps to direct limited resources for measure development to the most appropriate areas
- Lists on flip charts reflect yesterday's discussion of measure gaps



Use the dot stickers provided to indicate the sub-domains you believe should be prioritized for development.

You may use multiple dots per sub-domain, if desired.

Take five minutes to think, vote, and return to your seat.

NQF staff will tally the results for discussion.

What do the results of the sub-domain prioritization exercise tell us?

Working Session: Potential Measures to Address High-Priority Gaps

Suggesting Potential Measures

- Select one or two collaborators
- Review the staff suggestions for potential measures for future development on the worksheet provided
- **Confirm the suggestions you agree with…**
- **Edit the suggestions that need refinement…**
- **Create your own potential measures…**
- Be creative! This time there are no wrong answers
- Help yourself to lunch while you work
- Plan to turn in your worksheet

Reporting Out

- What were your general impressions of this exercise?
- What made it challenging?
- Domain by domain, Alice will call on groups to describe their suggestions for potential new measures.

Opportunity for Public Comment

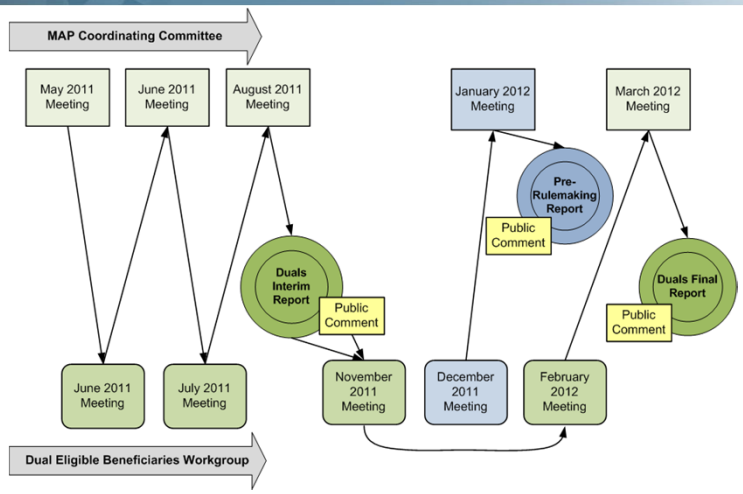
Final Report Recommendations to MAP Coordinating Committee

Final Report Outline

I. MAP Background
II. Strategic Approach to Performance Measurement
III. Initial Core Set and Primary Measure Gaps
IV. Strategies to Address Measure Gaps
    a. Potential Measure Modifications
    b. Potential Measure Schemas for Future Development
V. Levels of Analysis and Potential Applications of Core Set
VI. Alignment Across Programs

Summation and Next Steps

Flow of Information to Inform Reports



MAP Nominations

- MAP's annual call for member nominations will open soon and continue through Spring 2012
- 30-day nomination period, followed by public vetting of proposed rosters and approval by the NQF Board of Directors
- One-third of MAP Coordinating Committee and Workgroup members are affected
- Members holding one-year terms are eligible and encouraged to re-nominate themselves

Membership Terms

Chair	Term Length
Alice Lind, MPH, BSN	3

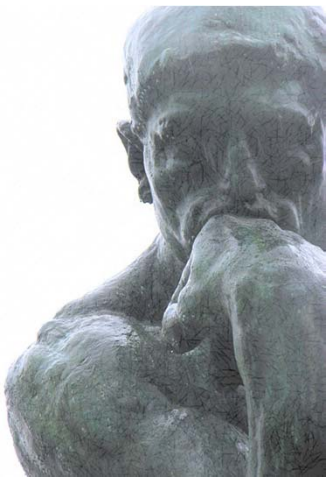
Organizational Members	Term Length
American Association on Intellectual and Developmental Disabilities	3
American Federation of State, County and Municipal Employees	1
American Geriatrics Society	2
American Medical Directors Association	2
Better Health Greater Cleveland	1
Center for Medicare Advocacy	1
National Health Law Program	3
Humana, Inc.	2
LA Care Health Plan	3
National Association of Public Hospitals and Health Systems	1
National Association of Social Workers	2
National PACE Association	1

Subject Matter Experts	Term Length
Mady Chalk, PhD, MSW	2
James Dunford, MD	2
Lawrence Gottlieb, MD, MPP	1
Juliana Preston, MPA	3
Susan Reinhard, PhD, RN, FAAN	3
Rhonda Robinson Beale, MD	3
Gail Stuart, PhD, RN	2

Federal Government Members	Term Length
Agency for Healthcare Research and Quality	1
CMS Medicare-Medicaid Coordination Office	1
Health Resources and Services Administration	3
HHS Office on Disability	2
Substance Abuse and Mental Health Services Administration	3
Veterans Health Administration	2

Closing Reflections from Workgroup Members

- In your opinion, what is the most important aspect of MAP's work on quality measurement for dual eligible beneficiaries?
- Where would you like to see this work go in the future?
- What process improvements would help workgroup members stay informed and engaged?



Final Opportunity for Public Comment

Day 2 Themes: Measure Development Process

- Measurement challenges for addressing measure gaps for Dual eligible population
  - Evidence base, small numbers, data collection, accountability, patient/family centered approach, cognition /literacy /use of proxies
  - Patient Reported Outcomes: Information, involvement, concordance … "Appropriateness does not equate to medical necessity" contrast to traditional measurement developed based on solely on scientific evidence
  - Expansion of measures to new areas can be addressed/evaluated via an 'ad hoc review'; NQF and developers want ideas on gaps or measure concepts
- Discussion
  - Interest in use of mobile technology to collect patient-reported information
  - Cost and resource use work is important, consider periods longer than one year
  - Need roadmap of what's important to measure (concepts, what's good, what isn't)
  - Developing approaches that work in the future is in underway now, but takes time

Day 2 Themes: Environmental Scan

- Measure gaps/needs
  - High touch, person-centered care planning and management happens when needed; Process and structures are in place to support this as an ongoing activity
  - Problems: lack of 'system-ness', data, methods and adoption, care planning
- Discussion
  - Challenges of shared accountability in ways that reflect differences in populations
  - Major barrier is access to mental health and substance use data: absolutely a perceived 'reality'
    - » Perhaps more exploration is needed to understand the restrictions (42CFR)
    - » Some states have figured out approaches to access information

Day 2 Themes: Measure Set Input

- Voting exercise:
  - Measures that are good, just the way they are
    - » Top (>3 votes): depression screening, medical home adequacy, CAHPS, initiation of drug dependence treatment
    - » Mid (3 votes): HIT at point of care, diabetes management, fall risk screening, medication reconciliation, transition record communicated
  - Measures that need to be modified in some small way
    - » Top (>9 votes): survey of health-related Quality of Life, all-cause hospital readmission, medical home adequacy, IP/ER transition records created / communicated, psych discharge plan created / submitted,
    - » Mid (5-8 votes): fall risk screening, CAHPS, patient experience of care transition

Day 2 Themes: Measure Set Input

- Voting exercise, continued
  - Measure gaps
    - » Top (>=9 votes): person-centered planning and consistency with goals,, cognitive status/psychosocial health, appropriateness of initial hospitalization, connection with HCBS, optimal functioning
    - » Mid (>=6 votes): medication management , utilization benchmarking, health literacy, LTSS, coordination b/w systems of payment, sense of control/autonomy, assistance navigating Medicaid/Medicare

Thank You!

Measure Applications Partnership

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

DRAFT OUTLINE

Executive Summary

I. MAP Background
   a. Role of MAP
   b. Methodology and Limitations

II. Strategic Approach to Performance Measurement (this section intended to briefly summarize and update contents of Interim Report)
   a. Charge/Purpose
   b. Frameworks and Inputs
   c. Vision
   d. Guiding Principles
   e. High-Leverage Opportunities for Improvement Through Measurement

III. Core Set
   a. Initial Core Set (Table)
   b. Primary measure gaps
      i. Quality of Life Measures
      ii. HCBS Measures
      iii. Others as prioritized by workgroup…
   c. Discussion

IV. Addressing Gaps in Measurement
   a. Potential Measure Modifications
      i. Suggested Modifications
      ii. Opportunities to Influence
         1. Upcoming Endorsement Cycles
         2. Measure Maintenance
   b. Proposed draft measure concepts for future development

V. Levels of Analysis and Potential Applications of Core Set
   a. Where will measurement occur?
   b. Data sources
   c. Accountability
   d. Pros and cons of various levels of analysis

VI. Alignment Across Federal Programs
   a. Contribution to Pre-Rulemaking Deliberations
   b. Medicaid Adult Core Measures
   c. Future opportunities and follow-on work

APPENDIX 6: DUAL ELIGIBLE BENEFICIARIES CORE MEASURE SET (DRAFT)

NQF # and Status	Measure Title and Description	Quality of Life	Care Coord	Screening	Mental/Subst	Structural	Specified Setting of Care	Use in Federal Programs
0329 Endorsed	*All-Cause Readmission Index (risk adjusted)* Overall inpatient 30-day hospital readmission rate, excluding maternity and pediatric discharges		•				Hospital	
0228 Endorsed	*3-Item Care Transition Measure (CTM-3)* Uni-dimensional self-reported survey that measures the quality of preparation for care transitions. Namely: 1. Understanding one's self-care role in the post-hospital setting 2. Medication management 3. Having one's preferences incorporated into the care plan		•				Hospital	Under Consideration for Hospital Inpatient Quality Reporting **(Supported)**
0558 Endorsed	*HBIPS-7 Post Discharge Continuing Care Plan Transmitted to Next Level of Care Provider Upon Discharge* Patients discharged from a hospital-based inpatient psychiatric setting with a continuing care plan provided to the next level of care clinician or entity		•		•		Hospital	Under Consideration for Inpatient Psychiatric Facility Quality Reporting (**Supported**)
0418 Endorsed	*Screening for Clinical Depression and Follow-up Plan* Percentage of patients aged 12 years and older screened for clinical depression using an age-appropriate standardized tool and follow-up plan documented			•	•		Ambulatory, Hospital, PAC/LTC Facility	Finalized for use in PQRS and Medicare Shared Savings, Medicaid Adult Core Measures Under Consideration for Meaningful Use **(Supported)**

NQF # and Status	Measure Title and Description	Quality of Life	Care Coord	Screening	Mental/Subst	Structural	Specified Setting of Care	Use in Federal Programs
0647 Endorsed	*Transition Record with Specified Elements Received by Discharged Patients (Inpatient Discharges to Home/Self Care or Any Other Site of Care)* Percentage of patients, regardless of age, discharged from an inpatient facility to home or any other site of care, or their caregiver(s), who received a transition record (and with whom a review of all included information was documented) at the time of discharge including, at a minimum, all of the specified elements		•				Hospital, PAC/LTC Facility	
0430 Endorsed	*Change in Daily Activity Function as Measured by the AM-PAC* The Activity Measure for Post-Acute Care (AM-PAC) is a functional status assessment instrument developed specifically for use in facility and community dwelling post-acute care (PAC) patients. A Daily Activity domain has been identified that consists of functional tasks that cover the following areas: feeding, meal preparation, hygiene, grooming, and dressing	•		•			Ambulatory, Home Health, Hospital, PAC/LTC Facility	
0576 Endorsed	*Follow-up After Hospitalization for Mental Illness* Percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner		•		•		Ambulatory, Behavioral Health	Finalized for use in Medicaid Adult Core Measures, CHIPRA Core Measures
0005 Endorsed	*CAHPS Adult Primary Care Survey: Shared Decision-making* 37 core and 64 supplemental question survey of adult outpatient primary care patients		•				Ambulatory	Finalized for use in Medicare Shared Savings
0006 Endorsed	*CAHPS Health Plan Survey v 4.0—Adult questionnaire: Health Status/Functional Status* 30-question core survey of adult health plan members that assesses the quality of care and services they receive	•					Ambulatory	Finalized for use in Medicare Shared Savings and Medicaid Adult Core Measures

NQF # and Status	Measure Title and Description	Quality of Life	Care Coord	Screening	Mental/Subst	Structural	Specified Setting of Care	Use in Federal Programs
0490 Endorsed	*The Ability to Use Health Information Technology to Perform Care Management at the Point of Care* Documents the extent to which a provider uses a certified/qualified electronic health record (EHR) system capable of enhancing care management at the point of care. To qualify, the facility must have implemented processes within their EHR for disease management that incorporate the principles of care management at the point of care, which include: a. The ability to identify specific patients by diagnosis or medication use; b. The capacity to present alerts to the clinician for disease management, preventive services, and wellness; c. The ability to provide support for standard care plans, practice guidelines, and protocol					•	Ambulatory	
0494 Endorsed	*Medical Home System Survey* Percentage of practices functioning as a patient-centered medical home by providing ongoing, coordinated patient care. Meeting Medical Home System Survey standards demonstrates that practices have physician-led teams that provide patients with: a. Improved access and communication; b. Care management using evidence-based guidelines; c. Patient tracking and registry functions; d. Support for patient self-management e. Test and referral tracking; f. Practice performance and improvement functions;					•	Ambulatory	

