NATIONAL QUALITY FORUM

Agenda

Measure Applications Partnership
Dual Eligible Beneficiaries Workgroup Web Meeting

September 5, 2012

1:00 pm - 3:00 pm ET

Participant Instructions:

- Please log in 15 minutes prior to the scheduled start in order to allow time for troubleshooting.
- Direct your web browser to: http://nqf.commpartners.com
- Under "Enter a meeting," type in the meeting number 847943 and click "Enter."
- In the "Display Name" field, type in your first and last name and click "Enter Meeting."
- Dial (877) 771-7022 and use conference ID code 90365748 to access the audio platform.

Meeting Objectives:

- Introduce the workgroup's updated charge and the analytic approach to planned activities
- Review NQF's Multiple Chronic Conditions Framework
- Connect updated charge to other current activities across MAP
- Prepare for upcoming in-person meeting

1:00 pm **Welcome, Roll Call, and Review of Meeting Objectives**

Alice Lind, Workgroup Chair

- Roll call and introductions of new members
- Building on last year's work
- New workgroup charge

1:20 pm **Activities to Accomplish New Work**

Sarah Lash, Senior Program Director, NQF

Amaru Sanchez, Project Analyst, NQF

Megan Duevel Anderson, Project Analyst, NQF

- Methodology for revising core measure set
- Profile of high-need population subgroups
- Defining the framework of quality issues
- Discussion and questions

2:00 pm **Multiple Chronic Conditions Framework**

Aisha Pittman, Senior Program Director, NQF

- Review framework
- Discussion and questions

2:25 pm **Connections to Other MAP Activities for 2012/2013**

Connie Hwang, Vice President, Measure Applications Partnership, NQF

- Connections with MAP Strategic Plan, families of measures, pre-rulemaking input to HHS
- Discussion and questions

2:45 pm **Opportunity for Public Comment**

2:50 pm **Homework Assignment: Gathering Feedback on Core Measure Set**

Alice Lind

2:55 pm **Summary and Next Steps**

Alice Lind

3:00 pm **Adjourn**

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Dual Eligible Beneficiaries Workgroup Membership

Workgroup Chair: Alice Lind, MPH, BSN

Organizational Members

American Association on Intellectual and Developmental Disabilities	Margaret Nygren, EdD
American Federation of State, County and Municipal Employees	Sally Tyler, MPA
American Geriatrics Society	Jennie Chin Hansen, RN, MS, FAAN
American Medical Directors Association	David Polakoff, MD, MsC
Center for Medicare Advocacy	**Alfred Chiplin, JD, M.Div.**
Consortium for Citizens with Disabilities	**E. Clarke Ross, DPA**
Humana, Inc.	Thomas James, III, MD
L.A. Care Health Plan	Laura Linebach, RN, BSN, MBA
National Association of Public Hospitals and Health Systems	Steven Counsell, MD
National Association of Social Workers	Joan Levy Zlotnik, PhD, ACSW
National Health Law Program	Leonardo Cuello, JD
National PACE Association	Adam Burrows, MD
SNP Alliance	**Richard Bringewatt**

Dual Eligible Beneficiaries Workgroup Membership

Subject Matter Experts

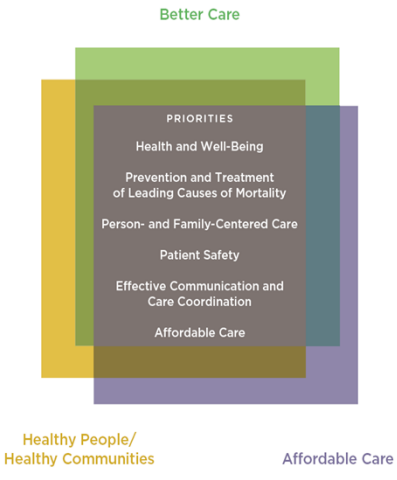
Substance Abuse	Mady Chalk, MSW, PhD
Disability	**Anne Cohen, MPH**
Emergency Medical Services	James Dunford, MD
Measure Methodologist	Juliana Preston, MPA
Home & Community Based Services	Susan Reinhard, RN, PhD, FAAN
Mental Health	Rhonda Robinson-Beale, MD
Nursing	Gail Stuart, PhD, RN

Federal Government Members

Agency for Healthcare Research and Quality	D.E.B. Potter, MS
CMS Federal Coordinated Healthcare Office	Cheryl Powell
Health Resources and Services Administration	Samantha Meklir, MPP
Administration for Community Living	Henry Claypool
Substance Abuse and Mental Health Services Administration	**Frances Cotter, MA, MPH**
Veterans Health Administration	Daniel Kivlahan, PhD

MAP Framework for Aligned Performance Measurement: National Quality Strategy

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

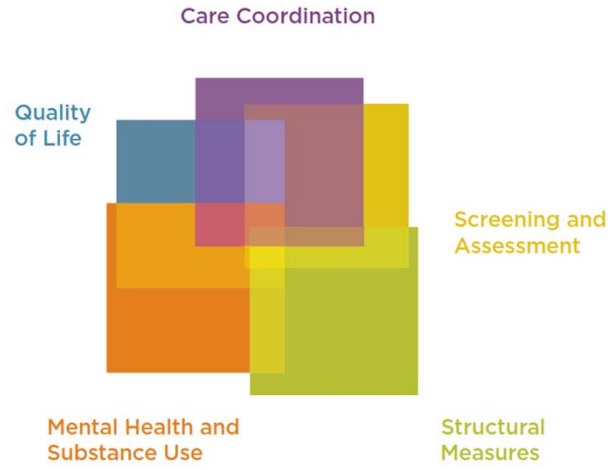


Measuring Healthcare Quality for the Dual Eligible Beneficiary Population: Final Report to HHS

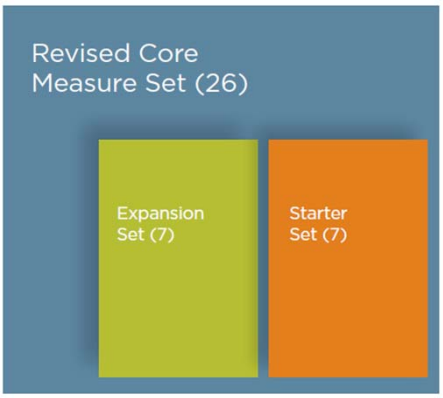
June 2012 Final Report primarily contains:

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

High-Leverage Opportunities for Improvement Through Measurement



Appropriate Measures for Dual Eligible Beneficiaries: Measure Sets

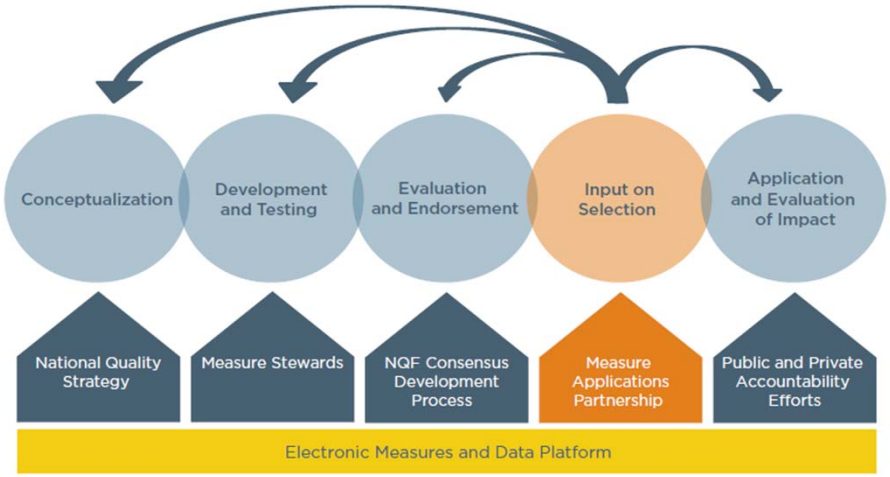


- MAP examined hundreds of currently available measures, both NQF-endorsed and outside measures
  - Narrowed to a core set of 26
- Identified subsets of measures within core set:
  - Starter Set – best available measures for use
  - Expansion Set – measures require modification for use

