NATIONAL QUALITY FORUM

Public Agenda

Measure Applications Partnership

Dual Eligible Beneficiaries Workgroup In-Person Meeting

October 11-12, 2012

NQF Conference Center at 1030 15th Street NW, 9th Floor, Washington, DC 20005

Remote Participation Instructions:

Streaming Audio Online

- Direct your web browser to: http://nqf.commpartners.com
- Under "Enter a meeting" type in the meeting number for Day 1: **613003** or for Day 2: **708535**
- In the "Display Name" field, type in your first and last name and click "Enter Meeting"

Teleconference

- Dial (877) 303-9138 and use conference ID code for Day 1: **28897982** and for Day 2: **28922722** to access the audio platform.

Meeting Objectives:

- Update MAP's core measure set for dual eligible beneficiaries in the context of newly available measures and the experience of stakeholders in applying the set
- Use core measures to provide pre-rulemaking input to MAP workgroups and consider program-specific measurement opportunities
- Discuss States' application of core set to demonstration programs and develop targeted guidance
- Establish quality issues, measures, and measure gaps for high-need subpopulations of medically complex older adults and adults 18-65 with physical disabilities
- Explore targeted activities to fill measure gaps

Day 1: October 11, 2012

9:00 am **Welcome, Review of Meeting Objectives, and Disclosures of Interest**

Alice Lind, Workgroup Chair

9:30 am **Review and Edit MAP's Dual Eligible Beneficiaries Core Measure Set**

Alice Lind, NQF Staff, and Workgroup Members

- Relationship to families of measures
- Web meeting homework results
- Measures newly endorsed

- Workgroup discussion

11:00 am **Pre-Rulemaking Input Part 1: Using Core to Inform Guidance and PAC/LTC Program Example**

Allen Leavens, Senior Director, National Quality Forum

Joan Levy Zlotnik, PAC/LTC Workgroup Liaison for Pre-Rulemaking

- Uptake of prior recommendations
- Focus on ESRD program and measures for potential stratification
- Workgroup discussion
- Opportunity for public comment

12:00 pm **Lunch on Your Own**

12:30 pm **Pre-Rulemaking Input Part 2: Hospital and Clinician Program Examples**

Jim Dunford, Hospital Workgroup Liaison for Pre-Rulemaking

Clinician Workgroup Liaison for Pre-Rulemaking

- Focus on IQR and VBP programs and measures for potential inclusion in value-based purchasing
- Focus on clinician programs and increasing the likelihood of reporting relevant measures
- Workgroup discussion
- Opportunity for public comment

1:30 pm **State Experience Applying MAP Duals Core Measures in Context of Demonstration Programs**

Alice Lind

Jane Ogle, Deputy Director, Health Care Delivery Systems, California Department of Health Care Services

Neal Kohatsu, Medical Director, California Department of Health Care Services

- California's demonstration program planning experience
- Analyze measures proposed for use
- Provide guidance on this application of MAP's recommended measures
- Opportunity for public comment

3:15 pm **Break**

3:30 pm **Data-Related Feasibility of Implementing Core Measures**

Cheryl Powell, Centers for Medicare and Medicaid Services

Sharon Donovan, Centers for Medicare and Medicaid Services

Mady Chalk, Subject Matter Expert: Substance Use

- Medicare-Medicaid linked data set
- Barriers and opportunities in behavioral health confidentiality
- Workgroup discussion

4:00 pm **Review List of Quality Issues for High-Need Subpopulations**

Sarah Lash, Senior Program Director, NQF

- Workgroup discussion
- Opportunity for public comment

5:00 pm **Summarize Progress and Adjourn for the Day**

Day 2: October 12, 2012

9:00 am **Confirm Previous Day's Recommendations on Core Measure Set**

Alice Lind, Workgroup Chair

10:00 am **Specialized Measures for Medically Complex Older Adults and Adults 18-65 with Physical Disabilities**

Alice Lind, NQF Staff, and Workgroup Members

- Discuss contextual issues and assumptions
- Review and refine draft matrices of measures and gaps
- Opportunity for public comment

12:30 pm **Lunch on Your Own**

1:00 pm **Small Group Activity: Gap-Filling Pathways**

- Confirm prioritization of gaps
- Expand on ideas for gap-filling measures

1:45 pm **Report Out from Small Group Activity**

2:30 pm **Break**

2:45 pm **Measure Gap-Filling Opportunities: Experience of Care Survey Tool for Community-Based Long-Term Supports and Services (LTSS)**

Anita Yuskauskas, Technical Director for HCBS Quality, Centers for Medicare and Medicaid Services

Sara Galantowicz, MPH, Research Manager, Truven Health Analytics

Elizabeth Frentzel, MPH, Senior Research Scientist, American Institutes for Research (AIR)

DEB Potter, Agency for Healthcare Research and Quality

- CMS goals under Demonstration Grant for Testing Experience and Functional Assessment Tools (TEFT)
- Development and testing of HCBS Consumer Experience Survey
- Workgroup discussion

3:45 pm **Measure Gap-Filling Opportunities: Prior Development of Quality Measures for People with Disabilities**

Margaret Mastal, RN, PhD

Sue Palsbo, PhD

Anne Cohen, Subject Matter Expert: Disability

- Measure stewardship opportunity
- Workgroup discussion
- Opportunity for public comment

4:15 pm **Wrap Up**

Alice Lind

- Confirm outline and themes for Interim Report
- Next steps

4:45 pm **Adjourn**

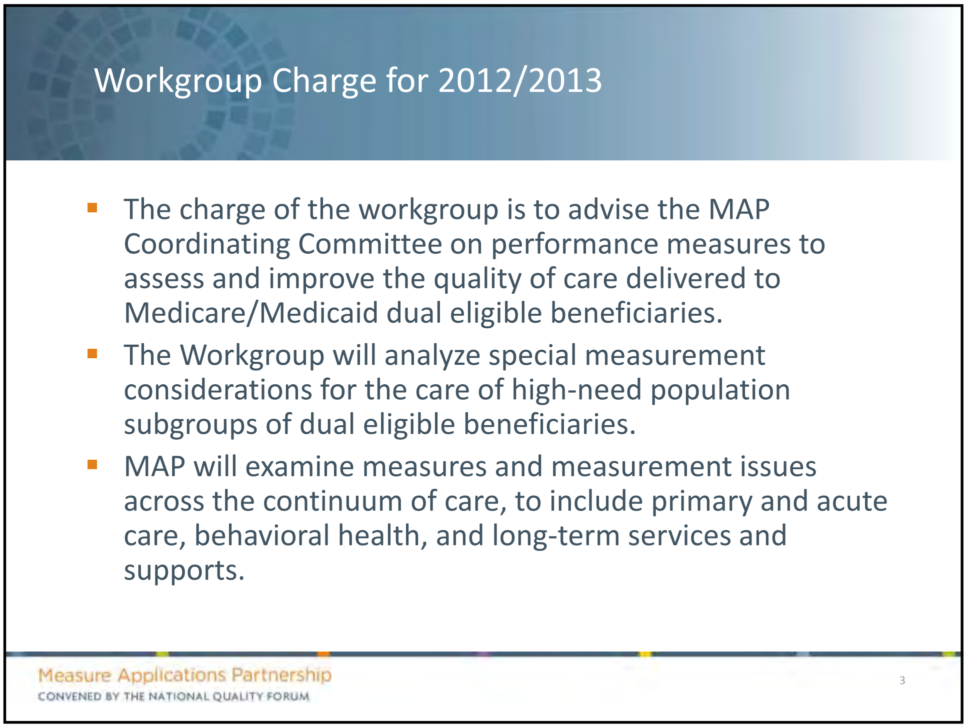
Measure Applications Partnership

Dual Eligible Beneficiaries Workgroup In-Person Meeting

October 11-12, 2012

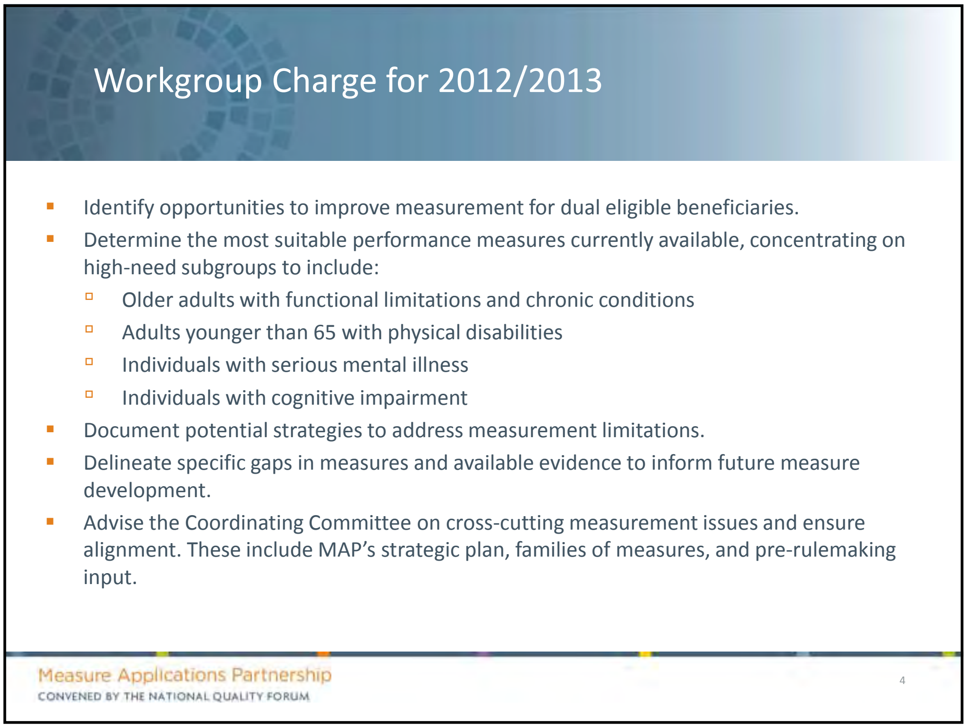
NATIONAL QUALITY FORUM

Welcome



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.



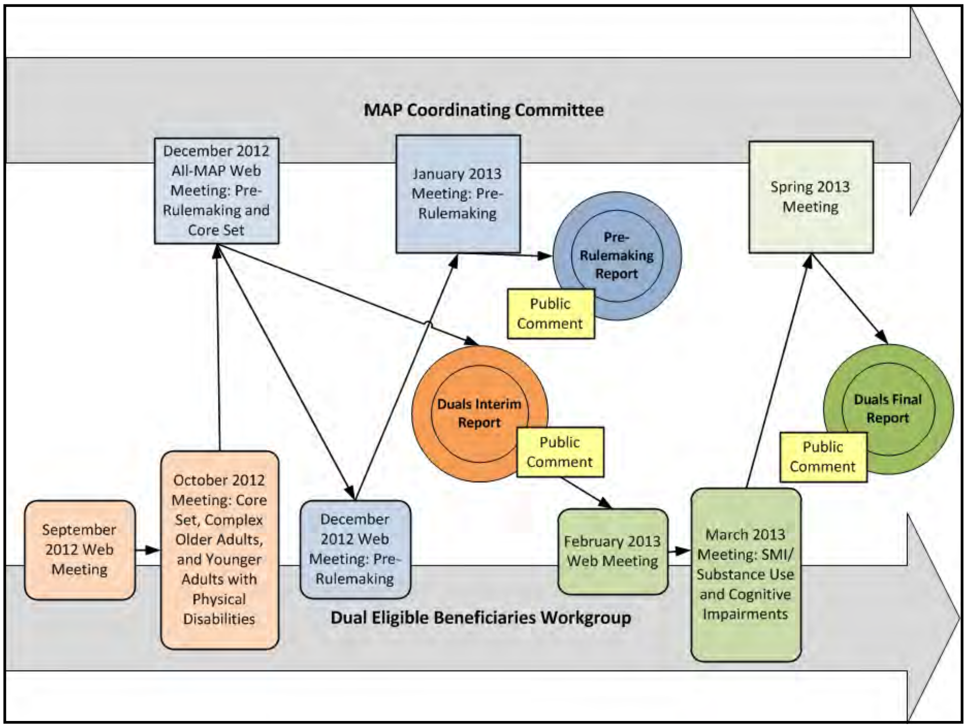
Workgroup Charge for 2012/2013

- 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.

Past and Future Milestones

- **Year 1**
  - 4 In-Person Meetings
  - 3 Web Meetings
  - Interim Report (October 2011)
  - First Round of MAP's Pre-Rulemaking Input (February 2012)
  - Final Report including Core Measure Set (June 2012)
- **Year 2**
  - 2 In-Person Meetings
  - 3-4 Web Meetings
  - Interim Report (December 2012)
  - Second Round of MAP's Pre-Rulemaking Input (February 2013)
  - Final Report with focus on high-need subpopulations (July 2013)

Remarks from CMS' Federal Coordinated Healthcare Office



MAP Coordinating Committee

December 2012 All-MAP Web Meeting: Pre-Rulemaking and Core Set

January 2013 Meeting: Pre-Rulemaking

Pre-Rulemaking Report

Public Comment

Spring 2013 Meeting

Duals Interim Report

Public Comment

Duals Final Report

Public Comment

September 2012 Web Meeting

October 2012 Meeting: Core Set, Complex Older Adults, and Younger Adults with Physical Disabilities

December 2012 Web Meeting: Pre-Rulemaking

February 2013 Web Meeting

March 2013 Meeting: SMI/ Substance Use and Cognitive Impairments

Dual Eligible Beneficiaries Workgroup

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

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

Pre-Rulemaking Input

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

Meeting Objectives

- Update MAP's core measure set for dual eligible beneficiaries in the context of newly available measures and the experience of stakeholders in applying the set
- Use core measures to provide pre-rulemaking input to MAP workgroups and consider program-specific measurement opportunities
- Discuss States' application of core set to demonstration programs and develop targeted guidance
- Establish quality issues, measures, and measure gaps for high-need subpopulations of medically complex older adults and adults 18-65 with physical disabilities
- Explore targeted activities to fill measure gaps

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

Disclosures of Interest

Day 1 Agenda

- Review and Edit MAP's Dual Eligible Beneficiaries Core Measure Set
- Pre-Rulemaking Input: Using Core to Inform Guidance and PAC/LTC Program Example
- Pre-Rulemaking Input: Hospital and Clinician Program Examples
- State Experience Applying MAP Duals Core Measures in Context of Demonstration Programs
- Data-Related Feasibility of Implementing Core Measures
- Review List of Quality Issues for High-Need Subpopulations

Review and Edit MAP's Dual Eligible Beneficiaries Core Measure Set

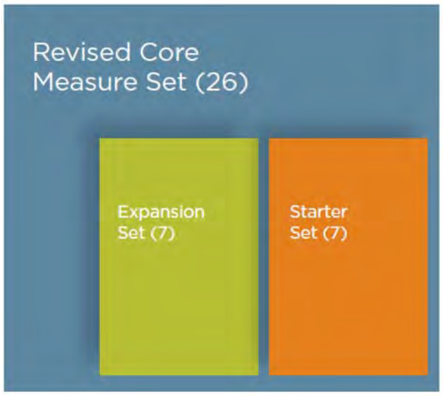
Revising the Core Measure Set

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.

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

High-Leverage Opportunity Area	Measures
Quality of Life	• Family Evaluation of Hospice Care (0208) • Comfortable Dying: Pain Brought to a Comfortable Level Within 48 Hours of Initial Assessment (0209) • Consumer Assessment of Healthcare Providers and Systems (CAHPS) Surveys (0005, 0006, 0007, 0008, 0009, 0258, 0517)
Care Coordination	• Medication Reconciliation (0097) • 3-Item Care Transition Measure (0228) • HBIPS-6 Post Discharge Continuing Care Plan Created (0557) • HBIPS-7 Post Discharge Continuing Care Plan Transmitted to Next Level of Care Provider Upon Discharge (0558) • Transition Record with Specified Elements Received by Discharged Patients (0647) • Timely Transmission of Transition Record (0648) • Plan All-Cause Readmissions (1768) • Hospital-Wide All-Cause Unplanned Readmissions (1789)

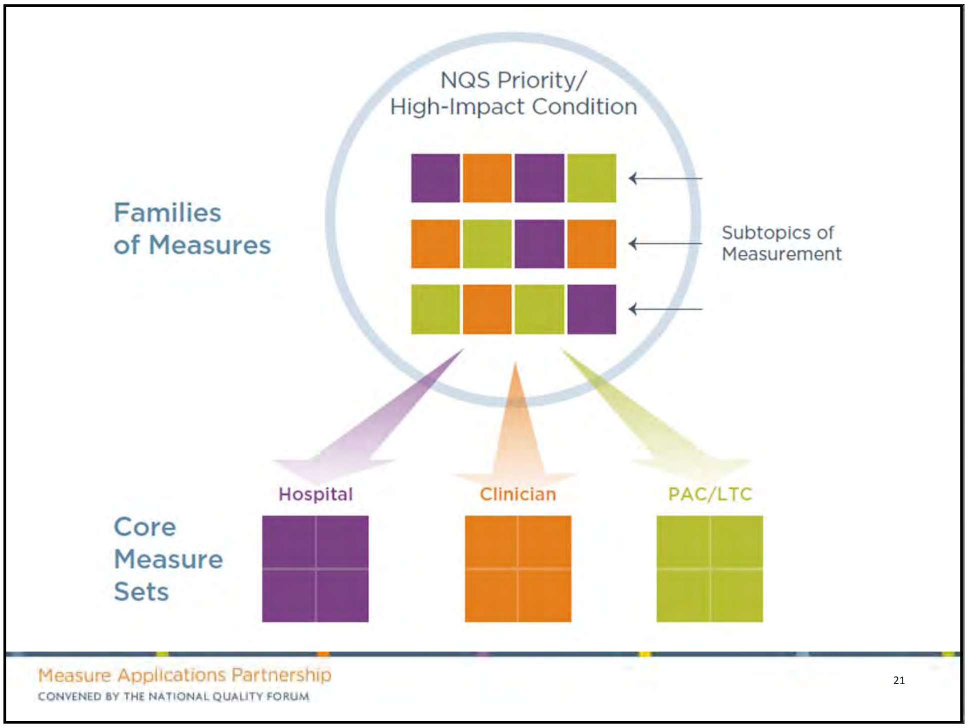
High-Leverage Opportunity Area	Measures
Screening and Assessment	• Use of High-Risk Medications in the Elderly (0022) • Screening for Fall Risk (0101) • Assessment of Health-related Quality of Life (Physical and Mental Functioning) (0260) • Adult Weight Screening and Follow-Up (0421) • Change in Daily Activity Function as Measured by the AM-PAC (0430) • Pain Assessment Conducted (0523) • Optimal Diabetes Care (0729)
Mental Health and Substance Use	• Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (0004) • Tobacco Use Assessment and Tobacco Cessation Intervention (0028) • Screening for Clinical Depression (0418) • Follow-Up After Hospitalization for Mental Illness (0576) • Alcohol Misuse: Screening, Brief Intervention, Referral for Treatment (not endorsed)
Structural Measures	• Medical Home System Survey (1909) • SNP 6: Coordination of Medicare and Medicaid Coverage (not endorsed) • The Ability to Use Health Information Technology to Perform Care Management at the Point of Care (endorsement removed)

Prioritized Measure Gaps for Future Development

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

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

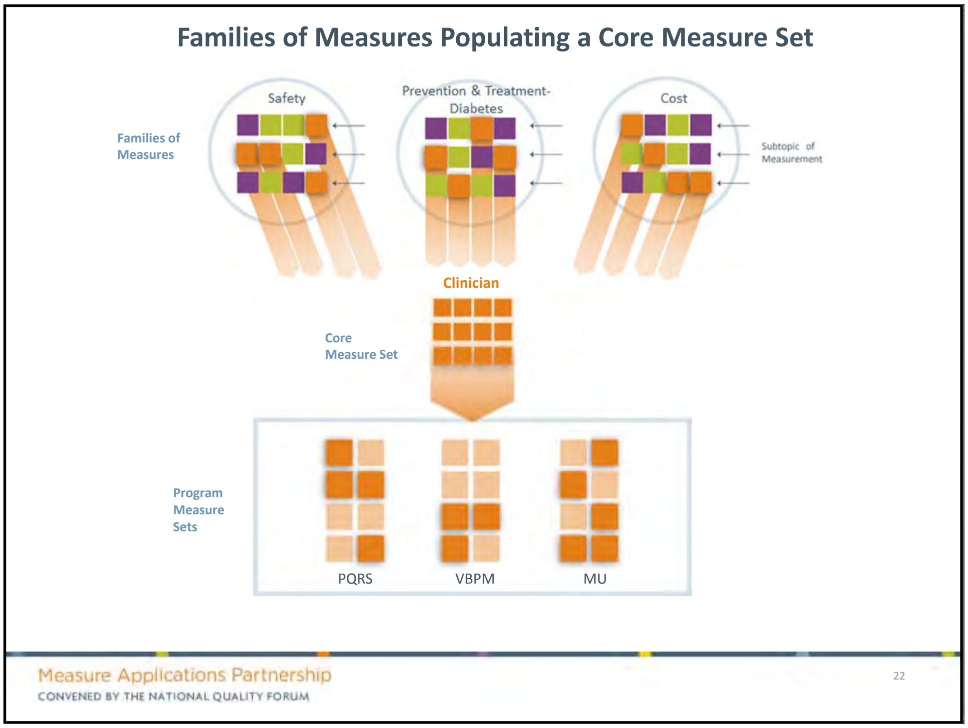
Subtopics of
Measurement

Core
Measure
Sets

Hospital

Clinician

PAC/LTC



Families of Measures Populating a Core Measure Set

Families of
Measures

Safety

Prevention & Treatment-
Diabetes

Cost

Subtopic of
Measurement

Clinician

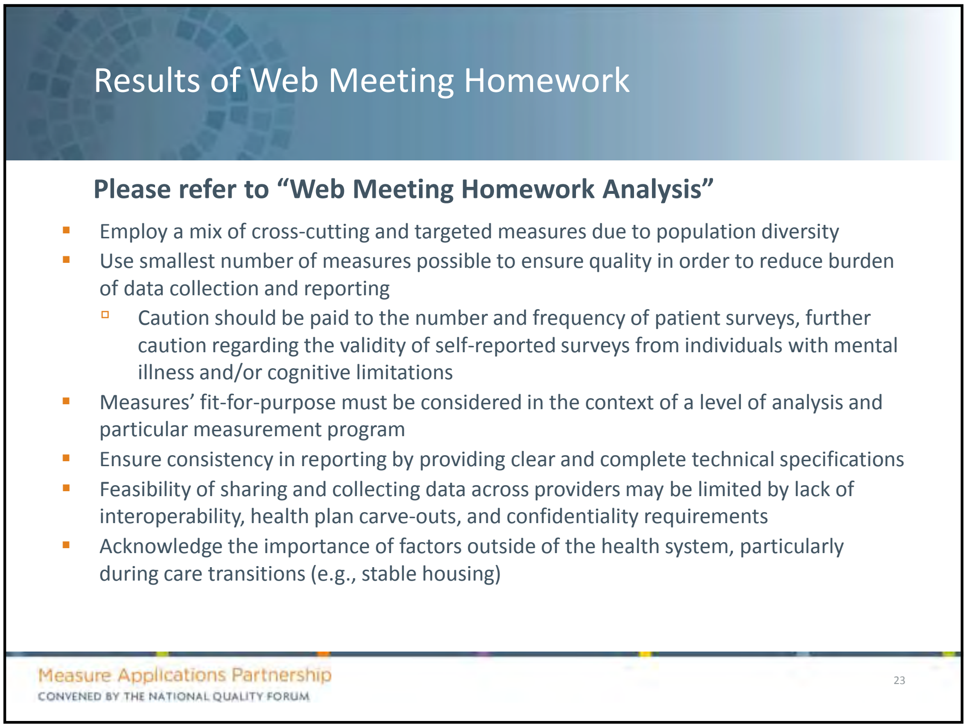
Core
Measure Set

Program
Measure
Sets

PQRS

VBPM

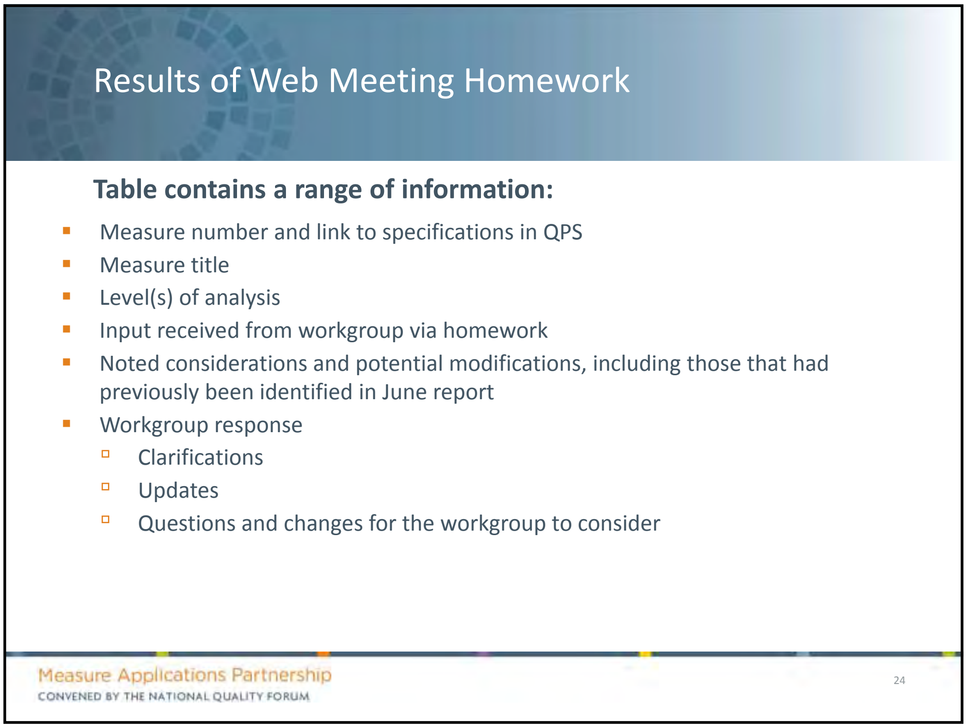
MU



Results of Web Meeting Homework

Please refer to “Web Meeting Homework Analysis”

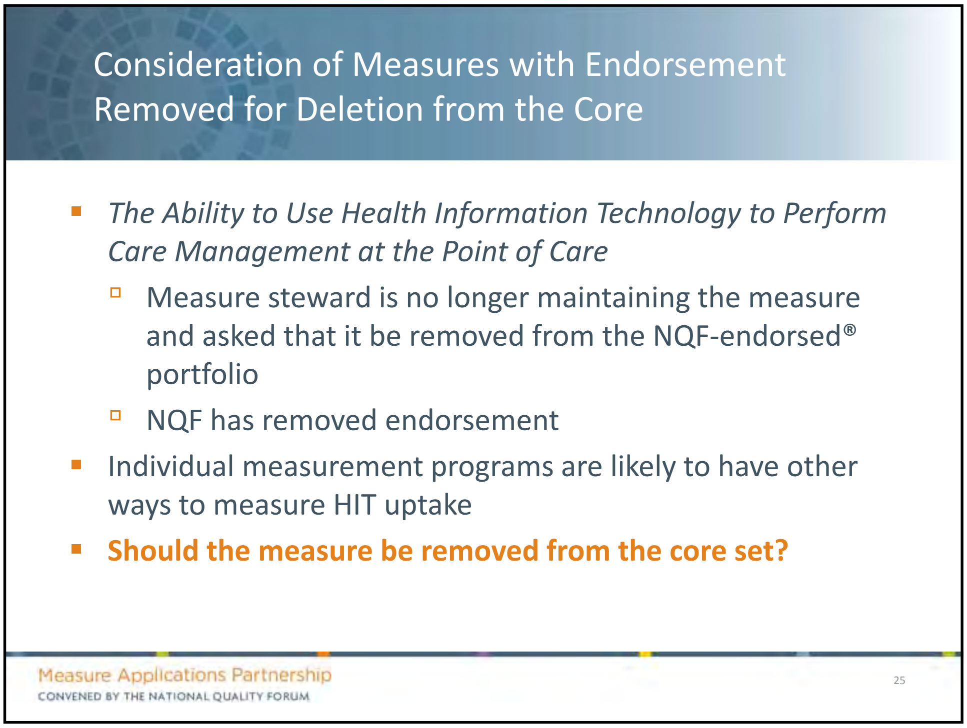
- Employ a mix of cross-cutting and targeted measures due to population diversity
- Use smallest number of measures possible to ensure quality in order to reduce burden of data collection and reporting
  - Caution should be paid to the number and frequency of patient surveys, further caution regarding the validity of self-reported surveys from individuals with mental illness and/or cognitive limitations
- Measures’ fit-for-purpose must be considered in the context of a level of analysis and particular measurement program
- Ensure consistency in reporting by providing clear and complete technical specifications
- Feasibility of sharing and collecting data across providers may be limited by lack of interoperability, health plan carve-outs, and confidentiality requirements
- Acknowledge the importance of factors outside of the health system, particularly during care transitions (e.g., stable housing)



Results of Web Meeting Homework

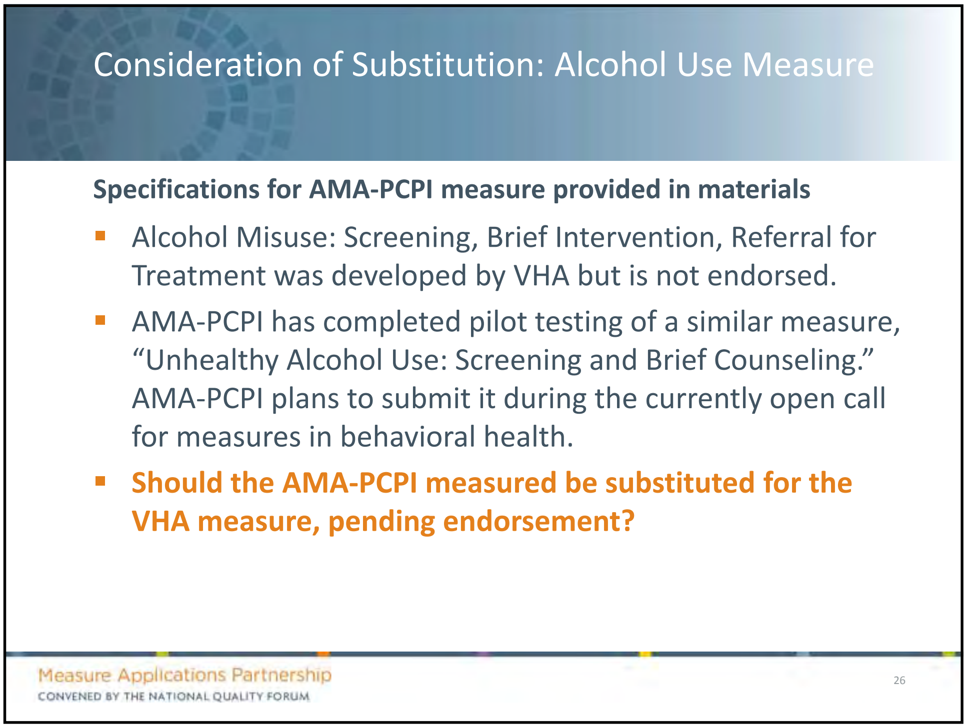
Table contains a range of information:

- Measure number and link to specifications in QPS
- Measure title
- Level(s) of analysis
- Input received from workgroup via homework
- Noted considerations and potential modifications, including those that had previously been identified in June report
- Workgroup response
  - Clarifications
  - Updates
  - Questions and changes for the workgroup to consider



Consideration of Measures with Endorsement Removed for Deletion from the Core

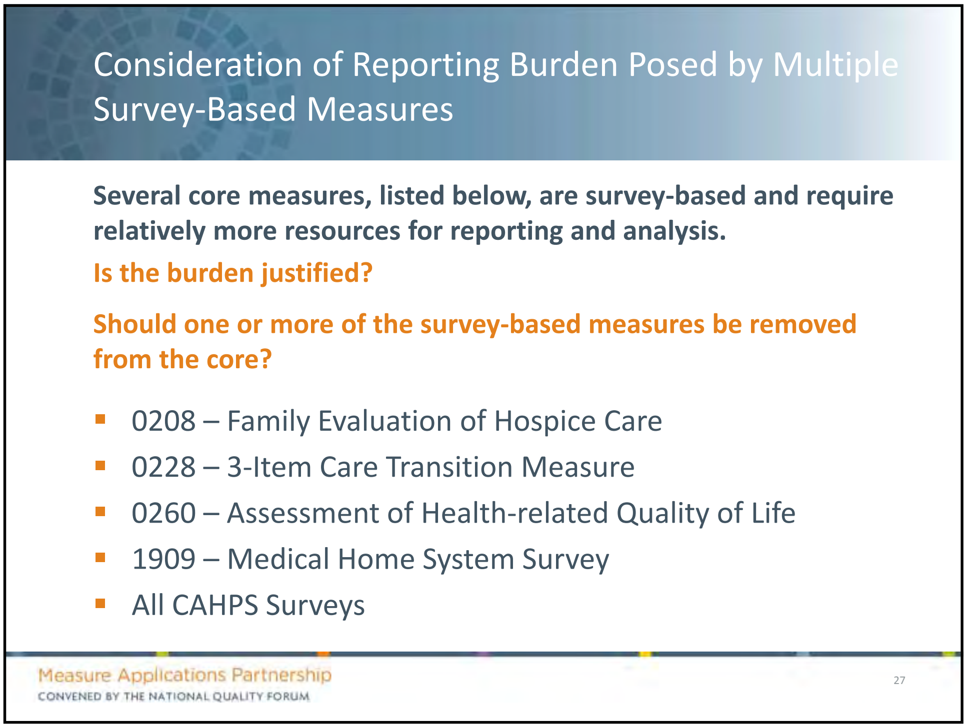
- *The Ability to Use Health Information Technology to Perform Care Management at the Point of Care*
  - Measure steward is no longer maintaining the measure and asked that it be removed from the NQF-endorsed® portfolio
  - NQF has removed endorsement
- Individual measurement programs are likely to have other ways to measure HIT uptake
- **Should the measure be removed from the core set?**



Consideration of Substitution: Alcohol Use Measure

Specifications for AMA-PCPI measure provided in materials

- Alcohol Misuse: Screening, Brief Intervention, Referral for Treatment was developed by VHA but is not endorsed.
- AMA-PCPI has completed pilot testing of a similar measure, “Unhealthy Alcohol Use: Screening and Brief Counseling.” AMA-PCPI plans to submit it during the currently open call for measures in behavioral health.
- **Should the AMA-PCPI measured be substituted for the VHA measure, pending endorsement?**



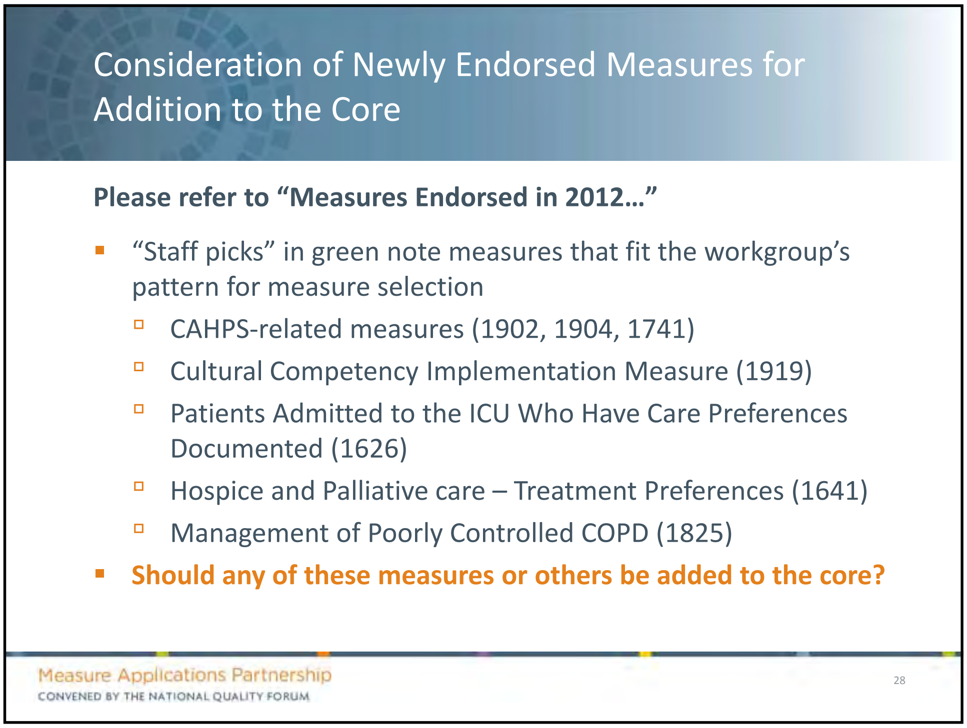
Consideration of Reporting Burden Posed by Multiple Survey-Based Measures

Several core measures, listed below, are survey-based and require relatively more resources for reporting and analysis.

Is the burden justified?

Should one or more of the survey-based measures be removed from the core?

- 0208 – Family Evaluation of Hospice Care
- 0228 – 3-Item Care Transition Measure
- 0260 – Assessment of Health-related Quality of Life
- 1909 – Medical Home System Survey
- All CAHPS Surveys



Consideration of Newly Endorsed Measures for Addition to the Core

Please refer to “Measures Endorsed in 2012…”

- “Staff picks” in green note measures that fit the workgroup’s pattern for measure selection
  - CAHPS-related measures (1902, 1904, 1741)
  - Cultural Competency Implementation Measure (1919)
  - Patients Admitted to the ICU Who Have Care Preferences Documented (1626)
  - Hospice and Palliative care – Treatment Preferences (1641)
  - Management of Poorly Controlled COPD (1825)
- **Should any of these measures or others be added to the core?**

Discussion and Questions

Pre-Rulemaking Input Part 1:
Using Core to Inform Guidance and PAC/LTC Program Example

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.**

Year 2 Pre-Rulemaking Strategy

- Update general guidance, rely on core concepts and core measures to inform MAP generally.
- Where a measure from the Duals Core Set is under consideration for use in a program, MAP should recommend it for inclusion.
- The Duals Workgroup will also consider one high-priority program issue for each of the setting-specific workgroups.
- Chair and liaisons will help carry communications between the groups, giving presentations on workgroup-specific and All-MAP web meetings.
- Written guidance customized to each setting workgroup will also be provided.
- Duals Workgroup will review other groups’ activities during December 19 web meeting and provide further recommendations to the MAP Coordinating Committee if needed.

Dual Eligible Beneficiaries Workgroup Liaisons for Pre-Rulemaking

PAC/LTC Workgroup: Joan Levy Zlotnik

Clinician Workgroup: Tom James

Hospital Workgroup: Jim Dunford

Responsibilities will rotate annually

Sources: Bonnie and Wallace 2002, Dong 2005, World Health Organization 2011

Year 2 Pre-Rulemaking Strategy

Please refer to “2012/2013 Pre-Rulemaking Guidance…”

- Similar format as Year 1:
  - General principles on cover page
  - Setting-specific information
    - Duals’ quality issues in that setting of care
    - Summary of MAP’s actions on relevant measures in Year 1
    - Targeted input on a high-priority program
  - Core set of measures and their use in federal programs reviewed by MAP
- Content will be updated and customized based on the results of this meeting

Pre-Rulemaking Input Part 1:
Using Core to Inform Guidance and PAC/LTC Program Example

Dual Eligible Beneficiaries Workgroup Pre-Rulemaking Input

- In late 2011, the Dual Eligible Beneficiaries Workgroup created a draft core set of measures, and provided input to other MAP workgroups about application of measures in Federal programs.
- The MAP Clinician, Hospital, and PAC/LTC Workgroups took specific actions based on this input.
- The following summary describes the outcomes of the workgroup actions and the current disposition of measures in the core set.

Specific Actions Taken by the Hospital Workgroup on Core Measures

- Supported inclusion of **NQF#0558** (*HBIPS-7 Post-discharge continuing care plan transmission to next level of care provider upon discharge*) in Inpatient Psychiatric Facility Quality Reporting
    - Status: **NQF#0558** was finalized for use in IPF reporting

- Supported inclusion of **NQF#0228** (*3-Item Care Transition Measure, CTM-3*) in Inpatient Quality Reporting
    - Status: **NQF#0228** was finalized for use in IQR

Specific Actions Taken by the Clinician Workgroup on Core Measures

- Supported addition of **NQF#0729** (*Optimal Diabetes Care)* in PQRS
    - Status: **NQF#0729** was proposed for PQRS (final rule is pending)

- Supported addition of **NQF#0418** (*Screening for Clinical Depression and Follow-Up Plan*) in the Meaningful Use program
    - Status: **NQF#0418** was finalized for use in the Meaningful Use Stage 2 program

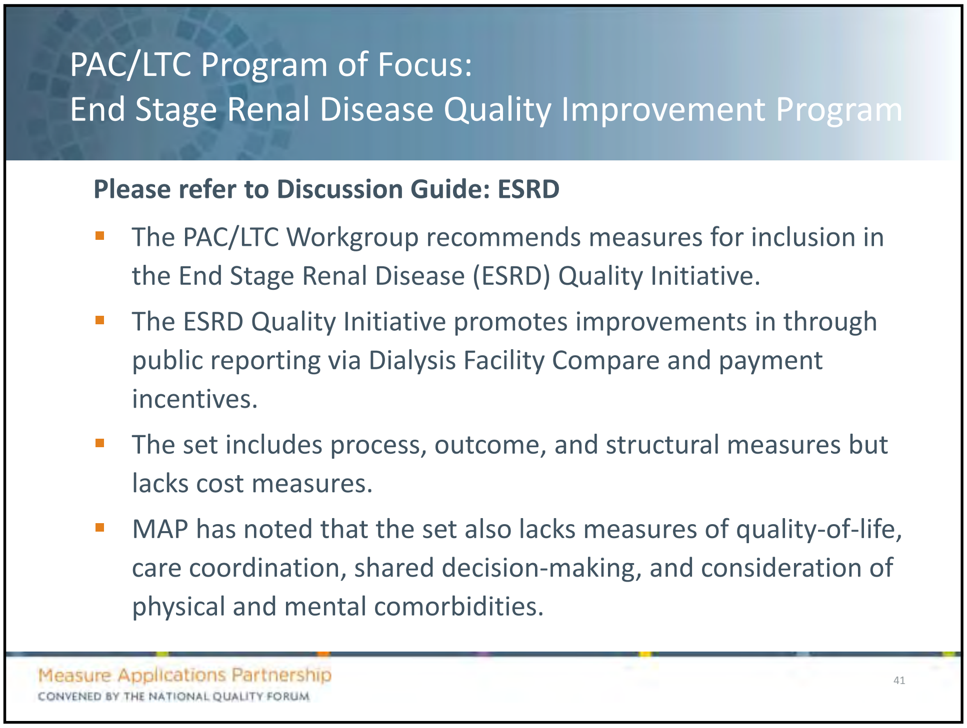
- Supported retention of four core measures in the Value Modifier set, five core measures in the PQRS set, and three core measures in the Meaningful Use set
    - Status: All of these measures were proposed and/or finalized to be retained in the respective programs

Specific Actions Taken by the PAC/LTC Workgroup on Core Measures

- Supported inclusion of **NQF#0260** (*Assessment of Health-related Quality of Life in Dialysis Patients*) in ESRD set
  - Status: **NQF#0260** was not proposed for the ESRD set; it is currently going through NQF endorsement maintenance
- Supported addition of **NQF#0208** (*Family Evaluation of Hospice Care*) in the Hospice Quality Reporting program
  - Status: **NQF#0208** was deemed under consideration for an expanded measure set used in annual payment determinations beyond FY2015
- Supported retention of all core measures finalized for use in programs
  - Status: All of these measures specified for PAC/LTC were proposed and/or finalized to be retained in the respective programs

Summary

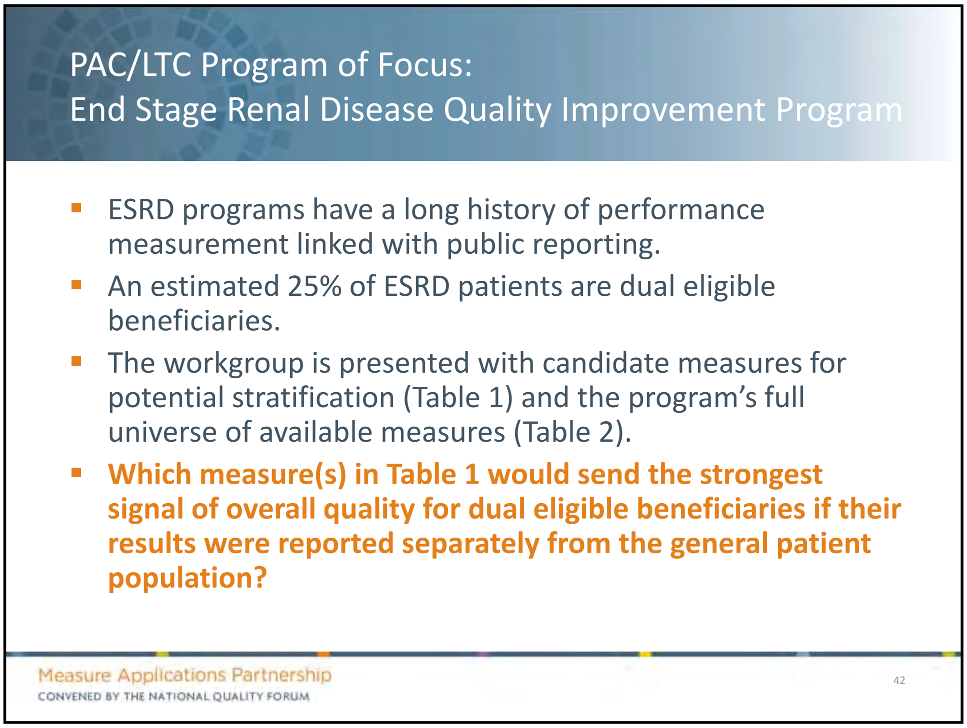
- HHS uptake of measures in proposed and final rules was generally consistent with MAP workgroups' specific recommendations made as a result of input from the Dual Eligible Beneficiaries Workgroup
- Frequency of revised core set measure use in HHS programs currently is as follows:
  - Proposed/finalized in 2 or more HHS programs: 11 measures
  - Proposed/finalized in 1 HHS program: 8 measures
  - Not in use in an HHS program: 7 measures



PAC/LTC Program of Focus: End Stage Renal Disease Quality Improvement Program

Please refer to Discussion Guide: ESRD

- The PAC/LTC Workgroup recommends measures for inclusion in the End Stage Renal Disease (ESRD) Quality Initiative.
- The ESRD Quality Initiative promotes improvements in through public reporting via Dialysis Facility Compare and payment incentives.
- The set includes process, outcome, and structural measures but lacks cost measures.
- MAP has noted that the set also lacks measures of quality-of-life, care coordination, shared decision-making, and consideration of physical and mental comorbidities.



PAC/LTC Program of Focus: End Stage Renal Disease Quality Improvement Program

- ESRD programs have a long history of performance measurement linked with public reporting.
- An estimated 25% of ESRD patients are dual eligible beneficiaries.
- The workgroup is presented with candidate measures for potential stratification (Table 1) and the program’s full universe of available measures (Table 2).
- **Which measure(s) in Table 1 would send the strongest signal of overall quality for dual eligible beneficiaries if their results were reported separately from the general patient population?**

PAC/LTC Program of Focus: End Stage Renal Disease Quality Improvement Program

Candidate Measures for Stratification – Plain Language

- 0249: measure of how completely waste products are removed from the blood *via hemodialysis*
- 0318: measure of how completely waste products are removed from the blood *via peritoneal dialysis*
- 0258: measure of consumer experience
- 0369: measure of mortality at the facility level
- 1463: number of dialysis facility patients requiring hospitalization

Opportunity for Public Comment

Pre-Rulemaking Input Part 2:
Hospital and Clinician Program Examples

Hospital Programs of Focus: Inpatient Quality Reporting and Value-Based Purchasing

Please refer to Discussion Guide: Hospital IQR and VBP

- The Hospital Workgroup recommends measures for several programs, including the Inpatient Quality Reporting (IQR) and Value Based-Purchasing Program (VBP).
- IQR promotes improvement through public reporting on Hospital Compare.
- VBP promotes improvement through a payment incentive related to hospital reimbursement.
  - VBP is cost-neutral to the system: 1% of payments to all hospitals are withheld to create a pool of funding for incentive payments; hospitals are scored relative to others and their own improvement over time; payments are dependent upon these scores.
- By statue, measures are eligible for inclusion in VBP after one year of reporting through IQR on the CMS Hospital Compare website.

Hospital Programs of Focus: IQR and VBP

- MAP has noted that future iterations of the measure sets should more thoroughly address the NQS priorities of affordable care, person- and family-centered care (IQR), and supporting better health in communities (VBP).
- The workgroup is presented with candidate measures from IQR that could be included in VBP (Table 1) and all of the previously finalized VBP measures for reference (Table 2).
- **Which measure(s) in Table 1 are most relevant for dual eligible beneficiaries and therefore merit inclusion in the higher-stakes application of VBP?**

Hospital Programs of Focus: IQR and VBP

Candidate Measures for Inclusion in VBP – Plain Language

- 0113, 0493: hospital’s participation in a registry database for different types of care (stroke, surgery, etc.)
- 0138: healthcare-associated CAUTIs among inpatients
- 0753: infections of surgical sites
- 495 and 497: emergency department throughput
- 1653 and 1659: inpatients given vaccinations before discharge
- Not Endorsed Measure: inpatients who experienced a treatable complication after surgery and died as a result

Clinician Performance Measurement Programs

Please refer to Discussion Guide: Clinician Programs

- The Clinician Workgroup recommends measures for inclusion in multiple performance measurement programs both at the individual clinician and group practice levels
- Each program has a different purpose, structure, and set of reporting requirements

Clinician Performance Measurement Programs

Physician Quality Reporting System (PQRS)

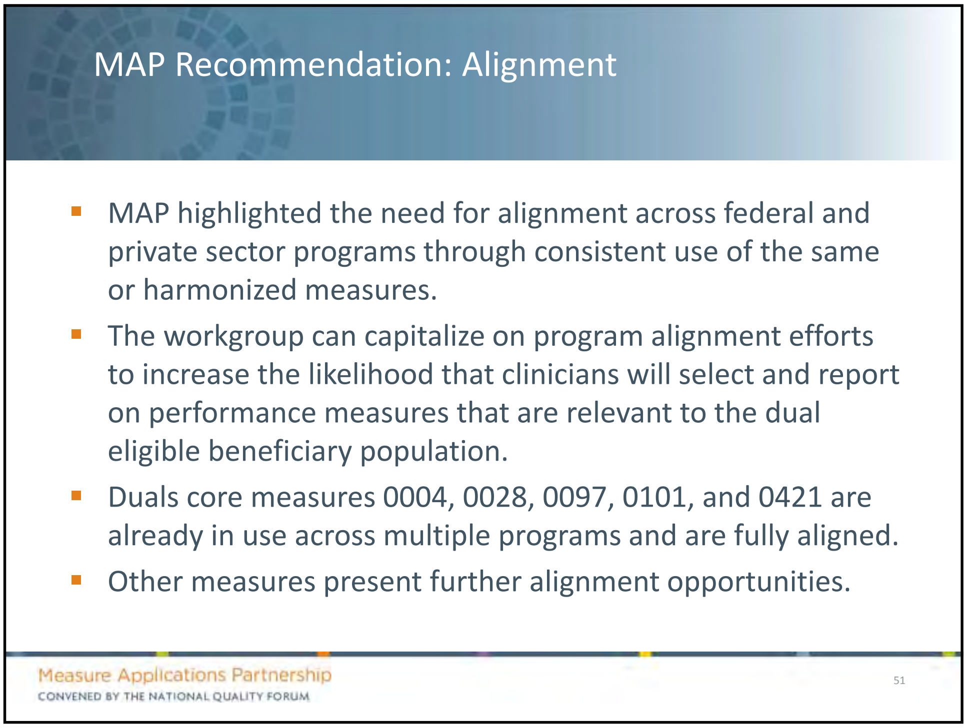
- Pay-for-reporting program for individual clinicians and group practices that satisfactorily report data on quality measures for covered professional services

Value-Based Payment Modifier Program (VBPM)

- Physician payment system that will adjust Medicare payments based on the quality and cost of care provided
- Will be phased in over a two-year period beginning in 2015

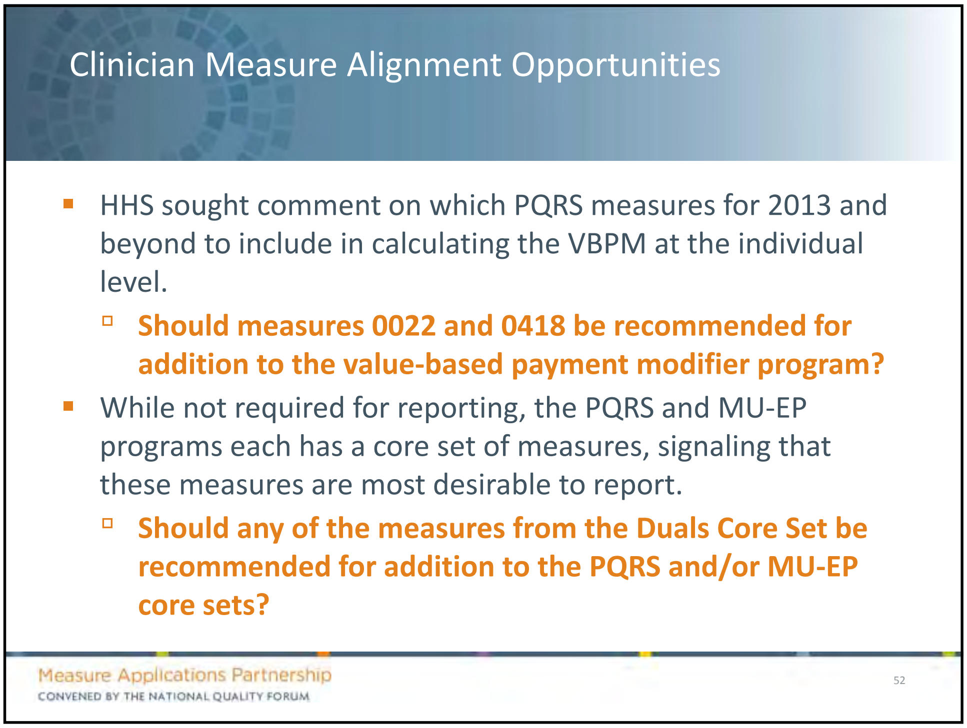
Medicare/Medicaid EHR Incentive Program for Eligible Professionals (MU-EP)

- Provides for incentive payments for Medicare eligible professionals who are meaningful users of certified electronic health record (EHR) technology
- Program consists of three stages, each having its own set of requirements to demonstrate meaningful use



MAP Recommendation: Alignment

- MAP highlighted the need for alignment across federal and private sector programs through consistent use of the same or harmonized measures.
- The workgroup can capitalize on program alignment efforts to increase the likelihood that clinicians will select and report on performance measures that are relevant to the dual eligible beneficiary population.
- Duals core measures 0004, 0028, 0097, 0101, and 0421 are already in use across multiple programs and are fully aligned.
- Other measures present further alignment opportunities.



Clinician Measure Alignment Opportunities

- HHS sought comment on which PQRS measures for 2013 and beyond to include in calculating the VBPM at the individual level.
  - **Should measures 0022 and 0418 be recommended for addition to the value-based payment modifier program?**
- While not required for reporting, the PQRS and MU-EP programs each has a core set of measures, signaling that these measures are most desirable to report.
  - **Should any of the measures from the Duals Core Set be recommended for addition to the PQRS and/or MU-EP core sets?**

Opportunity for Public Comment

State Experience Applying MAP Duals Core Measures in Context of Demonstration Programs

Observations from State & Regional Measure Selection and Use

- What drives *selection* of measures?
  - **Priorities** of local, state or regional organizations (individual, collective) and from national efforts that impact requirements and/or payment
    - Reducing costs and maximizing revenue are significant (*sometimes the only)* drivers
  - **Program** structures (FFS, managed care, carve-outs) and technical capacity
  - **Data** (existence in e-format, match to specific measures, compatibility across various sources, recency)
  - **Proof of concept** showing that it can be done (politically and technically)
- What drives *use* of the measure results?
  - **What**: access to the measure results
  - **How**: pathways to aligning incentives (different approaches for different roles)
  - **Why**: examples from others showing that the desired impact was achieved

States' Experience Interpreting MAP Recommendations

- MAP's Duals Core Set was not compiled with a specific program application or use in mind.
- It presented a menu of options from which policymakers and project planners can choose when designing a measurement program that fits their unique needs.
- The first high-profile users of MAP's report were state officials launching demonstration programs to better integrate care for dual eligible beneficiaries.
  - *Where were MAP's recommendations most helpful?*
  - *What questions remained unanswered?*
  - *What other factors drive states' decision-making around quality measurement and improvement?*

Commentary from California Department of Health Care Services

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Staff Analysis of Measures Proposed for Use in Demonstrations by Massachusetts and California

Refer to "Draft Interpretive Guide"

- Staff compared the measures publicly proposed in two integrated care demonstrations and with MAP's Dual Eligible Beneficiaries Core Set.
- Each state proposed to implement more than 95 measures
- Many measures apply to health plan features of the demonstrations
- Of the 26 MAP Duals Core Set measures:
  - 7 measures are selected for use in both states
  - 5 additional core measures are selected by MA
  - 14 are not selected for use in either demonstration

Sources: Bonnie and Wallace 2002, Dong 2005, World Health Organization 2011

Measurement Implications of Private Health Plans as the Unit of Analysis

- A primary driver of measure selection is the use of health plans as the unit of analysis. Measures must be designed for this purpose.
- Not all measures are appropriate for health plans' populations or data collection infrastructure; review specifications carefully.
- Encourage selection of measures that align with other quality efforts to minimize data collection burden.

Sources: Bonnie and Wallace 2002, Dong 2005, World Health Organization 2011

Review and Refine the Interpretive Guide

- Reporting Burden
- Phased Implementation
- Alignment of High-Leverage Measures
- Review Measures' Full Specifications
- Assign Accountability and Attribution Appropriately
- Understand Value of NQF Endorsement and Avoid "Off-Label" Applications

What modifications or additional measure implementation guidance does the workgroup have to add?

Sources: Bonnie and Wallace 2002, Dong 2005, World Health Organization 2011

Opportunity for Public Comment

Data-Related Feasibility of Implementing Core Measures

TREATMENT RESEARCH INSTITUTE
Applying Science to Transform Lives

Issues in Drug and Alcohol Confidentiality Regulations: Real and Imagined

Mady Chalk, Ph.D., MSW
Treatment Research Institute
Dir., Policy Research and Analysis

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42 CFR Part II

- Prohibits disclosure of records related to substance abuse treatment without patient consent
- Applies to entities that provide substance abuse diagnosis, treatment or referral, including general medical facilities receiving federal funds in any form incl. tax exemption or tax deductions for contributions
- Key issues re: services in general medical facilities
  - Is it a <u>program</u> or an <u>identified unit</u>?
  - Is the <u>primary function</u> of personnel the provision of alcohol or drug abuse and have promoted themselves to the community as being such a provider?