NQF # and Status	Measure Title and Description	Quality of Life	Care Coord	Screening	Mental/Subst	Structural	Specified Setting of Care	Use in Federal Programs
0101 Endorsed	*Falls: Screening for Fall Risk* Percentage of patients aged 65 years and older who were screened for fall risk (2 or more falls in the past year or any fall with injury in the past year) at least once within 12 months			•			Ambulatory	Finalized for use in PQRS, Medicare Shared Savings, and Value Modifier Under consideration for Meaningful Use (Supported)
0729 Endorsed	*Optimal Diabetes Care* 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 < 14090, Tobacco non-user and for patients with a diagnosis of ischemic vascular disease daily aspirin use unless contraindicated			•			Ambulatory	Components of this composite are finalized for use in Medicare Shared Savings and Value Modifier Under Consideration for PQRS (Supported)
0421 Endorsed	*Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-up* Percentage of patients aged 18 years and older with a calculated BMI in the past six months or during the current visit documented in the medical record AND if the most recent BMI is outside of normal parameters, a follow-up plan is documented Normal Parameters: Age 65 and older BMI ≥23 and <30; Age 18 – 64 BMI ≥18.5 and <25			•			Ambulatory	Finalized for use in PQRS, Meaningful Use, Medicare Shared Savings Program, and Value- Modifier
0028 Endorsed	*Measure pair: a. Tobacco Use Assessment, b. Tobacco Cessation Intervention* Percentage of patients who were queried about tobacco use one or more times during the two-year measurement period Percentage of patients identified as tobacco users who received cessation intervention during the two-year measurement period			•	•		Ambulatory	Finalized for use in PQRS, Meaningful Use, Medicare Shared Savings Program, and Value- Modifier

NQF # and Status	Measure Title and Description	Quality of Life	Care Coord	Screening	Mental/Subst	Structural	Specified Setting of Care	Use in Federal Programs
0004 Endorsed	*Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: (a) Initiation, (b) Engagement* The percentage of adolescent and adult patients with a new episode of alcohol and other drug (AOD) dependence who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter, or partial hospitalization within 14 days of the diagnosis and who initiated treatment and who had two or more additional services with an AOD diagnosis within 30 days of the initiation visit				•		Ambulatory	Finalized for use in PQRS, Meaningful Use, Value-Modifier, and Medicaid Adult Core Measures
0523 Endorsed	*Pain Assessment Conducted* Percentage of patients who were assessed for pain, using a standardized pain assessment tool, at start/resumption of home healthcare	•		•			Home Health	Finalized for use in Home Health
0167 Endorsed	*Improvement in Ambulation/locomotion* Percentage of home health episodes where the value recorded for the OASIS item M0702 on the discharge assessment is numerically less than the value recorded on the start (or resumption) of care assessment, indicating less impairment at discharge compared to start of care	•		•			Home Health	Finalized for use in Home Health
0208 Endorsed	*Family Evaluation of Hospice Care* Percentage of family members of all patients enrolled in a hospice program who give satisfactory answers to the survey instrument	•					Hospice	Under Consideration for Hospice Quality Reporting (Supported)
0260 Endorsed	*Assessment of Health-related Quality of Life (Physical & Mental Functioning)* Percentage of dialysis patients who receive a quality of life assessment using the KDQOL-36 (36-question survey that assesses patients' functioning and well-being) at least once per year	•		•	•		Dialysis Facility	Supported for ESRD Quality Reporting

NQF # and Status	Measure Title and Description	Quality of Life	Care Coord	Screening	Mental/Subst	Structural	Specified Setting of Care	Use in Federal Programs
Not Endorsed	*SNP 6: Coordination of Medicare and Medicaid coverage* Intent: The organization helps members obtain services they are eligible to receive regardless of payer, by coordinating Medicare and Medicaid coverage. This is necessary because the two programs have different rules and benefit structures and can be confusing for both members and providers					•	[not available]	
Not Endorsed	*Alcohol Misuse: Screening, Brief Intervention, Referral for Treatment* a. Patients screened annually for alcohol misuse with the 3-Item AUDIT-C with item-wise recording of item responses, total score and positive or negative result of the AUDIT-C in the medical record. b. Patients who screen for alcohol misuse with AUDIT-C who meet or exceed a threshold score who have brief alcohol counseling documented in the medical record within 14 days of the positive screening.			•	•		[not available]	
Not Endorsed	*Potentially Harmful Drug-Disease Interactions in the Elderly* Percentage of Medicare members 65 years of age and older who have a diagnosis of chronic renal failure and prescription for non-aspirin NSAIDs or Cox-2 selective NSAIDs; Percentage of Medicare members 65 years of age and older who have a diagnosis of dementia and a prescription for tricyclic antidepressants or anticholinergic agents; Percentage of Medicare members 65 years of age and older who have a history of falls and a prescription for tricyclic antidepressants, antipsychotics or sleep agents		•	•			Pharmacy	

MAP Dual Eligible Beneficiaries Workgroup – Measure Gaps and Modifications for Consideration
February 2012

Measure Gaps	Measure Modifications
STRUCTURAL MEASURES	

• System structures to assure connection between health system and HCBS/social supports
• Access to support services and care
  o Appointment availability
  o Transportation readily available
• Inability to obtain needed care
• Measuring "medical home-ness"
• Consideration of global costs
• Cultural competence
• Coordination between systems of payments
• Workforce capacity measurement data
• Harmonization of programs
• Change in eligibility
• Blend payment streams
• Unit of service data/HIT
• Community service integration (rating system)
• Assistance navigating Medicare/Medicaid
	• *Medical Home System Survey (#0494)*
	  o Care management must be designed for duals population
	  o Emphasize care management by most appropriate "person" (e.g., family member, personnel from their living center, etc.)
	  o Assess whether a contract has been created
	• *The Ability to use Health Information Technology to Perform Care Management at the Point of Care (#0490)*
	  o Communication must be bi-directional
	  o Ensure that patient preference are incorporated
	  o Be able to bring what community resources are available

CARE COORDINATION	

• Person-centered planning
• Single plan integrating medical/behavioral/functional/social issues
• Care consistent with goals
• Communication
  o Quality of provider-patient communication
  o Provider-to-provider communication
• Appropriateness of an initial hospitalization
• Informed decision-making
• LTSS
• All parties receive discharge info (timely)
• Follow-up visit
• Home care plan and follow up
	• *Transition Record with Specified Elements Received by Discharged Patients (Inpatient Discharges to Home/Self Care or Any Other Site of Care) (#0647)*
	  o Focus outside of just inpatient facility; do not limit to certain transition sites/settings
	  o Add ER and Medicaid Nursing Facility, not just SNFs
	• *Care Transitions Measure CTM-3 (#0228)*
	  o Add ER and Medicaid Nursing Facility, not just SNFs
	• *HBIPS-7 Post discharge continuing care plan transmitted to next level of care provider upon discharge (#0558)*
	  o Broaden to all inpatient discharges
	  o Make 3-part: Hospital/SNF/Primary care provider

QUALITY OF LIFE	

• Optimal functioning
  o Improving when possible
  o Maintaining function
  o Managing decline
• Pain and symptom management
• Caregiver quality of life
• Caregiver education and support
• Dignity/respect
• Self-efficacy
	• *Assessment of Health-related Quality of Life (Physical & Mental Functioning) (#0260)*
	  o Need to expand beyond just ESRD patients (e.g. all programs and other diseases)
	• *Improvement in Ambulation/locomotion (#0167)*
	  o Include maintenance of status
	• *Change in Daily Activity Function as Measured by the AM-PAC (#0430)*
	  o Broaden beyond post-acute

MAP Dual Eligible Beneficiaries Workgroup – Measure Gaps and Modifications for Consideration
February 2012

Measure Gaps	Measure Modifications
• Sense of control/autonomy/self-determination • Community inclusion/participation • Life enjoyment (health psychology) • Choice of care-giver	o Include maintenance of status • *Family Evaluation of Hospice Care (#0208)* o Expand beyond just hospice care
MENTAL HEALTH AND SUBSTANCE USE	
• Initiation of pharmacotherapy after diagnosis of substance dependence • Regular assessment of weight/BMI for all patients on anti-psychotic medication • Outcome measures for smoking cessation • Medication adherence and persistence for all mental health or substance use conditions • Suicide risk assessment for any type of depression diagnosis	• *Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: (a) Initiation, (b) Engagement (#0004)* o Separate Identification/Initiation/Engagement • *Follow-up after hospitalization for mental illness (#0576)* o Needs to be expanded to incorporate substance use disorders and not just mental health o Include detox • *Alcohol Misuse – Screening, Brief Intervention, Referral for Treatment (Not NQF-endorsed)* o Screen all duals for all types of substance use
SCREENING AND ASSESSMENT	
• Reducing poly-pharmacy • Medication management • Generalizable measures of medication adherence and persistence • Broad population screening for diabetes and cardiovascular risks • Sexual health for disenfranchised groups • More "Optimal Care" composite measures (e.g., #0076) • Appropriate follow-up intervals • Assessment for rehabilitative therapies • Health literacy • Cognitive status/psychosocial health • Appropriate prescribing • Cardiovascular disease management • Safety risk assessment	• *Falls: Screening for Fall Risk (#0101)* o Do not limit to >65 o Should be patient-reported o Consider obesity a fall risk • *Pain Assessment Conducted (#0523)* o Expand beyond just home health care
OTHER	
Utilization benchmarking e.g., outpatient/ED (HEDIS)	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of the Secretary

[CMS-2420-FN]

Medicaid Program: Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults

AGENCY: Office of the Secretary, HHS.

ACTION: Final notice.

SUMMARY: This final notice announces the initial core set of health care quality measures for Medicaid-eligible adults, as required by section 2701 of the Affordable Care Act, for voluntary use by State programs administered under title XIX of the Social Security Act, health insurance issuers and managed care entities that enter into contracts with Medicaid, and providers of items and services under these programs.

FOR FURTHER INFORMATION CONTACT: Karen Llanos, Centers for Medicare & Medicaid Services, (410) 786-9071.

SUPPLEMENTARY INFORMATION:

I. Background

Section 2701 of the Patient Protection and Affordable Care Act (Affordable Care Act) (Pub. L. 111-148) added new section 1139B to the Social Security Act (the Act). Section 1139B(a) of the Act directs the Secretary of Health and Human Services (HHS) to identify and publish for public comment a recommended initial core set of health care quality measures for Medicaid-eligible adults, and section 1139B(b)(1) of the Act requires that an initial core set be published by January 1, 2012. Additionally, the statute requires the initial core set recommendation to consist of existing adult health care quality measures in use under public and privately sponsored health care coverage arrangements or

that are part of reporting systems that measure both the presence and duration of health insurance coverage over time and that may be applicable to Medicaid-eligible adults.

Section 1139B of the Act also requires the Secretary to complete the following actions:

-- By January 1, 2012:

- Establish a Medicaid Quality Measurement Program to fund development, testing, and validation of emerging and innovative evidence-based measures.

-- By January 1, 2013:

- Develop a standardized reporting format for the core set of adult quality measures and procedures to encourage voluntary reporting by the States.

-- By January 1, 2014:

- Annually publish recommended changes to the initial core set that shall reflect the results of the testing, validation, and consensus process for the development of adult health quality measures.
- Include in the report to Congress mandated under section 1139A(a)(6) of the Act on the quality of health care of children in Medicaid and the Children's Health Insurance Program (CHIP) similar information for adult health quality with respect to measures established under section 1139B of the Act. This report must be published every 3 years thereafter in accordance with the statute.

-- By September 30, 2014:

- Collect, analyze, and make publicly available the information reported by the States as required in section 1139B(d)(1) of the Act.

Identification of the initial core set of measures for Medicaid-eligible adults is an important first step in an overall strategy to encourage and enhance quality improvement. States that chose to collect the initial core set will be better positioned to measure their performance and develop action plans to achieve the three part aims of better care, healthier people, and affordable care as identified in HHS' National

Strategy for Quality Improvement in Health Care. Additional information about the National Quality Strategy can be found at: http://www.ahrq.gov/workingforquality/nqs/.

The initial core set of quality measures for voluntary annual reporting by States has been determined based on recommendations from the Agency for Healthcare Research and Quality's Subcommittee to the National Advisory Council for Healthcare Research and Quality, as well as public comments, before being finalized by the Secretary. These core set measures will support HHS and its State partners in developing a quality-driven, evidence-based, national system for measuring the quality of health care provided to Medicaid-eligible adults.