Appropriate Measures for Dual Eligible Beneficiaries: Measure Topics

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

Resolving Gaps in Measurement



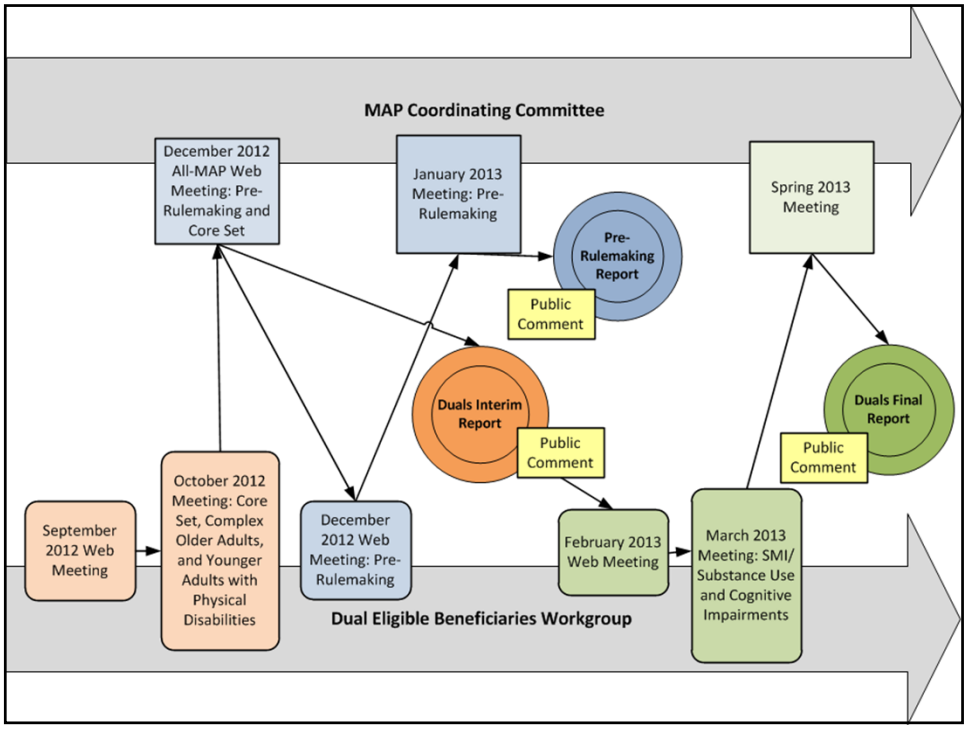
Reflection from CMS

Workgroup Charge for 2012/2013

- The charge of the workgroup is to advise the MAP Coordinating Committee on performance measures to assess and improve the quality of care delivered to Medicare/Medicaid dual eligible beneficiaries.
- The Workgroup will analyze special measurement considerations for the care of high-need population subgroups of dual eligible beneficiaries.
- MAP will examine measures and measurement issues across the continuum of care, to include primary and acute care, behavioral health, and long-term services and supports.

Workgroup Charge for 2012/2013

- Identify opportunities to improve measurement for dual eligible beneficiaries.
- Determine the most suitable performance measures currently available, concentrating on high-need subgroups to include:
  - Older adults with functional limitations and chronic conditions
  - Adults younger than 65 with physical disabilities
  - Individuals with serious mental illness
  - Individuals with cognitive impairment
- Document potential strategies to address measurement limitations.
- Delineate specific gaps in measures and available evidence to inform future measure development.
- Advise the Coordinating Committee on cross-cutting measurement issues and ensure alignment. These include MAP's strategic plan, families of measures, and pre-rulemaking input.



Discussion and Questions

Activities to Accomplish New Work

Revising the Core Measure Set

Workgroup will consider additions or deletions based on:

- Stakeholder feedback, including additional Medicaid and State perspectives
- Progress made on newly developed and endorsed measures
- Other changes in endorsement status
  - endorsement removed, time-limited endorsement, reserve status

Most measures will remain the same, but targeted changes will fine-tune the set.

High-Need Population Subgroups

Initial focus on two subgroups of dual eligible beneficiaries:

- Older than 65 with one or more functional impairments and one or more chronic conditions
  - shorthand title = medically complex older adults
- Younger than 65 with a physical or sensory disability

Understanding that the complex and heterogeneous dual eligible population does not lend itself well to clean categorization…

- Behavioral health populations to follow in 2013 for inclusion in July 2013 Final Report

Two Primary Activities in October

The two activities are related but running in parallel to inform different components of MAP's work

Revise Core Set of Measures from June 2012 Report

Incorporate additional stakeholder feedback (e.g., Medicaid, States implementing demonstrations)

Consider addition or deletion of measures with changes in endorsement status

Pre-Rulemaking Input

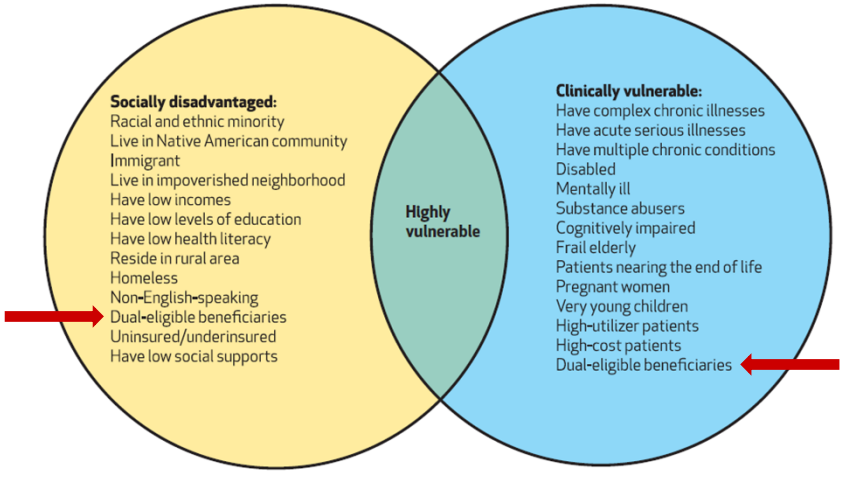
Consider Additional Measures for High-Need Subgroups

Using high-leverage opportunity areas, identify best available measures to promote quality improvement for high-need population subgroups across care continuum

Interim Report and Future Work in 2013 on Other High-Need Subgroups

Understanding High-Need Population Subgroups

Categories And Overlap Of Vulnerable Populations In The US Health Care System



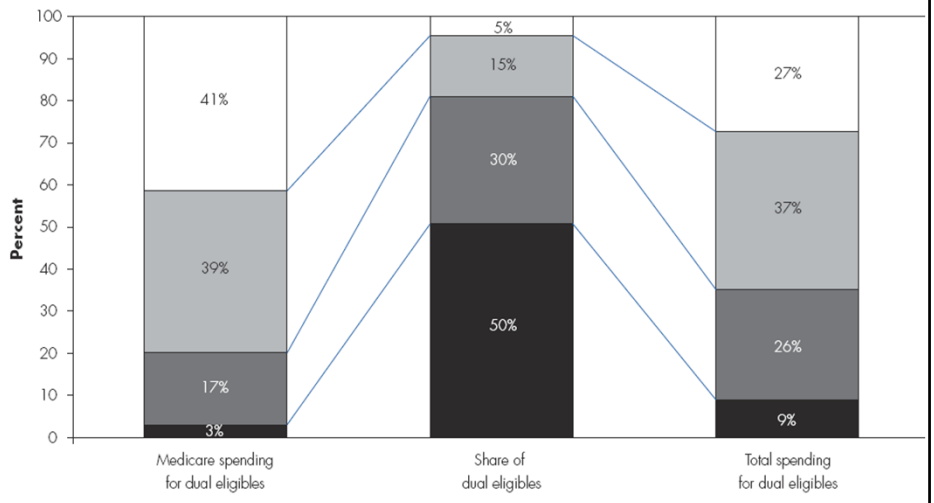
Important characteristics:
Geographic concentration
High use of social services
Health care concentrated in low-performing health care systems

Important characteristics:
Social needs exacerbate clinical needs
Greatest opportunity to reduce cost, improve quality, and reduce disparities

Important characteristics:
Geographically dispersed
High use of clinical care
All socioeconomic groups affected

Lewis, Larson, McClurg, Boswell, and Fisher. *Health Affairs* 31, No. 8 (2012): 1777-1785

Both Medicare and total spending are concentrated among dual beneficiaries, 2001



SOURCE: MedPAC analysis of Cost and Use file, 2001 Medicare Current Beneficiary Survey
NOTES: Columns may not sum due to rounding. Total spending includes Medicare, Medicaid, supplemental insurance, and out-of-pocket spending.

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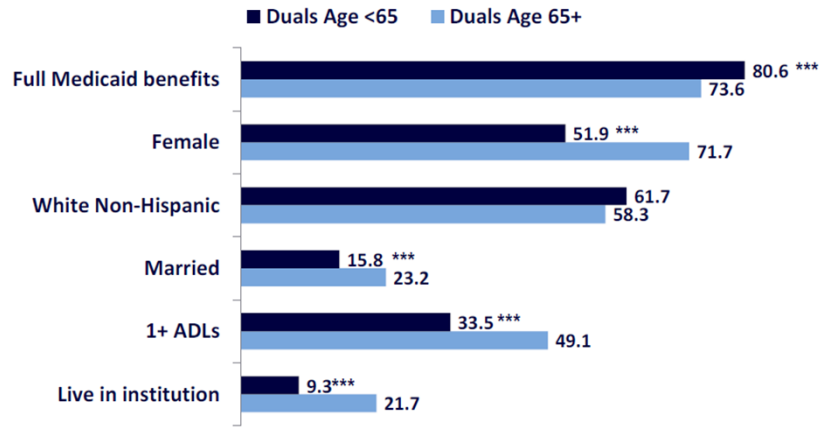
Selected Characteristics of Medicaid-Medicare Dual Eligibles by Age, 2007



SOURCE: Urban Institute analysis of MSIS-MCBS 2007 linked file for the Kaiser Commission on Medicaid and the Uninsured.
* (**) (***) Non-elderly dual beneficiaries are significantly different from elderly dual beneficiaries at the .10 (.05) (.01) level, two-tailed test.