42 CFR Part 2 Allowable Disclosures

- Written authorization
- Internal communication ("need to know")
- *No patient-identifying information*
- Medical emergency
- *Qualified Service Organization (QSO)*
- Research
- *Audit and evaluation*
- Crimes (or threats of) on program premises or against program personnel
- Initial reports of suspected child abuse or neglect
- Court order meets the specifications of Part 2

42 CFR: Resources

- SAMHSA, in collaboration with ONC has created two sets of Frequently Asked Questions (FAQs).
- These FAQs can be accessed at: http://www.samhsa.gov/healthprivacy/docs/EHR-FAQs.pdf and http://www.samhsa.gov/about/laws/SAMHSA_42CFRPART2FAQII_Revised.pdf
- Series of webinars by the Legal Action Center on 42 CFR Part 2 http://www.lac.org/index.php/lac/webinar_archive

Sharing Data

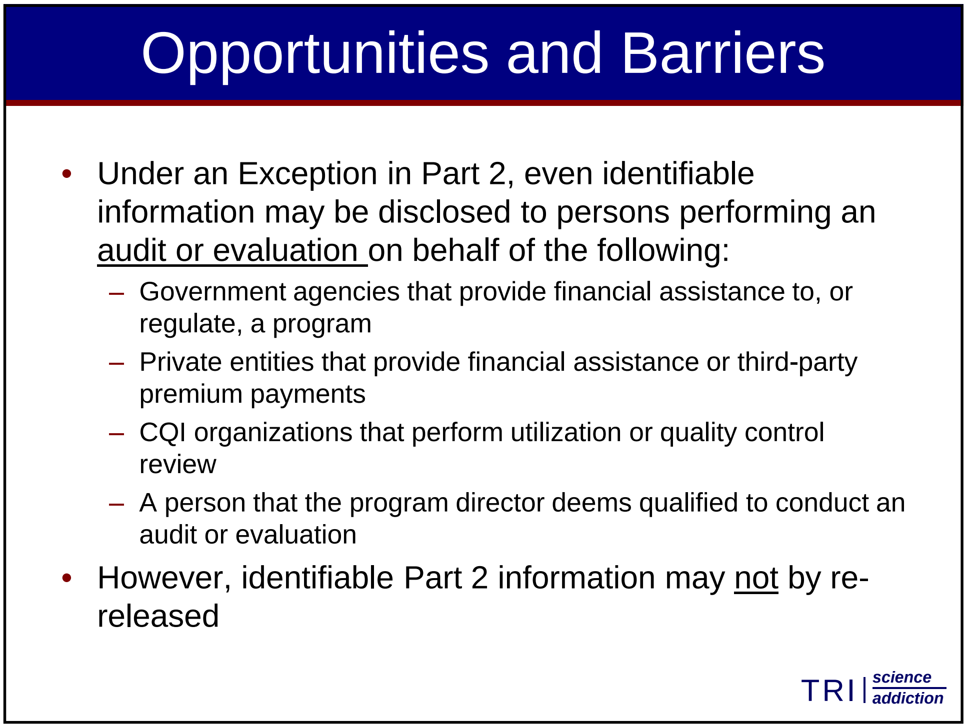
- No patient identifying information
  - If individual cannot be identified directly or indirectly, information-sharing is not covered by Part 2

- Procedures for de-identification of data used for research or performance testing are governed by HIPAA regulations

Opportunities and Barriers

- Qualified Service Organization (QSO) Agreements facilitate information sharing between Part 2 entities and others, e.g. HIOs
  - Applies primarily to cases where entities involved in evaluation have access to identifiable patient data

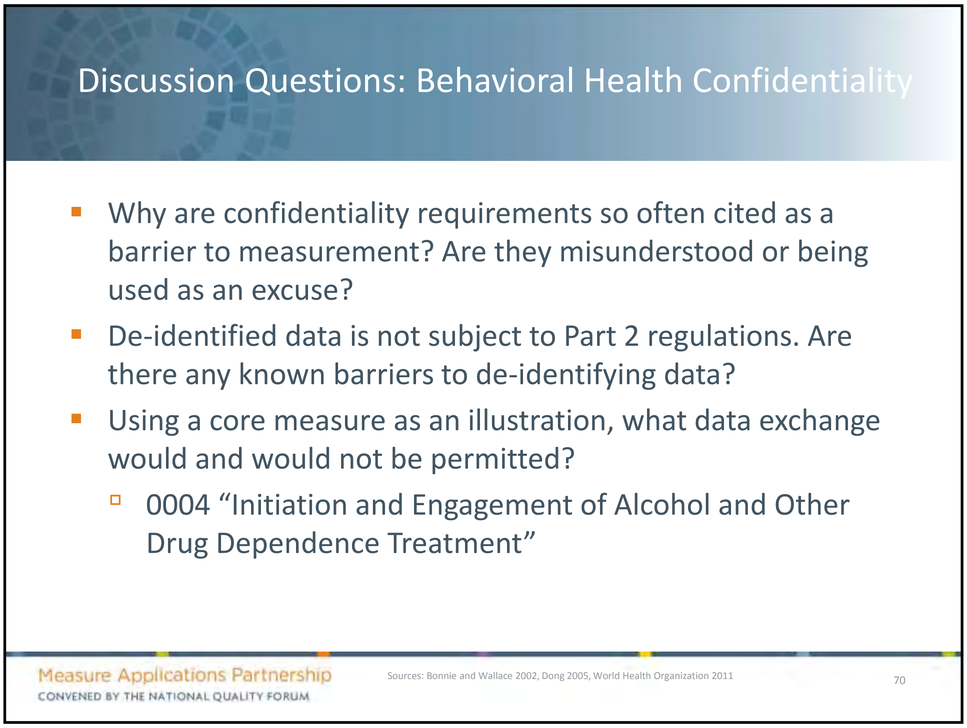
- Carve Outs
  - Problems with access to data in behavioral health carve outs or PBMs with separate data systems should not be confused with privacy constraints of Part 2



Opportunities and Barriers

- Under an Exception in Part 2, even identifiable information may be disclosed to persons performing an audit or evaluation on behalf of the following:
  - Government agencies that provide financial assistance to, or regulate, a program
  - Private entities that provide financial assistance or third-party premium payments
  - CQI organizations that perform utilization or quality control review
  - A person that the program director deems qualified to conduct an audit or evaluation
- However, identifiable Part 2 information may not by re-released

TRI | science addiction



Discussion Questions: Behavioral Health Confidentiality

- Why are confidentiality requirements so often cited as a barrier to measurement? Are they misunderstood or being used as an excuse?
- De-identified data is not subject to Part 2 regulations. Are there any known barriers to de-identifying data?
- Using a core measure as an illustration, what data exchange would and would not be permitted?
  - 0004 “Initiation and Engagement of Alcohol and Other Drug Dependence Treatment”

Measure Applications Partnership
CONVENED BY THE NATIONAL QUALITY FORUM

Sources: Bonnie and Wallace 2002, Dong 2005, World Health Organization 2011

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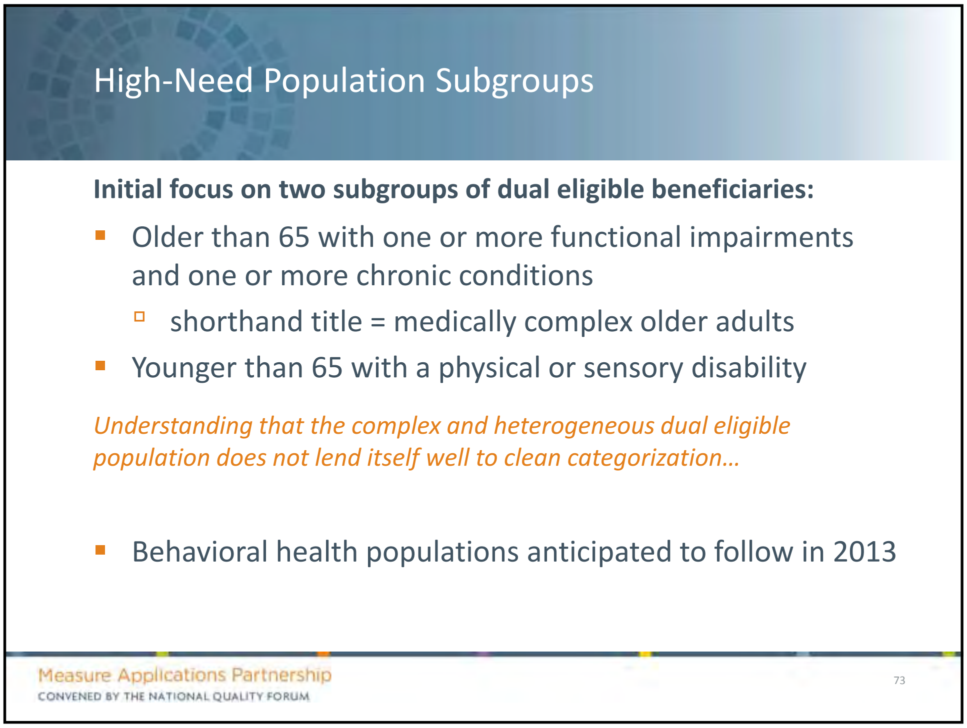
Workgroup Discussion and Questions

Review List of Quality Issues for Medically Complex Older Adults and Adults 18-65 with Physical Disabilities



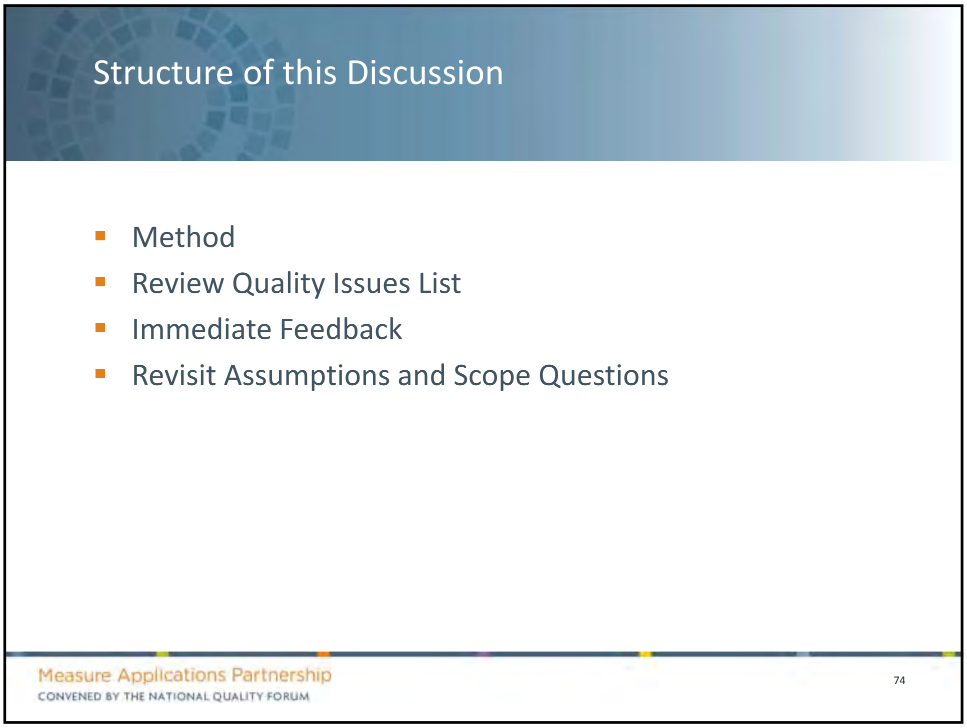
High-Need Population Subgroups

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

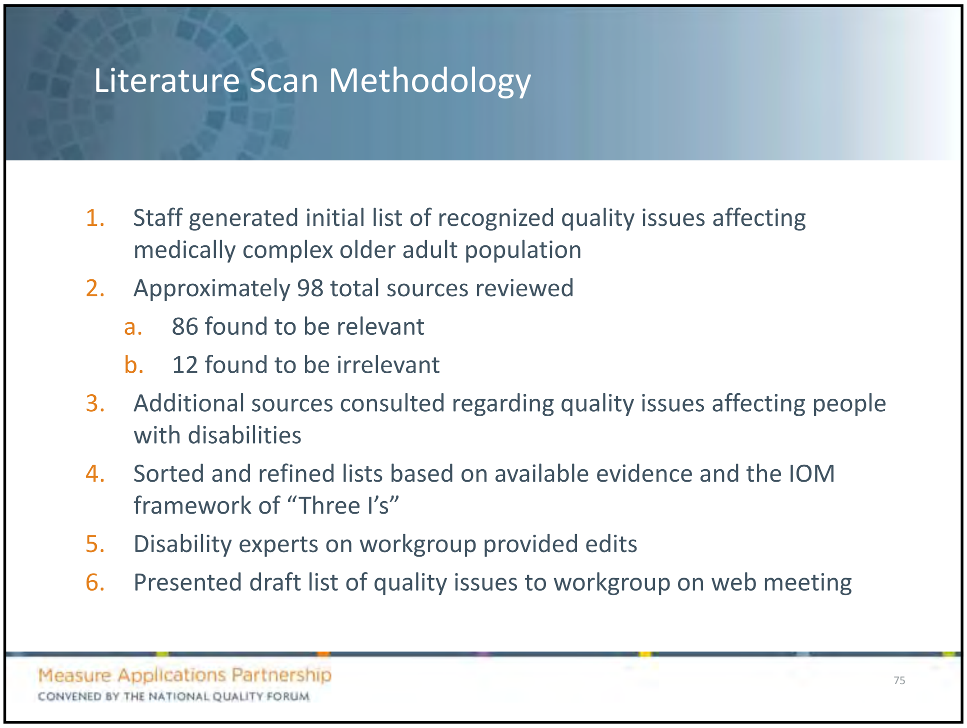
Understanding that the complex and heterogeneous dual eligible population does not lend itself well to clean categorization…

- Behavioral health populations anticipated to follow in 2013



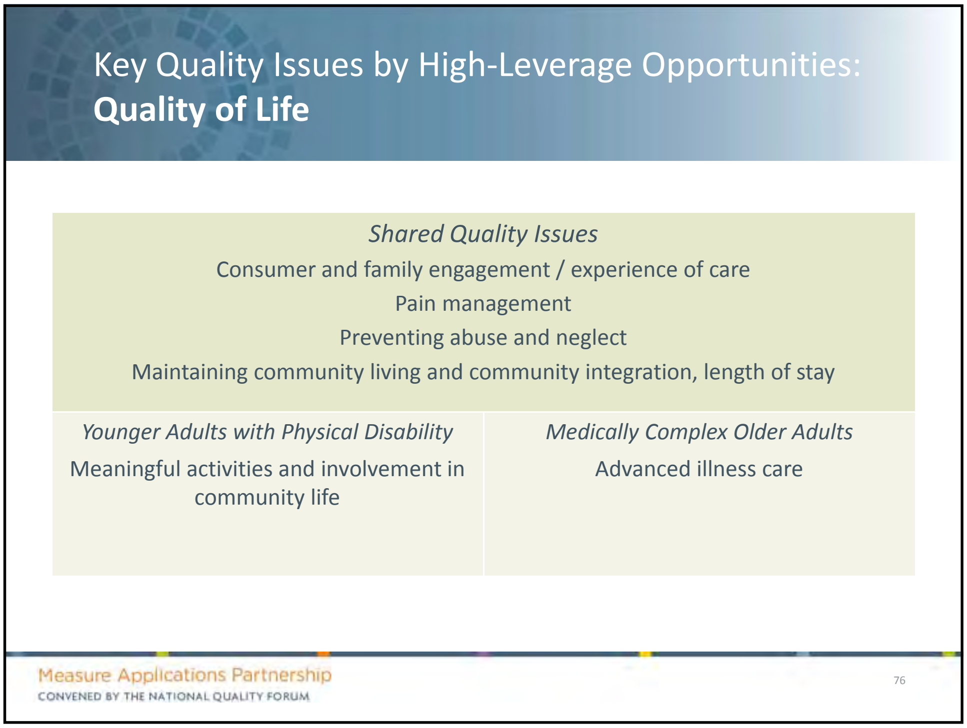
Structure of this Discussion

- Method
- Review Quality Issues List
- Immediate Feedback
- Revisit Assumptions and Scope Questions



Literature Scan Methodology

1. Staff generated initial list of recognized quality issues affecting medically complex older adult population
2. Approximately 98 total sources reviewed
    a. 86 found to be relevant
    b. 12 found to be irrelevant
3. Additional sources consulted regarding quality issues affecting people with disabilities
4. Sorted and refined lists based on available evidence and the IOM framework of "Three I's"
5. Disability experts on workgroup provided edits
6. Presented draft list of quality issues to workgroup on web meeting



Key Quality Issues by High-Leverage Opportunities: **Quality of Life**

Shared Quality Issues	
Consumer and family engagement / experience of care Pain management Preventing abuse and neglect Maintaining community living and community integration, length of stay	
Younger Adults with Physical Disability	*Medically Complex Older Adults*
Meaningful activities and involvement in community life	Advanced illness care

Key Quality Issues by High-Leverage Opportunities: **Care Coordination**

Shared Quality Issues

Avoidable admissions, readmissions , complications

Care transitions, discharge planning

Communication between providers

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

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

Safety: catheter-associated urinary tract infection, pressure ulcers, falls

Over-utilization

Timely initiation of services and supports

Cultural sensitivity, cultural competence

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

Shared Quality Issues

Person-centered planning

Functional abilities including ADLs and IADLs (i.e., change in …, improvement, managing decline)

Preventive services and immunizations

Nutrition

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

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

<table>
<tr><th colspan="2"><i>Shared Quality Issues</i>
Social relationships
Screening for depression and other mental illness</th></tr>
<tr><td><i>Younger Adults with Physical Disability</i>
Weight management
Screening for substance use, primarily alcohol and tobacco</td><td><i>Medically Complex Older Adults</i></td></tr>
</table>

Key Quality Issues by High-Leverage Opportunities: **Structural Measures**

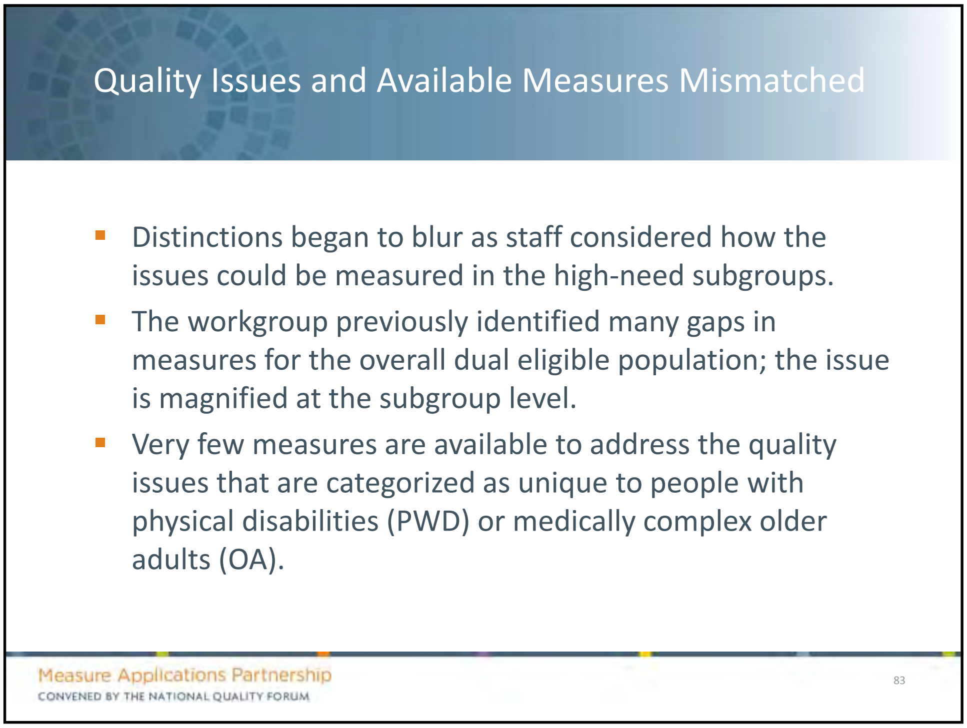
<table>
<tr><th colspan="2"><i>Shared Quality Issues</i>
Workforce adequacy, stability, and training
Provider access (primary care, specialty care, health home, dental care, vision care, durable medical equipment, rehabilitation services)
Providers’ linkages to community resources
Caregiver support</th></tr>
<tr><td><i>Younger Adults with Physical Disability</i>
Consumer choice of provider
Self-direction of services and supports
Physical accessibility: ADA compliance, location, and adaptive technologies
Provider access (habilitation services)</td><td><i>Medically Complex Older Adults</i></td></tr>
</table>

Quick Face Validity Check

- Some updates have been made based on feedback received on the web meeting.
- Are any major quality issues affecting older adults or people with physical disabilities glaringly absent?
- Is anything extraneous included in the list?

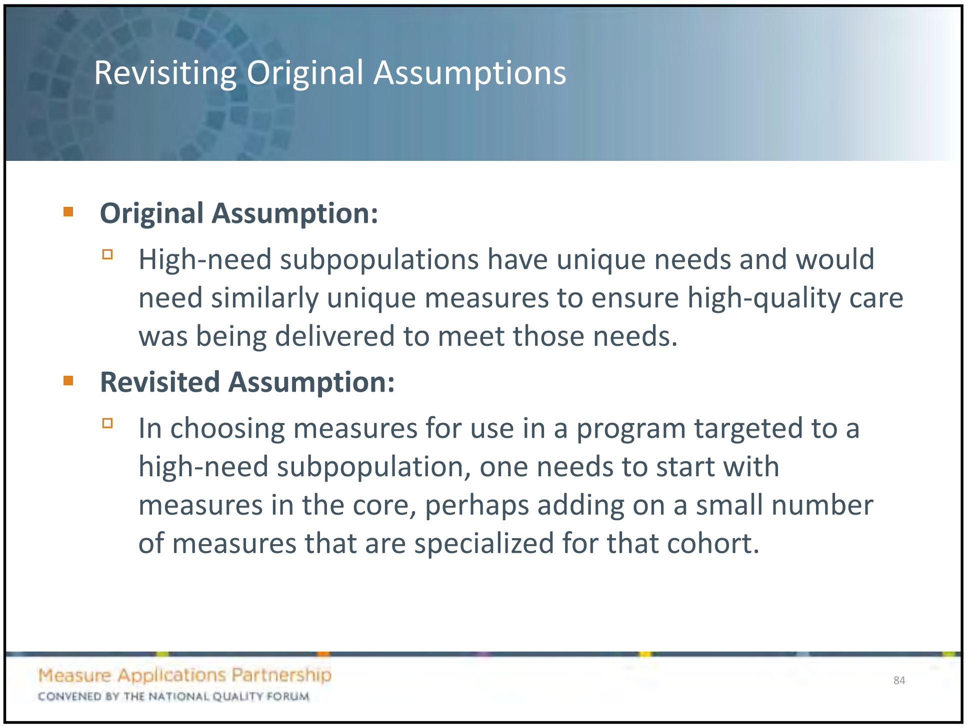
Analysis Revealed Interesting Patterns…

- Distinctions Across High-Need Subgroups:
  - Issues may have relatively more importance in certain cohorts.
    - Preventive care like cancer screening is more important in younger populations.
  - Issues are shared at a high level but have different nuances in certain cohorts.
    - Pressure ulcers are equally important to avoid in both high-need groups but the etiology will differ and therefore the measures would differ.
  - Likelihood differs that a beneficiary of a certain type will use particular services.
    - Older adults are much more likely to use nursing facility services. Younger adults with disabilities are more likely to use outpatient therapy services.
- Similarities:
  - There are plenty of opportunities for improvement.
  - Most quality issues applied to BOTH sub-populations; many of the basic tenets of high-quality care seem to be shared.



Quality Issues and Available Measures Mismatched

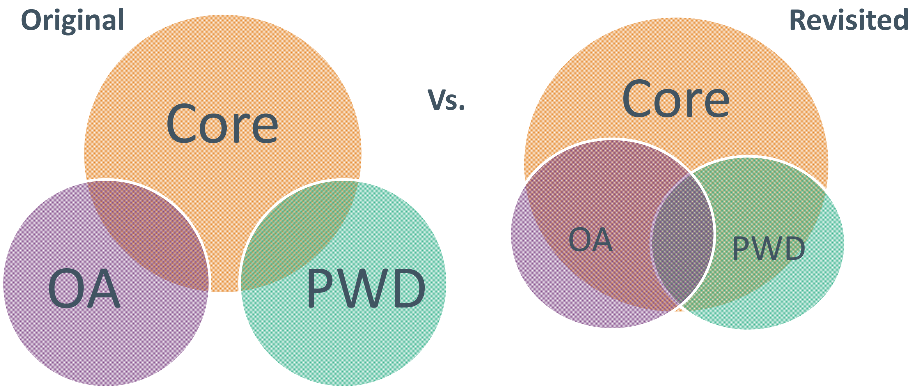
- Distinctions began to blur as staff considered how the issues could be measured in the high-need subgroups.
- The workgroup previously identified many gaps in measures for the overall dual eligible population; the issue is magnified at the subgroup level.
- Very few measures are available to address the quality issues that are categorized as unique to people with physical disabilities (PWD) or medically complex older adults (OA).



Revisiting Original Assumptions

- **Original Assumption:**
  - High-need subpopulations have unique needs and would need similarly unique measures to ensure high-quality care was being delivered to meet those needs.
- **Revisited Assumption:**
  - In choosing measures for use in a program targeted to a high-need subpopulation, one needs to start with measures in the core, perhaps adding on a small number of measures that are specialized for that cohort.

Revisiting Original Assumptions



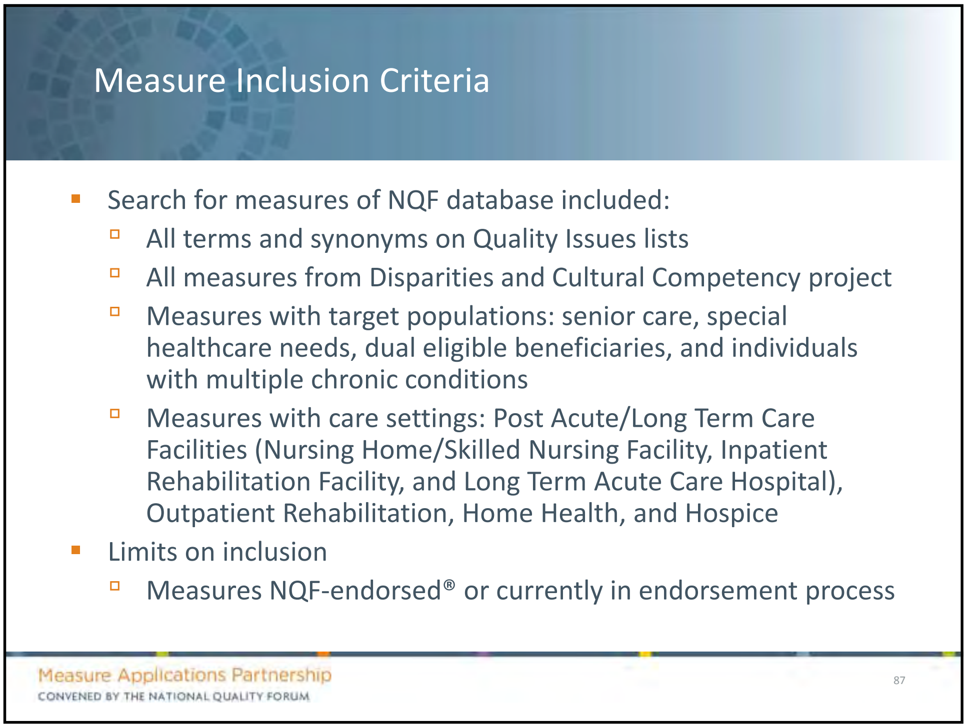
Discussion Questions

How different are high-need beneficiaries from the overall dual eligible beneficiary population in terms of measures?

Re-examine the quality issues list and try to define some of the shared quality issues more narrowly in order to make them fit just one sub-population.

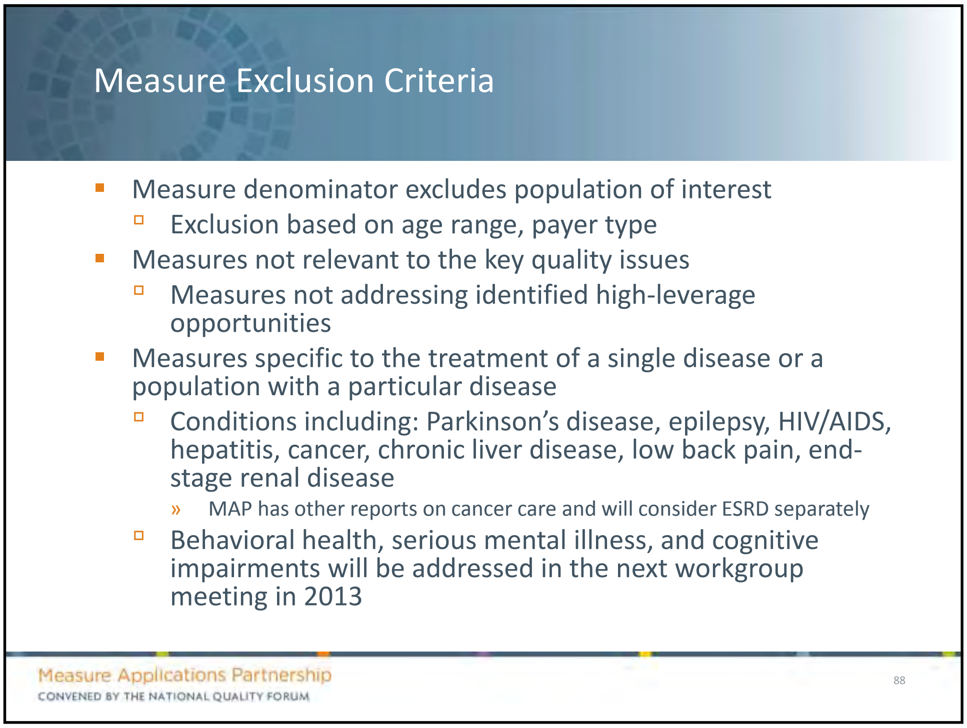
- What are the quality issues DISTINCT to complex older adults?
- What services are more often used by older adults?

- What are the quality issues DISTINCT to people with physical disabilities?
- What types of services are more often used by people with physical disabilities?



Measure Inclusion Criteria

- Search for measures of NQF database included:
    - All terms and synonyms on Quality Issues lists
    - All measures from Disparities and Cultural Competency project
    - Measures with target populations: senior care, special healthcare needs, dual eligible beneficiaries, and individuals with multiple chronic conditions
    - Measures with care settings: Post Acute/Long Term Care Facilities (Nursing Home/Skilled Nursing Facility, Inpatient Rehabilitation Facility, and Long Term Acute Care Hospital), Outpatient Rehabilitation, Home Health, and Hospice
- Limits on inclusion
    - Measures NQF-endorsed® or currently in endorsement process



Measure Exclusion Criteria

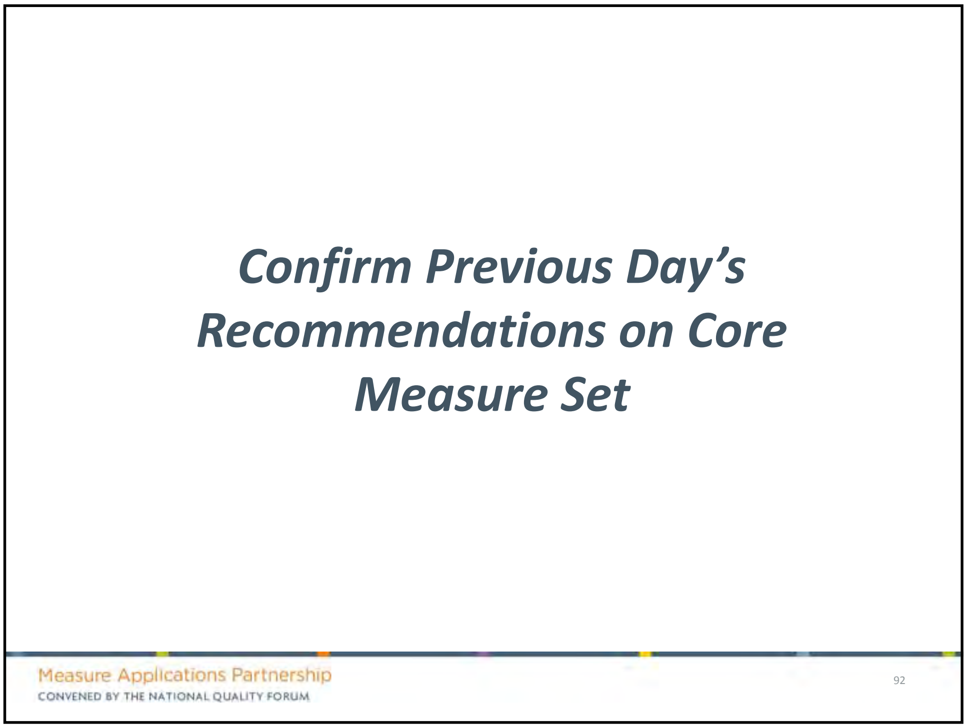
- Measure denominator excludes population of interest
    - Exclusion based on age range, payer type
- Measures not relevant to the key quality issues
    - Measures not addressing identified high-leverage opportunities
- Measures specific to the treatment of a single disease or a population with a particular disease
    - Conditions including: Parkinson’s disease, epilepsy, HIV/AIDS, hepatitis, cancer, chronic liver disease, low back pain, end-stage renal disease
        - MAP has other reports on cancer care and will consider ESRD separately
    - Behavioral health, serious mental illness, and cognitive impairments will be addressed in the next workgroup meeting in 2013

Opportunity for Public Comment

Summary of Progress and Discussion Themes

Day 2 Agenda

- Confirm Yesterday’s Recommendations on Core Measure Set
- Specialized Measures for Medically Complex Older Adults and Adults 18-65 with Physical Disabilities
- Small Group Activity: Gap-Filling Pathways
- Measure Gap Filling Opportunities:
  - Experience of Care Survey Tool for Community-Based Long-Term Supports and Services
  - Prior Development of Quality Measures for People with Disabilities
- Wrap Up



Confirm Previous Day’s Recommendations on Core Measure Set

Specialized Measures for Medically Complex Older Adults and Adults 18-65 with Physical Disabilities

Review and Refine Draft Arrays of Measures

Please refer to "Quality Measure Array"

- What does the workgroup want to communicate with these measures? How might they be used?
- Row by row, which measures warrant keeping in the array?
- Are any measures specific to adults with disabilities worth calling out as add-ons to the core?
- Are any measures specific to older adults worth calling out as add-ons to the core?

Discussion Questions

- The list of quality issues list is high-level and idealistic. Available measures are lacking in many areas.
  - What can be done to ground the quality issues list?
  - What can be done to stimulate measure development to meet needs identified in the quality issues list?
- When discussing high-need subgroups, is it more important for MAP to focus on **measures and gaps** or the implications that special populations have on the **implementation of a measurement strategy**?

Opportunity for Public Comment

Small Group Activity

Gap-Filling Pathways

MAP's Role in Addressing Measure Gaps

- MAP can serve as a catalyst for gap-filling by systematically identifying and categorizing measure gaps along the measure lifecycle.
- Most measure gaps affecting the dual eligible population require *de novo* measure development.
- Other measure gaps may be filled by using existing measures as a template and modifying them accordingly.
- Prioritization of needs and greater specificity of ideas are needed by measure developers.

Instructions for Small Group Activity: Choose Your Own Adventure

Threshold Question:

Is it more important to pursue measure development in gap areas that apply to:

- **all dual eligible beneficiaries?**

  or

- **high-need subgroups?**

- Break into three small groups.
- Identify a scribe to take notes on the flip chart and someone who will be responsible for reporting out to the full group.
- You will have 45 minutes to discuss in your small group and 45 minutes to share your thoughts with the full workgroup.

Small Group Assignments

Group 1	Group 2	Group 3
Rich Bringewatt	Joan Levy Zlotnik	Leo Cuello
Alfred Chiplin	Sally Tyler	Adam Burrows
Steve Counsell	Clarke Ross	Susan Reinhard
David Polakoff	Jennie Chin Hansen	Gail Stuart
Anne Cohen	Jim Dunford	D.E.B. Potter
Cheryl Powell	Rhonda Robinson Beale	Daniel Kivlahan
Fran Cotter	Claypool / Scala-Foley	

Option 1: Measure Gap-Filling Activities for All Dual Eligible Beneficiaries

- Considering the needs of the full dual eligible beneficiary population, is the previous prioritization of measures still accurate?
    - If not, please provide proposed changes/updates.
    - Can any gap concepts be modified to be more specific?
- Do you agree or disagree with the proposed measure ideas for gap-filling?
    - Please edit as necessary.

Spend the last 5-10 minutes deciding on major points and be prepared to report them to the group.

Option 2: Measure Gap-Filling Activities for High-Need Subgroups

- What are the top two measure gaps for adults 18-65 with physical disabilities?
- What are the top two measure gaps for medically complex older adults?
- Do you agree or disagree with the proposed measure ideas for gap-filling?
    - Please edit as necessary.

Spend the last 5-10 minutes deciding on major points and be prepared to report them to the group.

Reporting Out

Please describe…

- Results of prioritization
- How you reached those decisions
- Response to proposed measure ideas for gap-filling

Measure Gap-Filling Opportunities: Experience of Care Survey Tool for Community-Based LTSS

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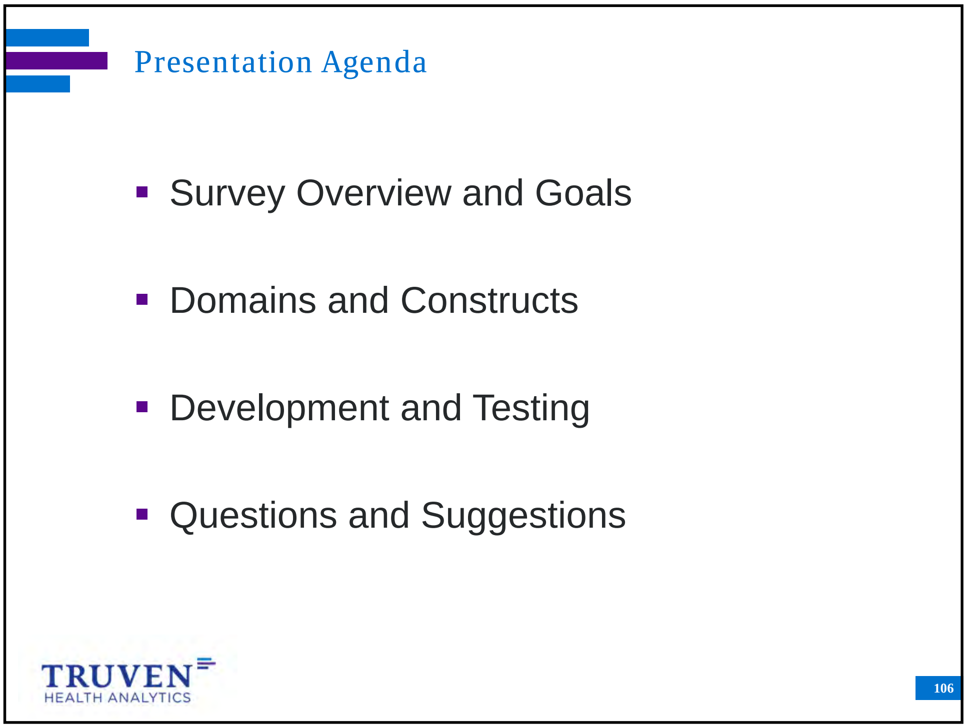
HEALTH ANALYTICS

HCBS EXPERIENCE SURVEY

Presentation to NQF MAP Dual Eligibles Workgroup

October 12, 2012



Presentation Agenda

- Survey Overview and Goals
- Domains and Constructs
- Development and Testing
- Questions and Suggestions

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The HCBS Experience Survey

- Goal of the survey is gather feedback on individuals' experience with Medicaid home and community-based services (HCBS)
  - All program authorities
- HCBS programs, not providers, are the unit of analysis
- Self-report
  - Designed to maximize individual response and avoid proxies
- Funded by CMS
  - Developed by Truven Health Analytics, in partnership with the American Institutes for Research
    - Other consultants provide additional support

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Key Survey Features

- **Cross-disability**
  - All disability populations receiving Medicaid-funded HCBS
  - Physical, cognitive and behavioral disabilities
- **Focus on experience, not satisfaction**
  - Actionable results
- **Address quality of life issues**
  - Includes domains and measures valued by program participants
- **Interviewer-administered**
  - Telephone and in-person modes
- **Alignment with existing CAHPS® tools**
  - Allow for benchmarking and comparisons between programs, states, and across the life span
  - Draft tool includes several standard CAHPS constructs

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Policy Context

- Affordable Care Act, Section 2701: Adult Quality Measures
  - Legislative authority
- AHRQ DRA measure scan findings
  - Paucity of tested, cross-disability measures for HCBS in key domains
- National Quality Strategy
  - Patient experience is a key component
- CMS long-standing use of the CAHPS family of instruments
- Select survey items relate to statutory requirements for Medicaid 1915c waivers
  - Primary authority for Medicaid HCBS

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Survey Domains

- Getting Needed Services from Personal Assistant and Behavioral Health Staff
- How Well Personal Assistant and Behavioral Health Staff Communicate and Treat You
- Getting Needed Services from Homemakers
- How Well Homemakers Communicate and Treat You
- Your Case Manager

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Survey Domains (con.)

- Choosing Your Services
- Transportation
- Personal Safety
- Community Inclusion and Empowerment
- Employment
    - Supplemental module

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Sample Constructs

- **Getting Needed Services from Personal Assistant and Behavioral Health Staff**
    - Unmet need in toileting
    - Unmet need in taking medication
- **How Well Homemakers Communicate and Treat You**
    - Individualized/responsive treatment by homemaker staff
    - Homemaker staff listen carefully
- **Your Case Manager**
    - Case manager responsive to service requests
- **Choosing Your Services**
    - Service plan includes what is important to participant
- **Personal Safety**
    - Assistance addressing physical abuse by paid staff
- **Community Inclusion and Empowerment**
    - Able to get together with friends when want

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CAHPS

- Tool is being developed and tested according to the principles of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) initiative
- Survey team collaborating with the Agency for Healthcare Research and Quality (AHRQ) and the CAHPS Consortium to obtain a CAHPS trademark for the final survey tool
  - Preliminary application in 2011
  - Formal review and feedback
  - Consulting expertise from Julie Brown, RAND Corporation
- CAHPS provides alignment with other CMS measurement initiatives
- Final application will be submitted after field testing

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HEALTH ANALYTICS

CAHPS Principles

- CAHPS surveys ask about aspects of care for which the recipient is the best or only source of information.
- CAHPS surveys ask about aspects of care that recipients say are most important and relevant to them.
- CAHPS surveys are developed with an understanding of how the data will be reported.
- All CAHPS products, including surveys, are in the public domain and free of charge.
- CAHPS surveys ask recipients to report on and rate the services they receive.
- CAHPS surveys consist of a common core set of measures that are administered to all respondents in a standardized manner to enable meaningful comparisons of providers.

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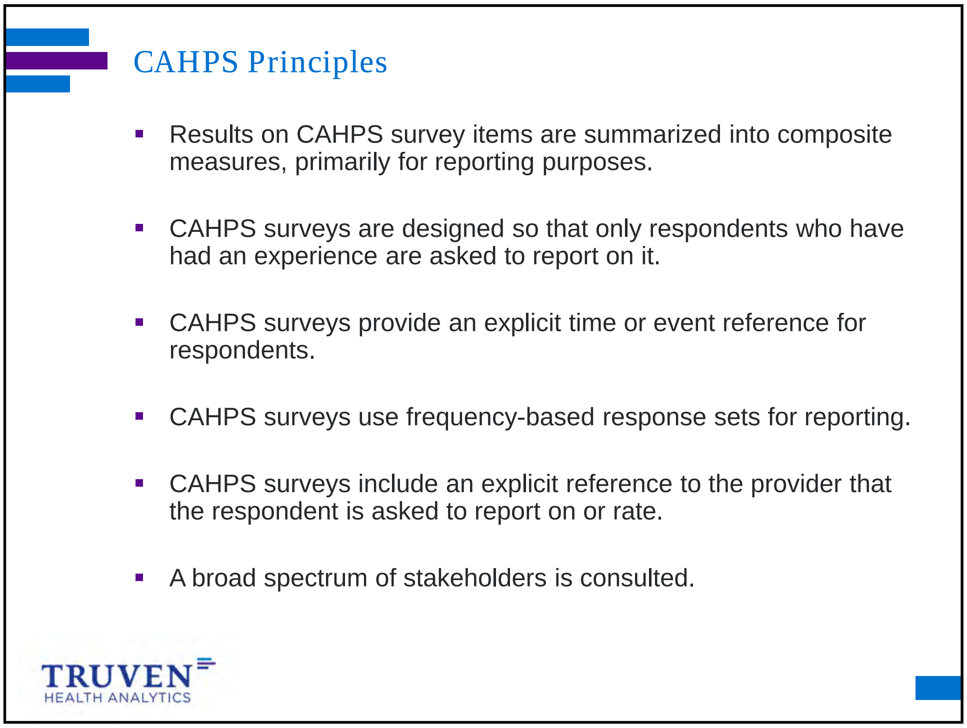
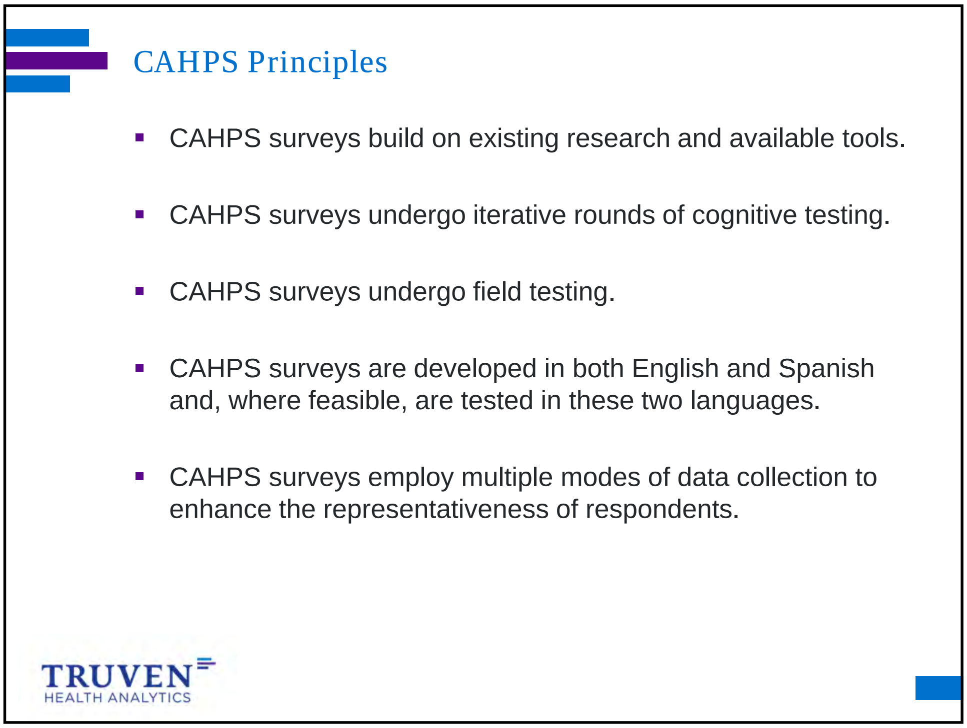
HEALTH ANALYTICS



CAHPS Principles

- Results on CAHPS survey items are summarized into composite measures, primarily for reporting purposes.
- CAHPS surveys are designed so that only respondents who have had an experience are asked to report on it.
- CAHPS surveys provide an explicit time or event reference for respondents.
- CAHPS surveys use frequency-based response sets for reporting.
- CAHPS surveys include an explicit reference to the provider that the respondent is asked to report on or rate.
- A broad spectrum of stakeholders is consulted.

TRUVEN HEALTH ANALYTICS



CAHPS Principles

- CAHPS surveys build on existing research and available tools.
- CAHPS surveys undergo iterative rounds of cognitive testing.
- CAHPS surveys undergo field testing.
- CAHPS surveys are developed in both English and Spanish and, where feasible, are tested in these two languages.
- CAHPS surveys employ multiple modes of data collection to enhance the representativeness of respondents.

TRUVEN HEALTH ANALYTICS

Phase I: Formative Research

- Literature review and collection of extant survey tools potentially relevant to HCBS services and populations
- Development of an 1,100 item “bank” of potential survey items culled from extant tools
- Formative research interviews and focus groups with a range of HCBS recipients (all disability types) in several states
    - Determine which services are used and how
    - Identify and rank potential quality domains and constructs
    - Identify common terms and titles for services and providers
    - 24 total participants
- Formative interviews revealed common quality domains and values across disability groups

TRUVEN
HEALTH ANALYTICS

Technical Expert Panel

- Technical Expert panel convened to provide input on survey development and testing. Representatives from:
    - Advocacy groups (e.g. SABE, NAMI, AARP, and ADAPT)
    - State Medicaid and Operating Agencies
    - State Associations (e.g. NASUAD, NASDDDS, and NASMHPD)
    - Federal Agencies
    - Researchers and survey development professionals
- Shoshanna Sofaer, PhD serves as the TEP facilitator
- Three TEP meetings held to date
    - In-person meeting with TEP (June 2010) to overview project and seek input on survey domains and data collection modes
    - Presentation of preliminary cognitive testing results to TEP, January 2011
    - Present draft instrument and field test methodology to TEP, April 2012

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Phase II: Cognitive Testing

- Drafted survey to reflect formative research findings and CAHPS principles, including standard CAHPS items where appropriate
- Conducted three rounds of in-depth cognitive testing interviews in English with HCBS recipients to assess comprehension and accessibility
    - All disability groups
    - Concurrent probes
    - 6 states total
- Response “experiments” per CAHPS Consortium recommendation to test appropriate item wording response options, with a focus on individuals with cognitive impairments
    - Compared multiple ordinal scales and item formats
        - Frequency
        - Rating
        - Time references

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HEALTH ANALYTICS

Cognitive Testing: Findings

- Alternate response options needed for some respondents
    - Frequency: Never/Sometimes/Usually/Always
    - Dichotomous: Mostly Yes/Mostly No
- Items should be set in the indefinite present
    - Explicit time reference (e.g. last six months) did not work for some respondents
- Need to determine services received by respondent to tailor survey, along with preferred/familiar staff titles
- Adjectival scales and willingness-to-recommend items perform better as ratings and are more accessible than numeric scales

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Spanish Language Version

- Survey and interviewing protocol translated into Spanish
  - Two certified translators conducted independent, simultaneous translation
  - Meet with senior translator to reconcile any differences
- One round of cognitive interviews with Spanish-speaking HCBS recipients and/or proxies
  - Texas and Florida
- Margarita Hurtado, PhD serves as a consultant on testing and translation
- Final survey draft reconciled English and Spanish translation issues

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Phase III: Field Testing

- Draft instrument and field testing proposal currently with OMB for review and approval to conduct large-scale, national data collection
- Training materials and protocols for survey vendors and interviewers under development
- Data collection will be conducted under the TEFT demonstration
  - Up to 10 states
  - 2 or more programs per state
- Sampling design to yield composites at the program level
- Goals
  - Compare the ability of disability groups to respond
  - Conduct psychometric analyses of field test data to evaluate reliability and validity
  - Evaluate survey administration logistics

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HEALTH ANALYTICS

Mode Test

- Field test includes mode test
- In-person interviews via computer-assisted personal interview (CAPI)
  - 80% of sample
- Telephone interviews via computer-assisted telephone interview (CATI)
  - 20% of sample
- Hypothesis is that CATI will not work well for some disability groups
  - Individuals with intellectual impairments
  - Individuals with dementia
  - Individuals with auditory or speech impairments
- However, CATI is less resource-intensive

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HEALTH ANALYTICS

Phase IV: Reporting Composites and Tool Endorsement

- Field test data will be used to modify items and create final version of survey
- Factor analysis to guide development of reporting composites and to determine which items to retain
- Draft templates for public reporting back to field test states
- Final CAHPS submission package following field test, to seek trademark
- Application to the National Quality Forum for endorsement

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Discussion Questions

- Does the HCBS Experience Survey have applicability for use in dual eligible programs (e.g., Medicare/Medicaid integrated care demo)?
  - Is it relevant to all duals, or to specific subpopulations of duals?
  - If relevant to only some, how should an accountable care entity identify subpopulations that are important to measure?
- As currently designed, the HCBS Experience Survey holds the HCBS **program** (e.g., the 1915(c) waiver) as the accountable entity. Can the HCBS Experience Survey be used to hold a health **plan** accountable (a plan that provides services articulated in the survey)?
  - Can the survey be used to hold a health plan's care coordination provider accountable?

Discussion Questions

- Because some persons in the HCBS population have cognitive impairments, the HCBS Experience Survey has been designed as an interviewer administered survey, rather than a mail survey. As a result the survey is expensive, in comparison to other experience surveys.
  - How important is it to measure person reported outcomes (e.g., experience with care), among the venerable dual eligible population, using an in-person data collection method?
  - How might CMS and the States balance the importance of person reported outcomes with survey data collection costs?
- Excluding traditional acute care services (which are measured in other experience surveys) are their other services important to the duals that should be included in the experience survey, but are not?

Measure Gap-Filling Opportunities: Prior Development of Quality Measures for People with Disabilities

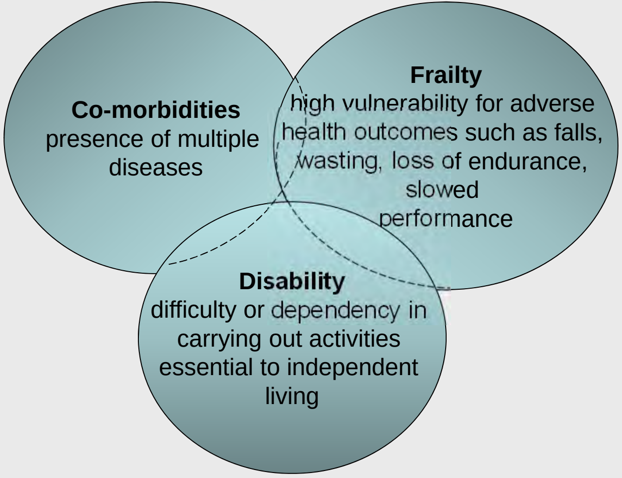
Quality Measures for People with Disabilities

Sue Palsbo, PhD
Margaret Mastal, PhD, RN

Funders

- National Institute for Disability and Rehabilitation Research
  - 6 years
  - #H133A040016
- California HealthCare Foundation
  - #07-1085
- Center for Health Care Strategies
- 6 years and 9 peer reviewed publications

Why Develop New Measures?



Co-morbidities
presence of multiple diseases

Frailty
high vulnerability for adverse health outcomes such as falls, wasting, loss of endurance, slowed performance

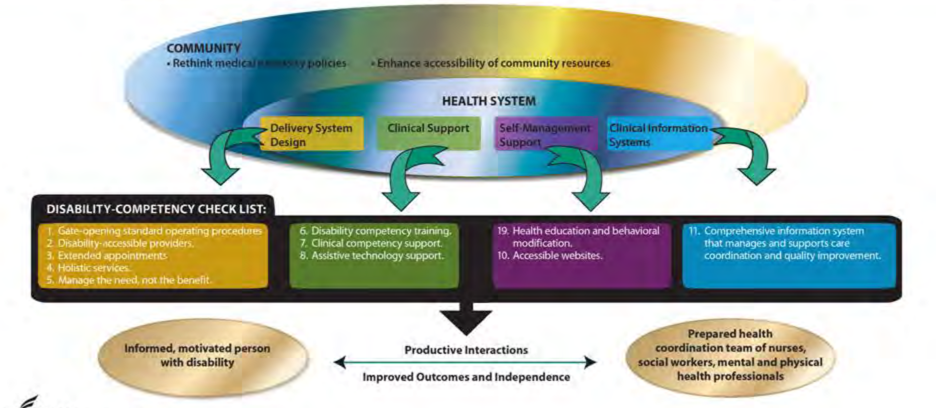
Disability
difficulty or dependency in carrying out activities essential to independent living

Fried LP, Ferrucci L, Darer J, Williamson JD, Anderson G. Untangling the concepts of disability, frailty, and comorbidity: implications for improved targeting and care. ***The Journal of Gerontology*** Series A, Biological Sciences And Medical Sciences. 2004;59(3):255-63.

Desired Attributes

- Minimize additional reporting burden
- Clinically meaningful and actionable measures
- Mark progress towards public health and public policy goals
  - Healthy People 2010
- Street credibility
  - Adopted by a measurement steward
  - Used by measurement brokers

DISABILITY-COMPETENT HEALTH SYSTEMS



DISABILITY-COMPETENCY CHECK LIST:

1. Gate-opening standard operating procedures
2. Disability-accessible providers.
3. Extended appointments
4. Holistic services.
5. Manage the need, not the benefit.

6. Disability competency training.
7. Clinical competency support.
8. Assistive technology support.

19. Health education and behavioral modification.
10. Accessible websites.

11. Comprehensive information system that manages and supports care coordination and quality improvement.

GEORGE MASON UNIVERSITY | Center for the Study of Chronic Illness and Disability

SOURCE: Palsbo, Susan E. and Kailes, June I., in *Disability Studies Quarterly*, 26(2), Spring 2006.
Adapted from: Wagner, E.H. "Chronic Disease Management" *Effective Clinical Practice* 1998;1:2–4.

Strategic 2-Pronged Approach

- Administrative measures
  - Claims and membership data collected *in the course of doing daily care coordination*
- Survey measures
  - Measures reporting health care experiences
  - Measures for which the respondent is the best or only source of information
  - Led to development of an “enabled” Medicaid CAHPS instrument called the ***AHPPPAL Survey.***

Measurement Advisory Panel

- Medical Directors and CEOs of Medicaid delivery systems for dual eligibles of working age with physical disabilities
  - These measures come out of real-world experiences
- Statisticians
- Experts in providing health care to people with disabilities
- Some of the panelists had personal experience in living with disability

Appendix A: New Measurement Set

- 41 measures
- Access to care
- Access to care coordination
- Effectiveness of care and care coordination
- Use of selected services

Comparison of Existing and New Measures

- 19 existing HEDIS measures
- 5 existing CMS measures
- 17 new measures identified as important for disability CCOs, *and* which are retrievable from electronic databases.
  - Living arrangements
  - Timely assessment screens and individual service plans
  - Encounters with different types of physicians
  - Hospital and ER utilization
  - Timely dispensing and repair of wheelchairs
  - Pressure ulcers, urinary tract infections, bowel disorders, spasticity management, screening for osteoporosis for wheelchair users

Appendix B: Technical Specifications

New measures that, in our MAP's experience, are important for quality care coordination of dual eligibles

1. Types of Living Arrangements
2. Migration from Institution to Community Setting
3. Migration from Community Setting to an Institution
4. Termination of Participation
5. Member Complaints and Grievances
6. Timely Individual Service Plan Initiation
7. Beneficiaries with Dental Encounters
8. Timely Access to Durable Medical Equipment: Wheelchair
9. Timely Access to Durable Medical Equipment: Wheelchair Repair
10. Pressure Ulcer Management
11. Urinary Tract Disorders Management
12. Bowel Disorder Management
13. Spasticity Management
14. Screening of High-Risk Beneficiaries for Osteoporosis

Also, 19 of the HEDIS Measures

1. Enrollment by product line (Medicaid, Medicaid/Medicare, etc)
2. Race/Ethnicity Diversity of Membership
3. Language Diversity of Membership
4. Beneficiaries with Primary Care Physician encounters
5. Beneficiaries with Medical Specialist encounters
6. Beneficiaries with Surgical Specialty encounters
7. Beneficiaries with Dental Encounters
8. Hospital admissions
9. Hospital readmissions within 7 days and 14 days
10. Ambulatory visits to emergency rooms, ambulatory surgery facilities and total outpatient visits.*
11. Identification of Alcohol and other Drug Services
12. Colorectal Cancer Screening
13. Breast Cancer Screening
14. Cervical Cancer Screening
15. Comprehensive Diabetes Care
16. Asthma Management
17. Management of Mental Illness after Hospital Discharge

** Item #10 is actually 3 separate measures.*

Findings

- At time of study, there was no CPT code for developing an Individual Service Plan.
- Depending on target population, number of people in denominator may be very small.
  - But if have 100% information, confidence interval is 0!
- May want to adjust for functional mix
  - Limitations across 4 realms: neuropsychological, activities of daily living, sensory, ambulatory
  - (see Palsbo, Diao, Palsbo et al.)

Next Step

- Identify a measurement steward.
- We prefer that the measures be in the public domain, since the bulk of the work was funded by the federal government.

Workgroup Discussion and Questions

Opportunity for Public Comment

Wrap Up

Outline for December 2012 Interim Report

Major sections anticipated to include:

I. Revised Duals Core Measure Set
II. Guidance to States Applying MAP Recommendations
III. Pre-Rulemaking Input Across MAP
IV. Specialized Measures for High-Need Subpopulations of Dual Eligible Beneficiaries
V. Measure Gaps and Gap-Filling Activities
VI. Technical Requirements and Data Needs
VII. Next Phase of Work

Important Future Dates

- **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

- Dual Eligible Beneficiaries Workgroup: Anticipated Meetings in 2013
  - February Web Meeting
  - March In-Person Meeting

Thank You!

Web Meeting Homework Analysis

Responses

NQF received responses from ten workgroup members. Additional comments were provided by United Healthcare and several stakeholders in the California Dual Eligible Beneficiaries Demonstration Project. Roughly half of respondents provided a health plan perspective.

Themes

- Employ a mix of cross-cutting and targeted measures due to heterogeneity of dual eligible population
- Use smallest number of measures possible to ensure quality in order to reduce burden of data collection and reporting
    - Caution should be paid to the number and frequency of patient surveys, further caution regarding the validity of self-reported surveys from individuals with mental illness and/or cognitive limitations
- "One size does not fit all" – measures' fit-for-purpose must be considered in the context of a level of analysis and particular measurement program
- Ensure consistency in reporting by providing clear and complete technical specifications on each measure to those collecting and analyzing data
- Feasibility of sharing and collecting data across providers may be limited by lack of interoperability, health plan carve-outs, and confidentiality requirements
- Acknowledge the importance of factors outside of the health system, particularly during care transitions (e.g., stable housing)

Measure Number	Measure Title	Level(s) of Analysis	Input Received from Workgroup	Noted Considerations and Potential Modifications	Workgroup Response
NQF #0004	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Health Plan; Integrated Delivery System; Population: County or City, Regional, National	• Health plans concerned about how much accountability can be placed on providers and plans; improvement is tied to social and individual factors • Consider a composite measurement strategy of multiple elements that allows for "partial credit" • Privacy barriers to identify denominator population	Suggest to represent identification of dependence, initiation of treatment, and engagement in treatment as separate elements in a composite measure.	Note that denominator is derived from claims for individuals diagnosed with an episode of alcohol or drug dependency. No additional action needed.

Measure Number	Measure Title	Level(s) of Analysis	Input Received from Workgroup	Noted Considerations and Potential Modifications	Workgroup Response
NQF #0022	Use of High Risk Medications in the Elderly	Clinician: Individual, Group/Practice; Health Plan; Integrated Delivery System	• Measure should be updated to reflect new criteria for determining high-risk meds • Many drug/disease interactions are possible and vary across populations; this measure is not appropriate for application beyond specified population		The measure steward is aware of the change in clinical guidelines and is working with NQF to update the measure. No additional action needed.
NQF #0028	Measure pair: a. Tobacco Use Assessment, b. Tobacco Cessation Intervention	Clinician: Individual, Team, Group/Practice	• Data collection methodology unclear for SNPs, other plans • Smoking status is reported by patient; concerned about validity. CMS has removed this measure from Medicare Part C plan ratings. • Individuals with SMI/SAD disproportionately affected by tobacco use		Note that measure includes codes to identify tobacco use items or medical record review may be conducted. Note that measure is specified for individual clinician or practice-level measurement. Measure #0027 is similar; it is derived through patient survey but is used by NCQA and may be an alternative for health plans.
NQF #0097	Medication Reconciliation	Clinician: Individual, Group/Practice; Integrated Delivery System; Population: County or City	• Population should be expanded (e.g., 18-64) • Time window should be shorter	• Suggest that the time window in which patient should see physician after discharge be condensed, potentially to 30 days or fewer. • Suggest that denominator population be expanded to include all age groups.	Note that measure is specified for population, delivery system, or individual clinician or practice-level measurement. Measure #0554 is similar and may be an alternative for health plans, but it has been recommended that the two be combined.

Measure Number	Measure Title	Level(s) of Analysis	Input Received from Workgroup	Noted Considerations and Potential Modifications	Workgroup Response
NQF #0101	Falls: Screening for Fall Risk	Clinician : Individual, Team, Group/Practice	• Populations should be expanded (e.g., 18-64) • Needs to go beyond screening • Measure in HOS requires beneficiary to recall and report if they were screened and counseled. Suggest alternative data sources to supplement.	• Suggest that the measure be expanded to include anyone at risk for a fall (e.g., individuals with mobility impairments), not just individuals older than 65. • Suggest that an intervention be incorporated for those who screen positively. Other measures may address this. • Suggest that multiple data sources be used for accuracy.	No additional action needed. Considerations and modifications will be documented in MAP Report.
NQF #0208	Family Evaluation of Hospice Care	Facility; Population: National	• Data collection methodology unclear for SNPs, other plans as health plans do not cover hospice services • Should also be expanded to palliative care	Suggest an additional survey or modifications to the survey which would include palliative care more generally.	Note that measure is specified for facility-level or national measurement. **Survey-based measure; is the burden of reporting justified?**
NQF #0209	Comfortable Dying: Pain Brought to a Comfortable Level Within 48 Hours of Initial Assessment	Facility; Population: National	• Data collection methodology unclear for SNPs, other plans as health plans do not cover hospice services • Should be expanded to all appropriate settings • Requested clarification on meaning of "comfortable"	• Give consideration to operationalizing this measure as pain assessment across settings; at a minimum could be applied more broadly to other types of palliative care. • Suggest that advance care directives are equally important to ensure high-quality care.	Note that measure is specified for facility-level or national measurement. Note that pain level is reported by individual receiving treatment. No additional action needed.