Over the next year, CMS will phase in components of the Medicaid Adult Quality Measures Program that will help to further identify measurement gap areas and begin testing the collection of some of the initial core measures. The Medicaid Adult Quality Measures Program will focus on developing and refining measures, where needed, so that future updates to the initial core set can meet a wider range of States' health care quality measurement needs. By September 2012, CMS will release technical specifications as a resource for States that seek to voluntarily collect and report the initial core set of health care quality measures for Medicaid-eligible adults. Additionally, as required in statute, by January 1, 2013, CMS will issue guidance for submitting the initial core set to CMS in a standardized format. Lastly, much like activities conducted under section 1139A of the Act for the initial core child health care quality measures, the Secretary will launch a Technical Assistance and Analytic Support Program to help States collect, report, and use the voluntary core set of adult measures.

II. Method for Determining the Initial Set of Health Care Quality Measures for Medicaid-Eligible Adults

The Affordable Care Act requires the development of a core set of health quality measures for adults eligible for benefits under Medicaid. The statute parallels the requirement under section 1139A of the Act to identify and publish a recommended initial core set of quality measures for children in Medicaid and the CHIP. HHS used a similar process to identify the initial set of health care quality measures for Medicaid-eligible adults.

The Centers for Medicare & Medicaid Services (CMS) partnered with the Agency for Healthcare Research and Quality (AHRQ) to collaborate on the identification of the initial core set of health care quality measures for adults. Working through its National Advisory Council for Healthcare Research and Quality, which provides advice and recommendations to the Director of AHRQ and to the Secretary of HHS on priorities for a national health services research agenda, AHRQ created a Subcommittee in the fall of 2010 to evaluate candidate measures for the initial core set. The Subcommittee consisted of State Medicaid representatives, health care quality experts, and representatives of health professional organizations and associations, and was charged with considering the health care quality needs of adults (ages 18 and older) enrolled in Medicaid in its recommendation for an initial core set of measures to HHS. The Subcommittee reviewed and evaluated measures from nationally recognized sources, including measures endorsed by the National Quality Forum (NQF), measures submitted by Medicaid medical directors, measures currently in use by CMS, and measures suggested by the Co-chairs and members of the Subcommittee. Starting from approximately 1,000 measures, a total of 51 measures were recommended and posted for public comment. A report detailing the initial convening of the Subcommittee may be found on the AHRQ website: http://www.ahrq.gov/about/nacqm/.

The measures were posted for public comment through a **Federal Register** (75 FR 82397) notice published on December 30, 2010, with comments due by March 1, 2011. The public submitted 100 comments. Public comments suggested concern about the large size of the proposed set, with many requesting alignment to the extent possible with existing Federal initiatives. An additional 43 measures were suggested through public comment. See discussion in section III of this final notice for a more detailed discussion.

To be responsive to the public comments, the Subcommittee sought to identify measures that ensured comprehensive representation of variables affecting Medicaid-eligible adults while considering ways to decrease the number of measures in the set. AHRQ and CMS identified five criteria against which to evaluate the proposed core measures: importance; scientific evidence supporting the measure; scientific soundness of the measure; current use in and alignment with existing Federal programs; and

feasibility for State reporting (a background report detailing the selection criteria and Subcommittee process can be found at: http://www.ahrq.gov). The criteria represented attributes desired of State-level measures that would represent Medicaid-eligible adults. In particular, those criteria regarding current use in and alignment with existing Federal programs and feasibility for State reporting were given particular emphasis, since those were attributes identified repeatedly in the public comments. Documented use of or alignment with existing Federal programs such as the National Quality Strategy's six priorities, the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, and Physician Quality Reporting was taken into consideration as the Subcommittee reviewed each measure.

As in the initial meeting, the Subcommittee broke into workgroups focusing on four dimensions of health care related to adults in Medicaid: Adult Health, Maternal/Reproductive Health, Complex Health Care Needs, and Mental Health and Substance Use. Workgroups were assigned two sets of measures that related to their specific areas: originally recommended measures and measures proposed in public comment. To assess how each measure fared against the five criteria, the Subcommittee reviewed background information (including numerator, denominator, exclusions, prevalence, clinical guidelines, past performance rates, etc.) on each measure from the measure owners, developers, or stewards.

A. Adult Health

The workgroup prioritized 10 of the original measures to be included in the final set, dropping five measures that were duplicative of other measures. The workgroup brought forward one measure that was suggested in public comment, Adult Body Mass Index (BMI) Assessment, replacing a similar BMI measure that had been originally recommended for the core set, Preventive Care and Screening: BMI Screening and Follow-Up. The workgroup did not recommend including the remaining 16 newly suggested measures received from the public comment period.

B. Maternal/Reproductive Health

After evaluating the measures against the criteria, the Maternal/Reproductive Health workgroup recommended keeping each of the five measures originally posed for the core set, noting that these measures addressed areas of high importance to women and reproductive health, were feasible to report

and aligned well with current programs (including the initial core set of children's health care quality measures[1]). The workgroup noted that, while future measures should tie screenings to outcomes and assess additional issues outside of pregnancy that affect women (for example, access to care, incontinence due to multiple pregnancies), the measures being recommended for the core set were an important first step of using performance measures for quality improvement. Of the measures newly suggested through public comment, the workgroup recommended bringing one measure forward to a Subcommittee vote: Chlamydia Screening in Women. The workgroup rated this measure high on each criterion and noted its alignment with the initial core set of children's health care quality measures (the initial core set of children's measures specified only the lower age group of this measure; adding the higher age range means the measure now would be reported in full).

C. Complex Health Care Needs

The Complex Health Care Needs workgroup recommended nine of the 18 measures originally posed for inclusion in the draft core set. Although the topic areas represented in the measures suggested through public comment were important to Medicaid, many of the measures scored low on multiple criteria (for example, scientific soundness and feasibility for State reporting) and thus were deemed not ready for wide-scale implementation. Further, although several of the proposed measures assessed the very important topic of care coordination for patients who are hospitalized or transferred across multiple facilities, the workgroup noted that many of these measures were challenged by complex requirements for data collection and excluded target populations (for example, dually eligible beneficiaries and individuals with long-term care services and supports needs). Many of the measures, for example, required medical record review across time or at more than one site (for example, Change in Basic Mobility as Measured by the AM-PAC and Medication Reconciliation Post-Discharge). The workgroup concluded that the remaining measures suggested in public comment, though relevant to people with complex health care

[1] Initial Core Set of Children's Health Care Quality Measures
https://www.cms.gov/MedicaidCHIPQualPrac/Downloads/CHIPRACoreSetTechManual.pdf

needs, addressed very narrow clinical conditions, excluded key populations, were difficult to collect at the State level, or were duplicative of other, more highly-rated measures.

D. Mental Health and Substance Use

After discussing how well the 13 measures originally proposed fared against the selection criteria, the Mental Health and Substance Use workgroup recommended nine measures for inclusion in the draft core set and decided against bringing forward any of the additional measures suggested in public comment. In general, the workgroup prioritized measures that were broadly applicable to the Medicaid population or to primary care settings. For example, the workgroup included measures that assessed conditions that may be prevalent in a low-income population, including depression, schizophrenia, and substance use, in addition to measures that assessed utilization of general mental health services. The workgroup did not recommend including any of the five measures suggested in public comment, as they concluded that these measures addressed similar content areas as other higher-rated measures or were rated very low in feasibility for State collection and reporting.

E. Summary

A total of 35 measures received a majority vote from the full Subcommittee. The measures voted upon by the Subcommittee included recommendations from each workgroup that were based on the original 51 measures as well as new measures identified through public comment that were brought forth by each workgroup. The Adult Health work group recommended eleven measures for inclusion in the initial core set. The Maternal/Reproductive Health work group recommended six measures. The Complex Health Care Needs work group recommended nine measures and the Mental Health and Substance Use recommended nine measures.

The Subcommittee discussed how these measures represented conditions and populations relevant to Medicaid, and examined each measure's data source and use in existing programs. In the final round

of voting, 24[2] measures ultimately received a majority vote by Subcommittee members. In order to ensure priority populations were fully represented and that the goals of planned initiatives could be monitored, we then added two measures originally proposed for the draft core set (PC-01 Elective Delivery and Timely Transmission of Transition Record*)*. The Subcommittee deferred the decision to CMS and AHRQ on which of the two HIV-related measures under consideration (HIV/AIDS Screening: Members at High Risk of HIV/AIDS and HIV/AIDS: Medical Visits*)* would be included in the core set. Upon discussion with colleagues from the Centers for Disease Control and Prevention and the Health Resources and Services Administration, the decision was made to include the measure originally proposed for the core set, HIV/AIDS: Medical Visit. A total of 26 are included in the initial core set.

III. Analysis of and Responses to Public Comments on the Notice of Comment Period

In response to the publication of the December 30, 2010 notice with comment period, we received 100 timely public comments. The following are a summary of the public comments that we received related to that notice, and our responses to the comments:

Comment: About a third of the comments specifically noted that the draft core set published in the **Federal Register** on December 30, 2010, was too large or raised the burden of reporting by States as a concern. Commenters also suggested reducing the measures to two measures per category or considering a phase-in approach.

Response: To address these concerns, the size of the core set was reduced by almost half (from 51 measures in the draft core set to 26 measures in the initial core set). Although the numbers of measures was reduced, we believe that this initial core set still reflects the health care needs of Medicaid-eligible adults. In addition to reducing the size of the initial core set, to support States in collecting and reporting these measures, CMS will provide technical assistance as well as additional guidance and tools to increase the feasibility of voluntary reporting.

[2] The CAHPS Health Plan Survey v 4.0 -Adult Questionnaire and the CAHPS Health Plan Survey v 4.0H - NCQA Supplemental Items for CAHPS are counted as one measure.

Comment: Numerous comments suggested avoiding measures for inclusion in the initial core set that require medical record review.

Response: To the degree possible, measures that require medical record review were excluded in large-scale from the initial core set. However, in order to address aspects of health care quality important to the adult Medicaid population and to align with existing measurement programs (for example, the Medicare & Medicaid EHR Incentive Programs) a few measures that require medical record review (for example, controlling high blood pressure) were included in the initial core set.

Comment: Many comments suggested aligning measures with existing reporting programs, such as the Medicare and Medicaid EHR Incentive Programs and the Inpatient Hospital Quality Reporting program, as a way to decrease burden.

Response: We agree with these comments. To the degree possible, the initial core set aligns with existing Federal reporting programs. Seventeen measures from the initial core set are used in other CMS programs (refer to table at the end of Notice). Alignment was a key criterion employed in the review, based in part, on the strength of related public comments. At the same time, the areas addressed by the measures in the initial core set, however, must reflect the requirements of the statute to provide an overall assessment of the quality of care received by adults in Medicaid. As such, the types of quality measures included in other reporting programs may not fully represent the health care measurement needs of Medicaid-eligible adults.

Comment: Several commenters suggested using only measures endorsed by the National Quality Forum or National Committee for Quality Assurance Health Employer Data and Information Set (HEDIS®) measures. Many comments also emphasized the importance of ensuring the initial core set measures met thresholds for evidence, validity, reliability and feasibility.

Response: A key priority used in selecting the initial core set measures was whether or not the measure was relevant to the Medicaid population. While NQF endorsement signifies that measures have been deemed as meeting certain criteria for scientific soundness, validity and reliability, requiring NQF endorsement would have eliminated inclusion of measures in the initial core set that are relevant for

assessing important aspects of care for the Medicaid population. Similarly, selecting only HEDIS measures, which were originally developed for health plan use, would have limited the initial core set's ability to address the range of care settings and conditions relevant to the Medicaid population.

Comment: Public comments questioned the appropriateness of some proposed measures.

Response: These comments are appreciated and helped us narrow the list. Each measure included in the initial core set has been compared against five criteria—importance, scientific evidence, scientific soundness, alignment with existing programs and feasibility for State reporting. Public comments related to specific measures were also reviewed and considered. To aid in assessing each measure for inclusion in the initial core set, specific information was collected for each measure, including:

- Measure description, numerator, denominator and exclusions.
- Data sources (for example, claims, medical records, electronic health records).
- Description of health importance, prevalence, financial importance and opportunity for improvement, including what is known about gaps in care and health care disparities.
- Brief description of the scientific literature, including what is known about effectiveness of the intervention being addressed, and what is known about management and follow-up.
- Published clinical guidelines relevant to the measure.
- Validity and reliability of results, including a description of the study sample and methods used.
- Performance rates (most recent and two years prior).