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Kaiser Family Foundation 2012

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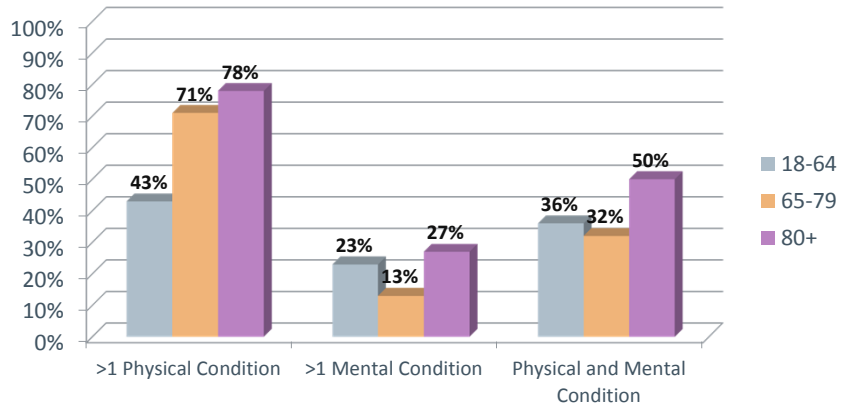
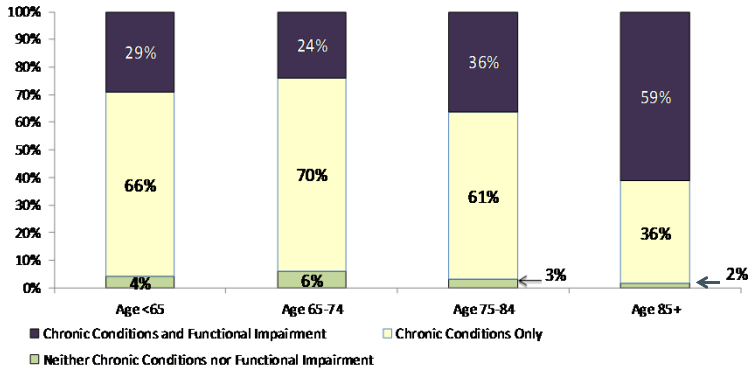
Comorbidity Among Dual Eligible Beneficiaries by Age Group



SOURCE: Kaiser Commission on Medicaid and the Uninsured analysis of weighted linked 2003 MSIS data and MCBS file.

Dual Eligibles by Age Group, Number of Chronic Conditions, and Functional Impairment

SCAN Foundation *Data Brief* No. 26



N = 3,279,733 duals age <65, 2,140,048 duals age 65-74, 1,692,792 duals age 75-84 and 942,033 duals age 85+
Note: Totals may not sum to 100% because duals with functional impairment only are not shown in this chart; among all duals, 1% have functional impairment only. Among the age groups, 1.1% of <65, 0.44% of 65-74, 0.19% of 75-84, and 3.34% of 85+ duals had functional impairment only. Also, 4% of dual eligibles under age 65 have neither chronic conditions nor functional impairment as defined in this analysis, but may have qualified for Medicare due to a condition not included in the current definition of chronic disease (e.g., end stage renal disease or amyotrophic lateral sclerosis).

Adults with Physical Disabilities Younger than 65

- Of the 9 million dual eligible beneficiaries in 2008, 3.6 million (39%) were disabled adults under 65
  - 18.2% of beneficiaries under 65 have 1-2 ADL limitations
  - 17.1% of beneficiaries under 65 have 3 or more ADL limitations
- Few studies examine beneficiaries with a primary physical disability separately from other dual eligible individuals under 65 with other types of disability.
  - Because nearly three out of every four dual eligible beneficiaries under 65 have a cognitive or mental impairment, comorbidity is very common.
  - All categories of disabled dual eligible beneficiaries are significantly more costly to Medicare than their non-dual eligible counterparts.
- Younger beneficiaries tend to use different providers and services are more interested in navigating the health/LTSS system on their own.

Kaiser Family Foundation. Where Does The Burden Lie? 2009
MedPAC Duals Overview 2004

Hypothetical Profile: Adult with Physical Disability

- Isabel, 45 y/o female
- Uses a wheelchair following spinal cord injury
- Cardio/metabolic factors not well-managed, at major risk for Type 2 diabetes
- History of pressure ulcers
- Native Spanish speaker
- Lives in rural area
- Relies on public paratransit to attend medical appointments
- Wants to participate in more activities outside her home but lacks resources and social connections

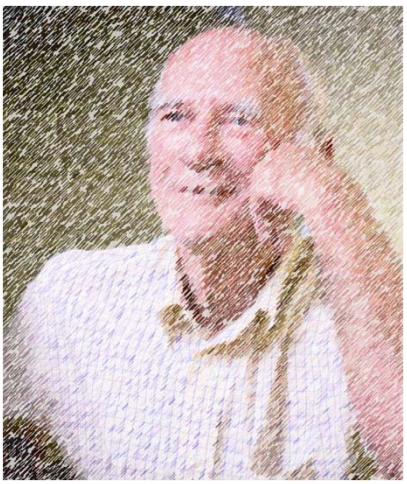
Photo CNW Group/CANADIAN PARALYMPIC COMMITTEE (CPC) via Canada Newswire

Medically Complex Older Adults

- Half of dual eligible beneficiaries age 80 or older have both physical and mental/cognitive conditions.
  - Over 90% of dual eligible beneficiaries age 65 and older have at least one chronic condition.
  - Over 40% of dual eligible beneficiaries age 65 and older have a mental/cognitive condition, Alzheimer's disease being the most common.
- In a given year, more than 40% of older dual eligible beneficiaries with physical and cognitive conditions are hospitalized and almost 35% use post-acute care.
- 38% of older dual eligible beneficiaries with physical and cognitive conditions use Medicaid nursing home care and 22% use HCBS.
- Annual spending for older dual eligible beneficiaries in 2003 was $32,600 per beneficiary, more than half of which was paid by Medicaid.

Hypothetical Profile: Medically Complex Older Adult

- Samuel, 91 y/o male
- History of multiple strokes, causes mobility and speech difficulties
- Increasingly incontinent
- Lives alone in senior apartment complex since death of spouse 3 years prior
- Undiagnosed depression
- Prescribed 8 medications but not taking them consistently
- Receives home-delivered meals and personal attendant services on a daily basis
- Wants to do whatever he can to avoid a nursing home



The Three I's

IOM criteria for choosing clinical priority areas:

Impact	• Extent of burden of the quality issue on the specific population • Severity of disability, morbidity and mortality, and financial burden • Effects on patients, families, communities, and societies
Improvability	• Gap between current practice and evidence-based best practice • Ability to close this gap and improve the quality of care in this issue • Opportunity to achieve improvements in national quality aims
Inclusiveness	• Relevance of a quality issue area to a broad range of individuals • Effect of quality issue across age, gender, socioeconomic status, and ethnicity/race (equity) • Generalizability of strategies to improve this quality issue across the spectrum of healthcare (representativeness) • Breadth of change effected through improvement strategies across a range of healthcare settings and providers (reach)

Three I's Framework Example: Quality of Life Issue

Preventing Abuse and Neglect

- Though the problem is under-studied, an estimated 1-2 million Americans age 65 or older have been injured, exploited or mistreated by a caregiver.
- **Impact**: Abuse and neglect are independent predictors for higher mortality. They are also associated with worsened functional status and progressive dependency, feelings of helplessness, stress, and further psychological decline.
- **Improvability**: Interventions are available in the form of caregiver support, caregiver trainings, awareness campaigns, and screening potential victims and/or abusers.
- **Inclusiveness**: Abuse and neglect are present in both community and institutional settings and affect all ethnic groups, genders, and SES levels.