Measure Number	Measure Title	Level(s) of Analysis	Input Received from Workgroup	Noted Considerations and Potential Modifications	Workgroup Response
NQF #0228	3-Item Care Transition Measure (CTM-3)	Facility/Agency	• Should be expanded to all appropriate settings • Consider importance of components beyond healthcare in transitions • Caution regarding accuracy of self-reported survey data	Broaden to additional settings beyond inpatient, such as ER and nursing facility discharges.	**Survey-based measure; is the burden of reporting justified?** No additional action needed. Considerations and modifications will be documented in MAP Report.
NQF #0260	Assessment of Health-related Quality of Life (Physical & Mental Functioning)	Facility/Agency	• Should be broadened to include other populations (e.g., <65 and non-dialysis) • Many additional constructs are often a part of the concept of "quality of life" and should be considered for measurement.	• Emphasized for its consideration of quality of life, a rarity among available measures. • Current survey is dialysis-specific and therefore inappropriate to use more broadly. It should be used as a template for the development of a related measure of general health-related quality of life. • Outcome measure preferred.	Measure asks for survey to be administered; is the burden of reporting justified? **Workgroup will discuss quality of life as a measure gap area during the October meeting.** Considerations and modifications will be documented in MAP Report.
NQF #0418	Screening for Clinical Depression	Clinician: Individual	• Important to measure, but other measures can/should be used. Consider PHQ-2, PHQ-9. • Claims and encounter data may be incomplete for this process		Note that measure is specified for individual clinician level measurement. Clinicians would have freedom to use validated tool of their choice (e.g., PHQ-9).

Measure Number	Measure Title	Level(s) of Analysis	Input Received from Workgroup	Noted Considerations and Potential Modifications	Workgroup Response
NQF #0421	Adult Weight Screening and Follow-Up	Clinician: Individual, Group/Practice; Population: County or City, Regional, State, National	• Lack of accessible equipment may lead to large numbers of people with disabilities being excluded • Potential unintended consequences; appropriate adherence to psychotropic medications may dramatically increase BMI	• Noted as especially important in psychiatric patients, because individuals receiving certain medications are susceptible to increased BMI. • Physical activity may be equally important to measure.	No additional action needed. Considerations and modifications will be documented in MAP Report.
NQF #0430	Change in Daily Activity Function as Measured by the AM-PAC	Clinician: Individual; Facility	• Population age and care settings should be expanded • Consideration should be given to account for not only measuring improvement, but also maintenance of functional as well as management of decline • Data collection methodology unclear for SNPs, other plans	• Emphasized for its consideration of functional status, a rarity among available measures. • Suggest it be adapted beyond post-acute care. • Measure has curative orientation. Include maintenance of functional status if this is all that can be realistically expected. If goal is to slow the rate of decline, this measure is not appropriate. • Address floor effects observed when tool is applied to complex patients. • Presents data collection burden.	Note that measure is specified for facility and individual clinician level measurement. Presents a large data collection burden, relies on EHR, and applies to small patient population. **Consider for removal from set?** Considerations and modifications will be documented in MAP Report.

Measure Number	Measure Title	Level(s) of Analysis	Input Received from Workgroup	Noted Considerations and Potential Modifications	Workgroup Response
NQF #0523	Pain Assessment Conducted	Facility	• Difficult for health plans to use; duplicative of HEDIS measure "Care of Older Adults - Pain Assessment"	• Suggest expansion beyond home health care. • Outcome measure of pain management would be preferred.	Note that measure is specified for facility level measurement. No additional action needed. Considerations and modifications will be documented in MAP Report.
NQF #0557	HBIPS-6 Post discharge continuing care plan created	Facility	• Not appropriate for health plan use • Consider importance of components beyond healthcare in transitions • Should apply to all discharges	• This type of transition planning/communication is universally important. • Suggest expansion to all discharges, not just psychiatric. At a minimum, the measure should include inpatient detox. • This measure is paired and should be used in conjunction with HBIPS-7.	Note that measure is specified for facility level measurement. No additional action needed. Considerations and modifications will be documented in MAP Report.
NQF #0558	HBIPS-7 Post discharge continuing care plan transmitted to next level of care provider upon discharge	Facility	• Not appropriate for health plan use • Consider importance of components beyond healthcare in transitions • Should apply to all discharges	• This type of transition planning/communication is universally important. • Suggest expansion to all discharges, not just psychiatric. At a minimum, the measure should include inpatient detox. • Information should be transmitted to both nursing facility and primary care provider, if applicable. • This measure is paired and should be used in conjunction with HBIPS-6.	Note that measure is specified for facility level measurement. No additional action needed. Considerations and modifications will be documented in MAP Report.

Measure Number	Measure Title	Level(s) of Analysis	Input Received from Workgroup	Noted Considerations and Potential Modifications	Workgroup Response
NQF #0576	Follow-Up After Hospitalization for Mental Illness	Clinician: Team, Integrated Delivery System; Health Plan; Population: County or City, Regional, State, National	• Consider importance of components beyond healthcare in transitions and links to the system of community mental health providers • Plans requested experience collecting this measure before it is used for accountability purposes	Suggest expansion to incorporate substance use disorders/detox.	No additional action needed. Considerations and modifications will be documented in MAP Report.
NQF #0647	Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	Facility; Integrated Delivery System	• Broaden beyond specified sites/settings • Consider importance of components beyond healthcare in transitions	Do not limit to certain transition sites/settings.	No additional action needed. Considerations and modifications will be documented in MAP Report.
NQF #0648	Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	Facility; Integrated Delivery System	• Broaden beyond specified sites/settings • Providers may require experience collecting this measure before it is used for accountability purposes	Do not limit to certain transition sites/settings.	No additional action needed. Considerations and modifications will be documented in MAP Report.

Measure Number	Measure Title	Level(s) of Analysis	Input Received from Workgroup	Noted Considerations and Potential Modifications	Workgroup Response
NQF #0729	Optimal Diabetes Care	Clinician: Group/Practice; Integrated Delivery System	• Stratification may be needed to target quality improvement efforts (e.g., SMI/SAD, elderly, etc.)	• While the all-or-none composite measure is considered to be the gold standard that reflects the best patient outcomes, the individual components may be measured as well. • Comments considered this measure to be resource-intensive because it requires review of medical charts; proposed that diabetes measures in the HEDIS set would be less burdensome to report. • Stakeholders expressed concerns that the individual targets within the measure may be too aggressive, especially for individuals who are older and/or who have multiple chronic conditions.	Note that measure is specified for clinician practice or integrated delivery system level measurement. No additional action needed. Considerations and modifications will be documented in MAP Report.
NQF #1768	Plan All-Cause Readmissions	Health Plan	• Appropriate risk-adjustment needed • Differentiate between planned and unplanned admissions		Note that the measure is risk-adjusted. MAP Families of Measures Report includes guidance on the application of admission/readmission measures used in payment and public reporting programs.

Measure Number	Measure Title	Level(s) of Analysis	Input Received from Workgroup	Noted Considerations and Potential Modifications	Workgroup Response
NQF #1789	Hospital-Wide All-Cause Unplanned Readmission Measure (HWR)	Facility	• Appropriate risk-adjustment needed		Note that the measure is risk-adjusted. MAP Families of Measures Report includes guidance on the application of admission/readmission measures used in payment and public reporting programs.
NQF #1909 (formerly 0494)	Medical Home System Survey	Clinician: Individual, Team, Group/Practice,	• Consider non-healthcare related components • Health home should have meaningful consumer and family involvement • Varying levels of medical "homeness" (e.g., different levels of readiness, targeted populations)	• Care management might be appropriately conducted by other parties besides primary care physician (e.g., family member, clinical specialist, PACE site). • A health home's approach to care management must consider both Medicaid and Medicare benefits. • Consider broader application in shared accountability models such as ACOs and health homes. • May be more important to measure whether duals have access to a usual source of primary care rather than the primary care providers' ability to meet these high standards.	**Extensive survey-based measure; is the burden of reporting justified?** **This NCQA accreditation standard for a medical home may not be widely applicable. Remove from set?** No additional action needed. Considerations and modifications will be documented in MAP Report.

Measure Number	Measure Title	Level(s) of Analysis	Input Received from Workgroup	Noted Considerations and Potential Modifications	Workgroup Response
NQF #s 0005, 0006, 0007, 0258, 0517	CAHPS Surveys (Consumer Assessment of Healthcare Providers and Systems)	Various	• Needs to be re-examined for applicability within the disabled/SMI population • Concern about over-surveying consumers	• High prevalence of cognitive impairment and language barriers in dual eligible population will complicate reliable data collection. • Individual providers may not treat a large enough number of dual eligible beneficiaries to have sufficient sample size to calculate the measures. • Case mix and risk adjustment are considerations when comparing across health plans, providers, or other entities.	**Survey-based measures; is the burden of reporting justified?** Workgroup will discuss measures of care experience for people with disabilities and/or long-term care needs. Considerations and modifications will be documented in MAP Report.
n/a	SNP 6: Coordination of Medicare and Medicaid Coverage.	Health Plan	• Suggest looking at accessibility of DME • Needs to be expanded beyond SNP	Measure currently applies to Medicare Advantage Special Needs Plans only. Suggest modification and expansion to other entities if possible.	No additional action needed. Considerations and modifications will be documented in MAP Report.
n/a	Alcohol Misuse: Screening, Brief Intervention, Referral for Treatment	Not Available	• Needs to be expanded beyond alcohol • Measure is not endorsed. Similar AMA-PCPI measure will be submitted to NQF.	Suggest screening for other types of risky substance use.	**Replace with AMA-PCPI measure "Unhealthy Alcohol Use: Screening and Brief Counseling" pending NQF endorsement?**
n/a (Endorsement Removed)	The Ability to Use Health Information Technology to Perform Care Management at the Point of Care	Not Available	• Varying levels of HIT readiness to evaluate current usefulness	Could also capture this concept as a percentage of providers in a defined area or network achieving Meaningful Use incentives.	**Endorsement was removed at the request of the measure steward because that organization is no longer maintaining the measure. Remove from set?**

Preventative Care & Screening
Unhealthy Alcohol Use: Screening & Brief Counseling

Measure: Percentage of patients aged 18 years and older who were screened for unhealthy alcohol use at least once during the two-year measurement period using a systematic screening method AND who received brief counseling if identified as an unhealthy alcohol user

.

Measure Specification

Measure #3: Unhealthy Alcohol Use: Screening & Brief Counseling

Preventive Care & Screening

This measure may be used as an Accountability measure.

Measure Description

Percentage of patients aged 18 years and older who were screened for unhealthy alcohol use at least once during the two-year measurement period using a systematic screening method AND who received brief counseling if identified as an unhealthy alcohol user

Measure Components

Numerator Statement	Patients who were screened for unhealthy alcohol use* at least once during the two-year measurement period using a systematic screening method[§] AND who received brief counseling** if identified as an unhealthy alcohol user **Unhealthy alcohol use covers a spectrum that is associated with varying degrees of risk to health. Categories representing unhealthy alcohol use include risky use, problem drinking, harmful use, and alcohol abuse, and the less common but more severe alcoholism and alcohol dependence. Risky use is defined as >7 standard drinks per week or >3 drinks per occasion for women and persons >65 years of age; >14 standard drinks per week or >4 drinks per occasion for men ≤65 years of age.* ***Brief counseling refers to one or more counseling sessions, a minimum of 5-15 minutes, which may include: feedback on alcohol use and harms; identification of high risk situations for drinking and coping strategies; increased motivation and the development of a personal plan to reduce drinking[5].*
Denominator Statement	All patients aged 18 years and older who were seen twice for any visits or who had at least one preventive care visit during the two-year measurement period
Denominator Exclusions	Documentation of medical reason(s) for not screening for unhealthy alcohol use (eg, limited life expectancy)
Supporting Guideline	The following evidence statements are quoted verbatim from the referenced clinical guidelines. The USPSTF strongly recommends screening and behavioral counseling interventions to reduce alcohol misuse by adults, including pregnant women, in primary care settings. (B Recommendation) (USPSTF, 2004[1]) During new patient encounters and at least annually, patients in general and mental healthcare settings should be screened for at-risk drinking, alcohol use problems and illnesses, and any tobacco use. (NQF, 2007[2]) All patients identified with alcohol use in excess of National Institute on Alcohol Abuse and Alcoholism guidelines and/or any tobacco use should receive brief motivational counseling intervention by a healthcare worker trained in this technique. (NQF, 2007[2])

[§] A systematic method of assessing for unhealthy alcohol use should be utilized. Please refer to the National Institute on Alcohol Abuse and Alcoholism publication: *Helping Patients Who Drink Too Much: A Clinician's Guide* for additional information regarding systematic screening methods., Available at: http://pubs.niaaa.nih.gov/publications/Practitioner/CliniciansGuide2005/guide.pdf.

Measure Importance

Relationship to desired outcome	Brief counseling interventions for unhealthy alcohol use have shown to be effective in reducing alcohol use[3,4,5].
Opportunity for Improvement	From 1998-2000, 45% of patients were screened for problem drinking[6].
Exclusion Justification	The measure development Work Group determined that the provision of preventive care and screening services—such as for patients with terminal illness—is not appropriate in all cases. Therefore, a medical exclusion is included in this measure so that those patients may be excluded from the denominator.
Harmonization with Existing Measures	This measure was harmonized to the extent feasible with the National Committee for Quality Assurance Health Effectiveness Data Information Set (HEDIS).

Measure Designation

Measure Purpose	• Quality Improvement • Accountability
Type of Measure	• Process
Care Setting	• Ambulatory Care
Data Source	• Administrative Data combined with medical record review • Medical record • Electronic health record system • Prospective data collection flowsheet

Technical Specifications: Administrative Data

Administrative claims data collection requires users to identify the eligible population (denominator) and numerator using codes recorded on claims or billing forms (electronic or paper). Users report a rate based on all patients in a given practice for whom data are available and who meet the eligible population/denominator criteria.
The specifications listed below are those needed for performance calculation.

Denominator (Eligible Population)

All patients aged 18 years and older who were seen at least twice for any visits or who had at least one preventive care visit during the two-year measurement period

CPT E/M Service code:
Two visits during the two year measurement period

- 99201, 99202, 99203, 99204, 99205 (Office or other outpatient services-new patient)
- 99212, 99213, 99214, 99215 (Office or other outpatient services-established patient)
- 90801, 90802 (Psychiatric diagnostic or evaluative interview)
- 90804, 90805, 90806, 90807, 90808, 90809, 90810, 90811, 90812, 90813, 90814, 90815 (Psychiatric therapeutic procedures-office or other outpatient)
- 90845, 90862 (Other Psychotherapy)
- 96150, 96152 (Health and Behavior Assmt/Intervention)
- 97003, 97004 (Occupational therapy evaluations)
- 97802, 97803, 97804, G0270, G0271 (Medical Nutrition Therapy)
- 98960, 98961, 98962 (Education and Training-patient self-management)

OR

CPT E/M Service Code:
One preventive care visit during the two year measurement period

- 99385, 99386, 99387 (Initial comprehensive preventive medicine-new patient)
- 99395, 99396, 99397 (Initial comprehensive preventive medicine-established patient)
- 99401, 99402, 99403, 99404 (Preventive medicine, Individual Counseling)
- 99411, 99412 (Preventive medicine, Group Counseling)
- 99420 (Other preventive medicine services-administration and interpretation of health risk assmt)
- 99429 (Unlisted preventive)

Numerator

Patients who were screened for unhealthy alcohol use* at least once during the two-year measurement period using a systematic screening method[**] AND who received brief counseling if identified as an unhealthy alcohol user

The numerator for this measure cannot be captured by a CPT Category II code. Data may be collected from other sources, such as medical record abstraction, prospective data collection flowsheet, or through electronic health record systems.

Additionally, the numerator can be met through identification of the CPT Category I code listed below. Please note that the CPT Category I Codes below require at least a fifteen minute intervention, but the numerator of this performance measure does not have a length of time requirement. Shorter interventions also meet the numerator requirements.

CPT Category I code-Screening and Brief Intervention
**The following codes are applicable if the patient screened positive for unhealthy alcohol use and brief interventional services were provided for at least 15 minutes. Services of less than 15 minutes may not be reported using the following codes.*

- 99408, 99409 (Alcohol structured screening and brief intervention)

Denominator Exclusions

Documentation of medical reason(s) for screening for unhealthy alcohol use (eg, limited life expectancy)

Technical Specifications: Electronic Health Record System

Technical specifications for electronic health record systems are developed for all measures after they are approved.

Technical Specifications: Prospective Data Collection Flowsheet

Prospective data collection flowsheets are developed for measure sets after they are approved.

References

[**] A systematic method of assessing for unhealthy alcohol use should be utilized. Please refer to the National Institute on Alcohol Abuse and Alcoholism publication: *Helping Patients Who Drink Too Much: A Clinician's Guide* for additional information regarding systematic screening methods., Available at: http://pubs.niaaa.nih.gov/publications/Practitioner/CliniciansGuide2005/guide.pdf.

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[1] U.S. Preventive Services Task Force. Screening and behavioral counseling interventions in primary care to reduce alcohol misuse: recommendation statement. April 2004. Agency for Healthcare Research and Quality. Rockville, MD. Available at: http://www.ahrq.gov/clinic.3rd uspstf/alcohol/alcomisrs.htm. Accessed November 2007.

[2] National Quality Forum. National voluntary consensus standards for the treatment of substance use conditions: evidence-based treatment practices. Washington, DC: National Quality Forum; 2007.

[3] Fleming MF. Screening and brief intervention in primary care settings. *Alcohol Res Health* 2005/2005;28:57-62

[4] Saitz R. Unhealthy alcohol use. *N Engl J Med* 2005;352:596-607.

[5] Kaner EFS, Beyer F, Dickinson HO, Pienaar E, Campbell F, Schlesinger C, Heather N, Saunders J, Burnand B. Effectiveness of brief alcohol interventions in primary care populations. *Cochrane Database of Systematic Reviews* 2007, Issue 2. Art. No.: CD004148. DOI: 10.1002/14651858.CD004148.pub3.

[6] Technical Appendix to McGlynn EA, Asch SM, Adams JL, et al. Who is at greatest risk for receiving poor quality health care? *N Engl J Med* 2006;354:1147-1156. Available at http://www.rand.org/pubs/working_papers/WR-174-1. Accessed January 2008.

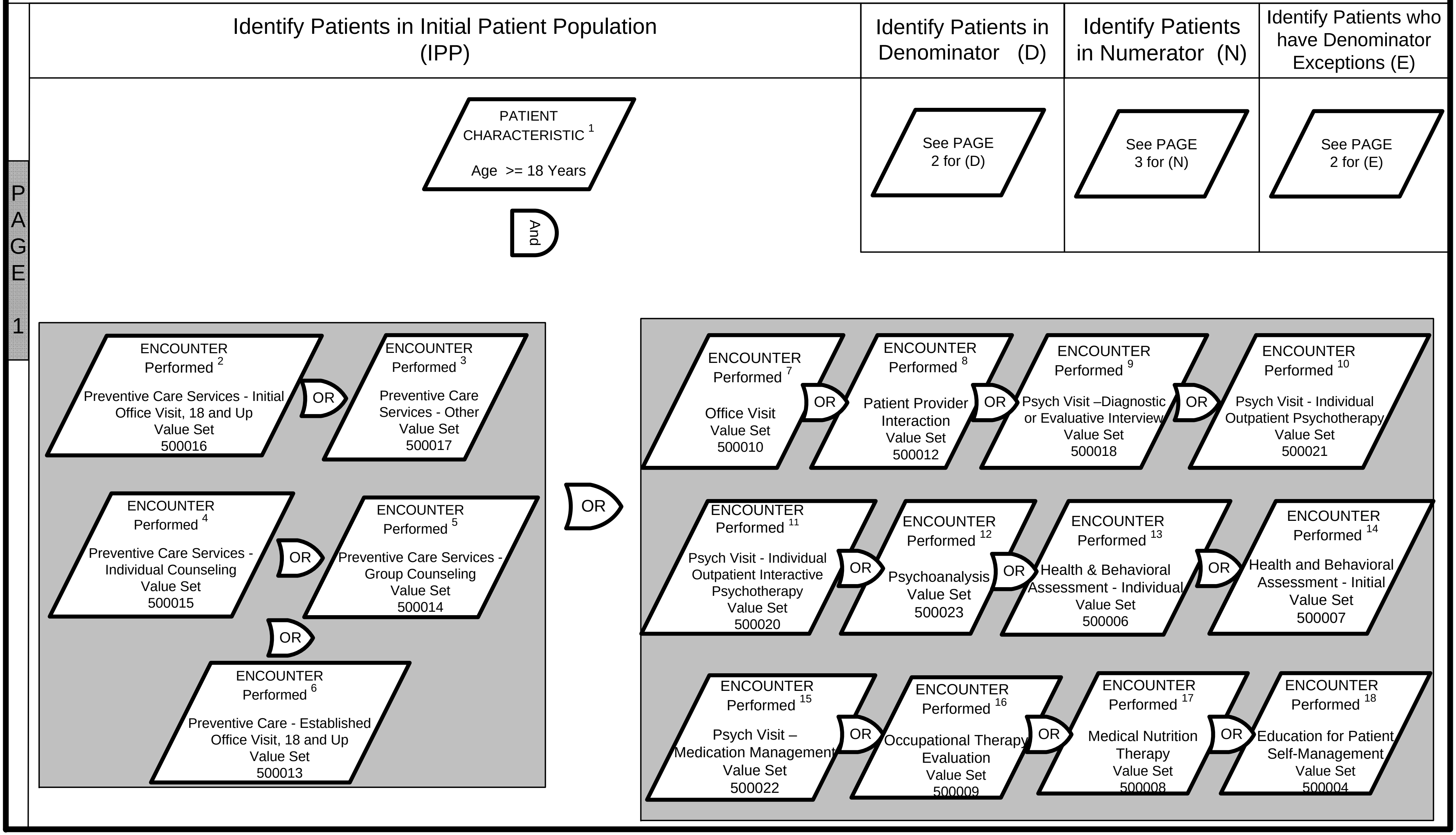
Measure eSpecification

Text Description for PCPI eSpecification

Clinical Topic	**Preventive Care & Screening**
Measure Title	**Unhealthy Alcohol Use: Screening & Brief Counseling**
Measure #	**PCPI # PCS-3**
Measure Description	Percentage of patients aged 18 years and older who were screened for unhealthy alcohol use at least once within 24 months using a systematic screening method AND who received brief counseling if identified as an unhealthy alcohol user
Measurement Period	12 consecutive months
Initial Patient Population	Patient Age: Patient aged 18 and older starts before the start of the measurement period Encounter Performed: At least two patient provider interactions or encounters during measurement period OR one preventive care visit during measurement period
Denominator Statement	All patients aged 18 years and older who were seen twice for any visits or who had at least one preventive care visit during the measurement period
Numerator Statement	Patients who were screened for unhealthy alcohol use* at least once within 24 months using a systematic screening method AND who received brief counseling** if identified as an unhealthy alcohol user Numerator Notes: *Unhealthy alcohol use covers a spectrum that is associated with varying degrees of risk to health. Categories representing unhealthy alcohol use include risky use, problem drinking, harmful use, and alcohol abuse, and the less common but more severe alcoholism and alcohol dependence. Risky use is defined as >7 standard drinks per week or >3 drinks per occasion for women and persons >65 years of age; >14 standard drinks per week or >4 drinks per occasion for men ≤65 years of age. **Brief counseling refers to one or more counseling sessions, a minimum of 5-15 minutes, which may include: feedback on alcohol use and harms; identification of high risk situations for drinking and coping strategies; increased motivation and the development of a personal plan to reduce drinking.
Denominator Exceptions	Documentation of medical reason(s) for not screening for unhealthy alcohol use (eg, limited life expectancy, other medical reasons)

Visual Representation for PCPI eSpecification

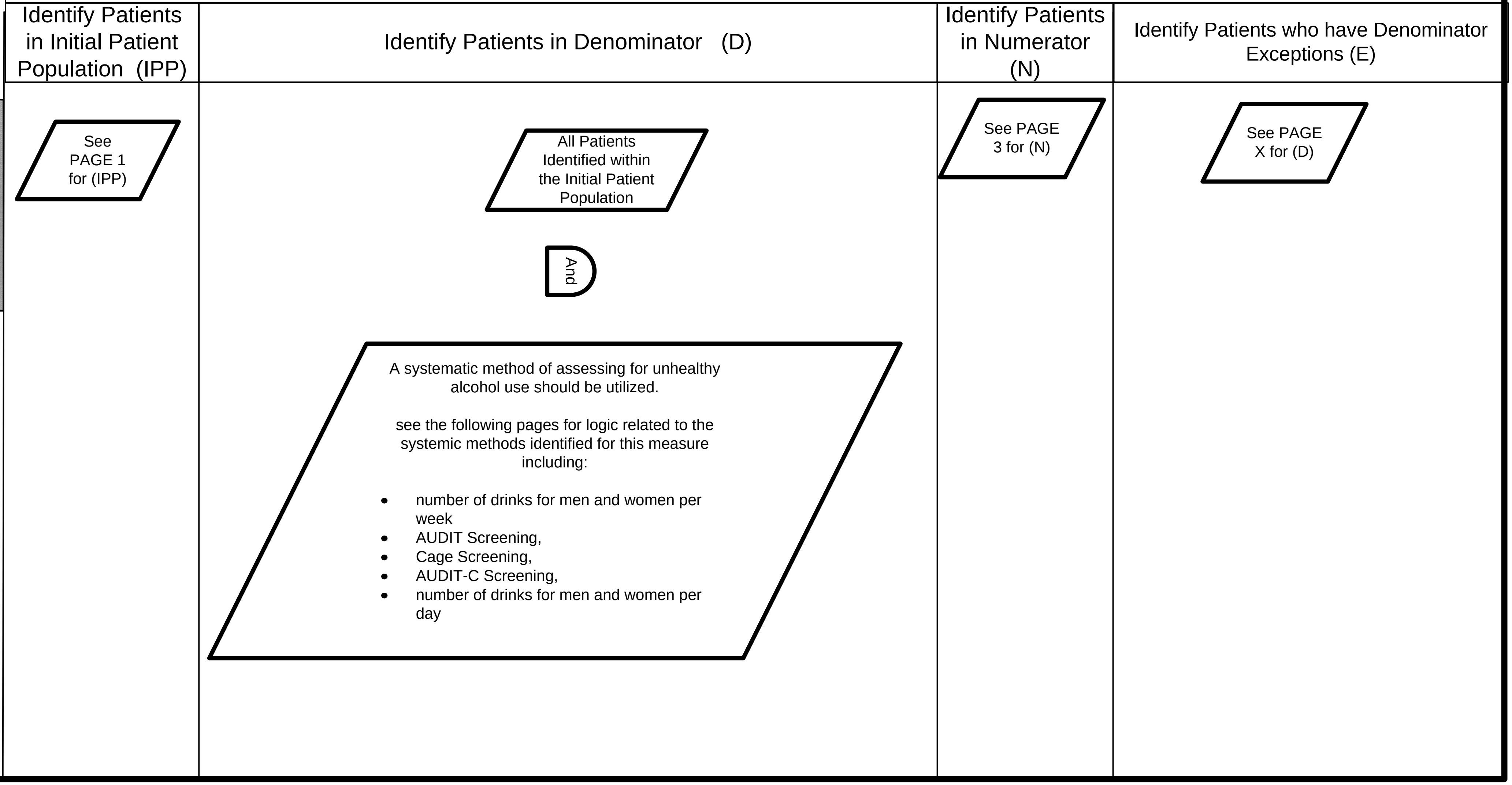
Measure Logic for Preventive Care & Screening: Unhealthy Alcohol Use: Screening & Brief Counseling
Measure Description: Percentage of patients aged 18 years and older who were screened for unhealthy alcohol use at least once within 24 months using a systematic screening method AND who received brief counseling if identified as an unhealthy alcohol user
Measurement Period: 12 Consecutive Months
PCPI Measure #: PCS-3



PARAMETER SPECIFICATIONS (Value Sets are found in the Coding Appendices):
IPP: [1] Patient Characteristic: measurement start date minus birth date (value set 500001) ≥ 18 years starts before the start of measurement period;
[2 3 4 5 6] Encounter, Performed: during measurement period – COUNT >= 1; [7 8 9 10 11 12 13 14 15 16 17 18] Encounter, Performed: during measurement period – COUNT >= 2;

Visual Representation for PCPI eSpecification

Measure Logic for Preventive Care & Screening: Unhealthy Alcohol Use: Screening & Brief Counseling
Measure Description: Percentage of patients aged 18 years and older who were screened for unhealthy alcohol use at least once within 24 months using a systematic screening method AND who received brief counseling if identified as an unhealthy alcohol user
Measurement Period: 12 Consecutive Months
PCPI Measure #: PCS-3



A systematic method of assessing for unhealthy alcohol use should be utilized.

see the following pages for logic related to the systemic methods identified for this measure including:

- number of drinks for men and women per week
- AUDIT Screening,
- Cage Screening,
- AUDIT-C Screening,
- number of drinks for men and women per day

PARAMETER SPECIFICATIONS (Value Sets are found in the Coding Appendices):
D: [19] Patient Characteristic: during measurement period; [20] Patient Characteristic: during measurement period; [21] Patient Characteristic: measurement start date minus birth date (value set 500001) <= 65 years starts before the start of measurement period; [22] Patient Characteristic: during measurement period; [23] Patient Characteristic: measurement start date minus birth date (value set 500001) > 65 years starts before the start of measurement period;
E: [24] Attribute, Negation Rationale: during measurement period; [25] Diagnosis, Active: starts before or during measurement period;

****Patients will fall into one of the three denominator pathways -- D(a) OR D(b) OR D(c); all patients in (D) will be evaluated for (N) criteria****

Visual Representation for PCPI eSpecification

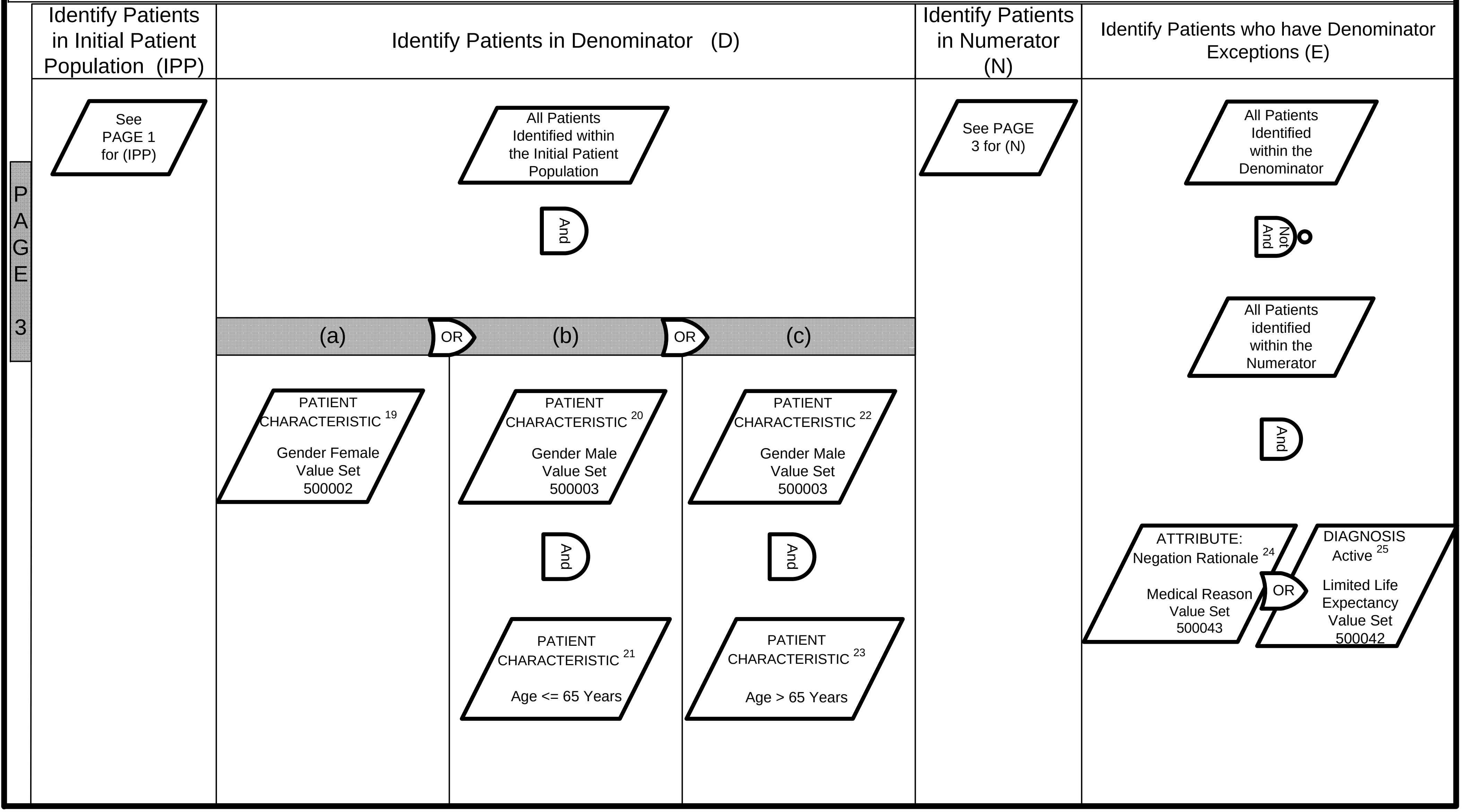
Weekly Use Logic

Measure Logic for Preventive Care & Screening: Unhealthy Alcohol Use: Screening & Brief Counseling

Measure Description: Percentage of patients aged 18 years and older who were screened for unhealthy alcohol use at least once within 24 months using a systematic screening method AND who received brief counseling if identified as an unhealthy alcohol user

Measurement Period: 12 Consecutive Months

PCPI Measure #: PCS-3



PARAMETER SPECIFICATIONS (Value Sets are found in the Coding Appendices):

D: [19] Patient Characteristic: during measurement period; [20] Patient Characteristic: during measurement period; [21] Patient Characteristic: measurement start date minus birth date (value set 500001) <= 65 years starts before the start of measurement period; [22] Patient Characteristic: during measurement period; [23] Patient Characteristic: measurement start date minus birth date (value set 500001) > 65 years starts before the start of measurement period;

E: [24] Attribute, Negation Rationale: during measurement period; [25] Diagnosis, Active: starts before or during measurement period;

****Patients will fall into one of the three denominator pathways -- D(a) OR D(b) OR D(c); all patients in (D) will be evaluated for (N) criteria****

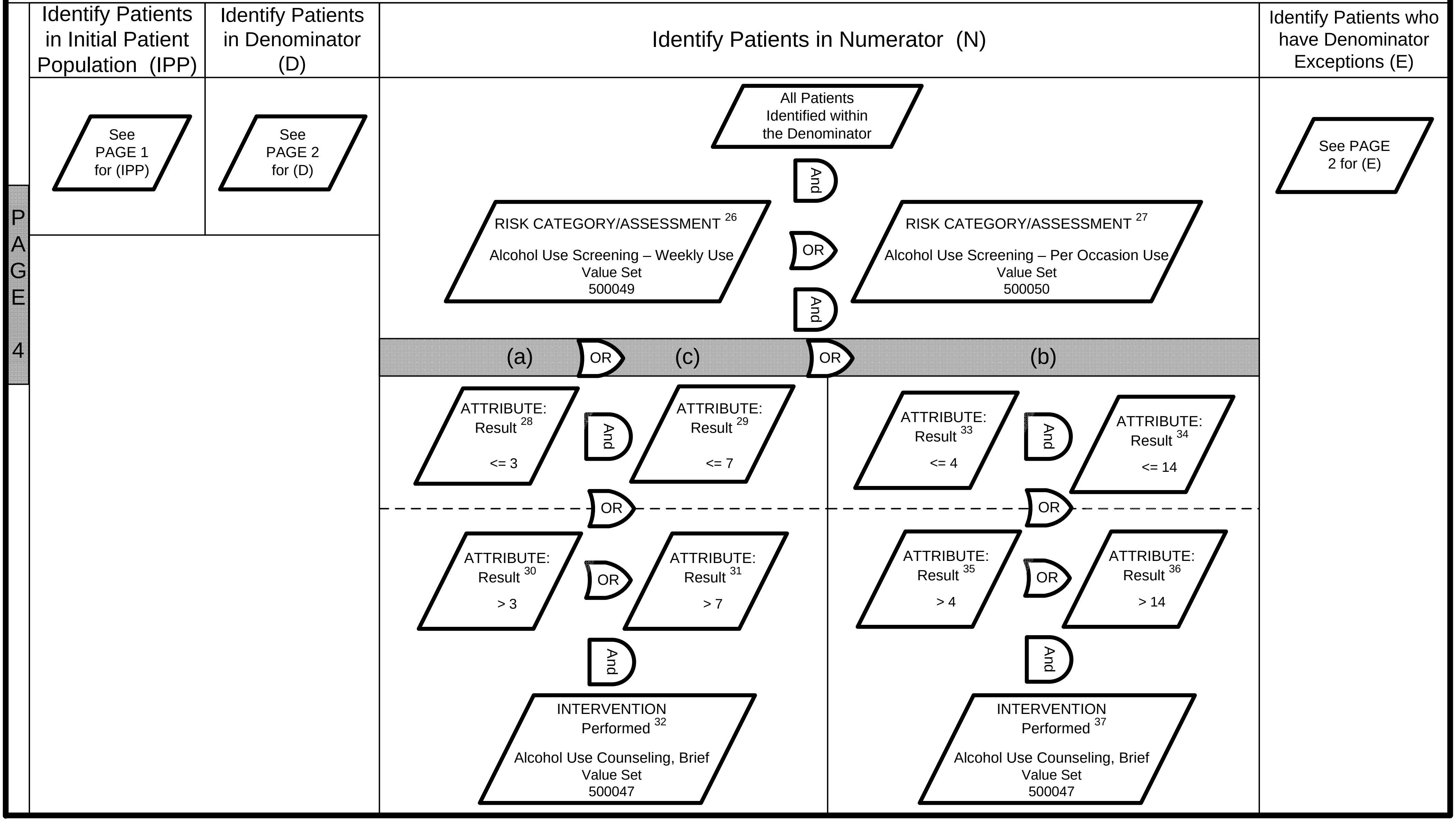
Visual Representation for PCPI eSpecification

Measure Logic for Preventive Care & Screening: Unhealthy Alcohol Use: Screening & Brief Counseling

Measure Description: Percentage of patients aged 18 years and older who were screened for unhealthy alcohol use at least once within 24 months using a systematic screening method AND who received brief counseling if identified as an unhealthy alcohol user

Measurement Period: 12 Consecutive Months

PCPI Measure #: PCS-3



PARAMETER SPECIFICATIONS (Value Sets are found in the Coding Appendices):

To meet this measure, patients in D(a) and D(c) should follow pathway N(a) and N(c); patients in D(b) should follow pathway N(b);

N: [26] Risk Category/Assessment: starts before start of [measurement end date] <= 24 months; [27] Risk Category/Assessment: starts before start of [measurement end date] <= 24 months; [28] Attribute, Result: this attribute is applied to [27] [Risk CategoryAssessment]; [29] Attribute, Result: this attribute is applied to [26] [Risk Category/Assessment]; [30] Attribute, Result: this attribute is applied to [27] [Risk Category/Assessment]; [31] Attribute, Result: this attribute is applied to [26] [Risk Category/Assessment]; [32] Intervention, Performed: starts before start of [measurement end date] <= 24 months; [33] Attribute, Result: this attribute is applied to [27] [Risk Category Assessment]; [34] Attribute, Result: this attribute is applied to [26] [Risk Category/Assessment]; [35] Attribute, Result: this attribute is applied to [27] [Risk Category/Assessment]; [36] Attribute, Result: this attribute is applied to [26] [Risk Category/Assessment]; [37] Intervention, Performed: starts before start of [measurement end date] <= 24 months;

Visual Representation for PCPI eSpecification

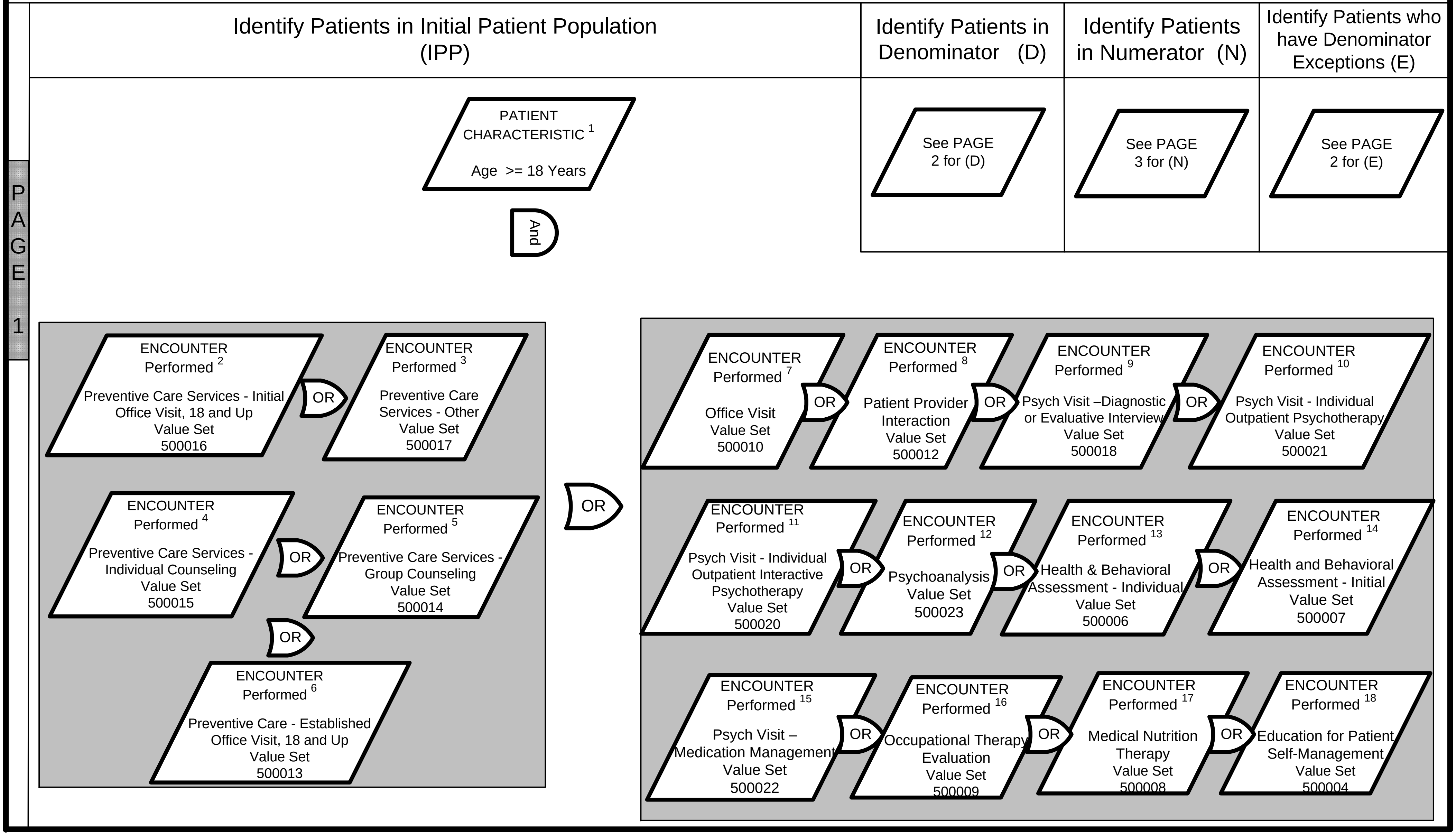
AUDIT Logic

Measure Logic for Preventive Care & Screening: Unhealthy Alcohol Use: Screening & Brief Counseling

Measure Description: Percentage of patients aged 18 years and older who were screened for unhealthy alcohol use at least once within 24 months using a systematic screening method AND who received brief counseling if identified as an unhealthy alcohol user

Measurement Period: 12 Consecutive Months

PCPI Measure #: PCS-3



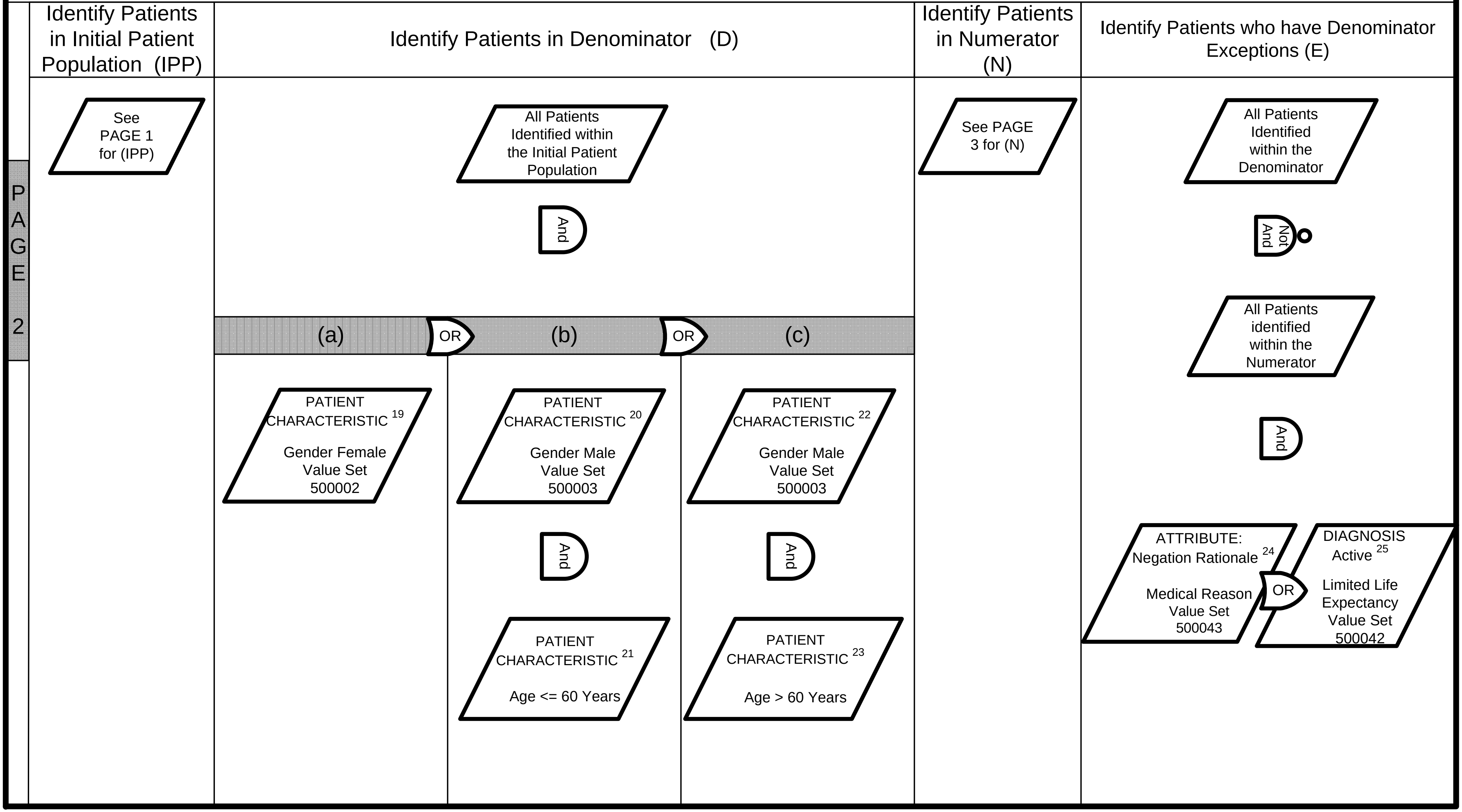
PARAMETER SPECIFICATIONS (Value Sets are found in the Coding Appendices):

IPP: [1] Patient Characteristic: measurement start date minus birth date (value set 500001) ≥ 18 years starts before the start of measurement period;

[2 3 4 5 6] Encounter, Performed: during measurement period – COUNT >= 1; [7 8 9 10 11 12 13 14 15 16 17 18] Encounter, Performed: during measurement period – COUNT >= 2;

Visual Representation for PCPI eSpecification

Measure Logic for Preventive Care & Screening: Unhealthy Alcohol Use: Screening & Brief Counseling
Measure Description: Percentage of patients aged 18 years and older who were screened for unhealthy alcohol use at least once within 24 months using a systematic screening method AND who received brief counseling if identified as an unhealthy alcohol user
Measurement Period: 12 Consecutive Months
PCPI Measure #: PCS-3



PARAMETER SPECIFICATIONS (Value Sets are found in the Coding Appendices):

D: [19] Patient Characteristic: during measurement period; [20] Patient Characteristic: during measurement period; [21] Patient Characteristic: measurement start date minus birth date (value set 500001) <= 60 years starts before the start of measurement period; [22] Patient Characteristic: during measurement period; [23] Patient Characteristic: measurement start date minus birth date (value set 500001) > 60 years starts before the start of measurement period;

E: [24] Attribute, Negation Rationale: during measurement period; [25] Diagnosis, Active: starts before or during measurement period;

****Patients will fall into one of the three denominator pathways -- D(a) OR D(b) OR D(c); all patients in (D) will be evaluated for (N) criteria****

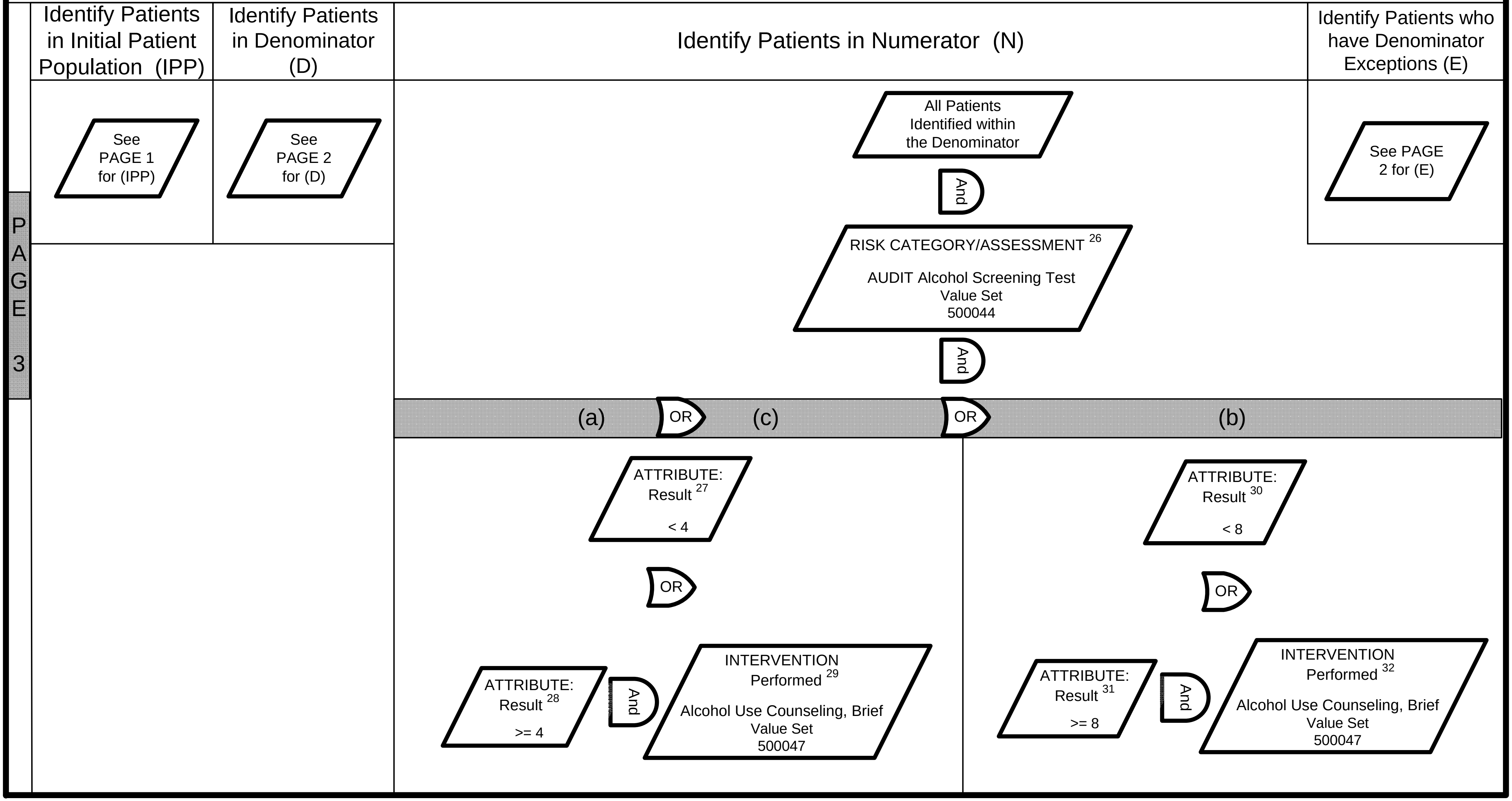
Visual Representation for PCPI eSpecification

Measure Logic for Preventive Care & Screening: Unhealthy Alcohol Use: Screening & Brief Counseling

Measure Description: Percentage of patients aged 18 years and older who were screened for unhealthy alcohol use at least once within 24 months using a systematic screening method AND who received brief counseling if identified as an unhealthy alcohol user

Measurement Period: 12 Consecutive Months

PCPI Measure #: PCS-3



PARAMETER SPECIFICATIONS (Value Sets are found in the Coding Appendices):

To meet this measure, patients in D(a) and D(c) should follow pathway N(a)/N(c); patients in D(b) should follow pathway N(b);

N: [26] Risk Category/Assessment: starts before start of [measurement end date] <= 24 months; [27] Attribute, Result: this attribute is applied to [26] [Risk CategoryAssessment]; [28] Attribute, Result: this attribute is applied to [26] [Risk Category/Assessment]; [29] Intervention, Performed: starts before start of [measurement end date] <= 24 months; [30] Attribute, Result: this attribute is applied to [26] [Risk Category/Assessment]; [31] Attribute, Result: this attribute is applied to [26] [Risk Category/Assessment]; [32] Intervention, Performed: starts before start of [measurement end date] <= 24 months;

Visual Representation for PCPI eSpecification

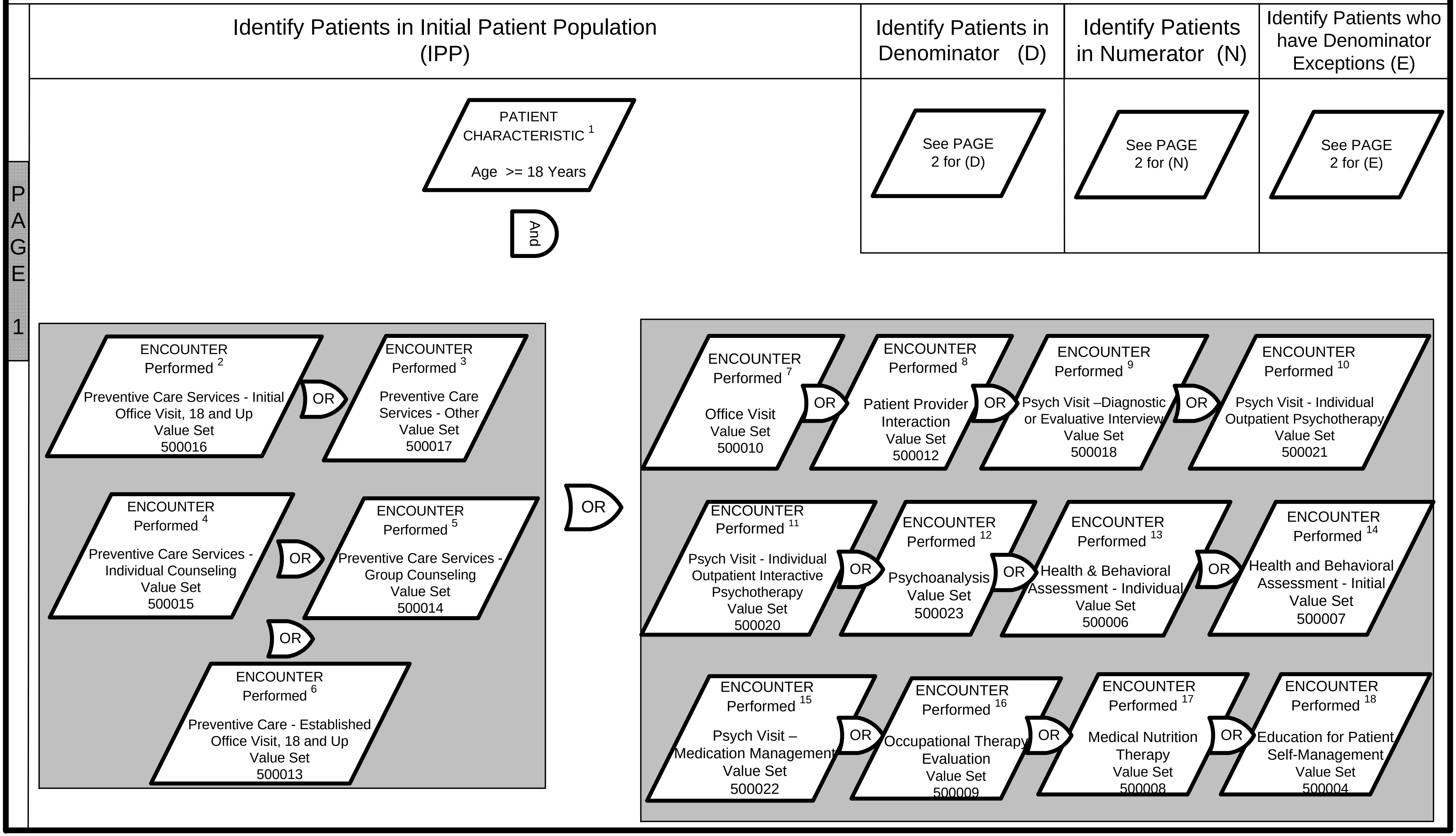
CAGE LOGIC

Measure Logic for Preventive Care & Screening: Unhealthy Alcohol Use: Screening & Brief Counseling

Measure Description: Percentage of patients aged 18 years and older who were screened for unhealthy alcohol use at least once within 24 months using a systematic screening method AND who received brief counseling if identified as an unhealthy alcohol user

Measurement Period: 12 Consecutive Months

PCPI Measure #: PCS-3



PARAMETER SPECIFICATIONS (Value Sets are found in the Coding Appendices):

IPP: [1] Patient Characteristic: measurement start date minus birth date (value set 500001) ≥ 18 years starts before the start of measurement period;

[2 3 4 5 6] Encounter, Performed: during measurement period – COUNT >= 1; [7 8 9 10 11 12 13 14 15 16 17 18] Encounter, Performed: during measurement period – COUNT >= 2;

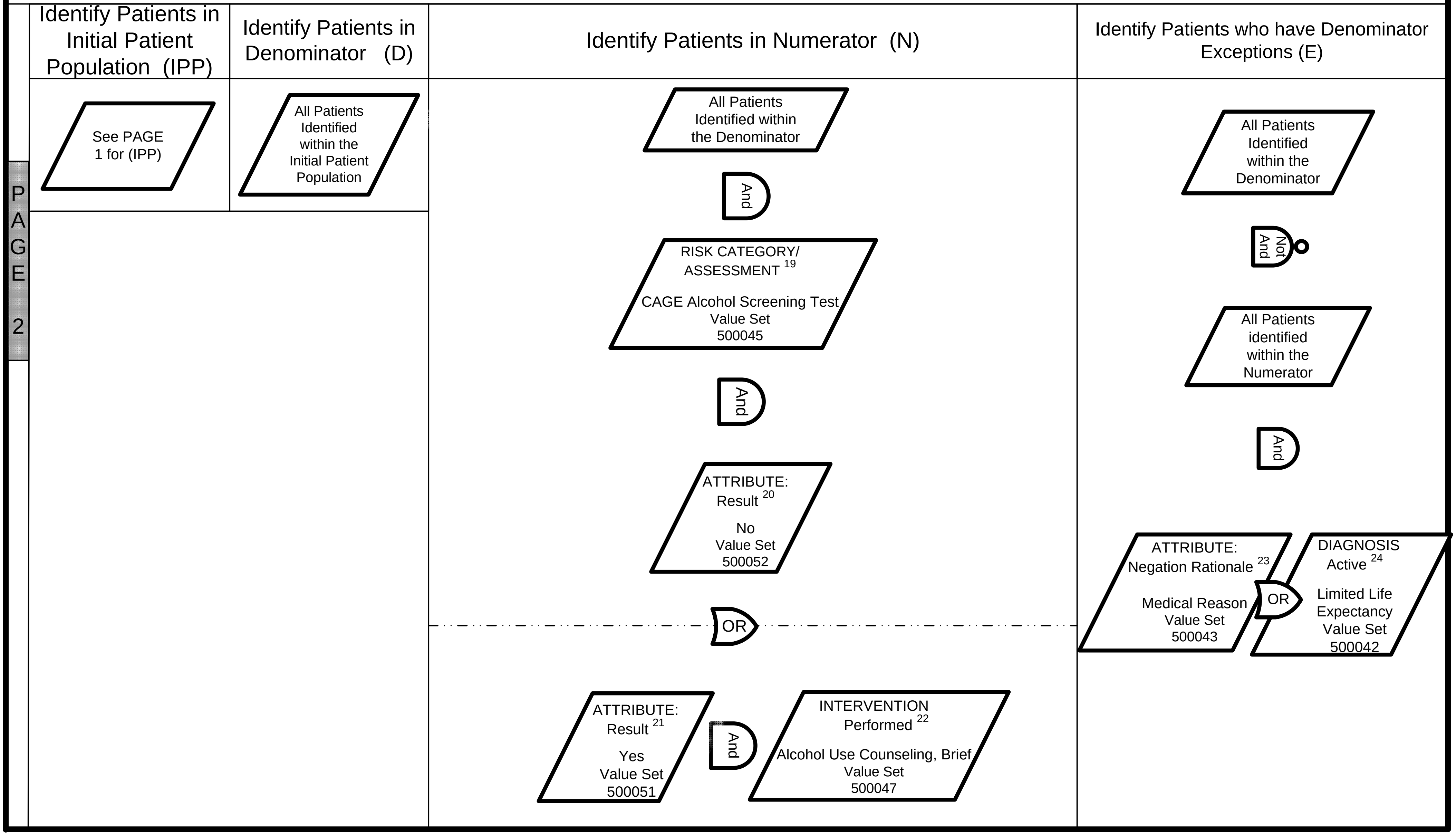
Visual Representation for PCPI eSpecification

Measure Logic for Preventive Care & Screening: Unhealthy Alcohol Use: Screening & Brief Counseling

Measure Description: Percentage of patients aged 18 years and older who were screened for unhealthy alcohol use at least once within 24 months using a systematic screening method AND who received brief counseling if identified as an unhealthy alcohol user

Measurement Period: 12 Consecutive Months

PCPI Measure #: PCS-3



PARAMETER SPECIFICATIONS (Value Sets are found in the Coding Appendices):