Comment: Two comments requested clarification on whether the initial core measures would be applied to Medicaid fee-for-service, Medicaid managed care or both types of health care delivery systems. Other commenters requested clarification on the target Medicaid population, particularly since NCQA measures included in the draft measures list had varying age ranges.

Response: The initial core set will be used by States to assess the quality of health care provided in their Medicaid programs for adults (ages 18 years and older) and across all health care delivery systems

(for example, fee-for-service, managed care, primary care case management). We understand that some of the measures are currently specified only for a particular delivery system (for example, managed care). However, additional guidance will be provided to States so that these measures can be used across delivery systems and Medicaid funded programs targeting adults, including long-term services and supports.

Comment: Multiple comments suggested including measures related to patient safety and rehabilitation services. Specifically, commenters noted the need for measures that address a range of disabilities present among Medicaid beneficiaries and those receiving home and community-based services. The need for outcome measures for management of chronic conditions and care coordination measures was also noted.

Response: The measurement topic areas identified in these public comments are ones that CMS recognizes as important to assessing the health care quality of all adults enrolled in Medicaid, and we agree on the importance of measurement for chronic conditions and care coordination as well as for those receiving home and community-based services. However, the Subcommittee did not identify any existing measures in these areas that met the criteria for scientific soundness. As such, these topics will be considered measurement gap areas and will be prioritized for new measure development as part of the Medicaid Adult Quality Measures Program required under this statute.

Comment: In addition to public comments received about each of the proposed measures, 43 measures were suggested by the public.

Response: We appreciate these suggestions. Forty-two of the 43 measures had been previously considered by the Subcommittee and CMS for inclusion in the draft core measures set. The one measure that had not been considered was a newly developed measure that had not appeared in the original inventory of candidate measures (Healthy Term Newborn). The Subcommittee reviewed all 43 of these measures again and evaluated them based on the established selection criteria. The Healthy Term Newborn measure did not rate highly when compared against the selection criteria and the Subcommittee felt the measure would be more effective if paired with a process of care measure.

For additional information on consideration of the public comments and the finalization of the initial core set of health care quality measures for Medicaid-eligible adults, a background report can be found at: http://www.ahrq.gov/.

IV. Collection of Information Requirements

This final notice announces the initial core set of health care quality measures for Medicaid-eligible adults for voluntary use by State Medicaid programs. As required in statute, by January 1, 2013, CMS will issue guidance for submitting the initial core set to CMS in a standardized format. States choosing to collect the initial core set of measures will use that reporting template to submit data to CMS. Voluntary reporting will not begin until December 2013.

The guidance, core measures, and template are subject to the Paperwork Reduction Act and will be submitted to the Office of Management and Budget (OMB) for their review and approval at a later time. No persons are required to respond to a collection of information (whether voluntary or mandatory) unless it displays a valid OMB control number issued by OMB.

V. Executive Order 12866

In accordance with the provisions of Executive Order 12866, this notice was reviewed by the Office of Management and Budget.

Authority: Sections XIX and XXI of the Social Security Act (42 U.S.C.13206 through 9a).

Dated: November 16, 2011

Marilyn B. Tavenner

Acting Administrator,

Centers for Medicare & Medicaid Services.

Approved: December 21, 2011

Kathleen Sebelius,

Secretary,

Health and Human Services.

BILLING CODE: 4120-01-P

INITIAL CORE SET OF HEALTH CARE QUALITY MEASURES

FOR MEDICAID-ELIGIBLE ADULTS

This table of the initial core set of health care quality measures for Medicaid-eligible adults includes National Quality Forum (NQF) identifying numbers for measures that have been endorsed, provides the measure stewards and indicates those measures which are used in various Federal and public sector programs including: Initial Core Set of Children's Health Care Quality Measures; the Medicare & Medicaid EHR Incentive Programs for eligible health care professionals and hospitals that adopt certified Electronic Health Record technology under the Final Rule published in the July 28, 2010 Federal Register (75 FR 44314); the Medicare Physician Quality Reporting System (PQRS); Health Employer Data and Information Set (HEDIS); National Committee for Quality Assurance Accreditation; The Joint Commission's ORYX ® Performance Measurement Initiative and other national programs.

	NQF #†	Measure Steward ‡	Measure Name	Programs in Which the Measure is Currently Used¥
Prevention & Health Promotion	0039	NCQA	Flu Shots for Adults Ages 50-64 *(Collected as part of HEDIS CAHPS Supplemental Survey)*	HEDIS®, NCQA Accreditation,
	N/A	NCQA	Adult BMI Assessment	HEDIS®, Health Homes Core
	0031	NCQA	Breast Cancer Screening	MU1, HEDIS®, NCQA Accreditation, , PQRS GPRO, Shared Savings Program
	0032	NCQA	Cervical Cancer Screening	MU1, HEDIS®, NCQA Accreditation
	0027	NCQA	Medical Assistance With Smoking and Tobacco Use Cessation *(Collected as part of HEDIS CAHPS Supplemental Survey)*	MU1, HEDIS®, Medicare, NCQA Accreditation
	0418	CMS	Screening for Clinical Depression and Follow-Up Plan	PQRS, CMS QIP, Health Homes Core, Shared Savings Program
	N/A	NCQA	Plan All-Cause Readmission	HEDIS®
	0272	AHRQ	PQI 01: Diabetes, Short-term Complications Admission Rate	
	0275	AHRQ	PQI 05: Chronic Obstructive Pulmonary Disease (COPD) Admission Rate	Shared Savings Program
	0277	AHRQ	PQI 08: Congestive Heart Failure Admission Rate	Shared Savings Program
	0283	AHRQ	PQI 15: Adult Asthma Admission Rate	
	0033	NCQA	Chlamydia Screening in Women age 21-24 *(same as CHIPRA core measure, however, the State would report on the adult age group)*	MU1, HEDIS®, NCQA Accreditation, CHIPRA Core

	NQF #†	Measure Steward ‡	Measure Name	Programs in Which the Measure is Currently Used¥
Management of Acute Conditions	0576	NCQA	Follow-Up After Hospitalization for Mental Illness	HEDIS®, NCQA Accreditation, CHIPRA Core, Health Home Core
	0469	HCA, TJC	PC-01: Elective Delivery	HIP QDRP, TJC's ORYX Performance Measurement Program
	0476	Prov/CWISH/NPIC/QAS/TJC	PC-03 Antenatal Steroids	TJC's ORYX Performance Measurement Program
Management of Chronic Conditions	0403	NCQA	Annual HIV/AIDS medical visit	
	0018	NCQA	Controlling High Blood Pressure	MU1, HEDIS®, NCQA Accreditation, PQRS GPRO, Shared Savings Program
	0063	NCQA	Comprehensive Diabetes Care: LDL-C Screening	MU1, HEDIS®, NCQA Accreditation, PQRS
	0057	NCQA	Comprehensive Diabetes Care: Hemoglobin A1c Testing	MU1, HEDIS®, NCQA Accreditation, PQRS
	0105	NCQA	Antidepressant Medication Management	MU1, HEDIS®, NCQA Accreditation
	N/A	CMS-QMHAG	Adherence to Antipsychotics for Individuals with Schizophrenia	VHA
	0021	NCQA	Annual Monitoring for Patients on Persistent Medications	HEDIS®, NCQA Accreditation
Family Experiences of Care	0006 & 0007	AHRQ & NCQA	CAHPS Health Plan Survey v 4.0 - Adult Questionnaire *with* CAHPS Health Plan Survey v 4.0H - NCQA Supplemental	HEDIS®, NCQA Accreditation, Shared Savings Program (NQF#0006)
Care Coordination	648	AMA-PCPI	Care Transition – Transition Record Transmitted to Health care Professional	Health Homes Core
Availability	0004	NCQA	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	MU1, HEDIS®, Health Homes Core
	1391	NCQA	Prenatal and Postpartum Care: Postpartum Care Rate *(second component to CHIPRA core measure "Timeliness of Prenatal Care," State would now report 2/2 components instead of 1)*	HEDIS®

† NQF ID *National Quality Forum identification numbers are used for measures that are NQF-endorsed; otherwise, NA is used.*

‡ Measure Steward

AHRQ – Agency for Healthcare Research and Quality

CMS – Centers for Medicare & Medicaid Services

CMS-QMHAG – Centers for Medicare & Medicaid Services, Quality Measurement and Health Assessment Group

HCA, TJC – Hospital Corporation of America-Women's and Children's Clinical Services, The Joint Commission

NCQA –National Committee for Quality Assurance

Prov/CWISH/NPIC/QAS/TJC – Providence St. Vincent Medical Center/Council of Women's and Infant's Specialty Hospitals/National Perinatal Information Center/Quality Analytic Services/The Joint Commission

TJC – The Joint Commission

¥ Programs in which Measures are Currently in Use:

CHIPRA Core – Children's Health Insurance Program Reauthorization Act - Initial Core Set

CMS QIP – CMS Quality Incentive Program

HIP QDRP – Hospital Inpatient Quality Data Reporting Program

Health Homes Core-- CMS Health Homes Core Measures

MU1 – Meaningful Use Stage 1of the Medicare & Medicaid Electronic Health Record Incentive Programs

PQRS – Physician Quality Reporting Program Group Practice Reporting Option

Shared Savings Program – Medicare Shared Savings Program

VHA – Veterans Health Administration

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L&M POLICY RESEARCH

Memorandum

To: National Quality Forum

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

Date: January 27, 2012

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

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

Methods

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

Following review of the initial measure cull with NQF, the team solicited the expertise of key informants to further delve into the existing as well as ideal or potential measures. In doing so, the team presented each interviewee with a table of the measures identified through the filtering

process and used a protocol with open-ended questions to gauge the informant's insights about the areas most relevant to capture when measuring the quality of care delivered to duals, as well as the strengths and weaknesses of the currently available measures. As directed and specified by NQF, the project team conducted up to nine interactions with key informants representing a range of perspectives during December and January. Table 1 below lists interviewees, their organizations, and the perspective they offered. The team spoke with a range of interviewees representing different backgrounds so as to acquire a more robust picture of current gaps and barriers in measurement as well as areas that should be emphasized the most when dealing with duals.

Table 1: Expert discussions

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

General findings

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

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

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

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

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

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

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

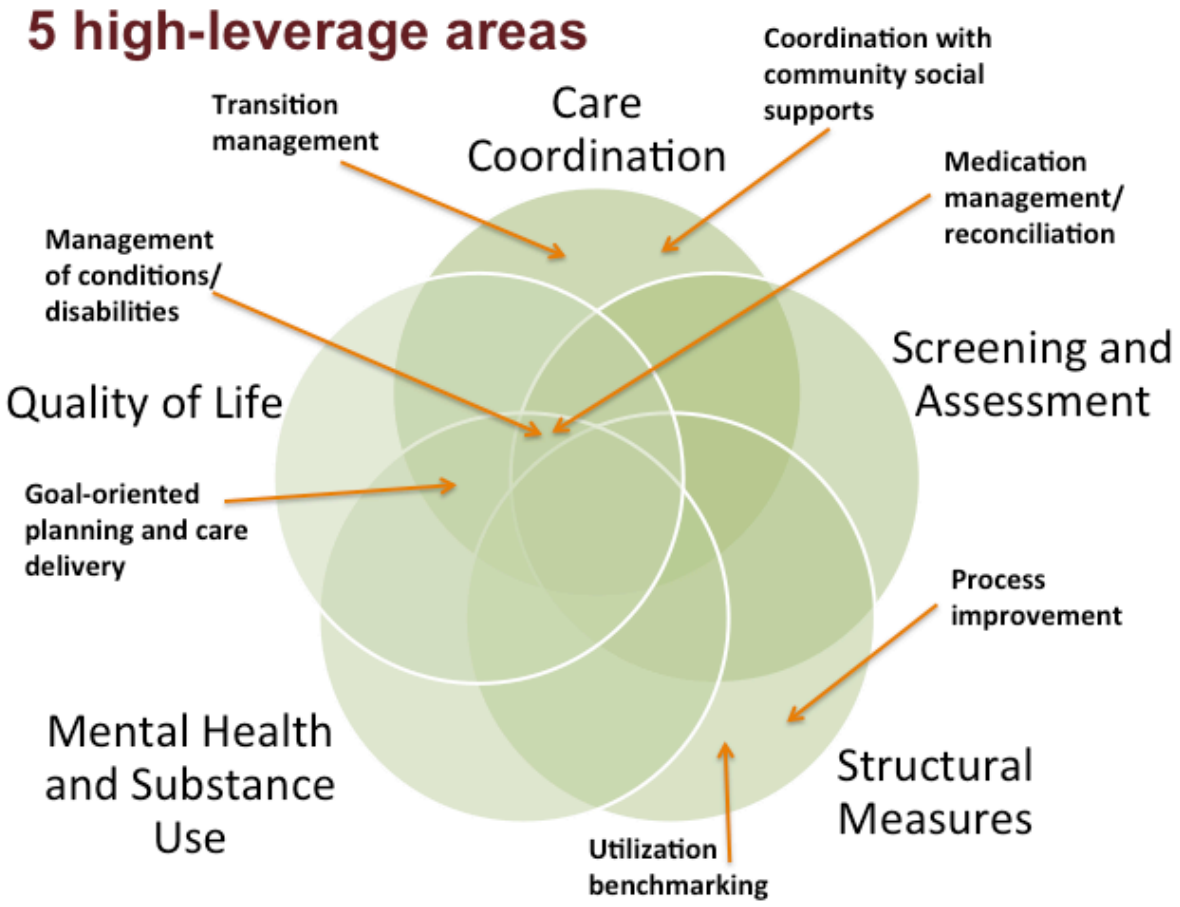
- **Process improvement across settings** – Ensure quality improvement programs are in place within and across settings and organizations that serve duals and their subpopulations