Organizing Measures Across the Care Continuum

		Ambulatory Care	Acute Care	Long-Term Care	Behavioral Health
High-Leverage Opportunity A	Quality Issue 1	Measure or Gap	Measure or Gap	Measure or Gap	Measure or Gap
	Quality Issue 2	Measure or Gap	Measure or Gap	Measure or Gap	Measure or Gap
High-Leverage Opportunity B	Quality Issue 3	Measure or Gap	Measure or Gap	Measure or Gap	Measure or Gap
	Quality Issue 4	Measure or Gap	Measure or Gap	Measure or Gap	Measure or Gap

Organizing Measures Across the Care Continuum: Care Coordination Example

		Ambulatory Care	Acute Care	Long-Term Care	Behavioral Health
Care Coordination	Discharge planning	Measure Gap	NQF# 0649 – Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges to Ambulatory Care [Home/Self Care] or Home Health Care)	NQF# 0646 – Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	NQF# 0557 – HBIPS 6: Post Discharge Continuing Care Plan Created
	Communication Between Providers	*Measure or Gap*	*Measure or Gap*	*Measure or Gap*	*Measure or Gap*

Key Quality Issues by High-Leverage Opportunities: Quality of Life Opportunity Area

Shared Quality Issues

Pain management

Preventing abuse and neglect

Consumer and family engagement / experience of care

Younger Adults with Physical Disability	*Medically Complex Older Adults*
Meaningful involvement in community life	End-of-life / hospice care

Key Quality Issues by High-Leverage Opportunities: Care Coordination Opportunity Area

Shared Quality Issues

Care transitions / discharge planning

Avoidable admissions and readmissions / maintaining community living

Communication between providers

Communication between provider and beneficiary/caregiver/family, including shared decision-making

Cultural sensitivity / cultural competence

Medication management: access, appropriateness, reconciliation, adherence, reducing polypharmacy

Safety: infections such as UTI, pressure ulcers, falls

Key Quality Issues by High-Leverage Opportunities: Screening and Assessment Opportunity Area

Shared Quality Issues

Person-centered planning
Functional abilities including ADLs and IADLs (i.e., change in …, improvement, managing decline)
Nutrition
Preventive services and immunizations

Younger Adults with Physical Disability	*Medically Complex Older Adults*
Screening for and treatment of: cancer, cardio-metabolic disease, HIV and other sexually transmitted infections Weight management	Screening for malnutrition and dehydration Ability to self-manage

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Key Quality Issues by High-Leverage Opportunities: Mental Health and Substance Use Opportunity Area

Shared Quality Issues

Social relationships
Screening and treating depression and other severe mental illness
Substance Use, primarily alcohol and tobacco

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Key Quality Issues by High-Leverage Opportunities: Structural Measures Opportunity Area

Shared Quality Issues

Workforce adequacy, stability, and training

Provider access (primary care, specialty care, health home, dental care, vision care, DME, rehabilitation services)

Providers' linkages to community resources

Younger Adults with Physical Disability	*Medically Complex Older Adults*
Consumer choice of provider	
Self-direction of services and supports	
Provider site physical accessibility: ADA compliance, location, and adaptive technologies	
Provider access (habilitation services)	

Key Quality Issues by High-Leverage Opportunities: Other Issues

Shared Quality Issues

Over-utilization / cost

Caregiver support

Mortality

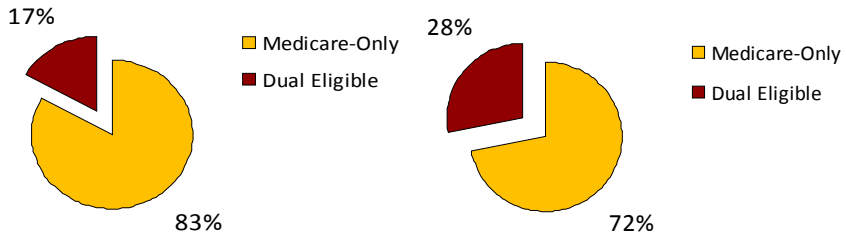
Younger Adults with Physical Disability	*Medically Complex Older Adults*
	Length of stay

Workgroup Discussion and Questions

NQF-Endorsed® Multiple Chronic Conditions Framework

Dual eligible beneficiaries comprise only 17% of the Medicare population but represent 28% of Medicare beneficiaries with 5 or more chronic conditions

SCAN *Data Brief* No. 2



Percent of Total Medicare Population (N=45 million)

Percent of Medicare Population with 5 or More Chronic Conditions (N=585,740)

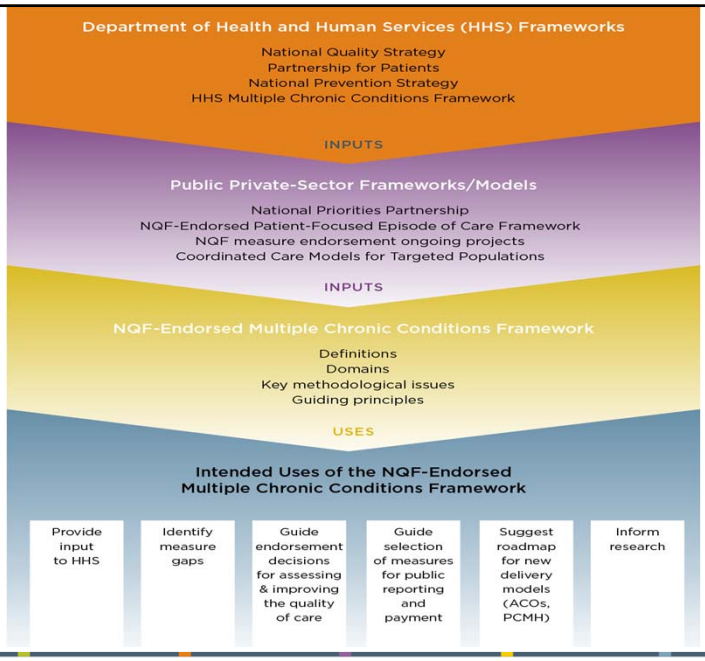
Purpose: Building a Framework for Multiple Chronic Conditions Measurement

This project seeks to achieve consensus through NQF's Consensus Development Process (CDP) on a measurement framework for assessing the efficiency of care—defined as quality and cost—provided to individuals with multiple chronic conditions (MCCs).

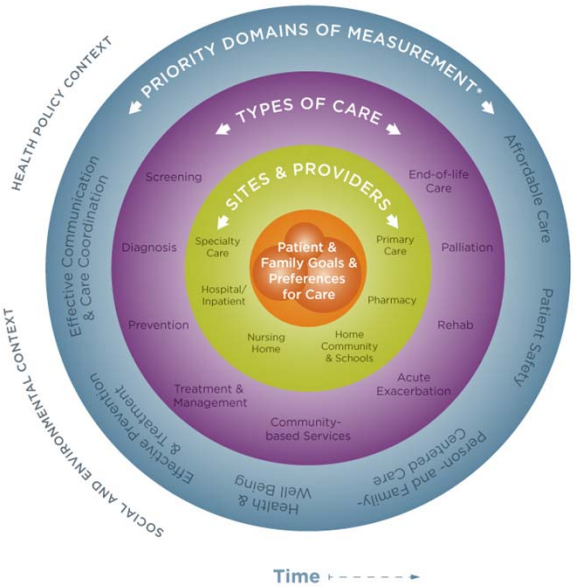
This project was funded by The Department of Health and Human Services

Scope

- Establish definitions, domains, and guiding principles that are instrumental for measuring and reporting the efficiency care for patients with MCCs;
- Adapt the NQF-endorsed Patient-focused Episodes of Care Measurement Framework for patients with MCCs;
- Build upon the National Quality Strategy, HHS's Multiple Chronic Conditions Framework and the work of other private sector initiatives; and
- Support the development and application of measures.



Conceptual Model for Measuring Care Provided to Individuals with MCCs



* Each priority domain of measurement may be addressed using several types of measures, including structure, process, outcome, efficiency, cost/resource use, and composite measures. The use of outcomes measures, when available, and process measures that are most closely linked to outcomes is preferable.

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Current Landscape of MCC Measurement

- Clinical practice guidelines are developed for and emphasize a single disease perspective; accordingly people with MCCs are not addressed by available quality measures.
- Uses of condition-specific performance measures for pay-for-performance programs, public reporting, or quality improvement may result in poor quality care and even harm to patients with MCCs, as well as provide misleading feedback for their physicians.

Definition of Multiple Chronic Conditions

Persons with multiple chronic conditions are defined as having two or more concurrent chronic conditions that collectively have an adverse effect on health status, function, or quality of life and that require complex healthcare management, decision-making, or coordination. [a,b]

[a] In the context of this definition, chronic conditions encompass a spectrum of disease and other clinical (e.g., obesity), behavioral (e.g., problem drinking), and developmental (e.g., learning disabilities) conditions. Additionally, the social context in which a person lives (e.g., homelessness) also is considered an important influencing factor.

[b] A complication associated with a primary diagnosis also would meet the requirement of two or more concurrent conditions (e.g., cystic fibrosis in children with an associated complication such as pancreatic insufficiency).

Definition of Multiple Chronic Conditions

Assessment of the quality of care[c] provided to the MCCs population should consider persons with two or more concurrent chronic conditions that require ongoing clinical, behavioral,[d] or developmental care from members of the healthcare team and act together to significantly increase the complexity of management and coordination of care—including but not limited to potential interactions between conditions and treatments.

Importantly, from an individual's perspective the presence of MCCs would:

- affect functional roles and health outcomes across the lifespan;
- compromise life expectancy; or
- hinder a person's ability to self-manage or a family or caregiver's capacity to assist in that individual's care.