N: [19] Risk Category/Assessment: starts before start of [measurement end date] <= 24 months; [20] Attribute, Result: this attribute is applied to [19] [Risk Category/Assessment]; [21] Attribute, Result: this attribute is applied to [19] [Risk Category/Assessment] – COUNT >= 2; [22] Intervention, Performed: starts before start of [measurement end date] <= 24 months;

E: [23] Attribute, Negation Rationale: during measurement period; [24] Diagnosis, Active: starts before or during measurement period;

Visual Representation for PCPI eSpecification

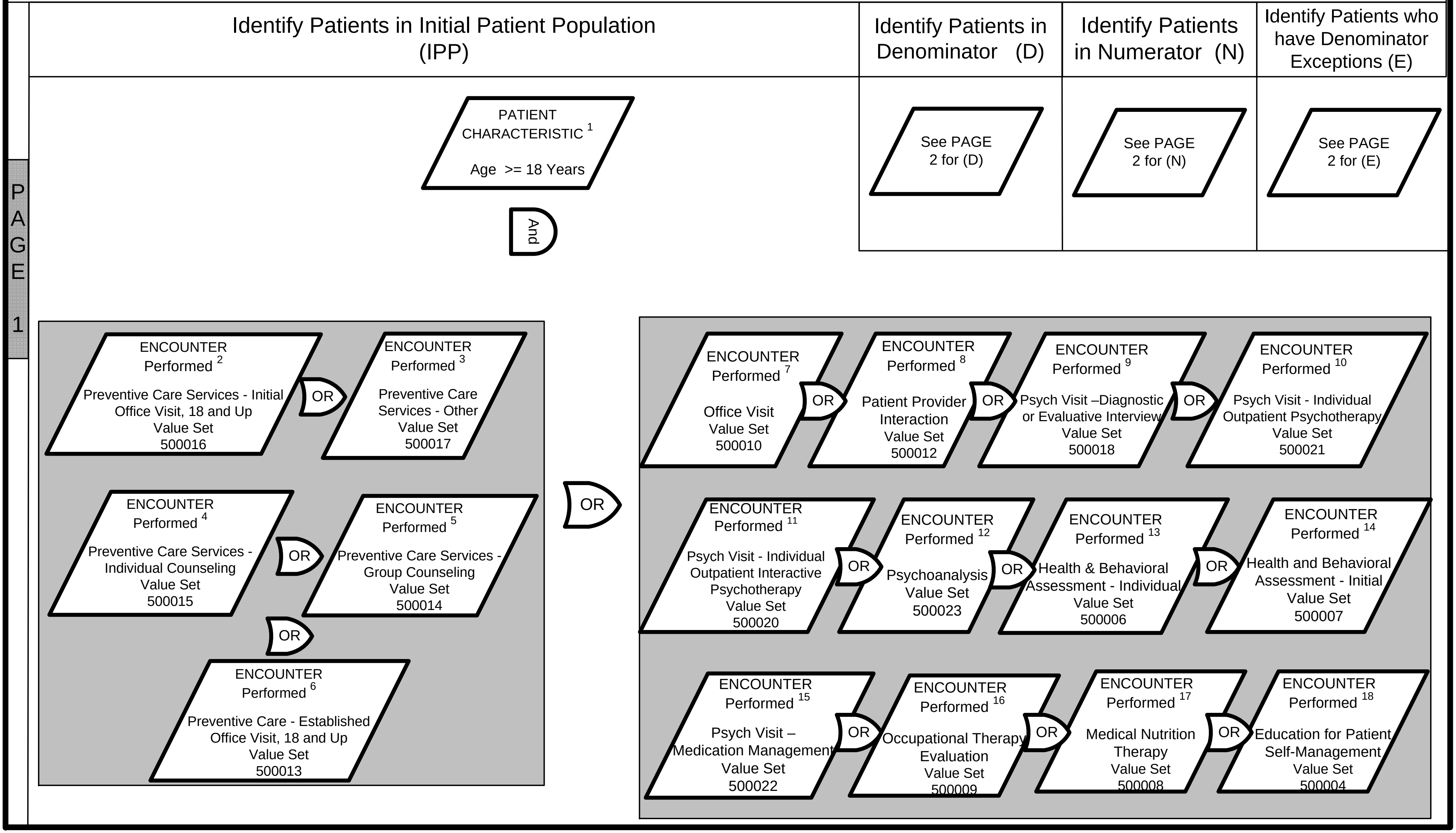
AUDIT-C Logic

Measure Logic for Preventive Care & Screening: Unhealthy Alcohol Use: Screening & Brief Counseling

Measure Description: Percentage of patients aged 18 years and older who were screened for unhealthy alcohol use at least once within 24 months using a systematic screening method AND who received brief counseling if identified as an unhealthy alcohol user

Measurement Period: 12 Consecutive Months

PCPI Measure #: PCS-3



PARAMETER SPECIFICATIONS (Value Sets are found in the Coding Appendices):

IPP: [1] Patient Characteristic: measurement start date minus birth date (value set 500001) ≥ 18 years starts before the start of measurement period;

[2 3 4 5 6] Encounter, Performed: during measurement period – COUNT >= 1; [7 8 9 10 11 12 13 14 15 16 17 18] Encounter, Performed: during measurement period – COUNT >= 2;

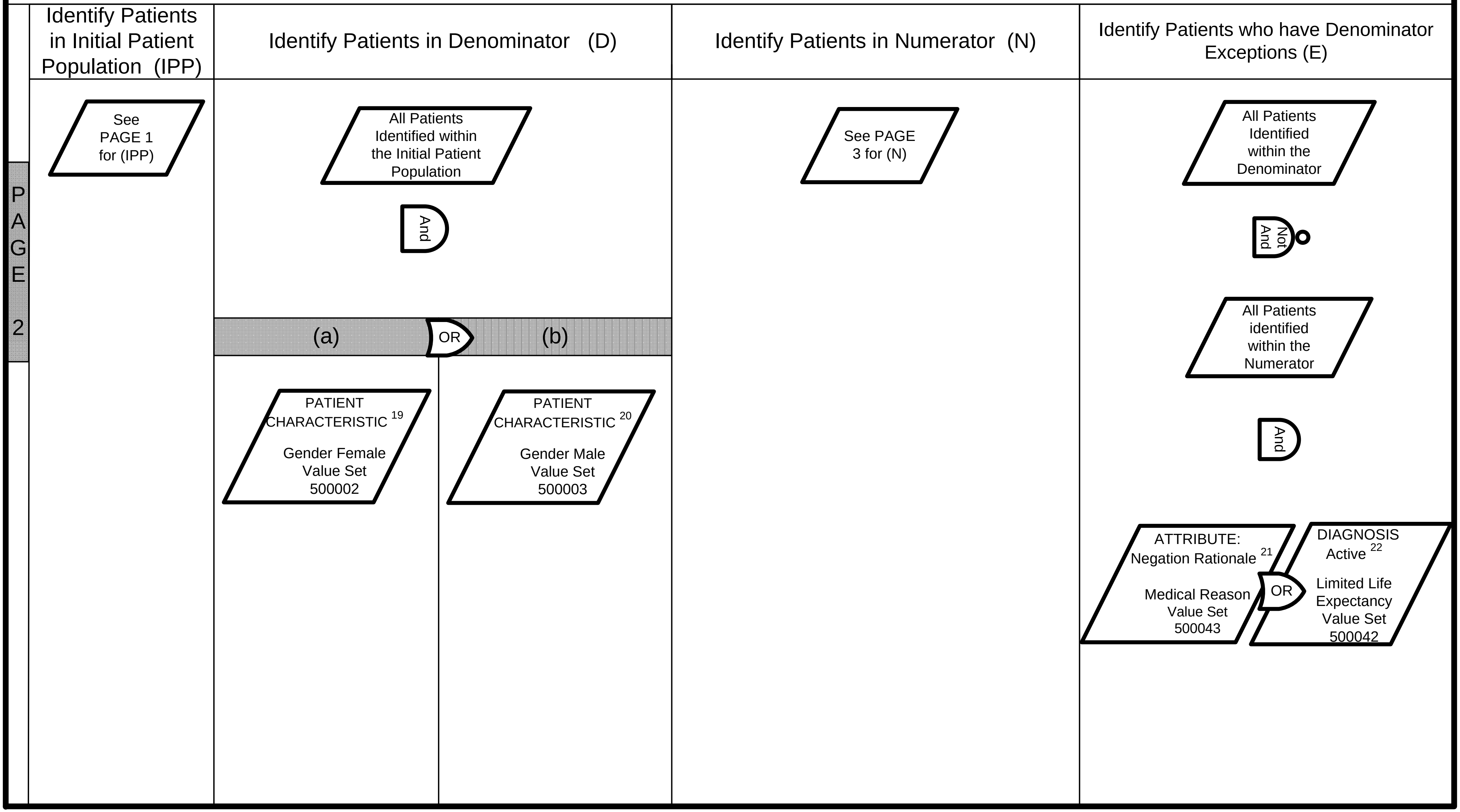
Visual Representation for PCPI eSpecification

Measure Logic for Preventive Care & Screening: Unhealthy Alcohol Use: Screening & Brief Counseling

Measure Description: Percentage of patients aged 18 years and older who were screened for unhealthy alcohol use at least once within 24 months using a systematic screening method AND who received brief counseling if identified as an unhealthy alcohol user

Measurement Period: 12 Consecutive Months

PCPI Measure #: PCS-3



PARAMETER SPECIFICATIONS (Value Sets are found in the Coding Appendices):

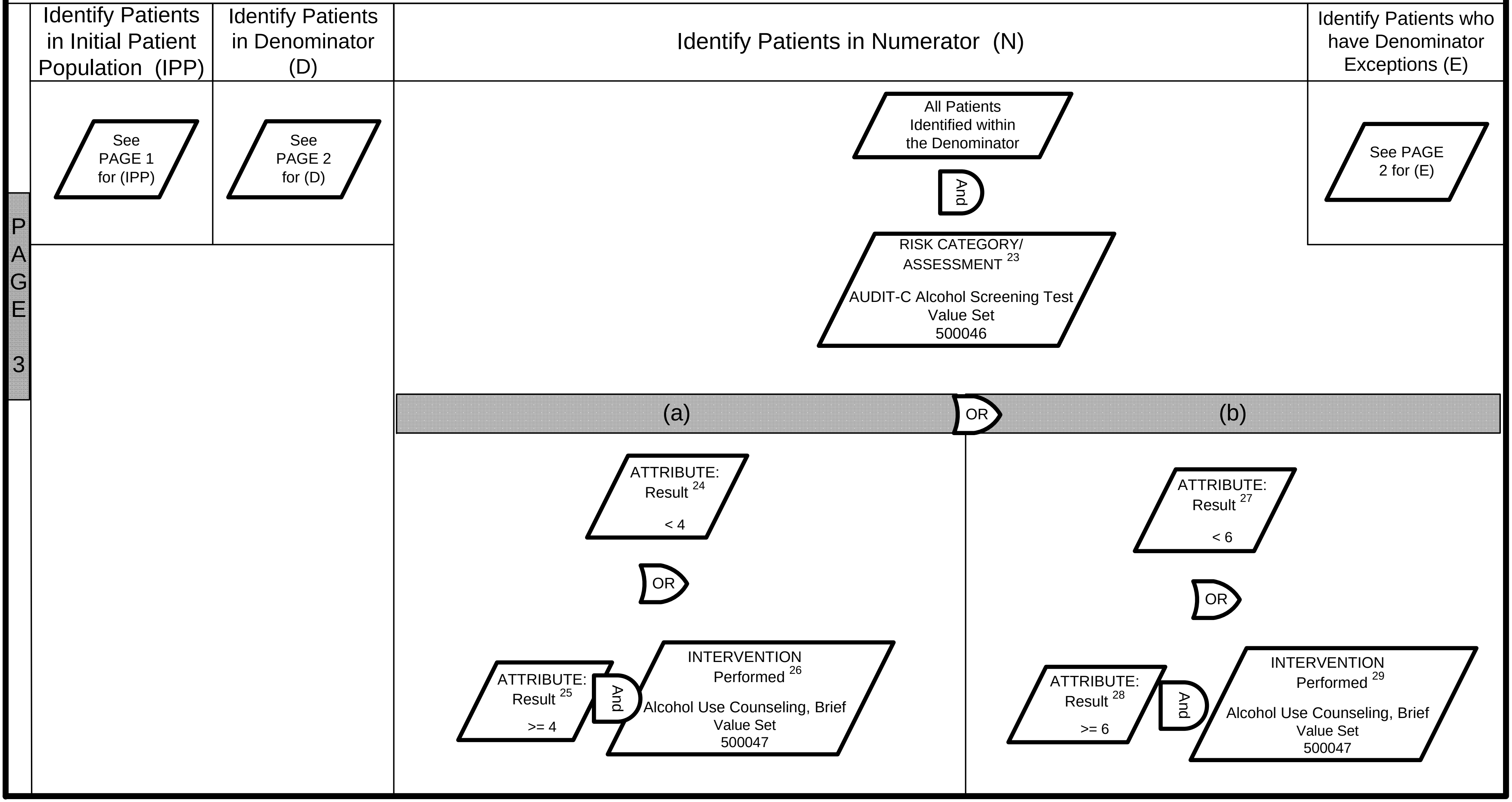
D: [19] Patient Characteristic: during measurement period; [20] Patient Characteristic: during measurement period; [21] Patient Characteristic: measurement start date minus birth date (value set 500001) <= 60 years starts before the start of measurement period; [22] Patient Characteristic: during measurement period; [23] Patient Characteristic: measurement start date minus birth date (value set 500001) > 60 years starts before the start of measurement period;

E: [21] Attribute, Negation Rationale: during measurement period; [22] Diagnosis, Active: starts before or during measurement period;

****Patients will fall into one of the two denominator pathways -- D(a) OR D(b); all patients in (D) will be evaluated for (N) criteria****

Visual Representation for PCPI eSpecification

Measure Logic for Preventive Care & Screening: Unhealthy Alcohol Use: Screening & Brief Counseling
Measure Description: Percentage of patients aged 18 years and older who were screened for unhealthy alcohol use at least once within 24 months using a systematic screening method AND who received brief counseling if identified as an unhealthy alcohol user
Measurement Period: 12 Consecutive Months
PCPI Measure #: PCS-3



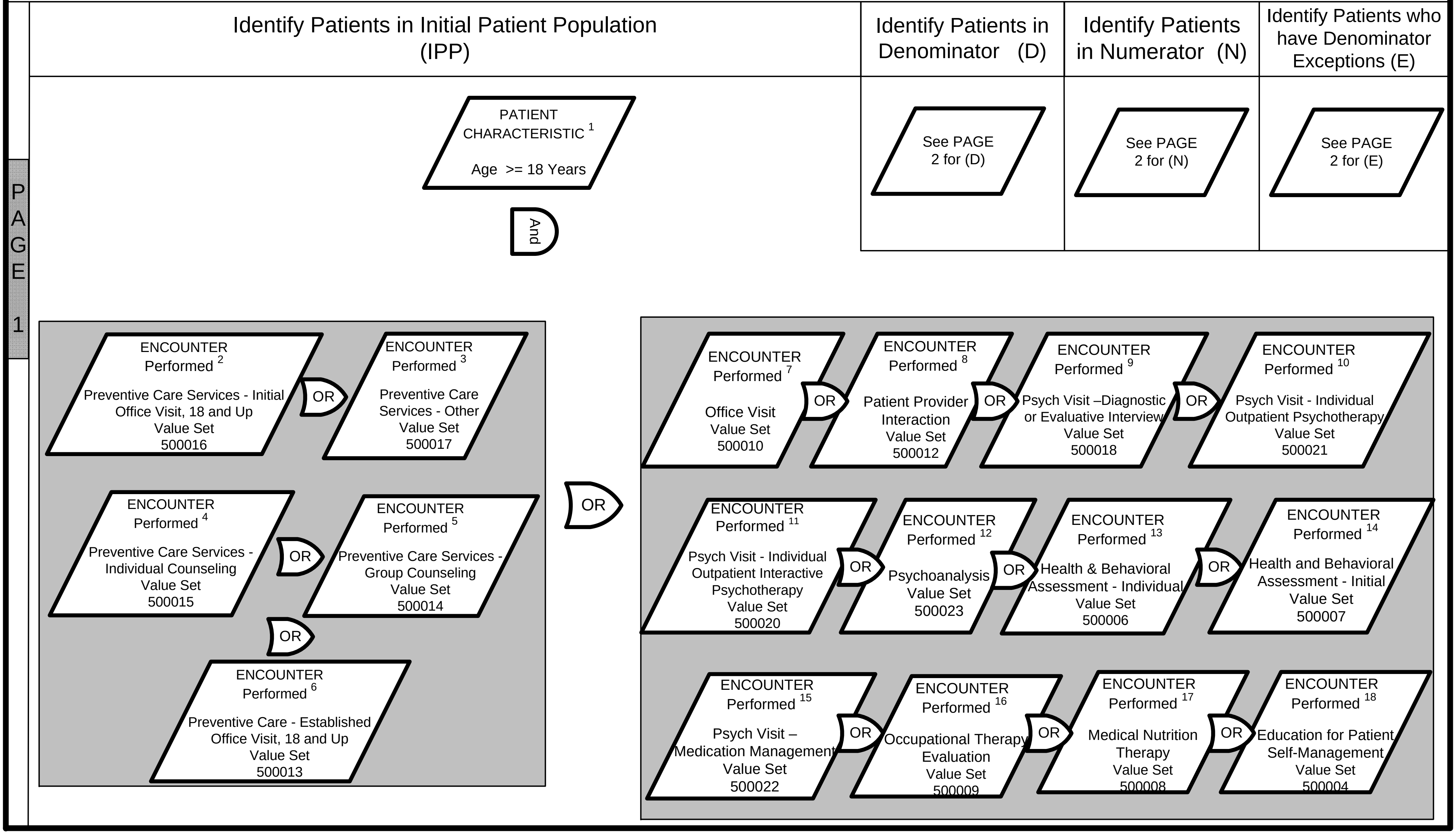
PARAMETER SPECIFICATIONS (Value Sets are found in the Coding Appendices):

To meet this measure, patients in D(a) should follow pathway N(a); patients in D(b) should follow pathway N(b);

N: [23] Risk Category/Assessment: starts before start of [measurement end date] <= 24 months; [24] Attribute, Result: this attribute is applied to [23] [Risk CategoryAssessment]; [25] Attribute, Result: this attribute is applied to [23] [Risk Category/Assessment]; [26] Intervention, Performed: starts before start of [measurement end date] <= 24 months; [27] Attribute, Result: this attribute is applied to [23] [Risk Category/Assessment]; [28] Attribute, Result: this attribute is applied to [23] [Risk Category/Assessment]; [29] Intervention, Performed: starts before start of [measurement end date] <= 24 months;

Visual Representation for PCPI eSpecification

Measure Logic for Preventive Care & Screening: Unhealthy Alcohol Use: Screening & Brief Counseling
Measure Description: Percentage of patients aged 18 years and older who were screened for unhealthy alcohol use at least once within 24 months using a systematic screening method AND who received brief counseling if identified as an unhealthy alcohol user
Measurement Period: 12 Consecutive Months
PCPI Measure #: PCS-3



PARAMETER SPECIFICATIONS (Value Sets are found in the Coding Appendices):
IPP: ^{1} Patient Characteristic: measurement start date minus birth date (value set 500001) ≥ 18 years starts before the start of measurement period;
$^{2\ 3\ 4\ 5\ 6}$ Encounter, Performed: during measurement period – COUNT >= 1; $^{7\ 8\ 9\ 10\ 11\ 12\ 13\ 14\ 15\ 16\ 17\ 18}$ Encounter, Performed: during measurement period – COUNT >= 2;

Visual Representation for PCPI eSpecification

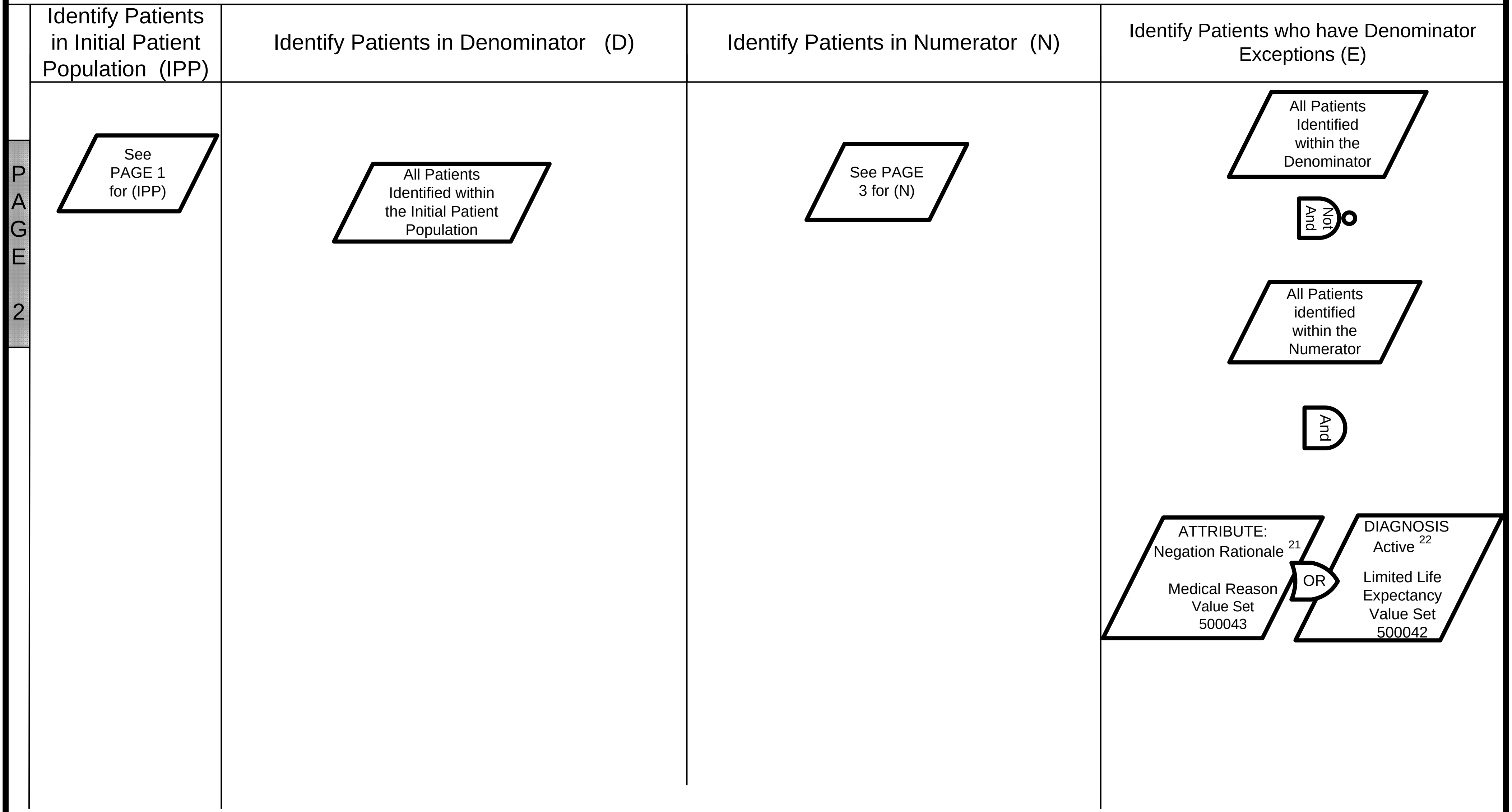
Single Item Alcohol Screen Test

Measure Logic for Preventive Care & Screening: Unhealthy Alcohol Use: Screening & Brief Counseling

Measure Description: Percentage of patients aged 18 years and older who were screened for unhealthy alcohol use at least once within 24 months using a systematic screening method AND who received brief counseling if identified as an unhealthy alcohol user

Measurement Period: 12 Consecutive Months

PCPI Measure #: PCS-3



PAGE 2

Identify Patients in Initial Patient Population (IPP)

See PAGE 1 for (IPP)

Identify Patients in Denominator (D)

All Patients Identified within the Initial Patient Population

Identify Patients in Numerator (N)

See PAGE 3 for (N)

Identify Patients who have Denominator Exceptions (E)

All Patients Identified within the Denominator

All Patients identified within the Numerator

ATTRIBUTE: Negation Rationale [21]

Medical Reason Value Set 500043

DIAGNOSIS Active [22]

Limited Life Expectancy Value Set 500042

PARAMETER SPECIFICATIONS (Value Sets are found in the Coding Appendices):

D: [19] Patient Characteristic: during measurement period; [20] Patient Characteristic: during measurement period;

E: [21] Attribute, Negation Rationale: during measurement period; [22] Diagnosis, Active: starts before or during measurement period;

****Patients will fall into one of the two denominator pathways -- D(a) OR D(b); all patients in (D) will be evaluated for (N) criteria****

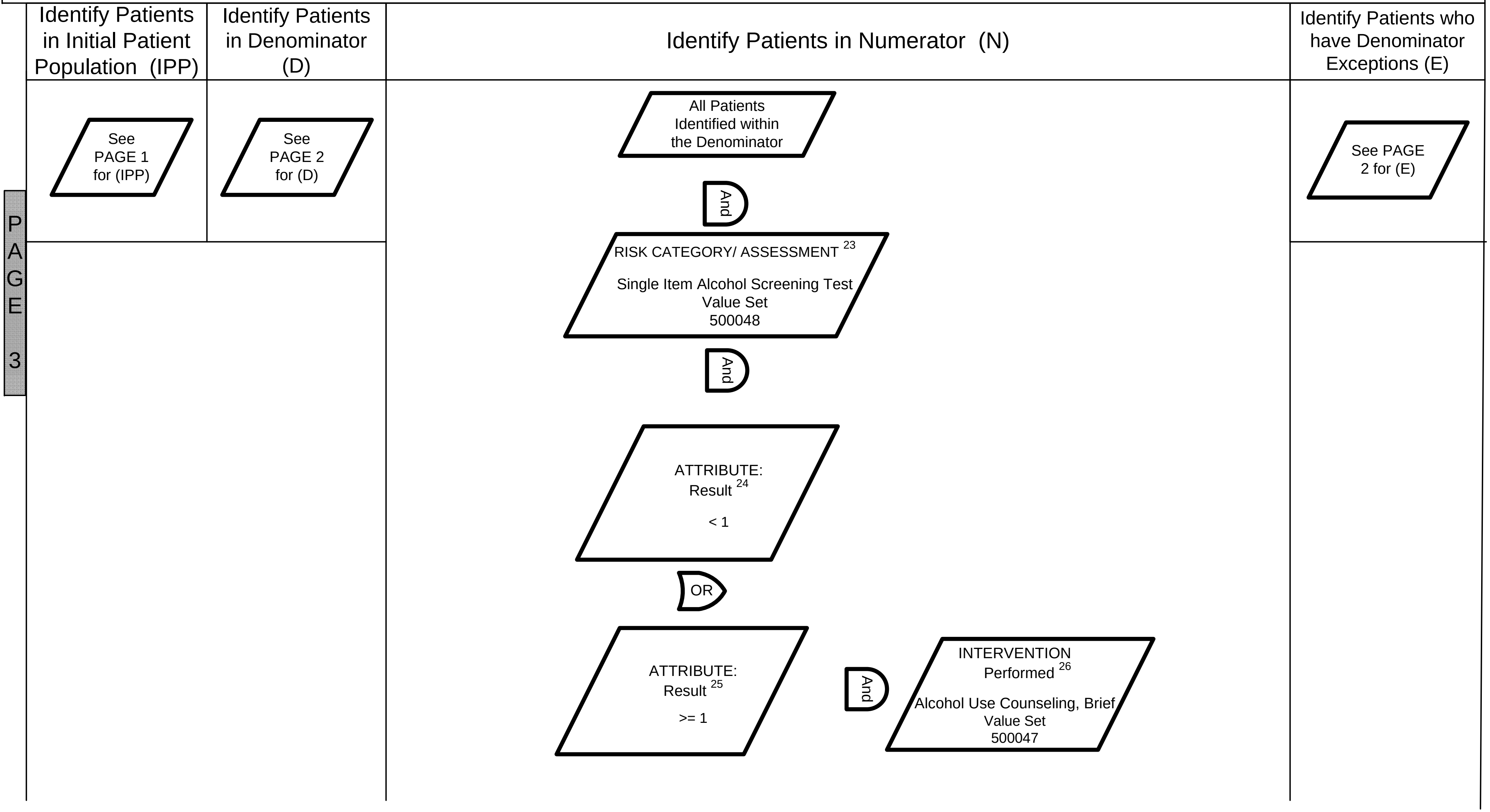
Visual Representation for PCPI eSpecification

Measure Logic for Preventive Care & Screening: Unhealthy Alcohol Use: Screening & Brief Counseling

Measure Description: Percentage of patients aged 18 years and older who were screened for unhealthy alcohol use at least once within 24 months using a systematic screening method <u>AND</u> who received brief counseling if identified as an unhealthy alcohol user

Measurement Period: 12 Consecutive Months

PCPI Measure #: PCS-3



PARAMETER SPECIFICATIONS (Value Sets are found in the Coding Appendices):

To meet this measure, patients in D(a) should follow pathway N(a); patients in D(b) should follow pathway N(b);

N: [23] Risk Category/Assessment: starts before start of [measurement end date] <= 24 months; [24] Attribute, Result: this attribute is applied to [23] [Risk CategoryAssessment]; [25] Attribute, Result: this attribute is applied to [23] [Risk CategoryAssessment]; [26] Intervention, Performed: starts before start of [measurement end date] <= 24 months; [27] Attribute, Result: this attribute is applied to [23] [Risk CategoryAssessment]; [28] Attribute, Result: this attribute is applied to [23] [Risk CategoryAssessment]; [29] Intervention, Performed: starts before start of [measurement end date] <= 24 months;

Measures Endorsed in 2012 to Consider for Addition to Dual Eligible Beneficiaries Core Measure Set

Measure #	Measure Name	Consensus Endorsement Project	Notes
1888	Workforce development measure derived from workforce development domain of the C-CAT	Disparities and Cultural Competency	Cluster of measures based on AMA's Communication Climate Assessment Toolkit (CCAT). Applies to clinician office, urgent care, hospitals and is reported at facility level.
1892	Individual engagement measure derived from the individual engagement domain of the C-CAT	Disparities and Cultural Competency	
1894	Cross-cultural communication measure derived from the cross-cultural communication domain of the C-CAT	Disparities and Cultural Competency	
1896	Language services measure derived from language services domain of the C-CAT	Disparities and Cultural Competency	
1898	Health literacy measure derived from the health literacy domain of the C-CAT	Disparities and Cultural Competency	
1901	Performance evaluation measure derived from performance evaluation domain of the C-CAT	Disparities and Cultural Competency	
1905	Leadership commitment measure derived from the leadership commitment domain of the C-CAT	Disparities and Cultural Competency	
1902	Clinicians/Groups' Health Literacy Practices Based on the CAHPS Item Set for Addressing Health Literacy	Disparities and Cultural Competency	Included in core based on standing guidance that all CAHPS tools be supported.
1904	Clinician/Group's Cultural Competence Based on the CAHPS® Cultural Competence Item Set	Disparities and Cultural Competency	
1821	L2: Patients receiving language services supported by qualified language services providers	Disparities and Cultural Competency	Measure is specific to hospital care.
1824	L1A: Screening for preferred spoken language for health care	Disparities and Cultural Competency	Measure is specific to hospital care.
1919	Cultural Competency Implementation Measure	Disparities and Cultural Competency	Survey-based, applies to hospitals, urgent care, clinician office, health plans, nursing homes, and dialysis organizations. Reported at facility, plan, or health system level.
1634 (paired, 1637)	Hospice and Palliative Care - Pain Screening	Palliative and End-of-Life Care	Measure is specific to individuals in palliative or hospice program.
1637 (paired, 1634)	Hospice and Palliative Care - Pain Assessment	Palliative and End-of-Life Care	Measure is specific to individuals in palliative or hospice program.
1617	Patients treated with an Opioid who are given a bowel regimen	Palliative and End-of-Life Care	
1628	Patients with advanced cancer assessed for pain at outpatient visits	Palliative and End-of-Life Care	

*Green highlighting denotes NQF staff pick

Measures Endorsed in 2012 to Consider for Addition to Dual Eligible Beneficiaries Core Measure Set

Measure #	Measure Name	Consensus Endorsement Project	Notes
1638 (paired, 1639)	Hospice and Palliative Care - Dyspnea Treatment	Palliative and End-of-Life Care	Measure is specific to individuals in palliative or hospice program.
1639 (paired, 1638)	Hospice and Palliative Care - Dyspnea Screening	Palliative and End-of-Life Care	Measure is specific to individuals in palliative or hospice program.
1626	Patients admitted to the ICU who have care preferences documented	Palliative and End-of-Life Care	Measure is specific to individuals in ICU.
1641	Hospice and Palliative Care - Treatment Preferences	Palliative and End-of-Life Care	Measure is specific to individuals in palliative or hospice program.
1647	Percentage of hospice patients with documentation in the clinical record of a discussion of spiritual/religious concerns or documentation that the patient/caregiver did not want to discuss	Palliative and End-of-Life Care	Measure is specific to individuals in palliative or hospice program.
1625	Hospitalized patients who die an expected death with an ICD that has been deactivated	Palliative and End-of-Life Care	
1632	CARE - Consumer Assessments and Reports of End of Life	Palliative and End-of-Life Care	Survey-based, includes non-traumatic deaths and deaths from chronic progressive illnesses for individuals in hospital, home health, nursing home, or hospice.
1659	Influenza immunization (hospital)	Population Health: Prevention	
1653	Pneumococcal immunization (hospital)	Population Health: Prevention	
1666	Patients on Erythropoiesis Stimulating Agent (ESA)—Hemoglobin Level > 12.0 g/dL	Renal	
1668	Laboratory Testing (Lipid Profile)	Renal	
1501	Risk-adjusted operative mortality for mitral valve (MV) repair (STS)	Surgery	Defer to MAP Cardiovascular Family of Measures
1502	Risk-adjusted operative mortality for MV repair + CABG surgery (STS)	Surgery	Defer to MAP Cardiovascular Family of Measures
1519	Statin therapy at discharge after lower extremity bypass (LEB) (SVS)	Surgery	Defer to MAP Cardiovascular Family of Measures
1540	Postoperative stroke or death in asymptomatic patients undergoing carotid endarterectomy (SVS)	Surgery	Defer to MAP Cardiovascular Family of Measures

*Green highlighting denotes NQF staff pick

Measures Endorsed in 2012 to Consider for Addition to Dual Eligible Beneficiaries Core Measure Set

Measure #	Measure Name	Consensus Endorsement Project	Notes
1543	Postoperative stroke or death in asymptomatic patients undergoing carotid artery stenting (CAS) (SVS)	Surgery	Defer to MAP Cardiovascular Family of Measures
1550	Hospital-level risk-standardized complication rate (RSCR) following elective primary total hip arthroplasty (THA) and total knee arthroplasty	Surgery	
1551	Hospital-level 30-day all-cause risk standardized readmission rate (RSRR) following elective primary total hip arthroplasty (THA) and total knee arthroplasty (TKA)	Surgery	
1536	Cataracts: Improvement in patient's visual function within 90 days following cataract surgery	Surgery	Outcome measure specified for use in clinician office or ambulatory surgery center (ASC).
1523	In-hospital mortality following elective open repair of AAAs	Surgery	Defer to MAP Cardiovascular Family of Measures.
1534	In-hospital mortality following elective EVAR of AAAs	Surgery	Defer to MAP Cardiovascular Family of Measures.
1741	Patient experience with surgical care based on the Consumer Assessment of Healthcare Providers and Systems (CAHPS)	Surgery	Included in core based on standing guidance that all CAHPS tools be supported.
1524	Assessment of thromboembolic risk – (CHADS 2)	Cardiovascular	Defer to MAP Cardiovascular Family of Measures.
1525	Chronic anticoagulation therapy	Cardiovascular	
1522	ACE/ARB therapy at discharge for ICD implant patients with LVSD	Cardiovascular	
1528	Beta blocker at discharge for ICD implant patients with a previous MI	Cardiovascular	
1529	Beta blocker at discharge for ICD implant patients with LVSD	Cardiovascular	
0964	Therapy with aspirin, P2Y12 inhibitor and statin at discharge	Cardiovascular	

*Green highlighting denotes NQF staff pick

Measures Endorsed in 2012 to Consider for Addition to Dual Eligible Beneficiaries Core Measure Set

Measure #	Measure Name	Consensus Endorsement Project	Notes
0965	Patients with an ICD implant who receive prescriptions for all medications (ACE/ARB and beta blockers) for which they are eligible for at discharge	Cardiovascular	
1854 (time limited)	Barrett´s Esophagus	Cancer	
1790	Risk-Adjusted Morbidity and Mortality for Lung Resection for Lung Cancer	Cancer	
1853 (time limited)	Radical Prostatectomy Pathology Reporting	Cancer	
1822	External Beam Radiotherapy for Bone Metastases	Cancer	
1799	Medication management for people with asthma (MMA)	Pulmonary and Critical Care	Specific to individuals 5-64 years of age with moderate to severe persistent asthma.
1800	Asthma medication ratio (AMR)	Pulmonary and Critical Care	Specific to individuals 5-64 years of age with moderate to severe persistent asthma.
1825	COPD - management of poorly controlled COPD	Pulmonary and Critical Care	Specific to individuals 18 and older with poorly controlled COPD. Applies to clinician office, urgent care, home health, nursing home, and inpatient rehabilitation facilities. Reported at facility, clinician group/practice, health plan, health system, or population level.

*Green highlighting denotes NQF staff pick

2012/2013 Pre-Rulemaking Guidance from MAP Dual Eligible Beneficiaries Workgroup

In providing input to HHS regarding the selection of measures for Federal payment and public reporting programs, MAP must consider how the programs may impact the quality of care delivered to Medicare-Medicaid dual eligible beneficiaries. More than 9 million Americans eligible for both Medicare and Medicaid comprise a heterogeneous group that includes many of the poorest and sickest individuals covered by either program. Despite their particularly intense and complex needs, the healthcare and supportive services accessed by these individuals are often highly fragmented. HHS is pursuing several strategies to improve the quality of care provided to dual eligible beneficiaries, including tasking MAP with considering the implications of existing Federal measurement programs affecting this vulnerable group.

General Principles for Measure Selection

The Dual Eligible Beneficiaries Workgroup has identified the subject areas in which performance measurement can provide the most leverage in improving the quality of care: **quality of life, care coordination, screening and assessment, mental health and substance use,** as well as **structural measures**. A list of measures in these areas which are collectively considered core is provided in the last section of this document. The core set was updated in 2012 to reflect current priorities and the best available measures.

MAP workgroups should consider that the following issues are strongly related to quality of care in the dual eligible beneficiary population, regardless of the type of care being provided.

- **Setting goals for care:** Wherever possible, measurement should promote a broad view of health and wellness. Person-centered plans of care should be developed in collaboration with an individual, his/her family, and his/her care team. A plan of care should establish health-related goals and preferences for care that incorporate medical, behavioral, and social needs.
- **Chronicity of care:** More than 60 percent of dual eligible beneficiaries have three or more chronic conditions, with the most common being cardiovascular disease, diabetes, Alzheimer's disease and related disorders, arthritis, and depression. Many people with disabilities require long-term supports and services, of varying intensity, throughout their lifetimes.
- **Cognitive status**: More than 60 percent of dual eligible beneficiaries are affected by a mental or cognitive impairment. Etiologies of these impairments are diverse and may include intellectual/developmental disability, mental illness, dementia, substance abuse, or stroke.
- **Care transitions and communication:** Many factors, including those listed above, make dual eligible beneficiaries more vulnerable to problems that arise during all types of care transitions. Communication and coordination across all providers is vital. Transactions between the medical system and the community-based services system are particularly important for beneficiaries who use long-term supports.

Considerations for Hospital Programs

The Hospital Workgroup should consider the overarching factors identified by the Dual Eligible Beneficiaries Workgroup that are linked to high-quality care in the hospital setting. Of primary importance is the need to manage the risks associated with hospitalizations, whether related to safety, medication management, or symptoms that can affect geriatric patients such as delirium. Facilitating a smooth transition from a hospital stay to another setting of care is vital, as dually eligible patients are frequently the least able to navigate that change themselves. Coordinated care also helps to reduce readmissions, another important quality factor for this population. Finally, quality and care coordination must be considered from the perspective of “frequent users” of hospital care, including vulnerable patients accessing the emergency department.

Measure Exceptions

The Dual Eligible Beneficiaries Workgroup urged caution when recommending clinical process measures. Use of these measures should not negatively impact quality of life decisions made in collaboration with a patient and his/her family. In addition, the workgroup felt that condition-specific measures are marginally important compared to the cross-cutting issues identified. In addition, maternal and pediatric measures generally do not apply to the dual eligible beneficiary population.

Results of MAP’s First Year of Pre-Rulemaking Input in Hospital Programs

- MAP supported and HHS finalized inclusion of *HBIPS-7: Post discharge continuing care plan transmitted to next level of care provider upon discharge (0558)* in the Inpatient Psychiatric Facility Quality Reporting program.
- MAP supported and HHS finalized inclusion of the *3-Item Care Transition Measure (CTM-3) (0228)* in the Inpatient Quality Reporting program. HHS also recommended CTM-3 for inclusion in HCAHPS.

Targeted Input: Inpatient Quality Reporting (IQR) and Hospital Value-Based Purchasing (VBP) Programs

[to be added following October meeting discussion]

Considerations for Clinician Programs

The Clinician Workgroup should consider the overarching factors identified by the Dual Eligible Beneficiaries Workgroup that are linked to high-quality care for clinicians. A primary role for any clinician, but especially for those practicing in primary care, is to screen, assess, and manage chronic conditions. For the dual eligible population, those chronic illnesses are likely to include a mental health problem, substance use disorder, or other cognitive impairment. Because the conditions themselves are so diverse, measures that apply across clinical conditions or to individuals with multiple chronic conditions should be considered. These would include measures of functional status, quality of life, communication, care coordination, medication management, patient experience, etc. When certain high-impact conditions like diabetes or heart disease need to be evaluated, Federal programs should emphasize outcome and composite measures.

Measure Exceptions

The Dual Eligible Beneficiaries workgroup noticed the abundance of measures related to screening and disease monitoring. They cautioned that appropriate exclusions should be in place for such measures. For example, a 90-year old man with Alzheimer's disease does not need to have his cholesterol under tight control. In addition, maternal and pediatric measures generally do not apply to the dual eligible population.

Results of MAP's First Year of Pre-Rulemaking Input in Clinician Programs

- Value-Based Modifier Program
    - MAP supported retention of four core measures in the Value Modifier set. HHS concurred; none of the measures were proposed for removal.
- Physician Quality Reporting System (PQRS)
    - MAP supported retention of five core measures in the PQRS set. The final rule has not yet been released.
    - MAP supported addition of *Optimal Diabetes Care (0729)* to the PQRS set. The final rule has not yet been released.
- Meaningful Use for Eligible Professionals
    - MAP supported retention of three core measures in the Meaningful Use set. HHS concurred; none of the measures were proposed for removal.
    - MAP supported and HHS finalized inclusion of *Screening for Clinical Depression and Follow-Up Plan (0418)* in the Meaningful Use set for Stage 2.

Targeted Input: Clinician Programs

[to be added following October meeting discussion]

Considerations for Post-Acute Care/Long-Term Care Programs

Most of the issues MAP has considered for post-acute and long-term care are relevant to the dual eligible beneficiary population, and vice versa. The PAC/LTC Workgroup discussed the overarching factors identified by the Dual Eligible Beneficiaries Workgroup that are linked to high-quality care in post-acute and long-term care settings. Promoting dignity and quality of life through person- and family-centered care is of primary importance. To do so, measures of fidelity to a plan of care that incorporates individualized goals and promotes self-determination are preferred. Supports and services should be delivered in the least intense setting possible. It is also important to evaluate the extent to which institutional settings are linked to home- and community-based services and are assisting residents who desire to transition to independent living. Finally, appropriate prescribing and dosing of medications is important, including minimizing the number of medications taken by an individual to reduce polypharmacy risks.

Results of MAP's First Year of Pre-Rulemaking Input in PAC/LTC Programs

- MAP supported retention of all core measures finalized for use in PAC/LTC programs.
- MAP supported inclusion of *Assessment of Health-related Quality of Life (Physical and Mental Functioning) (0260)* in the End-Stage Renal Disease Quality program. HHS did not propose the measure.
- MAP supported inclusion of *Family Evaluation of Hospice Care (0208)* in the Hospice program. HHS deemed this measure under further consideration for an expanded measure set to be used in annual payment determinations beyond FY2015.
- MAP conceptually agreed with many additional core measures and asked that potential modifications be explored to make them applicable to additional PAC/LTC settings:
    - *Screening for Clinical Depression and Follow-Up Plan (0418)*
    - *Transition Record with Specified Elements Received by Discharged Patients (0647)*
    - *3-Item Care Transitions Measure (CTM-3) (0228)*
    - *Improvement in Ambulation/Locomotion (0167)*
    - *Change in Daily Activity Function as Measured by the AM-PAC (0430)*
    - *Medical Home System Survey (1909, previously 0494)*

  HHS did not specifically reference modifications to these measures for PAC/LTC programs.

Targeted Input: End-Stage Renal Disease Quality Improvement Program

[to be added following October meeting discussion]

MAP Dual Eligible Beneficiaries Workgroup: Core Set of Measures

The workgroup identified a core set of measures from an extensive and ongoing search of currently available measures. It was most recently updated in October 2012 to inform 2012/2013 pre-rulemaking deliberations. HHS uptake of measures in proposed and final rules in 2012 was generally consistent with MAP's specific recommendations made as a result of input from the Dual Eligible Beneficiaries Workgroup. The overall frequency of revised core set measure use in HHS programs is currently as follows:

- Proposed/finalized in 2 or more HHS programs: 11 measures
- Proposed/finalized in 1 HHS program: 8 measures
- Used in no HHS programs: 7 measures

The appropriateness and feasibility of any single measure depends upon the program context in which it is being considered for use. Careful consideration should be given to the care setting and level of analysis for which a measure is specified and endorsed.

Many measure gaps and limitations in current measures were identified during the process of compiling and revising the core set. The workgroup will continue to consider a range of potential modifications to measures that would make them more appropriate for use with the dual eligible beneficiary population.

NQF # and Status	Measure Title and Description	Specified Setting of Care	Use in Federal Programs Reviewed by MAP
0004 **Endorsed**	*Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: (a) Initiation, (b) Engagement* The percentage of adolescent and adult patients with a new episode of alcohol and other drug (AOD) dependence who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis and who initiated treatment and who had two or more additional services with an AOD diagnosis within 30 days of the initiation visit	Ambulatory	Finalized for use in PQRS, Meaningful Use, Value Modifier, and Medicaid Adult Core Measures
0028 **Endorsed**	*Measure pair: a. Tobacco Use Assessment, b. Tobacco Cessation Intervention* Percentage of patients who were queried about tobacco use one or more times during the two-year measurement period Percentage of patients identified as tobacco users who received cessation intervention during the two-year measurement period	Ambulatory	Finalized for use in PQRS, Meaningful Use, Medicare Shared Savings Program, and Value Modifier
0101 **Endorsed**	*Falls: Screening for Fall Risk* Percentage of patients aged 65 years and older who were screened for fall risk (2 or more falls in the past year or any fall with injury in the past year) at least once within 12 months	Ambulatory	Finalized for use in PQRS, Medicare Shared Savings, Value Modifier, and Meaningful Use
0208 **Endorsed**	*Family Evaluation of Hospice Care* Percentage of family members of all patients enrolled in a hospice program who give satisfactory answers to the survey instrument	Hospice	Under consideration for future rulemaking for Hospice Quality Reporting.
0228 **Endorsed**	*3-Item Care Transition Measure (CTM-3)* Uni-dimensional self-reported survey that measures the quality of preparation for care transitions. Namely: 1. Understanding one's self-care role in the post-hospital setting 2. Medication management 3. Having one's preferences incorporated into the care plan	Hospital	Finalized for Hospital Inpatient Quality Reporting.
0260 **Endorsed**	*Assessment of Health-related Quality of Life (Physical & Mental Functioning)* Percentage of dialysis patients who receive a quality of life assessment using the KDQOL-36 (36-question survey that assesses patients' functioning and well-being) at least once per year	Dialysis Facility	
0418 **Endorsed**	*Screening for Clinical Depression and Follow-up Plan* Percentage of patients aged 12 years and older screened for clinical depression using an age appropriate standardized tool and follow up plan documented	Ambulatory, Hospital, PAC/LTC Facility	Finalized for use in PQRS, Medicare Shared Savings, Meaningful Use, and Medicaid Adult Core Measures

NQF # and Status	Measure Title and Description	Specified Setting of Care	Use in Federal Programs Reviewed by MAP
0421 **Endorsed**	*Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-up* Percentage of patients aged 18 years and older with a calculated BMI in the past six months or during the current visit documented in the medical record AND if the most recent BMI is outside of normal parameters, a follow-up plan is documented Normal Parameters: Age 65 and older BMI ≥23 and <30; Age 18 – 64 BMI ≥18.5 and <25	Ambulatory	Finalized for use in PQRS, Meaningful Use, Medicare Shared Savings Program, and Value Modifier. Not finalized for Medicaid Adult Core Measures.
0430 **Endorsed**	*Change in Daily Activity Function as Measured by the AM-PAC* The Activity Measure for Post-Acute Care (AM-PAC) is a functional status assessment instrument developed specifically for use in facility and community dwelling post-acute care (PAC) patients. A Daily Activity domain has been identified which consists of functional tasks that cover in the following areas: feeding, meal preparation, hygiene, grooming, and dressing	Ambulatory, Home Health, Hospital, PAC/LTC Facility	
0523 **Endorsed**	*Pain Assessment Conducted* Percent of patients who were assessed for pain, using a standardized pain assessment tool, at start/resumption of home health care	Home Health	Finalized for use in Home Health
0558 **Endorsed**	*HBIPS-7 Post discharge continuing care plan transmitted to next level of care provider upon discharge* Patients discharged from a hospital-based inpatient psychiatric setting with a continuing care plan provided to the next level of care clinician or entity	Hospital	Finalized for Inpatient Psychiatric Facilities (IPF) Quality Reporting Program.
0576 **Endorsed**	*Follow-up after hospitalization for mental illness* Percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner	Ambulatory, Behavioral Health	Finalized for Medicaid Adult Core Measures
0647 **Endorsed**	*Transition Record with Specified Elements Received by Discharged Patients (Inpatient Discharges to Home/Self Care or Any Other Site of Care)* Percentage of patients, regardless of age, discharged from an inpatient facility to home or any other site of care, or their caregiver(s), who received a transition record (and with whom a review of all included information was documented) at the time of discharge including, at a minimum, all of the specified elements	Hospital, PAC/LTC Facility	Proposed but not finalized for Medicaid Adult Core Measures.
0729 **Endorsed**	*Optimal Diabetes Care* Patients ages 18 -75 with a diagnosis of diabetes, who meet all the numerator targets of this composite measure: A1c < 8.0, LDL < 100, Blood Pressure < 14090, Tobacco non-user and for patients with a diagnosis of ischemic vascular disease daily aspirin use unless contraindicated	Ambulatory	Components of this composite are finalized for use in Medicare Shared Savings and Value Modifier, Proposed for PQRS

NQF # and Status	Measure Title and Description	Specified Setting of Care	Use in Federal Programs Reviewed by MAP
1909 Endorsed (formerly 0494)	*Medical Home System Survey (Composite Measure)* The Medical Home System Survey (MHSS) is a survey instrument used to gather information from primary care providers and practices. This survey measures the proportion of factors (both structure and process) met by practices across six domains or composites. The score for each composite describes the degree to which a practice has implemented elements of the patient-centered medical home (PCMH). The MHSS survey is used by NCQA to determine eligibility for the NCQA Recognized PCMH program.	Ambulatory	
0005 Endorsed	*CAHPS Adult Primary Care Survey: Shared Decision Making* 37 core and 64 supplemental question survey of adult outpatient primary care patients	Ambulatory	Finalized for use in Medicare Shared Savings
0006 Endorsed	*CAHPS Health Plan Survey v 4.0 - Adult questionnaire: Health Status/Functional Status* 30-question core survey of adult health plan members that assesses the quality of care and services they receive	Ambulatory	Finalized for use in Medicare Shared Savings and Medicaid Adult Core Measures
0007 Endorsed	NCQA Supplemental items for CAHPS® 4.0 Adult Questionnaire (CAHPS 4.0H) This supplemental set of items was developed jointly by NCQA and the AHRQ-sponsored CAHPS Consortium and is intended for use with the CAHPS 4.0 Health Plan survey. Some items are intended for Commercial health plan members only and are not included here. This measure provides information on the experiences of Medicaid health plan members with the organization. Results summarize member experiences through composites and question summary rates. *In addition to the 4 core composites from the CAHPS 4.0 Health Plan survey and two composites for commercial populations only, the HEDIS supplemental set includes one composite score and two item-specific summary rates.* *1. Shared Decision Making Composite* *1. Health Promotion and Education item* *2. Coordination of Care item*	Ambulatory	Finalized for Medicaid Adult Core Measures.
Not Endorsed	*SNP 6: Coordination of Medicare and Medicaid coverage* Intent: The organization helps members obtain services they are eligible to receive regardless of payer, by coordinating Medicare and Medicaid coverage. This is necessary because the two programs have different rules and benefit structures and can be confusing for both members and providers	[not available]	

NQF # and Status	Measure Title and Description	Specified Setting of Care	Use in Federal Programs Reviewed by MAP
Not Endorsed	*Alcohol Misuse: Screening, Brief Intervention, Referral for Treatment* a. Patients screened annually for alcohol misuse with the 3-item AUDIT-C with item-wise recording of item responses, total score and positive or negative result of the AUDIT-C in the medical record. B. Patients who screen for alcohol misuse with AUDIT-C who meet or exceed a threshold score who have brief alcohol counseling documented in the medical record within 14 days of the positive screening.	[not available]	Proposed but not finalized for Medicaid Adult Core measures.

The following measures were not included draft core measure set at the time of 2011/2012 pre-rulemaking input but have since been **added**:

NQF # and Status	Measure Title and Description	Specified Setting of Care	Use in Federal Programs Reviewed by MAP
0022 **Endorsed**	*Use of High Risk Medications in the Elderly* Percentage of Medicare members 65 years of age and older who received at least one high-risk medication. And Percentage of Medicare members 65 years of age and older who received at least two different high-risk medications. For both rates, a lower rate represents better performance.	Ambulatory, Pharmacy	Finalized for Meaningful Use, Proposed for PQRS
0097 **Endorsed**	*Medication Reconciliation* Percentage of patients aged 65 years and older discharged from any inpatient facility (e.g. hospital, skilled nursing facility, or rehabilitation facility) and seen within 60 days following discharge in the office by the physician providing on-going care who had a reconciliation of the discharge medications with the current medication list in the medical record documented.	Ambulatory	Not finalized for Meaningful Use, proposed for PQRS and Value-Based Modifier
0209 **Endorsed**	*Comfortable Dying: Pain Brought to a Comfortable Level Within 48 Hours of Initial Assessment* Number of patients who report being uncomfortable because of pain at the initial assessment (after admission to hospice services) who report pain was brought to a comfortable level within 48 hours.	Hospice	Finalized for Hospice Quality Reporting.

NQF # and Status	Measure Title and Description	Specified Setting of Care	Use in Federal Programs Reviewed by MAP
0557 Endorsed	*HBIPS-6 Post discharge continuing care plan created* Patients discharged from a hospital-based inpatient psychiatric setting with a continuing care plan created overall and stratified by age groups: Children (Age 1 through 12 years), Adolescents (Age 13 through 17 years), Adults (Age 18 through 64 years), Older Adults (Age greater than and equal to 65 years). Note: this is a paired measure with HBIPS-7: Post discharge continuing care plan transmitted to next level of care provider upon discharge.	Hospital	Finalized for Inpatient Psychiatric Facilities (IPF) Quality Reporting Program.
0648 Endorsed	*Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)* Percentage of patients, regardless of age, discharged from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home or any other site of care for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge	Ambulatory, Hospital, PAC/LTC	Finalized for Medicaid Adult Core Measures.
1789 Endorsed	*Hospital-Wide All-Cause Unplanned Readmission Measure (HWR)* This measure estimates the hospital-level, risk-standardized rate of unplanned, all-cause readmission after admission for any eligible condition within 30 days of hospital discharge (RSRR) for patients aged 18 and older. The measure reports a single summary RSRR, derived from the volume-weighted results of five different models, one for each of specified specialty cohorts. The measure also indicates the hospital standardized risk ratios (SRR) for each of these five specialty cohorts.	Hospital	Finalized for Hospital Inpatient Quality Reporting.
0008 Endorsed	*Experience of Care and Health Outcomes (ECHO) Survey (behavioral health, managed care versions)* 52- questions including patient demographic information. The survey measures patient experiences with behavioral health care (mental health and substance abuse treatment) and the organization that provides or manages the treatment and health outcomes. Level of analysis: health plan- HMO, PPO, Medicare, Medicaid, commercial	Behavioral Health	
0258 Endorsed	*CAHPS In-Center Hemodialysis Survey* Percentage of patient responses to multiple testing tools. Tools include the In-Center Hemodialysis Composite Score: The proportion of respondents answering each of response options for each of the items summed across the items within a composite to yield the composite measure score. (Nephrologists' Communication and Caring, Quality of Dialysis Center Care and Operations, Providing Information to Patients) Overall Rating: a summation of responses to the rating items grouped into 3 levels	Dialysis Facility	Finalized for ESRD Quality Improvement Program.

NQF # and Status	Measure Title and Description	Specified Setting of Care	Use in Federal Programs Reviewed by MAP
0517 **Endorsed**	*CAHPS® Home Health Care Survey* CAHPS Home Health Care Survey is a standardized survey instrument and data collection methodology for measuring home health patients´ perspectives on their home health care in Medicare-certified home health care agencies. AHRQ and CMS supported the development of the Home Health CAHPS to measure the experiences of those receiving home health care	Home Health	Finalized for use in Home Health.

The following measures were included in the draft core measure set at the time of 2011/2012 pre-rulemaking input but have since been **removed**:

NQF # and Status	Measure Title and Description	Specified Setting of Care	Use in Federal Programs Reviewed by MAP
Not Endorsed	*All-Cause Readmission Index (risk adjusted)* Overall inpatient 30-day hospital readmission rate, excluding maternity and pediatric discharges	Hospital	None
Not Endorsed	*Potentially Harmful Drug-Disease Interactions in the Elderly* Percentage of Medicare members 65 years of age and older who have a diagnosis of chronic renal failure and prescription for non-aspirin NSAIDs or Cox-2 selective NSAIDs; Percentage of Medicare members 65 years of age and older who have a diagnosis of dementia and a prescription for tricyclic antidepressants or anticholinergic agents; percentage of Medicare members 65 years of age and older who have a history of falls and a prescription for tricyclic antidepressants, antipsychotics or sleep agents	Pharmacy	None
0167 **Endorsed**	*Improvement in Ambulation/locomotion* Percentage of home health episodes where the value recorded for the OASIS item M0702 on the discharge assessment is numerically less than the value recorded on the start (or resumption) of care assessment, indicating less impairment at discharge compared to start of care	Home Health	Finalized for use in Home Health

MAP Dual Eligible Beneficiaries Workgroup

Discussion Guide:
End Stage Renal Disease Quality Improvement Program

Program Description

The End Stage Renal Disease (ESRD) Quality Initiative promotes improvements in the quality of care provided to ESRD patients through two closely related strategies. First, CMS publicly reports quality measure information to consumers on the Dialysis Facility Compare website. Second, the End Stage Renal Disease Quality Incentive Program (ESRD QIP) provides payment incentives for performance on selected measures. ESRD QIP was established by the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) section 153(c)[1] and is the first value-based purchasing model to be implemented in a public program. Starting in 2012, payments to dialysis facilities are reduced if facilities do not meet the required total performance score, which is the sum of the scores for established individual measures during a defined performance period.[2] Payment reductions will be on a sliding scale, which could amount to a maximum of two percent per year. CMS will report performance scores in two places, the Dialysis Facility Compare website and certificates posted at each participating facility.[3] Different groups of measures in the quality improvement program are utilized in ESRD QIP and publicly reported on Dialysis Facility Compare.

Statutory requirements apply to the ESRD Quality Initiative. To the extent possible, the program must include measures pertaining to anemia management that reflect the labeling approved by the FDA for such management, dialysis adequacy, patient satisfaction, iron management, bone mineral metabolism, and vascular access.[4]

The finalized measure set for PY 2014 includes six measures, one of which has two components (#0257, #0256) and the proposed measure set for PY 2015 includes ten measures. In the PY 2015 set, five measures would be carried forward from the PY 2014 list and five measures would be new. One measure finalized for use in PY 2014 is proposed for removal in PY 2015. Many, but not all, of the measures are NQF-endorsed; pending changes would incorporate more endorsed measures. The measure set addresses three of the NQS priorities: effective prevention and treatment, making care safer, and person- and family-engagement. The measure set includes process, outcome, and structural measures but lacks cost measures.

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[1] Final Rule. Medicare Program; End-Stage Renal Disease Prospective Payment System and Quality Incentive Program; Ambulance Fee Schedule; Durable Medical Equipment; and Competitive Acquisition of Certain Durable Medical Equipment, Prosthetics, Orthotics and Supplies. Nov 1, 2011

[2] https://www.cms.gov/apps/media/press/factsheet.asp?Counter=4006

[3] Centers for Medicare & Medicaid Services. Fact Sheets. Medicare Proposed Framework for the ESRD Quality Incentive Program. Available at: https://www.cms.gov/apps/media/press/factsheet.asp?Counter=4006

[4] Final Rule ESRD PY 2012

MAP's Input to Date

During 2011/2012 pre-rulemaking deliberations, MAP reviewed five measures under consideration by HHS for addition to ESRD programs. MAP supported the inclusion of three measures that address statutory requirements and important clinical management issues. MAP supported the direction of a composite measure that combined two endorsed measures but urged that it undergo further testing as such. MAP did not support other measures under consideration because NQF endorsement had been removed or the measure was thought to be duplicative.

Looking forward, MAP would like to see the measure set for ESRD address aspects of patients' health beyond clinical practices for dialysis. Noted measure gap areas include care coordination, consideration of physical and mental comorbidities, shared decision-making, quality of life, and cost. MAP suggested that currently available depression screening measures be explored for potential application in ESRD facilities. In 2012 rulemaking, HHS indicated that priority topic areas for future measure development include access to care, 30-day readmissions, efficiency, health-related quality of life, and issues pertaining to population/community health.

As an initial step to addressing patient goals and preferences, and at the prompting of the Dual Eligible Beneficiaries Workgroup, MAP had supported the inclusion of a process measure that would have prompted providers to administer a survey assessing health-related quality of life (NQF #0260, Assessment of Health-related Quality of Life). This recommendation was not reflected in the 2012 rulemaking cycle.