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

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

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

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



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

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

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

Limitations

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

Table 2: Delivery system areas and measures related to duals

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

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

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

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

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

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

	0520 NQF Endorsed: Percent of patients or caregivers who were instructed during their episode of home health care on how to monitor the effectiveness of drug therapy, how to recognize potential adverse effects, and how and when to report problems	• No patient perspective – important to gauge whether patient actually understood instructions so as to manage own medications	*know what drugs patients are on when they come in, then the patients leave with new drugs. It's a much more complex problem we're getting at right now."*
	CAHPS NQF Endorsed (NQMC:002460, CAHPS Hospital Survey (HCAHPS)): Hospital inpatients' experiences: percentage of adult inpatients who reported how often the hospital staff communicated well about medications.	• Limited to experience in hospital setting	
	NCQA (NQMC:002922) Geriatrics: percentage of patients aged 65 years and older discharged from any inpatient facility (e.g., hospital, skilled nursing facility, or rehabilitation facility) and seen within 60 days discharge in the office by the physician providing on-going care who had a reconciliation of the discharge medications with the current medication list in the outpatient medical record documented.	• No sense of whether medication list was explained to and understood by patient and whether there was follow-up to make sure patient was managing medications. Documentation does not signal adherence to medication list	
Transition management	**0646-**0647 NQF Endorsed:** Percentage of patients, regardless of age, discharged from an inpatient facility to home or any other site of care, or their caregiver(s), who	• Limited to measuring transition from acute care setting but stops there. • Missing component of reinforcement – either a visit	• Ideally, a measure for this area would track a patient's transition within and across multiple settings, throughout the full continuum of care - noting communication among

	received a reconciled medication list/ transition record/ at the time of discharge including, at a minimum, medications in the specified categories	to home to make sure management of medications is occurring properly or, at least, reinforcement through communication with PCP	providers, services agencies, and patients/families/caregivers; documentation of conditions; and follow-up • Transition management tends to stop when patient is discharged from hospital and not extend to other settings. Measures for this area must encourage and capture whether communication and documentation occur among multiple providers in various settings.
	0648 NQF Endorsed: Percentage of patients, regardless of age, discharged from an inpatient facility to home or any other site of care for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge	• Important in that it measures level of communication among providers and follow-up but only focuses on movement from inpatient facility	
	0649 NQF Endorsed: Percentage of patients, regardless of age, discharged from an emergency department (ED) to ambulatory care or home health care, or their caregiver(s), who received a transition record at the time of ED discharge including, at a minimum, all of the specified elements	• Limited to transition from hospital setting; no sense of whether follow-up regularly occurs (despite existence of transition record) • Still, important measure for duals because many enter system through ED	
	0291-0297 NQF Endorsed: Percentage of patients transferred to another acute hospitals whose medical record documentation indicated that administrative information/ vital signs/ medication information/ patient information/ physician information/ nursing information/ procedures and tests was communicated to the receiving hospital within 60 minutes of departure.	• Does not include Medicare (only commercial and Medicaid members)	

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

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

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

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

**MAP workgroup measure

Proposed Addition of New Condition Flags in CMS Chronic Condition Warehouse

The Medicare-Medicaid Coordination Office has proposed the addition of thirteen new condition flags to the Chronic Condition Warehouse (CCW). These new flags will permit CMS, external researchers and other stakeholders to better understand conditions of individuals enrolled in both Medicare and Medicaid, Medicare-Medicaid enrollees. They were the product of a CMS-wide collaboration and much hard work, and we are grateful to those that helped make this happen.

We have published proposed algorithms for identifying 13 new chronic conditions among the dually eligible Medicare and Medicaid population. These proposed algorithms are being made available for a three month public comment period which will expire April 20, 2012. After reviewing all comments and making any necessary modifications, we expect to incorporate the algorithms into a data set by the end of June, 2012. The link to view and comment on the algorithms is: http://www.ccwdata.org/chronic-conditions/index.htm#DRAFT_Clinical_Conditions

The proposed enhancements will further strengthen the ability to study conditions more prevalent in Medicare-Medicaid enrollees, including those with severe and persistent mental illness, HIV, substance abuse and developmental disorders. The flags were the product of newly developed algorithms to identify additional conditions to be flagged for beneficiaries. These algorithms will be applied to both Medicare and Medicaid claims for 2006 and 2007 data—resulting in a flag for Medicare, Medicaid and Medicare-Medicaid enrollees. The conditions identified by this panel include the following:

1. ATTENTION DEFICIT HYPERACTIVITY DISORDER, CONDUCT AND IMPULSE DISORDERS
2. ALCOHOL USE DISORDERS AND COMPLICATIONS
3. ANXIETY DISORDERS
4. BIPOLAR DISORDER
5. TYPE 1 MAJOR DEPRESSION AND TYPE 2 DEPRESSIVE DISORDERS
6. DEVELOPMENTAL DISORDERS
7. HUMAN IMMUNODEFICIENCY VIRUS / ACQUIRED IMMUNODEFICIENCY SYNDROME (HIV/AIDS)
8. PERSONALITY DISORDERS
9. POST-TRAUMATIC STRESS DISORDERS
10. SCHIZOPHRENIA
11. SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDERS
12. SUBSTANCE RELATED DISORDERS
13. TOBACCO USE

Because the algorithms are still in a public comment period the data set that will contain these chronic condition flags has not yet been created or priced. Data availability and pricing information should be published on www.resdac.org by June 1, 2012. All questions regarding the proposed algorithms should be directed to June Wilwert at Vangent at 515-645-3151 or June.Wilwert@vangent.com. Please do not contact ResDAC with any questions regarding these condition flags.

We hope these additional CCW flags will help CMS staff, researchers and other stakeholders as they continue to better understand and improve care for Medicare-Medicaid enrollees. General information on the CCW can be found at: www.ccwdata.org. Additionally, researchers wishing to request access to the CCW can find more information at: www.resdac.org.

NATIONAL QUALITY FORUM

Measure Applications Partnership (MAP)

Bios of the MAP Dual Eligible Beneficiaries Workgroup

Chair (voting)

Alice Lind, MPH, BSN
Alice R. Lind is Director of Long Term Supports and Services and Senior Clinical Officer at the Center for Health Care Strategies (CHCS). She plays an integral role in the organization's efforts to improve care for Medicaid's high-need, high-cost populations, providing technical assistance through a variety of national initiatives. She is also involved in ongoing efforts to improve provider practices and child health quality. Ms. Lind has extensive clinical and Medicaid program development expertise through her 15 years of work in Washington State. She was previously Chief of the Office of Quality and Care Management in the Division of Healthcare Services, Health and Recovery Services Administration for Washington State, where she was responsible for the development and implementation of care coordination programs for Medicaid beneficiaries with chronic conditions and disabilities. She led the start up of a disease management program for 20,000 fee-for-service clients with asthma, congestive heart failure, diabetes, and end-stage renal disease. Under her direction, Washington implemented managed care programs that integrate health care, behavioral health and long-term care for Medicaid and Medicare dual eligible beneficiaries. In prior positions, Ms. Lind managed Washington's Quality Management section, which was responsible for conducting research and evaluation on the quality of care provided to Medicaid managed care clients. She has held clinical positions in occupational health, hospice home care, managing a long-term care facility for terminally ill persons with AIDS, and intensive care. Ms. Lind received a master's degree in public health from the University of North Carolina-Chapel Hill, and a bachelor's degree in nursing from Texas Christian University.

Organizational Members (voting)

American Association on Intellectual and Developmental Disabilities
Margaret Nygren, EdD
Dr. Nygren has 20 years of experience in the field of intellectual and developmental disabilities in a variety of capacities, including administrator, researcher, policy analyst, and consultant. As Executive Director of AAIDD, she has the honor of leading the oldest Association of professionals concerned with the promotion of progressive policies, sound research, effective practices, and universal human rights for people with intellectual and developmental disabilities. In her most recent previous position as Associate Executive Director for Program Development at the Association of University Centers on Disabilities (AUCD), Dr. Nygren was responsible for the management of national datasets and programs funded by the US Administration on Developmental Disabilities (ADD), Maternal and Child Health Bureau (MCHB), US Department of Education (ED), and US Department of Labor (DOL). Within the Disabled and Elderly Health Programs Group at the Centers for Medicare and Medicaid Services (CMS), Dr. Nygren completed a Fellowship where she provided and technical assistance in program policy areas that supported the President's New Freedom Initiative, including the development of Money Follows the Person initiative. Other previous positions include Director of the Center on Aging and Disabilities at the Lieutenant Joseph P. Kennedy Institute in Washington, DC, and Director of Family Support Services and Director of Mental Retardation Services at Kit Clark Senior Services in Boston. Dr. Nygren earned a Doctorate of Education in Organizational Leadership from Nova Southeastern University, a MA in Clinical Psychology from West Virginia University, and a BA in Psychology from Beloit College.

American Federation of State, County and Municipal Employees
Sally Tyler, MPA
Sally Tyler is the senior health policy analyst for the American Federation of State, County and Municipal Employees (AFSCME), based in Washington, DC. She reviews both federal and state health policy for potential impact on the union's members. Areas of specialization include Medicaid, health care delivery systems, health care information technology and quality standards reporting. She recently served as co-chair of the steering committee for the National Quality Forum's patient safety project on serious reportable events. She was a consumer member of the Health Care Information Technology Standards Panel (HITSP) as it made recommendations for interoperability regarding adoption of electronic health records. She is on the advisory board of the American Academy of Developmental Medicine. Tyler has an undergraduate degree from Emory University and a graduate degree from Harvard's Kennedy School of Government.

American Geriatrics Society
Jennie Chin Hansen, RN, MS, FAAN
Jennie Chin Hansen is CEO of the American Geriatrics Society and immediate past President of AARP. The AGS is the nation's leading membership organization of geriatrics healthcare professionals, whose shared mission is to improve the health, independence and quality of life of older people. As a pivotal force in shaping practices, policies and perspectives in the field, the Society focuses on: advancing eldercare research; enhancing clinical practice in eldercare; raising public awareness of the healthcare needs of older people; and advocating for public policy that ensures older adults access to quality, appropriate, cost-effective care. In 2005, Hansen transitioned after nearly 25 years with On Lok, Inc., a nonprofit family of organizations providing integrated, globally financed and comprehensive primary, acute and long-term care community based services in San Francisco. The On Lok prototype became the 1997 federal Program of All Inclusive Care to the Elderly (PACE) Program into law for Medicare and Medicaid. PACE now has programs in 30 states. In May 2010, she completed her two year term as President of AARP during the national debate over health care reform, in addition to, the other six years she was on AARP's national board of directors. Since 2005, she has served as federal commissioner of the Medicare Payment Advisory Commission (MedPAC). In 2010 she served as an IOM member on the RWJ Initiative on the Future of Nursing. She currently serves as a board member of the SCAN Foundation and a board officer of the National Academy of Social Insurance. In 2011 she begins as a board member of the Institute for Healthcare Improvement (IHI). Jennie has received multiple awards over the years including the 2003 Gerontological Society of America Maxwell Pollack Award for Productive Living, a 2005 Administrator's Achievement Award from the Centers for Medicare and Medicaid Services, and an honorary doctorate from Boston College in 2008.

American Medical Directors Association
David Polakoff, MS, MsC
Dr. David Polakoff is the Chief Medical Officer of MassHealth, and Director of the Office of Clinical Affairs of the Commonwealth Medicine Division of the University of Massachusetts Medical School. Dr. Polakoff is a noted Geriatrician, with over a decade of experience as a senior health care executive. Dr. Polakoff served as Chief Medical Officer of Mariner Health Care, and Genesis Health Care, and is the founder of Senior Health Advisors, a consulting firm. Dr. Polakoff has a longstanding interest in health policy, with a particular eye toward quality of services for the aging population, research on related topics, and has delivered hundreds of invited presentations.