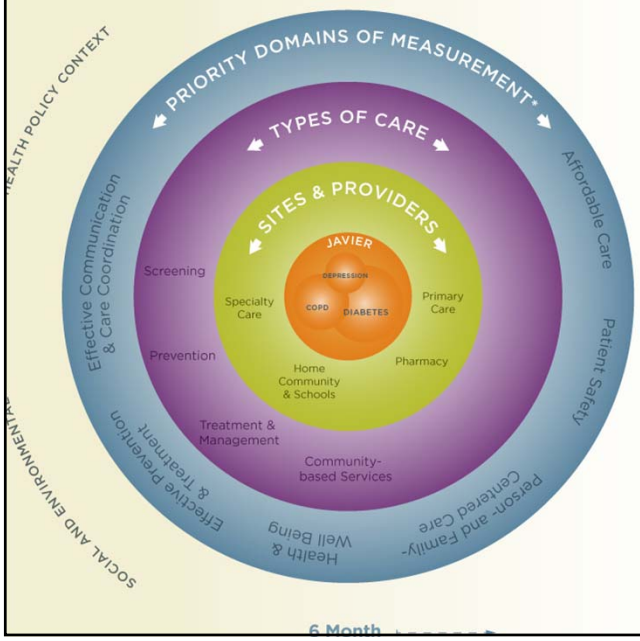
[c] Quality of care is defined by the Institute of Medicine (IOM) six aims: safe, timely, effective, efficient, equitable, and patient-centered.

[d] Behavioral includes mental health and substance use illness.

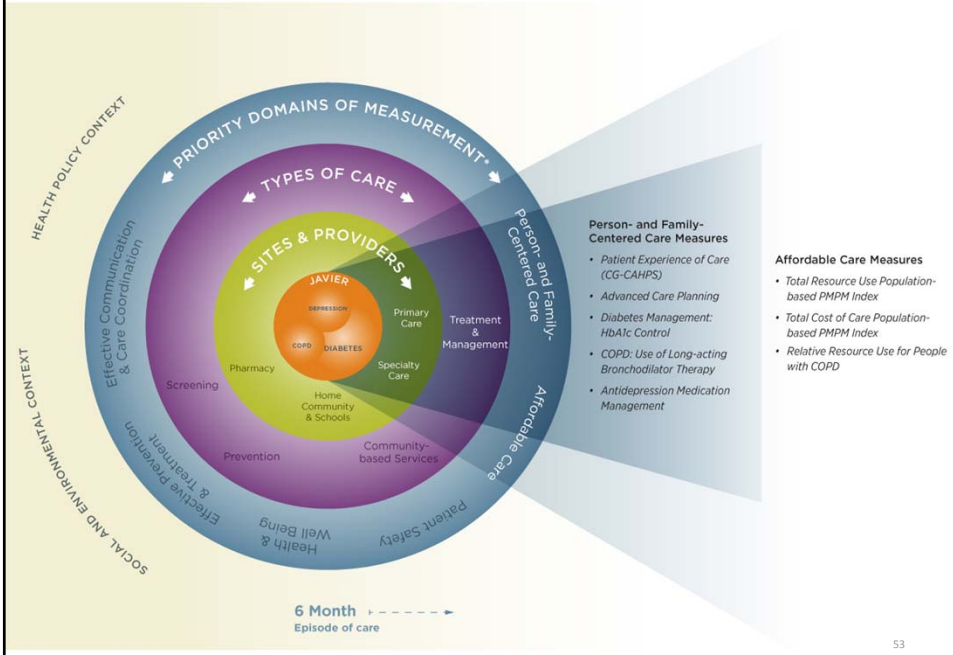
Key Measurement Priorities and Concepts

- Optimize function, maintain function, or preventing further decline in function
- Seamless transitions between multiple providers and sites of care
- Access to usual source of care
- Shared accountability across patients, families, and providers
- Patient important outcomes (includes patient-reported outcomes and relevant disease-specific outcomes)
- Avoiding inappropriate, non- beneficial care, including at the end of life
- Transparency of cost (total cost)
- Shared decision-making

Application of the MCC Conceptual Model to Javier as Case Study



Application of the MCC Conceptual Model to Javier: Measurement Opportunities



Guiding Principles for Measuring Care Provided to Individuals with MCCs

To evaluate the full spectrum of care for individuals with MCCs, measurement should:

1. Promote collaborative care among providers and across settings at all levels of the system,[a] while aligning across various public- and private-sector applications (e.g., public reporting, payment).

[a] The system includes, but is not limited to, individual patients, individual healthcare professionals, group practices, hospitals, health systems and other provider organizations, and health plans.

Guiding Principles for Measuring Care Provided to Individuals with MCCs

To evaluate the full spectrum of care for individuals with MCCs, measurement should:

2. Assess the quality of care[b] and incorporate several types of measures including cross-cutting,[c] condition-specific, structure,[d] process, outcomes, efficiency, cost/resource use, composites, behavioral,[e] and that address appropriateness of care.[f]

[b] Quality of care is defined by the IOM six aims: safe, timely, effective, efficient, equitable, and patient-centered.

[c] Cross-cutting measures apply to a variety of conditions at the same time or a single disease with multi-organ system ramifications (e.g., cystic fibrosis). Example measure concepts include: care coordination and integration, shared decision-making, medication reconciliation, functional status, health-related quality of life, and screening and assessment.

[d] Structural measures assess if essential infrastructure (e.g., team-based care, registries, EHRs) is in place to support integrated approaches to care management.

[e] Behavioral measures targeting major behavioral health risk factors such as obesity, smoking, alcohol and substance abuse, poor diet/nutrition, and physical inactivity.

[f] Appropriateness of care includes measures of overuse, underuse, and misuse, for example, measures that assess overuse of services such as imaging. Evidence-based guidelines for people with MCCs are not well developed in this area.

Guiding Principles for Measuring Care Provided to Individuals with MCCs

To evaluate the full spectrum of care for individuals with MCCs, measurement should:

3. Be prioritized based on the best available evidence of links to optimum outcomes and consider patient preferences jointly established through care planning.
4. Assess if a shared decision-making process was undertaken as part of initial and ongoing care planning and ultimately that the care provided was in concordance with patient preferences or, as appropriate, family or caregiver preferences on behalf of the patient.
5. Assess care longitudinally (i.e., provided over extended periods of time) and changes in care over time (i.e., delta measures of improvement or maintenance rather than attainment).

Guiding Principles for Measuring Care Provided to Individuals with MCCs

6. Be as inclusive as possible, as opposed to excluding individuals with MCCs from measure denominators. Where exclusions are appropriate, either existing measures should be modified or new measures developed.
7. Include methodological approaches, such as stratification, to illuminate and track disparities and other variances in care for individuals with MCCs. In addition to stratifying the MCC population in measurement (which is particularly important to understanding application of disease-specific measures to the MCC population), bases for stratification include disability, cognitive impairments, life expectancy, illness burden, dominant conditions, socioeconomic status, and race/ethnicity.

Guiding Principles for Measuring Care Provided to Individuals with MCCs

8. Use risk adjustment for comparability with caution, as risk adjustment may result in the unintended consequence of obscuring serious gaps in care for the MCC population. Risk adjustment should be applied only to outcomes measures and not process measures.
9. Capture inputs in a standardized fashion from multiple data sources, [g] particularly patient-reported data, to ensure key outcomes of care (e.g., functional status) are assessed and monitored over time.

[g] Data sources include, but are not limited to: claims, EHRs, PHRs, HIEs, registries, and patient-reported data.

Strategic Opportunities for Implementing the MCC Framework

Identifying and Filling Measure Gaps

- Key measure gaps persist across multiple populations (MCC, post-acute care, long-term care, dual-eligible beneficiaries)
  - Cross-cutting measures that incorporate patient-reported data
- Measures that address children with MCC
- Iterative processes needed to inform measurement approaches
  - Core elements of this framework should be considered in the development of clinical practice guidelines (CPGs) and measures
  - Need systematic capture of implementation experiences to improve framework, CPGs, measures, and to monitor for unintended consequences

Strategic Opportunities for Implementing the MCC Framework

Standardizing Data Collection, Measurement, and Reporting

- Common data platform to capture the multiple data sources necessary to comprehensively assess care
- Data platform that enables gathering of patient-reported information
- Standardized data elements
- HIT infrastructure that promotes use of PHRs and EHRs to transfer information is necessary
  - As HIT infrastructure is built, the complex needs of people with MCCs should be considered

Strategic Opportunities for Implementing the MCC Framework

Payment and Delivery System Reform

- Cultural shift for organizations operating in provider-centric models of care
- Accountable care organizations and medical homes are promising delivery systems for providing coordinated, integrated care to individuals with MCC
- Evidence-based benefit design
- Public reporting to ensure transparency and help inform choices of patients and their caregivers
- Payment incentives to address the underlying cost drivers for the MCC population

MCCs Project Partners and Staff

Co-Chairs:

Caroline S. Blaum, MCC Co-Chair
University of Michigan Health System – Institute of Gerontology

Barbara McCann, MCC Co-Chair
Interim HealthCare

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Tom Valuck, MD, JD
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Workgroup Discussion and Questions