Further Guidance for 2012/2013

ESRD programs have a relatively long history of performance measurement linked with public reporting. In addition, an estimated 25 percent of individuals undergoing dialysis are dual eligible beneficiaries. This breadth and depth of reporting experience, combined with a large patient cohort of interest, presents an opportunity for CMS and measure stewards to explore the feasibility of stratifying measure results by dual eligible status.

Table 1, on the following page, presents candidate measures for potential stratification. ESRD measures are generally very technical and specific; the measures in Table 1 are relatively broad indicators of quality. All of the measures currently finalized or under consideration for ESRD quality improvement as of October 2012 are presented in Table 2 to provide a sense of the available universe. The workgroup is asked to consider which measure(s) from Table 1 would send the strongest signal of overall quality for dual eligible beneficiaries if measure results presented dual eligible beneficiaries as a separate stratum.

Table 1. ESRD Measures for Potential Stratification by Dual Eligible Status

NQF # and Status	Measure Name	Measure Description	Status in Program
0249 Endorsed	Hemodialysis Adequacy Clinical Performance Measure III: Hemodialysis Adequacy--HD Adequacy--Minimum Delivered Hemodialysis Dose	Percentage of all adult (greater than or equal to 18 years old) patients in the sample for analysis who have been on hemodialysis for 90 days or more and dialyzing thrice weekly whose average delivered dose of hemodialysis (calculated from the last measurements of the month using the UKM or Daugirdas II formula) was a spKt/V greater than or equal to 1.2 during the study period.	Proposed for PY 2015
0318 Endorsed	Peritoneal Dialysis Adequacy Clinical Performance Measure III - Delivered Dose of Peritoneal Dialysis Above Minimum	Percentage of all adult (>= 18 years old) peritoneal dialysis patients whose delivered peritoneal dialysis dose was a weekly Kt/Vurea of at least 1.7 (dialytic + residual) during the four month study period.	Proposed for PY 2015
0258 Endorsed	Consumer Assessment of Healthcare Providers and Systems In-Center Hemodialysis Survey (ICH CAHPS)	Percentage of patient responses to multiple testing tools. Tools include the In-Center Hemodialysis Composite Score: The proportion of respondents answering each of response options for each of the items summed across the items within a composite to yield the composite measure score. (Nephrologists' Communication and Caring, Quality of Dialysis Center Care and Operations, Providing Information to Patients) Overall Rating: a summation of responses to the rating items grouped into 3 levels	Finalized for use in PY 2014
0369 Endorsed	Dialysis facility risk-adjusted standardized mortality ratio	Risk-adjusted standardized mortality ratio for dialysis facility patients.	Finalized for DFC. Under consideration for QIP for future rulemaking.
1463 Endorsed	Standardized Hospitalization Ratio for Admissions	Risk-adjusted standardized hospitalization ratio for admissions for dialysis facility patients.	Not currently finalized for QIP or DFC. Under consideration for future rulemaking.

Table 2: All Measures Finalized or Under Consideration for ESRD as of Oct. 2012

NQF # and Status	Measure Name	Measure Description	Status in Program	Measure Type
0256 Endorsed	Hemodialysis Vascular Access- Minimizing use of Catheters as Chronic Dialysis Access	Percentage of patients on maintenance hemodialysis during the last HD treatment of study period with a chronic catheter continuously for 90 days or longer prior to the last hemodialysis session.	Finalized for PY 2014 QIP	Process
0257 Endorsed	Hemodialysis Vascular Access- Maximizing Placement of Arterial Venous Fistula (AVF)	Percentage of patients on maintenance hemodialysis during the last HD treatment of month using an autogenous AV fistula with two needles	Finalized for PY 2014 QIP	Process
0258 Endorsed	Consumer Assessment of Healthcare Providers and Systems In-Center Hemodialysis Survey (ICH CAHPS)	Percentage of patient responses to multiple testing tools. Tools include the In-Center Hemodialysis Composite Score: The proportion of respondents answering each of response options for each of the items summed across the items within a composite to yield the composite measure score. (Nephrologists' Communication and Caring, Quality of Dialysis Center Care and Operations, Providing Information to Patients) Overall Rating: a summation of responses to the rating items grouped into 3 levels	Finalized for PY 2014 QIP	Process
Not Endorsed	Mineral Metabolism Measure (Monitor)	This measure assesses whether providers/facilities monitor a patient's phosphorus and calcium levels on a monthly basis throughout the proposed performance period during which the patient was treated. This is a reporting measure only.	Finalized for PY 2014 QIP	Process
Not Endorsed	NHSN Dialysis Reporting Measure	This measure assess whether providers/facilities enroll and report dialysis event data to the NHSN. This is a reporting measure only.	Finalized for PY 2014 QIP	Structure
Not Endorsed	Anemia Management – Percentage of Patients with Hemoglobin >12 g/dL	Hemodialysis and Peritoneal Dialysis patients, with ESRD > 3 months, who have a mean Hemoglobin >12 g/dL for a 12 month reporting period, treated with ESA. The last valid hemoglobin value reported for the end of each reporting month (end-of-month Hemoglobin) is used for the calculation.	Finalized for PY 2013 QIP	Intermediate Outcome

NQF # and Status	Measure Name	Measure Description	Status in Program	Measure Type
Not Endorsed	Percentage of the facility's hemodialysis patients with a urea reduction ratio (URR) of 65% or greater in the calendar year	Eligible Medicare hemodialysis patients at the facility during the calendar year with a median URR value of 65% or higher.	Currently finalized but proposed for removal before PY 2015	Process
0249 Endorsed	Hemodialysis Adequacy Clinical Performance Measure III: Hemodialysis Adequacy-- HD Adequacy-- Minimum Delivered Hemodialysis Dose	Percentage of all adult (greater than or equal to 18 years old) patients in the sample for analysis who have been on hemodialysis for 90 days or more and dialyzing thrice weekly whose average delivered dose of hemodialysis (calculated from the last measurements of the month using the UKM or Daugirdas II formula) was a spKt/V greater than or equal to 1.2 during the study period.	Proposed for PY 2015 QIP	Process
0318 Endorsed	Peritoneal Dialysis Adequacy Clinical Performance Measure III - Delivered Dose of Peritoneal Dialysis Above Minimum	Percentage of all adult (>= 18 years old) peritoneal dialysis patients whose delivered peritoneal dialysis dose was a weekly Kt/Vurea of at least 1.7 (dialytic + residual) during the four month study period.	Proposed for PY 2015 QIP	Outcome
1423 Endorsed	Minimum spKt/V for pediatric hemodialysis patients	Percentage of all pediatric (less than 18 years old) in-center HD patients who have been on hemodialysis for 90 days or more and dialyzing 3 or 4 times weekly whose delivered dose of hemodialysis (calculated from the last measurements of the month using the Urea Kinetic Modeling (UKM) or Daugirdas II formula) was a spKt/V =1.2	Proposed for PY 2015 QIP	Outcome
1454 Endorsed	Proportion of patients with hypercalcemia	Proportion of patients with 3-month rolling average of total uncorrected serum calcium greater than 10.2 mg/dL	Proposed for PY 2015 QIP	Outcome

MAP Dual Eligible Beneficiaries Workgroup

Discussion Guide: Clinician Performance Measurement Programs

Multiple federal measurement programs seek to evaluate the performance of clinicians, both at the individual and group practice levels. Each program has a different purpose, structure, and set of reporting requirements.

Physician Quality Reporting System (PQRS)

The 2006 Tax Relief and Healthcare Act required the establishment of a physician quality reporting system, including an incentive payment for eligible professionals who satisfactorily report data on quality measures for covered professional services furnished to Medicare beneficiaries. Individual clinicians participating in PQRS may select three measures (out of more than 200 possible measures) to report or may choose to report a group of measures specific to a single condition. Individual eligible professionals who meet the criteria for satisfactory submission qualify to earn an incentive payment equal to 1 percent of their total estimated Medicare Part B Physician Fee Schedule allowed charges. Group practices may also submit and are qualified to receive an incentive payment of 1 percent if the practice similarly meets criteria for participation. Beginning in 2011, physicians have the opportunity to earn an additional incentive of 0.5 percent by working with a Maintenance of Certification entity to submit data.[1]

Value-Based Payment Modifier Program (VBPM)

Section 3007 of the Affordable Care Act of 2010 (ACA) requires the Centers for Medicare & Medicaid Services (CMS) to pay physicians differentially based on a modifier derived from composites of quality and cost measures. The program's goal is to develop and implement a budget-neutral payment system that will adjust Medicare physician payments based on the quality and cost of the care they deliver. This system will be phased in over a two-year period beginning in 2015. By 2017, the value-based payment modifier will be applied to the majority of clinicians. The program must include a composite of appropriate, risk-based quality measures and a composite of appropriate cost measures.[2]

Medicare and Medicaid EHR Incentive Program for Eligible Professionals (MU-EP)

The American Recovery and Reinvestment Act of 2009 provides for incentive payments for Medicare eligible professionals (EPs) who are meaningful users of certified electronic health record (EHR) technology. The Recovery Act defines the term "eligible professional" to include: a doctor of medicine or osteopathy, a doctor of oral surgery or dental medicine, a doctor of podiatric medicine, a doctor of optometry, or a chiropractor. These professionals can receive incentive payments if all program

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[1] U.S. Department of Health and Human Services (HHS), Centers for Medicare & Medicaid Services (CMS), Medicare Program; Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule, DME Face-to-Face Encounters, Elimination of the Requirement for Termination of Non-Random Prepayment Complex Medical Review and Other Revisions to Part B for CY 2013 (20*12 Proposed Rules)*, *Fed Reg,* 2012, 75 (133): 40113-40116.

[2] *Ibid.*

requirements are met. The program consists of three stages, each having its own set of requirements to demonstrate meaningful use.[3]

Uptake of MAP Recommendations

During 2011/2012 pre-rulemaking deliberations, MAP highlighted the need to promote alignment across federal clinician measurement programs and private sector programs by consistent use of the same or harmonized measures. HHS has been engaged in a range of activities to improve alignment across federal programs. For instance, the final rule for the Medicare Shared Savings Program indicates that HHS chose a final measure set that is closely aligned with the PQRS measurement program.[4] Additionally, providers can now meet the reporting requirements for Stage 2 Meaningful Use by reporting clinical quality measures through an EHR for PQRS.[5]

Further Guidance for 2012/2013

MAP and the Dual Eligible Beneficiaries Workgroup can capitalize on program alignment efforts to increase the likelihood that clinicians will select and report on performance measures that are relevant to the dual eligible beneficiary population. Table 1 displays the measures in the Dual Eligible Beneficiaries Core Set that are specified for use at the clinician level. The table also shows the current adoption of each measure in the clinician reporting programs.

Several measures in the Dual Eligible Beneficiaries Core Set are already in use across multiple programs, serving as examples of the type of alignment that can be achieved. Specifically, measures 0004, 0028, 0097, 0101, and 0421 do not present further alignment opportunities. Other measures might be incorporated into additional programs to further enhance alignment and the use of measures relevant to the dual eligible population.

In the CY 2013 Physician Fee System Proposed rule, HHS sought comment on which PQRS measures for 2013 and beyond to include in calculating the VBPM at the individual level. Measures 0022 and 0418 are among measures being proposed for reporting through PQRS for 2013 and beyond.

The workgroup is asked to consider:

- **Should 0022 be recommended for addition to the value-based payment modifier?**
- **Should 0418 be recommended for addition to the value-based payment modifier?**

While not required for reporting, the PQRS and MU-EP programs each has a core set of measures, signaling that these measures are most desirable to report. MAP can suggest modifications to the PQRS

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[3] CMS *EHR Incentive Programs*, Baltimore, MD:CMS;2012. Available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/CMS_eHR_Tip_Sheet.pdf. Last accessed September 2012.

[4] Rules and Regulations, *Fed Reg*, 2011; 76(212):67802- 67990. Available at http://www.gpo.gov/fdsys/pkg/FR-2011-11-02/pdf/2011-27461.pdf. Last accessed September 2012.

[5] Rules and Regulations, Fed Reg, 2011; 77(45):13698-13829. Available at https://www.federalregister.gov/articles/2012/03/07/2012-4443/medicare-and-medicaid-programs-electronic-health-record-incentive-program-stage-2. Last accessed September 2012.

and MU-EP cores as an additional opportunity to increase the likelihood that clinicians will select and report on performance measures that are relevant to the dual eligible beneficiary population.

The workgroup is asked to consider which measure(s) should be recommended for addition to the PQRS and MU-EP core sets.

Table 1. Adoption of Clinician-level Duals Core Measures in Federal Measurement Programs

NQF #	Measure Name	VBPM	PQRS	MU-EP
0004	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Finalized	Finalized for use in CY 2012 and proposed for CY 2013 and beyond	Finalized for use in stage 1 and 2
0005, 0007	CAHPS Surveys			
0022	Use of High Risk Medications in the Elderly		Finalized for use for CY 2012 and proposed for use for CY 2013 and beyond	Finalized for use in stage 2 *(Recommended Adult Core for EPs)*
0028	Measure pair: a. Tobacco Use Assessment, b. Tobacco Cessation Intervention	Finalized	Finalized for use for CY 2012 and proposed for use for CY 2013 and beyond *(designated as a core measure)*	Finalized for use in stage 1 and 2 *(Recommended Adult Core for EPs)*
0097	Medication Reconciliation	Finalized	Finalized for use for CY 2012 and proposed for use for CY 2013 and beyond	Proposed but not finalized for use in stage 2
0101	Falls: Screening for Fall Risk	Finalized	Finalized for use for CY 2012 and proposed for use for CY 2013 and beyond	Finalized for use in stage 2
0418	Screening for Clinical Depression		Finalized for use for CY 2012 and proposed for use for CY 2013 and beyond	Finalized for use in stage 2 *(Recommended Adult Core for EPs)*
0421	Adult Weight Screening and Follow-Up	Finalized	Finalized for use for CY 2012 and proposed for use for CY 2013 and beyond	Finalized for use in stage 1 and 2 *(Recommended Adult Core for EPs)*
0430	Changes in Daily Activity Function as Measured by the AM-PAC			
0729	Optimal Diabetes Care		Proposed for use for 2013 and beyond	

***Empty cells indicate a measure was not under consideration for 2011/2012 pre-rulemaking.*

MAP Dual Eligible Beneficiaries Workgroup

Discussion Guide: Hospital Inpatient Quality Reporting and Value-Based Purchasing Programs

Program Description: Inpatient Quality Reporting (IQR)

Since 2004, CMS has collected quality and patient experience data from acute care hospitals on a voluntary basis under the Hospital Inpatient Quality Reporting (IQR) program. The program was originally mandated by the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003. MMA authorized CMS to pay hospitals that successfully report designated quality measures a higher annual update to their payment rates. The Deficit Reduction Act of 2005 provided for a 2 percentage point reduction in the annual market basket update (the measure of inflation in costs of goods and services used by hospitals in treating Medicare patients) for hospitals that did not successfully report.[1] Information gathered through the Hospital IQR program is reported on the Hospital Compare Website.

Statutory requirements apply to the IQR program. Following initial adoption of a measure set based on a report from the Institute of Medicine, the HHS Secretary adds other measures that reflect consensus among the affected parties and includes measures set forth by national consensus-building entities. The Secretary reports on the CMS website quality measures of process, structure, outcome, patients' perspectives on care, efficiency, and costs of care that relate to services furnished in inpatient settings.

MAP's Input to Date: IQR

During 2011/2012 pre-rulemaking deliberations, MAP reviewed 22 new measures under consideration by HHS for addition to the existing 72 finalized measures in the IQR program. MAP supported the inclusion of one composite and three condition-specific measures that address transitions. MAP supported the addition of the Hospital-Wide Readmission measure contingent on receipt of NQF endorsement and encouraged broader all-condition reporting on all adults as soon as possible. MAP also supported a heart failure measure strongly tied to improved outcomes and an elective delivery measure supporting alignment with public and private programs. MAP also suggested removing several measures from this and other program sets because they lost endorsement or similar NQF-endorsed measures are available.

MAP stated that it would like to see future iterations of the measure set for IQR more thoroughly address the NQS priorities of affordable care and person- and family-centered care. Noted measure gap areas in IQR include child health; maternal care; disparities-sensitive measures; behavioral health beyond substance abuse; patient-reported outcomes; sepsis measures; and cost and resource use measures.

MAP recommendations are strongly reflected in HHS' most recent final rule for IQR. All measures MAP recommended be removed were eliminated to reduce redundancy. Three of the four measures MAP did

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[1] CMS, *Hospital Inpatient Quality Reporting Program*, Baltimore, MD: CMS; 2011. Available at www.cms.gov/HospitalQualityInits/08_HospitalRHQDAPU.asp. Last accessed December 2011.

not support were not included in the final rule. Of the ten measures MAP conditionally supported, one was finalized and nine will be considered for future rulemaking contingent upon e-specifications and electronic health record-based collection.

Program Description: Hospital Value-Based Purchasing (VBP)

Starting October 1, 2012, Medicare began basing a portion of hospital reimbursement on performance through the Hospital Value-Based Purchasing (VBP) program. Medicare began withholding 1 percent of its regular hospital reimbursements from all hospitals paid under its inpatient prospective payment system (IPPS) in order to fund a pool of VBP incentive payments. Hospitals are scored based on their performance on each measure within the program relative to other hospitals as well as on how their performance on each measure has improved over time. The higher of these scores on each measure is used in determining incentive payments. Measures eligible for inclusion in the VBP program must initially be included in IQR and reported on Hospital Compare for at least one year. The majority of the measures previously finalized for this program are NQF endorsed. All NQS priorities are addressed; safer care and prevention/treatment of cardiovascular disease are well-addressed while other priorities, such as affordable care and supporting better health in communities, are less so.

MAP's Input to Date: VBP

In 2011, MAP reviewed 13 new measures under consideration for the VBP program for potential addition to the 17 previously finalized measures. MAP supported the addition of two measures related to patient safety. MAP also identified two measures that should be removed from the program. MAP did not support the inclusion of the Medicare Spending per Beneficiary measure, but strongly supported the direction pending additional specification and testing information. However, CMS chose to finalize this measure for the FY 2015 measure set in the most recent IPPS rule.

Further Guidance for 2012/2013

Both IQR and VBP are important quality improvement programs, though their goals differ somewhat. Arguably, VBP is the higher-stakes program because of the newly implemented one percent reimbursement reduction and the need to earn back these funds through incentive payments. Because of the clear path that measures must take to be included in VBP, first becoming part of IQR and then publicly reported for a period of time, MAP is able to identify the measures eligible for VBP and make advance recommendations about which should be included.

Table 1, on the following page, presents candidate measures currently in IQR that could be eligible for inclusion in VBP. For reference, the measures already finalized for VBP as of October 2012 are presented in Table 2.

The workgroup is asked to consider which measure(s) from Table 1 would be most relevant for dual eligible beneficiaries and therefore merit inclusion in the VBP.

Table 1. IQR Measures Eligible for Inclusion in VBP[2]

NQF Measure #	Measure Name and Description	Added to IQR	Reported on Hospital Compare
0113 Reserve Status	*Participation in a Systematic Database for Cardiac Surgery* Participation in a clinical database with broad state, regional, or national representation, that provides regular performance reports based on benchmarked data	FY 2010	Yes
0138 Endorsed	*Catheter-Associated Urinary Tract Infection* Standardized Infection Ratio (SIR) of healthcare-associated, catheter-associated urinary tract infections (CAUTI) will be calculated among patients in the following patient care locations: • Intensive Care Units (ICUs) (excluding patients in neonatal ICUs [NICUs: Level II/III and Level III nurseries]) • Specialty Care Areas (SCAs) - adult and pediatric: long term acute care, bone marrow transplant, acute dialysis, hematology/oncology, and solid organ transplant locations • other inpatient locations	FY 2014*	Will be added January 2013
0753 Endorsed	*Surgical site infection (see OP-24 surgical site infection)* Prototype measure for the facility adjusted Standardized Infection Ratio (SIR) of deep incisional and organ/space Surgical Site Infections (SSI) at the primary incision site among adult patients aged >= 18 years as reported through the ACS National Surgical Quality Improvement Program (ACS-NSQIP) or CDC National Health and Safety Network (NHSN). Prototype also includes a systematic, retrospective sampling of operative procedures in healthcare facilities. This prototype measure is intended for time-limited use and is proposed as a first step toward a more comprehensive SSI measure or set of SSI measures that include additional surgical procedure categories and expanded SSI risk-adjustment by procedure type. This single prototype measure is applied to two operative procedures, colon surgeries and abdominal hysterectomies, and the measure yields separate SIRs for each procedure.	FY 2014*	Will be added January 2013
0493 Time-Limited Endorsed	*Participation in a Systematic Clinical Database for Nursing Sensitive Care* Participation in a systematic qualified clinical database registry involves: a. Physician or other clinician submits standardized data elements to registry b. Data elements are applicable to consensus endorsed quality measures c. Registry measures shall include at least two (2) representative NQF consensus endorsed measures for registry's clinical topic(s) and report on all patients eligible for the selected measures. d. Registry provides calculated measures results, benchmarking, and quality improvement information to individual physicians and clinicians.	FY 2011	Yes

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[2] QualityNet. Hospital Inpatient Quality Reporting (IQR) Program Measures. Measure Comparison Document (CY 2012). Available at www.qualitynet.org (Reference for both tables)

NQF Measure #	Measure Name and Description	Added to IQR	Reported on Hospital Compare
	e. Registry must receive data from more than 5 separate practices and may not be located (warehoused) at an individual group's practice. Participation in a national or state-wide registry is encouraged for this measure. f. Registry may provide feedback directly to the provider's local registry if one exists.		
0493 Time-Limited Endorsed	*Participation in a Systematic Clinical Database Registry for General Surgery* Participation in a systematic qualified clinical database registry involves: a. Physician or other clinician submits standardized data elements to registry b. Data elements are applicable to consensus endorsed quality measures c. Registry measures shall include at least two (2) representative NQF consensus endorsed measures for registry's clinical topic(s) and report on all patients eligible for the selected measures. d. Registry provides calculated measures results, benchmarking, and quality improvement information to individual physicians and clinicians. e. Registry must receive data from more than 5 separate practices and may not be located (warehoused) at an individual group's practice. Participation in a national or state-wide registry is encouraged for this measure. f. Registry may provide feedback directly to the provider's local registry if one exists.	FY 2014	Will be added January 2014
0493 Time-Limited Endorsed	*Participation in a Systematic Clinical Database Registry for Stroke Care* Participation in a systematic qualified clinical database registry involves: a. Physician or other clinician submits standardized data elements to registry b. Data elements are applicable to consensus endorsed quality measures c. Registry measures shall include at least two (2) representative NQF consensus endorsed measures for registry's clinical topic(s) and report on all patients eligible for the selected measures. d. Registry provides calculated measures results, benchmarking, and quality improvement information to individual physicians and clinicians. e. Registry must receive data from more than 5 separate practices and may not be located (warehoused) at an individual group's practice. Participation in a national or state-wide registry is encouraged for this measure. f. Registry may provide feedback directly to the provider's local registry if one exists.	FY 2011	Yes
0495 Time-Limited Endorsed	*ED–1 Median time from emergency department arrival to time of departure from the emergency room for patients admitted to the hospital* Median time from emergency department arrival to time of departure from the emergency room for patients admitted to the facility from the emergency department	FY 2011	Will be added January 2013
0497 Time-Limited Endorsed	*ED–2 Median time from admit decision to time of departure from the emergency department for emergency department patients admitted to the inpatient status*	FY 2011	Will be added January 2013

NQF Measure #	Measure Name and Description	Added to IQR	Reported on Hospital Compare
	Median time from admit decision time to time of departure from the emergency department for emergency department patients admitted to inpatient status		
1653 Endorsed	*IMM-1 Pneumonia Immunization* Inpatients age 65 years and older and 6-64 years of age who have a high risk condition who are screened for 23-valent Pneumococcal Polysaccharide Vaccine (PPV23)status and vaccinated prior to discharge if indicated.	FY 2011	Will be added January 2013
1659 Endorsed	*IMM-2 Flu Immunization* Inpatients age 6 months and older discharged during October, November, December, January, February or March who are screened for influenza vaccine status and vaccinated prior to discharge if indicated.	FY 2011	Will be added January 2013
Not Endorsed	*Nursing Sensitive Care (NSC)(and AHRQ PSI): Death among Surgical Inpatients with Serious Treatable Complications*	FY 2011*	Yes

*Beginning in 2012, CAUTI and SSI data has been reported to NHSN and shared with CMS. Measures were finalized for FY 2014 payment determination.

**AHRQ PSI 4 Failure to Rescue and NSC Death Among Surgical Patients with Serious Treatable Complications measures were originally added for FY 2010 and were harmonized for FY 2011

Table 2. Measures Finalized for VBP*

NQF Measure #	Measure Name	Added to IQR	Added to VBP
0136 Endorsement Removed	*HF-1 Discharge instructions* Percentage of heart failure patients discharged home with written instructions or educational material given to patient or caregiver at discharge or during the hospital stay addressing all of the following: activity level, diet, discharge medications, follow-up appointment, weight monitoring, and what to do if symptoms worsen.	FY 2007	FY 2013
0147 Endorsed	*PN–6 Appropriate initial antibiotic selection* Percentage of pneumonia patients 18 years of age or older selected for initial receipts of antibiotics for community-acquired pneumonia (CAP)	FY 2007	FY 2013
0148 Endorsed	*PN–3b Blood culture performed in the emergency department prior to first antibiotic received in hospital* Percentage of pneumonia patients 18 years of age and older who have had blood cultures performed in the emergency department prior to initial antibiotic received in hospital	FY 2007	FY 2013
0163 Endorsed	*AMI–8a Timing of receipt of primary percutaneous coronary intervention (PCI)* Percentage of acute myocardial infarction (AMI) patients with ST-segment elevation or LBBB on the ECG closest to arrival time receiving primary percutaneous coronary intervention (PCI) during the hospital stay with a time from hospital arrival to PCI of 90 minutes or less.	FY 2007	FY 2013
0164 Endorsed	*AMI–7a Fibrinolytic (thrombolytic) agent received within 30 minutes of hospital arrival* Percentage of acute myocardial infarction (AMI) patients with ST-segment elevation or LBBB on the ECG closest to arrival time receiving fibrinolytic therapy during the hospital stay and having a time from hospital arrival to fibrinolysis of 30 minutes or less.	FY 2007	FY 2013
0166 Endorsed	*HCAHPS survey* 27-items survey instrument with 7 domain-level composites including: communication with doctors, communication with nurses, responsiveness of hospital staff, pain control, communication about medicines, cleanliness and quiet of the hospital environment, and discharge information	FY 2008	FY 2013
0218 Endorsed	*SCIP–VTE-2: Surgery patients who received appropriate VTE prophylaxis within 24 hours pre/post-surgery* Percentage of surgery patients who received appropriate Venous Thromboembolism (VTE) Prophylaxis within 24 hours prior to surgery to 24 hours after surgery end time	FY 2008	FY 2013
0284 Endorsed	*SCIP Cardiovascular-2: Surgery Patients on a beta blocker prior to arrival who received a beta blocker during the perioperative period* Percentage of surgery patients who received appropriate Venous Thromboembolism (VTE) Prophylaxis within 24 hours	FY 2010	FY 2013

NQF Measure #	Measure Name	Added to IQR	Added to VBP
	prior to surgery to 24 hours after surgery end time		
0300 Endorsed	*SCIP INF–4: Cardiac surgery patients with controlled 6AM postoperative serum glucose* Cardiac surgery patients with controlled postoperative blood glucose (less than or equal to 180mg/dL) in the timeframe of 18 to 24 hours after Anesthesia End Time.	FY 2009	FY 2013
0527 Endorsed	*SCIP INF–1 Prophylactic antibiotic received within 1 hour prior to surgical incision* Surgical patients with prophylactic antibiotics initiated within one hour prior to surgical incision. Patients who received vancomycin or a fluoroquinolone for prophylactic antibiotics should have the antibiotics initiated within two hours prior to surgical incision. Due to the longer infusion time required for vancomycin or a fluoroquinolone, it is acceptable to start these antibiotics within two hours prior to incision time.	FY 2007	FY 2013
0528 Endorsed	*SCIP INF–2: Prophylactic antibiotic selection for surgical patients* Surgical patients who received prophylactic antibiotics consistent with current guidelines (specific to each type of surgical procedure).	FY 2008	FY 2013
0529 Endorsed	*SCIP INF–3 Prophylactic antibiotics discontinued within 24 hours after surgery end time (48 hours for cardiac surgery)* Surgical patients whose prophylactic antibiotics were discontinued within 24 hours after Anesthesia End Time (48 hours for CABG or Other Cardiac Surgery). The Society of Thoracic Surgeons (STS) Practice Guideline for Antibiotic Prophylaxis in Cardiac Surgery (2006) indicates that there is no reason to extend antibiotics beyond 48 hours for cardiac surgery and very explicitly states that antibiotics should not be extended beyond 48 hours even with tubes and drains in place for cardiac surgery.	FY 2007	FY 2013
0229 Endorsed	*Heart failure (HF) 30-day mortality rate* The measure estimates a hospital-level risk-standardized mortality rate (RSMR), defined as death from any cause within 30 days after the index admission date, for patients 18 and older discharged from the hospital with a principal diagnosis of HF.	FY 2008	FY 2014
0230 Endorsed	*Acute myocardial infarction (AMI) 30-day mortality rate* The measure estimates a hospital-level risk-standardized mortality rate (RSMR), defined as death from any cause within 30 days after the index admission date, for patients 18 and older discharged from the hospital with a principal diagnosis of AMI.	FY 2008	FY 2014
0453 Endorsed	*SCIP INF–9: Postoperative urinary catheter removal on post-operative day 1 or 2 with day of surgery being day zero* Surgical patients with urinary catheter removed on Postoperative Day 1 or Postoperative Day 2 with day of surgery being day zero.	FY 2011	FY 2014

NQF Measure #	Measure Name	Added to IQR	Added to VBP
0468 Endorsed	*Pneumonia (PN) 30-day mortality rate* The measure estimates a hospital-level risk-standardized mortality rate (RSMR) defined as death for any cause within 30 days of the admission date for the index hospitalization for patients discharged from the hospital with a principal diagnosis of pneumonia. The target population is patients 18 and over. CMS annually reports the measure for patients who are 65 years or older and are either enrolled in fee-for-service (FFS) Medicare and hospitalized in non-federal hospitals or are hospitalized in Veterans Health Administration (VA) facilities. Since NQF-endorsement, the measure has been tested and shown to perform well in an all-payer population aged 18 and older and has been re-specified for this broader age group. The full details of the all-payer analysis and testing are attached.	FY 2009	FY 2014
0139 Endorsed	*Central line associated bloodstream infection* Standardized Infection Ratio (SIR) of healthcare-associated, central line-associated bloodstream infections (CLABSI) will be calculated among patients in the following patient care locations: • Intensive Care Units (ICUs) • Specialty Care Areas (SCAs) - adult and pediatric: long term acute care, bone marrow transplant, acute dialysis, hematology/oncology, and solid organ transplant locations • other inpatient locations.	FY 2013	FY 2015
0531 Endorsed	*Complication/patient safety for selected indicators (composite)* A composite measure of potentially preventable adverse events for selected indicators	FY 2010	FY 2015
Not Endorsed	*Medicare Spending per Beneficiary*	FY 2014**	FY 2015

*Table does not include SCIP-VTE-1 Surgery Patients with Recommended Venous Thromboembolism (VTE) Prophylaxis Ordered which was finalized for removal for FY 2015
**Currently reported on Hospital Compare. Adopted for FY 2014 payment determination

MAP Dual Eligible Beneficiaries Workgroup: Specifications for Measure #0004

NQF Measure # and Status: 0004 Endorsed

Measure Name: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

Measure Type: Process

Description:
The percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) dependence who received the following.
a. Initiation of AOD Treatment. The percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis.
b. Engagement of AOD Treatment. The percentage of members who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.

Numerator:
a) Initiation of AOD Dependence Treatment: Initiation of AOD treatment through an inpatient admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of diagnosis.

- If the Index Episode was an inpatient discharge, the inpatient stay is considered initiation of treatment and the member is compliant
- If the Index Episode was an outpatient, intensive outpatient, partial hospitalization, detoxification or ED visit, the member must have an inpatient admission, outpatient visit, intensive outpatient encounter or partial hospitalization (Table IET-B) with an AOD diagnosis (Table IET-A) within 14 days of the IESD (inclusive)
  – If the initiation encounter is an inpatient admission, the admission date (not the discharge date) must be within 14 days of the IESD (inclusive)
- Do not count Index Episodes that include detoxification codes (including inpatient detoxification) as being initiation of treatment

b) Engagement of AOD Treatment:
Initiation of AOD treatment and two or more inpatient admissions, outpatient visits, intensive outpatient encounters or partial hospitalizations (Table IET-B) with any AOD diagnosis (Table IET-A) within 30 days after the date of the Initiation encounter (inclusive). Multiple engagement visits may occur on the same day, but they must be with different providers in order to be counted.
For members who initiated treatment via an inpatient stay, use the discharge date as the start of the 30-day engagement period.

- If the engagement encounter is an inpatient admission, the admission date (not the discharge date) must be within 30 days of the Initiation encounter (inclusive).

Do not count engagement encounters that include detoxification codes (including inpatient detoxification)

Denominator:
Patients age 13 years and older with a medical and chemical dependency benefit who were diagnosed with a new episode of alcohol and drug dependency during the intake period of January 1-November 15 of the measurement year. The Intake Period is used to capture new episodes of AOD.

Exclusions:
Exclude members who had a claim/encounter with a diagnosis of AOD (Table IET-A) during the 60 days (2 months) before the IESD.

For an inpatient IESD, use the admission date to determine the Negative Diagnosis History.
For an ED visit that results in an inpatient stay, use the ED date of service to determine the Negative Diagnosis History.

Exclude from the denominator members whose initiation encounter is an inpatient stay with a discharge date after December 1 of the measurement year.

Risk Adjustment: No

Care Setting: Clinician Office; Hospital/Acute Care Facility

Level of Analysis: Clinician: Individual, Group/Practice; Health Plan; Integrated Delivery System; Population: State, Regional, National

Data Sources: Administrative claims, Electronic Health Record, Paper Records

Measure Steward: National Committee for Quality Assurance (NCQA)

Key Quality Issues for Dual Eligible Beneficiary Subgroups: Medically Complex Older Adults and Adults 18-65 with a Physical Disability

	Distinct Issues for Medically Complex Older Adults	*Distinct Issues for Adults 18-65 with Physical Disability*	*Quality Issues Common Across Subgroups (for potential inclusion in Core Set)*
Quality of Life	• Advanced illness care	• Meaningful activities and involvement in community life	• Consumer and family engagement in and experience of care • Pain management • Preventing abuse and neglect • Maintaining community living and community integration, length of stay
Care Coordination and Safety			• Avoidable admissions, readmissions, complications • Care transitions, discharge planning • Communication between providers • Communication between provider and beneficiary/caregiver, including shared decision-making • Medication management: access, appropriateness, reconciliation, adherence, reducing polypharmacy • Safety o Catheter-associated urinary tract infections (CAUTI) o Pressure Ulcers o Falls • Over-utilization • Timely initiation of services and supports • Cultural sensitivity, cultural competence
Screening and Assessment	• Screening for malnutrition, dehydration • Ability to self-manage care	• Weight management • Screening for and treatment of: cancer, cardio-metabolic disease, HIV and other sexually transmitted infections	• Person-centered planning • Functional abilities including ADLs and IADLs (change in…, improvement, managing decline) • Preventive services / immunizations • Nutrition
Mental Health & Substance Use		• Screening for substance use, primarily alcohol and tobacco	• Screening for depression and other mental illness • Social relationships
Structural Measures		• Consumer choice of provider • Self-direction of services and supports • Physical accessibility (ADA compliance, location, adaptive technologies) • Provider access (habilitation)	• Workforce adequacy, stability, and training • Provider access (health home, primary care, specialty care, dental care, vision care, durable medical equipment, rehabilitation) • Providers’ linkages to community resources • Caregiver support

MAP Dual Eligible Beneficiaries Workgroup: Quality Measure Array for High-Need Subgroups

QI	Opportunity	Ambulatory Care	Acute Care	Home Health	Long Term Care Facility
SHARED QUALITY ISSUES: Quality of Life	*Consumer and Family Engagement in and Experience of Care*	**NQF 0005 (Core, CC):** CAHPS Clinician/Group Surveys - (Adult Primary Care, Pediatric Care, and Specialist Care Surveys) **NQF 0006 (Core, CC):** CAHPS Health Plan Survey v 4.0 - 4.0 Adult Questionnaire **NQF 0007 (Core, CC):** CAHPS Health Plan Survey v 4.0H - NCQA Supplemental Items for CAHPS® 4.0 Adult Questionnaire, **NQF 1741 (Core):** Patient Experience with Surgical Care Based on the Consumer Assessment of Healthcare Providers and Systems (CAHPS)® Surgical Care Survey **NQF 1909 (Core):** Medical Home System Survey (MHSS)	**NQF 0166 (Core, CC):** HCAHPS, **NQF 0228 (Core, CC):** 3-Item Care Transition Measure (CTM-3), **NQF 1741 (Core):** Patient Experience with Surgical Care Based on the Consumer Assessment of Healthcare Providers and Systems (CAHPS)® Surgical Care Survey	**NQF 0517 (Core, CC):** CAHPS® Home Health Care Survey	**NQF 0691 (Core, CC):** Consumer Assessment of Health Providers and Systems (CAHPS®) Nursing Home Survey: Discharged Resident Instrument, **NQF 0692 (Core, CC):** Consumer Assessment of Health Providers and Systems (CAHPS®) Nursing Home Survey: Long-Stay Resident Instrument, **NQF 0693 (Core, CC):** Consumer Assessment of Health Providers and Systems (CAHPS®) Nursing Home Survey: Family Member Instrument, **NQF 1632 (CC):** CARE - Consumer Assessments and Reports at End of Life
	Pain Management	NQF 0420: Pain Assessment Prior to Initiation of Patient Therapy		**NQF 0177 (Safety):** Improvement in pain interfering with activity, **NQF 0523 (Core):** Pain Assessment Conducted, NQF 0524: Pain Interventions Implemented During Short Term Episodes Of Care	NQF 0676: Percent of Residents Who Self-Report Moderate to Severe Pain (Short-Stay), NQF 0677: Percent of Residents Who Self-Report Moderate to Severe Pain (Long-Stay)
	Preventing Abuse and Neglect		NQF 0203: Restraint prevalence (vest and limb)		NQF 0687: Percent of Residents Who Were Physically Restrained (Long Stay)
	Maintaining community living and community integration, Length of Stay		NQF 0327: Risk-Adjusted Average Length of Inpatient Hospital Stay, NQF 0328: Inpatient Hospital Average Length of Stay (risk adjusted)		

Bold numbers indicate measures previously selected by MAP. **Core** notes measures in the Dual Eligible Beneficiary Core Set. **CC (Care Coordination), Safety, Cardio (Cardiovascular), and Diabetes** indicates measures in a MAP Family.

MAP Dual Eligible Beneficiaries Workgroup: Quality Measure Array for High-Need Subgroups

QI	Opportunity	Ambulatory Care	Acute Care	Home Health	Long Term Care Facility
SHARED QUALITY ISSUES: Care Coordination and Safety	*Avoidable Admissions, Readmissions, and Complications*	**NQF 0265 (CC):** Hospital Transfer/Admission, NQF 0706: Risk Adjusted Colon Surgery Outcome Measure	**NQF 0698 (CC):** 30-Day Post-Hospital AMI Discharge Care Transition Composite Measure, **NQF 0699 (CC):** 30-Day Post-Hospital HF Discharge Care Transition Composite Measure, **NQF 0706:** Risk Adjusted Colon Surgery Outcome Measure Plan All-Cause Readmissions, **NQF 1768 (Core, CC):** Plan All-Cause Readmissions, **NQF 1789 (Core, CC):** Hospital Wide-All-Cause Unplanned Readmissions Measure (HWR), NQF 0505: Hospital 30-day all-cause risk-standardized readmission rate (RSRR) following acute myocardial infarction (AMI) hospitalization, NQF 0506: Hospital 30-day, all-cause, risk-standardized readmission rate (RSRR) following pneumonia hospitalization, NQF 1891: Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization	**NQF 0173 (CC, Safety):** Emergency Department Use without Hospitalization, **NQF 0176 (Safety):** Improvement in management of oral medications, NQF 0171: Acute care hospitalization (risk-adjusted)	
	Care Transitions and Discharge Planning		**NQF 0647 (Core, CC):** Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care), **NQF 0648 (Core, CC):** Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care), **NQF 0649 (CC):** Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges to Ambulatory Care [Home/Self Care] or Home Health Care)	**NQF 0526 (CC):** Timely Initiation of Care	**NQF 0647 (Core, CC):** Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care), **NQF 0648 (Core, CC):** Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)
	Communication between Providers	NQF 0045: Communication with the Physician Managing On-going Care Post Fracture of Hip, Spine or Distal Radius for Men and Women Aged 50 Years and Older	**NQF 0648 (Core, CC):** Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)		**NQF 0648 (Core, CC):** Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)

Bold numbers indicate measures previously selected by MAP. **Core** notes measures in the Dual Eligible Beneficiary Core Set. **CC (Care Coordination), Safety, Cardio (Cardiovascular), and Diabetes** indicates measures in a MAP Family.

MAP Dual Eligible Beneficiaries Workgroup: Quality Measure Array for High-Need Subgroups

QI	Opportunity	Ambulatory Care	Acute Care	Home Health	Long Term Care Facility
	Communication between provider and beneficiary/caregiver, including Shared Decision-Making	NQF 1892: Individual engagement measure derived from the individual engagement domain of the C-CAT, NQF 1898: Health literacy measure derived from the health literacy domain of the C-CAT, NQF 1901: Performance evaluation measure derived from performance evaluation domain of the C-CAT	**NQF 0647 (Core, CC):** Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care), NQF 0509: Reminder system for mammograms, NQF 1892: Individual engagement measure derived from the individual engagement domain of the C-CAT, NQF 1898: Health literacy measure derived from the health literacy domain of the C-CAT, NQF 1901: Performance evaluation measure derived from performance evaluation domain of the C-CAT		**NQF 0647 (Core, CC):** Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)
	Medication Management: Access, Appropriateness, Reconciliation, Adherence, Reducing Polypharmacy	**NQF 0419 (Safety):** Documentation of Current Medications in the Medical Record, **NQF 0496 (Safety):** Adoption of Medication e-Prescribing, **NQF 0646 (Safety):** Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care) NQF 0021: Medication Monitoring (ACE/ARBs, Digoxin, and Diuretics), NQF 0541: Proportion of Days Covered (PDC): 5 Rates by Therapeutic Category, NQF 0542: Adherence to Chronic Medications, NQF 0586: Warfarin_PT/ INR Test NQF 0612: Warfarin - INR Monitoring, NQF 0614: Steroid Use - Osteoporosis Screening, NQF 0620: Asthma - Short-Acting Beta Agonist Inhaler for Rescue Therapy, NQF 0621: Non-Diabetic Nephropathy - Use of ACE Inhibitor or ARB Therapy, NQF 0624: Atrial Fibrillation - Warfarin Therapy, NQF 0633: Osteopenia and Chronic Steroid Use - Treatment to Prevent Osteoporosis, NQF 0634: Osteoporosis - Use of Pharmacological Treatment	**NQF 0419 (Safety):** Documentation of Current Medications in the Medical Record, **NQF 0646 (Safety):** Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care), NQF 0612: Warfarin - INR Monitoring, NQF 0614: Steroid Use - Osteoporosis Screening, NQF 0620: Asthma - Short-Acting Beta Agonist Inhaler for Rescue Therapy, NQF 0621: Non-Diabetic Nephropathy - Use of ACE Inhibitor or ARB Therapy	**NQF 0419 (Safety):** Documentation of Current Medications in the Medical Record, NQF 0612: Warfarin - INR Monitoring, NQF 0620: Asthma - Short-Acting Beta Agonist Inhaler for Rescue Therapy, NQF 0621: Non-Diabetic Nephropathy - Use of ACE Inhibitor or ARB Therapy, NQF 0624: Atrial Fibrillation - Warfarin Therapy, NQF 0633: Osteopenia and Chronic Steroid Use - Treatment to Prevent Osteoporosis, NQF 0634: Osteoporosis - Use of Pharmacological Treatment	**NQF 0419 (Safety):** Documentation of Current Medications in the Medical Record

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QI	Opportunity	Ambulatory Care	Acute Care	Home Health	Long Term Care Facility
	Safety: Catheter-Associated UTI		**NQF 0138 (Safety):** National Healthcare Safety Network (NHSN) Catheter-associated Urinary Tract Infection (CAUTI) Outcome Measure		**NQF 0138 (Safety):** National Healthcare Safety Network (NHSN) Catheter-associated Urinary Tract Infection (CAUTI) Outcome Measure**,** NQF 0684: Percent of Residents with a Urinary Tract Infection (Long-Stay)
	Safety: Pressure Ulcers		**NQF 0201 (Safety):** Pressure ulcer prevalence (hospital acquired)	**NQF 0181 (Safety):** Increase in number of pressure ulcers, NQF 0538: Pressure Ulcer Prevention and Care, NQF 0539: Pressure Ulcer Prevention Implemented during Short Term Episodes of Care, NQF 0540: Pressure Ulcer Risk Assessment Conducted	**NQF 0201 (Safety):** Pressure ulcer prevalence (hospital acquired), NQF 0678: Percent of Residents with Pressure Ulcers That Are New or Worsened (Short-Stay),
	Safety: Falls	**NQF 0266 (Safety):** Patient Fall	**NQF 0141 (Safety):** Patient Fall Rate, **NQF 0202 (Safety):** Falls with injury, **NQF 0266 (Safety):** Patient Fall		**NQF 0674 (Safety):** Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay)
	Over-utilization	NQF 0510: Exposure time reported for procedures using fluoroscopy	**NQF 0668 (Safety):** Appropriate Head CT Imaging in Adults with Mild Traumatic Brain Injury, **NQF 0755 (Safety):** Appropriate Cervical Spine Radiography and CT Imaging in Trauma NQF 0510: Exposure time reported for procedures using fluoroscopy		
	Timely initiation of services and supports			**NQF 0526 (CC):** Timely Initiation of Care	
	Cultural Sensitivity and Cultural Competence	NQF 1902: Clinicians/Groups' Health Literacy Practices Based on the CAHPS Item Set for Addressing Health Literacy, NQF 1904: Clinician/Group's Cultural Competence Based on the CAHPS® Cultural Competence Item Set, NQF 1919: Cultural Competency Implementation Measure	NQF 1821: L2: Patients receiving language services supported by qualified language services providers, NQF 1824: L1A: Screening for preferred spoken language for health care, NQF 1919: Cultural Competency Implementation Measure		NQF 1919: Cultural Competency Implementation Measure

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QI	Opportunity	Ambulatory Care	Acute Care	Home Health	Long Term Care Facility
SHARED QUALITY ISSUES: SCREENING AND ASSESSMENT	*Person-Centered Care Planning*		**NQF 1626 (CC):** Patients Admitted to ICU who Have Care Preferences Documented		
	Functional Abilities, ADL/IADLs			NQF 0174: Improvement in bathing NQF 0179: Improvement in dyspnea	NQF 0686:Percent of Residents Who Have/Had a Catheter Inserted and Left in Their Bladder (Long-Stay), NQF 0688:Percent of Residents Whose Need for Help with Activities of Daily Living Has Increased (Long-Stay)
	Preventative Services/Immunizations	NQF 0577: Use of Spirometry Testing in the Assessment and Diagnosis of COPD, NQF 0680: High Risk for Pneumococcal Disease - Pneumococcal Vaccination, NQF 0635: Chronic Liver Disease - Hepatitis A Vaccination	NQF 1653: Pneumococcal Immunization (PPV 23), NQF 1659: Influenza Immunization	NQF 0577: Use of Spirometry Testing in the Assessment and Diagnosis of COPD NQF 0525: Pneumococcal Polysaccharide Vaccine (PPV) Ever Received (Home Health), NQF 0552: Influenza Immunization Received for Current Flu Season (Home Health), NQF 0635: Chronic Liver Disease - Hepatitis A Vaccination	NQF 0617: High Risk for Pneumococcal Disease - Pneumococcal Vaccination, NQF 0680: Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short-Stay), NQF 0681: Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Long-Stay), NQF 0682: Percent of Residents or Patients Assessed and Appropriately Given the Pneumococcal Vaccine (Short-Stay), NQF 0683: Percent of Residents or Patients Assessed and Appropriately Given the Pneumococcal Vaccine (Long-Stay)
	Nutrition				NQF 0689: Percent of Residents Who Lose Too Much Weight (Long-Stay)

MAP Dual Eligible Beneficiaries Workgroup: Quality Measure Array for High-Need Subgroups

QI	Opportunity	Ambulatory Care	Acute Care	Home Health	Long Term Care Facility
SHARED QUALITY ISSUES: Mental Health and Substance Use	*Screening for Depression and Other Mental Illness*	NQF 0418: Screening for Clinical Depression	NQF 0418: Screening for Clinical Depression	NQF 0518: Depression Assessment Conducted	NQF 0418: Screening for Clinical Depression, NQF 0690: Percent of Residents Who Have Depressive Symptoms (Long-Stay)
	Social Relationships				

QI	Opportunity	Ambulatory Care	Acute Care	Home Health	Long Term Care Facility
SHARED QUALITY ISSUES: Structural Measures	*Workforce adequacy, stability, and training*	NQF 1888: Workforce development measure derived from workforce development domain of the C-CAT, NQF 1905: Leadership commitment measure derived from the leadership commitment domain of the C-CAT	NQF 0204: Skill mix (Registered Nurse [RN], Licensed Vocational/Practical Nurse [LVN/LPN], unlicensed assistive personnel [UAP], and contract), NQF 0205: Nursing Hours per Patient Day, NQF 0207: Voluntary Turnover, NQF 1888: Workforce development measure derived from workforce development domain of the C-CAT, NQF 1905: Leadership commitment measure derived from the leadership commitment domain of the C-CAT		NQF 0204: Skill mix (Registered Nurse [RN], Licensed Vocational/Practical Nurse [LVN/LPN], unlicensed assistive personnel [UAP], and contract), NQF 0205: Nursing Hours per Patient Day
	Provider access				
	Providers' linkages to community resources				
	Caregiver support				

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QI	Opportunity	Ambulatory Care	Acute Care	Home Health	Long Term Care Facility
QUALITY ISSUES FOR PEOPLE WITH DISABILITIES	*Meaningful activities and involvement in community life*				
	Weight management	**NQF 0421 (Core, Cardio/Diabetes):** Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	**NQF 0421 (Core, Cardio/Diabetes):** Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	**NQF 0421 (Core, Cardio/Diabetes):** Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	**NQF 0421 (Core, Cardio/Diabetes):** Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up
	Screening for and treatment of: cancer, cardio-metabolic disease, HIV and other sexually transmitted infections	**NQF 0018 (Cardio/Diabetes):** Controlling High Blood Pressure, **NQF 0729 (Core, Diabetes):** Optimal Diabetes Care NQF 0508: Inappropriate use of "probably benign" assessment category in mammography screening, NQF 0568: Appropriate Follow-Up for Patients with HIV, NQF 0573: HIV Screening: Members at High-Risk of HIV, NQF 0579: Annual cervical cancer screening or follow-up in high-risk women, NQF 0603: Adult(s) taking insulin with evidence of self-monitoring blood glucose testing, NQF 0604: Adult(s) with diabetes mellitus that had a serum creatinine in last 12 reported months. NQF 0605: Patient(s) with hypertension that had a serum creatinine in last 12 reported months., NQF 0610: Heart Failure - Use of ACE Inhibitor (ACEI) or Angiotensin Receptor Blocker (ARB) Therapy, NQF 0611: Hyperlipidemia (Primary Prevention) - Lifestyle Changes and/or Lipid Lowering Therapy, NQF 0613: MI - Use of Beta Blocker Therapy, NQF 0615: Heart Failure - Use of Beta Blocker Therapy, NQF 0616: Atherosclerotic Disease - Lipid Panel Monitoring, NQF 0618: Diabetes with LDL greater than 100 – Use of a Lipid Lowering Agent, NQF 0619: Diabetes with Hypertension or Proteinuria -	**NQF 0642 (Cardio):** Cardiac Rehabilitation Patient Referral From an Inpatient Setting, NQF 0508: Inappropriate use of "probably benign" assessment category in mammography screening, NQF 0603: Adult(s) taking insulin with evidence of self-monitoring blood glucose testing, NQF 0604: Adult(s) with diabetes mellitus that had a serum creatinine in last 12 reported months, NQF 0610: Heart Failure - Use of ACE Inhibitor (ACEI) or Angiotensin Receptor Blocker (ARB) Therapy, NQF 0611: Hyperlipidemia (Primary Prevention) - Lifestyle Changes and/or Lipid Lowering Therapy, NQF 0613: MI - Use of Beta Blocker Therapy, NQF 0615: Heart Failure - Use of Beta Blocker Therapy, NQF 0616: Atherosclerotic Disease - Lipid Panel Monitoring, NQF 0619: Diabetes with Hypertension or Proteinuria - Use of an ACE Inhibitor or ARB, NQF 0630: Diabetes and Elevated HbA1C – Use of Diabetes Medications, NQF 0631: Secondary Prevention of Cardiovascular Events - Use of Aspirin or	NQF 0610: Heart Failure - Use of ACE Inhibitor (ACEI) or Angiotensin Receptor Blocker (ARB) Therapy, NQF 0611: Hyperlipidemia (Primary Prevention) - Lifestyle Changes and/or Lipid Lowering Therapy, NQF 0613: MI - Use of Beta Blocker Therapy, NQF 0615: Heart Failure - Use of Beta Blocker Therapy, NQF 0616: Atherosclerotic Disease - Lipid Panel Monitoring, NQF 0618: Diabetes with LDL greater than 100 – Use of a Lipid Lowering Agent, NQF 0619: Diabetes with Hypertension or Proteinuria - Use of an ACE Inhibitor or ARB, NQF 0632: Primary Prevention of Cardiovascular Events in Diabetics – Use of Aspirin or Antiplatelet Therapy NQF 0635: Chronic Liver Disease - Hepatitis A Vaccination, NQF 0636: Atherosclerotic Disease and LDL Greater than 100 - Use of Lipid Lowering Agent NQF 0644: Patients with a transient	NQF 0508: Inappropriate use of "probably benign" assessment category in mammography screening, NQF 0603: Adult(s) taking insulin with evidence of self-monitoring blood glucose testing., NQF 0604: Adult(s) with diabetes mellitus that had a serum creatinine in last 12 reported months., NQF 0605: Patient(s) with hypertension that had a serum creatinine in last 12 reported months., NQF 0610: Heart Failure - Use of ACE Inhibitor (ACEI) or Angiotensin Receptor Blocker (ARB) Therapy, NQF 0644: Patients with a transient ischemic event ER visit that had a follow up office visit., NQF 1668: Laboratory Testing (Lipid Profile)

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QI	Opportunity	Ambulatory Care	Acute Care	Home Health	Long Term Care Facility
		Use of an ACE Inhibitor or ARB, NQF 0630: Diabetes and Elevated HbA1C – Use of Diabetes Medications, NQF 0631: Secondary Prevention of Cardiovascular Events - Use of Aspirin or Antiplatelet Therapy NQF 0632: Primary Prevention of Cardiovascular Events in Diabetics – Use of Aspirin or Antiplatelet Therapy, NQF 0635: Chronic Liver Disease - Hepatitis A Vaccination, NQF 0636: Atherosclerotic Disease and LDL Greater than 100 - Use of Lipid Lowering Agent NQF 0644: Patients with a transient ischemic event ER visit that had a follow up office visit., NQF 1666: Patients on Erythropoiesis Stimulating Agent (ESA)--Hemoglobin Level > 12.0 g/dL, NQF 1668: Laboratory Testing (Lipid Profile)	Antiplatelet Therapy NQF 0644: Patients with a transient ischemic event ER visit that had a follow up office visit.,	ischemic event ER visit that had a follow up office visit., NQF 1666: Patients on Erythropoiesis Stimulating Agent (ESA)--Hemoglobin Level > 12.0 g/dL,, NQF 1668: Laboratory Testing (Lipid Profile)	
	Screening for substance use, primarily alcohol and tobacco	**NQF 0004 (Core):** Initiation and Engagement of Alcohol and Other Drug Dependence Treatment , **NQF 0027/0028 (Core, Cardio):** Measure pair: a. Tobacco Use Assessment, b. Tobacco Cessation Intervention	**NQF 0004 (Core):** Initiation and Engagement of Alcohol and Other Drug Dependence Treatment		
	Consumer choice of provider				
	Self-direction of services and supports				
	Physical accessibility (ADA compliance, location, adaptive technologies)				
	Provider access (habilitation)				

Bold numbers indicate measures previously selected by MAP. **Core** notes measures in the Dual Eligible Beneficiary Core Set. **CC (Care Coordination), Safety, Cardio (Cardiovascular), and Diabetes** indicates measures in a MAP Family.

QI	Opportunity	Ambulatory Care	Acute Care	Home Health	Hospice	Long Term Care Facility
QUALITY ISSUES FOR OLDER ADULTS	*Advanced illness care*	**NQF 0326 (CC):** Advanced Care Plan	**NQF 0326 (CC):** Advanced Care Plan, **NQF 1632 (CC):** CARE - Consumer Assessments and Reports of End of Life, **NQF 1634 (Safety):** Hospice and Palliative Care -- Pain Screening, **NQF 1637 (Safety):** Hospice and Palliative Care -- Pain Assessment, NQF 1638: Hospice and Palliative Care – Dyspnea Treatment, NQF 1639: Hospice and Palliative Care – Dyspnea Screening, NQF 1641: Hospice and Palliative Care – Treatment Preferences	**NQF 0326 (CC):** Advanced Care Plan, **NQF 1632 (CC):** CARE - Consumer Assessments and Reports of End of Life	**NQF 0208 (Core, CC):** Family Evaluation of Hospice Care, **NQF 0209 (Core, Safety):** Comfortable Dying: Pain Brought to a Comfortable Level Within 48 Hours of Initial Assessment, **NQF 0326 (CC):** Advanced Care Plan**,** **NQF 1632 (CC):** CARE - Consumer Assessments and Reports of End of Life, **NQF 1634 (Safety):** Hospice and Palliative Care -- Pain Screening, **NQF 1637 (Safety):** Hospice and Palliative Care -- Pain Assessment, NQF 1623: Bereaved Family Survey, NQF 1638: Hospice and Palliative Care – Dyspnea Treatment, NQF 1639: Hospice and Palliative Care – Dyspnea Screening, NQF 1641: Hospice and Palliative Care – Treatment Preferences, NQF 1647: Percentage of hospice patients with documentation in the clinical record of a discussion of spiritual/religious concerns or documentation that the patient/caregiver did not want to discuss	**NQF 0326 (CC):** Advanced Care Plan, **NQF 1632 (CC):** CARE - Consumer Assessments and Reports of End of Life, NQF 1623: Bereaved Family Survey
	Screening for malnutrition and dehydration		**NQF 0290 (CC):** Dehydration (PQI 10)			
	Ability to Self-Manage Care					

Bold numbers indicate measures previously selected by MAP. **Core** notes measures in the Dual Eligible Beneficiary Core Set. **CC (Care Coordination), Safety, Cardio (Cardiovascular), and Diabetes** indicates measures in a MAP Family.

Measure Gap-Filling Pathways

Gaps in performance measurement are of great interest and concern to those who receive, purchase, and provide care. Without a coordinated approach among measure developers, funders, program implementers, and other stakeholders, mismatches will exist between what is desired for measure development and what is ultimately generated. Measure development is resource-intensive and efforts should be targeted to the most productive areas.

MAP Gap-Filling Strategy

MAP recently put forth its three-year strategic plan that includes tactics for addressing measure gaps. MAP can serve as a catalyst for gap-filling by systematically identifying and categorizing measure gaps along the measure lifecycle (Figure 1). Successful development and implementation of measures follows a multi-step process: the measure lifecycle is initiated by identification of performance gaps and measure ideas to fill those gaps; moves forward with the development, testing, and endorsement of potential measures; and eventually completes with implementation and evaluation of measure impact.

By pinpointing where measure development is stalled along the steps of the measure lifecycle, barriers and potential solutions may become more evident. For example, where a gap requiring *de novo* measure development is identified, MAP will suggest measure ideas. Most measure gaps affecting the dual eligible population are at this stage of the life cycle. Other measure gaps may be filled by using existing measures as templates, qualifying as gaps in development and testing.

Figure 1. Measure Lifecycle Diagram

Small Group Activity

The MAP Dual Eligible Beneficiaries Workgroup will be engaging in a small group activity to provide the measure development community with greater specificity and prioritization of measurement gaps.

As a framing question, the workgroup is asked to consider if it is more important to pursue measure development in areas that apply to all dual eligible beneficiaries or to high-need subgroups?

HCBS Experience Survey: Draft Domains and Constructs
September, 2012

Getting Needed Services from Personal Assistant and Behavioral Health (PA/BH) Staff

- PA/BH staff arrive on time
- PA/BH staff stay full shift
- Participant notified when PA/BH staff not coming
- Unmet need in dressing, showering or bathing
- PA/BH staff assure personal privacy while dressing, showering or bathing
- Unmet need in meals
- Unmet need in taking medications
- Unmet need in using bathroom

How Well Personal Assistant and Behavioral Health Staff Communicate and Treat You

- Respectful and polite treatment by PA/BH staff
- Participant able to understand non-native English-speaking PA/BH staff
- Individualized/responsive treatment by PA/BH staff
- PA/BH staff explain things in manner easy to understand
- PA/BH staff listen carefully
- PA/BH staff know individual support needs
- PA/BH staff encourages participant’s independence with tasks

Getting Needed Services from Homemakers

- Homemakers arrive on time
- Homemakers stay full shift
- Unmet need in homemaker tasks

How Well Homemakers Communicate and Treat You

- Respectful and polite treatment by homemakers
- Participant able to understand non-native English-speaking homemaker staff
- Individualized/responsive treatment by homemakers
- Homemakers listen carefully
- Homemakers know individual support needs

Your Case Manager

- Knows case manager
- Able to contact case manager

- Case manager responsive to equipment requests
- Case manager responsive to service requests

Choosing Your Services

- Participation in annual planning meeting
- Plan includes what is important to participant
- Staff know plan contents
- Knows how to change service plan

Transportation

- Able to get to all medical appointments
- Transportation service timely
- Transportation service accessible

Personal Safety

- Knows who to contact in case of an emergency
- Has someone to contact if abused
- Theft by paid staff
- Assistance with theft by paid staff
- Verbal abuse by paid staff
- Assistance with verbal abuse by paid staff
- Physical abuse by paid staff
- Assistance with physical abuse by paid staff

Community Inclusion and Empowerment

- Able to get together with family
- Able to get together with friends
- Able to participate in preferred community activities
- Unmet need in community participation
- Makes decisions about daily activities and routines
- Knows can change staff
- Able to change staff

Employment (module)

- Has a job
- Perceived barriers to employment
- Knows can get help finding job
- Unmet need in finding employment
- Able to participate in choosing a job
- Unmet need in job coaching support
- Respectful and polite treatment by job coach
- Job coach explains things in manner easy to understand
- Job coach listens carefully
- Job coach encourages independence at job

Overall Ratings

- Overall rating for PA/BH staff
- Overall recommendation PA/BH staff
- Overall rating for homemakers
- Overall recommendation homemakers
- Overall rating for case manager
- Overall recommendation case manager
- Overall rating of job coach

Home- and Community-Based Services Experience Survey

Instructions

INSTRUCTIONS FOR VENDOR

- **Use Appropriate Versions Of The Survey**. The scripts provided in this document use the questions from the Home- and Community-Based Services (HCBS) Experience Survey. There are four different versions:

    1. **Primary survey in English**. For all surveys conducted in English, begin with using this version.