Better Health Greater Cleveland
Patrick Murray, MD, MS
Dr. Patrick Murray is an associate professor of Physical Medicine and Rehabilitation at Case Western Reserve University School of Medicine. Dr. Murray has more than 30 years experience in practice, administration, and research related to long term care services and supports and rehabilitation services. He

has worked in Cleveland for 26 years at both MetroHealth Medical Center and Case Western Reserve University serving as Director of the Department of Physical Medicine and Rehabilitation and as medical director of the PACE program in Cleveland. He was co-director of the Program for Research and Education on Aging in the Center for Health Care Research and Policy where he is currently a senior scholar. Before coming to Cleveland, Dr. Murray was on the faculty at the University of Rochester and was in medical practice in rural West Virginia in a practice focused on geriatrics at a community clinic sponsored by the United Mine Workers. Dr. Murray's research has focused on rehabilitation issues in long term care especially in the post acute settings. He serves on the editorial board of the Archives of Physical Medicine and Rehabilitation. He has participated with Better Health Greater Cleveland over the past three years with special interests in the care of persons in nursing homes. Presently his work is focused on developing and evaluating approaches that improve the efficiency and quality of long term services and supports in underserved urban settings. Dr. Murray has a bachelor's degree in Biology from the University of Chicago, an MD degree from SUNY at Stonybrook, and a Master's Degree in Health Services Research from Case Western Reserve University. He is board certified in both Internal Medicine with Special Qualifications in Geriatrics and Physical Medicine and Rehabilitation.

Center for Medicare Advocacy, Inc.
Patricia Nemore, JD

Patricia Nemore specializes in issues affecting low income beneficiaries dually eligible for Medicare and Medicaid. For the past ten years, she has done that work as an attorney in the Washington, DC office of the Center for Medicare Advocacy. She was actively involved in designing and advocating for low-income beneficiary-related provisions in legislation passed in 2008 and in the Affordable Care Act of 2010. Ms. Nemore's work includes litigation, testimony, training, and legislative and administrative advocacy. She has authored or co-authored three reports on the Medicare Savings Programs and several articles on Medicare Advantage Special Needs Plans. She received a J.D. from Catholic University and a B.A. from Northwestern University.

National Health Law Program
Leonardo Cuello, JD

Leonardo Cuello joined the National Health Law Program in December 2009 as a Staff Attorney in the D.C. office. Leonardo works on health care for older adults, reproductive health, and health reform implementation. Prior to joining NHeLP, Leonardo worked at the Pennsylvania Health Law Project (PHLP) for six years focusing on a wide range of health care issues dealing with eligibility and access to services in Medicaid and Medicare. From 2003 to 2005, Leonardo was an Independence Foundation Fellow at PHLP and conducted a project focused on immigrant and Latino health care, including direct representation of low-income immigrants and Latinos. From 2006 to 2009, Leonardo worked on numerous Medicaid eligibility and services issues though direct representation and policy work, and served briefly as PHLP's Acting Executive Director. During that time, he also worked on Medicare Part D implementation issues, PHLP's Hospital Accountability Project, and also served as legal counsel to the Consumer Subcommittee of Pennsylvania's Medical Care Advisory Committee. Leonardo graduated with a B.A. from Swarthmore College and a J.D. from The University of Pennsylvania Law School.

Humana, Inc.
Thomas James, III, MD

Dr. Tom James is Corporate Medical Director for Humana. In this capacity he is responsible for providing the clinical input into the quality and efficiency measurements and display of health care providers within the Humana network. Dr. James works closely with national and local professional organizations and societies to explain Humana's goals on transparency and other clinical issues, and to receive feedback that allows for greater alignment between Humana and the national professional groups. He is also involved with Humana's group Medicare clinical program development. He is providing consulting services to Humana's major and national accounts. Dr. James was previously Humana's chief medical officer for

Kentucky, Indiana and Tennessee and the Medical Advisor to the Strategic Advisory Group of Humana Sales. He has nearly thirty years of experience in health benefits having served as medical director for such health companies as HealthAmerica, Maxicare, Sentara, Traveler's Health Network, and Anthem, in the Mid-Atlantic, Midwest and South. Dr. James is board certified in Internal Medicine and in Pediatrics. He received his undergraduate degree from Duke University and his medical degree from the University of Kentucky. Dr. James served his residencies at Temple University Hospital, Pennsylvania Hospital, and Children's Hospital of Philadelphia. He is currently the chairman of the Patient Safety Task Force for the Greater Louisville Medical Society. He is on the Board of such organizations as Kentucky Opera, Hospice of Louisville Foundation, and Kentucky Pediatrics Foundation. He chairs the Health Plan Council for the National Quality Forum (NQF), and is on work groups for both the AQA Alliance and the AMA PCPI. Dr. James remains in part-time clinical practice of internal medicine-pediatrics.

L.A. Care Health Plan
Laura Linebach, RN, BSN, MBA

Laura Linebach, RN, MBA is the Quality Improvement Director for L.A. Care Health Plan, the largest public entity health plan in the country with over 800,000 members. She directs the company-wide quality improvement programs as well as the disease management program for several product lines including Medicaid and Medicare HMO Special Needs Plan. Before L.A. Care, she was the Quality improvement Director in the commercial HMO area. She has more than 30 years of experience as a healthcare quality professional and leader and has taught numerous classes on nursing history and Quality Improvement throughout her career. Ms. Linebach has had extensive experience in quality management in the military, managed care organizations, community mental health centers and the state mental health hospital setting. She has led organizations through multiple successful NCQA accreditation reviews as well as several of The Joint Committee visits. She founded the Nursing Heritage Foundation in Kansas City Missouri to collect and preserve nursing history and has written several articles related to nursing history. Ms Linebach also served as a flight nurse in the Air Force Reserves and later as Officer-in-Charge of the Immunization Clinic for the 442nd Medical Squadron. She is a member of the National Association for Healthcare Quality and the California Association for Healthcare Quality. Ms. Linebach has a Bachelor of Science degree in nursing from Avila College, Kansas City, Missouri and a master's in history as well as business administration from the University of Missouri-Kansas City.

National Association of Public Hospitals and Health Systems
Steven Counsell, MD

Steven R. Counsell, MD is the Mary Elizabeth Mitchell Professor and Chair in Geriatrics at Indiana University (IU) School of Medicine and Founding Director of IU Geriatrics, a John A. Hartford Foundation Center of Excellence in Geriatric Medicine. He serves as Chief of Geriatrics and Medical Director for Senior Care at Wishard Health Services, a public safety net health system in Indianapolis, Indiana. Dr. Counsell recently returned from Australia where as an Australian American Health Policy Fellow he studied "Innovative Models of Coordinating Care for Older Adults." Prior to his sabbatical, he served as Geriatrician Consultant to the Indiana Medicaid Office of Policy and Planning. Dr. Counsell is a fellow of the American Geriatrics Society (AGS), immediate past Chair of the AGS Public Policy Committee, and current member of the AGS Board of Directors. Dr. Counsell has conducted large-scale clinical trials testing system level interventions aimed at improving quality, outcomes, and cost-effectiveness of healthcare for older adults. He was the PI for the NIH funded trial of the Geriatric Resources for Assessment and Care of Elders (GRACE) care management intervention shown to improve quality and outcomes of care in low-income seniors, and reduce hospital utilization in a high risk group. Dr. Counsell was a 2009-2010 Health and Aging Policy Fellow and is currently working to influence health policy to improve integration of medical and social care for vulnerable elders.

National Association of Social Workers
Joan Levy Zlotnik, PhD, ACSW

Dr. Zlotnik has more than 20 years of experience working in leadership positions within national social work organizations. Her pioneering work has focused on forging academic/agency partnerships and on strengthening the bridges between research, practice, policy and education. She currently serves as the director of the Social Work Policy Institute (SWPI), a think tank established in the NASW Foundation. Its mission is to strengthen social work's voice in public policy deliberations. SWPI creates a forum to examine current and future issues in health care and social service delivery by convening together researchers, practitioners, educators and policy makers to develop agendas for action. Dr. Zlotnik served as the director of the Strengthening Aging and Gerontology Education for Social Work (SAGE-SW), the first project supported by the John A. Hartford Foundation as part of its Geriatric Social Work Initiative (GSWI) and has undertaken several projects to better meet psychosocial needs in long term care. Dr. Zlotnik's work in aging, family caregiving and long term care has been recognized through her election as a Fellow of the Gerontological Society of America and as a recipient of the Leadership Award of the Association for Gerontology Education in Social Work (AGE-SW). Prior to being appointed as director of SWPI, Dr. Zlotnik served for nine years as the Executive Director of the Institute for the Advancement of Social Work Research (IASWR), working closely with the National Institutes of Health (NIH), other behavioral and social science disciplines and social work researchers. Under her leadership the growth in social work research was documented and training and technical assistance was offered to doctoral students, early career researchers and deans and directors on building social work research infrastructure and capacity. Previous to IASWR she served as Director of Special Projects at the Council on Social Work Education (CSWE) and as a lobbyist and Staff Director of the Commission on Families for the National Association of Social Workers. Dr. Zlotnik is an internationally recognized expert on workforce issues for the social work profession, and is the author of numerous publications covering the lifespan including developing partnerships, enhancing social work's attention to aging, providing psychosocial services in long term care, and evidence-based practice. She holds a PhD in Social Work from the University of Maryland, an MSSW from the University of Wisconsin-Madison, and a BA from the University of Rochester. Dr. Zlotnik is an NASW Social Work Pioneer© was recognized by the National Institute of Health's (NIH) Social Work Research Working Group for her efforts on behalf of social work research at NIH, and is a recipient of the Association of Baccalaureate Social Work Program Director's (BPD) Presidential Medal of Honor.

National PACE Association
Adam Burrows, MD

Dr. Adam Burrows has been the Medical Director of the Upham's Elder Service Plan, the PACE program operated by the Upham's Corner Health Center in Boston, since the program's inception in 1996. Dr. Burrows is a member of the Boston University Geriatrics faculty and Assistant Professor of Medicine at the Boston University School of Medicine, where he has twice received the Department of Medicine's annual Excellence in Teaching Award for community-based faculty. Dr. Burrows has been active nationally in promoting and supporting the PACE model of care, serving as chair of the National PACE Association's Primary Care Committee, health services consultant for the Rural PACE Project, editor of the PACE Medical Director's Handbook, and member of the National PACE Association Board of Directors. Dr. Burrows is also the statewide Medical Director for the Senior Care Options program of Commonwealth Care Alliance, a Medicare Advantage Special Needs Plan and one of the four Massachusetts Senior Care Organizations. He has developed ethics committees for Commonwealth Care Alliance and for a consortium of rural PACE organizations, where he serves as chair. Dr. Burrows lectures frequently on dementia, depression, care delivery, ethical issues, and other topics in geriatrics, and since 1997 has led a monthly evidence-based geriatrics case conference at Boston Medical Center. He is a graduate of the Mount Sinai School of Medicine and completed his medical residency at Boston City Hospital, chief residency at the Boston VA Medical Center, and geriatric fellowship at the Harvard Division on Aging. He is board-certified in Internal Medicine and Geriatric Medicine.

Individual Subject Matter Expert Members (voting)

Substance Abuse
Mady Chalk, MSW, PhD

Mady Chalk, Ph.D. is the Director of the Center for Policy Analysis and Research at the Treatment Research Institute (TRI) in Philadelphia, PA. The Center focuses on translation of research into policy, particularly focused on quality improvement and standards of care, new purchasing strategies for treatment services, implementation and evaluation of performance-based contracting, and integrated financing for treatment in healthcare settings. The Center also supports the Mutual Assistance Program for States (MAPS) which provides an arena in which States and local policy makers, purchasers, elected officials, and treatment providers meet with clinical and policy researchers to exchange ideas and develop testable strategies to improve the delivery of addiction treatment. Prior to becoming a member of the staff of TRI, for many years Dr. Chalk was the Director of the Division of Services Improvement in the Federal Center for Substance Abuse Treatment (CSAT)/Substance Abuse and Mental Health Services Administration (SAMHSA). For 15 years before coming to the Washington area, Dr. Chalk was a faculty member in the Yale University School of Medicine, Department of Psychiatry and the Director of the Outpatient /Community Services Division of Yale Psychiatric Institute. She received her Ph.D. in Health and Social Policy from the Heller School at Brandeis University.