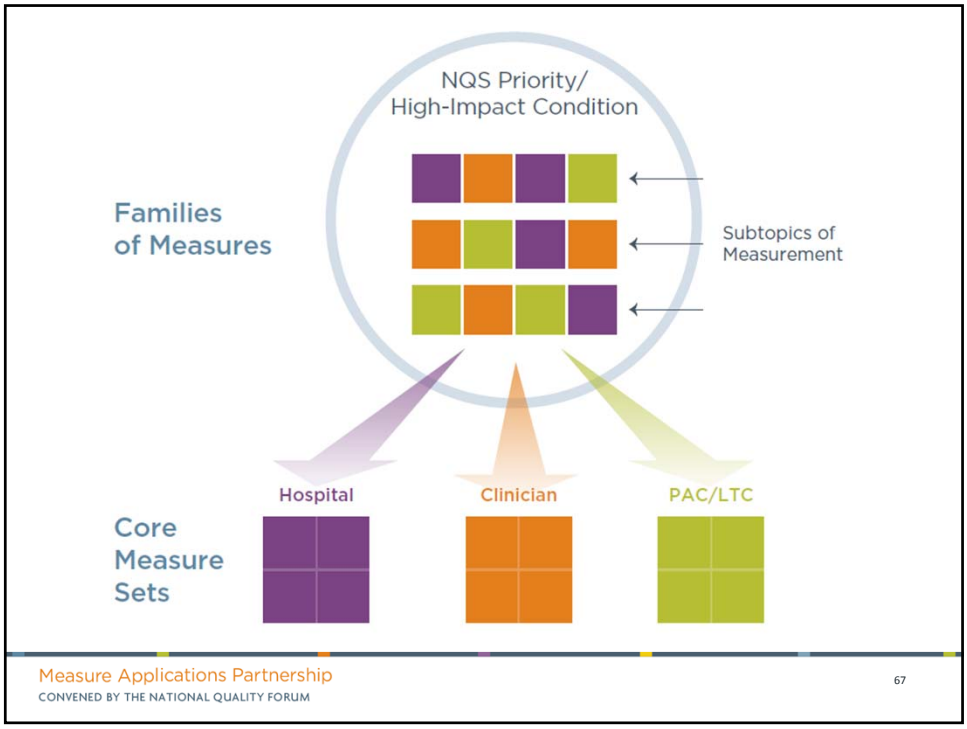
MAP Activities for 2012/2013

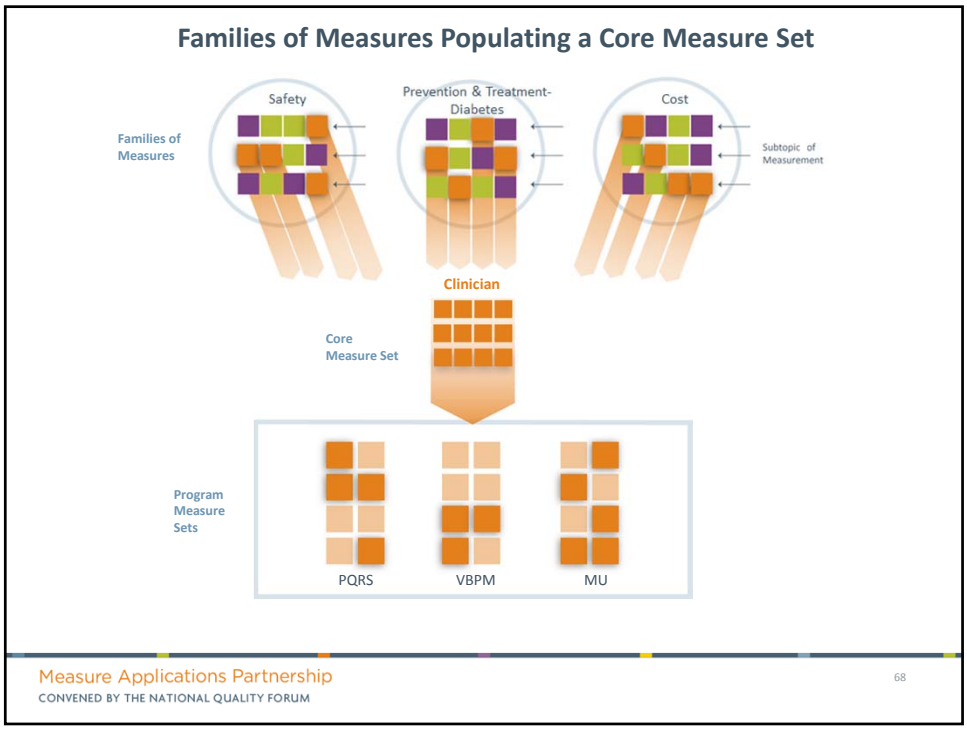
Related 2012 MAP Work

- MAP 3-year strategic plan for achieving aligned performance measurement that enables improvement, transparency, and value
- Families of measures for specific topics and core measure sets composed of available measures and gaps
  - Enhance existing two-tiered structure with topic-focused, time-limited task forces
- Pre-rulemaking input to HHS on measures under consideration for rulemaking
  - Expand decision-making support for activities

Families of Measures and Core Measure Sets

- Families of Measures and Core Measure Sets to Align Performance Measurement Across Federal Programs and Public and Private Payers and to encourage best use of available measures in specific HHS and private sector programs
  - Family of measures – "related available measures and measure gaps for specific topic areas that span programs, care settings, levels of analysis, and populations" (e.g., care coordination family of measures, diabetes care family of measures)
  - Core measure set – "available measures and gaps drawn from families of measures that should be applied to specified programs, care settings, levels of analysis, and populations" (e.g., care coordination family of measures, diabetes care family of measures)


NQS Priority/
High-Impact Condition
Families
of Measures
Subtopics of
Measurement
Hospital
Clinician
PAC/LTC
Core
Measure
Sets
Measure Applications Partnership
CONVENED BY THE NATIONAL QUALITY FORUM
67


Families of Measures Populating a Core Measure Set
Safety
Prevention & Treatment-
Diabetes
Cost
Families of
Measures
Subtopic of
Measurement
Clinician
Core
Measure Set
Program
Measure
Sets
PQRS
VBPM
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Measure Applications Partnership
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Approach to Developing Measure Families

1. Identify and Prioritize High-Leverage Opportunities for Measurement
2. Scan of Measures that Address the High-Leverage Opportunities
3. Define the Family for Each High-Leverage Measurement Opportunity
4. Establish Gap-Filling Pathways

Proposed Families of Measures

2012
- Patient Safety
- Care Coordination
- Cardiovascular Care
- Diabetes Care

2013
- Affordability
- Population Health
- Patient- and Family-Centered Care
- Mental Health

2014
- Revisit families as needed
- Additional high-impact conditions
- Other?

Measure Alignment Across Federal Programs: Input into MAP Pre-Rulemaking Deliberations

- Federal measurement programs have traditionally focused on a single setting or type of healthcare
- In order to expand the use of measures that are relevant to the dual eligible population's unique needs, those types of measures must be added to existing programs
- During Year 1 of Pre-rulemaking, MAP considered the implications and the types of measures that would be most responsive to the needs of the dual eligible population
- **In Year 2, the Workgroup will provide more targeted guidance to the setting-specific workgroups and Coordinating Committee regarding the potential inclusion of specific measures.**

Workgroup Discussion and Questions

Opportunity for Public Comment

Homework Assignment

Homework Instructions

- Worksheet and background information provided in meeting materials
- Exercise is based on the initial core set of measures from MAP's June 2012 report
- Most feedback on the core set has been positive, but some comments have included specific and well-reasoned suggestions for edits
- Purpose is to gather that detailed feedback to inform MAP's refinements to the core set
- Core set is used as an input to 2012 pre-rulemaking deliberations and will be a part of the continued focus on high-need subpopulations
- Please provide any commentary or stakeholder feedback regarding the real-world applicability and feasibility of the core measures
- Consider potential modifications (in addition to those already noted in Appendix G) as well as if any measures need to be added or removed from the set
- **Teamwork is encouraged. If you have not yet vetted the list with colleagues or your stakeholder network, now is the time!**

Example

NQF#9999	Measure Title	*Data for this HEDIS measure is captured on an annual basis and on a specific calendar cycle, which has implications for how soon and how frequently it can be reported.*

Click on measure number to access full specifications online via QPS

Provide information related to the feasibility of implementation of the measure, additional modifications not already suggested in June report, or other data MAP needs to consider. Use your own expertise or share what you've heard from other stakeholders.