    2. **Alternate version in English**. If an English-speaking respondent finds answering the primary survey cognitively challenging, use this version. Use this only after a respondent is unable to answer three questions with the "never, sometimes, usually, and always" response options.

    3. **Primary survey in Spanish**. For all surveys conducted in Spanish, begin with using this version.

    4. **Alternate version in Spanish**. If a Spanish-speaking respondent finds answering the primary survey cognitively challenging, use this version.

- **Use Appropriate Response Options:**

    - All questions include a "REFUSED" response option. In this case, "refused" means the respondent did not provide any answer to the question.
    - For response options of "never, sometimes, usually, and always", if the respondent cannot use that scale, the alternate version of the survey should be used which uses the response options of "mostly yes and mostly no." These response options are reserved for individuals who find the "never, sometimes, usually, always" response scale cognitively challenging.
    - All questions include a "DON'T KNOW" response option. This is used when the respondent indicates that he or she does not know the answer and cannot provide a response to the question.
    - All questions include an "UNCLEAR" response option. This should be used when a respondent answers, but the interviewer cannot clarify the meaning of the response even after minor probing **or** the response is completely unrelated to the question—for example, the response to "Do your homemakers listen carefully to what you say?" is "I like to sit by Mary."
    - Some responses have skip patterns, which are expressed as "if 'X' go to Q#." That means the interviewer should skip all following questions until Q#.

- **Use Singular/Plural as needed:** Modify items such that the interviewer can use the correct form (singular or plural) of the survey item.

- **Use Program-Specific Terms:** Where appropriate, add in the program-specific terms for staff (e.g., [*program-specific term for these types of staff*]) but allow the interviewer to modify the term based on the respondent's choice of the word. It will be necessary to obtain information for program-specific terms. State administrative data should include the following information:

- Agency name(s)
- Titles of staff who provide care
- Names of staff who provide care
- Activities that each staff member provides (this will help with identifying appropriate skip logic)
- Hours of staff who come to the home

Title	Name	Agency	Roles	Hours
PCA	Jane Doe	Happy Home	Bathing Dressing Prepping meals	# of hours
Homemaker	John Doe	Happy Home	Cleaning	# of hours

- Please be aware that to conduct this survey, you may need approval from an Institutional Review Board (IRB). Regardless of whether you need IRB approval, you must get the respondent's consent to participate in the survey. In addition, there may be state statutory requirements that apply to interviewers regarding reporting suspected abuse and neglect. Although information should be kept confidential, these state laws may mandate reporting in certain cases and should be reviewed prior to implementation.

INSTRUCTIONS FOR INTERVIEWER

- Interviewers should read aloud all text that appears in initial uppercase and lowercase letters. Text that appears in **bold, lowercase letters** should be emphasized.

- Text in {*italics and in braces*} will be provided by the program. However, if the interviewee provides another term, use that in place of the program-specific term wherever indicated. For example, some interviewees may refer to their case manager by another title, which should be used instead throughout the survey.

- Text in uppercase letters should **not** be read aloud. For example, "DON'T KNOW," "REFUSED," or "UNCLEAR RESPONSE" answer categories appear in uppercase and should not be read to the respondent, but may be used for coding a response. In addition, items that ask the interviewer to INDICATE GENDER and WHETHER SOMEONE HELPED RESPONDENT COMPLETE THIS SURVEY AND HOW should not be read aloud. Interviewer instructions appear in [UPPERCASE LETTERS ENCLOSED IN BRACKETS] and also should not be read aloud.

- Skip patterns are indicated with a → [GO TO Q#].

- Record each response by selecting the box to the left of the answer.

INTRODUCTION

Hello, my name is {*interviewer name*}. I am from {*name of organization*}. How are you today?

Thank you again for letting me talk with you. Today I would like to hear about your life and your experience with the people who help you. What you say will help us learn more about the care you get from {*name of program}*. It will also help us make the questions that I will be asking you better. We are asking these questions of many other people like you who get services and supports from {*name of program}.*

I will ask you questions about people who work with you and the help they give you. I will also ask some questions about you. It should take about 30 minutes. [State] and the Centers for Medicare and Medicaid Services are sponsoring this research study.

[PROVIDE CONSENT FORM] You can choose whether or not you want to answer each question. You can also choose if you want to be interviewed at all. The services you get will not change based on what you say. You can stop answering questions at any time. The services you get will not change.

Being in the study will not help you but might help other people who get care and services in the future. There is also a chance the some of the questions might make you sad or upset.

All of your answers will be kept private under the Privacy Act. That means we won't share what you have to say with anyone except the people who are doing the research. The only people allowed to see your answers will be the people who work on the study and people who make sure we run our study the right way. None of the people who help you will know what you say, unless you want them in the room while we talk. {*ADD STATE-SPECIFIC LANGUAGE HERE REGARDING MANDATED REPORTING, IF APPROPRIATE.*}

Some people may not be able to answer a question quickly. Some people may not know the answer. This is not a test. If you don't know the answer to a question, or can't remember it, let me know. "I don't remember" could be the best answer.

Also, we can take as much time as you would like to go through the survey. I am not in a hurry. Let me know if you would like me to repeat a question. We can take a break if you would like. We can also stop any time you want.

Do you have any questions before we start?

[ANSWER ANY QUESTIONS RAISED BY THE RESPONDENT, THEN GO TO COGNITIVE SCREENING QUESTION 1.]

COGNITIVE SCREENING QUESTIONS

CS-1. Today I will ask you about the people paid to help you around your house or in your area. Please tell me in your own words what I will be asking about.

CS-2. Taking part in the survey is completely voluntary. Completely voluntary means you can choose whether or not to talk to me. You are free to participate in the interview or not. You can also stop at any time, for any reason. If you do not participate or you stop early, you will not lose any services that you normally expect to get. What you say will not affect the services you receive, Medicaid, Medicare, or other health insurance. When I say your participation is completely voluntary, what does that mean to you?

CS-3. All of your answers kept private under the Privacy Act. That means we won't share what you have to say with anyone except the people who are doing the research. We will not use your name in connection with anything you say. Your name won't be on anything we write for or about the study. We won't share anything you say with the people paid to help you or the program staff in your state. None of the people who help you will know what you say, unless you want them in the room while we talk. When I say that your answers will be kept private, what does that mean to you?

[IF RESPONDENT CANNOT ANSWER THESE THREE QUESTIONS, STOP THE INTERVIEW AND THANK THE RESPONDENT. IF RESPONDENT CAN, CONTINUE ON]

[MANDATORY STATE INFORMATION EXAMPLE: If we have a reason to think that you are being hurt or are in danger, we have a legal responsibility to tell the [STATE CONTACT].

CS-5. Do you agree to being asked questions about the people who are paid to help you?

☐ YES [CONTINUE TO IDENTIFYING QUESTIONS]
☐ NO [THANK AND END]

Thank you. Just so you have a copy for later, here is information about the study for you to look at later. [PROVIDE RESPONDENT WITH CONSENT INFORMATION]

IDENTIFICATION QUESTIONS

People might be paid to help you get ready in the morning, with housework, go places, or get mental health services. This survey is about the people who are paid to help you in your home and community with everyday activities. It also asks about the services you get.

ID-1. Our records show that you get {*program specific term for personal assistance*}. Is that right?

☐ YES
☐ NO
☐ DON'T KNOW
☐ REFUSED
☐ UNCLEAR RESPONSE

ID-2. What do you call the person or people who give you {*program specific term for personal assistance*}? For example, do you call them {*program specific term for personal assistance*}, staff, personal care attendants, PCAs, workers, or something else?

ID-3. Our records show that you get {*program specific term for behavioral health specialist services*}. Is that right?

☐ YES
☐ NO
☐ DON'T KNOW
☐ REFUSED
☐ UNCLEAR RESPONSE

ID-4. What do you call the person or people who give you {*program specific term for behavioral health specialist services*}? For example, do you call them {program-specific term for behavioral health specialists}, counselors, peer supports, recovery assistants, or something else?

ID-5. Our records show that you get {*program specific term for homemaker services*}. Is that right?

☐ YES
☐ NO
☐ DON'T KNOW
☐ REFUSED
☐ UNCLEAR RESPONSE

ID-6. What do you call the person or people who give you {*program specific term for homemaker services*}? For example, do you call them {*program-specific term for homemaker*}, aides, homemakers, chore workers, or something else?

ID-7. [IF RESPONDENT REPORTS HAVING PCA AND HOMEMAKER STAFF, THEN ASK]. Do the same people who help you with everyday activities also help you to clean your home?

☐ YES ➔ ASK ALL PCA ITEMS AND SELECT HOMEMAKER ITEMS
☐ NO ➔ ASK PCA ITEMS AND SELECT HOMEMAKER ITEMS SEPARATELY
☐ DON'T KNOW ➔ ASK ALL PCA ITEMS AND SELECT HOMEMAKER ITEMS
☐ REFUSED ➔ ASK ALL PCA ITEMS AND SELECT HOMEMAKER ITEMS
☐ UNCLEAR RESPONSE ➔ ASK ALL PCA ITEMS AND SELECT HOMEMAKER ITEMS

ID-8. Our records show that you get {*program specific term for case manager services}* to help make sure that you have all the services you need, like help from {*list of assistance identified previously*}. Is that right?

☐ YES
☐ NO
☐ DON'T KNOW
☐ REFUSED
☐ UNCLEAR RESPONSE

ID-9. What do you call the person who gives you {*program specific term for case manager services*}? For example, do you call the person a {*program-specific term for case manager*}, case manager, care manager, service coordinator, supports coordinator, social worker, or something else?

[RESPONDENT TITLES SHOULD BE AUTOMATICALLY ADDED INTO SECTIONS, WHEREEVER IT STATES {*personal assistance/behavioral health staff*}, {*case manager*}, or {*homemaker*}.]

[IF RESPONSE IS NEGATIVE TO ALL SUPPORTS, THEN GO TO CHOOSING YOUR SERVICES SECTION.]

SERVICES AND SUPPORTS FROM PERSONAL ASSISTANT AND BEHAVIORAL STAFF

GETTING NEEDED SERVICES FROM PERSONAL ASSISTANT AND BEHAVIORAL HEALTH STAFF

1. First I would like to talk about the {*personal assistance/behavioral health staff*}who are paid to help you complete everyday activities—for example, getting dressed, using the bathroom, taking a bath or shower, or going places. How often do {*personal assistance/behavioral health staff*} come to work on time? Would you say . . .

☐ Never,
☐ Sometimes,
☐ Usually, or
☐ Always?
☐ DON'T KNOW
☐ REFUSED
☐ UNCLEAR RESPONSE

i. Alternate Version: First I would like to talk about the {*personal assistance/behavioral health staff*}who are paid to help you complete everyday activities—for example, getting dressed, using the bathroom, taking a bath or shower, or going places. Do {*personal assistance/behavioral health staff*} come to work on time? Would you say

☐ Mostly yes, or,
☐ Mostly no?
☐ DON'T KNOW
☐ REFUSED
☐ UNCLEAR RESPONSE

2. How often do {*personal assistance/behavioral health staff*} work as long as they are supposed to? Would you say . . .

☐ Never,
☐ Sometimes,
☐ Usually, or
☐ Always?
☐ DON'T KNOW
☐ REFUSED
☐ UNCLEAR RESPONSE

i. Alternate Version: Do {*personal assistance/behavioral health staff*} work as long as they are supposed to? Would you say . . .

☐ Mostly yes, or,
☐ Mostly no?
☐ DON'T KNOW
☐ REFUSED
☐ UNCLEAR RESPONSE

3. Sometimes staff cannot come to work on a day that they are scheduled. When staff cannot come to work on a day that they are scheduled, does someone let you know if {*personal assistance/behavioral health staff*} cannot come that day?

   ☐ YES
   ☐ NO
   ☐ DON'T KNOW
   ☐ REFUSED
   ☐ UNCLEAR RESPONSE

4. Do you need help from {*personal assistance/behavioral health staff*} to get dressed or to take a shower or bath?

   ☐ YES
   ☐ NO ➔[GO TO Q8]
   ☐ DON'T KNOW ➔[GO TO Q8]
   ☐ REFUSED ➔[GO TO Q8]
   ☐ UNCLEAR RESPONSE ➔[GO TO Q8]

5. Do you **always** get dressed or take a shower or bath when you need one?

   ☐ YES ➔[GO TO Q7]
   ☐ NO
   ☐ DON'T KNOW ➔[GO TO Q7]
   ☐ REFUSED ➔[GO TO Q7]
   ☐ UNCLEAR RESPONSE ➔[GO TO Q7]

6. Is this because there are no {*personal assistance/behavioral health staff*} to help you?

   ☐ YES
   ☐ NO
   ☐ DON'T KNOW
   ☐ REFUSED
   ☐ UNCLEAR RESPONSE

7. How often do {*personal assistance/behavioral health staff*} make sure you have enough privacy when you get dressed or take a shower or bath? Would you say…

   ☐ Never,
   ☐ Sometimes,
   ☐ Usually, or
   ☐ Always?
   ☐ DON'T KNOW
   ☐ REFUSED
   ☐ UNCLEAR RESPONSE

   i. Alternate Version: Do {*personal assistance/behavioral health staff*} make sure you have enough privacy when you get dressed or take a shower or bath? Would you say…

      ☐ Mostly yes, or,
      ☐ Mostly no?
      ☐ DON'T KNOW
      ☐ REFUSED

☐ UNCLEAR RESPONSE

8. Do you need help from {*personal assistance/behavioral health staff*} with your meals, such as help making or cooking meals or help eating?

☐ YES
☐ NO ➔[GO TO Q11]
☐ DON'T KNOW ➔[GO TO Q11]
☐ REFUSED ➔[GO TO Q11]
☐ UNCLEAR RESPONSE ➔[GO TO Q11]

9. Are you **always** able to get something to eat when you are hungry?

☐ YES ➔[GO TO Q11]
☐ NO
☐ DON'T KNOW ➔[GO TO Q11]
☐ REFUSED ➔[GO TO Q11]
☐ UNCLEAR RESPONSE ➔[GO TO Q11]

10. Is this because there are no {*personal assistance/behavioral health staff*} to help you?

☐ YES
☐ NO
☐ DON'T KNOW
☐ REFUSED
☐ UNCLEAR RESPONSE

11. Sometimes people need help taking their medicines, such as reminders, help pouring them, or setting up their pills. Do you need help from {*personal assistance/behavioral health staff*} to take your medicines?

☐ YES
☐ NO ➔[GO TO Q14]
☐ DON'T KNOW ➔[GO TO Q14]
☐ REFUSED ➔[GO TO Q14]
☐ UNCLEAR RESPONSE ➔[GO TO Q14]

12. Do you **always** take your medicine when you are supposed to?

☐ YES ➔[GO TO Q14]
☐ NO
☐ DON'T KNOW ➔[GO TO Q14]
☐ REFUSED ➔[GO TO Q14]
☐ UNCLEAR RESPONSE ➔[GO TO Q14]

13. Is this because there are no {*personal assistance/behavioral health staff*} to help you?

☐ YES
☐ NO
☐ DON'T KNOW
☐ REFUSED
☐ UNCLEAR RESPONSE

14. Help with toileting includes helping someone get on and off the toilet or helping to change disposable briefs or pads. Do you need help from {*personal assistance/behavioral health staff*} with toileting?

☐ YES
☐ NO ➔[GO TO Q16]
☐ DON'T KNOW ➔[GO TO Q16]
☐ REFUSED ➔[GO TO Q16]
☐ UNCLEAR RESPONSE ➔[GO TO Q16]

15. Do you get all the help you need with toileting from {*personal assistance/behavioral health staff*} when you need it?

☐ YES
☐ NO
☐ DON'T KNOW
☐ REFUSED
☐ UNCLEAR RESPONSE

HOW WELL PERSONAL ASSISTANT AND BEHAVIORAL HEALTH STAFF COMMUNICATE AND TREAT YOU

The next several questions ask about how {*personal assistance/behavioral health staff*} treat you.

16. How often are {*personal assistance/behavioral health staff*} nice and polite to you? Would you say . . .

☐ Never,
☐ Sometimes,
☐ Usually, or
☐ Always?
☐ DON'T KNOW
☐ REFUSED
☐ UNCLEAR RESPONSE

i. Alternate Version: Are {*personal assistance/behavioral health staff*} nice and polite to you? Would you say . . .

☐ Mostly yes, or,
☐ Mostly no?
☐ DON'T KNOW
☐ REFUSED
☐ UNCLEAR RESPONSE

17. How often are the explanations {*personal assistance/behavioral health staff*}gives you hard to understand because of an accent or the way the provider speaks English? Would you say . . .

☐ Never,
☐ Sometimes,

☐ Usually, or
☐ Always?
☐ DON'T KNOW
☐ REFUSED
☐ UNCLEAR RESPONSE

i. Alternate Version: Are the explanations {*personal assistance/behavioral health staff*} give you hard to understand because of an accent or the way {*personal assistance/behavioral health staff*} speaks English? Would you say. . .

☐ Mostly yes, or,
☐ Mostly no?
☐ DON'T KNOW
☐ REFUSED
☐ UNCLEAR RESPONSE

18. How often do {*personal assistance/behavioral health staff*} treat you the way you want them to? Would you say . . .

☐ Never,
☐ Sometimes,
☐ Usually, or
☐ Always?
☐ DON'T KNOW
☐ REFUSED
☐ UNCLEAR RESPONSE

i. Alternate Version: Do {*personal assistance/behavioral health staff*} treat you the way you want them to? Would you say . . .

☐ Mostly yes, or,
☐ Mostly no?
☐ DON'T KNOW
☐ REFUSED
☐ UNCLEAR RESPONSE

19. How often do {*personal assistance/behavioral health staff*} explain things in a way that is easy to understand? Would you say . . .

☐ Never,
☐ Sometimes,
☐ Usually, or
☐ Always?
☐ DON'T KNOW
☐ REFUSED
☐ UNCLEAR RESPONSE

i. Alternate Version: Do {*personal assistance/behavioral health staff*} explain things in a way that is easy to understand? Would you say . . .

☐ Mostly yes, or,
☐ Mostly no?

- ☐ DON'T KNOW
- ☐ REFUSED
- ☐ UNCLEAR RESPONSE

20. How often do {*personal assistance/behavioral health staff*} listen carefully to you? Would you say . . .

- ☐ Never,
- ☐ Sometimes,
- ☐ Usually, or
- ☐ Always?
- ☐ DON'T KNOW
- ☐ REFUSED
- ☐ UNCLEAR RESPONSE

i. Alternate Version: Do {*personal assistance/behavioral health staff*} listen carefully to you?
Would you say . . .

- ☐ Mostly yes, or,
- ☐ Mostly no?
- ☐ DON'T KNOW
- ☐ REFUSED
- ☐ UNCLEAR RESPONSE

21. Do you feel {*personal assistance/behavioral health staff*} know what kind of help **you** need with everyday activities, like getting ready in the morning, getting groceries, or going places in your community?

- ☐ YES
- ☐ NO
- ☐ DON'T KNOW
- ☐ REFUSED
- ☐ UNCLEAR RESPONSE

22. Do *{personal assistance/behavioral health staff}* encourage you to do things for yourself if you can?

- ☐ YES
- ☐ NO
- ☐ DON'T KNOW
- ☐ REFUSED
- ☐ UNCLEAR RESPONSE

23. How would you rate the help you get from {*personal assistance/behavioral health staff*}? Would you say . . .

- ☐ Excellent,
- ☐ Very good,
- ☐ Good,
- ☐ Fair, or
- ☐ Poor?
- ☐ DON'T KNOW

☐ REFUSED
☐ UNCLEAR RESPONSE

24. Would you recommend the {*personal assistance/behavioral health staff*} who help you to your family and friends if they needed help with everyday activities? Would you say you recommend the {*personal assistance/behavioral health staff*} . . .

☐ Definitely no,
☐ Probably no,
☐ Probably yes, or
☐ Definitely yes?
☐ DON'T KNOW
☐ REFUSED
☐ UNCLEAR RESPONSE

SERVICES AND SUPPORT FROM HOMEMAKERS

The next several questions are about the {*homemakers*}, the staff who are paid to help you do tasks around the home—such as cleaning, grocery shopping, or doing laundry.

GETTING NEEDED SERVICES FROM HOMEMAKERS

25. How often do {*homemakers*} come to work on time? Would you say . . .

☐ Never,
☐ Sometimes,
☐ Usually, or
☐ Always?
☐ DON'T KNOW
☐ REFUSED
☐ UNCLEAR RESPONSE

i. Alternate Version: Do {*homemakers*} come to work on time? Would you say . . .

☐ Mostly yes, or,
☐ Mostly no?
☐ DON'T KNOW
☐ REFUSED
☐ UNCLEAR RESPONSE

26. How often do {*homemakers*} work as long as they are supposed to? Would you say . . .

☐ Never,
☐ Sometimes,
☐ Usually, or
☐ Always?
☐ DON'T KNOW
☐ REFUSED
☐ UNCLEAR RESPONSE

i. Alternate Version: Do {*homemakers*} work as long as they are supposed to? Would you say . . .

☐ Mostly yes, or,
☐ Mostly no?
☐ DON'T KNOW
☐ REFUSED
☐ UNCLEAR RESPONSE

27. Do your household tasks, like cleaning and laundry, **always** get done when you need them to? [ASK IF HOMEMAKER IS THE SAME AS PCA STAFF]

☐ YES ➔[GO TO Q29]
☐ NO

☐ DON’T KNOW NO ➔[GO TO Q29]
☐ REFUSED NO ➔[GO TO Q29]
☐ UNCLEAR RESPONSE ➔[GO TO Q29]

28. Is this because there are no {*homemakers*} to help you? [ASK IF HOMEMAKER IS THE SAME AS PCA STAFF]

☐ YES
☐ NO
☐ DON’T KNOW
☐ REFUSED
☐ UNCLEAR RESPONSE

HOW WELL HOMEMAKERS COMMUNICATE AND TREAT YOU

The next several questions ask about how {*homemakers*} treat you.

29. How often are {*homemakers*} nice and polite to you? Would you say . . .

☐ Never,
☐ Sometimes,
☐ Usually, or
☐ Always?
☐ DON’T KNOW
☐ REFUSED
☐ UNCLEAR RESPONSE

i. Alternate Version: Are {*homemakers*} nice and polite to you? Would you say . . .

☐ Mostly yes, or,
☐ Mostly no?
☐ DON’T KNOW
☐ REFUSED
☐ UNCLEAR RESPONSE

30. How often are the explanations {*homemaker*} gives you hard to understand because of an accent or the way the provider speaks English? Would you say . . .

☐ Never,
☐ Sometimes,
☐ Usually, or
☐ Always?
☐ DON’T KNOW
☐ REFUSED
☐ UNCLEAR RESPONSE

i. Alternate Version: Are the explanations {*homemakers*} give you hard to understand because of an accent or the way {*homemakers*} speaks English? Would you say. . .

☐ Mostly yes, or,
☐ Mostly no?
☐ DON'T KNOW
☐ REFUSED
☐ UNCLEAR RESPONSE

31. How often do {*homemakers*} treat you the way you want them to? Would you say . . .

☐ Never,
☐ Sometimes,
☐ Usually, or
☐ Always?
☐ DON'T KNOW
☐ REFUSED
☐ UNCLEAR RESPONSE

i. Alternate Version: Do {*homemakers*} treat you the way you want them to? Would you say . . .

☐ Mostly yes, or,
☐ Mostly no?
☐ DON'T KNOW
☐ REFUSED
☐ UNCLEAR RESPONSE

32. How often do {*homemakers*} listen carefully to you? Would you say . . .

☐ Never,
☐ Sometimes,
☐ Usually, or
☐ Always?
☐ DON'T KNOW
☐ REFUSED
☐ UNCLEAR RESPONSE

i. Alternate Version: Do {*homemakers*} listen carefully to you? Would you say . . .

☐ Mostly yes, or,
☐ Mostly no?
☐ DON'T KNOW
☐ REFUSED
☐ UNCLEAR RESPONSE

33. Do you feel {*homemakers*} know what kind of help you need?

☐ YES

☐ NO
☐ DON'T KNOW
☐ REFUSED
☐ UNCLEAR RESPONSE

34. How would you rate the help you get from {*homemakers*}? Would you say . . .

☐ Excellent,
☐ Very good,
☐ Good,
☐ Fair, or
☐ Poor?
☐ DON'T KNOW
☐ REFUSED
☐ UNCLEAR RESPONSE

35. Would you recommend the {*homemakers}* who help you to your family and friends if they needed {*respondent-specific term for homemaker services*}? Would you say you recommend the {*homemakers*} . . .

☐ Definitely no,
☐ Probably no,
☐ Probably yes, or
☐ Definitely yes?
☐ DON'T KNOW
☐ REFUSED
☐ UNCLEAR RESPONSE

YOUR CASE MANAGER

Now I would like to talk to you about your {*case manager*}, the person who helps make sure you have the services you need.

36. Do you know who your {*case manager*} is?

☐ YES
☐ NO ➔[GO TO Q44]
☐ DON'T KNOW ➔[GO TO 44]
☐ REFUSED ➔[GO TO Q44]
☐ UNCLEAR RESPONSE ➔[GO TO Q44]

37. Can you contact this {*case manager*} when you need to?

☐ YES
☐ NO
☐ DON'T KNOW
☐ REFUSED
☐ UNCLEAR RESPONSE

38. Some people need to get equipment, such as wheelchairs or walkers, to help them, and other people need their equipment replaced or repaired. Have you asked this {*case manager*} for help with getting or fixing equipment?

☐ YES
☐ NO ➔[GO TO Q40]
☐ DON'T KNOW ➔[GO TO Q40]
☐ REFUSED ➔[GO TO Q40]
☐ UNCLEAR RESPONSE ➔[GO TO Q40]

39. Did this {*case manager*} work with you when you asked for help with getting or fixing equipment?

☐ YES
☐ NO
☐ DON'T KNOW
☐ REFUSED
☐ UNCLEAR RESPONSE

40. Have you asked this {*case manager*} for help in getting any changes to your services, such as more help from {*personal assistance/behavioral health staff and/or homemakers if applicable*}, or for help with getting places or finding a job?

☐ YES
☐ NO ➔[GO TO 42]
☐ DON'T KNOW ➔[GO TO 42]
☐ REFUSED ➔[GO TO 42]
☐ UNCLEAR RESPONSE ➔[GO TO 42]

41. Did this {*case manager*} work with you when you asked for help with getting other changes to your services?

☐ YES
☐ NO
☐ DON'T KNOW
☐ REFUSED
☐ UNCLEAR RESPONSE

42. How would you rate the help you get from the {*case manager*}? Would you say . . .

☐ Excellent,
☐ Very good,
☐ Good,
☐ Fair, or
☐ Poor?
☐ DON'T KNOW
☐ REFUSED
☐ UNCLEAR RESPONSE

43. Would you recommend the {*case manager*} who helps you to your family and friends if they needed {*respondent-specific term for case-management services*}? Would you say you recommend the {*case manager*} . . .

☐ Definitely no,
☐ Probably no,
☐ Probably yes, or
☐ Definitely yes?
☐ DON'T KNOW
☐ REFUSED
☐ UNCLEAR RESPONSE

CHOOSING YOUR SERVICES

44. A [*program-specific term for "service plan"*]—sometimes called a care plan, goals, or service plan—lists the services you need and who will provide them. Did you work with someone to develop your [*program-specific term for "service plan"*]?

☐ YES
☐ NO
☐ DON'T KNOW
☐ REFUSED
☐ UNCLEAR RESPONSE

45. Does your [*program-specific term for* "service *plan"*] include . . .

☐ **None** of the things that are important to you,
☐ **Some** of the things that are important to you,
☐ **Most** of the things that are important to you, or
☐ **All** of the things that are important to you?
☐ DON'T KNOW ➔[GO TO 47]
☐ REFUSED ➔[GO TO 47]
☐ UNCLEAR RESPONSE ➔[GO TO 47]

46. Do you feel {*personal assistance/behavioral health staff*} know what's on your [*program-specific term for "service plan"*], including the things that are important to you?

☐ YES
☐ NO
☐ DOES NOT HAVE PERSONAL ASSISTANCE STAFF
☐ DON'T KNOW
☐ REFUSED
☐ UNCLEAR RESPONSE

47. Who would you talk to if you wanted to change your [*program-specific term for "service plan"*]? Anyone else? [INTERVIEWER MARKS ALL THAT APPLY]

☐ CASE MANAGER
☐ OTHER STAFF
☐ FAMILY/FRIENDS
☐ OTHER
☐ I DON'T KNOW
☐ REFUSED
☐ UNCLEAR RESPONSE

TRANSPORTATION

The next questions ask about how you get to places in your community.

48. Medical appointments include seeing a doctor, a dentist, a therapist, or someone else who takes care of your health. How often do you have a way to get to your medical appointments? Would you say . . .

☐ Never,
☐ Sometimes,
☐ Usually, or
☐ Always?
☐ DON'T KNOW
☐ REFUSED
☐ UNCLEAR RESPONSE

i. Alternate Version: Medical appointments include seeing a doctor, a dentist, a therapist, or someone else who takes care of your health. Do you have a way to get to your medical appointments? Would you say . . .

☐ Mostly yes, or,
☐ Mostly no?
☐ DON'T KNOW
☐ REFUSED
☐ UNCLEAR RESPONSE

49. Do you use a van or some other transportation service? Do not include a van you own.

☐ YES
☐ NO ➔[GO TO Q52]
☐ DON'T KNOW ➔[GO TO Q52]
☐ REFUSED ➔[GO TO Q52]
☐ UNCLEAR RESPONSE ➔[GO TO Q52]

50. Are you able to get in and out of this ride easily?

☐ YES
☐ NO
☐ DON'T KNOW
☐ REFUSED
☐ UNCLEAR RESPONSE

51. How often does this ride arrive on time to pick you up? Would you say . . .

☐ Never,
☐ Sometimes,
☐ Usually, or
☐ Always?
☐ DON'T KNOW
☐ REFUSED

☐ UNCLEAR RESPONSE

i. Alternate Version: Does this ride arrive on time to pick you up? Would you say . . .

☐ Mostly yes, or,
☐ Mostly no?
☐ DON'T KNOW
☐ REFUSED
☐ UNCLEAR RESPONSE

PERSONAL SAFETY

The next few questions ask about your personal safety.

52. Who would you contact in case of an emergency?

☐ FAMILY MEMBER OR FRIEND
☐ CASE MANAGER
☐ AGENCY THAT PROVIDES HOME- AND COMMUNITY-BASED SERVICES
☐ PAID EMERGENCY RESPONSE SERVICE (E.G., LIFELINE)
☐ 9–1–1 (FIRST RESPONDERS, POLICE, LAW ENFORCEMENT)
☐ SOMEONE ELSE, PLEASE SPECIFY ___________________
☐ DON'T KNOW
☐ REFUSED
☐ UNCLEAR RESPONSE

53. Is there a person you can talk to if someone hurts you or does something to you that you don't like?

☐ YES
☐ NO
☐ DON'T KNOW
☐ REFUSED
☐ UNCLEAR RESPONSE

The next few questions ask if <u>anyone</u> paid to help you <u>now</u> is treating you badly. This includes {*personal assistance/behavioral health staff, homemakers, or your case manager*}. We are asking everyone the next questions—not just you. [ADD STATE-SPECIFIC LANGUAGE HERE REGARDING MANDATED REPORTING, IF APPROPRIATE—
"I want to remind you that, although your answers are confidential, I have a legal responsibility to tell {*STATE*} if I hear something that makes me think you are being hurt or are in danger"]

54. Do **any** of the {*personal assistance/behavioral health staff, homemakers, or your case managers*} that you have **now** take your money or your things without asking you first?

☐ YES
☐ NO ➔[GO TO Q57]
☐ DON'T KNOW ➔[GO TO Q57]
☐ REFUSED ➔[GO TO Q57]
☐ UNCLEAR RESPONSE ➔[GO TO Q57]

55. Is someone working with you to fix this problem?

☐ YES
☐ NO ➔[GO TO Q57]
☐ DON'T KNOW ➔[GO TO Q57]
☐ REFUSED ➔[GO TO Q57]
☐ UNCLEAR RESPONSE ➔[GO TO Q57]

56. Who is working with you to fix this problem? Anyone else? [INTERVIEWER MARKS ALL THAT APPLY]

☐ FAMILY MEMBER OR FRIEND
☐ CASE MANAGER
☐ AGENCY
☐ SOMEONE ELSE, PLEASE SPECIFY ____________________
☐ DON'T KNOW
☐ REFUSED
☐ UNCLEAR RESPONSE

57. Do any {*staff*} that you have now yell, swear, or curse at you?

☐ YES
☐ NO ➔[GO TO Q60]
☐ DON'T KNOW ➔[GO TO Q60]
☐ REFUSED ➔[GO TO Q60]
☐ UNCLEAR RESPONSE ➔[GO TO Q60]

58. Is someone working with you to fix this problem?

☐ YES
☐ NO ➔[GO TO Q60]
☐ DON'T KNOW➔[GO TO Q60]
☐ REFUSED➔[GO TO Q60]
☐ UNCLEAR RESPONSE ➔[GO TO Q60]

59. Who is working with you to fix this problem? Anyone else? [INTERVIEWER MARKS ALL THAT APPLY]

☐ FAMILY MEMBER OR FRIEND
☐ CASE MANAGER
☐ AGENCY
☐ SOMEONE ELSE, PLEASE SPECIFY ____________________
☐ DON'T KNOW
☐ REFUSED
☐ UNCLEAR RESPONSE

60. Do any {*staff*} that you have now hit you or hurt you?

☐ YES
☐ NO ➔[GO TO Q63]
☐ DON'T KNOW ➔[GO TO Q63]
☐ REFUSED ➔[GO TO Q63]
☐ UNCLEAR RESPONSE ➔[GO TO Q63]

61. Is someone working with you to fix this problem?

☐ YES
☐ NO ➔[GO TO Q63]
☐ DON'T KNOW ➔[GO TO Q63]

☐ REFUSED ➔[GO TO Q63]
☐ UNCLEAR RESPONSE ➔[GO TO Q63]

62. Who is working with you to fix this problem? Anyone else? [INTERVIEWER MARKS ALL THAT APPLY]

☐ FAMILY MEMBER OR FRIEND
☐ CASE MANAGER
☐ AGENCY
☐ SOMEONE ELSE, PLEASE SPECIFY ___________________
☐ DON'T KNOW
☐ REFUSED
☐ UNCLEAR RESPONSE

COMMUNITY INCLUSION AND EMPOWERMENT

Now I'd like to ask you about the things you do in your community.

63. Do you have any **family** members who live nearby? Do not include family members you live with.

☐ YES
☐ NO ➔[GO TO Q65]
☐ DON'T KNOW ➔[GO TO Q65]
☐ REFUSED ➔[GO TO Q65]
☐ UNCLEAR RESPONSE ➔[GO TO Q65]

64. When you want to, how often can you get together with these family members who live nearby? Would you say . . .

☐ Never,
☐ Sometimes,
☐ Usually, or
☐ Always?
☐ DON'T KNOW
☐ REFUSED
☐ UNCLEAR RESPONSE

i. Alternate Version: When you want to, can you get together with these family members who live nearby? Would you say . . .

☐ Mostly yes, or,
☐ Mostly no?
☐ DON'T KNOW
☐ REFUSED
☐ UNCLEAR RESPONSE

65. Do you have any **friends** who live nearby?

☐ YES
☐ NO ➔[GO TO Q67]
☐ DON'T KNOW ➔[GO TO Q67]
☐ REFUSED ➔[GO TO Q67]
☐ UNCLEAR RESPONSE ➔[GO TO Q67]

66. When you want to, how often can you get together with these friends who live nearby? Would you say . . .

☐ Never,
☐ Sometimes,
☐ Usually, or
☐ Always?
☐ DON'T KNOW
☐ REFUSED

☐ UNCLEAR RESPONSE

i. Alternate Version: When you want to, can you get together with these friends who live nearby? Would you say . . .

- ☐ Mostly yes, or,
- ☐ Mostly no?
- ☐ DON'T KNOW
- ☐ REFUSED
- ☐ UNCLEAR RESPONSE

67. When you want to, how often can you do things in the community that you like, such as shopping or going out to eat? Would you say . . .

- ☐ Never
- ☐ Sometimes
- ☐ Usually, or
- ☐ Always?
- ☐ DON'T KNOW
- ☐ REFUSED
- ☐ UNCLEAR RESPONSE

i. Alternate Version: When you want to, can you do things in the community that you like, such as shopping or going out to eat? Would you say . . .

- ☐ Mostly yes, or
- ☐ Mostly no?
- ☐ DON'T KNOW
- ☐ REFUSED
- ☐ UNCLEAR RESPONSE

68. Do you need more help than you get now from {*personal assistance/behavioral health staff*} to do things in your community?

- ☐ YES
- ☐ NO
- ☐ DON'T KNOW
- ☐ REFUSED
- ☐ UNCLEAR RESPONSE

69. Do you take part in deciding **what** you do each day—for example, what you do for fun at home or in your community?

- ☐ YES
- ☐ NO
- ☐ DON'T KNOW
- ☐ REFUSED
- ☐ UNCLEAR RESPONSE

70. Do you take part in deciding **when** you do things each day—for example, deciding when you get up, eat, or go to bed?

☐ YES
☐ NO
☐ DON'T KNOW
☐ REFUSED
☐ UNCLEAR RESPONSE

The next few questions ask about making changes in {*personal assistance/behavioral health staff, homemakers, and case manager*}.

71. Have you asked for a change in {*personal assistance staff, behavioral health staff, homemakers, or case manager*}?

☐ YES
☐ NO ➔[GO TO Q74]
☐ DON'T KNOW ➔[GO TO Q74]
☐ REFUSED ➔[GO TO Q74]
☐ UNCLEAR RESPONSE ➔[GO TO Q74]

72. Did someone work with you when you asked to change {*personal assistance/behavioral health staff, homemakers, or case manager*}?

☐ YES
☐ NO ➔[GO TO EM]
☐ DON'T KNOW ➔[GO TO EM]
☐ REFUSED ➔[GO TO EM]
☐ UNCLEAR RESPONSE ➔[GO TO EM]

73. Who did you work with when you asked to change {*personal assistance/behavioral health staff, homemakers, or case manager*}

☐ Family MEMBER OR FRIEND ➔[GO TO EM OR Q75]
☐ Case MANAGER ➔[GO TO EM OR Q75]
☐ Agency ➔[GO TO EM OR Q75]
☐ Someone ELSE, PLEASE SPECIFY ____________________ ➔[GO TO EM OR Q75]
☐ DON'T KNOW ➔[GO TO EM OR Q75]
☐ REFUSED ➔[GO TO EM OR Q75]
☐ UNCLEAR RESPONSE ➔[GO TO EM OR Q75]

74. Do you know you can ask someone to change {*personal assistance/behavioral health staff, homemakers, or case manager*}?

☐ YES
☐ NO
☐ DON'T KNOW
☐ REFUSED
☐ UNCLEAR RESPONSE

SUPPLEMENTAL EMPLOYMENT MODULE

EM1. Do you work for pay at a job?

☐ YES ➔[GO TO QEM9]
☐ NO
☐ DON'T KNOW ➔[GO TO Q75]
☐ REFUSED ➔[GO TO Q75]
☐ UNCLEAR RESPONSE ➔[GO TO Q75]

EM2. Do you want to work for pay at a job?

☐ YES
☐ NO ➔[GO TO EM4]
☐ DON'T KNOW ➔[GO TO Q75]
☐ REFUSED ➔[GO TO Q75]
☐ UNCLEAR RESPONSE ➔[GO TO Q75]

EM3. Sometimes people feel that something is holding them back from working when they want to. Is this true for you? If so, what is holding you back from working? (INTERVIEWER LISTENS AND MARKS ALL THAT APPLY)

☐ BENEFITS ➔[GO TO EM5]
☐ HEALTH CONCERNS ➔[GO TO EM5]
☐ DON'T KNOW ABOUT JOB RESOURCES ➔[GO TO EM5]
☐ ADVICE FROM OTHERS ➔[GO TO EM5]
☐ TRAINING/EDUCATION NEED ➔[GO TO EM5]
☐ LOOKING AND CAN'T FIND WORK ➔[GO TO EM5]
☐ ISSUES WITH PREVIOUS EMPLOYMENT ➔[GO TO EM5]
☐ TRANSPORTATION ➔[GO TO EM5]
☐ CHILD CARE ➔[GO TO EM5]
☐ OTHER (____________________________) ➔[GO TO EM5]
☐ NOTHING IS HOLDING ME BACK ➔ [GO TO EM5]
☐ DON'T KNOW ➔[GO TO EM5]
☐ REFUSED ➔[GO TO EM5]
☐ UNCLEAR RESPONSE ➔[GO TO EM5]

EM4. Sometimes people would like to work for pay, but feel that something is holding them back. Is this true for you? If so, what is holding you back from wanting to work? (INTERVIEWER LISTENS AND MARKS ALL THAT APPLY)

☐ BENEFITS ➔[GO TO 75]
☐ HEALTH CONCERNS ➔[GO TO 75]
☐ DON'T KNOW ABOUT JOB RESOURCES ➔[GO TO 75]
☐ ADVICE FROM OTHERS ➔[GO TO 75]
☐ TRAINING/EDUCATION NEED ➔[GO TO 75]
☐ LOOKING AND CAN'T FIND WORK ➔[GO TO 75]
☐ ISSUES WITH PREVIOUS EMPLOYMENT ➔[GO TO 75]
☐ TRANSPORTATION ➔[GO TO 75]

☐ CHILD CARE ➔[GO TO 75]
☐ OTHER (____________________________) ➔[GO TO 75]
☐ NOTHING/DOESN’T WANT TO WORK ➔[GO TO 75]
☐ DON’T KNOW ➔[GO TO 75]
☐ REFUSED ➔[GO TO 75]
☐ UNCLEAR RESPONSE ➔[GO TO 75]

EM5. Have you asked for help in getting a job for pay?

☐ YES ➔[GO TO EM7]
☐ NO
☐ DON’T KNOW
☐ REFUSED
☐ UNCLEAR RESPONSE

EM6. Do you know you can get help to find a job for pay?

☐ YES ➔[GO TO Q75]
☐ NO ➔[GO TO Q75]
☐ DON’T KNOW ➔[GO TO Q75]
☐ REFUSED ➔[GO TO Q75]
☐ UNCLEAR RESPONSE ➔[GO TO Q75]

EM7. Help getting a job can include help finding a place to work or help getting the skills that you need to work. Is someone paid to help you get a job?

☐ YES
☐ NO ➔[GO TO Q75]
☐ DON’T KNOW ➔[GO TO Q75]
☐ REFUSED ➔[GO TO Q75]
☐ UNCLEAR RESPONSE ➔[GO TO Q75]

EM8. Are you getting all the help you need to find a job?

☐ YES ➔[GO TO Q75]
☐ NO ➔[GO TO Q75]
☐ DON’T KNOW ➔[GO TO Q75]
☐ REFUSED ➔[GO TO Q75]
☐ UNCLEAR RESPONSE ➔[GO TO Q75]

EM9. Who helped you to find the job that you have now? (INTERVIEWER LISTENS AND MARKS ALL THAT APPLY)

☐ EMPLOYMENT/VOCATIONAL STAFF/JOB COACH
☐ CASE MANAGER
☐ OTHER PAID PROVIDERS
☐ OTHER CAREER SERVICES
☐ FAMILY/FRIENDS
☐ ADVERSTISEMENT
☐ SELF-EMPLOYED ➔[GO TO EM11]

☐ OTHER (____________________________)
☐ NO ONE HELPED ME—I FOUND IT MYSELF ➔[GO TO EM11]
☐ DON'T KNOW ➔[GO TO EM11]
☐ REFUSED ➔[GO TO EM11]
☐ UNCLEAR RESPONSE ➔[GO TO EM11]

EM10. Did you help to choose the job you have now?

☐ YES
☐ NO
☐ DON'T KNOW
☐ REFUSED
☐ UNCLEAR RESPONSE

EM11. Sometimes people need help from other people to work at their jobs. For example, they may need help getting to or getting around at work, help getting their work done, or help getting along with other workers. Is someone paid to help you with the job you have now?

☐ YES
☐ NO ➔[GO TO Q75]
☐ DON'T KNOW ➔[GO TO Q75]
☐ REFUSED ➔[GO TO Q75]
☐ UNCLEAR RESPONSE ➔[GO TO Q75]

EM12. What do you call this person? A job coach, peer support provider, personal assistant, or something else?

☐

USE THIS TERM WHEREVER IT SAYS {*job coach*} BELOW.

EM13. Did you hire your {*job coach*} yourself?

☐ YES ➔[GO TO Q75]
☐ NO
☐ DON'T KNOW
☐ REFUSED
☐ UNCLEAR RESPONSE

EM14. Is your {*job coach*} with you all the time that you are working?

☐ YES
☐ NO
☐ DON'T KNOW
☐ REFUSED
☐ UNCLEAR RESPONSE

EM15. How often does your {*job coach*} give you all the help you need? Would you say . . .

☐ Never,
☐ Sometimes,

☐ Usually, or
☐ Always?
☐ DON'T KNOW
☐ REFUSED
☐ UNCLEAR RESPONSE

i. Alternate Version: Does your {*job coach*} give you all the help you need? Would you say . . .

☐ Mostly yes, or,
☐ Mostly no?
☐ DON'T KNOW
☐ REFUSED
☐ UNCLEAR RESPONSE

EM16. How often is your {*job coach*} nice and polite to you? Would you say . . .

☐ Never,
☐ Sometimes,
☐ Usually, or
☐ Always?
☐ DON'T KNOW
☐ REFUSED
☐ UNCLEAR RESPONSE

i. Alternate Version: Is your {*job coach*} nice and polite to you? Would you say . . .

☐ Mostly yes, or,
☐ Mostly no?
☐ DON'T KNOW
☐ REFUSED
☐ UNCLEAR RESPONSE

EM17. How often does your {*job coach*} explain things in a way that is easy to understand? Would you say . . .

☐ Never,
☐ Sometimes,
☐ Usually, or
☐ Always?
☐ DON'T KNOW
☐ REFUSED
☐ UNCLEAR RESPONSE

i. Alternate Version: Does your {*job coach*} explain things in a way that is easy to understand? Would you say . . .

☐ Mostly yes, or,
☐ Mostly no?

☐ DON'T KNOW
☐ REFUSED
☐ UNCLEAR RESPONSE

EM18. How often does your {*job coach*} listen carefully to you? Would you say . . .

☐ Never,
☐ Sometimes,
☐ Usually, or
☐ Always?
☐ DON'T KNOW
☐ REFUSED
☐ UNCLEAR RESPONSE

i. Alternate Version: Does your {*job coach*} listen carefully to you? Would you say . . .

☐ Mostly yes, or,
☐ Mostly no?
☐ DON'T KNOW
☐ REFUSED
☐ UNCLEAR RESPONSE

EM19. Does your {*job coach*} encourage you to do things for yourself if you can?

☐ YES
☐ NO
☐ DON'T KNOW
☐ REFUSED
☐ UNCLEAR RESPONSE

EM20. How would you rate the help you get from your {*job coach*}? Would you say . . .

☐ Excellent,
☐ Very good,
☐ Good,
☐ Fair, or
☐ Poor?
☐ DON'T KNOW
☐ REFUSED
☐ UNCLEAR RESPONSE

ABOUT YOU

Now I just have a few more questions about you.

75. In general, how would you rate your overall health? Would you say . . . (CM)

☐ Excellent,
☐ Very good,
☐ Good,
☐ Fair, or
☐ Poor?

76. **[IF NECESSARY, ASK, AND VERIFY IF OVER THE PHONE]** Are you male or female? (CM)

☐ MALE
☐ FEMALE

77. What is your age? (CM)

☐ 18 TO 24 YEARS ➔[GO TO Q79]
☐ 25 TO 34 YEARS ➔[GO TO Q79]
☐ 35 TO 44 YEARS ➔[GO TO Q79]
☐ 45 TO 54 YEARS ➔[GO TO Q79]
☐ 55 TO 64 YEARS ➔[GO TO Q79]
☐ 65 TO 74 YEARS ➔[GO TO Q79]
☐ 75 YEARS OR OLDER ➔[GO TO Q79]
☐ DON'T KNOW
☐ REFUSED ➔[GO TO Q79]
☐ UNCLEAR RESPONSE

78. **[IF NO ANSWER TO Q77, ASK]** In what year were you born?

_____________ (YEAR)

79. Are you of Hispanic or Latino origin or descent? (CM)

☐ YES, HISPANIC OR LATINO
☐ NO, NOT HISPANIC OR LATINO
☐ DON'T KNOW
☐ REFUSED
☐ UNCLEAR RESPONSE

80. What is your race? You may choose one or more of the following. Would you say you are . . . (CM)

☐ White
☐ Black or African-American
☐ Asian
☐ Native Hawaiian or other Pacific Islander

☐ American Indian or Alaska Native
☐ OTHER
☐ DON'T KNOW
☐ REFUSED
☐ UNCLEAR RESPONSE

81. Have you ever served as a member of the Armed Forces of the United States—such as the Army, Navy, Air Force, Marines, Coast Guard—in either an active duty, guard, or reserve capacity?

☐ YES
☐ NO
☐ DON'T KNOW
☐ REFUSED
☐ UNCLEAR RESPONSE

82. Have you actively participated in any armed conflicts as a member of the Armed Forces? For example, did you serve in World War two, Korea, Vietnam, Grenada, Panama, Desert Storm, or Operation Iraqi Freedom?

☐ YES
☐ NO
☐ DON'T KNOW
☐ REFUSED
☐ UNCLEAR RESPONSE

83. Are you currently categorized as a disabled veteran? [IF NECESSARY, ASK] Do you receive or are able to receive any medical or dental care from the U.S. Department of Veterans Affairs for your service related to a disability?

☐ YES
☐ NO
☐ DON'T KNOW
☐ REFUSED
☐ UNCLEAR RESPONSE

84. **[ENGLISH VERSION]:** What language do you mainly speak at home? Would you say…

☐ English, ➔[GO TO Q85]
☐ Some other language, or
☐ Both English and some other language?
☐ DON'T KNOW ➔[GO TO Q85]
☐ REFUSED ➔[GO TO Q85]
☐ UNCLEAR RESPONSE ➔[GO TO Q85]

84A. What other language do you speak? ______________________________
[SPANISH VERSION]: What language do you mainly speak at home? Would you say . . .

☐ English,
☐ Spanish,

☐ Both English and Spanish, or
☐ Some other language ➔Which one? ____________________
☐ DON'T KNOW
☐ REFUSED
☐ UNCLEAR RESPONSE

85. **[IF NECESSARY, ASK]** Do you live with any family members?

☐ YES
☐ NO
☐ DON'T KNOW
☐ REFUSED
☐ UNCLEAR RESPONSE

86. **[IF NECESSARY, ASK]** Do you live with people who are not family or are not related to you?

☐ YES ➔[GO TO Q88]
☐ NO
☐ DON'T KNOW
☐ REFUSED
☐ UNCLEAR RESPONSE

87. **[IF NECESSARY, ASK]** Do you live alone?

☐ YES
☐ NO
☐ DON'T KNOW
☐ REFUSED
☐ UNCLEAR RESPONSE

88. WAS THE RESPONDENT ABLE TO GIVE VALID RESPONSES?

☐ YES
☐ NO

89. WAS ANY ONE ELSE PRESENT DURING THE INTERVIEW?

☐ YES
☐ NO ➔[END SURVEY]

90. WHO WAS PRESENT DURING THE INTERVIEW? (MARK ALL THAT APPLY.)

☐ SOMEONE **NOT** PAID TO PROVIDE SUPPORT TO THE RESPONDENT
☐ STAFF OR SOMEONE PAID TO PROVIDE SUPPORT TO THE RESPONDENT

91. DID SOMEONE HELP THE RESPONDENT COMPLETE THIS SURVEY?

☐ YES
☐ NO ➔[END SURVEY]

92. HOW DID THAT PERSON HELP? (MARK ALL THAT APPLY.)

☐ ANSWERED ALL THE QUESTIONS FOR RESPONDENT
☐ RESTATED THE QUESTIONS IN A DIFFERENT WAY OR REMINDED/ PROMPTED THE RESPONDENT
☐ TRANSLATED THE QUESTIONS OR ANSWERS INTO THE RESPONDENT'S LANGUAGE
☐ HELPED WITH THE USE OF ASSISTIVE OR COMMUNICATION EQUIPMENT SO THAT THE RESPONDENT COULD ANSWER THE QUESTIONS
☐ OTHER, SPECIFY___________________________

93. WHO HELPED THE RESPONDENT? (MARK ALL THAT APPLY.)

☐ SOMEONE **NOT** PAID TO PROVIDE SUPPORT TO THE RESPONDENT
☐ STAFF OR SOMEONE PAID TO PROVIDE SUPPORT TO THE RESPONDENT

Quality Indicators for Individuals with Disabilities in Managed Care

A project funded by the National Institute on Disability and Rehabilitation Research
NIDRR

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Susan E. Palsbo, PhD
Principal Investigator
InnovAbility@comcast.net
541-505-7589

Margaret F. Mastal, PhD, RN
Co-Investigator
pegmastal@verizon.net
703- 360-3302

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Quality Indicators for Individuals with Disabilities in Managed Care

This 6-year study developed and tested comparative measures of quality and access, and devised a case-mix adjusted comparative dashboard of quality measures specifically geared to the interests of people with disabilities. The study took place in Virginia, Oregon, California, Minnesota, Maryland, Wisconsin, and New York. It was a joint project of George Mason University (Virginia) and the Delmarva Foundation for Medical Care (Maryland), with subcontractors on specific projects to Kaiser-Permanente Center for Health Research (Oregon), Baylor University (Texas), American Institutes for Research, and Mathematica Policy Research.

The first component of the study refined a computer algorithm that mines claims data. The output is a list of people who are at one of three different levels of risk of facing challenges to getting the care they need as a consequence of a disability.

A second component reviewed the two most widely-used health plan quality indicators, the CAHPS survey on consumer reported quality of care, and the HEDIS® Medicaid measures. The study identified measures (such as rates of preventive care) that are especially appropriate for people with disabilities and that are statistically valid even when a relatively small number of people are being looked at. New measures were developed and field-tested.

The third component of the study interviewed working age adults with disabilities in Oregon, California, and Baltimore-Washington DC, to learn what types of information they would like to know when selecting a health plan, and how they would like to obtain that information.

This study generated comparative measures that could improve the ability of people to make informed choices of health plans; help the health plans to monitor and improve their internal quality improvement programs; and help states to monitor health plan performance.

I. **Problem:** Population-based measures are needed to measure quality provided to people with disabilities.

- Sensory, intellectual, behavioral, physical, emotional
- Not necessarily sick
- Not necessarily frail
- 17% of US population; most under age 65

II. **Specific Aim:** Develop and field-test quality measures derived from administrative and survey data sources.

- Build on HEDIS® and CAHPS®
- Develop a "functional ability" case-mix adjustment system.

III. **Methods**

A. Years 1 and 2 - Groundwork.

- Focus groups of consumers and plan providers.
- Refined and validated an "access risk classification system" (ARCS) algorithm to identify people with disabilities using claims data.
- Concurrent grant from CHCS to visit 7 MCOs targeting adults of working age with disabilities, evaluate data collection capabilities, and identify structures and processes necessary for disability care

B. Years 3 and 4 – Concurrent leveraging collaborations.

- Contract with AHRQ on supplemental **CAHPS** questions for people with mobility impairments (PWMI).
- TEP convened by CHCS on performance measures for dual eligible programs.
- We convened a Measurement Advisory Panel to develop **HEDIS**-like, administratively-derived measures.

C. Years 5 and 6 – Field Testing, Finalization, Adoption.

- Concurrent grant from California HealthCare Foundation to cognitively test, translate into Spanish, and field-test a "disability CAHPS" called the "Assessment of Health Plans and Providers by People with Activity Limitations" (AHPPPAL).
    1. Medicaid CAHPS with supplemental content arising in focus groups and other TEPS.
    2. Proxy-respondent version being cognitively tested, now.
    3. Supplemental questions will be formally submitted to CAHPS team meeting in July.
- Worked with 2 Medicaid HMOs to determine their ability to collect quality measures from their organizational databases.
    1. Delmarva performed a BAT.
    2. Wrote HEDIS-like Technical Specification Manual.

IV. **Next steps**

A. Identify a "Measurement steward".

B. Evaluate utility of adjusting measures for "functional case mix".

C. We prefer to keep the measures in the public domain since they were developed with federal funds.

Study-related publications

1. Palsbo SE, Diao G, Palsbo GA; Tang L, Rosenberger WF, Mastal MF. 2010. Case-mix Adjusted and Enabled Reporting of CAHPS Surveys – The AHPPPAL Dashboard. *Archives of Physical Medicine and Rehabilitation.* 91:1339-46. PMID: 20801250

2. Palsbo SE, Hurtado MP, Levine RE, Barrett KA, Mastal MF. 2010. Enabling a Survey of Primary Care to Measure the Health Care Experiences of Adults with Disabilities. *Disability and Rehabilitation.* 33(1):73-85. PMID: 20528104

3. Palsbo SE, Sutton C, Mastal MF, Johnson S, Cohen A. 2008. Identifying and Classifying People with Disabilities Using Claims Data: Further Development of the Access Risk Classification System (ARCS) Algorithm. *Disability and Health Journal.* 1(4):215-223 (October). PMID: 21122732

4. Palsbo SE and Ho, PS. 2007. Consumer Evaluation of a Disability-Care Coordination Organization. *Journal of Healthcare for the Poor and Underserved* 18(4):887-901. (November). PMID: 17982213.

5. Palsbo SE and Kroll T. 2007. Meeting information needs to facilitate decision making: report cards for people with disabilities. *Health Expectations* 10(3), 278–285. (September). PMID: 17678516.

6. Mastal MF , Reardon ME, English M. 2007. Innovations in disability care coordination organizations: integrating primary care and behavioral health clinical systems. *Professional Case Management,* 12(1), 27-36.

7. Palsbo SE, Mastal MF, O'Donnell L. 2006. Disability Care Coordination Organizations. *Case Management* 11(5):255-264. (September/October). PMID 17013056.

8. Palsbo SE and Kailes JI. 2006. Disability-Competent Health Systems. *Disability Studies Quarterly* Spring. 26(2): www.dsq-sds.org (internet publication). Also available at http://chhs.gmu.edu/ccid/bibliography.html.

9. Palsbo SE, Hornbrook M, Brody K, Perrin N. 2005. Creating a Disability Registry Using Claims Data. *Managed Care Quarterly* 13(1):6-12. CINAHL AN: 2009019299.

MEDICAID QUALITY INDICATORS FOR INDIVIDUALS WITH DISABILITIES
NIDDR PROJECT: MEASURE ADVISORY PANEL (MAP)

Composite Table: Database Retrievable Quality Measures *

Access Measures: Member Demographics				
No.	**Measure**	**Working Definition**	**Numerator**	**Source/Owner**
1	**Age**	% beneficiaries with any type of disability diagnosis, enrolled continuously in the reporting year, between the ages of 18 through 64 years.	# beneficiaries with any type of disability diagnosis, enrolled continuously in the reporting year, between the ages of 18 through 64 years.	NCQA
2	**Gender**	% beneficiaries with any type of disability diagnosis, enrolled continuously in the reporting year, who are male and female.	# beneficiaries with any type of disability diagnosis, enrolled continuously in the reporting year, who are male and female.	NCQA
3	**Race/Ethnic Origins**	% beneficiaries with disabilities, continuously enrolled in the reporting year, in race and/or ethnic categories as specified by the US Census Bureau.	# beneficiaries with disabilities, continuously enrolled in the reporting year, in race and/or ethnic categories as specified by the US Census Bureau.	NCQA
4	**Language Translation**	% beneficiaries with disabilities, continuously enrolled in the reporting year, who required language translation services.	# beneficiaries with disabilities, continuously enrolled in the reporting year, who required language translation services..	CMS
5	**Type of Health Insurance: Dual Eligibility**	% beneficiaries with disabilities, continuously enrolled in the reporting year, who are dually-eligible for Medicaid and Medicare benefits.	# beneficiaries with disabilities, continuously enrolled in the reporting year, who are dually-eligible for Medicaid and Medicare benefits.	CMS
6	**Type of Living Arrangements**	% of working age beneficiaries with disabilities who live in the different types of living structures: • <u>Institutions</u> -Long term (residing in a hospital, nursing home, LTAC, etc. 6 months or longer) -Short stay (residing in an LTAC or nursing home less than 6 months) • <u>Structured Community Residences</u>	# working age beneficiaries with disabilities in reporting year living in Institutions # working age beneficiaries with disabilities in reporting year living in structured community residences; # working age beneficiaries with disabilities in the reporting year living in independent situations ***Note:*** *Specify carefully the types of possible*	New**

		(residing in group/foster homes, assisted living, congregate living, homeless shelters) - <u>Independent Living</u> (reside alone or with significant other/s in an apartment, house.	*labels for the different categories of living arrangements*.	