Emergency Medical Services
James Dunford, MD

Dr. Dunford has served as Medical Director of San Diego Fire-Rescue since 1986 and became City Medical Director in 1997. Jim is Professor Emeritus at the UC, San Diego School of Medicine where he has practiced emergency medicine since 1980. Dr. Dunford attended Syracuse University and Columbia University College of Physicians & Surgeons and is board-certified in Emergency Medicine and Internal Medicine. He previously served as flight physician and medical director of the San Diego Life Flight program and founded the UCSD Emergency Medicine Training Program. Dr. Dunford's interests include translating research in heart attack, trauma and stroke care to the community. He investigates the interface between public health and emergency medical services (EMS). For his work with the San Diego Police Department Serial Inebriate Program (SIP) he received the 2007 United States Interagency Council on Homelessness Pursuit of Solutions Award. Dr. Dunford collaborates with the SDPD Homeless Outreach Team (HOT) and directs the EMS Resource Access Program (RAP) to case-manage frequent users of acute care services. He is a Co-investigator in the Resuscitation Outcomes Consortium (ROC), a US-Canadian effort responsible for conducting the largest out-of-hospital cardiac arrest and trauma resuscitation trials in North America.

Disability
Lawrence Gottlieb, MD, MPP

Larry Gottlieb is a board-certified internal medicine physician with 25 years of experience in health care quality management and improvement with numerous publications on quality in the medical and health policy literature. He has held several senior leadership positions in managed care and clinical information systems development and has been widely recognized for strategic thinking and effective leadership among healthcare industry executives. Larry has also been a leader in the launching and ongoing success of several healthcare collaborative efforts designed to improve care for patients and simplify processes for providers and has numerous publications. Immediately prior to joining Commonwealth Care Alliance, Larry served as Vice President and Senior Medical Director at Health Dialog, a Boston-based international wellness and chronic care support organization. From 2000 to 2007, Larry served as Senior Vice President and Chief Medical Officer of two early stage care management information technology companies using internet technology and home monitoring technology to support improved care for patients with chronic diseases. From 1987 to 2000, Larry served as a Medical Director at Harvard Community Health Plan and Harvard Pilgrim Health Care in a variety of leadership positions focused on

improving the quality of care delivered to the Health Plan's members. During that time, Larry led multiple successful NCQA accreditation efforts, oversaw the development of highly successful preventive care and chronic disease management programs, and developed and implemented the first comprehensive managed care evidence-based clinical practice guidelines program in the United States, achieving international recognition. Larry also played a leadership role in the launching of several Massachusetts healthcare collaboratives, including the Massachusetts Healthcare Quality Partnership, the Alliance for Health Care Improvement, the New England Region Public Health Managed Care Collaborative, and the Massachusetts eHealth Collaborative. He has served on the Board of Directors of several other healthcare organizations, including Health New England, Network Health, and MassPRO. Larry obtained his undergraduate degree in engineering and his medical degree from Tufts University and a Master of Public Policy degree from Harvard's Kennedy School of Government. He completed a residency in internal medicine at Tufts New England Medical Center and was a Robert Wood Johnson Clinical Scholar at Stanford University.

Measure Methodologist
Juliana Preston, MPA

Juliana Preston is the Vice President of Utah Operations for HealthInsight. Ms. Preston is responsible for leading the organization's quality improvement division in Utah. As the leader of the quality improvement initiatives, she oversees the management of the Medicare quality improvement contract work and other quality improvement related contracts in Utah. Ms. Preston has extensive experience working with nursing homes. She has developed numerous workshops and seminars including root cause analysis, healthcare quality improvement, human factors science, and resident-centered care. In addition to her experience at HealthInsight, she has held various positions during her career in long-term care including Certified Nursing Assistant, Admissions & Marketing Coordinator. Ms. Preston graduated from Oregon State University in 1998 with a Bachelor's of Science degree with an emphasis in Long Term Care and minor in Business Administration. In 2003, she obtained her Master's degree in Public Administration from the University of Utah with an emphasis in Health Policy.

Home & Community-Based Services
Susan Reinhard, RN, PhD, FAAN

Susan C. Reinhard is a Senior Vice President at AARP, directing its Public Policy Institute, the focal point or public policy research and analysis at the federal, state and international levels. She also serves as the Chief Strategist for the Center to Champion Nursing in America at AARP, a national resource and technical assistance center created to ensure that America has the nurses it needs to care for all of us now and in the future. Dr. Reinhard is a nationally recognized expert in nursing and health policy, with extensive experience in translating research to promote policy change. Before coming to AARP, Dr. Reinhard served as a Professor and Co-Director of Rutgers Center for State Health Policy where she directed several national initiatives to work with states to help people with disabilities of all ages live in their homes and communities. In previous work, she served three governors as Deputy Commissioner of the New Jersey Department of Health and Senior Services, where she led the development of health policies and nationally recognized programs for family caregiving, consumer choice and control in health and supportive care, assisted living and other community-based care options, quality improvement, state pharmacy assistance, and medication safety. She also co-founded the Institute for the Future of Aging Services in Washington, DC and served as its Executive Director of the Center for Medicare Education. Dr. Reinhard is a former faculty member at the Rutgers College of Nursing and is a fellow in the American Academy of Nursing. She holds a master's degree in nursing from the University of Cincinnati, and a PhD in Sociology from Rutgers, The State University of New Jersey.

Mental Health
Rhonda Robinson Beale, MD

Rhonda Robinson Beale, MD, has more than 30 years' experience in the fields of managed behavioral healthcare and quality management. She is the chief medical officer of OptumHealth Behavioral Solutions (formerly United Behavioral Health). Before joining United, she served as the senior vice president and chief medical officer of two prominent organizations, PacifiCare Behavioral Health (PBH) and CIGNA Behavioral Health. As a highly respected member of the behavioral health community, Dr. Robinson Beale has been involved extensively with the National Committee for Quality Assurance (NCQA), National Quality Forum, and the Institute of Medicine. Dr. Robinson Beale was a member of the committee that produced To Err is Human: Building a Safer Health System and Crossing the Quality Chasm: A New Health System for the 21st Century. Dr. Beale served over 8 years on Institute of Medicine's (IOM) Neuroscience and Behavioral Health and Health Care Services Boards. She serves as a committee member and consultant to various national organizations such as NQF, NCQA, NBGH, NIMH, SAMHSA, and is a past Board Chair of the Association for Behavioral Health and Wellness.

Nursing
Gail Stuart, PhD, RN

Dr. Gail Stuart is dean and a tenured Distinguished University Professor in the College of Nursing and a professor in the College of Medicine in the Department of Psychiatry and Behavioral Sciences at the Medical University of South Carolina. She has been at MUSC since 1985 and has served as Dean of the College of Nursing since 2002. Prior to her appointment as Dean, she was the director of Doctoral Studies and coordinator of the Psychiatric-Mental Health Nursing Graduate Program in the College of Nursing. She was also the Associate Director of the Center for Health Care Research at MUSC and the administrator and Chief Executive Officer of the Institute of Psychiatry at the Medical University where she was responsible for all clinical, fiscal, and human operations across the continuum of psychiatric care. She received her Bachelor of Science degree in nursing from Georgetown University, her Master of Science degree in psychiatric nursing from the University of Maryland, and her doctorate in behavioral sciences from Johns Hopkins University, School of Hygiene and Public Health. Dr. Stuart has taught in undergraduate, graduate, and doctoral programs in nursing. She serves on numerous academic, corporate, and government boards and represents nursing on a variety of National Institute of Mental Health policy and research panels, currently serving on the NINR Advisory Council. She is a prolific writer and has published numerous articles, chapters, textbooks, and media productions. Most notable among these is her textbook, *Principles and Practice of Psychiatric Nursing*, now in its 9th edition, which has been honored with four Book of the Year Awards from the *American Journal of Nursing* and has been translated into 5 languages. She has received many awards, including the American Nurses Association Distinguished Contribution to Psychiatric Nursing Award, the Psychiatric Nurse of the Year Award from the American Psychiatric Nurses Association, and the Hildegard Peplau Award from the American Nurses Association.

Federal Government Members (non-voting, ex officio)

Agency for Healthcare Research and Quality (AHRQ)
D.E.B. Potter, MS

D.E.B. Potter is a Senior Survey Statistician, in the Center for Financing, Access and Cost Trends (CFACT), Agency for Healthcare Research and Quality (AHRQ), U.S. Department of Health and Human Services (HHS). Her work focuses on improving the measurement of the long-term care (LTC) and disabled populations at the national level. Efforts include data collection and instrument design; measuring use, financing and quality of health care; and estimation issues involving people with disabilities that use institutional, sub-acute and home and community-based services (HCBS). In 2002, she (with others) received HHS Secretary's Award "for developing and implementing a strategy to provide information the Department needs to improve long-term care." She currently serves as Co-Lead, AHRQ's LTC Program, and is responsible for AHRQ's Assisted Living Initiative and the Medicaid HCBS quality measures project.

Centers for Medicare & Medicaid Services (CMS), Medicare-Medicaid Coordination Office

Cheryl Powell

Cheryl Powell has recently been appointed the Deputy Director of the Medicare-Medicaid Coordination Office at the Centers for Medicare & Medicaid Services (CMS). As the Deputy Director, Ms. Powell will assist the Director in leading the work of this office charged with more effectively integrating benefits to create seamless care for individuals' eligible for both Medicare and Medicaid and improving coordination between the federal government and states for such dual eligible beneficiaries. Ms. Powell has extensive experience in both Medicare and Medicaid policy development and operations. She is an expert on Medicaid reform activities and policy development. During her tenure at CMS, she designed and oversaw the implementation of Medicaid program and financial policy as well as national Medicaid managed care, benefits and eligibility operations. While working at Hilltop Institute, Ms. Powell evaluated Medicaid programs and worked with state and local officials to improve quality and health care delivery. Ms. Powell also has extensive knowledge of Medicare operations which will assist in the management of the new office. As Director of Medicare Policy at Coventry Health Care, she worked to improve compliance processes and business operations for Medicare Advantage plans. Ms. Powell previously managed Medicare beneficiary services at the CMS Chicago regional office and played a key role in the implementation and outreach of the Medicare Modernization Act. Ms. Powell earned a master's degree in public policy from The John F. Kennedy School of Government at Harvard University and graduated *summa cum laude* from the University of Virginia a bachelor's degree in psychology.

Health Resources and Services Administration (HRSA)

Samantha Wallack Meklir, MPP

Samantha Wallack Meklir, MPP, is an Analyst in the Office of Health Information Technology and Quality (OHITQ) of the Health Resources and Services Administration, U.S. Department of Health and Human Services, where she supports planning and implementing policies and programs related to quality and to health information technology across HRSA and with external stakeholders. As such, some of her activities include (but are not limited to) serving as the Federal Government Task Leader on a Report to Congress on quality incentive payments currently underway and helping to prepare HRSA grantees for meaningful use stage two measures. Samantha began her federal career as a Presidential Management Intern (PMI) and worked at both HRSA and CMS in various positions focusing on Medicaid legislation and programs, health information technology and quality, and the safety net. She served as Legislative Fellow for the late U.S. Senator Paul Wellstone (D-MN) and later as a Social Science Research Analyst in the CMS Office of Legislation Medicaid Analysis Group. Samantha worked for CMS not only in their OL but also in their Chicago Regional Office where she focused on home and community based waivers and later in the Baltimore Center for Medicaid and State Operations Children's Health Program Group where she focused on Section 1115 demonstration programs in family planning, health insurance flexibility employer-sponsored insurance programs, and SCHIP. Samantha contributed to the President's New Freedom Initiative during her tenure at CMS OL. Since 2006, Samantha has been focused on health information technology and quality at HRSA. Samantha has a bachelor's degree in American Studies from Tufts University and a master's degree in public policy from the Lyndon B. Johnson School of Public Affairs (UT Austin).

HHS Office on Disability

Henry Claypool

As the Director of the Office on Disability, Mr. Henry Claypool serves as the primary advisor to the HHS Secretary on disability policy and oversees the implementation of all HHS programs and initiatives pertaining to Americans with disabilities. Mr. Claypool has 25 years of experience with developing and implementing disability policy at the Federal, State, and local levels. As an individual with a disability, his personal experience with the nation's health care system provides a unique perspective to the agencies

within HHS and across the Federal government. Mr. Claypool sustained a spinal injury more than 25 years ago. In the years following his injury, he relied on Medicare, Medicaid, Social Security Disability Insurance and Supplemental Security Income, which enabled him to complete his bachelor's degree at the University of Colorado. After completing his degree, he spent five years working for a Center for Independent Living, after which he became the Director of the Disability Services Office at the University of Colorado-Boulder. Mr. Claypool also served as the Director of Policy at Independence Care System, a managed long-term care provider in New York City. Mr. Claypool served for several years as an advisor to the Federal government on disability policy and related issues. From 1998-2002, he held various advisory positions at HHS, including Senior Advisor on Disability Policy to the Administrator of the Centers for Medicare and Medicaid Services during the Clinton administration. From 2005-2006, he served as a Senior Advisor to the Social Security Administration's Office of Disability and Income Support Programs. In 2007, Mr. Claypool was also appointed by Governor Tim Kaine of Virginia to serve on the Commonwealth's Health Reform Commission.