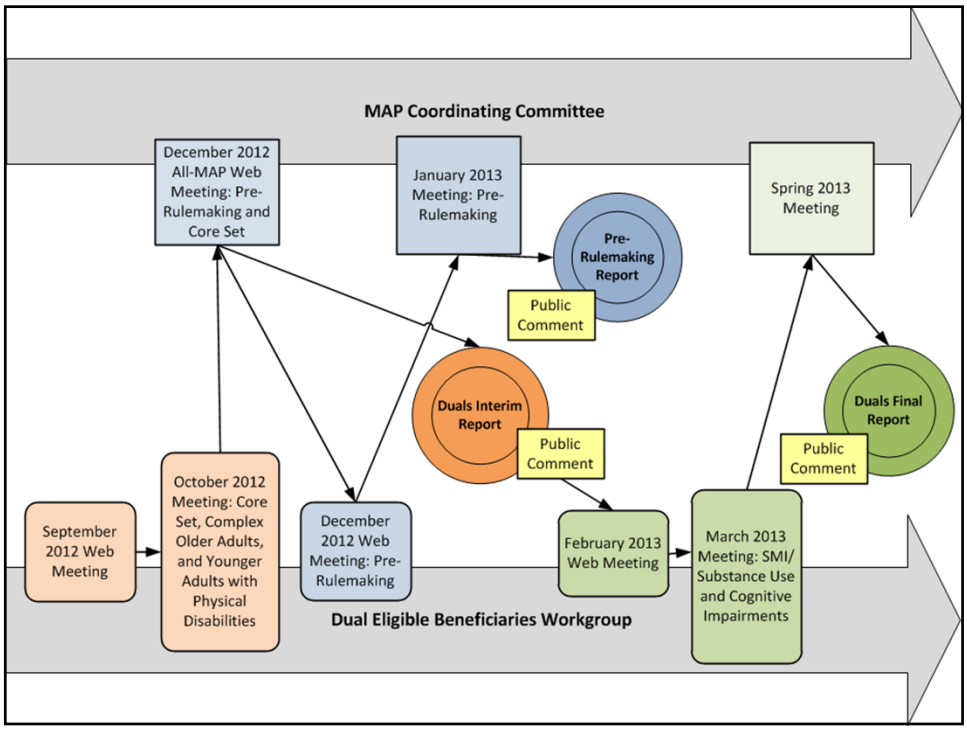
Homework is due to slash@qualityforum.org
next Wednesday, September 12

Questions?

Summary and Next Steps

October In-Person Meeting Objectives

- Consider experience of States and other stakeholders in applying core measure set and make updates
- Provide program-specific guidance to MAP workgroups and Coordinating Committee to inform pre-rulemaking
- Establish quality issues, measures, and measure gaps for subpopulation of medically complex older adults
- Establish quality issues, measures, and measure gaps for subpopulation of younger adults with physical disabilities



Important Future Dates

- Homework due to NQF Staff by Wednesday, September 12
- Next in-person meeting is October 11-12
  - Watch your email for a travel memo
  - Meeting materials will be made available through SharePoint
- **Save the Date for Pre-Rulemaking Activities**:
  - All-MAP Web Meeting to be held December 4 from 11:00 AM to 1:00 PM Eastern
  - Workgroup Web Meeting to be held December 19 from 3:00 PM to 5:00 PM Eastern

Thank You!

Measure Applications Partnership
Dual Eligible Beneficiaries Workgroup Charge for 2012/2013

Purpose

The charge of the Measure Applications Partnership (MAP) Dual Eligible Beneficiaries Workgroup is to advise the MAP Coordinating Committee on performance measures to assess and improve the quality of care delivered to Medicare/Medicaid dual eligible beneficiaries. In its first year, the Workgroup identified opportunities to promote significant improvement in quality through measurement. MAP developed a multi-component measurement framework, an initial core set of quality measures, and in-depth input on measurement gaps and potential applications of measures. For its second year, the Workgroup will continue its work by analyzing special measurement considerations for the care of high-need, high-cost subgroups of dual eligible beneficiaries. MAP will examine measures and measurement issues across the continuum of care, to include primary and acute care, behavioral health, and long-term services and supports.

Through the two-tiered MAP structure, the Workgroup will not give input directly to HHS; rather, the Workgroup will advise the Coordinating Committee. The scope of this input will include the analysis of high-need subgroups, described above, as well as cross-cutting issues before the MAP Coordinating Committee. The Workgroup will continue to be guided by the MAP Strategic Plan, including maintaining alignment with the HHS National Quality Strategy, families of measures, and the MAP Measure Selection Criteria.

The activities and deliverables of the MAP Dual Eligible Beneficiaries Workgroup do not fall under NQF's formal consensus development process (CDP).

Tasks

The Dual Eligible Beneficiaries Workgroup will provide input to the Coordinating Committee through the following tasks:

1. Identify opportunities to improve measurement specific to the population of dual eligible beneficiaries, with specific consideration to the five high-leverage subject areas previously identified.
2. Determine the most suitable performance measures currently available for dual eligible beneficiaries, concentrating on high-need subgroups to include:
    a. Older adults with functional limitations and chronic conditions
    b. Adults younger than 65 with physical disabilities
    c. Individuals with serious mental illness
    d. Individuals with cognitive impairment
3. Document potential strategies to address measurement limitations.
4. Delineate specific gaps in available measures to inform future measurement development and analyze whether sufficient evidence exists to pursue measure development in the identified gap areas.

5. Advise the Coordinating Committee on cross-cutting measurement issues with implications for dual eligible beneficiaries and ensure alignment. These include MAP's strategic plan, families of measures, and pre-rulemaking input.

Timeframe

This work will begin in June 2012. An interim report on measures for high-need older adults and pre-rulemaking guidance is due to HHS on December 28, 2012. A final report on measures for high-need subgroups, including individuals with cognitive impairment and individuals with serious mental illness, is due to HHS on July 1, 2013.

Membership

The 2012/2013 MAP Dual Eligible Beneficiaries Workgroup roster is available on the NQF website.

The terms of MAP members are for three years. The initial members serve staggered terms, determined by random draw at the first in-person meeting. MAP workgroups are convened as needed, thus a Workgroup may be dissolved after the completion of the initial timeframe.

ROSTER FOR THE MAP DUAL ELIGIBLE BENEFICIARIES WORKGROUP

CHAIR (VOTING)
Alice Lind, MPH, BSN

ORGANIZATIONAL MEMBERS (VOTING)	REPRESENTATIVE
American Association on Intellectual and Developmental Disabilities	Margaret Nygren, EdD
American Federation of State, County and Municipal Employees	Sally Tyler, MPA
American Geriatrics Society	Jennie Chin Hansen, RN, MS, FAAN
American Medical Directors Association	David Polakoff, MD, MsC
Center for Medicare Advocacy	Alfred J. Chiplin, JD, M.Div.
Consortium for Citizens with Disabilities	E. Clarke Ross, DPA
Humana, Inc.	Thomas James, III, MD
L.A. Care Health Plan	Laura Linebach, RN, BSN, MBA
National Association of Public Hospitals and Health Systems	Steven Counsell, MD
National Association of Social Workers	Joan Levy Zlotnik, PhD, ACSW
National Health Law Program	Leonardo Cuello, JD
National PACE Association	Adam Burrows, MD
SNP Alliance	Richard Bringewatt

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

FEDERAL GOVERNMENT MEMBERS (NON-VOTING, EX OFFICIO)	REPRESENTATIVE
Agency for Healthcare Research and Quality	D.E.B. Potter, MS
CMS Federal Coordinated Healthcare Office	Cheryl Powell
Health Resources and Services Administration	Samantha Meklir, MPP
Administration for Community Living	Henry Claypool
Substance Abuse and Mental Health Services Administration	Frances Cotter, MA, MPH
Veterans Health Administration	Daniel Kivlahan, PhD

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

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.

CENTER FOR MEDICARE ADVOCACY

Alfred Chiplin, JD, M.Div.

Alfred J. Chiplin, Jr., Esq. is a Senior Policy Attorney with the Center for Medicare Advocacy, Inc. in its Washington, DC office. His practice is devoted primarily to health care matters, with a concentration on Medicare and managed care coverage and appeal issues. He is also a specialist in legal assistance development and services under the Older Americans Act. Mr. Chiplin served as a consulting attorney with the Consumer Coalition for Quality Health Care and, for over 10 years, as a staff attorney for the National Senior Citizens Law Center, where he focused on the Medicare program and on developments in managed care. He also coordinated Older Americans Act programs for the National Senior Citizens Law Center, including planning and developing the annual Joint Conference on Law and Aging (JCLA). He currently serves on the planning committee for the annual National Aging and Law Conference. Mr. Chiplin is the immediate past chair of the Public Advisory Group (PAG) of the Joint Commission on Accreditation of health care Organizations (JCAHO). Along with Judith A. Stein, Mr. Chiplin is co-editor-in-chief of the Medicare Handbook (Aspen Publishers, Inc., updated annually). Mr. Chiplin received his J.D. degree from the George Washington University and his M. Div. from Harvard University. He is a Fellow of the National Academy of Elder Law Attorneys and a former member of its board of directors, including its executive committee. He is also a member of the National Academy of Social Insurance (NASI), and served on its "Medicare and Markets" study panel.