Access Measures: Member Demographics (cont'd)				
No.	**Measure**	**Working Definition**	**Numerator**	**Source/Owner**
7	**Migration between types of living arrangements: De-institutionalized**	% beneficiaries with disabilities whose living arrangements changed from a hospital or nursing home stay of longer than 6 months to either a structured living arrangement or an independent living arrangement	# beneficiaries with disabilities in the reporting year whose living arrangements changed from a hospital or nursing home stay of longer than 6 months to either a structured living arrangement or an independent living arrangement.	New
8	**Migration between types of living arrangements: Institutionalized**	% beneficiaries whose living arrangements changed from structured living and independent living arrangements to a hospital or nursing home for longer than 6 mos.	# beneficiaries whose living arrangements changed from structured living and independent living arrangements to a hospital or nursing home for longer than 6 mos.	New
9	**Voluntary Termination**	% beneficiaries in the reporting year who choose of their own volition to terminate participating in the program.	# beneficiaries in the reporting year who choose of their own volition to terminate participating in the program.	CMS
10	**Involuntary Terminations**	% beneficiaries who terminate from the program as a result of the program's decision or due to loss of eligibility from change in geographic location; death; incarceration; income exceeds eligibility standards.	# beneficiaries who terminate from the program as a result of the program's decision or due to loss of eligibility from change in geographic location; death; incarceration; income exceeds eligibility standards.	CMS
11	**Complaints and Grievances**	% beneficiaries in the reporting year who filed written complaints or grievances. ***Note:****States have different definitions of and requirements for handling complaints and/or grievances*.	# beneficiaries in the reporting year who filed written complaints or grievances.	CMS

Access Measures to Care Coordination: Staffing Patterns

12	**Advanced Practice Nurses (APNs)**	% APNs, continuously employed for the full reporting year, directly providing care coordination services for beneficiaries with disabilities within the scope of APN practice as defined by state regulations and the organization's job description.	# of APNs, continuously employed for the full reporting year, directly providing care coordination services for beneficiaries with disabilities within the scope of APN practice as defined by state regulations and the organization's job description.	New
13	**Registered Nurses (RNs)**	% RNs, continuously employed for the full reporting year, directly delivering care coordination services for beneficiaries with disabilities within the scope of *licensed* RN practice as defined by state regulations and the organizational job description.	# RNs, continuously employed for the full reporting year, directly delivering care coordination services for beneficiaries with disabilities within the scope of *licensed* RN practice as defined by state regulations and the organizational job description.	New

Access Measures to Care Coordination: Staffing Patterns (cont'd)

No.	Measure	Working Definition	Numerator	Source/Owner
14	**Social Workers (LCSWs)**	% Social Workers, continuously employed for the full reporting year, directly providing care coordination services for beneficiaries with disabilities within the scope of *licensed* social worker practice as defined by state regulations and organizational job descriptions.	# Social Workers, continuously employed for the full reporting year, directly providing care coordination services for beneficiaries with disabilities within the scope of *licensed* social worker practice as defined by state regulations and organizational job descriptions.	New
15	**Unlicensed Assistive Personnel (UAPs)**	% Unlicensed Assistive Personnel, as defined by organizational job descriptions, continuously employed in the reporting year, directly providing care coordination services for beneficiaries with disabilities. **Note:** *List the specific types of positions that organizations are to include as "unlicensed care coordination staff,"* ***excluding personal care assistant personnel***	# Unlicensed Assistive Personnel, as defined by organizational job descriptions, continuously employed in the reporting year, directly providing care coordination services for beneficiaries with disabilities.	New

Access Measures to Care Coordination: Timely Initiation of Admission Screens and ISPs

16	**New Beneficiary Assessment Screens within 30 days of admission**	% new beneficiaries with disabilities in the reporting year receiving initial intake assessment screens within 30 days of admission to the program.	# new beneficiaries with disabilities in the reporting year receiving initial intake assessment screens within 30 days of admission to the program.	New
17	**New Beneficiary Assessment Screens within 60 days of admission**	% new beneficiaries with disabilities in the reporting year receiving initial intake assessment screens within 60 days of admission to the program.	# new beneficiaries with disabilities in the reporting year receiving initial intake assessment screens within 60 days of admission to the program.	New
18	**Individual Service Plans (ISPs) initiated within 30 days of admission**	% new beneficiaries with disabilities in the reporting year with ISPs initiated within 30 days of admission.	# new beneficiaries with disabilities in the reporting year with ISPs initiated within 30 days of admission.	New
19	**Individual Service Plans (ISPs) initiated within 60 days of admission**	% new beneficiaries with disabilities in the reporting year with ISPs initiated within 60 days of admission.	# new beneficiaries with disabilities in the reporting year with ISPs initiated within 60 days of admission.	New

Access Measures: Utilization of Medical Benefits and Services

No.	Measure	Working Definition	Numerator	Source
20	**Beneficiaries with PCP Encounters**	% beneficiaries with disabilities, continuously enrolled in the reporting year, who had PCP encounters during the reporting year.	# beneficiaries with disabilities, continuously enrolled in the reporting year, who had PCP encounters during the reporting year.	NCQA
21	**Beneficiaries with Medical Specialist Encounters**	% beneficiaries with disabilities, continuously enrolled in the reporting year, who had an office visit with a medical specialist during the reporting year.	# beneficiaries with disabilities, continuously enrolled in the reporting year, who had an office visit with a medical specialist during the reporting year.	NCQA
22	**Beneficiaries with Surgical Specialty Encounters**	% beneficiaries with disabilities, continuously enrolled in the reporting year, who had an office visit with a surgical specialist during the reporting year.	# beneficiaries with disabilities, continuously enrolled in the reporting year, who had an office visit with a surgical specialist during the reporting year.	NCQA
23	**Beneficiaries with**	% beneficiaries with disabilities, continuously	# beneficiaries with disabilities, continuously	NCQA

	Dental Encounters	enrolled in the reporting year, who had dental encounters during the reporting year.	enrolled in the reporting year, who had dental encounters during the reporting year.	
24	**Beneficiaries with Hospitalizations**	% beneficiaries with disabilities, continuously enrolled in the reporting year, who had hospital stays during the reporting year.	# beneficiaries with disabilities, continuously enrolled in the reporting year, who had hospital stays during the reporting year.	NCQA
25	**Beneficiaries with ER Encounters**	% beneficiaries with disabilities, continuously enrolled in the reporting year, who had ER encounters during the reporting year	# beneficiaries with disabilities, continuously enrolled in the reporting year, who had ER encounters during the reporting year.	NCQA
26	**Access to Durable Medical Equipment (DME): Wheelchair**	During the reporting year, the average time in days from the dates a first-time request for wheelchairs were submitted until disabled beneficiaries received the wheelchair.		New
27	**Access to Functional DME: Wheelchair**	During the reporting year, the average time in days from the date wheelchair repair requests were submitted for beneficiaries until the wheelchairs were repaired.		New
Effectiveness of Care Measures: Preventive Care				
28	**Colorectal Cancer Screening**	HEDIS	HEDIS	NCQA NQF***
29	**Breast Cancer Screening**	HEDIS	HEDIS	NCQA NQF
30	**Cervical Cancer Screening**	HEDIS	HEDIS	NCQA NQF
31	**Chlamydia Screening: Women**	HEDIS	HEDIS	NCQA NQF
32	**Flu Shots for Adults Ages 50-64**	HEDIS	HEDIS	NCQA NQF

Effectiveness of Care Measures: Management of Disabilities, Chronic Conditions and Secondary Complications				
No.	**Measure**	**Working Definition**	**Numerator**	**Source**
33	**Diabetes management**	HEDIS	HEDIS	NCQA NQF
34	**Asthma management**	HEDIS	HEDIS	NCQA NQF
35	**Depression management**	HEDIS	HEDIS	NCQA NQF

36	**Substance Abuse**	HEDIS	HEDIS	NCQA NQF
37	**Mental Illness management**	HEDIS	HEDIS	NCQA NQF
38	**Pressure Ulcer Management**	% beneficiaries in the reporting year with a diagnosis of pressure ulcer listed as one of the top 5 diagnoses on hospital discharge	# members in the reporting year with a diagnosis of pressure ulcer listed as one of the top 5 diagnoses on hospital discharge	New
39	**Urinary Tract Disorders Management**	% beneficiaries in the reporting year with a diagnosis of urosepsis listed as one of the top 5 diagnoses on hospital discharge	# members in the reporting year with a diagnosis of urosepsis listed as one of the top 5 diagnoses on hospital discharge	New
40	**Management of Bowel Disorders**	% beneficiaries in the reporting year with a diagnosis of bowel disorder listed as one of the top 5 diagnoses on hospital discharge	# members in the reporting year with a diagnosis of bowel disorder listed as one of the top 5 diagnoses on hospital discharge	New
41	**Spasticity Management**	% beneficiaries receiving botox injections and/or IV baclofen pump for spasticity	# members receiving botox injections and/or IV baclofen pump for spasticity	New

***Quality measures identified by this project as important for disability care coordination organizations,** *and* **which are available for retrieval from electronic databases.**

**** Measurement Advisory Panel for the research project of the National Institute for Disability and Rehabilitation Research, U.S. Department of Education.**

***** National Quality Forum, Voluntary Consensus Standards for Ambulatory Care: An Initial Physician Focused Performance Measure Set**

TECHNICAL SPECIFICATIONS OF ADMINISTRATIVE QUALITY MEASURES

FOR

Care Provided to People with Disabilities Enrolled in: HMOs, Medicaid programs, Special Needs Plans, Organized Health Systems, and Care Coordination Organizations

NATIONAL INSTITUTE FOR DISABILITY AND REHABILITATION RESEARCH
GRANT #H33A040016

Submitted by:
Margaret Fisk Mastal, PhD, RN
Peg Barnaba, BSN, CCS, PMP

Delmarva Foundation for Medical Care
March 2008

Table of Contents

HEDIS Measures for Data Collection

In addition to the measures contained in this manual, the Measurement Advisory Panel reviewed all of the HEDIS measures in use at the time (2007), and recommended the following as part of a quality performance measurement system for DCCOs:

1. Enrollment by product line (Medicaid, Medicaid/Medicare, etc)
2. Race/Ethnicity Diversity of Membership
3. Language Diversity of Membership
4. Beneficiaries with Primary Care Physician encounters
5. Beneficiaries with Medical Specialist encounters
6. Beneficiaries with Surgical Specialty encounters
7. Beneficiaries with Dental Encounters
8. Hospital admissions
9. Hospital readmissions within 7 days and 14 days
10. Ambulatory visits to emergency rooms, ambulatory surgery facilities and total outpatient visits.
11. Identification of Alcohol and other Drug Services
12. Colorectal Cancer Screening
13. Breast Cancer Screening
14. Cervical Cancer Screening
15. Comprehensive Diabetes Care
16. Asthma Management
17. Management of Mental Illness after Hospital Discharge

The remainder of this document contains the technical specifications for the new measures.

Types of Living Arrangements (TLA)

Description

Percentage of working age beneficiaries with disabilities who live in different types of living structures:

- Institutions
- Structured Residences in the Community
- Independent Living

The health plans and programs that coordinate and/or provide care for working aged people with disabilities generally have as one of their major goals to provide benefits so that the beneficiary can live in the community rather than in an institutional setting. Members living in the community, either independently or in a structured community environment, is the plan's goal for every member as long as it is the best environment for the member.

Definition of Living Arrangements

- Institutions
  -Long term - resides in a hospital, nursing home, Long Term Acute Care (LTAC) Setting, etc. 6 months or longer during the measurement year
  -Short stay - resides in an LTAC or nursing home for less than 6 continuous months during the measurement year.
- Structured Community Residences resides in group/foster homes, assisted living, congregate living, homeless shelters for 6 continuous months or longer during the measurement
  Measurement year.
- Independent Living - resides alone or with significant other/s in apt. or house for 6 continuous months or longer during the measurement year.

Eligible Population

Product Lines	Medicaid and dual eligible beneficiaries (Medicare-Medicaid) with disabilities.
Ages	Eligible beneficiaries with disabilities between the ages of 18 – through 64 years.
Continuous enrollment	The measurement year.
Allowable gap	No more than one gap of up to 45 days during each year of continuous enrollment. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e. a member whose

	coverage lapses for 2 months (60 days) is not considered continuously enrolled.
Anchor Date	Enrolled as of December 31 of the measurement year

Administrative Specification

Denominator	Eligible population of Medicaid and dual-eligible (Medicaid and Medicare) beneficiaries who have been continuously enrolled in the plan during the measurement year.
Numerator 1	Numbers of eligible beneficiaries who resided in an institution (hospital, or long term acute care setting (LTAC) or nursing homes) for *6 months or more* continuously in the measurement year.

- Review the facility claims (UBs) for bill types below, for the continuous service date range of six months or more.

Type of Bills UBs

011X Hospital Inpatient (Part A)
012X Hospital Inpatient Part B
013X Hospital Outpatient
014X Hospital Other Part B
018X Hospital Swing Bed
021X SNF Inpatient
022X SNF Inpatient Part B
023X SNF Outpatient
028X SNF Swing Bed
041X Religious Nonmedical Health Care Institutions

AND/OR

Review the out patient/professional claims (HCFA 1500s) for the place of service codes which show services provided in the institutional settings below for the six month or more.

Place of Service

31	Skilled Nursing
32	Nursing Facility
33	Custodial Care Facility
34	Hospice
54	Intermediate care facility/mentally retarded

OR

The Plan maintains an in house residence classification on all eligible beneficiaries which indicates that the beneficiary is institutional in facilities such as nursing home, skilled or non-skilled for six months or more.

Numerator 2	Number of eligible beneficiaries who resided in an institution (hospital, or long term acute care setting (LTAC) or nursing homes) for *less* than *6 continuous months* of the measurement year. Looking across claims spans for from/through dates = 6 months

Review the facility claims (UBs) for bill types below, for any occurrence and any duration less than six months AND a status code in the Status Code listing below.

Type of Bills UBs

011X Hospital Inpatient (Part A)
012X Hospital Inpatient Part B
013X Hospital Outpatient
014X Hospital Other Part B
018X Hospital Swing Bed
021X SNF Inpatient
022X SNF Inpatient Part B
023X SNF Outpatient
028X SNF Swing Bed

Status Code UBs

01 Discharged to home or self care (routine discharge)
06 Discharged/transferred to home under care of organized home health service organization in anticipation of covered skills care (effective2/23/05)
50 Discharged/transferred to Hospice – home

OR

Review the out patient/professional claims (HCFA 1500s) for the place of service codes which show services provided in the institutional settings below for less than six months.

Place of Service

31 Skilled Nursing
32 Nursing Facility
33 Custodial Care Facility
34 Hospice
54 Intermediate care facility/mentally retarded

OR

The Plan maintains an in house residence classification on all eligible beneficiaries which indicates that the beneficiary is institutional in facilities such as nursing home, skilled or non-skilled facility for less than six months.

Numerator 3	Number of beneficiaries who resided in structured community residences (e.g. group home, assisted living, congregate living or homeless shelters for a minimum of six months during the measurement year.

Review of facility claims (UBs) where any claims should the identified type of bill over a six month or more period.

Type of Bill

013X Hospital Outpatient
032X Home Health
033X Home Health
034X Home Health (Part B Only)
071X Clinical Rural Health
072X Clinic ESRD
074X Clinic OPT
075X Clinic CORF
076X Community Mental Health Centers
081X Nonhospital based hospice
083X Hospital Outpatient (ASC)

OR

Review the out patient/professional claims (HCFA 1500s) for the place of service codes which show services provided while in one of the settings below.

Place of Service (HCFAs)

13 Assisted living facility
14 Group Home

OR the Plan maintains an in house residence classification on all eligible beneficiaries which indicates that the beneficiary is residing in a structured environment such as group home, assisted living or being cared for in someone else home on a full time basis.

Numerator 4	Number of beneficiaries in the program during the measurement year who resided in the independent setting (apartment or house) for a minimum of 6 continuous months alone or with significant other/s

Review of facility claims (UBs) where any claims should the identified type of bill over a six month or more period.

Type of Bill

013X Hospital Outpatient
032X Home Health
033X Home Health
034X Home Health (Part B Only)
071X ClinicalRural Health
072X Clinic ESRD
074X Clinic OPT
075X Clinic CORF
076X Community Mental Health Centers
081X Nonhospital based hospice
083X Hospital Outpatient (ASC)

OR
Review the out patient/professional claims (HCFA 1500s) for the place of service codes which show services provided while in one of the settings below.

Place of Service (HCFAs)

12 home

OR

The Plan maintains an in house residence classification on all eligible beneficiaries which indicates that the beneficiary is residing independently in a home or in someone else's home but independent on a full time basis.

Note:
Type of Bill Code on UB: FL7 Type of Bill
Status Codes on UB: FL22 Patient Discharge Status/UB92 or FL17 Patient Discharge Status/UB04.
Place of Service Code on HCFA: FL24b for any service listed.

Migration from Institution to Community Setting (MTLAD)

Description

Percentage of eligible beneficiaries with disabilities who moved their residence from an institution (hospitals, LTACs, nursing homes) to a community type setting (structured community or independent) during the measurement year

Eligible Population

Product Lines	Medicaid and dual eligible beneficiaries (Medicare-Medicaid) with disabilities.

Ages	Eligible beneficiaries with disabilities between the ages of 18 – through 64 years.
Continuous enrollment	The measurement year.
Allowable gap	No more than one gap of up to 45 days during each year of continuous enrollment. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e. a member whose coverage lapses for 2 months (60 days) is not considered continuously enrolled.
Anchor Date	Enrolled as of December 31 of the measurement year.

Administrative Specification

Denominator	Eligible population of Medicaid and dual-eligible (Medicaid and Medicare) beneficiaries who have been continuously enrolled in the plan during the measurement year.
Numerator	Number of eligible beneficiaries who resided in an institutional setting (hospital, long term acute care (LTAC) or nursing home) and moved to an independent or structured community setting (e.g. group home, assisted living, congregate living or homeless shelters) during the measurement year. Looking across claims spans for from/through dates = 6 months

- Review the facility claims (UBs) for type of bill below with a continuous service date range of six months or more AND a status code below at the end of the final service date (discharge date).

Type of Bills UBs

011X Hospital Inpatient (Part A)
012X Hospital Inpatient Part B
013X Hospital Outpatient
014X Hospital Other Part B
018X Hospital Swing Bed
021X SNF Inpatient
022X SNF Inpatient Part B
023X SNF Outpatient
028X SNF Swing Bed
041X Religious Nonmedical Health Care Institutions

Status Code UBs

01 Discharged to home or self care (routine discharge)
06 Discharged/transferred to home under care of organized home health service organization in anticipation of covered skills care (effective2/23/05)
50 Discharged/transferred to Hospice – home

OR

the Plan maintains an in house residence classification on all eligible beneficiaries which indicates that the beneficiary is institutional in facilities such as nursing home, skilled or non-skilled for six months or more then notes the change in residence to structured community (group home, assisted living facility) or independent living for a period of six months or more.

Migration from Community Setting to an Institution (MTLAI)

Description

Percentage of eligible beneficiaries with disabilities who moved their residence for four or more months continuously from a community or independent setting to an institution (hospitals, LTACs, nursing homes) setting during the measurement year.

Eligible Population

Product Lines	Medicaid and dual eligible beneficiaries (Medicare-Medicaid) with disabilities.
Ages	Eligible beneficiaries with disabilities between the ages of 18 – through 64 years.
Continuous enrollment	The measurement year.
Allowable gap	No more than one gap of up to 45 days during each year of continuous enrollment. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e. a member whose coverage lapses for 2 months (60 days) is not considered continuously enrolled.
Anchor Date	Enrolled as of December 31 of the measurement year.

Administrative Specification

Denominator	Eligible population of Medicaid and dual-eligible

	(Medicaid and Medicare) beneficiaries who have been continuously enrolled in the plan during the measurement year.
Numerator	Number of eligible beneficiaries who resided in an independent or structured community setting and moved for four or more months to an institutional setting (hospital, long term acute care (LTAC) or nursing home) during the measurement year.

Review the facility claims (UBs) for bill types below, for any occurrence and any duration less than four months AND a status code in the Status Code listing below.

Type of Bills UBs

011X Hospital Inpatient (Part A)
012X Hospital Inpatient Part B
013X Hospital Outpatient
014X Hospital Other Part B
018X Hospital Swing Bed
021X SNF Inpatient
022X SNF Inpatient Part B
023X SNF Outpatient
028X SNF Swing Bed

Status Code UBs

01 Discharged to home or self care (routine discharge)
06 Discharged/transferred to home under care of organized home health service organization in anticipation of covered skills care (effective2/23/05)
50 Discharged/transferred to Hospice – home

OR

Review the out patient/professional claims (HCFA 1500s) for the place of service codes which show services provided in the institutional settings below for four months or less.

Place of Service

21 Inpatient Hospital
31 Skilled Nursing
32 Nursing Facility
33 Custodial Care Facility
34 Hospice
51 Inpatient Psychiatric Hospital
54 Intermediate care facility/mentally retarded
61 Comprehensive inpatient rehabilitation facility

OR the Plan maintains an in house residence classification on all eligible beneficiaries which indicates that the beneficiary starts out with a residence of structured community (group home, assisted living) or independent living and move to an institutional facilities such as hospital, long-term acute center, nursing home, skilled or non-skilled facility for four months or less during that period.

Termination of Participation (TP)

Description

The percentage of beneficiaries with disabilities whose membership in the health plan is terminated in the measurement year, voluntarily or involuntarily.

Definition of Involuntary	Member is terminated by the state involuntarily for multiple reasons: • Income that exceeds eligibility standards; • Incarceration; • Change in geographic location outside plan parameters; • Health plan request.
Definition of Voluntary	Beneficiaries who choose to terminate their membership in the plan of their own volition.

Eligible Population

Product lines	Medicaid and dual eligible (Medicare and Medicaid) beneficiaries with disabilities.
Ages	18-through 64 years as of December 31 of the measurement year
Continuous enrollment	The measurement year.
Allowable gap	No more than one gap of up to 45 days during each year of continuous enrollment. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e. a member whose coverage lapses for 2 months (60 days) is not considered continuously enrolled.
Anchor date	Enrolled as of December 31 of the measurement year

Administrative Specification

Denominator	Number of beneficiaries with disabilities in the plan between 18-64 years who were continuously enrolled in the measurement year.
Numerator 1	Number of beneficiaries with disabilities between 18-through 64 years whose membership in the program was *involuntarily* terminated.
Numerator 2	Number of beneficiaries with disabilities between 18-through 64 years whose membership in the program was *voluntarily* terminated.
Termination Codes	Many plans receive codes from the state that indicate members who are terminating their membership in the program. Other plans report members who are terminating to the state.. Regardless of notification methods, codes usually indicate the reason – either involuntary or voluntary termination.

Member Complaints and Grievances (MCG)

Description

The percentage of beneficiaries, continuously enrolled in the measurement year, who reported verbal and/or written complaints and/or grievances to the plan or to the state Medicaid agency. (States have different definitions and requirements for the reporting and handling complaints and/or grievances).

Definition of Complaint

Complaint refers to a criticism or statement of dissatisfaction that addresses one or more of the following categories:

- Access to care;
- Billing;
- Doctor/patient communication and rapport;
- Lack of cleanliness and/or unsafe conditions within the treating facility.

Eligible Population

Product lines	Medicaid and dual eligible (Medicare and Medicaid) beneficiaries with disabilities
Ages	18-through 64 years as of December 31 of the measurement

year

Continuous enrollment The measurement year.

Allowable gap No more than one gap of up to 45 days during each year of continuous enrollment. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e. a member whose coverage lapses for 2 months (60 days) is not considered continuously enrolled.

Anchor date Enrolled as of December 31 of the measurement year.

Administrative Specification

Denominator Number of beneficiaries with disabilities in the plan between 18-through 64 years who were continuously enrolled in the measurement year.

Numerator Number of beneficiaries with disabilities between 18-through 64 years who had submitted complaints or grievances, written or verbal, in the measurement year.

Data Collection Due to the diverse nature of the way states and individual plans define complaints and grievances, there are no standardized codes.
Programs would have to specify:

- how they define “complaints” and “grievances,”
- identify their collection methods and
- report their outcomes..

Timeliness of New Beneficiary Assessment Screens (NBEAS)

Description

The percent of new beneficiaries (18 yrs – through 64 years) enrolled during the measurement year that had their initial assessment screens completed within 30 days, 60 days or 120 days of enrollment in the health plan.

Definition of new beneficiary

New beneficiary is defined in two ways:

- Person with a disability new to the plan

- Person with a disability who was in the plan previously, terminated from the plan, and is now being readmitted.

Eligible Population

Product Lines	Medicaid and dual eligible beneficiaries (Medicare-Medicaid) with disabilities.
Ages	Beneficiaries with disabilities between the ages of 18 – through 64 years.
Anchor Date	Enrolled as of September 30 of the measurement year

Administrative Specification

Denominator	Eligible population of Medicaid and dual-eligible beneficiaries admitted in the measurement year.
Numerator 1	Beneficiaries who receive the admission screen within 30 days of admission
Numerator 2	Beneficiaries who receive the admission screen within 60 days of admission
Numerator 3	Beneficiaries who receive the admission screen within 120 days of admission

Review the out patient/professional claims (HCFA 1500s) for the evidence of admission screening within the period.

Admission Screening

1003F – Level of Activity Assessment
99450 – 99456 Assessment of Disability

OR

The Plan maintains an in house system of noting the date of enrollment to the Plan and the date of completion of the beneficiary assessment screening.

Timely Individual Service Plan Initiation (ISPI)

Description

The percent of new beneficiaries (18 yrs – 64 years) enrolled during the measurement year that had their initial Individual Service Plan (ISP) initiated within 30 days or 60 days of enrollment in the health plan.

Definition of new beneficiary

New beneficiary is defined in two ways:

- Person with a disability new to the plan
- Person with a disability who was in the plan previously, terminated from the plan, and is now being readmitted.

Eligible Population

Product Lines	Medicaid and dual eligible beneficiaries (Medicare-Medicaid) with disabilities.
Ages	Beneficiaries with disabilities between the ages of 18 – through 64 years.
Anchor Date	Enrolled as of October 31 of the measurement year

Administrative Specification

Denominator	Eligible population of Medicaid and dual-eligible beneficiaries (Medicaid and Medicare) admitted in the measurement year.
Numerator 1	Beneficiaries with ISPs completed within 30 days of admission to the plan.
Numerator 2	Beneficiaries with ISPs completed within 60 days of admission to the plan.

Review the out patient/professional claims (HCFA 1500s) for the evidence of the creation of the individuals' service plan within the period.
Individual Service Plan

S0315-S0320 Disease Management Planning Elements

OR

The Plan maintains an in house system of noting the date of enrollment to the Plan and the date of completion of the individuals' service plan.

Beneficiaries with Dental Encounters (BWDE)

Description
The percentage of beneficiaries with disabilities, continuously enrolled in the measurement year, who had at least one dental encounter for routine dental care.

Definition of Routine	One or more visits with a dental practitioner during the measurement year.

Dental Care	Diagnostic, preventive, and restorative interventions related to the teeth and gums.

Eligible Population

Product lines	Medicaid and dual eligible (Medicare and Medicaid) beneficiaries with disabilities
Ages	18-through 64 years as of December 31 of the measurement year
Continuous enrollment	The measurement year.
Allowable gap	No more than one gap of up to 45 days during each year of continuous enrollment. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e. a member whose coverage lapses for 2 months (60 days) is not considered continuously enrolled.
Anchor date	Enrolled as of December 31 of the measurement year.

Administrative Specification

Denominator	Number of beneficiaries with disabilities in the plan between 18-64 years who were continuously enrolled in the measurement year.
Numerator	Number of beneficiaries with disabilities between 18-64 years who had at least one dental visit during the measurement year.

Review the out patient/professional claims (HCFA 1500s) for the evidence of the following dental encounter codes within the period.

Dental Encounters

70300-70320 Radiological Examinations
70350-70355 Radiological Examinations
D0120-D9999 Oral Evaluations & Treatments

Timely Access to Durable Medical Equipment: Wheelchair (TADMEW)

Description

The average time in days it takes an eligible beneficiary to receive a wheelchair during the measurement year from the date of request to the date of authorization and the time from the date of authorization until the date of delivery (assumed to be the date the claim was submitted).

Eligible Population

Product lines	Medicaid and dual eligible (Medicare and Medicaid) beneficiaries with disabilities who received a wheelchair during the measurement year..
Ages	18-through 64 years as of December 31 of the measurement year
Continuous enrollment	The measurement year, continuous enrollment not necessary. New members who have not been in the plan may require a wheelchair as one of the initial benefits.
Anchor date	Enrolled as of December 31 of the measurement year.

Administrative Specification

Denominator	Number of beneficiaries in the plan between 18-through 64 years who received wheelchairs in the measurement year.
Numerator1	The average number of days between the initial request and the authorization of the wheelchair request.
Numerator 2	The average number of days between the authorization date of the wheelchair and the date the beneficiary receives the wheelchair (i.e. date on the claim).

Numerator 1

Review the prior authorization system to identify both the request date of a wheelchair and the final decision of approval of that request.

Numerator 2

Review the prior authorization system and the out-patient/professional claims (HCFA 1500s) for the evidence of the wheelchair rental or purchase within the period. Capturing both the date of approved authorization and the date of delivery of the wheelchair (include both rental and purchased methods).

Wheelchair

E1031-E1298 Wheelchairs (reclining, standard, amputee, special size, & varies weights
K0001-K1009 Wheelchairs and accessories for wheelchairs
K0800-K0898 Power operated vehicles & motorized wheelchairs

Note: Modifiers may include NR, NU, or RR

Timely Access to Durable Medical Equipment: Wheelchair Repair (TADMEWR)

Description

The average time in days it takes an eligible beneficiary to get a wheelchair repaired and/or obtain additional parts..

Eligible Population

Product lines	Medicaid and dual eligible (Medicare and Medicaid) beneficiaries with disabilities who had a wheelchair repaired or had additional parts added during the measurement year.
Ages	18-64 years of the measurement year.
Continuous enrollment	The measurement year, continuous enrollment not necessary. New or continuing beneficiaries may require a wheelchair repair.
Anchor date	Enrolled as of December 31 of the measurement year.

Administrative Specification

Denominator	Number of beneficiaries in the plan between 18-64 years who received wheelchair repairs or additional parts in the measurement year.
Numerator	The average number of days between the authorization and the wheelchair repair completed.
Numerator 2	The average number of days between the authorization date of the wheelchair and the date the beneficiary receives the wheelchair (i.e. date on the claim).

Numerator 1

Review the prior authorization system to identify both the request date of a wheelchair and the final decision of approval of that request.

Numerator 2

Review the prior authorization system and the out-patient/professional claims (HCFA 1500s) for the evidence of the wheelchair rental or purchase within the period. Capturing both the date of approved authorization and the date of delivery of the wheelchair (include both rental and purchased methods).

Wheelchair

E1340 Repair, Durable medical equipment
K0098, K0601-K0605 Replacement part essential to wheelchair basic functioning

Note: Modifier of RP is most desired

Pressure Ulcer Management (PUM)

Description

The percentage of members hospitalized in the measurement year that had pressure ulcer listed as one of the top 5 discharge diagnoses.

Eligible Population

Product lines	Medicaid and dual eligible (Medicare and Medicaid) Beneficiaries with disabilities
Ages	18-thrpugh 64 years as of December 31 of the measurement year
Continuous enrollment	The measurement year and the year prior to the measurement year.
Allowable gap	No more than one gap of up to 45 days during each year of continuous enrollment. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e. a member whose coverage lapses for 2 months (60 days) is not considered continuously enrolled.
Anchor date	Enrolled as of December 31 of the measurement year.

Administrative Specification

Denominator	Number of beneficiaries between 18-64 years who were hospitalized in the measurement year.

Numerator	Number of beneficiaries between 18-64 years who were hospitalized in the measurement year and had pressure ulcer listed as one of the top 5 discharge diagnoses.

Review the facility claims (UBs) for diagnoses code specified to indicate pressure ulcers below within the reporting period.

Pressure Ulcers

707.0X Pressure ulcers
707.8-707.9 Chronic ulcers of skin

Urinary Tract Disorders Management (UTIM)

Description

The percentage of members hospitalized in the measurement year that had urosepsis listed as one of the top 5 hospital discharge diagnoses.

Eligible Population

Product lines	Medicaid and dual eligible (Medicare and Medicaid) Beneficiaries with disabilities
Ages	18-64 years as of December 31 of the measurement year
Continuous enrollment	The measurement year and the year prior to the measurement year.
Allowable gap	No more than one gap of up to 45 days during each year of continuous enrollment. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e. a member whose coverage lapses for 2 months (60 days) is not considered continuously enrolled.
Anchor date	Enrolled as of December 31 of the measurement year.

Administrative Specification

Denominator	Number of beneficiaries between 18-64 years who were hospitalized in the measurement year.
Numerator	Number of beneficiaries between 18-64 years who were hospitalized in the measurement year and had urosepsis listed as one of the top 5 discharge diagnoses.

Review the facility claims (UBs) for diagnoses code specified to indicate presence of urinary tract below within the reporting period.

Urinary Tract Infection

098.0-098.3X Acute & Chronic Genitourinary Tract Infection
112.2 Candidasis of Urinary Tract
131.0X Urogenital Trichomoniasis
599.0 Urinary Tract Infection

Bowel Disorder Management (BDM)

Description

The percentage of members with disabilities hospitalized in the measurement year that had bowel disorders such as severe constipation, fecal impaction or paralytic ileus listed as one of the top 5 discharge diagnoses.

Eligible Population

Product lines	Medicaid and dual eligible (Medicare and Medicaid) Beneficiaries with disabilities
Ages	18-through 64 years as of December 31 of the measurement year
Continuous enrollment	The measurement year and the year prior to the measurement year.
Allowable gap	No more than one gap of up to 45 days during each year of continuous enrollment. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e. a member whose coverage lapses for 2 months (60 days) is not considered continuously enrolled.
Anchor date	Enrolled as of December 31 of the measurement year.

Administrative Specification

Denominator	Number of beneficiaries between 18-through 64 years who were hospitalized in the measurement year.
Numerator	Number of beneficiaries between 18-64 years who were hospitalized in the measurement year and had bowel

disorder listed as one of the top 5 discharge diagnoses.

Review the facility claims (UBs) for diagnoses code specified to indicate presence of fecal Impaction or severe constipation below within the reporting period.

Bowel Disorders

560.30 Impaction of the intestine
560.39 Fecal impaction
564.0X Constipation

Spasticity Management (SM)

Description

The percentage of members with contractures and/or spasticity in the measurement year that had Baclofen to manage the spasticity.

Eligible Population

Product lines	Medicaid and dual eligible (Medicare and Medicaid) Beneficiaries with disabilities
Ages	18-through 64 years as of December 31 of the measurement year.
Continuous enrollment	The measurement year.
Allowable gap	No more than one gap of up to 45 days during each year of continuous enrollment. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e. a member whose coverage lapses for 2 months (60 days) is not considered continuously enrolled.
Anchor date	Enrolled as of December 31 of the measurement year.

Administrative Specification

Denominator	Number of beneficiaries between 18-through 64 years who had contractures and/or spasticity in the measurement year.
Numerator	Number of beneficiaries between 18-through 64 years with spasticity and contractures who had Baclofen injections in the measurement year.

Review the out-patient/professional claims (HCFAs) for the diagnosis indicating spasticity and the treatment code indicating baclofen administration.

Spasticity (diagnoses)
333.6 Torsion
443.9 NEC spasm
343.X Infantile Cerebral Palsy
344.XX Other paralytic syndromes
718.4X Derangement of lateral meniscus
724.8 Contractures, back
727.81 Contracture, tendon
728.85 Contracture, muscle
756.89 Congenital Contracture, muscle

Baclofen (treatment)
J0585 Botulinum Toxin
64612-64614 Chemodenervation of muscle(s)
67345 Chemodenervation of extraocular muscle

Screening of High-Risk Beneficiaries for Osteoporosis

Description

The percentage of members with have limited mobility, requiring the person to spend large amounts of time in a wheelchair or in bed that received bone density screenings in the measurement year.

Eligible Population

Product lines	Medicaid and dual eligible (Medicare and Medicaid) Beneficiaries with disabilities
Ages	18-through 64 years as in the measurement year.
Continuous enrollment	The measurement year.
Allowable gap	No more than one gap of up to 45 days during each year of continuous enrollment. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e. a member whose coverage lapses for 2 months (60 days) is not considered continuously enrolled.
Anchor date	Enrolled as of December 31 of the measurement year.

Administrative Specification

Denominator	Number of beneficiaries between 18-through 64 years who are have physical impairments requiring the use of a wheelchair or are largely bedbound.
Numerator	Number of beneficiaries between 18-through 64 years with spend large amounts of time in a wheelchair or in bed who had bone density testing in the measurement year.

Denominator

Review outpatient/professional claims (HCFAs) for the presence of a diagnosis below during the period.

Immobility (diagnoses)

333.6 Torsion
334.1 Hereditary spastic paraplegia
335.X Anterior Horn cell disease
336.X Other Diseases of spinal Cord
337.22 Reflex dystrophy of lower limbs
337.3 Autonomic dysreflexia
341.X Multiple sclerosis
342.X Hemiplegia & Hemiparesis
343.X Infantile Cerebral Palsy
344.00-344.1 Quadriplegia, Paraplegia lower limbs
344.3X-344.81 Other paralytic syndromes
343.X Infantile Cerebral Palsy
344.XX Other paralytic syndromes
438.4X Late effect of CVA, Monoplegia, lower limb
438.53 Late effect of CVA, other paralytic syndrome, bilateral
443.9 NEC spasm
718.4X Derangement of lateral meniscus
724.8 Contractures, back
727.81 Contracture, tendon
728.85 Contracture, muscle
756.89 Congenital Contracture, muscle
806.00-806.5 Fracture of vertebral column with spinal cord injury

Or

Have a claim for a wheelchair dispense or repair by reviewing the prior authorization system and the out-patient/professional claims (HCFA 1500s) for the evidence of the wheelchair rental or purchase within the period, capturing both the date of approved authorization and the date of delivery of the wheelchair (include both rental and purchased methods).

Wheelchair

E1031-E1298 Wheelchairs (reclining, standard, amputee, special size, & varies weights
E1340 Repair, Durable medical equipment
K0001-K1009 Wheelchairs and accessories for wheelchairs
K0098, K0601-K0605 Replacement part essential to wheelchair basic functioning
K0800-K0898 Power operated vehicles & motorized wheelchairs

Note: Modifiers may include NR, NU, RP or RR

Codes for the screening bone density (numerator)

77078-77079 CT Scanning
78350-78351 Nuclear Medicine, density, bone
78300-78320 Nuclear Medicine, imaging, bone
0028T DEXA Scan CPT: 76070, 76071, 76075-76077, 76078, 76977, 77078-77083 HCPCS: G0130 ICD-9-CM Diagnosis: V82.81 ICD-9-CM Procedure: 88.98

Glossary of Terms

TERMS	MEANING
Measurement year	Year the data is collected. The measurement year for 2008 is data from 2007
Data collection methodology	The manner in which data will be collected. Data will only be collected from electronic databases.
Eligible population	♦ Beneficiaries who meet the criteria for inclusion, i.e. working age adults with disabilities between the ages of 18 through 64 years ♦ For administration data, the eligible population is selected. This is the universe for each measure.
Minimum required sample size	The minimum required sample size is 30
Final sample size	Number of members who meet the measures criteria
Denominator	The number of members used to report the measure
Number of numerator events by administrative data	Number of members in the denominator who met the numerator criteria using system or transactional data.

Biographies of the Investigators

Susan E. Palsbo, PhD
Principal Investigator

Sue Palsbo is a Principal Research Scientist and Professor at George Mason University's Center for the Study of Chronic Illness and Disability. She has worked in the fields of managed care and vulnerable populations for over 20 years as a financial analyst at several HMOs, and as an external researcher, including 7 years at the predecessor organization of America's Health Insurance Plans (AHIP).

In 1999, she joined the Center for Health and Disability Research, located at the National Rehabilitation Hospital in Washington DC, and served as its Director for two years. While there, she began to explore how the successes of Medicare HMO product lines for the elderly could be applied to working-age adults with disabilities. In 2005, she joined the research faculty at George Mason University.

She has served as Principal Investigator or co-Investigator on 10 peer reviewed, federally-funded public domain studies using survey and routine claims data for managed care performance reporting, with the goal of improving access and eliminating health disparities for all 54 million Americans with disabilities. To date, she has 23 peer-reviewed publications and a patent application to use health claims data to identify people with disabilities.

Margaret Fisk Mastal, PhD, RN
Co-Principal Investigator

Peg Mastal spent seven years at Delmarva Foundation for Medical Care, a quality improvement organization (QIO). She was the Director of Special Projects and also served as the Director of the evaluation of the Washington, D. C. Medicaid programs.

From 1998 to 2001, she was the Chief Operating Officer for Health Services for Children with Special Needs (HSCSN), in Washington D.C., where she lead and managed a Medicaid managed care plan that coordinated health care and life services for the District of Columbia's pediatric SSI population.

She held several management positions at Kaiser Permanente, Mid-Atlantic Region, including Clinical Coordinator of Specialties, and Director of Operations, coordinating with service chiefs and lead physicians in managing the staff and operations needed for 250,000 members to access quality medical care. She has managed personnel, budgets, programs, nursing professional development, and patient care activities multiple hospitals

Her determination to improve quality arose from her clinical experience in direct patient care as a charge nurse and staff nurse in multiple specialties, including intensive care, coronary care, medicine, surgery, rehabilitation, operating rooms, and PACU. To date, she has 13 publications in peer-reviewed journal and has written chapters in four professional nursing textbooks.

Measurement Advisory Panel

The coinvestigators invited different types of representatives for the MAP, based on the programs they represented and their experiences and interest in quality management of the care for persons with disabilities. MAP members represented the perspectives of the specialized disability care coordination organizations (DCCOs), other managed care programs that served general and disabled populations, but also included the perspectives of mental/behavioral health, quality management of mental retardation and development delay services, mobility impaired research expertise, state Medicaid agencies and consumers.

Delmarva convened the MAP of nineteen members to serve as the expert base for identifying specific indicators, retrievable from existing administrative databases that would be used to measure quality in programs that coordinate care and life services for persons with disabilities. The experts and their credentials are briefly summarized here.

MAP Project Team

· **Moderator, Measurement Advisory Panel and CoPrincipal Investigator,** Margaret Fisk Mastal, PhD, RN, Director Special Projects, Delmarva Foundatio, District of Columbia, Washington, DC.
· **Principal Investigator,** Susan E. Palsbo, PhD, Principal Research Associate, Center for the Study of Chronic Illness and Disability, George Mason University, Fairfax, Virginia
· **Program Coordinator** Sidney Johnson, MS, COTA/L, Research Analyst, Center for Health Policy, Research, and Ethics, George Mason University, Fairfax, Virginia

Behavioral Health Representatives

· **Ron Diamond, MD,** Medical Director, Dane County Mental Health Services, Madison, Wisconsin
· **Andrew Pomerantz, MD** Chief, Mental Health and Behavioral Sciences, White River Junction VA Medical Center, White River Junction, Vermont, and Associate Professor of Psychiatry, Dartmouth Medical School, Lebanon, New Hampshire

Consumer Representatives

· **June Isaacson Kailes**, Associate Director, Center for Disability Issues and the Health Professions, Western University of Health Sciences, Playa del Rey, California
· **Brenda Premo**, Director, Center for Disability Issues and the Health Professions, Western University of Health Sciences, Playa del Rey, California

Disability Care Coordination Organization Representatives

· **Todd Costello,** Director of Program Operations, Community Living Alliance, Madison, Wisconsin**.** Community Living Alliance (CLA), a community-based organization in the Wisconsin Partnership Program (WPP), provides comprehensive health care primarily for the physically disabled population and those with chronic diseases between the ages of 18 and 64 in Dane County. The CLA service area is largely urban and suburban, as it serves the city of Madison and its immediate environs; some rural areas also included. Community Living Alliance is the umbrella for three separate programs: The Wisconsin Partnership Program, the Personal Care Program and the Service Coordination program.

· **Keith Sperling, MD,** Medical Director Community Living Alliance, Madison, Wisconsin

· **Chris Duff,** CEO, AXIS Healthcare, Inc., Minneapolis, Minnesota. AXIS is a nonprofit corporation contracting with UCare Minnesota to provide capitated Medicare/Medicaid services to adults of working age with physical disabilities. AXIS has been in operation for 5 years (1 year as a pilot program), serves the 4 counties comprising the central Twin Cities and is expanding to other parts of the states. Membership in 2006 is 1000 enrollees with primarily physical disabilities.

· **Brad Gilbert, MD**, Medical Director Inland Empire Health Plan, San Bernadino, Callifornia**.** Inland Empire Health Plan (IEHP) is an NCQA accredited health plan serving over 250,000 Medicaid beneficiaries across southern California. IEHP has an estimated disabled population base of 13, 000 members.

· **Stephen Ryter, MD,** Medical Director Community Health Partnerships, Eau Claire, Wisconsin. Community Health Partnerships, Inc. (CHP) is one of four community-based organizations in the Wisconsin Partnership Program (WPP). CHP provides health care, long term support services, and care coordination for both the frail elderly and working age adults with disabilities in West Central Wisconsin. The CHP urban and rural service area covers three counties: Dunn, Eau Claire and Chippewa, covering a surface area of approximately 2500 square miles. Distances and the rural nature of much of the service area provide some challenges to timely access. The membership with disabilities totaled 750 in 2006.

· **Rick Surpin,** President, Independence Care System (ICS) New York, New York. Independence Care System is a nonprofit organization located in downtown Manhattan, serving Medicaid adults with physical disabilities living in New York City. ICS coordinates comprehensive health and social services for this population. However, it directly pays only for Medicaid-funded long term care, dentistry and podiatry. It does not pay for Medicare-reimbursed services, or Medicaid physician and hospital services. Membership in 2006 totaled 1000 members.

· **Anna Fay,** Director Consumer Directed Personal Assistance Services, Independence Care System, New York, New York.

· **M. Elizabeth Sandel, MD,** Medical Director/Chief of Physical Medicine and Rehabilitation, Kaiser Foundation Rehabilitation Center and Hospital, Vallejo, California.

State Medicaid Representatives

· **Steve Landkamer**, Project Manager, Wisconsin Partnership Program, Wisconsin Department of Health and Family Services Madison, Wisconsin.

· **M. Elizabeth Reardon**, Managed Care Director, Office of Vermont Health Access Waterbury, Vermont

Mental Retardation/Developmental Delay Representative

- **Bob Foley**, Director Florida Operations, Delmarva Foundation for Medical Care, Tampa, Florida. Mr. Foley directs the Delmarva contract with Florida Medicaid that oversees the quality of care for Florida’s MR/DD population.

Statistician

- **Daniel E. Graves, Ph.D**., Assistant Professor PM&R, Baylor College of Medicine and Director NeuroRecovery Center, Director Spinal Cord Injury Research, The Institute for Rehabilitation and Research, Texas.

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.

NATIONAL QUALITY FORUM STAFF

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.

MEASURE APPLICATIONS PARTNERSHIP
DUAL ELIGIBLE BENEFICIARIES WORKGROUP

Convened by the National Quality Forum

Summary of the Web Meeting

A web meeting of the National Quality Forum (NQF) Measure Applications Partnership (MAP) Dual Eligible Beneficiaries Workgroup was held on Wednesday, September 5, 2012. An online archive of the web meeting is available on the MAP Dual Eligible Beneficiaries Workgroup project webpage.

Workgroup Members in Attendance at the September 5, 2012 Meeting:

Alice Lind, Workgroup Chair	David Polakoff, American Medical Directors Association
Richard Bringewatt, SNP Alliance	DEB Potter, Agency for Healthcare Research and Quality (AHRQ)
Mady Chalk, Subject Matter Expert: Substance Use	Cheryl Powell, Centers for Medicare & Medicaid Services (CMS)
Anne Cohen, Subject Matter Expert: Disability	Susan Reinhard, Subject Matter Expert: Home and Community-Based Services
Fran Cotter, Substance Abuse and Mental Health Services Administration (SAMHSA)	Rhonda Robinson Beale, Subject Matter Expert: Mental Health
Leonardo Cuello, National Health Law Program	Clarke Ross, Consortium for Citizens with Disabilities
Jim Dunford, Subject Matter Expert: Emergency Medical Services	Marisa Scala-Foley, Administration for Community Living (substitute for Henry Claypool)
Tom James, Humana	Gail Stuart, Subject Matter Expert: Nursing
Laura Linebach, L.A. Care Health Plan	

The primary objectives of the meeting were to:

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

Welcome, Roll Call, and Review of Meeting Objectives

MAP Dual Eligible Beneficiaries Workgroup Chair, Ms. Alice Lind, began the meeting with a welcome and review of the meeting objectives. Ms. Lind summarized the major components of MAP’s June 2012 Final Report to the Department of Health and Human Services (HHS) containing the workgroup’s strategic approach to performance measurement for dual eligible beneficiaries. The report is grounded in the National Quality Strategy and includes a vision for high-quality care, guiding principles, and five high-leverage opportunity areas. The five high-leverage opportunity areas are: quality of life, care coordination, screening and assessment, mental health and substance use, structural measures, and other (e.g., patient experience). The report also defines a core set of 26 measures, including a starter set of seven available measures and an expansion set of seven measures that need modification to best meet the needs of the dual eligible population. The June 2012 Final Report also prioritizes measure gap areas and provides input on levels of analysis, potential applications of measures, and program alignment.

Ms. Lind reviewed the updated 2012-2013 workgroup charge. It instructs the workgroup to advise the MAP Coordinating Committee on performance measures to assess and improve the quality of care delivered to the Medicare and Medicaid dual eligible beneficiaries; specifically, the workgroup is charged with analyzing special measurement considerations for high-need population subgroups of these beneficiaries. MAP will also examine measures and measurement issues across the continuum of care, to include primary and acute care, behavioral health, and long-term services and supports (LTSS).

Activities to Accomplish the Workgroup's 2012-2013 Work

Ms. Sarah Lash, Senior Program Director at NQF, discussed the planned workgroup activities for 2012-2013 to build on the previous year accomplishments and ultimately result in a July 2013 Final Report to HHS. The first major area of activity will be to revise the core set of measures to respond to feedback from the field and accommodate changes in measure endorsement status. The core set is expected to remain largely intact, but targeted changes will allow the workgroup to fine-tune the set.

The second major area of activity is to consider measurement for high-need population subgroups. This work will progress with the understanding that the complex and heterogeneous dual eligible population does not lend itself well to categorization. One group will be adults 65 and older with one or more functional impairments and one or more chronic conditions, otherwise known as medically complex older adults. The other group will be younger adults 18-65 years old with a physical or sensory disability. The work planned for 2013 will address two populations of beneficiaries with behavioral health needs. The NQF Performance Measures department is currently conducting a behavioral health measure endorsement project, so a greater number of endorsed and up-to-date measures should be available for MAP review in 2013.

Understanding High-Need Dual Eligible Beneficiary Subgroups

Ms. Lash presented demographic data regarding high-need beneficiaries, drawn from a staff-conducted literature review. High-need dual eligible beneficiaries are both clinically vulnerable and socially disadvantaged. These needs exacerbate one another and present an opportunity to reduce cost and improve quality. High-need dual eligible beneficiaries consume a disproportionate amount of Medicare and Medicaid resources. Compared to other people with Medicare, dual eligible beneficiaries are more likely to be female, have one or more functional limitations, and live in institutions. In the cohort of dual eligible beneficiaries 18-65, 43% of people report a functional limitation. As the dual eligible population ages, the number of individuals with chronic conditions and functional impairments increases dramatically.

Mr. Amaru Sanchez, Project Analyst at NQF, reviewed data describing approximately 3.6 million dual eligible beneficiaries younger than 65 years old who live with a physical disability. Of this population, 18.2% have one to two limitations in their activities of daily living (ADL), and 17.1% have three or more

ADL limitations. This population of younger beneficiaries tends to use different types of providers and services and is more interested in navigating the health and LTSS systems on their own. To illustrate his points, Mr. Sanchez described a hypothetical dual eligible beneficiary of this type. Ms. Megan Duevel Anderson, Project Analyst at NQF, provided a similar overview of the medically complex older adult population. Service utilization is high in this cohort, with 40% using hospital services, almost 35% using post-acute care, 38% using Medicaid nursing home care, and 22% using home and community-based services in a given year. Annual Medicare and Medicaid spending exceeds $30,000 per beneficiary. Ms. Duevel Anderson also described a hypothetical dual eligible beneficiary who would be part of this population.

Literature Review to Support Quality Issue Analysis for High-Need Dual Eligible Beneficiary Subpopulations

Ms. Lash described the literature review approach undertaken by NQF staff to identify and prioritize high-leverage quality issues for medically complex older adults. The NQF staff collaborated with workgroup members with expertise in disability to develop a related list of key issues for that population. Evidence was organized and evaluated based on the Institute of Medicine “Three I’s” Framework defined by the impact, inclusiveness, and improvability of the five high-leverage opportunities.[1] Ms. Lash provided an example of the analysis for the topic of care coordination. The workgroup will be asked to review and respond to the draft lists of identified quality issues. The objective will be to trace numerous quality issues across the continuum of care and identify a measure or measure gap for each care setting.

The workgroup members requested clarification or modification of a few key terms used in the presentation. A participant asked what was included in the term “cognitive conditions.” Cognitive conditions for older adults might include dementia or the sequelae of stroke. For persons in all age groups, cognitive conditions might include intellectual or developmental disability. Mr. Clarke Ross requested that the workgroup refer to Long Term Supports and Services (LTSS) in its work instead of long-term care. Ms. Susan Reinhardt requested that the workgroup replace the term end-of-life care with advanced illness care.

Ms. Gail Stuart commented that behavioral health care is provided throughout inpatient and ambulatory care settings therefore it should be represented within all care settings. Ms. Lash clarified that the intention of the separate column was to make sure that behavioral health care was always considered explicitly for each quality improvement issue, but that staff will review the construction of the table before the October meeting. Workgroup members also commented on the concepts of frailty and disability, highlighting articles that might be valuable for review. At members’ suggestions, articles by Linda Fried and Lisa Iezzoni will be provided to the workgroup members in advance of the October meeting.

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[1] *Priority Areas for National Action: Transforming Health Care Quality*. Summary of Institute of Medicine report. January 2003. Agency for Healthcare Research and Quality, Rockville, MD. http://www.ahrq.gov/qual/iompriorities.htm

Multiple Chronic Conditions Framework

Ms. Lind introduced Ms. Aisha Pitman, Senior Program Director at NQF, to review the recently completed NQF-endorsed Multiple Chronic Conditions Framework, available on the NQF website. This HHS-funded framework is intended to identify measure gaps, guide endorsement decisions for assessing and improving the quality of care, guide selection of measures for public reporting and payment, suggest a roadmap for new delivery models, and inform research.

From an individual's perspective, the presence of multiple chronic conditions can affect functional roles and health outcomes across the lifespan, compromise life expectancy, and hinder a person's ability to self-manage or a family or caregiver's capacity to assist in that individual's care. Ms. Pitman provided an example of how the conceptual model applies across sites, providers, and types of care for a hypothetical person with multiple chronic conditions. She explained how application of the model would lead to the selection of measures important to this person and his care within each of the priority domains of measurement. She also described how the guiding principles for measuring care provided to individuals with multiple chronic conditions are designed to evaluate the full spectrum of care for this population. Strategic opportunities for implementing the MCC Framework include identifying and filling measure gaps; standardizing data collection, measurement, and reporting; and payment and delivery system reform.

Connections to Other MAP 2012-2013 Activities for and Next Steps

Ms. Lind introduced Dr. Connie Hwang, Vice President, MAP, to provide an overview of the related MAP work including the three-year strategic plan, families of measures, and pre-rulemaking input to HHS. The strategic plan details the goals, objectives, strategies, and tactics for MAP. It also describes MAP planned activities for the ACA-mandated role of providing input to HHS on selection of performance measures for public reporting in programs as well as promoting alignment between the public and private sectors. Dr. Hwang outlined the current informational inputs MAP will use for pre-rulemaking activities, including families of measures and core measure sets. Four families of measures were developed in 2012, activity in which several Dual Eligible Beneficiaries Workgroup members participated. The Dual Eligible Beneficiaries Workgroup will also provide targeted guidance to the setting-specific workgroups and Coordinating Committee regarding the potential inclusion of specific measures under consideration for rulemaking by HHS. Ms. Lind facilitated group discussion and questions on MAP strategy, including explaining the possibility of stratification of measures within the federal programs.

Workgroup members were assigned follow-up work to provide detailed feedback from users' experiences applying the dual eligible beneficiaries core set of measures. Workgroup members are asked to provide information on implementation, feasibility, and suggested modifications of the core measure set. Results will inform deliberations at the October meeting.

The meeting concluded with a discussion of next steps. The next meeting of the Dual Eligible Beneficiaries Workgroup will be held in-person on October 11-12, 2012, in Washington, DC. Please see the meeting registration website for details.

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SPECIAL ISSUE: HEALTH SERVICES RESEARCH IN 2020

Multiple Chronic Conditions and Disabilities: Implications for Health Services Research and Data Demands

Lisa I. Iezzoni

Increasing numbers of Americans are living with multiple chronic conditions (MCCs) and disabilities. Addressing health care needs of persons with MCCs or disabilities presents challenges on many levels. For health services researchers, priorities include (1) considering MCCs and disabilities in comparative effectiveness research (CER) and assessing quality of care; and (2) identifying and evaluating the data needed to conduct CER, performance measure development, and other research to inform health policy and public health decisions concerning persons with MCCs or disabilities. Little information is available to guide CER or treatment choices for persons with MCCs or disabilities, however, because they are typically excluded from clinical trials that produce the scientific evidence base. Furthermore, most research funding flows through public and private agencies oriented around single organ systems or diseases. Likely changes in the data landscape—notably wider dissemination of electronic health records (EHRs) and moving toward updated coding nomenclatures—may increase the information available to monitor health care service delivery and quality for persons with MCCs and disabilities. Generating this information will require new methods to extract and code information about MCCs and functional status from EHRs, especially narrative texts, and incorporating coding nomenclatures that capture critical dimensions of functional status and disability.

Key Words. Chronic conditions, disability, functional status, comparative effectiveness research, quality measurement, health information technology, coding nomenclatures

At either end of the life span—and at all points in between—growing numbers of Americans are living with chronic conditions and disability (Institute of Medicine 2007; Centers for Disease Control [CDC] 2009). Many factors contribute to this trend, including stunning therapeutic breakthroughs that preserve the lives of individuals, young and old, who would once have died from severe impairments. Other factors are less heroic, such as rising rates of overweight and obesity and stubbornly persistent tobacco use. The increasing recognition of multiple coexisting chronic health problems has generated its own acronym—multiple chronic conditions (MCCs)—and is attracting widespread notice among clinicians, health policy makers, and public health officials worldwide (Schoen et al. 2009). Three-quarters of the more than U.S.$2 trillion now spent annually on U.S. health care goes to treating chronic conditions (Hoffman and Schwartz 2008).

Addressing health care needs of Americans with MCCs or disabilities presents challenges on many levels. Certain provisions of the American Recovery and Reinvestment Act of 2009 (ARRA), current public health initiatives (including development of federal Healthy People 2020 objectives), and approaches for fundamentally reforming U.S. health care all carry important consequences for persons with MCCs or disabilities. Given this broad context, this paper has two goals: (1) to underscore the need to consider MCCs and disabilities in performing comparative effectiveness research (CER) and evaluating quality of care; and (2) to suggest the data needed to conduct CER, performance measure development, and other health services research (HSR) to inform health policy and public health decisions concerning persons with MCCs or disability. The paper starts by defining chronic health conditions and disabilities.

DEFINITIONS OF CHRONIC CONDITIONS AND DISABILITY

Disease and disability are distinct concepts, although they often coexist (Iezzoni and O'Day 2006). Disease frequently (although not always) contributes to disability (e.g., osteoarthritis impairing ambulation). Disability, in turn, can precipitate secondary conditions or new diseases (e.g., spinal cord injury contributing to urosepsis or pressure ulcers). In May 2009, the CDC reported that the numbers of Americans living with disabilities is growing, and the three most important underlying causes are chronic health conditions—arthritis, back or spine problems, and heart troubles, in order of decreasing prevalence (CDC 2009). Adults reporting disabilities are 30 percent more likely than nondisabled respondents to describe being in fair or poor overall health (CDC 2008).

Address correspondence to Dr. Iezzoni, Director, James J. Mongan Institute for Health Policy, Massachusetts General Hospital, 50 Staniford Street, Room 901B, Boston, MA 02114; e-mail: liezzoni@partners.org

Defining disease requires specifying the organ or organ system involved, the underlying pathology or pathophysiology, and an etiology or cause. By definition, chronic diseases persist over time, without cure or resolution. Here, the word "condition" refers broadly to health problems caused by some underlying disease or pathological process, even if the precise etiology is not explicitly specified (e.g., arthritis, chronic back pain). Many chronic conditions occur with aging. In 2005, among U.S. noninstitutionalized residents ages 0–19 years, 16.5 percent had one, 3.7 percent had two, and 1.2 percent had three or more chronic conditions (Paez, Zhao, and Hwang 2009). In contrast, among those ages 65–79 years, 20.2 percent had one, 21.5 percent had two, and 45.3 percent had three or more chronic conditions.

Specific meanings of the word "disability" vary by context. For example, the Social Security Administration has its own definition for disability determinations, as does the Americans with Disabilities Act for meriting civil rights protections (Iezzoni and Freedman 2008). Nonetheless, regardless of setting, assessment of disability typically requires information about physical, sensory, cognitive, or emotional functioning, and the extent to which individuals participate in daily activities in their homes and communities, facilitated by or impeded by environmental factors. In a framework supported by the Institute of Medicine (2007), the World Health Organization (WHO) defines disability as an "umbrella term for impairments, activity limitations or participation restrictions" conceiving "a person's functioning and disability . . . as a dynamic interaction between health conditions (diseases, disorders, injuries, traumas, etc.) and contextual factors," including environmental and personal attributes (WHO 2001). Forty to 54 million Americans live with disabilities, and as with chronic conditions, disability rates also rise with increasing age: 6 percent among persons ages 5–15 years; 7 percent for ages 16–20; 13 percent for ages 21–64; 30 percent for ages 65–74; and 53 percent for ages 75 and older (Erickson and Lee 2008).

MEASURING QUALITY AND EFFECTIVENESS OF CARE

Development of performance measures and CER studies generally proceed disease by disease, ignoring the consequences of MCCs and disability (Vogeli et al. 2007). In a simple but compelling example, Boyd et al. (2005) applied evidence-based practice guidelines to a hypothetical 79-year-old woman with hypertension, diabetes mellitus, osteoporosis, osteoarthritis, and chronic obstructive pulmonary disease. To meet guideline specifications, the woman needed to undertake 14 nonpharmaceutical activities and consume 12 separate medications in a regimen requiring 19 daily drug doses. Some recommendations contradicted each other, putting her overall health at risk. The numerous guideline requirements also neglected her preferences for different types of care.

As HSR researchers mobilize to perform ARRA-funded CER and develop evidence-based performance measures (e.g., to support performance-based payments), considering persons with MCCs or disabilities will become critical. Certainly, important approaches do exist for evaluating care provided to frail, clinically complex populations, such as measures developed for the Assessing Care of Vulnerable Elders (ACOVE) program (ACOVE Investigators 2007). Nonetheless, clinical and research leaders from across the country recently used a consensus process to outline a research agenda for improving clinical care for older persons with MCCs (Norris et al. 2008). Their report started by noting that almost half (48 percent) of Medicare beneficiaries over age 65 have three or more chronic conditions and 21 percent have five or more. Despite this, little information is available to guide treatment choices for persons with MCCs or disabilities because they are typically excluded from the clinical trials that produce the scientific evidence base (Norris et al. 2008). Furthermore, most research funding flows through public and private agencies oriented around single organ systems or diseases. Disease- or condition-specific therapies and management approaches may not apply to persons with MCCs or certain disabilities. Many performance measures representing processes of care therefore build in explicit inclusion or exclusion criteria, indicating which patients qualify for receiving the care process (Kahn et al. 2006).