Substance Abuse and Mental Health Services Administration (SAMHSA)
Rita Vandivort-Warren, MSW

Rita Vandivort-Warren is a Public Health Analyst and government project officer in the Division of Services Improvement, Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration. She has over 20 years' experience in mental health, substance abuse and health administration, program development and policy formulation. At SAMHSA, she handles numerous assignments in financing of treatment, including the SAMHSA Spending Estimates, CSAT lead on Medicaid and health reform issues, directs cost studies, and provides technical assistance on financing to states, grantees and providers. Previously, she worked at the National Association of Social Workers over eight years, crafting responses--through speeches, papers and acting in coalitions--on social work policy in the areas of managed care, mental health and substance abuse, Medicaid and other funding systems, behavioral health care best practices and telehealth. In Hawaii, Rita worked at the Queen's Medical Center in Honolulu for 10 years, as Ambulatory Manager, directing an intensive outpatient substance abuse treatment program, an interdisciplinary mental health clinic, a psychiatric partial hospitalization program. Prior to that at Queens, she created a foster family for elderly program and obtained foundation and ultimately Medicaid home and community based funding.

Veterans Health Administration (VHA)
Daniel Kivlahan, PhD

Dr. Kivlahan received his doctoral degree in clinical psychology from the University of Missouri-Columbia in 1983. Since 1998, he was been Director of the Center of Excellence in Substance Abuse Treatment and Education (CESATE) at VA Puget Sound in Seattle where he has been an addiction treatment clinician and investigator since 1985. He is Associate Professor, Department of Psychiatry and Behavioral Sciences, University of Washington and from 2004 – 2010 served as Clinical Coordinator of the VA Substance Use Disorders (SUD) Quality Enhancement Research Initiative to implement evidence-based practices in treatment of SUD. He co-chaired the work group that in 2009 completed the revision of the VA/DoD Clinical Practice Guideline for SUD and participated in the VHA expert consensus panel on clinical guidance for integrated care of concurrent SUD and PTSD. In May 2010, Dr. Kivlahan accepted the new field-based position as Associate National Mental Health Director for Addictive Disorders, Office of Mental Health Services, VHA. He was recently appointed as the representative from the Office of Mental Health Services to the Pain Management Working Group chartered by the VA/DoD Health Executive Council. Among his 100+ peer reviewed publications are validation studies on the AUDIT-C to screen for alcohol misuse across care settings and reports from clinical trials including the COMBINE Study for combined pharmacologic and psychosocial treatment of alcohol dependence.

MAP Coordinating Committee Co-Chairs (non-voting, ex officio)

George Isham, MD, MS

George Isham, M.D., M.S. is the chief health officer for HealthPartners. He is responsible for the improvement of health and quality of care as well as HealthPartners' research and education programs. Dr. Isham currently chairs the Institute of Medicine (IOM) Roundtable on Health Literacy. He also chaired the IOM Committees on *Identifying Priority Areas for Quality Improvement* and *The State of the USA Health Indicators*. He has served as a member of the IOM committee on *The Future of the Public's Health* and the subcommittees on the Environment for Committee on Quality in Health Care which authored the reports *To Err is Human* and *Crossing the Quality Chasm.* He has served on the subcommittee on performance measures for the committee charged with redesigning health insurance benefits, payment and performance improvement programs for Medicare and was a member of the IOM Board on Population Health and Public Health Policy. Dr. Isham was founding co-chair of and is currently a member of the National Committee on Quality Assurance's committee on performance measurement which oversees the Health Employer Data Information Set (HEDIS) and currently co-chairs the National Quality Forum's advisory committee on prioritization of quality measures for Medicare. Before his current position, he was medical director of MedCenters health Plan in Minneapolis and In the late 1980s he was executive director of University Health Care, an organization affiliated with the University of Wisconsin-Madison.

Elizabeth McGlynn, PhD, MPP

Elizabeth A. McGlynn, PhD, is the director for the Center of Effectiveness and Safety Research (CESR) at Kaiser Permanente. She is responsible for oversight of CESR, a network of investigators, data managers and analysts in Kaiser Permanente's regional research centers experienced in effectiveness and safety research. The Center draws on over 400 Kaiser Permanente researchers and clinicians, along with Kaiser Permanente’s 8.6 million members and their electronic health records, to conduct patient-centered effectiveness and safety research on a national scale. Kaiser Permanente conducts more than 3,500 studies and its research led to more than 600 professional publications in 2010. It is one of the largest research institutions in the United States. Dr. McGlynn leads efforts to address the critical research questions posed by Kaiser Permanente clinical and operations leaders and the requirements of the national research community. CESR, founded in 2009, conducts in-depth studies of the safety and comparative effectiveness of drugs, devices, biologics and care delivery strategies. Prior to joining Kaiser Permanente, Dr. McGlynn was the Associate Director of RAND Health and held the RAND Distinguished Chair in Health Care Quality. She was responsible for strategic development and oversight of the research portfolio, and external dissemination and communications of RAND Health research findings. Dr. McGlynn is an internationally known expert on methods for evaluating the appropriateness and technical quality of health care delivery. She has conducted research on the appropriateness with which a variety of surgical and diagnostic procedures are used in the U.S. and in other countries. She led the development of a comprehensive method for evaluating the technical quality of care delivered to adults and children. The method was used in a national study of the quality of care delivered to U.S. adults and children. The article reporting the adult findings received the Article-of-the-Year award from AcademyHealth in 2004. Dr. McGlynn also led the RAND Health’s COMPARE initiative, which developed a comprehensive method for evaluating health policy proposals. COMPARE developed a new microsimulation model to estimate the effect of coverage expansion options on the number of newly insured, the cost to the government, and the effects on premiums in the private sector. She has conducted research on efficiency measures and has recently published results of a study on the methodological and policy issues associated with implementing measures of efficiency and effectiveness of care at the individual physician level for payment and public reporting. Dr. McGlynn is a member of the Institute of Medicine and serves on a variety of national advisory committees. She was a member of the Strategic Framework Board that provided a blueprint for the National Quality Forum on the development of a national quality measurement and reporting system. She chairs the board of AcademyHealth, serves on the board of the

American Board of Internal Medicine Foundation, and has served on the Community Ministry Board of Providence-Little Company of Mary Hospital Service Area in Southern California. She serves on the editorial boards for Health Services Research and The Milbank Quarterly and is a regular reviewer for many leading journals. Dr. McGlynn received her BA in international political economy from Colorado College, her MPP from the University of Michigan's Gerald R. Ford School of Public Policy, and her PhD in public policy from the Pardee RAND Graduate School.

National Quality Forum Staff

Janet Corrigan, PhD, MBA

Janet M. Corrigan, PhD, MBA, is president and CEO of the National Quality Forum (NQF), a private, not-for-profit standard-setting organization established in 1999. The NQF mission includes: building consensus on national priorities and goals for performance improvement and working in partnership to achieve them; endorsing national consensus standards for measuring and publicly reporting on performance; and promoting the attainment of national goals through education and outreach programs. From 1998 to 2005, Dr. Corrigan was senior board director at the Institute of Medicine (IOM). She provided leadership for IOM's Quality Chasm Series, which produced 10 reports during her tenure, including: To Err is Human: Building a Safer Health System, and Crossing the Quality Chasm: A New Health System for the 21st Century. Before joining IOM, Dr. Corrigan was executive director of the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry. Among Dr. Corrigan's numerous awards are: IOM Cecil Award for Distinguished Service (2002), American College of Medical Informatics Fellow (2006), American College of Medical Quality Founders' Award (2007), Health Research and Educational TRUST Award (2007), and American Society of Health System Pharmacists' Award of Honor (2008). Dr. Corrigan serves on various boards and committees, including: Quality Alliance Steering Committee (2006–present), Hospital Quality Alliance (2006–present), the National eHealth Collaborative (NeHC) Board of Directors (2008–present), the eHealth Initiative Board of Directors (2010–present), the Robert Wood Johnson Foundation's Aligning Forces for Healthcare Quality (AF4Q) National Advisory Committee (2007–present), the Health Information Technology (HIT) Standards Committee of the U.S. Department of Health and Human Services (2009–present), the Informed Patient Institute (2009 – present), and the Center for Healthcare Effectiveness Advisory Board (2011 – present). Dr. Corrigan received her doctorate in health services research and master of industrial engineering degrees from the University of Michigan, and master's degrees in business administration and community health from the University of Rochester.

Thomas Valuck, MD, JD, MHSA

Thomas B. Valuck, MD, JD, is senior vice president, Strategic Partnerships, at the National Quality Forum (NQF), a nonprofit membership organization created to develop and implement a national strategy for healthcare quality measurement and reporting. Dr. Valuck oversees NQF-convened partnerships—the Measure Applications Partnership (MAP) and the National Priorities Partnership (NPP)—as well as NQF's engagement with states and regional community alliances. These NQF initiatives aim to improve health and healthcare through public reporting, payment incentives, accreditation and certification, workforce development, and systems improvement. Dr. Valuck comes to NQF from the Centers for Medicare & Medicaid Services (CMS), where he advised senior agency and Department of Health and Human Services leadership regarding Medicare payment and quality of care, particularly value-based purchasing. While at CMS, Dr. Valuck was recognized for his leadership in advancing Medicare's pay-for-performance initiatives, receiving both the 2009 Administrator's Citation and the 2007 Administrator's Achievement Awards. Before joining CMS, Dr. Valuck was the vice president of medical affairs at the University of Kansas Medical Center, where he managed quality improvement, utilization review, risk management, and physician relations. Before that he served on the Senate Health, Education, Labor, and Pensions Committee as a Robert Wood Johnson Health Policy Fellow; the White House

Council of Economic Advisers, where he researched and analyzed public and private healthcare financing issues; and at the law firm of Latham & Watkins as an associate, where he practiced regulatory health law. Dr. Valuck has degrees in biological science and medicine from the University of Missouri-Kansas City, a master's degree in health services administration from the University of Kansas, and a law degree from the Georgetown University Law School.

Diane Stollenwerk, MPP

Diane Stollenwerk, MPP, is Vice President, Community Alliances at the National Quality Forum (NQF), where she leads efforts to identify and pursue opportunities to engage and provide stronger support for state and community leaders. Ms. Stollenwerk has more than 20 years experience in public affairs, strategic communication, fundraising and sustainability, product development, and organizational strategic planning. Before joining NQF, she provided consulting services for local and national organizations involved in healthcare quality improvement. Ms. Stollenwerk was one of the first directors of the nationally-recognized Puget Sound Health Alliance (the Alliance), a coalition of employers, unions, doctors, hospitals, consumer groups, insurers, pharmaceutical companies, government, and others in the Pacific Northwest. She served as project director of the Robert Wood Johnson Foundation's Aligning Forces for Quality program in the Puget Sound region, was liaison to the Agency on Healthcare Research and Quality's Chartered Value Exchange efforts, and represented the Alliance in the Washington Health Information Collaborative to promote the use of health information technology. She has also held public affairs and marketing roles at the executive level for several Catholic healthcare systems, a Blue Shield plan, and within the software and transportation industries. She has been an active board member and volunteer for several businesses and nonprofit groups, such as the Association of Washington Business, Epilepsy Foundation, American Marketing Association, and the Society of Competitive Intelligence Professionals. Ms. Stollenwerk has a bachelor's degree in English and speech communication from San Diego State University, and a master's degree in public policy from Harvard University.

Sarah Lash, MS, CAPM

Sarah Lash is a Program Director in the Strategic Partnerships department at the National Quality Forum. Ms. Lash staffs the NQF-convened Measure Applications Partnership, leading a task focused on measuring and improving the quality of care delivered to Medicare/Medicaid dual eligible beneficiaries. Prior to joining NQF, Ms. Lash spent four years as a policy research consultant at The Lewin Group, where she specialized in supporting Federal initiatives related to aging, disability, and mental/behavioral health issues. Ms. Lash studied Public Health and Psychology at Johns Hopkins University and went on to earn a master's degree in Health Systems Management from George Mason University. Ms. Lash was recognized with GMU's Graduate Award for Excellence in Health Policy and is also a Certified Associate in Project Management (CAPM).