CONSORTIUM FOR CITIZENS WITH DISABILITIES

E. Clarke Ross, DPA

Clarke has worked 40 years with six national mental health and disability organizations. He currently is the policy associate for the American Association on Health and Disability (AAHD) and is the 2011-2012 Chair of the “Friends of NCBDDD” (National Center on Birth Defects and Developmental Disabilities) at CDC (Centers for Disease Control and Prevention) Advocacy Coalition, having previously served as the Friends chair. He is a member of the SAMHSA Wellness Campaign Steering Committee. Clarke represents the Consortium for Citizens with Disabilities (CCD) on the NQF MAP work group on persons dually eligible for Medicare and Medicaid. His work history includes Chief Executive Officer of CHADD – Children and Adults with Attention-Deficit/Hyperactivity Disorder; Deputy Executive Director for Public Policy, NAMI – National Alliance on Mental Illness; Executive Director, American Managed Behavioral Healthcare Association (AMBHA); Assistant Executive Director for Federal Relations and then Deputy Executive Director, National Association of State Mental Health Program Directors (NASMHPD); and Director of Governmental Activities, UCPA – United Cerebral Palsy Associations (UCPA). His doctorate is in public administration (D.P.A.) from The George Washington University, class of 1981. He is the father of a 21-year-old son with special challenges.

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 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.

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.

SNP ALLIANCE

Richard Bringewatt

Richard J. Bringewatt is President of the National Health Policy Group and Chair of the Special Needs Plan Alliance, an initiative of the NHPG. The SNP Alliance is an invitation-only national leadership group developed to advance specialized managed care programs for high-risk/high-need persons, particularly for persons dually eligible for Medicare and Medicaid. Founding membership of the SNP Alliance included plans involved in national integration demonstrations prior to transitioning to SNP status. Prior to his current position, Mr. Bringewatt was co-founder and President and CEO of the National Chronic Care Consortium. The NCCC was an invitation-only national leadership organization established to design and implement new methods for integrating primary, acute and long-term care among leading health and long-term care systems. During that time, Mr. Bringewatt also provided consultation to many of the early state integration programs, including the Minnesota Senior Health Options program. Over the years, Mr. Bringewatt also has developed and lead national leadership groups, workshops and conferences; developed and advanced legislation; provided legislative testimony to state and federal governments; worked with state and local governments; published articles on a wide range of issues related to integration and specialized managed care; developed materials, tools, models, and products for integration and specialized managed care; crafted and managed new programs, and provided consultation to a broad spectrum of organizations on improving care for high-risk/high-need persons. Mr. Bringewatt has a Master Degree in Social Work with certification in gerontology from the University of Michigan.

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.

DISABILITY

Anne Cohen, MPH

Anne Cohen, has over fifteen years experience in the disability field. She has served on state and federal advisory committees that address disability issues including the Agency for Healthcare Research and Quality (AHRQ)'s technical panel for the development of CAHPS for People with Mobility Impairments and the California Health Care Foundation's (CHCF) development of Medicaid Health Plan Performance Standards and Measures for People with Disabilities and Chronic Conditions. She founded Disability Health Access, LLC, in 2005, advising healthcare organizations on how to improve services for seniors and people with disabilities. Among her projects she collaborated with Dr. Sue Palsbo, on the development of disability targeted health plan quality measures. In 2012, Anne also began collaborating with Harbage Consulting, a health policy-consulting firm, with expertise in public programs and delivery system reform. Through her work with Harbage she has advised the State of California on implementing integration of Dual eligible individuals. Before forming Disability Health Access, Ms. Cohen was a disability manager at Inland Empire Health Plan, a non-profit Medicaid Health Plan in Southern California. At IEHP, she developed community outreach strategies and coordinated service delivery enhancements to improve care. Her accomplishments included implementing a national model health education curriculum and facilitating strategic research partnerships aimed at utilizing available data to better understand and manage members' care. Ms. Cohen has a Master of Public Health degree in Health Policy and Administration, and a Bachelor of Science degree in Social Science from Portland State University, Portland, Oregon.

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.

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.

CMS FEDERAL COORDINATED HEALTHCARE 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 Meklir, MPP

Samantha 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).

ADMINISTRATION FOR COMMUNITY LIVING

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)

Frances Cotter, MA, MPH

Bio not provided at this time.

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.

Laura Miller, FACHE

Interim President and CEO

Laura Miller is the senior vice president and chief operating officer at the National Quality Forum (NQF). Ms. Miller provides leadership in formulating NQF's operations and policies, oversees organization programs, and assists in identifying new initiatives and opportunities for NQF. She has more than 25 years of experience working in healthcare operations. As deputy undersecretary for health for operations and management at the U.S. Department of Veterans Affairs, Ms. Miller was the chief operating officer for the VA healthcare system and directed all VA healthcare facilities. She achieved significant improvements in patient safety and quality that resulted in the Veterans Health Administration achieving the highest levels in 18 national measures of care quality. Before joining NQF, Ms. Miller served as the interim and founding executive director of the National eHealth Collaborative, an organization to advance the interoperability of health information technology, where she established the board of directors, bylaws, strategic plan, and operational plans for the new organization. Ms. Miller was honored twice with the Presidential Rank Award, including the Distinguished Rank Award, the highest civilian honor. Ms. Miller received masters of public administration and Bachelor of Arts degrees from the University of Missouri. She is a fellow of the American College of Healthcare Executives.

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.

Constance Hwang, MD, MPH

Constance W. Hwang is vice president of the Measure Applications Partnership (MAP), which is responsible for providing input to the Department of Health and Human Services on the selection of performance measures for public reporting and performance-based payment programs. Dr. Hwang is a board-certified general internist, and prior to joining NQF, was the Director of Clinical Affairs and Analytics at Resolution Health, Inc (RHI). RHI is a wholly-owned subsidiary of WellPoint Inc., providing

data-driven disease management interventions aimed at both patients and providers to improve quality of care and cost efficiency. At RHI, Dr. Hwang managed an analytics team that developed and implemented clinical algorithms and predictive models describing individual health plan members, their overall health status, and potential areas for quality and safety improvement. Dr. Hwang has served as clinical lead for physician quality measurement initiatives, including provider recognition and pay-for-performance programs. She has experience designing and programming technical specifications for quality measures, and represented RHI as a measure developer during NQF's clinically-enriched claims-based ambulatory care measure submission process. Nominated to two different NQF committees, Dr. Hwang has participated in both NQF's measure harmonization steering committee, which addressed challenges of unintended variation in technical specifications across NQF-endorsed quality measures, and the NQF technical advisory panel for resource use measures regarding cardiovascular and diabetes care. Dr. Hwang is a former Robert Wood Johnson Clinical Scholar at Johns Hopkins and received her Master of Public Health as a Sommer Scholar from the Johns Hopkins Bloomberg School of Public Health. She completed her internal medicine residency at Thomas Jefferson University Hospital in Philadelphia, and received her medical degree from Mount Sinai School of Medicine in New York.

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).

Amaru Sanchez, MPH

Amaru J. Sanchez, MPH, is a Project Analyst at the National Quality Forum (NQF), a private, nonprofit membership organization created to develop and implement a national strategy for healthcare quality measurement and reporting. Mr. Sanchez is currently supporting the work of the NQF Measure Applications Partnership, established to provide multi-stakeholder input to the Department of Health and Human Services on the selection of performance measures for public reporting and payment reform programs. Prior to joining NQF, Mr. Sanchez served as a Health Policy Research Analyst for the bicameral Public Health Committee at the Massachusetts Legislature. At the legislature, Mr. Sanchez influenced the passage of several novel public health and healthcare related laws as well as drafted legislative proposals relative to medical debt, chronic disease management, health disparities and health care transparency. Mr. Sanchez is a graduate of the Boston University School of Public Health (MPH, Social Behavioral Sciences/Health Policy and Management) and the University of Florida (BS, Integrative Biology).

Megan Duevel Anderson, MS

Megan Duevel Anderson is a Project Analyst at the National Quality Forum (NQF). Ms. Duevel Anderson contributes to the Dual Eligible Workgroup, Cardiovascular and Diabetes Task Force, and Data Analytics Team of the Measure Applications Partnership (MAP). Ms. Duevel Anderson comes from the US Army Bavaria Medical Department Command where she was the Joint Commission and Performance Improvement Officer; responsible for accreditation and quality management of US Army outpatient clinics. Her post-graduate fellowship was completed at the Veteran's Administration National Center for Patient Safety Field Office; with research in Patient Safety in Women's Health and Measurement in developing countries. Ms. Duevel Anderson has a Bachelor of Arts from Gustavus Adolphus College in Minnesota and a Master's of Science from The Dartmouth Institute for Health Policy and Clinical Practice Research.

Y. Alexandra Ogungbemi

Alexandra Ogungbemi, BS, is an Administrative Assistant in Strategic Partnerships, at the National Quality Forum (NQF). Ms. Ogungbemi contributes to the Clinician, Dual Eligible Beneficiaries, and Post-Acute Care/Long-Term Care Workgroups, as well as the Cardiovascular and Diabetes Task Force of the Measure Applications Partnership (MAP). Post-graduation, she spent 2 years managing the Administrative side of Cignet Healthcare, a multi-specialty physician's practice in Southern Maryland, before joining NQF. Ms. Ogungbemi has a Bachelor of Science in Health Services Administration from The Ohio University.