If performance measures do not adequately account for patients' associated with MCCs or disabilities, clinicians or health care facilities might succumb to "risk aversion," trying to avoid clinically challenging patients (Birkmeyer, Kerr, and Dimick 2006; McMahon, Hofer, and Hayward 2007; Petersen et al. 2006). Early experiences from the United Kingdom's National Health Service pay-for-performance initiative for general practitioners, which began in 2004, suggests one possible outcome (Roland 2004; Velasco-Garrido et al. 2005). Physicians could "game" the incentive system by avoiding complex patients or reporting that these patients were "exceptions" to required clinical actions or outcomes. While widespread gaming failed to materialize, 91 practices (1.1 percent) excluded more than 15 percent of their patients from performance reporting (Doran et al. 2006).

In 2006, the Health Services Research and Development Service of the Veterans Health Administration held a state-of-the-art conference to explore management of MCCs and suggest future research directions in this area (Weiss 2007). The Department of Veterans Affairs (VA) confronts two imperatives

Table 1: Selected Research Topics Relating to Multiple Chronic Conditions (MCCs) from Veterans Health Administration State-of-the-Art Conference

Enhance understanding of gene and environment interactions that lead to common MCCs (basic and clinical science research)
Increase the evidence base of efficacy and effectiveness studies to support guidelines that apply to MCCs and social complexity
Advance work in outcome assessment, including measures of comprehensive care needs and optimized outcomes for patients with MCCs
Evaluate new health information technologies to support complex care management
Examine best practices in patient–physician communication strategies for care management decisions for patients with MCCs or with social complexity
Evaluate systems changes that organize care around MCCs and social complexity of illness management

Adapted from Weiss 2007.

forcing this focus: first, growing numbers of aging veterans with MCCs; and second, thousands of veterans from Iraq and Afghanistan who have returned home with complex physical, sensory, cognitive, and emotional disabilities. A literature review found large gaps in knowledge about MCCs, along with worrisome preliminary evidence (Vogeli et al. 2007). For example, complex disease–disease interactions might produce greater than expected disability levels in patients with MCCs; poor coordination of care among multiple specialists might contribute to high rates of adverse drug events and suboptimal quality of care; MCCs complicate the efforts of patients to self-manage their diseases; and single-condition disease management programs may fail to improve outcomes and lower costs for persons with MCCs. Conference members suggested research priorities to address the substantial knowledge gaps about caring effectively for persons with MCCs, including topics shown in Table 1.

DATA DEMANDS AND HSR ROLE

To address the issues raised above, HSR CER studies and research to specify performance measures will require readily available data sources that contain complete and accurate information about MCCs and disabilities. As new information infrastructures are built—under certain provisions of ARRA and public health data-gathering initiatives—HSR should lead evaluations of data quality. In particular, HSR studies could elucidate the potential for biased results should problems exist with data completeness and accuracy.

Because of space constraints, this data discussion focuses exclusively on data generated through clinical care or administering health care. Topics relating to health surveys, which are essential data sources especially for studies about population disability, are described elsewhere (Bradley, Penberthy, and Devers in press). In addition, although surveys provide essential data about population disability, various methodological challenges to capturing this information are undergoing active discussion among survey scientists. A recent report from Wunderlich et al. (2009) provides a more complete presentation of these concerns.

HEALTH INFORMATION TECHNOLOGY (HIT) AND HIT INFRASTRUCTURE

The promise of electronic health information for HSR—and more importantly for improving the safety, quality, and efficiency of health care—has bred cautious enthusiasm for more than two decades. However, with the exception of certain HIT-rich pockets within the health care delivery system (such as the VA's extensive clinical information system and some centers and delivery systems that have made substantial HIT investments over many years), much of this promise remains illusory rather than real. A survey in late 2007–early 2008 of physicians nationwide, found that only 4 percent had extensive, fully functional electronic medical record (EMR) systems, and just 13 percent had basic EMRs (DesRoches et al. 2008). A parallel survey of hospitals found that only 1.5 percent had comprehensive EMRs, while an additional 7.6 percent had a basic EMR system (Jha et al. 2009). The grander notion, of linking electronic HIT systems within communities to share individual health data across providers and advance public health goals, remains even more distant (Adler-Milstein, Bates, and Jha 2009). Beyond these implementation concerns, the evidence base supporting the value of HIT in improving care and increasing efficiency is ambiguous (Parente and McCullough 2009; Walker and Carayon 2009).

The ARRA authorizes federal expenditures of U.S.$20 billion to advance the HIT infrastructure in different care settings nationwide, including supporting "coordination of care and information among hospitals, laboratories, physician offices, and other entities." Theoretically, any effort that improves information exchange and care coordination should particularly benefit persons with MCCs or disabilities, who typically obtain care from multiple clinicians in different settings. HSR will be critical to assess whether this promise is fulfilled, as well as to devise ways to extract information from EMRs and other HIT sources to inform this research and meet other public health goals.

Potential Advantages of HIT

Simply having information in electronic form does not always ensure data will be complete and accurate, as suggested by experiences within the VA—long considered a pioneer in widespread EMR adoption (Kuehn 2009; McGinnis et al. 2009). Nonetheless, electronic algorithms can improve the completeness of documentation, a process that should assist with capturing data on MCCs and disabilities. A comparison of EMRs versus paper records at three large mental health centers found more complete recording of medications in EMRs, along with the additional benefit of timelier retrieval of information (Tsai and Bond 2008).

One study used clinical decision support tools and computerized physician order entry for medications within an EMR to extract information about health conditions and then to populate patients' problem lists (Galanter et al. 2009). Chart reviews determined that problems added by these electronic algorithms were 95 percent accurate. Another study used natural language processing to create an Automated Problem List among patients admitted to intensive care or cardiovascular surgery units (Meystre and Haug 2008). In the ICU, the completeness and timeliness of problem reporting improved significantly using this electronic algorithm. The Automated Problem List created from free text EMRs using natural language processing can also potentially improve the efficiency and accuracy of diagnosis coding (Meystre and Haug 2006). Natural language processing techniques applied to EMRs could provide timely information about brewing epidemic illnesses (Hripcsak et al. 2009) or medication complications (Wang et al. 2009).

Need for Coding and Classification Systems

Extracting information from HIT systems that can be easily compiled, compared, and analyzed requires a reliable and meaningful coding scheme. For several decades researchers have worked toward this goal. The Unified Medical Language System (UMLS), created and maintained by the National Library of Medicine (2006), aims to facilitate the understanding of biomedical terms and concepts by computerized information systems. UMLS offers several software tools, including the Metathesaurus, which is a large, multilingual vocabulary database that crosswalks and categorizes codes and concepts from other classification systems and code sets. The structural and semantic properties of UMLS are robust enough to explore relationships among different concepts (Patel and Cimino 2009).

Licensees of the UMLS Metathesaurus have access to the Systematized Nomenclature of Medicine Clinical Terms, generally known as SNOMED

CT (owned and maintained by the International Health Terminology Standards Development Organisation in Denmark), which is a multilingual terminology developed to retrieve and code clinical information reliably from EMRs (Cornet and de Keizer 2008). SNOMED CT is part of a suite of U.S. government-designated standards for the electronic exchange of clinical health information. Researchers within the VA have developed a method using coded clinical concepts from SNOMED to assess the quality of veterans' disability examinations with electronic algorithms (Brown et al. 2008).

Other widely used classification schemes include those developed by the WHO and groups with interests in specific scientific areas (e.g., laboratory testing, genetics). These various classification schemes often do not overlap, necessitating methods such as the UMLS Metathesaurus for cross-walking concepts and terms (Pathak et al. 2009). Some clinical areas have less developed classification approaches than do others. As consensus develops over the next several years about the best methods for coding clinical data from EMRs and other HIT sources, it will be important to ensure that the classification systems thoroughly reflect the full range of health conditions and disabilities.

As clinical information from HIT is coded and becomes more accessible for conducting research—or examining public health or health policy questions—linking these data to other information sources (e.g., data generated through administering health care delivery) could provide valuable insight (Luft 2010; Bradley, Penberthy, and Devers 2010). As described in other papers in this series (Lane and Schur 2009; Rosenbaum and Goldstein 2010), such linkages inevitably raise questions about privacy, along with other concerns (Diamond, Mostashari, and Shirky 2009). Nonetheless, these linkages may facilitate better understanding of the health care experiences of the heavy users of the system: persons with MCCs or disabilities.

CODING DIAGNOSES AND PROCEDURES

As noted above, efforts to summarize health information for populations requires data in clinically interpretable but analytically manageable bites. Since the mid-19th century, organizations interested in public health have recognized the need to produce information about health in meaningful and statistically manipulable codes. Today, the WHO governs worldwide efforts to code and classify health conditions, continually reviewing and revising their flagship nomenclature, the *International Statistical Classification of Diseases and Related Health Problems* (known simply as ICD). By international treaty, countries must report causes of death using ICD. Therefore, the United States has reported mortality causes using ICD-10, the 10th edition, since January 1, 1999.

Several decades ago, however, U.S. clinicians, managers, and health policy makers sought coded diagnostic and procedural data for purposes beyond classifying causes of death. Specifically, U.S. users wanted coding systems for reporting "morbidity" and inpatient procedures. U.S. professional organizations developed a so-called clinically modified version of WHO's ICD—the *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM)—for these other purposes. The United States adopted ICD-9-CM for morbidity reporting (and for reporting hospital procedures) in 1979. Electronic administrative data systems contain slots for recording ICD-9-CM codes, and since 1983, these codes have supported Medicare's inpatient prospective payment system (i.e., ICD-9-CM diagnosis and procedure codes generate diagnosis related group [DRG] assignments).

Over the ensuing years, the National Center for Health Statistics has maintained ICD-9-CM's diagnosis classification, while the Health Care Financing Administration (renamed the Centers for Medicare & Medicaid Services [CMS]) updated the inpatient procedure classification. CMS also maintains another service and procedure classification system, the *Healthcare Common Procedure Coding System*, for coding services of physicians and other health care professionals and coding durable medical equipment and other items. Yearly, a government contractor updates the DRGs, adding the new diagnosis and procedure codes to the DRG classification algorithm.

Going beyond ICD-9-CM

Despite this updating process, ICD-9-CM has considerable limitations for today's purposes. Most obviously, knowledge about disease has grown enormously since the 1970s, and new diseases, such as human immunodeficiency virus infections, have appeared. WHO has begun developing ICD-11 (Üstün et al. 2007), and many other countries already use ICD-10 (or their own clinically modified versions, as in Australia and Canada) for morbidity reporting.

U.S. professional organizations and coding experts have developed clinically modified versions of ICD-10's diagnosis classification system (ICD-10-CM) and a newly conceived procedure classification system (ICD-10-PCS). These new classifications have important advantages in terms of clinical content and depth over their predecessors, which should substantially improve the ability to capture complete diagnostic information about persons with MCCs.

The U.S. government has delayed implementation dates for the new classification systems multiple times because of concerns about the feasibility and costs of moving from ICD-9-CM to ICD-10-CM and ICD-10-PCS. The new classifications have different organizational structures and thousands more codes than ICD-9-CM. Making the change will therefore require intensive staff and clinician training and modifications of computer software. In addition, critical administrative code-based algorithms will need reprogramming and recalibration with the new codes: examples include the DRGs, which as of October 2008 began transitioning to the more coding-intensive Medicare Severity-DRGs (MS-DRGs); and the Hierarchical Condition Categories (HCCs) used for Medicare Advantage plan payment. Nonetheless, on August 22, 2008, the U.S. Department of Health and Human Services (DHHS) finally published a proposed rule to replace ICD-9-CM with ICD-10-CM and ICD-10-PCS for electronic health information transactions covered by the Health Insurance Portability and Accountability Act of 1996. After a comment period, DHHS published final guidelines on January 16, 2009, specifying an anticipated implementation date of October 1, 2013.

HSR and ICD-10

International HSR researchers have already begun to explore the consequences of moving to ICD-10-based classifications. In 2005, investigators who use administrative data for HSR from Australia, Canada, China, Switzerland, the United Kingdom, and the United States met in Banff, Canada, to discuss these implications (De Coster et al. 2006). They identified various priorities relating to HSR, such as translating the code-based version of the Charlson comorbidity index and classification system designed by Elixhauser and colleagues into ICD-10 and redoing the Agency for Healthcare Research and Quality's Patient Safety Indicators using ICD-10-based codes. Beyond these types of activities, researchers will need to develop familiarity with ICD-10-CM and ICD-10-PCS to learn the strengths and limitations of these systems.

Although ICD-10-CM should theoretically improve the ability to represent the clinical conditions of persons with MCCs, concerns arise, at least initially, about data quality for this subpopulation. Coders overwhelmed by learning a new and massive classification scheme may not code all conditions comprehensively but instead code only those diagnoses required for administrative purposes (e.g., computing the MS-DRG or HCC). Both MS-DRGs and HCC assignments, however, require complete diagnosis coding, perhaps aligning payment incentives with the impetus for ensuring thorough coding of

MCCs. In fact, expectations about increases in diagnosis coding with implementation of MS-DRGs have led CMS to constrain payment increases to hospitals to avoid rewarding coding artifact rather than true increases in patient severity (Medicare Payment Advisory Commission 2009).

In the past, HSR researchers have analyzed longitudinal data to examine the completeness of coding of chronic conditions. Using Medicaid data from seven states, percentages of persons who had diagnoses coded in the next year after having had the code the previous year included the following: 80 percent for schizophrenia; 68 percent for diabetes; 58 percent for multiple sclerosis; 57 percent for quadriplegia; and 34 percent for cystic fibrosis (Kronick et al. 2000). Because these conditions do not disappear, their absence in the subsequent year suggested the level of incomplete coding. Efforts to identify persons with MCCs using coded administrative data must recognize this possibility.

CODING FUNCTIONING AND DISABILITY

WHO recognized that ICD (and even ICD-10) does not contain sufficient codes—or a meaningful conceptual model—for classifying concepts relating to functional impairments and disabilities. Thus, while ICD-coded data adequately capture diseases, they do not represent the disabling consequences of disease or disabilities from other causes (e.g., congenital conditions, injuries). In 1980, WHO approved a sister classification scheme to the ICD, the *International Classification of Impairments, Disabilities, and Handicaps* (ICIDH). After a lengthy revision process, in 2001 WHO approved a revised system, the *International Classification of Functioning, Disability and Health* (ICF) (WHO 2001).

Explicitly recognizing the role of external forces—physical, social, and attitudinal environments—in precipitating or mitigating disability represents one of ICF's major contributions. In addition, ICF introduces participation in daily and community life as an explicit component of health, a concept that shifts the emphasis from strictly prevention or restoring functioning to maximizing functioning and well-being—perspectives consistent with public health goals in an aging society (Iezzoni and Freedman 2008). As noted above, ICF defines disability as an "umbrella term for impairments, activity limitations or participation restrictions" (WHO 2001). To respond to specific issues relating to children with disabilities, WHO recently published the *International Classification of Functioning, Disability and Health for Children and Youth* (ICF-CY), which aims to support reporting on the characteristics of child development, environmental factors that affect child development, and developmental delays (WHO 2007).

Use of ICF

For some reason, ICF has not gained widespread traction in the United States, although WHO and some member countries are using ICF in surveys and routine data collections (WHO 2007). In 2002 and 2003, the World Health Survey Program applied the ICF framework to generate population norms for disability prevalence and selected ICF domains across 71 countries. Efforts ongoing in Australia, Canada, Italy, India, Japan, and Mexico are streamlining and adapting ICF for routine reporting in home care, care of elderly populations, rehabilitation services, and disability evaluations. In the United States, ICF's use is concentrated among some groups of rehabilitation professionals, such as training occupational therapists.

Recognition of the ICF—if not its widespread use—may finally be growing in the United States. In its 2005–2006 activities, the Phase II Disability Work Group of the Consolidated Health Informatics (CHI) Initiative considered ICF for populating its Functioning and Disability Domain. (The CHI Initiative is a collaborative effort of the Departments of Health and Human Services, Defense, and Veterans Affairs to set uniform standards for electronic health information exchanges.) In a 2006 report, the National Committee on Vital and Health Statistics recommended ICF for a variety of purposes, noting its endorsement as a CHI standard and mapping to SNOMED CT terms.

In 2007, the Institute of Medicine (2007) recommended adopting ICF's conceptual framework in all U.S. efforts to monitor and measure population disability, although it acknowledged that a single definition of disability cannot meet all societal needs (e.g., disability insurance eligibility determinations). The IOM also recognized that aspects of the ICF coding scheme require further development. Finally, in 2009 the National Library of Medicine incorporated ICF and ICF-CY terms into UMLS, in partnership with WHO. This means that UMLS users can now link ICF terms with other classifications, terminologies, and vocabularies within UMLS.

Other Data Collection Approaches for Functioning and Disability

Meanwhile, for administrative purposes, CMS (and sometimes state Medicaid programs and private payers) has mandated extensive gathering of information about patients' functional status and disabilities in specific care settings. Nursing homes must gather this information using the Minimum Data Set (MDS); home health agencies must collect these data using the Outcome and Assessment Information Set (OASIS); and inpatient rehabilitation facilities (IRFs) must use the Patient Assessment Instrument (IRF-PAI) to collect these data. MDS, OASIS, and IRF-PAI data are each used by CMS to set prospective payment amounts and in some instances to assess quality of care. Although each method collects similar types of information, the tools have important differences, and various efforts over the years to streamline and homogenize these data-gathering approaches have not yet succeeded.

Section 723 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 required the DHHS to make Medicare data about beneficiaries with chronic conditions readily available to researchers. The resultant database, the Chronic Condition Warehouse (CCW), selected its longitudinal cohort using the 5 percent national Medicare sample from 1999 to 2004, with all beneficiaries within that cohort tracked continually over time. From 2005 forward, CCW contains information for 100 percent of enrolled Medicare beneficiaries with the targeted conditions. CCW uses diagnosis and procedure data on Medicare claims to identify 21 chronic conditions (e.g., acute myocardial infarction, Alzheimer's disease, breast cancer, depression, diabetes, glaucoma, heart failure, hip fracture, osteoporosis, and stroke). Most important, all information gathered using the MDS, OASIS, and IRF-PAI about these beneficiaries is merged onto the CCW data. The 2006 CCW contained 2.3 million Medicare beneficiaries. Although this database offers a rich source of functional information, all these data are derived during provision of specific services, raising the potential for bias relating to differences in service availability or use by individual patients.

RESEARCH RECOMMENDATIONS

HSR methods and findings will play central roles as health care reform efforts proceed. As mandated in ARRA, the government is investing heavily in CER, with leading policy makers asserting that new evidence about relative treatment effectiveness could save both money and lives (Pear 2009b). Similarly, as White House and Congressional leaders write legislation to reform Medicare and health care more generally, tying reimbursements to quality (e.g., national benchmarks) has gained currency (Pear 2009a). Both efforts must consider those patients who are growing in numbers and generate the greatest costs—persons with MCCs and disabilities (Wolff, Starfield, and Anderson 2002). Wennberg and colleagues (2007) suggest that building pay-for-performance incentives around providing effective care to patients with chronic conditions offers a critical strategy for improving overall efficiency of U.S. health care. Some dispute whether such efforts will indeed reduce costs (Marmor,

Table 2: Research Recommendations for Health Services Research (HSR) Concerning Multiple Chronic Conditions (MCCs) and Disability

Develop methods to systematically assess the effectiveness, efficiency, and quality of care that explicitly consider persons with MCCs and disabilities
Study the consequences of MCCs and disabilities in all comparative effectiveness research
When developing quality indicators for performance measurement, explicitly consider concerns relating to persons with MCCs and disabilities
Invest in training HSR investigators for transition to ICD-10-CM and ICD-10-PCS coding, with special focus on implications for persons with MCCs or disabilities
After transition to ICD-10-CM and ICD-10-PCS, monitor the completeness and accuracy of coded data relating to persons with MCCs and disabilities
Develop collaborative efforts to explore using ICF and ICF-CY for coding functional status disability data from EMRs or from administrative sources, such as mandated post-acute care data sets
Develop methods (e.g., using tools developed or disseminated by the National Library of Medicine) to automatically extract information from EMRs to provide information on MCCs and disability
Create and evaluate new models of care for persons with MCCs and disabilities that aim to improve quality and efficiency of care for this population

Oberlander, and White 2009), and studies about the results of pay-for-performance initiatives offer mixed results (Greene and Nash 2009). Nevertheless, given their extraordinary costs and intensive clinical needs persons with MCCs or disabilities must figure prominently in any reform proposal.

As suggested in the examples listed in Table 1, persons with MCCs or disabilities raise a range of issues that HSR could address, beyond the specific topics emphasized here. Most of these suggestions, however, require preliminary research looking at basic questions about treatment effectiveness for persons with MCCs or disabilities. Table 2 lists research recommendations targeting the issues addressed in this paper. With population trends suggesting that growing numbers of Americans will live with MCCs or disabilities in coming decades, a concerted HSR focus on these individuals is essential. Improving the efficiency and quality of health care are obvious goals, but so too is the imperative of improving quality of life and health outcomes for individuals with MCCs or disabilities.

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Review Article

Untangling the Concepts of Disability, Frailty, and Comorbidity: Implications for Improved Targeting and Care

Linda P. Fried,[1,2,3] Luigi Ferrucci,[3] Jonathan Darer,[4] Jeff D. Williamson,[5] and Gerard Anderson[2]

Departments of [1]Medicine, [2]Epidemiology, and [3]Health Policy and Management, The Johns Hopkins
University School of Medicine and Bloomberg School of Public Health, Baltimore, Maryland.
[4]Longitudinal Studies Section, Clinical Research Branch, National Institute on Aging, Bethesda, Maryland.
[5]Mid-Atlantic Permanente Medical Group, Baltimore, Maryland.
[6]Wake Forest University School of Medicine, Winston-Salem, North Carolina.

Three terms are commonly used interchangeably to identify vulnerable older adults: comorbidity, or multiple chronic conditions, frailty, and disability. However, in geriatric medicine, there is a growing consensus that these are distinct clinical entities that are causally related. Each, individually, occurs frequently and has high import clinically. This article provides a narrative review of current understanding of the definitions and distinguishing characteristics of each of these conditions, including their clinical relevance and distinct prevention and therapeutic issues, and how they are related. Review of the current state of published knowledge is supplemented by targeted analyses in selected areas where no current published data exists. Overall, the goal of this article is to provide a basis for distinguishing between these three important clinical conditions in older adults and showing how use of separate, distinct definitions of each can improve our understanding of the problems affecting older patients and lead to development of improved strategies for diagnosis, care, research, and medical education in this area.

IN 1990, an American Medical Association white paper concluded that "one of the most important tasks that the medical community faces today is to prepare for the problems in caring for the elderly in the 1990s and the early 21st century" (1). This report particularly emphasized the growing population of *frail*, vulnerable older adults, "the group of patients that presents the most complex and challenging problems to the physician and all health care professionals." The vulnerable subset of the older population has also been identified as those older adults with *multiple chronic conditions, or comorbidity* (2,3), or those who are *disabled or dependent* (4). In fact, these three terms, frailty, comorbidity, and disability, are often used interchangeably to identify the physically vulnerable subset of older adults requiring enhanced care. However, recent research supports geriatricians' perceptions that these are distinct clinical entities, although interrelated, and that clinical management of each of these has its own unique content and challenges. If this is the case, we would gain from defining how these concepts are distinct.

We posit that improved clarity as to definition and criteria for distinguishing these three conditions could improve diagnostic accuracy and development of effective, targeted strategies for prevention and treatment. To support this goal, this article offers, first, definitions for each of the three concepts based on current knowledge and supporting evidence, so as to distinguish them, and considers the challenges at present in establishing definitive criteria. Second, we describe the interrelationships of frailty, comorbidity, and disability. Third, we describe clinical presentations of these conditions and discuss the issues in clinical management for older adults who have each one, or two, or three of these conditions. Finally, we consider the future research questions that must be answered to further the applicability of these concepts to improving clinical practice and to facilitating clinical research.

MAJOR COMPONENTS OF HEALTH STATUS IN AN AGING POPULATION: THREE DISTINCT CONCEPTS

Disability

Disability is defined as difficulty or dependency in carrying out activities essential to independent living, including essential roles, tasks needed for self-care and living independently in a home, and desired activities important to one's quality of life (4,5). While disability is, in some contexts, defined as a social phenomenon (6), i.e., one's ability to carry out one's roles in life, it is also a medical entity. Physical disability is mostly diagnosed by self-report of difficulty in specific tasks, but objective, performance-based tests of function also exist. It is recommended by several organizations that clinicians screen for disability in self-care tasks (Activities of Daily Living, ADL) and tasks of household management (Instrumental Activities of Daily Living, IADL) on an annual basis in persons aged older than 70 years (7–9). In addition, new

Table 1. Characteristics of Moderately and Severely Disabled Women, Aged 65 to 101 Years, in the Community: The Women's Health and Aging Study I ($n = 1002$)

Characteristic	
Chronic diseases	
Mean no.	4.3
Range	1–13
Frail	28%
Disability (difficulty in task)	
Walking 2–3 blocks	74%
Meal preparation	19%
Using telephone	10%
Bathing	45%
Dressing	21%
Homebound	15%
Live alone	46%
Still drive	25%
Sensory impairment	
Trouble with blurred vision	37%
Not able to see well enough to recognize someone across the room	5%
Difficulty with hearing hampers personal or social life	9%

screening methods can be used to identify older adults at high risk of mobility difficulty (10).

Physical disability occurs frequently in older adults. An estimated 20%–30% of community-dwelling adults aged older than 70 years report disability in mobility, IADLs (tasks essential to household management, such as meal preparation, shopping, and managing money) and/or ADLs (basic self-care tasks, such as bathing, dressing, and eating); the frequency of disability rises steadily with age among those aged 65 years and older (5). To provide an example of the import of such disability in peoples' lives, Table 1 shows the frequency of difficulty with household and self-care tasks in the one third most disabled older women living in the community. Although perception of "difficulty" is the most frequently used definition of disability, in some instances disability is defined as the need for help from another person in performing essential tasks. This is particularly important for the most disabled, dependent subset of older adults, who reside in nursing homes: approximately 5% of those aged 65 years and older.

Physical disability in late life is, in the main, an outcome of diseases and physiologic alterations with aging, with the impact of these underlying causes modified by social, economic, and behavioral factors as well as access to medical care. Individual diseases, specific pairs of comorbid diseases, comorbid impairments (such as muscle weakness and balance decrements or decreased exercise tolerance), and frailty itself (see below) are identified risk factors for physical disability (11,12); these may act independently or, more often, in synergistic combinations. Approximately half of disability in older adults develops chronically and progressively in association with underlying severity of disease, comorbidity, and frailty; the other half develops acutely, or catastrophically, in association with acute clinical events such as hip fracture or stroke (13). While disability itself is an adverse health outcome, it is also a risk factor for other adverse events. Mobility disability predicts subsequent difficulty in IADLs and ADLs (14,15), and difficulty in these tasks is predictive of future dependency (16). Further, disability (defined as difficulty in these tasks), independent of its causes, is associated with an increased risk for mortality (17), hospitalization and high health care costs (see Table 2), need for long-term care (11,12), and higher health care expenditures (18).

Frailty

It is generally agreed that frailty is a state of high vulnerability for adverse health outcomes, including disability, dependency, falls, need for long-term care, and mortality. The challenges in finding a standard definition of frailty that could be widely recognized and valid in different settings makes any estimation of prevalence approximate and tentative. However, the American Medical Association has stated that as many as 40% of adults aged 80 years and older are frail (1). It is also thought that the vast majority of the 1.6 million elderly nursing home residents in the United States are frail (19). Thus, frailty occurs in a significant subset of older adults; if correct, this offers some evidence of its import. Because of the similarity with disability in associated outcomes (with the exception of frailty itself being a cause of disability), and the frequency of co-occurrence of frailty and disability (see below), there has been much definitional confusion between frailty and disability/dependency. However, there is increasing consensus that differentiating frailty from disability may improve our understanding of the aging process and offer new opportunities for prevention and care in clinical geriatrics. According to current views, frailty can be defined as a physiologic state of increased vulnerability to stressors that results from decreased physiologic reserves, and even dysregulation, of multiple physiologic systems. This decreased reserve results in difficulty maintaining homeostasis in the face of perturbations (20–24), whether they are extremes of environmental temperature, exacerbations of a chronic disease, an acute illness, or an injury. There are numerous systems in which such physiologic decrements in mass or function have been demonstrated with age, including neuromuscular, such as sarcopenia and decrease in muscle fiber function; osteopenia; dysregulation of the hypothalamic axis, of inflammation and of immune function; and even heart rate variability (21,24). Frailty is an *aggregate* expression of risk resulting from age- or disease-associated physiologic accumulation of subthreshold decrements affecting multiple physiologic systems. Although the early stages of this process may be clinically silent, when the losses of reserve reach an *aggregate* threshold that leads to serious vulnerability, the syndrome may become detectable by looking at clinical, functional, behavioral, and biological markers.

Central to the clinical definition of frailty has been the concept that no single altered system defines this state, but that multiple systems must be involved. The hypothesized subclinical dysregulations of frailty, as above, are under active investigation (24,25–32). However, it appears that these multisystem dysregulations become clinically apparent

Table 2. Utilization Patterns for Adults Aged 65 Years and Older With Comorbidity, With or Without Disability

Number of Chronic Conditions	Disability and/or Functional Limitation*	Total Inpatient and Medication Costs	Percent Hospitalized	Mean Number of Physician Visits	Mean Number of Home Care Visits	Mean Number of Prescription Drugs
None	No	$316	4%	2.1	0.1	2.7
None	Yes	$790	8%	3.0	4.5	6.4
2 or more	No	$2141	15%	8.0	1.2	19.4
2 or more	Yes	$4865	28%	10.2	27.7	23.5

Notes: *Disability and/or functional limitation defined in Medicare Expenditure Panel Survey as physical or mental impairments with or without substantial limitation or disability in 1 or more major life activities. Specifically, this included any of the following: 1) need for help or supervision with any activities of daily living or instrumental activities of daily living; 2) use of assistive technology; 3) difficulty walking, climbing stairs, grasping objects, reaching overhead, lifting, bending or standing for long periods of time; 4) any limitation in work, housework or school; 5) social/recreational limitations; 6) cognitive limitations such as confusion or memory loss, problems making decisions, or requiring supervision for their own safety; 7) deafness or difficulty hearing (5).

From 1996 Medicare Expenditure Panel Survey.

either when unmasked by stressors or in a clinical phenotype of a final common pathway (21,22). Clinical consensus as to that phenotype has been reported by numerous authors to include wasting (both loss of muscle mass and strength, and weight loss), loss of endurance, decreased balance and mobility, slowed performance and relative inactivity, and, potentially, decreases in cognitive function (21,34).

These clinical observations were systematically assessed (by L.F. and J.D.W.) in a survey of geriatricians at six academic medical centers at Wake Forest University, Mt. Sinai School of Medicine, University of Tennessee, Saint Louis University, Johns Hopkins University, and Oxford University (Britain). A standardized, self-administered questionnaire was distributed by one local member to all geriatricians in their program, and then returned by mail to the developers of the survey (L.F. and J.D.W.). There was 100% response by 62 geriatricians. In this survey, we first asked the respondents whether frailty and disability were the same (21). As shown in Table 3, 98% of responding geriatricians stated that frailty and disability are separate clinical entities; rather, they thought them causally related. Among these same geriatricians, 97% supported a statement that frailty involves the concurrent presence of more than one characteristic. At least 50% cited each of the following characteristics as likely to be observed in association with frailty (in descending order): undernutrition, functional dependence, prolonged bed rest, pressure sores, gait disorders, generalized weakness, aged >90 years, weight loss, anorexia, fear of falling, dementia, hip fracture, delirium, confusion, going outdoors infrequently, and polypharmacy.

To explore thresholds for clinical identification of a patient as frail, these geriatricians were presented with standardized case scenarios developed for this purpose (by L.F. and J.D.W.). In these, they were asked to rank a series of clinical profiles as to the likelihood of frailty, scored on a scale from 0 (not frail) to 100 (frail). The results are presented in Table 4 for several representative profiles, displaying the aggregate mean scores from the respondents. The results support the impression that clinicians identify "frailty" in the presence of a critical mass of consequences of disease and aging-related changes, including: a) generalized weakness, b) poor endurance, c) weight loss and/or undernourished, d) low activity (even homebound), and e) fear of falling and/or unsteady gait. Individual diseases were not sufficient for identification of those who were frail, nor were any two disease(s), or disability alone. In the presence of disease, other manifestations—which may or may not be a result of the disease—must also be present to constitute frailty clinically. Cognitive compromise may also be a component of frailty in some persons, although its role is less well defined. In sum, geriatricians' perceptions suggest that a critical mass of impairments or geriatric conditions add up to the phenotype of frailty, more than any one condition or disease.

All of the above findings indicate that frailty is a distinct entity recognized by clinicians, with multiple possible manifestations and no single manifestation, by itself, being sufficient or essential in the presentation. This definition is consistent with that of a medical syndrome (35). Building on the clinical consensus and research evidence to date, a phenotype of the clinically frail older adult was recently operationalized, based on the presence of a critical mass of three or more core "frail" elements, with the core entities being weakness, poor endurance, weight loss, low physical activity, and slow gait speed (21,23). This definition was tested in the Cardiovascular Health Study, a sample of 4317 community-dwelling adults aged 65 years and older who lived in four communities in the United States (23). Seven percent of community-dwelling adults aged over 65 years in this population were frail; the proportion increased steadily with age, up to 30% of those aged 80 years and older. To offer criterion validity for this definition, it was demonstrated that the presence of frailty significantly predicted disability and other adverse outcomes in older adults. This is shown in Table 5: Frailty predicted 3-year incidence or progression of disability in both mobility and ADLs, independent of comorbid diseases, health habits, and psychosocial characteristics (23). These findings provided evidence that frailty, as defined, is a separate entity and an independent cause of physical disability.

Table 3. Geriatricians' Position on the Relationship Between Frailty and Disability ($N = 62$)

	Response		
		Yes (%)	
Question	No (%)	Sometimes	Usually/Always
Are frailty and disability the same?	97.5	2.5	—
Is disability a cause of frailty?	12.5	75.0	12.5
Is frailty a cause of disability?	10.0	50.0	40.0

Table 4. Geriatricians' Ranking of the Likelihood of Frailty* for Specific Clinical Profiles: Survey of Geriatricians at 6 Medical Schools (U.S. and Britain, $N = 62$)

Clinical Profile	Frailty Score (Mean ± *SD*)*
A. 1. Arthritis; independent in ADLs and IADLs	13.6 ± 20
2. 1. plus depression	25.3 ± 17
3. 1. plus anxiety about gait stability/security (no falls)	28.3 ± 19
4. 1. plus poor stamina, goes outdoors infrequently	45.9 ± 23
5. 3. plus history of 2 falls in past 4 months	52.3 ± 23
B. 1. Systolic Hypertension	5.8 ± 13
2. 1. plus arthritis	12.6 ± 14
3. 2. plus diabetes, well controlled on oral agents	15.3 ± 16
4. 3. plus fatigues on performance of ADLs	30.1 ± 20
5. 4. plus mild dementia (MMSE = 25)	40.1 ± 23
6. 5. plus gait unsteady; in bed or chair most days	64.6 ± 24
C. 1. Dementia (MMSE = 20); dependent in IADLs; independent in ADLs	30.2 ± 22
2. 1. plus generalized weakness; goes outdoors infrequently	48.3 ± 22
3. 2. plus unintended weight loss of 20 lbs.	74.3 ± 20
D. 1. Excessive fatigue with:	
a. heavy housework (e.g., vacuuming)	18.5 ± 18
b. walking around the block	22.3 ± 20
c. climbing 2 flights of stairs	22.4 ± 19
d. light housework (e.g., dusting)	27.8 ± 19
e. making a bed	31.6 ± 20
f. walking around the house	31.8 ± 21
2. Steadies self with furniture or shopping cart when walking around home or shopping	36.6 ± 23
E. 1. Unintended weight loss (20 lbs)	30.3 ± 22
2. 1. plus fear of falling	42.6 ± 22
3. 1. plus weakness and secondary difficulty with ADLs	66.1 ± 21
F. 1. Osteoporosis; history of single compression fracture	21.3 ± 20
2. 1. plus generalized weakness	37.3 ± 23
3. 2. plus has fallen 2 times in past 3 months	60.2 ± 23
4. 3. plus unintended 20 lb weight loss	79.1 ± 23
G. 1. Anxiety about gait stability and security; fear of falling; goes outdoors infrequently (once a week); appetite good	40.4 ± 23
2. 1. plus poor appetite, 20 lb weight loss	63.6 ± 24
H. 1. Occasional urinary incontinence	5.8 ± 13
2. 1. plus unsteady gait	32.5 ± 20
3. 1. plus undernourished	45.9 ± 23
4. 3. plus difficulty with ADLs due to weakness	76.0 ± 18

Notes: *Frailty score = mean of all scores assigned by 62 geriatricians for probability of frailty in a given case scenario, with probability range from 0 (not frail) to 100% (frail).

SD = standard deviation; ADL = activities of daily living; IADL = instrumental activities of daily living; MMSE = Mini-Mental State Exam.

Comorbidity

At first blush, comorbidity should be the most straightforward concept to define medically, compared with disability and frailty. Its formal definition is the concurrent presence of two or more medically diagnosed diseases in the same individual, with the diagnosis of each contributing disease based on established, widely recognized criteria. In this sense, the concept of comorbidity could be viewed as an interface between the geriatric paradigm of health and the more traditional medical definition of disease. With aging, the presence of comorbidity increases markedly, in large part because the frequency of individual chronic conditions rises with age. For example, after age 65, 48% of community-dwelling persons in the United States report arthritis, 36% hypertension, 27% heart disease, 10% diabetes, and 6% a history of stroke (2,5). As a result of these prevalences, 35.3% of the population in the United States at ages 65–79 reports two or more diseases, and this reaches 70.2% at age 80 years and older (36). Analysis of Medicare claims data shows that two thirds of all beneficiaries aged older than 65 years have two or more chronic conditions, and one third have four or more (37). Comorbidity is associated with high health care utilization and expenditures (Table 2), with 96% of annual Medicare spending attributable to beneficiaries with multiple chronic conditions (37). Additionally, comorbidity heightens the risk of disability and mortality, over and above the risk from individual diseases (11,12,17,38–40). Particular pairs of chronic diseases are prevalent, and are synergistic in increasing risk for disability (38–40). For example, the concurrent presence of heart disease and osteoarthritis of the knee increased the relative risk of developing mobility disability to 13.6, from a relative risk of 4.4 for those with osteoarthritis alone, or 2.3 for those with heart disease alone (compared to those with neither disease) (40).

As shown in Figure 1, using the standard definition of comorbidity in the Cardiovascular Health Study data described above, the presence of two or more diseases can be shown to identify a different, though overlapping, subset of the population than does the definition of frailty or the definition of disability, in this case by difficulty in one or more ADLs. Overall, of the 368 participants (of 4317) who were frail, 27% reported disability in one ADL (with or without comorbidity) and 68% reported having two or more chronic conditions (with or without disability); 21% of those who were frail were also disabled and had comorbid disease (23). Thus, these definitions offer distinction of these conditions and evidence for their co-occurrence.

Recent work developed in clinical geriatrics suggests that comorbidity could be thought of as occurring at multiple physiologic/pathophysiologic levels, beyond just that of clinically diagnosed diseases. For example, researchers are increasingly evaluating the interactions of concurrently present impairments, such as strength and balance (41) or vision and hearing (Windham BG, et al. Unpublished observations), or biomediators, such as interleukin-6 and insulin-like growth factor-I (42), in contributing to downstream outcomes of frailty and disability. In fact, it is also possible that a clinical disease can be undiagnosed due to atypical or silent presentation or subclinical status, but contribute substantially to the burden of comorbidity. As a consequence of this work, we are starting to understand that current definitions of comorbidity based on diseases that are fully manifest should be revisited. If the value of considering comorbidity is capturing the synergistic interactions that lead to worsened outcomes than would be found from just the additive effects of the individual conditions alone, then comorbidity should, theoretically, involve interactions between any two conditions, even of clinical or subclinical

Table 5. Baseline Frailty Status Predicting Disability, Falls, Hospitalizations, and Death over 3 Years: Community-Dwelling Men and Women Aged 65 Years and Older, Cardiovascular Health Study

	Hazard Ratios* Estimated Over 3 Years Frail*** (Versus Not Frail)
Worsening mobility disability	1.50**
Worsening ADL disability	1.98**
Incident fall	1.29**
First hospitalization	1.29**
Death	2.24**

*Cox proportional hazards models, covariate adjusted (Ref. 17, reprinted with permission).

**$p \leq .05$.

***Frailty is defined as the presence of 3 or more characteristics among weight loss ≥10 lbs in past year, weak grip strength (lowest quintile), exhaustion (by self-report), slow gait speed (slowest quintile), and low physical activity (lowest quintile).

ADL = activity of daily living.

diseases with impairments or physiologic biomediators. This issue leads to more questions than answers at this point. However, given that both comorbidity (38–40) and frailty (23) are independent risk factors for disability, perhaps at this time we can think about comorbidity as the aggregation of clinically manifest diseases present in an individual, and frailty as the aggregate of subclinical losses of reserve across multiple physiologic systems.

Interrelationships of Disability, Frailty and Comorbidity

Thus, as demonstrated epidemiologically (Table 5 and Figure 1), frailty is distinct from, but overlapping with, both comorbidity and disability. In addition, both frailty and comorbidity predict disability, adjusting for each other; disability may well exacerbate frailty and comorbidity, and comorbid diseases may contribute, at least additively, to the development of frailty. Early data from the Cardiovascular Health Study also suggest that the presence of disability or frailty could contribute to development or progression of chronic diseases, possibly through the lower activity levels associated with the former two conditions, or through other pathways affecting some basic biological mechanism essential to the maintenance of homeostasis, such as inflammation, or sympathetic–parasympathetic equilibrium (25,26). These causal relationships provide explanation for the frequent co-occurrence of these conditions, and suggest the clinical importance of differentiating them so as to identify appropriate interventions that could prevent one condition, given that its precursor is present.

Thus, there are causal interrelationships that can help explain why these three entities are likely to co-occur. A clinical manifestation of this co-occurrence is the high likelihood of finding a greater proportion of frail persons among those who are disabled than among the nondisabled; this is supported in data from the Women's Health and Aging Study, in which 28% of this moderately to severely disabled population of women aged 65 years and older living in the community were frail, compared to 7% of a healthier subset of older women in the Cardiovascular Health Study (Boyd CM, et al. Unpublished observations).

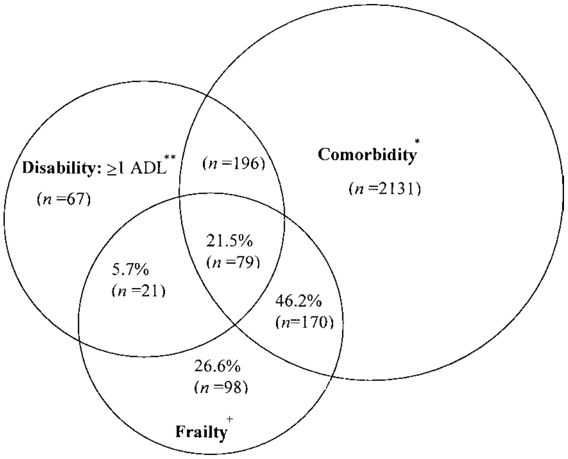

Figure 1. Prevalences—and overlaps—of comorbidity, disability, and frailty among community-dwelling men and women 65 years and older participating in the Cardiovascular Health Study (Ref. 23, reprinted with permission). Percents listed indicate the proportion among those who were frail ($n = 368$), who had comorbidity and/or disability, or neither. Total represented: 2762 participants who had comorbidity and/or disability and/or frailty. $^{+}n = 368$ frail participants overall. $^{*}n = 2576$ overall with 2 or more of the following 9 diseases: myocardial infarction, angina, congestive heart failure, claudication, arthritis, cancer, diabetes, hypertension, chronic obstructive pulmonary disease. Of these, 249 (total) were also frail. $^{**}n = 363$ overall with an activity of daily living disability; of these, 100 (total) were also frail.

The Complexity of Medical Care for Patients With Comorbidity, Frailty, and/or Disability

Why should we care clinically that not all frail patients are disabled, not all disabled patients are frail, and comorbidity may or may not be present with these? One reason is that comorbidity, frailty, and disability each confer specific care needs in older patients (see Figure 2), and the complexity of health care needs and necessity for coordination of care among multiple providers and services increases with the number of these conditions present. The second is that prognosis differs for each condition. We address, first, the treatment issues for each condition, independently, as a basis for describing the additive complexity when multiple conditions are present, and then address prognosis.

Regarding patients with *comorbid conditions*, it is recognized that specialized care focused on a single disease can lead to inadequate attention to other illnesses present (43). Beyond recognition and treatment appropriate for each condition, there can be complications due to competition or clinical interactions between conditions. Evidence-based protocols for treatment of a given disease may indicate the use of medication and treatment regimens that may be beyond the patient's tolerance or ability to comply due to other comorbid diseases that are present, as when dementia (or depression) can limit ability to adhere to treatments selected for other diseases (43,44). The treatment for one disease can also adversely affect the other, as in the case of antidepressant or vasodilator medications that may increase fall risk (45,46), or the use of nonsteroidal antiinflammatory

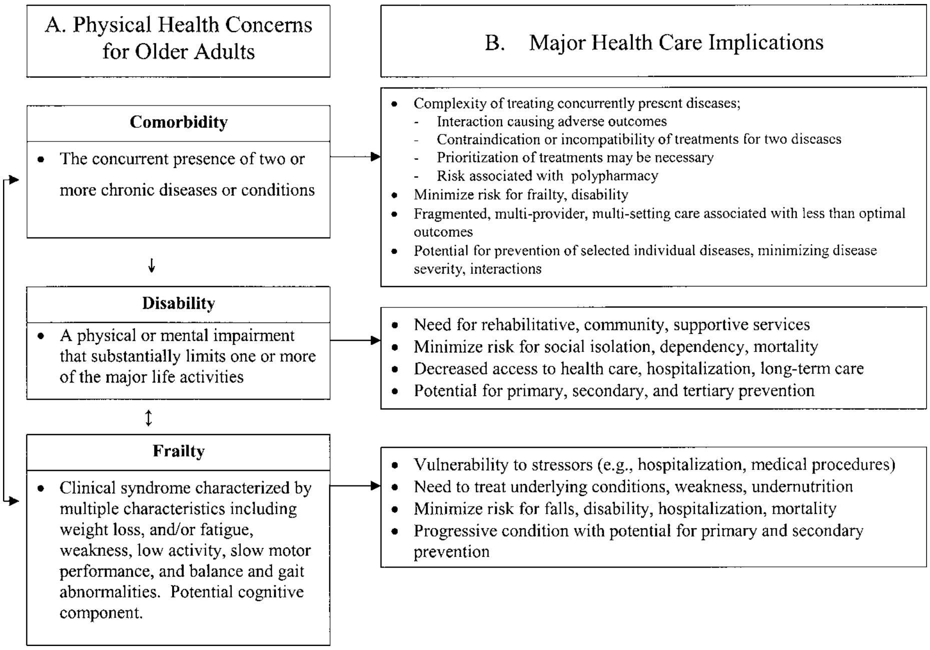

Figure 2. Comorbidity, disability, and frailty: definitions and major health care implications. Theoretical pathway showing the relationships between comorbidity, disability, and frailty and summarizing the health care implications of each condition.

drugs to treat arthritis, which could also exacerbate gastritis (47). In some cases, it may be necessary to prioritize the diseases requiring treatments because all those indicated may not be feasible, simultaneously, for the patient. In another variant of this issue, in patients with poor short-term prognoses due to other health conditions, it may be inappropriate to implement treatments recommended by clinical guidelines for a given condition because the patient is unlikely to experience any short-term benefit from a treatment (as, perhaps, in use of statins in a patient with a terminal illness) (48). In each of these situations, clinical attention to these dynamics between comorbid diseases could improve overall outcomes and decrease adverse sequellae, as well as minimize medical regimens that may be unlikely to improve outcomes within the patient's life expectancy. Overall, in the face of comorbidity, the care of patients becomes predictably complex.

Medical care for *disability* heavily involves rehabilitation to minimize compromised function, regain function, or prevent further decline. The patient may be unable to ambulate or drive, or may need assistive devices or human assistance in the home or outside activities, and community services such as transportation to health care or "Meals on Wheels." Disabled older adults are also at risk for other adverse outcomes such as social isolation, dependency, and the need for long-term care, each necessitating appropriate interventions. When patients are disabled, needs for medically related services increase while their ability to navigate the health care system without help may decrease. Care of disabled older adults, often in the setting of comorbid diseases, requires coordination of medical care among multiple providers, and services to compensate for losses in function—such as meal provision—to maintain the patients in their homes. Finally, decreased activity resulting from disability might increase risk for onset of new chronic diseases or initiation of frailty.

Frail patients also appear to have specific care needs, beyond care of underlying or coincident comorbidities and associated disability, as above. Medical care for frail older adults needs to include ruling out, and treatment of, pathologic causes of progressive weakness, weight loss, decreased exercise tolerance, slowed task performance (i.e., walking speed), and/or low activity. Underlying diseases that could be causing secondary frailty could range from depression to congestive heart failure, hypothyroidism, or tumors (21). Treatment should include attention to minimizing further loss of weight, muscle mass, and strength, which are hallmarks of frailty and risk factors for resulting disability. Randomized trials indicate that even the frailest nursing home patients can benefit from resistance exercise, with almost two-fold increases in lean body mass and resulting improvements in strength, exercise tolerance, and walking speed, and even greater improvements with the addition of nutritional supplements (49). Additionally, frail older adults clinically appear to have lower ability to tolerate stressors such as medical procedures or hospitalization (Boyd CM, et al. Unpublished observations), which may place them at risk for disability or other adverse outcomes, relative to others their age. Rehabilitation of frail older patients with disability presents special challenges. Frailty is characterized by wide fluctuations of health status and high risk of acute complications (e.g., infection) that can interrupt, multiple times, the recovery program, negatively impact the functional progress, and greatly increase the health care cost. Intensive and frequent medical surveillance of these patients, aimed at preventing acute fluctuations in health status, may allow more effective rehabilitation and strongly affect the prognosis of these patients. These observations may warrant screening to identify frail older adults, so as to minimize risk from such stressors, to prevent adverse outcomes for which a frail older adult is vulnerable, including decompensation with acute illness or injury, falls, hospitalization, disability, and mortality, or to intervene quickly to prevent a spiral of physiologic decline.

It is not uncommon for older adults to concurrently have comorbid diseases and be frail and/or disabled. The frequency, illness burden, and limitations associated with having these multiple conditions are exemplified by the representative sample of moderately to severely disabled, community-dwelling women aged 65 to 101 years who participated in the Women's Health and Aging Study I (Table 1) (50). In this cohort, 74% reported difficulty walking 2 to 3 blocks and 15% were homebound. They had an average of 4.3 chronic diseases and 28% were frail. This population is at high risk of social isolation due to sensory and mobility impairments (11). Observing all of the health issues simultaneously at play in these disabled older women in the community offers insight into the complex health care needs for this population. They also highlight the simultaneous necessities to minimize the severity of multiple chronic diseases, promote the maintenance of function, and prevent further frailty, functional decline, and loss of independence. These simple data also exemplify some of the issues for disabled older adults that can lead to difficulty in organizing or traveling to health care, such as mobility and sensory decrements. Thus, in this subset of community-dwelling older adults, the care of patients becomes quite complex.

Prognostic Implications of Frailty, Comorbidity, and Disability

Each of these three conditions has serious prognostic implications independent of the others. Each condition is also independently associated with increased health care needs and costs, including hospitalization risk (18,23,37, 51,52). When two of these health conditions are present, there can be additive or synergistic effects on health costs and utilization. This is demonstrated by analyses we conducted of the 2455 persons aged 65 years and older assessed in the Medical Expenditure Panel Survey 1996 data (a national random survey of 22,061 Americans) (53), assessing the relationship of health care utilization and cost with number of chronic conditions (none vs two or more) and with a standard, joint measure of disability and functional limitations. As shown in Table 2, costs for inpatient care and medications for older adults with two or more chronic conditions and a disability were five-fold greater than for those with disability alone, and over two-fold greater than for those with comorbidity alone. There are similar relationships for rates of hospitalization and number of prescription drugs, while use of home care occurs almost exclusively among those with *both* comorbidity and disability (53). These findings give additional weight to the argument that comorbidity and disability, while having distinct and important influences on the health of older adults, also have aggregate effects.

Opportunities for Prevention

Another important reason for distinguishing the three conditions is mounting evidence that each is preventable, but requiring different interventions. Based on evidence that physical disability in older adults is preventable (11,12, 49,54), disability prevention, with attendant screening, diagnosis, and treatment, has entered the province of primary care providers as well as the rehabilitation specialist. Screening older adults for those at high risk of disability (7,8,10) and for reversible risk factors (11,12) may identify persons who would benefit from specific interventions. Many chronic diseases—such as cardiovascular disease—also are preventable into the oldest ages, and thus comorbidity can also potentially be diminished. Frailty, as well, has potential for prevention, both from the evidence above regarding resistance exercise being effective in increasing lean body mass (49), and because new evidence indicates that frailty is a progressive condition that begins with a preclinical stage (23), thus offering opportunities for early detection and prevention.

Import of Diagnosis and Treatment of Each of Frailty, Comorbidity, and Disability

An individual can be experiencing, simultaneously, multiple symptoms of comorbid diseases, difficulty doing valued or necessary ADLs, and the progressive weakness and vulnerability associated with frailty. As shown above, they may also cause or exacerbate each other. For example, disability may limit ability to access, or comply with, health care, and thus lead to an increase in unrecognized and untreated health needs. Additionally, decreased activity or nutritional intake due to disability could increase risk of specific diseases or of frailty. The causal interconnectedness of these conditions, as well as their co-occurrence, makes diagnosis and treatment of each condition that is present important to improving overall health outcomes for older adults. Clinical outcomes for these patients will likely benefit from improving our ability to differentiate these entities and target therapies.

Health status evolves as people age, and the health care needed evolves as well. With the accumulation of these three composite conditions affecting health outcomes in an aging population, the complexity of health status associated with two or three of these conditions concurrently being present can lead to the need for multiple health care providers, caregivers, and community services, and to rapid changes in health status over time. Together, these necessitate effective coordination of care between providers or sites of care. The challenge to the physician and to the health care system generally, in caring for these complex patients, should not be underestimated (see Figure 2). Future research needs to build on this evolving ability to distinguish disability, frailty, and comorbidity, to refine their definitions and criteria, to develop standardized approaches to screening and risk assessment, and to gain knowledge of interventions to prevent onset and adverse outcomes for each condition.

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Address correspondence to Linda P. Fried, MD, MPH, Center on Aging and health and the Division of Geriatric Medicine and Gerontology, The Johns Hopkins Medical Institutions, 2024 E. Monument Street, Suite 2-700, Baltimore, MD 21205. E-mail: lfried@jhmi.edu

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Editor Nominations

Journal of Gerontology: Medical Sciences

The Gerontological Society of America's Publications Committee is seeking nominations for the position of Editor of the *Journal of Gerontology: Medical Sciences.*

The position will become effective January 1, 2005. The Editor makes appointments to the journal's editorial board and develops policies in accordance with the scope statement prepared by the Publications Committee and approved by Council (see the journal's masthead page). The Editor works with reviewers and has the final responsibility for the acceptance of articles for his/her journal. The editorship is a voluntary position. Candidates must be dedicated to developing a premier scientific journal.

Nominations and applications may be made by self or others, but must be accompanied by the candidate's curriculum vitae and a statement of willingness to accept the position. **All nominations and applications must be received by May 1, 2004.** Nominations and applications should be sent to the GSA Publications Committee, Attn: Jennifer Campi, The Gerontological Society of America, 1030 15th Street, NW, Suite 250, Washington, DC 20005-1503.

ENDORSEMENT SUMMARY: Multiple Chronic Conditions Measurement Framework

MAY 2012

Purpose of the Project

People with multiple chronic conditions (MCCs) now comprise over one-quarter of the U.S. population. As the population ages in coming decades, that percentage is expected to grow. This population is at significantly higher risk of adverse outcomes and complications. They are also more likely to see multiple clinicians, take five or more medications, and receive care that is fragmented, incomplete, inefficient, and ineffective. As a result, MCCs are associated with higher healthcare costs and utilization rates, and individuals with MCCs are at increased risk for potentially avoidable inpatient admissions and preventable hospital complications.

Despite the growing prevalence of MCCs and associated complications, existing quality measures largely do not address individuals with MCCs. As a result, in June 2010 NQF – under contract with the Department of Health and Human Services (HHS) – convened a multi-stakeholder steering committee to develop a measurement framework for individuals with MCCs. The steering committee's work was informed by several important national initiatives spearheaded by HHS and public-private sector initiatives, including HHS's Multiple Chronic Conditions Strategic Framework, the National Quality Strategy, and the National Priorities Partnership, among others.

This framework will serve as a guide for future NQF-endorsement decisions for measures that address the MCC population. Specifically, the framework:

- Establishes a definition for MCCs in order to achieve a common understanding and a shared vision for effectively measuring the quality of care for individuals with MCCs;
- Identifies high-leverage measurement areas for the MCCs population in an effort to mitigate unintended consequences and measurement burden;
- Presents a conceptual model that serves as an organizing structure for identifying and prioritizing quality measures; and
- Offers guiding principles to address methodological and practical measurement issues.

In addition, the report identifies several timely strategic opportunities for applying the framework that are relevant to current policy context. These include: a coordinated approach for filling measure gaps; building a common data platform to consistently and seamlessly collect information, including patient-reported data; opportunities to apply the core tenets of the framework as new delivery models are implemented and tested; and transparency through public reporting to enable informed consumer decision-making.

Components of the Framework

The MCC framework endorsed by NQF includes several core components:

DEFINITION OF MULTIPLE CHRONIC CONDITIONS

MCCs are defined in a multitude of ways in literature and in practice. Widespread adoption of a standardized definition will help align quality measurement initiatives across the healthcare spectrum. As a result, the steering committee built upon previously established definitions from HHS and the Agency for Healthcare Research and Quality and defined MCCs to be:

Persons 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.

NATIONAL QUALITY FORUM

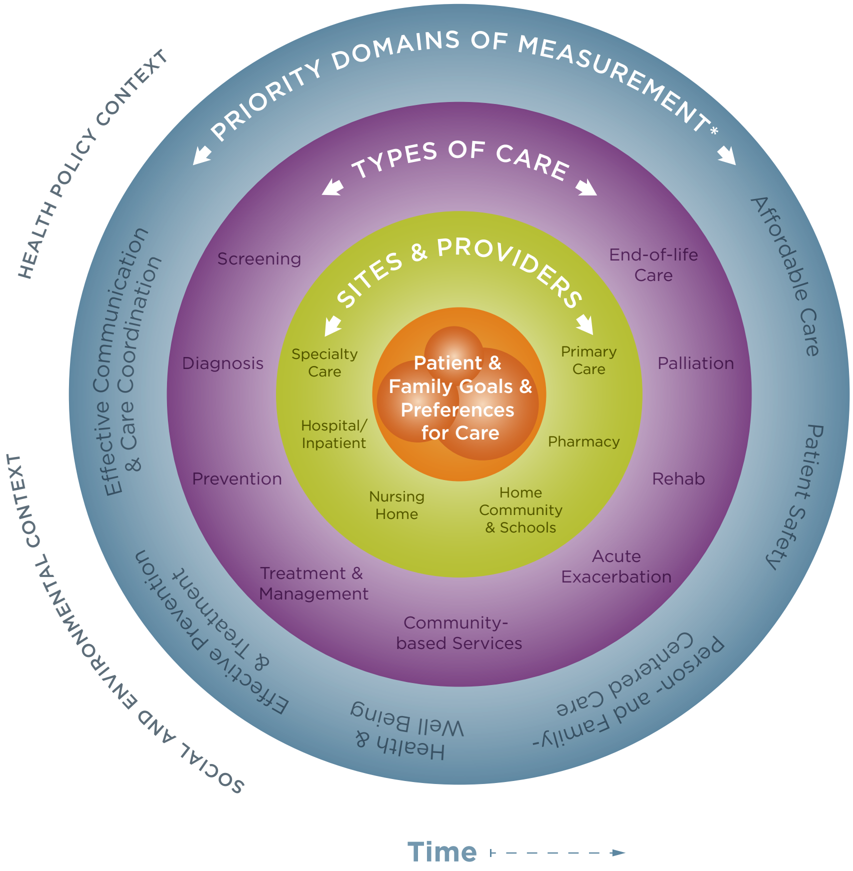
KEY MEASUREMENT CONCEPTS

Strict adherence to disease-specific measures for patients with MCCs may lead to the unintended consequences of delivering inappropriate care that is not aligned with patient goals and preferences. Additionally, applying numerous measures targeting a variety of diseases could lead to high measurement burden. Therefore, the steering committee sought to identify the highest-leverage measurement areas for the MCC population in an effort to mitigate these two important concerns. The committee's selection criteria was based on identifying cross-cutting areas that offer the greatest potential for reducing disease burden and cost and improving well-being, and are valued most by patients and their families. The final measure concepts include:

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

CONCEPTUAL MODEL FOR MEASURING CARE PROVIDED TO MCC INDIVIDUALS

The steering committee's measurement priorities set the stage for the development of a conceptual model to guide measurement for individuals with MCCs. This model is designed to illustrate the complexity of providing care for these individuals by showing the various ways that conditions, patient and family preferences, sites and providers of care, and types of care interact. Also represented in the model are the social and environmental context in which the individual lives and receives care and the public and private health policy priorities that guide care delivery.



* 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.

Please see the full report for a further explanation of the conceptual model.

GUIDING PRINCIPLES

In considering implementation challenges for the conceptual model and measure concepts, the steering committee adopted the following guiding principles:

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, while aligning across various public- and private-sector applications, such as public reporting and payment.
2. Assess the quality of care and incorporate several types of measures including cross-cutting, condition-specific, structure, process, outcomes, efficiency, cost/resource use, composites, and behavioral; and that address appropriateness of care.
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 (care provided over extended periods of time) and changes in care over time (delta measures of improvement or maintenance rather than attainment).
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.
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, particularly patient-reported data, to ensure key outcomes of care (e.g., functional status) are assessed and monitored over time.

The guiding principles address methodological considerations including assessment of care across episodes, measure prioritization, and the infrastructure needed for data collection. These methodological considerations are further discussed in the final report.

The Future of Quality Measurement for MCCs

The MCC framework will need to evolve over time as it is implemented in real-life settings. It will be critical to have a feedback loop to capture experiences from the field to further refine the approaches recommended within.

The forward-looking considerations for applying this framework lay out a pathway toward providing patient-centered, efficient care to people with MCCs. This pathway will be critical to achieving the aims of the National Quality Strategy – better care, healthy people and communities, and affordable care.

For further explanation of the MCC framework, please see the final report.

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WASHINGTON, DC 20005
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